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Caring for profit? The impact of for-profit providers on the quality of employment in paid care

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Nursing homes and hostels are active partners in the delivery of care services in Australia and there is no doubt that the ways these organisations operate can either help or hinder the provision of good care (Meagher 2006, p. 48; Scott et al. 1995, p. 78). One of the central ways in which aged care organisations influence the quality of care is through the recruitment and management of the care workforce. Indeed, in a detailed multivariate analysis of the supply of careworkers, Martin (2007, p. 194) argued that 'all of the most important predictors of aged care workers' job satisfaction are determined primarily by how work is organised in aged care facilities, and are therefore largely under the control of facility managers'. But facility managers do not have absolute autonomy. They are embedded in a particular organisational setting, with specific administrative procedures, access to technology, funding and accountability processes, and overarching values—all of which influence their capacity to organise careworkers in ways which would maximise the quality of care that can be provided to residents.

One of the most obvious differences between aged care organisations is the form of ownership. Analysts argue that for-profit organisations prioritise the needs of shareholders/owners to maximise profit over the needs of either those in receipt of care, or the careworkers who provide it (Knijn 2004, p. 234; Cancian 2000), In contrast, government and non-profit organisations are viewed as somewhat less market oriented and capable of prioritising professional and

welfare state objectives over those focused on maximising returns (Knijn 2004). In particular, proponents of non-profits argue that they derive superior performance and productivity from shared values and commitment to common goals that overrides a narrow focus on profits and costs (for example, Cheverton 2007, p. 432). The corollary of this argument is the belief that the quality of care provided within for-profit organisations is likely to be inferior.

More broadly an influential line of thought has seen an inherent tension between care and money (England 2005; Folbre 2006; Ungerson 1997). This tension is said to be particularly problematic when money is the *primary* reason that care is provided: hence the suspicion of for-profit ownership of care organisations. The money versus care argument is typically applied at the level of careworkers—that is, the extent to which paying careworkers compromises the quality of care that they will provide. This debate often focuses on the difference between the qualities and values of familial care, which is mostly unpaid, and those of contracted care which is undertaken only because of the payment that ensues. More recently, the debate has expanded to include the moral and political dimensions of care which places the payment associated with the contractual arrangement within a broader context. Meagher (2006), for example, argues that taking this broader approach facilitates a perspective that views paid carers as capable of providing 'good enough' care. The focus in this debate has been on the relationship between careworker and care recipient. However the relationship between careworkers and the organisations that pay them is equally important, since this relationship frames the way careworkers can actually provide care to care recipients.

This paper examines whether differences in the form of ownership of residential aged care facilities has any influence on the experience of work for aged care workers. Do for-profit facilities organise staffing and work differently from others? Do workers providing care in for-profit organisations have different work experiences than others? To address these questions, we examine the perception

that the market approach to the provision of aged care services is inappropriate or deficient. We then draw upon data collected by the National Institute of Labour Studies (NILS) for the Commonwealth Department of Health and Ageing to test the argument that for-profit provision makes a difference. Two data-sets are analysed: a census of all residential aged care facilities across Australia, and a random survey of employees in these facilities. The evidence suggests that, despite there being some differences in the aged care workforce according to the form of facility ownership, there was little support for the argument that for-profit residential aged care facilities are worse employers or that their workforce is less satisfied with the level of care they are allowed to provide. The paper concludes with a discussion about why the form of ownership may not matter to careworkers as much as some arguments suggest.

Caring for-profit? Or caring for *profit*?

For-profit providers have been an important component in Australian residential aged care since at least the 1960s. Their concentration today in providing 'high care' places reflects their historic focus on nursing home, rather than hostel ('low care'), provision. In contrast to some other areas of care provision, notably child care, the proportion of residential aged care beds provided by for-profits has not changed markedly over the past three decades (see Healy 2002; Howe & Healy 2005; Kendig & Duckett 2001). However, governments have moved to progressively increase the role of market mechanisms in the provision and allocation of residential aged care places (Howe & Healy 2005). At the same time, government funding arrangements and regulation, particularly through licensing requirements, mean that all residential aged care providers must conform to a range of key constraints imposed by government (see Hogan 2004, Ch. 2; Stack 2003). In this complex environment, the question of whether for-profit facilities should be expected to differ in their staffing practices and characteristics as workplaces is especially difficult.

One possibility is that for-profit organisation produces greater efficiency and lower costs (Bishop 1988). Here, for-profits are taken as a paradigm for best practice because market principles, based on the commodification of care, price sensitivity and rational economic behaviour, are best able to meet demand, manage supply and distribute services efficiently. Although the operation of such a mechanism will be limited in Australian aged care because there is little or no price competition, for-profit facilities may still represent best practice. In seeking profits, they may maximise the most important forms of efficiency by focusing on the provision of quality care at minimum cost. In relation to staffing, they might make optimal arrangements to hire and retain workers and organise their work. For-profit aged care organisations may be far less likely than non-profit or government organisations to exhibit internal conflict between market principles and other principles such as charity, benevolence, welfare or professional duty that may guide their operations.

Of course, many analysts have argued that 'market failure' is much more likely than successful competition in areas like aged care. Placing a feminist slant on this view, Nancy Folbre has argued that paid care services cannot be 'bought and sold like any other commodity, simply relying on the forces of demand and supply' (2006, p. 12). She points out that for the market to operate efficiently in the field of aged care it would need to ensure that both workers and consumers have perfect information upon which to make a rational choice; and that price changes would induce efficient adjustments. She demonstrates that, given the nature of aged care, neither of these has occurred or is likely to occur in the future. Folbre's analysis is focused on the United States, where price competition is much more important than in Australia. Indeed, a plausible view might be that Folbre's concerns are not particularly relevant to Australia because government subsidies and regulation will minimise market failure. Nevertheless, a focus on profits in for-profit facilities may lead to a kind of secondary market failure, through a tendency to exploit

workers and provide lower quality care. Indeed, the consistent reporting of abuse of residents and low standards of care within the aged care sector suggest that cost cutting and quality of care issues still affect the lives of at least some residents in aged care (Choice 2006; Owen 2007).

Thus, both proponents and critics of market-based provision of care might expect differences in staffing arrangements and the experience of work in for-profit and other aged care facilities. However, while proponents expect more efficient staffing, more focused (and, possibly, positive) work experiences, and overall higher quality care, critics expect the opposite. In contrast to both these views, other interpretations suggest that ownership type should make little difference to these outcomes.

One body of research suggests that market relations need not undermine the provision of care, as long as certain conditions are met. These conditions include: restricting profit-making or cost-cutting; having structures of authority that provide caregivers and care receivers with considerable power; having values, incentives and training that promote the emotional/relational as well as physical/technical aspects of care (Cancian 2000); and providing caregivers with a degree of role flexibility, and time to engage with care recipients and allow continuity of care over time (Scott et al. 1995). This work may accept the view that the market imperfections in aged care and the moral paradox of caring for profit result in a possible tension between care, profit and quality. However, it also implies this tension may be resolved without negative effects. The empirical question is whether the relevant arrangements are effective in achieving this end.

The literature on organisational 'isomorphism' suggests another perspective on why there may be little difference between for-profit and other aged care facilities. Aged care facilities face a range of pressures that might be expected to produce what DiMaggio and Powell (1983) famously referred to as 'institutional isomorphism'—a tendency for organisations in a given 'field' to look very similar, irrespective of differences such as those of ownership. Certainly, all aged

care facilities face strong 'coercive' pressures through government funding and regulatory arrangements (see Braithwaite et al. 2007; Hogan 2004, Ch. 2; Stack 2003), and these may lead to similar cost constraints and work arrangements irrespective of ownership type.[1] Moreover, the professional background of most facility managers in nursing, and their continued professional networks, may lead to 'normative' processes that produce otherwise unexpected similarities in how facilities arrange staff and their work.

One of the few pieces of empirical research conducted on the organisation of aged care in Australia and its impact on careworkers focused on the trend toward accountability, continuous improvement and flexibility within aged care (Stack 2003; Stack and Provis 2000a; 2000b). This case-study research focused on four facilities operated by a non-profit body in Adelaide, South Australia. It involved semi-structured interviews with careworkers and managers, observation, and a survey of about 70 careworkers in the facilities. While this study was not differentiated by ownership type, it nevertheless points to a range of issues relevant to our research. The researchers were particularly concerned to find that when the provision of care was dominated by economic imperatives, the labour process became depersonalised 'in the interest of speeding it up and making

1 All Australian residential aged care facilities are heavily subsidised by the Commonwealth government. Funding is provided primarily on a per bed basis (at differing rates depending on the care level provided), with additional capital and other funding available through various programs. Facilities are licensed to provide a specific number of beds, and funding is not provided beyond the licensed beds. Facilities are not permitted to charge costs for care beyond the levels of funding provided by government, though they can make charges for additional so-called 'hotel' services (for example, larger rooms, higher quality food). Regulation is primarily through a system of inspections and accreditation; it is illegal for unaccredited facilities to continue to operate. To maintain accredited status, facilities must meet certain standards when inspected. These standards are focused around the care provided to residents (including the maintenance of physical infrastructure, the provision of competent caring, and management systems), but do not include prescriptive standards on staffing levels or training.

it cheaper' (Stack 2003, p. 8). When analysing the organisational response to 'flexibility', for example, Stack and Provis (2000a) found tensions in the organisation and delivery of care work between:

- performance of emotional labour and the increased controls over the performance of work;
- requirements for effective caring and other attempts by organisations to seek efficiency;
- workers' emotional commitment to individual clients and workers' inability to provide effective assistance;
- flexible performance of caring work and the control of quality or management of risk;
- use of staff committed to professional values, and numeric flexibility, standardised procedures and detailed control of work;
- workers' commitments to their own wellbeing and to standards of care, and attempts to gain 'attitudinal' flexibility from workers.

Similarly, they found that desirable elements of care work were devalued on the basis of efficiency: the time allowed with patients was decreased; rosters were introduced which limited the levels of continuity staff had with aged clients; investment in training and development was undervalued; and the scope for collegial interaction and effective team communication was diminished (Stack & Provis 2000b, p. 6–7). Subsequently, Stack (2003, p. 8) argued that cost-efficiency and the marketisation of aged care has meant that the structure of work in residential aged care is increasingly unable to deliver the vision of a 'community of care' that aged care is supposed to be.

Within this research, tensions around care and quality appeared to be as much about definitions as they were about accountability. Quality care meant something quite different to the organisation, where it was an issue of accountability and accreditation, than it did to the workers for whom it was an issue of alleviating distress and

tending to the vulnerable. As Stack and Provis (2000a, p. 13) claimed in their conclusion, 'where cost is the only consideration, quality as a social outcome appears to be devalued'.

This brings us back to the tension between profit and care in aged care facilities, and the impact on workers. The review of current thinking indicates one line of analysis suggesting that workers may be worse off working in organisations that are primarily organised around profit-making principles, as for-profit aged care facilities ostensibly are. In contrast, other arguments suggest that there are strong forces homogenising the organisation of aged care work. In the following sections these contrasting possibilities are examined in more detail by comparing the work conditions and work experiences of direct care staff in for-profit aged care facilities to those working in non-profit and government facilities. In particular the analysis focuses on whether for-profit organisations:

- are more likely to have a smaller, more flexible, less qualified workforce;
- minimise the continuity in, and amount of time that workers have to care for aged residents;
- have lower levels of job satisfaction among their workers.

The data

In 2003, a census of residential aged care facilities and survey of workers from each facility was conducted by NILS on behalf of the Commonwealth Department of Health and Ageing. This resulted in data relating to the workforce profile of each facility, and to the workplace experience of direct careworkers (nurses, personal care attendants and allied health workers).[2] Once de-identified, these data were merged to enable analysis of the experience of carework-

2 The survey of workers was carried out by asking each facility to distribute questionnaires to a random sample of their direct care employees. For further details of the census and survey see Richardson and Martin (2004).

ers in relation to the facility where they worked. For the purpose of this paper, facilities have been differentiated according to ownership type: for-profit, non-profit and government.

Of the 2881 facilities included in the census, 1737 responded (covering 1801 facilities due to some facilities being co-located), producing a 62.5 per cent response rate. For-profit facilities made up 24 per cent of all facilities, with non-profits comprising 66 per cent (N=1155) and government facilities 10 per cent (N=167).[3] For-profit facilities showed some systematic differences from others.

Table 5.1: Ownership type by state

State	Non-profit %	For-profit %	Govt %	Total
NT	100.0	-	-	*100*
NSW	75.4	22.1	2.5	*100*
VIC	46.4	30.7	22.8	*100*
QLD	72.8	20.4	6.8	*100*
SA	72.9	20.0	7.1	*100*
WA	75.7	23.7	0.7	*100*
TAS	80.9	10.6	8.5	*100*
ACT	83.3	16.7	-	*100*
Total N=	*1,155*	*415*	*167*	*1,737*

As Table 5.1 indicates, the state with the highest proportion of for-

3 For-profits were, on average, slightly larger than other facilities. They contained about 25.7 per cent of all beds in responding facilities, compared to official figures indicating that 28.5 per cent of beds were in high care facilities at the time of the census. Thus, respondents to the census were quite closely representative of all facilities, and there is no evidence of significant non-response bias.

profit facilities was Victoria (which also had the highest proportion of government facilities), with fairly similar distributions in each of the other mainland states. Reflecting their historical development as nursing homes (rather than hostels), for-profit facilities are much more likely than the other ownership types to have only high care beds (Table 5.2). Consistent with this pattern, for-profits are also much more likely to be located in metropolitan areas, especially compared to government-owned facilities. These features of for-profits are likely to influence their workforce profiles, given that facilities with only high care beds may require a different mix of staff than others. Moreover, the availability and recruitment of staff may be easier in metropolitan areas than in regional and remote areas.

Table 5.2: Ownership type by location, and levels of care

Location	For-profit %	Non-profit %	Govt %	Total N=
Metropolitan	70.1	49.1	14.4	879
Regional	17.1	21.1	19.8	347
Rural	12.8	29.8	65.8	505
Total	*100*	*100*	*100*	*1,731*
Level of Care				
Low care	13.2	41.9	21.8	568
High care	69.0	18.9	50.9	587
High and low care	17.8	39.2	27.3	566
Total	*100*	*100*	*100*	1,721

A representative sample of workers was taken from each facility (response rate = 41.2 per cent). Four categories of worker were surveyed: registered nurses (RN), enrolled nurses (EN), personal care attendants (PCA) and allied health workers. This chapter focuses on the experiences of nurses and personal care attendants. Responses were received from 1093 workers (nurses and PCAs) in for-profit facilities, 3336 workers in non-profit facilities, and 485 workers in government facilities. Just over 93 per cent of aged care workers are women, with for-profit facilities having a slightly higher (two percentage points) proportion of men than non-profit facilities. For-profit facilities also employed younger workers as PCAs than other ownership types. The average age of 39.8 years for PCAs in for-profit facilities was five years younger than those in other facilities. An indication of the proportion of migrants working in aged care is the level of employment of workers with fluency in a language other than English. For-profit facilities employ higher proportions of workers with fluency in another language—28.4 per cent compared to 20.8 per cent in non-profit facilities and just 13.7 per cent in government facilities. However, for-profit facilities are no more likely than others to ask their workers to use these language skills in their job. While 48 per cent of workers in for-profit facilities who spoke a language other than English used it in their work, 50 per cent of those in non-profit and 52 per cent of those in government facilities used their language skills at work.

Working in aged care

In comparing the workplace for nurses and PCAs in for-profit facilities to those in other forms of ownership, there are two levels of analysis: the facility and the workers. As outlined above, there are a number of competing hypotheses about likely differences in the organisation of staffing and the experience of workers in for-profit facilities compared to others. These are the focus of our analysis. The first is the hypothesis that for-profit facilities would have worse

work conditions, exemplified here by whether they employ fewer staff on a more casualised (flexible) basis and are less concerned with qualifications (especially for PCAs). Secondly, given that part of the motivation and reward of care work are related to a worker's relationship with residents, the hypothesis that the profit imperative will lead to work conditions that decrease contact with residents can be examined in relation to staff: bed ratios, the time workers actually spend in direct care, and the capacity for continuity of care vis-à-vis use of agency staff and staff turnover. Finally, the argument that working in for-profit facilities is likely to be less satisfying will be explored through an analysis of employee opinions about and satisfaction with their work.

The workplace: flexibility and the staffing mix

Over the past 15–20 years there has been a general shift in Australian workplaces towards increasing casualisation and enhancing flexibility (Watson et al. 2003). These trends have been particularly noticeable in jobs with high proportions of women (Watson et al. 2003). With its high proportion of female workers, it would be expected that the aged care workplace would exemplify this trend. The question here, though, is whether for-profit facilities have gone further than other ownership types in paring back work conditions to maximise financial returns.

The level of casualisation can be gauged by the extent to which facilities employ casual workers. As illustrated in Table 5.3, the majority of employees are *not* on casual contracts, although PCAs are more likely to be than nurses. In comparing the facility type, for-profit facilities have a higher proportion of ENs on casual contracts than do either non-profit or government facilities.

Having a flexible workforce is important in an industry where resident numbers and levels of care fluctuate. In addition, there are also 'peak' periods, such as showering, that require more staff than at others. However, flexibility can become a problem when it works to disadvantage employees by splitting shifts or not offering them enough

Table 5.3: Proportion employees who are casual and part-time by employment category by ownership of facility*

Casual	For-profit %	Non-profit %	Govt %
Registered nurse	15.4	16.1	14.8
Enrolled nurse	26.2	16.2	13.8
PCAs	32.4	34.9	36.0
Total N=	1404	3066	479
Part-time*			
Registered nurse	53.0	60.5	61.3
Enrolled nurse	70.9	67.1	65.4
PCAs	69.2	77.2	79.5
Total N=	1393	3022	478

*Part-time workers are those working less than 35 hours per week.

hours. As illustrated above (Table 5.3), most employees in aged care work part-time, and this may well be their preference. To examine whether organisational flexibility is meeting the needs of employees or the needs of the organisation, we have measured the extent to which employees are working their preferred number of hours. As demonstrated in Table 5.4, it appears that over a quarter of workers in aged care are underemployed. This differs by ownership type, but in this case it is non-profit facilities that have the lowest proportion of employees satisfied with their working hours. That similar majorities of employees in all facility types are working their preferred hours indicates that for-profits are no more likely than others to be achieving flexibility by circumventing workers' preferred hours.

Table 5.4: Hours employees would like to work by ownership of facility

	For-profit %	Non-profit %	Govt %
Want to work MORE hours	27.0	30.4	20.3
Want to work SAME hours	60.0	55.3	63.8
Want to work LESS hours	12.9	14.3	15.9
Total N =	703	1541	271

Table 5.5: Proportion of effective full-time equivalent employees by employment category by ownership of facility

	For-profit %	Non-profit %	Govt %	Total N=
Registered nurse	35.8	38.4	37.2	3,079
Enrolled nurse	25.8	25.9	34.1	2,252
PCAs	38.4	35.7	28.7	3,083
Total N=	1,922	5,499	993	8,414

Nevertheless, having a good workplace is about more than job security and getting the desired number of hours of work each week. It is also about whether the staffing mix is right. This influences whether there are enough supervisors to ensure that staff are not taking responsibility for tasks they are not trained for or, alternatively, whether workers get the opportunity to use their skills in their work. The staffing mix is influenced by a number of factors, one of the most important being the level of care the facility offers—the numbers of high and low care beds. As discussed earlier, for-profit facilities are predominantly high care facilities and it would be expected that their staffing mix would reflect this by having a higher proportion of nurses and qualified staff.

Yet, as Table 5.5 illustrates, for-profit facilities employ a slightly lower proportion of nurses and higher proportion of PCAs than either of the other ownership categories. This is especially so at the RN level. RNs in for-profit facilities comprise 35.8 per cent of the direct care workforce, compared to being 37.2 per cent of the workforce in government facilities and 38.4 per cent in non-profit facilities. As will be demonstrated in the next section of the paper, this has a flow-on effect regarding workload.

This disparity in staffing mix might be off-set by for-profit facilities employing qualified PCAs, especially those with a Certificate IV in Aged Care which reflects similar levels of skill as a Diploma in Nursing. Tables 5.6 and 5.7 show that for-profit facilities certainly employ more qualified PCAs than government facilities, but they are very similar to the profile of non-profit facilities. In addition, the proposition that they might employ more PCAs with a Certificate IV is not borne out by the evidence. However, as there is no 'wage premium' associated with Certificate III or IV qualifications (Martin 2005), and while facilities may well desire more qualified PCAs, there is little financial incentive for employees to undertake this level of training.

Overall, the for-profit workplace is slightly better than that of non-profit workplaces for offering preferred hours of work; and is much better than government facilities for employing qualified PCAs. Where the for-profit workplace may fall down, comparatively speaking, is in the staffing mix. Despite being much more likely to have only high care beds, for-profits have no higher proportions of nursing staff than other ownership types. The next section examines the affect of this on the level of care that workers can give to residents.

Table 5.6: Proportion of facilities with more than half or less than half of PCAs with Certificate III in Aged Care, by ownership of facility

	For-profit %	Non-profit %	Govt %
Less than half with Cert III	41.2	37.6	56.6
Half or more with Cert III	58.9	62.5	43.3
Total N =	389	1062	150

Table 5.7: Proportion of facilities with some or no PCAs with Certificate IV in Aged Care, by ownership of facility

	For-profit %	Non-profit %	Govt %
No PCAs have Cert IV	61.5	59.0	75.3
Some PCAs have Cert IV	38.5	40.9	24.6
Total N =	408	1129	162

The work: caring for residents

One of the key issues in 'caring for profit' debates is whether paying for care will result in the decreasing quality of care for care recipients. The provision of quality care is a concern at all levels of the care chain. At the organisational level, indicators of quality care are built into accreditation processes, though some analysts doubt that they are valid measures of whether residents actually receive quality care (Stack 2003). At another level, being able to provide quality care is an important aspect of care work and contributes to the intrinsic motivations and job satisfaction of employees within the aged care industry (Martin 2007). Previous studies on care work have found that careworkers receive non-monetary rewards from their work if they are permitted to meet the emotional and social needs of residents as well as their physical/medical needs—that is, when they see their work as contributing to the wellbeing and quality of life of another person (King 2007).

Two factors contribute to the capacity of careworkers to provide levels of care that incorporate both the physical/medical dimension and the emotional/relational dimension: time and continuity. The amount of time that carers spend in direct care work, as opposed to doing paperwork and other administrative tasks, provides an indication of a facility's priorities, for example, whether it is overly bureaucratised or whether it focuses on resident care. Direct care staff are employed specifically to tend to residents' needs, but their capacity to do this is affected by the ways in which their work is scheduled, including the allocation of tasks and the intensity of work. Aged care workers and residents also recognise the value of providing continuity of care. The ability of careworkers to build long-term relationships with residents facilitates both social wellbeing and physical wellbeing as changes in health status are more easily picked up when a resident is 'known' to a carer. The question for this section, then, is whether working in a for-profit organisation diminishes the capacity to fulfil the caring role that employees seek in their care work.

Differences in the amount of time employees say they spend actually caring for residents can be seen in Table 5.8. A higher proportion of workers (44 per cent) in for-profit facilities spend at least two-thirds of their time in direct care work than do workers in other kinds of facilities. When this is broken down to the different levels of staff, PCAs in for-profit facilities are much more likely to spend the majority of their work time performing direct care tasks. The story is somewhat different for nurses, who are more likely to perform direct care tasks in government facilities. Nevertheless, even nurses in for-profit facilities spend more time in direct care than those in non-profit facilities.[4]

4 The pattern in government facilities arises because more of their nurses are ENs, and ENs do more direct care than RNs. Although government facilities, mostly located in Victoria, have fewer PCAs than others, it is striking the their PCAs are much less likely than those in other facilities to spend more than two-thirds of their time in direct care work.

Table 5.8: Proportion of staff who spend more than two-thirds of their time in direct care work by employment category by ownership of facility

	For-profit %	Non-profit %	Govt %
Nurses	22.9	17.9	37.7
PCAs	58.0	48.3	35.5
All staff	44.0	39.7	37.0

While for-profit facilities certainly appear to prioritise the performance of direct care tasks (rather than paperwork, for example) by their careworkers, the capacity to spend sufficient time with residents is also influenced by the number of beds each person has to look after. As Table 5.9 makes clear, for-profit facilities have more beds per EFT-equivalent staff member than either of the other ownership types. In some areas the differences are very large. For example, in the 13.2 per cent of for-profit facilities which offer only low care places, there is an average of one full-time registered nurse to work on 91.4 beds—this is nearly double the workload that registered nurses have in either of the other ownership types. It is not just that for-profits give nurses greater caring workloads, since even PCAs in low care for-profit facilities have a 30 per cent higher staff/bed ratio than in other types of facilities. Workload differences are also evident in the high care facilities. Here, all three categories of staff in for-profit facilities have a higher staff/bed ratio than in other ownership types. However, while still markedly above the ratio in government facilities, these are more in line with the ratios in non-profit facilities.

This evidence suggests that work is organised somewhat differently in for-profit, non-profit and government-owned facilities. For-profit facilities somehow are able to have their staff spend more time on direct care, possibly by using the higher level organisational skills of RNs to undertake non-caring tasks. This may explain the greater

Table 5.9: Average ratio of beds per employed EFT-equivalent staff by employment category in each type of facility by ownership of facility

Type of facility	Employee level	For-profit	Non-profit	Govt	Total N=
Low care places only	RN	91.4	42.1	48.5	230
	EN	34.0	42.4	27.2	137
	PCA	8.9	6.3	5.1	303
High care places only	RN	9.6	8.0	5.3	393
	EN	29.0	25.1	4.2	314
	PCA	4.3	3.7	2.6	337

use of full-time RNs in for-profits noted earlier. As a result, they may operate with somewhat fewer staff per resident than other facilities. Our data cannot tell us whether the net result is that staff in for-profit facilities spend more or less time with each resident than those in other facilities.

In examining whether employees in for-profit facilities had more continuity with residents, indicators such as the numbers of shifts worked by agency staff and the tenure of employees were analysed. The capacity to give continuity of care to residents is important for developing the kinds of caring relationships that are recognised as contributing to the overall quality of care (Stone 2000; James 1992). Where there is a dependence on agency or temporary staff, it is less likely that such continuity of care would be possible. As Table 5.10 illustrates, only a very small proportion of shifts in residential facilities is worked by agency staff, irrespective of ownership type. However, for-profit facilities did cover a greater proportion of shifts with agency staff compared to other types of facilities. This is particularly so for RNs, with an average of 3.3 per cent of shifts worked by RNs in

Table 5.10: Average proportion of shifts worked by agency staff in each employment category by ownership of facility

	For-profit %	Non-profit %	Govt %	Total N=
Registered Nurse	3.3	1.6	1.3	1601
Enrolled nurse	0.6	0.6	1.5	1684
PCAs	2.8	1.4	2.0	1545

for-profit facilities being done by an agency RN. This is more than double the proportion worked in other ownership types, however the percentages are quite low. Somewhat greater reliance on agency staff by for-profit facilities is also evident at the level of PCAs. While reliance on agency staff can be institutionalised, with 'regular' staff being sourced from agencies, it does point to a certain level of temporariness among staff that could affect the continuity of care of residents. These figures may also indicate difficulties in finding replacements when vacancies arise. If so, then it seems that for-profit facilities may well have higher vacancy rates than other ownership types.

Indeed, as Table 5.11 shows, for-profit facilities have a somewhat higher turnover than others, particularly among ENs and PCAs. On average, for-profit facilities have 31 per cent of PCAs who have been in their jobs less than one year, compared to 23 per cent in government facilities and 24 per cent in non-profits. In a similar vein, for-profit facilities have an average of 25 per cent of ENs with less than a year's tenure, compared to 18 per cent in government and non-profit facilities. With regard to RNs, there is little difference between for-profit and non-profit facilities, but government facilities have significantly lower RN turnover.

The evidence from this section indicates that employees in for-profit facilities care for more residents than other employees. The impact of

Table 5.11: Proportion of employees with tenure of less than one year by employment category by ownership of facility

	For-profit %	Non-profit %	Govt %	Total N=
Registered nurse	26.6	25.6	17.1	1523
Enrolled nurse	25.0	17.5	18.4	1130
PCA	31.0	23.5	23.3	1634

this apparent higher workload on workers' capacity to provide care could be moderated by the fact that they spend a higher proportion of their time on direct care tasks. However, if the higher staff/resident ratios in for-profits reflect higher workloads in these facilities, then we might expect effects on worker motivation and job satisfaction, which in turn could explain the slightly higher turnover that we observe in for-profits. In the next section we turn to how workers view their jobs, including their job satisfaction, to see whether the apparently different staffing and work organisation of for-profits does produce differences in the subjective experience of work.

The workers: attitudes, opinions and job satisfaction

The previous sections have focused on the more objective measures relating to the experience of work for direct care employees. This section draws on employees' subjective assessment of what it is like to work in aged care facilities. Three groups of questions were asked to assess what employees thought about their work. The first asked employees to rank their level of agreement or disagreement with statements about their work along a seven-point scale. These statements were identified from discussions of current issues affecting careworkers in the literature and within aged care industry forums. The second group of questions asked employees their satisfaction with various aspects of their work: pay, job security, the work itself, ability to balance paid work and other commitments, hours of work, and overall

Table 5.12: Proportion of employees agreeing with the following statements, by ownership of facility

	For-profit %	Non-profit %	Govt %
I feel under pressure to work harder in my job	41	42	44
I am able to spend enough time with each resident	23	22	24
I have a lot of freedom to decide how I do my work	51	51	48
I use many of my skills in my current job	85	87	81

job satisfaction. The questions asked respondents to rate their satisfaction in each area on an eleven-point scale with higher values representing greater satisfaction. The third group were open-ended questions asking respondents to identify the best and worst things about their job. The responses, received from 764 careworkers, were subsequently coded and the top responses for each question analysed in relation to the ownership type of the facility.[5]

From the analysis of the data so far, it would be reasonable to expect employees in for-profit facilities to be experiencing greater pressure to work harder in their job and have less time to spend with residents than employees in other types of facilities. However, Table 5.12 shows how little variation there is between the types of facilities on these two questions. If anything, it is employees at government facilities who appear to be under more pressure at work, despite having a better staff/bed ratio. Furthermore fewer than a quarter of employees, irrespective of their workplace, claimed to have enough time to spend with each resident. For the remaining two issues—work autonomy and usage of skills—responses from employees are virtually

5 See Moskos and Martin (2005) for the full report on this aspect of the research.

Table 5.13: Average job satisfaction of employees by ownership of facility

	For-profit	Non-profit	Govt	Total
Total pay	3.4	3.7	5.3	3.8
Job security	7.1	7.2	6.7	7.1
Work itself	7.1	7.0	6.8	7.0
Hours worked	7.5	7.1	7.5	7.2
Work-life balance	7.0	6.7	6.8	6.8
Overall job satisfaction	7.2	7.1	7.1	7.1

Source: Adapted from Martin 2005.[6]

identical in all ownership types. In short, there is no indication from these figures that for-profit employees feel disadvantaged compared to their counterparts in other facilities.

Turning to employees' levels of satisfaction with their work, it is interesting to note a similar phenomenon. Overall, employees in for-profit facilities are just as—even slightly more—satisfied with their jobs than employees in either non-profit or government facilities. Table 5.13 depicts the mean rating given by employees for each item relating to job satisfaction, with the maximum score for any item being 10. As is evident from the table, levels of satisfaction with the amount of pay in aged care were very low. While employees in for-profit facilities were even less satisfied with their pay than employees in other facilities, they were not markedly different from employees in non-profit organisations. In addition, the higher than average mean score for satisfaction with hours worked (7.5 against an average of 7.2) and work-life balance (7.0 against an average of 6.8) reflect the

6 Note that figures in Tables 5.13 and 5.14 represent *all* staff: nurses, PCAs and allied health workers.

Table 5.14: Proportion of employees nominating the worst things about work, by ownership category*

	For-profit %	Non-profit %	Govt %	Total %
Pay	29.0	19.7	14.8	21.7
Too much paperwork	12.6	19.1	21.9	17.5
Staff shortages	17.0	14.7	10.9	14.7
Time constraints	13.4	15.6	8.7	13.4
Not enough time to care for residents	11.8	14.8	10.0	12.8

* Respondents often mentioned more than one area, therefore columns do not add up to 100 per cent.

higher levels at which employees in for-profit facilities are able to work their desired hours (discussed earlier). Perhaps more surprisingly, given the access to full-time work and stability in employment in government facilities, is the fact that employees in for-profit facilities have higher levels of satisfaction (7.1) than their government counterparts (6.7) about job security. These data suggest that for-profit facilities could compensate for dissatisfaction with pay by being more accommodating of employees' preferences in the hours worked and therefore in their ability to manage their work-life responsibilities.

The third set of data, obtained from two open-ended questions, reinforce issues identified earlier. On the one hand, the worst aspects of the job were identified by employees as the pay and those aspects of work that prevented them from feeling as though they could provide adequate care for the residents (Table 5.14).

Employees in for-profit facilities were far more likely to mention pay than those in other facilities, at 29.0 per cent compared to 19.7 per cent of employees in non-profit facilities and 14.8 per cent of government

Table 5.15: Proportion of employees nominating the best things about work, by ownership category*

	For profit %	Non-profit %	Govt %	Total %
Care for residents	51.9	49.3	38.4	47.9
Supportive coworkers	34.8	42.3	46.7	40.7
Flexibility in hours	17.6	13.5	18.5	15.9
Social environment	10.0	16.3	20.1	15.0

* Respondents often mentioned more than one area, therefore columns do not add up to 100 per cent.

employees. Other research has noted the very low pay satisfaction of aged care workers, and found that it cannot be explained by objectively low pay rates (see Martin 2007).[7] All of the other issues in the top five worst things about their job had consequences for the amount of time employees could spend with residents (this was also identified as a separate issue by some people). Overall, the patterns across facilities of different ownership type were consistent with the finding that workers in for-profit, non-profit and government facilities had almost identical levels of job satisfaction.

While it is not surprising that care for residents is high on the list of the best things employees nominated about their work, the differences between facilities is interesting (Table 5.15). Employees from government facilities mentioned care less often than they mentioned having supportive coworkers. Employees in for-profit facilities, however, were less likely than their counterparts in other facility types to mention their coworkers or having a good social environment as positive aspects of their work. This could be due to the younger co-

7 Accounting for the apparently greater concern about pay among private facility employees must remain a topic for further research, as the data used here cannot further illuminate it.

hort of PCAs in for-profit facilities who would be more likely to be combining child-rearing with their aged care work. In contrast, the older workers in government and non-profit facilities seem to place a high value on their workplace as a social environment, rather than simply being a place where they earn money or provide care to the aged.

Does ownership type really matter?

Our results show that, contrary to many expectations, the small differences between for-profit facilities and others in staffing patterns do not translate into differences in the subjective experience of work. Though for-profit facilities have fewer staff per bed, younger PCAs, somewhat greater use of agency staff and higher staff turnover, the mode of ownership had little impact on workers' perceptions of their job and experiences of work. Furthermore, the data suggest that the impact of cost pressures on care provision occurred across all three modes of ownership. For employees, then, there was not a lot of difference whether their employers were caring 'for profit' or not. The question is, why not?

Some have argued that market values are now so pervasive in the aged care industry that the differences between ownership types have become negligible (Stack 2003; Stack & Provis 2000a; 2000b). This seems to point towards facilities experiencing a kind of 'normative' pressure that leads to similar organisational structures and practices—DiMaggio and Powell's 'institutional isomorphism' (1983). However, 'coercive' pressures in the form of regulatory and subsidy regimes seem at least as likely to produce this effect as simple 'market values'. In other words, the demands placed on facilities as conditions of receiving subsidies and remaining accredited are directly coercive, so that adherence to them does not require belief in the intrinsic value of the market model (see Braithwaite et al. 2007). Although our results lend support to this interpretation, there is one area in which facilities arrange their staffing differently depending

on ownership type. It appears that for-profit facilities operate with somewhat leaner resident/staff ratios than others, but that they compensate for this by having staff spend more of their time providing direct care. However, this does not translate into significant differences in employees' subjective experience of work. This result suggests that facilities face another set of constraints too, ones that produce further pressures towards institutional isomorphism. In order to retain staff, employers—irrespective of ownership type—need to respond to a variety of their employees' needs and values.

Notwithstanding their concerns about pay, what mattered to employees was that they be given the opportunity to care. That careworkers express a moral orientation to their work is not a new insight. Being able to care for and care about residents has long been recognised as one of the motivations and intrinsic rewards of being a careworker (Meagher 2006; King 2007). What this research pointed to, however, was that the employees' commitment to providing care was not restricted to caring for residents. It also extended to caring for their families and caring for their coworkers.

The importance of having their preferred work hours and being able to achieve work-life balance is well recognised for workers with family responsibilities. While this is mostly thought of in terms of being able to balance work with caring for children, it is also relevant to those workers who have older relatives to care for. The skills involved in this kind of familial care work would be valued in the aged care sector, and family carers would be an obvious source of workers, especially as PCAs. It is therefore of benefit for both employers and employees for workers to be provided with the opportunity for achieving their desired work-life balance.

The value that many aged care workers placed on their relationships with coworkers also reinforces the overall care orientation of careworkers. The capacity to use workplace relationships to generate and sustain emotional wellbeing in the workplace is particularly important in care work where employees engage in high levels

of emotional labour (James 1992). If they are not provided with opportunities to replenish their emotional needs, this can lead to burnout and withdrawal from the labour market. At the same time, having good emotional connections with colleagues is important for developing skills related to emotional intelligence—also used extensively in care work. Although Stack and Provis (2000a) found that organisational concerns regarding efficiency were decreasing the likelihood of collegiality developing within the workplace, it is obviously an aspect of work that many employees value and which is likely to have flow-on benefits for clients and the levels of morale within an organisation.

It could well be, then, that the differences between for-profit and other ownership types in the organisation of work are being masked by the extent to which employers are providing their workers with equal opportunities to care: whether that be for clients, family or colleagues. Perhaps, as Martin (2007) suggests, it is the facility managers in their role of recruitment and rostering, rather than the ownership type per se, that has the most influence over workers' experience of work. Nevertheless, it is interesting to note slight differences between the ownership types on how the relationship between the care orientations—and pay—is played out. Employees within all ownership types were dissatisfied with their pay, none more so than those in for-profit facilities. The majority of employees were also dissatisfied with the amount of time they had to spend with residents, though the actual work of caring for residents was rated highly by employees in all facilities except for government facilities.

The implications of such an argument are double-edged for workers. On one side, it seems that employees are able to weave their aged care work into their lives in ways that are highly satisfying. On the other side, employers can use careworkers' 'care orientation' to offset the need for decent pay and work conditions. Perhaps, as Folbre (2006) argues, there is a need to develop more powerful political coalitions to bring about change, but the kind of change needed goes

beyond the high pay/high quality strategy she suggests. It needs to addresses the four dimensions identified by our research: pay, quality care, work-life balance and collegiality.

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