



Scoping the Australian Care Economy A Gender Equity Perspective

A Report for Security4Women

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About the author

Dr Valerie Adams conducts independent research across the social sciences. Her doctoral research analysed the work experience of residential aged care nurses from a feminist economics perspective. Her continuing research interests are centred on empirical investigations of paid and unpaid care work, the undervaluation of care work, gender equity issues, and the emerging feminist economics literature on caring labour.

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Abbreviations and acronyms

ABS	Australian Bureau of Statistics
ACOSS	Australian Council of Social Service
AIHW	Australian Institute of Health and Welfare
Auslan	A ustralian S ign L anguage for hearing impaired people
CPH	Census of Population and Housing
CURF	Confidentialised Unit Record Files
DEEWR	Department of Education, Employment and Workplace Relations, Australian Government
DSP	Disability Support Pension
FaHCSIA	Department of Families, Housing, Community Services and Indigenous Affairs, Australian Government
GDP	Gross Domestic Product
GSS	General Social Survey
HILDA	Household, Income and Labour Dynamics in Australia Survey
LSAC	Longitudinal Study of Australian Children
NDRC	National Disability Recruitment Coordinator
NGO	Non-government organisations
NLC	Negotiating the Life Course Survey
NRCP	National Respite for Carers Program
PPS	Parenting Payment Single
RAC	Residential Aged Care
SDAC	Survey of Disability, Ageing, and Carers
SEARS	Survey of Employment Arrangements, Retirement and Superannuation
SIH	Surveys of Income and Housing
SNA	System of National Accounts
TUS	Time Use Survey
UNIFEM	United Nations Development Fund for Women
UNRISD	United Nations Research Institute for Social Development

Key messages

- The Care Economy is a relatively new but highly significant concept with increasing importance for the Australian economy and the economic wellbeing of citizens, especially women
- The Care Economy encompasses both macroeconomics and microeconomics. Macroeconomics encompasses the performance and decision-making of an entire economy: regional, state, national or global. Microeconomics views economic activity at an individual level, e.g. from the perspective of households or firms. Both are relevant to an economic assessment of the care economy
- The provision of care has public good qualities with the benefits of providing care, both paid and unpaid, ‘spilling over’ to the wider community. As people who require care cannot exercise consumer rights in the way that well people can, the public goods aspect and impaired consumer sovereignty signal an important role for government policy and public funding to support both paid and unpaid care
- The demand for care increases during economic downturn and the substantial role of public support in the care sector makes it particularly vulnerable to budget cuts
- Care work, both paid and unpaid, affects women’s economic wellbeing. Paid care services are characterised by a highly feminised workforce with high levels of casual and part-time employment. Informal caring impacts negatively on women’s lifetime earnings
- Because women have to balance their workforce participation with their caring responsibilities, a lack of workplace flexibility is instrumental in keeping the existing gendered division of labour in place
- The combination of an ageing population and increased longevity poses a challenge to the adequate future supply of caring labour. There will be an increasing number of care recipients with complex care needs. Rather than juggle the competing demands of paid work and care, many carers tend to reduce their paid working hours or exit the workforce
- There has been no comprehensive mapping of the Australian Care Economy as a whole. This mapping is a matter of urgency, especially as different statistical data measure and report on different aspects and the literature is also fragmented around different aspects of the care economy.

Executive summary

This research was commissioned by *Security4Women* in recognition of the significance of the care economy. The notion of the ‘care economy’ has arisen from feminist critiques of mainstream economics which traditionally only considered goods and services produced in the market economy as ‘productive’. Looking at care work as an economic activity is a way of making women’s work visible so that it can be valued. Encompassing both paid and unpaid work, the majority of care is provided by women with the erroneous assumption that the supply of care is infinitely forthcoming or elastic, whether it is paid or unpaid. Of importance is the tension between unpaid work in the home, voluntary work in the community, and paid work in the market as the time spent in each of these areas impacts on the amount of time available for the other two.

Another issue is the relational nature of care work that involves different motivations to utility maximisation considered to be central to market production. *Caring labour* has been described as labour-intensive work requiring face-to-face contact and person-specific knowledge involving love as well as labour. *Caring* is an ambiguous notion which encompasses physical care, which can be provided independently of a relationship between the carer and the care recipient, and emotional care in which the person caring is inseparable from the care given. Rather than being the actions of an independent and autonomous economic actor, care is a relational activity. This relational nature of caring work prevents it from being subject to the usual economies of scale when supplied in a market.

Mainstream economics assumes economic actors to be non-relational, detached individuals who make decisions based on individual choice. In contrast, feminist economists argue that economic actors are embodied and in-relation to the world around them. This notion incorporates interdependencies and also takes into account that, across the life course, people have times in their life from birth to old age when they are dependent on others to care for them. Feminist economists assert that economic activities can be better explained by the concept of ‘provisioning’ for human needs (Nelson 1993; Power 2004; González-Arnal & Kilkey 2009: 89-92). Care, wherever it is provided, is a relational activity underpinned by quite different motivations to that of ‘individual choice’.

The objectives of this project were to scope the Australian care economy by identifying recent literature to:

- Examine how the care economy may be defined
- Identify the issues relevant to paid and unpaid care
- Collate a list of public policies which provide government support to the care economy
- Identify the impact of the care economy on women’s economic wellbeing
- Research recent statistics on the Australian care economy
- Identify gaps in the literature and areas for further research.

Defining the care economy

When assessing the care economy from an economic perspective, both macroeconomic and microeconomic viewpoints are relevant. Macroeconomics encompasses the performance, structure, behaviour and decision-making of an entire economy, which can be regional, state, national or global. Microeconomics views economic activity at an individual level, e.g. from the perspective of households or firms.

The care economy encompasses relevant parts of all four sectors of the wider economy: the domestic sector, the private sector, the public sector and the non-government organisations (NGO) sector. The most comprehensive definition to date comes from a case study of the state of Massachusetts in the United States (Albelda et al. 2009), which categorised both paid and unpaid care work into:

- *Interactive care work*, labour supplied directly through a face-to-face relationship directed to meeting the needs of a care recipient, and
- *Care support work*, the less visible support work that keeps the institutions of care running.

Different definitions have been used to describe different aspects of the care economy:

- *Informal care*—provided by the care recipient’s family or friends usually, but not always, free of charge, according to communal norms and obligations and without direction from the state (Hales 2007: 18)
- *Family carers*— used to distinguish the role of unpaid care in the home from other caring roles such as that of paid care providers (Carers Australia 2007b)
- *Voluntary care*—care provided by volunteers who are not family or friends of the care recipient, e.g. Meals on Wheels
- *Extended caring*—caring for a child with a disability into adulthood (Cuskelly 2006: 20)
- *Primary carer*—the person providing most of the care, usually daily, which can be intense, and typically extends over a number of years (Hales 2007: 18), and

- *Marketised care*—paid caring labour provided in both the public and private sectors of an economy by both for-profit and not-for-profit providers because paid care services are increasingly being subjected to market principles (Adams 2008: 7).

In this study encompassing both paid and unpaid caring labour, the term used is *care work*. It is important to note that:

- Caring covers a wide variety of situations and the needs of care recipients differ greatly
- The issues involved require new theories and approaches and are complex and changing
- The similarities between paid and unpaid care work often override the differences and many caring situations involve a combination of unpaid and paid caring work
- The linkages between unpaid care and paid care services are not well understood, involve issues around resourcing, and are under-researched.

Issues in the Australian care economy

The following issues are identified as important. As these issues are diverse, they impact on the care economy on different ways as explained in each section.

Data issues

A search of the statistical sources relevant to the Australian care economy reveals that different statistical data measure and report on different aspects of the care economy. The most comprehensive study found is the case study of Massachusetts which uses US Census and Time Use data to measure both paid and unpaid care work including care support work (Albelda et al. 2009). No such study has yet been undertaken in Australia.

Specific data issues identified are:

- Time Use data is the most comprehensive source of information on the unpaid productive work undertaken in households but time use surveys are not undertaken on a regular basis. To date, the Australian Bureau of Statistics (ABS) has conducted time use surveys in 1992, 1997 and 2006. The most recent Time Use Survey was undertaken in the same year as the *2006 Census of Population and Housing* which also included questions on unpaid work. This offers new opportunities for analysis of the productive unpaid work undertaken in the home. Regular collection of time use data, preferably in the same year as the Census is undertaken, is necessary to inform decisions regarding support for unpaid care work

- Satellite accounts were recognised in the 1993 revision of the international System of National Accounts (SNA) as a means of placing a monetary value on unpaid work. They are useful for measuring trends in unpaid work over time and how this relates to the market economy. Australian satellite accounts were produced by the Australian Bureau of Statistics in 1992 and 1997. Given the importance of unpaid care, satellite accounts need to be produced regularly.

Gender Equity

The provision of care is a highly gendered activity, which reproduces inequality between men and women. More women than men provide both paid and unpaid care:

- An overwhelming 93% of residential workers and 91% of community based workers in the residential and community aged care workforce in 2007 were women (Martin & King 2008)
- Of care workers in community services, 89.6% were female in 1996, and in 2001, 88.4% of care workers were female; in several caring occupations in community service industries—nursing, therapies, pre-primary school teaching, and child care—more than 90% of workers were female in both 1996 and 2001 (Meagher & Healy 2005)
- Paid caring work attracts a ‘wage penalty’ and pays less than other occupations after controlling for the education and experience of the workers, many occupation and industry characteristics (England, Budig & Folbre 2002)
- The personal costs of providing both paid and unpaid care are borne disproportionately by women and can lead to inequality among women, e.g. single childless women and widows typically earn a higher disposable income than mothers of young children (Folbre 2006b: 184).
- Gender norms play a key role in maintaining the gender division of labour in care work (Baxter, Hewitt & Western 2009: 22).

Longevity and an ageing population

The combination of an ageing population and increased longevity poses a challenge to the adequate future supply of caring labour:

- There is going to be an increasing number of care recipients whose care needs are becoming more complex (Hales 2007: 23)

- Rather than juggle the competing demands of paid work and care, many carers may reduce their paid working hours or exit the labour force (Hales 2007: 23)
- The aging population is spawning a ‘sandwich’ generation of carers who are caring for a child and have an elderly relative who also requires care (Hill et al. 2008: 27).

Informal care

Informal carers are most likely women, older than the general population, and either working part-time or not in the workforce (Access Economics 2005: 11 & 12). Almost half have caring responsibilities equivalent to a full-time job and over half experience some form of financial difficulty (Australian Bureau of Statistics 2008b: 5). About half have no regular assistance with the care they provide and around one-third would like an improvement in their caring role including better financial support (Hales 2007: 22) . Carers have the lowest subjective wellbeing of any group yet researched with women’s wellbeing lower than men’s. Sole parents are the most disadvantaged in terms of wellbeing (Cummins & Hughes 2007: vi).

The government subsidy for informal care is much lower than other care streams even though informal care was estimated to be worth at least 9.9% of value added in the formal health and community sector in 2005 (Access Economics 2005: 37). There is a lack of affordable care options for many carers. If not better supported by public funding, the future supply of informal care may fall short of the demand for family-based care.

‘Welfare to work’

Welfare to Work as a policy package was introduced by the previous Australian Government in the 2005-06 Budget. Its relevance to the care economy is that it introduced ‘participation requirements’ from 1 July 2006 for parents receiving the Parenting Payment once their youngest child was 7 years of age and people with disabilities who were able to work 15 – 30 hours per week. With the stated goal of reducing welfare dependency and increasing workforce participation, some recipients of the Parenting Payment and Disability Support Pension were moved to the Newstart unemployment benefit which was a lower payment. In addition to the participation requirements, there were also harsher penalties for non-compliance despite there being significant barriers to workforce entry for sole parents and people with disabilities.

Of the sole parents who were required to be on Newstart, 49% experienced a net financial loss compared to being on the Parenting Payment (Single) (Department of Families 2009k). There is also evidence of significant workplace discrimination against people with disabilities. As the Austudy payment was less than Newstart, unemployed job seekers were discouraged from entering further study to improve their employment prospects.

The current Australian Government incorporated many of the *Welfare to Work* provisions into its *Fair Work Australia* policy and increased public funding to assist in the transition from welfare to work. A new Disability Employment Services began operating from 1 March 2010 and was set up uncapped so that all disabled people seeking work would have access to support. It also incorporated training for employers of people with disabilities. However, it is too early for any assessments of these new initiatives to be available.

Young carers

Young carers are a group of young Australians under 26 years of age who provide unpaid care in families where someone has an illness, a disability, a mental health issue or who has an alcohol or other drug problem. Around 170,600 Australians under the age of 18 years and 380,000 under the age of 26 provide care to a family member. The time that young carers spend caring can be as much as 30 hours a week, which impacts on their education or workforce participation. Over half of Australian young carers care for a parent. The parent is likely to be a mother and the household is likely to be a sole parent family (Carers Australia 2007a)

In Australia girls are only slightly more likely to be a young carer than boys. This appears to be a shift in the gender dimension of care. Young carers are often not identified or choose not to self-identify and there is a widespread lack of awareness of young carers. There is now government funding for a Young Carers Respite and Information Services Program to assist young carers to better manage their educational and caring responsibilities. However, it is underfunded and does not meet the needs of all young carers.

Paid care

In Western post-industrial countries, the increased labour force participation of women has reduced the time available for non-market work and has increased the demand for paid care services. Paid care services are less likely to benefit from economies of scale than other industries because there are limits to the degree to which productivity can be increased before the quality of care decreases. Economists have called this a 'cost disease'. Because providing care involves a personal service, it is difficult to increase productivity because there is a limit to the number of people who can be cared for at the same time. Efforts to increase productivity can result in lower quality care.

The quality of direct care work is difficult to monitor or specify in an explicit contract and the pressure to reduce costs can lead to a decrease in the quality of care. Low wages can result in care workers feeling undervalued and demoralised in their work. Paid care tends to be undervalued in market terms wherever it is supplied and adequate public funding is critical to ensuring that the quantity and quality of care supplied meets demand.

Residential aged care

Residential aged care facilities provide a good example of a marketised care service, providing 24-hour care to frail elderly people whose care needs exceed the level of care that can be provided in the community. Residential aged care direct care staff are predominately women, have experienced work intensity, and the combination of inequitable remuneration, poor working conditions and the issue of the quality of care being compromised has seen a steady exodus of workers from aged care. There is a pressing need for an improvement in wages and conditions in residential aged care to retain staff.

Exploitation

Carers providing both paid and unpaid care work are vulnerable to exploitation due to 'prisoner of love' dynamics that make it difficult for them to withhold their care. This situation contributes to many women's economic vulnerability. Both women and men pay a penalty in terms of foregone income when they assume responsibility for the care of dependents. Care workers deep sense of obligation can dampen their demands for higher wages or improved working conditions; instead many workers simply leave their jobs and seek work in sectors in which wages and conditions are better.

Government policy

The provision of care has public good qualities with the benefits of providing good care, both paid and unpaid, 'spilling over' to the wider community. However, people who require care cannot exercise consumer rights in the way that well people can. The public goods aspect and the issue of impaired consumer sovereignty signal an important role for government policy and public funding to support both paid and unpaid care. The demand for care increases during economic downturn and the substantial role of public support in the care sector makes it particularly vulnerable to budget cuts. In Australia, the national health system and a range of pensions, benefits and funding arrangements support both paid and unpaid care to some extent.

Assistance to parents

Higher government spending on family and social benefits is associated with lower child poverty rates. In Australia income support is available to low-income families in the form of a fortnightly Parenting Payment to assist with the cost of raising children. Financial assistance is also available to eligible families to assist with the cost of paid child care to enable parents to participate in the labour market and tax benefits to assist low income families with the cost of raising children. Labour force participation is the main reason that Australian families use both formal and informal child care with sole parents needing more child care than comparable couple families. Child care use is highest in families where the youngest child is 3 to 4 years old. Despite government assistance, families often have difficulty with the cost of child care. Parents also have some difficulty with accessing child care to suit their needs with accessing child care when children are sick being particularly problematic.

Financial assistance to carers

Financial assistance to carers is provided through the Carer Payment, the Carer Allowance and the Carer Supplement Payment. The majority of Carer Payment recipients are women caring for adults. Only 13% had income from employment sufficient to reduce the amount of Carer Payment received. Most recipients of the Carers Allowance are also female and over half receive an income support payment. The numbers of people receiving both payments has greatly increased reflecting demographic changes such as the ageing of the population and an increased public awareness of the two payments.

Care recipients as pensioners

Although not all people receiving a pension require care, many care recipients in Australia are pensioners. Also many pensioners provide care. The main income support is the Age Pension and the Disability Support Pension.

Additional benefits to assist pensioners

Some of the additional payments to assist pensioners are the Bereavement Payment, the Pensioner Education Supplement, the Pensioner Concession Card, and the Pension Loans Scheme which apply to all pensioners including carers receiving the Carer Payment. The Bereavement Payment is particularly relevant to pensioners who have been providing care at the end stage of life and are faced with funeral expenses.

Health Care Cards, Rent Assistance and the Pensioner Bonus Scheme

There are a number of Health Care cards available to people who do not qualify for a Pensioner Concession Card but are receiving some other allowances. Rent Assistance is available to eligible income support recipients who are in rental accommodation supplied through the private rental market. The Pension Bonus Scheme is an incentive for older Australians to defer claiming the Age Pension and remain in the workforce longer. The subsidy provided by Health Care Cards are particularly helpful to carers and care recipients who are pensioners as there are often additional expenses involved in providing care.

Government funded care services

The Federal government funds a range of community care services to assist people to stay in their own homes but this is often only possible if there is an informal carer available. The largest source of community care assistance is provided through the Australian Government and State/Territory funded Home and Community Care (HACC) program. Community Aged Care Packages (CACP) provide care for frail or disabled older people whose dependency and complex care needs would qualify them for entry to an aged care facility, at least for low-level care, if they were not supported at home. These initiatives are complemented by Extended Aged Care at Home (EACH) Packages and EACH Dementia packages aimed at delivering care at home equivalent to high-level residential care.

All the community care packages are provided in accordance with a provision ratio set by the Federal Government. There is also additional assistance for community care available in the form of respite care, the Day Therapy Centre Program, Rural Health Multi-Purpose Services, and the Transition care Program. When care needs become too great for a person to continue living in the community, 24-hour care is available in residential aged care facilities. Over 70% of residential aged care residents are female and most are pensioners.

Impact on women's economic wellbeing

Care work, both paid and unpaid, affects women's economic wellbeing. Paid care services are characterised by a highly feminised workforce with high levels of casual and part-time employment. Informal caring is known to impact negatively on women's lifetime earnings. Many women's workforce participation varies through the life course and of importance to many women is the issue of workplace flexibility. Because women have to balance their workforce participation with their caring responsibilities, a lack of workplace flexibility is instrumental in keeping the existing gendered division of labour in place.

Paid care work

Caring occupations pay less than jobs with similar characteristics and women's segregation in caring jobs helps explain the persistence of gender differences in pay. Care workers in community services are more likely to be sole parents than professional workers are and two-thirds of personal carers earned between \$500 and \$1,000 per week. More than half of community care workers earn \$500 or less per week. Many work short part-time hours (Martin & King 2008: 71 & 72).

Unpaid caring

Informal carers are less likely than non-carers to be employed and less likely to be working full-time. Because of their reduced workforce participation, many carers have little capacity to prepare for retirement. Carers who experience financial hardship also experience low face-to-face social contact with relatives and friends outside their household. A large majority of primary carers of adults with an intellectual disability are mothers and up to half of ageing carers are not using any formal services and so are unknown to service providers. Overwhelmingly mothers or other female relatives, such as grandmothers, are predominantly the providers of care. Caring and lifelong caring in particular has resulted in many women having to abandon careers or limit their ability to work and contribute to the family income. This, together with the high incidence of single parent families providing lifelong care, strengthens the likelihood that families with disability will be in a lower income group in the community.

Women's workforce participation

Over the past three decades there has been a rise in the overall workforce participation rate of women in Australia. Female participation drops off markedly from the age of 55 years but

has increased by more than 20% over the last 20 years. Recent increases in participation have been evenly split between full and part-time work, with today's women showing an increasing desire to work longer hours than their predecessors. Workforce flexibility and the availability and responsiveness of community support services will be a prime consideration for an increasing number of mature age workers providing care to a frail parent or a spouse with a disability. However, many women's workforce participation is not resulting in adequate superannuation to fund their retirement. The benefits of women's workforce participation in Australia are also dampened by the effect of a long-standing gender wage gap. Eliminating the gender wage gap in its entirety could be worth around \$93 billion or 8.5% of GDP (Cassells et al. 2009: vi).

Unpaid care and workforce participation

There is a higher unmet need for family-friendly work arrangements among employees caring for an adult than among workers with solely child care responsibilities and, as the population ages, there will be increasing numbers of care recipients with increasingly complex care needs. Employers wishing to retain mature age workers will need to respond flexibly to the needs of those with caring responsibilities. As women can now expect to spend more years caring for elderly parents than they do rearing children, workforce flexibility and the availability and responsiveness of community support services will be a prime consideration.

Becoming a carer results in an increased likelihood of women leaving the paid labour force and there is a strong association between being an informal carer and casual or part-time work. Care needs can significantly impact on a carer's ability to engage in substantial participation in the workforce. The productivity losses associated with the provision of informal care are mainly borne by the individuals providing the care whose wage income is reduced. Over the course of a working life, the risk of employees acquiring substantial caring responsibilities is high.

Mothers with infants and young children

Casual and self-employment for mothers of young children is associated with higher levels of flexibility in the hours worked and lower levels of negative work effects on family life. However, casual employees and, to a lesser extent, the self-employed are in lower status occupations than those in permanent employment. There is a relatively high rate of returning to work among one-child mothers when their child is one or two years old but for mothers with two or more children, it is the return to part-time work that increases as the youngest child gets older with return to full-time work remaining low. Women with tertiary levels of education are most likely to return to full-time work. More sole mothers return to work than married and cohabiting women.

Although there has been an increase in the number of women returning to work after child-bearing, the increased likelihood of returning to work appears to be associated with increases in the return to part-time employment. The increased workforce participation of mothers with young children suggests that the demand for access to affordable and high quality child care

will continue to increase. Also of importance is mothers' access to flexible working hours and part-time work that does not jeopardise their chance of promotion.

Sole parents

Sole parent families are at an increased risk of disadvantage in terms of employment, housing, income and social participation. However, where the child and parent have good health, income is sufficient, there is an extended family and/or social network, the family has secure housing, and access to services is available, there is no increased risk of poor outcomes. The need for child supervision is a real constraint on sole parents' ability to work outside the home. Methods of support such as outreach service provision or work from home options are very real ways in which sole parents can be supported.

Flexible working hours

Women are much more likely than men to use shift, casual or part-time work as a means of managing their caring responsibilities, especially childcare, and there are high levels of unmet need for flexible work arrangements to care for disabled or elderly adults. More lone mothers make use of family-friendly work arrangements to provide care than couple mothers. Lone mothers are more likely than couple mothers to prefer to work full-time because of their need to earn a sufficient family income and unmet need for use of some type of family-friendly work arrangement is higher for lone mothers. About a quarter of employees who become carers do not have access to any carer-friendly workplace arrangements. Although flexible work arrangements are important to women, few women are able to access them regularly.

Recommendations

The following recommendations have been identified as needing urgent attention by *Security 4 Women* and other relevant bodies.

Data Issues

Recommendation 1 (see pp. 9 & 10)

That *Security4Women* commission a study using a similar methodology to the *Counting on Care Work* study in Massachusetts using data from, for example, the 2006 Census of Population and Housing and the 2006 Time Use Survey. This study will require estimates to be calculated (or updated) of the economic value of both paid and unpaid 'care work' in Australia.

Recommendation 2 (see p. 12)

That the Australian Bureau of Statistics undertake regular Time Use Surveys in the same year as the Census of Population and Housing to inform decisions regarding support for unpaid care work.

Recommendation 3 (see pp. 12 & 13)

That the Australian Bureau of Statistics regularly produces satellite accounts in line with the international System of National Accounts so that estimates of the value of unpaid care services are available for comparison with the value of Gross Domestic Product.

Gender equity

Recommendation 4 (see pp. 14 & 15)

That *Security4Women* lobby for policies that encourage men as well as women to combine paid work with care in the home to rectify the gender imbalance in the provision of unpaid care in line with international best practice which includes specified ‘daddy leave’ days, parental leave paid at replacement level and flexible leave provisions.

Intergenerational caring

Recommendation 5 (see p. 16)

That *Security4Women* investigate what forms of support would assist ‘sandwich’ generation carers who are caring for children as well as an adult family member who requires care.

Unpaid care

Recommendation 6 (see p. 18)

That *Security4Women* advocate for the availability of paid and unpaid leave to cover family, friend and neighbourhood care, similar to parental leave provisions, to assist carers to participate in the labour market.

Recommendation 7 (see p. 19)

That *Security4Women* advocate for increased instrumental support for unpaid care in the form of affordable assistance from formal care services such as domiciliary care.

Recommendation 8 (see p. 19)

That *Security4Women* advocate for an increase in the availability and affordability of respite care for sole-parent carers, carers on a low income, and carers of people with a disability, mental illness or chronic conditions.

Recommendation 9 (see p.20)

That the Australian Government works with State/Territory Governments to reduce the waiting lists for respite care of families with disabled children.

Recommendation 10 (see p. 20)

That FaHCSIA undertake a proper assessment of the needs of families with disabled children and establish a minimum amount of respite care to be made available to families of differing circumstances.

Formal care

Recommendation 11 (see p. 35)

That *Security4Women* in conjunction with *Fair Work Australia* and other relevant bodies advocate for improved wages and working conditions for direct care staff employed in the community services industry.

Recommendation 12 (see p. 37)

That *Security4Women* in conjunction with *Fair Work Australia* and other relevant bodies advocate for increased wages and better working conditions for nurses and carers employed in residential aged care.

Impact on women's economic wellbeing

Recommendation 13 (see p. 62)

That *Security4Women* advocate for increased public funding to improve the income of carers providing extended care in the home.

Recommendation 14 (see pp. 64 & 65)

That *Security4Women* lobby for government intervention to address the gender wage gap in Australian workplaces.

Recommendation 15 (see p. 72)

That *Security4Women* in conjunction with *Fair Work Australia* and other relevant bodies advocate for flexible working conditions, in particular access to leave when required and flex-time, time off in lieu and the ability to change starting and finishing times throughout the Australian workforce to enable employees to undertake both child care and care for disabled or elderly adults.

Recommendation 16 (see pp. 76 – 79)

That *Security4Women* in conjunction with the *Office for Women* and other relevant organisations commission further research investigating the care economy, especially from a gender equity perspective, to address the paucity of data identified and so to better inform decision making.

1. Introduction

This research has been commissioned by *Security4Women* in recognition of the importance of the care economy. The notion of the ‘care economy’ has emerged out of the past two decades of feminist critiques of the conventional conceptualisation of how economies operate and the gender impacts of government policy. Mainstream economists have traditionally only considered goods and services in the market as productive in an economy. These conventional conceptualisations of the economy leave out much of the productive activities (or work) that women undertake on an unpaid basis. Feminists argue that gender equality and women’s economic well-being require a new vision of economic life that counts women’s care work in statistics, explains the role of care (as well as commodities) in the working of economies and integrates the care economy into policy.

The care economy encompasses a broad range of activities and services which are provided in various combinations of paid or unpaid work. Caring activities usually involve close personal or emotional interaction. Often care provided within families is unpaid, such as parents caring for young children. Some care involves informal market work such as a family member providing child care for a relative with the terms of payment agreed informally between the two family members. Other forms of care involve paid employment such as nurses and child care workers and may be market substitutes for services women once provided in the home. As the majority of care is provided by women there is an interface between paid and unpaid care work and a tension in the allocation of time between unpaid care in the home and paid work in the market.

Caring labour has been described as labour-intensive requiring face-to-face contact and person-specific knowledge (Folbre 2001: 48), where the caregivers are ‘expected to provide love as well as labor’ (England & Folbre 2003: 64). *Caring* has been described as an ‘ambiguous notion’ which encompasses physical care, which can be provided independently of a relationship between the carer and the care recipient, and emotional care in which the person caring is ‘inseparable from the care given’ (Himmelweit 1995: 8). The relational nature of caring work prevents it from being subject to the usual economies of scale when supplied in a market.

Although there is a vast literature on different aspects of the care economy, to date there has been no comprehensive mapping of the care economy as a whole. It has been estimated that in 2000, nearly half of all economic production came from the household or non-market sector (Soupourmas & Ironmonger 2000: 13). Much of non-market work involves unpaid caring provided in the home and through the work of volunteers in community services provided by not-for-profit organisations. Also, a large and growing part of the paid economy is care work. The care economy plays a significant role in the development of social assets, social capital, human capital and social reproduction. If the supply of caring labour is inadequate in either quantity or quality, then the economy could be expected to not operate as well. The conceptualisation of the care economy is a way to make women’s activities visible which is needed to develop policies that improve their economic well-being.

The objectives of this project were to scope the Australian care economy by:

- Examining how the care economy may be defined
- Identifying the issues relevant to paid and unpaid care
- Collating a list of public policies which provide government support to the care economy
- Identifying the impact of the care economy on women's economic wellbeing
- Researching recent statistics on the Australian care economy, and
- Identifying gaps in the literature and areas for further research.

The approach was to conduct an extensive literature review. Searches were conducted using:

- Online journal data bases
- The Australian Bureau of Statistics and the Australian Institute of Health and Welfare websites
- Websites for Carers Australia and Australian research institutes, e.g. the Australian Institute of Family Studies, the National Centre for Social and Economic Modelling (NATSEM) and Access Economics
- Google and Google Scholar searches.

This report is a first attempt to outline the Australian care economy. Undertaken from primarily a feminist economics perspective, this care economy project covers both paid and unpaid care work and identifies the links between the two as important and under-researched. The next section discusses defining the care economy before moving to discuss the issues identified in the third section. The fourth section deals with the role of government and looks at policies in place to assist with both paid and unpaid care. The fifth section focuses on the impact of providing care on women's economic wellbeing. The final section presents the recommendations from this research and areas which have been identified as needing further research. An annotated bibliography of statistics currently available to measure various aspects of the care economy is included as an appendix.

The information contained in this report is intended as a first step towards mapping the scope and importance of the care economy and identifying issues that need to be addressed, particularly in relation to the economic security of women.

2. Defining the care economy

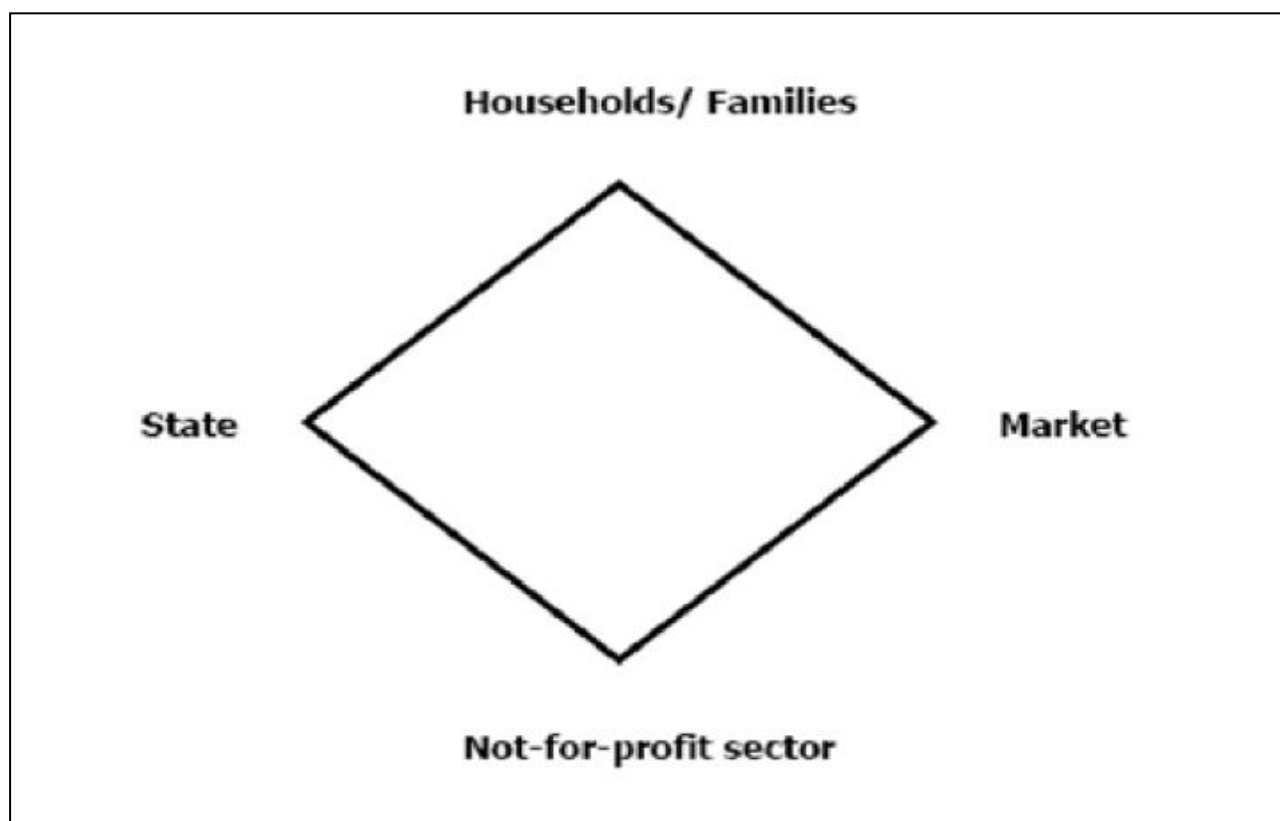
The care economy is very broad in its scope and covers both paid and unpaid care services. Research tends to be focused on specific aspects or particular types of services and there is scant literature that deals with the care economy as a whole. When assessing the care economy from an economic perspective, both macroeconomic and microeconomic viewpoints are relevant. Macroeconomics encompasses the performance, structure, behaviour and decision-making of an entire economy, which can be regional, state, national or global. Microeconomics views economic activity at an individual level, e.g. from the perspective of households or firms.

At a macroeconomic level, the care economy encompasses relevant parts of all four sectors of the wider economy: the domestic sector, the private sector, the public sector and the non-government organisations (NGO) sector. An American feminist economist Nancy Folbre recently defined direct care services as ‘paid or unpaid efforts to meet the needs of dependents, including direct care work that involves personal connection and emotional attachment to care recipients’ (Folbre 2009: 112). Households, businesses, governments and non-profit organisations are all involved in providing care services with each of these entities playing a part in the myriad of activities that comprise the care economy.

Feminist economists have argued that the care economy is influenced by macroeconomic factors and that the unpaid domestic sector is a primary site of production, such as bringing up children, with the domestic sector playing ‘a role in constituting the market circuit and determining how well it functions’ (Elson 1998: 195). The design, funding and delivery of care occur across families, markets, the state and the not-for-profit sector. Although these institutions can be represented by a ‘care diamond’ (Box 2.1), the boundaries between them are not clear-cut or static and the interactions between these institutions are complex. An example is the state funding not-for-profit organisations to deliver care services to the community.

The state is both a provider of services and a significant decision maker when it comes to the rights and responsibilities of other institutions. How the state uses its role fundamentally defines who has access to care and who bears the cost of its provision. ‘The effective creation, regulation and funding of care services can increase the access, affordability and quality of care and reduce time burdens placed on unpaid care-givers’ (United Nations Research Institute for Social Development (UNRISD) 2010: 2).

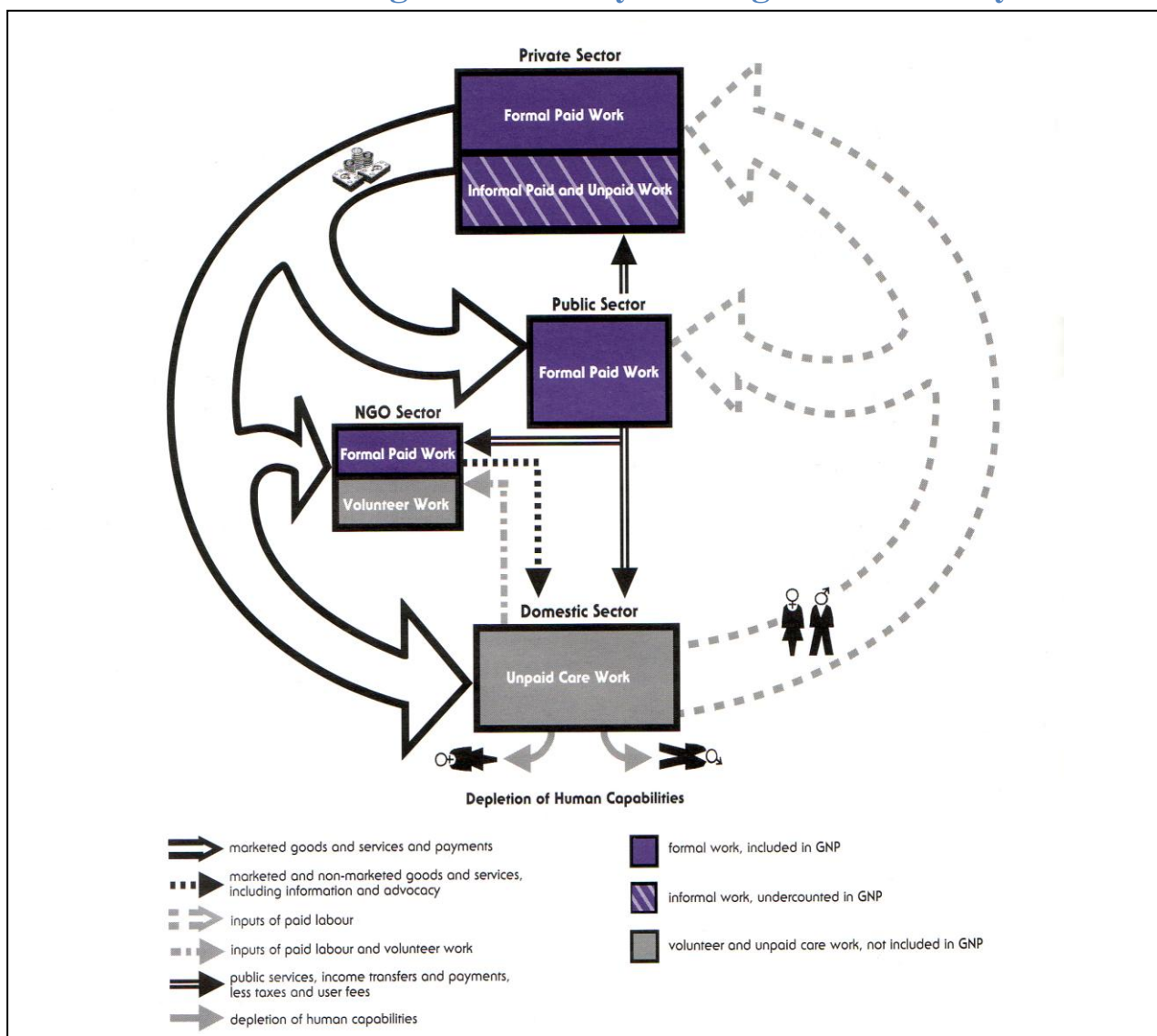
Box 2.1 The Care Diamond



Source: United Nations Research Institute for Social Development (UNRISD) 2010, *Why Care matters for Social Development*, United Nations, Geneva, p. 2.

The relationship between the domestic sector, the private sector, the public sector and the non-government organisations (NGO) sector is depicted in more detail in Box 2.2 as all four sectors are relevant to the care economy. These four sectors are linked by both market and non-market channels. The domestic or household sector supplies people to work in all the other sectors and the private sector sells goods and services to all other sectors. The public sector raises income through taxes and user fees, makes income transfers, and provides public services to the other sectors. The NGO sector is involved in providing services to the domestic sector sometimes for a fee and often financed by state funding (United Nations Development Fund for Women (UNIFEM) 2000: 26). An example is a wide range of community services provided in Australia by the NGO sector with the assistance of state funding. The care economy is now developing a significant international dimension with many women in developing countries leaving their families to work in childcare or eldercare in rich countries thereby producing a 'care drain' in their homelands (Folbre 2009: 190).

Box 2.2 Revisioning the Economy Through Women's Eyes



Source: United Nations Development Fund for Women (UNIFEM) 2000, *Progress of the World's Women*, New York, p. 26.

The most comprehensive definition from a macroeconomic perspective to date comes from a case study of the state of Massachusetts in the United States (Albelda et al. 2009), which categorised both paid and unpaid care work into *interactive care work* and *care support work*:

- *Interactive care work* is labour that is supplied directly through a face-to-face relationship that is directed to meeting the needs of a care recipient. Examples of unpaid direct care work are parents providing childcare in the home or a family member caring for a sick relative. Examples of paid direct care work are childcare workers providing childcare in a childcare centre and nurses providing health care in a hospital or via a community service.

- *Care support work* is the less visible support work that keeps the institutions of care running such as grocery shopping and cooking food in the home and clerical, cleaning and other staff that provide essential back-up services in formal care setting such as hospitals and childcare centres (Albelda et al. 2009: 7).

This study measured in detail three intersecting spheres : paid care work, unpaid care work and government investment in care (Albelda et al. 2009: 2) which made the value of care work visible (see pp. 9 & 10). No such study has yet been undertaken in Australia.

Different definitions have been used to describe different aspects of the care economy. ‘Care work’ and ‘carers’ has been defined differently by different individuals or institutions depending on the context in which they are dealing with the topic. As Folbre (2009) notes, the similarities between paid and unpaid care work often override the differences (p. 113) and many forms of care required by dependents involve a combination of paid and unpaid work. Families often need assistance from formal services to care for dependents and hospitals and schools rely on the cooperation of family members to operate successfully (p.114). The provision of unpaid care ‘may precede, substitute for, or take place alongside’ services provided by the formal care sector (Hales 2007: 18).

Much of the research on care work has focused on unpaid care. The term *informal* is used to describe care provided by the care recipient’s family or friends according to ‘communal norms and obligations without direction from the state’ (Hales 2007: 18) and is usually, but not always, provided free of charge (Access Economics 2005: 1). Informal care is provided to people who need assistance due to disability, chronic illness, a mental illness, terminal condition or frail, old age (Access Economics 2005: i; Carers Australia 2007b). Sometimes the term *family carers* is used to distinguish the role of unpaid care in the home from other caring roles such as that of paid care providers (Carers Australia 2007b). Although family care is usually provided as a response to the traditional role of families providing for their members, ‘the reality is that there are few acceptable care alternatives’ (Spicer 2007: 30). *Extended caring* has been used to describe caring for a child with a disability into adulthood (Cuskelly 2006:20) while *primary carer* refers to the person providing most of the care. Primary caregiving usually occurs daily, can be intense and typically extends over a number of years. About one-fifth of carers in Australia are primary carers (Hales 2007: 18).

Unpaid caring in the home covers a wide variety of caring situations and the needs of care recipients can differ greatly. To be able to provide care therefore requires an ongoing analysis of the issues involved, which are complex and changing (Spicer 2007: 30). Carers are most likely female and, on average, older and less likely to be employed than the general population (Access Economics 2005: 11). The reasons why people provide unpaid care include a sense of family responsibility, a belief that they can provide better quality care, a perceived emotional obligation, or because no one else was available (Hughes 2007: 32) with family responsibility and emotional attachment being the main drivers for the provision of care (Hales 2007; 22). Unpaid care activities usually centre on providing the care recipient/s with assistance in the activities of daily living, such as feeding, dressing, toileting and mobility, bathing and communication (Cuskelly 2006: 20; Hales 2007: 18). However, it has

been argued that there is a 'care load' which needs to be conceptualised much more broadly than just physical and personal care. A large number of caring roles involve 'constant vigilance, supervision, encouragement, nurturing, and the ensuring of medication compliance' (Carers Australia 2009b: 8).

Many of the issues surrounding unpaid care work also exist in paid care. Although formal care services are situated in 'the market', whether they are provided by for-profit or non-profit organisations, they have characteristics which transcend the boundaries of the market. 'Recipients of care benefit from the cultural construction of caring obligation, as well as from the personal connections and emotional attachments that often grow out of the care process itself' (Folbre 2009: 114). The term *marketised care* has been used to refer to paid caring labour provided in both the public and private sectors of an economy by both for-profit and not-for-profit providers because paid care services are increasingly being subjected to market principles (Adams 2008: 7).

However, care work has a 'different rationality' from other forms of paid labour based on a personal relationship which develops between the carer and the care recipient (Himmelweit 1995: 8). In the case of emotional labour, the 'work' cannot be separated from the worker (Himmelweit 1995: 9). Himmelweit (1999: 28) argues that a defining characteristic of labour is that it is done only for extrinsic reward and that 'care' cannot be understood within the same rationality as labour. Work contains a non-commodified element and so can encompass many of the relational characteristics of caring. 'In practice, it seems that the relationships developed through paid and unpaid care differ less than talk in terms of the rigid dichotomies of "public and private", "paid and unpaid", and "market and nonmarket" would suggest' (Himmelweit 1999: 36). This study scopes the care economy as encompassing both paid and unpaid care work.

In summary

The care economy encompasses relevant parts of all four sectors of the wider economy: the domestic sector, the private sector, the public sector and the non-government organisations (NGO) sector. The design, funding and delivery of care occurs across families, markets, the state and the not-for-profit sector. The boundaries between each are not clear-cut and the interactions between them can be complex. The state is both a provider of services and a significant decision maker defining who has access to care and who bears the cost of its provision.

The most comprehensive definition of the care economy found was in a case study of the state of Massachusetts in the United States (Albelda et al. 2009) which categorised both paid and unpaid care work into *interactive care work* and *care support work*:

- *Interactive care work* is labour that is supplied directly through a face-to-face relationship that is directed to meeting the needs of a care recipient.
- *Care support work* is the less visible support work that keeps the institutions of care running.

Unpaid care in the home has been defined by various terms including *informal care* (Hales 2007: 18), *family care* (Carers Australia 2007b), and *extended care* (Cuskelly 2006:20). The term *marketised care* has been used to refer to paid caring labour provided in both the public and private sectors of an economy by both for-profit and not-for-profit providers because paid care services are increasingly being subjected to market principles (Adams 2008: 7). Many forms of care required by dependents involve a combination of paid and unpaid care work.

Paid care has a different rationality to other forms of work in the market because it involves a non-commodified element involving a relationship between the carer and the care recipient.

3. Issues in the Australian care economy

The following section discusses issues relevant to the care economy across both paid and unpaid care. The range of issues is diverse but all are significant in their own way. Data issues affect how much can be known about the care economy. Longevity and an ageing population signal an increase in the demand for care and raise the issue of intergenerational caring. Informal care is essential for many care recipients to remain living in their own homes. *Welfare to work* was a policy package that impacted adversely on many lone parents and disabled people. Young carers are of concern because many do not self-identify and so are unknown while the care they provide often impacts adversely on their education and workforce participation. Formal care services provide important assistance to informal care and, in cases where a care recipient can no longer be cared for at home, provide residential care. Across the care economy both paid and unpaid carers are vulnerable to exploitation.

3.1 Data issues

A search of the statistical sources relevant to the Australian care economy reveals that different statistical data measure and report on different aspects of the care economy. Time Use Surveys (TUS) conducted by the Australian Bureau of Statistics (ABS) are the most important source of data on unpaid caring work in the home. Other ABS surveys provide complimentary data. Also useful is the Household, Income and Labour Dynamics in Australia (HILDA) Survey conducted by the Melbourne Institute. The Australian Institute of Health and Welfare (AIHW) provides annual statistics on government funded aged care services. Some of the data sources identified are specific surveys conducted for a particular purpose. An annotated bibliography of the statistical sources identified in this study is provided as Appendix 1. This section is focused on the issues identified in the available data.

The most comprehensive study found was the case study of Massachusetts (Box 3.1a) which used US Census and Time Use data to measure both paid and unpaid care work including care support work. This study makes the value of care work visible by calculating the percentage of the labour force involved in paid care work and the value this generated in terms of Gross Domestic Product (GDP); the number of hours spent in paid work as an equivalent of full-time workers; a monetary value for the unpaid care work supplied, the extent to which women supply paid and unpaid care; and the amount of local and state government spending on the care sector. No such study has yet been undertaken in Australia.

Box 3.1a The care economy in Massachusetts

Counting on Care Work: Human Infrastructure in Massachusetts

Randy Albelda, University of Massachusetts Boston

In September, Randy Albelda (University of Massachusetts Boston), Mignon Duffy (University of Massachusetts Lowell) and Nancy Folbre (University of Massachusetts Amherst) released the report, "Counting on Care Work: Human Infrastructure in Massachusetts." The report discusses the economic importance of care work, the role of the public sector in funding this work and then measures the care work in Massachusetts in 2007 by examining in detail three intersecting spheres: paid care work, unpaid care work, and government investment in care. The authors include in the *care sector* the labour and resources devoted to the daily care of Massachusetts residents, especially children, the elderly and those who are disabled; the provision of K-12 education; and the administration of health care to both the well and the sick, regardless of age.

Key findings include:

- In 2007 paid care work accounted for 22 percent of Massachusetts' paid labour force (800,000 workers) and generated a total value of \$46.8 billion, making up 13 percent of Massachusetts' state Gross Domestic Product (GDP).
- Massachusetts residents 16 years and older spent an average of 4.8 hours a day providing unpaid care or supervising those who need care, for a total of 24.9 million hours a day of unpaid care work (the equivalent of 3.1 million full-time workers).
- Valuing unpaid care work at the typical wages for paid care workers, the total value of unpaid care time is \$151.6 billion annually. If the value of the Massachusetts GDP were expanded to include unpaid labour, unpaid and paid care work together would account for 36 percent of the total.
- Women comprise 75 percent of paid care workers and provide 64 % of all time devoted to unpaid care activities.
- In fiscal year 2007, state and local governments in Massachusetts spent \$24 billion on the care sector. State and local government spending accounts for just under half (49 percent) of the total value of paid care services in the state.

Paid and unpaid care work are often complements, when combined they enhance the quality and efficacy of care work. State policies can and should support both unpaid and paid work. In the paid sector, government financed care work should require all care sector workers be paid appropriately with formal work protection. To support unpaid work, all workers need the ability to negotiate work-time flexibility with employers, paid sick days and family and medical leave, and viable part-time work options. Finally, the maintenance of the states' human infrastructure requires sustained and adequate public financing.

The research was funded by the UMass President's Office Create Economy Initiative and the executive summary and full report can be downloaded at <http://countingcare.org/>

Source: *International Association for Feminist Economics Newsletter* December 2009.

Recommendation 1

That *Security4Women* commission a study using a similar methodology to the *Counting on Care Work* study in Massachusetts using data from, for example, the 2006 Census of Population and Housing and the 2006 Time Use Survey. This study will require estimates to be calculated (or updated) of the economic value of both paid and unpaid 'care work' in Australia.

A study into the value of informal care in Australia highlights the importance of methodology when undertaking quantitative studies of care work and the different outcomes that arise from different methods. *Access Economics* calculated the dollar value of the informal care provided in Australia as a first step in estimating whether the current usage of informal and formal care models is socially optimal. This study used data from the 2003 Survey of Disability, Ageing, and Carers (SDAC) and extrapolated the number of carers in 2005 by applying the rates of informal care provision to 2005 demographics based on the ABS' population projections from 2001 Census data (*Access Economics 2005: i & 5*). Box 3.1b outlines the differences according to the methodologies used.

Box 3.1b Valuing Carers' Time

Access Economics identified three potential methodologies which can be used to place a dollar value on the level of informal care:

- the **opportunity cost method** – measures the formal sector productivity losses associated with caring because time spent in caring activities is time which cannot be spent in the paid workforce;
- the **self-valuation method** – measures that carers themselves feel they should be paid; and
- the **replacement cost method** – measures the cost of 'buying' an equivalent amount of care from the formal sector if the informal care were not supplied.

Estimates of the value of informal care are very sensitive to the estimation methodology used. In this study, the opportunity cost method was used to estimate a lower bound of the value of informal care, and the replacement cost method for the upper bound estimate.

Opportunity Cost Valuation – an attempt to measure the amount of paid work carers would have undertaken but for their caring responsibilities:

- It was estimated that in 2005 at least 112,600 carers would not be employed due to their caring responsibilities (4.3% of 2.64 million carers). In February 2005 the average weekly earnings of all workers was \$784.50 per week, equivalent to \$4.6 billion per annum
- **The minimum estimate of the opportunity cost of informal care is \$4.6 billion in lost earnings in 2005**
- Calculating the opportunity cost separately for primary and non-primary carers results in a higher figure
 - Primary carers have much lower rates of employment than the national average (42.1% compared to 59.1%) suggesting that 17.0% of primary carers were not in employment in 2005, a total of 84,100 primary carers
 - In 2005, 1.6% of non-primary carers were not in paid employment due to their caring role, around 35,200 people. Combined with 84,100 primary carers, this gives a total of 119,300 carers who were not in the workforce in 2005, equivalent to 1.1% of Australia's workforce in 2005
- **At average weekly earnings, this is equivalent to an opportunity cost of just under \$4.9 billion in 2005.**

Replacement Valuation – a method based on the cost of buying the number of hours of informal care provided from the formal care sector:

- Imputed average values are calculated for the average number of hours of care given per week by primary and non-primary carers
- The average hourly cost of employing a carer in the formal sector to replace an informal carer was estimated as \$25.01 in 2005.
- The value of informal care provided by primary carers in 2005 was estimated as \$16.6 billion
- The replacement value of care provided by non-primary carers was estimated to be \$14.0 billion p.a.
- **The total replacement cost of informal care in 2005 was estimated to be \$30.5 billion.**

Source: Access Economics. (2005). *The Economic Value of Informal Care*, Carers Australia, Canberra, pp. 10-15.

Time Use data, collected by the use of time diaries, provides a means of capturing the daily labour process of caring and studying how caring affects day-to-day activities (Bittman et al. 2004: 69). Because informal care is unpaid, it is not included in conventional accounting for welfare expenditure (Bittman et al. 2004: 70). Time Use diaries make care work in the home visible but there are some complications. Time Use diaries focus on activities which are recorded in Australia as primary or secondary. So when a parent is not actively involved in child care but is keeping an eye on children while doing other household work, the supervision of children is counted as a secondary activity. However, activities which are conducted on behalf of children are not usually considered as care. For example, cooking a child's meal is counted as part of meal preparation. 'The distinction between time spent in activities with children and time spent in activities on behalf of children has significant quantitative implications' (Budig & Folbre 2004: 53).

Another complication is that carers do not recognise much of the care work they perform as care (Bittman et al. 2004: 73). This results in coresidential caregivers recording only small amounts of time in 'voluntary work and care activities' which is designed to capture caregiving (Bittman et al. 2004: 76). 'This points to the displacement of the time signature of coresidential caregivers from voluntary work and caring activities to domestic activities', with coresidential carers working longer hours in most of the major categories of domestic activities (Bittman et al. 2004: 77). Despite its limitations, Time Use data is still the most comprehensive source of information on the unpaid but productive work undertaken in households but time use surveys are not undertaken on a regular basis. To date, the Australian Bureau of Statistics (ABS) has conducted time use surveys in 1992, 1997 and 2006. The most recent was undertaken in the same year as the *2006 Census of Population and Housing* which also included questions on unpaid work.

Recommendation 2

That the Australian Bureau of Statistics undertake regular Time Use Surveys in the same year as the Census of Population and Housing to inform decisions regarding support for unpaid care work.

Satellite accounts were recognised in the 1993 revision of the international System of National Accounts as a means of placing a monetary value on unpaid work. They are useful for measuring trends in unpaid work over time and how this relates to the market economy. Australian satellite accounts were produced by the ABS in 1992 and 1997. Given the importance of unpaid care, satellite accounts need to be produced regularly. It has been argued that for as long as economists define 'output' entirely in terms of market income, efforts to increase the level and quality of care will be deemed 'unproductive' and inefficient. The availability of time use surveys provides an important opportunity to incorporate estimates of the value of unpaid care services into the value of Gross Domestic Product and household standards of living which is essential to the development of a stronger care economy (Folbre 2009: 124).

When viewed at a macroeconomic level, care is an important contributor to the economy but also limits its growth. Satellite accounts reveal that the output derived from unpaid care is comparable with the output of major industries in the paid economy. As GDP growth rates do not account for unpaid labour, they can over- or under-estimate the growth rates for the economy as a whole (paid and unpaid) because there is no acknowledgement of the extent to which the transfers of unpaid care or other labour between the paid and unpaid economies inflate or deflate GDP. Because caring labour is increasingly being transferred from the unpaid economy to the paid economy, it is probable that GDP-based growth rates are systematically higher than ‘whole economy’ growth rates which are a better indication of the sustainability of current trends (Himmelweit 2007: 582).

Recommendation 3

That the Australian Bureau of Statistics regularly produces satellite accounts in line with the international System of National Accounts so that estimates of the value of unpaid care services are available for comparison with the value of Gross Domestic Product.

The ABS *2003 Survey of Disability, Ageing, and Carers (SDAC)* is the most comprehensive source of information on the informal care provided to people with disabilities. It has been undertaken again in 2009 but the results are not yet available. This means that there is no recent information available at the time of this report.

In summary

Methodology is important when undertaking quantitative studies of care work as different outcomes arise from different methods.

Time Use Surveys (TUS) are the most important source of data on unpaid caring work in the home. Because informal care is unpaid, it is not included in conventional accounting for welfare expenditure. Regular collection of Time Use Surveys is needed to inform decisions on unpaid care work undertaken in Australian homes.

Satellite accounts, recognised in the 1993 revision of the international System of National Accounts, place a monetary value on unpaid work. They are useful for measuring trends in unpaid work over time and how this relates to the market economy. As GDP growth rates do not account for unpaid labour, they can over- or under-estimate the growth rates for the economy as a whole (paid and unpaid).) Because there is no acknowledgement of the extent to which the transfers of unpaid care or other labour between the paid and unpaid economies inflate or deflate GDP, satellite accounts provide a better indication of the sustainability of current trends and need to be produced regularly.

3.2 Gender equity

The provision of care is a highly gendered activity which reproduces inequality between men and women (Folbre 2009: 112). Although care work is undertaken by both men and women, in the market as well as within the family, the concept of care is located more within the feminine than the masculine realm because caring has ‘particularly salient emotional dimensions, and it often involves strong moral obligations’ (England & Folbre 2003: 63). More women than men provide both paid and unpaid care. In Australia, according to the *2003 Survey of Disability, Ageing and Carers*, informal care was provided by 2.5 million carers aged 15 years and over (16% of this population) to someone with a disability or someone who was aged 60 years and over. A higher proportion of women (17%) than men (14%) provided care. (Australian Bureau of Statistics 2008b: 7).

Although providing informal care generates intrinsic rewards, stronger family ties, and high-quality services for dependents (Folbre 2006b: 184) and results in the caregiver experiencing a personal sense of satisfaction and achievement (Spicer 2007: 30), it also imposes a significant social, emotional and economic cost to the caregiver (Spicer 2007: 30). The economic costs take the form of financial obligations, lost opportunities and foregone wages (Folbre 2006b: 184).

Similarly, in paid care industries, most of the workers providing care are women. In 1996, 89.6% of care workers in community services were female, and in 2001, 88.4% of care workers were female. In several caring occupations in community service industries—nursing, therapies, pre-primary school teaching, and child care—more than 90% of workers were female in both 1996 and 2001 (Meagher & Healy 2005: 11). In the residential and community aged care workforce, an overwhelming 93% of residential workers and 91% of community based workers are women (Martin & King 2008: ii). The gendered nature of caring was recognised well over a century ago by Florence Nightingale:

Every woman, or at least almost every woman, in England has, at one time or another of her life, charge of the personal health of somebody, whether child or invalid,—in other words, every woman is a nurse. (Nightingale 1861: 3)

A study using US Census data found that caring work attracts a ‘wage penalty’ in that care work pays less than other occupations after controlling for the education and experience of the workers, many occupation and industry characteristics (England, Budig & Folbre 2002). An Australian study found that registered nurses earn significantly less than other female professionals and that the observed differentials cannot be explained by differences in human capital endowments (Nowak & Preston 2001).

Because of the gender breakdown, the personal costs of providing both paid and unpaid care are borne disproportionately by women. This situation can lead to inequality among women. Single childless women and widows typically earn a higher disposable income than mothers

of young children. Women may choose not to pay this price by remaining childless. Decline in fertility rates below replacement levels has already occurred in Italy, Spain, Japan and North Korea and appears to be a growing trend. Conversely, women who fear for the well-being of children or other dependents are reluctant to pursue gender equality. Policies that encourage both men and women to combine paid work with family care are needed to rectify these inequities (Folbre 2006b 184). Improved working conditions and wages are also needed in paid caring occupations (Folbre 2006b: 119). ‘The social provision of a generous, equitable, sustainable, and efficient supply of care is a prerequisite of genuine gender equality’ (Folbre 2009: 112).

Recommendation 4

That *Security4Women* lobby for policies that encourage men as well as women to combine paid work with care in the home to rectify the gender imbalance in the provision of unpaid care in line with international best practice which includes specified ‘daddy leave’ days, parental leave paid at replacement level and flexible leave provisions.

In summary

More women than men provide both paid and unpaid care. Although providing informal care generates intrinsic rewards, it also imposes a significant social, emotional and economic cost to the caregiver. Paid care work attracts a ‘wage penalty’ in that care work pays less than other occupations. Because of the gender breakdown, the personal costs of providing both paid and unpaid care are borne disproportionately by women and can lead to inequality among women. Policies that encourage both men and women to combine paid work with family care are needed to rectify these inequities and improved working conditions and wages are needed in paid caring occupations.

3.3 Longevity, an ageing population and intergenerational caring

The combination of an ageing population and increased longevity poses a challenge to the adequate future supply of caring labour. Due to advances in medical care and other services, people with disabilities are now living longer. At the same time, family carers are ageing and will increasingly be unable to keep providing the same level of care. It is also the case that people with certain disabilities age at a faster rate than non-disabled people. This may lead to an increase in their disability level. To date there has been little planning or support given to determine who will care for people with disabilities when their family carer can no longer continue to provide an adequate level of care (Spicer 2007: 31).

Two important implications of an ageing population is that there is going to be an increasing number of employed carers and care recipients whose care needs are becoming more complex. Rather than juggle the competing demands of work and care, many carers will reduce their working hours or exit the labour force (Hales 2007: 23). The aging population is spawning a 'sandwich' generation of carers who are caring for a child and have an elderly relative who also requires care (Hill et al. 2008: 27) or a frail parent and a partner or child with a disability or chronic condition. The majority of these carers are women (Carers Australia 2007b). A 2009 survey of women members of the Community and Public Sector Union found that of the 51.3% of women caring for their parents, 38.9% also have dependent children and that almost two-thirds of this 'sandwich generation' worked full-time (64.1%) (Community and Public Sector Union (CPSU) 2010: 19).

Recommendation 5

That *Security4Women* investigate what forms of support would assist 'sandwich' generation carers who are caring for children as well as an adult family member who requires care.

Another intergenerational issue is that when a mother providing care to an adult disabled child becomes too old to continue the role, siblings may have to undertake the caring. Caring should not be a lifelong or inter-generational commitment where death or inability are the only ways in which it can be concluded. For people with disabilities and their families to exercise any choice there must exist a range of alternative care and support arrangements. Such intergenerational issues have not received a high degree of community attention which is complicated by a lack of adequate data on these issues (Spicer 2007: 31).

A US study of intergenerational filial responsibility found that filial norms weakened from the 1980s to the 1990s which provides some empirical evidence for claims that the family as an institution may be in decline (Gans & Silverstein 2006: 972). However, the same study found that women from young adulthood through to old age consistently expressed stronger norms of filial responsibility than men but the strength of the norms began to weaken earlier in life for women. The researchers surmised that women's greater socialisation and involvement in caring roles resulted in a more realistic appreciation of the effort and demands involved (Gans & Silverstein 2006: 973).

Many chronic and disabling conditions are age-related which suggests that more people may require care in the future. As there will be a smaller number of younger people and work and family conditions are changing, there may be a reduction in the desire or the ability to provide informal care. This would result in either a lower supply of informal care or a growth in supply which is lower than the demand (Access Economics 2005: ii). However, it has been argued that increased demand due to an increasing number of people who need assistance does not necessarily mean that families are not as willing to care for their own as previously. 'There is plenty of evidence to suggest that such an implication lacks substance' (Hales 2007: 20).

In summary

The combination of an ageing population and increased longevity poses a challenge to the adequate future supply of caring labour. There is going to be an increasing number of care recipients whose care needs are becoming more complex. Rather than juggle the competing demands of paid work and care, many carers may reduce their paid working hours or exit the labour force. The aging population is also spawning a 'sandwich' generation of carers who are caring for a child and have an elderly relative who also requires care.

3.4 Unpaid care

In Australia, informal carers are more likely to be women and older than the general population (Access Economics 2005: 11). All carers are less likely to working full-time than the Australian average (42.05) with the rate of full-time employment for primary carers being less than half that of the general population at 19.2%. The full-time employment rate for non-primary carers is also below average at 36.4%. Carers are more likely to be working part-time with 22.8% of primary carers and 21.1% of non-primary carers employed part-time compared to 17.2% of the general population (Access Economics 2005: 12). It was estimated that in 2005, at least 112,600 carers were not in employment due to their caring responsibilities (4.3% of 2.64 million carers) (Access Economics 2005: 12).

In 2003, almost half of primary carers (48%) had hours of caring at least equivalent to a full-time paid job of 40 hours or more per week. One-fifth of all carers (22%) had taken dissaving actions such as borrowing money in the previous 12 months, 19% had experienced cash flow problems, and 15% had difficulty paying bills (Australian Bureau of Statistics 2008b: 5). It has been argued that paid and unpaid parental leave should be extended to cover family, friend and neighbour care for people who are sick, elderly or disabled as well as young children thereby assisting carers to participate in the labour market (Folbre 2009: 122).

Recommendation 6

That *Security4Women* advocate for the availability of paid and unpaid leave to cover family, friend and neighbourhood care, similar to parental leave provisions, to assist carers to participate in the labour market.

Documented positive aspects of caring are a personal sense of satisfaction and achievement (Spicer 2007: 30) and, for parents caring for intellectually disabled adults, mutual benefits including companionship, assistance with household tasks and emotional support. In some cases the care that the adult child provides assists elderly parents to stay in their own home. Parents also report personal growth and improved family relationships (Cuskelly 2006: 20). It has also been reported that factors contributing to a positive caring experience are having the support of other family members and having a sense that there was some choice in the decision to provide care (Milward in Hales 2007: 21).

Negative aspects of caregiving experienced by parents of adults with intellectual disabilities include coping with behaviour problems, negative emotional reactions to some of the consequences of extended caring, carers experiencing physical and mental health problems, subjective burden, social isolation (Cuskelly 2006: 22 & 23) and loneliness (Spicer 2007: 31). A national survey of carers who were receiving government assistance to care for a person with a disability found that carers had lower levels of face-to-face contact with friends or relatives not living with them than the general population. Face-to-face contact outside the household once or twice every three months was experienced by 18.3% of carers compared to

10.2% of the general population (Edwards, Higgins & Zmijewski 2007: 12). This signals a need for better access to respite care.

In 2003, about half of primary carers reported that they had no main source of assistance with their caring role. Although about the same proportion said there was a fall-back informal carer, 13 % nominated a formal service provider as their main source of assistance. Access to a fall-back carer was less likely for spouses and partners than other groups of primary carers. Although 69 % of primary carers in 2003 were not receiving assistance and said they did not need it, around one-third of primary carers desired an improvement or more support. This included instrumental assistance, non-instrumental assistance and improved personal circumstances such as improved health or an improved capacity to care with better financial support being a prominent desired form of additional support (Hales 2007: 22). Research into the subjective wellbeing of carers found that carers have the lowest health and wellbeing of any group yet researched; female carers have lower wellbeing than male carers; and in terms of household composition, the most disadvantaged group are sole parents (Cummins & Hughes 2007: vi).

Decisions to continue or relinquish caregiving by family carers providing assistance with daily living to frail older people and young people with a disability were influenced by the experience of caregiving and external signals of its value. 'Perhaps the greatest single jeopardy to the future supply of informal care is a failure to acknowledge and adequately support the present high levels of caregiving by families' (Hales 2007: 22). Part of the required support is an increased system capacity for family-focused and timely intervention (Hales 2007: 23).

Recommendation 7

That *Security4Women* advocate for increased instrumental support for unpaid care in the form of affordable assistance from formal care services such as domiciliary care.

An analysis conducted by Access Economics on the average cost of care found that combinations of informal care and community-based formal care generally cost less than institutional care. However, the government subsidy for informal care is much lower than other care streams (Access Economics 2005: 37). Services such as respite that are more directly related to carers' needs are generally perceived to be inadequate and inflexible (Cuskelly 2006: 24). There is funding for respite for employed carers through the Employed Carers Innovative Project but there is a lack of affordable care options for sole-parent carers, carers on low income, and carers of people with a disability, mental illness or chronic conditions (Hughes 2007: 33).

Recommendation 8

That *Security4Women* advocate for an increase in the availability and affordability of respite care for sole-parent carers, carers on a low income, and carers of people with a disability, mental illness or chronic conditions.

A report on government services found that only 12.8% of the potential population of disabled people were using respite services in 2007-08 (Productivity Commission 2010b: 14.28). Of the disabled people using respite services, 82.2% needed assistance with activities of daily living (Productivity Commission 2010b: 14.31). Nationally, in 2007-08, the proportion of the outer regional and remote/very remote population who used government funded respite services was 1.9 service users per 1000 population. This is higher than the proportion of the major cities and inner regional population where the rate of usage is 1.5 service users per 1000 population (Productivity Commission 2010b: 14.35). The proportion of the Indigenous population who used government funded respite service nationally in 2007-08 was also higher at 3.3 users per 1000 population compared to 1.5 service users per 1000 of the non-Indigenous population who used these services (Productivity Commission 2010b:39). However, the report did not contain any data on people who require respite care but have not been able to access it.

A national survey of 1,002 carers who receive an Australian Government Carer Payment and/or Carer Allowance conducted in 2006 found that almost half of the carers' families did not use any support services (47.9%). For those who did, the most commonly used services were respite care or a general practitioner. Respite care was used by 13% of families caring for a disabled person. For the few who did use respite services, over one-third of families used 10 hours or less a month (37.1%), one in five used 11 to 20 hours per month, and 16.9% of families used 51 hours or more a month (Edwards et al. 2008: 26 & 27). There were 46.1% of carers who indicated that they needed more support (Edwards et al. 2008: 40). One of the tasks that carers most often indicated they had no support with was 'going to the shops' (Edwards et al. 2008: 38). This is a task which respite care in the home could greatly assist. Media reports indicate that many families caring for disabled children receive no support (Noonan 2010).

Recommendation 9

That the Australian Government works with State/Territory Governments to reduce the waiting lists for respite care of families with disabled children.

Ozchild, a not-for-profit Australian children's welfare agency, is unable to meet the growing needs of disabled children with over 100 children currently on waiting lists and desperately requiring respite care (Ozchild n.d.). Anglicare, another not-for-profit organisation, reports that in families where one or more children have a severe or profound intellectual disability there are no long term adequate respite support services for these families. Nor are there

sufficient out of home long term accommodation options once the child reaches 18 years of age (Anglicare 2010).

Recommendation 10

That FaHCSIA undertake a proper assessment of the needs of families with disabled children and establish a minimum amount of respite care to be made available to families of differing circumstances.

While informal carers are providing care that benefits the person they support, they also ‘significantly reduce the ever-increasing strain on Australia’s health care system (Hughes 2007: 32). A comparison between the value of informal care in dollar terms and the formal health and community sector showed that informal care provides significant cost savings to individuals and governments. In 2005, informal care was estimated to be worth at least 9.9% of value added in the formal health and community sector. If it were to be replaced, it would require 62.2% of current health and community sector resources (Access Economics 2005: 18).

It is also important to note that the market does not offer a perfect substitute for the informal care provided in families. The relationships and person-specific skills involved in family caregiving is not easily replaced in formal care services (Albelda et al. 2009: 19). ‘Policies designed to support and reward family care cannot be considered costly “luxuries” but instead are necessary investments in our work force as well as a testimony to our humanity’ (Albelda et al. 2009: 20). If governments do not implement generous support for informal care, those who assume caring responsibilities will pay a high price for doing so, people will become less willing or able to fulfil caring norms and those norms will become eroded. Standards and availability of care will fall with a high cost, both to society as a whole and to those individuals who continue to care (Himmelweit 2007: 598).

In summary

Carers providing unpaid care are mostly older women who are working part-time or are not in the labour force due to their caring responsibilities. They frequently experience financial difficulties and need support to be able to participate in the labour force. Although having the support of other family members contributes to a positive experience of caring, about half of carers have no main source of support and one-third of primary carers require more support. Carers have the lowest subjective wellbeing of any group yet studied with lone parents being the most disadvantaged. Combinations of informal care and community-based formal care cost less than institutional care but the government subsidy for informal care is much lower than other care streams. In particular, there is a shortage of respite care. Adequate public support for unpaid care is necessary if an adequate supply is to be maintained.

3.5 ‘Welfare to Work’

Welfare to work was introduced shortly after *WorkChoices* as a continuation of the neoliberal project of removing market constraints such as labour market protections and social security provision (Cook 2006: 83). The discussion in this report is centred on those aspects of *Welfare to Work* relevant to the care economy.

In the 2005-06 Budget the previous (Howard Coalition) Australian Government introduced *Welfare to Work*, a policy package with the stated aims of simultaneously increasing workforce participation and reducing welfare dependency with a ‘strong safety net’ in place for those who needed it. The Government argued that before the introduction of this reform package only 15% of the 2.6 million Australians on income support were required to actively look for work. Since 1974, the proportion of working age Australians receiving income support had risen from 5% to 20%. Although strong economic growth since 1996 had lowered unemployment, there was little reduction in the growth of single parents and people with disabilities on welfare. Around 690,000 children were living in jobless households. The government’s stated rationale was that strong economic growth and the increasing desire for and availability of part-time work provided an opportunity to rebalance Australia’s welfare system so that it better met the needs of the 21st century (Australian Government 2006).

The funding allocated to *Welfare to Work* in the 2005-06 Budget was a total of \$3.6 billion over four years. More than \$2 billion was targeted on services to underpin the reforms over four years commencing in 2005-06 which included \$681 million for Job Network, \$266 million for child care and \$170 million on disability open employment services. The changes to Newstart (the main unemployment benefit in Australia) was estimated to cost \$3.6 billion over four years (Australian Government 2006).

The *Welfare to Work* package introduced ‘participation’ requirements for new applicants after 1 July 2006 including sole parents and people with disabilities who are able to work between 15-30 hours a week, placing them on Newstart. The Newstart allowance payment was lower than pension payments and partially offset by ‘enhancements’ such as access to pharmaceutical benefits, health cards or mobility allowances for disabled people, or child care or support programmes within the Job Network to assist in entering the workforce (Carney 2006: 27 & 28).

Much of the responsibility for the government’s participation agenda has been moved from the Department of Families and Community Services to the Department of Education, Employment and Workplace Relations where the *Welfare to Work* guidelines were developed (McDonald & Marston 2006: 177). These reforms closed the divide between welfare and work and have been critiqued as ‘a stark example of the capacity to transform welfare into an instrument for insisting that people accept any job, on any minimally acceptable terms and conditions, including irregular or “non-standard” employment’ (Carney 2006: 28).

As recipients of the Carer Payment and payments from the Department of Veterans' Affairs were exempt from the *Welfare to Work* provisions (Australian Government 2006), the main impact from a care perspective was on parents receiving the Parenting Payment and people receiving a Disability Support Pension. The Australian Council of Social Service predicted that the people who would be worse off under *Welfare to Work* were people with disabilities and single parents who apply for social security after July 2006 and receive Newstart Allowance, Austudy Payment or Youth Allowance instead of the Disability Support Pension or Parenting Payment (Single). As well as being lower than pensions, these payments have stricter income tests for part-time workers and the student payments lack some of the supplements and benefits that apply to pensioners (Australian Council of Social Service (ACOSS) 2006: 2).

Under the *Welfare to Work* provisions, breaches of the requirements resulted in penalties. As a last resort, payment could be stopped for eight weeks for serious participation failures although there was a provision for case management to 'avoid unreasonable hardship on individuals and their families' (Australian Government 2006). However, it has been argued that 'the inequities and lack of "rights culture" associated with benefit sanctioning behaviour within the Job Network flouts core legal principles, undermining both principles of procedural fairness (natural justice) and the rule of law'. The operational discretion of Agencies has been greatly expanded in the Job Network 'market' with power being concentrated in the hands of front-line workers in these organisations. The 'operating culture is now the entrepreneurial culture of "what-ever-works" rather than the culture of bureaucratic regularity and fair process' (Carney 2006: 40). The combination of greater participation requirements and harsher penalties for non-compliance drives some of the most disadvantaged sections of the population into competition for low wages and precarious employment (Cook 2006: 89).

A research project on social workers and welfare reform within Centrelink reported that the social work service has been transformed from a generalist service to the promotion of 'participation' as core business, which binds social workers into the 'work first' agenda (McDonald & Marston 2006: 178). Social workers' decisions in relation to adverse participation reports requires more justification under *Welfare to Work* than previously (McDonald & Marston 2006: 179) and their intention to support people's material and social wellbeing is in conflict with 'an organisational requirement to reduce their income support payments' (McDonald & Marston 2006). The next two sections looks more specifically at *Welfare to Work* in relation to low income parents and people with disabilities.

3.5.1 Parents

Under *Welfare to Work* current Parenting Payment recipients had access to their current payment protected but were required to seek part-time work once their youngest child was seven years old. They had a year to seek work voluntarily from 1 July 2006 or when their youngest child turned six years of age. After that, they become subject to an obligation, based on their capacity, to seek part-time work of at least 15 hours per week. These stipulations were applicable to both partnered and single Parenting Payment recipients.

When their youngest child became six years of age, these parents received enhanced Newstart Allowance which provided financial support to people looking for work. Single parents on Newstart with a youngest child aged six to 15 years of age receive a Pensioner Concession Card and Pharmaceutical Allowance. Partnered parents on Newstart continue to receive the Health Care Card (Australian Government 2006). To assist parents in the transition from welfare to employment, education or training, the Government implemented a \$266 million package which included 84,300 extra Outside School Hours Care places, 2,500 extra Family Day Care places, 1,000 extra In-Home Care places, and assistance with any 'gap' in child care fees for 52,000 families through Jobs, Education and Training Child Care fee assistance (Australian Government 2006).

Lone parents receiving Parenting Payment were a major target group of the *Welfare to Work* policy. In 2005 when the policy was introduced, around 45% of single Parenting Payment recipients were already employed, mainly part-time. In July 2005, the unemployment rate for single parents was 12%, more than double the national average of 5%. In response to the *Welfare to Work* policy, the Australian Council of Social Services argued that the 55% of Parenting Payment (Single) recipients who were unemployed would have more difficulty getting a job than the 45% who were already employed (Australian Council of Social Service (ACOSS) 2006: 3).

Barriers to employment for jobless single parents are numerous. For 60% who have only 10 years of schooling, the prospect of finding a job is halved. Just over 50% have spent most of their 'working lives' since leaving school caring for children limiting their opportunity to gain work experience. Over 20% have experienced physical or sexual violence within the last year; 45% have a mental illness, including 20% who suffer from depression; around 5% have a disabled child and a quarter have a disability themselves. Many have recently separated from their partner, a major life change which often involves moving home, new schools for children and legal disputes. Also, around 10% of Parenting Payment (Single) recipients move out of capital cities each year due to marital separation or unaffordable rents which reduces their job prospects in the short term by half (Australian Council of Social Service (ACOSS) 2005: 4). Unemployment is higher in regional Australia so people in rural areas who receive lower payments under *Welfare to Work* have difficulty in avoiding income losses by getting full-time work (Australian Council of Social Service (ACOSS) 2006: 3).

Many low-skilled sole parents who have spent years outside the paid workforce caring for children have latent skills which they haven't had the opportunity to test or develop. These jobseekers are often highly motivated to study or undertake training and benefit from such opportunities (Australian Council of Social Service (ACOSS) 2008: 20). However, the average training using Job Seeker Accounts funds was just \$300 per person. An official evaluation of Customised Assistance indicated that, on average, it improved the short term prospects of long-term unemployed people by 10%. Because 8% of this improvement occurred during the first month of Customised Assistance, this improvement in job prospects may be concentrated on those job seekers who are most likely to obtain a job quickly.

Although not all jobseekers in the Customised Assistance stream need substantial help to overcome barriers to work, providers were discouraged from offering extended assistance to those that do (Australian Council of Social Service (ACOSS) 2008: 23). Even though modest improvements in overall job outcomes can sharply reduce overall reliance on income support over time, providers were discouraged from risking investment in jobseekers to overcome barriers to work because returns were uncertain and rewards limited. This suggested that in the Job Network system too much of the risk of investment had been shifted to providers (Australian Council of Social Service (ACOSS) 2008: 24).

An analysis of payees affected financially by *Welfare to Work*, which focused on those who may have qualified for Parenting Payment Single (PPS) if *Welfare to Work* rules had not been introduced, was conducted by the Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA). As at 1 July 2008, the difference between receiving Parenting Payment Single and receiving Newstart Allowance 'with child' was \$37 per week. Around 10,700 single payee parents were financially affected by both the *Welfare to Work* changes and child support changes. (This represents 9% of single parents on income support with participation requirements. The remaining 91% remained eligible for PPS under *Welfare to Work*).

There were slight differences in the proportion of payees having no change (18% of the *Welfare to Work* cohort compared to 13% overall) and in those experiencing a net increase (33% of the *Welfare to Work* cohort compared to 37% overall). Approximately 38% of the 10,700 parents had an income over \$15,000 which indicated that they had earnings in addition to income support payments. Approximately 33% of the 10,700 parents had a net increase in combined child support and Family Tax Benefit, 18% experienced no change, and 49% had a net loss. Most parents experienced a change of \$20 per week or less, with many having a change of \$10 per week or less. For most (92%) of the parents who experienced a change, the change represented less than 21% of their child support and FTB entitlement (Department of Families 2009k). However, for a sole parent already living on a low income, a decrease in income of \$10-20 per week increases stress and financial hardship.

According to UNICEF's report on child wellbeing in rich countries, variations between countries in the proportion of children growing up in lone-parent families do not explain national poverty rates. Sweden has a higher proportion of its children living in lone parent families than the United States or the United Kingdom but a much lower child poverty rate than either. The deciding factor is higher government support and social benefits (UNICEF 2007: 7).

3.5.2 People with disabilities

People in receipt of Disability Support Pension (DSP) prior to 1 July 2006 were able to remain on DSP with no part-time work obligation. They remained subject to the normal review process for DSP which applies the existing eligibility criteria based on being able to work 30 hours per week. People seeking to go on DSP after 1 July 2006 received DSP if they were assessed as being incapable of 15 hours work a week at award wages. If they were

capable of working 15-29 hours per week, they received Newstart and were subject to an obligation to seek part-timework. People with disabilities with a part-time obligation received a Pensioner Concession Card and Pharmaceutical Allowance. They were also be eligible for a higher rate of Mobility Allowance of \$100 per fortnight (Australian Government 2006). The introduction in Australia of compulsory participation requirements for jobseekers with disability is a trend evident in OECD countries with similar stipulations in place in Austria, Denmark, Spain and Switzerland (Macali 2006: 233).

In the 2005-2006 Commonwealth Budget, the number of places in disability open employment services to help people with disabilities to find and retain jobs was increased by 20,600 places to meet the demand from new job seekers. Similarly, rehabilitation places were increased by 41,600 places. Additional funding was also provided for an extra 12,300 vocational education and training places at a cost of \$43 million over three years. The Language, Literacy and Numeracy Programme was also expanded by 2,900. Two schemes in place to help employers of people with disabilities were also expanded: the Workplace Modification Scheme was expanded at a cost of \$29 million over four years and the Wage Subsidy Scheme was expanded by \$12 million over four years (Australian Government 2006).

It was reported in 2004 (Macali 2006) prior to the reforms that for the majority of people assisted by Open Employment Services, about 85% of those placed in work achieved permanent employment. Over one-third were employed on a full-time basis and 66.5% worked over 16 hours per week (Macali 2006: 230). However, these were people with a disability who voluntarily sought employment. Major barriers to employment for people with disabilities include lower levels of tertiary qualification, post-school and secondary education completion; increased costs associated with everyday living and participation in work or study; and a high proportion of disabled people do not have basic literacy and numeracy skills. In addition, 'the compounding impact of socio-economic disadvantage can affect health, nutrition, environment and social networks which in turn can reduce individual capacity for work, study or participation in the community' (Association of Competitive Employment (ACE) 2005 in Macali 2006: 233). It was also reported by the Productivity Commission in 2004 that discrimination in employment for people with disabilities had not been significantly reduced nor greater opportunities for employment created despite the Disability Discrimination Act being in place for over 10 years (Macali 2006: 236).

However, employment assistance for jobseekers with chronic illnesses or social barriers to work such as mental health disorders, addiction or homelessness are poorly integrated with health and social support services. Personal Support Program providers often find that the support services their clients need are either not available or are not oriented towards helping them secure employment (Australian Council of Social Service (ACOSS) 2008: 26).

Semi-structured interviews conducted with mental health professionals in New South Wales found that since the introduction of *Welfare to Work* there had been a heightened anxiety in their clients who were living with mental illness, there was a lack of employment support for

their clients, and there had been a negative effect on mental health professionals themselves with an increased workload and decreased well-being (Breakspear & O'Neill 2007: 5).

This situation provides an example of how tightening support through the welfare system in one area produces an increased demand in another area. Because of the stress generated by the *Welfare to Work* changes in people with mental illness, additional support is required from mental health services. This, in turn, produces stress in the professionals who experience work intensification. Changes in one area of the care economy impact on other areas. The implication of these flow-on effects is that saving public funding in one area often means that more resources are required in another area.

3.5.3 Other factors affecting both sole parents and people with disabilities

The income support system for working-age people implemented through *Welfare to Work* was based on a simple distinction between two groups of recipients—‘pensioners’ who are ‘unable to work’ and ‘allowees’ who are ‘able to work’ with payment levels reflecting this distinction. In 2008 the Newstart Allowance for a single adult was \$215 per week which was \$58 per week less than the pension when the Pharmaceutical and Telephone Allowances paid to pensioners was included. The gap in payments for a sole parent was \$41 per week. People on Allowance Payments also usually missed out on the concessions received by pensioners.

Commentators/critics of the program argued that these inequities in the system arose because payments were based on historical views about which groups are more or less ‘deserving’ of support rather than people’s actual income support needs. For example, a disabled person on Newstart with high transport costs due to their disability received less than a Disability Support pensioner who might not have incurred such costs. In the past the justification for separate payment rates for pensions and allowances was that only short term income support was needed by people on Allowances but as the profile of Newstart Allowees has become more disadvantaged, that assumption is no longer correct (Australian Council of Social Service (ACOSS) 2008: 28). ‘The argument for compulsory economic and social requirements is based on the false premise that people with disabilities and parents do not participate “sufficiently”, de-legitimising child care and other activities as participation’ (Cook 2006: 90).

Another inequity contrary to the spirit of the Government’s Skills Agenda was that Austudy payment for full-time adult students was \$37 per week less than Newstart Allowance thereby discouraging jobless people from undertaking educational courses to improve their future job prospects. A further complication was that a range of conditions of payment such as assets tests and residency requirements were different for working-age pensioners and Allowees. These historical differences have no logical basis and substantially increase administration costs. Such barriers to employment embedded in the two-tier income support system make transitions between the pension and allowance systems, such as when a sole parent’s child reaches the age of eight years, particularly difficult (Australian Council of Social Service (ACOSS) 2008: 29 & 30). Furthermore, many of those who gain employment are ‘likely to cycle through periods in precarious part-time or casual low wage employment and periods of

income support and will comprise a ready supply of low wage labour with little discretion over their employment conditions (Cook 2006: 92).

In summary

The *Welfare to Work* policy package was introduced in the 2005-06 Budget with the stated aim of reducing welfare dependency by requiring more Australians on income support to look for work. ‘Participation’ requirements applied after 1 July 2006 requiring 15 – 30 hours per week of labour force participation with targeted people being moved to Newstart allowance payment which was lower than pension payments. From a care economy perspective, those most affected were single parents receiving Parenting Payment whose youngest child was school age and people on the Disability Support Pension. Despite numerous barriers to work force entry for single mothers and disabled people, there was inadequate funding allocated for job training and providers of Customised Assistance were discouraged from providing substantial help to overcome barriers to work due to uncertain returns on their investment.

The *Welfare to Work* policy package ‘participation’ requirements impacted most on parents receiving the Parenting Payment whose children are school age and people who applied for a Disability Support Pension after 1 July 2006. From a care perspective, under *Welfare to Work*, caring for a family full-time in low-income families was no longer a legitimate form of ‘participation’ in Australian society. Neither was any activities, other than workforce participation, engaged in by people with disabilities. The low income of almost half (49%) of the sole parents required to transfer to *Newstart* was further reduced. The stress and financial hardship experienced by some sole parents and people with disabilities translated into increased demand for other forms of support within the care economy.

3.5.4 Changes implemented by the current Australian Government

With the election of the current (Rudd Labor) Australian Government, *Welfare to Work* was replaced by *Fair Work Australia*. This policy maintained many of the provisions of *Welfare to Work* along with increased public funding to assist in the transition from welfare to work. In July 2009 the current Australian Government announced a temporary training supplement to Newstart and Parenting payment recipients without a Year 12 or equivalent qualification who undertake training.

A \$74.1 million targeted, time limited measure, the Training Supplement provides a \$1,158 bonus to sign up to training (\$950 Training and Learning Bonus plus \$208 Education Entry Payment), extra places to study (711,000 productivity places including 319,000 available for jobseekers) and \$41.60 per fortnight available to people receiving Newstart and Parenting Payment to operate from 1 July 2009 to 30 June 2011. The fortnightly payment is available until any approved training commenced in this period is completed. The Training Supplement was described as ‘a modest, practical measure to ensure those most at risk of becoming long term unemployed in the days of the global recession are properly skilled when the economy begins to recover’. The government estimated that more than 50,000 low skilled job seekers will take up this measure over the period 1 July 2009 to 30 June 2011 (Gillard 2009).

At the Mental Health Council of Australia's *Reforming Welfare to Work* forum in February 2008, the Australian Government announced the development of a National Mental Health and Disability Employment Strategy to identify why people with a disability and mental illness find workforce participation difficult and to put in place strategies to address these challenges. A survey in 2007 found that since the Welfare to Work changes targeting people who received a Disability Support Pension, just 1,205 of the 705,000 recipients had been successful in gaining work. The new strategy was to be developed in close consultation with people with a disability, employers, disability employment services and training providers (O'Connor & Shorten 2008).

Following an extensive consultation process, including an invitation for initial submissions, a discussion paper responding to those submissions, and two nation-wide consultation periods, the new \$1.2 billion Disability Employment Services began operating from 1 March 2010. Designed to provide job seekers with a disability with immediate access to tailored services that are flexible and responsive to both their needs and those of their employers, the service implemented two programs. Disability Employment Services Program A is for job seekers with disability, injury or a health condition who require the assistance of a Disability Employment Service but are not expected to need long-term support in the workplace. Disability Employment Services Program B is for job seekers with permanent disability and with an assessed need for more long-term, regular support in the workplace.

Disability Employment Services has been set up uncapped so that all eligible people will have immediate access to the service they need and there will be no waiting lists. Individually tailored services include capacity building, training, work experience and other interventions to assist participants to obtain and maintain suitable employment. Participants are involved in developing their own Employment Pathway Plan. An employment Assistance Fund will provide job seekers, employers and providers with easier access to resources to assist with finding and maintaining employment, such as workplace modifications and Auslan (**Australian Sign Language** for hearing impaired people) interpreting services (Australian Government 2010b).

As well as the above programs, the new Disability Employment Services initiative includes JobAccess, a National Disability Recruitment Coordinator (NDRC) and a Disability Employment National Panel of Assessors. The JobAccess service has four key components: a JobAccess website, a disability employment advisory service, management of the employment Assistance Fund, and disability employment promotional services. From 1 March 2010 JobAccess is providing financial assistance to employers for deafness and disability awareness training and mental health first aid training. The NDRC service aims to create at least 1,000 new job opportunities each financial year for participants of Disability Employment Services, and provide assistance to large employers (more than 100 employees) to develop and implement disability employment strategies. The Panel of Assessors will carry out a range of assessment services to enhance employment participation by people with disability and their access to employment and workplace productivity. In addition, a Supported Wage System aims to increase the employment of people with disability by

providing an industrial relations mechanism that enables the payment of a productivity-based wage to people who cannot work at full productivity (Australian Government 2010a).

It remains to be seen how effective these new initiatives are and it will be some time before any assessments of these programmes are available. In general terms however, the amount of consultation which the current Australian Government has engaged in with the disability support sector and the additional support being provided to employers and people with disabilities is a substantial improvement on the previous policy package.

In summary

The current Australian Government has retained many of the provisions of *Welfare to Work* and incorporated them into their *Fair Work Australia* policy. However, increased public funding has been provided to assist in the transition from welfare to work. A temporary training supplement has been introduced to assist Newstart and Parenting payment recipients without a year 12 or equivalent qualification who undertake training. A National Mental Health and Disability Employment Strategy has also been introduced in consultation with people with a disability, employers, disability employment services and training providers. An uncapped Disability Employment Services has been set up commencing on 1 March 2010 to provide eligible people with immediate access to the service they need with be no waiting lists. An employment Assistance Fund will provide job seekers, employers and providers with easier access to resources to assist with finding and maintaining employment, such as workplace modifications and Auslan (**Australian Sign Language** for hearing impaired people) interpreting services. It is too soon to know how effective these new initiatives are but the wide ranging consultation with the disability support sector and the additional support provided is a welcome improvement.

3.6 Young carers

There is not a lot of information on young carers and, in the Australian context, most of the available information is provided by Carers Australia who actively provide support to and lobby on behalf of young carers. Research on family caregiving has primarily focused on partners and adult children providing care with an emphasis on the primary carer. However, caregiving can be shared among family members such as the care recipient's adult children and the caregivers' family members are involved either directly or indirectly (Szinovacz 2008: 162).

Young carers are a group of young Australians under 26 years of age who provide unpaid care in families where someone has an illness, a disability, a mental health issue or who has an alcohol or other drug problem. Around 170,600 Australians under the age of 18 years and 380,000 under the age of 26 provide care to a family member (Carers Australia 2007a). They are required to perform the same caring tasks as older carers including providing emotional support, intimate care tasks, assisting with mobility, administering medications, and doing housework. The time that young carers spend caring can be as much as 30 hours a week. As this is almost equivalent to full-time employment, young carers have to juggle their caring responsibilities and their schooling (Carers Australia 2009a: 3).

Over half of Australian young primary carers are caring for a parent who is more likely to be a mother and the family is also likely to be a sole-parent household (Carers Australia 2009a: 4). Studies in Britain and the US have found that child caregiving prevails among lower socioeconomic families but it is not clear to what extent socioeconomic status is confounded with other family characteristics such as minority status or having a single parent and there is no data which links the families' socioeconomic status to the outcomes of child caregiving (Szinovacz 2008: 167).

Cultural norms impinge on caregiving and gender ideology is one such norm. Overseas studies have found that girls are assigned caregiving tasks more often than their brothers but the extent of the gender bias appears to vary across countries (Szinovacz 2008: 166). An interesting aspect of Australian young carers is that the gender dynamics are different. Females are only slightly more likely to become young carers than males. (Carers Australia 2009a: 4). Although young carers appear to be providing care because of extenuating circumstances, the fact that young males are providing care in close to the same proportion as females suggests that they may be willing to be engaged in active caring roles throughout their lives and contribute to a de-gendering of caring work.

Although Australian young carers have been identified by services as being as young as six years of age, there are a number of reasons why they are often not identified or choose not to identify themselves. These include a complex range of social and cultural values, beliefs and attitudes; the perceived stigma of being associated with disability or illness, the wish not to be labelled by others; and the fear that child protection services might see them as 'at risk' and

remove them from their family. There is also a general lack of awareness by government, professionals in the areas of health, welfare, community care, education and disability, and the wider community (Carers Australia 2009a: 4).

Children's caregiving can be in response to parental authority but also occurs by default because there are no adults available or willing to provide care. When children take on major care responsibilities, especially in caring for a parent, it can violate child protection laws or school attendance regulations. This may prevent parents who need more formal support from seeking assistance due to concerns about punitive intervention. Studies have also found that caregiving children may be reluctant to talk to others about their situation or find them unsupportive (Szinovacz 2008: 166 & 167). Both these factors are likely to be relevant when a young carer is caring for a single mother.

Young carers can be at risk of socio-economic disadvantage, isolation, low levels of health and emotional wellbeing, impaired psychosocial development, limited friendships, low participation and attainment levels in school and employment, difficulties in making the transition to independence, and a significant lack of opportunity and choices. Caring responsibilities can significantly curtail or disrupt the education of young carers (Carers Australia 2009a: 5). Only 4% of primary carers between the age of 15 to 25 years are still in education compared to 23% of the general population in that age group. Also, 60% of young primary carers aged 15 to 25 years are unemployed or not in the paid workforce compared to 38% of the general population in the same age group. The risk of not making the transition from education to employment is higher for young carers from indigenous or multicultural backgrounds as education participation rates are much lower for these groups (Carers Australia 2009a 6).

The increasing identification of young carers requires that legislative frameworks of equity and fairness be put in place with developed welfare support and an increase in community awareness (Carers Australia 2009a: 5). Carers Australia have a websites for young carers (<http://www.carersaustralia.com.au/?/national/section/27:young-carers>) and Carers NSW also host a young carers website funded by the Australian Government (<http://www.youngcarersnsw.asn.au/>). Three stories submitted online by young carers are reproduced in Box3.6.

My mother has BPD (Borderline Personality Disorder) She has had several suicide attempts and is an emotional alcoholic. She has been going on a downward spiral for about six years now and I'm almost 17. She relies on me to be her sole career as she has on, off relationships with those around her. If someone is having a problem, she believes it is a direct cause of her or she is hurting more than they are. She then distances herself from them and continues her depressive cycle. My mother also has several incurable health conditions such as IST (Inappropriate Sinus Tachycardia) and severely low blood pressure, lung conditions, bleeding conditions, blood sugar conditions and so on. She has just recently been getting slightly better but it was short lived as yet another family situation took control over her and she has now lost control over herself. She doesn't seem to grasp the concept of other people and their feelings towards situations and it's very frustrating. I live with my 19 year old sister and cousin and they also have mental conditions, as have I. Although reactionary to these issues, they are nowhere near as severe as that of my mother's. We all love her dearly and are at a loss as to what to do. I wish I could make her okay. I wish I could take her pain away and I wish I could go back in time when we still lived in New Zealand and none of these things were happening within the family. I want my old mum back. It's kind of sad to miss someone when they're right there in front of you.

Young Carer, 16 years

I'm trying my hardest to continue to take care of everyone. When I was 11 or so my mother was diagnosed with Breast Cancer and she fought with it for three years and various operations until the cancer took to her entire body and she died. Now five years later my father has got aggressive cancer too, which affects us financially as well as in every other possible way. My wider family are not very nice people and so I am striving to do my best around what I have been given and hope that that there is something more in life than cancer. I have been taking care of my family for the last five years and despite the illness affecting my father and sister's mental states I am trying my hardest to continue take care of everyone as well as hopefully get a chance to live a happy life as a young adult and go to university.

Young Carer, 18 years

Hi. I'm 17 and am a young carer. I have looked after my mum since the age of 12. I have an older sister she is now 18 but she said mum was a freak then soon after left and moved to Nan's. My mum sees people that aren't there, she hears voices coming from the fridge and thinks I'm going to poison her when I give her the pills, it's hard being only 17 and working 38 hours a week. I used to wish I was like normal kids and have no one to care for but I would be bored as, I'm grateful that god gave me the mum he did. I love her so much and even though she kicks me out she calls me when there is washing and cleaning to do. The main idea of this post is I went to a camp at Burrendong Dam and I felt normal. I felt like I could go home and someone else was somewhere else doing the same thing. It feels good to be normal.

Young Carer, 17 years

Source: Carers NSW 2007, *Young Carer Stories*, Carers Australia, viewed 15 April 2010, <http://www.youngcarersnsw.asn.au/StoryList.aspx?PageID=142>

¹ These stories, which were posted online (Carers NSW 2007), have been edited for spelling and punctuation and the young carer's name removed but the content remains unchanged.

The Australian Government currently funds the Young Carers Respite and Information Services Program to assist young carers who are at risk of not completing their secondary education or a vocational equivalent due to the demands of their caring role. With funding of over \$7.7 million for 2009-10, this service is delivered through the Commonwealth Respite and Carelink Centres across Australia. This program aims to assist young carers to better manage their educational and caring responsibilities; enable young carers to access age appropriate support and respite services to undertake activities such as studying for exams or to attend education, training or recreational activities; and to provide a range of information, advice and referral services, including referral to counselling, to support young carers in managing the challenges they face as part of their caring role (Department of Families Housing Community Services and Indigenous Affairs (FaHCSIA) 2009d). However, both components—the respite program and the information service—are underfunded and do not meet the needs of all young carers (Carers Australia 2009a: 9).

In summary

Young carers are a group of young Australians under 26 years of age who provide unpaid care in families. The time that young carers spend caring can be as much as 30 hours a week. Over half of Australian young primary carers are caring for a parent who is more likely to be a mother and the family is also likely to be a sole-parent household. An interesting aspect of Australian young carers is that the gender dynamics are different with females only slightly more likely to become young carers than males. This may be the first sign of a de-gendering of care work in Australia. There are many reasons why young carers may choose not to self-identify and, among other disadvantages, they often have low participation and attainment levels in school and employment. The Australian Government currently funds the Young Carers Respite and Information Services Program to assist young carers. It has two components, a respite program and an information service, but both are underfunded and do not meet the needs of all young carers.

3.7 Formal care

In Western post-industrial countries, the increased labour force participation of women has reduced the time available for non-market work and has increased the demand for paid care services (Folbre 2006a: 14). In Australia there has been a continuous increase in the demand for child care services. Between 1999 and 2002, the number of children using child care increased by 27% while between 2004-2006, the increase was a much more moderate 6% (Department of Education Employment and Workplace Relations (DEEWR) 2008: 6). The cost of using child care has also increased. In 2006 the average weekly fee in long day care centres was \$233, compared to \$209 in 2004 and the average weekly fee in family day care schemes for 50 hours in care was \$215 compared to \$185 in 2004 (Department of Education Employment and Workplace Relations (DEEWR) 2008: 7).

In 2001, the number of people employed in a community services industry was estimated to be 8,298,602 workers (Meagher & Healy 2006: 27), up 19% from 1996 with direct care work predominantly performed by women. There was evidence of deinstitutionalisation, deprofessionalisation, functional underemployment, and relatively poor pay in community service industries. It appeared that these factors were driving care workers out of community services and into other human service industries such as health and education (Meagher & Healy 2006: 9).

Recommendation 11

That *Security4Women* in conjunction with *Fair Work Australia* and other relevant bodies advocate for improved wages and working conditions for direct care staff employed in the community services industry.

The person-specific characteristics of direct care services means they are less likely to enjoy economies of scale and are more vulnerable to diseconomies of scale than other economic activities (Folbre 2006b: 189). Because care involves the development of a relationship, not merely the production of an output which is separable from the person delivering it, there are implications for the extent to which productivity in caring can rise without affecting the quality of care (Himmelweit 2007: 583). Although it differs among different types of care, in marketised care services there is a limit to how many people can be cared for at the same time. ‘After a certain point spreading care over more people becomes synonymous with reducing quality’ (Himmelweit 2007: 584).

Marketised caring services suffer from a ‘cost disease’—because caring labour involves a personal service, it is difficult to raise the productivity of caring in terms of either production or consumption because spreading it over more people reduces the quality of the care service (Himmelweit 2005: 169)². As an increase in productivity lowers costs per unit, industries

² This ‘cost disease’ was first identified by economists Baumol and Bowen (1965) with the analysis being later extended to cover market-provided personal services such as education and health care (Baumol & Blinder 2006).

such as care services, in which productivity usually fails to rise, will face increasing costs relative to the rest of the economy; an inherent effect of the relational nature of care (Himmelweit 2005: 170). Because care services are so labour intensive, the costs are likely to continue to rise even if the wages of care workers remain low (England & Folbre 2003: 75). 'Increased productivity can only result in lower quality care: time cannot be saved while maintaining standards of care' (Himmelweit 2007: 585).

The quality of direct care work is difficult to monitor or specify in an explicit contract (Folbre 2006b: 189). Because care is often specific to the context and the person requiring care, the intrinsic motivation of the caregiver often affects the quantity and quality of the service provided. As care involves both personal connection and emotional attachment, 'care services are often "co-produced" by care providers and care recipients' (Folbre 2009: 113). Care workers who feel genuine affection and concern for those in their care are likely to do a better job, all else equal, than those lacking personal connection. In formal child care and elder care services, low rates of turnover are likely to increase quality while the pressure to reduce costs often leads to a decrease in the quality of care (Folbre 2006a: 15) and low wages can result in care workers feeling undervalued and demoralised in their work (Nelson 1999: 53).

In the workplace mental labour is rewarded more than manual labour with pay differentials, working conditions and status hierarchies which distinguish between them (Wolkowitz 2006: 25). In this way, care work, which often involves the use of the carer's body to provide physical care to the care recipient, has always been undervalued wherever it is supplied (Adams 2008: 18). Adequate and stable public funding is critical to ensuring that both the quality and quantity of paid care meets the needs of care recipients requiring formal care services. It is equally important that policy tools are in place to ensure fair wages and working conditions for care workers at all levels (Albelda et al. 2009: 14). The next section discusses residential aged care which provides a good example of a marketised care service.

3.7.1 Residential aged care

Due to demographic changes, the aggregate burden of child care has decreased while that of elder care has increased (Folbre & Nelson 2000: 124). Residential aged care facilities provide 24-hour care to frail, elderly people and operate at the high end of the care spectrum. Although aged care has been traditionally provided in the home, usually by women, and such familial arrangements are still common, the level of dependency and the resultant care needs can become too complex to be provided in the home or community necessitating a move into residential care. As an ageing population requiring care is not only a characteristic of Australia but is also common to many other countries, the demand for aged care services will increase over time.

Nursing has always been a female-dominated profession, and residential aged care has characteristics typical of women's traditional areas of employment to an even greater degree than most other forms of nursing. Residential aged care facilities have a significantly lower level of male nurses (5.2 %) than the two nursing areas in which males are most prevalent: mental health (33.6%) and development disability services (28.3%). Residential aged care

services also have the third highest percentage of part-time nurses (58.8%), exceeded only by doctors' rooms (68.9%) and hospices (60.4%) (Australian Institute of Health and Welfare 2005: 25).

In residential aged care, nurses are positioned at the interface of 'home' and 'work' and straddle daily the crossover between public and private forms of care. Although these nurses are providing paid caring labour to earn a living, the facilities in which they work are now the residents' 'home' (Adams 2008: 4). Aged care nursing in Australia is accorded a lower status within the nursing profession than other areas of nursing (Jones, Cheek & Ballantyne 2002: 229).

A recent report (Access Economics 2009) on nurses working in residential aged care (RAC) found that that nurses working in RAC are paid at least 10% less than their counterparts in acute care; work intensity for RAC nurses has increased; the quality of care is potentially compromised; the combination of inequitable remuneration, increasing workloads and the frustration of compromised quality outcomes is driving nurses from the sector; and there is a pressing need for reform in aged care to address these issues (Access Economics 2009: i).

Another report on the aged care workforce which included community based aged care (Martin & King 2008) and all direct care workers found that an overwhelming 93% of residential workers and 91% of community based workers are women; 20% of direct care staff have no post school qualifications; overseas born workers are more common in residential facilities than they were in 2003; and workers remain strikingly dissatisfied with their pay (Martin & King 2008: ii & iii).

If the wages and career prospects of care workers continue to lag behind those available in other occupations, retaining care workers will become increasingly difficult. 'A continually increasing gap between the standard of living of carers and their families and that of other workers is unlikely to be sustainable in the long term' (Himmelweit 2007: 586).

Recommendation 12

That *Security4Women* in conjunction with *Fair Work Australia* and other relevant bodies advocate for increased wages and better working conditions for nurses and carers employed in residential aged care.

In summary

The increased labour force participation of women has reduced the time available for non-market work and has increased the demand for paid care services. Child care services have increased as has the number of people employed in the community services industry.

However, low wages and inadequate working conditions are resulting in care workers exiting into other human service industries.

Direct care services are vulnerable to diseconomies of scale and attempts to improve productivity result in lower quality care, termed a 'cost disease' by economists. Because care services are labour intensive, costs continue to rise even if the wages of care workers remain low. Direct care work is difficult to monitor and the intrinsic motivation of the caregiver often affects the quantity and quality of the service provided. Low rates of turnover are likely to increase quality while the pressure to reduce costs often leads to a decrease in the quality of care. Care work has always been undervalued wherever it is supplied and adequate public funding is critical to ensuring that both the quality and quantity of paid care meets the demand for formal care services.

Residential aged care, an example of a marketised care service, provides 24-hour care to frail, elderly people whose care needs are too high for community care. Residential aged care facilities are predominantly staffed by women and aged care nursing has a lower status than other forms of nursing. Aged care nurses are paid less than acute care nurses. This, in conjunction with work intensification and compromised quality of care, is causing nurses to exit the sector.

3.8 Exploitation

Carers providing both paid and unpaid care work are vulnerable to exploitation. Although caring labour is undertaken by both men and women, in the market and in the family, and has productive and reproductive dimensions, care is still a highly gendered concept located more within the feminine than the masculine realm as caring has ‘particularly salient emotional dimensions, and it often involves strong moral obligations’ (England & Folbre 2003: 63).

Carers providing both paid and unpaid care can become vulnerable to ‘prisoner of love’ dynamics. Most women providing unpaid care would prefer to share the responsibility for care equally but usually do not threaten to withdraw their care in order to achieve this. Similarly, when paid care work no longer takes the form of a simple exchange, it is difficult to withhold it. Women also continue to enter caring occupations even when they are aware that these occupations offer less economic security than others (Folbre 2009: 114). When men assume responsibility for the care of others, they also pay a penalty in terms of foregone income (Folbre 2009: 115).

The wages paid to many care workers do not reflect the value of the services they provide (Albelda et al. 2009: 19). The personal relationships and emotional connections that develop between care workers and care recipients improve care quality but can disempower care workers (Folbre 2009: 112). Care workers deep sense of obligation can dampen their demands for higher wages or improved working conditions. This can result in workers leaving their jobs to seek work in sectors where wages and conditions are better (Albelda et al. 2009: 7).

Conclusion

The issues identified are diverse and of significant to the care economy in different ways. The availability of adequate and timely data to map trends and changes in the care economy is necessary to inform decisions and provide adequate support for care work. The gendered nature of both paid and unpaid care means that the costs of providing care are borne disproportionately by women. Increased longevity means that people with disabilities are living longer while Australia's ageing population has resulted in a 'sandwich' generation of carers who are caring for children and elderly parents. This raises issues of intergenerational caring and it is possible that the supply of unpaid care in the home may not keep pace with the demand. Carers providing unpaid care require assistance to participate in the labour force and adequate support in their caring role including respite care and access to assistance from formal care services.

The *Welfare to Work* policy package 'participation' requirements impacted most on parents receiving the Parenting Payment whose children are school age and people who applied for a Disability Support Pension after 1 July 2006. From a care perspective, under *Welfare to Work*, caring for a family full-time in low-income families was no longer a legitimate form of 'participation' in Australian society. The stress and financial hardship experienced by some sole parents and people with disabilities translated into increased demand for other forms of support within the care economy.

The current Australian Government has retained many of the provisions of *Welfare to Work* and incorporated them into their *Fair Work Australia* policy. However, increased public funding has been provided to assist in the transition from welfare to work. . A temporary training supplement has been introduced to assist Newstart and Parenting payment recipients without a year 12 or equivalent qualification who undertake training. A National Mental Health and Disability Employment Strategy has been introduced in consultation with people with a disability, employers, disability employment services and training providers. An employment Assistance Fund will provide job seekers, employers and providers with easier access to resources to assist with finding and maintaining employment.

Young carers are a group of young Australians under 26 years of age who provide unpaid care in families which can be as much as 30 hours per week. . Over half of Australian young primary carers are caring for a parent, most likely a mother in a single parent household. As females are only slightly more likely to become young carers than males, this may be the first sign of a de-gendering of care work in Australia. Young carers often choose not to self-identify for many reasons and often have low participation and attainment levels in school and employment. The Young Carers Respite and Information Services Program funded by the Australian Government assists young carers but is not funded well enough to meet the needs of all young carers.

The increased labour force participation of women has resulted in an increased demand for formal care services which are predominantly staffed by women. Low wages and unsatisfactory working conditions are common throughout the community service and

residential aged care industries. Attempts to improve productivity results in lower quality care and the labour intensive nature of formal care services means that costs will continue to rise even if wages remain low signalling a need for adequate public funding.

Carers providing both paid and unpaid care work are vulnerable to exploitation because they find it difficult to withhold care. Both women and men working in paid care services suffer a 'wage penalty' in comparison with other areas of employment. Care workers deep sense of obligation can dampen their demands for higher wages or improved working conditions. This results in care workers exiting to sectors where wages and conditions are better.

4. Government policy

Care is both a public and a private good and its provision has widespread benefits (Albelda et al. 2009: 7). Therefore both public and private investments in infrastructure are equally important in supporting the care economy and maintaining our quality of life (Albelda et al. 2009: 24). However the public good component means that care services improve productive human capabilities with the benefits of providing good care ‘spilling over’ to improve the wellbeing of the community as a whole (Folbre 2006b: 189). This public goods’ aspect and its spillover effect make care services vulnerable to undervaluation by the market. Neither children nor other dependents can exercise consumer sovereignty (Folbre 2009: 113). The care recipients’ dependence on their caregivers is often so fundamental that they cannot exercise choice over the care provided (Eika 2009: 114). There is, therefore, an important role for government policy and public funding to support both paid and unpaid care otherwise the demand for care services will exceed the level of care supplied (Albelda et al. 2009: 8). ‘Efforts to increase public support for care work reflect appreciation of its contribution to the public good as well as awareness of the limits of purely market-based production’ (Albelda et al. 2009: 25).

Because care needs, the responsibilities for fulfilling these needs and the resources to do so are unequally distributed and tend not to go together, this signals a need for the public provision of care and support for carers if socially determined care needs are to be met (Himmelweit 2007: 583). Inequality does not just exist in the ability to provide care directly but it also exists in the ability to pay for care by other means (Himmelweit 2007: 589). The stories of young carers (see Box 3.4.2) are testament to the fact that such inequality exists in Australia. Also, as discussed in Section 3.2, conditions in and funding for the care sector have important gender equity consequences (Albelda et al. 2009: 13). The demand for care services increases in difficult economic times and the substantial role of public support in the care sector makes it particularly vulnerable to budget cuts at both the state and federal levels (Albelda et al. 2009: 10).

The Australian care economy is supported by both the Federal and State/Territory Governments. Care recipients usually require ongoing medical care, medication and a range of allied health services. The major component of the national health system is Medicare which provides affordable and accessible health care to all Australians. Commonwealth funding for Medicare is mainly provided as subsidies for prescribed medicines, grants to State and Territory Governments to contribute to the cost of providing access to public hospitals at no cost to patients, and specific grants to State/Territory Governments and other bodies. The system is financed from general taxation revenue which includes a Medicare levy based on a person’s taxable income. It operates alongside a substantial private sector thus providing choice for individuals who may be treated in the public health system or finance their own private health care through individual and family private health insurance (Department of Health and Aged Care 2000: 5).

The Pharmaceutical Benefits Scheme (PBS) subsidises the cost of certain prescription medicines. Based on the premise that cost should not present a substantial barrier to people's access to the medication they need, the Pharmaceutical Benefits Scheme provides prescription medicines to all Australians at less than the market cost. Subsidies occur when designated medications are supplied by pharmacies or hospitals. The cost is borne by the community as a whole through the taxation system (Department of Health and Ageing 2000: 2).

In addition to the national health system, there is a range of pensions, benefits and funding arrangements to support both paid and unpaid care. It has been estimated that well over five million Australians, or more than one quarter of the total Australian population, are affected by carer policy decisions (Hughes 2007: 32). The following subsections outline the Australian government's current policy and funding initiatives applicable to the care economy. The aim of this section is to provide an overview of the scope of government funding to the care economy and the various forms it takes but the list is not exhaustive. As can be seen from the following sections, government support is available for both paid and unpaid care. Sometimes both are available for a particular care situation.

4.1 Assistance for parents

UNICEF reports that higher government spending on family and social benefits is associated with lower child poverty rates. No OECD country devoting 10% or more of GDP to social transfers has a child poverty rate higher than 10% and no country devoting less than 5% of GDP to social transfers has a child poverty rate of less than 15%. Variations in government policy appear to account for most of the variation in child poverty levels between OECD countries and there appears to be little relationship between levels of employment and levels of child poverty. It is the distribution of employment among different kinds of households, the proportion of those in work who are on low-pay, and the level of state benefits for the unemployed and the low-paid that contributes most to differences in child poverty rates between countries (UNICEF 2007: 7).

In Australia income support is available to low-income families in the form of a fortnightly Parenting Payment (Centrelink 2009) to assist with the cost of raising children. Financial assistance is also available to eligible families in the form of the Child Care Benefit (Family Assistance Office 2009b) and the Child Care Rebate (Family Assistance Office 2009c) to assist with the cost of paid child care to enable parents to participate in the labour market. There is also assistance in the form of Family Tax Benefit Part A (Family Assistance Office 2009d) and Part B (Family Assistance Office 2009e) to assist low income families with the cost of raising children. In addition, a Baby Bonus (Family Assistance Office 2009a) is paid to families following the birth or adoption of a child. Table 4.1 outlines the main benefits available which are all administered by the Family Assistance Office of the Australian Government.

Table 4.1 Financial assistance for parents

Policy	Purpose	Additional information
Parenting Payment ¹	To assist low income families with the cost of raising children. Available to single or coupled parents, grandparents or foster parents. Income and assets tested and part-time participation requirements apply when youngest child is 6-7 years old.	From 20 March 2010 paid at a maximum fortnightly payment of \$417.70 for partnered parents & \$601.30 for single parents
Child Care Benefit ²	To assist with the cost of child care. Paid to a parent, foster parent or grandparent if the child in their care is attending childcare approved by/registered with the government	Immunisation & residency requirements & income tested. Maximum rate per week from 6 July 2009 to 30 June 2010 (for 50 hours of approved care) \$180.00 for 1 child, \$376.21 for 2 children, \$587.13 for 3 children & \$197.71 for each additional child
Child Care Rebate ³	To assist working families with the cost of child care. Must use approved childcare, be eligible for Child Care Benefit, & pass the work, study, training test	Covers 50% of out-of-pocket childcare expenses up to \$7,778 (indexed) per child per year.
Family Tax Benefit Part A ⁴	To assist with the costs of raising children. Paid for dependent children under 21 years or full-time students aged between 21-24 years who are not receiving Youth Allowance or similar payments	Must meet certain residency requirements. Amount payable determined on family income & number of dependents. Maximum rate of \$156.94 per fortnight for each child under 13 yrs, \$204.12 for 13-15 yrs, \$50.12 for 16-17 yrs, & \$67.34 for 18-24 yrs
Family Tax Benefit Part B ⁵	To give extra assistance to sole parent families and families with 1 main income and 1 parent at home or balancing some paid work with childcare	Paid at maximum rate up to an income of \$150,000. Maximum rate of \$133.56 per fortnight for child under 5 yrs & \$93.10 for 5-15 yrs (or 16-18 yrs if a full-time student).
Baby Bonus ⁶	Paid to families following the birth (including stillborn babies) or adoption of a child, recognising the costs incurred at the time of a new birth or adoption	Paid in 13 equal fortnightly instalments & payable for each child in multiple births. The rate is \$5,185 as at 1 July 2009 & the family income limit for the baby bonus is \$75,000 in the 6-month period following the child's birth or entry into care.

Sources:

1. Centrelink 2009, *Parenting Payment*, Australian Government, Canberra.
2. Family Assistance Office 2009, *Child Care Benefit*, Australian Government, Canberra.
3. Family Assistance Office 2009, *Child Care Rebate*, Australian Government, Canberra.
4. Family Assistance Office 2009, *Family Tax Benefit Part A*, Australian Government, Canberra.
5. Family Assistance Office 2009, *Family Tax Benefit Part B*, Australian Government, Canberra.
6. Family Assistance Office 2009, *Baby Bonus*, Australian Government, Canberra.

Analysis of data from Waves 1 and 2 of the Household, Income and Labour Dynamics in Australia (HILDA) Survey found that in 2002 the take-up of eligible families receiving the Parenting Payment was 71.1% overall with the take-up being much higher among single mothers (80.6%) than partnered mothers (51.3%) (Mood 2006: 451). Take-up was also found to be significantly lower for immigrant than for Australian-born mothers, lower for those

living outside the major cities, and lower for mothers with higher education. A mother in a household where someone is self-employed or where the home is owned was also less likely to take-up the Parenting Payment (Mood 2006: 452).

A study of teenage mothers conducted in 2004-2005 with 41 participants found that all the mothers were receiving some form of government assistance such as Parenting Payment Single and Family Tax Benefit Part A and 28 were receiving a weekly income of \$450 or less (Morehead & Soriano 2005: 66). With a few exceptions, the father's role was minimal during the pregnancy and non-existent after the birth (Morehead & Soriano 2005: 68). It was also noted that teenage mothers are much less likely to be in paid work than other mothers and their households are extremely unstable (Morehead & Soriano 2005: 70).

An analysis of the Child Care Survey 1996 and 2002 found that labour force participation was the main reason that families used both formal and informal child care. It was most likely to be used by couple parents where both parents are in the labour force and sole parents in the labour force more than other family types. Sole parents out of the labour force require more child care than comparable couple households and child care use is highest across family types for those with a youngest child aged 3-4 years (Kalb 2009: 280). A Community and Public Sector Union survey of women members found that among the respondents with dependent children, 47.3% said that the cost of childcare was an important or very important financial factor in their career decisions and 36.5% said that the effect on Centrelink payments or family benefits was an important or very important factor in their career decisions (Community and Public Sector Union (CPSU) 2010: 43).

The child care rebate provides a tax deduction for work-related child care expenses and gives the greatest benefit to high-income earners who have the highest child care costs and effectively offsets the progressive nature of the child care benefit which provides the greatest gains to low-income parents. Since the rebate is only available to offset tax, many low income families miss out. Although couples can transfer any unused portion of the rebate to their partners, single parents do not have this option (Brennan 2007: 47).

Despite the government assistance available to parents, data from Waves 1 to 6 of the Household, Income and Labour Dynamics in Australia (HILDA) Survey show that parents commonly have difficulty with the cost of child care. Over 20% of couple households have reported this problem every year while the proportion of lone parents experiencing problems with the cost of child care ranges from 15% in 2002 to 26% in 2005. Finding the right person to take care of their children was a problem for 14% of couple households and 18% of lone parent households who used child care in 2006. Compared to couple households, it was more common for lone parents to report difficulties with getting care for the hours they needed, finding care during school holidays, finding a place at a child care centre of their choice, and finding care that their children were happy with. Although it was found that difficulties with child care usually did not persist for more than one year, finding care for a sick child was the most persistent problem—49% of households reported difficulties in finding care for a sick child in at least one of three years, 17% reported problems in two of the three years and 10%

had difficulties finding care for a sick child in all three years (Wilkins, Warren & Hahn 2009: 19).

4.2 Financial Assistance to carers

The main financial support provided for carers by the Australian Government is through the Carer Payment (Department of Families Housing Community Services and Indigenous Affairs (FaHCSIA) 2009c), the Carer Allowance (Department of Families Housing Community Services and Indigenous Affairs (FaHCSIA) 2009b) and the Carer Supplement Payment (Department of Families 2009b). Both the Carer Payment and Carer Allowance are paid fortnightly to people providing care in the home of the person being cared for while the Carer Supplement Payment is a recently introduced annual payment to assist with the costs of extended care. These policies are administered by the Department of Families, Housing, Community Services & Indigenous Affairs (FaHCSIA) and payments are made through Centrelink, a Commonwealth agency.

Table 4.2 Financial support for carers

Policy	Purpose	Additional information
Carer Payment ¹	An income support payment for people whose caring responsibilities prevent them from undertaking substantial paid employment	Subject to income and assets tests & is paid at the same rate as other social security pensions (see Age Pension above). <i>Applicable to all extended unpaid care.</i>
Carer Allowance ²	Income supplement available to people who provide daily care and attention at home to a person with disability or a severe medical condition	Not taxable or income and assets tested & can be paid in addition to a social security income support payment. Rate is \$106.70 per fortnight from 1 January 2010.
Carer Supplement Payment ³	An annual \$600 payment to recipients of the Carer Allowance for each person being cared for	Introduced as part of the Secure and Sustainable Pension Reform package in the 2009-10 Budget.

Sources:

1. Department of Families Housing Community Services and Indigenous Affairs (FaHCSIA) 2009, *Carer Payment*, Commonwealth of Australia, Canberra.
2. Department of Families Housing Community Services and Indigenous Affairs (FaHCSIA) 2009, *Carer Allowance*, Commonwealth of Australia, Canberra.
3. Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA), 2009, *Carer Supplement Payment*, Commonwealth of Australia, Canberra.

As at June 2007, there were 116,614 people receiving the Carer Payment. The majority cared for adults and two-thirds of payment recipients were female with the proportion of females increasing annually. More than a third of people receiving the Carer Payment were aged between 50 – 59 years and nearly 65% were partnered. Only 13% had income from employment sufficient enough to reduce the amount of Carer Payment received. Most recipients received the maximum amount. Although less than 1% had been on the payment

for more than 15 years, nearly 75% had been receiving the payment for less than five years (Edwards et al. 2008: 8 & 9).

As at June 2007, there were 393,263 recipients of Carers Allowance. Most (278,602) were caring for adults; 109, 118 were caring for children under 16 years of age; and 4,902 recipients were caring for both adults and children. Of those caring for adults, 32% were male and 68% were female while 94% of those caring for children were female. Over half the recipients caring for children were under 40 years of age while over 40% of recipients caring for adults were aged 60-79 years. Over half of Carer Allowance recipients also received an income support payment such as Carer Payment, Age Pension, Parenting Payment or Disability Support Pension. While just under half had been receiving the payment for less than three years, just over 20% had been receiving the payment for six years or more (Edwards et al. 2008: 9).

Although the Carer Allowance is not taxable or assets and income tested, it is accessed by less than 15% of the total carer population (Hughes 2007: 32). However, eligibility involves an assessment of the care needs of the person requiring care (Edwards et al. 2008: 6). In 2007 carers relying solely on the Carer Payment plus the Carer Allowance were paid \$200 per week below the minimum wage (Hughes 2007: 33). Research is needed to investigate whether some primary carers are not claiming this allowance and if so, why not (Access Economics 2005: 40). Higher financial support from government has been found to be associated with lower carer stress and direct funding to carers to buy services can result in increased carer satisfaction with services (Cuskelly 2006: 24).

There is evidence that the take-up of these two payments has improved. Between 1999-2000 and 2006-07, the number of people receiving the Carer Payment grew by 145% and expenditure increased by 283%. During the same period, the number of people receiving Carer Allowance increased by 102% and annual expenditure increased by 223%. These increases reflect demographic changes such as the ageing of the population and the associated increase in the incidence of people suffering from a disability and greater public awareness of the two payments (Edwards et al. 2008: 7).

4.3 Pensions for care recipients

Although not all people receiving a pension require care, many care recipients in Australia are pensioners. In the 2003 Survey of Disability, Ageing, and Carers (SDAC) conducted by the Australian Bureau of Statistics, 62.7% of people with disabilities, comprised of 55.3% of males and 69.2% of females, were living on a government pension or allowance as their principal source of income (Australian Bureau of Statistics 2004: 45). A 'Government pension or allowance' was the main source of personal income for about half (52%) of people aged 60 years and over living in households without a disability and three-quarters (74%) of those with a disability (Australian Bureau of Statistics 2004: 9). The Age Pension (Department of Families Housing Community Services and Indigenous Affairs (FaHCSIA) 2009a) provisions require certain age, residence, and means test qualifications to be met (Department of Families Housing Community Services and Indigenous Affairs (FaHCSIA)

2009a) but it does provide a basic level of ongoing financial support to people unable to adequately fund their own retirement from the workforce. The Disability Support Pension (Centrelink 2010b) provides income support to disabled people who are not able to participate in the labour force. Table 4.3 provides an outline of these two income support pensions.

Table 4.3 Pensions

Policy	Purpose	Additional information
Age Pension ¹	A non-contributory payment to ensure senior Australians have adequate means of support. Only paid to Australian residents & subject to an income test & an assets test	Currently a maximum of \$671.90 for single persons and \$506.50 each for couples (rates effective from 1 January 2010) ² .
Disability Support Pension ³	Provides income support to people who are aged 16 or over and under Age Pension age not able to work for 15 hours or more per week at or above the relevant minimum wage or be reskilled for such work for at least the next 2 years because of illness, injury or disability, or are working under the Supported Wage System (SWS) or are permanently blind	Paid at the same rate as the Age Pension. Subject to income & assets testing in most cases.

Sources:

1. Department of Families Housing Community Services and Indigenous Affairs (FaHCSIA) 2009, *Age Pension*, Commonwealth of Australia, Canberra.
2. Centrelink 2010, *Age Pension Payment Rates*, Commonwealth of Australia, Canberra.
3. Centrelink 2010, *Disability Support Pension*, Australian Government, Canberra.

4.4 Additional benefits to assist pensioners

Table 4.4 outlines additional benefits to assist pensioners: the Bereavement Payment (Department of Families 2009a), the Pensioner Education Supplement (Department of Families 2009i), the Pensioner Concession Card (Department of Families 2009h), and the Pension Loans Scheme (Department of Families 2009g). These are not restricted to age pensioners but apply to recipients of any pension including the Carer Payment.

Table 4.4 Additional benefits available to pensioners

Policy	Purpose	Additional information
Bereavement Payment ¹	To assist with settling financial affairs associated with expenses incurred by the deceased prior to death	Available to couples, single people, parents & carers who were receiving an eligible social security payment at the time of the death & is a continuation of the payment that was being received prior to the death. It continues to be paid at generally the same rate it was being paid prior to death and for a maximum period of 14 weeks.
Pensioner Education Supplement (PES) ²	Provides financial assistance to undertake full-time or part-time study	Must be undertaking approved full-time or part-time study. Secondary education courses, graduate courses, undergraduate courses, and some Masters, diplomas and TAFE courses are approved for Pensioner Education Supplement. The part-time study must be at least 25 % of a full-time study load & can be approved if you are a sole parent, carer or you have a substantial disability.
Pensioner Concession Card ³	Assists pensioners & selected benefit recipients with certain living costs by allowing access to specific goods and services at a concessional rate & is automatically issued to all social security pensioners	Card holders and their dependants may receive the following concessions: medicines listed on the Pharmaceutical Benefits Scheme (PBS) at the concessional rate & reduced PBS prescriptions (after reaching the PBS Safety Net); bulk-billed GP appointments (at the discretion of the doctor); reduced out-of-hospital medical expenses above a concessional threshold through the extended Medicare Safety Net, free hearing assessments & hearing rehabilitation; and low-cost maintenance of hearing aids and a regular supply of batteries.
Pension Loans Scheme ⁴	Provides a loan that will increase part-rate pensioners & self-funded retirees fortnightly pension payment from a part-rate or nil rate up to the maximum pension rate	Available to part-rate pensioners & some self-funded retirees who own real estate in Australia, & who are not entitled to a maximum rate of pension, or any pension, because of their income or assets (but not both).

Sources:

1. Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA), 2009, *Bereavement Payment*, Commonwealth of Australia.
2. Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA), 2009, *Pensioner Education Supplement*, Commonwealth of Australia, Canberra.
3. Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA), 2009, *Pensioner Concession Card*, Commonwealth of Australia, Canberra.
4. Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA), 2009, *Pension Loans Scheme*, Commonwealth of Australia, Canberra.

The Bereavement Payment is available to people who have been in receipt of a social security benefit for a minimum of 12 months prior to the death. Where a single pensioner dies, or a pensioner whose surviving partner is not reliant on income support, the deceased's estate receives a bereavement payment in the form of one additional pension payment after the date of death. Where a member of a pensioner couple dies, the survivor continues to receive the couple combined rate of payment for up to 14 weeks after death. Where loss of the survivor's entitlement occurs as a result of a death (e.g. Carer Payment) they remain qualified for the pension for up to 14 weeks after the death (Department of Families 2009a).

The Pensioner Education Supplement (PES) assists people receiving the Carer Payment for either child or adult care, a Parenting Payment for single parents, or a Disability Support Pension to undertake study. It is a non-taxable payment and is not subject to an assets or income test (Department of Families 2009i). As of 1 July 2010, the rate paid is \$31.20 per fortnight for approved students with a 25% study load and \$62.40 per fortnight for approved students with at least a 50% study load or students granted a 25% workload concession who are either Disability Support Pensioners or Invalidity Service Pensioners (Centrelink 2010c).

The Pensioner Concession Card is automatically issued to all social security pensioners and people receiving the Carer Payment. As well as the benefits provided by the Federal Government (see table), state/territory and local governments may provide the following concessions: discounted fares on public transport; reduced rates (e.g., council and water); reduced utilities (e.g., electricity); and discounted motor vehicle registrations. Cardholders get discounted rail travel on Great Southern Rail services and in most (but not all) states, at least one free rail journey a year within the state of residence. State/territory and local governments and some private providers may offer some additional health, household, transport, education and recreation concessions to Pensioner Concession Card holders (Department of Families 2009h).

Although the Pension Loan Scheme can provide some financial support to part-pensioners and self-funded retirees, it is only available to people who own real estate and is set up to be paid back by the person's estate if not repaid during their lifetime (Department of Families 2009g). This scheme targets people who are asset rich and cash poor.

4.5 Health Care Cards, Rent Assistance and Pensioner Bonus Scheme

Table 4.5 outlines the benefits available from health care cards, rent assistance and the pension bonus scheme. The Health Care Card (Department of Families 2009e) is automatically issued to people who are not qualified for a Pensioner Concession Card but are receiving other allowances such as the Sickness Allowance, the Carers Allowance or the Parenting Payment (partnered). The Health Care Card can be retained for up to 26 weeks after returning to work in some instances to assist people make the transition from long-term income support to work. There are several other health care cards available on application

under this scheme such as the Carer Allowance (child) Health Care Card issued in the child's name, the low-income Health Care Card which is income but not assets tested, and the Foster Child Health Care Card also issued in the name of the child and not means tested (Department of Families 2009e).

Table 4.5 Health Care Cards, Rent Assistance and Pensioner Bonus Scheme

Policy	Purpose	Additional information
Health Care Card ¹	Assists benefit recipients, low income earners and selected other customer groups with access to Pharmaceutical Benefits Scheme prescription medicines and certain Medicare services at a concessional rate	The low-income Health Care Card is available on application. Income test applies to average weekly gross income for the 8 weeks immediately prior to applying for the card. There is no assets test for the low-income HCC.
Commonwealth Seniors Health Card ²	Assists self-funded retirees of age pension age with certain living costs by providing access to certain pharmaceutical, Medicare, household and transport services at a concessional rate	A person must be of age pension age; be an Australian citizen, a holder of a permanent visa, or a Special Category Visa holder; not be receiving a social security pension or benefit, & have an annual adjusted taxable income of less than \$50 000 for singles or \$80 000 for couples. There is no assets test.
Rent Assistance ³	A non-taxable income supplement payment added on to the pension, allowance or benefit of eligible income support customers who rent in the private rental market	The rate of Rent Assistance payable may be affected by the income or assets test applicable to the primary payment.
Pension Bonus Scheme ⁴	Provides an incentive for older Australians to defer claiming Age Pension and instead remain in the workforce. The scheme pays a tax-free lump sum to members when they eventually claim and receive the Age Pension	To receive a bonus a person must work a minimum of 12 months from the date of registration and complete at least 960 hours of paid work in this and any subsequent years. This is an average of 20 hours each week for 48 weeks each year. A bonus can be accrued for a maximum of 5 years and cannot be accrued after the age of 75 years. The bonus is paid when a person first claims and receives the Age Pension.

Sources:

1. Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA), 2009, *Health Care Card*, Commonwealth of Australia, Canberra.
2. Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA), 2009, *Commonwealth Seniors Health Card*, Commonwealth of Australia, Canberra.
3. Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA), 2009, *Rent Assistance*, Commonwealth of Australia, Canberra.
4. Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA), 2009, *Pension Bonus Scheme*, Commonwealth of Australia, Canberra.

The Commonwealth Seniors Health Card (Department of Families 2009c) is designed to assist self-funded retirees who benefit from medicines listed on the Pharmaceutical Benefits

Scheme (PBS) at the concessional rate and reduced PBS prescriptions (after reaching the PBS safety net); bulk-billed GP appointments (at the discretion of the doctor); and reduced out-of-hospital medical expenses above a concessional threshold through the extended Medicare Safety Net. Card holders may also receive a discounted rail travel on Great Southern Rail services (includes the Indian Pacific, the Ghan, and the Overland); and a Seniors Supplement (replaces Seniors Concession Allowance and Telephone Allowance). State/territory and local governments and some private providers may offer some additional health, household, transport, education and recreation concessions (Department of Families 2009c).

Rent Assistance (Department of Families 2009j) is paid at the rate of 75 cents for every dollar of rent paid above the specified threshold until the maximum rate is reached. The maximum rates and thresholds vary according to a customer's family situation and the number of children they have. For singles without children, the maximum rate also varies according to whether or not accommodation is shared with others. Rent thresholds and maximum rates are indexed in March and September each year to reflect increases to the consumer price index (Department of Families 2009j). The Pension Bonus Scheme (Department of Families 2009f) is an innovative incentive for older Australians to defer claiming the Age Pension and remain in the workforce.

In summary

Care is both a public and a private good and its provision has widespread benefits. The public good component means that care services improve the wellbeing of the community as a whole but make care services vulnerable to undervaluation by the market. This signals an important role for government policy and public funding to support both paid and unpaid care. Conditions in and funding for the care sector also have important gender equity consequences and the substantial role of public support in the care sector makes it particularly vulnerable to budget cuts at both the state and federal levels. Care recipients need for health care is supported in Australia by the publically funded national health system. There is a range of pensions, benefits and funding arrangements to support both paid and unpaid care.

There are a number of benefits available to assist low income families with the cost of raising children including income support payments, assistance with the cost of child care, tax rebates and a baby bonus paid on the birth or adoption of a child. Single mothers have a higher take-up of income support payments than partnered mothers and labour force participation is the main reason that families used both formal and informal child care. The cost of childcare and the effect on Centrelink payments or family benefits are important factors in mothers' career decisions. Despite assistance, parents often have problems with the cost of child care. Finding child care for a sick child is also a persistent problem.

Financial assistance is also available to carers providing extended care in the home in the form of income support and other payments. Two-thirds of carers receiving income support are women and one-third are in the 50 – 59 age group. The majority of recipients of income supplements for providing care are also women. Although the Carer Allowance is not taxable

or assets and income tested, eligibility involves an assessment of the care needs of the person requiring care. The take-up of both the Carer Payment and Carer Allowance has improved markedly since 1999 reflecting the ageing of the population and the associated increase in the incidence of people suffering from a disability and greater public awareness of the two payments.

Many care recipients in Australia are pensioners. The main sources of income support are the Age Pension and the Disability Support Pension. Additional support available in the form of concession cards, an education supplement and a bereavement payment. A Pension Loan Scheme is available to assist part-rate pensioners and some self-funded retirees who are assets rich and cash poor. Health care cards are available to assist income support recipients and low income people with the cost of health care. Rent assistance is available to pensioners who rent in the private rental market and the Pension Bonus Scheme encourages older Australians to defer claiming the Age Pension and remain in the workforce.

4.6 Government funded formal care services

The Australian aged care system is focused on assisting people to live in their own home for as long as possible. However, the effectiveness of this strategy relies heavily on the availability of informal carers while the capacity of carers to continue to care and maintain an attachment to the labour market relies on the availability and accessibility of quality aged and community services (Department of Health and Ageing 2003: 21). Research has shown that the majority of older Australians prefer that any care they may need is provided in their own home. This is often only possible if there is a family member or friend willing to provide informal care (Access Economics 2005: 37). The main formal care services available to assist people to remain in their own homes are outlined in Table 4.6a.

The largest source of community care assistance is provided through the Australian Government and State/Territory funded Home and Community Care (HACC) program (Department of Health and Ageing 2009f). In 2007–08, an estimated 831,500 people received assistance from the HACC program. Community care in the person's home is also provided as tailored packages through Community Aged Care Packages (CACP) (Department of Health and Ageing 2009b) which provide care for frail or disabled older people whose dependency and complex care needs would qualify them for entry to an aged care facility, at least for low-level care. They are complemented by Extended Aged Care at Home (EACH) Packages (Department of Health and Ageing 2009d) and EACH Dementia packages (Department of Health and Ageing 2009c), whose aim is to deliver care at home that is equivalent to high-level residential care. EACH Dementia packages are individually tailored packages of care for approved care recipients who have complex care needs because of behavioural and psychological symptoms of dementia that affect their ability to live independently in the community (Australian Institute of Health and Welfare 2009: vii & viii).

Table 4.6a Formal care services to assist home and community care

Policy	Purpose	Additional information
Home & Community Care (HACC) Program Overview ¹	Provides a range of basic maintenance & support services for frail older people, younger people with disabilities & their carers	Includes nursing care; allied health care; meals and other food services; domestic assistance; personal care; home modification and maintenance; transport; respite care; counselling, support, information & advocacy; & assessment.
Community Aged Care Packages (CACP) ²	Individually planned & coordinated packages of care to help frail older Australians remain living in their own homes	Includes personal care, social support, transport to appointments, home help, meal preparation & gardening. Requires assessment by an Aged Care Assessment Team (ACAT). Fee payable must not exceed 17.5% of a pension (\$7.69 from 20 September 2009) or up to 50% of any income above the maximum pension rate.
Extended Aged Care at Home (EACH) Packages ³	Individually planned and coordinated packages to provide a high level of care	Includes registered nursing care; care by an allied health professional such as a physiotherapist or podiatrist; personal care; transport to appointments; social support; home help; and assistance with oxygen and/or enteral feeding.
Extended Aged Care at Home Dementia (EACHD) Packages ⁴	To help older Australians who experience difficulties in their daily life because of behavioural and psychological symptoms associated with their dementia	Includes registered nursing care; care by an allied health professional such as a physiotherapist, podiatrist or other type of allied health care; personal care; transport to appointments; social support; home help; and assistance with oxygen and/or enteral feeding PLUS approaches and strategies to meet the specific needs of care recipients with dementia who experience behaviours impacting on their daily quality of life.

Sources:

1. Department of Health and Ageing 2009, *Home and Community Care Program Overview*, Commonwealth of Australia, Canberra.
2. Department of Health and Ageing 2009, *Community Aged Care Packages*, Commonwealth of Australia, Canberra.
3. Department of Health and Ageing 2009, *Extended Aged Care at Home Program*, Commonwealth of Australia, Canberra.
4. Department of Health and Ageing 2009, *Extended Aged Care at Home Dementia Program*, Commonwealth of Australia, Canberra.

All the community care packages as well as residential aged care places are provided in accordance with a provision ratio set by the Federal Government which was increased in 2008 to 113 places and packages per 1,000 persons aged 70 years and over, to be achieved by June 2011. The intended mix was set at 44 high-care and 44 low-care places, and 25 community care packages, including four for high-level care per 1,000 persons aged 70 years and over (Australian Institute of Health and Welfare 2009: 1). In 2007-08, there were 40,280 Community Aged Care Packages (ratio 20.1) and 6,240 Extended Aged Care at Home

(EACH) Packages and EACH Dementia packages (ratio 3.1) provided nationally (Australian Institute of Health and Welfare 2009: 2). Additional assistance to support people to remain living in their own homes is outlined in Table 4.6b.

Table 4.6b Additional assistance for community care

Policy	Purpose	Additional information
Respite Care ¹	To support and assist relatives and friends caring at home for people who are unable to care for themselves because of disability or frailty.	Provides information and support for carers; and assistance to help carers take a break from caring which can be in their home with care ranging from a few hours a week to overnight care; in a Day Care Centre which provides full or half day care; or in a residential aged care home for two or three weeks. There are 54 Commonwealth Respite and Carelink Centres established across Australia under the National Respite for Carers Program (NRCP). ²
Day Therapy Centre Program ³	Provides a wide range of therapy services to frail older people living in the community and to residents of Australian Government funded residential aged care facilities	Therapy services include: physiotherapy; occupational therapy; podiatry; and speech therapy.
Rural Health Multi-Purpose Services ⁴	Integrated health and aged care services that provide flexible and sustainable service options for small rural and remote communities	Has been shown to work well in communities where: the population is not large enough to support separate services such as a hospital, a residential aged care service, and home and community care services; there is support from both the Australian Government and state governments; there is a strong community commitment to improving the local health care; the existing health service providers are supportive of an MPS; & an MPS would be viable and sustainable under the funding arrangements.
Transition Care Program ⁵	Designed to improve older people's independence and confidence after a hospital stay	A package of services that includes low intensity therapy (such as physiotherapy, occupational therapy and social work) and nursing support and/or personal care. It helps older people complete their restorative process and optimise their functional capacity while assisting them and their family or carer to make long-term care arrangements.

Sources:

1. Department of Health and Ageing 2008, *Respite Care*, Australian Government, Canberra.
2. Department of Health and Ageing 2008, *Day Therapy Centres Overview*, Commonwealth of Australia, Canberra.
3. Department of Health and Ageing 2009, *Rural Health Services: Multi-Purpose Services*, Commonwealth of Australia, Canberra.
4. Department of Health and Ageing 2009, *Aged and Community Care: Transition Care Program*, Commonwealth of Australia, Canberra.

Respite care (Department of Health and Ageing 2008d) primarily supports carers by providing alternative care while the carer takes a break. Respite care can be provided in their own home, in the wider community, or in a residential aged care facility. Commonwealth Respite and Carelink Centres established under the National Respite for Carers Program (NRCP) (Department of Health and Ageing 2008c) provide a single point of contact for the general public, service providers, general practitioners and other health professionals for information on community, aged and disability services and carer support. However, there is a need to increase funding for these centres to provide case coordination for both the carer and care recipient as well as longer term case management for both (Anglicare 2010).

Respite care provided in residential aged care facilities accounts for almost half (49%) of admissions to residential aged care during 2007–08 although at any one time the number of respite residents is small. Respite care is usually of short duration with an average length of stay of 3.3 weeks. The majority of respite residents (77%) return to the community, but 16% continue in residential care (either permanent care or additional respite care) (Australian Institute of Health and Welfare 2009: vi).

The Day Therapy Centre Program (Department of Health and Ageing 2008b) provides a range of therapy services assist people to maintain or to recover a level of independence that will allow them to remain either in the community or in low level residential care. The Transition Care Program (Department of Health and Ageing 2009a) is for older people who would otherwise be eligible for residential aged care and can be provided in either a home-like residential setting or in the community. The average duration of care is 7 weeks, with a maximum duration of 12 weeks that may in some circumstances be extended by a further 6 weeks.

Rural Health Multi-Purpose Services (Department of Health and Ageing 2009g) are specifically designed for small rural and remote centres with state and territory government funding for health services and infrastructure to bring a flexible mix and range of aged care and health services together under one management structure. This provides small communities who are having difficulty supporting a range of independently run services the opportunity to develop a more coordinated and cost-effective approach to service delivery.

Despite the assistance available for community care, sometimes it is not possible for elders to continue to live at home and admission to a residential aged care facility is required. Table 4.5c provides the basic details of Australian residential aged care services (Department of Health and Ageing 2007), the means-tested fees and charges that apply (Department of Health and Ageing 2009e) and the Community Visitors Scheme (Department of Health and Ageing 2008a).

In 2007-08, there were 175,472 places (ratio 87.7) provided nationally in residential aged care facilities (Australian Institute of Health and Welfare 2009: 2). On average, the length of time people spend in residential aged care is increasing. The average completed length of stay for permanent residents who left residential aged care during 2007–08 was 147.8 weeks compared with 131.3 weeks in 1998–99 and 145.9 weeks in 2006–07. Length of stay was longer for women (170.4 weeks) than for men (109.8 weeks) (Australian Institute of Health and Welfare 2009: vi).

Table 4.5c Residential aged care

Policy	Purpose	Additional information
Residential Aged Care ¹	To provide accommodation and support for people who can no longer live at home. Two levels of residential care are provided: low level (hostel) services, and high level (nursing home) services	Assessment by an Aged Care Assessment Team (ACAT) is required. Residents of aged care homes may be asked to pay a basic daily care fee . This fee contributes to living expenses like meals, laundry, heating/cooling, and nursing and personal care. Residents (other than respite residents) may also be asked to pay an income-tested fee , depending on their income and level of care. Residents will not be asked to pay more than they can afford and no resident will pay more than the cost of their care. In addition, residents may be asked to contribute towards the cost of their accommodation in an aged care home by paying an accommodation bond or accommodation charge . A resident can only be asked to pay a bond or charge if their assets exceed an amount set by the Australian Government. ²
Community Visitors Scheme ³	A national program that provides companionship to socially or culturally isolated people living in Australian Government-subsidised aged care homes	Residents of aged care homes may become isolated and lonely because of limited family and social contact, for cultural reasons, or through disability. The Community Visitors Scheme arranges community volunteers to visit selected residents on a regular, one-to-one basis, is funded by the Australian Government & operates in every state & territory.

Sources:

1. Department of Health and Ageing 2007, *Residential Care Services*, Commonwealth of Australia, Canberra.
2. Department of Health and Ageing 2009, *Fees and Charges: Revised Residential Care Fees and Charges*, Australian Government, Canberra.
3. Department of Health and Ageing 2008, *Community Visitors Scheme*, Commonwealth of Australia, Canberra.

Over half (55%) of the residents in aged care services at 30 June 2008 were aged 85 years and over, and over one-quarter (27%) were aged 90 years and over. Excluding those with unknown status, 56% were widowed at the time of admission, 26% were either married or in a de facto relationship, 10% had never married and 8% were divorced or separated. Female permanent residents were over two times as likely to be widowed than their male counterparts (68% compared with 28%), and less than half as likely to be married or in a de facto relationship (19% compared with 43%). (Australian Institute of Health and Welfare 2009: 39).

A high proportion of permanent residents were in receipt of a government pension, with 71% receiving a Centrelink pension, and 18% an Australian Government Department of Veterans' Affairs (DVA) pension. Similar proportions of female and male permanent residents were receiving Centrelink pensions (71% females, 70% males) or DVA pensions (18% females, 19% males) (Australian Institute of Health and Welfare 2009: 40). As at 30 June 2008, of a total of 160,250 residents, 113,596 were female (70.9%) and 46,654 were male (29.1%) (Australian Institute of Health and Welfare 2009: 48).

In summary

Although most Australians who provide care prefer to remain in their own home, this is only possible if an informal carer is available. Formal community care services assist both care recipients and carers. Community Care Packages are available at a provision ratio set by the Federal Government and provide a range of basic maintenance & support services for frail older people, younger people with disabilities & their carers.

Respite care provides support for carers to have a break and can be provided in their own home, in the wider community, or in a residential aged care facility. Various therapies are available to assist people to maintain enough independence to remain in their own homes is provided by the Day Therapy Centre Program. Small rural and remote communities who are having difficulty supporting a range of independently run services can access assistance for integrated health and aged care services under the Rural Health Multi-Purpose Services scheme. The Transition Care Program assists older people to regain independence following a hospital admission.

Despite the assistance available for community care, sometimes admission to residential aged care is required. On average, the length of time people spend in residential aged care is increasing and length of stay is longer for women than men. Over half the residents in aged care are 85 years and over. Female permanent residents were over two times as likely to be widowed as their male counterparts. Over 80% of permanent residents are pensioners.

Conclusion

The public goods component of care services means that the benefits of providing good care spillover to improve the wellbeing of the community as a whole but makes care services

vulnerable to undervaluation by the market. Children and other dependents who require care cannot exercise consumer sovereignty. In order for the supply of care services to meet demand there is an important role for government in supporting both paid and unpaid care. Benefits which assist low income families with the cost of raising children, financial assistance for carers providing extended care in the home, and income support and other assistance to care recipients who cannot participate in the labour force are all important publicly funded support mechanisms for the care economy.

Formal care services assist people requiring extended care and their carers. A range of Community Care Packages funded by the Australian Government provide support to frail older people, younger people with disabilities & their carers. Respite care provides alternative care while the carer takes a break and the Day Therapy Centre Program provides therapies to assist people to maintain enough independence to stay in their own homes. Despite this support, the length of time people spend in residential aged care is increasing. Most residents are pensioners over 85 years of age and the length of stay is longer for women than men.

5. Impact on women's economic wellbeing

This section looks at the impact of care work, both paid and unpaid, on women's economic wellbeing. It begins with a discussion of the issues involved in women earning an income from working in formal care services which are characterised by a highly feminised workforce with high levels of casual and part-time employment. The next issue discussed is the impact of extended informal caring on women's economic wellbeing. This is followed by the topic of women's workforce participation which, although it has increased, varies through the life course with the workforce participation of mother's with young children and sole parents warranting particular attention. The final issue, of importance to many women, is that of workplace flexibility.

5.1 Formal care work

Across developed countries, many women are employed in caring occupations which pay less than jobs with similar characteristics. Research in the United States identified a 'wage penalty' where people employed in care work earned less would be predicted based on the characteristics of the jobs, their skill demands, and the qualifications of those holding the jobs (England, Budig & Folbre 2002: 455). A significant net wage penalty of 5 – 6% for both men and women was identified (England, Budig & Folbre 2002: 464). No such similar research has been conducted in Australia but research which used Australian Census data to look at incomes of female professionals found that there was a gap in the earnings of registered nurses compared to other female professionals (Nowak & Preston 2001: 236). Registered nurses earned 27.1% less than health professionals and 18.7% less than business professionals. The researchers concluded that 'differences in the earnings of nurses and other highly feminised professionals are manifestations of the historical undervaluation of women's work' (Nowak & Preston 2001: 242). Women's segregation in caring jobs helps explain the persistence of gender differences in pay (Folbre 2006b: 186).

The undervaluation of women's caring work in market terms is linked to a deep-seated societal belief that care should be provided for 'love' not money. There is a public concern that if care is provided for money, it may not be good quality care (Folbre 1995: 75). However, caring labour when supplied in a market tends to be incompletely commodified (Himmelweit 1999: 37) because when caring is chosen as a career, the choice is not likely to be entirely motivated by extrinsic rewards (Himmelweit 1999: 34). In fact, it is possible to take a caring job 'for the money' and be exceptionally nonmaterialistic and generous (Nelson 1999: 46).

An analysis using 2001 Census data of workers in a caring occupation in the Australian community services industry where the majority of workers are women found that half (51.6%) of all care workers who live in families are secondary earners contributing 40% or less to family income. Sharp differences were found among occupational groups with 60.6% of intermediate service workers contributing 40% or less to family income. The majority of

these workers (56.5%) worked part-time (Meagher & Healy 2006: 72). The same study found that in 2001, workers in property and business services reported higher incomes than care workers in community services. The modal weekly income for caring professionals was \$800 to \$1,000 and 87.2% of these workers earned less than \$1,000 per week. By comparison, the modal weekly income for professionals in property and business services was more than \$1,500 with 49.5% of these professionals earning less than \$1,000 per week (Meagher & Healy 2006: 87).

The same study also found that care workers in community service industries were more likely to be lone parents than professionals, associate professionals, and intermediate service workers in the labour market overall. Of all care workers with one or more dependent children at home, 20.3% of care workers in nursing homes lived in lone parent families, and 15.9% of child care workers and 23.5% of care workers employed in non-residential care services lived in one parent families (Meagher & Healy 2006: 62).

A later study of the residential and community based aged care workforce found that, of the residential aged care workforce, nurses were much more likely than other residential care workers to be in the upper pay brackets. Nearly all those earning over \$1,000 per week in 2007 were nurses. Two-thirds of personal carers earned between \$500 and \$1,000 per week while just over half of allied health workers earned this much. The wages were determined by the workers' hourly pay and the number of hours worked and it is likely that the relatively high proportion of allied health workers with a weekly pay of under \$500 is due to a low number of hours worked (Martin & King 2008: 20). In the community care workforce, it was found that more than half of community care workers (55.7%) earned \$500 or less per week compared to 31% of personal carers in residential aged care facilities. These low earnings are consistent with the substantial proportion of community care workers who work short part-time hours (Martin & King 2008: 71 & 72).

In summary

Most workers in caring occupations are women who earn less than comparable workers in non-caring occupations. Women's segregation in caring jobs helps explain the persistence of gender differences in pay. A societal belief that care should be provided for love, not money contributes to the undervaluing of paid care work. Care workers' economic wellbeing is further hampered by working in casual or part-time positions due to their caring responsibilities in the home. A substantial number of care workers are lone parents.

5.2 Unpaid caring

In 2003, 27% of primary carers experienced difficulty meeting everyday living costs, 21% had lost income due to caring and 23% were incurring extra expense associated with caring (Hales 2007: 22). In 2009 it was reported that carers were less likely than non-carers to be employed and less likely to be working full-time, 54% of carers who had returned from retirement to work cited financial need as their main reason for returning to work compared to 38% of non-carers, superannuation coverage was slightly lower for carers (68% compared with 71%) and the median superannuation balance for carers was around \$9,000 lower than

for non-carers (Australian Bureau of Statistics 2009: 4). Because of their reduced workforce participation, many carers do not benefit from the existing compulsory superannuation scheme and therefore have little capacity to prepare for retirement (Hughes 2007: 33).

A national survey of 1002 people receiving government assistance to care for a person with a disability found that 14% of these carers experienced one and 16.6% experienced two or more financial hardships. There was evidence that financial hardship contributes to social isolation. The percentage of carers who experience two or more financial hardship events and experience low face-to-face social contact with relatives and friends outside their household (27.7%) was almost double that of carers with no experience of financial hardship (15.3%). Carers who experience two or more financial hardship events were 1.89 times more likely than those who did not experience any financial hardship to want more face-to-face social contact (Edwards, Higgins & Zmijewski 2007: 14). Greater household wealth and having a spouse who is employed can lead to having either a greater capacity to purchase caring services or a buffer against reduced income from employment (Hill et al 2008: 27).

An analysis of Wave 6 data from the Household, Income and Labour Dynamics in Australia (HILDA) Survey which examined the economic consequences of being the primary carer for a disabled child in women 30 – 64 years of age found that family income was below four-fifths of that of families who do not have to care for a child with disabilities and that the income of the male partner, who is often the secondary carer, was also substantially reduced (Nepal et al. 2009: 14). Although primary carers receive more government support, when income from all sources is examined, the work-life income of primary carers would be 70 – 80% of the income of other women at the individual level and 80 – 90% at the family level (Nepal et al. 2009: 15).

Recommendation 13

That *Security4Women* advocate for increased public funding to improve the income of carers providing extended care in the home.

A large majority of primary carers of adults with an intellectual disability are mothers, even when both parents are retired (Cuskelly 2006: 20) and 25 – 50% of ageing carers are not using any formal services and so are unknown to service providers (Cuskelly 2006: 21). Employment of mothers is significantly lower in comparison with those without a child with a disability, both while the child is young and in adulthood, while fathers' working hours have been found to have a bimodal distribution with about half the fathers working part-time to provide support for their wives and the remainder working very long hours (Cuskelly 2006: 22). Socioeconomic need within families will increase the difficulties of caring for an adult disabled child and lead to increased distress (Cuskelly 2006: 23).

Overwhelmingly mothers or other female relatives, such as grandmothers, are predominantly the providers of care. For those people with a disability who have high support needs and

lifelong disability, the pressure on mothers and family can be great (Spicer 2007: 30). Caring and lifelong caring in particular has resulted in many having to abandon careers or limit their ability to work and contribute to the family income. This, together with the high incidence of single parent families providing lifelong care, strengthens the likelihood that families with disability will be in a lower income group in the community. This is a significant challenge for many when the disability frequently brings with it additional costs (Spicer 2007: 31).

In summary

Carers providing unpaid care often have financial difficulties and their workforce participation is often adversely affected by their care commitments. There is evidence that financial hardship contributes to social isolation for some carers. Despite the availability of government support, the work-life income of primary carers is 70 – 80% of the income of other women. Overwhelmingly mothers or other female relatives are the predominant care providers. Families providing extended care often have a low income which is exacerbated by the cost of providing care.

5.3 Women's workforce participation

Over the past three decades there has been a rise in the overall workforce participation rate in Australia. That rise has been driven by a dramatic shift of women into the paid workforce, and builds on increased availability of part-time employment, childcare and a more flexible work-life balance. There has been a major shift in the gender balance of Australia's workforce. Workforce participation rates continue to differ between men and women but the overall gap has been narrowing. Much of the overall lift in female participation rates has come from older women and those of prime working age (Access Economics 2006: 6).

Workforce participation rates for those aged 45-54 started in the 1980s at a lower base than the younger cohorts but have since caught up standing at just over 70%. Female participation drops off markedly from the age of 55 years, but it has been rising too: participation by women aged 55-59 has increased by more than 20% over the last 20 years (Access Economics 2006: 7). Female participation rates have fallen at younger ages and risen at older ages in the past four years which suggests that women are gaining more education in their younger years, which in turn will see them working harder for longer as they age (Access Economics 2006: 8).

Recent increases in participation have been evenly split between full and part-time work, with today's women showing an increasing desire to work longer hours than their predecessors (Access Economics 2006: 9). Participation by women aged 20-54 seems to have reached a plateau during the 1990s particularly in the younger cohorts. This may have to do with the time taken off to have and look after children. If so, government policy to improve access to childcare may increase participation.

Older workers have produced the biggest surprise with the last four years seeing a dramatic acceleration in the number of women choosing to work longer rather than opt for an early

retirement. Increases in participation by mature Australians in the 55-70 age range have perhaps the greatest potential to dampen the effects on the economy of an ageing population, both because of the size of these cohorts and their relatively low starting positions. With a change in policy and attitude, participation could build on recent increases to lift further still in these cohorts (Access Economics 2006: 10). Workforce flexibility and the availability and responsiveness of community support services will be a prime consideration for an increasing number of mature age workers providing care to a frail parent or a spouse with a disability (Hales 2007: 20). Increasing the share of women working full-time (and therefore the total number of hours worked) has the potential to further boost future prosperity (Access Economics 2006: 12).

However, increased participation in paid employment affects the relationship between time and money in the household. Women's labour force participation is often purchased at the expense of time devoted to personal care, sleep and leisure (Folbre 2006b: 184) and the allocation of women's time and money affects their ability to develop their own capabilities and those of their children (Folbre 2006b: 185). It also appears to be the case that women's workforce participation is not resulting in adequate superannuation to fund their retirement. A 2009 union survey of women members found that many of the women respondents did not have enough superannuation to fund their retirement and that it will at best be a small supplement to the aged pension. It also found that over a quarter of the women did not know how much they had in their superannuation accounts. Although half of them made extra contributions, the key reason for not contributing to superannuation was that they could not afford to put extra money in because they were using the money to pay off their mortgage or other debts. Nearly two-thirds of women had not seen a financial planner about their superannuation and over half the respondents had never attended a training or information session on superannuation (Community and Public Sector Union (CPSU) 2010: 58).

The benefits of women's workforce participation in Australia are also dampened by the effect of a long-standing gender wage gap. Analysis of Australian Bureau of Statistics earnings data confirmed that Australia has a persistent gender wage gap which remained between 15% to 17% from 1990 to 2009 reaching a low of 15.1% in February 2005 and steadily increasing to 17% in February 2009. The major contributing factor to the gap, which accounted for 60% of the difference between women's and men's earnings, was simply being female. If the effects of being female were removed, the average wage of an Australian woman would increase by \$1.87 per hour resulting in an income increase of \$65 per week or \$3,394 per annum based on a 35 hour week. (Cassells et al. 2009: v). Measured in terms of Gross Domestic Product (GDP) per capita, a 1% decrease in the gender wage gap would increase GPP per capita by \$260 which equates to around \$5,497 million (in 2007 dollars) or 0.5% of total GDP. Eliminating the entire gender wage gap from 17% to zero could be worth around \$93 billion or 8.5% of GDP (Cassells et al. 2009: vi). This modelling provides evidence that the gender wage gap does not just impose a cost to women's lifetime earnings; it impacts negatively on the performance of the Australian economy.

Recommendation 14

That *Security4Women* lobby for government intervention to address the gender wage gap in Australian workplaces.

In summary

The workforce participation rates of women in Australia has been steadily rising resulting in a major shift in the workforce gender balance. Recent increases in participation have been evenly split between full and part-time work but, overall, Australian women are working longer. As there are an increasing number of mature age workers providing care to a frail parent or a spouse with a disability, workplace flexibility and the availability of community support services is an important issue. Also of concern is the fact that women's workforce participation is not resulting in adequate superannuation to fund their retirement and their earnings are adversely affected by long-standing gender wage gap. The major contributing factor to this gap is simply being female, a discrimination which costs the Australian economy an estimated 8.5% of GDP (\$93 billion) per annum.

5.3.1 Informal care and workforce participation

According to the *Managing Caring Responsibilities and Paid Employment Survey* published by the Australian Bureau of Statistics in 2000, there is a higher unmet need for family friendly work arrangements among employees caring for an adult than among workers with solely child care responsibilities (Gray & Hughes 2005: 22). As the population ages there will be increasing numbers of caregivers and care recipients with increasingly complex care needs. Faced with competing demands of paid employment and caregiving, many carers will relinquish or reduce employment. Employers wishing to retain mature age workers will need to respond flexibly to the needs of those with caring responsibilities. Some carers require time off as regularly as once a week, or infrequent but extended periods of leave to provide care (Hales 2007: 23).

There is a concern that the increased labour force participation, particularly among mature age women who perform the bulk of unpaid caring work, will cause a slide in informal care, and abdication of family responsibility will add to increased reliance on publicly funded services. It is questionable that the policy goal of increased labour force participation by mature age people can be realised given the increasing demand for elder care which falls largely on this population group. The issue of balancing the demands of employment and caregiving in a much broader context than child care has long been recognised and it has been suggested that women can now expect to spend more years caring for elderly parents than they do rearing children (Hales 2007 19). Workforce flexibility and the availability and responsiveness of community support services will be a prime consideration for an increasing number of mature age workers providing care to a frail parent or a spouse with a disability (Hales 2007: 20).

Based on an analysis of HILDA data, about 10% of those who became carers left the workforce (Hill et al. 2008: 28). The baseline predicted probability of a new carer leaving the labour force was 8%. Having more demanding care responsibilities and having preschool age children were independently associated with leaving employment at the onset of informal care. Caring for more than 20 hours per week increased the predicted probability of leaving employment from 8% to 26%. Having a child under 5 years as well as caring for more than 20 hours per week further increased this probability to 50%. Higher levels of partner earnings

were associated with a greater probability of leaving employment although with a smaller effect but having a spouse who was also a carer lowered the probability of leaving employment by 5% (Hill et al. 2008: 29).

Working in a casual rather than a permanent job increased the probability of leaving paid work by 12%. If the new carer was caring for 5-20 hours per week, the effect of casual employment was a 17% increase in the probability of leaving, and if caring intensively (more than 20 hours per week) the effect of being a casual employee was a 22% increase. This finding that casual employees are more likely to leave employment may indicate that employees in these jobs are less able to negotiate changes in their employment conditions that facilitate caring (Hill et al. 2008: 29).

Working part-time instead of full-time increased the likelihood of an intensive carer leaving paid work by 22%. There was a strong association between casual employment and part-time work with 84% of casual workers employed part-time. Full-time work was strongly associated with permanent employment with only 5% of full-timers being casuals. Part-time work was more likely to be precarious with 43% of part-timers working as casual employees. Intensive carers who were not union members had an 11% probability of leaving employment compared with union members and if they were working in a smaller firm (less than 100 employees) the effect was a 10% increase (Hill et al. 2008: 30).

The category 'labourers and related workers' which includes cleaners, factory workers and product packagers were the occupational group most likely to leave employment at the onset of care. Employment characteristics which were not significantly associated with leaving employment included being self-employed, working some hours from home, working irregular schedules, and whether working in the private or the public sector (Hill et al. 2008: 29). Higher ratings of satisfaction with job security and satisfaction with pay were significantly associated with a lower probability of leaving work (Hill et al. 2008: 30).

Many carers who may be able to participate in paid work during school hours still experience the impacts of their caring role at work, away from the person for whom they provide support. For example, carers may be sleep-deprived, stressed, distracted, or constantly primed to respond to crises that require them to 'drop everything' at work. This can significantly impact on their ability to find and maintain employment (Carers Australia 2009c: 7 & 8).

Research has consistently shown that carers have the lowest health and wellbeing of any group yet discovered. The caring role can be highly stressful and psychologically demanding, with emotional and psychological investment carrying over into times when carers are not directly providing care. These care needs can significantly impact on a carer's ability to engage in substantial participation in the workforce (Carers Australia 2009c: 8). The productivity losses associated with the provision of informal care are mainly borne by the individuals providing the care whose wage income is reduced (Access Economics 2005: i). Newly available longitudinal data from the HILDA survey shows that, over the course of a

working life, the risk of employees acquiring substantial caring responsibilities is high, probably close to 1 in 2 (Hill et al. 2008: 31).

In summary

There is a high unmet need for flexible work arrangements for employees providing care in the home. As women can now expect to spend more years caring for elderly parents than they do rearing children, workplace flexibility and adequate community support services are a prime consideration. Providing unpaid care for a family member in addition to caring for pre-school age children and providing care for more than 20 hours per week substantially increased the likelihood of carers exiting the paid labour force. Casual and part-time workers are more likely to leave the workforce at the onset of caring. ‘Labourers and related workers’ were the occupational group most likely to leave employment at the onset of care while workers with high job satisfaction and job security were significantly less likely to leave the workforce.

There is strong evidence that the demands of providing care impacts negatively on carers’ ability to find and maintain employment. Carers have the lowest health and wellbeing of any group yet researched. The costs of providing care are primarily borne by the carer whose income is reduced. There is a high risk of workers acquiring substantial caring responsibilities over their working life.

5.3.2 Mothers with infants and young children

According to data from the first wave of *Growing up in Australia: The Longitudinal Study of Australian children (LSAC)* collected in 2004 (infant cohort of 5,107 children), the employment rate of mothers with an infant was 38% (2,014 mothers employed) with a further 10% of mothers on maternity leave (Baxter & Gray 2006: 35). The trend towards increasing educational attainment of women means that mothers with an infant have a higher average level of education than is the case for all women. Therefore, everything else being equal, mothers with an infant are on average likely to be employed in higher status occupations than are all women (Baxter & Gray 2006: 37).

The average hours in paid work for mothers with an infant in 2004 was 20.4 hours per week which is much lower than the average for all women of 31.2 hours (Baxter & Gray 2006: 37). Just over a quarter of all employed mothers with an infant were self-employed (27.4%), 52.5% were permanent or ongoing employees and 20.1% were casual employees (Baxter & Gray 2006: 38). The findings suggest that for women with young children, casual and self-employment is associated with higher levels of flexibility in the hours worked and lower levels of negative work effects on family life being reported. However, casual employees and to a lesser extent the self-employed are in lower status occupations than those in permanently employment (Baxter & Gray 2006: 41).

Data from Waves 1 and 2 (1996-97 and 2001) of the national *Negotiating the Life Course Survey* found that more women worked part-time when they had their first child (18%)

compared with working full-time (15%). The majority of women who were working full-time before the birth of their first child and returned to work after the birth moved from full-time to part-time work (Baxter 2005: 12 & 13). There was a relatively high rate of returning to work among one-child mothers when their child is one or two years old – 30% of women who did not work in the year of their first birth went back to work when the child was one year old (18% to part-time work and 13% to full-time work) and 21% of women returned to work when the child was aged two (16% part-time and 5% to full-time work) Once a second (or later) child is born, if the mother has not yet returned to work, the likelihood of returning in a particular year is lower and it is the return to part-time work that increases as the youngest child gets older with return to full-time work remaining low (Baxter 2005: 13).

The mother's level of education was a significant factor. Almost one quarter of mothers with incomplete secondary education were not working before and after the first birth, compared with less than 8% of those with bachelor degrees or higher. Women with a bachelor degree or higher had the highest percentage of returning to full-time work (Baxter 2005: 14). Of the mothers who were not partnered who worked before the birth, more remained working after, compared to married and cohabiting women who were more likely to leave work. There has been an increase in the proportion of women who report remaining in work after the commencement of childbearing especially when the 1980s and 1990s are compared to the 1970s (Baxter 2005: 15). The increased likelihood of returning to work appears to be associated with increases in the return to part-time employment (Baxter 2005: 16).

Data from Wave 3 of the Household, Income and Labour Dynamics in Australia (HILDA) Survey collected in 2003 revealed that mothers' workforce participation has increased. The proportion of mothers whose youngest child was up to four years old working 1-14 hours who want to work 'longer hours' had increased substantially: in 1996 15% of mothers working these minimal hours said they would like to increase their work hours while in 2003, 40% of such mothers indicated this preference. For mothers whose youngest child was five to twelve years old with less than full-time work, the proportion expressing a preference for longer hours was higher in the 2003 survey than the 1996 survey, with the difference being most marked for those working minimal hours (1-14 hours) with 31% in 1996 and 50% in 2003 indicating a preference for 'longer hours'. Of those working half-time (15-29 hours), the proportion expressing a preference for 'longer hours' rose from 13% to 21% (Qu & Weston 2005: 74).

Analysis of the 2003 survey showed a general drive towards increased workforce participation of mothers which suggests, other things being equal, demands for access to affordable and high quality child care will continue to increase. One avenue to help mothers participate in paid work without jeopardising non-financial aspects of their children's wellbeing involves fathers taking on a greater share of 'hands-on' non-discretionary aspects of parenting. Another avenue involves the continuation of adjustments within the workplace and community to accommodate workers with parenting responsibilities including access to flexible working hours and part-time work that does not jeopardise their chance of promotion (Qu & Weston 2005: 77).

In a study of couples with young children, using data from the data from the Longitudinal Study of Australian Children (LSAC), working longer hours in paid work was significantly associated with more work-to-family strain for working mothers than fathers (Alexander & Baxter 2005: 21). Being self employed was associated with less negative impact from work onto the family for both mothers and fathers while being a casual employee reduced the amount of negative work-to-family spillover for mothers but increased it for fathers. Parents with the most flexible hours had significantly lower work-to-family strain as did those with high levels of autonomy in how they decided to do their work. Work was most likely to have a negative impact on family in higher skilled jobs, especially professionals, managers and administrators, and associate professionals. The effect was larger for mothers than fathers although the differences were small (Alexander & Baxter 2005: 22).(Alexander & Baxter 2005: 22).

Each additional child was associated with more work-to-family strain and where a child in the family had a long-term medical condition, mothers experienced more work-to-family strain whereas fathers were unaffected. A greater level of perceived support and a higher value of relationship quality were associated with less work-to-family strain for both mothers and fathers (Alexander & Baxter 2005: 23). Mothers were about five times more likely than fathers to say they did 'more' or 'much more' than their fair share of the unpaid work in the home but the minority of fathers who reported doing more than their fair share were experiencing significantly less work-to-family strain (Alexander & Baxter 2005: 24).(Alexander & Baxter 2005: 24).

Data from Wave 3 of the Longitudinal Study of Australian Children (LSAC) collected in 2008-09 showed that more mothers were working as their children got older. Three-quarters of mothers with children 8 to 9 years were in employment compared with 63% of mothers with children aged 4 to 5 years. Working part-time was common in both groups of mothers with close to half of mothers engaged in part-time work while 2% of mothers were looking for work (Department of Families 2009d).

In summary

Mothers of young children have a higher level of education and are likely to be employed in higher status occupations than is the case for all women. Casual and self-employment provides more flexibility in the hours worked for mothers of young children. Most mothers of young children return to work part-time and the likelihood of returning to work increases as the child gets older. Mothers with tertiary education are the most likely to return to work. More single mothers return to work after the birth of a child than partnered mothers. Overall, mothers' workforce participation has increased and many mothers would like to work more hours in paid employment. This signals an increase in the demand for child care services.

However, mothers experience more work-to-family strain than fathers. Parents with flexible hours and high autonomy had significantly less work-to-family strain. When parents worked in highly skilled jobs, it was more likely to have a negative impact on family. Additional children increase the work-to-family strain and having a child with a medical condition

increases the work-to-family strain for mothers but not fathers. Higher levels of support and relationship result in less work-to-family strain for both parents. Most mothers did more than their fair share of the unpaid work in the home.

5.3.3 Sole parents

Although there is some difficulty in measuring intra-household inequalities, 'intra-family inequalities are often reflected in increases in the share of households with children maintained by mothers on their own' (Folbre 2006b: 184). Sole parent families are at an increased risk of disadvantage in terms of employment, housing, income and social participation. The estimated risk of being in housing stress is highest for sole parents as compared to singles and couples with or without children (Robinson 2009: 48). However, where the child and parent have good health, income is sufficient, there is an extended family and/or social network, the family has secure housing, and access to services is available, there is no increased risk of poor outcomes. However, the need for child supervision is a real constraint on sole parents' ability to work outside the home. Methods of support such as outreach service provision or work from home options are very real ways in which sole parents can be supported (Robinson 2009: 49).

In 2003, according to data from Wave 3 of the Household, Income and Labour Dynamics in Australia (HILDA) Survey, 35% of partnered mothers worked full-time compared with 40% of sole mothers (Qu & Weston 2005: 75). Sole mothers were more likely than partnered mothers to prefer to increase their hours of work especially those working fewer than 15 hours (68% compared to 38%). While most partnered mothers working such hours wanted to retain them, most sole mothers working these minimal hours wanted to increase their work hours (Qu & Weston 2005: 76). Sole mothers without paid work were more likely than partnered mothers in this situation to report that they wanted a paid job (66% compared to 38%) and a higher proportion of sole mothers without a job wanted to work full-time (17% compared with 7%) (Qu & Weston 2005: 76).

5.3.4.1 Flexible working hours

Analysis based on the Managing Caring Responsibilities and Paid Employment Survey (2000), New South Wales conducted by the Australian Bureau of Statistics found that women were much more likely than men to use shift, casual or part-time work as a means of managing their caring responsibilities, especially childcare (Gray & Hughes 2005: 21). However, there were higher levels of unmet need for flexible work arrangements to care for disabled or elderly adults. Both women and men caring for an adult were much more likely to say that they didn't apply to use flexible work arrangements because they thought that their employer would say no. For women with child care responsibilities, 31.1% said they hadn't asked for flexible work arrangements because they thought their employer would refuse (Gray & Hughes 2005: 22).

Both women and men with both adult and childcare responsibilities had the highest rate of making job changes in the previous six months in order to provide care (10.5% for adult care and 14.1% for child care). A higher proportion of women with care responsibilities had not

made a job change they wanted to make because of care responsibilities—8.9% with child care, 11.0% with adult care and 17.5% of with both adult and child care responsibilities. Women who had caring responsibilities were almost twice as likely to be self-employed (17.6%) as women with no caring responsibilities (9.9%) (Gray & Hughes 2005: 23). Although 9.1% of self-employed men had childcare responsibilities, over three times the number of women (29.105) moved to self-employment to make caring for children easier (Gray & Hughes 2005: 24).

The same data was used to analyse the use of flexible working arrangements by lone mothers who were less likely to be in employment than couple mothers but, of those in the workforce, lone mothers were more likely to be working fulltime (50.1%) than couple mothers (41.4%) (Hughes & Gray 2005: 19). Nearly two-thirds of lone mothers (63.1%) had made use of family-friendly work arrangements to provide care compared to 54.8% of couple mothers (Hughes & Gray 2005: 19 & 20). Lone mothers (10.2%) were almost twice as likely to use shift work as couple mothers (5.2%) to manage their caring responsibilities. Couple mothers (21.0%) were more likely than lone mothers (16.5%) to use part-time work to assist in providing care but lone mothers (12.7%) are about one-third more likely than couple mothers (8.4%) to use casual employment to manage care responsibilities. However, lone mothers are more likely than couple mothers to prefer to work full-time because of their need to earn a sufficient family income (Hughes & Gray 2005: 20).

Unmet need for use of some type of family-friendly work arrangement was higher for lone mothers (21.2%) than couple mothers (14.5%). There were twice as many lone mothers (20.2%) than couple mothers (10.3%) who said they did not make use of family-friendly work arrangements because of subtle or other pressures from their employer or other workers and almost twice as many lone mothers (27.4%) as couple mothers (15.0%) who had not made greater use of family-friendly work arrangements because they thought that if they applied, their boss would refuse (Hughes & Gray 2005: 21).

In a study of the paid work characteristics of mothers with infants using 2004 data from the Longitudinal Study of Australian Children (LSAC), 56.3% of employed mothers with an infant indicated that they could vary their start and finish times without needing to get approval, 27.0% could vary their start and finish times with approval and 16.7% could not vary their hours. In two-parent families, parents may organise their work hours so that one parent is available to look after the child while the other works (termed ‘shift-parenting’) (Baxter & Gray 2006: 39). Slightly more than half of the mothers (51.8%) said they sometimes worked evenings or nights and over half of employed mothers with infants (54.8%) sometimes worked on weekends (Baxter & Gray 2006: 40).

In a study of employees who had recently commenced caring for a frail older person or an adult with disabilities using HILDA data, researchers found that the most common carer-friendly workplace arrangement was the ability to use permanent part-time in their current job which was available to over 50% of carers while the least common was the ability to work from home which was available to less than 20% of both new carers and all employees (Hill et al. 2008: 29). Around a quarter of both employees who became carers and all

employees did not have access to any carer-friendly workplace arrangements. The researchers found that the distribution of carer-friendly arrangements was heavily skewed towards low access to carer-friendly provisions. The majority of employees reported access to two or fewer carer-friendly workplace provisions. The analysis suggests that the critical factor is having access to any carer-friendly arrangement rather than none because, among the employees who became carers, having a greater number of provisions was not associated with a greater likelihood of being employed, holding all other factors constant (Hill et al. 2008: 30).(Hill et al 2008: 30).

A survey of 9,504 women who are members of the Community and Public Sector Union, conducted in 2009 found that the most important flexible working arrangement was the women's ability to access leave when they needed it (77.2%) with most women with dependent children rating this as important or very important (99.3%). Flexible work hours were also ranked as very important which included flex-time, time off in lieu and the ability to change starting and finishing times (Community and Public Sector Union (CPSU) 2010: 27). The ability to negotiate part-time work was important or very important to 78.8% of women with dependents while just over a quarter of respondents rated job sharing as important or very important with the group of women aged 35 – 54 years most likely to report this (Community and Public Sector Union (CPSU) 2010: 28).

Paid maternity/paternity leave was ranked as important or very important by 60.5% of women with dependents compared to 43.2% without dependents. The results showed that although flexible work arrangements were important to women, they were rarely able to access them regularly. Of the flexible working provisions available, only flexitime was accessed regularly (51.0% of women). It was reported that taking time away from work for personal matters was frowned on by 23.5% of women. Although nearly two-thirds of respondents agreed that their current workplace entitlements enabled them to balance their work and non-work commitments sufficiently, over a quarter of women who worked over 10 hours extra per week said that their current entitlements did not enable them to balance their work and non-work commitments (Community and Public Sector Union (CPSU) 2010: 29).

Recommendation 15

That *Security4Women* in conjunction with *Fair Work Australia* and other relevant bodies advocate for flexible working conditions, in particular access to leave when required and flex-time, time off in lieu and the ability to change starting and finishing times throughout the Australian workforce to enable employees to undertake both child care and care for disabled or elderly adults.

In summary

Women, much more than men, use shift, casual or part-time work as a means of managing their caring responsibilities, particularly child care. There are high levels of unmet need for flexible work arrangements to care for disabled or elderly adults. Both women and men make

job changes in order to provide care but caring responsibilities also prevent some women from making job changes. Women also move to self-employment in order to provide care. Lone mothers are almost twice as likely as couple mothers to use shift work to provide care but are more likely to prefer full-time work in order to earn a sufficient family income.

There is evidence that both lone and couple mothers are not making use of family-friendly work arrangements because of pressure from employers or other workers. Working permanent part-time is the most carer-friendly work arrangement used by employees caring for a frail older person or an adult with disabilities. About a quarter of employees do not have access to any carer-friendly workplace arrangements. Important carer-friendly work arrangements are the ability to access leave when required and flexible working hours including flex-time, time off in lieu and the ability to change starting and finishing times. Many women cannot access flexible work arrangements regularly.

Conclusion

Most paid care workers are women and women's segregation in caring jobs helps explain the persistence of gender differences in pay. Care work is undervalued in market terms and many care workers participate in the labour market on a part-time basis due to their caring responsibilities at home. Most unpaid care in the home is provided by women who frequently experience financial hardship and have lower incomes across the life course than other women.

Although women's workforce participation rates have been steadily increasing, this is not resulting in sufficient superannuation to fund retirement for many women. A long standing gender wage gap adversely affects women's earnings. Workplace flexibility and the availability of community support services are important for a growing number of working women who are providing unpaid care in the home.

The onset of caring responsibilities, particularly if it is in addition to caring for children or providing care for more than 20 hours per week is likely to result in carers exiting the workforce. Casual, part-time and low income workers are more likely to exit than those whose job satisfaction and job security is high.

Mothers' workforce participation has increased with more mothers returning to work as their children get older. Many mothers would like to work more paid hours so the demand for child care will increase. Mothers experience more work-to-family strain than fathers and most mothers do more than their fair share of the unpaid work in the home.

Sole parent families are at an increased risk of disadvantage in terms of employment, housing, income and social participation. The need for child supervision is a real constraint on sole parents' ability to work outside the home and sole mothers are more likely than

partnered mothers to want to increase their hours of paid work. Sole mothers not in the workforce are also more likely than partnered mothers to want paid work.

Women use shift, casual or part-time work to manage their care responsibilities. Both women and men make job changes in order to provide care and women also move to self-employment. Working permanent part-time is the most carer-friendly work arrangement used by employees caring for a frail older person or an adult with disabilities. About a quarter of employees do not have access to any carer-friendly workplace arrangements and many women cannot access carer-friendly work arrangements regularly.

6. Conclusion

The notion of the ‘care economy’ has emerged from feminist critiques of the conventional conceptualisation of how economies operate which have traditionally only considered goods and services in the market as productive in an economy. Feminists argue that gender equality and women’s economic wellbeing require a new vision of economic life: women’s care work needs to be counted in statistics; the role of care, as well as commodities, needs to be included in the working of economies; and the care economy needs to be integrated into public policy.

The care economy encompasses a broad range of activities and services provided in various combinations of paid and unpaid work, usually involving close personal or emotional interaction. The relational nature of care work involves different motivations to the profit maximising which is considered to be central to market production and prevents it from being subject to the usual economies of scale when supplied in a market. The care economy plays a significant role in the development of social capital, human capital and social reproduction. A supply of caring labour inadequate in either quantity or quality will adversely affect the operation of the economy.

The care economy encompasses both macroeconomic and microeconomic aspects of the wider economy from the level of households and individual firms to regional, state, national and the global economy. The care economy underpins the wider economy at every level and is important for the economic wellbeing of citizens, especially women who provide the bulk of paid and unpaid caring labour.

The provision of care has public goods qualities with the benefits of providing good quality care ‘spilling over’ to the wider community. Coupled with the fact that people who are dependent on care have limited consumer sovereignty, the public goods aspect signals a strong role for public policy and funding to support both paid and unpaid care work. As the demand for care increases during economic downturn, the substantial role of public support in the care sector makes it particularly vulnerable to budget cuts.

Both paid and unpaid care work affects women’s economic wellbeing. Paid care work is highly feminised with high levels of part-time and casual work and relatively low wages compared to other industries. The provision of unpaid care in the home impacts negatively on women’s lifetime earnings.

To participate in the labour force, women have to balance their care responsibilities with paid employment. A lack of workplace flexibility is contributing to the existing gendered division of labour. Due to the combination of an ageing population and increased longevity, there will

be an increasing number of care recipients with complex care needs. Rather than juggle the competing demands of paid work and care, many carers will reduce their paid working hours or exit the labour force, as is currently the case.

This scoping project was commissioned by *Security 4 Women* as a first step in recognising the significance of the care economy. To date both the data and literature available are focused on different aspects of the care economy. A comprehensive mapping of the care economy as a whole is needed as a matter of urgency.

6.1 Areas for further research

A number of gaps have been identified in the literature which mainly relate to a paucity of available data. Further research is needed across the care economy in Australia as a matter of urgency to generate data to inform decision-making.

- Workforce participation of mothers
 - The Australian Bureau of Statistics' *Managing Caring Responsibilities and Paid Employment Survey (2000)*, *New South Wales* provides useful data but was only conducted in New South Wales so, in some cases, does not provide a large enough sample in relation to lone mothers (Hughes & Gray 2005: 21)
 - The survey showed that a greater proportion of lone mothers (63.1%) than couple mothers (54.8%) had made use of family-friendly work arrangements to provide care. However, the data only captures whether the work arrangement was used, not the intensity of use so differences in the intensity of use between lone and couple mothers is not known (Hughes & Gray 2005).
 - Twice as many lone mothers as couple mothers did not make use of family-friendly work arrangements because of subtle or other pressure from others or because they thought that if they asked, their manager would refuse. There are several possible explanation for this (Hughes & Gray 2005: 21). Further research is needed to explore these possibilities.
 - The *Managing Caring Responsibilities and Paid Employment Survey* needs to be conducted nationally
 - Information has been obtained from analysis of data from Waves 1 and 2 (1996-1997 and 2000) of the Negotiating the Life Course (NLC) Survey of women's transitions out of and into work following childbirth (Baxter 2005). However in this survey data, short breaks from work are hidden and there is no information on whether a year away from work was taken using formal maternity leave, or taken as a break from a job using a less formal arrangement,

or whether it involved resigning from one job and starting another. Also, no information is available on whether a break from work was paid or unpaid (Baxter 2005: 12)

- Further analysis of these or similar data could be used to examine the intermittent nature of employment for mothers – for example, how many of those mothers who worked after their first child continued to work, or how many had later breaks? Also, to what extent did those moving into part-time work stay in part-time work, or did they later move to full-time work?
 - A more detailed data set, perhaps showing monthly work episodes, and also showing information about the use of paid or unpaid maternity leave, would be of immense value in understanding the transitions women made (Baxter 2005: 17).
- The interplay between formal and informal care
 - There is scope to improve data collections to more uniformly and consistently describe the interplay between formal and informal care. Although there is national data on primary carers, little data is available on the activity of wider care networks and the provision of informal care for people in cared accommodation (Hales 2007: 23)
 - There is a lack of robust and detailed Australian data on the relative costs of providing a similar amount of care through different combinations of formal and informal care so it is difficult to make broad assessments on the relative cost-effectiveness of informal care (Access Economics 2005: 36)
 - Intergenerational family caring
 - There is a lack of adequate data on the issues involved in intergenerational caring (Spicer 2007: 31)
 - Informal care
 - There is a lack of information about people who, faced with the option of taking on a role as primary carer, do not do so (Hales 2007: 23)
 - Formal care
 - More empirical work is needed on the changes in the structure and composition of the care service labour force: ‘research that treats the job of “housewife” as what it is: a job’ (Folbre 2009: 119)

- Respite care
 - Research for this report revealed that there is no nationally available data on the total unmet need for respite for parents of children or adults with disabilities or respite for carers providing aged care across different types of respite services.
 - It is not unknown for respite centres for adults with disability to be used as a place where desperate parents have ‘abandoned’ their child/young adult with a disability who without adequate support are unable to continue their caring role and see no other alternative. There is little information on the extent of this tragic practice or what pushed the primary carer into such a desperate measure (Spicer 2007: 31)
 - Research into this situation would require liaison with organisations operating respite centres for disabled adults to indentify the affected families and would need to be conducted by qualitative researches experienced in dealing with the problems of researching sensitive topics (Lee & Renzetti 1990)

Recommendation 16

That *Security4Women* in conjunction with the *Office for Women* and other relevant organisations commission further research investigating the care economy, especially from a gender equity perspective, to address the paucity of data identified and so to better inform decision making.

6.2. Recommendations

The following recommendations have been identified for implementation.

Data issues

Recommendation 1 (see pp. 9 & 10)

That *Security4Women* commission a study using a similar methodology to the *Counting on Care Work* study in Massachusetts using data from, for example, the 2006 Census of Population and Housing and the 2006 Time Use Survey. This study will require estimates to be calculated (or updated) of the economic value of both paid and unpaid 'care work' in Australia.

Recommendation 2 (see p. 12)

That the Australian Bureau of Statistics undertake regular Time Use Surveys in the same year as the Census of Population and Housing to inform decisions regarding support for unpaid care work.

Recommendation 3 (see pp. 12 & 13)

That the Australian Bureau of Statistics regularly produces satellite accounts in line with the international System of National Accounts so that estimates of the value of unpaid care services are available for comparison with the value of Gross Domestic Product.

Gender equity

Recommendation 4 (see pp. 14 & 15)

That *Security4Women* lobby for policies that encourage men as well as women to combine paid work with care in the home to rectify the gender imbalance in the provision of unpaid care in line with international best practice which includes specified ‘daddy leave’ days, parental leave paid at replacement level and flexible leave provisions.

Intergenerational caring

Recommendation 5 (see p. 16)

That *Security4Women* investigate what forms of support would assist ‘sandwich’ generation carers who are caring for children as well as an adult family member who requires care.

Unpaid care

Recommendation 6 (see p. 18)

That *Security4Women* advocate for the availability of paid and unpaid leave to cover family, friend and neighbourhood care, similar to parental leave provisions, to assist carers to participate in the labour market.

Recommendation 7 (see p. 19)

That *Security4Women* advocate for increased instrumental support for unpaid care in the form of affordable assistance from formal care services such as domiciliary care.

Recommendation 8 (see p. 19)

That *Security4Women* advocate for an increase in the availability and affordability of respite care for sole-parent carers, carers on a low income, and carers of people with a disability, mental illness or chronic conditions.

Recommendation 9 (see p. 20)

That the Australian Government works with State/Territory Governments to reduce the waiting lists for respite care of families with disabled children.

Recommendation 10 (see p. 20)

That FaHCSIA undertake a proper assessment of the needs of families with disabled children and establish a minimum amount of respite care to be made available to families of differing circumstances.

Formal care

Recommendation 11 (see p. 35)

That *Security4Women* in conjunction with *Fair Work Australia* and other relevant bodies advocate for improved wages and working conditions for direct care staff employed in the community services industry.

Recommendation 12 (see p. 37)

That *Security4Women* in conjunction with *Fair Work Australia* and other relevant bodies advocate for increased wages and better working conditions for nurses and carers employed in residential aged care.

Impact on women's economic wellbeing

Recommendation 13 (see p. 62)

That *Security4Women* advocate for increased public funding to improve the income of carers providing extended care in the home.

Recommendation 14 (see pp. 64 & 65)

That *Security4Women* lobby for government intervention to address the gender wage gap in Australian workplaces.

Recommendation 15 (see p. 72)

That *Security4Women* in conjunction with *Fair Work Australia* and other relevant bodies advocate for flexible working conditions, in particular access to leave when required and flex-time, time off in lieu and the ability to change starting and finishing times throughout the Australian workforce to enable employees to undertake both child care and care for disabled or elderly adults.

Recommendation 16 (see pp. 76 – 79)

That *Security4Women* in conjunction with the *Office for Women* and other relevant organisations commission further research investigating the care economy, especially from a gender equity perspective, to address the paucity of data identified and so to better inform decision making.

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Appendix 1

Bibliography of statistical publications relevant to the care economy

This bibliography represents the first attempt to scope the statistical information currently available in Australia for analysis of the care economy or specific segments of it. The bibliography is presented in two broad sections: paid care and unpaid care. As far as possible information is provided on the main definitions used, the data source/s, what is covered in the content, the main findings (briefly), and the limitations of the data. In the reports on carers only the findings which show carers differ significantly from non-carers are listed. The limitations reported refer to limitations in the context of the care economy. Limitations in the data collection methods or the methodology used are usually provided in each report. Statistics from this bibliography have been used throughout the *Scoping the Australian care economy* report.

Unpaid care

1. Access Economics (2005), *The Economic Value of Informal Care*, Carers Australia, Canberra, viewed 12 January 2010,

<http://www.accesseconomics.com.au/publicationsreports/showreport.php?id=6&searchfor=2005&searchby=year>.

- Defines carers as people providing ‘informal care to people who need assistance due to disability, chronic illness or old age’ (p. i) who are usually family or friends of the care recipient/s (p. 1)
- Defines informal care as care ‘generally provided free of charge to the recipient and is not regulated by government’ (p. 1)
- Used data from the ABS 2003 Survey of Disability, Ageing, and Carers (SDAC) and, in order to calculate the economic value of care in 2005, extrapolated the number of carers to 2005 by applying the rates of informal care provision to the current demographic structure of the population using the ABS Series B or mid-level population projections based on 2001 census data (p. 5)
- Examined the amount of informal care being provided in Australia by placing a dollar value on the work of informal carers as the first step in evaluating whether the current usage of informal and formal care models is socially optimal in terms of both efficiency and equity (p. i)

- Uses the opportunity cost method for the lower bound estimate of the value of informal care and the replacement cost method for the upper bound estimate (p. 10) [See Box 3.2 for more detail on methodology and valuation figures]
- Concluded that ‘combinations of informal care and community based formal care are generally lower cost than institutionalised care (including a housing component), even when the opportunity cost of the carer’s time is included. However, the government subsidy for informal care is much lower than other care streams’ (p. 37)
- Includes a case study on osteoporosis carers (pp. 41-52)
- Limitations of the data: Does not include child care provided in the home to healthy children.

2. Australian Bureau of Statistics (2009), *Carers and Employment* Australian Social Trends Cat No 4102.0, viewed 24 February 2010, [http://www.ausstats.abs.gov.au/ausstats/subscriber.nsf/LookupAttach/4102.0Publication24.09.094/\\$File/41020_Carers.pdf](http://www.ausstats.abs.gov.au/ausstats/subscriber.nsf/LookupAttach/4102.0Publication24.09.094/$File/41020_Carers.pdf)

- Defines carers as ‘people aged 15 years or over who, in the week prior to the interview, cared for someone who needed assistance because they had a disability, a long-term health condition, or who was frail or aged, where this care was not done as part of paid work or voluntary work’ (p. 1)
- Draws mostly on data from the 2007 Survey of Employment Arrangements, Retirement and Superannuation (SEARS) which asked questions of those aged 45 years and over (p. 1)
- Provides an insight into how carers balance caring with paid work and the subsequent implications for their retirement and superannuation (p. 1)
- Found that carers were less likely than non-carers to be employed and less likely to be working full-time, 60% of employed carers always or often felt rushed or pressed for time compared to 47% on non-carers (p. 2), 54% of carers who had returned from retirement to work cited financial need as their main reason for returning to work compared to 38% of non-carers (p. 30), superannuation coverage was slightly lower

for carers (68% compared with 71%) and the median superannuation balance for carers was around \$9,000 lower than for non-carers (p. 4)

- Limitations of the data: The population of carers in this survey is not identical to that in the 2003 Survey of Disability, Ageing, and Carers (SDAC) as this survey ‘limited its scope to those who provided care in the week prior to the survey in order to link this care provision to working arrangements’ (p. 1) so direct comparisons cannot be made and it does not cover people who provided general child care for a child without a disability or long-term health condition or who provided care for a short-term illness.

3. Australian Bureau of Statistics (2008a), *4153.0 - How Australians Use Their Time, 2006: Summary of Findings*, Canberra, viewed 24 February 2010, [<http://www.abs.gov.au/AUSSTATS/abs@.nsf/Latestproducts/4153.0Main%20Features22006?opendocument&tabname=Summary&prodno=4153.0&issue=2006&num=&view=>](http://www.abs.gov.au/AUSSTATS/abs@.nsf/Latestproducts/4153.0Main%20Features22006?opendocument&tabname=Summary&prodno=4153.0&issue=2006&num=&view=>)

- Reports on data from the 2006 Time Use Survey (TUS), the third and most recent such national survey in Australia
- Defines the activities on which people spend their time in four categories:
 - Necessary time – activities which are performed for personal survival, such as sleeping, eating and personal hygiene
 - Contracted time – activities such as paid work and regular education where there are explicit contracts which control the periods of time in which the activities are performed
 - Committed time – activities to which a person has committed her/himself because of previous social or community interactions, such as establishing a household or volunteering. The consequent housework, other household management activities, child care, shopping or provision of help to others are all examples of committed time activities
 - Free time – the amount of time left when the previous three types of time have been taken out of a person’s day
- Reports on the amount of time taken up with necessary time, contracted time (employment and education), committed time (domestic activities, child care,

purchasing, and voluntary work and care), and free time (social and community interaction, and recreation and leisure)

- Includes the use of time by young people aged 15 to 24 years (domestic activities, child care, and recreation and leisure), older people aged 65 years and over, and time spent with others across age groups
- Covers the amount of time spent on child care by both mothers and fathers and as both a primary and secondary activity for parents of children 0 to 4 years and children under 15 years
- Also provides some comparisons between the 2006 TUS results and those from the previous Time Use Surveys in 1992 and 1997
- Found that women spent more time than men in child care as both a primary and secondary activity whether parents were employed or not (i.e. mothers employed full-time spent more time than fathers employed full-time) which was reflected across the age spectrum of the children and across different types of caring. Time spent on caring activities decreased significantly for both mothers and fathers as the age of the youngest child increased
- Limitations of the data: The brief summary of finding is the only available ABS publication on the 2006 TUS. However, data cubes are available and other researchers have analysed and published findings from the 2006 TUS on particular topics.

4. Australian Bureau of Statistics (2008b), *A Profile of Carers in Australia* Cat. No. 4448.0, Canberra, viewed 26 January 2010,

[http://www.ausstats.abs.gov.au/Ausstats/subscriber.nsf/0/4D0A63D991E01ED3CA2574E1000DF871/\\$File/final%20pdf%204448.0.pdf](http://www.ausstats.abs.gov.au/Ausstats/subscriber.nsf/0/4D0A63D991E01ED3CA2574E1000DF871/$File/final%20pdf%204448.0.pdf)

- Defines carers as people who provide informal assistance to people with disabilities, long-term health conditions or to older people (p. 5)
- Uses information drawn from the 2006 Census of Population and Housing and three ABS surveys: the 2003 Survey of Disability, Ageing and Carers (SDAC), the 2006 General Social Survey (GSS), and the 2006 Time Use Survey

- Provides estimates of carers and looks at their age distribution and sex (Chapter 1); examines their geographic distribution and provides carer rates for Aboriginal and Torres Strait Islander people (Chapter 2); discusses the way carers use their time (Chapter 3); carers' wellbeing and participation in social and community activities (Chapter 4); employment, income and housing (Chapter 5); sources of support and uses of respite care (Chapter 6); and the way caring varies over the life course by focusing on young carers, carers aged 35 to 54 years, and older carers

- Reports that
 - In 2003, carers represented 16% of the population (2.5 million carers) and 19% (475,000 carers) were primary carers; women were more likely to take on a caring role at an earlier age than men; carers were, on average, older than non-carers; almost half of primary carers (48%) had hours of caring at least equivalent to a full-time paid job of 40 hours or more per week; 26% of primary carers said that they felt satisfied as a result of their caring role while 34% said they often felt weary or lacking in energy; primary carers were more likely to work part-time than full-time; 17% of carers said they needed access (or further access) to respite care (p. 5); of parents aged 35 to 54 years with young children, 22% of mothers and 15% of fathers were carers – about half were caring for a child with a disability and half were combining raising young children with care of another relative or friend; and 83% of older primary carers were living with the person they assisted (p. 6)

 - In 2006, carers spent more time on domestic activities than did non-carers of the same age; primary carers spent less than two-thirds the amount of time per day on employment related activities than did non-carers and also spent less time sleeping or trying to sleep; over one-fifth of all carers (22%) had taken dissaving actions such as borrowing money in the previous 12 months; 19% had experienced cash flow problems, and 15% had difficulty paying bills (p. 5); and young carers spent around 3 hours less per week on personal care, social and community interaction and recreation and leisure combined than did young non-carers (p. 6)

- Limitations of the data: Does not include child care provided in the home to healthy children.

5. Australian Bureau of Statistics (2004), *4430.0 Disability, Ageing and Carers, Australia: Summary of Findings 2003*, Commonwealth of Australia, Canberra, viewed 26 February 2010,

[http://www.ausstats.abs.gov.au/Ausstats/subscriber.nsf/0/978A7C78CC11B702CA256F0F007B1311/\\$File/44300_2003.pdf](http://www.ausstats.abs.gov.au/Ausstats/subscriber.nsf/0/978A7C78CC11B702CA256F0F007B1311/$File/44300_2003.pdf)

- The 2003 SDAC was largely a repeat of the 1998 survey with some additions to content in the areas of cognitive and emotional support, and computer and internet use. Comparisons with previous disability surveys are possible (p. 2)

- The SDAC collected information about three population groups: people with disabilities (defined as ‘any limitation, restriction or impairment, which has lasted, or is likely to last, for at least six months and restricts everyday activities (p. 3)); older people (aged 60 years and over); and carers (people who provide assistance to older people and people with disabilities) (p. 2)

- The following information was reported for 2003:
 - Disabilities - one in five people in Australia (3,958,300 or 20.0%) had a reported disability, with the rate much the same for males as females; there was little change in the disability rate between 1998 (20.1%) and 2003 (20.0%); 30% had completed year 12 and 13% had completed a bachelor degree or higher (compared to 49% and 20% with no disability); the labour force participation rate of persons with a disability was 53% and the unemployment rate was 8.6% (corresponding rates for those without a disability were 81% and 5.0%); the median gross personal income per week of persons aged 15–64 years with a reported disability living in households was \$255 (compared to \$501 for those without a disability); median gross personal income per week decreased with increasing severity of disability and was lowest (\$200 per week) for those with a profound core-activity limitation

 - Older people - there were 3.35 million people aged 60 years and over (17% of the population) which compares to 3.0 million people (16%) in 1998.; just over half had a reported disability (51%) and 19% had a profound or severe core-activity limitation; of all people aged 60 years and over, less than half (41%) reported needing assistance because of disability or old age to manage health conditions or cope with everyday activities but people aged 85 years and over reported a much higher need for assistance than those aged 60–69 years (84% compared with 26%)

 - Carers - there were 2.6 million carers who provided some assistance to those who needed help because of disability or age; about one fifth of these (19%) were primary carers; just over half (54%) of all carers were women and women were also more likely (71%) to be primary carers; of those providing care 1.0 million (39%) were in the 35–54 year age range (caring responsibilities involved children, partners and/or ageing parents); those who provided care to people with a disability were more likely to be older and/or have a disability than those who did not provide care (24% of primary carers were aged 65 years and over compared to 13% of the total population) and the disability rates were 40% for primary carers, 35% for all carers and 20% for non-carers (p. 3).

6. Australian Institute of Health and Welfare (AIHW) (2009a), *Australia's Welfare 2009: Carers and Informal Care*, Canberra, viewed 24 February 2010,

< <http://www.aihw.gov.au/publications/aus/aw09/aw09-c05.pdf>>

- Uses data from the ABS 2003 Survey of Disability, Ageing, and Carers (SDAC) (p. 191); data on Carer Allowance and Carer Payment from Centrelink's administrative database; data on the National Respite for Carers Program, Community Aged Care Packages (CACPs), Extended Aged Care at Home (EACH) and EACH dementia (ECHD) from a 1-week community care census conducted in 2008; and data from the Commonwealth State/Territory Disability Agreement (CSTDA) services (p. 199)
- Defines carers as 'a person of any age who provides any informal assistance, in terms of help or supervision, to persons with disabilities or long-term conditions, or older persons (that is, aged 60 years and over). This assistance has to be ongoing, or likely to be ongoing, for at least 6 months
- This report covers the characteristics of carers and care recipients, how carers help, assistance and support for carers, the costs of caring, quality of data about carers, and support for carers in the future
- Reports that informal carers, mostly women, are the main source of assistance and enables many people to continue to live at home; most primary carers are family members and live with the care recipient; carers are supported by a range of services including financial support and respite and community care services; respite is the major service supporting carers yet few carers report using this service; many carers experience lower health and wellbeing than non-carers and are financially disadvantaged; policy makers face an ongoing challenge to ensure that suitable support is available; and support services in the future will need to close service gaps and adopt new approaches to service delivery
- Limitations of the data: the SDAC does not count young carers under 15 years of age and potentially undercounts carers 15 to 17 years of age (p. 229) and there is some fragmentation of the data from relevant programmes because of inconsistency in the way carers are identified (p. 230).

7. Cummins, RA & Hughes, J (2007), *The Wellbeing of Australians - Carer Health and Wellbeing*, Deakin University and Australian Unity Limited, Geelong, AU, viewed 22 January 2010,

- Uses data collected in a survey to carers contacted through Carers Australia to measure the subjective wellbeing of carers with data analysis undertaken by Deakin University (p. vi)
- Carers were defined as all members of Carers Australia (p. 2)
- Significant findings are reported as follows:
 - Demographics and employment – carers have the lowest collective wellbeing of any group yet surveyed; have an average rating of moderate depression; females have lower wellbeing than male carers; the most disadvantaged group is sole parents; 20.6% of the carer sample are unemployed; and for employed carers, over one-third has a degree of worry about losing their job that depresses their wellbeing even further
 - Carer challenges – the wellbeing of carers is more vulnerable to physical pain than normal; carers are more likely to be experiencing chronic pain; are highly likely to have an injury; and not receiving treatment for a significant medical or psychological condition is extremely damaging to wellbeing (p. vi) with the major reasons for not receiving treatment are that they have no time or cannot afford the treatment (p. vii)
 - Carer resources – the wellbeing of carers is less than that of the general population; their financial security is significantly less than the general population and household income is a double jeopardy (average household income is lower than normal and their wellbeing is more depressed than is normal due to low income)
 - Intensity of the carer role – wellbeing decreases linearly as the number of hours spent caring increases; primary carer responsibility for any time each day is extremely damaging to wellbeing; female primary carers have lower wellbeing than male carers; and caring for adults poses less burden than caring for disabled children
 - Satisfaction with caring and leisure – satisfaction with caring hours, leisure time and leisure quality are all strongly related to personal wellbeing and high satisfaction with leisure time is more strongly associated with high carer wellbeing than satisfaction with caring hours (p. vii)

- Limitations of the data: many of the results are not reported by gender.

8. Department of Families, H, Community Services and Indigenous Affairs (FaHCSIA), (2009d), *Growing Up in Australia: The Longitudinal Study of Australian Children 2008-09 Annual Report* Commonwealth of Australia viewed 13 January 2010,

< http://www.fahcsia.gov.au/sa/families/pubs/lisac_report_2009/Documents/LSAC_AR_08-09.pdf>

- Uses data collected by the third wave the Longitudinal Study of Australian Children (LSAC) by face-to-face interviews, direct assessment of children, telephone interviews for parents living apart from the study child, self-complete instruments for mothers, fathers, carers and teachers, and time use diaries completed by parents about their child's activities (p. 5)
- Studies two cohorts of children – approximately 5,000 children aged 0 to 1 years and 5,000 children aged 4 to 5 years when the families agreed to take part in 2004 (p. 5)
- Covers children's physical health and social, cognitive and emotional development, as well as their experiences in key environments such as the family., community, child care, preschool and school settings (p. 5)
- Found that working part-time was common among mothers with children from both age groups with close to half of mothers working part-time (p. 15); 89% of parents reported their child was in excellent or very good health (p. 21); overweight and obese children perceive themselves to be heavier than children of normal weight and also want to lose weight (p. 22); almost all infants (96%) spent some time with their mother and 93% spent time with mothers when fathers were not present; breastfeeding was associated with more time being cuddled/comforted but less time sleeping and more time crying or upset (p. 28); and while siblings can provide emotional support and socialisation for children, they can also lead to rivalry and make competing claims on parents' resources (p. 32)
- Limitations of the data: gives a gender breakdown for parents (mothers and fathers) but often does not provide a gender breakdown on the results reported for children.

9. McNamara, J, Harding, A, Daly, A & Tanton, R (2008), *Child Social Exclusion: An Updated Index from the 2006 Census*, National Centre for Social and Economic Modelling (NATSEM), University of Canberra, Canberra, viewed 12 January 2010,

http://www.canberra.edu.au/centres/natsem/publications?sq_content_src=%2BdXJsPWh0dHAlM0EIMkYIMkZ6aWJvLndpbi5jYW5iZXJyYS5lZHUuYXUIMkZuYXRzZW0IMkZpbmRleC5waHAlM0Ztb2RIJTNEcHVibGljYXRpb24IMjZwdWJsaWNhdGlvbiUzRDEwOTAmYWxsPTE%3D.

- Describes the development of a composite index of child social exclusion risk for Australian small areas using 2006 ABS Census data and builds on earlier work based on 2001 Census data
- Variables included in the index are based on characteristics of children's parents, families and households, and include data about parental partnership status, employment and volunteerism, family educational attainment and occupation, household income, housing, transport and internet connection
- Results show that there are pronounced spatial differences in the risk of child social exclusion, with areas of high social exclusion risk common in Australia's rural and regional areas and in clusters of outer areas in most of Australia's capital cities
- Limitations of the data: there is no gender disaggregated data on the characteristics of children's parents.

10. Miranti, R, Harding, A, Ngu, VQ, McNamara, J & Tanton, R (2008), *Children with Jobless Parents: National and Small Area Trends for Australia in the Past Decade*, Gold Coast, AU, viewed 12 January 2009,

http://www.canberra.edu.au/centres/natsem/publications?sq_content_src=%2BdXJsPWh0dHAlM0EIMkYIMkZ6aWJvLndpbi5jYW5iZXJyYS5lZHUuYXUIMkZuYXRzZW0IMkZpbmRleC5waHAlM0Ztb2RIJTNEcHVibGljYXRpb24IMjZwdWJsaWNhdGlvbiUzRDEwOTAmYWxsPTE%3D.

- Uses data from the ABS 1995-96 Confidentialised Unit Record Files (CURFs) of the Surveys of Income and Housing (SIH) and the 2001 and 2006 Censuses of Population and Housing
- Examines national and spatial trends in the number and proportion of children with jobless parents during the last decade
- The proportion of dependent children living in jobless households fell from 15.6% in 1995-96 to 13.8% in 2005-06

- Despite this progress, one in every seven dependent children in Australia in 2005-06 still lived in a household where no parent had a job
- The risk of being jobless is much higher within single parent households than within couple households; around one in every two children living in a single parent household lives in a jobless household; for seven out of every 10 children living in a jobless household, the head of the household has no post-school qualification; and the overwhelming majority of all children with jobless parents live in the capital cities making this an urban phenomenon.
- Limitations of the data: there is no gender disaggregated data on the characteristics of children's parents.

11. National Centre for Social and Economic Modelling (NATSEM) (2008), *Commonwealth Financial Planning Women Carers in Financial Stress Report*, Carers Australia, Canberra, viewed 12 February 2010, < http://www.commbank.com.au/about-us/news/media-releases/2008/191008_CFP_Women_Carers_in_Financial_Stress.pdf>

- Uses data from the Household, Income and Labour Dynamics in Australia (HILDA) Survey, Wave 6 and the 2003 Survey of Disability, Ageing, and Carers (SDAC)
- Assesses financial stress in terms of prospective income accumulated over the remaining working life and the income indicators examined included individual and family (defined as income unit) income from wages and salaries, government benefits (public transfer) and superannuation (pp. vii & viii)
- Key findings:
 - Impacts of caring on health – two to four times the proportion of primary carers report their health as being only fair or poor compared with women of a similar age; the impact of caring on the health of the carer increases as the carer ages; women who are primary carers are likely to be in a healthy state for a shorter period of their working life compared to other women in the Australian population; the self-reported health status of women is positively associated with household income and primary carers experience a lower level of general health compared to other women across quintiles (p. viii)
 - Impacts of caring on economic wellbeing – over half of female primary carers aged 30 to 64 years of age are not in the paid labour force compared to less

than a third of other women in the same age group; of those who do work, primary carers spend fewer hours in paid employment than do other women; and primary carers with a post-secondary level education tend to work more hours per week than carers without a post-secondary level education

- The study looked at two scenarios:
 - Financial impact on women aged 30 years with two or more children who are primary carers caring for their child with a disability - the consequence of not being able to participate in paid work is that female primary carers earn considerably less income from wages and salaries over their working life compared to women with similar characteristics but without the caring responsibilities; mothers caring for a child with a disability are likely to earn over their working life – depending on their level of education – between a quarter and half the income of women sharing the same characteristics but who are not primary carers; while mothers caring for children with a disability receive more in government benefits than other women, these payments do not compensate fully for the income they forgo from paid work; and the superannuation likely to be available to 30 year old mothers caring for children with a disability when they reach 65 years of age would be negligible for many and may be insufficient to provide an adequate retirement income for most (p. ix)
 - Financial impact on women aged 50 years who are primary carers caring for their male partner with a disability – based on current work and earning patterns, 50 year old women taking on a primary carer role for a partner with a disability and who are able to maintain some paid work would expect to earn approximately 80% of the accumulated income up to age 65 years that would be earned by other women without caring responsibilities; for working women aged 50 years caring for a male partner with disability, access to government benefits goes a considerable way but does not totally compensate for the loss of income of becoming a primary carer; and there is over a two-fold difference in the amount of superannuation that a 50 year old woman primary carer of a male partner who is no longer able to work because of her caring role, and who has secondary school qualifications only, can expect to access at 65 years of age compared to women who have post-secondary schooling, who continue to work up to retirement at 65 years of age and who do not have the same caring responsibilities (pp. ix & x)
- Limitations of the data: this study did not assess whether the estimated incomes, benefits or superannuation amounts are sufficient for supporting a family (p. 31).

12. Nepal, B, Brown, L, Ranmuthugala, G & Percival, R (2009), *Lifetime Economic Consequences to Women Informal Carers in Australia, 2006*, National Centre for Social and Economic Modelling, University of Canberra, Melbourne, AU, viewed 12 January 2010, <http://www.canberra.edu.au/centres/natsem/publications?sq_content_src=%2BdXJsPWh0d

[HAIM0EIMkYIMkZ6aWJvLndpbi5jYW5iZXJyYS5lZHUuYXUIMkZuYXRzZW0IMkZpbmRleC5waHAIM0Ztb2RIJTNEcHVibGJjYXRpb24IMjZwdWJsaWNhdGlvbUzRDEyMDgmYWxsPTE%3D>](http://www.melbourneinstitute.com/hilda/statreport/statreport-v4-2009.pdf)

- Examines the impact of taking on a primary carer's role on financial well-being of women in Australia over the course of their working life by comparing women primary carers and other women
- Estimates are based on information drawn from the Household, Income and Labour Dynamics in Australia (HILDA) Survey Wave 6 and the life tables for Australian women
- The economic indicators examined cover labour force participation and income and include individual and family income from wages and salaries, and government benefits (public transfer)
- The study focused on women aged 30 to 64 years with two or more children who are primary carers to their child with a disability
- Found that primary carers lag much behind other women in terms of their prospective income over their working life; family income remains below four-fifths of that for families who do not have to care for a child with a disability; the income of the male partner, who is often the secondary carer, is also substantially reduced (p. 14); and when income earned from all sources is examined, work-life income of primary carers would be about 70 – 80% of income of other women at the individual level and 80-90% at the family level (p. 15).

13. Wilkins, R, Warren, D & Hahn, M (2009), *Families, Incomes and Jobs, Volume 4: A Statistical Report on Waves 1 to 6 of the HILDA Survey*, Melbourne Institute of Applied Economic and Social Research, University of Melbourne, viewed 2 March 2010,

< <http://www.melbourneinstitute.com/hilda/statreport/statreport-v4-2009.pdf> >

- Reports on data from the Household, Income and Labour Dynamics in Australia (HILDA) Survey, Waves 1 to 6
- A comprehensive report with numerous topics relevant to the care economy, such as changes in household structure (Chapter 1) and changes in marital status (Chapter 2); parenting stress and work-family stress (Chapter 3); child care issues and persistence

of problems (Chapter 4); relative income poverty (Chapter 7); welfare reliance (Chapter 8); physical and mental health (Chapter 18); and social capital deficits and their persistence (Chapter 19)

- Limitations of the data: the homeless are excluded from the sample survey as is usually the case and also excluded from the initial sample were persons living in institutions but people who move into institutions in subsequent years remain in the sample (p. v).

Paid care

14. Access Economics (2009), *Nurses in Residential Aged care*, Australian Nursing Federation, Canberra, viewed 12 January 2010, <http://www.accesseconomics.com.au/publicationsreports/getreport.php?report=224&id=284>.

- This report commissioned by the Australian Nursing Federation examined changes in the residential aged care (RAC) workforce over recent years and their implication for the future in terms of the workforce mix, emerging critical shortages and implication for quality of care. A focus is on the importance and benefits of adequate training, staffing strategies that will deliver quality outcomes for residents and financing implications (p. ii)
- Defines the RAC workforce as comprising registered and enrolled nurses, and personal carers (pp. 3 & 4)
- Draws on the findings of the National Institute for Labour Studies (NILS) studies of all residential aged care facilities in Australia in 2003 and 2004 for classification and data issues regarding the RAC workforce (p. 3) (see No. 19 in this bibliography)
- Utilises the most recent Australian Institute of Health and Welfare data on the RAC sector in Australia for the 2007-08 financial year which provides a statistical overview of the entire sector with a focus on RAC residents (p. 5)
- Concluded that nurses working in RAC are paid at least 10% less than their counterparts in acute care; work intensity for RAC nurses has increased; the quality of care is potentially compromised; the combination of inequitable remuneration, increasing workloads and the frustration of compromised quality outcomes is driving nurses from the sector; and there is a pressing need for reform in aged care to address these issues

- Limitations of data: does not include non-direct care staff, doctors and other allied health professionals not dedicated to RAC (p.4).

15. Australian Institute of Health and Welfare (2009), *Residential Aged Care in Australia 2007–08: A Statistical Overview*, Aged Care Statistics Series Number 28, Cat. No. AGE 58, AIHW, Canberra, viewed 23 October 2009,

< <http://www.aihw.gov.au/publications/age/age-58-10709/age-58-10709.pdf>>

- Covers operational places and packages in aged care provision, types of organisations providing services, patterns of use, and resident characteristics and is the 11th such report
- The main source of data in this report is administrative by-product data from the System for the Payment of Aged Residential Care (SPARC)
- The main findings as at 30 w June 2008 were:
 - Aged care provision continues to increase – there were 175,472 residential aged care places, an increase of 5,401 compared with 30 June 2007 (the current planning target for residential aged care provision is 88 places per 1,000 persons aged 70 years and over); including other aged care programs such as aged care packages in the community, the corresponding ratio of available places and packages increased from 109.5 to 111.9 during the 12-month period to 30 June 2008 (relative to the overall planning target of 113 places and packages per 1,000 persons aged 70 or over); average occupancy in residential aged care from 1 July 2007 to 30 June 2008 was 93.5% compared to 94.3% in the previous year
 - Average length of stay continues to increase – there were 105,030 admissions to residential aged care between 1 July 2007 and 30 June 2008, of which 53,737 were for permanent care; during the same period there were 53,819 separations from permanent care, with the most common reason for separation being death (88%); on average the length of time people spend in residential aged care is increasing (the average completed length of stay for permanent residents who left residential aged care during 2007–08 was 147.8 weeks compared with 131.3 weeks in 1998–99 and 145.9 weeks in 2006–07); length of stay was longer for women (170.4 weeks) than for men (109.8 weeks)
 - Respite care is an important component of residential service provision – while at any one time the number of respite residents is small, almost half (49%) of admissions to residential aged care during 2007–08 were for respite care (respite care is usually of short duration with an average length of stay of

3.3 weeks); the majority of respite residents (77%) return to the community but 16% continue in residential care either in permanent care or additional respite care (p. vi).

- Limitations of data:
 - Excluding the reporting on provision, the data presented relate to mainstream services and their residents and exclude residents in places provided by Multi-purpose Services or funded through the National Aboriginal and Torres Strait Islander Flexible Aged Care Program

 - Death indicator: some terminally ill residents are transferred to acute-care institutions before death; hence, there is an under-enumeration of discharges due to death

 - Information on whether an admission was from an acute hospital is not available on SPARC (pp. 140 & 141).

16. Australian Institute of Health and Welfare (AIHW) (2006), *Trends in the Affordability of Child Care Services 1991-2004*, Australian Government, Canberra, viewed 5 March 2010,

< <http://www.aihw.gov.au/publications/aus/bulletin35/bulletin35.pdf> >

- Analysis is based on having one child in care for 20 to 40 hours per week in either private long day care, community-based day care or family day care (p. 4) and covers sole parents and couple families

- Found that between 1991 and 2000 child care affordability declined for many families but the introduction of the Child care Benefit in 2000 turned this around; by 2004 some of the gains in affordability had been eroded due to fee increases that outstripped average weekly earnings and government assistance offered to families with a resultant greater 'gap' payable by parents; the new Child care tax rebate offers another avenue of assistance with the cost of child care but the impact on affordability will not be felt until the latter part of 2006 (p. 14).

17. Australian Institute of Health and Welfare (AIHW) (2009b), *Younger People with Disability in Residential Aged Care Program: Final Report on the 2007–08 Minimum Data Set*, Cat. no. DIS 53, Australian Government, Canberra, viewed 7 March 2010,

< <http://www.aihw.gov.au/publications/dis/dis-53-10730/dis-53-10730.pdf> >

- This report includes information from the 2007–08 Younger People with Disability in Residential Aged Care Minimum Data Set (YPIRAC MDS) and summarises the characteristics of people who were ‘on the books’ during 2007–08 and the YPIRAC services they received
- People included in ‘on the books’ are those who accepted YPIRAC services in 2006–07 and continued to receive services (including monitoring only) in 2007–08, along with new starters in 2007–08
- The report covers the YPIRAC program, YPIRAC service users, service use, new and continuing service users, target population, and data processing and quality
- Found that in the 2007–08 financial there were an additional 376 new service users and as at 30 June 2008, a total of 580 people were accessing YPIRAC-funded services; 2007–08 saw a shift in focus from relocating people living in residential aged care accommodation to diverting people to living in the community who were at risk of admission to residential aged care; the program continued to focus on the initial priority age group, under 50 years, which accounted for 83% of service users in 2007–08; acquired brain injury (ABI) was the predominant primary disability group—46% of service users—and more than half of service users with ABI recorded as a primary disability were in residential aged care awaiting alternative accommodation; support packages varied in composition—common service types were attendant care/personal care (accessed by 20% of users), community access (other than day programs) (18%), assistive products and technology (17%) and individual therapy support (16%); and only 3 continuing service users (from 2006–07) received YPIRAC-funded respite care compared with 13 new users of respite care in 2007–08 at least partly reflecting the shift towards in-home support packages for people at risk of entering residential aged care (p. vi).

18. Department of Education Employment and Workplace Relations (DEEWR) (2008), *2006 Census of Child Care Services*, Australian Government, Canberra, viewed 5 March 2010, <>.

<http://www.deewr.gov.au/EarlyChildhood/Resources_expired/Documents/Main_20updated_202006.pdf>

- The 2006 Census of Child Care Services conducted by the Australian Government Department of Education, Employment and Workplace Relations provides details of child care users, staff and carers, and operational details of the ten child care services funded through Australian Government Child Care Support: Aboriginal playgroups and enrichment programs; family day care schemes; in home care schemes; long day care services (private and community); mobiles and toy libraries; multifunctional Aboriginal children's services; multifunctional children's services; occasional care services; outside school hours care services; and vacation care services

- Findings in 2006 compared to the results of the 2004 Census:
 - Services – the number of child care services increased by 534 (14%) in the number of long day services; an increase of 113 (8%) in the number of vacation care services; and an increase of 119 (6%) in the number of outside school hours care services; and the average weekly fee in long day care centres was \$233, compared to \$209 in 2004; the average weekly fee in family day care schemes for 50 hours in care was \$215 (\$185 in 2004) (p. 8)
 - Children - There were an estimated 801,060 children attending child care at May 2006 compared with an estimated 752,760 children attending child care in 2004 (an increase of 6%) (p. 8)
 - Staff: An estimated 90,485 paid and 1,440 unpaid staff including staff working in family day care coordination units, were providing care in Australian Government approved and supported services; also an estimated 11,080 family day care caregivers providing care in their own homes and 845 in home care caregivers providing care in other people's homes (p.8).

19. Martin, B & King, D (2008), *Who Cares for Older Australians? A Picture of the Residential and Community Based Aged Care Workforce, 2007*, National Institute of Labour Studies, Adelaide, AU.

<http://nils.flinders.edu.au/assets/publications/NILS_Aged_Care_Final.pdf>

- A comprehensive report on the aged care workforce using data from four surveys conducted by the National Institute for Labour Studies in 2007 which builds on an earlier survey conducted in 2003 and extends it to include the community based aged care workforce
- The surveys covered all residential aged care facilities in Australia, all service outlets receiving funding from Commonwealth programmes supporting community based aged care together with surveys of direct care workers employed in residential facilities and those employed by community based providers
- Between 2003 and 2007, total employment in aged care facilities rose from about 157,000 to about 175,000 with direct care employees increasing from 116,000 to 133,000 (p.i); community based outlets employed about 87,500 people of whom about 74,000 are direct care workers (p. ii)

- Findings include an overwhelming 93% of residential workers and 91% of community based workers are women; 20% of direct care staff have no post school qualifications; overseas born workers are more common in residential facilities than they were in 2003; and workers remain strikingly dissatisfied with their pay (pp. ii & iii)
- Findings for residential aged care (care of the most frail and vulnerable elderly) include an increased use of carers and a fall in the numbers of registered nurses employed (p. 8); an increase in the casualisation of the aged care workforce (p. 9); high turnover (p. 20); unpaid care as a route into paid care work (pp. 21 & 22); not enough time to (p. 28); work intensification (p. 29); high stress levels (p. 31); low satisfaction with pay (p. 31); achievements not respected (p. 31); and an increase in agency staff (pp. 40-41).

20. Meagher, G & Healy, K (2005), *Who Cares? Volume 1: A Profile of Care Workers in Australia's Community Services Industries*, Paper 140, updated June, Australian Council of Social Services, Strawberry Hills, AU, viewed 7 March 2010,

<http://acoss.org.au/images/uploads/387_P_140_Carers.pdf>

- This report covers what care work is, care work as women's work, indigenous care workers and ethnic diversity, and the social geography of the community services workforce
- Uses data from the Census of Population and Housing in 1996 and 2001 to present a profile of care workers across Australia's community service industries
- This report and the second volume are the only studies to look at care workers across industries
- Findings include that in 1996, 89.6% of care workers in community services were female, and in 2001, 88.4% of care workers were female; in several caring occupations in community service industries—nursing, therapies, pre-primary school teaching, child care work — more than 90% of workers were female in both 1996 and 2001; Indigenous workers were nearly twice as likely as non-Indigenous workers to be employed as care workers in community service industries; and approximately 4.5% of all employed Aboriginal and Torres Strait Islanders work in caring occupations in community service industries (p. 11).

21. Meagher, G & Healy, K (2006), *Who Cares? Volume 2: Employment Structure and Incomes in the Australian Care Workforce*, Paper 141, updated January, Australian Council of Social Services, Strawberry Hills, AU, viewed 7 March 2010,

< http://acoss.org.au/images/uploads/389_Paper_141_care_workers_vol2_for_website.pdf >

- Uses data from the 2001 census to build on the earlier report
- Covers pre-primary school teachers; social workers; welfare and community workers; counsellors, psychologists; registered nurses; therapists; enrolled nurses; welfare associate professionals; education aides; child care workers; special care workers; and personal care and nursing assistants (p. 26)
- Findings: evidence of deinstitutionalisation, deprofessionalisation, functional underemployment, and relatively poor pay in community services industries.

22. Productivity Commission (2010a), *Contribution of the Not-for-Profit Sector*, Australian Government, Canberra, viewed 20 February 2010,

< http://www.pc.gov.au/data/assets/pdf_file/0003/94548/not-for-profit-report.pdf >

- Uses data from the Australian Bureau of Statistics and the Australian Institute of Health and Welfare supplemented with data provided by not-for-profit organisations (p. 89)
- Provides statistics on the composition of the not-for-profit workforce including hospitals, health and community/social services (p. 261) a discussion on skills and training requirements; difficulties attracting and retaining staff; and issues affecting long-term demand for paid workers (pp. 260-271); and a section on the trends in the delivery of human services (pp. 299-308).