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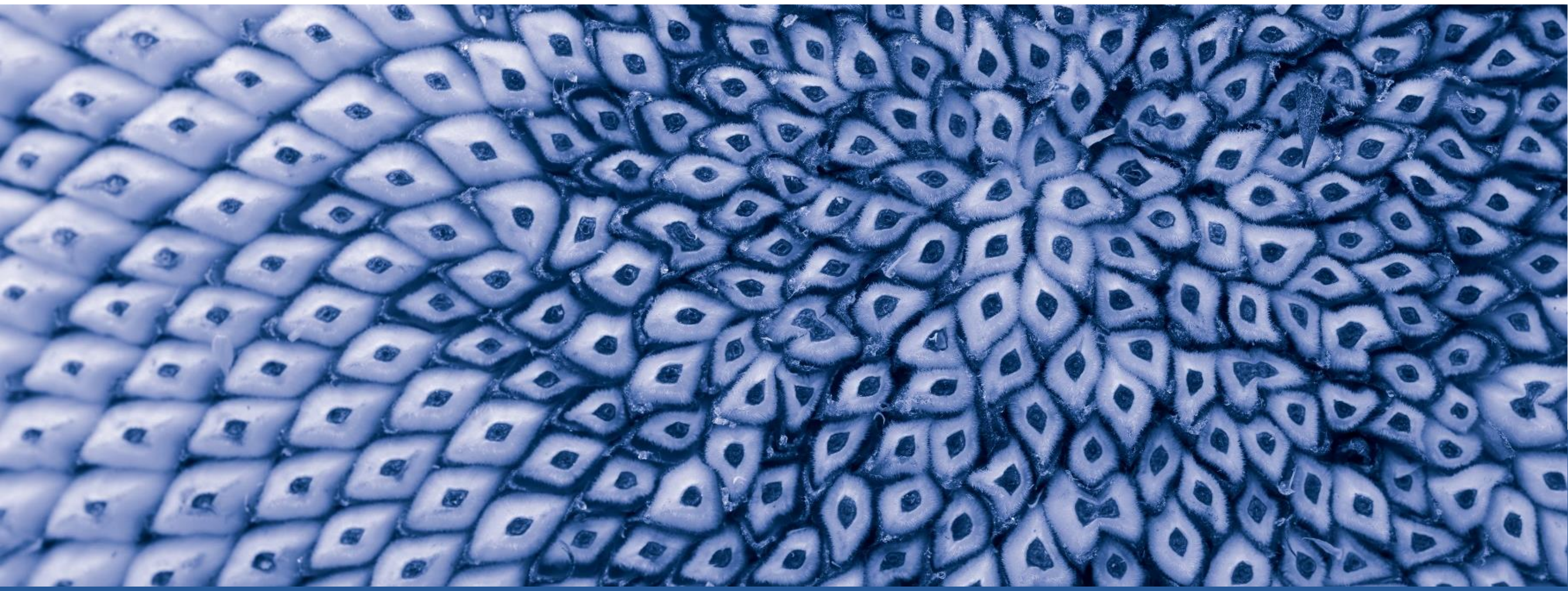

Senate Select Committee on Work and Care

Productivity Commission submission

The Productivity Commission acknowledges the Traditional Owners of Country throughout Australia and their continuing connection to land, waters and community. We pay our respects to their Cultures, Country and Elders past and present.

The Productivity Commission

The Productivity Commission is the Australian Government's independent research and advisory body on a range of economic, social and environmental issues affecting the welfare of Australians. Its role, expressed most simply, is to help governments make better policies, in the long term interest of the Australian community.

The Commission's independence is underpinned by an Act of Parliament. Its processes and outputs are open to public scrutiny and are driven by concern for the wellbeing of the community as a whole.

Further information on the Productivity Commission can be obtained from the Commission's website (www.pc.gov.au).

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Productivity Commission submission to Senate Select Committee on Work and Care

The Productivity Commission (Commission) is pleased to make this submission to the Senate Select Committee on Work and Care.

The Commission is the Australian Government's independent research and advisory body on economic, social and environmental issues affecting the wellbeing of Australians. We contribute by providing quality, independent advice and information to governments, and on the communication of ideas and analysis.

The core function of the Commission is to conduct public inquiries at the request of the Australian Government on key policy or regulatory issues that affect Australia's economic performance and community wellbeing. In addition, we undertake research at the request of the Government and to support its annual reporting, performance monitoring and other responsibilities.

Although the Commission has not published research that relates specifically to the interactions between work and care, several reports published over the last decade address some aspects of the issue (figure 1). The reports into the mental health system, childcare services, services provided to older Australians and the National Disability Agreement are particularly relevant and still current. We summarise some observations from the Commission reports below and refer the Committee to the original reports for more detail.

The Commission is also undertaking inquiries into carer leave and aged care employment which are relevant to the Senate Select Committee on Work and Care.

Figure 1 – The Commission's published reports on work and care

The Commission has looked at carers of:

Children	People with mental illness	People with disability	Older people
***Childcare and Early Childhood Learning* (2014)**	***Mental Health* (2020)**	***Disability Care and Support* (2011)** ***National Disability Insurance Scheme (NDIS) Costs* (2017)** ***Review of the National Disability Agreement* (2019)**	***Caring for Older Australians* (2011)** ***Aged care employment* (2022 *forthcoming*)** ***Carer leave* (2023 *forthcoming*)**

All these groups were affected by COVID-19
***Working from home* (2021)**

The annual *Report on Government Services* provides quantitative information on services used by these groups and by carers

1. Who are the carers, who are they caring for and how do they balance work and care?

This section relates to terms of references a, b, g, h, and e (box 1).

Box 1 – Terms of reference addressed in this section

a. The extent and nature of the combination of work and care across Australia and the impact of changes in demographic and labour force patterns on work-care arrangements in recent decades.

b. The impact of combining various types of work and care (including of children, the aged, those with disability) upon the well-being of workers, carers and those they care for.

g. Consideration of gendered, regional and socio-economic differences in experience and in potential responses including for First Nations working carers, and potential workers.

e. Consideration of the impact on work and care of different hours and conditions of work, job security, work flexibility and related workplace arrangements.

h. Consideration of differences in experience of disabled people, workers who support them, and those who undertake informal caring roles.

Informal carers provide unpaid care and support to family members and friends. They are distinct from people who are employed or contracted to provide care (in-home or residential care workers). Informal carers are an integral part of the care system in Australia; their work complements (and in some cases substitutes for) the care that formal carers provide.

People who are cared for can be split into broad groups, although there is some overlap between them.

- **Children**. Almost all of Australia's 4.7 million children (0-14 years) have participated in some form of early childhood education and care (ECEC), and for around half of these, formal or informal ECEC is the usual type of care. For just under half of all children, the usual form of care is likely to be parental-only (updated from PC 2014, pp. 96–97).
- **People with disability, a long-term health condition and older people**. The ABS Survey of Disability, Ageing and Carers estimated that were 2.6 million informal carers in Australia in 2018, including 862,000 primary carers (PC 2022, p. 3).
- **People with mental illness**. Almost one million Australians were mental health carers in 2018 (this is 37 per cent of all carers), with 273,000 people being the primary carer of someone with mental illness (PC 2020, p. 873).

Most informal carers are women.

- Women take on most of the responsibility for caring for children and are often regarded as the secondary income earner in their household.
- In 2015, more than two-thirds of carers of people with disability were female (PC 2019, p. 41).
- In 2018, about 68 per cent of primary carers of people with mental illness were female (PC 2020, p. 873).
- The primary source of informal carers for older Australians is spouses/partners or other family members, particularly daughters (PC 2011, p. 56).

Each of the Commission's reports provides greater detail on the demographics of informal care. One finding of note is that the availability of carers for older Australians may diminish over time. The number of people aged over 70 years relative to those of traditional working age (15–64) is projected to double, from 14 per cent in 2010 to 28 per cent by 2050. While an extension of the traditional working age can partially offset the effects on the labour force, this could reduce the availability of informal carers if they are less able to combine their caring role with working (PC 2011, p. 56).

How is work and care balanced?

Time spent caring means less time available for paid work. The Commission analysed the effect of caring on the likelihood of being employed for the Australian population between 2001 and 2018 in its Mental Health inquiry (table 1) (PC 2020, pp. 880–882). The analysis showed that providing more than 10 hours of care per week significantly reduced a carer's likelihood of being in paid employment. The effect was largest for carers who provided over 30 hours of care per week; their likelihood of employment was 14.8 percentage points lower than if they were not providing care. The negative effect of caring on employment persisted after people ceased providing care.

Not only does providing care reduce the probability of employment it also reduces the hours that carers worked if employed (table 1). For example, employed carers who provided care for 30 or more hours per week worked 3.2 fewer hours on average than people who do not provide care. Over one-third of mental health carers who were not employed stated that the main reason they stopped work was due to their caring role.

Table 1 – Effects of caring on employment and work hours

Regression results using HILDA waves 1–18

Carer status	Difference in probability of being employed compared with non-carers (percentage points)	Difference in hours worked per week compared with non-carers (hours)
0–9 hours of care provided each week	~0	-0.6
10–19 hours of care provided each week	-6.0	-1.7
20–29 hours of care provided each week	-8.4	-2.8
30+ hours of care provided each week	-14.8	-3.2
Ex-carer (was a carer in the previous 3 years)	-6.3	-1.2

Source: Productivity Commission (PC 2020, p. 881).

The Commission’s inquiry into Childcare and Early Childhood Learning conducted a range of analyses on the workforce participation of mothers. It found that ‘the workforce participation rate of mothers with a child aged under 15 years … has grown substantially in recent decades, from 57 per cent in 1994 to 67 per cent in 2014’ (PC 2014, p. 183). Many mothers work part time and their workforce participation is still well below that of fathers. We also found:

- the participation rate of partnered mothers is above that for single mothers across all age groups of children and by numbers of children
- the participation rate of mothers of older children is substantially higher than that for mothers of younger children
- the participation rate of mothers decreases with the number of children
- more employed mothers work part time than full time — in 2014, around 58 per cent of employed mothers worked part time (PC 2014, pp. 189–190).

Carers’ wellbeing is lower than that of non-carers

The wellbeing of carers can be affected by both the difficulties of their caring role and the challenges of balancing this caring role with work and other responsibilities. While not all carers are negatively affected by their caregiving role, those who provide a high level of care and combine it with full-time work can face significant costs. These costs can be: physical, emotional and mental; lower labour force participation and productivity; reduced engagement in education and work; decreased income and increased financial hardship in the short term (by working less) and in the long term (lower superannuation and savings balances); and reduced social participation (PC 2020, pp. 883–884). There are two groups in particular:

- carers who combine care with work, and face significant time pressures and stress
- carers who exit the workforce, and may face isolation or financial pressures.

Carers of people with mental illness are more likely than other carers to report consequences for their own mental health and wellbeing, and have different needs and experiences compared with other carers due to the nature of their role (PC 2020, pp. 873–874) (table 2). For example:

- carers of people with mental illness are also likely to provide emotional and psychosocial support
- symptoms of mental illness can strain relationships and make providing support particularly difficult
- since mental illness can be episodic, the duration and intensity of a person’s caring needs are unpredictable, making it more difficult for carers to juggle caring and employment
- mental illness has an earlier age of onset and can have mean a long and large effect on a carer’s wellbeing
- the stigma related to mental illness can further complicate the caring role (PC 2020, pp. 873–875).

Table 2 – Emotional and mental effects of caregiving

	Primary carers of people with:[a,b]					
	Mental illness (main condition)	Mental illness (secondary condition)	Other behavioural or cognitive conditions	Physical conditions	All carers[c]	Not a carer[c]
	%	%	%	%	%	%
Psychological distress[d]						
Low distress level	32	38	46	54	53	60
Moderate distress level	25	29	29	26	23	21
High distress level	24	18	16	14	13	12
Very high distress level	19	14	9	7	10	7
Effects that carers attributed explicitly to caring						
Had a stress related illness	20	17	12	8	..	..
Feels weary or lacks energy	53	43	47	31	..	..
Feels worried or depressed	43	37	33	22	..	..

a. 2018. **b.** Mental illness includes: depression and mood affective disorders; schizophrenia and other psychoses; phobic and anxiety disorders, obsessive-compulsive disorder, and other neurotic, stress-related and somatoform disorders; aggression; mental disorders due to alcohol and other psychoactive substance use; eating disorders; adult personality and behavioural disorders; attention deficit disorder/hyperactivity; speech impediment; insomnia; and other mental and behavioural disorders. Other behavioural and cognitive conditions includes: dementia; intellectual disability, autism, developmental learning disorders, coordination disorder, and other intellectual and developmental disorders; dyslexia; dyslalia; memory loss and problems; agitation or confusion; and acquired brain injury. Physical conditions included all other conditions. **c.** 2017. **d.** Measured by Kessler 10. **..** Not applicable.

Source: Productivity Commission (PC 2020, p. 879).

2. What support is provided to carers and is it adequate and effective?

This section addresses terms of references c, d, and I (box 2).

Box 2 – Terms of reference addressed in this section

c. The adequacy of workplace laws in relation to work and care and proposals for reform.

d. The adequacy of current work and care supports, systems, legislation and other relevant policies across Australian workplaces and society.

i. Consideration of the policies, practices and support services that have been most effective in supporting the combination of work and care in Australia, and overseas.

There are many sources of support for carers

There are systems in place to help those who require care, and supports for carers are included in each of these systems. For example, respite in the aged care system helps both people who require care and their carers.

People who require care and their carers can obtain support from multiple systems. For example, some older Australians receive support from the government through the aged care system (if they have a home care package) and the tax and transfer system (if they have a pension). Their carers would also obtain support through the aged care system (for example, short-term respite care for the care recipient to provide the carer with rest and other support services) and the tax and transfer system (for those who qualify for the Carer Payment or Carer Allowance).

Not all of these services and systems are integrated, and some may be more effective for certain people than others. The Commission's reports take a holistic view of these systems to determine which services are effective and how they work together to achieve their intended objectives.

Lack of clarity around governments' roles hinders the effectiveness of supports

One consistent finding in Commission reports is that the systems set up to support people who require care and their carers lack clarity around government roles.

- In the disability support system, there are widespread concerns about future support for carers. Much of the concern over carer support appears to be rooted in the reduction in services provided by some State and Territory Governments as the National Disability Insurance Scheme (NDIS) is rolled out, especially for carers of people with disability who are not NDIS participants. Clarifying — via the National Disability Agreement — the responsibilities of the Australian, State and Territory Governments to provide services to people with disability could help to narrow service gaps or prevent them from emerging (PC 2019, p. 69).
- In the mental health system, both Australian and State and Territory Governments partially fund carer support services, but neither is accountable for ensuring that services are effective and meet community needs (PC 2020, p. 908).

Greater clarity in governments' roles would remove complexity in the systems, enable users and their carers to navigate them better and reduce the likelihood of service gaps.

The Fair Work Act regulates how employees can also be carers

One way in which carers can be supported is to provide them with the flexibility to discharge their caring responsibilities, through leave arrangements and flexible work arrangements.

The *Fair Work Act 2009* (Cth) regulates the pay and conditions of about 70 per cent of employees and their employers (PC 2021, p. 48). The National Employment Standards (NES) are set out in Part 2-2 of the Act and determine the minimum terms and conditions that employers in the national workplace relations system must provide for their employees.

The NES includes three entitlements that are designed to assist informal carers in managing their work and caring obligations.

- 10 days of paid personal/carer leave (inclusive of sick leave) per year for full-time and pro-rata for part-time employees. Personal/carer leave accumulates during each year of employment. There is no limit to the amount of accumulated personal/carer leave that an employee can take within a year, however an employer can request evidence for the need to take leave.

- 2 days of unpaid carer leave for each episode of care required, available to all employees, including casuals. Full-time and part-time employees can only access unpaid carer leave once they have exhausted their paid personal/carer's leave balance.
- A right to request flexible working arrangements — changes to hours, patterns and locations of work – for carers who have worked with their employer for at least 12 months. Employers may refuse requests on reasonable business grounds. There is no mechanism to appeal such refusals.

Existing leave entitlements for carers are intended for brief periods of care to deal with an illness or unexpected event or emergency. The NES does not preclude a business from offering carer leave over and above the minimum standards.

The Commission has been asked to evaluate the possible effects of inserting an entitlement to an extended period of leave to take care of an older person. The terms of reference also ask the Commission what other supports might help carers of older people and whether some of these supports might help other types of carers. The inquiry draft report should be published by February 2023 and the final report delivered to Government in May 2023.

The Commission has identified specific areas of improvement

Eligibility of the Carer Payment and the Carer Allowance should reflect the needs of mental health carers

The Carer Payment and Carer Allowance are key income support payments provided for carers who provide full-time care. The Commission has made recommendations regarding several of the many eligibility requirements. For example, the Commission recommended reviewing the scoring requirement on the Adult Disability and Assessment Tool (ADAT) when considering carers of people with mental illness (discussed more below) (PC 2020, p. 919). The Commission also recommended that other eligibility tests be reconsidered to better include mental health carers (PC 2020, p. 922).

For the Carer Payment, the Commission recommended changes to the 25 hour rule (PC 2020, p. 920). The requirement allows carers to only work, volunteer or study for a set 25 hours each week. The requirement that prevents a willing and able carer from investing in their education is difficult to justify. Similarly, preventing volunteering can stop carers from accessing an important steppingstone to employment as well as benefits of social integration and the outcomes of the volunteering activities. While a restriction on hours worked does assist with maintaining the integrity of the Carer Payment, more flexibility would enable carers to better deal with the episodic nature of support needs for people with mental illness. The Commission recommended that the requirement be changed from a 25 hours per week restriction on work, volunteering and study to be a 100 hours per month restriction on work only. It also recommended that the Carer Payment requirement for 'constant care' be replaced with a requirement to provide 'care on a regular basis every week' (PC 2020, p. 922).

For the Carer Allowance, the Commission recommended replacing the requirement to provide 'care and attention on a daily basis' with a requirement to provide 'care on a regular basis every week'. The Commission also recommended removing requirements for the carer to live with the care recipient, or provide care that relates to the care recipient's bodily functions — or to sustaining their life — for more than 20 hours per week.

Finally, for both the Carer Payment and the Carer Allowance, the Commission recommended that the requirement that care be provided in a private residence that is the home of the care recipient be replaced with a requirement that the recipient must reside in a private residence (PC 2020, p. 922).

Reform the Adult Disability and Assessment Tool to better support carers

The ADAT is a key eligibility test in determining whether a carer can receive either the Carer Payment or the Carer Allowance (PC 2020, p. 916). The ADAT consists of two questionnaires — the carer completes one and a health professional providing treatment for the care recipient completes the other. Each questionnaire has three sections and attempts to capture the type of care a carer provides. The first section covers activities required for daily living (such as eating and washing), while the second relates to cognitive function and the third records behaviours and symptoms of mental illness.

Inquiry participants were critical of the ADAT due to the weightings of the questionnaire. These weightings were seen to disadvantage carers of people with mental illness due the ADAT's focus on tasks required for daily living (PC 2020, p. 916).

Beyond the weightings, the questions themselves do not adequately capture the care provided by mental health carers. As an example, the first section focuses on basic self-care but does not include questions about support required to organise and attend appointments or need for assistance with household chores.

The Commission agreed with inquiry participants, finding that the ADAT was in need of reform (PC 2020, p. 919). At the time of publishing the Mental Health report the Department of Social Services (DSS) was initiating a review of the ADAT. The Commission recommended that DSS expand the list of persons who can complete the health professional questionnaire to include psychologists and accredited mental health social workers, and that DSS complete and publish its review. There seems to be no further updates publicly available on this review.

Respite helps carers, but may be missing from the NDIS

Respite services can improve informal carers' wellbeing and help them care for longer. A lack of respite can prevent informal carers from supporting family members and friends who need care, can reduce the effectiveness of care or can jeopardise sustainability.

The Commission's NDIS costs study heard from participants that respite services were not well catered for under the NDIS. Concerns raised included that there was a lack of respite supports in plans, or insufficient quantities of respite options for family members (PC 2017, pp. 353–355).

Without respite services, the sustainability and success of the scheme are imperilled. It is the Commission's view that it is appropriate for respite supports to be allocated to participants on the basis of the amount of informal supports expected of informal carers, that respite should be more clearly labelled, and that the options available to participants to use their core supports for respite are clearly set out (PC 2017, p. 355).

Beyond the sustainability of the NDIS, respite care is essential to the sustainability of informal care, which is an integral part of the Australian system of care.

The tax and transfer system can be a disincentive for childcare and working

The structure of the tax and transfer system affects how people can combine work and care responsibilities. In particular, it creates a disincentive for some parents to enter the workforce or to increase their hours of work. For some second income earners (usually mothers) who return to work and use ECEC, the combination of a decrease in Family Tax Benefits, of progressive income tax rates and of reduced Child Care Subsidy at higher income levels, can result in high effective marginal tax rates (EMTR). This observation from the Commission's 2014 inquiry still holds today. High EMTRs can reduce the incentive for second income earners to work while their children are young (PC 2014, pp. 11–12). High EMTRs could also be an obstacle for informal carers of other people who require care.

There is no simple solution to high EMTRs. In general, they exist because of desirable design elements of the tax and transfer system — a progressive income tax scale and means-tested benefits that phase out gradually as incomes rise. Careful design can address the highest EMTRs in the system, but generally by smoothing peak EMTRs, which can have the effect of raising EMTRs at another point in the income scale. Moreover, EMTRs are but one consideration in the design of benefit payments — affordability and targeting also have to be weighed up as part of any policy options.

That said, the Commission has noted that changes in the tax and transfer system and other policy areas are likely to have a far greater impact on workforce participation than any changes in ECEC policies (PC 2014, p. 16).

Travel assistance and assistive technologies help carers

The availability of other support services, especially transport options and assistive technologies, can contribute to the ability and willingness of carers to continue caring and help with workforce participation.

Transportation services contribute to maintaining social inclusion as they are an essential link between older people and their community. However, transport is often unaffordable for people who require care, and informal carers (and volunteers) often provide such services, spending considerable time, effort and money doing so (PC 2011, p. 338).

Appointments and other activities generally occur during business hours, and this can adversely affect the capacity of the informal carer to participate in the workforce. The benefits of respite may be reduced or even negated if the carer is required to transport the older person between home and the respite location. Community transport schemes provide valuable assistance to older people and people with disability and, indirectly, to their carers.

Assistive technologies can increase the independence of frail older people and reduce the physical and emotional burden on carers. For example, wheelchairs, home modifications and, in some cases, lifting devices, can limit the amount of time required of carers and the amount of physical exertion and, as a result, the injuries that carers may sustain as part of their caring activities. Greater access to these technologies can also reduce carer burnout and avoid or defer the use of more intensive aged care services.

The Commission proposed that such schemes continue to be funded in recognition of the important role that they play (PC 2011, pp. 338–339).

Partnership and family-based programs for mental health carers

Another way to help carers is to help the people they care for. Better outcomes can be achieved for people with mental illness when recovery is understood as a social process. One such example is the Open Dialogue approach (PC 2020, p. 870). The Open Dialogue approach was developed in Finland in the 1980s. The model views the care recipient’s support network as fundamentally involved in their recovery. This social network is invited to treatment meetings and open communication between the consumer, their network and treatment team is encouraged. The evidence supporting this approach looks promising. After two years, 84 per cent of Open Dialogue patients were in full-time employment or study. More research is needed to understand how effective such an approach could be if introduced in Australia (PC 2020, p. 871).

Family- and carer-inclusive practices in mental health services acknowledge the importance of family and friends in treatment. It is also important for these practices to include services for carers because these are a fundamental element of evidence-based best practice and would enhance collaboration and recognition of carers.

The Commission noted the importance of increasing access to funding for family interventions and agreed with a recommendation from the Medicare Benefit Schedule Review Mental Health Reference Group about introducing a new family and carer Medicare Benefit Schedule item for psychologists and allied mental health professionals, with a four-session limit per year (PC 2020, p. 897).

3. How COVID-19 changed Australia's system of work and care

This section addresses the terms of reference f: the impact and lessons arising from the COVID-19 crisis for Australia's system of work and care.

The Commission's research on working from home found that working from home and avoiding the commute can effectively reduce the 'cost of working', which could induce an increase in labour supply. This may include more work opportunities for people who face barriers to labour force participation such as parents of young children or other caring responsibilities, some people with disability, as well as people living in remote or regional areas where there are often fewer job opportunities in close proximity. Importantly, working from home could make it possible for some carers to remain in the workforce and could reduce some of the costs of caring.

Working from home could also promote a more gender-balanced workforce (PC 2021, p. 5). More women than men are in jobs that can be done remotely. Also, since women in Australia still carry most of the responsibility for raising children, and are also more likely than men to care for others, the option to work from home may facilitate greater access to paid employment.

The impacts on wellbeing for mental health carers were found to have increased since the pandemic. A survey by Caring Fairly found that due to the pandemic, many carers experienced increased stress from their caring role and experienced a deterioration in their own mental health (PC 2020, p. 878). Some mental health carers reported working fewer hours due to caring responsibilities. When formal supports were no longer accessible, informal carers were left to replace supports that were no longer available (PC 2020, p. 879).

References

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