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Who cares for older Australians?

A picture of the residential and community based aged care workforce 2007

by Bill Martin and Debra King

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Executive Summary[1]

Aged care services are provided by paid carers to older Australians in residential aged care homes and in people's own homes. Whether this care is given in dedicated residential aged care homes or in people's own homes, older Australians receiving care depend on it, often for many of their daily needs. There is wide public concern that the quality and availability of aged care services should ensure comfort for Australians in later life. Amongst the most discussed issues is that of the workforce itself, of guaranteeing that the necessary number and quality of workers will be available as we have more dependent elderly in coming years. Providers of aged care themselves, as well as government, are amongst those most concerned that it may become difficult to meet expectations about workforce quality and numbers.

In 2003, the first major study of the aged care workforce, covering only the residential aged care workforce, provided a clear picture of important aspects of how paid carers support the elderly (Richardson and Martin 2004). In this Report, we detail the results of a follow-up study to this earlier work, and new information that covers the community based part of the workforce which has previously been unstudied. Using these studies we are able to assess important aspects of the evolution of the residential aged care workforce, provide the first picture of community based aged care workers, and explore how the residential and community based workforces compare. Our source of information is four surveys that we conducted of all residential aged care homes in Australia, all service outlets receiving funding from Commonwealth programs supporting community based aged care, together with surveys of 7,566 direct care workers employed in residential homes, and 4,693 employed by community based providers. It should be noted that the surveys of direct care workers does not include medical practitioners or other staff who are not directly involved in caring for residents (such as purely administrative staff, gardeners and cleaners). In reporting on the existing workforce, it is not our purpose to make judgements about whether it is optimal or whether it should be changed in any way.

A substantial majority of the community based outlets surveyed for this research provided services under the Home and Community Care (HACC) program. HACC is a program funded jointly by the Commonwealth and States and Territories, and administered by States and Territories. It provides community based services to the disabled as well as to the elderly, and relies on significant volunteer input alongside that of paid workers. Our survey focused on paid workers providing services to the elderly, though some staff, particularly nurses, provide services to both the elderly and the disabled.

1 The surveys on which this report is based were administered by The Nielsen Company. We wish to express our appreciation of their ultimate commitment to ensuring that the surveys were fielded successfully and high quality data was produced. The team at NILS has also assisted greatly in the production of this report, in particular Tracy Bai, Jessica Sutherland, Darcy Fitzpatrick, Llainey Smith, Trish Amee and Helen Walton. Sue Richardson provided an invaluable and supportive guiding hand throughout the research, for which we are very grateful. We thank also the thousands of managers and workers who took the trouble to complete the surveys.

The Workforce

Our estimates of employment in residential aged care homes show steady increases between 2003 and 2007. Total employment in aged care homes rose from about 157,000 to about 175,000, with direct care employees increasing from about 116,000 to about 133,000. Proportionately, the rise in equivalent full time (EFT) direct care workers was smaller, with an increase from about 76,000 in 2003 to about 79,000 in 2007. There has been something of a rebalancing of the workforce towards greater use of Personal Carers (PCs), and reduced reliance on Registered Nurses (RNs). Between 2003 and 2007, total employment of RNs fell by about 1,600 to 22,400, while PC employment rose by about 17,500 to nearly 85,000. Employment of Enrolled Nurses (ENs) and Allied Health workers rose slightly to just over 16,000 and nearly 10,000 respectively.

Community based outlets providing aged care under Commonwealth supported programs employ about half the number of workers found in residential homes. Overall, we estimate that these outlets employ about 87,500 people, of whom about 74,000 are direct care workers. Community Care Workers, the community based equivalent of Personal Carers, make up the bulk of this community based workforce. Our best estimate is that service outlets employ about 60,500 of them to deliver Commonwealth supported community based aged care programs, with about 9,500 nurses, mostly RNs, and 4,000 Allied Health workers employed alongside them.

Some major facts about this workforce and their employers, derived from the surveys, include:

- Two-thirds of residential home workers and 60% of community based workers are permanent part-time employees. The proportion who are casual has risen slightly amongst residential home workers since 2003, while the proportion of permanent full-time workers has fallen. At 29% of workers, casual employment is more likely in the community based than in the residential sector. Overall, the residential workforce would still like to work more hours than they actually do, and community based workers are somewhat more likely than residential workers to want more work.
- An overwhelming 93% of residential workers and 91% of community based workers are women, and 40% of residential aged care workers are younger than 40, as are 30% of community based workers. This compares with 63% cent of all Australian women workers.
- Most of the workforce has post school qualifications appropriate to its work. About 20% of direct care staff have no post school qualifications. Fully one quarter of recently appointed staff were currently studying some post-school qualification, as were nearly 20% of all staff. Qualification at the Certificate III level has increased slightly amongst PCs since 2003. Workers are generally confident that they have the skills they need to do their work, and they believe that they use their skills effectively in doing the job.
- Two thirds of the residential aged care workforce and nearly three quarters of the community based aged care workforce is Australian born—a little less than for all Australian women employees. Overseas born workers are more common in residential homes than they were in 2003.

- Aged care workers tend to enter the area at more mature ages, so that the older profile of the aged care workforce does not necessarily presage an ageing crisis.
- Workers find considerable reward and satisfaction in the work of providing care for the elderly who cannot look after themselves. They generally express reasonable levels of job satisfaction compared to the relevant Australian workforce, with some evidence of small increases in satisfaction amongst residential workers since 2003. However, workers remain strikingly dissatisfied with pay, even though residential workers' pay satisfaction is somewhat higher than in 2003. Residential care workers also continue to be unhappy with the amount of time they are able to spend with the residents they care for.
- Community based workers are generally more content than residential ones. This is because they spend more of their time in direct care work, they are more able to spend the amount of time they wish with those they care for, they are under less pressure and stress, and they have more autonomy in deciding how to do their work.
- When asked to look *three* years ahead, most workers expected to continue in aged care work. Of those who had a clear view about what they expected to be doing, 80–90% expected to be working in aged care.
- The number of vacancies for direct care workers in aged care homes varies by occupational group, with relatively more vacancies for Registered Nurses than other occupations. Vacancy levels have increased somewhat in residential homes since 2003. Homes and community based outlets rely on responses to job advertisements, 'walk-ins' and word-of-mouth as the main sources when hiring PCs and CCWs.
- Agency and contract staff supply a small proportion of the direct care labour in aged care homes, with around 6% of RN and 4% of PC shifts in residential homes and 6% of CCW shifts in community based outlets being performed by these workers. Some community based outlets rely very heavily on agency staff, directly employing very few staff.
- Nearly half of community based aged care providers indicate that they aim to cater for a specific ethnic or cultural group, as do about 17% of residential homes. Many providers say that a large proportion of their PCs or CCWs come from a particular ethnic group. About half of this ethnic concentration of PCs and CCWs seems to be associated with the ethnic specialization of homes, and about half is due to other factors.

In sum, the typical worker is female, Australian born, aged about 50, in good health, has at least 12 years of schooling and some relevant post school qualification and works 16–34 hours per week. She is likely to be a Personal Carer or Community Care Worker, working a regular daytime shift. The post-school qualification is likely to be a Certificate III in Aged Care or Home and Community Care. The typical recently hired worker has a similar profile, but with some differences. She is younger, in somewhat better health, and more likely to currently be studying.

Turnover of the workforce continues to be an issue that has to be managed by the industry. The data suggest that a quarter of PCs and CCWs and one in five nurses have to be replaced

each year — by their current employer, if not by the whole industry. Levels of turnover in the residential sector have not changed significantly since 2003.

The Aged Care Labour Market

The aged care labour market has several key features that affect how employers' needs are met. These include:

- A large majority of workers are women working part-time. They usually have significant non-work responsibilities and demands. Their paid aged care work must therefore be compatible with these responsibilities and demands. Employers can make accommodations in hours and shifts to allow workers to meet their work and non-work responsibilities. However, employers will not be able to respond successfully to all their workers' changing non-work circumstances. For this reason, employers are likely to continue to need to make significant recruitment efforts. Given the importance of informal methods of recruitment—through prior links between employers and workers, word-of-mouth, and walk-ins—cultivation of informal networks may help employers in their recruitment efforts.
- Labour markets for aged care workers combine local dynamics with wider, state and national, ones. Some state and national labour market trends affect aged care labour markets. For example, a national shortage of RNs is reflected in the aged care field, and the labour market for all aged care workers appears to be tighter in states where such events as the minerals boom have produced a generally tight labour market. At the same time, the dominance of part-time women workers means that most workers seek jobs within range of their homes, so that local labour market conditions affect labour supply. The overall effect of the combination of local and wider dynamics in the aged care labour market is to increase local variation in the balance between supply and demand of aged care workers.
- Most workers perceive their pay to be inadequate for the social importance of the work they do. This means that current levels of employment and supply of workers depend on the other rewards workers experience in their jobs. Some of these relate to the fit between employees' work and non-work lives mentioned above. Others arise from the intrinsic satisfactions of the work. Workers gain greater satisfaction when they spend more of their work time in direct care work, are able to spend the time they feel is necessary with each person they care for, have control over how they do their work, and do not feel pressured and stressed in their jobs.

The research was not primarily oriented to assessing the state of the aged care labour market. However, there are relevant indicators in the data. Overall, our results indicate that the difficulties residential homes found in recruiting RNs in 2003 had increased further by 2007, and are consistent with DEEWR's view of a general 'shortage' of RNs. The general tightening of the Australian labour market has also found its way to the labour market for such workers as PCs and CCWs, though it remains much less problematic for employers to

recruit these workers compared to RNs. Beyond these generalizations, it is clear that aged care labour market conditions vary somewhat between localities, so that employers in some locations face quite different recruitment problems to those in others.

Some of the key findings in our report that point towards this state of the aged care labour market are the following:

- Overall, the fraction of shifts worked by Agency staff remains fairly small, although some community based organizations appear to rely largely on Agency staff. However, the proportion of shifts worked by Agency RNs has risen significantly. Statewide variation in the increased use of agency staff of all kinds in residential homes is also significant.
- Vacancy levels in residential homes have risen a little since 2003. They are generally lower in community based outlets than residential homes. Vacancy levels of PCs and CCWs are consistent with a functioning labour market. Vacancies for RNs in residential homes are more suggestive of difficulties in recruitment.
- The length of time to fill vacancies indicates real difficulties in filling many RN positions. On the other hand, vacancies for such workers as PCs and CCWs are generally filled within a quite short period, and PC and CCW vacancy length suggests a labour market for these workers that continues to function. Beyond this general picture, there are some state and regional variations suggesting that some employers face greater recruitment difficulties for all aged care workers than others.
- There continues to be evidence of real excess capacity in the aged care labour force in that a significant group of workers is prepared to work longer hours than they currently do.
- Members of the aged care workforce generally see themselves as appropriately skilled, are mostly content with their work and jobs, and usually say they expect to continue working in the sector for at least the next 3 years.
- The proportion of PCs who appear to be overqualified for their jobs has declined since 2003, an indicator of a tightening labour market in that workers are more able to find jobs concomitant with their qualifications.
- Residential workers have become much less likely to wish to change their shift arrangements since 2003. This may occur as employers seek to attract and retain workers in a tighter labour market.

The recruitment and retention challenge facing the aged care sector has undoubtedly risen in recent years. If the labour market remains tight, employers may face increased challenges in the future in meeting their needs for skilled, committed workers. The record suggests that they have so far been reasonably successful in finding strategies that adjust pay and all the conditions of work to maintain an adequate workforce even as labour market conditions become more challenging. It is to be hoped that they will continue to do so, with the essential assistance and goodwill of the committed direct care workers who make up this important labour force.

1. Introduction

Australia's population is ageing. In the most recent ABS projections, the proportion of Australians aged 65 or over will nearly double in the next 50 years, increasing from 13% in 2007 to between 23% and 25% in 2056. The proportion aged 85 and over will rise from less than 2% to between 5% and 7% over the same period.[2] This ageing population has many implications, not least of which is a rising proportion of the population who will need care and assistance in daily living. At the same time, we face an ageing workforce. A declining proportion of the population will fall into the prime working ages of 18–65, and more of those who do will be in the older age groups.

Older Australians who cannot fully care for themselves receive assistance from relatives or friends, from paid carers in their own homes, and from paid carers in residential aged care homes. As our population ages, the need for care for the elderly will grow. While some of this need will be met by family, neighbours and friends, much will be the responsibility of paid workers, whether they care for people in their own homes or in dedicated residential homes. Understanding the workforce that provides paid care to older Australians is central to ensuring that there will be adequate provision in the future. It is especially important to monitor carefully this workforce to be alert to its response to changing conditions of the work itself, and in its response to wider issues in workplaces and the labour market. In recent years, for example, a strong policy emphasis has been to emphasise the provision of services aimed at supporting older people to remain in their homes, while also ensuring that adequate provision is available for those who can no longer do so. At the same time, in recent years Australia has experienced a marked tightening of the labour market, with increasing employment and an unemployment rate that has fallen to levels not seen for more than 30 years.

This Report is about the paid workforce that provides care to dependent older Australians, whether in their homes or in residential aged care homes. It follows research conducted in 2003 on the residential aged care workforce that, for the first time, provided a nuanced picture of the workforce. Using that research as a baseline, we assess the trajectory of the direct care residential aged care workforce between 2003 and 2007. In addition, and unlike the 2003 research, we examine the paid workforce providing community based care to the elderly. No existing data provides an accurate picture of this workforce, so our analysis represents a significant step forward in understanding the community care workforce.

The source of our new portraits of the residential and community based aged care workforces is four new surveys conducted between October and December 2007. We undertook a census of residential aged care homes and community based service outlets providing aged care services under six Commonwealth supported programs. We also collected information from direct care workers themselves through sample surveys of residential and community based aged care workers. In all we received useable responses from 2,674 residential aged care homes, 1,496 community based service outlets (representing 1,738 outlets), 7,566 workers in residential homes, and 4,693 workers in community based outlets. The surveys were commissioned by the Commonwealth

2 See ABS, *Population Projections, Australia, 2006 to 2101*, Cat. No. 3222.0, September 2008.

Department of Health and Ageing. They had the active support of relevant peak bodies, namely Aged Care Association Australia (ACAA), Aged and Community Services Australia (ACSA) and the Australian Nursing Federation (ANF). Questionnaires for the project were developed by the National Institute of Labour Studies (NILS) and approved by a project steering group.[3] Where possible, the surveys used wording and questions that were comparable with those asked in the 2003 surveys of residential aged care homes and workers, and with Australian Bureau of Statistics and other general surveys. This will enable the results of the survey to be compared with data from these other sources. NILS sought and received the endorsement of the questionnaire by the Australian Bureau of Statistics Statistical Clearing House.

The census of residential homes and community based service outlets asked organizations to provide information about their aged care workforce, and their experience in recruiting it. Organizations were asked to assist in the distribution of a second questionnaire to their staff. They were asked to pass the employee questionnaire to four randomly chosen direct care workers employed by them. Random choice of direct care workers was ensured by instructing organizations to choose the four workers with birthdays closest to the date of the census. This enables us to make reliable statements, based on the survey data, about the whole workforce. A single survey, of course, just gives a snapshot of the situation at the time that the survey is taken. The workforce of today comprises people who have been in their jobs for many years, as well as new comers and those in between. To assess the dynamics of the workforces we are interested in here, we use two strategies. For the residential aged care workforce, we are able to compare our 2007 data with the results of the 2003 research. This gives us direct measures of change. However, this approach is not possible with regard to the community based workforce because it was not surveyed in 2003. Nevertheless, we have sufficient workers in both our surveys who were hired within the 12 months before the survey to examine them as a separate group. We can compare these people—the new hires—with the average worker, who is represented by the respondents selected by date of birth. On this basis, we are able to make some inferences about the direction of any major change in the workforces, particularly the community based one for which we have no earlier data.

For the most part, homes were asked questions to which they alone were likely to know the answers, such as the number of staff of various classifications they employed, their vacancy levels, and their use of agency staff. Similarly, employees were asked to supply information (such as their age and qualifications) which they would readily know but which would be hard for their employer to provide. In addition to asking such factual questions, we asked staff to respond to several questions about the character of the job they did and how they felt about it. Information about the home was linked to information about each employee.

3 The surveys were administered by The Nielsen Company, a Sydney based market and social research company.

2. Our Surveys and What we Sought from Them

Our research on the residential and community based aged care workforce is based primarily on four surveys. We surveyed all residential aged care homes and all community based organizations providing aged care services under a defined set of Commonwealth supported programs. These were our first two surveys. We also surveyed a sample of workers drawn from each residential home and each community based organization in our census. The census and survey of residential aged care homes and direct care workers in those homes were designed to replicate an equivalent census and survey conducted in 2003, thus allowing assessment of change in the residential direct care workforce between 2003 and 2007. Our survey also collected a small amount of information not sought in the 2003 surveys, particularly in relation to workers' career paths. The census and survey of the community based direct aged care workforce aimed to give a first picture of this workforce, and to allow it to be compared with the workforce in residential homes.

Through our censuses and surveys, we sought to gather information about the aged care workforce from both employers and employees. Our aim was to ask employers about the matters they were most likely to know best, and to gather responses from employees to the questions that they would be best placed to answer. In some domains, we gathered information on the same topic from both employers and employees. This allowed each perspective to be represented, and, sometimes, it permitted us to check one set of responses against the other.

The Nielsen Company conducted all fieldwork for the censuses and the workers survey. The Nielsen Company received all responses, entered data where necessary, and provided final data files to the National Institute of Labour Studies.

2.1 The Censuses of Residential Homes and Community Based Service Outlets

Some information about organizations providing care to the elderly are available, largely through information collected by the Commonwealth as part of its funding of these services. For example, residential homes are funded for specific numbers of places at specified levels of care. However, existing information sheds little light on workforce issues, even such basic ones as how many direct carers are employed by funded providers. Our censuses sought information on core workforce issues and experiences, including such matters as the numbers and types of direct care employees, the contracts on which they are employed, their hours of work, vacancy levels, practices and experiences in recruiting workers, and experiences with workers from diverse cultural and linguistic backgrounds.

The basic methodology we used for each census was the same. We were provided by the Commonwealth Department of Health and Ageing with a full list and contact details for all Australian residential aged care homes funded by the Commonwealth, and all community based service outlets which provided services under a set of Commonwealth supported programs. These organizations were posted a package containing an introductory letter

about the research, instructions about how to complete the census, a census questionnaire, and a package of workers questionnaires. The introductory letter indicated support for the project from the Commonwealth, Aged Care Association Australia (ACAA), Aged and Community Services Australia (ACSA) and the Australian Nursing Federation (ANF). The package also contained a testimonial sheet containing statements from ACAA, ACSA, and ANF about the value of the 2003 research to the industry. The cover letter assured organizations of the anonymity of their response.

Organizations were invited to complete the employer questionnaire either by filling in an on-line questionnaire or by completing the enclosed paper based form and returning it to The Nielsen Company. Internet responses were much less frequent than originally anticipated, with 18% of useable residential home responses and 10% of useable community based responses being provided via the internet. Telephone support was offered to organizations in the cover letter for the project. An attempt was made to contact all organizations by telephone to ensure they had received their census and questionnaire packages, and to encourage them to respond. Where packages had not been received, a second package was sent. Non-respondent organizations were followed up by telephone, and non-respondent organizations were assisted to complete the census where necessary. Residential homes had a strong incentive to complete the census since their funding through the Conditional Adjustment Payment (CAP) was dependent on receipt of a census response from them.

Community based organizations providing aged care services were included in the census on the basis that they were funded to provide services under one of six programs to which the Commonwealth contributes funds. These programs were the Community Aged Care Packages (CACPs) program, the Extended Aged Care at Home (EACH) and EACH Dementia (EACH-D) packages programs, the Home and Community Care (HACC) program, the Day Therapy Centres (DTCs) program, and the National Respite for Carers Program (NRCP). Details of these programs are outlined in Chapter 6 of this report. Community based service outlets could provide services under more than one of these programs. Thus, the listings of outlets funded under these programs by the Commonwealth included some duplication. Where possible, this duplication was noted to avoid the sending of multiple questionnaire packages to single outlets.

Fieldwork exposed some inaccuracies in the lists of residential and community providers used to contact organizations for the censuses and surveys. Approximately 13% of homes and service outlets said that they did not receive the packages in the first mail out. One of the major reasons (44%) for non-receipt was that the package was sent to the incorrect address. In addition, approximately 11% of the community service outlets that did respond to the survey indicated that the survey was not relevant to them. Reasons provided varied from not providing aged care to not employing paid staff. These inaccuracies mean that exact calculation of response rates is not possible because we cannot be certain how many providers that failed to respond were actually not in scope for the census and survey.

A total of 2,674 residential homes provided useable responses from a population of 2,875. This represents a response rate of 93% for these homes. Useable responses were received from 1,496 community based service outlets. In some cases, these responses covered several

outlets. Taking these into account, the useable responses from community based outlets represented at least 1,738 service outlets.[4] We are only able to calculate an approximate number of service outlets in the relevant population for the reasons outlined in the previous paragraph. We estimate that there were, at most, 3,534 in scope service outlets to which packages were sent.[5] Thus, a conservative estimate of the response rate for community based outlets is 49%, while our best guess is that the response rate was closer to 60%.[6]

Overall, the response rates for censuses of both the residential aged care homes and community based service outlets are good. The response rate for residential homes gives us a great deal of confidence that our results accurately represent the characteristics and experience of the full population of homes. While the response rate of community based aged care service outlets was not as high as that for residential homes, it is nevertheless a good response rate for a survey of this kind. It can be expected to give an accurate picture of the experience and characteristics of the full population of community based providers.

2.2 The Surveys of Direct Care Workers

We sought to obtain a random sample of direct care workers employed by residential homes and service outlets surveyed for the project. Employers (residential homes and community based outlets) were asked to pass a questionnaire package to four randomly selected direct care employees in their organization. They were instructed to select employees by choosing those with the most recent birthdays at the time of the survey. The packages given to employees included a cover letter explaining the project and indicating how to participate, and a copy of the employee questionnaire. The letter assured respondents that their responses would be treated confidentially. Employees were given the option of completing an on-line survey or a mailback questionnaire. Very few (2% in each survey) chose the on-line option. Telephone support was offered to employees needing it to complete their responses. All employee questionnaires contained an identification number representing their employer, so that worker responses could be linked to those of their employers.

A total of 7,566 useable responses was received from direct care workers in residential aged care homes.[7] This represents a response rate of 66%, assuming that all 2,875 homes actually distributed questionnaires to four in-scope direct care workers. In fact, the actual response rate was somewhat higher because homes sometimes passed questionnaires to workers

4 This figure is almost certainly an underestimate of the number of outlets represented by the service outlets from which packages were received. It is based on the service outlets for which respondents explicitly indicated they were responding. Some 38% of outlets indicated that they had received more than one package, and therefore could be assumed to be responding for more than one service outlet. If we take account of these multiple responses as well as explicit ones, it is likely that the 1,496 useable responses represent about 2,180 in-scope service outlets.

5 This number is almost certainly an overestimate.

6 This is based on assuming that the number of community based outlets represented by responses was as specified in footnote 4 above.

7 This number, and that below for community based workers, excludes some responses returned and deemed to be out of scope for a variety of reasons. The two most common reasons were that the respondent was not a direct care worker, and that more than four responses had been received from a particular residential home. In the latter case, four responses were randomly selected, and the remainder excluded.

who were not direct care workers as defined for this project, and these were excluded. It is not possible to be certain how often this occurred, but we can be certain that the actual response rate amongst residential direct care workers was at least 66%.

A total of 4,693 useable responses was received from direct care workers in community based aged care outlets. It is not possible to accurately calculate a response rate for this survey, for much the same reasons that it is not possible to accurately calculate a response rate for community based service outlets. A lower bound on the response rate is given by assuming that 3,534 organizations distributed questionnaires to four direct care workers each. This would give a response rate of 33%. However, the actual response rate is undoubtedly significantly higher than this. If we assume that the level of duplication of service outlet representation in our service outlet census is as suggested above, then the response rate to the workers survey is probably more like 47%. This does not take account of organizations giving questionnaires to out of scope workers, so that the real response rate was probably somewhat higher than this.

Because the same number of direct care employees was sampled from each residential home or community based provider, employees from small homes (i.e., those employing small numbers of direct care workers) had a higher chance of being included in the survey than those from large homes. To allow for this sampling effect, employees' surveys were linked to responses from their employers. This allowed the calculation of sampling weights to adjust for the variation in employees' chance of being selected into the workers sample due to variation in organization size. In addition, residential employee weights had a *post hoc* component to correct for the substantial over-representation of RNs in the sample of residential home direct care workers (see Chapter 4). This *post hoc* component was not used for the community based workers survey because there was no significant over-representation of RNs in the community based workers survey.[8] These sampling and *post hoc* weights were used in all data analysis reported here.

2.3 Supplementary Data—Interview Studies of Personal Carers and Experiences with CALD and Aboriginal and Torres Strait Islander Workers

As well as results from the censuses and surveys described above, this Report presents the outcomes of two more qualitative studies. The first was an interview study of the work experiences of 50 direct carers employed in residential aged care homes and 50 employed in community based service outlets. The second was a set of interviews with 75 managers of residential aged care homes and 50 interviews with managers of community based aged care service outlets.

The direct care workers interviewed for the first study were respondents to the workers' survey described above whose survey responses had indicated a willingness to be interviewed about their work. They were interviewed by telephone. The aim of these

8 The weighted results from the residential workers survey and the community based survey in the remainder of this report represent the best estimates we can make from our surveys of the characteristics of the population of residential and community based aged care workers. As such, they are directly comparable with each other.

interviews was to understand better the experiences of direct care workers, particularly how they managed the relationship between their work and non-work lives, given that most are women with family responsibilities.

The first purpose of the interviews with managers was to better understand their experiences with Culturally and Linguistically Diverse (CALD) and Aboriginal and Torres Strait Islander workers. The second purpose was to assess whether these workers were represented in appropriate numbers in the workers surveys. All 50 of the community based service outlets whose managers were interviewed were randomly chosen from respondents to the census, as were 50 of the residential aged care homes whose managers were interviewed. The additional 25 residential homes that participated were chosen because they were known to cater specifically to Aboriginal and Torres Strait Islander residents.

3. The Residential Care Workforce

In our 2003 study of the residential aged care workforce we, for the first time, provided a comprehensive picture of the residential aged care workforce. The research reported here updates that picture to late 2007. In addition, it allows us to assess trends in the workforce, which is particularly important for future workforce planning. To provide additional insight into the aged care workforce, where possible we compare it with the whole Australian female workforce (since 93% of direct care workers employed in residential homes are women). We begin with an estimate of the total number of direct care workers in aged care homes. We then show how they are divided among the different occupational groups, the types of employment contracts, the hours worked and preferred, age, health, education and country of birth. In doing so, we draw on data provided by the homes about their staff. We also draw on the responses of the employees. These two sources do not always give the same picture on issues such as the pattern of hours worked. Where there are differences, we discuss these and say which we think is the more reliable.

3.1 Total Employment and Main Workforce Characteristics

3.1.1 Total Employment

The question of how many people work in residential aged care, and how this is changing, is crucial to workforce planning. Table 3.1 shows our 2003 and 2007 estimates of total employment in residential aged care. There has been an increase of about 15.3% in the number of direct care workers employed in the residential homes, slightly higher than the overall 11.5% rise in employment when non-care employees are included. The result is that the proportion of residential home employees involved in direct care rose slightly from 73.8% in 2003 to 76.2% in 2007. The rise in full-time equivalent direct care employees—a more useful measure of overall direct care labour being supplied than the number of employees—was about 3.4%, smaller than the rise in actual employees. Between 2003 and 2007, the number of places in Australian aged care homes rose by about 12.5%, quite close to the rise in direct care employment, but more than the rise in equivalent full-time direct care employment. A steady increase in the average dependency level of home residents since at least 2000 is also well documented (AIHW 2007, Table 3.16).

Table 3.1: Estimated total employment in residential aged care homes

	Total employees	Total direct care employees	Total equivalent full-time direct care employees
2003	156,823	115,660	76,006
2007	174,866	133,314	78,849

Source: Census of residential aged care homes.

Our previous report noted that estimates of total employment in residential aged care at the time varied widely, usually because they arose from larger data collections that did not allow precise identification of the direct care residential aged care workforce. Our new 2007 estimates of the size of the workforce are particularly notable because of their consistency with our 2003 estimates. They add weight to the belief that our approach has produced consistent and accurate measures of the total workforce.

3.1.2 Occupation

Our previous research showed that Personal Carers (PCs) were the single largest occupational group amongst direct care workers in Australian residential homes, an unsurprising result. Our new estimates confirm this pattern. We can calculate the occupational distribution of direct care workers from both our home census and our employee survey. The two sources provide somewhat different pictures. We believe that the data from homes is more accurate, and focus on those results here, especially in assessing change over time.[9]

Since 2003, there has been a significant increase in both the proportion of direct care employees who are PCs and the proportion of all direct care work that is done by PCs (Table 3.2). In 2003, about 59% of employees were PCs and 57% of equivalent full-time (EFT) staff were PCs. By 2007, both these figures had risen to about 64%, indicating that nearly two-thirds of residential home direct care workers are now PCs. The proportion of direct care EFT employees who are nurses declined quite sharply from about 36% to about 29%, with the share of both categories of nurses declining. These patterns are consistent with trend indications from the 2003 survey, which indicated that a greater proportion of new hires were PCs than was the case in the workforce overall. While this partly reflected the higher turnover amongst PCs compared to other staff, it also suggested an increasing use of PCs compared to nurses. Overall, these figures suggest a significant reorganisation of care in residential aged care homes, so that more care is provided by PCs and less by nurses. Moreover, a greater proportion of new hires continue to be PCs, suggesting that the trend towards increased use of PCs will continue.

These shifts in the proportion of direct care workers who are nurses and personal carers corresponds to a fall of about 1,600 in the total number of Registered Nurses employed in residential aged care homes between 2003 and 2007, and a rise of more than 17,500 (or just over a quarter) in personal carer numbers. During the same period, employment of enrolled nurses and allied health workers also rose slightly (by about 700 and 1,000 respectively), though their proportion of total employment and equivalent fulltime numbers fell.

9 In fact, the difference in distributions from the two sources strongly suggests that our employee survey over-represents nurses. This issue is discussed in detail in Appendix 1 of this report.

Table 3.2: Occupation of the residential aged care workforce (employment and distribution), Homes Census, 2003 and 2007 (per cent)

	2003		2007	
Occupation	Number of persons	Equivalent full-time	Number of persons	Equivalent full-time
Registered Nurse	24,019 (21.0)	16,265 (21.4)	22,399 (16.8)	13,247 (16.8)
Enrolled Nurse	15,604 (13.1)	10,945 (14.4)	16,293 (12.2)	9,856 (12.5)
Personal Carer	67,143 (58.5)	42,943 (56.5)	84,746 (63.6)	50,542 (64.1)
Allied Health	8,895 (7.4)	5,776 (7.6)	9,875 (7.4)	5,204 (6.6)
Total number	**115,660**	**76,006**	**133,314**	**78,849**

Source: Census of residential aged care homes.

Note: Estimated total numbers are the estimated total number of workers in each category employed in all Australian aged care homes. Thus, we estimate that altogether, aged care homes employ 24,019 Registered Nurses in 2003 and 22,399 in 2007. The numbers in brackets are per cent of total number in each occupational group. Thus 21.0% of direct care workers were Registered Nurses in 2003, and 16.8% were Registered Nurses in 2007.

3.1.3 Employment Arrangements and Hours Worked

The arrangements through which direct care workers are employed are important for a range of reasons. They can provide an indication of the extent to which employers and employees are able to achieve employment arrangements that suit them, thus acting as an indicator of the state of the labour market. They are also an important measure of the availability of additional labour within the existing workforce.

Table 3.3 shows that the majority of direct care employees in all occupations continue to be employed on permanent part-time contracts, with around 70% of personal carers and 60% of registered nurses being permanent part-time workers. However, this proportion has declined slightly since 2003, when about 62% of RNs and 72% of PCs were employed on such contracts. The proportion of direct care workers on permanent full-time contracts also fell for all occupations, with the result that only 9.1% of all workers (16.6% of RNs and 6.7% of PCs) are now permanent full-time employees. More direct care workers in all occupations are now employed casually than in 2003, with the steepest rise being amongst RNs (from 19.6% of RNs to 23.6%). Our estimates indicate that, although the total number of RNs employed in residential aged care homes fell between 2003 and 2007, the number employed casually rose by over 500. At the same time the number of PCs working on casual contracts rose by just over 6,000 (corresponding to about a third of the increase in PC numbers), so that casuals were 23.4% of PCs in 2007, compared to 20.5% in 2003.

Table 3.3: Nature of employment contract of residential aged care workers, 2007 (estimated total number and per cent)

Employment Contract	Registered Nurse	Enrolled Nurse	Personal Carers	Allied Health workers	Total
Permanent full-time	3,713 (16.6)	1,707 (10.5)	5,697 (6.7)	1,019 (10.3)	12,139 (9.1)
Permanent part-time	13,407 (59.9)	11,882 (72.9)	59,188 (69.8)	6,919 (70.1)	91,393 (68.6)
Casual or Contract	5,279 (23.6)	2,705 (16.6)	19,861 (23.4)	1,937 (19.6)	29,781 (22.3)
Total employees	**22,399 (100)**	**16,293 (100)**	**84,746 (100)**	**9,875 (100)**	**133,314 (100)**

Source: Census of residential aged care homes.

Note: Estimated total numbers are the estimated total number of workers in each category employed in all Australian aged care homes. Thus, we estimate that altogether, aged care homes employ 3,713 Registered Nurses, on permanent full-time contracts. The numbers in brackets are per cent of total number in each occupational group. Thus 16.6% of Registered Nurses are employed on a permanent full-time basis.

More detail about the direct care workers' hours of employment is available from both the census of homes and the employee survey. These sources give different pictures of the patterns, with home responses suggesting many more workers work short hours (1–15 hours per week) and fewer work full-time than do worker responses, irrespective of occupation (Table 3.4(a)). For example, the home census suggests that about 22% of personal carers work short hours and 21% work full-time, compared to 6% and 37% according to the employee survey. Very similar results were found in the 2003 survey and census. While we cannot be certain about which source is more accurate, it seems most likely that the home responses are more reliable. The estimates derived from worker responses will be affected by any bias away from short hours workers in the employee sample, and such a bias seems very plausible for two reasons. Short hours workers may have been less likely to receive questionnaires than others because employers see them less often, and may have been less likely to return questionnaires if they did receive them because they are less engaged with their jobs. For these reasons, we believe the home responses are more reliable.

There is something of a contradiction between home responses on hours worked and the information they provided about full and part-time employment numbers. Table 3.3 indicates that homes said that only 9% of direct care employees were permanent full-time workers, whereas Table 3.4(a) shows that homes' responses imply that 21% worked full-time hours. This suggests that a very high proportion of contract and casual workers are employed full-time hours, or there is flexibility in the hours of work of even part-time permanent employees, or both. This pattern was also noted in the 2003 data.

The distribution of hours of work has not changed much since 2003. The most notable change is an increase in the proportion of PCs who say that they usually work full-time hours (35 or more), from 30% to 37%. However, home returns suggest a much more modest

increase, from 19% working full-time hours in 2003 to 21% in 2007. There are certainly consistent indications that more direct care workers were working full-time hours in 2007 than in 2003. However, the shift was generally very small.

Table 3.4(a): Distribution of hours worked per week, residential aged care workforce, by occupation (per cent)

Hours worked per week	Respondent	Nurse	PC	Allied Health	Total
1–15	Workers response	5	6	8	6
	Homes response	26	22	35	24
16–34	Workers response	51	57	50	55
	Homes response	51	57	48	54
35–40	Workers response	34	31	38	32
	Homes response	21	19	16	19
>40	Workers response	10	6	5	7
	Homes response	2	2	1	2

Source: Census of residential aged care homes and survey of residential care workers.

In Table 3.4(b) we examine whether recently hired workers ('new hires', defined as those who have been in their jobs for one year or less) work different hours from the whole direct care workforce, the preferred hours of workers, and how our sample's hours compare with those of the wider workforce. New hires work much the same hours as the whole direct care workforce. Though we cannot be certain, it seems likely that new hires were working hours closer to those of the whole workforce in 2007 than they were in 2003 (when they worked slightly shorter hours). Compared to the Australian female workforce, aged care workers are much less likely to work long hours (more than 40 per week), and more likely to work part-time. This conclusion is clearer still if we use the home supplied data on hours worked.

Table 3.4(b) also suggests quite significant willingness to work longer hours amongst the residential aged care workforce, with about 39% actually working full-time (more than 34 hours per week) and 47% being willing to work these hours. Table 3.4(c) confirms this view, indicating that some 28% of employees would like to work longer hours, while only 11% would choose to work shorter hours. Around 60% are happy with their current hours. Comparing these results to those from the 2003 survey indicates no significant change. However, there is an intriguing suggestion of increased unused capacity in the aged care workforce, despite the small increase in average hours worked. In 2003, if all workers had worked their preferred hours, hours worked would have increased by about 2%, and if those preferring to work longer had been able to do so with all others continuing to work the same hours, hours worked would have increased by about 7%. In 2007, the equivalent figures are 4% and 7%, suggesting no significant change in unused capacity in this workforce.

Table 3.4(b): Distribution of hours worked, and hours preferred, by the residential aged care workforce, by new hires and by the Australian female workforce (per cent)

	Hours actually worked		Hours desired to work		Hours worked
Hours per week	Whole workforce	New hires	Whole workforce	New hires	Australian female workforce
1–15	6	9	4	5	19
16–34	55	58	49	48	36
35–40	32	26	41	41	29
>40	7	7	6	6	16
Total	**100**	**100**	**100**	**100**	**100**

Source: Survey of residential care workers and, for the Australian data, ABS Labour Force Australia (Detailed Electronic Delivery) catalogue no. 6291.0.55.001 ST EM1, October 2007.

Table 3.4(c): Preferred change in hours residential aged care workforce, 2003 and 2007 (per cent)

Desired change in hours	Per cent of employees wishing to work this number	
	2003	2007
10+ hours less	5.5	4.0
1–9 hours less	8.5	7.5
No change in hours	57.6	60.4
1–5 hours more	13.2	12.2
6–10 hours more	10.5	10.7
11+ hours more	4.6	5.1

Source: Survey of residential care workers.

3.1.4 Age

The 2003 research demonstrated clearly that the aged care workforce was significantly older than the Australian workforce. Table 3.5 shows that the workforce had a somewhat older age profile in 2007 than it did in 2003, though the Australian workforce as a whole aged during this period too. In 2003, 16.7% of direct care workers in our survey were 55 or older, while by 2007 the proportion had increased to 22.5%. However, the proportion under 35 hardly changed during this period, remaining at about 18%, indicating that the main loss was in the 35–54 age group. The ageing of the direct care workforce is broadly evident. For example, the proportion of RNs aged 55 or more rose from 24% to 32% between 2003 and 2007. For ENs, the rise was from 11% to 17%, for PCs it was 15% to 20%, while for Allied Health workers there was a small fall from 35% to 32%. The ageing of all occupational groups preserved the tendency for RNs to be older than PCs or ENs, while ENs were the youngest of the three groups.

Comparing the age distribution of recent hires in 2003 and 2007 shows a move towards hiring at the upper and lower ends of the age distribution, with the proportion of recent hires under 35 rising from nearly 29% in 2003 to nearly 34% in 2007, and the proportion aged 55 and over rising from 11% to 15% in the same period.

Table 3.5: Age of the residential aged care workforce, recent hires, and the Australian workforce, 2003 and 2007 (per cent)

Age	Whole workforce		Recent hires		Australia	
	2003	2007	2003	2007	2003	2007
16–24	6.0	6.1	11.8	14.8	19.5	18.9
25–34	12.4	11.4	17.1	18.8	23.6	21.1
35–44	25.5	22.3	28.6	24.4	23.6	23.3
45–54	39.2	37.6	31.6	26.9	21.3	23.2
55–64	16.1	20.8	10.4	14.3	10.4	11.8
>65	0.8	1.7	.5	.8	1.5	1.7
Total	**100**	**100**	**100**	**100**	**100**	**100**

Source: Survey of residential care workers and, for Australian data, electronic version of ABS Labour Force, Australia, Detailed, October 2003.

Note: 2003 whole workforce figures have been recalculated using same weighting principle as 2007.

Overall, these figures confirm a widespread concern that the residential aged care workforce is itself ageing quite rapidly. However, they also indicate that this ageing is in line with the ageing of the wider Australian workforce. Employers appear to be looking to both younger and older workers to fill the vacancies created by workforce ageing.

3.1.5 Country of Birth

In 2007, two-thirds of the direct care aged care workforce was born in Australia, with Australian born workers making up about the same proportion of recent hires. Despite the continuing predominance of Australian born workers, since 2003 there has been a substantial increase in the proportion of the residential direct care workforce that was born outside Australia. In 2003 about 25% of the whole workforce was overseas born, while the proportion increased to about 33% by 2007. The result was by 2007 this workforce had become significantly more likely to be born outside Australia than the Australian female workforce in general. Comparing Table 4.6 with the equivalent table from the 2003 survey suggests that Asian and Islander born workers are the fastest growing group of overseas born workers. However, the numbers for these groups remain small, with workers born in New Zealand, the UK, Ireland or South Africa still making up nearly 30% of overseas born workers. Consistent with the rise in overseas born employees, the proportion of direct care workers who said they were fluent in a language other than English rose from 21% in 2003 to 28% in 2007, with half saying they used this language in their work.

Table 3.6: Country of birth of the residential aged care workforce, recent hires and the Australian workforce (per cent)

Country of birth	Whole workforce	Recent hires	Australia
Australia	67.5	66.4	79.8
New Zealand	3.5	3.9	3.1
UK, Ireland, South Africa	9.2	7.6	8.3*
Italy, Greece, Germany, Netherlands	1.9	1.3	1.9
Vietnam, HK, China, Philippines	5.2	5.2	3.4†
Poland	0.3	0.7	1.2‡
Fiji	1.6	0.9	0.9#
India	1.3	1.8	1.4
Other	9.6	12.3	0.0£
Total	**100**	**100**	**100**

Source: Survey of residential care workers and, for Australian data, ABS Labour Force Australia (Detailed Electronic Delivery) catalogue no. 6291.0.55.001 ST LM6, October 2007.

** Figure includes 'UK, Ireland' and 'Sub-Saharan Africa'*

† Figure includes 'Vietnam', 'China (excluding SAR's and Taiwan Province) and the 'Philippines'

‡ Figure includes 'Rest of Southern and Eastern Europe'

 # Figure includes 'Rest of Oceania and Antarctica'

£ Figure includes 'Other' rather than the remaining ABS 'Country of Birth (detailed)' categories

3.1.6 Health

Self-rated health is widely recognised as a useful indicator of people's actual health. Workers' health is also an important factor in their capacity to do their jobs well and with satisfaction. The 2003 survey showed that the residential aged care workforce had somewhat better self-rated health than the whole Australian population, using a standard measure adopted by ABS. The 2007 results are shown in Table 4.7. They differ little from those in 2003, with nearly two-thirds of those surveyed seeing themselves as having very good or excellent health.

Table 3.7: Self-assessed health of the residential aged care workforce, new hires and the Australian population aged over 15 (per cent)

Self-assessed health	Whole workforce	Recent hires	Australia
Poor	.8	1.1	4.4
Fair	6.1	3.9	11.3
Good	29.9	26.7	27.8
Very Good	42.8	45.3	35.4
Excellent	20.4	23.0	21.0
Total	**100**	**100**	**100**

Source: Survey of residential care workers and, for Australian data, ABS National Health Survey 2004–5.

3.1.7 Education

The level of education of the direct care workforce is an indicator of its skills and capacity for the acquisition of new skills. Beginning with the level of schooling of the workforce, Table 3.8 shows that there has been little change in the profile of the residential direct care workforce. Compared to the overall Australian workforce, residential direct care workers are more likely to have completed at least year 10, though they are no more likely to have completed year 12. In both 2003 and 2007, nearly half of the aged care workforce had finished school at year 10 or 11. In 2007, almost exactly the same proportion of this workforce was currently studying as in 2003—nearly 20%; and, as in 2003, a quarter of recent hires were currently studying. Clearly, this is a workforce in which formal education is well entrenched.

Table 3.8: Highest level of secondary schooling for the residential aged care workforce, new hires and the Australian workforce, and whether currently studying (per cent)

Highest level of schooling	Whole workforce		Recent hires	Australia
	2003	2007	2007	2003
Did not go to school	0.3	0.1	0.3	1.1
Year 8 or below	2.4	3.5	2.1	10.5
Year 9 or equivalent	6.9	7.1	4.2	8.4
Year 10 or equivalent	32.6	31.7	26.9	26.7
Year 11 or equivalent	16.4	15.6	15.3	10.8
Year 12 or equivalent	41.3	42.0	51.2	42.5
Currently Studying	19.0	18.8	25.9	

Source: Survey of residential care workers.
Note: Figures for 2003 have been adjusted to use same weighting principles as 2007.

We have two sources of information about residential aged care workers' post-school qualifications. Workers were asked about their qualifications in the sample surveys. These responses provide the only data on the qualifications of employees other than PCs. For PCs we also have data from homes on the number of PCs holding Certificates III and IV in areas related to their care work. These two sources tell somewhat different stories about the trend in PCs' qualifications.

Focusing first on the results from the workers' survey, it appears that the proportion of residential aged care workers with post-secondary qualifications fell between 2003 and 2007. In 2003 about 13% were estimated to have no post-secondary qualifications, while the proportion in 2007 was 20%. This rise appears for both nurses (from 6% to 12% without post-secondary qualifications) and PCs (from 16% to 24% without post-secondary qualifications). Some of this change may be due to a small change in how we asked about

post-school qualifications.[10] It seems particularly likely that nurses who said they had no post-secondary qualification misunderstood the survey question, since workers require appropriate qualifications in order to be employed as nurses. The same proportion of allied health workers reported having completed post-school qualifications in both years. Examining the pattern of change in qualification prevalence is illuminating. If we focus on PCs, it is clear that there was no decline in the proportion of PCs with qualifications relevant to their jobs and at a level appropriate to their jobs. The proportion of PCs with the Certificate III in Aged Care, generally viewed as the base qualification for PCs, remained virtually unchanged at about 65%.[11] Moreover the prevalence of the Certificate IV in Aged Care almost doubled, with over 13% of PCs having completed it in 2007 compared to about 8% in 2003. However, there was a clear decline in the proportion of PCs with relevant qualifications that would make them clearly overqualified for their jobs (e.g., those with non-degree basic nursing qualifications or post-basic nursing qualifications in aged care). This pattern of change is highly consistent with a tightening labour market, as is the rising proportion with no post-school qualifications.

Amongst nurses, the change in the distribution of post-school qualifications largely reflects two trends. First, there will be a gradual succession of younger, degree trained RNs into positions previously held by older hospital trained RNs. This will produce a rise in the proportion of nurses with degree qualifications in nursing and a decline in the proportion with non-degree basic nursing qualifications, as seen in Table 3.9. The second trend is the rising proportion of Nurses in aged care homes who are ENs rather than RNs, producing a rise in the proportion with EN qualifications.

With regard to the Allied Health workforce, there has been a clear rise in the prevalence of aged care relevant post-secondary qualifications. Thus, the proportion of allied health workers with the Certificate III in Aged Care rose from 26% to about 37%, and the proportion with the Certificate IV doubled from 9% to 18%. The proportion with nursing qualifications, whether degree or not, fell significantly, as did that with other qualifications. Again, these patterns suggest something of a tightening of the labour market, but in a context of well entrenched in-service training that leads to the award of relevant qualifications.

10 In the 2007 survey, respondents were first asked whether they had a post-secondary qualification, with only those who indicated that they did have a qualification being asked to specify that qualification (or qualifications). In the 2003 survey, no filter question was used, and respondents were simply asked to tick the box indicating what qualifications they had. This probably led to a small overestimation of the proportion with lower level qualifications in 2003.

11 The report on the 2003 survey did not provide a figure for the proportion of all PCs who said they had the Certificate III in Aged Care (Richardson and Martin 2004). Instead, in Table 4.9, it indicated the proportion of PCs who said they had the Certificate III in Aged Care *amongst those who had some post-school qualification*. Thus, in 2003, about 79% of PCs who had some post-school qualification reported having a Certificate III in Aged Care, and this equates to about 66% of all PCs having such qualifications as indicated in Table 3.9 above.

Table 3.9: Post-school qualifications of the residential aged care workforce, by occupation (per cent)

Post-school qualification	Nurse		PC		Allied Health		Total	
	2003	2007	2003	2007	2003	2007	2003	2007
No post-school qualifications	5.6	11.8	16.4	23.7	17.1	17.9	12.8	19.8
Certificate III in aged care	7.1	9.7	65.9	64.6	25.5	36.9	42.9	46.6
Certificate IV in aged care	4.9	5.2	7.9	13.3	9.3	17.5	7.0	11.3
Certificate IV/diploma in enrolled nursing	26.6	35.1	2.9	3.4	2.9	2.5	11.0	12.5
Bachelor degree in nursing	23.6	28.3	1.7	1.6	3.9	0.6	9.3	9.3
Other basic nursing qualification	34.6	21.4	7.3	3.8	8.3	4.6	16.7	9.0
Post basic nursing qual in aged care	13.2	10.0	2.8	0.7	3.4	0.8	6.4	3.4
Post basic nursing qual not in aged care	16.2	15.1	1.9	1.1	2.4	0.2	6.8	5.1
Other	9.0	12.3	9.8	13.7	49.0	44.7	12.4	15.6

Source: Surveys of residential care workers.

Note: Because staff can have more than one qualification, the totals do not sum to 100. Figures for 2003 have been adjusted to use same weighting principles as 2007.

Data from homes provide another perspective on PCs' qualifications. Homes' responses indicate that the overall proportion of their PCs with a relevant Certificate III rose significantly from 54.6% in 2003 to 65.3% in 2007.[12] Clearly, this estimate, and the trend it reveals, is different from that we saw based on the worker surveys. It is not possible to be certain which estimate of the trend is closer to the truth. However, it seems most likely that the trend based on home returns, showing an increase in the prevalence of the Certificate III amongst PCs, is most accurate. As we noted above, it is very plausible that a change in the way we asked about post-school qualifications in the workers' survey between 2003 and 2007 would have suppressed the estimated prevalence of qualifications in 2007 compared to 2003, especially for lower level qualifications. There is no such obvious reason to think the trend evident from the home returns might be wrong. We therefore place more weight on the results from this latter source. Finally, we should note that home responses indicate that the proportion of PCs with a relevant Certificate IV rose from 5.4% to 8.8%.

12 A small part of this change will be due to a shift in how the question was asked. In 2003 it referred only to the Certificate III in Aged Care, while in 2007 it referred to a Certificate III 'related to their direct care work'. The only other significant Certificate III that the 2007 questionnaire could include is the Certificate III in Home and Community Care. The employee survey indicates that only 1.3% of PCs had this certificate but not the Certificate III in Aged Care.

3.1.8 Summary

In large measure, the picture we developed of the residential aged care workforce from 2003 remained accurate in 2007. Residential direct care workers are almost all women, they are most likely to be employed on permanent part-time contracts and work 16–34 hours per week, be employed as PCs, have some relevant post-secondary qualifications (usually a Certificate III in Aged Care), be aged 45 or over, and have been born in Australia. In fact, some of these characteristics of the 'average' worker have become even more typical: PCs make up a larger proportion of the workforce, slightly more have a relevant post-secondary qualification, and more are aged 45 or over. However, in a couple of areas, the workforce has become slightly less like this typical picture: employees in 2007 were more likely than in 2003 to be employed casually and slightly more likely to be working full-time, and less likely to have been born in Australia.

3.2 The Main Characteristics of the Work

3.2.1 Shifts and Shift Preferences

The shifts aged care staff work, and how these shifts correspond to their preferences, are widely recognised as being important in recruitment and retention of staff. Residential aged care homes, by their nature, need to have staff working at all hours. Arranging shifts to optimise the needs and desires of all staff is undoubtedly one of the many challenging tasks faced by managers in aged care homes.

Table 3.10 shows the various types of shifts worked by each occupational group, how many would like to work different shifts, and what their preferences would be. A little over half of nurses and just half of PCs work a regular daytime shift, with most of the remainder working either a regular evening or rotating shifts. Almost all allied health workers work a regular daytime shift. The main change since 2003 has been a rise in the proportion of PCs working a regular daytime shift (from just over 40% in 2003 to 51% in 2007) and a corresponding fall in the proportion working a rotating shift (from around 27% in 2003 to 20% in 2007).

Almost all residential aged care workers were employed on the work schedule they preferred in 2007, with less than 10% wishing to change their shift arrangements. This is a very significant change from 2003 when 40% of nurses, nearly 55% of PCs, and nearly 30% of allied health workers wanted to change their shift arrangements. This change can be expected to contribute to employees' job satisfaction and their inclination to remain in their jobs. It is consistent with a significant tightening of the labour market, one that requires employers to accede to workers' shift preferences in order to attract and retain them.

Table 3.10: Actual and desired work patterns of residential aged care workers, by occupation (per cent)

	Nurse		PC		Allied Health	
Work schedule	Actual	Desired	Actual	Desired	Actual	Desired
A regular daytime shift	57.1	4.1	50.6	5.2	95.6	–
A regular evening shift	12.5	1.2	14.0	1.5	0.4	–
A regular night shift	5.8	0.4	5.3	0.7	0.2	–
A rotating shift	16.2	1.3	19.7	1.3	1.7	–
Split shift	0.5	0.2	0.6	0.3	0.2	–
On call	0.6	0.0	1.3	0.0	0.4	–
Irregular schedule	5.1	0.3	6.7	0.3	1.1	–
Other	2.1	0.9	1.8	0.5	0.4	
No change		91.5		90.2		97.5

Source: Survey of residential care workers.

3.2.2 Terms of Employment

The type of contract on which workers are employed, whether permanent, fixed term or casual, is often regarded as an important indicator of the difficulty employers have in filling positions. Where employers face more difficulties, it is often assumed, they find it necessary to offer more attractive terms of employment, particularly ones that are permanent rather than temporary (such as casual or fixed-term contracts). However, there is some debate about whether this assumption is appropriate in Australia, particularly with respect to casual employment. In particularly tight labour markets where some employees have relatively weak attachment to the labour market or where they have significant demands on their time outside work, they may prefer casual contracts because of the flexibility this provides them. In addition, Australia is unique in its common practice (included in awards) of paying a higher hourly wage to workers employed on casual terms (to compensate for absence of paid leave) and this additional cash payment is attractive to some. We have information about the residential aged care workers' terms of employment from both the homes census and the workers' survey. Whatever source we use, it is clear that the level of casual employment amongst the residential aged care workforce remains quite low compared to the 28% of all Australian female employees on casual contracts.

However, the data from homes and workers suggest different trends in the use of casual contracts. The data from employers suggests that there have been small increases in the proportion of all direct care staff who are employed casually or on limited term contracts (see above). However, as Table 3.11 shows, the proportion of the residential aged care workforce that says they are employed casually fell, particularly for PCs. The apparent difference between employer and employee responses could be due to a rise in the use of limited term contracts, though this is unlikely since almost no employees said they were employed on limited term contracts in 2007. Using the criterion for casual employment that

ABS has long employed, whether an employee is entitled to paid sick leave, gives another picture. It suggests that the level of casual employment changed little between 2003 and 2007. A possible interpretation of these rather confusing responses is that workers think of themselves as casually employed if they have no ongoing expectation of employment, rather than if they are formally employed on a casual rather than a permanent contract. Thus, the declining proportion that describes itself as casually employed indicates that more assume their employment is ongoing, even though their formal contracts may be temporary. This interpretation would be consistent with the tightening labour market suggested by other indicators. It would imply that if employers are employing more workers on contracts that are formally casual (as they indicate), this is because workers want the flexibility that goes with such contracts, rather than primarily because of the flexibility it offers employers.

Table 3.11: Terms of employment of the residential aged care workforce (per cent)

Terms of employment	Nurse		PC		Allied Health		Total	
	2003	2007	2003	2007	2003	2007	2003	2007
Casual	8.3	7.8	17.2	10.4	8.5	5.0	13.4	9.3
No paid sick leave	7.7	8.3	12.7	11.3	5.3	4.5	10.3	9.9

Source: Survey of residential care workers.

Note: Figures for 2003 have been adjusted to use same weighting principles as 2007.

3.2.3 Job Tenure

The tenure of a workforce is an important issue for employers, workforce planning, and workers. High levels of turnover, and corresponding short tenure, mean that employers need to expend considerable effort in replacing departing employees, workers do not gain the commitment and satisfactions that often go with longer tenure, and residents have to deal with constantly changing faces. The 2003 census and survey found that the aged care workforce had relatively high turnover levels, with overall turnover at nearly 25% per annum and PCs having the shortest job tenure of the main direct care occupations. Very little has changed. It appears that turnover may have increased slightly, particularly for PCs and ENs, but the changes are very small. The residential aged care workforce continues to display slightly higher turnover rates than their counterparts in the rest of the economy, with the proportion of Australian women with tenure of less than 1 year being 23.1% in 2006 (ABS 2006). On the other hand, a tightening of the residential aged care labour market might have produced a sharp increase in turnover, as workers changed jobs to achieve higher wages or better conditions. This does not appear to have happened, suggesting either that labour market tightening has been limited, or that employers have been willing to improve wages or conditions to retain workers who might otherwise leave. Certainly, the latter possibility is consistent with the sharp rise in the proportion of residential direct care employees who are able to work the shift arrangements they prefer.

Table 3.12: Tenure in current job of the residential aged care workforce, by occupation (per cent)

Tenure in current job	Registered Nurses		Enrolled Nurses		PCs		Allied Health		Total	
	2003	2007	2003	2007	2003	2007	2003	2007	2003	2007
Less than 1 year	21.4	21.4	17.5	18.8	26.0	27.8	23.5	22.6	23.7	25.2
1 to 5 years	41.2	43.8	39.4	39.3	48.1	48.5	45.9	47.6	45.3	46.5
6 or more years	37.4	34.8	43.1	41.8	26.0	23.7	30.6	29.8	30.9	28.4

Source: Survey of residential aged care workers.

3.2.4 Wages

Wages are a crucial factor in all labour markets. Combined with conditions and non-financial rewards, they have large effects on workers' willingness to accept jobs and to stay in them. They are also the major influence on the living conditions of the households of most workers. Detailed consideration of wages, such as whether aged care workers are well rewarded for their work compared to other workers, is beyond the scope of this report. However, we present the basic distribution of weekly wages. Nurses are much more likely than other workers to be in the upper of our pay brackets. Indeed, nearly all those earning over $1,000 per week in 2007 were nurses. Two-thirds of PCs earn between $500 and $1,000 per week, while just over half of allied health workers earn this much. Only the nurses have any numbers earning over $1,000 per week. The wages reported below are determined by both the workers' hourly pay and their weekly hours worked. It is very likely that the relatively high proportion of Allied Health workers who have a weekly wage between $1 and $500 is the result of low hours worked.

Table 3.13: Weekly wage in current job of the residential aged care workforce before deductions, by occupation (per cent)

Weekly wage ($)	Nurse	PC	Allied Health	Total
1–500	14.3	31.4	40.4	27.1
501–1000	57.4	67.3	56.4	63.7
1001–1500	24.4	1.2	3.1	8.0
1501–2000	3.7	0.1	0.0	0.1
2000+	0.2	0.0	0.0	0.1
Total	**100**	**100**	**100**	**100**

Source: Survey of residential aged care workers.

3.3 Career Paths

The pathways through which workers arrive at their jobs are a central aspect of the dynamics of labour markets, and of the ability of employers to find the workers they need. Information about workers' routes into their jobs may suggest both how common pathways can be smoothed or enhanced, and where untapped labour resources may lie. The 2007 residential aged care workers survey collected new data on employees' pathways into their current jobs, including information about when they first began working in aged care, the total amount of time they have worked in aged care, and what occupations they held before working in aged care. In this section, we present this new information.

While we have previously examined the tenure of workers in their current jobs, this does not indicate whether they had previously worked in the field, and in what capacity. Table 3.14 shows that, while many current workers had worked in aged care before their current jobs, employers are recruiting many new employees from outside the existing aged care workforce. This is particularly striking amongst PCs, with just over half not having worked in the field before their current job. But the proportions are substantial for nurses and allied care workers too, with a third of nurses and 40% of allied health workers not having worked in aged care before their current jobs.

Unpaid aged care work is sometimes thought to be a route into paid work in the field. Table 3.14 suggests that this is currently rarely the case for nurses, though it may be a more important route for PCs and allied health workers. It is likely that a higher proportion than the 7–8% of each of these groups shown in Table 3.14 began by doing unpaid aged care work, since this table refers only to the aged care job workers had before their current one.

Table 3.14: Proportion of residential aged care workers who had worked in aged care prior to their current job (per cent)

Had worked in aged care before?	Nurses	PCs	Allied Health	All direct care workers
Yes, paid work	65.1	40.4	52.7	48.5
Yes, unpaid work	1.6	7.6	6.8	5.8
No	33.3	51.9	40.5	45.7
Total	**100**	**100**	**100**	**100**

Source: Survey of residential aged care workers.

Though many workers will have no prior relationship with an employer before finding a job, some have relationships with employers that pre-exist the beginning of their current job. This may occur because they have previously worked for the employer, left their jobs, and then seek to return. Alternatively, workers may have done unpaid work for an employer, and then been successful in obtaining a paid position. In either case, workers' or employers' use of these previous relationships to fill vacancies smoothes the operation of labour markets. It is likely to benefit both worker and employer because each knows much more about the other's characteristics than would be the case if they did not have a pre-existing relationship.

Residential aged care workers often had relationships with their present employer before obtaining their current job (Table 3.15). Nearly a quarter of nurses and PCs had worked for their current home before obtaining their present job, whether the work was paid or unpaid. Nurses' previous relationships with homes have usually been in paid work. However, PCs were slightly more likely to have done unpaid or volunteer work for their home before their current job than to have done paid work for it. Unpaid work may be a more significant pathway into an initial aged care job, especially since Table 3.15 refers only to workers' current jobs, not their first ones.

These results suggest that many residential aged care workers either move in and out of the workforce, or circulate from one home to another. It indicates that they quite often return to homes for which they had previously worked when they want to change jobs or re-enter the labour force. This pattern may also reduce the problems caused by the fairly high turnover rates previously noted. Homes may be able to replace up to a quarter of the workers who resign by drawing from a pool of direct care workers who had previously worked for them, either as volunteers or in paid jobs. This is likely to decrease both the monetary and non-monetary costs of replacing workers.

Table 3.15: Proportion of residential aged care workers who had worked for their current home before obtaining their current job (per cent)

Had worked for home previously?	Nurses	PCs	Allied Health	All direct care workers
No	77.3	77.5	71.5	77.0
Yes, paid work	20.9	10.1	20.1	14.0
Yes, unpaid or volunteer work	1.8	12.2	8.2	8.9
Yes, paid and unpaid work	0.0	0.2	0.2	0.1
Total	**100**	**100**	**100**	**100**

Source: Survey of residential aged care workers.

The fact that many current residential aged care workers had worked in the field before their current jobs raises the issue of how much time workers have actually spent in aged care work. Distinct from tenure in their current job, this provides an indication of workers' total experience in the field. As Table 3.16 shows, long experience in aged care is particularly common for nurses. Nearly two thirds had worked in aged care for 10 years or more, and one third had done so for 20 years or more. In contrast, only about 37% of PCs had been working in aged care this long, with Allied Health workers falling between PCs and Nurses. The overall experience in aged care reflected in Table 3.15 is greater than a simple focus on the tenure of workers' current job would suggest. For example, some 36% of nurses said they had been in their current positions for 10 years or more, compared to the nearly two-thirds who had this much experience in the aged care field. Although PCs generally had less aged care experience than nurses, they show a similar pattern. While about 52% of PCs said they had been in their current job less than 5 years, only 37% had less than 5 years experience in aged care.

Table 3.16: Total years for which residential aged care workers have been working in aged care, by occupation (per cent)

Total years working in aged care	Nurses	PCs	Allied Health	All direct care workers
1 or less	3.7	12.1	3.6	9.0
2–4	13.5	25.2	17.7	21.2
5–9	18.3	25.3	25.9	23.3
10–14	16.9	15.7	19.2	16.3
15–19	15.3	9.1	17.9	11.5
20 or more	32.3	12.6	15.8	18.6

Source: Survey of residential aged care workers.

We have already noted that many residential aged care workers had not worked in aged care before their current jobs. Table 3.17 shows workers' occupations before their first job in aged care. First, very few workers take aged care jobs as their first occupation; PCs are the most likely to do this, but only 11% had not worked for pay before their first aged care job. The pathways of Nurses and PCs into aged care work are quite different. Sixty percent of nurses had worked as nurses in other settings before working in aged care, with only about a third having worked in non-nursing occupations immediately before starting in aged care. In contrast, PCs had worked in a range of previous occupations, but most commonly in lower white collar jobs not requiring post-school qualifications where women predominate. Almost half (45%) of PCs had worked in either sales, clerical work, other care work, hospitality work, or cleaning before commencing aged care work. [13] Allied Health workers also come to aged care from a range of previous occupations.

As we have already observed, many aged care workers had worked in aged care before their current jobs. The reasons workers leave one job and take another in the same industry provide a window on the extent to which employers might reduce turnover by altering aspects of how workers are employed or how work is organised. Table 3.18 indicates that some of the main reasons aged care workers leave their jobs could be ameliorated by home management, while many could not. Amongst the most commonly cited reasons are relocation, a desire to be closer to home, and the need to fulfil care responsibilities (such as having a baby). Together, these reasons account for nearly half of PCs' most important reasons for leaving jobs, while they are also important for other workers too. They reflect the ways paid work is embedded in other aspects of workers' lives, a particularly relevant issue when almost all workers are women whose domestic responsibilities tend to be greater than men's. However, other considerations were also important. Seeking more congenial hours or shifts, or higher pay, together explained 20% of PCs moves. These reasons also explained a significant proportion of the moves of nurses and allied health workers. Some workers moved seeking greater fulfilment through more challenging work, though the number was quite small. Some issues were rarely cited as reasons for changing jobs. Few

13 We do not know whether workers moved directly into aged care from these occupations, or whether they spent some time out of the paid labour force before beginning work in aged care. Of course, some will have followed each of these pathways.

left because of problems in relationships with managers or co-workers, with these reasons being particularly uncommon amongst PCs. Few said they had left because they could not spend enough time with residents, although, as we see below, many workers complain about this. And about 1 in 20 cited stress as a reason for leaving a previous job.

Table 3.17: Occupation of residential aged care workers before first aged care job, by occupation (per cent)

Last occupation before first aged care job	Nurses	PCs	Allied Health	All direct care workers
No previous paid employment	6.7	11.2	7.7	9.6
Nurse in other setting	59.8	6.2	4.4	21.9
Carer in other setting	3.5	9.3	10.0	7.6
Salesperson	4.6	8.2	7.3	7.1
Clerical worker	4.1	10.5	12.1	8.7
Hospitality worker (waitress, etc.)	3.7	11.1	8.1	8.7
Cleaner	1.0	6.6	4.2	4.8
Professional (other than nurse)	2.5	3.9	13.4	4.2
Manager	2.1	2.9	4.0	2.8
Other paid employment	11.9	30.0	28.8	24.6
Total	**100**	**100**	**100**	**100**

Source: Survey of residential aged care workers.

Although these data provide useful insight into why aged care workers move from one aged care job to another, they do not directly indicate why some leave the field altogether. It is possible, for example, that many PCs who leave the aged care industry do so when these jobs no longer fit with their non-work lives, as, for example, when their families relocate or care demands in their private lives change. In a labour market where PCs are able to find other jobs that provide a better fit with their non-work activities, perhaps in the occupation from which they came to aged care work, they may choose to change jobs. While such pathways would be consistent with the results in Table 3.18, and other indicators of a tightening labour market for PCs, we cannot say with certainty that they are common. On the other hand, if, for example, many workers leave aged care work permanently because of occupational injuries, this will not be evident from the data in Table 3.18. Research based on exit interviews with departing PCs may be illuminating here.

Table 3.18: Most important reason for leaving previous aged care job, residential aged care workers, by occupation (per cent)

Most important reason	Nurses	PCs	Allied Health	All direct care workers
Other: relocated/ moved/migrated	13.7	17.8	18.8	16.3
To be closer to home	15.2	17.5	9.6	16.0
To get shifts or hours of work I wanted	12.9	15.1	9.2	13.8
To find more challenging work	12.2	9.1	15.7	10.8
To fulfill care responsibilities (including having a baby)	8.8	10.1	7.7	9.4
To avoid managers or management I did not get along with or like	7.9	3.3	9.6	5.5
To achieve higher pay	5.2	5.2	2.7	5.0
The job was too stressful	6.6	3.8	5.7	5.0
Other: redundant/ retrenched/ contract finished/home closed	4.9	3.5	5.7	4.2
Other: study	4.1	0.9	3.4	2.3
Not able to spend sufficient time with residents	1.5	2.0	3.4	1.9
To avoid workmates or colleagues I did not get along with or like	1.2	1.8	2.7	1.7
To find easier work	0.8	1.1	0.8	1.0
Other	4.9	8.7	5.0	7.0
Total	**100**	**100**	**100**	**100**

Source: Survey of residential aged care workers.

Note: Categories above that begin with 'Other:' were not explicitly offered to respondents in the question; they are a summary of common responses written in to an unspecified 'other' category in answers.

The age at which workers begin working in aged care has a large impact on the overall age structure of the workforce. If workers typically begin their aged care careers when they are mature, then the relatively old profile of the workforce is probably sustainable. Table 3.19 shows that, indeed, many aged care workers first begin working in the field at relatively advanced ages. Around 40% of PCs and allied health workers did not start their aged care careers until they were 40 or older. Nurses were the most likely to begin aged care work at younger ages, though over half did not start before they turned 30 (62% of RNs began aged care work after they turned 30). Given that most nurses, particularly RNs, complete their basic training and begin nursing work in their early 20s, it is clear that aged care work is frequently a later career choice for nurses.

Table 3.19: Age at which residential aged care workers began working in aged care, by occupation (per cent)

Age	Nurses	PCs	Allied Health	All direct care workers
21 or under	20.3	17.9	15.5	18.4
22–29	24.4	15.6	14.8	18.1
30–39	28.9	28.0	28.8	28.4
40–49	20.3	29.7	30.3	27.0
50+	6.1	8.8	10.6	8.1
Total	**100**	**100**	**100**	**100**

Source: Survey of residential aged care workers.

Table 3.20 shows that how long workers have worked in aged care is strongly associated with the age at which they began their aged care careers, an unsurprising finding.[14] However, recruiting workers at younger ages may make only a small difference to the number of years they ultimately spend working in aged care. For example, on average, PCs recruited in their 30s have spent only a year less in aged care than those recruited after 21. Similarly, there is little difference in aged care career length for allied health workers whether they began aged care work in their 20s, 30s, or 40s. Even amongst nurses, those beginning aged care work in their 20s have spent only about 2 years more in the field than those beginning in their 30s. These patterns suggest that, for whatever reasons, there may be limits to the amount of time most workers are prepared to undertake aged care work.

Table 3.20: Average number of years of working in aged care by age at which residential aged care workers began working in aged care, by occupation

Age at which began working in aged care	Nurses	PCs	Allied Health	All direct care workers
21 or under	17.5	11.2	17.2	13.6
22–29	17.0	10.8	11.7	13.3
30–39	14.8	9.8	11.8	11.5
40–49	10.1	7.1	10.4	8.0
50+	6.9	5.7	6.9	6.1
Total	**14.5**	**9.1**	**11.7**	**10.8**

Source: Survey of residential aged care workers.

Note: this table shows, for instance that nurses who began working in aged care at age 21 or less have spent an average of 17.5 years working in aged care overall. It also indicates that the average number of years all nurses had worked in aged care was 14.5 years.

14 The results in this table need to be interpreted with some caution, since they show only workers who are currently working in aged care, and therefore do not indicate the final total years spent in aged care by those beginning aged care work in each age group. In particular, changes over time in the age at which workers begin their career will affect these final achieved career lengths.

As we have seen, aged care workers often begin their careers in aged care when they are relatively mature workers. Therefore changes over time in the age at which they typically begin aged care work provide an indication of whether the workforce's relatively older age profile is likely to lead to particular recruitment problems. If the age at which workers begin working in aged care homes remains fairly constant, then the more mature profile may not be a particular concern. Indeed, it may be seen to have advantages for the quality of care. Indeed, Table 3.21 confirms that residential aged care homes have never recruited workers new to the industry from new entrants to the labour market. In recent years, the average age of RNs taking their first aged care job has been over 40, and PCs newly entering the field have had average ages of about 37. Table 3.21 suggests that, with the exception of RNs, the average age at which aged care workers begin their aged care careers was not markedly different for those commencing between 2004–2007 than it was for those commencing in earlier periods.[15] If anything, PCs seem to have been becoming younger when they start aged care work. However, it seems very likely that, at least since about 1999, RNs recruited to the field have been significantly older than in the 1990s. In short, the age structure of the residential aged care workforce is much more a reflection of the older age at which workers begin their aged care careers than of any particularly dramatic ageing of that workforce.

Table 3.21: Average age at which current residential aged care workers began working in aged care by year in which began aged care work, by occupation

First year in aged care	RNs	ENs	PCs	Allied Health	All direct care workers
1988 or before	28.4	23.5	26.0	26.5	26.2
1989–1998	34.6	32.4	35.1	38.0	35.0
1999–2003	40.0	34.3	37.5	38.8	37.5
2004–2007	42.4	32.4	36.6	39.9	37.0
All years	33.9	29.3	34.6	35.5	33.9

Source: Survey of residential aged care workers.

Note: this table shows, for instance that RNs who began working in aged care before 1988 were, on average, 28.4 years old when they began working in aged care.

3.4 How Aged Care Staff Feel About Their Work

How workers feel about their work has effects on the effort they apply to their jobs, their inclination to stay in them, and employers' ability to recruit new workers, whatever the field. In 2007, we asked workers about how they evaluated various aspects of their work in the

15 The figures in Table 3.21 should be interpreted with caution. Because they are based on responses from the current workforce, they do not indicate the average age of all aged care workers who began work in the designated periods. Insofar as workers who were older when they first began working in aged care were more likely to have left the workforce before 2007, the figures will be more inaccurate for earlier periods than later ones. In particular, the apparently younger age of recruitment of workers who began working in aged care before 1989 will be largely due to this effect.

same ways as in the 2003 survey. In general, we found very little change in this respect, with no evidence at all of worsening experiences. In some areas there appear to have been small improvements in workers' evaluation of their workplace experience. We also asked about some aspects of their work experience that were not examined in 2003, particularly workers' view about the quality of support from management and other workers, and the quality of relationships with them.

3.4.1 Doing the Work

By definition, caring for residents is the main purpose of aged care workers' jobs. Whether they feel they have enough time to do this work is therefore an important aspect of their experience of the work. The 2003 survey found that the majority of direct care workers felt that they were not able to spend enough time with residents. This pattern continued in 2007 (Table 3.22). More than half of respondents in each occupation disagreed with a statement suggesting that they were able to spend enough time with each resident. However, between 2003 and 2007, there was a small increase in the proportion indicating that they could spend enough time with residents, particularly amongst nurses (for whom the proportion rose from about 13% to 23%).

Table 3.22: Responses of the residential aged care workforce to the question "I am able to spend enough time with each resident" by occupation (per cent)

Response	Nurse	PC	Allied Health	Total	New hires Total
Disagree	58.4	51.3	52.0	53.4	50.0
Neither agree nor disagree	18.4	22.8	18.4	21.2	21.6
Agree	23.2	25.9	29.6	25.4	28.3
Total	**100**	**100**	**100**	**100**	**100**

Source: Survey of residential aged care workers.

Many direct care workers spent substantial parts of their work time in tasks other than direct caring, as Table 3.23 shows. About a quarter of nurses, just over half of PCs and 40% of Allied Health workers say they spend more than two thirds of their time in direct care tasks. These figures are much the same as in 2003, with only PCs showing any sign of increased time spent in direct care work (rising from 50% to 55% spending more than two thirds of their time directly caring).

Together, these responses show that there has been little change in a pattern highlighted by the 2003 survey: that many residential direct care workers feel that they do not have sufficient time or opportunity to engage in the caring tasks for which they were employed. Since, as we confirm below, aged care workers derive much of their job satisfaction from feeling that they do a good job in providing care to the elderly, it remains of substantial concern that workers feel they are not able to do the job to their satisfaction. Especially in an industry that is unlikely to be able to compete with other potential employers on wages or employment conditions, this issue must remain central to workforce planning.

Table 3.23: Responses of the residential aged care workforce to the question "In a typical shift, how much time do you spend in direct caring?" by occupation (per cent)

Time spent caring	Nurse	PC	Allied Health	Total
Less than a third	36.1	11.6	17.4	19.2
Between one third and two thirds	40.2	33.0	43.7	35.9
More than two thirds	23.7	55.4	38.9	44.9
Total	**100**	**100**	**100**	**100**

Source: Survey of residential aged care workers.

Feeling pressure to work harder is widespread in the Australian workforce, as in many equivalent countries. As Table 3.23 shows, it is a feature of the residential aged care workforce. Half of nurses, 45% of PCs and 40% of Allied Health workers feel under pressure to work harder in their jobs. These figures are very close to those found in the 2003 survey. Workers feeling under pressure to work harder, yet unable to spend the time they would like in caring work, are unlikely to be able to take on additional responsibilities or tasks. In other words, these results continue to indicate that few residential aged care workers will be in a position to take on greater workloads. Indeed, given the impact of perceived insufficient time for caring and work pressure, it is likely to be counterproductive to do so, both in terms of workers' job satisfaction and retention.

Table 3.24: Responses of the residential aged care workforce to the question "I feel under pressure to work harder in my job" by occupation (per cent)

Response	Nurse	PC	Allied Health	Total	New hires Total
Disagree	32.0	36.3	42.0	35.5	39.6
Neither agree nor disagree	18.1	18.4	18.2	18.3	21.0
Agree	49.9	45.2	39.8	46.2	39.4
Total	**100**	**100**	**100**	**100**	**100**

Source: Survey of residential aged care workers.

On a more positive note, aged care workers continue to feel that they have the skills they need to do their jobs, and that their skills are being used in their jobs. Well over 90% of aged care workers in all occupational groups believe they have the skill they need to do their jobs. Moreover, almost the same proportion believes their skills are used in their jobs. It is notable that nurses are the most equivocal on this score, with nearly 15% implying that their skills are not well used in their jobs. Fewer PCs and Allied Health workers feel this way. Aged care homes may have become slightly more efficient at using the skills of their direct care workers, since the proportion who say that many of their skills are not used has declined slightly (e.g., from

about 10% for nurses in 2003). Nevertheless, the overall picture is clearly one of a workforce that feels confident in its skills, and satisfied that those skills are being used.

Table 3.25: Responses of the residential aged care workforce to the question "I have the skill I need to do my job" by occupation (per cent)

Response	Nurse	PC	Allied Health	Total	New hires Total
Disagree	0.9	2.3	2.5	1.9	2.8
Neither agree nor disagree	3.0	4.3	4.9	4.0	7.2
Agree	96.1	93.4	92.6	94.1	90.0
Total	**100**	**100**	**100**	**100**	**100**

Source: Survey of residential aged care workers.

Table 3.26: Responses of the residential aged care workforce to the question "I use many of my skills in my current job" by occupation (per cent)

Response	Nurse	PC	Allied Health	Total	New hires Total
Disagree	5.5	2.4	3.0	3.3	5.0
Neither agree nor disagree	8.6	4.3	5.3	5.6	7.2
Agree	86.0	93.3	91.7	91.1	87.9
Total	**100**	**100**	**100**	**100**	**100**

Source: Survey of residential aged care workers.

Workers who feel that they have control over important aspects of their work are likely to be more committed to it, to perform better, and to remain in their jobs. The 2003 survey showed that many aged care workers do feel this autonomy, with about 55% of nurses, 44% of PCs and 80% of Allied Health workers agreeing that they have a lot of freedom to decide how to do their work. The picture was similar in 2007, though a slightly higher proportion of nurses and PCs agreed with the statement. Although the change is small, it indicates that any change in how work is organised in aged care homes is not reducing autonomy, and may be increasing it. While the situation is not getting worse, employers would be wise to consider how to increase the degree of autonomy among their PCs. It is firmly established in the health literature that low levels of autonomy, especially when combined with stress and expectations of a high level of effort, are damaging for worker health.

Table 3.27: Responses of the residential aged care workforce to the question "I have a lot of freedom to decide how I do my work" by occupation (per cent)

Response	Nurse	PC	Allied Health	Total	New hires Total
Disagree	17.5	26.6	10.2	22.7	24.9
Neither agree nor disagree	19.7	24.4	13.2	22.2	24.7
Agree	62.7	49.0	76.6	55.0	50.4
Total	**100**	**100**	**100**	**100**	**100**

Source: Survey of residential aged care workers.

Workers who feel stressed in their jobs are unlikely to perform at their best, are more likely to leave their jobs, and often experience work as a negative influence in their lives. Stress in aged care jobs may arise for a variety of reasons. It is often related to an overload of tasks, when employees feel unable to complete much of their work satisfactorily. We have already seen that many aged care workers feel under pressure to work harder. Stress in aged care jobs may also arise because of the nature of the work. For example, if workers feel unable to successfully care for residents, or to make their lives better. However, aged care workers feel that they have the skills they need to do their jobs, as we have seen, and they get satisfaction from the caring work they do. Whatever the cause, a large proportion of aged care workers (from 42% of Allied Health workers to 47% of nurses) agreed that their jobs were more stressful than they had ever imagined (Table 3.28). This is a strong statement of stress level, and suggests that stress may be a serious issue for a substantial minority of aged care workers.

Table 3.28: Responses of the residential aged care workforce to the question "My job is more stressful than I had ever imagined" by occupation (per cent)

Response	Nurse	PC	Allied Health	Total	New hires Total
Disagree	33.7	37.3	39.9	36.5	48.6
Neither agree nor disagree	19.4	19.7	18.3	19.5	18.5
Agree	46.8	43.0	41.8	44.0	32.9
Total	**100**	**100**	**100**	**100**	**100**

Source: Survey of residential aged care workers.

Aged care workers have very low satisfaction with their pay compared to similar other workers. This appears to be based in a feeling that their pay does not reflect the importance of the jobs they do. Other forms of appreciation of their work and commitment are therefore particularly important for these workers. Table 3.29 indicates that more than half of aged care workers do feel that their efforts and achievements are respected and acknowledged. This feeling is more common amongst Allied Health workers, with PCs being least likely

to express it. Indeed, nearly a quarter of PCs disagree with the statement that their efforts and achievements are respected and acknowledged. These results indicate that there is substantial scope to make aged care workers, particularly PCs, feel better recognised for the difficult work they do.

Table 3.29: Responses of the residential aged care workforce to the question "Considering all my efforts and achievements, I receive the respect and acknowledgement I deserve" by occupation (per cent)

Response	Nurse	PC	Allied Health	Total	New hires Total
Disagree	19.6	22.5	15.7	21.2	16.7
Neither agree nor disagree	17.0	18.9	17.7	18.2	20.1
Agree	63.3	58.6	66.6	60.6	63.2
Total	**100**	**100**	**100**	**100**	**100**

Source: Survey of residential aged care workers.

3.4.2 Workplace Relationships

The quality of workplace relationships, both between managers and workers and amongst workers, has lasting effects on many aspects of work and labour markets. When relationships are good, workers tend to have higher job satisfaction, are more likely to remain in their jobs and perform better. Research generally finds that employees are more likely to view these relationships positively than negatively, though there is variation between groups of employees. The 2007 workers survey asked three questions related to these issues (these were not asked in the 2003 survey), and the results are shown in Tables 3.30, 3.31 and 3.32.

About two thirds of direct care workers in residential homes describe the relationships between managers and employees in their workplaces positively. Employees were asked about these relations in two different questions, and the picture is remarkably similar irrespective of which is used (Tables 3.30 and 3.31). Nurses, PCs and Allied Health workers have very similar views about management/worker relationships. However, about 15–20% of direct care workers express negative views about these relationships, indicating that a significant minority of homes could do much better in this domain. Data collected on a national sample of all workers in 2005 produces similar results. In the Australian Survey of Social Attitudes (AuSSA), 71% of female workers viewed worker / management relationships as 'very good' or 'good', and 12% saw them as 'bad' or 'very bad'.[16] This comparison suggests that aged care workers may be slightly more likely to see worker / managements relationships as negative than the female workforce in general, but the difference is small.

16 The question in the AuSSA survey was identical to that used in the 2007 residential aged care workers survey, except that the AuSSA survey gave 6 answer choices (including 'can't choose') each labelled with a meaning (e.g., 'bad', 'very bad'), whereas the aged care survey asked respondents to rate the relationships on a scale from 1 ('very bad') to 7 ('very good').

Table 3.30: Responses of the residential aged care workforce to the question "Management and employees have good relations in my workplace" by occupation (per cent)

Response	Nurse	PC	Allied Health	Total
Disagree	19.4	19.8	18.0	19.6
Neither agree nor disagree	17.3	18.1	16.5	17.7
Agree	63.4	62.1	65.5	62.7
Total	**100**	**100**	**100**	**100**

Source: Survey of residential aged care workers.

Table 3.31: Residential aged care workforce assessment of quality of relationships between managers and workers by occupation (per cent)

Response	Nurse	PC	Allied Health	Total
Bad	15.2	14.9	12.4	14.8
Neither Good nor Bad	18.1	18.2	20.9	18.4
Good	66.6	66.8	66.7	66.8
Total	**100**	**100**	**100**	**100**

Source: Survey of residential aged care workers.

Table 3.32 shows that aged care workers are overwhelmingly positive about the quality of relationships between workmates in the homes where they are employed. Nearly 80% of every occupational group rate these relations as good, with less than 10% saying they are 'bad'. Again the results are similar to those from AuSSA, where 85% of women workers rated these relationships positively, and 2% saw them negatively. While the picture of these relationships in aged care homes is generally positive, there is a small number of workers who see them negatively. In particular, the 8% of PCs who see 'bad' relationships between workmates suggests that a few homes may have significant problems in this area.

Table 3.32: Residential aged care workforce assessment of quality of relationships between workmates/colleagues by occupation (per cent)

Response	Nurse	PC	Allied Health	Total
Bad	5.6	8.4	6.4	7.4
Neither Good nor Bad	14.0	14.3	14.7	14.2
Good	80.4	77.3	78.9	78.3
Total	**100**	**100**	**100**	**100**

Source: Survey of residential aged care workers.

3.4.3 Job Satisfaction—The Conditions of Work

Job satisfaction is a widely recognised and important indicator of workers' evaluation of the quality of their jobs. It is frequently measured on a number of dimensions (e.g., pay, job security, hours of work, etc.). Surveys generally find that employees are more likely to be satisfied than dissatisfied with their jobs, in all their aspects. This is because respondents generally answer these questions in relative terms—they respond on the basis of how aspects of their jobs compare with what they believe they might reasonably hope for. For example, workers in jobs that may be considered boring and repetitive compared to those of most other workers will often express satisfaction with the nature of their work because, given their qualifications and experience, they do not believe they could reasonably expect better. The 2003 survey generally found levels of job satisfaction amongst aged care workers that are similar, though slightly lower, to those found for other comparable workers. The exception was in the area of pay, where aged care workers expressed much higher levels of dissatisfaction than on other dimensions, and much higher levels of dissatisfaction than other comparable workers.

The job satisfaction question used in the 2007 aged care workers surveys asked respondents to rate their satisfaction with a range of aspects of their jobs on a scale from 1 ('highly dissatisfied') to 10 ('highly satisfied'). The 2003 survey asked them to rate satisfaction on a scale from 0 ('highly dissatisfied') to 10 ('highly satisfied'). In order to make the 2003 and 2007 results comparable, 2007 responses were rescaled to put them on a 0 to 10 scale. To analyse the job satisfaction results, we examine the average score on this latter 11 point scale. The midpoint of this scale, a score of 5, can be taken as meaning that a respondent is neither satisfied nor dissatisfied with an aspect of their job. Scores above 5 indicate some level of satisfacation, with higher scores indicating greater satisfaction. Similarly, scores below 5 indicate some level of dissatisfaction, with lower scores indicating greater dissatisfaction. For all of the aspects of job satisfaction we examine, it is the case that averages above 5 are associated with more respondents expressing satisfaction than dissatisfaction. By the same token, all averages below 5 are associated with more expressing dissatisfaction than satisfaction. In general, comparing averages across aspects of job satisfaction and across time allow us to make useful and easy interpretations.

Although there was some improvement in aged care workers' pay satisfaction, they are still much less satisfied with this aspect of their jobs than any other (Table 3.32), and a majority express dissatisfaction. Nurses showed the largest increase in pay satisfaction (from an average of 3.9 in 2003 rising to 4.8 in 2007), with PCs also feeling more satisfied in 2007 than 2003 (their average rose from 3.6 to 4.0). Allied Health workers' pay satisfaction hardly changed during the period. Indeed, by 2007 nurses were the most satisfied of all occupational groups with pay. Although some State based awards affecting aged care nurses were significantly altered between 2003 and 2007, which may partially explain the change in pay satisfaction, aged care RNs are still paid significantly less than acute care nurses (Productivity Commission 2008: 141). The fact that pay satisfaction remains so low amongst aged care workers must be a matter of concern for the future of this workforce. It requires further exploration and understanding.

Most aged care workers remain satisfied with their job security, with little change in the level of satisfaction between 2003 and 2007. As in 2003, nurses and PCs feel equally satisfied

with job security, with Allied Health workers being slightly more positive. That job security is not a major issue for any of these groups partly reflects the strength of the Australian labour market in general. But it also in accord with the tendency for most residential aged care workers to be on permanent contracts, and the fact that this is not an industry subject to significant cyclical fluctuations. Indeed, it is notable that, despite some indications of increases in the use of casual contracts, satisfaction with job security has not changed.

Much research now shows that many aged care workers are attracted to the field because they see the work of caring as important and satisfying. Confirming this pattern, Table 3.33 shows quite high levels of satisfaction with 'the work itself' amongst residential aged care workers. It is particularly encouraging that nurses, who had lower satisfaction than PCs with this aspect of their work in 2003 (6.5 compared to 7.2), are now almost equal in their satisfaction with PCs.

Most residential aged care workers are women who work part-time. They frequently have significant commitments outside their paid jobs, particularly in domestic care responsibilities. Indeed, 56% have financial dependents and 54% spend some time regularly each week caring for family members, with 19% spending 40 or more hours per week in such care. For these workers, hours of work and the flexibility their workplace offers for balancing work and non-work commitments are likely to be very important. One important dimension of whether workers can balance these commitments is whether they are able to work the shift arrangements they prefer. Being required to work, say, irregular shifts when also taking care of school age children may cause difficulties. We have already seen a sharp drop in the proportion of residential aged care workers wanting to change their shift arrangements.

As in 2003, aged care workers generally reported quite high levels of satisfaction with the hours and flexibility for their jobs. In fact, all aged care occupational groups became slightly more satisfied with the flexibility their jobs offered for balancing work and non-work commitments. This could be a consequence of the increasing proportion able to achieve the shift arrangements they desire, although the change in satisfaction is rather modest given the substantial decline in those wanting to change their shifts. The pattern with regard to workers' satisfaction with their hours of work is more mixed. Nurses became slightly less satisfied with their hours of work, while PCs' satisfaction increased noticeably. This latter result is consistent with indications that, on average, PCs worked slightly longer hours in 2007 than 2003, though it is interesting that the higher satisfaction with hours of work is not reflected in a decline in the proportion wanting to change their hours (see above). Overall, it appears that residential homes continue to satisfy many of the needs and desires of their direct care workers with regard to hours and flexibility.

The 2007 survey asked about two aspects of job satisfaction not examined in the 2003 survey, satisfaction with workers' opportunities to develop their abilities, and satisfaction with the support they received from their team or service provider. Workers who are not given the opportunities they want to develop their abilities are likely to become frustrated and disillusioned with their workplace, and are more likely to leave. Moreover, providing employees with these opportunities is a key way that organizations can improve the quality and productivity of their workforces and replace departing employees with higher level

skills. It is therefore encouraging that aged care employees were generally satisfied with their opportunities in this area. Allied Health workers expressed slightly higher levels of satisfaction than nurses or PCs, but the differences were small.

The support workers receive from those they work with or the organization that employs them is very important in maintaining their commitment to work. Again, most residential aged care workers were reasonably satisfied on this front, with Allied Health workers being slightly more positive than others. This result indicates that lack of support from teams or service providers is not a major problem for aged care workers.

Finally, workers were asked about their overall job satisfaction. Again, the main result is that most workers express satisfaction, rather than dissatisfaction, and the changes since 2003 are small or negligible. Only nurses show any real shift, with a small increase in average levels of satisfaction (from a mean of 6.73 to 7.09).

Table 3.33: Average job satisfaction scores, residential aged care workforce, various dimensions of job satisfaction, by occupation

Satisfaction with:	Nurse		PC		Allied Health		Total		New hires Total	
	2003	2007	2003	2007	2003	2007	2003	2007	2003	2007
Total pay	3.91	4.83	3.55	4.04	4.51	4.37	3.74	4.29 (6.94)	4.54	4.58
Job security	7.16	7.12	7.07	7.05	7.48	7.47	7.13	7.10 (8.07)	6.81	6.93
Work itself	6.46	7.02	7.22	7.30	8.14	7.94	7.03	7.26 (7.61)	7.38	7.42
Hours of work	7.42	7.26	7.07	7.44	7.48	7.60	7.22	7.40 (7.29)	6.74	6.97
Opportunity to develop abilities		6.79		6.99		7.28		6.95		6.96
Support from team		6.96		6.96		7.38		6.99		7.23
Work / Non-work flexibility	6.66	6.87	6.90	7.06	7.11	7.53	6.83	7.04 (7.55)	7.03	7.13
Overall job satisfaction	6.73	7.09	7.31	7.33	7.83	7.76	7.15	7.29 (7.72)	7.53	7.43

Source: Survey of residential aged care workers.

Note: Figures in this table are average (mean) scores on job satisfaction questions ranging from 0 ('totally dissatisfied') to 10 ('totally satisfied'). Thus higher scores represent greater satisfaction. Figures in brackets under 2007 Total column are means for the Australian female workforce from the 2006 wave of the Household and Income Labour Dynamics (HILDA) survey.

As we have already noted, the departure of workers from aged care jobs, and the need to recruit new workers, is a substantial issue for residential homes. For this reason, workers' future intentions are an important indicator of the likely future extent of the need to find replacements. As in 2003, we asked workers where they expected be working 12 months and three years from the date of the survey. About 80% expected to be working for their current employer in 12 months. Some 60% of all workers, and about the same proportion of each occupation, expected to continue working in aged care in three years, mostly in the residential sector (Table 3.34). Another quarter were unsure where they would be working in three years, with only just over 10% positively expecting to be working outside aged care, though the proportion was significantly lower for Allied Health workers at about 6%.[17] Very few workers expected to shift from residential care entirely to community based caring, though around 5% expected to work in both sectors. These results show that continuing to work in aged care is attractive to a large proportion of current aged care workers. Information on turnover from employers, and the fact that more than half of aged care workers had worked in the field before their current job, means that some of these workers can be expected to move to different homes. However, most of them will continue to offer their skills and experience to the industry.

Table 3.34: Responses of the residential aged care workforce to the question "Where do you see yourself working three years from now?", by occupation (per cent)

Response	Nurse	PC	Allied Health	Total	New hires Total
Working in aged care, residential	48.0	48.6	49.4	48.5	45.8
Working in aged care, community based	0.7	1.0	1.5	1.0	1.3
Working in aged care, residential and community	4.0	6.0	7.0	5.5	8.8
Working in aged care, unspecified	4.2	5.6	6.2	5.3	4.5
Working, not in aged care	12.4	11.1	5.8	11.1	14.2
Not working for pay	5.3	2.4	6.4	3.6	1.6
Don't Know	25.3	25.2	23.6	25.1	23.8
Total	**100**	**100**	**100**	**100**	**100**

Source: Survey of residential aged care workers.

17 The 2003 survey asked about this intention in a slightly different way, not offering a 'don't know' response, and found that about 75% of aged care workers expected to be working in aged care 3 years from the date of the survey. Excluding the 'don't know' responses in the 2007, about 80% of aged care workers who were able to give a response expected to be working in aged care in 3 years. This suggests that there was little change in the pattern of intentions between 2003 and 2007.

3.5 Personal Carers

Personal Carers (PCs) are the largest group of direct care workers in residential aged care homes. Comparing results of the 2003 and 2007 censuses of homes has confirmed that PCs are a rising proportion of direct care workers, increasing from 58.5% to 63.6% of all direct care workers between 2003 and 2007. For these reasons, PCs remain of central concern in workforce planning in the residential aged care sector. The 2003 research provided the first clear picture of PCs because this group had been impossible to isolate in other data sources. Here, we update that picture to 2007, largely focusing on homes' description of their PC workforce.

Table 3.35 shows the proportion of homes with varying levels of Certificate III and Certificate IV qualified PCs. The pattern of change from 2003 to 2007 reflects the trend to an increasingly qualified workforce evident from the homes data. The proportion of homes with no PCs with a Certificate III halved from nearly 10% to just over 5% between 2003 and 2007. At the same time, the proportion in which three quarters or more of PCs had a Certificate III rose from 35% to 47%. There was a sharp drop in the prevalence of homes with no PCs with a Certificate IV, from just over 60% to just over 40% of homes. The vast majority of homes employing PCs with Certificate IV qualifications continued to have less than a quarter of their PCs with this qualification, though 9% indicated that between a quarter and a half of their PCs were Certificate IV qualified.

Table 3.35: Percent of homes with varying proportions of PCs holding Certificate III and Certificate IV in Aged Care (per cent)

Proportion of PCs with qualification in home	With Aged Care III		With Aged Care IV	
	2003	2007	2003	2007
None	9.6	5.2	61.1	42.2
Less than a quarter	10.8	5.5	30.6	44.8
A quarter to less than a half	20.0	14.9	5.0	8.9
A half to less than three quarters	24.9	27.0	2.1	2.5
Three quarters or more	34.7	47.4	1.1	1.5
All	–	13.1	–	0.6

Source: Census of residential aged care homes.

We have already seen something of the pathways that workers follow into aged care work. How homes find workers is another important aspect of these pathways. As Table 3.36 shows, homes rely on a variety of methods to recruit PCs. Informal methods such as word of mouth and walk-ins are important, but so are formal methods such as placing newspaper and internet advertisements. It is notable that word of mouth is cited more frequently than waiting for walk-ins, indicating that even where homes rely on informal methods to recruit PCs, they do so actively.

Recently hired workers' accounts of how they found out about their jobs present another perspective on recruitment pathways. Table 3.37 suggests that walk-ins are actually much more important for the hiring of PCs than the data from homes might suggest. Just over

half of PCs reported approaching their home for a job without knowing that there was a vacancy. This kind of approach was also important for recently hired nurses, accounting for over half of pathways to jobs. Word of mouth was also an important source of information about their jobs for all occupations. Indeed, putting together walk-ins and word of mouth routes to jobs, amongst recent hires, 57% of nurses, 70% of PCs and 45% of Allied Health workers had found their jobs through informal means. For the remainder, newspaper advertisements remain the most important formal source of information leading to a job, with internet sites continuing to be of little consequence.

While informal means of recruitment are found in all areas of the economy, the level reported here for the aged care sector is particularly high. We think one reason will be the high levels of turnover in the sector. This has the effect that workers know that it is very likely that there will be a vacancy at any time in any home that they approach. It appears that homes underestimate the extent to which they fill vacancies through the initiative taken by workers to approach them. Homes cannot safely assume that there will, in a tighter labour market, be a steady flow of such approaches. We conclude that the apparent role of walk-ins as a source of hires for nurses and PCs should be further examined by employers, so they are alert to any risks it might pose.

Table 3.36: Most likely sources if hiring new PCs

Employment source	Per cent of homes likely to use method
Wait for walk-ins	18.8
Word of mouth	27.6
Newspaper job ad	37.5
Internet job ad	6.8
Newspaper and internet job ad	32.6
Existing job placement workers	24.3

Source: Census of residential aged care homes.

Table 3.37: Sources of information about the vacancy for their job for the most recently hired residential aged care workers (per cent)

Source of job information	Nurse	PC	Allied Health	Total
Walk in	38.4	51.8	19.4	46.4
Newspaper advertisements	23.9	15.6	37.1	19.0
Word of mouth	18.3	18.5	25.8	18.9
Internet sites	4.8	2.6	8.1	3.5
Company or professional contacts	4.8	2.8	8.1	3.6
Other	9.8	8.7	1.5	8.6

Source: Survey of residential aged care workers.

3.6 Agency and Contract Staff

Residential aged care homes use agency and contract staff to ensure that necessary staffing levels are maintained. This may occur when existing permanent or casual staff are unavailable or new ones cannot be recruited, or homes may prefer to use agency staff for some staffing needs because of the flexibility agency staff provide them. Use of these staff is quite widespread, though, for each occupation, the majority of homes do not use them in a given 2 week period. The use of agency staff did increase somewhat between 2003 and 2007. For example, 26% of homes used agency RNs and 30% used agency PCs in 2003, while by 2007 the proportions had gone up to 32% and 38% respectively. Although this increase was modest, the proportion of shifts covered by agency and contract RNs rose quite sharply, from 3.5% to 5.7%. Although agency and contract staff did cover more PC shifts in 2007 than 2003, the change was small. These patterns suggest a tightening of the labour market, particularly for RNs, assuming homes prefer not to use agency staff. Perhaps more importantly, the proportion of shifts covered by agency and contract staff remained quite small. It is beyond the scope of this research to suggest what level of agency staff use would constitute a 'crisis' in the supply of residential aged care staff. However, it seems unlikely that the current levels of agency and contract staff use amount to a crisis.

Table 3.38: Use of agency and contract staff, residential aged care

Employee Classification	Proportion of homes that did not use any agency staff during past 2 weeks (%)		Estimated no. of contract staff used during past 2 weeks in all Australian homes	Estimated no. of shifts worked by agency/ contract staff in past 2 weeks in all Australian homes	Average shifts worked per agency/ contract staff member	Estimated proportion of all shifts worked by agency/ contract staff (%)	
	2003	2007				2003	2007
RN	73.5	67.9	4,073	7,974	2.0	3.5	5.7
EN	91.0	85.3	2,448	3,585	1.5	2.3	3.5
PCs	70.2	61.6	12,558	21,261	1.7	3.5	4.0
Allied Health	88.9	87.5	732	2,377	1.5	2.6	2.1

Source: Census of residential aged care homes.

There is considerable interest in whether the labour market pressure in the residential aged care workforce varies by geographic location, and how this has been changing. Levels of use of agency staff may be an index of the difficulties faced by residential homes in recruiting permanent staff. However, changes in the use of agency staff may also arise for other reasons associated with the way work is organised in homes as, for example, if homes prefer the flexibility using agency staff gives them. Our research did not collect data on why homes use agency staff, so we are cautious in interpreting trends.

Although the overall use of agency staff has not increased enormously since 2003, this could mask significant regional variation. Table 3.39 shows that, indeed, the proportion of total shifts that are worked by agency staff does vary significantly across States, as does change since 2003. The situation is complex. With regard to RNs, the proportion of shifts worked by agency staff has grown in all States, except the ACT. However, the increase has been particularly striking in Queensland and Western Australia—in Queensland use of agency RNs increased four-fold between 2003 and 2007, while in Western Australia it nearly doubled. South Australia also shows a significant rise in agency RN use, very comparable to that of Western Australia. On the other hand, Queensland had relatively low agency RN use in 2003. In Victoria and NSW the increases were much more modest, as were the levels of use of agency RNs in 2007. Indeed, even in 2007, about 96% of RN shifts in Victoria and NSW were worked by employees rather than agency staff. In Queensland and Western Australia and South Australia 8–9% of RN shifts were worked by agency staff. There is no doubt that these figures indicate some differences between the latter three States and Victoria and NSW. Table 3.40 adds an important dimension to the picture, indicating that, in general, use of agency RNs is higher in remote and metropolitan areas than in regional or rural ones. Clearly, homes in regional and rural areas are generally able to employ RNs to do the work they require. In fact, use of agency RNs in metropolitan areas is higher than the State averages in Table 3.39 in all States except Tasmania and the Northern Territory. For example, agency RNs perform 10–11% of RN shifts in metropolitan areas of Queensland, South Australia and Western Australia.[18]

Use of agency PCs has increased much less consistently than that of RNs (Table 3.39). The proportion of PC shifts performed by agency PCs hardly changed in the ACT, NSW, South Australia, Tasmania, and Victoria. Variations across these States, from virtually no use of agency PCs in Tasmania to about 2% of shifts performed by them in NSW to nearly 8% in South Australia, are suggestive of differing patterns of work organisation producing differing use of agency staff, rather than sharply different PC labour markets across the States. Only in Queensland and Western Australia were there sharp increases in use of agency PCs. While these rises would be consistent with tighter labour market conditions in these States, due to the mining boom, it is still the case that 92% of PC shifts in Western Australia and 96% in Queensland are performed by employed PCs, rather than agency staff.

Examining the proportion of homes that do not use agency staff adds a further dimension to the picture of how agency staff are used, and how this has changed. Table 3.41 shows that there is variation by State in the proportion of homes using agency RNs. For example, about a quarter of NSW homes use agency RNs, compared to about 45% of those in South Australia. In most States, the proportion of homes using agency RNs has grown slightly since 2003. The exception is Queensland and the Northern Territory where the proportion rose quite sharply. The proportion of homes using agency PCs also increased. Again, there was considerable State by State variation, with a quarter of NSW homes using agency PCs compared to over 60% of those in South Australia and Western Australia. Again, the sharpest increase in the proportion of homes using agency PCs was in Queensland, though there

18 The high levels of agency RN use in remote homes in Table 3.40 refer to a very small number of homes, particularly 7 homes in Queensland and 7 in the Northern Territory.

were also significant increases in South Australia, Victoria, and Western Australia. Overall, the widely differing proportion of homes that make any use of agency staff, and the differences in how this pattern has changed over time, strongly suggest that use of agency staff is heavily affected by patterns of work organisation within homes.

Table 3.39: Estimated percent of total shifts performed by agency staff by State, residential aged care

State	RNs		ENs		PCs		Allied Health	
	2003	2007	2003	2007	2003	2007	2003	2007
ACT	8.1	5.4	0.7	22.5	6.7	5.8	7.1	4.1
NSW	2.0	3.7	0.3	0.2	1.6	1.8	0.7	1.5
Victoria	3.3	4.3	2.2	2.2	4.4	5.0	4.3	1.9
Qld	2.1	8.3	0.3	4.4	0.9	3.6	0.6	1.2
SA	5.4	8.6	7.1	8.5	6.9	7.7	4.7	4.5
WA	5.2	9.2	3.1	6.2	4.8	8.0	4.6	3.4
Tasmania	1.5	2.8	0.0	1.8	0.0	0.3	1.3	0.7
NT	13.8	31.0	2.7	0.0	6.9	3.2	0.0	17.9
Australia	**3.0**	**5.7**	**2.0**	**3.4**	**2.9**	**4.0**	**2.3**	**2.1**

Source: Census of residential aged care homes.

Table 3.40: Estimated percent of total shifts performed by agency staff by location, residential aged care

Location	RNs		ENs		PCs		Allied Health	
	2003	2007	2003	2007	2003	2007	2003	2007
Metro	4.3	6.9	3.7	5.5	4.6	5.7	3.5	2.7
Regional	1.1	4.0	0.3	2.0	0.8	2.0	0.7	1.1
Rural	1.6	2.6	1.2	1.1	0.9	0.5	1.1	0.9
Remote	–	16.3	–	2.8	–	0.2	–	1.6
Total	**3.0**	**5.7**	**2.0**	**3.5**	**3.0**	**4.1**	**2.3**	**2.1**

Source: Census of residential aged care homes.

Table 3.41: Proportion of residential aged care homes using agency RNs and PCs by State (per cent)

State	RNs		PCs	
	2003	2007	2003	2007
ACT	44.4	23.5	50.0	35.3
NSW	19.1	23.6	21.7	25.4
Victoria	25.9	31.9	31.6	45.7
Qld	27.3	44.1	24.1	42.2
SA	44.6	44.8	51.2	64.1
WA	30.3	38.9	48.3	62.3
Tasmania	15.6	21.4	2.2	5.7
NT	40.0	81.8	50.0	63.6
Total	**26.1**	**33.3**	**30.1**	**41.1**

Source: Census of residential aged care homes.

4. The Homes Survey

The homes that employ residential aged care workers vary in significant ways. Understanding the profile of homes, and how they see their workforces is necessary for a rounded picture of the labour market and work opportunities faced by those who work or seek to work in nursing homes and hostels.

4.1 A Profile of Homes

Homes vary in the overall number of high and low care beds they offer, and in their overall size. The 2007 census questionnaire asked homes how many high (RCS 1–4) and low care (RCS 5–8) residents they had. We were also able to merge data from the Department of Health and Ageing (DoHA) on the number of high and low care 'operational aged care places' for which each home was registered. These latter figures represent the places allocated to homes, and do not necessarily reflect the care levels of residents. Because residents often remain in a home as they age and their dependency level increases, they may shift from requiring lower levels of care to higher levels of care. As dependency levels increase, funding is provided in accordance with the requirements of residents, rather than the level of care of an allocated place. Our survey allowed comparison of homes' own assessments of their residents with their operational aged care places. Table 4.1 shows that only 10% of homes said they had no high care residents, and a third said they had no low care residents. By comparison, DoHA data indicated that 45% of homes were registered to have no high care operational places, and 35% to have no low care operational places (Table 4.2). Tables 4.1 and 4.2 show a close match between the distribution of total number of residents and total number of beds. However, as we would expect given ageing in place practices, homes had more high care and less low care residents than the comparable operational places for which they were registered. For example, 65.2% of homes said that they had more than 20 high care residents, while 49.3% were registered as having more than 20 high care operational places. On the other hand, 15.7% said they had more than 40 low care residents, while 34.2% were registered as having this number of operational places.

Measured by the number of residents, homes grew in size somewhat between 2003 and 2007. This occurred mainly through a growth in large homes. The proportion of homes with 21–40 total beds dropped from 32% to 27%, while the proportion with more than 60 beds grew from 30% to 35%. Given the funding pressures on homes, this is not a surprising development.[19]

19 Recent industry surveys indicate the funding pressures currently being felt by homes (e.g., Grant Thornton 2008). The 2004 Review of Pricing Arrangements in Aged Care (Hogan 2004) found significant scale effects in aged care homes, with small homes likely to be particularly inefficient. Thus, it is not surprising that homes tend to consolidate, producing larger average numbers of beds.

Table 4.1: Proportion of all homes with varying high care, low care and total residents

Number of residents	High care residents (% of all homes with indicated no. of high care residents)	Low care residents (% of all homes with indicated no. of low care residents)	Total residents (% of all homes with indicated no. of total residents)	
			2003	2007
None	10.4	32.9	0	0
1–20	24.3	26.6	8.5	7.8
21–40	26.8	24.8	32.1	26.8
41–60	19.5	10.7	29.3	30.6
61+	18.9	5.0	30.1	34.8
Total	**100**	**100**	**100**	**100**

Source: Census of residential aged care homes.

Table 4.2: Proportion of census homes with varying high care, low care and total operational places, 2007

Number of beds	High care places (% of all homes with indicated no. of high care places)	Low care places (% of all homes with indicated no. of low care places)	Total places (% of all homes with indicated no. of total places)
None	44.5	35.1	0
1–20	6.2	10.8	7.4
21–40	18.1	19.9	26.7
41–60	15.6	20.6	30.9
61+	15.6	13.6	35.0
Total	**100**	**100**	**100**

Note: The figures in this table refer to the number of operational places of each type that DoHA records for homes in the census.

Tables 4.3 and 4.4 show the composition of homes according to whether they have low care only, high care only or mixed residents and beds. DoHA data indicates that only a fifth of homes have both high and low care operational places, while home responses suggest that nearly 60% have both high and low care residents. Again, it is clear that homes with only high care operational places also tend to have only high care residents: about the same proportion of homes contain only high care residents and only high care operational places, and the average number of residents in these homes is about the same as the average number of beds in them.

Table 4.3: Distribution and size of homes (residents)

Type of home	Distribution	Average number of residents
Low care residents only	9.1%	43.2
High care residents only	32.0%	55.2
High and low care residents	58.9%	61.5

Source: Census of residential aged care homes.

Table 4.4: Distribution and size of homes (operational places)

Type of home	Distribution	Average number of operational places
Low care places only	44.5%	47.0
High care places only	35.1%	56.9
High and low care places	20.4%	79.2

Note: The figures in this table refer to the number of operational places of each type that DoHA records for homes in the census.

The size and composition of homes, in terms of whether they have high and low care residents and operational places, varies by location. Homes that are more remote from metropolitan regions are progressively more likely to have only low care residents and operational places (Tables 4.5 and 4.6). However, the gap between the kinds of operational places homes have and their residents appears to increase as they become more remote from metropolitan areas. According to DoHA figures, a fifth of metropolitan homes have both low and high care operational places, but 55% of metropolitan homes report having high and low care residents. For remote homes, the gap is much larger, with DoHA figures suggesting only 2% have both high and low care operational places, while 64% of homes have both types of residents.

Metropolitan and regional homes are of approximately the same overall size, and have about the same number of high care operational places and residents. Rural homes are smaller than metropolitan and regional ones, but larger than remote ones. Remote homes are rather small, having an average of about 26 operational places and 28 residents. It is notable that remote homes are the only ones where the average reported number of residents is greater than the average number of operational places as recorded by DoHA.

Table 4.5: Home type (residents) by location

	Metro	Regional	Rural	Remote
% low care residents only	7.9	10.3	10.4	14.5
% high care residents only	36.9	28.8	25.5	21.8
% both low and high care residents	55.2	60.9	64.2	63.6
Mean no. of high care residents	42.4	41.3	24.4	16.3
Mean no. of residents	62.6	63.6	41.1	27.7

Source: Census of residential aged care homes.

Table 4.6: Home type (operational places) by location

	Metro	Regional	Rural	Remote
% low care only	40.6	43.5	51.1	69.6
% high care only	39.2	32.3	30.1	28.6
% both low and high care	20.3	24.2	18.8	1.8
Mean no. of high care places	33.3	30.8	17.1	10.4
Mean no. of beds	64.3	64.9	41.3	26.4

Note: The figures in this table refer to the number of operational places of each type that DoHA records for homes in the census.

There is some variation in the relative preponderance of homes of different kinds across States (Tables 4.7 and 4.8). The Northern Territory has a greater proportion of homes with only high care residents and operational places than any other jurisdiction. It also has a much smaller average home size than elsewhere. The Northern Territory and Tasmania are the only jurisdictions in which the average number of residents per home is significantly greater than the average number of operational places per home registered with DoHA. This difference is particularly dramatic in the Northern Territory, where homes report an average of 39 residents, while DoHA data suggests an average of 30 operational places for these same homes. Homes in NSW, Queensland and the ACT are, on average, significantly larger than those in other States with average operational place and resident numbers around 60 (nearly 75 for the ACT), compared to 50–55 for other States.

The characteristics of homes vary significantly by ownership type (Tables 4.9 and 4.10). For profits are larger than others, and have many more high care residents and operational places. The proportion of homes that are run for profit has also increased slightly since 2003, when 23.9% of homes described themselves as for profit compared to 26.6% in 2007. Homes run by not for profit organizations continue to be the most common, with 63.5% of surveyed homes describing themselves this way. The average number of residents in homes has grown between 2003 and 2007, with the growth being entirely in for profits. In 2003, the latter had an average of 59.2 places compared to 67.7 residents in 2007. Not for profits remained virtually unchanged in size, while publicly owned homes became slightly smaller, declining from an average of 40.8 to 36.4 residents. While in all home types, the average

number of high care residents exceeded the average number of high care operational places from DoHA data, the gap was much larger in not for profits than either of the other ownership types. Thus, DoHA figures showed that not for profits had an average of 20 high care operational places, while these homes reported an average of nearly 33 high care residents.

Table 4.7: Home type (residents) by state

	NT	NSW	Vic	Qld	SA	WA	Tas	ACT
% low care residents only	6.7	8.4	9.6	12.2	7.4	8.2	3.9	10.0
% high care residents only	46.7	36.2	32.9	25.1	35.9	26.0	20.8	25.0
% both low and high care residents	46.7	55.4	57.4	62.7	56.7	65.8	75.3	65.0
Mean no. of high care residents	27.9	41.2	32.6	39.0	38.2	33.9	38.1	48.8
Mean no. of residents	39.4	60.9	52.3	61.4	54.2	52.9	56.9	73.9

Source: Census of residential aged care homes.

Table 4.8: Home type (operational places) by state

	NT	NSW	Vic	Qld	SA	WA	Tas	ACT
% low care only	46.7	45.7	42.9	46.7	39.3	50.0	31.6	61.1
% high care only	46.7	37.4	35.9	32.2	37.9	26.9	36.7	22.2
% both low and high care	6.7	16.9	21.2	21.2	22.8	23.1	31.6	16.7
Mean no. of high care places	18.1	33.4	24.8	28.4	26.7	24.1	26.7	30.1
Mean no. of beds	29.7	62.9	54.3	61.7	54.3	54.9	50.5	73.1

Note: The figures in this table refer to the number of operational places of each type that DoHA records for homes in the census.

Table 4.9: Home type (residents) by ownership

	Not for profit	For Profit	Public
% low care residents only	10.4	5.4	10.5
% high care residents only	22.4	49.2	46.1
% both low and high care residents	67.2	45.4	43.4
Mean no. of high care residents	32.7	52.8	26.0
Mean no. of residents	55.7	67.7	36.4
% of homes	63.5	26.6	9.9

Source: Census of residential aged care homes.

Table 4.10: Home type (operational places) by ownership

	Not for profit	For Profit	Public
% low care only	57.4	17.4	35.6
% high care only	23.8	54.0	56.7
% both low and high care	18.8	28.7	7.7
Average no. of high care places	19.9	49.8	24.4
Average no. of beds	56.2	70.8	37.4
% of homes	61.1	27.2	11.7

Note: The figures in this table refer to the number of beds of each type that DoHA records for homes in the census.

The distribution of direct care staff across locations, States and home types largely reflects the distribution of homes and beds (Table 4.11). In 2007, Victoria and NSW, the most populous States, together accounted for 60% of direct care employees, a slight fall since 2003. Queensland was the only State to significantly increase its share of direct care workers, with the proportion rising from 15.8% to 17.4%. The other significant shift evident in Table 4.11 is an increase in the proportion of staff employed by for profit homes. In parallel with the increasing average size of these homes relative to others, their share of direct care staff increased from 29% in 2003 to 33% in 2007. More than half of direct care staff are employed in homes that say they have a mix of high and low care residents. However, only just over a quarter are in homes that are registered with DoHA as having both types of operational places.

Table 4.11: Total employment by location, state, home type and ownership (per cent)

		Percent of total employees		Percent of all direct care employees	
		2003	2007	2003	2007
Location	Metropolitan	52.7	53.9	53.7	54.5
	Regional	22.4	25.5	22.6	26.3
	Rural	24.9	19.3	23.8	18.1
	Remote		1.3		1.1
State	NT	0.3	0.4	0.4	0.4
	NSW	31.2	31.6	32.1	31.8
	Vic	30.4	27.9	29.4	28.6
	Qld	16.1	18.0	15.8	17.4
	SA	9.3	9.9	9.7	9.9
	WA	7.6	7.9	7.8	8.0
	Tas	3.6	3.4	3.1	3.0
	ACT	1.5	0.9	1.5	0.9
Home type (residents)	Low care residents only		5.3		5.0
	High care residents only		36.8		38.7
	High and low care residents		58.0		56.2
Home type (places)	Low care places only		30.0		28.4
	High care places only		41.2		42.9
	High and low care places		28.7		28.7
Ownership Type	Not-for Profit	64.5	60.0	61.6	58.4
	For Profit	26.1	31.4	28.9	33.0
	Public	9.4	8.6	9.5	8.6

Source: Census of residential aged care homes.

4.2 Homes' Relationships with Larger Groups and the Provision of Community Based Care

Many residential aged care homes have formal relationships with other organisations, as parts of larger groups or being co-located and/or co-managed with other homes. With respect to co-location and co-management, the 2003 research showed that most publicly owned homes are co-located and co-managed with other homes (presumable mostly hospitals). However, this pattern was much less common amongst other ownership types. In the 2007 census, we asked whether homes were a part of a larger group. Nearly three quarters said they were (Table 4.12), with only small differences in the likelihood of being part of a larger group by ownership type.

Table 4.12: Proportion of residential homes that are part of larger group by ownership type (per cent)

	Not for profit	For Profit	Public	All
Per cent part of larger group	74.4	70.6	68.6	72.9
Per cent not part of larger group	25.6	29.4	31.4	27.1

Source: Census of residential aged care homes.

The relationship between residential and community based care for the aged is an increasingly important one, with strong policy emphasis on increasing the availability of community based services. Table 4.13 shows that about 13% of all residential homes also provide community based care. This provision is almost entirely by not for profit and public homes; only 3% of for profit homes provide both residential and community based care. A related issue is whether staff members work in both community based and residential provision, when this is available. Table 4.14 shows that the pattern is different for PCs compared to other occupations. It is unusual for RNs, ENs, or Allied Health to work in both residential and community based provision, when homes provide both. Indeed, 70–80% of homes providing both forms of service say that none of their workers in these categories work in both areas. However, it is much more common for homes to use some of the same PCs across residential and community based care. Just over half of those that provide both forms of care say that some PCs work in both areas, and 30% say that more than one in ten of their PCs do so.

Table 4.13: Proportion of residential homes providing community based care by ownership type (per cent)

	Not for profit	For Profit	Public	All
Per cent providing community based care	16.7	2.8	19.4	13.3
Per cent not providing community based care	83.3	97.2	80.6	86.7

Source: Census of residential aged care homes.

Table 4.14: Proportion of residential homes where direct care staff work in both residential and community provision, where both are provided

Proportion of staff working in residential and community	RNs	ENs	PCs	Allied Health
None	69.9	76.4	46.9	77.0
Some, 10% or less	14.7	11.7	22.7	14.1
More than 10%	15.3	12.0	30.4	8.9

Source: Census of residential aged care homes.

4.3 Ethnic Specialisation and Ethnicity of Direct Care Workers

Some homes cater for particular ethnic or cultural groups. In 2007, 17% of homes indicated that they did this, compared to 10% in 2003. Of those that catered to particular groups, 78% said they employed staff with particular language or cultural knowledge to assist in their cultural or language goals. In a small number of homes, the employment of staff with such abilities leads to more than two thirds of PCs being able to speak a language other than English—11% of homes fell into this category. However, three quarters of homes said that less than one third of their PCs were able to speak a non-English language, including about a third where no PCs had this ability.

Amongst homes catering for specific ethnic or cultural groups, the most common focus is on Italian background residents, with a focus on Indigenous Australians being the second most frequent (Table 4.15). Together, these two specializations represent one third of all homes with specializations.

Table 4.15: Proportion of homes catering for specific ethnic or cultural groups that specialise in specific groups (per cent)

Ethnic Group	Per Cent Specialising
Italian	18
Aboriginal	14
Chinese	5
Greek	7
Dutch	5
Polish	4

Source: Census of residential aged care homes.

As a measure of the concentration of non-English speaking background PCs in residential homes, we focus on homes that say that more than one third of their PCs speak a language other than English. Homes were asked which was the most common ethnic or cultural group amongst their PCs who speak a non-English language. Table 4.16 shows

that Philippinos are the group most likely to be identified in this way, followed by 'Asians' unspecified and Chinese. This indicates that in homes with more than one third of PCs who speak a language other than English, over a third identify PCs from Asian countries as the largest group. Interestingly, nearly 10% identify PCs from African countries in this way. Compared to the 2003 data, these figures suggest little change in the use of Asian background PCs, but an increase in those from African backgrounds and a decline in some European background concentrations. It is also notable that very few homes indicate a concentration of indigenous PCs, despite the quite high proportion identifying themselves as focusing on indigenous residents.

Table 4.16: Most common ethnic origin of PCs in homes with more than one third of PCs speaking a non-English language

Ethnic Group	Per cent of homes
Philippino	16
Asian	12
Chinese	9
African	9
Italian	5
Greek	3
Fijian	3
Aboriginal and Torres Strait Islander	1
Dutch	1

Source: Census of residential aged care homes.

Note: This table shows the proportion of homes that name the ethnic or cultural group listed as the most common non-English speaking one of PCs in the home. It includes only homes that say that more than 30% of their PCs are from non-English speaking backgrounds.

Another perspective on direct care workers' ethnic and cultural knowledge is provided by questions in the workers' survey asking whether respondents speak a language other than English, and whether they use it in their jobs. Nearly 30% of PCs speak a language that is not English, as do about a quarter of nurses and Allied Health workers (Table 4.17). Nearly half of PCs who are non-English speakers use this ability in their jobs, with non-English speaking nurses and Allied Health workers being slightly more likely to do so. Overall, then, 12–15% of direct care workers speak a language other than English, and use it in their jobs. About the same proportion are non-English speakers who do not use their ability in their jobs.

Table 4.17: Proportion of residential aged care workforce who speak a language other than English, and who use it in their jobs

	Nurses	PCs	Allied Health	Total
Speak a language other than English (per cent)	24.9	29.4	23.6	27.7
Use language in job (per cent of those who speak a language other than English)	52.3	46.7	62.6	49.1

Source: Survey of residential aged care workers.

Homes do sometimes employ staff for their ability to speak a language other than English, and staff do use their language abilities. However, as we have seen, this is not always the case, and language ability was not always behind the employment of staff whose first language was not English. Whatever the reason for the employment of these staff, homes were asked whether language problems amongst PCs cause difficulties. One third of all homes said that having PCs whose first language is not English caused some difficulties. Table 4.18 indicates that in about three quarters of the homes that experienced problems, the difficulties were in a range of communications—with management and other staff, with residents and with residents' families. In about half of the homes experiencing difficulties, there were problems related to occupational health and safety. A much smaller proportion, about a fifth, reported problems in written communication. These results do not tell us about the severity of these difficulties.

Table 4.18: Presence and type of difficulties caused by having PCs whose first language is not English

	Percent of homes
No difficulties	66.5
Some difficulties	33.5
Occupational health and safety	46.7
Communication with mgmt and/or other staff	71.6
Communication with residents	79.9
Communication with residents' families	69.9
Other—written communication	20.0

Source: Census of residential aged care homes.

4.4 Vacancies

Vacancy rates are an important indicator of the state of labour markets. The 2003 research concluded that vacancy rates in residential aged care homes indicated that homes were not facing huge problems in recruiting staff. The strongest indicator of difficulties was in recruiting RNs, where the proportion of homes with vacancies was higher than for other occupations, given the small number of RNs employed by homes. In general, the 2007 data shows increasing difficulty in recruiting staff, as would be expected given the strong performance of the Australian labour market between 2003 and 2007 (Table 4.19). Despite the decline in total employment of RNs in residential homes, the proportion of homes with RN vacancies increased slightly, from about 26% to 31% across the period. This is a small change, though, in the context of the overall fall in RN employment, it points to increasing difficulty in hiring RNs. Vacancy rates for ENs also increased somewhat, but again the change was small, and the EN vacancy rates remained lower than those for RNs and PCs. The largest change in vacancy patterns was for PCs. The proportion of homes with PC vacancies rose from 23% to 31%, with the proportion having more than 3 vacancies increasing by a half from 8% to 12%. Although these changes do suggest that homes have increasing difficulties recruiting PCs, it remains the case that nearly 70% had no PC vacancies at the time of the census.

Table 4.19: Proportion of aged care homes with varying number of EFT vacancies, by occupation (per cent)

Number of EFT vacancies	RNs		ENs		PCs		Allied Health		All direct care occupations	
	2003	2007	2003	2007	2003	2007	2003	2007	2003	2007
None	74.3	68.7	89.2	82.3	76.7	68.6	93.7	93.3	62.6	50.5
1 or less	15.8	19.5	6.3	10.1	9.2	11.4	4.6	5.1	13.3	14.8
More than 1 to 2	5.8	7.1	2.2	4.1	6.1	8.3	1.0	0.9	7.7	10.4
More than 2	4.1	4.7	2.2	3.5	7.9	11.7	.7	0.7	16.4	24.3

Source: Census of residential aged care homes.

The amount of time taken to fill vacancies is the single most important indicator of the state of a labour market. When there is ample supply of workers who can satisfy employers needs, the time taken to fill vacancies is usually short, while labour supply shortages typically produce significant delays in filling positions as employers search for suitable workers. Data on time taken to fill vacancies was collected for the first time in the 2007 survey of aged care homes. The amount of time taken to fill vacancies in residential aged care homes varied significantly between occupations (Table 4.20). If we take 2 weeks as a reasonable minimum time to fill vacancies, EN, PC and Allied Health vacancies appear to be equally easy to fill. Nearly 70% of homes' most recent vacancies in each of these occupations were filled within 2 weeks (slightly less for ENs workers). Recruiting new RNs generally takes much longer than recruiting other direct care workers. Less than half of RN vacancies are filled within 2 weeks,

and nearly 40% take more than a month to fill[20] (compared to 20% of EN vacancies, 10% of PC vacancies and 19% of Allied Health vacancies). Although Allied Health vacancies are usually filled quickly, a few seem to cause homes great difficulty, with 9% taking more than 6 months to fill. The time it takes to find a suitable RN is a clear indicator that it is this group that is in particularly short supply.

Table 4.20: Weeks taken to fill last vacancy, residential aged care homes

Number of weeks taken to fill last vacancy	RNs	ENs	PCs	Allied Health
Less than 1	24.5	45.9	20.8	52.1
1	6.6	7.2	21.8	8.0
2	11.8	11.3	26.0	9.3
3 to 4	18.8	16.2	21.6	12.1
5 to 8	16.2	10.5	6.8	5.5
9 to 12	10.0	3.8	1.7	2.4
13 to 26	7.5	3.2	1.1	1.9
More than 26	4.7	2.0	0.3	8.8

Source: Census of residential aged care homes.

Variation in the balance between labour supply and demand in the aged care industry is of considerable interest. As the single most useful indicator of this balance, the time taken to fill vacancies is particularly important. Table 4.21 shows that the length of vacancies does vary by State, though the variation is generally modest. In most States about 40% of RN vacancies are filled quickly, within 2 weeks, with NSW and Tasmania showing higher proportions. Overall, about 38% of RN vacancies take more than one month to fill, indicating that many homes do experience real difficulty in finding RN staff. Most States conform quite closely to this average. However, in Queensland and the Northern Territory, significantly more RN vacancies were open for over 4 weeks (49% and 67% respectively). Overall, these patterns confirm a tight national labour market for RNs, with particular difficulties in Queensland and the Northern Territory.

20 The Commonwealth Department of Employment, Education and Workplace Relations conducts a Survey of Employers who Recently Advertised (SERA) which includes employers advertising for RNs (in all health areas, not only Aged Care). This survey collects data from employers on how long advertised vacancies take to fill. Its results are not strictly comparable with ours, since our survey asked how long a home's most recent vacancy took to fill, irrespective of whether it was advertised or not. Thus, vacancies that were not advertised, but filled by informal mechanisms such as word of mouth or walk-ins would be included in our survey, but not in DEEWR's. On this basis, we would expect our survey to find shorter vacancy lengths than DEEWR's insofar as vacancies filled through informal means are likely to be filled more quickly. In its labour market reports, DEEWR regards vacancies open for more than 6 weeks as indicative of problems in the RN labour market. The 2007 SERA found the proportion of vacancies filled within this period to vary significantly by State. In Victoria, 75% were filled within 6 weeks, compared to 65% in Tasmania, 58% in NSW, 51% in Queensland and 22% in South Australia (DEEWR 2008). Thus, aside from the anomalous South Australian result, between half and three quarters of advertised RN vacancies are filled within 6 weeks according to SERA. Our results are in line with DEEWR's findings, especially given that our results cover all vacancies, not just those advertised. Thus, on this evidence, aged care RN vacancies do not appear to be much more difficult or easier to fill than those for RNs as a whole occupation. DEEWR regards the RN market as suffering from 'shortages' in all States (except Western Australia where it does not provide an estimate).

PC vacancies are generally more likely to be filled quickly than RN vacancies, with nearly 70% being filled within 2 weeks. Vacancies in Western Australia are somewhat less likely to be dealt with this quickly, though still 60% are filled within 2 weeks. Far fewer PC vacancies than RN vacancies remain open for more than 4 weeks, with about 10% of PC jobs remaining unfilled after this time. There is some State by State variation, with the extremes being represented by Victoria, where 6% of PC vacancies remain open for more than 4 weeks and Tasmania where 16% take over 4 weeks to fill. Remotely located homes face particular difficulties in recruiting PCs, with nearly a quarter of PC vacancies remaining open for over a month in these locations.

Table 4.21: Weeks taken to fill most recent RN and PC vacancies by State, residential aged care homes (per cent)

	2 weeks or less	More than 4 weeks
RNs		
ACT	50.0	8.3
NSW	49.8	32.3
Victoria	40.4	39.4
Qld	37.8	48.5
SA	38.8	38.4
WA	39.9	35.4
Tasmania	46.8	38.7
NT	33.3	66.7
Total	**42.9**	**38.3**
PCs		
ACT	75.0	12.5
NSW	70.4	10.1
Victoria	71.3	6.2
Qld	66.2	10.4
SA	66.5	12.0
WA	60.0	14.0
Tasmania	69.1	16.2
NT	64.3	7.1
Total	**68.6**	**9.8**

Source: Census of residential aged care homes.

Table 4.22: Weeks taken to fill most recent RN and PC vacancy by location, residential aged care homes (per cent)

	2 weeks or less	More than 4 weeks
RNs		
Metropolitan	41.6	38.0
Regional	45.0	36.0
Rural	42.3	41.3
Remote	50.0	43.2
Total	**42.8**	**38.4**
PCs		
Metropolitan	68.5	9.8
Regional	72.0	7.8
Rural	66.2	10.5
Remote	58.3	22.9
Total	**68.6**	**9.8**

Source: Census of residential aged care homes.

4.5 Occupational Health and Safety

Caring for the aged and infirm can be mentally and physically demanding work, and injuries on the job can be problems for workers and for those managing homes. Table 4.23 shows that over one third of homes had at least one PC on Workcover in the pay period before the census. Homes were much less likely to have nurses or Allied Health workers on Workcover. These results accord with reports of injuries from the staff survey. Some 1.9% of RNs and Allied Health workers and 2.5% of ENs reported having sustained an injury at work that has resulted in having at least one day off work during the 4 weeks before the survey. The equivalent proportion for PCs was much higher, at 4%.

Table 4.23: Number of staff in homes on workcover during last pay period (per cent)

Number	RNs	ENs	PCs	Allied Health
None	95.2	93.5	66.1	97.5
1	4.4	5.6	21.7	2.1
2	0.3	0.8	7.2	0.3
3 or more	0.0	0.2	5.1	0.1

Source: Census of residential aged care homes

5. The Community Based Aged Care Workforce

Community based care is provided to older Australians in their own homes under a range of government programs, some Commonwealth and some Commonwealth–State. The workforce that provides care through these programs cannot be identified in existing statistics or data. The research reported in this chapter represents the first attempt to systematically describe this workforce. Where appropriate, we compare the community based workforce to the residential aged care workforce described in Chapter 3 and 4, and to the Australian female labour force (91% of the community based workforce is female).

5.1 Total Employment and Main Workforce Characteristics

5.1.1 Total Employment

Estimating total employment in community based aged care from our surveys is difficult because of significant uncertainties about the number of in-scope service outlets, and the number represented by responses to our census (see Chapter 2). We estimate numbers using the assumptions about these matters that we find most plausible. However, we have less confidence about the accuracy of our estimates of these total numbers for the community based workforce than we do in those for the residential workforce. This uncertainty relates only to estimates of total numbers of employees, not to proportions, which are the main focus of this chapter. It should also be remembered that our estimates and survey relate only to service outlets and employees providing services under the Commonwealth supported programs described in Chapter 2. While these are certainly the bulk of community based services, they are not all of them.

Our estimates of the number of direct care workers employed to provide community based aged care under the abovementioned programs, and the total number of employees of organizations providing community based care, are based on the same procedures as our estimates for the residential aged care workforce. Our best estimate is that about 87,500 people are employed by these organizations, of whom about 85% are direct care workers. As we show below, most direct care workers work part-time, with the result that the number of equivalent full-time (EFT) direct care employees is less than the number of individuals employed as direct care workers—we estimate that there are about 46,000 EFT direct care workers providing community based care. To our knowledge, there are no existing estimates of the size of this workforce to which our estimates can be compared. However, comparison with the residential aged care workforce is relevant. Our estimates indicate that the community based direct care workforce in aged care is a little over half the size of the comparable residential aged care workforce. The two workforces are very similar in the ratio of EFT to total direct care employees, though the average community based worker does work a slightly higher proportion of a full-time job than a residential based one. Thus, community based workers on average are employed at 0.62 EFT, while residential workers are employed at 0.59 EFT.

It is worth emphasising that these estimates relate to community care workers who are directly employed by service outlets. Community care workers who are not directly employed by service outlets also provide services under the programs covered by our surveys. These workers may be agency staff, sub-contractors or self-employed contractors to outlets, or they may work under other brokered arrangements. While our surveys did provide some indications of the number of staff and shifts worked by agency staff, sub-contractors and self-employed workers (see Section Section 5.6 below), they do not cover brokered services. We do not have a reliable basis for estimating how much service is provided through such arrangements, though estimates from industry informants suggest it is unlikely to be more than a quarter. Given the nature of services, it is unlikely that the characteristics of workers who are employed under brokered arrangements would be significantly different than those covered by our services.

Table 5.1: Estimated total community based employment in aged care

Total employees	Total direct care employees	Total equivalent full-time direct care employees
87,478	74,067	46,056

Source: Census of service outlets.

5.1.2 Occupation

Providers of community based direct care are overwhelmingly Community Care Workers (CCWs), the equivalent of Personal Carers in residential aged care *homes*. Table 5.2 shows that the picture of the distribution of the community based care workforce across the main direct care occupations is much the same from the census of employers (outlets) and the survey of workers. The workforce survey indicates that 83% of direct care workers are CCWs, while the returns from outlets put the proportion at 82%. Both surveys indicate that 10% of direct care workers are RNs and 5% are Enrolled Nurses. Enrolled Nurses make up a tiny 2.5% of direct care workers in the community based sector. Because RNs usually work a higher proportion of an EFT appointment, they make up a slightly higher proportion of EFT workers than they do of persons employed. But CCWs still constitute 78% of the EFT direct care workforce. This is much higher than is the case in residential *homes*, where PCs are about 64% of workers and the same proportion of EFT workers. The lack of ENs in community based care is also a sharp difference from residential provision, where ENs makes up 12% of workers and about the same proportion of EFTs.

Table 5.2: Distribution of the community based aged care workforce, and new hires, by occupation (per cent)

	Data from Employees		Data from Outlets	
Occupation	Whole workforce	New hires	Number of persons	Equivalent full-time
Registered Nurse	10.2	10.6	10.2	13.2
Enrolled Nurse	2.4	2.4	2.7	2.6
Community Care Worker	82.6	81.8	81.8	77.8
Allied Health	4.8	5.1	5.3	6.4
Total number			**74,067**	**46,056**

Source: Census of service outlets and survey of community based workers.

5.1.3 Employment Arrangements and Hours Worked

The types of employment contracts on which workers are employed are affected both by the state of labour markets and how work is organised. More than half of all direct care workers in the community sector are employed on permanent part-time arrangements. About one third of RNs and Allied Health workers are employed on permanent full-time contracts, though only 7% of CCWs are employed this way. For RNs and Allied Health workers these are much higher rates of full-time employment than in the residential sector, where 16% of RNs and 10% of Allied Health workers are employed full-time. A substantial proportion of CCWs, nearly one third, is employed on a casual or contract basis. However, less than 15% of RNs and Allied Health workers are employed this way. Compared to the residential sector, casual or contract employment is much more likely for CCWs than for PCs, but less likely for RNs and Allied Health workers. Community care work seems to organised around a core of more highly skilled staff (RNs and Allied Health workers), with the bulk of the caring work being done by CCWs whose pattern of employment contract allows outlets the flexibilities associated with greater use of casuals.

As was the case in the data from residential *homes* and residential workers in aged care, there is something of a contradiction between outlet responses and workers responses in relation to the hours of work of direct care workers. As Table 5.4 shows, outlet responses indicated that 35% of direct care workers work no more than 15 hours per week. In contrast, 17% of respondents to the workers' survey said they worked 1–15 hours per week. We think the outlet responses provide the more reliable figures, for the same reasons we believe that residential home figures are more reliable in the residential workforce. Irrespective of which figures we believe, it is clear that a greater proportion of community based carers work short part-time hours (1–15 hours per week) than is the case in residential care. This is entirely due to CCWs being much more likely than PCs to work short hours. Thus, for example, based on employer responses, 37% of CCWs work between 1 and 15 hours per week, compared to 22% of PCs in residential homes. Overall, somewhat more CCWs than PCs work part-time, though in both areas more than three quarters are part-time workers. On the other hand, nurses and Allied Health workers are much more likely to work full-

time hours in the community based sector than in the residential sector—34% and 32% of nurses and Allied Health workers respectively work full-time in the community based sector, compared to 23% and 17% in the residential sector. This pattern conforms to the picture suggested above of a core of higher skilled workers on more permanent contracts working near full-time hours, with a substantial group of care workers working shorter, more flexible hours as needs arise.

Table 5.3: Nature of employment contract of community based aged care workers (estimated total number and per cent)

Employment Contract	Registered Nurse	Enrolled Nurse	Community Care Worker	Allied Health workers	Total
Permanent full-time	2,532 (33.5)	475 (24.1)	4,488 (7.4)	1,344 (34.1)	8,838 (11.9)
Permanent part-time	3,994 (52.9)	1,044 (52.9)	36,751 (60.6)	2,107 (53.5)	43,896 (59.3)
Casual or Contract	1,029 (13.6)	455 (23.0)	19,361 (31.9)	489 (12.4)	21,334 (28.8)
Total employees	**7,554 (100)**	**1,974 (100)**	**60,600 (100)**	**3,940 (100)**	**74,067 (100)**

Source: Census of service outlets.

Note: Estimated total numbers are the estimated total number of workers in each category employed to provide aged care by community based outlets. Thus, we estimate that altogether, outlets employ 2,586 Registered Nurses, on permanent full-time contracts. The numbers in brackets are per cent of total number in each occupational group. Thus 33.5% of Registered Nurses are employed on a permanent full-time basis.

Table 5.4: Distribution of hours worked per week, community based aged care workforce, by occupation (per cent)

Hours worked per week	Respondent	Nurse	CCWs	Allied Health	Total
1–15	Workers response	6	19	14	17
	Outlet responses	23	37	28	35
16–34	Workers response	45	64	50	61
	Outlet responses	42	48	41	47
35–40	Workers response	40	15	31	19
	Outlet responses	33	13	31	16
>40	Workers response	9	2	5	3
	Outlet responses	1	1	1	1

Source: Census of service outlets and survey of community based workers.

Note: Data are derived from two different sets of survey respondents. One is the randomly selected workforce. The other is outlets providing community based aged care (i.e., the managers thereof).

Recently hired direct care workers in the community sector tend to work slightly shorter hours than the whole workforce (Table 5.5). The somewhat higher proportion of new hires working short part-time hours (1–15 hours per week) is probably because some employers give new workers short hours until the employers have confidence in the workers, especially if they are employed on a casual basis.

Many workers indicate they would like to work longer hours. Table 5.5 shows that 21% of direct care workers in our sample say they currently work full-time hours (35 hours or more per week), while 29% say they would like to work these hours. A more direct indicator of unused capacity in the community based aged care workforce is in Table 5.6, which shows what proportion of our sample says they would like to work more or less hours. Less than 10% would like to reduce their hours, with most wanting to reduce by less than 10 hours per week. By contrast, 42% would like to increase their hours, with 19% wanting an additional 6 or more hours per week. This is a significantly higher proportion of workers wishing to increase hours than in the residential sector where 28% of direct care workers wanted to work longer hours. If workers were able to work their preferred hours, total hours worked would increase by about 8%, while if only those who wished to increase their hours did so, total hours would increase by about 11%.

Table 5.5: The distribution of hours worked, and hours preferred, community based aged care workforce, by new hires and by the Australian female workforce (per cent)

Hours per week	Hours actually worked		Hours desired to work		Australian workforce
	Whole workforce	Recent hires	Whole workforce	Recent hires	Australian female workforce
1–15	17	23	12	12	19
16–34	61	56	59	60	36
35–40	19	19	27	25	29
>40	3	3	2	3	16
Total	**100**	**100**	**100**	**100**	**100**

Source: Survey of community based workers and, for the Australian data, ABS Labour Force Australia (Detailed Electronic Delivery) catalogue no. 6291.0.55.001 ST EM1, October 2007.

Table 5.6: Preferred change in hours, community based aged care workforce, (per cent)

Desired change in hours	Per cent of employees wishing to work this number
10+ hours less	3.5
1–9 hours less	7.6
No change in hours	47.3
1–5 hours more	23.1
6–10 hours more	12.6
11+ hours more	6.0

Source: Survey of community based workers.

The number of hours worked in single blocks by community based carers is an important aspect of their work experience. Especially for casual workers, employers sometimes organise rosters so that employees may work for several short blocks in a day or week. Community based carers were asked about the shortest block of time they worked in a single day in the week prior to the survey. As Table 5.7 shows, less than 10% of nurses worked any blocks that were shorter than 5 hours, while for over 80% the shortest block was more than 6 hours. Allied Health workers showed a similar pattern, with more working a 5 or 6 hour block than nurses. CCWs showed a quite different pattern. One fifth had shortest blocks of 2 hours or less, while just over half sometimes worked 4 or less hours in at least one day during the past week. These results strongly suggest that part-time CCWs tend to work for 4 hours or less per day on all or most days each week, rather than working a full day on a few days per week. Again, this pattern is consistent with a CCW workforce that is organised to provide considerable flexibility for service outlets.

Table 5.7: Shortest blocks worked by community based care workers (per cent)

Block (hours)	Nurse	CCWs	Allied Health	Total
2 or less	1.8	20.5	1.1	17.3
3 or 4	5.9	31.9	5.9	27.5
5 or 6	8.8	25.4	18.4	23.1
7 or more	83.5	22.2	74.6	32.2
Total	**100**	**100**	**100**	**100**

Source: Survey of community based workers.

Many service outlets that provide care to the elderly also provide services to the younger disabled and others. An aspect of work organization that impacts on the supply of specialized workers and the experience of work is the extent to which each direct care worker provides services to each of these groups. We asked workers what proportion of the clients were aged. More than half of CCWs have only aged clients, as do more than a third of nurses and Allied Health workers (Table 5.8). Even

amongst workers who have some clients who are not aged, there is a strong tendency to have predominantly aged clients. In other words, direct care workers who provide assistance to the aged tend to do the vast majority of their work with the aged, especially if they are CCWs, even though many provide a small amount of assistance to other clients.

Table 5.8: Proportion of clients of community based aged care workers who are aged (per cent)

Percentage of clients who are aged	Nurse	CCWs	Allied Health	Total
Less than 50%	2.2	3.0	1.9	2.8
50–89%	31.0	13.3	20.3	16.0
90–99%	30.3	29.3	41.5	30.1
100%	36.5	54.4	36.3	51.1
Total	**100**	**100**	**100**	**100**

Source: Survey of community based workers.

5.1.4 Age

The age structure of the community based aged care workforce is essential information for workforce planning. We have already seen that the residential aged care workforce is relatively old. Table 5.9 shows that the community based workforce has an older age structure than the residential one. Some 70% of community based care workers are aged 45 or older, with 29% being 55 or older (compared to 60% and 23% respectively in the residential workforce). This pattern of an older workforce is even more marked amongst CCWs compared to other workers; 72% of CCWs are 45 or older, and 30% are 55 or older (compared to 60% and 25% of nurses). Those recently hired by service outlets tend to be much younger than the whole workforce, with only 40% being 45 or older. However, recruitment of workers under 35 is still limited, even compared to recruitment of these workers in the residential sector. For example, 22% of recently hired community based aged care workers are under 35 compared to 34% of recently hired residential aged care workers.

Table 5.9: Age of the community based aged care workforce (per cent)

Age	Whole workforce	Recent hires	Australian female workforce
16–24	2.0	6.5	18.9
25–34	7.7	15.9	21.1
35–44	20.4	27.4	23.3
45–54	40.7	32.6	23.2
55–64	26.7	16.3	11.8
Over 64	2.5	1.4	1.7
Total	**100**	**100**	**100**

Source: Survey of community based workers.

5.1.5 Country of Birth

As in the residential aged care sector, the community based direct care workforce is frequently called upon to care for people born outside Australia, with diverse backgrounds. Direct care workers with the same backgrounds as their clients may be able to provide more culturally appropriate care. In some comparable societies, migrants themselves are also an important source of direct care workers, independent of their contribution to caring for those whose backgrounds are the same as their own. Although overseas born workers make up an important part of the direct care workforce, nearly three quarters of direct care workers in the community based aged care sector were born in Australia (Table 5.10). This is a slightly smaller proportion than the 80% of all Australian women workers born in Australia. Of those born outside Australia, another 12% were born in English speaking countries (New Zealand, the UK or South Africa). Compared to the residential aged care workforce, community based carers are more likely to be from non-English speaking European countries, and less likely to be from Asian ones. However, workers born in these countries are a small minority of both workforces. The slightly higher proportion of new hires born outside Australia may indicate a small increase in the importance of migrants as a labour supply for these jobs.

Table 5.10: Country of birth, community based aged care workforce (per cent)

Country of Birth	Whole workforce	Recent hires	Australian workforce
Australia	73.3	69.0	79.8
New Zealand	3.4	3.4	3.1
UK, South Africa	8.5	9.2	8.3*
Italy, Greece, Germany, Netherlands	3.1	3.2	1.9
Vietnam, HK, China, Philippines	2.3	2.8	3.4†
Poland	1.1	0.8	1.2‡
Fiji	0.3	0.7	0.9#
India	0.4	0.5	1.4
Other	7.7	10.1	0.0£
Total	**100**	**100**	**100**

Source: Survey of community based workers and, for Australian data, ABS Labour Force Australia (Detailed Electronic Delivery) catalogue no. 6291.0.55.001 ST LM6, October 2007.

** Figure includes 'UK, Ireland' and 'Sub-Saharan Africa'*

† Figure includes 'Vietnam', 'China (excluding SAR's and Taiwan Province) and the 'Philippines'

‡ Figure includes 'Rest of Southern and Eastern Europe'

 # Figure includes 'Rest of Oceania and Antarctica'

£ Figure includes 'Other' rather than the remaining ABS 'Country of Birth (detailed)' categories

5.1.6 Health

As noted in Chapter 4, self-rated health is a widely recognised indicator of people's actual health. As shown in Table 5.11, the community based direct care workforce has a pattern of self-rated health that is very similar to that of the residential aged care workforce. Nearly two thirds of workers rate their health as 'excellent' or 'very good', with almost all the remainder describing it as 'good'. Overall, these direct care workers see their health as somewhat better than does the whole Australian workforce. There is little difference in the self-rated health of recently hired workers compared to the whole community based direct care workforce.

Table 5.11: Self-assessed health, community based aged care Workforce (per cent)

Self-assessed health	Whole workforce	Recent hires	Australian workforce
poor	0.3	0.0	4.4
fair	5.0	3.8	11.3
good	28.5	28.7	27.8
very good	46.8	46.4	35.4
excellent	19.4	21.1	21.0

Source: Survey of community based workers.

5.1.7 Education

The education and training of the community based workforce are important indicators of their skill and potential for future skill development. Table 5.12 shows that nearly 40% of community based aged care workers had completed Year 12 or its equivalent, with about half of recent hires having achieved this level. These levels of achievement are slightly lower than amongst residential aged care workers, as we might expect given the older age structure of the community based workforce compared to the residential one. Ongoing education was quite common in the community based workforce, with some 16% of the whole workforce and 23% of recently hired workers studying at the time of the survey. This is an impressive proportion, especially given the age structure of the workforce, and it indicates both workers' and their employers' commitment to skill development.

Table 5.12: Highest level of pre-tertiary education, community based aged care workforce (per cent)

Highest level of schooling	Whole workforce	Recent hires	Australian female workforce
Did not go to school	0.0	0.0	1.1
Year 8 or below	4.1	3.5	10.5
Year 9 or equivalent	6.8	4.7	8.4
Year 10 or equivalent	34.9	27.0	26.7
Year 11 or equivalent	15.2	15.5	10.8
Year 12 or equivalent	38.9	49.3	42.5
Total	100	100	100
Currently Studying	15.8	22.8	

Source: Survey of community based workers.

In aged care work, as in most other vocations, most training that is directly vocationally relevant is obtained after completing school. Our main source of information about community based aged carers' vocational skills is their post-secondary qualifications. In general, nurses in the community aged care sector have qualifications appropriate to their positions (Table 5.13). Over half have bachelor degrees in nursing, and nearly one quarter have other basic nursing qualifications. Only 6% of nurses say they have no post-secondary qualifications. Allied Health workers too appear to be appropriately qualified—only 5% have no post-school qualifications, and nearly half have a bachelor's degree in an area other than nursing, while another 10% have a certificate qualification in a non-aged care area.

The majority of CCWs in our survey had a post-secondary qualification related to their jobs. Nearly half have the Certificate III in Aged Care, and nearly a fifth have the Certificate III in Home and Community Care. More than half of those holding the latter qualification also have the former. The result is that 54% of CCWs have either one or both of these Certificates. Relevant Certificate IV qualifications are relatively rare, with a total of 11% of CCWs holding at least one of these awards (only a few CCWs hold more than one of them). Data from service outlets provide another perspective on Certificate III and 4 qualifications amongst CCWs. Service outlets were asked to specify the number of their CCWs who hold a relevant Certificate III and Certificate IV. Overall, these responses indicate that 59% hold relevant Certificate IIIs and 11% hold relevant Certificate IVs. These figures are quite consistent with those from the workers survey, especially for the prevalence of Certificate IVs. Overall, CCWs in community based aged care are a little less likely to hold a relevant Certificate III or 4 than are PCs in residential aged care homes. Nevertheless well over half do hold these qualifications.

CCWs are also different from PCs in being much more likely to hold post-secondary qualifications unrelated to their aged care work. Thus, whereas about 14% of PCs hold such qualifications, one quarter of CCWs have them. These other qualifications cover a range of areas—4% of CCWs have bachelor degrees in non-nursing areas, 5% have Diplomas in

non-nursing or aged care areas, and 4% have administrative or business qualifications. This pattern is undoubtedly partly a reflection of the fact that this is an older workforce with considerable life experience. It indicates that service outlets are drawing CCWs from a wide range of backgrounds and experiences. Given the relatively short hours some CCWs work, this may mean that a significant proportion of CCWs are not very strongly attached to the labour market

Table 5.13: Post-school qualifications of the community based aged care workforce, by occupation (per cent)

Post-school qualification	Nurse	CCWs	Allied Health	Total
No post-school qualifications	6.0	23.9	5.3	20.8
Certificate III in Aged Care	6.5	48.3	16.0	41.5
Certificate III in Home and Community Care	0.9	18.2	6.7	15.5
Certificate IV in aged care	2.1	6.2	6.7	5.7
Certificate IV/diploma in enrolled nursing	24.5	3.9	1.3	6.3
Certificate IV in Service Coordination (Ageing and Disability)	0.3	2.2	1.3	1.9
Bachelor degree in nursing	53.9	1.1	0.9	7.8
Other basic nursing qualification	22.9	4.6	4.9	6.9
Post basic nursing qual in aged care	13.0	0.5	0.4	2.1
Post basic nursing qual not in aged care	28.3	0.9	0.0	4.3
Other	19.6	25.0	75.1	26.8

Source: Survey of community based workers.

Note: Because staff can have more than one qualification, the totals do not sum to 100.

5.2 The Main Characteristics of the Work

5.2.1 Shifts and Shift Preferences

Unlike residential aged care work, most community based care takes place during the day. This is reflected in the fact that the vast majority of community based aged care employees work regular daytime rosters or shifts (Table 5.14). CCWs are the occupation most likely to work another shift type, with a quarter not working on a regular daytime basis. Irregular shifts are the most common pattern amongst this latter quarter of CCWs, with a total of 14% working on such arrangements. Given the dominance of regular daytime shifts amongst community based care workers, it is not surprising that very few workers wish to change their shift arrangements.

Table 5.14: Actual and desired work patterns, community based aged care workforce (per cent)

Work schedule	Nurse		CCW		Allied Health	
	Actual	Desired	Actual	Desired	Actual	Desired
Regular daytime roster/shift	84.2	2.7	75.4	4.9	95.9	1.4
Regular evening roster/shift	1.1	0.3	0.9	0.3	0.0	0.0
Regular night roster/shift	1.3	0.0	0.5	0.1	0.0	0.0
Rotating roster/shift (changes from days to evening to nights)	6.6	7.7	3.2	0.5	0.0	0.0
Split roster/shift (two distinct periods each day)	0.5	0.3	3.4	0.2	0.0	0.0
On call	0.5	0.0	0.8	0.1	0.5	0.5
Irregular schedule, between 9–5	1.8	0.3	7.6	0.1	2.3	0.0
Irregular schedule, outside of 9–5	1.3	0.0	1.2	0.0	0.0	0.0
Irregular schedule, anytime	2.4	0.0	6.5	0.0	0.9	0.0
Other	0.2	1.5	0.5	0.3	0.5	0.9
No change		86.9		93.5		97.3
Total	**100**	**100**	**100**	**100**	**100**	**100**

Source: Survey of community based workers.

5.2.2 Terms of Employment

As discussed in Chapter 3 in relation to residential aged care workers, the type of contract on which workers are employed is often taken as an indicator of the strength of the labour market, although exactly how patterns should be interpreted is sometimes a matter of debate. This is especially so where most workers are women, as in the direct care aged care workforce. Table 5.15 confirms the patterns noted above (section 5.1.2) that the community based aged care workforce has quite high levels of casual employment compared to the residential workforce. About a quarter of CCWs and 18% of nurses in our sample were employed on casual contracts, much higher than in our residential sample where the level was around 8–10%. Only Allied Health care workers in the community sector have such low levels of casual employment. Data from outlet providers suggest somewhat higher levels of casual employment, particularly for CCWs, with outlet responses indicating that nearly one third work casually or on contracts. Whatever the exact figure, it is clear that a substantial minority of CCWs are employed casually. As we have already suggested, this is indicative of a workforce that is employed in ways that provide considerable flexibility, perhaps to both employers and employees

Table 5.15: Terms of employment, community based aged care workforce (per cent)

Terms of employment	Nurse	CCWs	Allied Health	Total
Casual	17.5	25.4	7.6	23.5
No paid sick leave	17.8	26.0	8.4	24.1

Source: Survey of community based workers.

5.2.3 Job Tenure

As we outlined in Chapter 3, job tenure is an important indicator of the state of a labour market. Short tenure means that employers face a large task of recruiting and, often, training new workers, and also suggests that workers are frequently finding jobs less attractive than they had hoped. In community based aged care, the recruitment task facing employers appears to be substantial, with service outlets indicating that about a quarter of their direct care staff have been in their jobs for less than one year. This means that, on average, outlets must replace a quarter of their staff every year. The recruitment task does not vary substantially between occupations, though nurses are slightly less likely to have less than one year's tenure than other occupations, and more likely to have been in their jobs for more than 5 years. While these job tenure patterns suggest quite high employee turnover, they are almost identical to those amongst residential aged care workers.

Table 5.16: Tenure in current job, community based aged care workforce (per cent)

Tenure in current job	RNs	ENs	CCWs	Allied Health	Total
Less than 1 year	22.5	24.5	25.2	22.6	24.8
1 to 5 years	36.9	42.0	51.1	50.2	49.5
6 or more years	40.6	33.5	23.7	27.2	25.7
Total	**100**	**100**	**100**	**100**	**100**

Source: Census of community based outlets.

5.2.4 Wages

Workers' attachment to their jobs is linked to how much they earn in them. Workers who earn substantial sums are likely to depend heavily on their wages to support themselves and their families. On the other hand, when weekly earnings are low, workers may have less stake in maintaining their employment, especially if their household is not heavily dependent on their wages. The weekly earnings of nurses in community based aged care are very similar to those for nurses working in residential aged care. Some 60% earn between $500 and $1,000 per week, and about a quarter earn more than this, with very few earning more than $1,500 per week (Table 5.17). Allied Health workers in community based jobs earn less than nurses, but more than their colleagues in residential care jobs, in line with their greater likelihood of being employed full-time compared to those working

in residential homes. CCWs present a different picture, especially compared to PCs. More than half of CCWs earn $500 or less per week, compared to about 31% of PCs in residential homes. CCWs' quite low earnings are consistent with the substantial proportion who work short part-time hours. We might reasonably expect that CCWs working short hours and earning these low weekly pay packets will be less strongly tied to their jobs than those working longer hours and earning more.

Table 5.17: Weekly wage in current job, community based Aged care workforce (per cent)

Weekly wage($)	Nurse	CCWs	Allied Health	Total
1–500	13.7	55.7	33.5	49.8
501–1000	59.6	42.5	51.9	44.9
1001– 1500	24.2	1.7	14.6	4.9
1501–2000	1.7	0.1	0.0	0.3
2000+	0.8	0.0	0.0	0.1
Total	**100**	**100**	**100**	**100**

Source: Survey of community based workers.

5.3 Career Paths

Understanding the career paths of direct care workers is essential to understanding the labour markets on which they find jobs, as we have already noted with respect to aged care workers in the residential sector. We have the same data about career paths for community based workers as we did for residential workers, and we examine it in the same way as we did for residential workers.

Community based direct care workers had often worked in aged care before beginning their current job. Three quarters of nurses, nearly two thirds of Allied Health workers and half of CCWs were experienced in aged care work before the jobs they had at the time of our survey (Table 5.18). Nevertheless, community based service outlets are recruiting many of their employees from amongst workers with no previous aged care experience. This is particularly striking for CCWs, half of whom had not worked in aged care before their current jobs.

Unpaid and voluntary work is an important precursor for CCWs and Allied Health workers in community based aged care. Our data shows that 11% of CCWs and 9% of Allied Health workers had done unpaid or voluntary work in aged care before their current job. Since, for many, this will not be their first job, it is likely that a higher proportion of these groups had done unpaid work in aged care before obtaining their first paid job.

Table 5.18: Proportion of community based aged care workers who had worked in aged care prior to their current job (per cent)

Had worked in aged care before	Nurse	CCWs	Allied Health	All direct care workers
Yes, paid	72.7	40.0	59.2	45.1
Yes, unpaid/voluntary	1.9	10.9	9.0	9.7
No	25.4	49.1	31.8	45.2
Total	**100**	**100**	**100**	**100**

Source: Survey of community based workers.

As we outlined in Chapter 4, workers' prior relationships with employers can be an important aspect of the operation of labour markets, assisting the smooth filling of vacancies. While the majority of community based workers had not worked for their current employer before beginning the job, a significant minority had a previous relationship with the outlet (Table 5.19). This was particularly marked amongst nurses and Allied Health workers, of whom about 35% had worked for the outlet before their current job. Nearly one quarter of CCWs also had such experience. Overall, community based workers were somewhat more likely than residential workers to have previously worked for their current employer, particularly if they were nurses or Allied Health workers. Again, there is evidence of unpaid or voluntary work being a route into paid work in the community sector. Nearly one third of CCWs and Allied Health workers who had previously worked for their current employer had done so in an unpaid job.

These patterns do suggest that, as in the residential care sector, some community based workers move in and out of jobs quite flexibly, whether circulating between service outlets or moving in and out of the paid labour force. Moreover, the rehiring of workers known to outlets is likely to assist in the substantial recruitment task faced by a group of employers who replace about a quarter of their workers every year.

Table 5.19: Proportion of community based aged care workers who had worked for their current service outlet before obtaining their current job (per cent)

Had worked for service outlet previously?	Nurses	CCWs	Allied Health	All direct care workers
No	64.7	76.9	65.8	74.8
Yes, paid work	34.0	15.6	24.0	18.3
Yes, unpaid or volunteer work	1.2	7.0	9.8	6.4
Yes, paid and unpaid work	0.2	0.6	0.4	0.5
Total	**100**	**100**	**100**	**100**

Source: Survey of community based workers.

Although many aged care workers had quite short tenure in their current jobs, most had considerable experience working in aged care. Nearly 90% of nurses, more than 60% of CCWs and nearly three quarters of Allied Health workers had worked for 5 years or more in aged care (Table 5.20). Nurses tended to be particularly experienced in the field, with just over half having worked in aged care for a total of 15 years or more (compared to 18% of CCWs and a quarter of Allied Health workers).

Table 5.20: Total years for which community based direct care workers have worked in aged care (per cent)

Years working in aged care	Nurses	CCWs	Allied Health	All direct care workers
1 or less	5.0	11.7	10.3	10.7
2–4	7.9	27.8	17.9	24.8
5–9	22.2	28.4	25.1	27.5
10–14	12.3	14.2	20.6	14.3
15–19	12.3	8.6	12.6	9.3
20 or more	40.3	9.3	13.5	13.5
Total	**100**	**100**	**100**	**100**

Source: Survey of community based workers.

The community based aged care workforce is a relatively old workforce, with a substantial proportion of workers being aged 45 or older. Unsurprisingly, the vast majority had been in other paid work before beginning their aged care jobs (Table 5.21). Nurses had almost always been nurses in other settings. However, CCWs had a wide range of occupational backgrounds. Just over 10% had been carers in other settings before beginning aged care work. Some 45% had been in one of several routine service work occupations dominated by women (Salespersons, clerical workers, hospitality workers or cleaners). About 20% of CCWs had worked in professional (including nursing) or managerial jobs before their aged caring careers began. Allied Health workers had less disparate backgrounds, with over 40% having worked as professionals in other settings before moving to aged care; but a quarter had been in a routine service occupation.

As we have already noted, turnover in the community based aged care workforce is quite high, with about a quarter of workers departing every year. Understanding the reasons for this turnover is important for workforce planning. Table 5.22 shows the main reasons workers had left their last job in aged care prior to their current one. It shows that a substantial proportion of resignations arose because of the demands of workers' non-work lives and responsibilities, in ways that their employers could not accommodate. Thus, nearly 30% of CCWs said that they had left their previous aged care job to fulfil care responsibilities, because they relocated their home, or to be closer to their home. Some 43% of nurses had moved for these reasons, and so had 30% of Allied Health workers. Seeking better basic working conditions—higher pay or better hours or shifts—was also important, with 23% of nurses, 16% of CCWs and 13% of Allied Health workers moving for one of these reasons.

The fact that 20% of nurses had changed jobs to achieve better hours or shifts is particularly notable. A minority of respondents cited other job issues as the most important reason for their resignation. These included the lack of challenging work, limited time with clients, the difficulty of the work, and poor workplace relationships.

Table 5.21: Occupation of community based aged care workers before first aged care job, by occupation (per cent)

Current Age	Nurse	CCWs	Allied Health	All direct care workers
No previous paid employment	5.5	7.0	7.3	6.8
Nurse in other setting	81.7	5.8	2.7	15.6
Carer in other setting	1.9	12.0	8.6	10.5
Salesperson	2.6	10.1	5.0	8.8
Clerical worker	1.7	18.1	15.0	15.8
Hospitality worker (waitress, etc.)	1.4	9.0	5.5	7.8
Cleaner	0.0	8.1	0.9	6.7
Professional (other than nurse	1.2	6.9	43.2	7.9
Manager	1.9	6.9	3.2	6.1
Other paid employment	2.2	16.2	8.6	14.0
Total	**100**	**100**	**100**	**100**

Source: Survey of community based workers.

Workers who leave aged care altogether may not give the same reasons for resigning as those who move to other aged care jobs. Indeed, it seems likely that the proportion of all resignations that occur because workers seek to fit their paid jobs with their non-work lives will be higher than shown in Table 5.22. But other reasons for turnover that place workers permanently outside the aged care workforce (e.g., occupational injuries) will not be evident from asking those who return to aged care work about the reasons for their resignation. As in the case of residential aged care workers, exit interviews may be illuminating here.

The age at which aged care workers begin their careers in the field is of particular concern because the workforce is older than the Australian workforce. If aged care workers begin work in the field at more mature ages, then continued recruitment at these older ages is likely to ameliorate the effects of ageing on this workforce. We have already seen that this is the case for the residential aged care workforce. Table 5.23 shows that there is a clear pattern of beginning aged care work later in life amongst community based workers. Most dramatically, 58% of CCWs first worked in aged care at the age of 40 or older, with only 18% beginning before they turned 30. CCWs typically begin aged care work at much more advanced ages than PCs, 39% of whom had begun aged care work at 40 or older. Nurses and Allied Health workers typically begin their aged care careers at much younger ages than CCWs, with profiles that are very similar to those for these groups in residential homes.

Table 5.22: Most important reason for leaving previous aged care job, community based aged care workers (per cent of those with previous aged care experience)

Most important reason	Nurse	CCWs	Allied Health	All direct care workers
To fulfil care responsibilities (including having a baby)	15.9	13.3	16.4	14.0
To find more challenging work	10.8	14.2	22.7	14.0
Other: Relocated/moved/migrated	8.7	13.8	7.0	12.4
To be closer to home	16.5	11.4	7.8	12.2
To get shifts or hours of work I wanted	20.3	9.5	7.0	11.5
The job was too stressful	7.7	5.7	3.1	5.9
To achieve higher pay	2.3	6.6	6.3	5.8
Not able to spend sufficient time with clients	2.3	4.7	1.6	4.0
To avoid managers or management I did not get along with or like	2.1	3.5	5.5	3.4
Other: Redundant/retrenched/contract finished/home closed	1.8	2.6	3.9	2.5
To find easier work	1.8	2.3	0.8	2.1
To avoid workmates or colleagues I did not get along with or like	1.0	1.7		1.4
Other: Study	0.0	0.6	3.1	0.7
Other	8.7	10.2	14.8	10.2
Total	**100**	**100**	**100**	**100**

Source: Survey of community based workers.

Note: Categories above that begin with 'Other:' were not explicitly offered to respondents in the question; they are a summary of common responses written in to an unspecified 'other' category in answers.

Table 5.23: Age at which community based Direct Care workers began working in aged care (per cent)

Age	Nurse	CCWs	Allied Health	All direct care workers
21 or under	23.4	8.3	12.5	10.4
22–29	23.9	9.4	25.9	12.0
30–39	25.8	24.5	25.0	24.7
40–49	23.6	36.5	22.3	34.2
50+	3.2	21.3	14.3	18.7
Total	**100**	**100**	**100**	**100**

Source: Survey of community based workers.

Do workers who start working in aged care at earlier ages tend to spend longer working in the field? If they do, then the recruitment of older workers will increase the turnover of workers into and out of the industry. We saw that residential aged care workers who begin working in aged care at younger ages do not necessarily spend longer in the field. There are similar patterns amongst the community based aged care workforce. There are only small differences in average years worked in aged care whether nurses and Allied Health workers began their aged care careers in their 20s, 30s or 40s (Table 5.24).[21] Similarly, CCWs have much the same overall experience in aged care whether they began working in the field in their 20s or 30s. However, CCWs differ from nurses and Allied Health workers in showing a larger proportion fall in average aged care experience when workers begin work in their 40s or 50s compared to earlier ages. As we have seen, most CCWs begin aged care work in their 40s or 50s, and these workers tend to have much shorter aged care experience than those who began working in the field earlier. Although there is a similar pattern amongst PCs in residential care, the effect is less significant overall because they tend to begin aged care work at younger ages than community based carers. The result is that overall PCs have an average of 9.1 years of aged care experience compared to CCWs' average of 8.0 years.

Table 5.24: Mean years of working in aged care, by age at which community based aged care workers began working in aged care, by occupation

Age at which began working in aged care	Nurses	CCWs	Allied Health	All direct care workers
21 or under	17.9	13.2	12.7	14.5
22–29	14.1	11.0	9.8	11.6
30–39	13.8	9.5	11.8	10.2
40–49	11.9	6.9	8.9	7.4
50+	7.8	4.8	6.6	4.9
Total	**14.2**	**8.0**	**10.0**	**8.9**

Source: Survey of community based workers.

Note: this table shows, for instance, that nurses who began working in aged care at age 21 or less have spent an average of 17.9 years working in aged care overall. It also indicates that the average number of years all nurses had worked in aged care was 14.2 years.

By examining variation over time in the age at which aged care workers began their aged careers, it is possible to assess whether workforce ageing is likely to be a particular problem in this older workforce. If the pattern has always been for these workers to begin their careers later in life, then the relatively old age structure of the workforce probably reflects this pattern, rather than a more problematic ageing of this particular workforce. CCWs appear to have always begun their aged care careers at older ages (Table 5.25). There is very little difference in average age of commencement in aged care for CCWs who began working in the field between 2004 and 2007, compared to those who began in 1999–

21 The results in Table 5.23 need to be interpreted with some caution, since they show only workers who are currently working in aged care, and therefore do not indicate the final totals years spent in aged care by those beginning aged care work in each age group. In particular, changes over time in the age at which workers begin their career will affect these final total achieved career lengths.

2003.[22] Those who began careers between 1989 and 1998, and are still working in aged care, began at a younger age. However, this will not be an accurate indicator of the age of commencement of all CCWs who began work in those years because those who were older when they began are more likely to have left aged care by 2007. There are no indications that Allied Health workers are becoming older at commencement either. However, the average age of nurses who began working in community based aged care jumped by nearly 7 years in the 2004–2007 period compared to the 1999–2003 period.

For the bulk of the community care workforce, CCWs, the interpretation of these results is unequivocal and comforting. The relatively old age structure of the current CCW workforce is a reflection of the fact that most CCWs begin their aged care careers late in life, as they have always done. Ageing of this workforce explains very little of the current age structure.

Table 5.25: Mean age at which current community based aged care workers began working in aged care, by year in which began aged care work, by occupation

First year in aged care	Nurses	CCWs	Allied Health	All direct care workers
1988 or before	27.1	27.1	27.3	27.1
1989–1998	32.9	38.7	37.1	37.8
1999–2003	31.2	43.2	38.9	42.0
2004–2007	37.9	44.1	35.3	43.5
All years	**30.3**	**40.2**	**34.7**	**38.7**

Source: Survey of community based workers.

Note: this table shows, for instance that RNs who began working in aged care before 1988 were, on average, 27.1 years old when they began working in aged care.

5.4 How Staff Feel About Their Work

From our 2003 and 2007 surveys of the residential aged care workforce we now have a useful picture of how direct care staff in the residential sector feel about their work. In this section, we examine comparable data from the community based workforce.

5.4.1 Doing the Work

Community based aged care workers are employed primarily to deliver services to clients. Whether they feel they are able to spend enough time with each care recipient is likely to be a crucial factor in their sense of achievement and satisfaction in their jobs. Over 70% of the workers who deliver most of the care, CCWs, say that they are able to spend enough time

22 The figures in Table 5.20 should be interpreted with caution. Because they are based on responses from the current workforce, they do not indicate the average age of all aged care workers who began work in the designated periods. Insofar as workers who were older when they first began working aged care were more likely to have left the workforce before 2007, the figures will be more inaccurate for earlier periods than later ones. In particular, the apparently younger age of recruitment of workers who began working in aged care before 1989 will be largely due to this effect.

with clients. Nurses are much more likely to be equivocal on this score, while Allied Health workers are more positive. These results are vastly different from those for residential care workers, where only about a quarter of direct care workers felt they were able to spend enough time with care recipients. In short, community based carers, especially CCWs and Allied Health workers, generally find that their work is organised so that they can spend the time they need to with each client.

Table 5.26: Responses of the community based aged care workforce to the question "I am able to spend enough time with each care recipient" by occupation (per cent)

Response	Nurse	CCWs	Allied Health	Total	New hires Total
Disagree	37.6	14.0	26.3	17.6	18.2
Neither agree nor disagree	19.7	14.3	15.6	15.0	12.1
Agree	42.7	71.8	58.0	67.4	69.7

Source: Survey of community based workers.

One important reason that CCWs say they are able to spend enough time with each client is that just over 70% spend more than two thirds of their time in direct care work (Table 5.27). In comparison, only a quarter of nurses and 41% of Allied Health workers spend this much of their day in direct care. CCWs experience is in contrast to that of PCs, 55% of whom say they spend more than two thirds of their time in direct care. In this respect, we could expect that CCWs will be happier with their jobs, and therefore more committed to them, than PCs, all other things being equal.

Table 5.27: Responses of the community based aged care workforce to the question "In a typical shift, how much time do you spend actively caring for care recipients?" By occupation (per cent)

Time spent caring	Nurse	CCWs	Allied Health	Total
Less than a third	23.9	14.6	17.3	15.9
Between one third and two thirds	48.6	13.9	41.8	19.6
More than two thirds	27.6	71.6	40.9	64.5
Total	**100**	**100**	**100**	**100**

Source: Survey of community based workers.

Pressure to work harder may make workers feel stressed and uncommitted to their jobs, especially if they feel unable to do the work adequately because of time pressure. On this score, the experience of CCWs seems to be much more positive than that of nurses or Allied Health workers in the community based sector. Two thirds of CCWs do not feel under

pressure to work harder, compared to 38% of nurses and 45% of Allied Health workers. CCWs' experience is much more positive than PCs on this score too, with only 36% of PCs saying they do not feel under pressure to work harder.

Table 5.28: Responses of the community based aged care workforce to the questions "I feel under pressure to work harder in my job" by occupation (per cent)

Response	Nurse	CCWs	Allied Health	Total	New hires Total
Disagree	37.7	67.3	45.5	62.6	39.6
Neither agree nor disagree	18.5	14.7	16.5	15.3	21.0
Agree	43.8	18.0	37.9	22.1	39.4
Total	**100**	**100**	**100**	**100**	**100**

Source: Survey of community based workers.

Whether workers feel they have the skills they need to do their jobs, and whether they are able to use their skills in their jobs, are both important aspects of the workplace experience. Community based aged care workers overwhelmingly feel positive in both of these areas—they have the skills they need, and they are able to use them in their jobs (Tables 5.29 and 5.30). There is little difference between occupations on these matters. In feeling that they have appropriate skills and that they can use them, community based aged carers are no different from their colleagues who work in residential homes.

Table 5.29: Responses of the community based aged care workforce to the question "I have the skill I need to do my job" by occupation (per cent)

Response	Nurse	CCWs	Allied Health	Total	New hires Total
Disagree	1.2	2.0	3.1	2.0	2.6
Neither agree nor disagree	1.5	4.2	4.9	3.9	7.8
Agree	97.3	93.8	92.0	94.1	89.6
Total	**100**	**100**	**100**	**100**	**100**

Source: Survey of community based workers.

Table 5.30: Responses of the community based aged care workforce to the question "I use many of my skills in my current job" by occupation (per cent)

Response	Nurse	CCWs	Allied Health	Total	New hires Total
Disagree	3.6	3.1	5.3	3.3	4.3
Neither agree nor disagree	5.1	6.3	8.0	6.2	9.4
Agree	91.4	90.6	86.7	90.5	86.4
Total	**100**	**100**	**100**	**100**	**100**

Source: Survey of community based workers.

The extent to which workers feel they have control over aspects of how they do their work is an important contributor to their general satisfaction with their jobs, and their overall wellbeing at work. It also affects their likelihood of remaining in their jobs. More than 70% of community based age care workers are likely to see themselves as having a lot of freedom to decide how to do their work, irrespective of their occupation (Table 5.31). In many respects this is not a surprising result since these workers do most of their work without direct supervision in clients' homes. Comparing community based workers' responses with those of residential home workers shows that the former are much more likely to feel this work autonomy than the latter. The difference is particularly dramatic if we compare CCWs and PCs—71% of the former compared to 49% of the latter agree with the statement "I have a lot of freedom to decide how I do my work".

Table 5.31: Responses of the community based aged care workforce to the question "I have a lot of freedom to decide how I do my work" by occupation (per cent)

Response	Nurse	CCWs	Allied Health	Total	New hires Total
Disagree	15.6	13.1	5.3	13.1	12.8
Neither agree nor disagree	8.1	15.7	12.4	14.5	13.7
Agree	76.3	71.2	82.2	72.4	73.5
Total	**100**	**100**	**100**	**100**	**100**

Source: Survey of community based workers.

While work autonomy is an important positive aspect of workers' experience, job stress is an equally important negative experience. Overall, the community based workforce does not show a high level of job stress, though nurses are more likely to feel stress than other workers, particularly CCWs. Indeed, it is notable that nearly two thirds of CCWs reject the statement that their job is more stressful than they had ever imagined. Again, there is a sharp contrast with residential care workers where, for example, only 37% of PCs reject this statement.

Table 5.32: Responses of the community based aged care workforce to the question "My job is more stressful than I had ever imagined" by occupation (per cent)

Response	Nurse	CCWs	Allied Health	Total	New hires Total
Disagree	42.4	63.6	54.8	60.5	71.0
Neither agree nor disagree	23.0	15.7	19.0	16.8	12.9
Agree	34.6	20.7	26.2	22.8	16.1
Total	**100**	**100**	**100**	**100**	**100**

Source: Survey of community based workers.

Recognition of workers' efforts and achievements beyond pay is important in any area of work. Affirmation of the value and importance of their work provides rewards that are important to most workers, beyond the compensation represented by pay and formal employment conditions. In community care work, where much of the work is done in clients' homes in isolation from other workers and supervisors, this aspect of workers' experience is likely to be particularly important, and potentially problematic. In fact, community care workers appear to feel well recognised for their work, especially if they are CCWs (Table 5.33). Three quarters of the latter agree with a statement that they receive the respect and acknowledgement they deserve. Even amongst nurses and Allied Health workers, less than a quarter feel that they are not respected or acknowledged appropriately. Interestingly, nurses and Allied Health workers in the residential sector gave similar responses, however PCs were significantly less likely to feel recognised than CCWs. Again, this suggests that CCWs are more likely than PCs to experience their work positively.

Table 5.33: Responses of the community based aged care workforce to the question "Considering all my efforts and achievements, I receive the respect and acknowledgement I deserve" by occupation (per cent)

Response	Nurse	CCWs	Allied Health	Total	New hires Total
Disagree	23.1	11.7	21.3	13.6	12.0
Neither agree nor disagree	19.7	12.4	18.7	13.7	11.8
Agree	57.2	75.9	60.0	72.8	76.2
Total	**100**	**100**	**100**	**100**	**100**

Source: Survey of community based workers.

5.4.2 Workplace Relationships

Workplace relationships, those amongst employees and between employees and managers, have an important impact on work experience, workers' morale and commitment, and, ultimately, workers' inclination to stay in their jobs. As we have already noted, much of the day to day work done by community based age carers is in clients' homes and in isolation from other workers and managers. In this context, relationships with management and with other employees may have heightened significance. CCWs are very likely to say that relationships between workers and managers in their workplaces are good, with 80–85% describing them this way (Tables 5.34 and 5.35). Allied Health workers too usually regard these relationships positively. A somewhat smaller proportion of nurses is prepared to affirm positive relationships (Table 5.34), though 70% still describe the relationships as good. For nurses and Allied Health workers, these results are similar to those for residential aged care workers. However, CCWs are much more likely to be positive about worker/management relationships than PCs (even though around two thirds of PCs describe them positively).

Table 5.34: Responses of the community based aged care workforce to the question "Management and employees have good relations in my workplace" by occupation (per cent)

Response	Nurse	CCWs	Allied Health	Total
Disagree	16.0	9.7	19.6	11.0
Neither agree nor disagree	27.6	10.5	13.3	12.8
Agree	56.5	79.8	67.1	76.2
Total	**100**	**100**	**100**	**100**

Source: Survey of community based workers.

Table 5.35: Community based aged care workforce assessment of quality of relationships between managers and workers by occupation (per cent)

Response	Nurse	CCWs	Allied Health	Total
Bad	6.7	6.3	14.0	6.7
Neither Good nor Bad	22.4	8.6	15.4	10.6
Good	70.9	85.1	70.6	82.7
Total	**100**	**100**	**100**	**100**

Source: Survey of community based workers.

When it comes to relationships between workmates and colleagues, the community based aged care workforce is overwhelmingly positive, with over 90% seeing these relationships as 'good'. There is little difference between occupations here, though, if anything, nurses are the most positive group on this score. While residential aged care workers were also likely to

be positive on this aspect of their workplaces too, they were not so emphatic as community based carers (just under 80% of residential care workers said these relationships were good).

Table 5.36: Community based aged care workforce assessment of quality of relationships between workmates/colleagues by occupation (per cent)

Response	Nurse	CCWs	Allied Health	Total
Bad	1.2	2.6	1.8	2.4
Neither Good nor Bad	2.9	6.4	8.0	6.0
Good	95.9	91.0	90.2	91.6
Total	**100**	**100**	**100**	**100**

Source: Survey of community based workers.

5.4.3 Job Satisfaction—The Conditions of Work

Job satisfaction is an important indicator of workers' subjective responses to their jobs, having effects on their likelihood of staying in their positions, and their commitment to their work. Community based carers were asked the same questions about job satisfaction as residential carers, and we analyse the results in the same way as for the residential aged care workforce (see Section 3.3.3 above). Again, we focus on the average score on a scale ranging from 0 ('totally dissatisfied') to 10 ('totally satisfied'), in which higher scores indicate greater satisfaction. A score of 5 on this scale can be taken as meaning a worker is neither satisfied nor dissatisfied with an aspect of his/her job.

Pay is the area in which community based aged carers are least satisfied with their jobs (Table 5.37), although just over half of respondents did express some level of satisfaction with their pay. Allied Health workers were the least satisfied with pay. CCWs were much more satisfied with pay than PCs in residential homes (with averages of 5.4 and 4.0 respectively on pay satisfaction). Nurses and Allied Health workers employed by community based outlets were also somewhat more satisfied than their residential aged care counterparts (averages of 5.3 compared to 4.8, and 4.7 compared to 4.4 respectively). Overall, pay satisfaction amongst the community based aged care workforce is quite low compared to the broader Australian female labour force, though it is greater than that of the residential direct care workforce.

Community based carers are generally happy with their job security, with CCWs having the highest level of satisfaction. CCWs' satisfaction on this score is significant, given the indicators of flexibility in their employment arrangements noted above. Even though CCWs are more likely than PCs to be on casual contracts, to work short hours, and to have low weekly earnings, their satisfaction with job security is slightly higher than that of PCs (average of 7.4 compared to 7.1). Overall, though, there are only small differences in satisfaction with job security between occupations, and between the community based workforce and the residential workforce.

Our job satisfaction questions provide strong evidence that CCWs gain considerable satisfaction from caring for the elderly. Their satisfaction with the 'work itself' is very high, with some 91% expressing some level of satisfaction with this aspect of their work, and a quarter declaring themselves 'totally satisfied' with it. Although PCs too are highly content with their work, their satisfaction does not reach the levels of CCWs. Nurses and Allied Health care workers in community based outlets also like the work they do, though they are not as emphatic as CCWs.

Given the short hours worked by many community based carers, it is illuminating to examine satisfaction with their hours of work and with the flexibility their jobs offer for balancing their work and non-work lives. Although not quite as satisfied with their hours of work as with some other aspects of their jobs, workers are nevertheless generally happy with their work hours. This is one area where residential workers tend to be slightly more satisfied than community based workers, though the differences are so small as to be of little consequence. CCWs, however, are somewhat happier with the flexibility their jobs offer them than with the hours themselves. Their shorter hours and more flexible work arrangements appear to fit well with their non-work lives, noticeably better than those of PCs (whose average score on this job score item is 7.1 compared to CCWs' 7.9).

Community based carers clearly feel that their jobs give them opportunities to develop their abilities. As in many other areas, they tended to be slightly more satisfied than their counterparts in residential aged care. This suggests an environment in which workers' skills and skill development are valued and supported.

Support from workers' teams or service providers is likely to be particularly important to them in jobs where much of their work is done alone, as is the case in community based age care. It is therefore encouraging that those who do most of this work, CCWs, have very high satisfaction with this aspect of their work. Some 88% have some level of satisfaction with it, and 31% are 'totally satisfied'. Nurses and Allied Health workers are happy with this support too, but not as enthusiastic as CCWs. Again, although PCs in residential homes are generally happy with this aspect of their work, they are not as emphatic as CCWs.

Finally, the overall job satisfaction of community based direct care workers largely reflects the patterns we have described to this point. CCWs are quite emphatically satisfied with their jobs, some 91% expressed satisfaction at some level on this overall indicator, while 55% place themselves in one or other of the two most satisfied categories (i.e., 'totally satisfied' or one point below this on a 10 point scale). Indeed, CCWs are significantly more satisfied overall with their jobs than nurses or Allied Health workers, although the latter are generally satisfied. Moreover, CCWs are, again, much more emphatically satisfied than PCs. On the other hand, Allied Health workers are less satisfied overall in the community sector than in the residential sector (with averages of 7.3 and 7.8 respectively).

Table 5.37: Average job satisfaction scores, various dimensions of job satisfaction, community based aged care workforce, by occupation

Satisfaction with:	Nurse	CCWs	Allied Health	Total	New hires Total
Total pay	5.31	5.41	4.65	5.36 (6.94)	5.24
Job security	7.16	7.43	6.92	7.37 (8.07)	7.07
Work itself	7.24	8.03	7.39	7.90 (7.61)	7.75
Hours of work	7.10	7.22	7.37	7.21 (7.29)	6.71
Opportunity to develop abilities	7.08	7.35	6.65	7.29	7.20
Support from team	6.90	8.00	7.02	7.81	7.92
Work / Non-work flexibility	7.21	7.94	7.08	7.80 (7.55)	7.69
Overall job satisfaction	7.33	8.10	7.28	7.97 (7.72)	7.76

Source: Survey of community based workers.

Note: Figures in this table are average (mean) scores on a job satisfaction scale ranging from 0 ('totally dissatisfied') to 10 ('totally satisfied'). Thus higher scores represent greater satisfaction. Figures in brackets are averages for the Australian female workforce from the 2006 wave of the Household and Income Labour Dynamics (HILDA) survey.

We have already seen that the turnover levels for community based aged carers are quite high, comparable to those in residential aged care homes. Existing workers' intentions over the next 12 months and 3 years provide further insight into their likely future in aged care work. About 83% of community based aged carers say they expect to be working for their current service outlet in 12 months, with 86% of CCWs and 68% of nurses giving this response. CCWs are also the most likely occupational group to expect to be working in aged care 3 years from the survey (Table 5.38). Half of CCWs expect to be working solely in community based aged care, with a total of two thirds anticipating that they will be doing aged care work of some kind. In fact, if we only consider CCWs who say they *do* know what they will be doing in 3 years, nearly 90% expect to be working in some form of aged care. CCWs who intend to be working in aged care in 3 years are most likely to expect to be working for a community based outlet only. However, a significant minority, about one fifth of those positively expecting to continue working in aged care, think they will work in residential homes in 3 years. In contrast, less than 10% of PCs who expected to be working in aged care 3 years after the survey thought that they would work in community based capacities. These patterns suggest quite limited movement of PCs and CCWs between residential and community based work, with somewhat more movement of CCWs into residential aged care work than PCs into community based work.

Table 5.38: Responses of the community based aged care workforce to the question "Where do you see yourself working three years from now?" by occupation (per cent)

Response	Nurse	CCWs	Allied Health	Total	New hires Total
Working in aged care, residential	2.0	3.3	7.6	3.3	3.5
Working in aged care, community based	35.7	49.2	41.3	47.1	43.5
Working in aged care, residential and community	4.4	13.1	8.4	11.7	13.4
Working in aged care, unspecified	0.5	0.6	0.4	0.6	0.6
Working, not in aged care	14.4	5.1	10.7	6.6	7.3
Not working for pay	11.2	4.3	4.9	5.2	1.6
Don't know	31.7	24.4	26.7	25.4	30.0
Total	**100**	**100**	**100**	**100**	**100**

Source: Survey of community based workers.

5.5 Community Care Workers

Community Care Workers (CCWs) are the largest group of workers providing community based aged care. They make up about 82% of all community based direct care aged care workers, and constitute about 78% of equivalent full-time direct care staff in the community based aged care sector. They are closely equivalent to PCs in the residential aged care sector, having the same or equivalent qualifications, and a very similar profile. In this section of the report, we focus on this important group of workers.

CCWs' formal training is an important indicator of the skills they bring to their jobs. We have seen above that about 54% of CCWs hold a relevant Certificate III and 11% hold a Certificate IV. These qualified CCWs are not distributed evenly amongst service outlets (Table 5.39). About 11% of outlets have no CCWs with a relevant Certificate III, and in about a quarter, less than a quarter of CCWs have this level of qualification. On the other hand, in over a quarter of outlets more than three quarters of CCWs have this qualification. Table 5.38 also shows that the Certificate IV is much rarer, with three quarters of outlets having less than a quarter of their CCWs with this qualification.

Table 5.39: Percent of service outlets with varying proportions of CCWs holding relevant Certificate IIIs and Certificate IVs (per cent)

Proportion of CCWs with qualification in outlet	With Aged Care Cert III	With Aged Care Cert IV
None	10.9	41.6
Less than a quarter	14.5	35.8
A quarter to less than a half	22.0	11.1
A half to less than three quarters	24.7	6.7
Three quarters or more	16.2	1.8
All	11.8	3.0
Total	**100**	**100**

Source: Census of service outlets.

CCWs have quite high turnover rates, high enough that service outlets must replace up to a quarter of their CCWs every year. Service outlets were asked how they find new CCWs. Newspaper and internet advertisements are cited by outlets as key methods for filling CCW positions; about 80% of outlets use one or other of these methods, or both. Informal techniques for finding new CCWs are also important, though less commonly used than formal methods, according to outlets. On the other hand, CCWs themselves suggest that informal methods are the dominant means by which they found their jobs (Table 5.40). Indeed, just over half of CCWs say they found their jobs either by 'walking in' to an outlet and asking for employment, or through word of mouth. Nearly 40% used newspaper or internet advertisements to locate the vacancy. Nurses, however, did find their jobs mostly by the formal means of newspaper of internet advertisements.

Table 5.40: Most likely sources if hiring new CCWs, community based aged care outlets (per cent)

Employment source	Per cent of homes likely to use method
Wait for walk-ins	12.0
Word of mouth	37.9
Newspaper job ad	49.6
Internet job ad	12.4
Newspaper and internet job ad	36.9
Existing job placement workers	11.5

Source: Census of service outlets.

Table 5.41: Sources of information about the vacancy for their job for the most recently hired community based aged care workers (per cent)

Source of job information	Nurse	CCW	Allied Health	Total
Walk in	9.0	34.9	30.8	31.3
Newspaper advertisements	35.3	34.5	26.9	34.3
Word of mouth	14.3	18.2	21.2	17.8
Internet sites	36.8	4.0	19.2	9.1
Company or professional contacts	0.8	3.3	0.0	2.8
Other	3.8	5.1	1.9	4.8
Total	**100**	**100**	**100**	**100**

Source: Survey of community based workers.

5.6 Agency, Contract and Self-Employed Staff

Staff who are not directly employed by a service may be used for different purposes. In some cases, they may be engaged to fill gaps when permanent or casual staff are not available. This is the traditional use of agency staff. However, outlets may also use these staff as a part of their core care staff, if they prefer not to employ staff directly. In the community based aged care sector, such staff may be provided by agencies, may be sub-contracted, or may be self-employed. Staff employed under any of these arrangements were not included in our survey of direct care workers. However, we did ask outlets about their use of such staff.

In general, community based outlets use few agency, sub-contract or self-employed staff (Tables 5.42, 5.43, 5.44). Outlets were most likely to employ CCWs through these arrangements, with 11% using agency CCWs, 9% using sub-contracted CCWs, and 4% using self-employed CCWs. Overall, only these CCWs performed anything more than a negligible proportion of shifts. Our estimates indicate that about 13% of all CCW shifts were performed by either agency, sub-contract or self-employed CCWs. However, usage of these staff is very unevenly spread amongst the outlets that engage them. A very few outlets appear to operate by performing most of their work using staff they do not directly employ, primarily agency and sub-contract CCWs. And these few outlets account for most of the CCW shifts worked by CCWs not directly employed by outlets. For example, 61% of the shifts worked by agency CCWs were given to them by just 7% of the small group of outlets that used any agency CCWs. Similarly, 53% of the shifts worked by sub-contracted CCWs were given to them by just 9% of the small group of outlets that used any sub-contract CCWs. Thus, the quite significant proportion of all CCW shifts performed by agency, sub-contract and self-employed CCWs should not be taken as indicating that outlets have substantial difficulties in filling CCW positions. Instead, they seem to reflect that fact that a very small number of outlets choose to perform most their work using these staff rather than those they directly employ. We are unable to say whether this is a longstanding pattern. However, it is certainly a matter that it will be important to monitor in the future.

Table 5.42: Use of agency staff, community based aged care outlets

Employee Classification	Proportion of outlets that did not use any agency staff during past 2 weeks (%)	Estimated no. of agency staff used during past 2 weeks in all Australian outlets	Estimated no. of shifts worked by agency staff in past 2 weeks in all Australian outlets	Average shifts worked per agency staff member	Estimated proportion of all shifts worked by agency staff (%)
RN	97.8	157	956	6.1	1.3
EN	99.1	–*	–*	–*	–*
CCWs	88.4	4,945	30,543	6.2	7.6
Allied Health	98.3	248	486	2.0	1.4

Source: Census of service outlets.

**Numbers too small to be reliable.*

Table 5.43: Use of sub-contract staff, community based aged care outlets

Employee Classification	Proportion of outlets that did not use any sub-contract staff during past 2 weeks (%)	Estimated no. of sub-contract staff used during past 2 weeks in all Australian outlets	Estimated no. of shifts worked by sub-contract staff in past 2 weeks in all Australian outlets	Average shifts worked per sub-contract staff member	Estimated proportion of all shifts worked by sub-contract staff (%)
RN	98.4	189	1581	8.4	2.2
EN	99.3	–*	–*	–*	–*
CCWs	91.3	5,695	27,424	4.8	5.7
Allied Health	96.8	326	924	2.8	2.5

Source: Census of service outlets.

**Numbers too small to be reliable.*

Table 5.44: Use of self-employed staff, community based aged care outlets

Employee Classification	Proportion of outlets that did not use any self-employed staff during past 2 weeks (%)	Estimated no. of self-employed staff used during past 2 weeks in all Australian outlets	Estimated no. of shifts worked by self-employed staff in past 2 weeks in all Australian outlets	Average shifts worked per self-employed staff member	Estimated proportion of all shifts worked by self-employed staff (%)
RN	99.6	–*	–*	–*	–*
EN	99.8	–*	–*	–*	–*
CCWs	96.5	2,025	3,386	1.7	0.7
Allied Health	95.0	360	679	1.9	1.9

Source: Census of service outlets.

**Numbers too small to be reliable.*

There is considerable interest in whether the labour market pressure in the community based aged care workforce varies by geographic location. As we noted in Chapter 3 above, levels of use of agency staff may be an index of the difficulties faced by residential homes in recruiting permanent staff. However, agency staff may also be used for other reasons associated with the way work is organised as, for example, if community based outlets prefer the flexibility using agency staff gives them. Our research did not collect data on why outlets use agency staff, so we are cautious in interpreting trends.

Table 5.45 shows considerable variation by State in the use of some agency staff, notably CCWs. In general, agency staff appear to be rarely used to fill RN, EN and Allied Health roles, irrespective of State. However, 15% of CCW shifts are performed by agency staff in NSW, and 7–10% in Victoria, South Australia and Western Australia. On the other hand, in Queensland and Tasmania agency staff perform only a negligible proportion of CCW shifts. These differences are unlikely to reflect simple variation in the difficulty outlets find in recruiting staff. Instead, they are likely to be associated with variation in how community based aged care is organised across States.

Table 5.45: Estimated percent of total shifts performed by agency staff by State, community based aged care outlets

State	RNs	ENs	CCWs	Allied Health
ACT	–	–	–	–
NSW	2.0	3.9	15.2	2.3
Victoria	0.7	4.9	6.9	1.4
Qld	2.0	1.1	1.3	0.1
SA	2.0	1.4	9.1	1.2
WA	1.5	0.0	10.0	4.6
Tasmania	0.0	0.0	0.3	0.0
NT	–	–	–	–
Australia	**1.3**	**2.5**	**7.6**	**1.4**

Source: Census of service outlets.

Table 5.46: Estimated percent of total shifts performed by agency staff by location, community based aged care outlets

Location	RNs	ENs	CCWs	Allied Health
Metro	1.4	4.0	11.9	2.3
Regional	0.2	0.9	2.6	0.1
Rural	1.1	2.3	0.9	0.8
Remote	10.1	0.9	0.6	15.3
Australia	**1.3**	**2.5**	**7.7**	**1.4**

Source: Census of service outlets.

Examining State variation in the proportion of service outlets that use agency staff shows that at least 97% of outlets do not use agency RNs in most States, and about 85–90% do not use agency CCWs. Both figures indicate that outlets are able to fill most of their staff needs without recourse to agency staff in all States.

Table 5.47: Proportion of community service outlets using any agency RNs and CCWs in past 2 weeks by State, community based aged care outlets (per cent)

State	RNs	CCWs
ACT	7.7	15.4
NSW	1.5	14.3
Victoria	1.7	13.0
Qld	3.0	8.8
SA	3.3	13.0
WA	1.9	12.1
Tasmania	0.0	3.4
NT	3.0	6.1
Australia	**2.2**	**11.6**

Source: Census of service outlets.

6. The Census of Service Outlets

Service outlets providing community based care to older Australians vary in significant ways. Some are large, employing many people and delivering services to many people, while others are small. They are located in different States and some are in cities, while others are in regional or remote areas. Most are run by not-for-profit organizations, while some are directly government owned and run, and a few are for-profit enterprises. Some are part of larger organizations, and some specialise in offering services to particular cultural groups. They have varying experiences as they search for new employees, and manage their employees' health and safety at work. In this chapter we mainly use data from the census of service outlets to produce a picture of them on these dimensions.

6.1 A Profile of Service Outlets

The community based outlets providing aged care services that were surveyed in the census were included in the research because they provided services under at least one of a range of Commonwealth funded or supported programs. These programs vary considerably in purpose and scope. Community Aged Care Packages (CACPs) are provided to older Australians as an alternative to lower level residential care. They provide assistance with recipients' daily needs. Extended Aged Care at Home (EACH) packages provide a higher level of home based care, aiming to offer an alternative to higher level residential care. The EACH Dementia (EACH-D) program offers care packages to older people with complex needs that include dementia, so that they may continue to live in their homes as an alternative to higher level residential care. CACP is a much larger program than EACH or EACH-D, with 2007 estimates indicating that about 1,000 outlets provided CACP packages, compared to about 150 providing EACH and 42 providing EACH-D packages.

The Home and Community Care Program (HACC) is managed by States and Territories, with the Commonwealth providing 60% of funding and States contributing the remainder. It offers services that help frail older Australians, people with disabilities, and their carers to continue living independently. Services offered under HACC included domestic help, personal care, social support, provision of meals, and a range of other services. Alongside the paid workforce that is the subject of this research, volunteers make substantial contributions to the provision of HACC services. HACC is a large program, with 2007 estimates that over 3,300 outlets contribute to the HACC program. The National Respite for Carers Program (NRCP) aims to support people providing care to dependent Australians, including the elderly, by supporting them through the provision of various respite services. Finally, Day Therapy Centres (DTCs) provide a range of therapy services to older Australians, both those living in their own homes and those in residential aged care homes. Included in the services offered by DTCs are nursing, social work, physiotherapy, occupational therapy, podiatry and diversional therapy. In 2007, there were 149 organisations providing DTC services.

Over half the service outlets that responded to our census provide CACP packages, while the proportion providing EACH and EACH-D packages is much smaller (15% and 8%

respectively) (Table 5.1). Outlets offering these packages often provide a small number, particularly if they are EACH or EACH-D providers: over half of outlets that offer these packages actually provide 10 or fewer per month. CACP providers are sometimes much larger, with around half providing more than 25 packages per month and a quarter providing more than 50.

HACC providers are the most common in our census, with about two thirds offering HACC program services (Tables 6.2 and 6.3). Just under a third of these outlets are quite small, offering HACC services to 50 or fewer clients per month, while about half of them cater to more than 100 clients per month. About a quarter of outlets offer services under NRCP, with most having fewer than 50 NRCP clients each month. One tenth of our respondents were DTC providers. About 20% of those were quite large, serving more than 250 clients every month, while some 60% or so served 100 or less.

Table 6.1: Distribution of number Of CACP, EACH, And EACH-D packages delivered by service outlets (per cent)

Number of packages delivered last month	CACP	EACH	EACH-D
None	45.1	85.2	92.0
1–10	15.1	8.5	5.5
11–25	14.0	4.6	2.3
26–50	12.0	1.5	0.2
More than 50	13.7	0.2	0.0
Total	**100**	**100**	**100**

Source: Census of service outlets.

Table 6.2: Distribution of hours of service under HACC, NRCP And DTC delivered by service outlets (per cent)

Hours of service in last month	HACC	NRCP	DTC
None	33.5	75.4	89.3
1–300	20.0	11.2	5.4
301–1,000	18.3	7.9	3.4
1,001–2,500	15.4	4.2	1.6
More than 2,500	12.7	1.3	0.3
Total	**100**	**100**	**100**

Source: Census of service outlets.

Table 6.3: Distribution of number of HACC, NRCP And DTC clients served by service outlets (per cent)

Number of clients in last month	HACC	NRCP	DTC
None	31.4	74.5	89.8
1–50	20.3	21.2	4.0
51–100	14.8	2.8	2.2
101–250	16.5	1.4	1.8
More than 250	17.0	0.2	2.2
Total	**100**	**100**	**100**

Source: Census of service outlets.

A measure of the overall size of service outlets that is comparable irrespective of the services they offer is provided by the number of PAYE and direct care employees they employ. About a quarter of outlets are very small, employing no more than 5 direct care workers (Table 5.4). Large organizations are also quite unusual, with only 16% employing more than 40 carers.

Table 6.4: Service outlet size measured by number of PAYE and direct care employees (per cent)

Number of Employees	PAYE employees	Direct Care employees
1–5	22.3	24.0
6–10	21.0	22.3
11–20	20.5	20.3
21–40	16.8	16.9
More than 40	19.3	16.4
Total	**100**	**100**

Source: Census of service outlets.

The distribution of outlets offering services under different programs across regions is an important issue in relation to access to services and staff recruitment. With a few exceptions, it appears that the profile of programs offered by outlets does not vary according to whether they are located in metropolitan, regional, rural or remote areas (Table 6.5). The first exception is that metropolitan and regional outlets are more likely to offer EACH and EACH-D packages than rural and remote ones. Secondly, although two thirds of outlets offer HACC programs, remote outlets are even more likely to provide them. Finally, remote services are much less likely than others to have DTC programs, even though they are provided by only a small number of outlets anywhere.

Table 6.5: Proportion of service outlets offering some packages, some hours of service or having some clients by service outlet location (per cent)

	Metro	Regional	Rural	Remote
CACP packages	50.3	54.4	58.7	62.0
EACH packages	15.8	18.3	11.1	9.0
EACH-D packages	9.7	9.4	5.9	2.6
HACC hours of service	63.0	63.9	69.8	80.3
NRCP hours of service	23.8	27.7	22.2	27.5
DTC hours of service	12.8	8.7	10.6	6.5
HACC clients	65.1	65.6	72.4	81.0
NRCP clients	24.3	29.3	24.2	24.4
DTC clients	12.9	7.9	9.5	6.4

Source: Census of service outlets.

Note: This table give the percentage of service outlets that deliver some packages or services as indicated. For example, 50.3% of services located in metropolitan areas deliver CACP packages, 63.0% deliver some hours of HACC services, and 65.1% have HACC clients.

The amount of service outlets provide under each program varies systematically with their location (Table 6.6). Thus, for example, metropolitan outlets have an average of just over 350 HACC clients, compared to 250 for regional ones, 160 for rural ones and 42 for remote ones.

Table 6.6: Average number of packages, hours and clients by service outlet location

	Metro	Regional	Rural	Remote	Total
CACP packages	60.1	43.3	19.0	10.0	38.8
EACH packages	17.1	12.8	7.7	6.0	13.4
EACH-D packages	11.9	9.3	7.1	5.0	9.9
HACC hours of service	2595.7	1816.9	1090.5	443.3	1753.4
NRCP hours of service	898.0	721.8	489.9	504.1	705.1
DTC hours of service	539.2	917.9	319.4	242.6	533.2
HACC—no. of clients	355.7	249.5	159.4	42.0	240.9
NRCP—no. of clients	35.3	38.7	26.8	11.7	33.4
DTC—no. of clients	198.5	127.6	82.6	32.6	149.3

Source: Census of service outlets.

Note: This table gives averages for outlets that have activity in each area shown. For example, the average number of CACP packages delivered by metropolitan service outlets that delivered at least one CACP package was 60.1.

Community based service outlets providing aged care services are overwhelmingly operated by not-for-profit bodies. Indeed, 77% are run by such groups. Most of the remainder are operated by government organizations, with a very small number (3% overall) being run as for profit enterprises. Table 6.7 shows the average amounts of service provided by outlets in each of these sectors. The most striking difference is that the average government operated outlet provides much more HACC service than either the typical not-for-profit or for-profit organization. On the other hand, where government outlets provide DTC services, they do so to far fewer clients, on average, than not-for-profit or for-profit ones do.

Table 6.7: Average number of packages, hours and clients by service outlet ownership type

	Not-for-profit	For profit	Government	Total
CACP packages	42.3	42.4	21.6	39.0
EACH packages	13.5	13.3	10.1	13.3
EACH-D packages	9.7	10.3	10.8	9.8
HACC hours of service	1554.2	1230.3	2350.5	1765.4
NRCP hours of service	734.9	811.7	462.6	683.2
DTC hours of service	549.6	458.3	347.2	514.7
HACC—no. of clients	187.5	182.6	391.8	241.8
NRCP—no. of clients	33.3	36.3	30.4	32.8
DTC—no. of clients	162.7	171.7	49.1	148.1

Source: Census of service outlets.

Note: This table gives averages for outlets that have activity in each area shown. For example, the average number of CACP packages delivered by not-for-profit service outlets that delivered at least one CACP package was 42.3.

Variation in the scale of outlets across States is shown in Table 6.8. New South Wales is striking in apparently having smaller HACC outlets than other large States; for example, NSW outlets offering HACC services cater to an average of 118 clients, compared to 412 in Victoria and 234 in Queensland. Queensland and South Australian outlets providing EACH packages tend to provide far fewer than other large States. The average Northern Territory outlet generally provides many fewer packages and hours of service, and caters to fewer clients, than those in other jurisdictions.

Table 6.8: Average number of packages, hours and clients by state location of outlet

	ACT	NSW	VIC	QLD	SA	WA	TAS	NT
CACP packages	46.2	47.5	53.7	24.4	51.1	39.8	18.6	12.7
EACH packages	12.6	16.3	15.9	9.5	9.5	12.4	24.5	13.5
EACH-D packages	8.3	10.1	13.1	10.7	6.1	11.1	7.2	6.5
HACC hours of service	1949.9	977.4	2707.7	1471.6	1058.1	3097.5	1090.1	547.3
NRCP hours of service	963.4	621.6	883.3	501.2	507.9	1037.4	924.5	919.3
DTC hours of service	291.0	422.7	544.5	825.3	640.8	405.5	100.3	122.5
HACC—no. of clients	255.5	118.2	412.2	233.5	193.4	280.3	166.9	51.5
NRCP—no. of clients	52.4	33.7	41.3	22.0	41.0	24.3	43.3	28.4
DTC—no. of clients	102.0	113.4	119.6	106.9	274.7	119.4	86.9	20.0

Source: Census of service outlets.

Note: This table gives averages for outlets that have activity in each area shown. For example, the average number of CACP packages delivered by ACT service outlets that delivered at least one CACP package was 46.2.

Finally, we consider the distribution of employees across different locations and types of outlets. Half of community based direct care employees work in metropolitan outlets, while only 2% work in remote ones. New South Wales, Victoria and Queensland between them account for nearly three quarters of all community based aged carers. And the distribution of workers across outlet ownership types largely reflects their numbers, though for-profits account for a surprisingly large number of employees suggesting that the large ones are very large.

Table 6.9: Distribution of all PAYE employees and all direct care employees by location of outlet, state of outlet and type of outlet

		Percent of total PAYE employees	Percent of all direct care employees
Location	Metropolitan	51.3	49.5
	Regional	26.2	26.8
	Rural	20.6	21.8
	Remote	1.8	1.9
State	ACT	1.2	1.2
	NSW	20.5	22.7
	VIC	30.5	27.6
	QLD	20.3	22.3
	SA	9.0	9.4
	WA	11.3	10.7
	TAS	6.2	4.9
	NT	1.0	1.3
Ownership Type	Not-For-Profit	70.0	72.9
	For profit	7.6	4.7
	Government	22.5	22.4

Source: Census of service outlets.

6.2 Outlets' Relationships with Larger Groups and the Provision of Community Based Care

As is the case for homes in residential aged care, community based aged care outlets are quite often parts of larger groups. Amongst the dominant not-for-profits, 70% of outlets are part of larger groups, while the pattern is less common where outlets are run by government or for profit organizations (Table 6.10).

Table 6.10: Proportion of service outlets that are part of larger group by ownership type (per cent)

	Not for profit	For profit	Public	ALL
Per cent part of larger group	69.7	45.9	47.4	64.6
Per cent not part of larger group	30.3	54.1	52.6	35.4

Source: Census of service outlets.

Organizations that provide both residential and community based services are quite common amongst residential homes, with about 13% of all homes providing both forms of service. Table 6.11 shows this from the side of community based organizations, where nearly a quarter say they provide both residential and community based care.

Table 6.11: Proportion of service outlets providing residential care by ownership type (per cent)

	Not for profit	For profit	Public	Total
Per cent providing residential care	23.4	21.1	24.1	23.4
Per cent not providing residential care	76.6	78.9	75.9	76.6

Source: Census of service outlets.

From the point of view of workforce planning and workforce processes, a key issue is the extent to which direct care staff work in both residential and community based aged care provision when their employer does both. In the quarter of outlets that say they provide both residential and community based services, the dominant pattern is for no staff, or very few, to work across both areas. Even with regard to CCWs, the staff apparently most likely to work across residential and community based services, 43% of outlets say no staff do this, and another 15% say that a tenth or fewer of their CCWs do it. Nevertheless, in 40% of service outlets with both residential and community based services, more than a tenth of CCWs work across areas. Overall, it is clear that the vast majority of direct care workers work either in residential or community based provision of services to the elderly, but not in both.

Table 6.12: Proportion of service outlets where direct care staff work in both residential and community provision, where both are provided (per cent)

How many staff working in residential and community?	RNs	ENs	CCWs	Allied Health
None	71.0	80.1	43.0	75.4
Some, 10% or less	12.8	6.2	14.6	5.9
More than 10%	16.2	13.7	42.4	18.7

Source: Census of service outlets.

6.3 Ethnic Specialisation and Ethnicity of Direct Care Workers

Ethnic specialisation of aged care services is an important policy issue. We have seen that a small but significant group of residential aged care homes cater to specific ethnic and cultural groups. Ethnic specialisation is much more common amongst community based aged care providers than residential homes, with 47% of community based outlets saying they specialise compared to 17% of residential homes. Community based outlets that do specialise in this way are highly likely to employ at least some staff with language or cultural knowledge appropriate to their specialisation. The cultural groups for which outlets cater vary across almost the full range of cultures from which Australia's population has been drawn. Some 40% of outlets that specialise are focused on services for Aboriginal and Torres Strait Islanders, while another 6% provide services focused on older Australians of Italian heritage. Aside from these larger groups, no other specialisation accounts for more than 3% of outlets.

Table 6.13: Proportion of service outlets catering for specific ethnic or cultural groups (amongst those that specialise in specific groups) (per cent)

Ethnic Group	Per Cent of those specialising
Italian	5.9
Aboriginal and/or Torres Strait Islander	39.8
Chinese	3.2
Greek	2.4
Dutch	1.3
Polish	0.6

Source: Census of service outlets.

Service outlets were asked what proportion of their CCWs speak a language other than English. Those with non-English speaking CCWs were asked the most common ethnic or cultural background of their CCWs who spoke a language other than English. Using this information, we are able to assess the extent to which service outlets appear to employ CCWs whose background matches the profile of outlets' specialisation. Half (51%) of outlets said they employed CCWs who spoke a language other than English, and, of these, 35% indicated that one third or more had this ability. Table 6.14 summarizes the most common ethnic and cultural origin of CCWs in these outlets with concentrations of CCWs. It shows some match between concentration of CCWs and the pattern of ethnic specialization in Table 6.13, notably through the concentration of Italian background and Aboriginal CCWs.[23] However, other concentrations, such as those of Spanish and Chinese and unspecified Asian CCWs suggest that these workers are being employed for other reasons.

23 Of course, we cannot be certain about this match, since we do not know how dominant the specified ethnic group is amongst PCs who speak a language other than English. It could be, for example, that in an outlet where the largest group is Italian speakers, other ethnic groups make up more than half of all non-English speakers. Nevertheless, the assessment we have made is a useful first step in assessing the connection between language capacities of staff and ethnic specialization of outlets.

Table 6.14: Most common ethnic origin of CCWs in outlets with one third or more of CCWs from a single group (per cent)

Ethnic Group	Per cent of outlets
Italian	15
Chinese	13
Aboriginal	10
Spanish	6
Asian	3
Greek	7
Dutch	2
Philippino	1

Source: Census of service outlets.

Another perspective on these issues is provided by direct care staff themselves through our survey of staff. About a quarter of CCWs say they speak a language other than English, and nearly two thirds of these use this language in their work (Table 6.15). Allied Health workers show much the same pattern, but nurses are much less likely to be able to speak a language other than English, though very likely to use it in their work if they can. If we focus on CCWs, these results are consistent with the responses of service outlets. They suggest that a substantial proportion of CCWs with non-English abilities are employed at least partly for these abilities. We cannot be certain how large this proportion is, because some CCWs may use their non-English language abilities in their jobs only because they and other workers at their workplace are more comfortable with this language. At the same time, for a significant minority of CCWs, their non-English abilities play no direct role in their employment.

Table 6.15: Proportion of community based aged care workers who speak a language other than English, and who use it in their jobs (per cent)

	Nurses	CCWs	Allied Health	Total
Speak a language other than English (per cent)	11.1	23.9	22.1	22.2
Use language in job (per cent of those who speak a language other than English)	83.1	65.6	71.4	67.1

Source: Survey of community based workers.

For CCWs whose first language is not English, difficulties in communication may arise. Evidently, this is not a widespread problem since some 83% of outlets that employed CCWs from non-English speaking backgrounds said that it caused them no problems (Table 6.16). Of those that did experience problems, the most commonly cited issues were in

communication with management and/or other staff, and communication with clients. Communication problems with clients' families also occurred quite often where there were problems. Overall, though, the employment of CCWs from non-English speaking backgrounds seems to cause community based service outlets little difficulty. Indeed, the proportion reporting such problems is even lower than the proportion of residential homes indicating such difficulties with non-English speaking background PCs.

Table 6.16: Presence and type of difficulties caused by having CCWs whose first language is not English (per cent)

	Percent of outlets
No difficulties	82.6
Some difficulties	17.4
Occupational health and safety	36.0
Communication with mgmt and/or other staff	64.0
Communication with clients	61.3
Communication with clients' families	44.1
Other—written communication	9.0

Source: Census of service outlets.

Note: These figures include only outlets with some CCWs whose first language is not English.

6.4 Vacancies

Vacancy experiences provide an important indication of the state of labour markets. Where employers have many vacancies and have difficulty filling them, labour supply problems are indicated. Vacancy levels in community based aged care service outlets appear to be quite low, with few indications that outlets face significant difficulties in finding staff to perform the jobs they offer. Less than 8% of outlets had vacancies for RNs, ENs or Allied Health workers at the time of the survey (Table 6.16). About a quarter had vacancies for CCWs, with 9% having more than two CCW vacancies. These levels of average vacancies amongst providers compare favourably with the pattern for residential homes, especially with regard to RNs. To some extent the difference in vacancy levels may be due to the smaller size of community based service outlets compared to residential homes.

A further indication of vacancy experience is provided by the time taken by service outlets to fill their most recent vacancy (Table 6.17). Outlets usually face few difficulties in filling RN, EN and Allied Health vacancies, with 77%, 90% and 83% respectively being filled within one week. CCW vacancies appear to take a little longer to fill, with half being filled within 2 weeks and nearly 80% within 4 weeks. Based on these figures, community based outlets fill their nurse and Allied Health vacancies more easily than do residential homes. However, they have slightly more difficulty in dealing with CCW vacancies than residential homes find in filling PC positions. The striking ease with which community based outlets find RNs,

and their relative difficulty in locating CCWs, suggest that the labour market for community based carers is distinct from that for residential aged care workers, as other results in this and the previous chapter have suggested.

Table 6.17: Proportion of service outlets with varying number of EFT vacancies, by occupation (per cent)

Number of EFT vacancies	RNs	ENs	CCWs	Allied Health	All direct care occupations
None	93.9	97.5	77.8	94.8	71.2
1 or less	4.9	2.0	7.5	4.2	11.0
More than 1 to 2	0.8	0.4	5.9	0.6	7.0
More than 2	0.4	0.1	8.8	0.4	10.8
Total	**100**	**100**	**100**	**100**	**100**

Source: Census of service outlets.

Table 6.18: Weeks taken to fill last vacancy, community based service outlets (per cent)

Number of weeks taken to fill last vacancy	RNs	ENs	CCWs	Allied Health
Less than 1	75.3	89.0	21.1	82.5
1	2.1	0.8	11.3	0.8
2	4.7	2.5	18.1	1.7
3 to 4	6.4	3.6	27.6	4.3
5 to 8	6.3	2.7	15.2	5.7
9 to 12	2.4	0.5	4.0	2.2
13 to 26	1.8	0.3	2.1	1.8
More than 26	1.0	0.5	0.7	1.1
Total	**100**	**100**	**100**	**100**

Source: Census of service outlets.

As we noted in Chapter 3, one of the most useful indicators of the balance between labour supply and demand is the length of time taken to fill vacancies. Hence, State and regional variation in vacancy length is a useful indicator of variation in the state of labour markets. Table 6.19 suggests that there are some variations in the difficulties faced by community based outlets in securing both RNs and CCWs. Outlets in NSW, Victoria and Western Australia fill their RN vacancies most easily, with those in Queensland, South Australia and the Northern Territory facing more difficulty. At one extreme over 30% of South Australian outlets report that their last RN vacancy was unfilled after a month, compared to about 15% of outlets in NSW, Victoria, and Western Australia. In general, these patterns of State

variation are similar to those revealed in Chapter 3 for residential aged care homes, except that South Australian residential homes do not appear to face greater difficulties than those in most other States in filling RN vacancies.

With regard to CCW vacancy length, the pattern is rather different. In most States about 20% of CCW vacancies take more than a month to fill, while in NSW and Western Australia about 30% take this long to fill. Difficulties in filling these positions seem to be greater in metropolitan areas too (Table 6.20).

Table 6.19: Time taken to fill most recent RN and CCW vacancies by State, community based outlets (per cent)

	2 weeks or less	More than 4 weeks
RNs		
ACT	88.9	11.1
NSW	72.6	14.6
Victoria	69.3	16.3
Qld	61.6	24.4
SA	60.2	31.1
WA	82.9	15.9
Tasmania	91.5	6.4
NT	75.0	25.0
Australia	**69.6**	**19.2**
CCWs		
ACT	53.3	20.0
NSW	36.7	29.0
Victoria	45.1	23.9
Qld	48.3	20.4
SA	47.5	22.3
WA	37.1	31.1
Tasmania	62.1	15.2
NT	76.2	11.9
Australia	**44.7**	**24.2**

Source: Census of service outlets.

Table 6.20: Time taken to fill most recent RN and CCW vacancy by location, community based outlets (per cent)

	2 weeks or less	More than 4 weeks
RNs		
Metropolitan	73.5	17.3
Regional	68.3	16.9
Rural	66.0	22.4
Remote	66.7	31.0
Australia	**69.7**	**19.1**
CCWs		
Metropolitan	35.0	30.4
Regional	51.1	18.6
Rural	50.6	20.5
Remote	59.4	21.7
Australia	**44.8**	**24.1**

Source: Census of service outlets.

6.5 Occupational Health and Safety

Injuries at work are a potentially significant issue for the community based aged care workforce, given the physical and mental demands that can be associated with caring for the elderly. Very few service outlets had RNs, ENs, or Allied Health workers on Workcover at the time of the census (Table 6.21). Some 17% of outlets had CCWs who were unable to work because of occupational injuries. Most of these had one CCW on Workcover, but about 6% of all outlets had 2 or more. These patterns are reflected in responses from workers to a question asking whether, during the month before the workers survey, they had experienced an injury at work that required them to take at least one day off work. Only one nurse and two Allied Health workers in our sample had suffered such injuries. CCWs were much more likely to have sustained injuries, with 2% having been forced to take time off work for this reason. In general, the rates of occupational injury in the community based sector are lower than those we found in residential aged care homes. For example, one third of residential homes reported having at least one PC on Workcover at the time of the survey, and 4% of PCs had taken time off work because of injury during the month before the survey.

Table 6.21: Number of staff per service outlet on Workcover during last pay period (per cent of service outlets)

Number	RNs	ENs	CCWs	Allied Health
None	98.6	99.6	83.3	99.3
1	1.1	0.2	10.6	0.6
2	0.1	0.1	3.3	0.0
3 or more	0.3	0.1	2.8	0.1
Total	**100**	**100**	**100**	**100**

Source: Census of service outlets.

7 Direct Care Workers

7.1. Background

In response to issues arising from the 2003 survey, NILS was commissioned to undertake in-depth interviews with 100 direct care workers. As stated in the tender document:

> Many of the key issues with respect to future supply of aged care workers relate to workers' experiences of their jobs, and how their jobs are combined with their non-employment responsibilities and activities. For many aged care workers these issues are particularly complex since they are women who work part-time, combining their paid work with other caring responsibilities and other aspirations. How workers manage their complex lives will have enormous impact on the future supply of labour for the aged care sector.

While the structured survey of workers also asked questions relating to direct care workers' multiple responsibilities, the interviews were aimed more at collecting data that would allow for a better understanding of how these are actually balanced by workers. The core research question for the interviews was to 'identify how workers' jobs are combined with their non-employment responsibilities and activities.' The findings were to be related to the results from the main survey and their significance for workforce planning explained.

7.2. The Interview Process

The NILS qualitative team conducted semi-structured telephone interviews with 100 aged care workers (50 community-based and 50 residential workers), all of whom were working in direct-care positions e.g. nurses, personal care attendants, and allied health workers. These workers had previously taken part in the quantitative survey of direct-care workers and had nominated themselves to participate in the qualitative interviews, providing the necessary contact information for the NILS team to contact them directly. A randomised sample of these employees was created.

Initial phone calls were made to schedule a time when it was convenient for the participant to be interviewed for up to 30 minutes, with the subsequent interview conducted at the prearranged time. Each interview was digitally recorded after permission was obtained from the respondent. Interviewers called each participant from the sample group a maximum of three times before they were excluded from the sample list. When the interviewers had exhausted the sample list, further randomly selected respondents were added to each of the sample lists for community and residential aged care workers. This occurred until 50 direct care workers from residential homes, and 50 direct care workers from community-based providers were interviewed. Interviews took place from January until early March 2008.

All of the interviews were transcribed using a combination of notes and quotes rather than verbatim transcription. These transcripts were analysed by categorising units of text

around the core themes outlined by the interview schedule (developed in consultation with DoHA), and response patterns were identified. These themes were continually developed and refined throughout the coding process and categories were formed to allow for further detail to be incorporated into the analysis of the data. It should be noted that participants may have provided responses that cover multiple themes, and, given the nature of semi-structured interviews, some interviewees may not have addressed all of the questions. In order to gain further insight, once the coding was finalised the data were quantified and further analysed using cross tabulations. Microsoft Excel and SPSS software were used to manage both the qualitative data and the cross tabulations.

Analysis of the demographic information provided by participants in their questionnaire demonstrated that, of the 97 direct care workers who provided their job title, 60 were personal care attendants or community care workers, 8 were enrolled (Div 2) nurses, 10 were registered (Div 1) nurses, 11 were allied health workers, and 8 identified their job title as 'other'. Ninety of the 98 respondents who provided information about their gender were female and eight were male. The mean age of these participants was 47.11 years (*SD* = 10.23), ranging from 20 to 64 years.

The direct care workers who identified their country of origin (*N* = 97) were predominantly Australian (63 workers); 10 workers were from the United Kingdom, three were from New Zealand, two from Germany, and 19 from a variety of other countries. Of the 98 respondents who provided their Aboriginal and Torres Strait Islander status, two workers identified as being Torres Strait Islanders and two identified themselves as Aboriginal.

7.3. Combining Aged Care Work With Non-Work Responsibilities

In this section a brief overview of employment and non-employment responsibilities of direct care workers are discussed. This will assist in providing context for the analysis in the following sections. To achieve consistency in the comparison, the weighted, merged data is used for analysing responses from both the survey and the interviews. This has resulted in lower numbers in the interview sample for this section. In the following sections, the discussion is based on responses from all interviewees.

There are three key areas that were discussed in the interviews—employment, family responsibilities and commitment to education.

Table 7.1 illustrates that the sample of interviewees was remarkably similar to that of the general survey in relation to the average number of hours that workers were employed in their primary paid aged care role. The result for the average number of hours worked unpaid by interviewees in their primary aged care role was also similar to that of the general survey. In breaking this down further, it appears that from the survey data for both community and residential aged care organisations, RNs and Allied Health workers spent a lot more time than ENs or PCs/CCWs working in an unpaid capacity in any given week (see Table 7.2).

Table 7.1: The employment responsibilities of direct care workers, comparison of interview respondents with survey respondents by type of aged care provider

	COM Interview	COM Survey	RES Interview	RES Survey
Paid hours worked in main job, mean no. per week	24.0 hrs	25.0 hrs	32.0 hrs	31.0 hrs
Unpaid hours worked in main job, mean no. per week	0.9 hrs	1.0 hrs	1.8 hrs	2.0 hrs
More than one job (yes)	12.0%	19.3%	6.0%	13.9%
In aged care (yes)	33.3%	46.0%	16.7%	54.5%
Hours spent in other job, mean no. per week	12.5 hrs	13.3 hrs	12.6 hrs	16.5 hrs

Table 7.2: The mean number of unpaid hours worked for each occupational group, comparison of interview respondents with survey respondents by type of aged care provider

	COM Interview	COM Survey	RES Interview	RES Survey
RN	3.0	2.9	4.8	4.1
EN	0.0	1.8	1.0	1.8
PC/CCW	0.7	0.7	0.7	1.3
AH	3.5	1.9	2.4	3.5

As discussed later in the section on 'commitment to residents and care recipients', working unpaid is a regular occurrence in aged care organisations. From responses in the general surveys a total of 23.4 per cent of workers worked unpaid for their employer. Of this, 31.1 per cent of RNs, 9.9 per cent of ENs, 45.5 per cent of PC/CCWs and 12.8 per cent of allied health workers worked unpaid. Unpaid work was not limited to that done for their employer. Although not asked in the survey, the issue of volunteering more generally was raised in the interviews. A total of 36 interviewees reported being currently involved in volunteering or community activities, of these 14 identified their activities to be related to aged care whilst a further 19 identified that their activities were not related to aged care.

The interviewees were much less likely than the overall sample to have more than one job and, of those who did have another job it was less likely that this would be in aged care (see Table 7.1). This inconsistency may have been because people with multiple jobs were less available for interviews and either did not nominate themselves or were excluded from the sample after three unanswered attempts to contact them. Where interviewees did have a second job they tended to work fewer hours than those in the survey, especially for the residential aged care workers.

In the residential and community aged care surveys there was a similar proportion of workers in each of the categories for financial dependents (Table 7.3).

Table 7.3: Family and unpaid caring responsibilities of direct care workers, comparison of interview respondents with survey respondents by type of aged care provider

	COM Interview	COM Survey	RES Interview	RES Survey
Financial Dependents				
None	48.7%	42.6%	37.8%	42.9%
Spouse/partner only	10.3%	15.0%	15.6%	13.6%
Children only	30.8%	20.2%	22.2%	18.0%
Spouse/partner and children	10.3%	21.6%	24.4%	24.2%
Hours spent in unpaid caring, mean no. per week	15.7	15.7	12.6	17.0

For the interviewees, however, the pattern of financial dependents differed by the type of aged care provider. Interviewees in residential aged care homes were less likely to have no financial dependents than their counterparts in the survey; while interviewees from community aged care service outlets were more likely to have no financial dependents than their counterparts in the survey. The distribution of those with financial dependents also differed, with interviewees from the community sector more likely than those in the survey to have children only and less likely to have either a partner only or both children and a partner as financial dependents. In comparison, while having more workers with financial dependents in the residential home interviews, these were relatively evenly spread across the three remaining categories. The ensuing discussions about managing work and family will therefore be more representative for the residential aged care sector than the community aged care sector. Interestingly, however, the numbers of hours spent in unpaid caring activities is exactly the same for community aged care workers across the survey and interviews, while residential aged care interviewees spent 25 per cent less time in unpaid caring than those in the survey.

Education was another area in which workers had a time commitment that they needed to manage in relation to their employment responsibilities. As indicated in Table 7.4 the interviewees were much more likely to be currently studying than those in the general survey. As the interviews were conducted during the summer break (for university and TAFE), their educational commitments were unlikely to affect their availability to participate in the interviews.

Table 7.4: Educational commitments of direct care workers, comparison of interview respondents with survey respondents by type of aged care provider

	COM Interview	COM Survey	RES Interview	RES Survey
Currently studying (yes)	29.0%	15.8%	27.3%	18.8%

As illustrated in this section, direct care workers often have multiple responsibilities. The question for the reminder of this discussion about the experiences of direct care workers, is how these responsibilities impact on each other.

7.3.1. The Decision to be an Aged Care Worker

The desire (and capacity) to combine their non-employment responsibilities with their work as direct carers was evident even before the workers took jobs in aged care. For some, their non-employment responsibilities provided them with the experience to get into aged care work, while for others aged care work provided the flexibility to attend to non-work responsibilities.

Table 7.5: Proportion of respondents who utilised skills from non-work responsibilities to get into aged care work by type of aged care provider.

	Type of aged care Provider	
	Community N=50	Residential N=50
Cleaning background	10%	10%
History with elderly-unpaid	12%	4%
History with caring role-unpaid	12%	6%

Table 7.5 illustrates the proportion of respondents who mentioned that they had an unpaid history of being in a caring role and working with the elderly by the type of aged care provider. Care workers from the community aged care sector were more likely to mention these as reasons to explain how they originally got into aged care, although it was also applicable to residential aged care workers:

> We had a sick neighbour who had an operation and had a baby, so I nursed her for two years or so and it just lead from there, and I did some training, and it lead from there and I ended up in aged care. (RES, 50yrs, F, Allied Health)[24]

Other workers were able to convert their experience of cleaning in a domestic context to one in a paid work context. This gave them their point of access to aged care employers and they were then able to get work as direct care workers. This process of getting into aged care was mentioned by 10 per cent of all workers, with it being balanced between

24 Each quote is identified by the sector of aged care (COMmunity/RESidential), the age, gender (Female and Male) and occupation of direct care worker

residential and community aged care workers. As one care worker explained, she entered aged care:

> Mainly to help people out and the elderly in the district because we're a very small community, very tight knit, and there was an opening as a cleaner…..as a cleaner to start with, yeah. (COM, 55yrs, F, CCW)

While most interviewees talked about being drawn to aged care either because of the type of work involved, especially their desire to help people or because they like working with elderly people, it was evident that the flexibility of the work was also a factor (see Table 7.6). This enabled them to combine their employment and non-employment responsibilities. While 21 per cent of employees mentioned this as a reason why they entered aged care, there was a much higher proportion of workers, 59 per cent, who said that their non-employment responsibilities did not impinge on their paid work. This was most likely because these workers had been able to work the hours that suited their level of non-employment responsibilities. This was particularly important for workers with family responsibilities.

> It seemed to fit in with my life at the time as I had young children and I didn't want to be away from home all day. (RES, 62 yrs, F, Allied Health)

Another indicator of the suitability of the work for people with non-work responsibilities is that 30 per cent of the interviewees discussed aged care work as being easy to get into (see Table 7.6). For PCs and CCWs there was often no requirement for qualifications or prior experience and this suited people who had been out of the workforce for extended periods.

Table 7.6: Proportion of respondents who identified 'flexibility' or 'ease of getting into' as reasons for entering into aged care work by type of aged care provider.

	Type of aged care Provider	
	Community N=50	Residential N=50
Flexibility	16%	26%
Ease of getting into	28%	32%

The ease with which people could move in and out of aged care work, and therefore structure their work so that it fitted into their lives was also reinforced by the number of interviewees who consider leaving and re-entering aged care work. For example, 57 per cent of interviewees had considered leaving their current job with approximately one-third of these 'seriously considering' it. Of this 57 per cent, just over half said they would simply go to the same job in a different organisation, while another quarter said that they would go to a different aged care job. As can be seen in Table 7.7, those interviewees who would go to the same job in a different organisation were more likely to be in the community aged care sector.

Table 7.7: Proportion of respondents indicating where they would go if they left their current job by type of aged care provider

	Type of Aged Care Provider	
	Community N=26	Residential N=31
Same job, different employer	70%	35%
Different aged care job	23%	26%

7.3.2 Commitment to Residents / Care Recipients

Throughout the interviews it became evident that the commitment that interviewees had to care recipients in both community and residential aged care organisations was having an impact on the ways in which the interviewees managed the relationship between their employment and non-employment responsibilities. In particular, it raised questions about the capacity for direct care workers to emotionally (and sometimes physically) extract themselves from their work to attend to their non-employment responsibilities. As no direct questions were asked of this particular issue, the analysis in this section is based on answers that the interviewees gave across a range of areas.

As with most research on aged care workers, the relationships that are developed with care recipients were central to the interviewees' reasons for getting into aged care as well as being a main factor in their levels of satisfaction with their work. One of the most important achievements for one residential aged care worker was the care she could give to the really frail:

> Its those that really can't tell you what they want or need, or are really at the end of their life, and it's the care that you can give to them to make their life a bit more comfortable and for the people coming in to visit them, to know that they are being looked after and you're doing what you can for them (RES, 50 yrs, F, PC)

As Table 7.8 illustrates over one quarter of all interviewees entered aged care because they liked the elderly or wanted to make them happy.

Table 7.8: Proportion of respondents who viewed care recipients as a factor in entering into aged care and in their job satisfaction by type of aged care provider.

	Type of Aged Care Provider	
Care recipients as reason for:	Community	Residential
Entering aged care	28%	24%
Satisfaction with job	44%	56%

For half of the interviewees the aspect of their job they found most satisfying was being able to help people, with 10 interviewees mentioning that their greatest achievement in their work was just the "small things" they did for care recipients and their families. In

addition, 22 interviewees said they felt proudest when they had their work acknowledged by others, especially the elderly people that they cared for and their families.

> When someone says "thank you, I'm glad you're here." That is when you feel that is why you are here. The 'little things' (RES, 53 yrs, F, PC)

> Knowing that what I'm doing with my clients is making them happy and it's assisting them to live in the community to the highest standards that they can do so. Taking the time to respect them, and their wishes (COM, 58 yrs, F, EN)

This level of commitment to care recipients is not unusual among aged care workers, but the interviews revealed that it was a complex relationship. Generally this commitment is discussed as being a positive emotional relationship or connection; however the interviews made it clear that this was not always the case. It seemed that their commitment to care recipients was also a source of emotional distress and stress for many direct care workers.

The reasons behind this distress and stress can be found in three areas of the interviews: in discussions about their level of satisfaction with their work; when speaking about the most difficult aspects of their work; and in how they thought aged care work was perceived by the general public.

The extent of the commitment of direct care workers to care recipients was evident when interviewees discussed their dissatisfaction with the organisational aspects of their work. Over half of the interviewees discussed this issue. Often it was couched in terms of the impact on the clients or residents rather than on themselves or other workers (except by way of workload, which also impacted on their capacity to provide the level of care they thought appropriate). For example, of the 16 workers who talked about there being a lack of funding in aged care, nine felt that their clients were slipping through the cracks in the system and were not receiving the services that they need. All but one of these interviewees were from community based organisations. The following quotes indicate the levels of frustration expressed during the interviews.

> The paperwork is horrendous but if you don't do the paperwork you don't get the funding and then if you've got to do the paperwork you don't have enough time to spend with the residents or the clients, it's just a vicious circle. There's never enough staff, never enough money. (COM, 49 yrs, F, CCW)

> ….it's very frustrating to sit there and all your training tells you that you're supposed to protect this person and make their life the best it can be until the end, and the resources, money, government and your employer all fight against you. It's very disheartening and physically it's very hard on you... (COM, 36 yrs, F, EN)

Other sources of stress came more directly from having a relationship with care recipients. Nearly a quarter of the interviewees said that the relationships they developed made it difficult to watch the elderly people they care for decline in health or die.

> Even the most professional person gets attached, and it's hard when they die (RES, 25 yrs, F, Allied Health)

> Patients being aggressive……I think the worst part is when they have been there for so long (the residents) and they pass away (RES, 42 yrs, F, PC)

As suggested above, 18 workers said that another aspect of working with the elderly that was difficult was when they were abusive or aggressive, or had dementia. While there was a safety dimension to this, there was also a sense that it was difficult to establish the kinds of relationships that the workers had come to value:

> A lot of people don't understand dementia. Until you experience that these people need 24 hour nursing, They need the emotional support, the physical support. They are not numbers and they are not locked up because they are crazy (RES, 38 yrs, F, PC)

The complexity of caring for aged people was apparent in discussions about how the general public perceive aged care work. It was clear from these discussions that the workers felt that most of what they did went unrecognised and often undervalued. Of the 86 workers who felt that people outside of aged care did not understand the work, 50 felt that the complexity of the role was not understood, 23 said that people don't see the emotional demands of the role, while 6 thought that the general public just did not want to know about the reality of aged care.

> I don't think they've got any idea at all because what we actually do where I work is a lot more involved than just washing a resident and feeding them……Outside of aged care they don't realise. They think you just put a person in a nursing home and everything is sweet. They don't understand the logistics of having to look after a person 24 hours a day when you've got more than one person to look after. (RES, 59 yrs, F, PC)

> Certainly not the particular stresses of the industry….. the emotional, social and emotional strain that it puts on workers, and that ah, yeah basically the strain over the emotional states that people deal with; people don't come into aged care to get better, they come to die, and the effects on your private life, your personal life (COM, 35 yrs, M, Other)

> No, for a few reasons, people don't want to think about it, they don't want to face the fact that they are going to be old someday and they don't want to face the fact that they've put, ah, granny in someplace that is awful, and that maybe their mum might be in one. People don't really want to know because it is quite appalling, you know, even good ones are still bad, and that's not the fault of the carers, that's the way they are set up. (COM, 38 yrs, F, Other)

From the interviews it is possible to see that the emotional demands of caring for elderly, frail and sometimes vulnerable people can take a toll on the emotional (and physical) wellbeing of direct care workers. A question that came to the fore when analysing the

interviews was whether this was having an impact on how workers' combined their aged care work with their non-employment responsibilities. There are some indications that workers are responding to these emotional demands by working extra hours, unpaid, and by the impact that their work has on their family life.

Working beyond their paid hours within an organisation was one way in which direct care providers could ensure they were providing the level and type of care that they considered appropriate. Twenty-one interviewees said that they worked 'unpaid overtime', often to spend a bit more time with residents.

> I have the official hours of 76, or whatever it is, a fortnight, but honestly I do about 85 or so, about 10 hours a week I volunteer here and then just do the work anyway (COM, 35 yrs, M, Other)

> I do 5 shifts of 8 hours, but I have stayed longer—not paid overtime. Just stayed longer with some of the residents, not paid its just by choice. (RES, 49 yrs, F, Allied Health)

> Legally I do 40 hours a week; off the record it's nearly 50 hours on a normal week (RES, 38 yrs, F, PC)

It is also possible that the propensity of direct care workers to do this kind of overtime is being used by managers to fill gaps and manage the workload. This was not discussed in the interviews, and may be worthy of further investigation. There was some evidence, however, that managers are unwilling to pay for overtime even if the work is required:

> I work 40 hours paid, only 8 hours a day are paid, but I work 12 hours. We're not allowed to do overtime. We would have to put a request in writing to the CEO and then they question us about why we're still here (RES, 25 yrs, F, Allied Health)

The willingness to work extra hours, unpaid, necessarily means that the interviewees had less time for their family and other non-employment responsibilities. Twenty-seven direct care workers (11 from community and 16 from residential organisations) indicated that work impacted on the time they had for their non-employment responsibilities. In addition to this, 12 interviewees said that work impacted directly on their family.

Besides the workers' commitment to the care recipients there could be two other plausible explanations for this level of unpaid work. One is that the workers are committed to the organisation rather than the residents. However, there was no evidence of this from the interviews, with 31 interviewees being dissatisfied with the organisation and even more citing organisational factors as the most likely reason to leave the job. The second possible explanation is that workers feel obliged to work overtime for fear of losing shifts or projecting a poor work ethic. Once again, there is little evidence to support this. Not only were the interviews conducted at a time when the labour market was strong and employees have an advantage, but more full-time than part-time employees work extra unpaid hours. That workers are prepared to spend time with residents in lieu of spending time on their

non-employment activities is more likely to be because of the commitment they have to the residents. This is nicely articulated by one of the direct care workers:

> It cuts into my time because I never get out on time. If I go shopping, often I'll do shopping for work as well; also the little jobs for the residents—picking up stuff. I actually will take my lunch break and will walk them down in the wheelchair, do the errands I need to do for myself and then bring them back. (RES, 25 yrs, F, Allied Health)

7.3.3 Work–Life 'Balance'

The management of employment and non-employment responsibilities is commonly referred to as a quest for work–life 'balance'; although for many people this is more likely to be a 'juggle'. Aged care work is predominantly undertaken by women and, in Australia, this means that they are likely to have primary responsibility for domestic and family related work. This section discusses how the interviewees managed to combine their employment and non-employment responsibilities, focusing particularly on their family. Although there is some focus on the strategies they explicitly identified in doing this, most of the discussion is about the indirect strategies used: the factors influencing their hours of work, and the time–money / life–work nexus.

While the 46 workers with children consistently discussed their caring responsibilities in the interviews, when it came to what difference they thought that a good work–life balance had, their answers were primarily in terms of quality of life.

Table 7.9: Number of interviewees indicating the effect of a work–life balance by type of aged care provider

	Type of Aged Care Provider	
	Community	**Residential**
Mental health, mood and attitude	29	25
Lifestyle	18	13
Physical health	5	5

In short, a work–life balance would help them to be healthier and happier. As the following quote shows, sometimes the interviewees indicated that improving their quality of life would have a flow-on effect to the family:

> I'd have more time to concentrate on my children's schooling and to enjoy each other more; and enjoy the work I do more. At the moment they go 'oh, you have to go to work', so I think having a work–life balance would make life a little less stressful' (COM, 36 yrs, F, EN)

As discussed earlier, there was no doubt that some direct care workers found their work emotionally and physically demanding and that working fewer hours would be one way of dealing with this. Health was a recurring theme that was raised spontaneously in the discussions with workers about how they combined work and life.

While a work life balance was desirable, it was not always available. Table 7.10 shows that 59 interviewees said that their work impacted on their life and 41 said that their life impacted on their work.

Table 7.10: Number of interviewees answering 'yes' to questions about combining work and life by type of aged care provider

	Type of Aged Care Provider	
	Community	**Residential**
Work impacts on life	29	30
Life impacts on work	27	14

Of those workers discussing the impact of work on their lives, 27 said that they did not have enough time for non-employment responsibilities, 12 said that it had a negative impact on the family, 8 workers said they found it difficult to 'switch off' and that they thought about work outside of work-hours, and another 8 said that work had an impact on their health and wellbeing.

> Sometimes you can't leave work on time because you have something to sort out or I don't get back until late from the outreach work. That makes me late so I can't spend time with my partner or dogs. Also if I'm really stressed out or drained—the work takes a lot out of you—I don't feel like talking to anyone! My partner doesn't really get it because he's an electrician, but I don't have anything left to give when I get home (COM, 32 yrs, F, Allied Health)

> Because it's physically, mentally and emotionally draining I think it impacts on your social life because you can't be bothered. You tend to spend more time at home than socialising. I think it has a significant impact—my mother lives down the coast and if she didn't come up every second weekend we'd never see her (RES, 49 yrs, F, RN)

Nearly two-thirds of those workers discussing the impact of their life on work were employed in the community sector which has less regular shifts or work hours, resulting in the need to constantly reorganise personal and work schedules. As the quote below shows this issue was not totally confined to the community sector as it also affected some casual residential aged care workers.

> It is starting to impact on my non-work life, especially when I want to see people etcetera. I don't get much notice, sometimes its like 'can you come in now?' other times they give you three hours notice! (RES, 21 yrs, F, PC)

Ten workers said that a family emergency would have an impact on their work, but otherwise they tended to manage their life around their work.

> I make sure that the other activities don't clash with my work. Or my partner's home to look after the kids if I've got to go to work (COM, 36 yrs, F, CCW)

Most interviewees had explicit strategies for managing their work-life interaction. Of the 86 who said that they used strategies, 38 used organising strategies such as maintaining a diary or list, 22 had time-management strategies such as sticking to a routine, while seven said that just keeping fit or having a healthy diet helped them to manage their multiple responsibilities.

> I plan stuff, that helps (RES, 46 yrs, F, PC)

> When the children were young, I was at the hostel and I had permanent evening. My husband is a school teacher and that worked really well, it was ideal at that time (RES, 47 yrs, F, EN)

> You need to exercise regularly, my tips would be to exercise regularly, don't go home after work but to go exercise and then go home, that helps a lot (RES, 48 yrs, F, RN)

Although people did discuss explicit strategies for managing the interaction between work and their non-employment responsibilities, it was evident from the broader discussions that the main strategy was to have an employer who would provide regular hours, at the times needed (to work around non-employment responsibilities) and which provided the required amount of money. For many of the interviewees, direct care work provided an opportunity for structuring a work life around these considerations. This was evident when discussing what people might need to think about if they were asked to work more or less hours.

Answers to this question should be placed in the context of the existing work hours of the interviewees. There were 49 direct care workers who worked full time (more than 30 hours) while 45 worked less than 30 hours. For 18 of the part-time workers, their hours varied from week to week, with another 18 interviewees working in multiple jobs. The main considerations when deciding how much time interviewees should spend at work were money, time, family, physical or emotional limitations, and workload. Another issue mentioned by six community aged care workers was travel.

Table 7.11: Considerations when asked to work more or less hours, number of interviewees by type of aged care provider

	Type of Aged Care Provider	
	Community	**Residential**
Money	28	30
Time	21	15
Family	16	12
Physical/emotional limits	8	11
Workload	6	7
Other jobs or study	5	5

One theme that kept arising in the interviews was how, for many workers, there was a money—time trade-off that influenced how they managed their employment and non-employment responsibilities. That is, where possible, they worked 'enough' hours to satisfy their immediate financial needs. Once these were met, then the appeal of working more hours decreased—especially if they had other responsibilities that required an input of time such as family or study.

> I wouldn't want to work more, things are working out well at the moment. I could cope with a little less, but the less money I earn the less I can do with my family. (RES, 47 yrs, F, Allied Health)

> Less hours, I couldn't afford the drop in pay. More hours I could do depending on how many; I could do an extra shift or two but if you asked me to do three extra shifts, I wouldn't be able to do that. The home life, my husband wouldn't be happy about it. Nothing would get done. (RES, 45 yrs, F, PC)

Several interviewees with children mentioned having organised their work to fit in with their children's schedules. They work while the children are at school, or to fit in with their partner's schedule so that the children are cared for. Some comments were made about the feasibility of using childcare on the wages they receive. Overall, it seemed that once an employee had been in an organisation for a little while they were able to negotiate the shifts that suited them. This was possibly enhanced by there being a tight labour market at the time of the interviews. This would mean that employers would be more likely to address the needs of existing workers.

> I work with an agency, a nursing agency and I do that once a fortnight, twice a month and with (company name) I work every second fortnight on a Sunday and I take extra shifts when they need it, and at (another company name) I work five days a week…..(COM, 48 yrs, F, Allied Health)

> I wouldn't do a 9–5 job because of the kids … I asked for a half a day off one day a fortnight so I can get more things done before the kids get home and they gave it to me (RES, 42 yrs, F, PC)

While this level of flexibility was apparent for workers in metropolitan areas, it was less realistic in rural areas where the options for taking multiple jobs in aged care or changing shifts was more difficult:

> Last year I had to decrease my hours to look after my daughter who has a disability, and I haven't been allowed to go back to full-time yet. Financially I couldn't stay in the job if they decreased my hours more. I'm looking for a second job because at four days a week, this job isn't financially viable; we struggle from week to week (COM, 35 yrs, F, Other)

Despite dissatisfaction with the rates of pay, expressed by 69 workers, only 10 interviewees said that they would leave their job for more money. Mostly, decisions to leave were based

on organisational factors such as issues with management, organisational culture or work conditions. Only five interviewees said that they would leave for family reasons. This is another indication that the direct care workers feel as though they can achieve the flexibility required to meet their financial, family and other non-employment responsibilities within their current workplace.

7.3.4 Professional Development

One component of the interviews with direct care workers focused on their experiences of education and training. Discussions about education and training covered the kinds of training undertaken to enter the industry, the strategies used to combine work and study, the organisational support provided to undertake training and the relevance of internal training.

Nine interviewees entered aged care work through their training course, with residential aged care workers being twice as likely as community aged care workers to use this pathway. A further 13 interviewees (six community and seven residential aged care workers) entered aged care work because they saw it as a pathway into nursing; that is, undertaking further education was an explicit aim of working in the sector.

The survey responses indicated that 23 interviewees were currently undertaking formal study, and a further 51 had post-school qualifications in an aged-care related field. For some interviewees, going into aged care gave them an opportunity to update their skills and qualifications:

> I had been nursing, I had gone to clerical work and I wanted to get back into nursing and I saw a job advertised for Certificate III in Aged Care. Being a Div. 2 nurse, I know I've automatically got that, so I rang up and said "I don't have the certificate III but I'm a Div. 2," and they said, "Oh, send us your resume" and so I did, and I got the job. (COM, 46 yrs, F, EN)

Of the 23 interviewees who were currently studying, 17 mentioned that their study was related to aged-care. For those currently undertaking further education, it was evident that working in aged care gave them the flexibility to manage combining paid work and study:

> I work afternoons and the two days I go to school are my days off. (RES, 53 yrs, F, PC)

> Because I am working the afternoon shifts, it is allowing me to go to the gym in the morning; but university will be going back again in March so I will be dropping a lot more shifts at work. (RES, 26 yrs, F, EN)

Despite the flexibility it was apparent that, for some, combining work and study was challenging:

> While I'm not at university, life is running very smooth and I come home and try to unwind; doing things for myself. University is a very challenging and stressful time and the one has to give—but they don't. Because they are both demanding and I am not prepared to give up my work because I enjoy being out in the industry. That is probably why uni tends to suffer! (RES, 26 yrs, F, EN)

While for another six workers, the need to earn an income meant that they could not afford time off to study, or do any training that involved reducing hours or which had financial repercussions:

> Unfortunately I have to work. I have a mortgage on my home so I don't really have the luxury of trying to do any extra training. (RES, 47 yrs, F, PC)

> You can actually do the Certificate IV and some of the girls are doing it, but I can't afford the time without being paid. (COM, 56 yrs, F, CCW)

Once employed in the aged care sector, 79 interviewees found that their employers supported them to do further training. In contrast, only 14 direct care workers suggested that their employer was not supportive in this regard. A total of 38 interviewees discussed the distinction between internal and external study/training. Internal training was seen to be widely supported, with only two interviewees suggesting that they did not get support to do this form of training. On the other hand, seven interviewees said that they were not supported to do external training.

Interviewees emphasised three ways in which their employers could support their study: by advertising; by providing staff with time off for study; and by supporting staff financially by paying for their course or by paying them for study time (see Table 7.12). Twenty nine interviewees commented that their organisation let them know what training was available and when it was being held.

Table 7.12: Proportion of respondents who identified ways in which they were supported to undertake training by type of aged care provider

Support for Training	Type of Aged Care Provider	
	Community	Residential
Advertising	18	11
Financial	12	14
Time off	8	8

A total of 30 interviewees discussed being provided with financial assistance for their study, with 26 workers having either had their course paid for and/or having been paid for their time attending their course. The remaining four direct care workers mentioned that they had been required to pay for their course themselves or had not been paid for their time in work related study or training. A total of 21 interviewees discussed asking for time off to study, with 16 of these having access to time off while another five workers had requested, but were not given, time off to study.

During the discussions about training, five workers indicated that the internal courses were repetitive or were not particularly useful for their work. As the second quote below suggests there was a clear distinction between training and study.

> They do send us on courses but I feel sometimes the courses are a little bit, I've been better trained before. It's no new information. It's not very satisfactory to attend courses that you know you've done. (RES, 36 yrs, F, RN)

> They keep saying we've got to keep doing it….We've always got to do food safety and this and that, hygiene. We're constantly doing that, but real study? That's minimal. (COM, 62 yrs, M, Allied Health)

7.4 Conclusion

The interviews with direct care workers about their experiences of working in aged care were undertaken to gain a better understanding of how workers combine their aged care work with non-employment responsibilities. In analysing the interviews this issue was discussed under the headings of a) the decision to be an aged care worker, b) their commitment to residents or care recipients, c) work-life 'balance' and d) professional development. In concluding this section, these themes will be revisited to draw out some of their implications for workforce planning.

While there are multiple pathways into aged care work, the interviews highlighted the ways in which some women drew on skills developed from their non-employment responsibilities, such as cleaning and caring for family. The perceived similarities between the domestic sphere and the aged care sector in the type of work involved undoubtedly increased women's confidence in their capacity to do aged care work. However, to a certain extent this reinforces the idea that care work is unskilled work; that it is something that women do 'naturally', and it is therefore not necessary to 'value' these skills in the same way that other skills get valued. This type of thinking contributes to the argument for keeping wages in care work low. It is worth noting that low wages remain an issue for care workers with evidence from the survey indicating low levels of satisfaction with pay, although slightly higher than in 2003.

The assumption that women are 'natural' carers also fails to distinguish between good and bad care. Not every mother provides quality care to her children. If these domestic and familial skills are to be recognised as a) skills and b) a basis for entering aged care, then developing a process for assessing this form of prior learning would assist in both quality control and in placing a more realistic value on care work.

The general surveys show that another pathway into aged care, particularly for PCs and CCWs is through a variety of low paid, women's service occupations (e.g. sales, clerical, cleaning). The surveys did not ask for the reasons for getting into aged care work. In addressing this issue in the interviews it was apparent that the flexibility associated with aged care work and the ease of getting into this kind of work were important factors. It is possible that these reasons could also help to explain why people left their previous occupations and move into aged care. For example, the surveys provide evidence for the suggestion that workers move in and out of aged care work as they need, with many having previous relationships with a particular employer before getting their current jobs. About one quarter of CCWs and PCs had worked with their current employer—for pay or unpaid—before getting their current job, with the proportion being even higher for nurses.

The capacity to move in and out of aged care work is an indicator of the importance that flexibility in working arrangements has for enabling direct care workers to combine their work and non-employment responsibilities. The flexibility of aged care work was reinforced in the data from the surveys. Although flexible work arrangements are sometimes maligned as being more about flexibility for the employer than the employee, in aged care it seems that it also works for the employees. It is likely, however, that there would be limitations to this. The interviews suggested that workers saw flexibility as a reciprocal notion—they were willing to be flexible in their hours, as long as the employer took account of their needs, such as education and family, and provided suitable 'core' hours.

Beyond the issues of access and flexibility, many direct care workers move into and stay in aged care because of their commitment to residents or care recipients. The 'caring' part of care work features highly in both the interviews and the surveys: this is what people enjoy about their work. From the general surveys it was evident that levels of satisfaction with the work itself was very high, with CCWs having somewhat higher satisfaction than PCs—possibly a reflection of the fact that their role involves more time spent caring.

This level of commitment to care recipients was illustrated in the number of unpaid hours that the interviewees contributed to their employer. This was reinforced in the general survey where this kind of unpaid work is performed by nearly one quarter of all direct care workers. This level of unpaid work raises questions regarding the extent to which aged care organisations depend on this contribution in order to function. To put it another way, if direct care workers withdrew this voluntary labour, would employers need to employ more (paid) workers? It is not clear from the interviews or the surveys whether this is the case. However, it may be worth further investigation as it does have workforce implications. At the minimum it could be useful to formally recognise this unpaid work.

It was clear from the interviews that the relationships between direct care workers and the care recipients / residents were complex. While for the most part the workers enjoyed the company of the aged and helping to make them comfortable in their latter years, there was another side to the relationship. The elderly die, they can become demented causing aggression and confusion, and sometimes they can be physically abusive. Managing this was demanding and distressing for the workers. Many return home physically and emotionally drained. Addressing this issue is partly about occupational health and safety, but also about providing adequate opportunities for debriefing and attending to the emotional and mental wellbeing of the workers. This can be formal (e.g. counselling) or informal (e.g. encouraging workplace socialising/community) but would undoubtedly be beneficial to the long-term capacity of workers to deal with this aspect of their work.

Another issue influencing the wellbeing and quality of life of direct care workers is their capacity to achieve a level of work–life 'balance'. In this section of the analysis the focus turned to the capacity to combine aged care work with family and study. It is worth noting that the interview sample under-represents full-time workers and those with second jobs and may therefore overstate the capacity to achieve such 'balance'. From the interviews it was evident that the main strategy used to achieve a level of work–life balance was to have an employer who would provide regular hours, at the times needed (to work around non-employment responsibilities) and which provided the required amount of money. This

raises two interesting workforce issues. Firstly, that the appropriate rostering of employees is important. A manager who takes workers' non-employment responsibilities seriously is likely to be rewarded with lower turnover and a level of reciprocal flexibility mentioned earlier. Workers' capacity to manage the combination of work and non-employment responsibilities was largely influenced by their rosters and hours of work. Workers with less regular shifts or work hours had to constantly reorganise their daily lives around uncertain work schedules. Although more prevalent in the community sector, this issue was also discussed in interviews with residential aged care workers. The ability for organisations to take account of workers' non-employment responsibilities in rostering will be influenced by their location (rural services appear to be less flexible, possibly because they do not have the same pool of workers to draw upon), size and sector (community and residential services have different models of care). Nevertheless, it does highlight the important role that managers have in the retention of staff and on their levels of satisfaction with the work.

Secondly, when workers are offered more or less hours the main consideration is not always money, or at least not the capacity to earn more money. Many of the interviewees had structured their work so that they earned a certain amount of money—whatever was necessary to meet their obligations. Working fewer hours would affect their financial position. However, if they did not necessarily need to work more hours and they were offered more hours, the main consideration was the impact on their non-employment commitments and responsibilities, or on their health and wellbeing. In this context, the low levels of satisfaction with pay (discussed above) might also be influenced by the impact that working longer than preferred hours to achieve the required level of pay has on their non-employment responsibilities, including their own health.

The last area discussed in the interviews was how workers combined work with study and professional development. It was apparent from the general surveys that a lot of direct care workers are currently studying: between 15–20 per cent of all direct care workers and one quarter of those hired within the last 12 months. The interview sample had an even higher proportion. Most of the interviewees were studying courses related to aged care, and a substantial proportion entered aged care either through their training course or in order to do further study. Overall, it seems that direct care workers are obviously keen to improve their qualifications. This is reinforced in the survey data where the analysis uncovered a small increase in the proportion of PCs with Certificate 3, and a bigger increase in those with Certificate 4 (but still only a small minority have Certificate 4). It is slightly different in the community sector where approximately 40 per cent of CCWs still do not have a relevant Certificate 3 (approximately 10 percentage points higher than in the residential sector). Whether or not qualifications lead to a career-path in aged care could not be ascertained from the data. If aged care work is to be promoted as a career, rather than an unskilled job, then more information on education-related pathways may be required.

The main mechanism that workers use to combine work and study is to manage their flexibility: changing rosters, hours of work, etc. Study therefore has a financial implication for workers, who take a drop in pay as well as having to pay for their studies. Although some interviewed workers did receive financial assistance with their study, it was not clear which form this took: paid study leave, assistance with fees and books, or the prepayment of HECS (or similar) fees. These kinds of assistance are routinely offered in other industries as

incentives to study and as recognition that the industry will benefit from a more educated workforce. Whether or not these could be provided on an industry-wide basis rather than on an employer-basis might also be worth considering as this would alleviate employer concerns with workers leaving after gaining qualifications, while providing employees with the flexibility to change jobs and employers if desired.

Beyond formal study, the majority of interviewees thought that their employers provided adequate support for internal training, although the quality and relevance of this training was sometimes queried. Certainly the level at which the training is delivered appears to cater for PCs and CCWs rather than the nurses and allied health workers. Some stratification of the training course which acknowledges and builds on pre-existing skills and education might be useful.

8. Employment of Workers from Culturally and Linguistically Diverse and Aboriginal and Torres Strait Islander Backgrounds

8.1 Background

In response to concerns that the inclusion of culturally and linguistically diverse and Aboriginal and Torres Strait Islander background workers in the various workforce samples should appropriately represent their characteristics and experiences, the Department of Health and Ageing commissioned NILS to conduct case studies of 125 aged care providers. As stated in the tender, this approach aimed to validate the results for culturally and linguistically diverse and Aboriginal and Torres Strait Islander background workers from the main surveys:

> Results from the previous study of the residential aged care workforce suggested that there was no substantial over-representation of overseas born workers in the residential aged care workforce. However, the basic mailback survey approach, without follow-up, that was used in that survey may have under-estimated the number of overseas born, particularly those of culturally and linguistically diverse backgrounds, and may also of under-represented Aboriginal and Torres Strait Islander people.

This research aimed to provide definitive answers to the following questions:

- Do the results from the workforce surveys significantly under-represent (or over-represent) direct care workers from culturally and linguistically diverse (especially overseas born) or Aboriginal and Torres Strait Islander backgrounds?
- Do culturally and linguistically diverse and Aboriginal and Torres Strait Islander background workers face particular hurdles or barriers in working in the aged care sector?

In negotiation with the Department, a third question, about workers motivations, pathways, sources of job satisfaction or dissatisfaction was excluded as it would not be possible to gain this information from managers. These questions would need to be addressed by speaking with direct care workers from a culturally and linguistically diverse or Aboriginal and Torres Strait Islander background.

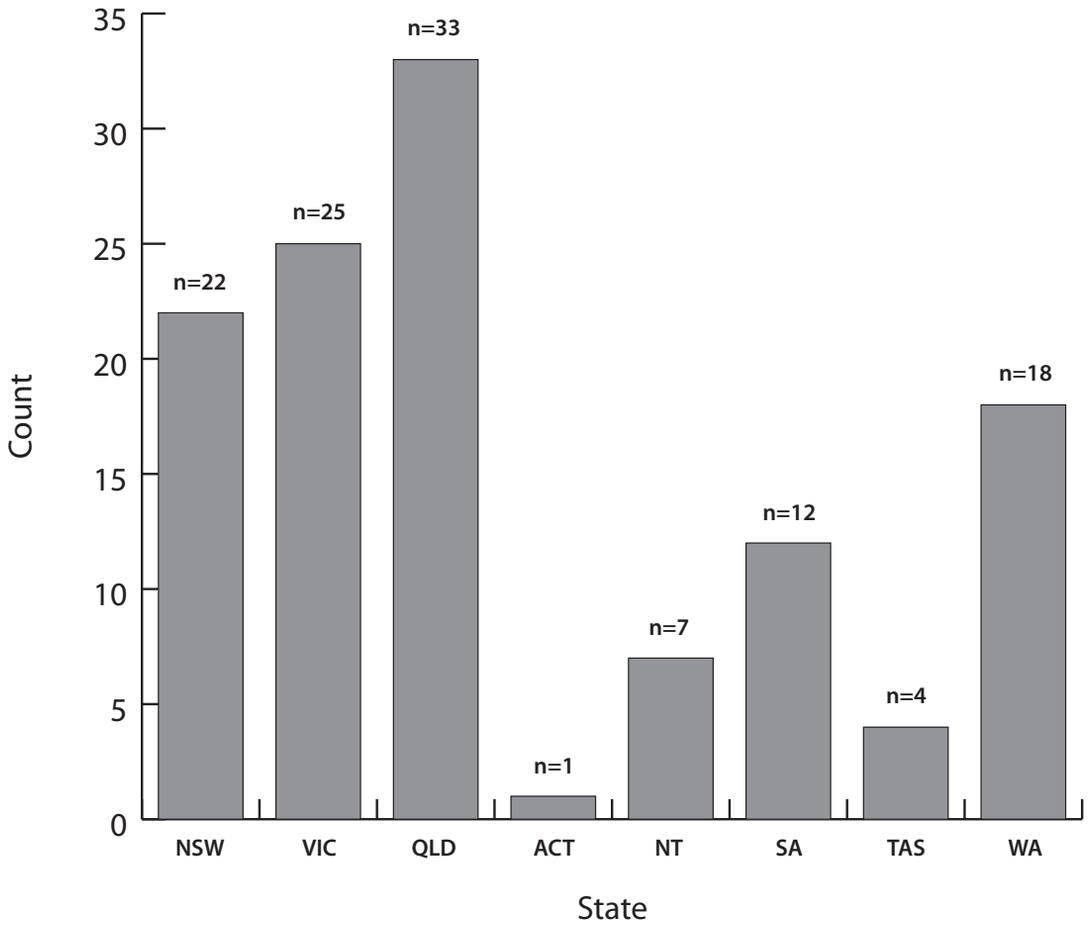
8.2 Methodology

Managers[25] from 125 aged care services were interviewed to gather information about workers from culturally and linguistically diverse and Aboriginal and Torres Strait Islander backgrounds at their organisation. Sample selection was based on two sources. The main Census sample frame was used to randomly select community aged care service outlets

25 This included nursing managers, CEOs and supervisors.

and residential aged care homes, while the sample for Aboriginal and Torres Strait Islander service outlets was provided by the Department of Health and Ageing. A total of 50 (from a sample of 84) community aged care service outlets and 75 (from a sample of 118) residential aged care homes participated in the interviews. Of the residential aged care homes, 25 were from the sample of Aboriginal and Torres Strait Islander organisations and 50 were from the random sample.[26] One of the residential aged care homes from the random sample also identified as catering specifically for Aboriginal and Torres Strait Islander clients. Although the sample was not stratified by state, it was checked to ensure that all states were included in the random sample (Figure 8.1).

Figure 8.1: Number of organisations interviewed by state



26 One organisation was interviewed twice, once as a community aged care service outlet, the other as a residential aged care home. As the information gained was the same, this organisation was only included in the interviews for the community sector.

A brief demographic overview of the 125 organisations demonstrates that a range of organisations were interviewed:

- Remoteness index (missing data = 2):
- 45 metropolitan
- 26 regional
- 35 rural
- 17 remote
- Ownership type (missing data = 3):
- 84 not-for-profit
- 13 for-profit
- 25 government

Managers were contacted by telephone and a mutually convenient time was scheduled for the interview. Each interview was digitally recorded after permission was obtained from the respondent. Interviewers called each participant from the sample group a maximum of three times before they were excluded from the sample list. Interviews took place from December 2007 until early March 2008.

The interview schedule addressed the issues of targeting, recruiting, training and retention of workers who were from Aboriginal and Torres Strait Islander or culturally and linguistically diverse backgrounds. Prompts were provided in the interview schedule for most questions and aided in eliciting further information and elaboration from interviewees. Two kinds of data were gathered. Numerical data was entered into SPSS for comparison with the data from the main Census and Survey. The qualitative aspects of the interviews were transcribed using a combination of notes and quotes, rather than verbatim transcription, and coded according to themes discussed. It should be noted that participants may have provided responses that cover multiple themes, and, given the nature of semi-structured interviews, some interviewees may not have addressed all of the questions.

8.3 Comparison of Data from Census / Survey with Organisations Interviewed

The central purpose of the interviews was to identify whether workers from culturally and linguistically diverse or Aboriginal and Torres Strait Islander backgrounds were represented fairly in the surveys. Questions were asked about the numbers of culturally and linguistically diverse or Aboriginal and Torres Strait Islander workers in each of the four occupational categories. Of the 125 organisations interviewed, 32 did not employ any culturally and linguistically diverse or Aboriginal and Torres Strait Islander workers. Workers from culturally and linguistically diverse backgrounds (CALD) were employed by a similar proportion of residential and community aged care organisations, while workers from an Aboriginal and Torres Strait Islander background (referred to as Indigenous in tables) were more likely to be in residential aged care organisations (Table 8.1). This is not surprising given that 25 of the organisations interviewed had been targeted because of the likelihood they were providing services to residents from an Aboriginal and Torres Strait Islander background.

Table 8.1: Number of interviewed* organisations employing Aboriginal and Torres Strait Islander (Indigenous) or Culturally And Linguistically Diverse (CALD) employees by type of aged care provider

	Type of Aged Care Provider			
	Community Indigenous	Community CALD	Residential Indigenous	Residential CALD
None	43 (86%)	16 (32%)	43 (57.3%)	26 (34.7%)
1 or more	7 (14%)	34 (68%)	32 (42.7%)	49 (65.3%)
Total	50 (100%)	50 (100%)	75 (100%)	75 (100%)

** Note: this includes all 125 organisations in the sample. One community provider had culturally and linguistically diverse workers but did not know how many; this organisation is included here but not in the tables below.*

The following two tables provide an overview of the numbers of workers from culturally and linguistically diverse and Aboriginal and Torres Strait Islander backgrounds in the organisations interviewed. Table 8.2 compares the numbers of workers in relation to whether they were employed by residential aged care homes or by community aged care service outlets. In contrast, Table 8.3 provides a comparison of the number of workers of culturally and linguistically diverse or Aboriginal and Torres Strait Islander background in each of the sample groups.

Table 8.2: Number of Aboriginal and Torres Strait Islander (Indigenous) and Culturally And Linguistically Diverse (CALD) employees in the organisations interviewed by type of aged care provider

		Type of Aged Care Provider		
	Community Indigenous	Community CALD	Residential Indigenous	Residential CALD
RN	3	12	6	80
EN	0	0	13	36
PC/CCW	41	320	109	338
AH	4	20	4	10
Total	**48**	**352**	**132**	**464**

Table 8.3: Number of Aboriginal and Torres Strait Islander (Indigenous) and Culturally And Linguistically Diverse (CALD) employees in the organisations interviewed by sample group

		Sample Group		
	Random* Indigenous	Random CALD	Targeted# Indigenous	Targeted CALD
RN	6	69	3	23
EN	1	30	12	6
PC/CCW	54	575	96	83
AH	4	25	4	5
Total	**65**	**699**	**115**	**117**

** Random—from the 100 organisations in the random sample*

 # Targeted—from the 25 organisations in the Aboriginal and Torres Strait Islander services sample

Our interviewers questioned homes directly about the number of their direct care workers who were Aboriginal and Torres Strait Islanders or from culturally and linguistically diverse backgrounds. Comparing the proportion of direct care workers in our interview sample who were of Aboriginal and Torres Strait Islander and culturally and linguistically diverse backgrounds with the proportions in our workers' survey samples provides a test of whether our surveys represented culturally and linguistically diverse and Aboriginal and Torres Strait Islander workers appropriately (see Table 8.4).

With regard to culturally and linguistically diverse workers, there are no indications that either of our samples of direct care workers under-represent these workers. In interviews with managers of 50 residential homes, managers indicated that 17.4% of their direct care workers were of culturally and linguistically diverse backgrounds, while a slightly higher proportion, 19.9%, of respondents to our worker survey were born in a country where English was not the main language. The pattern is very similar for community based outlets and the community based worker sample—outlet managers said that 20.1% of direct care workers in the sampled outlets were of culturally and linguistically diverse background, while 14.8% of respondents to our sample of direct care workers were born in non-English speaking countries. Overall, these results should give us considerable confidence that culturally and linguistically diverse workers are not significantly under-represented in our workers samples.

It also appears that our surveys represent Aboriginal and Torres Strait Islander workers in roughly appropriate numbers. The number of Aboriginal and Torres Strait Islander workers in the aged care workforce is clearly very small, in the order of 1–2% overall. In our random interview sample, we found 0.9% of residential workers were of Aboriginal and Torres Strait Islander background, while our workers sample gave a figure of 1.4%. Our random interview sample found 2.3% of Aboriginal and Torres Strait Islander workers amongst community based aged care workers, compared to 1.5% in our survey sample of community based workers. Thus, it seems unlikely that our sample surveys significantly under-represent

Aboriginal and Torres Strait Islander workers. They are a very small proportion of all aged care workers, and any study of their experiences and employment would need to be undertaken through targeted research.

Table 8.4: Proportion of Culturally and Linguistically Diverse (CALD) and Aboriginal and Torres Strait Islander (Indigenous) workers from interview samples and worker samples

	Proportion of workers who are CALD (per cent)	Proportion of workers who are Indigenous (per cent)
Residential		
Workers survey sample	19.9*	1.4
Interview sample	17.4	0.9
Community based		
Workers survey sample	14.8*	1.5
Interview sample	20.1	2.3

* Proportion of workers not born in an English speaking country, i.e., not born in Australia, the UK, New Zealand or South Africa.

Questions about workers from culturally and linguistically diverse backgrounds were also in the Census. Table 8.5 compares the results of these questions for the 125 managers interviewed with those of the whole sample in the Census. As would be expected, a higher proportion of organisations catered for specific culturally and linguistically diverse groups. This can be explained by the inclusion of Aboriginal and Torres Strait Islander specific organisations in the interviewed sample. Interestingly, however, there were less residential aged care organisations that targeted culturally and linguistically diverse staff in the interview sample than there was in the general sample. Conversely, more community aged care organisations targeted culturally and linguistically diverse staff in the interviews than would be expected, given that this sample was randomly selected. While some managers were notably cautious in answering questions about the targeting of staff for fear of appearing in contravention of Equal Opportunity regulations, this does not explain why the managers interviewed from the community sector target culturally and linguistically diverse staff more than their counterparts in the general survey.

Table 8.5: Comparison of census responses for questions relating to the employment of Culturally And Linguistically Diverse Workers for interviewed sample and total sample, by type of organisation

	COM Interview	COM Survey	RES Interview	RES Survey
Census comparisons				
A8: Cater for specific CALD group (yes)	52.3%	46.5%	32.4%	16.9%
A9: Target CALD staff (yes)	78.3%	72.3%	67.6%	77.9%

8.4 Employing Workers with a Culturally and Linguistically Diverse or Aboriginal and Torres Strait Islander Background

The second aim of the interviews was to identify any special hurdles or barriers faced by culturally and linguistically diverse and Aboriginal and Torres Strait Islander workers. To balance this discussion a question was also asked as to whether there were any benefits to employing culturally and linguistically diverse and Aboriginal and Torres Strait Islander workers. The discussion which follows is based on responses from the 93 organisations where there were Aboriginal and Torres Strait Islander or culturally and linguistically diverse (or both) direct care workers (this includes one organisation which had culturally and linguistically diverse workers but could not provide numbers).

8.4.1 Benefits

It was evident from the interviews that managers valued many aspects of employing culturally and linguistically diverse and Aboriginal and Torres Strait Islander workers, with only 11.8% of employers indicating that there were no benefits. Table 8.6 provides an overview of the main benefits discussed.

Table 8.6: Proportion of managers who identified benefits of employing Culturally And Linguistically Diverse and/or Aboriginal and Torres Strait Islander Workers

Benefits	%
Cultural understanding and activities	67.7
Language	58.1
Good work ethic	14.0
Linking clients to ethnic communities	10.8
Linking organisation to ethnic communities	6.5

The most frequent benefit cited by managers was that employing people from culturally and linguistically diverse or Aboriginal and Torres Strait Islander backgrounds enhances opportunities for ***cultural understanding*** as well as culturally specific activities. Of the 63 managers who discussed this benefit, 17 were from Aboriginal and Torres Strait Islander based organisations. The benefit of having culturally diverse employees was particularly appreciated when workers were culturally 'matched' with particular clients, however, cultural diversity was seen as positive for the client population as a whole.

> A lot of them are family to the residents; the benefit of having male and female is that it's culturally appropriate, males looking after males and females looking after females. (RES 0940, Indigenous)

> I know the residents appreciate the cultural diversity (RES 1927)

> It's very good for a facility to have backgrounds like that if you can because you just learn different things from different people…And I think that's a really big difficulty you have in aged care that there is a general lack of tolerance anyway because of the ageing process (RES 2048)

Related to this raised level of cultural understanding, managers also employed the term 'empathy' when describing benefits. In particular, managers mentioned empathy as being part of these employees' general attitudes towards other marginalised groups and the elderly in general.

Over half of the managers employing culturally and linguistically diverse or Aboriginal and Torres Strait Islander workers stated that benefits also flowed from having workers who could ***speak a language other than English***. Whilst there was recognition that care workers could not act as formal interpreters/translators, 10% specifically referred to the advantage of being able to have workers who could break down communication barriers. There was some acceptance that regardless of formal requirements, carers were acting as informal interpreters for clients in many situations. This was particularly important when clients reverted to their first language as they got older or acquired dementia.

> They communicate with clients who quite often revert the mother tongue…so the carer who is bi-lingual can communicate with the clients and understand and communicate with mainstream services, including nurses, community nurses or anyone else…they're not allowed to interpret or translate for them, they're allowed to work as language aides and that is a very important thing. (COM 2052)

> They can speak the same language quite often. They have a better understanding about cultural backgrounds … like education and things like that, they relate on a much better level (RES 0943, Indigenous)

> One of our carers is Fijian and we had a resident here for many, many years who's Fijian and who hadn't been back to Fiji and who actually, didn't have a passport and….she worked with him for some months and eventually she got him his passport and then got him in touch with his family and his daughter hadn't seen him for 30 years. (RES 1998)

> It certainly is an advantage because sometimes when they [the clients] get a little bit more demented they tend to go back to speaking Italian rather than speaking English so it is quite beneficial (RES 1394)

Beyond the worker-client benefits, the benefit of having a group of workers who spoke the same language was also recognised:

> Obviously if they do speak a different language—we've had other employees that have come on board, in the same boat, they feel comfortable working with each other as well as being able to provide assistance to the care recipients if needed. (RES1763)

Another benefit mentioned, particularly in relation to culturally and linguistically diverse workers, was the possession of a ***good work ethic***:

> Koreans are the most hard working people I've ever met in my life (RES 0376)

Having workers from culturally and linguistically diverse or Aboriginal and Torres Strait Islander backgrounds was also beneficial in terms of ***linking either individual clients, or the organisation as a whole with the wider community***. This linking into the wider community was considered to be particularly valuable for care recipients and their 'higher-order' needs.

> We're able to ensure we're providing culturally appropriate services….with the Polish group in particular we've been able to, for example, establish an ongoing group activity for a group of mainly Polish women who are care recipients… and what we've been able to do is set up a program around them… going out for, or sharing, a meal together. And that's facilitated by our staff, and what they do is get to the local Polish Community Centre. (COM 1881)

> Understanding, communication, talking at a grass roots level. Understanding that they do have extended family, so yeah, like we know their people, and their people and their people … usually one of the workers here knows their extended family … they're understanding of the problems that can be within their family (RES 1201, Indigenous)

8.4.2 Hurdles

While there were many positive features of employing culturally and linguistically diverse or Aboriginal and Torres Strait Islander workers, negative features were identified by approximately 29% of managers. Managers were asked whether they had experienced any issues when employing culturally and linguistically diverse or Aboriginal and Torres Strait Islander workers, with the probes focusing on the barriers or hurdles that workers might face in relation to different aspects of their work. The responses to these questions fell into three categories: hurdles relating to recruitment, to training and to the day-to-day management of culturally and linguistically diverse or Aboriginal and Torres Strait Islander employees

8.4.2.1 Recruitment

Although several managers noted issues with employing any direct care worker irrespective of their background, only a minority of managers identified any specific hurdles relating to the recruitment of culturally and linguistically diverse or Aboriginal and Torres Strait Islander workers. It is worth noting that this question appeared to cause some anxiety amongst a few of the managers who steadfastly maintained that they recruit according to equal opportunity legislation and do not discriminate on any basis.

> We are an Equal Opportunity organisation so they get the position on their merit. (COM 1205)

Although only raised by three managers, the NILS interviewers noted that other managers were also wary in answering this question, and that this may well have resulted in the under-reporting of hurdles in the recruitment process.

Table 8.7: Proportion of managers identifying issues with the recruitment of Aboriginal and Torres Strait Islander or Culturally And Linguistically Diverse workers

Recruitment Issues	%
Identifying potential workers	21.5
Short supply of workers with desired backgrounds	15.1
Lack of qualifications	5.4
Police Clearance	4.3
Visa restrictions	3.2
Issues in general	
Industry	5.4
Sector	4.3
Pay	4.3

Table 8.7 indicates that there appeared to be two key inter-related issues. On the one hand, managers had problems ***identifying potential workers***, that is, those people with specified culturally and linguistically diverse or Aboriginal and Torres Strait Islander characteristics who might be interested in working for their organisation. In terms of recruiting culturally and linguistically diverse or Aboriginal and Torres Strait Islander workers, 24% found that word of mouth was an effective measure, 27% used advertising, and 37% used linkages with other organisations (for example, job network agencies, local cultural groups etc) to recruit workers:

> The approach of recruitment…It's really about community development and getting out there. Most of the culturally and linguistically diverse workers don't read the newspapers, are not able to possibly read the language. So the way you advertise is different…through the community. So if we're trying to attract more Filipino workers we need to go to the Filipino community…More of that…and the hard thing is we're not funded, there's no funds to do this extra, it costs more. It costs more to have culturally and linguistically diverse workers on board. It's not easy. You have to do a lot more groundwork. You have to offer a lot more training. You have to offer a lot more service support within your agency so there's a lot more administrative support that happens. And that's all costly. So I think when funding is issued there needs to be an element where money needs to be forthcoming to compensate for that type of staff. (COM 3694)

Some managers, however, had resorted to brokering out clients who needed care workers with specific cultural or language knowledge:

> Due to the staff that don't have those languages, we've actually brokered those clients out to another service provider so they can find that level of service (COM 1393)

On the other hand, managers were also saying that there was a ***short supply*** of workers with desired backgrounds. Of the 14 managers suggesting this was an issue, 6 were from Aboriginal and Torres Strait Islander based organisations.

> Those kind of issues, ….in recruiting people who have a second language that could assist our clients who are from diverse backgrounds…availability, it's the availability of people who do speak a second language (COM 1296)

> Basically we prefer to employ Indigenous people…except in the current employment market…its basically the best person for the job and they have to be the best people for the job…all our clients are Indigenous, when we advertise we do prefer Indigenous people…[but] they have to meet the other criteria. (RES 0936, Indigenous)

> Everyone here is of Aboriginal and Torres Strait Islander descent…Management prefers getting the local Aboriginal people to work here…however sometimes, well there's no RNs…if there's no RN that's a Maree person, or Aboriginal and Torres Strait Islander person, well then we'll have to get a mainstream one (RES 1201, Indigenous)

As indicated in the last quote above, finding Aboriginal and Torres Strait Islander or culturally and linguistically diverse workers with the necessary ***qualifications*** was sometimes a challenge.

Two legal issues were raised in relation to recruiting culturally and linguistically diverse or Aboriginal and Torres Strait Islander workers. Both of these issues were raised spontaneously without prompting from the interviewers. For culturally and linguistically diverse workers the issue of Visa restrictions was mentioned by four managers, all of whom were in the community aged care sector.

> The casual nature of the industry…impacts on employing more people from culturally different backgrounds because of the Visa requirements (COM 1963)

The difficulty in providing either a suitable amount of work for the culturally and linguistically diverse employee or tracking the hours worked by the employee when the hours fluctuated or when the employee was also working for other organisations, were mentioned as impediments to employing more culturally and linguistically diverse workers on Visas. For Aboriginal and Torres Strait Islander workers, the legal requirement that staff have police clearance was an issue for four organisations, three of which were based in rural or remote locations.

> [We are] very sympathetic to why we have that criminal check and I endorse it, but it is an impediment to my employing everyone who is suitable and who comes through the door. Even if they are 40 now and they have lived an exemplary life since they were 18, the fact that they had this record from 20 years ago means that I can't consider them for employment here (RES 2792, Indigenous)

Three managers viewed difficulties in recruiting workers from culturally and linguistically diverse or Aboriginal and Torres Strait Islander backgrounds as being indicative of larger problems within the aged care industry.

> The pool of labour in aged care has shrunk unbelievably largely we believe as a result of the strong economy, full employment etc (COM 3712)

> We have an issue attracting workers full stop. So whatever background they came from we'd probably be keen to [employ them] (RES 1000)

Another three managers, all from the for-profit sector said that the shortage was due to better paid positions in the public health sector

> Ultimately the pool of skilled nursing professionals is extremely limited and very competitive where…we're a private sector and we're competing against the public sector that provides a different award structure which is far greater than ours (RES 2455)

It was also evident that a few managers saw themselves as facing multiple challenges in recruiting workers. In the following instance of attracting workers: to the industry; to the not for profit sector; and to a remote location.

> Why would you work in an industry like aged care when you can make much, much more money elsewhere…being in a remote area if you work for the public sector they give you 100per cent rebate on rental, a transport allowance to transfer food from Alice Springs to Tenant Creek from Woolworths or Coles and they also give you a car rebate (RES 0941)

8.4.2.2 Training Workers

Training and qualifications were discussed at several points in the interviews, indicating that it was an issue traversing various stages in the employment cycle from recruitment to retention. Managers distinguished between different types of training: work-skills, career-based and life skills (including communication). The provision of training around work skills was not viewed as an issue relating to culturally and linguistically diverse or Aboriginal and Torres Strait Islander workers in particular, with much of this kind of training being undertaken in response to legislative or accreditation requirements.

> We send out newsletters to the carers and we put what training is available in the near future and what opportunities are there (COM 2482)

> Training…Getting them organised with certificate III, which we are doing right now with them. (COM 1517)

In terms of training for life skills, communication was viewed as a top priority. The need for improved language skills were discussed by 28 managers, with 33 managers that written communication was an issue and 32 managers indicating that verbal communication was

an issue. The resources necessary to attend to such training needs were scarce, with most organisations not having the time, staff or money to provide English training for their workers from a non-English speaking background. For some, this made them reluctant to employ more workers for whom English was a second language.

> ….we've also had a number of hours where an external consultant came in and worked on a one-on-one work frame with the girls who didn't have English as their first language and our clinical specialist also spends extra time with them…she organises our in-service training (RES 1104)

> We don't have any specific training programs in improving their communication skills…we don't have the resources for that sort of training (COM 1963)

> Just the challenge of the written word…we spend one-on-one time with them… Given the numbers I've got now in my staff ratio, I suppose if I was recruiting and was faced with anyone that would require major support I would be hesitant cos' it stretches me too far (RES 1104)

In contrast to those organisations expressing difficulties in providing this kind of training, two organisations discussed innovative training programs that they had implemented to support the professional and personal development of their direct care workers. The strategy was also viewed as a benefit for attracting potential employees.

> We have learning workshops and all those sorts of things, they come in on a regular basis, they teach computer training they teach us, what our workers, they pick what they want to learn, even if its not relevant to the place-work here. We're an aged care and disabled facility, but say Joe, who is Indigenous, he wants to get a bus license or something like that. In the learning workshop, they provide all of that, they can go and get their HR license or MR license. They do computer training, they do literacy skills, they have all of this; this is all part of the training. That's just general skills that they want to learn…if they want to learn it, we'll provide it. (RES 1053, Indigenous, regional)

The other organisation, based in an ethnically diverse Victorian city, was working alongside a multicultural organisation in the area to assist connections with the various multi-cultural groups to enable capacity building among these groups.

> They are a resource we can draw on to access key people within a local community group. We're about to in fact…we've developed a program or project that we're trying to get up locally where we're going to provide some very specific training and support to key people within various communities, to broaden the skills base of the workers in those communities to enable them to bring people through to the mainstream services that are available now. Then if we need to adapt, we can adapt our mainstream stuff to make it specific to them…it could be the person who is the social director of the local Vietnamese group…seen in that community as a key

> resource to that community…So what we're going to do is engage with that person and those people and bring them through training, particularly about dementia… we're going to also introduce them to people from Alzheimer's and carer respite centres to talk about the services that can be provided…to build a bridge (COM 1881)

The capacity to provide training was influenced by the location and size of an organisation. Small organisations or those in remote or rural areas often had specific issues regarding the provision of appropriate training opportunities.

> It's very difficult to make anyone understand that when you're out in the middle of nowhere and you've got staff issues to begin with, that to send staff off for a week or two weeks to do training leaves a very big hole in your staffing structure. (RES 2724, Indigenous, remote)

Some of these issues were addressed when organisations had links with other services in the community (such as CDEP or Kimberley training) or were part of a larger organisation. This enabled small, rural or remote organisations to provide the kinds of training that would have otherwise been difficult:

> We're always offering certificate III and assistance with that…just to make sure that they know there's a course available and that's attached to us (RES 2773, Indigenous, remote)

> [Training] is very expensive for us…a lot of our staff don't have a driver's license, so getting them [here], accommodating them and making sure they go to the training is all very, very difficult. It's much easier for us to have the trainers come out here, for us to provide accommodation for the trainers… (RES 2724, Indigenous, remote)

8.4.2.3 Management Of Workers

From the managers' perspective, the day-to-day management of workers from an Aboriginal and Torres Strait Islander or culturally and linguistically diverse background required attending to issues that were specific to their cultural or linguistic backgrounds. It was evident that such issues were widespread, with only 5.4% of managers stating that there were no problems associated with managing culturally and linguistically diverse or Aboriginal and Torres Strait Islander workers. In addressing these problems, nearly 60% of the managers said effective management was the key. The main issues discussed by managers are shown in Table 8.8.

Table 8.8: Proportion of managers identifying specific problems in the management of Culturally And Linguistically Diverse or Aboriginal and Torres Strait Islander workers

Management Problems	Per cent
Cultural Issues	38.7
Written Communication	35.5
Verbal Communication	34.4
Discrimination towards workers	31.2
Discrimination by workers	3.2
Lack of transportation/accommodation	14.0

The most cited problem was workers' cultural issues which were believed to negatively affect the organisation's experience with these workers. Over half of the managers indicating that this was a problem were from Aboriginal and Torres Strait Islander based organisations. Family commitments and periods of mourning were commonly identified:

> It's a requirement of an employer to have an understanding that there will be some needs, and some of these needs are that if a family member dies—and that person may have died in far North Queensland, far from here—it's imperative for the worker to attend that funeral. It's a cultural need and that need is very, very strong in the indigenous culture (COM 0438)

> There are certain things—we have to respect childminding issues, we have to respect those sort of cultural attendances, we have to respect that they have to attend funeral services of families. So there's a lot of flexibility around the way we attract people, and say 'we are flexible'…so those sort of practices are really important….That approach has worked. Most definitely. We've got one of the highest records I think, in an agency, for staff retention. The majority of our people have stayed here for over 10 years (COM 3694)

> We're aware of the cultural side of it for them, and we just ensure that we cater for their needs as well as the needs of residents…As long as they give us notice and we know what is happening then we can always interchange our workers while they're off doing whatever. We cater culturally for them (RES 2773, Indigenous)

Sometimes there was a blurring of the boundaries between what was a cultural issue and what was otherwise termed a general 'lack of work ethic':

> A lack of dedication, frequent absenteeism without notice. Basically there are some cultural things that they need to attend but they don't need to take two weeks off to do it. (RES 0944, Indigenous)

> It's the time factor; people often from that culture don't recognise time. So we do find that people don't show up if they don't want to or they'll show up and they'll leave before their shift finishes (RES 2752, Indigenous)

As is shown in the quote above, these issues (for example, the impact on an Indigenous worker of a death in the family or kinship network), are not viewed as problematic on their own. Rather, it is the impact on the organisation and its management which was viewed as the challenge, for example, having to restructure rosters etc to accommodate this when there is already a staff shortage. Cultural issues put an extra burden on managers when it resulted in a spontaneous and/or prolonged absence of workers. However, as is evident from the quotes, some managers saw it as their job to accommodate their workers and engender an environment of cultural sensitivity (for mourning periods etc).

Challenges to do with communication were widely discussed. These issues were also identified by the managers in their response to QC3.b in the Census, with over two-thirds of managers indicating there were communication issues in employing workers who did not speak English as their primary language. From the interviews, written communication was seen as a problem for colleagues communicating with each other and verbal communication was seen to be more problematic in worker/client exchanges.

> The biggest difficulty we have is our expectations of our workers…often its because we have got expectations of documentation that are requirements that we have to meet through our funding bodies and they don't always understand that we have to do things the way we do them because of the funding bodies' requirements…It's difficult for our clients to understand them with their accents, because a lot of our clients have got hearing deficits and 70per cent have a dementia illness so you put those two together and then you've got somebody who's got quite strong accent… then it can become a little bit difficult. (COM 2724)

Of particular concern in the management of culturally and linguistically diverse or Aboriginal and Torres Strait Islander workers is their exposure to discrimination within their workplace. Just under a third of all managers identified instances of discrimination against their workers on the basis of attributes relating to race and ethnicity. For the majority of these the discrimination came from care recipients. Interviewees referred to the ageing process, and previous experiences of clients (i.e. war veterans) in explaining the causes of this discrimination. For some there was a certain level of acceptance of this phenomenon. Others however, saw it as unacceptable and an opportunity to (re)educate clients.

> Our culturally and linguistically diverse workers are Filipino ladies and some of our older clients tie them in with Japanese people…and still have prejudice from you know, their age group is world war two veterans and stuff like that (COM 4045)

> Yes, with the residents we've had a lot of issues with racial intolerance, a few actually. They have to be reminded constantly….I've had to speak with residents specifically and deal with complaints….They have to understand that this is Australia and it's a multicultural society. It wasn't in the 1950s…but that's the reality of it (RES 0376)

In contrast, only three managers mentioned instances of discrimination by their Aboriginal and Torres Strait Islander or culturally and linguistically diverse workers and each of these discussed the problem as a one-off occurrence which had been addressed and resolved by management.

The issue of lack of transportation and accommodation was spontaneously raised by 13 managers, 12 of whom were located in rural or remote areas. This was especially a problem in these areas when local industry (and associated salary) growth had resulted in a rise in rental costs, which were seen as beyond the means of low-paid, direct care workers.

> There's no accommodation here and that would probably interfere with a lot of people who apply for jobs here. We have a transient population and we usually end up with a lot of the workers living in the caravan park (RES 2783)

> Accommodation is always huge…and if we're employing PCs, there's no accommodation for PCs. Only RNs and ENs get accommodation here and half of them don't get it 'cos we don't have enough (RES 2760, Indigenous, remote)

> [Accomodation is] … The single biggest problem every business faces because the housing situation is hopeless…there's not enough of it…secondly, the rents are so high because it's assumed that everyone works at the mines and earns this fantastic money. Of course they don't. A lot of them work in aged care where we know that the wages aren't fantastic and these people have to compete in the same market… [We can provide some accommodation for our RNs so] we try and help wherever we can...[but it's a funding problem] (RES 1366, Indigenous, remote)

Managers were also asked whether they had an Aboriginal Liaison Officer (ALO) to assist with the day-to-day management of Aboriginal and Torres Strait Islander workers. Of the 12 managers who said they had an ALO, eight were from the Aboriginal and Torres Strait Islander sample. The role of the ALO's was discussed in relation to two functions: to support the Aboriginal and Torres Strait Islander workers already employed and to recruit workers through community engagement. Of those managers who did not have an ALO, some said that they did not really need one but knew that they could access one if necessary.

As well as ALOs, some organisations were able to employ a multicultural liaison officer who performed a similar task to the ALO, but for the culturally and linguistically diverse workers. These liaison officers tended to be employed in the large organisations, or those services which had a larger organisation as their 'umbrella'.

8.5 Conclusion

The interviews with managers about their experiences of employing workers of culturally and linguistically diverse or Aboriginal and Torres Strait Islander background was undertaken to a) assess whether these workers were fairly represented in the general surveys and b) gain a better understanding of any barriers or hurdles that these workers face in the workplace.

It was reassuring to discover that the number of workers from culturally and linguistically diverse and Aboriginal and Torres Strait Islander backgrounds was fairly representative of those in the general survey. This provides added confidence in analysing the survey data with respect to workers with cultural or linguistic differences.

Ninety-three of the 125 organisations interviewed employed either Aboriginal and Torres Strait Islander or culturally and linguistically diverse workers with more than two-thirds of these specifically targeting workers with these backgrounds. Of these organisations, 25 were specifically targeted as having an Aboriginal or Torres Strait Islander client base. Approximately half of the culturally and linguistically diverse and Aboriginal and Torres Strait Islander workers who speak a language other than English use it in their jobs and it is therefore a 'skill' that is utilised in the workplace. However, interviewers noticed some wariness from managers regarding speaking about the targeting of employees for fear of contravening Equal Opportunity regulations. In addressing this issue, some direction from the Department of Health and Ageing about when it is appropriate to target workers and how to source employees from specific cultural groups for their clients might be useful.

Over 80% of interviewed managers identified benefits of employing culturally and linguistically diverse or Aboriginal and Torres Strait Islander workers for reasons ranging from enhancing the cultural appropriateness of aged care provision for residents and care recipients to creating better linkages between the organisation and ethnic communities. This level of appreciation of culturally and linguistically diverse and Aboriginal and Torres Strait Islander employees resonates with the results from the general survey in which more than two-thirds of the organisations had no problems when employing PCs or CCWs with a non-English speaking background. Given this level of support for employing culturally and linguistically diverse and Aboriginal and Torres Strait Islander workers, their contribution to aged care could be given a higher profile. This may also help to attract new recruits from diverse backgrounds into the industry.

Approximately 30% of interviewed managers identified hurdles or barriers in employing workers from a culturally and linguistically diverse or Aboriginal and Torres Strait Islander background; a similar proportion to the general survey. In analysing the interviews, these hurdles were discussed under the headings of recruitment, training and management. Identifying and attracting potential workers with a suitable background was the main issue in the recruitment phase. Although partially linked to the wider problem of recruitment into aged care, some managers recognised a need to actively promote aged care as an employment option into their targeted ethnic communities. Currently these initiatives are undertaken on an ad-hoc and independent basis; however there may well be scope for a more coordinated, industry-wide recruitment strategy that targets culturally and linguistically diverse and Aboriginal and Torres Strait Islander workers.

Legal issues regarding Visa requirements for culturally and linguistically diverse employees and police checks for Aboriginal and Torres Strait Islander employees were also raised. While there is possibly little potential for relaxing the regulations around police checks, the idea of having a 'sunset clause' (for example, of 20 years) may be worth investigating. This is particularly so given that historically (young) Aboriginal people are more likely to

be convicted of offences in circumstances where non-Aboriginal people would be given a caution. The administrative requirements surrounding Visas was an issue for a small number of managers who could benefit from being provided with some additional support or resources (training?) to help them streamline the process.

Undoubtedly the biggest issue in employing culturally and linguistically diverse and Aboriginal and Torres Strait Islander workers was that of communication. This is confirmed in the general survey where, of the 33.5% of managers indicating that there were problems associated with employing culturally and linguistically diverse and Aboriginal and Torres Strait Islander workers, approximately 70% identified communication as an issue. Communication is linked to both knowledge of the dominant language in an organisation, usually English, and the ability to interact with people from cultural backgrounds different to that of the employee. Despite the extent of this issue, very little training was systematically provided to employees who require it. This is surprising given the implications of miscommunication for the treatment and care of care recipients; the occupational health and safety of employees; and the capacity of organisations to fulfil legal requirements (including risk management).

Clearly, if people from culturally and linguistically diverse and Aboriginal and Torres Strait Islander backgrounds are to be regarded as a valuable source of employees for aged care then this is an issue that requires attention. The complexity of the problem means that suggesting solutions is beyond the scope of this research project. Understanding these complexities will help to deliver programs that are suitable. Similar initiatives have been undertaken in other industries that may be worth investigating. For example, the 'Goal 100' project in rural South Australia has been a template for similar programs in the mining industry. Goal 100 provided life-skills training, including literacy and work-readiness programs, to long-term unemployed people over a period of six months. If the program was successfully completed the 'students' were guaranteed a job. This guarantee was integral to its success. While the issues associated with the employment of culturally and linguistically diverse and Aboriginal and Torres Strait Islander workers in aged care might be different, it is the type of program that could be adapted for the purpose.

Another initiative has been implemented by some trades whereby the industry, rather than an employer, takes responsibility for the training of apprentices or trainees. It is resourced through employer contributions. This strategy provides employers with the flexibility of employing workers on a needs basis (rather than supporting an employee through a period of education or training); and provides employees with the flexibility of working for their preferred employer. Some organisations that were interviewed were also implementing innovative programs, and systematically collating information on these could yield some interesting possibilities for expanding their scope across the aged care sector.

An issue that was raised in the interviews that could not be confirmed by data from the general surveys was that of discrimination. It is worrying that over 30% of the managers interviewed could identify instances of discrimination against their workers by residents or clients (and their families). The extent to which this type of discrimination is experienced by culturally and linguistically diverse and Aboriginal and Torres Strait Islander workers (and, perhaps, any worker) is worth further investigation. Being subjected to such discrimination

is likely to have an impact on the satisfaction of workers with their work and possibly on their retention in the aged care sector.

Finally, it is worth noting that organisations were different in the ease with which they could access resources and provide an optimal workplace for their culturally and linguistically diverse and Aboriginal and Torres Strait Islander employees. For example, those services which were part of larger organisational networks are able to utilise the resources of their 'umbrella' organisation. Training, recruitment, and even the sharing of particular staff were cited as resources that could be drawn upon as required. In contrast, smaller independent aged care services had to rely on their own resources. There may be scope for encouraging collaboration and networking between these independent organisations as a means of increasing their flexibility and 'economies of scale'. Organisations servicing Aboriginal and Torres Strait Islander populations also had specific problems, particularly in addressing the multi-layered disadvantages associated with location (rural, and often remote), attracting Aboriginal and Torres Strait Islander workers with appropriate skills, the requirement of police checks and managing the requirements of their employees' culturally-based commitments. Without the flexibility of staffing available in less isolated communities, and with extra costs associated with training (and sometimes recruiting) employees, these organisations can find the provision of consistent, good quality care difficult.

9. Conclusion

Our surveys of aged care providers and the workforce they employ, both residential and community based, have generated a great deal of new, robust information about the sector and its direct care workers. Comparing our 2007 surveys of residential homes and workers with those from 2003 has given us insights into the evolution of the residential workforce. Comparison of the community based and residential workforces has generated further understanding of work and labour markets in the aged care sector. Our interviews with direct care workers, and with managers of homes about their CALD and Aboriginal and Torres Strait Islander workers, have added further depth to the results of our surveys. From these we can draw some quite strong conclusions about the nature of the workforce, including trends in patterns of recruiting and retaining workers.

Our estimates of the number of direct care workers employed in residential aged care homes show steady increases in overall employment between 2003 and 2007. Overall, we estimate that residential homes employed about 175,000 people in 2007, with 133,000 of these being direct care workers. There has been something of a rebalancing of the workforce towards greater use of Personal Carers, and reduced reliance on Registered Nurses. Between 2003 and 2007, total employment of RNs fell by about 1,600 to 22,400, while PC employment rose by about 17,500 to nearly 85,000. Employment of Enrolled Nurses and Allied Health workers (mostly diversional therapists and recreational officers) rose slightly to just over 16,000 and nearly 10,000 respectively. Equivalent full-time employment (EFT) of direct care workers did not increase as much as the number of workers employed, with a rise of 3.4% to about 79,000 EFT workers between 2003 and 2007, compared to an overall increase of 15.3% in direct care workers employed.

We estimate that community based outlets providing aged care under the CACP, EACH, EACH-D, NRCP, HACC and DTC programs employ about 87,500 people altogether, of whom about 74,000 are direct care workers. This constitutes a little more than half the number of direct care workers found in residential homes. Community Care Workers, the community based equivalent of PCs, make up the bulk of this community based workforce. Our best estimate is that service outlets employ about 60,500 of them to deliver the abovementioned programs, with about 9,500 nurses, mostly RNs, and 4,000 Allied Health workers employed alongside them. In addition to these employed workers, community based services for the aged under the above programs are provided by workers employed through brokerage arrangements, through agencies, as sub-contractors and as self-employed workers.

Many of the key features of the residential aged care workforce that we identified in our 2003 surveys have not changed, although important trends are also evident. Thus, in 2007, the residential aged care workforce displays the following features and directions of change:

- It remains overwhelmingly female.
- It remains predominantly employed on part-time, permanent contracts, though there has been a small increase in casual employment since 2003.
- It remains significantly older than the overall Australian workforce, and has aged significantly since 2003. However, for the bulk of direct care occupations, workers continue to be recruited at similar ages to historical norms. This means

that new mature workers may replace older workers as they leave the workforce, thus preserving the age profile of the workforce without causing an ageing crisis.

- It remains mostly Australian born, though the proportion of overseas born workers has increased from one quarter to one third since 2003.
- About 80% of workers continue to expect to be working in aged care in three years.
- Workers are mostly content with the hours they work. Where they are not, they are more likely to want more hours of work than fewer hours.
- Workers are overwhelmingly happy with their current shift arrangements, representing a significant change from 2003 when many wished to change them.
- Workers mostly possess qualifications appropriate for their positions. A small but notable increase in the proportion of Personal Carers with aged care qualifications has occurred, though perhaps 30% of PCs have no formal aged care qualification.
- Workers are confident that they have the skills they need to do their jobs, and they believe that they use these skills effectively in doing the job.
- Workers continue to find considerable reward and satisfaction in the work of providing care for the aged. They generally express reasonable levels of job satisfaction compared to the relevant Australian workforce, with some evidence of small increases.
- Workers remain strikingly dissatisfied with pay, even though pay satisfaction is somewhat higher than in 2003.
- Workers continue to be unhappy with the amount of time they are able to spend with the residents they care for.
- Turnover rates in residential aged care remain somewhat higher than for the whole Australian workforce, with about a quarter of workers leaving their jobs every year.

This characterisation of the residential aged care workforce applies to the community based aged care workforce too, with a few qualifications. The main differences between the residential and community based workforces are:

- Although permanent part-time work predominates in community based aged care, community based workers are more likely to be employed casually than residential workers.
- The community based workforce has an age structure that is still older than that of the residential workforce, with, for example, 70% of community based care workers being 45 or older compared to 60% of residential workers.
- Hours of work are more polarized in the community based sector than in residential homes, with the community based sector having a core of full-time RNs and Allied Health workers, and a larger group of care workers working short hours (15 or fewer per week). As a result, a much higher proportion of community based workers compared to residential workers have low weekly earnings (below $500 per week).

- Community Care Workers are less likely than Personal Carers to have a qualification relevant to their jobs.
- Community based workers are more content with their jobs than residential workers on most of our measures. They have higher job satisfaction in most areas, they are much happier with the amount of time they spend with those they care for, they feel under much less pressure and stress at work, they feel more rewarded and respected for their work, and they feel more able to decide how to do their work.

In addition to providing a picture of the aged care workforce, in both residential homes and community based settings, our research has also revealed important features of the dynamics of the aged care labour market.

A large majority of the aged care workforce is made up of women who work part-time and have significant domestic responsibilities. How well they are able to fit their aged care work with these other demands and responsibilities is central to whether they choose to work in aged care, and whether they continue to do so. Employers can make accommodations in shift arrangements, and hours and times of work, to assist workers to balance their work and non-work lives. Employers who are most successful in being responsive to these needs are also likely to be most successful in retaining employees. However, employers will not be able to respond successfully to all of a workers' changing non-work circumstances, as, for example, when a worker finds a job to be unattractively far from home, or when a family decides to move to a new residence far from the home employing a worker. As a result, the significant job turnover amongst aged care workers seems unlikely to be easily reduced. Employers are therefore likely to continue to need to recruit new employees quite frequently. In this regard, our research suggests they may do well to maintain and develop their networks with potential workers in their local communities, since a very large proportion of workers find their jobs through these informal means. Of course, formal advertising remains an important route for recruiting new workers, but employers may find cultivating their local contacts pays real dividends.

Indeed, labour markets for aged care workers appear to combine quite local dynamics with wider, state and national, ones. Evidence for the importance of the local operation of aged care labour markets lies in the ways many workers fit their jobs with other aspects of their lives (so that many will look for local jobs rather than travelling far to find work), in the importance of informal contacts in finding jobs, and in the variations between locations within states that we found in such labour market features as the time taken to fill vacancies. This means that there may be quite significant local variations in the state of the aged care labour market, and employers may need to respond to local conditions. At the same time, some broad features of aged care labour markets operate at the state and even national level. For example, there are indications that state level variations in overall labour demand may impact on the availability of aged care workers. Western Australia and Queensland, where worker demand has been particularly high due to the mining boom, show more signs of stress in the aged care labour market than some other states. Moreover, we find national 'shortages' of RNs (DEEWR 2008) to be reflected in the difficulties aged care employers, especially residential homes, find in filling RN vacancies. Ensuring a sufficient supply of qualified workers into the future requires taking account of both these local and wider labour market dynamics.

As we have noted above, the major discontent of the workforce remains with their pay. In the residential sector, workers continue to be unhappy with the amount of time they are able to spend with residents. Workers clearly trade off what they perceive to be inadequately low pay against the other conditions of their work. The relevant conditions include shift arrangements and hours of work, but also involve the opportunity for workers to provide care to their satisfaction without feeling overly rushed and under pressure. Clearly, staffing levels and how work is organised will have the most effect on workers' ability to gain the satisfactions many want from the work of providing care to the dependent elderly. Thus, as much as these aspects of employment are critical to quality of care, they are also central to worker retention.

Comparing the residential and community based workforce is instructive here. Community based workers are more content than residential workers on most of our measures. They have higher job satisfaction in most areas, they are much happier with the amount of time they spend with those they care for, they feel under much less pressure and stress at work, they feel more rewarded and respected for their work, and they feel more able to decide how to do their work. These results strongly confirm the view that the way day to day work is organized by aged care providers has a large influence on workers' subjective experience of their work, and the likelihood that they will wish to keep their jobs. On some dimensions producing a contented community based workforce seems challenging: they are employed with limited job security and on short, variable hour arrangements more often than residential workers. Their relative happiness is almost certainly due to features of how their work is organized. They spend more of their time in direct care work than residential home workers; they are more able to spend the time they feel is necessary with those they care for; and they have more control over how they do their work. There are clear indications here of the kinds of arrangements that are most likely to produce higher job satisfaction amongst residential workers, and therefore assist in recruitment and retention. With regard to PCs, it remains the case that because there is not a long training period required in order to be eligible to perform PC work, the supply of workers for these jobs will probably respond quite quickly to changes in the relative attractiveness of these arrangements, as well as pay and other conditions.

Given these features of the aged care labour market, understanding workers' goals is important. For some workers, decisions about how much to work and what pay levels are sufficient are driven largely by their own financial needs balanced against the demands of their non-work commitments, as our qualitative research made clear. This is not to say that career development and advancement are not of concern to workers, but rather that they need to be understood in the context of workers' non-work lives. Interviews with carers also emphasised that they often require particular conditions or support to undertake formal training such as relevant Certificates III and IV. But they value and are committed to this training, and will respond positively to tying it to visible career advancement.

Pay levels are a complex issue for this workforce. As we have seen, pay satisfaction is already very low amongst aged care workers, so that any relative erosion in pay will only generate morale difficulties, and produce associated lack of commitment amongst existing employees. Pay is an important symbolic indicator of the value placed on work by employers and the community. It is understandable that nurses should feel underpaid and

undervalued when their colleagues in acute settings earn significantly more. And PCs and CCWs who legitimately view their work as of great social value feel slighted when they see their children earning similar wages to themselves in check-outs at the local supermarket. Indeed, the symbolic value of increased pay is likely to be substantial, and to have direct effects on job satisfaction and commitment. At the same time, particularly for PCs and CCWs, there are some indications that increasing pay may *reduce* labour supply amongst the existing workforce. However, increased pay is also likely to attract workers from other jobs into aged care, thus improving overall labour supply, especially given that many PCs and CCWs come to aged care work from other lower paid service jobs.

Although our research was not designed primarily to assess the state of the labour market for aged care workers, or how the state of the labour market is changing, it provides some useful pointers. Since our 2003 research on the residential direct care aged care workforce, the Australian labour market has tightened considerably. In 2003, we concluded that there were no signs of a systemic crisis in the labour market for residential direct care workers, and that the main stress in the labour market arose from difficulties hiring RNs. With the unemployment rate falling from 6.2% to 4.3% between July 2003 and July 2007, we expected to see increased signs of strain and stress in this labour market. Indeed, there are such signs, particularly amongst Registered Nurses. Overall, our results indicate that the difficulties residential homes found in recruiting RNs in 2003 had increased further by 2007, and are consistent with DEEWR's view of a general 'shortage' of RNs. The general tightening of the Australian labour market has also found its way to the labour market for such workers as PCs and CCWs, though it remains much less problematic for employers to recruit these workers compared to RNs. Beyond these generalizations, it is clear that aged care labour market conditions vary somewhat between localities, so that some workers are harder to recruit in some places than others, and employers in some locations face quite different recruitment problems to those in others.

Some of the key findings in our report that point towards this state of the aged care labour market are the following:

- Overall, the fraction of shifts worked by agency staff remains fairly small, although some community based organizations appear to rely largely on agency staff. Generally, where temporary staff are used to cover the usual fluctuations in the workplace, the level of use of these staff does not indicate significant inability to recruit regular staff. However, the proportion of shifts worked by Agency RNs has risen significantly. Statewide variation in the increased use of agency staff in residential homes is also significant, with WA and Queensland showing the most consistent significant rises. These states also show rises in the use of agency staff other than RNs.
- Vacancy levels in residential homes have risen a little since 2003. They are generally lower in community based outlets than residential homes. Given the quite high turnover of aged care staff, vacancy levels of PCs and CCWs are consistent with a functioning labour market. Vacancies for RNs in residential homes are more suggestive of difficulties in recruitment, especially rising vacancies as the total number of RNs employed has fallen.

- The length of time to fill vacancies suggests real difficulties in filling many RN positions. Our results are consistent with findings from a DEEWR survey that were interpreted as indicating general 'shortages' of RNs (DEEWR 2007). On the other hand, vacancies for such workers as PCs and CCWs are generally filled within a quite short period, and PC and CCW vacancy length suggests a labour market for these workers that functions fairly smoothly. Beyond this general picture, there are some state and regional variations suggesting that Queensland and Western Australian employers face greater recruitment difficulties for all aged care workers than others.
- There continues to be evidence of real excess capacity in the aged care labour force. There is a significant group of workers who would prefer to work longer hours in all occupations in both the residential and community based sectors. This is good evidence that employers have not yet been forced to use all possible sources to fill their labour needs.
- As we have noted above in detail, members of the aged care workforce generally see themselves as appropriately skilled, are mostly content with their work and jobs, and usually say they expect to continue working in the sector for at least the next 3 years. All of these features suggest a workforce whose members see real attraction in their jobs.
- The proportion of PCs who appear to be overqualified for their jobs has declined since 2003, an indicator of a tightening labour market in that workers are more able to find jobs concomitant with their qualifications.
- Residential workers have become much less likely to wish to change their shift arrangements since 2003. This may occur as employers seek to attract and retain workers in a tighter labour market.

In a tighter labour market, workers' experience of their jobs is likely to be of increasing concern to employers seeking to recruit and retain a competent, committed workforce. There remain quite high levels of turnover of direct care staff. New data in this Report shows that some of this turnover involves movement between aged care employers, rather than departure from aged care altogether. Because most aged care workers are women working part-time, whose jobs are often the secondary ones in dual earner households, a variety of factors associated with their personal and family life impact on their decisions about where and when to take jobs. Employers can accommodate some of these, but not all. From an industry perspective, the comforting point is that many of these workers seem to continue to work in aged care, even if they must change employers to accommodate the demands of their non-work lives. As we have noted above, it appears that informal relationships—whether word of mouth connections linking potential employees to jobs, or ongoing contacts between employers and former workers—are an essential underpinning of the labour market for aged care workers.

Culturally and Linguistically Diverse (CALD) and Aboriginal and Torres Strait Islander communities generate particular needs for aged care service providers. CALD and Aboriginal and Torres Strait Islander workers are not represented in the aged care workforce in proportion to the specialization of services in older clients from their communities. Aboriginal and Torres Strait Islander workers in particular are very rare in the aged care

workforce. While CALD workers are better represented, many are not from the communities whose members are residents in aged care homes and clients of community based providers. These circumstances provide a series of challenges for aged care providers. On the one hand, they may seek to employ workers with appropriate cultural and linguistic abilities. Yet these workers are not always easy to find and may require special support and assistance to be effective. On the other hand, some groups of CALD workers appear to be recruited as new lower skilled immigrants with limited employment alternatives. These workers too require support, not least in resisting some intolerance from residents and their families. Overall, employers seem supportive of these workers, finding only limited difficulties, and real advantages, in employing them.

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Appendix 1: Estimating Total Employment and Other Numbers from Sample Surveys

Our estimates of total employment in residential and community based aged care are based on inflating the total numbers employed by employers who responded to our surveys to take account of non-response.

In the case of the residential home responses, we simply take the total employment numbers for a category from responses to our survey, and inflate it according to the level of non-response on that question. For example, we received valid responses from 2,657 homes on the total number of RNs they employ, indicating that they employed a total of 20,672 RNs. Our estimate of total RN employment in residential homes results from inflating this total to the 2,879 homes in Australia at the time of the survey (giving our estimate of 22,399 RNs employed in Australian aged care homes).

Estimating total employment by the community based outlets covered in our survey is slightly more complicated because responses from community based outlets sometimes covered more than one outlet, though it follows the same principle. Overall, we received 1496 responses covering 1744 outlets. To estimate the total number of people employed in a category we take the total employment numbers for a category from responses to our survey, and inflate it according to the level of non-response on that question. In calculating non-response, we take account of the fact that some responses represent more than one outlet, and assume that the ratio of outlets represented to the responses we received is as for the whole survey (i.e., 1744:1496). For example, we received 1425 valid responses to our question about the number of full-time RNs employed by outlets. These responses indicate that 1190 full-time RNs were employed by these outlets. We assume this represents responses from 1661 outlets, based on the rate of multiple outlet response represented by the 1744:1496 ratio). We then inflate the number to our best estimate of the total number of outlets (i.e., 3534 outlets), giving our estimate of a total of 2,532 full-time RNs employed in all in-scope community service outlets.

Appendix 2: Questionnaires

Community Aged Care Service Outlet Questionnaire

IMPORTANT – PLEASE READ BEFORE STARTING

If you manage several Community Aged Care Services from the same location you can combine your answers onto one questionnaire for these Community services ***only***. Residential Aged Care Services must be completed on the Yellow questionnaire

It is extremely important that the information that we collect in this survey is accurate. So we ask that you please refer to records, when answering each question. To make this less trouble for you, we ask that you use information from the last pay period you have had in August 2007, in all your answers.

Please use a BLACK pen to complete the questionnaire

You can also fill this questionnaire out online at: http://acnonline.com/careworkforce

For assistance, please phone 1800 801 609 and mention the Census of Aged Care Workforce

Thank you for participating in the Census and taking the time to complete this questionnaire.

S.1(a) Have you received *one* or *more than one* Community Aged Care Service Outlet Questionnaire for this location?
(Please tick the appropriate box)

- One package ..... ☐ 1
- More than one package ..... ☐ 2

S.1(b) If you received more than one Community Services package can you please let us know the package IDs for the Community Aged Care Service Outlets you are completing this questionnaire for?*

COM				
COM				
COM				
COM				

** The package ID is found on the first line of the address field of the covering letter and also on the bottom right hand corner of the front page of each questionnaire. This will help us collate the national picture.*

Section A: About the Service Outlet

The following questions ask for basic information about your community aged care service. This information will help us to understand how the aged care workforce is distributed across different types of service outlets.

A.1(a) Where is your service located? *(Please tick the appropriate box)*

- Metropolitan ..... ☐ 1
- Regional ..... ☐ 2
- Rural ..... ☐ 3
- Remote ..... ☐ 4

A.1(b) What is your postcode?

A.2 In the last *monthly* reporting period, how many CACP, EACH and EACH-D packages were delivered? *(Please write '0' if no packages were funded in these programs)*

	CACP Packages
	EACH Packages
	EACH D Packages

A.3(a) **In the last *month*, how many hours of service were delivered through HACC, NRCP and DTC?** *(Please write '0' if you did not receive funding for these programs)*

	Home and Community Care (HACC) hours *
	National Respite Care Program (NRCP) hours **
	Day Therapy Centre (DTC) hours

** Provide the total number of hours for **HACC** services for the following: nursing care; personal care; case management and coordination; allied health services; respite care; assessment and/or referral services; centre-based day care; counselling, support, information and advocacy; domestic assistance; and social support. Do not provide hours for service types not listed here, or for services provided by volunteer workers*

*** Provide the total number of hours for **NRCP** for all care workers who deliver respite for carers of frail older people in all settings where respite is provided, ie: in their homes, community centres, overnight community cottages or in the general community*

A.3(b) **In the last *month*, how many HACC, NRCP and DTC clients (ie individuals) used your services?** *(Please write '0' if you do not provide care services through these programs)*

	HACC clients
	NRCP clients
	DTC clients

A.4 **How many people does your community aged care service employ in total, including all full-time, part-time and casual employees working in direct care roles, but exclude employees who are from an agency, sub-contracted or self-employed?** *(Count all employees for whom PAYE tax is deducted by your organisation)*

				PAYE employees

A.5 **Is your service** (please tick the appropriate box):

Not-for-Profit ☐ 1

For Profit ☐ 2

Government ☐ 3

A.6(a) **Does your service provide residential aged care services in addition to community based services?**

Yes ☐ 1

No ☐ 2

Go to A7

A.6(b) What percentage of your direct care employees in each classification work in both your community based and residential services? *(Please be sure to write '0' if no employees in a particular classification work in both services.)*

Employee Classification	%
Registered nurse (Div 1)	
Enrolled nurse / RN (Div 2)	
* Community Care Worker/ Personal Care Attendant	
** Allied health	

**Job titles of community care workers vary widely. They include, for example: personal care attendant, assistant or aide, home care worker (including domestic assistance), respite care worker, and planned activity group co-ordinator.*

*** Please include all direct care allied health workers, such as physiotherapists, diversional therapists, dieticians, occupational therapists, social workers and speech therapists. Exclude employees solely engaged in a coordinator/management role.*

A.7 **Is your service part of a larger organisation (e.g., owned by a company or not-for-profit agency that runs other community aged care services)?**

Yes ☐ 1

No ☐ 2

A.8 **Does your service aim to cater for specific ethnic or other cultural groups *(ie ATSI/CALD groups)?***

Yes ☐ 1

Go to A.9

No ☐ 2

Go to Section B

A.9 **For which ethnic or other cultural group/s does your service cater?**

_____

A.10 **Does your service employ staff with particular language or other cultural knowledge in order to cater to the group/s listed in A.9?**

Yes ☐ 1

No ☐ 2

Section B: About the Workforce

The following questions ask about the direct care workforce that you currently employ. For these data to be useful for planning in the industry, it is important that they are as accurate as possible. We are grateful for the time and effort you will contribute to assemble this information.

If you provide both residential and community based care, please confine your answers here to *employees providing community based care only*. Include all employees for whom PAYE tax is deducted by your organisation. Do not include agency staff and contract staff for whom PAYE tax is not collected. Agency and non-PAYE contract staff are covered in Section D.

Please provide the information for current employees (ie, for the last pay period you have had in August 2007). If you have no employees in a category please write '0' in the appropriate space.

B.1 In the spaces provided below, please record the number of people (headcount) employed, and the number of full-time equivalent (EFT/FTE) employees, in each classification in your service.
(Include only the time staff spend working in your aged care service when calculating EFT/FTEs)

Employee Classification	Permanent full-time	Permanent part-time	Casual/ contract	Full-time equivalent employees (EFT/FTEs)#
Registered nurse (Div 1)				
Enrolled nurse / RN (Div 2)				
Community care workers*				
Allied health**				

 # The full time equivalent (FTE/EFT) employees is the size of the employee body which considers both the number of employees and the fraction of full-time work status of each. For example, an employee working full-time will register as 1 FTE; while an employee working a fractional load of half-time will register as 0.5 FTE. One FTE employee works 70+ hours per fortnight.

**Job titles of community care workers vary widely. They include, for example: personal care attendant, assistant or aide, home care worker (including domestic assistance), respite care worker, care support workers and planned activity group co-ordinator.*

*** Please include direct care allied health workers, such as physiotherapists, diversional therapists, dieticians, occupational therapists, social workers and speech therapists.*

We now ask for more detail about the employees you listed in Q. B.1.

Please ensure that you include all these employees in your answers. If you have no employees in a particular category, please write '0' in your answer.

B.2 How many employees in each classification are female and how many are male?

Employee Classification	Female	Male
Registered nurse (Div 1)		
Enrolled nurse / RN (Div 2)		
Community care workers		
Allied health		

B.3 How many of the employees in each classification worked the following hours in the last pay period in August 2007?

	Hours worked in fortnight			
Employee Classification	1-30 hours	31-68 hours	69-80 hours	81+ hours
Registered nurse (Div 1)				
Enrolled nurse / RN (Div 2)				
Community care workers				
Allied health				

B.4 **How many of the employees in each classification have been continuously employed for the periods shown below?**

Employee Classification	Period Employed		
	Less than 1 year	1 to 5 years	6 or more years
Registered nurse (Div 1)			
Enrolled nurse / RN (Div 2)			
Community care workers			
Allied health			

B.5 **How many employees in each classification fall into the following age categories?**

Employee Classification	Age in Years				
	Under 30 yrs	30 to 39 yrs	40 to 49 yrs	50 to 59 yrs	60+ yrs
Registered nurse (Div 1)					
Enrolled nurse / RN (Div 2)					
Community care workers					
Allied health					

B.6 **For each employee classification, please indicate the approximate <u>PERCENT</u> of employees working under each form of employment contract.**

Employee Classification	Form of employment contract				
	Award	Enterprise Agreement *	Common Law Contract	AWA	Don't Know
Registered nurse (Div 1)					
Enrolled nurse / RN (Div 2)					
Community care workers					
Allied health					

** Enterprise Agreements include union agreements, non-union agreements and certified agreements*

B.7 **How many equivalent full-time (EFT/FTE) vacancies do you have in each classification***? (Please be sure to write '0' if you have no vacancies in a particular employee classification)*

Employee Classification	Number of EFT/FTE vacancies
Registered nurse (Div 1)	
Enrolled nurse / RN (Div 2)	
Community care workers	
Allied health	

B.8 **How many of your own regular employees in each classification were on Workcover or other injury related leave or a graduated return to work program during the last pay period in August 2007?** *(Please be sure to write '0' if no employees in a particular classification were on such leave.)*

Employee Classification	Number of Employees
Registered nurse (Div 1)	
Enrolled nurse / RN (Div 2)	
Community care workers	
Allied health	

B.9 **Approximately how long did it take you to fill the most recent vacancy for employees in each classification?**

Employee Classification	Weeks
Registered nurse (Div 1)	
Enrolled nurse / RN (Div 2)	
Community care workers	
Allied health	

Section C Community Care Workers

We would like to know some further information about the community care workers (CCWs) employed in your aged care service.

C.1 **How many of your CCW employees have completed a Certificate III or Certificate IV in an area related to their direct care work?**

☐ Completed Certificate III (only)

☐ Completed Certificate IV

C.2(a) **What proportion of your current CCWs would you estimate speak a language other than English as their first language?**

None ☐ 1 **Go to C.4**

Less than one third ☐ 2

One third to two thirds ☐ 3

More than two thirds ☐ 4

C.2(b) **What is the most common ethnic or cultural background of CCWs who speak a language other than English as their first language?**

_____

C.3(a) **Does lack of English language skills amongst your CCWs cause any difficulties in your service?**

Yes ☐ 1

No ☐ 2 **Go to C.4**

C.3(b) **In which areas does lack of English language skills amongst your CCWs cause difficulties? Please put a cross in all boxes that apply.**

Occupational Health and Safety ☐ 1

Communication with management and/or other staff ☐ 2

Communication with clients ☐ 3

Communication with clients' families ☐ 4

Other (please specify) _____ ☐ 5

C.4 If you wished to employ additional CCWs, how would you be most likely to find them?

Wait for walk-ins	☐ 1
Word of mouth	☐ 2
Place a newspaper job advertisement	☐ 3
Place an internet job advertisement	☐ 4
Place both newspaper and internet job advertisements	☐ 5
Employ those already working through a job placement program	☐ 6
Other/don't know (please specify) _____	☐ 7

Section D: Agency, Sub-Contracted and Self-Employed Staff

We would now like to ask about the nursing or employment agency staff or sub-contract or self-employed staff *for whom you do not deduct PAYE tax*, who worked in your service during the reference pay period.

D.1 How many people from nursing or employment agencies plus sub-contract or self-employed staff worked in your aged care service during the last pay period in August 2007? *(Please be sure to write '0' if you did not employ any agency, contract or self-employed staff in a particular employee classification.)*

Employee Classification	Number of Agency Staff *	Number of Sub-contract Staff **	Number of Self-employed Staff ***
Registered nurse (Div 1)			
Enrolled nurse / RN (Div 2)			
Community care worker			
Allied health			

* *Agency staff are contracted from a nursing or employment agency. Your service outlet has responsibility for training and supervising these staff members.*

** *Sub-contracted staff are contracted from other community care providers. Your service outlet does not have responsibility for training and supervising these staff members.*

*** *Self-employed staff are individuals who have their own ABN and operate as independent care workers. Your service outlet would broker directly with the individual to engage their services.*

D.2 How many shifts at each classification level were filled by agency/sub-contract/self-employed workers in the last pay period in August 2007? *(Please be sure to write '0' if you did not employ any agency, contract or self-employed staff in a particular employee classification.)*

Employee Classification	Number of Shifts: Agency Staff	Number of Shifts: Sub-contracted Staff	Number of Shifts: Self-employed Staff
Registered nurse (Div 1)			
Enrolled nurse / RN (Div 2)			
Community care worker			
Allied health			

THANK YOU VERY MUCH FOR YOUR HELP IN PROVIDING THIS INFORMATION.

TO ASSIST US IN DESIGNING FUTURE SURVEYS PLEASE PROVIDE AN ESTIMATE OF THE TIME TAKEN TO COMPLETE THIS FORM.	**_____Minutes**

Australian Government Statistical Clearing House Approval Number 01414 -- 02

Survey of Aged Care Workforce

HOW TO FILL OUT THIS QUESTIONNAIRE

1. To answer most of the questions you only need to **put a cross in the box**. Please tick the box which is **closest** to your situation or your view.

   Please use a BLACK pen to complete the questionnaire.

   Here is an example.

Q1 Did you take any sick leave last week?

Yes	☒	1
No	☐	2

If you took some sick leave last week, you would put a cross in the first box as shown above.

2. Sometimes you are asked to write in an answer — in that case, simply write your answer in the space provided, for example:

Q2 How long have you worked in your current job?

Number of years | 1 | 2 | (*enter to the nearest year*)

*Please read each question carefully. Remember, we just want to know about **your own** personal situation or opinions.*

You can also fill this questionnaire out online at:

http://acnonline.com/careworkforce

For assistance, please phone 1800 801 609 and mention the Survey of Aged Care Workforce

Thank you for participating in this survey and taking the time to complete the questionnaire

EGA1234__

SECTION A - ABOUT YOUR WORK

Please answer the questions in this section by thinking about the direct care job you do with this community aged care provider, unless the question refers specifically to another job you may have.

A1.1 What is your job?

Registered nurse (Division 1)..... ☐ 1
Go to A1.3

Enrolled nurse / RN (Division 2) ..... ☐ 2
Go to A1.3

*Community Care Worker (Direct Assistance) ..... ☐ 3
Go to A1.2

Physiotherapist ..... ☐ 4
Go to A1.3

Occupational therapist..... ☐ 5
Go to A1.3

Diversional therapist/recreational officer ..... ☐ 6
Go to A1.3

Speech therapist..... ☐ 7
Go to A1.3

Other – please specify _____ ☐ 8
_____ Go to A1.3_

*Please note: Job titles of direct assistance community care workers (CCW), vary widely. They **include,** for example: personal care attendant, assistant or aide, home care worker, respite care worker, and planned activity group coordinator.*

A1.2 What is your *main* role in your work as a community care worker? *(Please tick one box only)*

Personal care ..... ☐ 1
Home care/domestic assistance ..... ☐ 2
Respite care..... ☐ 3
Planned activity group assistant ..... ☐ 4
Other – please specify _____ ☐ 5

_____

A1.3 What proportion (percent) of the clients you work with are:

☐ % Aged
☐ % Younger people with a disability
☐ % Other

A2.1 Which of the following *best* describes your *current* work schedule?

A regular daytime roster/shift ..... ☐ 1
A regular evening roster/shift..... ☐ 2
A regular night roster/shift ..... ☐ 3
A rotating roster/shift *(changes from days to evening to nights)* ..... ☐ 4
Split roster/shift *(two distinct periods each day)* ..... ☐ 5
On call ..... ☐ 6
Irregular schedule, between 9-5..... ☐ 7
Irregular schedule, outside of 9-5 .... ☐ 8
Irregular schedule, anytime ..... ☐ 9
Other – please specify_____ . ☐ 10

A2.2a. Would you prefer to maintain your current work schedule, or to change it?

Prefer to maintain current schedule ..... ☐ 1 Go to A3.1
Change to different schedule ..... ☐ 2

A2.2b Which describes the work schedule you would *prefer*?

A regular daytime roster/shift ..... ☐ 1
A regular evening roster/shift..... ☐ 2
A regular night roster/shift ..... ☐ 3
A rotating roster/shift *(changes from days to evening to nights)* ..... ☐ 4
Split roster/shift *(two distinct periods each day)* ..... ☐ 5
On call ..... ☐ 6
Irregular schedule, between 9-5..... ☐ 7
Irregular schedule, outside of 9-5 .... ☐ 8
Irregular schedule, anytime ..... ☐ 9

Other – please specify_____.. ☐ 10

A3.1 How many hours on average do you *usually* work each week in this job?

☐☐ hours per week

A3.2 How many hours would you *like* to work each week in this job?

☐☐ hours per week

A3.3 How many of the hours you usually work each week are paid and unpaid? *(If you do not work any unpaid hours, write '0' in the corresponding box)*

☐☐ Paid hours
☐☐ Unpaid hours

A3.4 What was the *minimum* block of time in a day that you were required to work last week? (ie the minimum number of hours that you worked before your roster/shift ended)

☐☐ hours

A4. How long have you worked for this community aged care provider?

☐☐ years
☐☐ months

A5. Which best describes your form of employment?
(Please put a cross in the appropriate box)

Casual ..... ☐ 1
Permanent (full or part-time) ..... ☐ 2
Fixed term contract ..... ☐ 3

A6. Are you entitled to paid sick leave?
(Please put a cross in the appropriate box)

Yes ..... ☐ 1
No ..... ☐ 2
Don't know ..... ☐ 3

A7.1. Before you first obtained this job, had you done any work for this community aged care provider?
(Please put a cross in the appropriate box)

No ..... ☐ 1
Yes, paid work ..... ☐ 2
Yes, unpaid work/volunteer ..... ☐ 3

A7.2. When you approached this provider for your job, did you know there was a job available?
(Please put a cross in the appropriate box)

Yes ..... ☐ 1
Go to A7.3
No ..... ☐ 2
Go to A8.1
Don't know ..... ☐ 3
Go to A8.1

A7.3. How did you find out your job was available?
(Please put a cross in the appropriate box)

Job network employment agency .... ☐ 1
Other employment agency ..... ☐ 2
Career service at a tertiary educational institution ..... ☐ 3
School programs ..... ☐ 4
Newspaper advertisements ..... ☐ 5
Internet sites ..... ☐ 6
Centrelink job search services or touchscreens ..... ☐ 7
Company or professional contacts ... ☐ 8
Workplace noticeboards ..... ☐ 9
Word of mouth ..... ☐ 10

Other – please specify_____.. ☐ 11

A8.1. For this job, what was the total amount of your most recent pay *before* tax or anything else was taken out?

$						

A8.2. What period does that cover?
(Please put a cross in the appropriate box)

Week ..... ☐ 1
Fortnight..... ☐ 2
Month..... ☐ 3

A9. The following statements are about your current job with this community aged care provider. Please indicate, by putting a cross in <u>one</u> box on <u>each</u> line, how strongly you agree or disagree with each. The more you agree the higher the number you should choose. The more you disagree, the lower the number you should choose.

	Strongly Disagree						Strongly Agree
A: I am able to spend enough time with each care recipient	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7
B: I have the skills I need to do my job	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7
C: I use many of my skills in my current job	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7
D: I have a lot of freedom to decide how I do my work	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7
E: I feel under pressure to work harder in my job	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7
F: My job is more stressful than I had ever imagined	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7
G: Considering all my efforts and achievements, I receive the respect and acknowledgement I deserve	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7
H: Management and employees have good relations in my workplace	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7

A10.1. Do you expect to be working for this community aged care provider in 12 months time?
(Please put a cross in the appropriate box)

Yes ☐ 1
Go to A11.1

No ☐ 2
Go to A10.2

It depends ☐ 3
Go to A10.2

Don't know ☐ 4
Go to A10.2

A10.2. What is the main reason you may finish work for this provider in the next 12 months?
(Please put a cross in the appropriate box)

Changing jobs/seeking other employment in aged care ☐ 1
Changing jobs/seeking other employment not in aged care ☐ 2
Returning to study/travel ☐ 3
Family reasons ☐ 4
Financial reasons ☐ 5
Stress/burnout ☐ 6
Retiring ☐ 7
Temporary job/fixed contract ☐ 8
Retrenchment/Redundancy ☐ 9
Other – please specify_____ ☐ 10

A11.1 Where do you see yourself working 3 years from now?
(Please put a cross in the appropriate box)

Working, in aged care ..... ☐ 1
Go to A11.2

Working, *not* in aged care ..... ☐ 2
Go to A12

Not working for pay ..... ☐ 3
Go to A12

Don't know ..... ☐ 4
Go to A12

A11.2 Which kind of aged care work do you expect to be doing?
(Please put a cross in the appropriate box)

Residential (in an aged care facility)..... ☐ 1
Community based ..... ☐ 2
Residential and community based .... ☐ 3

A12. Thinking about a typical roster/shift, how much of your roster/shift would you spend actively caring for care recipients of the aged care provider (as opposed, for example, to doing paperwork, attending meetings, or in discussions with other staff)? *(Please put a cross in the appropriate box)*

Less than a third ..... ☐ 1
Between one third and two thirds..... ☐ 2
More than two thirds ..... ☐ 3

A13.1. Did you have more than one job last week?
(Please put a cross in the appropriate box)

Yes ..... ☐ 1
Go to A13.2

No ..... ☐ 2
Go to A14

A13.2. Is your other job in aged care?
(Please put a cross in the appropriate box)

Yes ..... ☐ 1
No ..... ☐ 2

A13.3. How many hours each week do you *usually* work in your other job?

☐☐ hours per week

A14. Returning attention to your work with this provider, here are some questions about how satisfied or dissatisfied you are with different aspects of your job. Using a scale from 0 to 10, where *0 is 'totally dissatisfied'* and *10 is 'totally satisfied'*, please put a cross in <u>one</u> box on <u>each</u> line to indicate how satisfied or dissatisfied you are with the following aspects of *your aged care job*. The more satisfied you are, the higher the number you should pick. The less satisfied you are, the lower the number.

	Totally Dissatisfied										Totally Satisfied
A: Your total pay	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10	

B: Your job security ..... ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

C: The work itself (what you do) . ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

D: The hours you work ..... ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

E: The opportunity to develop ..... ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
your abilities

F: The level of support from your ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
team / service provider

G: The flexibility available to ..... ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
balance work and non-work commitments

H: All things considered, how .... ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
satisfied are you with your job

A15. In the last 4 weeks have you sustained an injury at work (in this job) that has resulted in you having any days away from work?

Yes ☐ 1
No ☐ 2

A16. In general, how would you describe relations at your workplace…
(Please put a cross in the appropriate boxes. The better the relations at work the higher the number; the worse that relations are, the lower the number)

	Very Bad						Very Good	Can't Choose
Between management and employees	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐
Between workmates/colleagues	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐

A17. How old were you when you first began working in aged care?

☐☐ years

A18. Taking account of any breaks from working in aged care, for how many years have you actually worked in aged care?

☐☐ years

A19. What was your last paid job before you first worked in aged care?
No previous paid employment..... ☐ 1
Nurse in other setting..... ☐ 2

Carer in other setting ..... ☐ 3
Salesperson..... ☐ 4
Clerical worker..... ☐ 5
Hospitality worker (waitress, etc.) ..... ☐ 6
Cleaner ..... ☐ 7
Professional (other than nurse)..... ☐ 8
Manager..... ☐ 9
Other paid employment *(please specify)* ☐ 10

A20.1 Had you worked in aged care before you began your current job?

Yes, paid ..... ☐ 1
Yes, unpaid/voluntary ..... ☐ 2
No ..... ☐ 3

Go to Section B

A20.2 What was the most important reason you left the last (paid) aged care job you held before your current one?

To achieve higher pay ..... ☐ 1
To avoid workmates/colleagues I did not get along with or like ..... ☐ 2
To avoid managers/management I did not get along with or like ..... ☐ 3
The job was too stressful..... ☐ 4
Not able to spend sufficient time with clients..... ☐ 5
To get shifts or hours of work I wanted ..... ☐ 6
To be closer to home..... ☐ 7
To fulfil private care responsibilities (including having a baby) ..... ☐ 8
To find more challenging work..... ☐ 9
To find easier work ..... ☐ 10
Other (please specify) ☐ 11

SECTION B - ABOUT YOU

Please remember that this questionnaire is completely confidential. We do not even ask your name. No-one but the independent survey company will ever see your response. Your answers will be added to those of many other people who work in aged care, to give an overall picture.

B1. Are you male or female?

Male ☐ 1
Female ☐ 2

B2. How old were you on your last birthday?

☐☐ years

B3. In what country were you born?

.....

B4. Are you of Aboriginal or Torres Strait Islander origin?

No ☐ 1
Yes, Aboriginal ☐ 2
Yes, Torres Strait Islander ☐ 3
Yes, both ☐ 4

B5.1. Are you fluent in a language other than English?

Yes ☐ 1
Go to B5.2
No ☐ 2
Go to B6

B5.2. Do you use this language in your job?

Yes ☐ 1
No ☐ 2

B6. Do you have financial dependents?

No ☐ 1
Yes, spouse/partner only ☐ 2
Yes, children only ☐ 3
Yes, spouse/partner and children ☐ 4
Yes, other (please specify)_____ ☐ 5

B7. In a normal week, about how many hours would you spend caring for family members (eg children or disabled or elderly relatives)?
(If you have no care responsibilities, write 0 in the space provided)

☐☐ hours

B8. In general, would you say your health is:

Excellent ☐ 5
Very Good ☐ 4
Good ☐ 3
Fair ☐ 2
Poor ☐ 1

B9.1 What is the highest level of primary or secondary school you have completed?

Did not go to school ☐ 1
Year 8 or below ☐ 2
Year 9 or equivalent ☐ 3
Year 10 or equivalent ☐ 4
Year 11 or equivalent ☐ 5
Year 12 or equivalent ☐ 6

B9.2 Have you completed any post-school qualifications?

Yes ☐ 1
Go to B10.1
No ☐ 2
Go to B11.1

B10.1 What qualifications have you completed (tick as many boxes as necessary)?

Certificate III in Aged Care ..... ☐ 1
Certificate III in Home and Community Care ..... ☐ 2
Certificate IV in Aged Care..... ☐ 3
Certificate IV/Diploma in Enrolled Nursing..... ☐ 4
Certificate IV in Service Coordination (Ageing and Disability) ..... ☐ 5
Bachelor Degree in Nursing ..... ☐ 6
Other basic nursing qualification ..... ☐ 7
Post basic nursing qualification in aged care ..... ☐ 8
Post-basic nursing qualification not in aged care ..... ☐ 9
Other – please specify..... ☐ 10

B10.2 Did you study for a Certificate IV/Diploma in Enrolled Nursing while working as a Community care worker (CCW) or Personal care attendant (PCA)?

Yes ..... ☐ 1
No ..... ☐ 2
Never worked as a CCW/PCA..... ☐ 3
Do not have a Cert IV ..... ☐ 4

B11.1. Are you currently studying for any qualifications?

Yes ..... ☐ 1
Go to B11.2
No ..... ☐ 2
Go to B12

B11.2. Which qualification/s? *(e.g. Certificate III in Aged Care)*

B 12. What are the best things about your job at the moment?

B 13. What are the worst things about your job at the moment?

Do you have more to say about your work?

To further extend our knowledge about the aged care workforce we will be interviewing 100 direct care workers. These interviews will take place by phone during November – February and will take approximately 30 minutes of your time.

We invite you to take this opportunity to speak to us about your work. If you would like to participate please provide your name and phone number:

	Name
	Phone number

Please be assured that these details will be removed from the survey by AC Nielsen and will not be able to be associated with your responses in the questionnaire.

If you are selected to be interviewed, you will be contacted by researchers from the National Institute of Labour Studies, Flinders University, in November/December 2007.

THANK YOU VERY MUCH FOR YOUR HELP IN PROVIDING THIS INFORMATION.

TO ASSIST US IN DESIGNING FUTURE SURVEYS PLEASE PROVIDE AN ESTIMATE OF THE TIME TAKEN TO COMPLETE THIS FORM.	☐☐ **Minutes**

Australian Government Statistical Clearing House Approval Number 01431 – 02

(Census Return) Residential Facility Questionnaire

Under 21.26 G of the *Residential Care Subsidy Principles 1997* the approved provider must complete this Census Return to the satisfaction of the person specified on the Census Return. This specified person is AC Nielsen Ltd.

IMPORTANT – PLEASE READ BEFORE STARTING

Please complete a separate Residential Facility Questionnaire *for each* **RACS** you manage.

It is extremely important that the information that we collect in this survey is accurate. So we ask that you please refer to records, when answering each question. To make this less trouble for you, we ask that you use information from the last pay period you have had in August 2007, in all your answers.

Please use a BLACK pen to complete the questionnaire

You can also fill this questionnaire out online at: http://acnonline.com/careworkforce

For assistance, please phone 1800 801 609 and mention the Census of Aged Care Workforce

Closing date for return of the questionnaire is **31 October 2007**.

Thank you for participating in the Census and taking the time to complete this questionnaire.

Section A: About the Facility

The following questions ask for basic information about your aged care facility. This information will help us to understand how the aged care workforce is distributed across different types of homes.

A.1(a) **Where is your facility located?** *(Please put a cross in the appropriate box)*

Metropolitan ☐ 1

Regional ☐ 2

Rural ☐ 3

Remote ☐ 4

A.1(b) **What is your postcode?**

A.2 **How many high and low care residents are in your facility?**

High Care Places: RCS 1-4 (write in)

Low Care Places: RCS 5-8 (write in)

A.3 **How many people does your facility employ in total, including all full-time, part-time and casual employees, but excluding agency staff?** *(Count all employees for whom PAYE tax is deducted by your organisation)*

PAYE employees

A.4 **Is your facility** (please put a cross in the appropriate box):

Not-for-Profit ☐ 1

For Profit ☐ 2

Government ☐ 3

A5(a) **Does your facility provide community based aged care services in addition to residential services?** *(Please put a cross in the appropriate box)*

Yes ☐ 1

No ☐ 2

Go to A6

A.5(b) **What percentage of your direct care employees in each classification work in both your community based and residential services?** *(Please be sure to write '0' if no employees in a particular classification work in both services)*

Employee Classification	%
Registered nurse (Div 1)	
Enrolled nurse / RN (Div 2)	
Personal care attendant	
Allied health	

**Job titles of personal care attendants vary widely. They include, for example: personal care attendant, assistant or aide (PCA), personal care worker (PCW), Assistant-in-nursing (AIN), and others. They are workers, other than qualified nurses, who provide personal care to residents as a core part of their jobs.*

*** Please include direct care allied health workers, such as physiotherapists, diversional therapists, social workers and speech therapists. Exclude employees solely engaged in a coordinator / management role*

A.6 **Is your facility part of a larger organisation (e.g., owned by a company or not-for-profit agency that owns other aged care facilities)?**
(Please put a cross in the appropriate box)

Yes ..... ☐ 1

No ..... ☐ 2

A.7 **Does your facility aim to cater for specific ethnic or other cultural groups (ie ATSI/CALD groups)?**

Yes ..... ☐ 1
Go to A.8

No ..... ☐ 2
Go to Section B

A.8 **For which ethnic or other cultural group(s) does your facility cater?**

A.9 **Does your facility employ staff with particular language or other cultural knowledge in order to cater to the group/s listed in A.8?**
(Please put a cross in the appropriate box)

Yes ..... ☐ 1

No ..... ☐ 2

Section B: About the Workforce

The following questions ask about the workforce currently employed in your facility. For these data to be useful for planning in the industry, it is important that they are as accurate as possible. We are grateful for the time and effort you will contribute to assemble this information.

If you provide both residential and community based care, please confine your answers here to *employees providing residential care only* (ie, exclude CACP, EACH and EACH-D employees). Include all employees for whom PAYE tax is deducted by your organization. Do not include agency staff and contract staff for whom PAYE tax is not collected. Agency and other non-PAYE contract staff are covered in Section D.

Please provide the information for current employees (ie, for the last pay period you have had in August 2007). If you have no employees in a category please write '0' in the appropriate space.

B.1 **In the spaces provided below, please record the number of people (headcount) employed, and the number of full-time equivalent (EFT/FTE) employees, in each classification in your facility**.
(Include only the time staff spend working in your aged care facility when calculating EFT/FTEs)

Employee Classification	Permanent full-time	Permanent part-time	Casual/ contract	Full-time equivalent employees (EFT/FTEs)#
Registered nurse (Div 1)				
Enrolled nurse / RN (Div 2)				
Personal care attendant*				
Allied health**				

 # The full time equivalent (FTE/EFT) employees is the size of the employee body which considers both the number of employees and the fraction of full-time work status of each. For example, an employee working full-time will register as 1 FTE; while an employee working a fractional load of half-time will register as 0.5 FTE. One FTE employee works 70+ hours per fortnight.

**Job titles of personal care attendants vary widely. They include, for example: personal care attendant, assistant or aide (PCA), personal care worker (PCW), Assistant-in-nursing (AIN), and others. They are workers, other than qualified nurses, who provide personal care to residents as a core part of their jobs.*

*** Please include direct care allied health workers, such as physiotherapists, diversional therapists, social workers and speech therapists. Exclude employees solely engaged in a coordinator / management role.*

We now ask for more detail about the employees you listed in Q. B.1. Please ensure that you include all these employees in your answers.

If you have no employees in a particular category, please write '0' in your answer.

B.2 **How many employees in each classification are female and how many are male?**

Employee Classification	Female	Male
Registered nurse (Div 1)		
Enrolled nurse / RN (Div 2)		
Personal care attendant		
Allied health		

B.3 **How many of the employees in each classification worked the following hours in the last pay period in August 2007?**

	Hours worked in fortnight			
Employee Classification	1-30 hours	31-68 hours	69-80 hours	81+ hours
Registered nurse (Div 1)				
Enrolled nurse / RN (Div 2)				
Personal care attendant				
Allied health				

B.4 **How many of the employees in each classification have been continuously employed for the periods shown below?**

	Period Employed		
Employee Classification	Less than 1 year	1 to 5 years	6 or more years
Registered nurse (Div 1)			
Enrolled nurse / RN (Div 2)			
Personal care attendant			
Allied health			

B.5 **How many employees in each classification fall into the following age categories?**

Employee Classification	Age in Years				
	Under 30 yrs	30 to 39 yrs	40 to 49 yrs	50 to 59 yrs	60+ yrs
Registered nurse (Div 1)					
Enrolled nurse / RN (Div 2)					
Personal care attendant					
Allied health					

B.6 **For each employee classification, please indicate the approximate PERCENT of employees working under each form of employment contract.**

Employee Classification	Form of employment contract				
	Award	Enterprise Agreement *	Common Law Contract	AWA	Don't Know
Registered nurse (Div 1)					
Enrolled nurse / RN (Div 2)					
Personal care attendant					
Allied health					

** Enterprise Agreements include union agreements, non-union agreements and certified agreements.*

B.7 **How many equivalent full-time (EFT/FTE) vacancies do you have in each classification?** *(Please be sure to write '0' if you have no vacancies in a particular employee classification)*

Employee Classification	Number of EFT/FTE vacancies
Registered nurse (Div 1)	
Enrolled nurse / RN (Div 2)	
Personal care attendant	
Allied health	

B.8 **How many of your own regular employees in each classification were on Workcover or other injury related leave or a graduated return to work program during the last pay period in August 2007?** *(Please be sure to write '0' if no employees in a particular classification were on such leave)*

Employee Classification	Number of Employees
Registered nurse (Div 1)	
Enrolled nurse / RN (Div 2)	
Personal care attendant	
Allied health	

B.9 **Approximately how long did it take you to fill the most recent vacancy for employees in each classification?**

Employee Classification	Weeks
Registered nurse (Div 1)	
Enrolled nurse / RN (Div 2)	
Personal care attendant	
Allied health	

B.10 **What qualifications does the Care Manager in your facility have?**
(Please put a cross in the appropriate box)

Nursing qualifications ☐ 1

Managerial qualifications ☐ 2

Nursing and managerial qualifications ☐ 3

None of the above ☐ 4

Section C Personal Care Attendants

We would like to know some further information about the personal care attendants (PCAs) employed in your aged care facility.

C.1 **How many of your PCA employees have completed a Certificate III or Certificate IV in an area related to their direct care work?**

		Completed Certificate III (only)
		Completed Certificate IV

C.2(a) **What proportion of your current PCAs would you estimate speak a language other than English as their first language?**
(Please put a cross in the appropriate box)

None ☐ 1 **Go to C.4**

Less than one third ☐ 2

One third to two third ☐ 3

More than two thirds ☐ 4

C.2(b) **What is the most common ethnic or cultural background of PCAs who speak a language other than English as their first language?**

C.3(a) **Does lack of English language skills amongst your PCAs cause any difficulties in your facility?**
(Please put a cross in the appropriate box)

Yes ☐ 1

No ☐ 2 **Go to C.4**

C.3(b) **In which areas does lack of English language skills amongst your PCAs cause difficulties? Please put a cross in all boxes that apply.**

Occupational Health and Safety ☐ 1

Communication with management and/or other staff ☐ 2

Communication with residents ☐ 3

Communication with residents' families ☐ 4

Other (please specify) _____ ☐ 5

C.4 **If you wished to employ additional PCAs, how would you be most likely to find them?**
(Please put a cross in the appropriate box)

Wait for walk-ins	☐ 1
Word of mouth	☐ 2
Place a newspaper job advertisement	☐ 3
Place an internet job advertisement	☐ 4
Place both newspaper and internet job advertisements	☐ 5
Employ those already working through a job placement program	☐ 6
Other/don't know (please specify) _____	☐ 7

Section D: Agency Staff

We would now like to ask about the nursing or employment agency staff or contract staff *for whom you do not deduct PAYE tax*, who worked in your facility during the reference pay period.

D.1 **How many people from nursing or employment agencies plus contract staff worked in your aged care facility during the last pay period in August 2007?** *(Please be sure to write '0' if you did not employ any agency or contract staff in a particular employee classification.)*

Employee Classification	Number of Agency/Contract Staff
Registered nurse (Div 1)	
Enrolled nurse / RN (Div 2)	
Personal care attendant	
Allied health	

D.2 **How many shifts at each classification level were filled by agency/contract workers in the last pay period in August 2007?** *(Please be sure to write '0' if you did not employ any agency or contract staff in a particular employee classification)*

Employee Classification	Number of Shifts
Registered nurse (Div 1)	
Enrolled nurse / RN (Div 2)	
Personal care attendant	
Allied health	

THANK YOU VERY MUCH FOR YOUR HELP IN PROVIDING THIS INFORMATION.

TO ASSIST US IN DESIGNING FUTURE SURVEYS PLEASE PROVIDE AN ESTIMATE OF THE TIME TAKEN TO COMPLETE THIS FORM.	☐☐ **Minutes**

Australian Government Statistical Clearing House Approval Number 01414 -- 02

Survey of Aged Care Workforce

HOW TO FILL OUT THIS QUESTIONNAIRE

1. To answer most of the questions you only need to **put a cross in the box**. Please tick the box which is **closest** to your situation or your view.

   Please use a BLACK pen to complete the questionnaire.

   Here is an example.

Q1 Did you take any sick leave last week?

Yes	☒	(1)
No	☐	(2)

If you took some sick leave last week, you would place a cross in the first box as shown above.

2. Sometimes you are asked to write in an answer — in that case, simply write your answer in the space provided, for example:

Q2 How long have you worked in your current job?

Number of years | 1 | 2 | (*enter to the nearest year*)

*Please read each question carefully. Remember, we just want to know about **your own** personal situation or opinions.*

You can also fill this questionnaire out online at:

http://acnonline.com/careworkforce

For assistance, please phone 1800 801 609 and mention the Survey of the Aged Care Workforce

Thank you for participating in this survey and taking the time to complete the questionnaire

SECTION A - ABOUT YOUR WORK

Please answer the questions in this section by thinking about the direct care job you do in this aged care facility, unless the question refers specifically to another job you may have.

A1. What is your job?
(Please put a cross in the appropriate box)

Registered nurse (Division 1)..... ☐ 1
Enrolled nurse / RN (Division 2) ..... ☐ 2
*Personal care attendant..... ☐ 3
Physiotherapist ..... ☐ 4
Occupational therapist..... ☐ 5
Diversional therapist/recreational officer
..... ☐ 6
Speech therapist..... ☐ 7
Other – please specify _____ ☐ 8
_____

Please note: Job titles of personal care attendants vary widely. They include, for example: personal care attendant, assistant or aide (PCA), personal care worker (PCW), Assistant-in-nursing (AIN), and others. They are workers, other than licensed nurses, who provide personal care to residents as a core part of their jobs.

A2.1. Which of the following *best* describes your *current* work schedule?
(Please put a cross in the appropriate box)

A regular daytime shift..... ☐ 1
A regular evening shift..... ☐ 2
A regular night shift ..... ☐ 3
A rotating shift *(changes from days to evening to nights)*..... ☐ 4
Split shift *(two distinct periods each day)* .. ☐ 5
On call..... ☐ 6
Irregular schedule ..... ☐ 7
Other – please specify_____ ☐ 8
_____

A2.2a. Would you prefer to maintain your current work schedule, or change it?

Prefer to maintain current schedule..... ☐
1 Go to A3.1

Change to different schedule ..... ☐ 2

A2.2b. Which describes the work schedule you would *prefer*?
(Please put a cross in the appropriate box)

A regular daytime shift ☐ 1
A regular evening shift ☐ 2
A regular night shift ☐ 3
A rotating shift *(changes from days to evening to nights)* ☐ 4
Split shift *(two distinct periods each day)* ☐ 5
On call ☐ 6
Irregular schedule ☐ 7
Other – please specify_____ ☐ 8

A3.1. How many hours on average do you *usually* work each week in this job?

☐☐ hours per week

A3.2. How many hours would you *like* to work in this job?

☐☐ hours per week

A3.3. How many of the hours you usually work each week are paid and unpaid? *(If you do not work any unpaid hours, write '0' in the corresponding box.)*

☐☐ Paid hours
☐☐ Unpaid hours

A4. For how long have you worked in the aged care facility?

☐☐ years
☐☐ months

A5. Which best describes your form of employment?
(Please put a cross in the appropriate box)

Casual ☐ 1
Permanent (full or part-time) ☐ 2
Fixed term contract ☐ 3

A6. Are you entitled to paid sick leave?
(Please put a cross in the appropriate box)

Yes ☐ 1
No ☐ 2
Don't know ☐ 3

A7.1. Before you first obtained this job, had you done any work for this facility?
(Please put a cross in the appropriate box)

No ☐ 1
Yes, paid work ☐ 2
Yes, unpaid work/volunteer ☐ 3

A7.2. When you approached the aged care facility for your job, did you know there was a job available?
(Please put a cross in the appropriate box)

Yes ☐ 1
Go to A7.3
No ☐ 2
Go to A8.1
Don't know ☐ 3

A7.3. **How did you find out your job was available?** *(Please put a cross in the appropriate box)*

Job network employment agency ☐ 1
Other employment agency ☐ 2
Career service at a tertiary educational institution ☐ 3
School programs ☐ 4
Newspaper advertisements ☐ 5
Internet sites ☐ 6
Centrelink job search services or touchscreens ☐ 7
Company or professional contacts ☐ 8
Workplace noticeboards ☐ 9
Word of mouth ☐ 10
Other – please specify_____ ☐ 11
Go to A8.1

A8.1. For this job, what was the total amount of your most recent pay before tax or anything else was taken out?

$ | | | | | | |

A8.2. For what period does that cover? *(Please put a cross in the appropriate box)*

Week ☐ 1
Fortnight ☐ 2
Month ☐ 3

A9. The following statements are about your current job in the aged care facility. Please indicate, by putting a cross in <u>one</u> box on <u>each</u> line, how strongly you agree or disagree with each. The more you agree the higher the number you should choose. The more you disagree, the lower the number you should choose.

	Strongly Disagree						Strongly Agree
A: I am able to spend enough time with each care recipient	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7
B: I have the skills I need to do my job	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7
C: I use many of my skills in my current job	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7
D: I have a lot of freedom to decide how I do my work	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7
E: I feel under pressure to work harder in my job	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7
F: My job is more stressful than I had ever imagined	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7
G: Considering all my efforts and achievements, I	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7

receive the respect and acknowledgement I deserve

H: Management and employees have good relations in my workplace ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7

5

A10.1. Do you expect to be working for the aged care facility in 12 months time? *(Please put a cross in the appropriate box)*

Yes ☐ 1
Go to A11a

No ☐ 2
Go to A10.2

It depends ☐ 3
Go to A10.2

Don't know ☐ 4
Go to A10.2

A10.2. What is the main reason you may finish work for the aged care facility in the next 12 months?
(Please put a cross in the appropriate box)

Changing jobs/seeking other employment in aged care ☐ 1
Changing jobs/seeking other employment not in aged care ☐ 2
Returning to study/travel ☐ 3
Family reasons ☐ 4
Financial reasons ☐ 5
Stress/burnout ☐ 6
Retiring ☐ 7
Temporary job/fixed contract ☐ 8
Retrenchment/Redundancy ☐ 9
Other – please specify_____ ☐ 10

A11a. Where do you see yourself working 3 years from now?
(Please put a cross in the appropriate box)

Working, in aged care ☐ 1
Working, *not* in aged care ☐ 2
Go to A12

Not working for pay ☐ 3
Go to A12

Don't know ☐ 4
Go to A12

A11b. Which kind of aged care work do you expect to be doing?
(Please put a cross in the appropriate box)

Residential aged care ☐ 1
Community based ☐ 2
Residential and community based ☐ 3

A12. Thinking about a typical shift, how much of your shift would you spend actively caring for residents of the aged care facility (as opposed, for example, to doing paperwork, attending meetings, or in discussions with other staff)? *(Please put a cross in the appropriate box)*

Less than a third ..... ☐ 1
Between one third and two thirds..... ☐ 2
More than two thirds ..... ☐ 3

A13.1. Did you have more than one job last week?
(Please put a cross in the appropriate box)

Yes ..... ☐ 1
Go to A13.2
No ..... ☐ 2
Go to A14

A13.2. Is your other job in aged care?
(Please put a cross in the appropriate box)

Yes ..... ☐ 1
No ..... ☐ 2

A13.3. How many hours each week do you *usually* work in your other job?

☐☐ hours per week

A14. **Returning attention to your work at this facility, here are some questions about how satisfied or dissatisfied you are with different aspects of your job. Using a scale from 0 to 10, where 0 *is 'totally dissatisfied'* and 10 is *'totally satisfied'*, please put a cross in <u>one</u> box on <u>each</u> line to indicate how satisfied or dissatisfied you are with the following aspects of your aged care job. The more satisfied you are, the higher the number you should pick. The less satisfied you are, the lower the number.**

	Totally Dissatisfied										Totally Satisfied
A: Your total pay	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10	
B: Your job security	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10	
C: The work itself (what you do) .	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10	
D: The hours you work	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10	
E: The opportunity to develop ..... your abilities	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10	
F: The level of support from your team / service provider	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10	
G: The flexibility available to ..... balance work and non-work commitments	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10	
H: All things considered, how .... satisfied are you with your job	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10	

A15. **In the last 4 weeks have you sustained an injury at work (in this job) that has resulted in you having any days away from work?**
(Please put a cross in the appropriate box)

Yes ☐ 1
No ☐ 2

A16. **In general, how would you describe relations at your workplace…**
(Please put a cross in the appropriate boxes. The better the relations at work the higher the number; the worse that relations are, the lower the number)

	Very Bad						Very Good	Can't Choose
Between management and employees	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐
Between workmates/colleagues	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐

A17. **How old were you when you first began working in aged care?**

		Years

A18. **Taking account of any breaks from working in aged care, for how many years have you actually worked in aged care?**

		Years

A19. What was your last paid job before you first worked in aged care?
(Please put a cross in the appropriate box)

- No previous paid employment ☐ 1
- Nurse in other setting ☐ 2
- Carer in other setting ☐ 3
- Salesperson ☐ 4
- Clerical worker ☐ 5
- Hospitality worker (waitress, etc.) ☐ 6
- Cleaner ☐ 7
- Professional (other than nurse) ☐ 8
- Manager ☐ 9
- Other paid employment ☐ 10

A20.1 Had you worked in aged care before you began your current job?
(Please put a cross in the appropriate box)

- Yes, paid ☐ 1
- Yes, unpaid/voluntary ☐ 2
- No ☐ 3

If 'No' go to Section B

A20.2 What was the most important reason you left the last (paid) aged care job you held before your current one?
(Please put a cross in the appropriate box)

- To achieve higher pay ☐ 1
- To avoid workmates/colleagues I did not get along with or like ☐ 2
- To avoid managers/management I did not get along with or like ☐ 3
- The job was too stressful ☐ 4
- Not able to spend sufficient time with residents ☐ 5
- To get shifts or hours of work I wanted ☐ 6
- To be closer to home ☐ 7
- To fulfil care responsibilities (including having a baby) ☐ 8
- To find more challenging work ☐ 9
- To find easier work ☐ 10
- Other (please specify) ☐ 11

SECTION B - ABOUT YOU

Please remember that this questionnaire is completely confidential. We do not even ask your name. No-one but the independent survey company will ever see your response. Your answers will be added to those of many other people who work in aged care, to give an overall picture

B1. Are you male or female?

Male ..... ☐ 1
Female ..... ☐ 2

B2. How old were you on your last birthday?

☐☐ Years

B3. In what country were you born?

.....

B4. Are you of Aboriginal or Torres Strait Islander origin?

No ..... ☐ 1
Yes, Aboriginal ..... ☐ 2
Yes, Torres Strait Islander ..... ☐ 3
Yes, both ..... ☐ 4

B5.1. Are you fluent in a language other than English?

Yes ..... ☐ 1
Go to B5.2
No ..... ☐ 2
Go to B6

B5.2. Do you use this language in your job?

Yes ..... ☐ 1
No ..... ☐ 2

B6. Do you have financial dependents?

No ..... ☐ 1
Yes, spouse/partner only ..... ☐ 2
Yes, children only ..... ☐ 3
Yes, spouse/partner and children ..... ☐ 4
Yes, other (please specify)..... ☐ 5

B7. In a normal week, about how many hours would you spend caring for family members (eg children or disabled or elderly relatives)?
(If you have no care responsibilities, write 0 in the space provided)

☐☐ hours

B8. In general, would you say your health is:

Excellent..... ☐ 5
Very Good..... ☐ 4
Good ..... ☐ 3
Fair ..... ☐ 2
Poor ..... ☐ 1

B9.1 What is the highest level of primary or secondary school you have completed?

Did not go to school ..... ☐ 1
Year 8 or below ..... ☐ 2
Year 9 or equivalent ..... ☐ 3
Year 10 or equivalent ..... ☐ 4
Year 11 or equivalent ..... ☐ 5
Year 12 or equivalent ..... ☐ 6

B9.2 Have you completed any post-school qualifications?

Yes ..... ☐ 1
Go to B10.1
No ..... ☐ 2
Go to B11.1

B10.1 What qualifications have you completed (tick as many boxes as necessary)?

Certificate III in Aged Care ..... ☐ 1
Certificate III in Home and Community Care ..... ☐ 2
Certificate IV in Aged Care..... ☐ 3
Certificate IV/Diploma in Enrolled Nursing..... ☐ 4
Certificate IV in Service Coordination (Ageing and Disability) ..... ☐ 5
Bachelor Degree in Nursing ..... ☐ 6
Other basic nursing qualification ..... ☐ 7
Post basic nursing qualification in aged care ..... ☐ 8
Post-basic nursing qualification not in aged care ..... ☐ 9
Other – please specify_____
_____ ☐ 10

B10.2 Did you study for a Certificate IV/Diploma in Enrolled Nursing while working as a Personal care attendant (PCA)?

Yes ..... ☐ 1
No ..... ☐ 2
Never worked as a PCA..... ☐ 3
Do not have a Cert IV..... ☐ 4

B11.1. Are you currently studying for any qualifications?

Yes ..... ☐ 1
Go to B11.2
No ..... ☐ 2
Go to B12

B11.2. Which qualification/s? *(e.g. Certificate III in Aged Care)*

.....

B 12. What are the best things about your job at the moment?

_____
_____
_____
_____
_____
_____
_____
_____

B 13. What are the worst things about your job at the moment?

_____
_____
_____
_____
_____
_____
_____
_____

Do you have more to say about your work?

To further extend our knowledge about the aged care workforce we will be interviewing 100 direct care workers. These interviews will take place by phone during November – February and will take approximately 30 minutes of your time.

We invite you to take this opportunity to speak to us about your work. If you would like to participate please provide your name and phone number:

	Name
	Phone number

Please be assured that these details will be removed from the survey by ACNielsen and will not be able to be associated with your responses in the questionnaire.

If you are selected to be interviewed, you will be contacted by researchers from the National Institute of Labour Studies, Flinders University, in November/December 2007

THANK YOU VERY MUCH FOR YOUR HELP IN PROVIDING THIS INFORMATION.

TO ASSIST US IN DESIGNING FUTURE SURVEYS PLEASE PROVIDE AN ESTIMATE OF THE TIME TAKEN TO COMPLETE THIS FORM.	**Minutes**

Australian Government Statistical Clearing House Approval Number 01431 – 02