Australian Government
Department of Health and Ageing

the AGED CARE workforce 2012

final report

The Aged Care Workforce 2012 Final Report

King, Debra,
Mavromaras, Kostas
He, Bryan
Healy, Joshua
Macaitis, Kirsten
Moskos, Megan
Smith, Llainey
Wei, Zhang

Acknowledgements

This research report contributes to the body of knowledge about the aged care workforce in Australia. The research was commissioned by the Commonwealth Department of Health and Ageing and undertaken by the National Institute of Labour Studies (NILS).

The research has benefitted from the support it has received from several sources and we extend our appreciation to Dan Evans and Wesley Junkeer at Ipsos I-view for their contribution to the field work and data collation; to Professor Barbara Pocock and Dr Natalie Skinner from the Centre for Work + Life for enabling us to use the Australian Work and Life Index in the survey; and to the Expert Reference Group who helped shape the project in its early stages and promoted participation in the research. We are especially grateful to the managers and care workers who contributed their time and knowledge to the research by participating in the surveys and interviews.

The project was managed by Debra King with Kostas Mavromaras as the Chief Investigator. Staff at NILS have been generous in allocating time and expertise to the research. Kirsten Macaitis helped to clean the address lists and prepare the surveys; Josh Healy, Zhang Wei and Bryan He provided statistical expertise; and Llainey Smith managed the interviews, assisted by Megan Moskos and Tracey Sharples. The research has truly been a team effort.

2012 National Aged Care Workforce Census and Survey Report

Print ISBN: 978-1-74241-873-5
Online ISBN: 978-1-74241-874-2

Publications approval number: D1010

Contents

List of Tables

List of Figures

Please note that because of rounding of percentages, the table and figure totals do not always sum to exactly 100 throughout the report.

Executive Summary

This report provides detailed information about the workforce that delivers aged care to older Australians in both residential and community care. The data contained in the report was gathered as part of the third aged care workforce census and survey, funded by the Department of Health and Ageing and conducted by the National Institute of Labour Studies. In reporting on the 2012 aged care workforce, comparisons are made between the workforce in residential and community care, and with relevant findings from 2003 and 2007 so that the overall development of the sector can be tracked.

The report focuses primarily on direct care workers who are PAYG employees in residential facilities and community outlets, including Nurse Practitioners (NP), Registered Nurses (RN), Enrolled Nurses (EN), Personal Care Attendants (PCA) / Community Care workers (CCW), Allied Health Professionals (AHP) and Allied Health Assistants (AHA). Limited information is also provided on PAYG non-direct care workers (i.e. managers, administration and ancillary staff); non-PAYG workers (i.e. agency, brokered or self-employed staff; and volunteers).

The sampling is based on organisation at the facility and outlet level, the managers of which fill in the employer questionnaires and also ask some of their employees to fill in the employee questionnaires. The resulting Aged Care Workforce Census and Survey is an employer–employee linked data set of all Commonwealth funded residential facilities and all community outlets in Australia, and of a sample of their employees. The data set is augmented by administrative information about the employers, provided directly by the Department of Health and Ageing.

About the PAYG Direct Care Workforce, 2012

- More than 240,000 workers are employed in direct care roles in the aged care sector. Of these, 147,000 work in residential facilities, and 93,350 in community outlets.
- Personal Care Attendants comprise 68 per cent of the residential direct care workforce, while Community Care Workers comprise 81 per cent of the community direct care workforce.
- The workforce is predominantly female, although males have increased their share in residential facilities. In both residential and community sectors, males now comprise 10 per cent of the direct care workforce.
- The workforce is generally older than the national workforce and ageing further, but the majority assess their health as 'very good' or 'excellent'.
- The median age for residential direct care workers is 48 years while for community direct care workers it is 50 years.
- The proportion of the direct care workforce that was born overseas has increased to 35 per cent of the residential facilities and 28 per cent of community outlets. There is a higher proportion of newly arrived migrants (been in Australia for 5 years or less) among overseas born direct care workers in residential facilities than in community outlets. Around 80 per cent of residential facilities and 50 per cent of community outlets employed Personal Care Assistants and Community Care Workers who spoke a language other than English.
- More than 85 per cent of direct care workers have some form of post-secondary qualification, which is above national average. There has been a substantial increase in the proportion of Personal Care Assistants and Community Care Workers with Certificate IV qualifications.

- The direct care workforce displays a strong commitment to training and upskilling. Around 20 per cent of this workforce is currently studying; 80 per cent of direct care workers had engaged in one or more training courses in the previous 12 months; and more than half had been involved in continuing and professional development. In addition, direct care workers are gaining specialised qualifications in ageing and aged care (e.g. gerontology, palliative care), particularly those in clinical or care manager roles.
- Overall the direct care workforce is relatively stable, although some 'churn' was evident with workers moving between aged care employers. Workers appear highly committed to the sector as demonstrated by their long tenure (a third of residential direct care workers and a quarter of community direct care workers had been in the sector for 15 years or more). In relation to commitment to their current employer, less than 20 per cent indicated an intention to leave within the next 12 months (and only 5% stated they were considering leaving the sector). Main reasons for leaving aged care jobs were: prioritising household responsibilities, retirement and management issues.
- Most direct care workers are employed on a permanent part-time basis (72% of those in residential facilities and 62% in community outlets). About half of the direct care workforce in each sector work between 16–34 hours per week. Although there has been an increase of around 7 per cent in the proportion of direct care workers employed for 35 hours or more per week, this remains a highly part-time employment sector.
- Around a quarter of the residential direct care workforce and a third of the community direct care workforce would like to increase their hours; while around 16 per cent of direct care workers across the sector want to decrease their hours (mostly nurses).
- Job satisfaction is high across all areas except for pay.
- The analysis of work-life interference experienced by direct care workers indicated that residential direct care workers report higher work-life interference than those in community outlets. However, with the exception of Registered Nurses in residential facilities, direct care workers were close to or below the national average for all Australian workers. Some variations based on gender, work hours and dependents were identified.

Skill Shortages, Vacancies and Use of Non-PAYG Staff

- Three quarters of residential facilities and half of community outlets reported skill shortages in one or more occupations. Of the skill shortages in residential facilities, two-thirds reported Registered Nurse shortages and a half reported Personal Care Attendant shortages; of the skill shortages in community outlets, a third reported Community Care Worker shortages and 15 per cent reported shortages of Registered Nurses.
- Three main causes of skill shortages were given: lack of specialist knowledge; slow recruitment; and geographical location. Each of these causes was identified by a third of the residential facilities and community outlets reporting a skill shortage. Only 15 per cent identified low wages as a cause of skill shortages.
- In the designated fortnight (November 2011), around one-third of residential facilities reported vacancies for Registered Nurses and a third for Personal Care Attendants. The vacancy rate has increased since 2007, and this is most pronounced for Personal Care Attendants (from 31% to 36%). Each facility reporting vacancies had an average of 3.4 Personal Care Attendant vacancies and 2 Registered Nurse vacancies.

- Vacancies in residential facilities are now quicker to fill than in 2007: a third of Registered Nurse and Personal Care Attendant vacancies are filled within one week; another third of Registered Nurse and over half of Personal Care Attendant vacancies are filled between 1 and 4 weeks, and just under a third of Registered Nurse vacancies and 14 per cent of Personal Care Attendant vacancies took longer than 4 weeks to fill. The average time taken to fill vacancies was 7 weeks for Registered Nurses and 3.2 weeks for Personal Care Attendants.
- In the designated fortnight (November 2011), around one-fifth of community outlets had Community Care Worker vacancies and 6 per cent had Registered Nurse vacancies. Each outlet reporting vacancies had an average of 3.5 Community Care Worker and 1.5 Registered Nurse vacancies.
- Although the vacancy rate has remained the same in community outlets since 2007, they are now more difficult to fill. About 40 per cent of Registered Nurse vacancies and 16 per cent of Community Care Worker vacancies are filled within one week; around 30 per cent of Registered Nurse vacancies and 60 per cent of Community Care Worker vacancies take between 1 and 4 weeks; and just under one-third of Registered Nurse vacancies and a quarter of Community Care Worker vacancies took longer than 4 weeks to fill. The average time taken to fill vacancies was 4 weeks for both Registered Nurses and Community Care Workers.
- In both residential facilities and community outlets, there were regional differences in vacancy rates. In Victoria it is particularly difficult to recruit RNs in both sectors, while in NT it is difficult to recruit Personal Care Attendants/Community Care Workers. Residential facilities and community outlets in remote areas take nearly twice as long as the sector average to fill any vacancies.
- The picture gained from the discussion of vacancies is that Personal Care Attendant/Community Care Worker vacancies appear very frequently and are filled relatively quickly; while Registered Nurse vacancies appear far less frequently and are more difficult to fill.
- The problem with filling Registered Nurse vacancies is long-standing in the sector, and is impacted upon by shortages of Registered Nurses in other sectors of the health and social care industries. From the 2012 aged care workforce data we gained a better picture of how Registered Nurses are faring in aged care. Registered Nurses reported that they work more hours than they would like and they had the highest work-life interference (higher than the Australian workforce more generally) or all occupational groups in the direct care workforce. They were also more likely to be feeling under pressure and that their job was stressful; to have been in their jobs for 12 months or less; and to expect not to be working for their current organisation in 12 months.
- To cover vacancies and skill shortages, over half of the residential facilities and a quarter of community outlets used non-PAYG staff in the designated fortnight. Community outlets use non-PAYG staff at higher levels than residential facilities. While the use of non-PAYG staff has increased since 2007 for both Community Care Workers and Registered Nurses in community outlets, it has decreased for Personal Care Attendants and remained the same for Registered Nurses in residential facilities.

Emergent themes from the interviews

- Two categories of direct care workers were over-sampled to investigate their experience of working in aged care and to identify any issues facing the sector if they are to increase their share of the workforce: migrants who speak a language other than English and men. Both groups were committed to their work and sought ways to create a niche for themselves in aged care (e.g. linguistic matching with older Australians; or working with men or people with difficult behaviours). Workers in both groups sought training and support that would better prepare them for working in aged care; and they both experienced discrimination from colleagues, supervisors and clients.

- Despite being viewed as essential by direct care workers, the social and emotional skills associated with direct care work are not well-defined or incorporated into training or recruitment.
- Direct care workers who were identified by interviewees as unsuitable for care work were mostly seen to lack the required social and emotional skills. Unsuitable workers placed additional pressure on other direct care workers and reduced the quality of service provision.
- Older direct care workers were seeking ways to maximise the length of their work-lives and contribution to aged care. Further investigation of the strategies required to retain older workers for longer may assist in addressing skill shortages in the sector.
- There was quite extensive variation between workplaces in relation to management skills and training. This variation impacted on direct care workers' satisfaction with their workplace and the extent to which they felt valued and prepared for working in aged care.
- Specific issues were raised associated with the provision of community direct care: training is often based on residential care and not relevant to the community sector; out-of-pocket costs (mobile phones, petrol and care related costs) are borne by workers; the safety issues associated with working alone and going into private homes; and the tension between meeting client needs and protecting workers/employers.

1. Introduction

Aged care is on the cusp of change. Following reports by the Productivity Commission in 2011 (Productivity Commission, 2011) and extensive consultation across the sector, Minister Butler released the 'Living Longer, Living Better' aged care reform package on 20 April 2012. The centrality of the formal aged care workforce to the success of these reforms is well recognised and a Workforce Compact is currently being developed. One of the goals of the Workforce Compact is to address workforce pressures at a time of anticipated rapid growth in the sector, and to 'ensure that workforce reforms lead to improvements in terms and conditions for the aged care workforce [and] generate better care and services for older Australians' (DoHA, 2012a). As aged care moves into the future, workforce planning and development will not only be informed by existing issues around recruitment, retention and training, but also by the impact of planned structural changes to the model of care, which will be shaped by a shift toward consumer directed care; better transitions between acute and sub-acute care; and the extension of community care services. In this period of growth and change, it is likely that new opportunities for working in aged care will emerge.

The National Aged Care Workforce Census and Survey, 2012 sought information about the existing direct care workforce and will provide important baseline information to the sector as aged care reforms are implemented. This is the third census and survey that has been commissioned by the Commonwealth Department of Health and Ageing and we now have a picture of the aged care workforce that spans nearly a decade. The National Institute of Labour Studies first conducted research on the residential aged care workforce in 2003 in response to concerns among providers of aged care facilities that it was becoming increasingly difficult to find the number and quality of staff to provide high quality care for a growing number of older Australians (Richardson & Martin, 2004). These same concerns were expressed in 2007 when the second census and survey was undertaken. This time the research was expanded to cover both the residential and community aged care workforce, providing detailed information about both aspects of care work (Martin & King, 2008). Although we did not find an overall 'crisis' in the form of workforce shortages in these surveys, we did identify where problems existed and what workers thought about working in aged care. Information from these reports has been widely used by governments, professional associations, peak body organisations and aged care providers across the sector to inform decisions about meeting the challenges of workforce planning and development. The 2012 research extends the information collected in 2003 and 2007. We have replicated most questions, but also added new questions to find out more about specific issues of recent concern to the sector.

We distinguish in this report between 'aged care workers' which includes all workers in residential facilities and community outlets, and 'direct care workers' which is a subset of the broader aged care workforce. Direct care workers are defined here as workers who are paid to provide the personal, physical, social and emotional work required in caring for older Australians. All three data collections—2003, 2007 and 2012—focus on direct care workers who are employed (PAYG) in either a residential facility or community outlet This includes Registered Nurses, Enrolled Nurses, Personal Care Attendants/Community Care Workers and Allied Health workers. In response to interest from the sector, the 2012 data collection expanded the direct care workforce occupations to include Nurse Practitioners and differentiated between Allied Health Professionals and Allied Health Assistants.

In 2012 we capture information from employers about the numbers and hours of service of volunteers in residential facilities and community outlets. We were also provided with information about direct care workers who are employed through labour hire agencies or brokerage arrangements, or who are self-employed. We therefore provide a comprehensive picture of the direct care workforce. Beyond direct care work is a whole network of other people who make up the aged care workforce. While the occupations these people

work in vary widely, they mostly fall into two groups: managers, care managers and administrative staff; and ancillary workers who do, for example, the catering, cleaning, maintenance and gardening required by older Australians. We collect information about the number of workers in these categories as well, in order to add to the overall knowledge base about the total aged care workforce.

The National Aged Care Workforce Census and Survey, 2012 went out to residential facilities and community outlets in late January and was in the field until March 30. Data from facilities and outlets were based on workforce records for a designated fortnight, taken as the last pay period in November 2011. The Department of Health and Ageing supplied NILS with a list of organisations that received funding in specific aged care programs. This list was the basis of our sample. Each organisation was sent a package which included the census, the appropriate number of surveys (which was stratified based on care places/client numbers), and information about how to distribute the surveys to obtain a random sample of direct care workers. NILS provided workers with information in 10 languages about responding to the survey and offered assistance through an interpreter service. Both the census and the survey could be completed on the hard copy provided, or online through the username and password given in the cover letter. We received responses from 2,481 residential facilities and 1,357 community outlets. About one-fifth of these facilities and one-third of the outlets that responded covered more than one service at the same location, so the coverage of aged care services is higher than the number of individual responses suggests. Surveys were sent to an average of 6 workers per organisation, ranging between 4 and 50 depending on the size of the organisation, with the larger employers receiving more surveys. We received responses from 8,568 workers in residential facilities and 5,214 workers in community outlets. The data from all four data collections were weighted and analysed to provide a comprehensive snapshot of the national aged care workforce as at March 2012.

The findings presented in this report provide detailed information about how the direct care workforce is structured, who works in aged care, how workers are recruited, the extent to which they have adequate training, what their working conditions are, how they experience working in aged care and their pathways into and out of aged care work. We present this information in a variety of complementary ways. In order to understand how the workforce may have changed over time, we compare the 2012 data with information from the 2007 and 2003 reports. We can see, for example, that between 2007 and 2012 the direct care workforce has increased from 207,381 to 240,445. We also compare responses from the residential and community aged care workforces. While work in these two sectors has some overlaps, there are also significant differences in the skills required and way the work is structured. In identifying some of the similarities and differences between the residential and community aged care workforces we can understand better the way workers may transition between the two, or work in both. Following previous research we also sometimes differentiate between all direct care employees and 'recent hires' to see whether people who have been employed in the facility/outlet for 12 months or less have different characteristics and whether this might be indicative of change in employment patterns in aged care. This mix of cross-sectional (i.e. within each of the three data collections in 2003, 2007 and 2012) and comparative (i.e. between the three data collections) analyses provides information that will be relevant for a range of uses in planning for future workforce needs in aged care.

In supplementing the findings from the census and survey we conducted interviews with 101 direct care workers who offered to participate. The interview schedule was developed by the National Institute of Labour Studies in conjunction with the Department of Health and Ageing and the reference group for the project. It covered a range of issues that had emerged through consultation as relevant to the sector, and specifically targeted workers who were male or from a culturally and linguistically diverse background. These two categories of workers are both growing in size, one more quickly than the other, and we sought to investigate how these workers perceive working in aged care.

2. Finding Out About the Aged Care Workforce

Information about the National Aged Care Workforce, 2012, contained in this report comes from three sources. The first source is from our surveys. Survey packages were sent to all residential facilities and community outlets providing specific aged care services as defined by the Commonwealth Department of Health and Ageing. Each package contained a census, completed at the facility/outlet level; and several surveys, completed by a sample of direct care workers employed at that facility/outlet. The second source of information comes from administrative data supplied by the Department of Health and Ageing (for details see Section 2.1.1); while the third source is from interviews with direct care workers who had offered to be contacted about their work.

2.1 Overview of the Census and Survey

The census and surveys were mailed out on January 30 and were in the field for eight weeks. Ipsos I-view conducted the fieldwork and administered the process for disseminating the survey packages, collected and collated the data, and delivered the raw data files to NILS. NILS carried out the work necessary to prepare the data for statistical analysis. The surveys and the research process received approval from the ABS Statistical Clearing House and the Flinders University Ethics Committee, and complied with the National Privacy Guidelines for survey research.

2.1.1 What we wanted to know

The census of facilities/outlets and survey of a sample of the workforce sought information that was largely comparable with the research we conducted in 2007 and 2003. In 2012, we asked additional questions of both employers and employees to capture new information about topics relevant to workforce planning and development. Our report therefore discusses how aspects of the workforce in residential facilities and community outlets have changed over time; how the direct care workforce in the two sectors compare with one another; and how new knowledge about the workforce might inform the direction and types of changes needed to recruit and retain direct care workers into the future.

In line with previous censuses of facilities/outlets we sought information about the characteristics of the workforce, the conditions under which they are employed, their vacancy rates, the use of agency (non-PAYG) staff, and other characteristics of the organisation. In response to issues raised by the aged care sector and to research conducted on aged care work since 2007, several new areas were identified and included in the 2012 questionnaires:

- Management, administration and ancillary staff
- Volunteers and volunteer hours
- Nurse practitioners
- Allied health assistants
- Aboriginal and Torres Strait Islander workforce
- Culturally and Linguistically Diverse workforce
- Skill shortages

- Training
- Work-related injuries and illnesses

Information from the census of residential facilities was supplemented with administrative data provided by the Commonwealth. This administrative data included postcode, geographical location, ownership type and the number of operational places. To avoid duplication, these questions were not asked of the facilities.

As in 2003 and 2007, the survey of employees sought information about the characteristics of people who work in direct care roles, their career paths, their experiences of working in aged care and their intentions to stay in the sector. In 2012 we included Nurse Practitioners and Allied Health Assistants in the direct care workforce, and expanded the number of questions to ask about:

- The balance between work and non-work responsibilities
- Migrant status
- Proficiency in English
- Work-related injuries and illness
- Training

In some instances similar questions were asked of both employees and employers, which allowed us to discuss topics from both perspectives and sometimes compare the responses to one another.

2.1.2 The Research Process

Much of the planning involved in collecting data aims to produce information that is as extensive and as reliable as the funding and time constraints will permit. Ensuring high quality data requires that a number of strategies be followed. We list some core strategies here.

Cleaning the sample lists

The sample was based on a list of residential and community aged care services provided by the Commonwealth Department of Health and Ageing. The list identified 2,818 residential facilities; 98 facilities that provided both residential and community aged care (Multi-Purpose and National Aboriginal and Torres Strait Islander programs); and 6,600 community aged care services: a total of 9,516 services. From these lists we identified a number of services that were co-located, that is, where two residential services operated from the same site or where one community outlet provided different kinds of services. Where possible we identified these manually and adjusted the sample. We then went through a process of location testing whereby we contacted services to check whether they were co-located. Following these adjustments the resulting mailing lists contained 2,585 residential and 4,607 community aged care services (including services that provided both). These had to be adjusted further to reach the final number used in this report in order to accommodate changes that occurred after mailing with the final list containing 2,593 residential facilities and 4,178 community outlets.

Stratifying the worker sample

Stratifying the sample of workers improved the likelihood of employees being given an equal chance to participate in the survey. In 2012, the number of surveys sent to each organisation differed according to the size of the service as per operational places/services provided in the sample list. Small employers were sent

4 worker surveys, medium sized employers were sent 6 and large employers sent 8. A small number of very large employers were identified and these received 16, 32 or 50 surveys depending on their size. Overall, an average of 6 surveys was sent to each facility/outlet.

We requested that employers distribute the surveys to their employees following this stratification by selecting employees who were (a) on the payroll as PAYG employees, (b) providing direct care to older Australians (i.e. those over 65 years, or 50 years and older if Indigenous), and (c) who had their birthday nearest to the day the package was received. The latter criterion was added to provide a random element to the selection.

The survey package

Each organisation received a survey package which contained the census and relevant number of worker surveys. A letter inviting recipients to participate and instructions for completing the surveys was incorporated into each questionnaire. A separate insert in the employee surveys translated this invitation into 10 languages and provided the option of interpreter assistance in completing the survey. The package also contained a separate cover letter addressed to the manager with information about how to distribute the surveys.

For each survey, instructions were provided for participating online, including unique usernames and passwords. Overall, 25 per cent of responses were received online, comprised of 61 per cent of responses from employers (68% of residential facilities and 47% of community outlets) and 16 per cent of responses from workers (17% of workers in residential facilities and 14% of workers in community outlets).

Pre-survey testing

Most of the questions in the census and survey had been validated either through having been asked in the 2003 and 2007 data collections, or by having been drawn from established sources (e.g. ABS, HILDA). Pre-survey testing therefore focused primarily on process and two major changes were made. First, the 2012 data collection started to provide information and support to workers for whom English was not their primary language; and second, the timing was shifted from November–December 2011 to February–March 2012. Minor changes were also made to the instructions and letters of invitation.

Support and survey awareness

Support for employers and employees in completing the surveys was provided through a toll-free helpline with further information and answers to 'frequently asked questions' available on a dedicated website. In addition, emails were sent to residential facilities and community outlets to stimulate participation: an introductory email, two reminder emails and a final thank you/last chance email were sent to facilities/outlets. The Commonwealth supplemented these reminders with communications sent to all providers of aged care services. The census and survey were also advertised through professional and peak body organisations and aged care publications.

Weighting the data

In order to extrapolate the responses we received to make them relevant to the entire workforce that provides direct care services for older Australians, data from both residential facilities and community outlets has been weighted. Appendix A contains an explanation of how we did this. Weighted results from the census and surveys are used throughout the report because these represent the best estimates of the population for both the residential and community direct care workforces and allow us to derive comparable statistics for the two workforces.

2.2 Response to the Residential Aged Care Census and Surveys

With 96 per cent of residential facilities providing valid responses to the census we are confident that our data provides an accurate picture of the residential aged care workforce. Only minor adjustments were required to the original sample list to accommodate facilities that had opened or closed during the defined period; or which were deemed to be co-located after the packages were sent out. Out of the final population of 2,593 residential facilities, 2,481 provided valid responses.

The high response rate from residential facilities reflects the quality of the sample list, which was current and contained detailed information. In addition, the Commonwealth offered a participation incentive to facilities through the Conditional Adjustment Payment. The census required the collection of information from various sources, including care managers and payroll/HR.

Of the 15,858 employees in residential aged care who were invited to participate, 8,568 provided valid responses. This represents a response rate of 54 per cent.

Each employee questionnaire had a unique identification number which allowed us to merge the information provided with that of the residential facility in which the respondent worked. This allowed us to streamline the surveys and minimise the duplication of information requested. There were 1,925 facilities and 8,416 employees that could be linked in this way. The merged data file was used for calculating sample weights as discussed in Appendix A.

The analysis and discussion of the residential aged care workforce can be found in Chapters 3 and 4.

2.3 Response to the Community Aged Care Census and Surveys

As with the 2007 census and survey of community outlets, it was difficult to calculate accurately a response rate for community aged care. Although cleaning of the address lists to identify co-located services overcame some of the difficulties that affected the 2007 research, it was evident from calls to the Helpline and feedback from motivational calls that a significant number of services on the sample list were out of scope. If we use the same process to calculate the responses that we used for residential aged care, then we estimate the final population to be 4,178 of which 1,357, or 33 per cent, provided valid responses.

We calculated sample weights using the same methodology as for residential facilities (Appendix A). This was based on the merged census and survey data in which 884 outlets and 3,128 employees were linked through their unique ID numbers.

Information from the Helpline and motivational calls helped us to understand some of the difficulties with calculating the number of employees that should have received a survey. One factor that impacted on survey response rates was the distribution of surveys to outlets that only had volunteers. While the Commonwealth sought information about the extent to which volunteer workers contributed hours to aged care services, the volunteers themselves were out of scope. For example, outlets providing Meals on Wheels received 2208 surveys, but as their (direct care) workers are primarily volunteers their employees should be deemed out-of-scope. Other volunteer services were not as easy to identify from the sample lists and so the total number of out-of-scope employee surveys cannot be determined. In the absence of better information about volunteers, we only removed employee surveys for Meals on Wheels from the sample list.

Taking these factors into account, the response rate for employees in community aged care was 22 per cent. This is based on a total of 5,214 valid responses from the 23,988 that were invited to participate.

The analysis and discussion of the community aged care workforce can be found in Chapters 5 and 6.

2.4 Interviews with Direct Care Workers

Interviews with direct care workers provide qualitative accounts of working in aged care and enable us to better understand some of the information we obtained from the surveys. In 2012, 101 employees were interviewed, comprised of 51 from community outlets and 50 from residential facilities. The interviews had two purposes. The first purpose was to identify any issues that might impact on the capacity of direct care workers to continue working in the sector. The second purpose was to understand better the experience of working in aged care for men and workers from culturally and linguistically diverse backgrounds. Within the aged care sector these two groups have been identified as possible 'target' groups for recruitment and we wanted to hear what it was like for them to access and work in aged care jobs. The discussion of their experiences of direct care work and issues they raised is in Chapter 7.

3. The Residential Aged Care Workforce

This chapter provides detailed information about the aged care workforce using responses from workers (N=8,568) and their employers (N=2,481). In some areas we compare all workers to recent hires, that is direct care employees who have been working in aged care for 12 months or less (N=1,185). In 2012 we captured new information about Nurse Practitioners and differentiated between Allied Health Professionals and Allied Health Assistants. The proportions of these occupations in the residential direct care workforce are relatively low, but their emergence as core components of the workforce is noted. In selected tables we provide details on each of the occupations; however, most tables in the report combine Nurse Practitioners with Registered Nurses, and Allied Health Professionals with Allied Health Assistants.

We begin this chapter by providing an overview of the total workforce and then focus on the characteristics of workers. We then discuss the characteristics of the work, including the type of employment arrangements governing different occupational groups, how much they get paid and whether they are working their preferred hours. These all influence whether or not workers are attracted to working in aged care, or if they will stay once they have a job. The next four sections expand on this theme by investigating workers' career paths, their experiences of working in aged care (including their job satisfaction), the propensity for workers to acquire work-related injuries and whether they are able to combine their work and non-work commitments. The chapter finishes with a focus on workers from culturally and linguistically diverse backgrounds.

3.1 Total Employment and Main Workforce Characteristics

In this section we look at who works in the residential direct care workforce, their distribution across different occupational groups and their characteristics in terms of age, health, education ethnicity, and cultural background. We begin, though, with an overview of the size of the total workforce in residential facilities. It is perhaps worth noting at the outset that the workforce is predominantly female, although less so than in 2007. In 2012, 89 per cent of direct care workers in residential facilities were women compared with 93 per cent in 2007. This suggests that men are a small, but growing, proportion of the direct care workforce. To investigate how men experience working in aged care we purposively sampled them in the interviews as reported in Chapter 7.

3.1.1 Total Employment

One of the central questions when engaging in workforce planning is the size of the existing workforce. Our estimates of the residential aged care workforce are based on information from the census of residential facilities and include the imputation of values for missing data. Achieving such a high response rate meant that only minimal adjustments to the figures provided were required to produce the estimated numbers reported in the following tables.

Total employment in residential aged care for 2012 is estimated to be 202,344 workers, of which 147,086 are in direct care roles. Table 3.1 indicates that the whole PAYG workforce in residential aged care has grown by 29 per cent since 2003 (from 156,823 to 202,344). There are slight differences in the pattern of growth between all PAYG employees and direct care employees. In the period between 2007 and 2012, the increase for direct care employees was 10.3 per cent, lower than that of all PAYG employees which was 15.7 per cent. Consequently there is a decrease in the proportion of the residential aged care workforce working in direct care roles from 76 per cent in 2007 to 73 per cent in 2012.

Table 3.1: Size of the residential aged care workforce, all PAYG employees and direct care workers: 2003, 2007 and 2012 (estimated headcount)

Occupation	2003	2007	2012
All PAYG employees	156,823	174,866	202,344
Direct care employees	115,660	133,314	147,086

Source: Census of residential aged care facilities.

3.1.2 Occupation

The occupational composition of the headcount of direct care employees is presented in Table 3.2. PCAs form both the largest occupational group (68%) and the one growing at the fastest rate. Of all the occupations measured in previous years, it is the only one to be increasing both numerically and proportionally. In contrast, since 2007 the number of RNs has fallen by 483 employees and their share of the direct care workforce has decreased from 17 per cent to 15 per cent; while the number of ENs has increased by 622 employees but as a proportion of the direct care workforce they have decreased marginally from 12.2 per cent to 11.5 per cent. While the change is not as significant as between 2003 and 2007, the findings reinforce the pattern previously identified in the 2007 research whereby residential facilities are decreasing their reliance on RNs to provide direct care to residents.

Two new occupations are reported in 2012: nurse practitioners and allied health assistants. Nurse Practitioners are a relatively new development in aged care and make up a small proportion of the workforce (0.2%). They are reported separately in a few areas, but for the majority of tables Nurse Practitioners are combined with Registered Nurses. The Allied Health category of 2003 and 2007 was split into two separate occupational groups in 2012: Allied Health Professionals and Allied Health Assistants. However, given that together they comprise just over 5 per cent of the direct care workforce, we combine these two categories for most of the analyses throughout the report.

Table 3.2: Direct care employees in the residential aged care workforce, by occupation: 2003, 2007 and 2012 (estimated headcount and per cent)

Occupation	2003	2007	2012
Nurse Practitioner (NP)	n/a	n/a	294 (0.2)
Registered Nurse (RN)	24,019 (21.0)	22,399 (16.8)	21,916 (14.9)
Enrolled Nurse (EN)	15,604 (13.1)	16,293 (12.2)	16,915 (11.5)
Personal Care Attendant (PCA)	67,143 (58.5)	84,746 (63.6)	100,312 (68.2)
Allied Health Professional (AHP)	8,895* (7.4)	9,875* (7.4)	2,648 (1.8)
Allied Health Assistant (AHA)			5,001 (3.4)
Total number of employees (headcount) (%)	**115,660 (100)**	**133,314 (100)**	**147,086 (100)**

Source: Census of residential aged care facilities.
* In 2003 and 2007 these categories were combined under 'Allied Health'

The distribution of the full-time equivalent (FTE) direct care workforce by occupational group is very similar to that of the number of persons working in these occupations (Table 3.3). We observe a large increase in the estimated number of FTE direct care employees since 2007. The increase of just under 16,000 FTE employees in the last 5 years is much greater than the increase of around 2,800 between 2003 and 2007. In addition, while the rate of increase in the direct care workforce between 2007 and 2012 was 10.3 per cent, the increase for FTE employees was 20.3 per cent. Tables 3.2 and 3.3 combined suggest that the increase in headcount slowed down between 2007 and 2012, but this was partly offset by an increased proportion of workers employed for longer hours.

Table 3.3: Full-time equivalent direct care employees in the residential aged care workforce, by occupation: 2003, 2007 and 2012 (estimated FTE and per cent)

Occupation	2003#	2007	2012
Nurse Practitioner	n/a	n/a	190 (0.2)
Registered Nurse	16,265 (21.4)	13,247 (16.8)	13,939 (14.7)
Enrolled Nurse	10,945 (14.4)	9,856 (12.5)	10,999 (11.6)
Personal Care Attendant	42,943 (56.5)	50,542 (64.1)	64,669 (68.2)
Allied Health Professional	5,776* (7.6)	5,204* (6.6)	1,612 (1.7)
Allied Health Assistant			3,414 (3.6)
Total number of employees (FTE) (%)	**76,006 (100)**	**78,849 (100)**	**94,823 (100)**

Source: Census of residential aged care facilities.
For consistency, the figures reported in the 2007 report have been replicated here. Please note that there is a 0.1% rounding difference between the Total and the sum of the numbers for each occupation.
* In 2003 and 2007 these categories were combined under 'Allied Health'

The contents of Table 3.2 and Table 3.3 (with headcount and full time equivalent numbers and per cents respectively) are presented graphically in Figure 1 and Figure 2 overleaf.

In 2012, we asked facilities to provide an indication of the distribution of the different non-direct care occupations working in aged care (Table 3.4). The majority of these employees work in ancillary care roles in facilities. These ancillary workers include those with responsibility for resident well-being in areas such as cleaning rooms, providing meals and other services that support the personal care provided by direct care staff; and employees who have responsibility for ensuring that the buildings, property and gardens are maintained. Together they constitute 70 per cent of the non-direct care workforce in residential facilities.

Figure 1: Share of the occupations for the residential direct care employees (headcount and FTE, per cent)

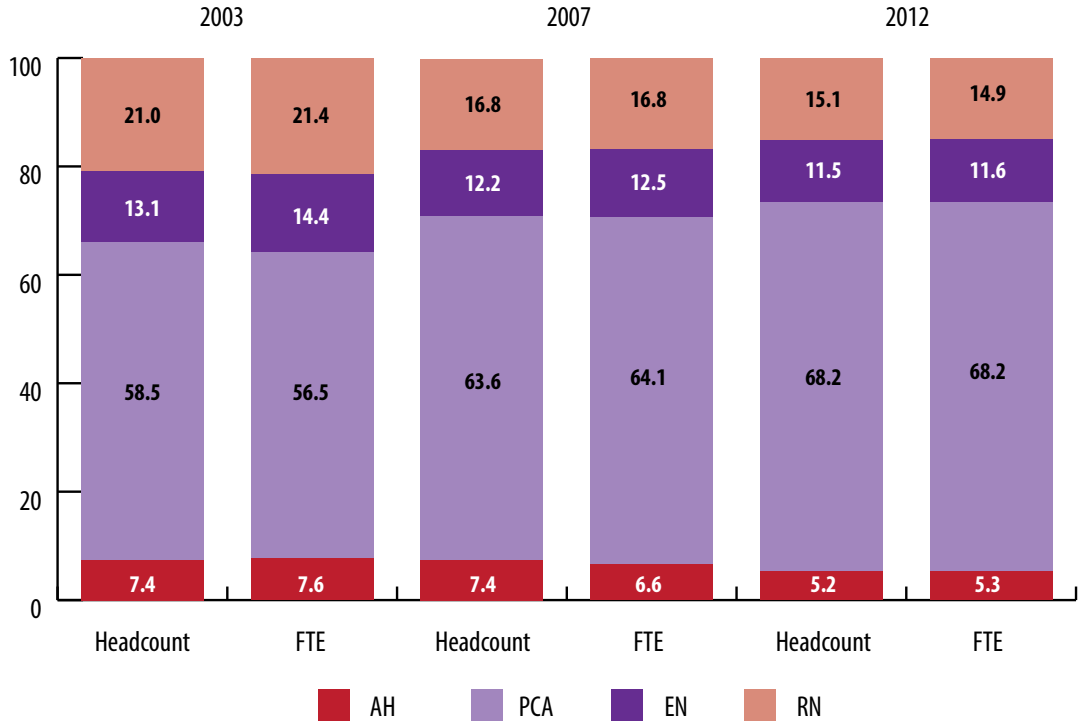
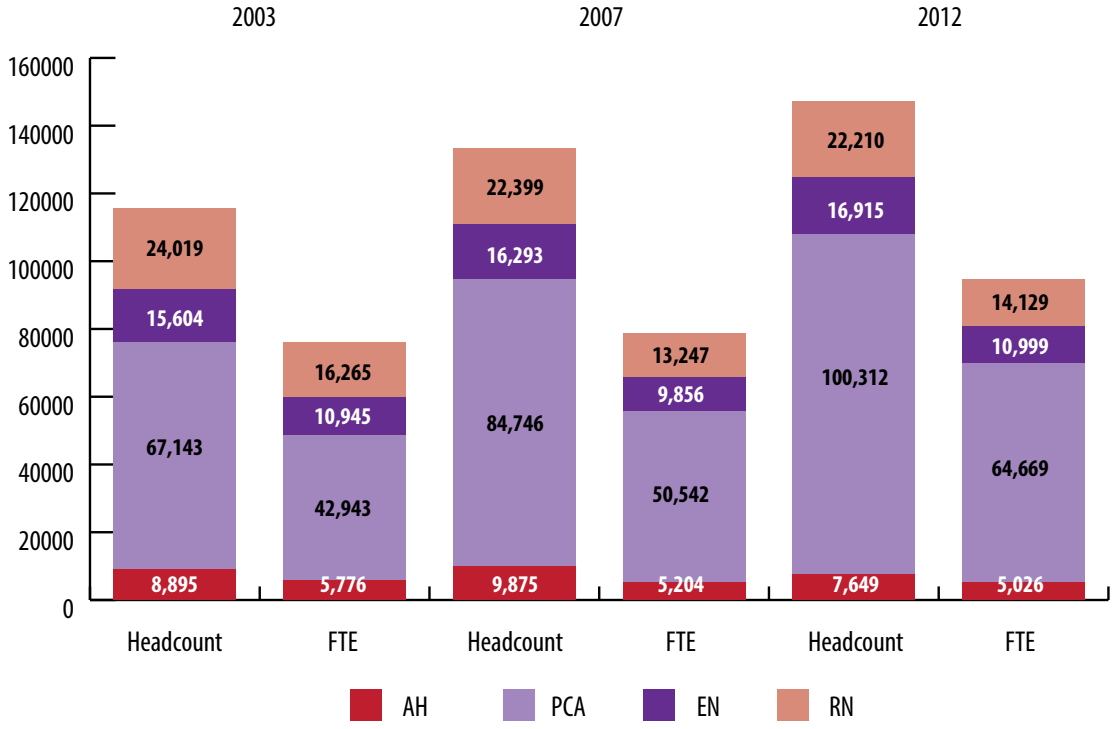


Figure 2: Number of the occupations for the residential direct care employees (headcount and FTE)



Note: Nurse Practitioners and Registered Nurses were combined under 'Registered Nurse' in 2012 in Figure 1 and Figure 2. Allied Health Professionals and Allied Health Assistants were combined under 'Allied Health' in 2003, 2007 and 2012 in Figure 1 and Figure 2.

Table 3.4: Employees not providing direct care in the residential aged care workforce, by occupation: 2012 (per cent)

Occupation	%
Care Manager/Co-ordinator	6.6
Management	8.8
Administration	12.6
Spiritual/pastoral care	1.7
Ancillary care	70.4
Total	**100**

Source: Census of residential aged care facilities.

3.1.3 Age

While it has been widely recognised that the changing age structure of the population will increase demand for aged care, it must be recognised that these demographic changes will also affect the supply of workers, especially in those parts of the labour market that employ older workers. In both 2003 and 2007 our research showed that the residential direct care workforce was, on average, older than the Australian workforce as a whole. In 2012, the age distribution of the workforce in residential aged care is very similar to previous years.

Table 3.5 and Figure 3 show that in 2012, 27 per cent of the direct care workforce was aged 55 years or over, an increase from 17 per cent in 2003 and 23 per cent in 2007. In contrast, the proportion of the workforce under the age of 35 years has barely changed since 2003, at around 18 per cent. The main loss of workers is in the 35–54 year age range which has gone from having 65 per cent of the workforce in 2003 down to 55 per cent in 2012.

The age distribution of the workforce who have been recently hired (i.e. been employed for 12 months or less) indicates that employment is increasing among workers aged 34 years or younger. This age group constitutes 36 per cent of all recent hires, an increase from 29 per cent in 2003. While employment of workers aged 55 years and over remained consistent between 2007 and 2012 at around 15 per cent, this is an increase from 2003. Again, there seems to be a decrease in the proportion of workers aged 35–54 years, but particularly in the 45–54 year age group which has decreased consistently since 2003.

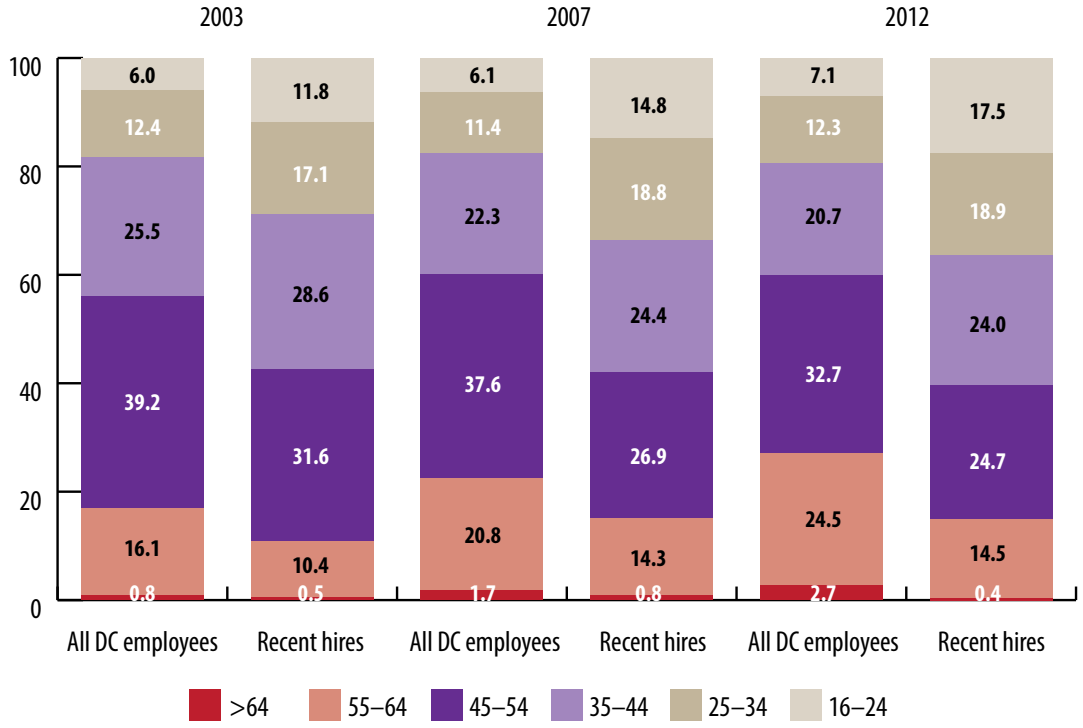
Table 3.5: Age distribution of the residential direct care workforce, all direct care employees and recent hires: 2003, 2007 and 2012 (per cent)

	All direct care employees			Recent hires*		
Age (years)	2003	2007	2012	2003	2007	2012
16–24	6.0	6.1	7.1	11.8	14.8	17.5
25–34	12.4	11.4	12.3	17.1	18.8	18.9
35–44	25.5	22.3	20.7	28.6	24.4	24.0
45–54	39.2	37.6	32.7	31.6	26.9	24.7
55–64	16.1	20.8	24.5	10.4	14.3	14.5
>64	0.8	1.7	2.7	0.5	0.8	0.4
Total	**100**	**100**[1]	**100**	**100**	**100**	**100**

Source: Survey of residential care workers
* Recent hires have been employed for 12 months or less

1 Please note that because of rounding of percentages, the totals do not always sum to exactly 100 throughout the report.

Figure 3: Age distribution of the residential aged care workforce: 2003, 2007, and 2012 (per cent)



To further illustrate the age of the workforce, we calculated the median age (mid-point) of the workforce for each of the occupations, as shown in Table 3.6. With a median age of 47 years, PCAs are the youngest of the occupational groups, with workers in the other occupations having a median closer to 50 years of age. However, the table clearly demonstrates that workers recently recruited into residential aged care are younger than the direct care workforce overall, the difference being 8 years. This differs by occupation. RNs not only have an older median age than other workers, they are also recruited at an older median age, with recent hires having a median age that is only 4 years younger. This is quite different to recently hired PCAs and AH workers who have a median age that is 9 years younger than that of their colleagues in the broader direct care workforce.

Table 3.6: Median age of the residential direct care workforce, by occupation, all direct care employees and recent hires: 2012 (number of years)

Occupation	All direct care employees	Recent hires*
Registered Nurse	51	47
Enrolled Nurse	49	44
Personal Care Attendant	47	38
Allied Health	50	41
All occupations	**48**	**40**

Source: Survey of residential care workers
* Recent hires have been employed for 12 months or less

3.1.4 Country of Birth

In 2007 we reported a large increase in the proportion of the residential direct care workforce that was overseas born. Between 2003 and 2007, the proportion of the workforce born outside of Australia rose from 25 per cent to 33 per cent. Although such a significant increase has not been repeated between 2007 and 2012, there has been a modest increase to 34 per cent.

Table 3.7 shows the distribution of the workforce by country of birth, comparing all direct care employees with recent hires. One of the major differences between 2007 and 2012 has been the increase in the proportion of direct care workers from Asia (including India), from 7 per cent to 10 per cent of the workforce. This is reflected in the proportion of *recent hires* from Asia, which constitutes just over 13 per cent of employees. From this we can see that around one-third of overseas born workers now come from Asia, with similar proportions coming from New Zealand, United Kingdom, Ireland and South Africa.

Table 3.7: Country of birth of the residential direct care workforce, all direct care employees and recent hires: 2007 and 2012 (per cent)

Country of birth	All direct care employees		Recent hires*	
	2007	2012	2007	2012
Australia	67.5	65.4	66.4	63.4
New Zealand	3.5	3.0	3.9	2.9
UK, Ireland, South Africa	9.2	7.5	7.6	7.9
Italy, Greece, Germany, Netherlands, Poland	2.2	1.8	2.0	0.8
Vietnam, HK, China, Philippines	5.2	7.4	5.2	9.7
India	1.3	2.7	1.8	3.5
Fiji	1.6	1.4	0.9	0.6
Other	9.6	10.7	12.3	11.2
Total	**100**	**100**	**100**	**100**

Source: Survey of residential care workers
* Recent hires have been employed for 12 months or less

We now examine the distribution of the overseas born workforce by occupation. We asked facilities to provide the numbers of workers from a culturally or linguistically diverse background for each occupation; and we also asked workers to state where they were born and whether they spoke a language other than English. Although not directly comparable, these questions provide different perspectives on the level and distribution of the residential direct care workforce that were overseas born.

We see in Table 3.8 that around a third of all workers are migrants and that their occupational distribution is similar to that of the broader direct care workforce as reported in Table 3.2, although facilities report having a slightly higher proportion of PCAs and lower proportion of ENs than in the broader direct care workforce.

One concern would be if surveys were not distributed equally to workers who were and were not from a culturally and linguistically diverse background. This is not supported by the data as we see in two occupational categories the facility reports a higher percentage, and in the other two it reports a lower percentage, and in none of the occupational groups are the differences particularly noteworthy (especially given the worker proportion is a sample estimate from a much larger population). There is a difference in the overall proportion of culturally and linguistically diverse employees in the workforce; with facilities indicating that 29 per cent of their workers were in this category, while worker responses indicated that 23 per cent were

both migrant and spoke a language other than English. Care needs to be taken in making direct comparisons of these proportions because they measure slightly different things; but the difference, while noted, is relatively small.

Table 3.8: The culturally and linguistically diverse residential direct care workforce, by occupation, comparing responses from all workers and all facilities: 2012 (per cent)

Occupation	Worker (migrant)[1]	Worker (migrant + LOTE)[2]	Facility (CALD)[3]
% of direct care employees	34.4	22.8	28.6
Distribution:			
RN	17.5	17.4	15.5
EN	8.0	5.9	6.5
PCA	69.5	72.4	74.4
AH	5.0	4.3	3.6
Total	**100**	**100**	**100**

Source: Survey of residential care workers, Census of residential aged care facilities.
1. Workers who report having migrated to Australia
2. Workers who report being both migrant and speaking a language other than English
3. Facilities that report employees from culturally and linguistically diverse backgrounds

For the first time in 2012 we asked migrant workers who spoke a language other than English how long they had been living in Australia. Although not precise, this allows us to see the extent to which workers are likely to be familiar with English as a language and with Australian customs and norms. Table 3.9 shows that about half of all migrant workers speaking a language other than English have been in Australia for over 10 years. At the other end of the spectrum, 35 per cent have been here for 5 years or less. Of the occupational groups, PCAs are most likely to have been in Australia for 5 years or less (39%), while nurses and AH workers are more likely to have been in Australia for more than 10 years.

Table 3.9: Time spent in Australia for migrant residential direct care workers who speak a language other than English, by occupation: 2012 (per cent)

Occupation	0–2 years	3–5 years	6–10 years	>10 years	Total
Registered Nurse	10.7	16.9	20.0	52.4	**100**
Enrolled Nurse	4.0	9.0	12.0	75.0	**100**
Personal Care Attendant	15.1	23.7	11.7	49.5	**100**
Allied Health	11.1	18.1	13.9	56.9	**100**
All occupations	**13.5**	**21.4**	**13.2**	**51.9**	**100**

Source: Survey of residential care workers

3.1.5 Aboriginal and Torres Strait Islander Workforce

Although the proportion of Aboriginal and Torres Strait Islander people in the residential direct care workforce is low, 1–2 per cent, this is proportional to their distribution in the wider population where they comprise 2.5 per cent of the Australian population (Australian Bureau of Statistics [ABS], 2012).

Table 3.10 compares responses from facilities and workers regarding the distribution of Aboriginal and Torres Strait Islander people in the direct care workforce. There is a slight difference in their overall proportion in the workforce that can possibly be explained by differences in the ways that people identify (or not) as being of Aboriginal and Torres Strait Islander background. There is more similarity between the responses from workers and facilities in the distribution of the workforce across occupations. Here we see that the vast majority of Aboriginal and Torres Strait Islander direct care workers are employed as PCAs. While this is true of the direct care workforce generally in which 68 per cent of workers are PCAs, more than 85 per cent of Aboriginal and Torres Strait Islander workers are PCAs. Correspondingly, this means that they are less likely to be in a Nursing or Allied Health role. It is not clear whether this is a result of a shortage of Aboriginal and Torres Strait Islander people with the appropriate qualifications or that they have the qualifications but choose not to work in aged care.

Table 3.10: The Aboriginal and Torres Strait Islander residential direct care workforce, by occupation, comparing facility and worker responses: 2012 (per cent)

Occupation	Worker	Facility
% of direct care employees	1.9	1.0
Distribution		
RN	4.3	5.2
EN	6.4	6.4
PCA	87.1	85.4
AH	2.1	3.0
Total	**100**	**100**

Source: Survey of residential care workers, Census of residential aged care facilities

3.1.6 Health

Health status is related to employees' capacity to do their work and their job satisfaction. As in previous years, we use a standard measure of self-assessed health drawn from the ABS (rating health as excellent, very good, good, fair or poor). Since 2007, the proportion of direct care employees assessing their health as 'excellent' has decreased slightly from 20 per cent. The proportion indicating that they are in either very good or excellent health (around 60%) is in line with the Australian average (63%) for people aged 18 years and over (ABS, 2011a). Very few direct care workers have fair or poor health (8%) which is perhaps indicative of the health requirements for working in aged care. We see, for example, that recent hires have even better self-assessed health than direct care employees generally. This is presumably because they are younger (see Table 3.5) and need to be of good health in order to do the physical work associated with aged care.

Table 3.11: Self-assessed health of the residential direct care workforce, all direct care employees and recent hires, by occupation: 2012 (per cent)

Self-assessed health	All direct care employees			Recent hires*		
	Nurse	PCA	AH	Nurse	PCA	AH
Excellent	18.1	18.1	13.5	23.4	24.5	13.2
Very good	42.1	40.5	48.0	40.9	42.1	52.8
Good	33.1	33.6	31.3	30.1	29.0	28.3
Fair	6.3	7.2	7.0	5.6	4.5	5.7
Poor	0.3	0.6	0.3	0.0	0.0	0.0
Total	**100**	**100**	**100**	**100**	**100**	**100**

Source: Survey of residential care workers
* Recent hires have been employed for 12 months or less

3.1.7 Education

Since 2007, there have been a number of initiatives to encourage direct care workers to undertake further education and training to enhance their careers and develop the skills required to provide quality care to older Australians. In 2012 we expanded the number of questions asked about education and training. In this section we focus on the formal education of the workforce.

For the first time in 2012 we have information about the qualifications of care managers and care leaders.[2] From the responses shown in Table 3.12 they seem to have different career pathways into leadership roles. The majority of care managers (54%) have at least a degree in nursing, with 19 per cent having a Certificate III or IV in management. In comparison, for care leaders the most common qualification is a Certificate III (42%) or IV (22%) in aged care, with a substantial minority having nursing qualifications but a relatively low proportion having completed a qualification in management. From this we see that while care managers are drawn primarily from RNs, care leaders are drawn from a wider cross-section of the workforce.

One of the noticeable features of Table 3.12 is that 88 per cent of the direct care workforce had post-secondary qualifications, indicating widespread engagement in further education. This is an increase from 2007 when 80 per cent of workers had post-secondary qualifications. As might be expected, there is variation between occupations. For example, the proportion of PCAs that had not undertaken further education (16%) is higher than that of RNs (3%).

Focusing now on the types of qualifications undertaken by direct care workers, there is quite close correspondence between qualification and occupation. Understandably, a high proportion of nurses have qualifications in health related areas, with RNs having mostly degree-level qualifications while ENs are more likely to hold a Certificate IV or diploma. A high proportion of PCAs and Allied Health workers[3] hold Certificate level qualifications in Aged Care.

2 Care managers were defined as having responsibility for all direct care workers in the facility; while care leaders were defined as having responsibility for a team of direct care workers, but reporting to a care manager.

3 The occupations covered under AH include both Allied Health professionals, many of whom would have degree level qualifications, and Allied Health Assistants who have a similar educational profile to PCAs.

Examining the educational attainments of PCAs further, we see that around two-thirds have a Certificate III in Aged Care, which is considered to be the standard qualification for working in this occupation. This proportion has stayed constant since 2003. In contrast, the proportion of PCAs with the Certificate IV in Aged Care has steadily increased from 8 per cent in 2003 to 20 per cent in 2012.

Table 3.12: Post-school qualifications completed by the residential direct care workforce, by occupation: 2012 (per cent)

Qualification	Care Manager	Care Leaders	RN	EN	PCA	AH	All DCW*
No Post-school							
Yr 10 or below	0.6	3.5	0.6	2.8	7.8	5.9	6.0
Yr 11/12	1.5	4.7	2.3	2.9	8.1	3.7	6.4
Health							
Certificate IV/Diploma in Enrolled Nursing	10.0	23.8	5.4	72.5	4.1	2.9	12.2
Other basic nursing qualification	19.8	12.2	20.2	10.3	6.9	4.4	9.3
Post-basic nursing qualification	19.3	6.0	18.0	3.3	0.9	0.7	3.9
Bachelor Degree in Nursing	53.9	20.4	64.2	1.5	1.8	2.2	11.7
Bachelor Degree in Allied Health Profession	0.6	0.4	0.5	0.0	0.3	8.3	0.7
Postgraduate allied health qualification	2.8	1.2	3.0	0.7	0.4	4.9	1.1
Other health related	13.2	8.9	11.6	8.1	7.2	19.6	8.7
Aged Care							
Certificate III in Aged Care	11.2	41.6	6.4	33.3	65.7	42.2	51.2
Certificate III in Home and Community Care	0.8	4.6	0.4	3.6	7.7	5.9	6.0
Certificate IV in Aged Care	6.0	21.6	1.9	13.0	20.0	17.4	16.2
Certificate IV in Service Coordination	0.9	2.3	0.3	1.7	1.3	2.7	1.3
Other Certificate in Care Work	4.3	6.6	2.4	4.2	7.5	14.5	6.7
Post basic nursing qualification in aged care	10.8	3.3	8.9	2.8	0.6	0.2	2.1
Other aged care related	8.9	7.2	7.8	5.7	5.9	18.6	6.9
Management							
Certificate III or IV (Management)	19.1	6.5	9.7	6.2	3.2	6.9	4.8
Diploma (Management)	15.7	3.1	9.0	4.2	1.4	4.9	3.1
Bachelor Degree (Management)	2.1	3.1	2.2	1.2	1.5	0.5	1.5
Postgraduate Degree (Management)	8.3	1.1	5.8	0.1	0.6	1.2	1.4
Other							
Certificate III or IV (Other)	14.0	10.9	10.2	11.9	10.7	24.0	11.5
Diploma (Other)	7.8	6.3	7.9	6.0	6.1	14.7	6.8
Bachelor Degree (Other)	3.6	3.1	3.5	2.1	4.3	4.7	3.9
Postgraduate Degree (Other)	6.4	2.1	6.5	0.7	1.3	1.7	1.0

Source: Survey of residential care workers.
* All DCW—all direct care workers, does not include care managers or care leaders
Note: Because staff can have more than one qualification, the columns do not sum to 100.

In addition to asking workers about their educational attainments, we also asked facilities to provide information about the extent to which PCAs working in their facility had completed the Certificate III or IV in Aged Care (Table 3.13). Their responses reinforce the picture of a highly qualified PCA workforce. The proportion of facilities with no PCAs with Certificate III qualifications fell to 2 per cent, less than half what it was in 2007. At the other end of the spectrum we see that the proportion of facilities with more than three-quarters of PCAs holding a Certificate III rose from 47 per cent in 2007 to 62 per cent in 2012. There was also a marked decrease in the number of facilities with no PCAs with a Certificate IV in Aged Care, dropping from 42 per cent in 2007 to 22 per cent in 2012. The majority of facilities (58%) had a quarter or less of their PCAs with a Certificate IV, with 4 per cent indicating that all of their PCAs had this qualification.

Table 3.13: Distribution of residential facilities by proportion of Personal Care Attendants (PCAs) with Certificate-level qualifications: 2007 and 2012 (per cent)

Proportion of PCAs with each type of qualification	Certificate III in Aged Care		Certificate IV in Aged Care	
	2007	2012	2007	2012
Zero	5.2	1.8	42.2	21.8
1–24	5.5	4.1	44.8	57.6
25–49	14.9	9.3	8.9	13.4
50–74	27.0	23.1	2.5	3.8
75–99	47.4*	43.9	1.5*	1.7
100		17.6		1.8
Total	**100**	**100**	**100**	**100**

Source: Census of residential aged care facilities.
* In 2007, the categories were for 75–100%

As the level and complexity of care increases for residents in facilities, the need for specialised aged care qualifications is likely to become more widespread. As Table 3.14 shows, 31 per cent of RNs and 37 per cent of Care Managers have specialised qualifications in ageing or aged care. These specialisations were selected as being important for aged care, but it is not an exhaustive list. As these are the occupations that provide leadership in the provision of care within a facility, the extent to which they understand the specific physical and mental health issues facing older Australians is important. Around one-quarter of Care Leaders and AH workers, and 15–20 per cent of ENs and PCAs also have these specializations. Of the specialised qualifications, palliative care is the most prevalent, although a similar proportion of RNs and Care Managers have qualifications in gerontology.

Table 3.14: Specialised qualifications in ageing or aged care of the residential direct care workforce, by occupation: 2012 (per cent)

Qualification	Care Manager	Care Leader	RN	EN	PCA	AH
None	63.0	75.8	69.0	80.2	84.0	74.1
Specialisation in:						
Gerontology	14.0	2.5	10.4	1.3	0.1	1.4
Palliative Care	12.0	11.5	11.0	8.4	6.8	6.3
Psychogeriatrics	2.4	0.8	2.1	1.0	0.2	0.3
Other	8.6	9.4	7.5	9.1	8.9	17.9
Total	**100**	**100**	**100**	**100**	**100**	**100**

Source: Survey of residential care workers.

The direct care workforce has shown that it is highly amenable to developing capacity and acquiring qualifications relevant to aged care. Areas and levels of current study also provide insights into the career aspirations of existing workers. The next two tables (3.15 and 3.16) look at those members of the workforce who are currently studying.

In 2012, 22 per cent of all direct care workers were undertaking study at the time of the survey (Table 3.15). Just under 25 per cent of PCAs, 13 per cent of RNs and around 20 per cent of both ENs and AH workers were engaged in study. The fields of study were grouped in accordance with the areas given in Table 3.12: aged care, health, management and other and the results are shown in Table 3.15. While 28 per cent of PCAs who were engaged in study are seeking qualifications in the field of aged care, the largest proportion of workers who are studying is aiming for health-related qualifications, irrespective of their current occupation. Although it is difficult to say for certain, it is possible that PCAs and ENs studying in health related areas are looking to move into more highly qualified nursing positions. For RNs, the career progression seems to be towards management, with 32 per cent of those studying doing so in management related fields.

The proportion of workers undertaking study in 'other' fields is interesting, with just under 20 per cent of RNs and AH workers and around 10 per cent of ENs and PCAs falling into this category. While there are numerous possible explanations for this, two stand out as worth mentioning. One is if workers in aged care are seeking to leave the sector and are preparing for a career in another area. Another reason is if some direct care employees are using aged care as a transitional job in the same way that students work in hospitality or retail while studying, prior to embarking on their chosen career. Either way there are implications for the sector in terms of recruitment and retention of the workforce. The intentions of workers to stay or not is discussed further in Section 3.3.3.

Table 3.15: Field of current study of the residential direct care workforce, by occupation: 2012 (per cent)

Field of study	RN	EN	PCA	AH	All occupations
Not currently studying	87.0	81.1	75.1	78.6	77.9
Currently studying	13.0	18.9	24.9	21.4	22.1
Of those studying					
Aged Care	8.5	1.3	27.7	9.6	22.2
Health	40.3	71.2	56.6	59.0	56.8
Management	31.8	19.0	5.2	13.3	9.4
Other	19.4	8.5	10.5	18.1	11.6
Total	**100**	**100**	**100**	**100**	**100**

Source: Survey of residential care workers.

The level of study being undertaken by the direct care workforce is shown in Table 3.16. A small proportion of PCAs and AH workers are undertaking Certificate III level studies while working. The majority of PCAs and AH workers currently studying are doing so at Certificate IV/Diploma level, although 25 per cent of PCAs and 14 per cent of AH workers are doing an undergraduate degree. RNs and ENs have a slightly different profile. Around 45 per cent of workers who are studying in each occupation are doing so at Certificate IV/Diploma level, although the same proportion of RNs is undertaking postgraduate studies while the majority of ENs studying are doing so at undergraduate degree level (53%).

Table 3.16: Level of study of the residential direct care workers who are currently studying, by occupation: 2012 (per cent)

Level of study	RN	EN	PCA	AH
Certificate I/II	0.8	0	0.4	0
Certificate III	1.6	1.4	10.5	9.1
Certificate IV / Diploma	46.0	44.8	62.6	74.0
Undergraduate Degree	5.6	53.1	25.3	14.3
Postgraduate Degree / Diploma / Certificate	46.0	0.7	1.3	2.6
Total	**100**	**100**	**100**	**100**

Source: Survey of residential care workers.

3.2 The Main Characteristics of the Work

Work in aged care is not only shaped by the skills and attributes that workers bring with them, but also by the factors that provide the context within which work takes place. In this section we focus on aspects of work that are primarily shaped by the employer: the forms of employment offered, the shifts and hours worked, and the extent of training provided. We also discuss the extent to which workers hold multiple jobs because this could be an indicator of the extent to which their current job is meeting their needs.

3.2.1 Employment Arrangements and Hours Worked

Flexibility in working hours for direct care workers has been important both for employers, who seek to distribute the workforce most effectively throughout a week, and for employees, many of whom combine work with family responsibilities and/or further study. Whether employees are working their preferred hours has also provided an indication of the extent to which there is excess capacity or shortages in the existing workforce.

As was the pattern in 2003 and 2007, the majority of workers in all direct care occupations are employed on permanent part-time contracts (Table 3.17). These now cover 72 per cent of the workforce, compared with 69 per cent in 2007. This is the result of a shift away from casual/contract arrangements, which now cover 19 per cent of the workforce (down from 22 per cent in 2007). This is an overwhelmingly part-time workforce which may have implications on latent capacity, as we discuss below.

There also continue to be occupational differences relating to the form of employment, with a higher proportion of RNs than other occupations employed on a permanent full-time basis. However, the proportion of RNs and PCAs employed on a casual contract is about the same (19.5%).

Between 2003 and 2007 there was a marked change in the types of shifts worked, with a move toward employing workers on regular shifts rather than rotating ones. In 2012 we see an even higher proportion of Nurses working a regular daytime shift (65%), with a corresponding reduction in the proportions working a rotating shift or a regular evening shift (Table 3.18). The work schedule for PCAs is remarkably similar to that in 2007, while for AH workers their work schedule has changed slightly, away from a regular daytime shift either to a regular evening shift or a rotating shift. On the whole fewer nurses are present outside of the regular daytime shift, which may indicate an evening/night skill shortage, but it may also be the result of re-organisation of work practices which can only be studied by examining these changes at the facility level.

Table 3.17: Form of employment of the residential direct care workforce, by occupation: 2012 (per cent)

Occupation	Permanent full-time	Permanent part-time	Casual or contract	Total
Registered Nurse	19.3	61.3	19.4	**100**
Enrolled Nurse	10.5	74.7	14.8	**100**
Personal Care Attendant	6.9	73.6	19.5	**100**
Allied Health	12.0	72.9	15.1	**100**
All occupations	**9.5**	**71.8**	**18.7**	**100**

Source: Census of residential aged care facilities.

Table 3.18: Work schedule of the residential direct care workforce, by occupation: 2007 and 2012 (per cent)

	Nurse		PCA		Allied Health	
Work schedule	**2007**	**2012**	**2007**	**2012**	**2007**	**2012**
A regular daytime shift	57.1	64.9	50.6	50.8	95.6	92.0
A regular evening shift	12.5	8.3	14.0	14.3	0.4	2.2
A regular night shift	5.8	3.9	5.3	5.1	0.2	0.0
A rotating shift	16.2	14.5	19.7	19.5	1.7	2.2
Spilt shift	0.5	0.5	0.6	1.1	0.2	0.5
On call	0.6	1.0	1.3	1.5	0.4	0.7
Irregular schedule	5.1	5.2	6.7	6.4	1.1	1.2
Other	2.1	1.6	1.8	1.3	0.4	1.0
Total	**100**	**100**	**100**	**100**	**100**	**100**

Source: Survey of residential care workers.

Table 3.19 below show the hours worked by employees in residential **facilities**.

In 2003 and 2007, the research showed evidence of excess capacity in the direct care workforce in that there was a significant group of workers who wanted to work longer hours than they were scheduled for. Since then, there has been increased demand for direct care workers so we could expect that excess capacity will be lower in 2012. In the next two tables we look at the hours worked and the preferred hours of the workforce to gauge whether there is still excess capacity.

We stated earlier (Table 3.17) that facilities reported that the rate of increase in their full-time equivalent workforce was greater than the increase in the number of direct care employees, indicating that employees were working longer hours than in previous years. The first section of Table 3.20, showing the actual hours worked per week, provides further evidence of this change. We see in this table that 46 per cent of the workforce is working for 35 hours or more per week, which falls within the ABS definition of full-time work. This is an increase from 39 per cent in 2007.

There is some variation in the hours worked across occupational groups with RNs being the occupation having the highest proportion of workers working long hours (>40), while PCAs are most likely to be working for 16–34 hours per week, which suggests a possible skills shortage in RNs and excess capacity among PCAs, ENs and AH.

Shifting attention toward the columns on the right-hand side of the table, we see that the hours preferred by the highest proportion of workers are 35–40 hours per week. This would mean a decrease in working hours for RNs and ENs, and an increase for PCAs. This reinforces the suggestion that for PCAs there may be some room to acquire further capacity from within the existing workforce, while the capacity of the nursing workforce may well be approaching over-utilisation and skill shortages.

Table 3.19: Actual working hours and preferred working hours of direct care workers in the residential aged care workforce, by occupation: 2012 (per cent)

	Actual hours per week				Preferred hours per week			
Occupation	**1–15**	**16–34**	**35–40**	**>40**	**1–15**	**16–34**	**35–40**	**>40**
Registered Nurse	3.6	33.5	34.2	28.6	3.0	39.3	51.7	6.0
Enrolled Nurse	3.9	42.7	36.0	17.4	3.5	41.5	45.4	9.7
Personal Care Attendant	3.9	56.4	32.1	7.6	2.5	43.9	44.6	9.0
Allied Health	6.4	41.5	41.5	10.4	4.7	42.5	44.7	3.7
All occupations	**4.0**	**50.3**	**33.4**	**12.3**	**2.8**	**42.9**	**45.9**	**8.3**

Source: Survey of residential care workers
(Row totals)

In examining the preferred change in working hours further, Table 3.20 shows the extent of the preferred change in terms of both the number of hours and the direction of change (more or less), and how these compare to previous research.

The information in Table 3.20 indicates that although 56 per cent of the workforce is happy with their current hours, this is a slightly smaller proportion than in either 2003 (58%) or 2007 (60%). Responses to this question indicate that 44 per cent of the direct care workforce is looking to change their hours: 17 per cent want to decrease their hours and 27 per cent want an increase. This supports the findings from the previous table (3.19), in which a significant proportion of the Nursing and AH workforce would prefer *not* to be working more than 40 hours per week, with more RNs preferring to work less hours than are currently doing so. In contrast, the proportion of workers wanting to increase their hours (27%) has remained the same since 2003. About half of these workers want a relatively small increase per week of 1–5 hours. However, if each of these workers increased their hours by 2.5 hours per week, this would result in an additional 1,300 FTE workers in aged care.

The contrast between what facilities report in Table 3.17 (i.e. 61 per cent of RNs work part-time) and what workers themselves report (i.e. 37 per cent work less than 35 hours) indicates a conflict in the perceptions or reporting of hours worked.

Table 3.20: Preferred change in working hours of the residential direct care workforce: 2003, 2007 and 2012 (per cent)

Desired change in hours	**2003**	**2007**	**2012**
10+ hours less	5.5	4.0	6.2
1–9 hours less	8.5	7.5	11.0
No change in hours	57.6	60.4	55.6
1–5 hours more	13.2	12.2	12.3
6–10 hours more	10.5	10.7	9.3
11+ hours more	4.6	5.1	5.6
Total	**100**	**100**	**100**

Source: Survey of residential care workers.

3.2.2 Wages

Wages paid to direct care workers have been a point of contention for several years. Most recently, the Productivity Commission recommended that the aged care reforms should 'take into account the need to pay fair and competitive wages to nursing and other care staff delivering appropriately approved aged care services' (Productivity Commission, 2011, p. 365). A comprehensive consideration of whether direct care workers are or are not being paid appropriately is beyond the scope of this report. Instead, we present the gross median earnings for each occupation participating in the survey by the number of hours worked per week (Table 3.21).[4]

The median wage for RNs is $1,200 per week. As discussed above, a high proportion of RNs work more than 35 hours per week and this is reflected in their median wage. However, even when working part-time, RNs have a higher median wage than other occupations.[5]

More than half of all PCAs work 16–34 hours per week, and they receive a median weekly wage of $600. In contrast, over half of all ENs work 35 hours or more, with a median weekly wage of between $900 and $950. Of all the occupations, the two Allied Health categories are the most difficult to interpret without further investigation. While AH Professionals have a higher median wage than AH Assistants, the difference is relatively small. This is somewhat surprising given the higher qualification required of AH Professionals. Except for those AH Professionals working more than 40 hours, their median wage is more like that of PCAs than of ENs or RNs. The median wage for AH Assistants is lower than that of any other occupation across all hours worked except for those working more than 40 hours per week. Part of the reason for Allied Health workers having lower median wages than other occupations may be that they nearly all work a regular daytime shift (Table 3.18) and would not receive any financial benefits of working evenings, nights or being on call.

Table 3.21: Median earnings (gross) of the residential direct care workforce, by occupation and working hours: 2012 ($ per week)

	Hours per week				
Occupation	**1–15**	**16–34**	**35–40**	**>40**	**All hours**
Nurse Practitioner	*	*	*	*	1110
Registered Nurse	472	950	1307	1487	1200
Enrolled Nurse	318	715	900	950	800
Personal Care Attendant	314	600	771	700	653
Allied Health Professional	300	582	800	879	730
Allied Health Assistant	225	553	733	750	645
All occupations	**324**	**625**	**830**	**923**	**700**

Source: Survey of residential aged care workers.
* Because the numbers of Nurse Practitioners are small, the wages earned have not been reported for individual categories

3.2.3 Multiple Job Holding

The extent to which employees hold multiple jobs is another indicator of spare capacity within the existing workforce. Approximately 10 per cent of direct care employees have more than one job (Table 3.22). This is nearly double the level in the Australian population more generally which is 5.4 per cent (ABS, 2011c). Among those who have multiple jobs, about half of the 'other' jobs held by RNs and PCAs are in aged care,

4 The alternative would be to calculate the hourly rate for each occupation. We have used the medians earnings to maintain comparability with previous reports.

5 Note that the small proportion of Nurse Practitioners in the direct care workforce (0.2%) makes the comparison of median wages across hours worked less reliable. As a consequence we have only provided the median for all hours worked by Nurse Practitioners.

while more than two-thirds of ENs and AH workers had another job outside of the aged care sector. Around 9 per cent of residential direct care workers with multiple jobs work in community aged care, suggesting transferability of skills between the two sectors.

Table 3.22: Prevalence of multiple job-holding among residential direct care workers, by occupation: 2012 (per cent)

Jobs held	RN	EN	PCA	AH	All occupations
Only have one job	88.1	89.0	89.9	88.1	89.4
Other job in residential aged care	5.5	3.5	4.4	2.5	4.4
Other job in community aged care	0.5	0.6	1.0	1.2	0.9
Other job not in aged care	6.0	7.0	4.7	8.4	5.4
Total	**100**	**100**	**100**	**100**	**100**

Source: Survey of residential aged care workers.

3.2.4 Training

Training is an important element of direct care work. We have already noted that the direct care workforce has a high level of post-school qualifications. Here we report on the training undertaken 'on the job' or to maintain these qualifications (e.g. continuing and professional development [CPD]). We asked workers about their participation in different forms of training and what the purpose of this training was; we also asked them about the areas of training they thought they needed in the next 12 months, and this question was also asked of facilities with respect to the additional training they thought was required for their PCA workforce. These questions were asked for the first time in 2012.

As Table 3.23 shows, the majority of workers had engaged in some form of training or CPD in the past 12 months. Mandatory training was the most common form undertaken, with 76 per cent of the workforce having participated in this type of training. Some differences are noted between occupations, with non-mandatory training being participated in by a higher proportion of RNs than workers in other occupations. The level of engagement in CPD was lower for PCAs than other occupational groups. As Nurses and AH professionals would be expected to engage in CPD as part of their regular professional activities, this result is not surprising.

Table 3.23: Participation in training and/or continuing professional development (CPD) by residential aged care employees in the past 12 months, by occupation: 2012 (per cent)

CPD/Training	RN	EN	PCA	AH	All occupations
CPD	88.0	79.1	49.6	63.4	**60.0**
Training:					
No training	15.9	19.1	19.2	18.1	**18.6**
Mandatory training	75.6	75.7	75.7	73.8	**75.6**
Non-mandatory training	40.8	32.6	21.5	32.9	**26.5**

Source: Survey of residential aged care workers.
Note: Multiple response allowed, columns will not sum to 100

Those workers who did participate in training identified a range of aims that motivated them to do so. High on the list was the aim of developing or improving skills either for their current job or in general.

Another widely nominated aim was to maintain professional/occupational standards, and this was particularly important for RNs and ENs. In addition, more than half of the workers in each occupational category nominated the need to meet accreditation requirements as the purpose of engaging in training.

A less frequently nominated reason for undertaking training was to address safety/health concerns, although this was still viewed as valuable by a quarter of PCAs and ENs. A smaller proportion of the workforce viewed engaging in training as a means to help directly with career development in terms of securing a future job or promotion or to help get started in their job.

Table 3.24: Stated aims of training undertaken by the residential direct care workforce during the last 12 months, by occupation: 2012 (per cent)

Aim of training	RN	EN	PCA	AH
Improve skills in current job	64.3	68.3	71.8	64.4
Develop skills generally	47.8	50.0	47.4	46.7
Maintain professional/ occupational standards	71.2	63.8	53.0	54.5
Meet accreditation requirement	50.9	53.7	53.9	58.8
Safety/health concerns	15.7	17.4	28.6	24.0
Prepare for future job/promotion	10.4	7.3	8.8	7.6
Help get started in job	5.8	2.0	7.4	4.3
Other	7.3	5.2	6.0	6.1

Source: Survey of residential aged care workers.
Note: Multiple response allowed, columns will not sum to 100

In terms of the types of training viewed as most needed (Table 3.25), there was variation between the occupational groups. Workers viewed dementia training, palliative care and wound management as priority areas, although RNs also sought training in management and leadership. The relatively high proportion of workers responding to a number of areas in which training is needed suggests a willingness to engage in such training if it were offered.

If we compare the responses from workers and facilities about the training most needed for PCAs we see they are closely matched in terms of priorities, although the extent to which they were nominated differed. The three areas of training viewed as most needed were dementia training, palliative care and wound management.

Table 3.25: Areas of training identified as most needed in the next 12 months for the residential direct care workforce, by occupation, comparing facility and worker responses: 2012 (per cent)

	RN	EN	PCA		AH
Area of training	Workers	Workers	Workers	Facilities*	Workers
Dementia training	42.2	37.4	52.8	88.3	51.1
Palliative care	45.9	48.6	50.5	73.3	32.7
Management and leadership training	47.0	27.9	19.3	17.9	24.8
Wound management	36.8	52.4	36.4	56.8	7.6
Mental Health	17.1	22.1	28.3	33.3	21.6
Allied health	4.0	8.5	9.3	15.0	29.0
Other	12.3	12.6	10.3	19.5	16.2

Source: Survey of residential aged care workers and Census of residential aged care facilities.
Note: Multiple responses were allowed, columns will not sum to 100
* Facilities were only asked about their training requirements for PCAs

3.3 Career Paths

This section looks at the pathways into and out of aged care jobs, both within the sector and within the current roles of direct care workers. This information provides a picture of the occupational backgrounds of the workforce, when they first considered entering the direct care workforce, how long they have been in the workforce and what their intentions are in the near future. We identify some of the common pathways for different occupations and highlight areas that have changed or may be of interest for future planning.

3.3.1 Into Aged Care

For around 10 per cent of all workers, aged care work is their first occupation, with this being the case for a greater proportion of PCAs and ENs than other workers. Apart from nursing, there is no clear pathway into aged care from other occupations (Table 3.26). With 71 per cent of RNs coming from previous work in health or other care settings, it is clear that they come to aged care after having worked for a portion of their career in the same occupation. While one-third of ENs share this occupational background, over 50 per cent had worked in different occupations before entering aged care. PCAs have the highest proportion of workers who had not previously had paid employment and only 15 per cent had worked in a health or social care setting prior to entering aged care. Just over one-third of PCAs had a background in sales, hospitality, cleaning or clerical work, all of which are female dominated occupations that do not require post-school qualifications. Allied Health workers came to aged care from a range of occupations, with 10 per cent having a professional (other than nurse) background and another 15 per cent having worked in health and social care occupations.

Table 3.26: Activity prior to first job in aged care of the residential direct care workforce, by occupation: 2012 (per cent)

Last occupation before first aged care job	RN	EN	PCA	AH
No previous paid employment	5.8	11.3	13.1	7.5
Nurse, acute care	48.1	17.6	1.6	3.4
Nurse, community	10.3	2.1	1.7	1.3
Other health care	9.4	7.9	3.9	8.8
Carer in other setting	3.2	5.7	7.8	4.1
Salesperson	2.4	5.9	8.3	12.9
Clerical worker	2.2	7.8	8.1	11.1
Hospitality worker	2.5	7.1	10.3	8.5
Cleaner	0.5	3.2	8.8	3.4
Professional (other than nurse)	1.5	4.2	3.5	9.6
Manager	5.8	3.2	2.0	3.1
Other paid employment	8.3	24.1	30.8	26.4
Total	**100**	**100**	**100**	**100**

Source: Survey of residential aged care workers.

As noted above, the majority of direct care workers have worked in other areas prior to entering aged care occupations and this may help explain the relatively high median age (48 years) of the workforce. The age at which workers enter aged care also helps to explain the overall age structure of the workforce and its sustainability over time. If workers are consistently recruited from the older age brackets, then the overall higher median age of the workforce may not be a major issue. Table 3.27 show that 37 per cent of the direct care workforce entered aged care at age 40 years or above, although there is variation between the occupational groups. For PCAs and AH workers, 40 per cent of workers fell into this category, while RNs and

ENs tend to begin working in aged care when they are younger. Of the two nursing occupations, 50 per cent of ENs entered aged care before they were 30 years of age, while around 40 per cent of RNs entered aged care before they were 30 years old. This reflects the educational pathway into aged care for RNs whereby they would complete their education and training in other health sectors before entering aged care.

Table 3.27: Age at which began working in aged care of the residential direct care workforce, by occupation: 2012 (per cent)

Age (years)	RN	EN	PCA	AH	All occupations
21 or under	16.6	28.3	17.4	15.2	**18.4**
22–29	23.7	22.3	15.3	17.7	**17.6**
30–39	28.2	25.4	27.3	27.4	**27.2**
40–49	21.4	18.8	29.3	28.4	**26.8**
50+	10.1	5.2	10.7	11.4	**10.0**
Total	**100**	**100**	**100**	**100**	**100**

Source: Survey of residential aged care workers.

The age at which workers enter aged care has an obvious bearing on the number of years they are able to remain in the workforce. This is reflected in Table 3.28. For example, PCAs, a relatively high proportion of whom start working in aged care at 40 years or above, have the lowest proportion (17%) still in the workforce after 20 years. The picture is different for both RNs and ENs, over 50 per cent of whom have worked in aged care for 15 years or more. Indeed, the information in Table 3.29 suggests that a relatively high proportion of workers are committed to working in aged care, with 58 per cent of the workforce having worked in the sector for 10 years or more.

Table 3.28: Total time spent working in aged care of the residential direct care workforce, by occupation: 2012 (per cent)

Total time in aged care (years)	RN	EN	PCA	AH	All occupations
1 or less	4.8	1.8	9.8	6.6	**7.7**
2–4	2.1	1.3	4.7	2.3	**3.7**
5–9	21.3	22.0	35.4	26.7	**30.7**
10–14	20.8	22.6	22.8	24.1	**22.5**
15–19	15.0	11.7	10.6	14.7	**11.8**
20 or more	36.0	40.5	16.7	25.6	**23.7**
Total	**100**	**100**	**100**	**100**	**100**

Source: Survey of residential aged care workers.

3.3.2 Into their Current Job

While the information provided in the previous section presents a picture of relative stability in the direct care workforce in terms of the commitment to working in aged care, this section focuses more on mobility within the sector. In previous research we have suggested that there is significant 'churn' in the direct care workforce, whereby workers move between employers within aged care rather than leaving aged care *per se*.

Table 3.29 shows that nearly 50 per cent of the direct care workforce had worked in aged care prior to getting their current job. Nurses in particular had moved from one aged care job to another, with 71 per cent of RNs and 63 per cent of ENs having done this. A much lower proportion of PCAs (41%) had worked in aged care before, indicating that a higher proportion would have been recruited from other occupations.

One route into direct care work is to acquire experience through voluntary work, which may be particularly important if a prospective employee had not held a job previously. Of the occupational groups, higher proportions of PCAs (5%) and AH workers (7%) than nurses had done unpaid work in aged care prior to getting their current job.

Table 3.29: Whether had worked in aged care prior to current job of the residential direct care workforce, by occupation: 2012 (per cent)

Whether had previous work in aged care	RN	EN	PCA	AH	All occupations
Yes, paid	71.4	63.1	40.5	53.0	**48.7**
Yes, unpaid	1.0	2.8	5.3	7.2	**4.4**
No	27.7	34.2	54.2	39.9	**46.8**
Total	**100**	**100**	**100**	**100**	**100**

Source: Survey of residential aged care workers.

Not only have many direct care workers been previously employed in other aged care jobs, some had even worked in their current facility prior to getting their current job. Table 3.30 focuses specifically on workers who started working in their current job in the last five years, because this provides information about recruitment patterns for the most recent cohort. While between 15 and 20 per cent of workers had a previous relationship with their current facility, the pattern differs according to occupation. The likelihood of having previously had paid work in their current facility is strongest for RNs (21%), whereas PCAs are likely to have had paid or unpaid work equally (8 per cent each). The findings reinforce the discussion above in which we found that unpaid work is most likely to be done by PCAs and AH workers. This may constitute a significant pathway into aged care for these occupations. Although we cannot differentiate from the data provided, this unpaid work could be from participation in a volunteer position or having a placement as part of a training course.

Table 3.30: Whether had worked in current facility prior to obtaining current job of residential direct care workers employed in the last five years, by occupation: 2012 (per cent)

Whether had previous work in current facility	RN	EN	PCA	AH
Yes, paid	20.6	12.1	8.0	12.1
Yes, unpaid or volunteer	1.3	4.7	8.0	9.5
No	78.1	83.2	84.0	78.4
Total	**100**	**100**	**100**	**100**

Source: Survey of residential aged care workers.
N=4,147 (weighted)

We asked those workers who had worked in aged care previously why they left that job. Understanding the reasons why workers leave one job and move into another within the same sector can provide insights into what may need to change to improve the retention of staff within a facility. Because the present data set combines the information of individual workers with that of their facilities (i.e. it is linked employer–employee data), particularly useful information is available. Table 3.27 indicates that while some of the turnover may be addressed at management level, other reasons are related to the personal circumstances of workers.

Three reasons shown in Table 3.31 related to the personal circumstances of employees (they needed to move house, find work closer to home or fulfil caring responsibilities) and these account for around 40 per cent of the most important reasons given for leaving by PCAs and ENs; 29 per cent by RNs, and 35 per cent by AH workers. As noted in 2007, this reflects the ways in which paid work is embedded in the broader context of family responsibilities and in how household decisions are made about where they live and work.

Other highly cited reasons were related to conditions in the workplace and hence may be amenable to being addressed through staff management. Of these, two reasons stand out as being consistently cited across occupational groups. The first of these is to find more challenging work, which was a particular issue for nurses and AH workers, although 8 per cent of PCAs also sought more challenging work. This could be an indication of there being willingness within the current workforce to upskill themselves and have more variety and greater complexity in their work. The second of these reasons is to get the shifts or hours desired. As discussed previously (Table 3.19), around 45 per cent of direct care workers would prefer a change in their working hours. What the findings reported below suggest is that they are willing to change employers in order to achieve their desired work patterns.

Of the remaining reasons, some were more important for particular occupations. For example, a higher proportion of RNs cited their reasons as not getting along with management (10%), wanting to achieve higher pay (10%) or because the job was too stressful (8%). ENs were more likely to leave because of redundancies and PCAs and AH workers were more likely to cite not having enough time with residents as their reason for leaving. However, these reasons were cited by a relatively low proportion of the workforce.

Table 3.31: Main reason for leaving prior aged care job of residential direct care workers with previous experience in sector, by occupation: 2012 (per cent)

Most important reason	RN	EN	PCA	AH
Moved house/location	17.5	20.5	25.7	21.7
To find more challenging work	10.5	12.3	7.9	14.6
To get shifts or hours of work I wanted	9.9	11.2	13.3	7.5
To avoid managers/management I did not get along with or like	9.9	4.3	4.0	6.6
To achieve higher pay	9.6	4.9	3.6	6.2
To be closer to home	7.9	12.7	10.7	8.8
The job was too stressful	8.0	3.0	3.4	1.8
To fulfil care responsibilities (including having a baby)	3.3	6.5	6.3	5.3
Made redundant/retrenched	2.8	4.5	1.8	1.8
Not able to spend sufficient time with residents	1.6	1.5	3.6	6.2
To avoid workmates/colleagues I did not get along with or like	0.7	0.6	1.8	0.9
To find easier work	0.5	0.4	0.3	0.9
Other	17.8	17.7	17.6	17.7
Total	**100**	**100**	**100**	**100**

Source: Survey of residential aged care workers.
N=3,606 (weighted)

Returning now from those workers who had worked in aged care previously to all direct care workers, Table 3.32 shows the length of time that workers had been in their current jobs. Nearly half of the workforce has worked in their current job for less than 5 years, but there is variation between the occupational groups. A higher proportion of ENs and AH workers have been in the their current job for 10 years or more, while nearly two-thirds of PCAs have been in their job for between 2 and 9 years. Compared with other occupations, a higher proportion of RNs (22%) have been in their job for 1 year or less.

While the 16 per cent who had been in their jobs for less than 12 months seems large it is lower than the average for female workers in Australia generally, which stands at 18 per cent.[6] The 24 per cent of workers who have been in their jobs for 10 years or more is also consistent with the proportion for Australian women in general (ABS, 2010a).

If we compare this table with the findings in Table 3.28 above, we find that although the majority of direct care workers have worked in aged care for 10 years or more, they are likely to have changed jobs during this period. This reinforces the findings from previous years that the issue for employers is not simply recruiting workers into aged care, but keeping them within a particular facility. The level of 'churn' within aged care cannot be accurately estimated because this would require more detailed information about the work histories of individuals. In the next section, however, we look at the intentions of workers as they move into the future, including their intentions to leave their current place of employment.

Table 3.32: Tenure in current job of the residential direct care workforce, by occupation: 2012 (per cent)

Tenure in current job (years)	RN	EN	PCA	AH	All occupations
1 or less	21.5	13.3	15.1	13.4	**15.8**
2–4	31.9	23.5	34.1	28.8	**32.2**
5–9	21.0	25.9	30.7	27.0	**28.4**
10 or more	25.5	37.3	20.1	30.8	**23.5**
Total	**100**	**100**	**100**	**100**	**100**

Source: Survey of residential aged care workers.

3.3.3 Into the Future

We have established above that direct care workers move between jobs for various reasons. In this section we look at what their intentions are as they think about their future in aged care. For the first time in 2012 we asked whether workers were actively seeking work at the time of the survey. Intentions to leave have been found to be significantly correlated with actual turnover (King, Wei, & Howe, forthcoming), so understanding the intentions of the workforce has an important role in thinking about future behaviour. In Table 3.33 we see that 9 per cent of the workforce is actively seeking work, with this being similar across all occupations and the lowest proportion by workers with tenure of 10 years or more (6%). At the other end of the scale, a relatively high proportion of RNs and AH workers who have been with their current employer for 12 months or less are actively seeking work.

6 Although there are slight differences in the time periods for capturing information, the results are broadly comparable and have little impact on the interpretation. Findings not reported here indicate that for 2012, there was 13% of the direct care workforce with tenure of less than one year.

Table 3.33: Proportion of the residential direct care workforce actively seeking work, by occupation and tenure in current job: 2012 (per cent)

	Actively seeking work				
Tenure in current job (years)	RN	EN	PCA	AH	All occupations
1 or less	13.8	11.4	7.9	14.8	**9.9**
2–4	11.7	8.9	10.4	10.3	**10.5**
5–9	6.5	8.6	11.3	10.1	**10.4**
10 or more	6.7	8.4	4.9	4.0	**5.8**
All years	**9.7**	**9.0**	**9.2**	**8.7**	**9.2**

Source: Survey of residential aged care workers.

We also asked workers where they saw themselves working in 12 months from now. As reported in Table 3.34, the vast majority, over 80 per cent, of workers indicated that they expect still to be with their current employer. Of the remaining 19 per cent, about half did not know what they would be doing while half intended to leave. Of all the occupational groups, a higher proportion of RNs expected to leave their current employer.

Just over 5 per cent of all employees indicated they intended to leave aged care, either to work in another sector or to retire from the paid workforce. This constitutes a relatively small proportion of the existing workforce that would be lost to aged care (although a further 10 per cent did not know what they would be doing) and reinforces the view of overall stability in the existing direct care workforce, albeit with some degree of 'churn' for individual facilities.

Table 3.34: Expected activity in 12 months' time of the residential direct care workforce, by occupation: 2012 (per cent)

Expected activity in 12 months	RN	EN	PCA	AH	All occupations
Working in aged care, this facility	77.5	81.9	82.0	84.4	**81.4**
Working in aged care, different facility	5.0	2.1	2.4	2.2	**2.7**
Working in community aged care	0.8	0.3	1.0	1.0	**0.9**
Working, but not in aged care	3.8	5.3	4.2	3.2	**4.2**
Not working for pay	1.1	0.9	0.9	0.7	**0.9**
Don't know	11.9	9.4	9.6	8.4	**9.9**
Total	**100**	**100**	**100**	**100**	**100**

Source: Survey of residential aged care workers.

3.4 Experiences of Working in Residential Aged Care

Findings from the 2003 and 2007 research on the residential direct care workforce challenged the persistent myth that there are high levels of dissatisfaction among care workers and that no-one wants to work in aged care. Subsequent research on the experiences of working in aged care has found that although satisfaction is relatively high, there is room for improvement and that this will have positive effects on employee retention (King et al., forthcoming). In this section we report on what direct care workers think about their work.

Throughout this section, responses to questions were ordered in scale form (i.e. respondents answered on a scale from 1–7 or 1–10). Before discussing the data, several caveats have to be noted. We discuss these in relation to the job satisfaction data (Table 3.35), but the same principles apply to Tables 3.36, 3.38 and 3.39.

First, many of the differences in average satisfaction levels at any point in time between different occupation groups in Table 3.35 are too small to be of statistical significance; hence they should not be over-interpreted. Differences in averages will typically also conceal the more informative differences across the whole distribution of the reported values from 1 to 10. Second, changes in averages over time for any occupation group (i.e. between the 2007 and 2012 data sets) will depend on the characteristics of the workforce being constant over time, which we know not to be the case in all aspects of the data. This is always a problem when comparing single cross-section data sets and can only be satisfactorily handled through the use of multivariate regression. Finally, it should be noted that satisfaction measures are ordinal measures, that is, they tell us if someone likes something more than an alternative, but they do not tell us by how much. This naturally limits the interpretation we can give to responses. More specifically, it means that when we observe two survey respondents, the first who is satisfied enough to be ticking the box with value 4, and the second the box with value 6, this does not mean that the second person is 1.5 times more satisfied than the first person because 6 is 1.5 times higher than 4. It only means that the second person is more satisfied than the first person. The same limitation applies to the same person becoming more satisfied, but this type of comparison is not feasible in our data, because we do not identify individuals over time. The discussion that follows will need to be interpreted according to these caveats and limitations.

3.4.1 Job Satisfaction

Whether a person is satisfied with their work can impact on their health, their willingness to undertake further study or training and their intentions to stay in or leave their job. Equally, a person's health, willingness and ability to undertake further study or training (and other such work-related aspects) can impact on whether they are satisfied with their work. Disentangling the empirical two-way relationships is very complex and what we report here should be interpreted as the net relationship between satisfaction and work-related factors.

We asked direct care workers to indicate their level of satisfaction with different aspects of their work on a scale of 1–10.[7] These are subjective assessments about different aspects of work and, as such, they are relative to the context within which they are made. These relative judgements may take into account, for example, what people might expect to achieve given their personal circumstances or what they think they should get given the alternative work options available to them. Overall, the findings indicate that workers are satisfied with what they do. This is not entirely surprising given that the sample is self-selected, that is, those who are dissatisfied are likely to have moved on to a different job.

In Table 3.35 we show the average scores for employees' responses to each aspect of their work. Information about the distribution of responses is in Appendix C, Tables A1–A9 In general, the distribution shows a similar pattern across aspects of work (apart from pay) and occupations, with the majority of workers selecting options 7–10 on the response scale.

As in 2003 and 2007, total pay stands out as being the area with which workers are least satisfied, with levels of satisfaction for all other aspects of work being relatively high. At 7.9, their overall satisfaction with direct care work has increased steadily since we began measuring this in 2003. We see slight variation between the occupations, with AH workers being somewhat more satisfied overall (8.1) with their work than PCAs (7.9) or

7 Note that the scales for job satisfaction sometimes differ and can be, for example, on a scale of 0–10. All comparisons with 2007 data have been rescaled.

Nurses (7.7). Apart from pay, Nurses are least satisfied with their hours, opportunities to develop abilities and the flexibility to balance work and non-work commitments; AH workers are least satisfied with job security; and PCAs are least satisfied with job security, support from their team, flexibility to balance work and non-work commitments and the match between work and qualifications.

Satisfaction with each aspect of work is discussed below.

Table 3.35: Average scores for responses from the residential direct care workforce, to statements about job satisfaction, by occupation: 2012 (range 1–10)

Satisfaction with	Nurse	PCA	AH	All occupations
1. Total pay	5.6	4.8	5.0	**5.0**
2. Job security	7.7	7.5	7.6	**7.5**
3. The work itself	7.7	7.8	8.3	**7.8**
4. Hours worked	7.5	7.7	8.0	**7.7**
5. Opportunities to develop abilities	7.5	7.6	7.8	**7.6**
6. Level of support from your team/service provider	7.7	7.5	7.9	**7.6**
7. Flexibility to balance work and non-work commitments	7.5	7.5	8.0	**7.5**
8. Match between work and qualifications	7.7	7.5	7.8	**7.6**
9. Overall satisfaction	7.7	7.9	8.1	**7.9**

Source: Survey of residential aged care workers.
Scale used is 1(totally dissatisfied) to 10 (totally satisfied)

1. Total pay. As discussed in Section 3.2.2, the wages that direct care workers receive are widely perceived to be low and this can be exacerbated if workers do not receive the hours of work they require to meet financial commitments. This perception is confirmed by the data, with the only facet of job satisfaction that is obviously lower being that of pay. In 2012, 60 per cent of PCAs expressed dissatisfaction with their total pay as did 57 per cent of AH workers (Table A1). While a significant minority (48%) of Nurses were also dissatisfied with their total pay, for the first time since 2003 more Nurses were satisfied than not. While these responses show an increase in satisfaction with pay since 2007, it remains that a significant proportion of the direct care workforce view pay as a problem and this is an obvious issue for workforce planning and development.

2. Job security. Concerns about job security can relate either to the labour market generally or to a specific position. In terms of the general labour market, direct care workers should feel relatively secure given the strong demand for workers and growth in the sector. As discussed earlier (Table 3.17), about 20 per cent of direct care workers are employed on casual contracts, with the remainder being permanent employees in relatively secure positions. Satisfaction with job security is therefore understandably high across all occupations. There has been little variation since 2007. Nurses and PCAs registered a slight increase in satisfaction, while AH workers were slightly less satisfied with their job security than previously (Table A2). This is the only occupation that registered a decrease in satisfaction across any of the areas of work where opinions were sought.

3. The work itself. Many care workers view what they do as essential, and for some it is a reflection of their professional identity or their perception of themselves as being 'caring' persons. Satisfaction with the actual work is therefore likely to be important to them. Indeed, levels of satisfaction with the work are high, with 85 per cent of all workers being satisfied with their work (Table A3). While all occupations registered an increase in their levels of satisfaction with the work, Nurses' satisfaction has increased the most from 7.3 in 2007 to 7.7 in 2012 (Table A10).

4. Hours worked. We have previously indicated that a significant proportion of workers would prefer to work different hours (Table 3.20). Although the overall satisfaction with hours worked is quite high, 19 per cent of workers expressed dissatisfaction. If we investigate this more closely, we see that 23 per cent of Nurses expressed dissatisfaction, which is possibly associated with the long hours that Nurses are currently working (and their preference to work shorter hours). In contrast, 18 per cent of PCAs expressed dissatisfaction with their hours, and they are likely to want longer hours given the preferences expressed in Table 3.20. There has been no change in satisfaction with hours worked by Nurses or PCAs since 2007.

5. Opportunities to develop abilities. There has been an emphasis on qualifications and training in aged care in recent years, with extra funding being allocated to this area. Although this has been discussed in detail in Section 3.4.1, it is worth noting that not only is satisfaction high in this area but that it increased from 7.2 in 2007, when it was the area in which workers expressed least satisfaction, to 7.6 in 2012 (Table A10). This is the largest increase on any of the individual indicators of satisfaction, apart from overall satisfaction.

6. Level of support. When working under tight time pressure or with people with complex care needs, the level of support provided to workers can influence their effectiveness and confidence. We saw above that, on the whole, workers thought that workplace relationships between themselves and management and their colleagues were good. At 7.6, the average score for satisfaction on the levels of support they receive reflect the previous discussion. There is some variation between occupational groups with PCAs (7.5) registering lower satisfaction than Nurses or AH workers. All occupational groups registered an increase in satisfaction with levels of support since 2007 (Table A10), with Nurses increasing the most, from 7.3 to 7.7. AH workers consistently scored higher on satisfaction on this aspect of their work for both 2007 (7.6) and 2012 (7.9).

7. Flexibility to balance work and non-work commitments. For many workers, especially if they have family or study commitments, the capacity to balance work with other areas of their life is particularly important. A detailed discussion of how workers manage the intersections between work and life is in Section 3.6. Here we focus on workers' satisfaction with their ability to achieve this while working in aged care. The average score of 7.5 suggests that workers are slightly less satisfied with this aspect of their work compared with others. Nevertheless, 80 per cent of all direct care workers indicated some level of satisfaction (Table A7), with a noticeable increase in the proportion of Nurses who are 'totally satisfied', from 15.7 per cent in 2007 to 22.1 per cent in 2012.

8. Match between work and qualifications. Previous research indicates that if there is a mismatch between qualifications and work, skills are under used and workers may be described as over skilled or over educated. This has been shown to have negative implications over and above the job dissatisfaction that it causes, such as reduced wages, increased mobility and lower long-term improvement in job conditions (Healy, Mavromaras, & Sloane, 2012). That the data reveals a high level of matching between the work and the qualifications of direct care workers is a welcome finding, which could in part be attributed to the very specific nature of the job and the training it requires, as well as to the reported good workplace relationships in the sector (among workers themselves and between workers and management).

9. Overall satisfaction. The average score of 7.9 across the occupational groups indicates that direct care workers are generally satisfied with their work. The occupational differences are similar to those in 2007 (Table A10). If we investigate these differences further, we see that average overall satisfaction of AH workers has changed very little over this time. Both PCAs and Nurses have increased their average satisfaction by 0.3 each. However, there is a larger increase in the proportion of Nurses that is 'totally satisfied' with their work overall, going from 14 per cent in 2007 to 19 per cent in 2012; compared with the proportion of PCAs which went from 19 per cent to 22 per cent.

3.4.2 Doing the Work

We asked workers to respond to a series of statements about their work on a scale of 1 (totally disagree) to 7 (totally agree). These statements refer to different aspects of their work, which we discuss below. Table 3.37 reports on the average scores calculated for each statement. The distribution of responses to these statements (i.e. the percentages for each level of response in each statement), used in the discussion, can be found in Appendix C (Tables A11–19).

Table 3.36 reports the average scores from direct care workers regarding what they think about their work and workplace. These subjective evaluations are important indicators of how confident they are in doing their work and what they view as areas that they would like changed. Overall, the highest average scores are in areas relating to skills and training, which receive scores of between 5.7 and 6.3. There is also remarkable consistency across the occupations in the average scores for these statements, with the possible exception of the level of agreement to the statement on 'freedom to decide how to do the work'. Responses to individual statements are discussed below.

Table 3.36: Average scores for responses from the residential direct care workforce to statements about their work, by occupation: 2012 (range 1–7)

Statement	Nurse	PCA	AH	All occupations
1. I am able to spend enough time with each care recipient	3.6	3.8	4.0	**3.8**
2. I have the skills and abilities I need to do my job	6.2	6.3	6.2	**6.3**
3. I use many of my skills and abilities in my current job	5.9	6.2	6.2	**6.1**
4. Adequate training is available through my workplace	5.5	5.8	5.6	**5.7**
5. I have a lot of freedom to decide how to do my work	5.0	4.4	5.3	**4.6**
6. I feel under pressure to work harder in my job	4.3	4.0	3.9	**4.1**
7. My job is more stressful than I had ever imagined	4.2	3.9	3.6	**4.0**
8. Considering all my efforts and achievements I receive the respect and acknowledgement I deserve	5.0	4.8	5.0	**4.9**
9. Management and employees have good relations in my workplace	5.1	4.9	5.0	**5.0**

Source: Survey of residential aged care workers.
Scale used is 1(strongly disagree) to 7 (strongly agree)

1. Time to care. Previous research has shown that direct care workers are often highly committed to care recipients (Martin & King, 2008; Moskos & Martin, 2005). This involves having the time and the skills to improve the well-being of care recipients and provide quality care, which they see as core components of their work. However, care work also involves meeting regulatory requirements, operating according to organisational schedules, and working within budgetary constraints. The relatively low average score of 3.8 for this statement suggests that many workers do not think they have enough time to provide care. If we look at the distribution of responses (Table A11) we see that 45 per cent of care workers disagreed with this statement, consistent across occupations. This is a slight improvement from 2007, when 50 per cent of workers said they did not spend enough time with care recipients.

To investigate this further, we asked workers how much time they spent in direct caring (Table 3.37). While 60 per cent of all workers spent more than two-thirds of their shifts doing direct care, this varied across occupations. Not surprisingly, PCAs spent the most time providing direct care, with nearly three-quarters spending the majority of their shift doing this kind of work. This is a large increase since 2007, when 55 per cent of PCAs spent this much time in direct care. In contrast, the largest proportion (41%) of Nurses spend less than a third of their shift performing direct care. What appears to have occurred with Nurses is that since 2007

the position has polarised, with lower proportions providing care for between one- and two-thirds of their shift. This reflects the increasing managerial role that Nurses, particularly RNs, are performing while ENs (and PCAs) are taking more responsibility for the direct care tasks.

Table 3.37: Responses of the residential direct care workforce to the question "In a typical shift, how much time do you spend in direct caring?" by occupation: 2012 (per cent)

Time spent caring	Nurse	PCA	AH	All occupations
Less than one-third	40.5	6.5	13.8	**16.3**
Between one-third and two-thirds	31.8	19.9	30.4	**23.8**
More than two-thirds	27.7	73.7	55.9	**59.9**
Total	**100**	**100**	**100**	**100**

Source: Survey of residential aged care workers.

2, 3 & 4. Skills, abilities and training. As previously discussed (Section 3.1.7), 90 per cent of the direct care workforce has post-secondary qualifications with the majority holding these in an aged care related field. In addition, around 80 per cent of all workers had taken part in some form of work-related training in the previous years. That workers think they have the skills and abilities to do their work is therefore unsurprising. The distributions of responses to each of the statements are in Tables A12 to A14. These are quite similar to responses in 2007, with a possible increase in skills utilisation. There is general agreement by workers that they receive adequate training, and this is particularly the case for PCAs.

5. Freedom to do the work. Having some freedom in how work is performed provides workers with a sense of control over their work and can influence their levels of motivation and enjoyment in what they do. The average scores for this statement range from 4.4 to 5.3 and indicate discrepancy between the occupations, with Nurses and AH workers having higher scores than PCAs. If we look further (Table A15), we see that Nurses and AH workers are more likely than PCAs to agree strongly that they have a lot of freedom to decide how to their work and a higher proportion of PCAs disagreed with the statement. Given that many Nurses have leadership roles within facilities with PCAs working mainly under their direction, and AH workers (especially AH Professionals) have relative autonomy depending on their field, this finding makes intuitive sense. The responses to this statement were consistent with those given in 2007.

6 & 7. Pressure and stress. Although most jobs have an element of pressure to them and this may contribute to increased productivity, when it is too high or permanent it can lead to stress. For example, we see in Section 3.5 below that of those workers who reported a work-related injury or illness, 21 per cent said it was stress or other type of mental condition (Table 3.41). At first glance the average scores for statements relating to pressure and stress suggest that workers, overall, neither agree nor disagree. However, the distribution of responses to these statements (Tables A16 & A17) show that rather than being neutral, the responses are fairly evenly divided but differ by occupation. For example, half of all Nurses felt under pressure to work harder compared with 42 per cent of PCAs and 39 per cent of AH workers. These results are similar to findings in 2007 which indicates that workers' feeling under pressure in their work is a long-term phenomenon in aged care.

Nurses were also more likely than other workers to indicate their job was more stressful than they imagined. However, since 2007, the proportion of Nurses agreeing with this statement has decreased slightly from 47 per cent to 44 per cent. This is a smaller decrease than for PCAs; the proportion of PCAs agreeing with this statement dropped from 43 per cent in 2007 to 38 per cent in 2012. These decreases may suggest that workers' expectations of stress have increased, or there has been a reduction in the factors relating to the stress. Without further analysis we cannot attach any statistical significance to these differences. Nevertheless,

the responses to this statement suggest that stress may be a serious issue for a substantial minority of direct care workers, with possible consequences regarding their labour market behaviour and outcomes. For example, we saw previously (Table 3.31) that Nurses were more likely than other workers to change their jobs because of stress.

8. Respect and acknowledgement. Feeling valued for work performed is especially important in occupations that are low paid or undertaken with a view to being able to 'make a difference'. Care work falls into this category. With an average score of 4.9 with little difference between the occupational groups, it would seem that workers feel they are receiving some respect and acknowledgement, even if it is not all they think they deserve. The distribution of responses to this question (Table A18) shows that two-thirds of Nurses and AH workers and 60 per cent of PCAs agree with the statement; however 23 per cent of PCAs disagree (compared with around 18 per cent for the other occupations). These findings suggest that PCAs are more likely to think they deserve more respect and acknowledgement than they currently get. If this is combined with dissatisfaction with pay, then the rewards from working in their current job may not be sufficient to retain them in the workforce.

9. Workplace relationships. The quality of the relationship between management and workers in a facility provides insights into the extent to which workers would feel confident in approaching management when issues arise and the perceived level of support they receive from management. The overall average of 5 indicates that the majority of workers think that management and employee relations are relatively good. There is little difference between occupations in the scores and this is further supported by looking at the distribution of responses (Table A19). The only variation of note is between Nurses and PCAs: 69 per cent of Nurses agree with this statement, compared with 63 per cent of PCAs. Some of the difference here may be in the level of management being referred to; for Nurses this is likely to be facility management, whereas for PCAs this is likely to refer to care management (e.g. RNs).

In addition to asking a question about workplace relationships generally, we also asked about the quality of relationships between the worker and management, and the worker and colleagues. Responses to these questions are shown in Tables 3.38 and 3.39. When considering workplace relationships at a personal level, workers are generally very positive with 82 per cent indicating that the relationship between themselves and management is good, and 89 per cent indicating the same for their relationship with colleagues. As with the more general question discussed above, a higher proportion of PCAs than other workers view their relationship with management negatively.

Table 3.38: Residential direct care workforce assessment of the quality of workplace relationships 'between management and yourself', by occupation: 2012 (range 1–7)

	Nurse	PCA	AH	All occupations
Bad	5.3	8.3	3.8	**7.2**
Neither good nor bad	9.1	11.3	10.5	**10.6**
Good	85.4	80.5	85.8	**82.1**
Total	**100**	**100**	**100**	**100**

Source: Survey of residential aged care workers, 2012
Scale used is 1(very bad) to 7 (very good)

Table 3.39: Residential direct care workforce assessment of the quality of workplace relationships 'between workmates/ colleagues and yourself', by occupation: 2012 (range 1–7)

	Nurse	PCA	AH	All occupations
Bad	1.8	4.0	1.5	**3.2**
Neither good nor bad	6.1	8.1	7.9	**7.6**
Good	92.1	88.0	90.4	**89.3**
Total	**100**	**100**	**100**	**100**

Source: Survey of residential aged care workers, 2012

3.4.3 Job Demands

In response to issues raised in the qualitative interviews with workers in 2007 and in line with research conducted in the European Union (Rubery et al., 2011), we asked facilities a series of questions about the prevalence of unusual job demands that may be made of workers. These types of job demand were viewed as stressful by workers during the interviews and we sought to understand the extent to which they are expected of workers throughout the sector.

Responses to these questions are reported in Table 3.40. Of the five unusual job demands listed, facilities are least likely to ask workers to work in very unsanitary conditions, which is not surprising given that this would breach accreditation standards. Fewer than 20 per cent of facilities ask workers to work alone at night after 10 pm, but of those that do this is often a normal requirement of the job.

Of the more prevalent unusual job demands, working with aggressive service users was a normal expectation in 33 per cent of facilities, with another 47 per cent indicating that workers were required to do this in exceptional circumstances. This is likely to be a consequence of the growing number of older Australians with dementia and other mental health problems who are living in facilities. As noted previously (Table 3.25), both workers and facilities recognise the need for training in the areas of dementia and mental health, and this will undoubtedly assist workers when they are required to work with aggressive service users.

The most prevalent job demands are associated with changes in work patterns, either in response to unanticipated needs of residents (91%) or because of management needs to vary hours or location at short notice (86%). The extent to which this impacts on workers' preference for a change in the hours they work is unknown, but given that workers often combine paid work with unpaid caring responsibilities, this may be a factor when considering their future intentions.

Table 3.40: Prevalence of unusual job demands in residential facilities: 2012 (per cent)

Job demand	Under normal circumstances	In exceptional circumstances	Never	Total
Working longer than scheduled due to unanticipated needs of residents	11.0	79.9	9.1	**100**
Variations in hours or location at short notice	13.8	72.3	13.9	**100**
Working in very unsanitary conditions	0.2	4.0	95.8	**100**
Working with aggressive service users	32.6	47.2	20.2	**100**
Working alone late at night (after 10 pm)	14.0	4.0	82.0	**100**

Source: Census of residential aged care facilities.

3.5 Work-related Injury and Illness

Despite the importance of safe work practices and the requirement for mandatory training for staff on a variety of safety issues, there is little available information about the extent of work-related injury or illness in aged care.[8] Ensuring a safe workplace is important for facilities because it reduces the time lost through injury or illness and enables employees to work at optimum levels for the required period of time. In 2012 we extended the number of questions asked about workplace injuries and illnesses in both the census and survey. In this section we report on and compare findings from both sources. It is noted that there are discrepancies between facilities and workers regarding the extent of work-related injuries, but the reasons for this cannot be determined from the available data. Contributing factors might be the different reporting periods, the withdrawal from the workforce of workers who experience work-related injuries, and difficulties in accurately recalling incidents over the designated period.

In Table 3.41 we see that 76 per cent of facilities reported work-related injuries and illnesses in the 3 months prior to the census. Of these, the most commonly reported injuries were sprains/strains (51% of all facilities and 70% of those that reported) and superficial injuries (33% of all facilities and 45% of those that reported), while chronic joint or muscle conditions and cuts/open wounds were each reported by around one-quarter of facilities.

Turning now to the incidents reported by workers in the previous 12 months, we see that 15 per cent of direct care workers had a work-related injury or illness during this period. Again the most commonly reported injuries are sprains/strains (6% of all workers and 45% of those who reported), followed by chronic joint or muscle condition (4% of all workers and 26% of those who reported). However, the next most prevalent work-related injury or illness is stress or other mental condition which is reported by 3 per cent of all workers and 21 per cent of those who reported. This may reflect a wider tendency to under count mental stress in compensation data (Safe Work Australia, 2009), or indicate that incidents of mental stress are clustered in a smaller proportion of workplaces or occur at specific times of year (outside of the reporting period for facilities).

Table 3.41: Types of reported work-related injuries and illnesses, comparing facilities and workers: 2012 (per cent)

Type of injury/illness	Facilities (last 3 months)		Workers (last 12 months)	
	All facilities	With any incidents	All workers	Who reported incidents
None reported	24.0	n/a	84.8	n/a
Fracture	3.9	5.3	0.2	1.7
Chronic joint or muscle condition	21.0	28.5	3.7	26.2
Sprain/strain	51.3	69.7	6.4	45.1
Cut/open wound	18.0	24.4	0.8	5.7
Crushing injury/internal organ damage	1.1	1.5	0.0	0.2
Superficial injury (minor)	33.0	44.8	1.9	13.4
Stress or other mental condition	9.3	12.7	2.9	20.6
Amputation	0.0	0.1	0	0
Burns	12.6	17.1	0.3	1.8
Other	7.2	9.8	2.3	16.5

Source: Census of residential aged care facilities.
Note: Multiple response allowed, totals will not sum to 100

8 Safe Work Australia reports on the workplace injuries and illnesses in the Health and Community Services sector which incorporates aged care, but does not separate it out from other areas (Safe Work Australia, 2009).

Table 3.42 shows the causes of reported work-related injuries and illnesses for facilities and workers. For the 76 per cent of facilities that reported one or more incidents during the previous 3 months, four main causes are evident: lifting, pushing, pulling or bending; hitting, being hit or cut by person, object or vehicle; a fall or repetitive movement.

Again, the pattern of worker responses to this question is quite similar to that of the facilities. The most commonly identified cause was lifting etc., followed by hitting or being hit and falls. For workers, however, exposure to mental stress was the next most commonly reported cause of work-related injury or illness.

Table 3.42: Causes of reported work-related injuries and illnesses, comparing facilities and workers: 2012 (per cent)

Cause of injury/illness	Facilities (last 3 months)		Workers (last 12 months)	
	All facilities	With any incidents	All workers	Who reported incidents
None reported	24.0	n/a	84.8	n/a
Lifting, pushing, pulling, bending	53.0	71.9	6.2	43.3
Repetitive movement	13.6	18.4	0.6	4.3
Prolonged standing, working in cramped or unchanging positions	1.2	1.6	0.2	1.1
Vehicle accident	2.7	3.7	0.1	0.8
Hitting, being hit or cut by person, object or vehicle	27.3	37.1	1.5	10.4
Fall	17.5	23.7	0.9	6.3
Exposure to mental stress	6.7	9.0	0.8	5.9
Long-term exposure to sound	0.0	0.1	0.0	0.0
Contact with chemical or substance	5.0	6.8	0.0	0.3
Fatigue	2.2	2.9	0.2	1.6
Other	15.3	20.7	2.3	15.9

Source: Census of residential aged care facilities.
Note: Multiple response allowed, totals will not sum to 100

One indicator of the seriousness of work-related injuries and illnesses is the extent to which employees are on Workcover. Table 3.43 indicates that 54 per cent of facilities had one or more employees on Workcover during the designated fortnight. This is an increase from 33 per cent in 2007. For each of these facilities, there was an average of 2.2 employees on Workcover. Although 46 per cent of facilities had PCAs on Workcover, the proportion of facilities with workers in any of the other occupational groups was much smaller, between 4 and 9 per cent.

Table 3.43: Proportion of facilities with employees on Workcover (per cent) and, of these, the mean number of employees per facility on Workcover during the designated fortnight: 2012

Occupation	Facilities Utilising Workcover (%)	Employees (average per facility)
Registered Nurse	6.7	1.2
Enrolled Nurse	8.5	1.3
Personal Care Attendant	46.3	2.1
Allied Health	4.2	1.4
All occupations	**53.6**	**2.2**

Source: Census of residential aged care facilities.

3.6 Work and Non-work Responsibilities

This section reports on work–life interference, using the Australian Work and Life Index (AWALI). AWALI measures two dimensions of work–life interference: the impact of work on respondents' capacity to engage satisfactorily in the activities and responsibilities of other spheres of life and the time available to spend on activities outside work.

AWALI measures work–life interference that includes, but is not confined to, work–family issues. Those without children also experience spill over from their working lives onto their relationships, recreation, households, health and well-being, family life and care responsibilities. AWALI also measures the effects of work on community connections. Putting more hours into paid work affects our relationships beyond home, including our capacity to build friendship networks in the broader community, but these are generally not investigated in assessments of work–life interference.

AWALI employs a commonly used single measure of time pressure in daily life (feeling rushed or pressed for time), which is an indirect measure of work–life fit and strain, and it also includes a general assessment of satisfaction with work–life balance.

In sum, AWALI measures perceptions of work–life interference focusing on:

- 'General interference' (frequency with which work interferes with responsibilities or activities outside work)
- 'Time strain' (frequency with which work restricts time with family or friends)
- Work-to-community interference (frequency with which work affects workers' ability to develop or maintain connections and friendships in their local community)
- Satisfaction with overall work–life 'balance'
- Frequency of feeling rushed or pressed for time.

To arrive at the AWALI composite work–life index measure, the five measures of work–life interference are averaged and standardised so that the minimum score on the index is 0 (indicating the lowest work–life interference) and the maximum score is 100 (the highest work–life interference). The five-item work–life index has satisfactory internal consistency (Cronbach's $\alpha = .82$).

In the national AWALI 2012 survey (N=2500 employees), the average (mean) score on the index was 42.8 (Skinner, Hutchinson, & Pocock, 2012), which we use as the most up-to-date national benchmark. Therefore, scores above the average score of around 43 indicate a work–life interference that is worse than average, and scores below this level indicate a better than average work–life relationship.

The national AWALI surveys have been conducted since 2007. Consistent patterns have emerged with regard to the groups most likely to experience high work–life interference, as defined by particular social or employment characteristics. These are:

- Gender
- Parenting status
- Work hours
- Type of employment contract
- Engagement in study.

This report examines how community and residential sector care workers' work–life interference varies by these characteristics. Care workers' scores on the work–life index are also compared with the national average from the AWALI 2012 survey, to examine whether care workers have better or worse work–life outcomes than the Australian average. In these tables, lower numbers equate to lower work–life interference.

Parental status

As Table 3.44 shows, residential workers with children aged under 18 years had higher work–life interference than those without children. This is the case for men and women, with little difference in work–life index scores between men and women regardless of parenting status.

These patterns mirror those observed in the national AWALI survey. Residential workers with children report slightly lower work–life interference than the national average for parents, whereas residential workers without children have work–life index scores comparable to the national average.

The main picture that arises is that people with no children have lower work–life interference and that the difference between those with and without children is lower among direct care workers than it is for the national benchmark (44.6 – 39.5 = 5.1, against 47.7 – 38.9 = 8.8). This holds for both men and women.

Table 3.44: AWALI work–life index scores of the residential direct care workforce and Australian workforce, by gender and parenting status: 2012

	Direct Care Workers	AWALI 2012
	Men	
Child < 18 years	44.0	48.3
No child	38.1	38.1
All	40.0	42.9
	Women	
Child < 18 years	44.7	47.1
No child	39.6	39.8
All	40.9	43.1
	All	
Child < 18 years	44.6	47.7
No child	39.5	38.9
All	40.8	42.8

Source: Survey of residential aged care workers; AWALI 2012

Work hours—part-time and full-time work

Full-time workers in the residential sector report higher work–life interference than part-time workers, and this is the case for men and women (Table 3.45).

Part-time workers in the residential sector, however, report higher work–life interference than the national average for part-timers; whereas full-time workers have lower work–life interference than the national average.

Both male and female part-time workers have lower work–life interference than full-time staff (46.9 – 35.3 = 11.6). We observe in Table 3.45 that although the difference is still present among workers, it is substantially lower (42.4 – 39.6 = 2.8). This reduction applies both to men and women. Importantly, this is the combination

of part-time direct care workers doing worse than their national counterparts (39.6 is worse than 35.3), while simultaneously full-time direct care workers are doing better than their national counterparts (42.4 is better than 46.9). This finding suggests that the divide between full-time and part-time workplace conditions and workforce characteristics is very different within aged care than in the national labour market.

Table 3.45: AWALI work–life index scores of the residential direct care workforce and Australian workforce, by gender and work hours: 2012

	Direct Care Workers	AWALI 2012
	Men	
Part-time	37.6	33.8
Full-time	42.0	45.0
	Women	
Part-time	39.7	36.0
Full-time	42.4	50.7
	All	
Part-time	39.6	35.3
Full-time	42.4	46.9

Source: Survey of residential aged care workers; AWALI 2012

Occupational role and employment contract

Nurses report the highest work–life interference (Table 3.46), with RNs reporting the highest work–life interference of all occupational groups, and higher than the national average for Australian workers. PCAs report the lowest work–life interference, followed by AH workers. The contrast between the index score of each occupational group with every other group is statistically significant.

Work–life interference also varies with employment contract, but to a lesser extent than observed for the community sector workers. Casual direct care workers in residential facilities have lower work–life interference than those on continuous contracts, whereas there are no statistically significant differences between those on fixed term compared with other types of employment contract.

The work–life index scores for workers on the three types of employment contract are comparable to the national average[9] with the exception of those on fixed term contracts, whose work–life outcome are slightly better than the national average of this group (the contrast with casual employees approached statistical significance, $P = .09$).

9 Bonferroni post-hoc tests have been conducted on these contrasts, and all other contrasts of 3+ groups ($P < .05$) where contrast is noted in text.

Table 3.46: AWALI work–life index scores of the residential direct care workforce and Australian workforce, by occupational role and employment contract: 2012

	Direct Care Workers	AWALI 2012
Occupational role		
Registered nurse	49.2	-
Enrolled nurse	42.7	-
Personal care assistant	32.2	-
Allied health worker	35.7	-
Employment contract		
Casual	37.9	35.7
Fixed term	41.1	45.9
Continuous	42.3	44.3

Source: Survey of residential aged care workers; AWALI 2012
Note. '-' indicates data not available from the national AWALI survey.

Participation in education or training

The AWALI 2009 survey (Pocock et al 2009) examined the association between participation in education and training and work-life interference. The AWALI data shows the work-life index scores of respondents who indicated they were studying for a university, vocational education or other type of qualification. Consistent with the patterns observed for workers in the community sector and the national AWALI survey, workers in the residential sector had higher work–life interference if they were currently undertaking study (Table 3.47), and this was the case for men and women.

The work–life index scores for residential workers combining work and study are equivalent to the national average for this group, whereas for those workers who were not studying their work–life interference was lower than the national average.

Table 3.47: AWALI work–life index scores of the residential direct care workforce (2012) and Australian workforce (2009), gender and engagement in study

	Direct Care Workers	AWALI 2009
	Men	
Currently studying	42.1	42.4
Not studying	35.3	42.8
	Women	
Currently studying	42.3	45.5
Not studying	38.4	42.9
	All	
Currently studying	42.3	44.1
Not studying	38.2	42.9

Source: Survey of residential aged care workers; AWALI 2009

3.7 Cultural and Linguistic Diversity

In a multicultural society, having a workforce that is culturally and linguistically diverse is to be expected: around 27 per cent of Australia's population is overseas born and three-quarters of these people are of working age. A further 20 per cent of the population are second generation migrants, some of whom would have spoken a language other than English in their family home (ABS, 2012). Linguistic diversity in a workplace is therefore expected in Australia and can have many benefits, for example in aged care it may mean being able to converse more comfortably with older migrants living in facilities. On the other hand it may also bring challenges in constructing workplaces that are respectful of cultural and linguistic differences. In this section we consider various aspects of being a worker from a culturally and linguistically diverse background in aged care.

In Section 3.1.4 we saw that around one-third of the direct care workforce was born overseas and that a majority of these were from countries in which the primary language was not English. Fluency in a language other than English is a skill held by 30 per cent of the direct care workforce. Of these, a relatively small proportion speaks their primary language more fluently than they do English (Table 3.48). Of the occupational groups, a higher proportion of ENs and AH workers who speak a language other than English are most fluent in English. On the other hand, a higher proportion of RNs and PCAs speak both languages equally well, with a further 13 per cent of RNs and 15 per cent of PCAs being most fluent in their primary language.

Table 3.48: Fluency in a language other than English (LOTE) of the residential direct care workforce, by occupation: 2012 (per cent)

Speak LOTE, most fluent in:	RN	EN	PCA	AH
English	39.5	49.3	37.0	51.5
LOTE	13.1	7.5	14.9	9.9
Both equally well	47.4	43.3	48.0	38.6
Total	**100**	**100**	**100**	**100**

Source: Survey of residential aged care workers.
N= 2,015 (weighted)

Approximately 25 per cent of facilities cater for a specific ethnic or cultural group (see Table 4.7). This provides opportunities for workers with relevant language skills to use these in their work. However, not all residents from a migrant background go to specialised facilities. Workers may therefore use their primary language skills in specialised or non-specialised settings. We found that 31 per cent of direct care workers speak a language other than English in their work.

Table 3.49 shows that of the occupational groups, ENs and AH workers were most likely to speak a language other than English in their work (41 per cent and 51 per cent respectively), however 28 per cent of PCAs and 32 per cent of RNs also use this ability in their jobs. If we place this in the context of the broader direct care workforce, about 15 per cent of all workers speak a language other than English and use it in their work. This is very similar to the results in 2007.

Table 3.49: Use of language other than English (LOTE) of the residential direct care workforce, by occupation: 2012 (per cent)

Speak LOTE and	RN	EN	PCA	AH	All occupations
Use LOTE in job	32.2	40.5	27.8	50.5	30.5
Do not use LOTE in job	67.8	60.3	72.2	49.5	69.5
Total	**100**	**100**	**100**	**100**	**100**

Source: Survey of residential aged care workers.

One of the new questions in the 2012 survey asked workers who spoke a language other than English how well they thought they could speak, read and write in English. Self-assessment provides one indicator of the extent to which workers from linguistically diverse backgrounds can understand instructions and requirements in their workplace. It may also influence whether they will seek assistance to develop their skills in English literacy. In Table 3.50 we focus on workers who identified as being most fluent in a language other than English. Of these workers, nearly all (95%) indicated that they could read in English 'well—very well'. Indeed they also rated their literacy in speaking and writing in English fairly high, although a higher proportion ranked themselves as doing these 'well' rather than 'very well'. Of all three areas, writing was the area in which they rated themselves lowest, with 13 per cent of workers indicating they could not write in English very well.

Table 3.50: Subjective assessment of English literacy for residential direct care workers most fluent in a language other than English (LOTE): 2012 (per cent)

English literacy	Not at all	Not very well	Well	Very well	Can't say	Total
Speaking	0	6.1	66.7	26.2	1.1	**100**
Reading	0	4.3	47.5	47.5	0.7	**100**
Writing	0	13.0	58.6	27.3	1.1	**100**

Source: Survey of residential aged care workers.

In the following tables we turn our attention to PCAs from culturally and linguistically diverse backgrounds. As we saw in Table 3.7, facilities report that the proportion of PCAs from diverse backgrounds is relatively high compared with other occupations in direct care, and there are higher proportions of them that have been in Australia for 5 years or less. In contrast to the information discussed above, the following information is provided by facilities; that is, we are now turning to facilities' perspectives on employing PCAs from culturally and linguistically diverse backgrounds.

Table 3.51 illustrates the extent to which PCAs from diverse backgrounds are distributed among facilities. Very few (13%) facilities employed no PCAs from a culturally and linguistically diverse background. This is quite different to 2007, when about a third of facilities fell into this category. This suggests that more facilities are now employing PCAs from diverse backgrounds. To illustrate this further, the proportion of facilities with more than two-thirds of PCAs coming from culturally and linguistically diverse backgrounds has increased from 11 per cent in 2007 to 25 per cent in 2012. Although the proportion of facilities that specialise in providing services to particular ethnic or cultural groups has increased (see Table 4.7), this is not sufficient to explain the change in distribution of PCAs from diverse backgrounds across facilities.

Table 3.51: Distribution by proportion of personal care attendants (PCAs) from culturally and linguistically diverse backgrounds (CALD) in residential facilities: 2012 (per cent)

% of CALD PCAs per facility	Facilities
Zero	13.3
1–33	40.1
34–66	21.8
67–100	24.8
Total	**100**

Source: Census of residential aged care facilities.

In 2007, we conducted a small qualitative study which indicated that facilities were committed to the principles of cultural and linguistic diversity in the workforce and could see many benefits of this for services. In the 2012 census we asked facilities to identify these benefits in relation to employing PCAs from diverse backgrounds.

As shown in Table 3.52, 97 per cent of facilities said that employing PCAs from culturally and linguistically diverse backgrounds had one or more benefits. Of these benefits, the opportunity to enhance cross-cultural understandings and activities were nominated most frequently. However, nearly 50 per cent of facilities also indicated that employing these PCAs was important for developing networks into particular communities.

Table 3.52: Stated benefits of employing personal care attendants (PCAs) from culturally and linguistically diverse backgrounds in residential facilities: 2012 (per cent)

Benefits	Facilities
No benefits	2.9
Stated benefits	
Enhance cross-cultural understandings	88.7
Offer different cultural activities	67.6
Language (other than English) skills	71.1
Link clients to ethnic communities	48.3
Link facility to ethnic communities	47.6
Other	9.1

Source: Census of residential aged care facilities.
Note: Multiple response allowed, totals will not sum to 100

Facilities that employ PCAs who spoke a language other than English (LOTE) were asked to nominate the most common ethnic or cultural background of those workers. Table 3.53 shows that a high proportion (79%) of residential facilities did employ PCAs from linguistically diverse backgrounds in 2012 and that India and the Philippines are the most common source countries for these PCAs.

When we focus on the facilities in which PCAs who speak a language other than English are present, the results again show widespread engagement of Indian and Filipino workers. In facilities where at least one-third of PCAs are identified as LOTE speakers, approximately 38 per cent of facilities identified Indian as the major background of these workers, and another 15 per cent of facilities identified their background as Filipino. Other less common backgrounds mentioned by these facilities include African, Nepalese and Chinese.

While we saw in Table 3.52 (overleaf) that employing workers from diverse backgrounds has benefits for a facility, the management of a multilingual workforce can also present challenges. We asked facilities to nominate areas in which employing PCAs who speak a language other than English creates difficulties in providing and managing care services. Around 40 per cent of facilities identified at least one area of difficulty (Table 3.54), with the majority of facilities stating a concern about communication, with communication with residents being of greatest concern. Occupational health and safety was an issue for 40 per cent of facilities.

Table 3.53: Proportion of residential facilities that employ personal care attendants (PCAs) from linguistically diverse backgrounds: 2012 (per cent)

Ethnic group	All facilities	Facilities with any PCAs speaking LOTE	Facilities with >33% PCAs speaking LOTE
None	21.0	n/a	n/a
Indian1	24.1	30.7	37.5
Filipino	18.7	23.3	15.1
African	9.5	11.9	12.8
Nepalese	4.6	5.9	10.2
Pacific Islander	4.4	5.5	4.7
Chinese	3.8	4.9	6.1
Italian	2.6	3.3	2.0
Other East European2	1.6	2.0	2.5
Greek	0.9	1.2	1.3
Aboriginal and Torres Strait Islander	0.8	1.0	1.0
German	0.8	1.0	0.2
Other	7.2	9.3	6.6
Total	**100**	**100**	**100**

Source: Census of residential aged care facilities.
1. Includes Hindi and other languages spoken in India and Sri Lanka
2. Includes Croatian, Serbian, Slovenian, Russian, Slovakian, Romanian and Slavic language groups

Table 3.54: Stated difficulties of employing personal care attendants (PCAs) who speak a language other than English in residential facilities: 2012 (per cent)

Difficulties	Facilities
Facilities identifying difficulties	40.2
Stated difficulties	
Occupational health and safety	40.1
Communication with management and/or other staff	72.6
Communication with residents	87.4
Communication with residents' families	73.9
Other—written communication	7.6

Source: Census of residential aged care facilities.
Note: Multiple response allowed, totals will not sum to 100

4. The Census of Residential Facilities

The information in this chapter is based on the census of aged care facilities. All residential facilities were sent a survey (a total of 2,593), and responses were received from 96 per cent or 2,481. Aged care employees work in facilities that differ in significant ways including size, location, internal structure and ownership type. Facilities in this report include facilities funded under the National Aboriginal and Torres Strait Islander Program and Multi-Purpose Services, both of which are offered in rural and remote areas and bring together a range of services in one location. This chapter provides an overview of the key characteristics of facilities and the ways these shape opportunities for working in residential aged care. The discussion moves beyond the employment of PAYG employees to incorporate information about agency, brokered and self-employed direct care workers and the extent to which volunteers provide services in aged care facilities.

In addition to the information we sought from facilities about their characteristics and workforce, we also used administrative data from the Department of Health and Ageing. These data were merged to allow us to examine the relationship between types of facilities and their workforce.

4.1 A Profile of Facilities

Data provided by the Department of Health and Ageing included location, ownership type and the number of high and low care operational places.[10] The Department defines care levels as:

> *High care:* provides people who need almost complete assistance with most activities of daily living with 24 hour care, either by registered nurses, or under the supervision of registered nurses. Nursing care is combined with accommodation; support services (cleaning, laundry and meals; personal care services (help with dressing, eating, toileting, bathing and moving around); and allied health services (such as physiotherapy, occupational therapy, recreational therapy and podiatry). High level care was previously known as 'Nursing Home' care.
>
> *Low care:* is the care which is provided for people who have been assessed by an Aged Care Assessment Team (ACAT or ACAS in Victoria), and need accommodation services such as meals, laundry, room cleaning as well as additional help with personal care, with nursing care provided if required. (DoHA, 2011a)

As Table 4.1 shows, there is no evidence of any significant change in the distribution of the workforce across States/Territories between 2007 and 2012. The picture is similar irrespective of whether we consider the distribution of all PAYG employees or only direct care employees.[11] Although Queensland, SA, WA and Tasmania increased their share of the workforce, the increases range from 0.1 per cent to 0.5 per cent so are relatively small.

10 Operational places are the number of places a facility is funded for and may not reflect the number, or care level, of actual residents.

11 This is not surprising given that direct care employees are a subset of All PAYG employees. Basic information about non-direct care employees is given in Tables 3.4 and 3.19

When compared with ABS data collected in 2011 (ABS, 2011b), the distribution of the direct care workforce by State/Territory is roughly proportional to the distribution of the Australian population. According to this ABS data, the largest Australian States by population were NSW, Victoria and Queensland. In the same order, these three States also have the highest numbers of direct care workers.

Among the smaller states, the proportion of direct care workers located in South Australia is higher than the State's share of total population, while the opposite is true for Western Australia. This reflects differences in the age composition of the two populations. According to the ABS demographic data used above, 7.7 per cent of South Australia's population was aged 75 years or older in 2011, while the comparable proportion in Western Australia was 5.4 per cent. Overall, the direct care workforce appears to be distributed across the States and Territories in the proportions that would be expected based on population patterns, including the distribution of the population of older Australians.

Direct comparison of the distribution of the workforce by geographical location between 2007 and 2012 is not possible because of a change in the reporting of this data. In 2007, the Rural, Remote, Metropolitan Area (RRMA) classification was used, whereas in 2012 the information was categorised according to the Accessibility Remoteness Index of Australia (ARIA). In 2012, approximately two-thirds of direct care workers are located in metropolitan areas, one-quarter in Inner Regional areas, and just over 1 per cent of workers in Remote or Very Remote areas.

When examined by facility ownership type, direct care workers are found predominantly in not-for-profit facilities. However, the overall importance of the not-for-profit sector as a share of total employment has been in gradual decline since 2003. Approximately 56 per cent of direct care employees worked in not-for-profit facilities in 2012, compared with approximately 62 per cent in 2003. The corollary of this reduction has been a steady increase in the proportion of direct care workers employed in for-profit facilities.

Finally, our data show a strong shift since 2007 away from employment of direct care workers in facilities that are exclusively high or low care, and towards employment in facilities that have a mixture of high and low care places. In 2012, over half of the direct care workforce was employed in mixed-care facilities.

There are two possible explanations for the marked change in the proportion of the workforce employed by different facility types. One possibility is that the shift in policy toward ageing in place, whereby 'low care' is increasingly provided in the private homes of older Australians and when people do enter aged care facilities they are able to stay in the one place even if their needs change. In 2007–08, for example, a much higher proportion of government funding went into high care places than previously (Australian Institute of Health and Welfare, 2010). The other possibility is that in 2012 a higher proportion of facilities identified as being co-located (i.e. where a high care facility and low care facility operate from the same location) than in previous surveys.

Table 4.1: Distribution of residential direct care workforce (per cent) by State/Territory, location, ownership type and facility type: 2003, 2007 and 2012

		All PAYG employees			Direct care employees		
		2003	2007	2012	2003	2007	2012
State/Territory	ACT	1.5	0.9	1.0	1.5	0.9	1.0
	NSW	31.2	31.6	30.6	32.1	31.8	31.0
	Victoria	30.4	27.9	27.6	29.4	28.6	27.8
	Queensland	16.1	18.0	18.5	15.8	17.4	17.7
	SA	9.3	9.9	10.4	9.7	9.9	10.4
	WA	7.6	7.9	8.2	7.8	8.0	8.6
	Tasmania	3.6	3.4	3.5	3.1	3.0	3.2
	NT	0.3	0.4	0.3	0.4	0.4	0.3
Location*	Major cities			64.0			65.6
	Inner Regional			24.9			23.9
	Outer Regional			9.9			9.3
	Remote			0.8			0.8
	Very Remote			0.4			0.4
Ownership Type	Not-for-profit	64.5	60.0	56.8	61.6	58.4	55.7
	For-profit	26.1	31.4	34.1	28.9	33.0	35.3
	Public	9.4	8.6	9.0	9.5	8.6	8.9
Facility type (places)	Low care places only		30.0	19.0		28.4	18.4
	High care places only		41.2	24.3		42.9	25.2
	High and low care places		28.7	56.7		28.7	56.4

Source: Census of residential aged care facilities.
* Direct comparison of location with previous years is not possible due to change in categories provided

A further breakdown of the changes in care level between 2007 and 2012 is shown in Table 4.2. Here we see that the proportion of *facilities* offering a mixture of high and low care places increased between 2007 and 2012. This is consistent with the results in Table 4.1 showing an increase in the proportion of direct care workers in mixed-care facilities. There has been a correspondingly sharp reduction in the proportion of all facilities that are exclusively low care. For example, between 2007 and 2012, the proportion of facilities with zero high care places fell from approximately 45 to 32 per cent. There has also been a reduction in the proportion of facilities that are exclusively high care, but it has not been so marked. Between 2007 and 2012, the proportion of facilities with zero low care places fell from approximately 35 per cent to 25 per cent.

Apart from the trend towards more facilities offering a mixture of high and low care places, there has also been an expansion in the proportion of facilities that are large when measured by their total number of places. Over half of facilities (52%) had more than 60 places in 2012, whereas the comparable proportion for 2007 was just 35 per cent. Some 22 per cent of facilities had more than 60 high care places in 2012. As indicated above, these findings can be partially explained by changes in how the data was collected (i.e. from co-located facilities); and changes in government policy during this period. It is also likely that small facilities have continued to consolidate or expand in response to funding pressures and economies of scale.

Table 4.2: Distribution of residential facilities (per cent) by number of operational places and care level: 2007 and 2012

Number of places	High care		Low care		All care levels	
	2007	2012	2007	2012	2007	2012
Zero	44.5	31.7	35.1	24.9	0	0
1–20	6.2	9.4	10.8	11.8	7.4	5.7
21–40	18.1	18.1	19.9	20.7	26.7	17.2
41–60	15.6	18.4	20.6	23.7	30.9	24.9
61+	15.6	22.3	13.6	18.9	35.0	52.3

Source: Census of residential aged care facilities.

We now look at the distribution of residential aged care *operational places*, as distinct from the distribution of workers or facilities. In Table 4.3, we see that the majority of residential aged care operational places (57%) were found in mixed-care facilities. The remaining operational places were distributed roughly equally between facilities offering only low care and facilities offering only high-care places.

Differences in the distribution of operational places within each state are small. Queensland and Tasmania have relatively high proportions of operational places in mixed-care facilities, but in all States and Territories except the Northern Territory, the majority of operational places are found in mixed-care facilities. In NT, the proportion is 45 per cent. The Australian Capital Territory is the only jurisdiction in which the proportion of places found in low-care facilities is significantly higher than the proportion found in high-care facilities. It should be noted, however, that in both of the Territories the small number of observations can exaggerate proportional differences.

Variations in the distribution of operational places by remoteness area are also small. Outer Regional areas are more likely than Metropolitan and Inner Regional areas to have places in low care only facilities.

There are more noticeable differences when comparing between facility ownership types. Places in not-for-profit facilities are much more likely to be low care only, whereas for-profit and publicly owned facilities are much more likely to have places that are exclusively high care.

Table 4.3: Distribution of residential aged care operational places (per cent) by care level in 2012

		Low care only	High care only	Mixed*
All facilities		22.1	20.9	57.0
State/Territory	ACT	31.5	14.7	53.8
	NSW	25.5	24.1	50.4
	Victoria	22.5	20.9	56.6
	Queensland	15.3	16.0	68.7
	SA	19.6	25.1	55.3
	WA	27.8	17.8	54.4
	Tasmania	5.6	10.2	84.3
	NT	23.8	31.2	44.9
Location	Major cities	21.2	23.3	55.5
	Inner Regional	23.1	15.4	61.5
	Outer Regional	27.4	19.0	53.6
	Remote	33.9	20.6	45.4
	Very Remote	17.9	5.7	76.4
Ownership Type	Not-for-profit	30.8	8.5	60.8
	For-profit	8.5	37.1	54.4
	Public	20.6	46.3	33.1

Source: Census of residential aged care facilities.
* Mixed care is where a facility has both high and low care places

Table 4.4 shows estimated staffing ratios in 2012. For each group of facilities, the figure is obtained by dividing the total number of direct care workers by the total number of operational places. For instance, the top row of the table shows that, in low care only facilities, the average number of direct care workers to places is 0.6 while for high care only facilities, the average number of direct care workers to places is 0.9. This is as we would expect given the higher care needs of residents in high care facilities. Across all residential facilities, the average staffing ratio was 0.8 direct care workers to places. This is the same ratio as that in facilities offering both high and low care (which are the majority of facilities).

There is minimal variation in these ratios between the mainland States and Territories, and while Tasmania appears to have higher staffing ratios than other jurisdictions, these differences should be interpreted with caution because of the relatively small number of facilities in Tasmania.

Staffing ratios differ slightly according to facility location. On average, staffing ratios in Metropolitan areas are lower than in Inner Regional areas and Outer Regional areas. These differences are apparent irrespective of whether the facilities offer low care only, high care only, or mixed care.

There are also differences according to facility ownership type. Staffing ratios in not-for-profit facilities are lower than in for-profit facilities, which in turn are lower than in public facilities. The results indicate that, on average, public facilities had one direct care worker per operational place in 2012.

Table 4.4: Mean ratio of residential direct care workers to operational places in 2012, by facility care level, State/Territory, location and facility type

		Low care only	High care only	Mixed	All care levels
All facilities		0.6	0.9	0.8	0.8
State/Territory	ACT	0.7	0.9	0.8	0.7
	NSW	0.6	0.8	0.7	0.7
	Victoria	0.7	1.0	0.8	0.8
	Queensland	0.7	0.9	0.7	0.8
	SA	0.7	0.9	0.8	0.8
	WA	0.7	0.9	0.8	0.8
	Tasmania	1.7	1.4	0.9	1.0
	NT	0.7	0.8	0.8	0.8
Location	Major cities	0.6	0.9	0.7	0.7
	Inner Regional	0.7	1.0	0.8	0.8
	Outer Regional	0.8	1.3	0.8	0.9
	Remote	0.7	1.3	0.8	0.9
	Very Remote	0.8	1.6	1.1	1.1
Ownership Type	Not-for-profit	0.6	1.0	0.8	0.7
	For-profit	0.6	0.8	0.7	0.8
	Public	**0.8**	**1.2**	**1.0**	**1.0**

Source: Census of residential aged care facilities.

4.2 Facilities' Relationships with Broader Aged Care Services

Many residential facilities have connections to the wider sphere of aged care service provision. We asked facilities to respond to the survey as a single entity that provided residential aged care services from one location. As we can see from Table 4.5, this does not reflect the true structure of the majority of facilities. Just over three-quarters of all facilities belong to a larger organisational/provider group, with this proportion being higher among facilities managed by not-for-profit and for-profit providers. Overall, this represents a small increase since 2007, when 73 per cent of facilities were part of a larger group.

Some residential facilities also provide community aged care services from the same location. In 2012, only 12 per cent of facilities provided both kinds of care services, a decrease from 13.3 per cent in 2007. As we can see, the proportion of facilities providing community aged care varies widely by ownership type with only 3 per cent of for-profit facilities offering these services.

Table 4.5: Proportion of residential facilities that are part of larger provider group or provide community aged care (per cent), by ownership type: 2012

	Not-for-profit	For-profit	Public	All facilities
Part of larger provider group	77.3	76.7	71.1	**76.4**
Providing community aged care	14.4	3.4	20.8	**11.7**

Source: Census of residential aged care facilities.

Facilities that do provide community aged care need to allocate employees to cover these services. Table 4.6 illustrates the proportions of staff in each of three major occupations that are working in community aged care, that is, workers who divide their time between residential and community aged care. Around 12 per cent of direct care workers in residential facilities also worked in community aged care. Across all facilities that provided some community aged care in 2012, Allied Health workers were more likely to be providing this care (27%) than Nurses (12%) or PCAs (10%). This difference is apparent across each of the facility ownership types. Public facilities had a higher proportion of their workforce that worked in both residential and community aged care (19%) compared with other ownership types.

Table 4.6: Proportion of residential aged care employees that work in both residential and community aged care (per cent), in facilities that provide some community aged care, by ownership type: 2012

Occupation	Not-for-profit	For-profit	Public	All facilities
Nurse	8.6	13.9	21.2	**12.2**
PCA	9.4	17.2	9.8	**10.2**
Allied Health	23.1	36.7	46.2	**27.0**
All occupations	**10.1**	**16.9**	**19.1**	**11.7**

Source: Census of residential aged care facilities.
N=305 facilities (weighted)

4.3 Ethnic Specialisation

With the number of older Australians from culturally and linguistically diverse backgrounds projected to increase by over 40 per cent in the next 15 years (DoHA, 2012a), the capacity to meet their care needs is a topical issue. The extent to which facilities have an ethnic specialisation and the groups for whom they cater are shown below.

The first column of Table 4.7 shows that just over one-quarter of residential facilities catered for a specific ethnic or cultural group in 2012. This represents a steady increase, from 17 per cent in 2007 and 10 per cent in 2003, and demonstrates the increasing demand for aged care services that are sensitive to ethnic and cultural needs.

Among the facilities that did have a specific ethnic or cultural specialisation, residents from a Polish background were most frequently catered for (32% of these facilities), followed by Italians (20%) and Aboriginal Australians (13%). The range of specialisations among facilities that have a specific ethnic or cultural focus is quite wide, with 25 per cent of these facilities catering to ethnic or cultural groups that are not separately listed.

Table 4.7: Residential facilities that cater for specific ethnic or cultural groups (per cent): 2012

Ethnic group	All facilities	% among facilities that specialise
None	74.5	n/a
Polish	8.0	31.7
Italian	5.0	19.8
Aboriginal	3.2	12.5
Chinese	1.5	6.1
Greek	1.2	4.9
Other	6.5	24.8
Total	**100**	**100**

Source: Census of residential aged care facilities.

4.4 Skill Shortages

As the demand for aged care services expands there is the possibility of new or deepening skill shortages for direct care workers. We asked residential facilities various questions about the incidence of skill shortages across key occupations, what factors caused these shortages (where they were present), and how facilities responded to them. The skill shortages (causes and responses) questions we used were shaped to resemble closely those of the Business Longitudinal Data (BLD) survey of the ABS, which surveyed small to medium sized firms in Australia initially from 2005 to 2007 (see Healy et al., 2012) and subsequently in 2008–2009. The similarity in the questions was intentional in order to allow for statistical comparisons between the aged care sector and the broader Australian national benchmark offered by the BLD.

Table 4.8 reports the incidence of skill shortages among residential facilities in 2012. A minority of facilities (24%) said they had no skill shortages. Around three-quarters of facilities therefore had shortages of workers in at least one direct care occupation.

Of these occupations, it is evident that shortages of RNs were the most common (reported by 62% of all facilities), followed by PCA shortages (49% of all facilities). Facilities generally had less difficulty finding the required numbers of Allied Health workers. In further analysis (not reported here) it was revealed that although many facilities faced skill shortages for one occupation in 2012, very few (0.4%) faced shortages in *all* these occupations.

To explore regional variations in skill shortage prevalence, Table 4.8 also shows separate results by facility location. There is some evidence that skill shortages are more prevalent in Regional and Remote areas. At one level this finding makes intuitive sense, given the lower populations in these areas from which to recruit workers. However, we will always need to bear in mind that the small number of respondents from Remote and Very Remote locations may skew findings based on proportions.

Table: 4.8: Proportion of residential facilities reporting skill shortages in 2012 (per cent), by location and occupation affected

Whether had skill shortage	Major cities	Inner regional	Outer regional	Remote	Very remote	All facilities
No	24.1	24.1	25.3	8.1	9.5	**23.9**
Yes	75.9	75.9	74.7	91.9	90.5	**76.1**
Yes, for:						
RN	62.2	63.8	62.3	70.3	42.9	**62.5**
EN	32.7	32.9	34.9	48.6	28.6	**33.2**
PCA	49.1	42.9	53.1	78.4	76.2	**48.7**
AH	19.5	18.2	21.6	18.9	9.5	**19.4**

Source: Census of residential aged care facilities.
Note: Multiple responses allowed, columns do not sum to 100

Facilities that reported skill shortages were asked what factors were responsible for it. Facilities could select more than one of the response options on the questionnaire, and could also nominate other factors not listed.

Facilities gave quite diverse responses about the reasons for their skill shortages (Table 4.9). No single reason stood out as being the most important above all others. The most frequently reported causes by facilities with skill shortages (in any occupation) were the specialist knowledge required to do the work (35% of facilities with skill shortages), the geographical location of the facility (also 35%), and slow recruitment processes (33%).

The analysis was then repeated separately for facilities that reported shortages for RNs and for PCAs. The results are similar to those already reported, with specialist knowledge, geographical location and slow recruitment being nominated as the main reasons for both RN and PCA skill shortages. One small difference is that facilities with PCA shortages were somewhat more likely to identify a 'lack of availability of adequate training' as a reason for the shortage (25%) than the facilities with RN shortages (19%).

Table 4.9: Proportion of residential facilities with skill shortages in 2012 that nominated each cause of that shortage (per cent), by occupation affected

	Facilities that reported skill shortages		
Cause of skill shortage	For any occupation	For RNs	For PCAs
Specialist knowledge required	35.3	38.4	36.8
Geographical location of facility	34.5	36.2	36.3
Wages or salary costs too high	16.1	18.0	17.0
Lack of availability of adequate training	20.2	18.9	24.8
Unsure of long term demands for service	4.9	4.4	6.0
Recruitment too slow	32.8	32.6	38.2
Aged care not attractive	5.0	5.5	4.4
Leave/sick or maternity leave	1.2	1.0	1.0
No suitable applicants	9.8	9.9	11.0
Shortage of (experienced) nurses/RNs	4.7	5.5	3.1
Other	6.7	6.7	7.3

Source: Census of residential aged care facilities.
Note: Multiple responses allowed, columns do not sum to 100
N=2,004 facilities (weighted)

The final part of this analysis investigates the responses taken by facilities to skill shortages in 2012. What strategies did the affected facilities employ, and did their approaches differ depending on the occupational group in which the skill shortage occurred?

In contrast to the causes of skill shortages, where there is no dominant factor, Table 4.10 indicates that there are some *responses* to skill shortages that are very widely used by residential facilities. The most common of these is to have existing staff work longer hours to cover the skill shortage. Well over half (63%) of facilities that reported skill shortages said that they took this response. This is a relatively common response across industries, with a similar result being found in an earlier and wider study of Australian skill shortages (Healy et al., 2012).

In addition to asking existing workers to increase their hours on the job, a majority of facilities with skill shortages (53%) made greater use of agency staff. The next most common response (used by 44% of facilities with skill shortages) was to offer on-the-job training to existing staff, with the aim of increasing their proficiency and skill. We note that in addition to on-the-job training, some 23 per cent of facilities with skill shortages increased their use of external training programs.

When we look separately at the types of responses taken by facilities with specific RN and PCA skill shortages, again we find few substantive differences from the overall picture. One exception is that PCA skill shortages are more likely to be countered by on-the-job training (50%) than RN skill shortages (41%).

Table 4.10: Proportion of residential facilities with skill shortages in 2012 that nominated each response to that shortage (per cent), by occupation affected

	Facilities that reported skill shortages		
Response to skill shortage	**For any occupation**	**For RNs**	**For PCAs**
External training of staff	23.4	23.7	27.4
On-the-job training of staff	43.7	42.1	50.8
Existing workforce worked longer hours	63.3	65.2	69.4
Greater use of agency staff	53.2	58.6	55.8
Sub-contracted or outsourced services	6.1	6.7	6.6
Employed staff on short term contracts	16.0	16.7	16.6
Wages, salaries and/or conditions increased	15.3	16.3	17.3
Reduced outputs or production	3.6	3.7	3.5
Overseas recruitment	2.0	2.5	1.3
Recruitment/advertising	3.4	3.7	3.6
Work short staffed	0.2	0.3	0.2
Other	2.1	2.1	1.7

Source: Census of residential aged care facilities.
Note: Multiple responses allowed, columns do not sum to 100

4.5 Vacancies

The number and types of vacancy are important indicators of the adequacy of the current labour supply to residential facilities. Reports on the aged care workforce in recent years have consistently stressed the difficulties in recruitment and the need to attract people into the sector (Productivity Commission, 2011). We asked facilities to report how many vacancies they had for employees in each occupational classification at the time of responding our questionnaire.

Table 4.11 uses the facilities' responses in two ways. Panel 1 of the Table shows vacancy rates by occupation. These are calculated as the proportion of facilities that said they had any vacancies for that occupation at the time of the survey. Vacancies are quite widely reported in 2012, especially for PCAs (36%) and RNs (33%). Vacancies in Allied Health occupations were much less common, being reported by approximately 9 per cent of facilities.

The proportion of facilities with vacancies has been increasing since 2003, although the increase between 2007 and 2012 was smaller than between 2003 and 2007 across all occupations. This increase has been most pronounced for PCAs, which are the largest group of workers. Despite the reduction in the size of the increase in vacancy rates for RNs, this needs to be placed in the context of there being fewer RNs in the workforce and suggests that the recruitment of RNs remains difficult.

Panel 2 of Table 4.11 shows the mean number of vacancies reported by facilities that had any vacancies in Panel 1. The calculations exclude the facilities that did not report any vacancies for a particular employee classification. Where facilities do have vacancies, they also report a higher number of vacancies for PCAs than for other types of employees. Measured in terms of equivalent full-time (FTE) vacancies, the mean number of unfilled positions for PCAs was 3.6 compared with 2.2 for Enrolled Nurses, 1.7 for Registered Nurses and 1.0 for Allied Health professionals. These results emphasise the point that, because there are so many PCAs, their turnover creates more vacancies. This means that facilities with vacancies often need multiple Personal Care Attendants to fill their staffing needs.

There is little change in these results if we use the headcount measure of vacancies in place of the FTE measure (not reported).

Table 4.11: Vacancy rate (per cent of all residential facilities) and mean number of vacancies (in facilities with vacancies), by occupation: 2003, 2007 and 2012

	Full-Time Equivalent		
	2003	**2007**	**2012**
Panel 1: % of facilities with any vacancies			
Registered Nurse	25.7	31.3	32.7
Enrolled Nurse	10.8	17.7	18.7
Personal Care Attendant	23.3	31.4	36.4
Allied Health	6.3	6.7	8.8
Panel 2: Mean number of vacancies in facilities with any vacancies			
Registered Nurse	n/a	n/a	1.7
Enrolled Nurse	n/a	n/a	2.2
Personal Care Attendant	n/a	n/a	3.6
Allied Health	n/a	n/a	1.0

Source: Census of residential aged care facilities.

Probably the most reliable way to directly assess shortages for residential aged workers is by looking at the time that facilities take to fill their advertised vacancies for different employee classifications. Tables 4.13 and 4.14 examine vacancy duration (measured in weeks) with reference to the *most recent* vacancy that facilities advertised. (We asked only about recent vacancies to minimise respondent recall errors.)

In Table 4.12, vacancy duration is divided into categories (e.g., 3–4 weeks) and the proportion of facilities in each category is reported for each employee classification. For instance, 33.9 per cent of facilities took less than one week to fill their most recent vacancy for RNs, and 52.5 per cent took less than one week to fill their most recent vacancy for ENs.

These results suggest that residential facilities are able to fill their vacancies for ENs and AH occupations more quickly than they are able to fill their vacancies for RNs and PCAs. For example, just over half of recent vacancies for ENs, and over two-thirds of recent vacancies for AH occupations, were filled within one week. By contrast, only one-third of recent vacancies for RNs and PCA vacancies were filled within one week. When compared with 2007, facilities are now filling vacancies in a shorter period of time across all occupations.

Based on the 2012 findings, RN vacancies are still somewhat harder for facilities to fill than vacancies for PCAs. Around 30 per cent of RN vacancies, compared with only 14 per cent of PCA vacancies, took more than four weeks to fill. Despite these findings, it seems that this is an improvement since 2007 when 38 per cent of facilities took longer than four weeks to fill RN vacancies.

Table 4.12: Weeks required for residential facilities to fill most recent vacancy, by occupation: 2012 (per cent)

% of facilities that took	RN	EN	PCA	AH	All occupations
Less than 1 week	33.9	52.5	33.7	71.1	**25.6**
1 week	7.9	6.6	15.7	5.5	**11.1**
2 weeks	11.5	9.8	20.3	5.5	**12.1**
3 to 4 weeks	16.8	14.0	16.7	8.2	**18.8**
5 to 8 weeks	15.3	8.6	7.5	3.7	**15.2**
9 to 12 weeks	6.0	4.2	2.7	2.8	**5.3**
13 to 26 weeks	4.3	2.4	1.7	1.8	**4.9**
More than 26 weeks	4.2	2.0	1.7	1.4	**3.3**

Source: Census of residential aged care facilities.
N=1,566 facilities (weighted)

The relative difficulty of recruiting RNs is further demonstrated in Table 4.13. This Table shows the estimated mean (average) duration of the most recent vacancies reported by facilities for RNs and PCAs. The mean statistic is calculated separately for facilities by State/Territory and geographical location.

On average across all facilities, recent vacancies for PCAs took about half as long to fill (3.2 weeks) as recent vacancies for RNs (7.0 weeks).

There are some differences between States/Territories, and between locations, in the average time taken to fill vacancies. Table 4.13 suggests that facilities in Victoria take longer than average (8.4 weeks) to recruit RNs, while facilities in South Australia take much less time (4.8 weeks). In recruiting PCAs, facilities in Western Australia and the Northern Territory take longer than average at 4.4 and 5.9 weeks respectively, while facilities in Tasmania take only 1.9 weeks.

Perhaps not surprisingly, facilities located in Remote and Very Remote areas take much longer on average to fill their vacancies than facilities located in Major Cities and Inner Regional areas. The recruitment difficulties encountered by more remotely located facilities are much more readily apparent with reference to vacancies for RNs than for PCAs.

Although not reported in the table, we also estimated the median vacancy duration, because in some cases there are extreme values at the upper end of the distribution that skew the mean statistic. Across all facilities, the median vacancy duration for RNs is 2 weeks (compared with a mean of 7.0 weeks) and the median vacancy duration for PCAs is 2 weeks (compared with a mean of 3.2 weeks). This suggests that there are a small number of facilities that take a relatively long time to fill vacancies, but that the 'normal' facility can expect to recruit RNs and PCAs within 2 to 4 weeks.

Table 4.13: Average vacancy duration (weeks) for RNs and PCAs, by State/Territory and location: 2012

		RN	PCA
All facilities		7.0	3.2
State/Territory	ACT	6.3	3.7
	NSW	6.9	3.2
	Victoria	8.4	2.8
	Queensland	6.5	2.8
	SA	4.8	3.5
	WA	6.6	4.4
	Tasmania	5.4	1.9
	NT	5.2	5.92
Location	Major cities	6.9	3.1
	Inner Regional	6.0	3.4
	Outer Regional	8.0	3.2
	Remote	15.2	4.5
	Very Remote	12.6	5.1

Source: Census of residential aged care facilities.

Table 4.14 examines the causes of vacancies. It shows the proportions of facilities selecting each of several reasons for their most recent vacancy, where multiple responses are permitted. Separate figures are shown in relation to facilities' most recent vacancies for RNs, PCAs and all employees (irrespective of occupation).

By far the most common reason that residential facilities give for their vacancies is the resignation of staff. Around 80 per cent of all facilities saw this as a reason for their most recent vacancy and it was also the most common reason when asked specifically about RNs and PCAs.

Other important reasons that facilities give for their most recent vacancies are the creation of a new position (37%) and retirement of staff (25%). These reflect the nature of the direct care workforce in that it is expanding rapidly, and has an age demographic that makes retirement a common occurrence.

In 2007 we indicated that facilities underestimated the extent to which they filled vacancies through informal means such as walk-ins and word of mouth. Although our categories changed slightly in the 2012 surveys, there is still evidence to suggest that while employers rely on formal recruitment methods, employees favour a more informal approach.

Table 4.15 looks at the methods used by facilities to recruit PCAs and those used by workers employed for 12 months or less to find employment opportunities. We compare the workers' and facilities' approaches, based on responses to their respective questionnaires.

The largest proportion of facilities (30%) said that they would use a combination of internet and newspaper advertising to recruit new PCAs. Another 31 per cent of facilities said they would use each of these (internet and newspaper advertisement) methods on their own. While these were not the favoured methods for workers to find out about employment opportunities, they were certainly important sources of information, with around one-quarter of all nurses and AH workers using these methods. For workers, the most common source of information about jobs was word of mouth, with over a third of all recent hires using this method. For PCAs it was particularly important (42%), especially as they are less likely to utilise the internet in their job search strategy.

The findings also indicate that agency services are very rarely the first option for facilities looking to hire additional PCAs.

Table 4.14: Proportion of residential facilities giving each reason for their most recent vacancy (per cent), by occupation: 2012

% of facilities stating	RN	PCA	All occupations
New position	20.3	15.2	**36.5**
Retirement	22.0	25.0	**25.3**
Injury/illness	3.4	0.8	**10.2**
Resignation	50.8	63.6	**80.7**
End of contract	1.7	1.5	**5.2**
Involuntary separation	5.1	4.5	**8.0**
Other	11.9	17.4	**41.6**

Source: Census of residential aged care facilities.
Note: Multiple response allowed, columns will not sum to 100

Table 4.15: Sources of information about recruitment opportunities used by recently hired* residential direct care workers and facilities: 2012 (per cent)

	Nurse	PCA		AH
Source of job information	Worker	Worker	Facility	Worker
Walk-in	n/a	n/a	8.6	n/a
Word of mouth	35.9	41.7	10.6	32.8
Newspaper job advertisement	19.0	23.4	16.5	29.5
Internet job advertisement	25.8	12.4	14.6	21.3
Both internet and newspaper advert	n/a	n/a	30.3	n/a
Job placement program / career service	0.3	3.9	11.8	0.0
Agency	10.1	6.9	1.2	4.9
Other	9.0	11.7	5.0	11.5
Don't know	n/a	n/a	1.4	n/a

Source: Census of residential aged care facilities and Survey of residential aged care workers.
Note: Multiple response allowed, columns will not sum to 100
* Recently hired workers have been employed for 12 months or less

4.6 Setting of Employment Conditions

The way in which employers set employment conditions is an indicator of the degree of enterprise flexibility that facilities are able to maintain. Table 4.16 reports the proportions of employees, across all residential facilities, whose employment terms and conditions are prescribed by each of several main methods. We suggest that these figures be treated with some caution, because some of the methods can operate in tandem (e.g., awards and agreements) and employers may not recognise the distinctions between them.

By far the most common method of setting employees' conditions is Enterprise Agreements. Our questionnaire defined these to include union and non-union agreements, whether certified with an industrial authority or not. Facilities reported that about three-quarters of all their employees had their employment conditions determined by Enterprise Agreements in 2012. The proportion was similar for Nurses and PCAs (74% and 75%, respectively), but slightly lower for Allied Health workers (66%).

Subject to the caveats noted above, the proportion of direct care workers covered by Enterprise Agreements appears to be quite high relative to the Australian workforce average. ABS data collected in 2010 show that 46 per cent of non-managerial employees have their pay set by 'collective agreements'. The comparison with our category of 'Enterprise Agreements' is far from exact, but it serves to highlight the large extent to which residential facilities use enterprise-level arrangements for setting their employees' wages and conditions.

Award-based arrangements also appear to be used in the residential aged care sector to a slightly greater extent than in the workforce at large, although the differences here are less pronounced (23% compared with 16% of non-managerial employees in the Australian workforce in 2010).

Table 4.16: Industrial methods used by residential facilities to set employment conditions (per cent), by employee occupation: 2012

% of employees with conditions set by method	Nurses	PCA	AH	All occupations
Award	24.2	22.6	24.0	**23.1**
Enterprise Agreement	73.6	75.4	66.1	**74.4**
Common Law Contract	0.5	0.2	3.5	**0.5**
Individual Flexibility Agreement	0.6	0.9	2.7	**0.9**
Don't Know	1.2	0.9	3.7	**1.1**
Total	**100**	**100**	**100**	**100**

Source: Census of residential aged care facilities.

4.7 Agency, Brokered and Self-employed Staff

Alongside the information about skill shortages and vacancies discussed above, the degree to which residential facilities use workers that they do not directly employ provides another perspective on their staffing needs. We asked facilities about their use of three types of workers who are not on their payrolls: agency, brokered and self-employed workers. We refer to these three groups together as 'non-PAYG' workers.

It is likely that facilities use non-PAYG workers for a variety of reasons: for flexibility, to cover shortages or vacancies, or to meet specific client needs on a short-term basis. Table 4.18 shows that there was quite widespread use of non-PAYG workers by residential facilities in 2012. Over half of all facilities (55%) employed at least one non-PAYG worker (in any occupation) in the designated fortnight (last pay period in November 2011).

Of the three types of non-PAYG workers, agency workers are by far the most widely used. Some 46 per cent of residential facilities used agency workers in 2012. Within this category, facilities were most likely to use agency workers for RN or PCA positions. About one in three facilities (34%) had at least one agency PCA in the designated fortnight, and a similar proportion (31%) had at least one agency RN. Use of agency workers in EN or AH roles is much less common (17% and 3% of facilities, respectively).

It is evident from Table 4.17 that many facilities engage agency workers in different occupations at the same time. The fact that 46 per cent of facilities in total use agency workers implies that the 31 per cent of facilities using agency RNs cannot be entirely separate from the 34 per cent using agency PCAs. Rather, these figures tell us that there is overlapping use of agency workers across different occupations within the same facilities.

The same cannot be said for the use by residential facilities of the other two types of non-PAYG workers: brokered and self-employed. For these two worker types, facilities' usage is dominated by AH workers. While few facilities in total make use of brokered or self-employed workers (approximately 5% and 12% of facilities, respectively), those that do so overwhelmingly rely on these workers to meet demand for AH workers. If we take into consideration the increase in use of non-PAYG AH workers from 13 per cent of facilities in 2007 to 17 per cent in 2012, this could partially off-set the decline in numbers of AH workers employed as PAYG workers by facilities.

Table 4.17: Proportion of residential facilities (per cent) using non-PAYG workers in the designated fortnight, by occupation and type of worker: 2012

Occupation	Agency	Brokered	Self-employed	All non-PAYG
Registered Nurse	31.2	0.9	1.2	**32.6**
Enrolled Nurse	16.9	0.2	0.2	**17.1**
Personal Care Attendant	33.9	0.3	0.3	**34.3**
Allied Health	3.2	4.0	11.2	**16.9**
All occupations	**45.8**	**4.9**	**11.8**	**55.0**

Source: Census of residential aged care facilities.

Estimates for each State/Territory of the proportions of residential facilities using non-PAYG RNs and/or PCAs in 2003, 2007 and 2012 are provided in Table 4.18.

In 2012, about one-third of facilities used non-PAYG workers in either RN or PCA positions. There are quite noticeable variations in these proportions by State/Territory. Facilities located in South Australia, Tasmania and the Northern Territory had above-average use of non-PAYG RNs in 2012. There is evidence of a strong increase in Tasmanian facilities' use of non-PAYG RNs since 2007. South Australian and Northern Territory facilities (but not Tasmanian facilities) also had above-average use of non-PAYG PCAs in 2012.

The national pattern for all facilities, which conceals regional differences, is one of increasing use of non-PAYG staff between 2003 and 2007, followed by stability or decline in the use of non-PAYG staff between 2007 and 2012. The proportion of facilities using agency RNs increased from 26 to 33 per cent between 2003 and 2007 and remained at approximately 33 per cent in 2012. The proportion of facilities using agency PCAs also increased, from 30 to 41 per cent between 2003 and 2007, but then fell back to 34 per cent in 2012.

The pattern of rising and then stable usage of agency RNs between 2003 and 2012, and of rising and then declining usage of agency PCAs over the same period, is seen in most of the States/Territories. Exceptions to this pattern are in the usage of agency RNs by South Australian facilities, which has been consistently high in all periods, and their usage by Tasmanian facilities, which has increased progressively since 2003.

Table 4.18: Proportion of residential facilities (per cent) using any non-PAYG RNs or PCAs in the designated fortnight, by State/Territory: 2012

	RN			PCA		
State / Territory	**2003**	**2007**	**2012**	**2003**	**2007**	**2012**
ACT	44.4	23.5	29.2	50.0	35.3	29.2
NSW	19.1	23.6	26.7	21.7	25.4	22.2
Victoria	25.9	31.9	31.2	31.6	45.7	35.9
Queensland	27.3	44.1	37.6	24.1	42.2	35.2
SA	44.6	44.8	47.3	51.2	64.1	60.8
WA	30.3	38.9	28.4	48.3	62.3	28.4
Tasmania	15.6	21.4	47.1	2.2	5.7	10.0
NT	40.0	81.8	40.0	50.0	63.6	40.0
All facilities	**26.1**	**33.3**	**32.6**	**30.1**	**41.1**	**34.3**

Source: Census of residential aged care facilities.

Table 4.19 provides a different picture of the extent to which non-PAYG workers contribute to the residential direct care workforce. We asked how many non-PAYG workers each facility had been engaged in the designated fortnight, and how many shifts these workers covered in that period.

When measured in terms of the total number of workers, non-PAYG PCAs were the most widely used by facilities. There were over 10,000 of these workers in residential facilities in the designated fortnight, representing approximately 60 per cent of all non-PAYG workers at that time. The next most widely used were non-PAYG RNs of which there were 3,600, representing approximately 20 per cent of all non-PAYG workers at that time.

Reinforcing the findings from previous tables, almost all non-PAYG workers are agency workers. For instance, over 95 per cent of the 3,600 non-PAYG RNs working in residential facilities were agency workers. Similar proportions of agency workers are found among the groups of non-PAYG ENs and PCAs. The exception is the non-PAYG AH workers, 60 per cent of whom were self-employed.

The final column on the right-hand side of Table 4.20 shows the number of *shifts* that non-PAYG covered, rather than the number of *workers*. This change in measurement has the effect of increasing the importance of non-PAYG RNs. Whereas RNs represented 21 per cent of the non-PAYG workers in residential facilities they covered approximately 27 per cent of the shifts done by non-PAYG workers. However, on either measure (number of workers or number of shifts), the majority of non-PAYG services are provided by PCAs.

Table 4.19: Number of non-PAYG workers in residential facilities in the designated fortnight, and the number of shifts they covered, by occupation: 2012

Occupation	Number of workers				Number of shifts
	Agency	Brokered	Self-employed	Total	Total
Registered Nurse	3,435	67	98	**3,600**	6,070
Enrolled Nurse	2,219	29	16	**2,264**	2,853
Personal Care Attendant	9,740	51	264	**10,055**	12,651
Allied Health	217	195	608	**1,020**	1,250
All occupations	**15,611**	**342**	**986**	**16,939**	**22,824**

Source: Census of residential aged care facilities.
N=1,429 facilities (weighted)

A final way to summarise the contribution that non-PAYG workers make to providing residential aged care services is to calculate the average number of shifts worked by each of these workers. Table 4.20 estimates the average number of shifts worked by each non-PAYG worker for the different occupations in total for all facilities, and then separately by State/Territory and facility location.

Across all facilities, non-PAYG RNs worked a higher average number of shifts (1.7) than non-PAYG workers from any other occupation. Similar differences are seen in most of the State/Territory jurisdictions and all of the locations. For instance, in facilities located in Inner Regional areas, the average number of shifts worked by non-PAYG Registered Nurses is 2.2, compared with an average of between 0.9 and 1.5 for non-PAYG workers in the other classifications.

These differences in shift ratios suggest that, while residential facilities do not engage large numbers of non-PAYG RNs (see Table 4.19 above), they typically require that these workers cover a larger than average number of shifts. This result might occur because facilities maintain contact with some RNs who are not seeking ongoing employment but who can be called upon when needed to cover otherwise unfilled shifts. Alternatively, the high number of shifts done by the average non-PAYG RN may be a reflection of the difficulties that facilities encounter in finding permanent employees or the costs involved in recruiting them.

Two exceptions to the general result of a higher average number of shifts worked by non-PAYG RNs are found in Western Australia and Tasmania. In the former, non-PAYG ENs work more shifts on average (2.2) than workers in the other classifications. In Tasmania, non-PAYG PCAs work the highest average number of shifts (2.1). Non-PAYG staff employed in Remote and Very Remote locations work more shifts than the average across all occupations, and Nurses and PCAs work more shifts than average in facilities located in Outer Regional areas.

Table 4.20: Average number of shifts worked in the designated fortnight by each non-PAYG worker in residential facilities, by occupation, State/Territory and location: 2012

		RN	EN	PCA	AH	All Occupations
All facilities		1.7	1.3	1.3	1.2	**1.3**
State/Territory	ACT	1.3	2.0	0.8	0.9	**0.9**
	NSW	2.0	1.7	1.4	1.2	**1.6**
	Victoria	1.4	1.2	1.2	1.3	**1.2**
	Queensland	1.9	1.3	1.0	1.3	**1.3**
	SA	1.4	1.2	1.3	1.1	**1.3**
	WA	1.8	2.2	1.4	1.6	**1.5**
	Tasmania	1.4	1.7	2.1	1.0	**1.6**
	NT	8.7	2.1	3.7	0.0	**4.0**
Location	Major cities	1.4	1.1	1.2	1.3	**1.2**
	Inner Regional	2.2	1.5	1.5	0.9	**1.6**
	Outer Regional	3.5	2.9	2.7	1.2	**2.8**
	Remote	6.7	5.5	3.6	0	**5.6**
	Very Remote	11.8	3.7	1.9	0	**3.9**

Source: Census of residential aged care facilities.

4.8 Volunteers in Residential Aged Care

For the first time in 2012 we collected information about the number of volunteers and the hours they contributed in residential facilities. Volunteers provide services such as companionship, entertainment and social activities that complement the kinds of care provided by the formal workforce. In recent years there have been government initiatives to increase the level of volunteering in residential aged care, and as a result numbers increased by 55 per cent between 2000 and 2009 (Productivity Commission, 2011, p. 342).

With over 22,000 volunteers providing more than 100,000 hours of service (Table 4.21), facilities are certainly providing opportunities for volunteers to contribute to aged care. Responses from facilities using volunteers indicate they have an average of 10 volunteers per facility, with each volunteer contributing an average of 4.8 hours per fortnight. If we extrapolate these hours over a year it comes to more than 2.5 million hours of volunteer service in residential aged care.

Table 4.21: Total number of volunteers and volunteer hours worked in residential facilities in the designated fortnight: 2012

Volunteer numbers	Volunteer hours	Average hours per volunteer
22,261	101,555	4.8

Source: Census of residential aged care facilities.

As shown in Table 4.22, 84 per cent of facilities have one or more volunteers. Facilities in Inner Regional locations are most likely to have volunteers, while those in Remote and Very Remote areas have fewer volunteers than the average. The use of volunteers also differs by ownership type with not-for-profit facilities more likely to use volunteers (92%) than for-profit or publicly owned facilities.

Table 4.22: Proportion of residential facilities employing volunteer workers (per cent) in the designated fortnight, by location and ownership type: 2012

		Volunteers
All facilities		84.1
Location	Major cities	81.4
	Inner regional	91.7
	Outer regional	87.4
	Remote	62.5
	Very remote	39.1
Ownership type	Not-for-profit	91.6
	For-profit	71.0
	Public	81.9

Source: Census of residential aged care facilities.

5. The Community Aged Care Workforce

The research reported in this chapter focuses on the workforce based in community outlets and uses data from workers (N=5,214) and outlets (N=1,357). In some areas we make comparisons with 'recent hires', that is direct care employees who have been working in aged care for 12 months or less (N=806). This is the second time that information has been captured on this workforce and we are building a more comprehensive picture of who works in community aged care and how that work is experienced by workers in different occupational groups. As in residential care we expanded the occupational groups in 2012 to include Nurse Practitioners, and distinguished between Allied Health Professionals and Allied Health Assistants. Where these occupational groups are not listed separately, we have combined Nurse Practitioners with Registered Nurses, and amalgamated Allied Health Professionals and Assistants under the umbrella of Allied Health worker as agreed with the Department of Health and Ageing.

The information in this chapter parallels that provided for the residential workforce in Chapter 3. In some areas we make direct reference to comparisons of the two workforces and it is relatively easy to find the equivalent tables if further comparisons are required. We also compare the findings from 2012 with those in 2007 where these are of interest. In this chapter we examine workforce characteristics, the characteristics of the work, career paths, the experiences of working in aged care, the extent of work-related injuries and illnesses, whether workers can combine their work and non-work commitments and how coming from a culturally or linguistically diverse background might impact on the work.

5.1 Total Employment and Main Workforce Characteristics

Before discussing the various aspects of the workforce, it is worth noting that the direct care workforce in community outlets is female dominated with 90 per cent of workers in the sector being women. This has not changed since 2007 and closely resembles the gender profile of the residential direct care workforce.

5.1.1 Total Employment

With community aged care likely to take a larger role in the provision of services to older Australians, understanding the size and composition of the existing workforce is necessary before estimations of the required growth and change can be made.

Calculating estimations of the community direct care workforce is less straightforward than for the residential sector. Although we used the same methodology to arrive at these estimates (see Appendix A), two factors impact on their reliability. One is the quality of the address lists from which the sample was drawn, which included volunteer organizations and providers that primarily broker employees to other outlets (as discussed in Chapter 2). We have made provision for these in our estimations, but the precise number of these outlets is unknown. The second is that while we could confidently claim to have a census of residential facilities, we cannot do the same for community outlets. With a response rate of 33 per cent from outlets, the weighting of the sample has a greater impact on the final estimation of numbers and, while we have made every effort to ensure that this is as reliable as possible, it is not the same as having a true census of the population.

Based on our estimation (which included the imputation of values for missing data), total employment in community aged care for 2012 was 149,801 workers. The reason for the large increase in the size of the total workforce since 2007 is not known, but may be partially accounted for by the difficulties in estimating the size of the workforce in 2007 given the unknown extent to which outlets were co-located, and for changes in the

sample list for 2012 which included organisations comprised of mainly volunteer direct care employees (for more information, see Chapter 2).

Of the 149,801 employees in the total workforce an estimated 93,359 work in direct care roles which is a substantial increase of around 25 per cent since 2007. While we need to bear in mind the issues raised above regarding the ways in which estimations are calculated, some of this increase may reflect the broadened definition of direct care worker for community aged care to include work that was previously listed under ancillary care.

In 2012, 63 per cent of the community aged care workforce was in a direct care role and these workers are the focus for most of this chapter.

Table 5.1: Size of the community aged care workforce, all PAYG employees and direct care employees: 2007 and 2012 (estimated headcount)

Occupation	2007	2012
All PAYG employees	87,478	149,801
Direct care employees	74,067	93,359

Source: Census of community aged care outlets.

5.1.2 Occupation

The occupational composition of the headcount of direct care employees is presented in Table 5.2. The largest occupation is that of Community Care Worker (CCW) which accounts for 81 per cent of employees. All of the occupations measured in 2007 have increased numerically, but RNs have decreased their share of the workforce. Some of the change in the proportion of RNs may be explained by the increase in the proportion of ENs and by the emergence of Nurse Practitioners in the workforce. For the first time in 2012 we delineated between AH Professionals and AH Assistants, and together they comprise 6 per cent of the direct care workforce, a slight increase since 2007.

Table 5.2: Direct care employees in the community aged care workforce, by occupation: 2007 and 2012 (estimated headcount and per cent)

Occupation	2007	2012
Nurse Practitioner	n/a	201 (0.2)
Registered Nurse	7,555 (10.2)	7,631 (8.2)
Enrolled Nurse	2,000 (2.7)	3,641 (3.9)
Community Care Worker	60,587 (81.8)	76,046 (81.4)
Allied Health Professional*	3,925 (5.3)	3,921 (4.2)
Allied Health Assistant*		1,919 (2.1)
Total number of employees (headcount) (%)	**74,067 (100)**	**93,359 (100)**

Source: Census of community aged care outlets.
* Note: in 2007, these categories were combined under Allied Health

Table 5.3 shows that there were 54,537 full-time equivalent employees (FTE) in community outlets in 2012. The distribution of the FTE direct care workforce across occupational groups has a slightly different profile to the distribution of persons described above. This indicates that some occupations have longer working hours than others, an issue that is examined in more detail in section 5.2.1 of the report. For example, CCWs comprise 81 per cent of employees in the direct care workforce, but 76 per cent of the FTE workforce; in contrast RNs are 8 per cent of employees, but 12 per cent of the FTE workforce.

Table 5.3: Full-time equivalent direct care employees in the community aged care workforce, by occupation: 2007 and 2012 (estimated FTE and per cent)

Occupation	2007	2012
Nurse Practitioner	n/a	55 (0.1)
Registered Nurse	6,079 (13.2)	6,544 (12.0)
Enrolled Nurse	1,197 (2.6)	2,345 (4.3)
Community Care Worker	35,832 (77.8)	41,394 (75.9)
Allied Health Professional*	2,948 (6.4)	2,618 (4.8)
Allied Health Assistant*		1,581 (2.9)
Total number (FTE) **(%)**	**46,056** **100**	**54,537** **100**

Source: Census of community aged care outlets.
* Note: in 2007, these categories were combined under Allied Health

The contents of Table 5.2 and Table 5.3 (with headcount and full time equivalent numbers and per cents respectively) are presented graphically in Figure 4 and Figure 5 overleaf.

Figure 4: Share of the occupations for the community direct care employees (headcount and FTE, per cent)

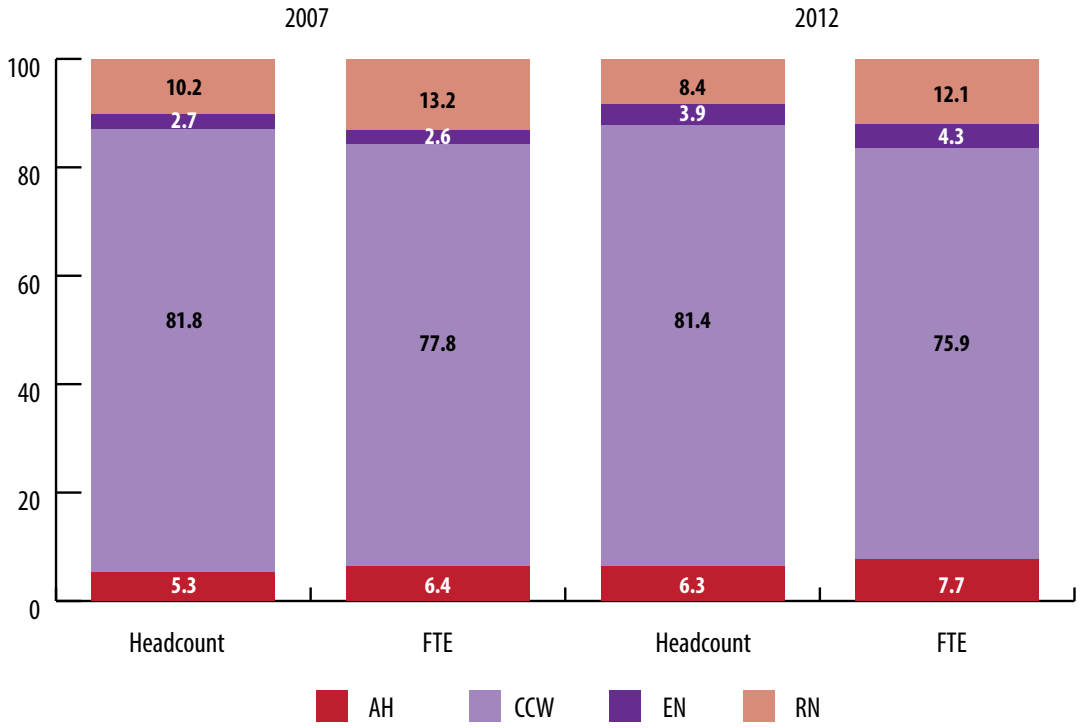
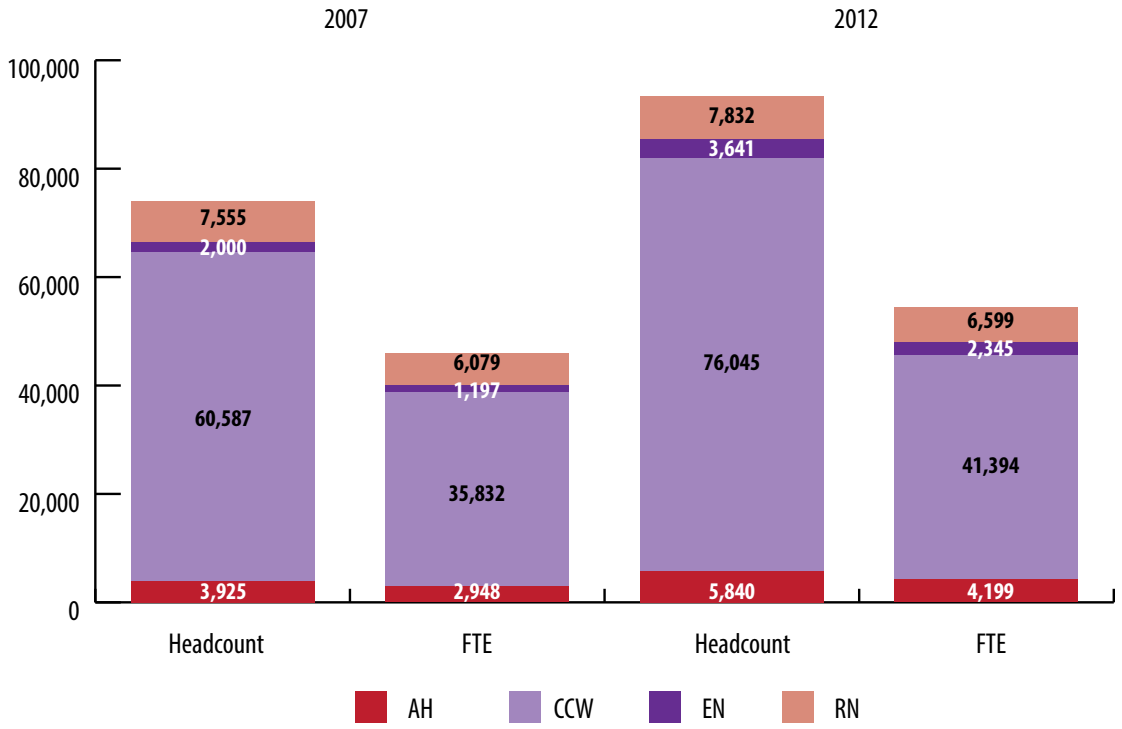


Figure 5: Number of the occupations for the community direct care employees (headcount and FTE)



Note: Nurse Practitioners and Registered Nurses were combined under 'Registered Nurse' in 2012 in Figure 4 and Figure 5. Allied Health Professionals and Allied Health Assistants were combined under 'Allied Health' in both 2007 and 2012 in Figure 4 and Figure 5.

In 2012 we asked a question about the roles of workers employed in outlets who are not in direct care roles. We see in Table 5.4 that about one-third of these employees work as care managers, another third work in administration, while just under a quarter work in management. This is quite a different profile to that in residential facilities, where 70 per cent of non-direct care workers were employed in ancillary care roles. In comparison, in community outlets ancillary workers comprised less than 10 per cent of the non-direct care workforce.

Table 5.4: Employees not providing direct care in the community aged care workforce, by occupation: 2012 (per cent)

Occupation	2012
Care Manager/Co-ordinator	33.2
Management	22.3
Administration	35.3
Spiritual/pastoral care	1.6
Ancillary care (home maintenance, modification, etc.)	7.7
Total	**100**

Source: Census of community aged care outlets.

5.1.3 Age

Aged care has been an occupation that has attracted older workers. Many women, in particular, see aged care as an option when they return to the workforce after raising a family or tending to other caring responsibilities. This is the case for both residential and community aged care. Table 5.5 and Figure 6 compare the age distribution of direct care workers to those who have been employed for 12 months or less.

In relation to direct care workers, we see that 33 per cent is aged 55 or above, an increase from 29 per cent in 2007. With only a very slight increase in the proportion of workers aged less than 35 years, the age profile of the community direct care workforce is getting older. This pattern in the age profile is similar to that of the residential workforce; however the proportion of the workforce in the older age groups is even higher in community than in residential.

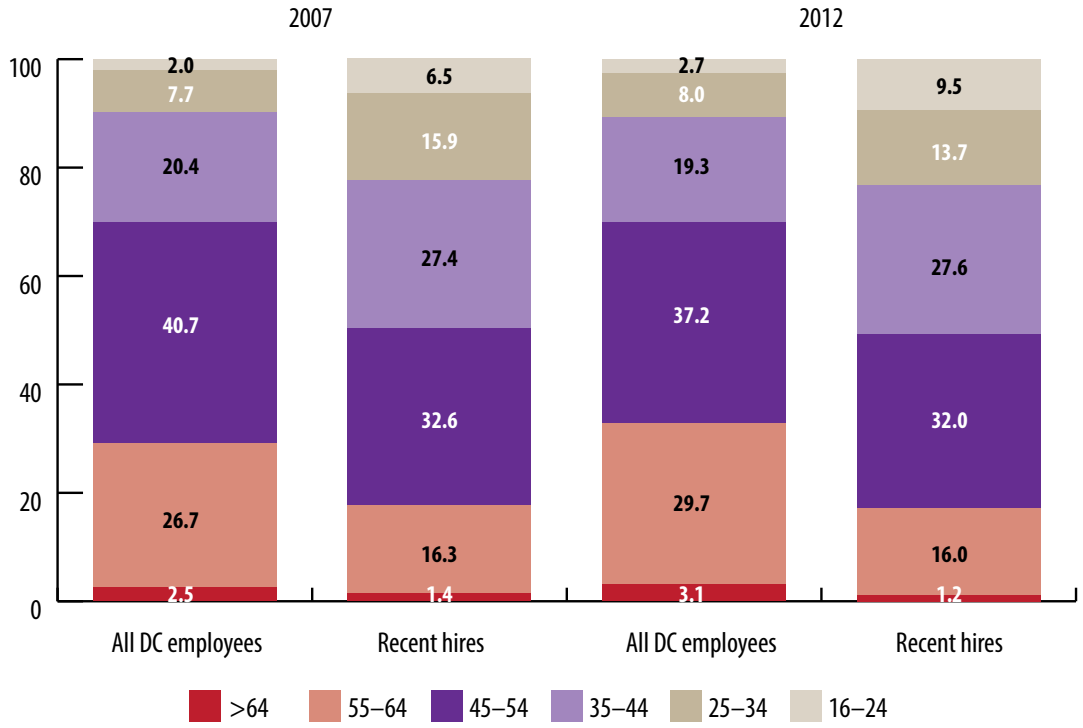
For workers who have been hired in the last 12 months we see that 51 per cent are under the age of 45 years (compared with 30% for all direct care workers), suggesting that younger people are attracted into community aged care. The age profile of recent hires is remarkably similar to that in 2007, with only slight variation in the two younger age brackets.

Table 5.5: Age distribution of the community direct care workforce, all direct care employees and recent hires: 2007 and 2012 (per cent)

Age	All direct care employees		Recent hires*	
(years)	2007	2012	2007	2012
16–24	2.0	2.7	6.5	9.5
25–34	7.7	8.0	15.9	13.7
35–44	20.4	19.3	27.4	27.6
45–54	40.7	37.2	32.6	32.0
55–64	26.7	29.7	16.3	16.0
>64	2.5	3.1	1.4	1.2
Total	**100**	**100**	**100**	**100**

Source: Survey of community aged care workers.
* Recent hires have been employed for 12 months or less

Figure 6: Age distribution of the community aged care workforce: 2007 and 2012 (per cent)



Another way to look at the age of the workforce is to compare the median age (mid-point) of the workforce for each of the occupations. Table 5.6 shows that the median age of 50 years for all direct care workers is higher than that of recent hires (44 years). It is also higher than that of the residential direct care workforce, which was 48 years. One of the key differences between these two workforces is in the median age of CCWs/PCAs. Whereas PCAs had a younger median age than other occupations across the workforce (47 years) and for recent hires (38 years), CCWs have the highest median age (shared with RNs), with recent hires being only 5 years younger. In community aged care, the youngest median age in the recent hires is for AH workers at 36 years.

Table 5.6: Median age of the community direct care workforce, by occupation, all direct care employees and recent hires: 2012 (number of years)

Occupation	All direct care employees	Recent hires*
Registered Nurse	50	47
Enrolled Nurse	49	45
Community Care Worker	50	45
Allied Health	48	36
All occupations	**50**	**44**

Source: Survey of community aged care workers
* Recent hires have been employed for 12 months or less

5.1.4 Country of Birth

Compared with residential aged care, a higher proportion of workers in community outlets is Australian born. At 28 per cent, the proportion of workers born outside of Australia has remained relatively stable since 2007 (Table 5.7). Around 11 per cent of direct care employees were born in an English speaking country (New Zealand, United Kingdom or South Africa), 4 per cent from non-English speaking European countries and a similar proportion from countries in the Asia–Pacific region. The profile of workers who had been hired in the last 12 months is very similar that of all direct care workers.

Table 5.7: Country of birth of the community direct care workforce, all direct care employees and recent hires: 2007 and 2012 (per cent)

Country of birth	All direct care employees		Recent hires*	
	2007	2012	2007	2012
Australia	73.3	72.2	69.0	70.1
New Zealand	3.4	2.6	3.4	4.0
UK, Ireland, South Africa	8.5	8.1	9.2	6.4
Italy, Greece, Germany, Netherlands	3.1	2.5	3.2	3.3
Vietnam, HK, China, Philippines	2.3	3.1	2.8	2.9
Poland	1.1	1.4	0.8	1.4
Fiji	0.3	0.3	0.7	0.1
India	0.4	0.3	0.5	0.3
Other	7.7	9.4	10.1	11.6
Total	**100**	**100**	**100**	**100**

Source: Survey of community aged care workers
* Recent hires have been employed for 12 months or less

In the 2012 census and survey we added extra questions for workers born outside of Australia to find out how long they had been here and whether they spoke English as their primary language. We also asked outlets to provide information about their culturally and linguistically diverse workforce. In Table 5.8 we compare these results. In the left hand columns are the worker responses. We see from these that 28 per cent of workers who responded to the survey were migrants, with 16 per cent being both a migrant and speaking a language other than English (LOTE). This compares with the information from outlets which indicates that 21 per cent of employees come from culturally and linguistically diverse backgrounds.

The question is whether surveys have been distributed equally to workers who were and were not from culturally and linguistically diverse backgrounds. The comparison across occupational categories shows some variation, however this is quite small. Slightly higher proportions of Nurses and AH workers responded to the survey than their prevalence in community aged care, with lower proportions of CCWs participating. Given that the worker proportion is a sample estimate from a much larger population, the discrepancy is not particularly noteworthy.

Table 5.8: The culturally and linguistically diverse community direct care workforce, by occupation, comparing outlet and worker responses: 2012 (per cent)

Occupation	Worker (migrant)[1]	Worker (migrant + LOTE)[2]	Outlet (CALD)[3]
% of direct care employees	27.8	15.6	21.0
Distribution			
RN	6.3	4.3	2.9
EN	2.5	1.5	0.9
CCW	84.8	87.3	92.3
AH	6.4	6.9	3.9
Total	**100**	**100**	**100**

Source: Survey of community aged care workers, Census of community aged care outlets
1.Workers who report having migrated to Australia
2. Workers who report being both migrant and speaking a language other than English
3. Facilities that report employees from culturally and linguistically diverse backgrounds

Asking migrant workers who speak a language other than English how long they have been in Australia provides an indication of their level of familiarity with English as a language and with Australian customs and norms. This may be particularly important in community aged care because workers are relatively autonomous and need to go into the homes of older Australians and respect their needs and ways of living. On the other hand, older Australians are also from a range of cultural backgrounds so understanding cultural differences is an important aspect of the work.

Table 5.9 shows that three-quarters of the migrant direct care workforce in community outlets who speak a language other than English have been in Australia for more than 10 years. There is some variation between occupational groups. For example, of the 42 per cent of RNs who have been in Australia for 10 years or less, more than half have been here for 6–10 years.

This is a much different profile to residential aged care which has a higher proportion of migrants who have recently arrived in Australia (around 50%). The difference relates mainly to workers in CCW/PCA roles, where a higher proportion of CCWs than PCAs have been in Australia for longer than 10 years.

Table 5.9: Time spent in Australia of migrant community direct care workers who speak a language other than English, by occupation: 2012 (per cent)

Occupation	0–2 years	3–5 years	6–10 years	>10 years	Total
Registered Nurse	9.7	6.5	25.8	58.0	**100**
Enrolled Nurse	*	*	*	*	*
Community Care Worker	4.7	8.8	9.6	76.9	**100**
Allied Health	14.0	10.0	14.0	62.0	**100**
All occupations	**5.5**	**8.5**	**10.3**	**75.7**	**100**

Source: Survey of community aged care workers
* The proportion of ENs in these categories was too small to report

5.1.5 Aboriginal and Torres Strait Workforce

Community outlets provide a range of services to older Aboriginal and Torres Strait Islander people, both in culturally specific services and as part of broader service options. Having a workforce that can advise on the cultural appropriateness of these services or being able to deliver services in a particular language, is part of providing quality care for people who choose to stay in their own homes as they age.

The proportion of workers from Aboriginal and Torres Strait Islander backgrounds (2–3%) reflects their share of 2.5 per cent in the wider Australian population (ABS, 2012). The comparison between worker and outlets responses in Table 5.10 shows that Aboriginal and Torres Strait Islander workers are just as likely as any other worker to respond to the survey.

The distribution of the Aboriginal and Torres Strait Islander workforce in community outlets shows a similar pattern to that in residential facilities: that is, a lower proportion holds Nursing or AH positions than in the workforce more generally. For example, 12 per cent of the community direct care workforce works in a Nursing role, compared with 2.5 per cent of the Aboriginal and Torres Strait Islander direct care workforce. The reason for differences in occupational distribution cannot be ascertained from the data, but may be worth further investigation.

Table 5.10: The Aboriginal and Torres Strait Islander community direct care workforce, by occupation, comparing outlet and worker responses: 2012 (per cent)

Occupation	Worker	Outlet
% of direct care employees	2.7	2.3
Distribution:		
RN	3.9	1.8
EN	1.6	0.7
CCW	92.2	95.6
AH	2.4	1.9
Total	**100**	**100**

Source: Survey of community aged care workers, Census of community aged care outlets

5.1.6 Health

Aged care often requires physical work, so the health status of the workforce provides a gauge of their capacity to continue to do the work. In measuring health status, we use a standard measure of self-assessed health drawn from the ABS which uses a rating of health as excellent, very good, good, fair or poor. Across each of the occupations self-assessed health is high, with around 60 per cent of workers indicating they are in excellent or very good health (Table 5.11). This is similar to the results from 2007 and about the same as the Australian average (63%) for workers aged 18 years and over (ABS, 2011a). Differences between the occupations are small, with perhaps only the smaller proportion of CCWs saying they had 'excellent' health being noteworthy. The contrast with the health of recent hires is also most noticeable for CCWs, where 70 per cent indicate they have excellent or very good health compared with 59 per cent of those in the direct care workforce more generally. This may be related to there being a greater proportion of younger workers among recent hires.

Table 5.11: Self-assessed health of the community direct care workforce, all direct care employees and recent hires, by occupation: 2012 (per cent)

Self-assessed health	All direct care employees			Recent hires*		
	Nurse	CCW	AH	Nurse	CCW	AH
Excellent	18.6	15.0	22.1	19.2	22.1	31.4
Very good	41.4	43.7	41.6	49.5	48.0	33.3
Good	33.3	33.6	29.4	31.2	25.4	27.5
Fair	6.5	7.1	6.5	10.1	4.3	7.8
Poor	0.2	0.6	0.4	0.0	0.2	0.0
Total	**100**	**100**	**100**	**100**	**100**	**100**

Source: Survey of community aged care workers.
* Recent hires have been employed for 12 months or less

5.1.7 Education

Government initiatives over recent years have placed a high priority on education and training for the aged care workforce. Having an appropriately qualified workforce is important for career development and satisfaction amongst workers, and for the provision of quality care to older Australians. In this section we focus on the formal education of the workforce.

Table 5.12 shows that 86 per cent of community direct care workers have post-school qualifications, an increase from 79 per cent in 2007, and is now nearly as high as for residential direct care workers. Of the occupations, a higher proportion of CCWs than others have no post-school qualification (16%), although this has decreased from 24 per cent in 2007.

As would be expected, the types of qualification reflect workers' occupational roles. Two-thirds of RNs have a Bachelor Degree in Nursing, with many having other nursing or health related qualifications; over 80 per cent of ENs have a Certificate IV/Diploma in Enrolled Nursing; and more than two-thirds of CCWs have certificate level qualifications in aged care. Because the AH category contains both AH Professionals and AH Assistants, their post-school qualifications are split between health and aged care.

Since 2007, the proportion of CCWs with relevant aged care related qualifications has increased. Nearly half have a Certificate III in Aged Care and 20 per cent have a Certificate III in Home and Community Care. There is, however, an overlap, with half of those with the latter qualification also having the Certificate III in Aged Care. This means that 60 per cent of CCWs hold one or both of these qualifications. In addition, 19 per cent of CCWs hold a relevant Certificate IV qualification with half of these also holding a Certificate III qualification. In all, then, just fewer than 70 per cent of CCWs hold relevant Certificate III or IV qualifications.

For the first time in 2012 we captured information about the post-secondary qualifications of care managers and care leaders.[12] The educational profile of these two leadership positions is quite similar. A slightly higher proportion of care leaders have Certificate III in Aged Care, while care managers are more likely to have a Bachelor Degree in Nursing, management or 'other' qualifications; but the differences between them are not of the same scale as we saw in residential facilities. One of the differences between care managers and leaders in the two sectors is that in community outlets a higher proportion hold qualifications in non-work related fields, suggesting that they had a different occupation before entering aged care.

Outlets provided information about the extent to which their CCWs had either a Certificate III or IV qualification in an aged-care related area. Their responses, reported in Table 5.13, indicate a substantial increase in the proportion of outlets that have higher percentages of CCWs with these qualifications. In 2012, the proportion of outlets with more than 75 per cent of CCWs with a relevant Certificate III was 40 per cent, up from 28 per cent in 2007. While CCWs with relevant Certificate IV qualifications are found less often, the proportion of outlets with no CCWs holding these qualifications decreased from 42 per cent in 2007 to 30 per cent in 2012.

Although the prevalence of CCWs with relevant Certificate III qualifications in outlets is not as high as we saw for PCAs in residential facilities, it is certainly increasing relatively quickly. On the other hand the distribution of CCWs with relevant Certificate IV qualifications is now very similar to the distribution of PCAs with these qualifications in residential facilities.

12 Care managers were defined as having responsibility for all direct care workers in the outlet; while care leaders were defined as having responsibility for a team of direct care workers, but reporting to a care manager.

Table 5.12: Post-school qualifications completed by the community direct care workforce, by occupation: 2012 (per cent)

Qualification	Care Manager	Care Leader	RN	EN	CCW	AH	All DCW*
No Post-school							
Yr 10 or below	1.4	4.4	1.1	1.8	10.2	2.7	8.7
Yr 11/12	1.3	2.3	0.3	3.0	6.1	1.5	5.3
Health							
Certificate IV/ Diploma in Enrolled Nursing	10.0	11.6	3.9	81.1	2.3	3.8	5.4
Other basic nursing qualification	9.5	8.4	20.8	14.2	4.2	2.3	5.7
Post-basic nursing qualification	6.5	6.4	20.8	5.9	1.2	0.8	2.8
Bachelor Degree in Nursing	17.7	12.8	64.8	1.8	0.9	0.8	5.8
Bachelor Degree in Allied Health Profession	4.3	3.8	0.3	0.6	0.7	38.0	2.8
Postgraduate allied health qualification	2.5	1.5	2.3	0.6	0.2	13.7	1.2
Other health related	14.9	12.5	13.2	7.7	8.3	16.3	9.1
Aged Care							
Certificate III in Aged Care	29.9	36.9	3.4	21.9	48.1	16.3	41.9
Certificate III in Home and Community Care	7.8	10.5	0.6	3.0	19.9	6.5	17.0
Certificate IV in Aged Care	19.6	18.0	0.8	5.9	13.3	8.4	11.8
Certificate IV in Service Coordination	15.9	9.3	0.3	4.7	6.1	4.6	5.5
Other Certificate in Care Work	10.9	13.4	3.1	3.6	11.1	5.7	9.9
Post basic nursing qualification in aged care	2.1	0.6	4.8	2.4	0.5	0.0	0.9
Other aged care related	10.7	9.9	6.5	5.9	7.0	8.0	7.0
Management							
Certificate III or IV (Management)	15.5	8.4	9.9	8.3	5.0	5.3	5.5
Diploma (Management)	18.4	5.8	9.0	7.7	4.9	8.4	5.5
Bachelor Degree (Management)	1.8	1.2	1.1	0.6	0.7	3.0	0.8
Postgraduate Degree (Management)	2.1	1.5	3.4	0.0	0.5	2.3	0.8
Other							
Certificate III or IV (Other)	16.7	19.5	14.4	12.4	14.1	13.3	14.0
Diploma (Other)	14.9	9.6	9.0	13.0	9.9	11.8	10.1
Bachelor Degree (Other)	6.3	3.8	3.7	0.6	4.7	13.7	5.0
Postgraduate Degree (Other)	4.3	2.3	7.0	1.8	1.4	0.0	1.7

Source: Survey of community aged care workers.
* All DCW—all direct care workers, does not include care managers or care leaders
Note: Because staff can have more than one qualification, the columns do not sum to 100.

Table 5.13: Distribution of community outlets by proportion of Community Care Workers (CCWs) with relevant Certificate-level qualifications: 2007 and 2012 (per cent)

Proportion of CCWs with each type of qualification	Relevant Certificate III		Relevant Certificate IV	
	2007	2012	2007	2012
Zero	10.9	12.5	41.6	29.9
1–24%	14.5	8.5	35.8	41.1
25–49%	22.0	14.2	11.1	14.0
50–74%	24.7	25.1	6.7	8.0
75–99%	16.2	25.7	1.8	1.7
100%	11.8	14.0	3.0	5.3
Total	**100**	**100**	**100**	**100**

Source: Census of community aged care outlets.

While the traditional trajectory of older Australians through the aged care system has been to enter residential facilities as they become increasingly frail or their needs become more complex, there has been a shift toward enabling people to stay in their homes for as long as possible. This means that community direct care workers are often faced with providing support to people with a wider range of care needs than previously. We therefore asked workers if they had specialised qualifications that would help them deal with these types of care needs. These specialisations were selected as being important for aged care, but this is not an exhaustive list.

Just under a quarter of RNs had one of these specialised qualifications. This was higher than other occupational groups, with only 4–6 per cent of other direct care workers and around 10 per cent of care managers/leaders having qualifications in any of the areas of specialty listed. This represents a smaller proportion of the workforce with specialised qualifications than in residential facilities.

Across all occupations except for AH workers, the most common specialty was in palliative care. AH workers and a significant proportion of RNs and Care Managers had specialised qualifications in gerontology.

Table 5.14: Specialised qualifications in ageing or aged care of the community direct care workforce, by occupation: 2012 (per cent)

Qualification	Care Manager	Care Leader	RN	EN	CCW	AH
None	88.8	91.8	77.9	93.7	96.2	96.0
Specialisation in:						
Gerontology	4.3	1.4	9.1	0.7	0.5	2.2
Palliative Care	5.1	6.0	10.1	4.2	3.0	0.9
Psychogeriatrics	1.8	0.7	2.9	1.4	0.3	0.9
Total	**100**	**100**	**100**	**100**	**100**	**100**

Source: Surveys of community aged care workers.

A willingness to engage in further education demonstrates commitment to personal and professional development. We have already seen that the vast majority of direct care workers in community outlets have post-school qualifications. The following two tables provide information about workers who are currently studying.

Table 5.15 shows that 20 per cent of direct care workers were studying at the time of the survey. Within the occupational groups this ranged from 13 per cent of RNs to 28 per cent of ENs.

Of those studying, a higher proportion of RNs and ENs were studying in a health related field, while CCWs and AH workers tended to be studying in an 'other' area. However, one-third of CCWs were studying for an aged care qualification.

Nearly 40 per cent of workers currently studying were doing so in an 'other' area. This is much higher than the residential direct care workforce where 12 per cent were studying in an 'other' field. Some of these fields may still be related to their work in aged care, for example, some workers indicated they were doing study in the area of leisure and fitness, while others were studying courses on administration and education. However, the high proportion studying for qualifications outside of the standard 'aged care' related fields indicates that, rather than this study preparing them for a career in community aged care, it may be being undertaken for the purpose of working elsewhere.

Table 5.15: Field of current study of the community direct care workforce, by occupation: 2012 (per cent)

Field of study	RN	EN	CCW	AH	All occupations
Not currently studying	86.6	72.1	78.6	82.8	**79.2**
Studying	13.4	27.9	21.4	17.2	**20.8**
Of those studying:					
Aged Care	13.6	0.0	33.3	11.9	**29.7**
Health	36.4	53.5	17.9	28.6	**21.0**
Management	22.7	9.3	9.2	16.7	**10.2**
Other	27.3	39.5	39.6	42.9	**39.1**

Source: Surveys of community aged care workers.

Of those workers who are studying, their level of study is shown in Table 5.16. Not surprisingly the level differs by occupation: three-quarters of RNs who are currently studying are doing so at Certificate IV/Diploma level with another 21 per cent studying at Postgraduate level; ENs are most likely to be undertaking Certificate IV/Diploma level studies although 39 per cent of those studying are doing so at Undergraduate Degree level; CCWs are mostly undertaking study at Certificate III and IV levels; while nearly two-thirds of AH workers studying are doing so at Certificate IV/Diploma level.

Table 5.16: Level of study of the community direct care workers who are currently studying, by occupation: 2012 (per cent)

Level of study	RN	EN	CCW	AH
Certificate I/II	0.0	0.0	0.9	0.0
Certificate III	0.0	2.8	35.6	12.8
Certificate IV/Diploma	76.5	58.3	57.0	64.1
Undergraduate Degree	2.9	38.9	5.8	7.7
Postgraduate Degree / Diploma / Certificate	20.6	0.0	0.5	15.4
Total	**100**	**100**	**100**	**100**

Source: Surveys of community aged care workers.

5.2 The Main Characteristics of the Work

We now turn our attention to the structural features of working in aged care: the types of arrangements under which workers are employed, their shifts and whether they are working their preferred hours, their wages and whether they need to hold multiple jobs, and the opportunities provided for additional training.

5.2.1 Employment Arrangements and Hours Worked

The employment arrangements and hours worked are indicators of the level of flexibility required by employers and employees. However, they also reflect the labour market. In a strong labour market, for example, employees are more likely to have the form of employment, shifts and hours that suit them.

Overall, the proportion of workers employed in different forms of employment has remained relatively constant since 2007. Table 5.17 shows that in 2012 the majority of workers (62%) are employed under permanent part-time arrangements. For the other forms of employment we see that a substantial proportion of RNs work under permanent full-time arrangements (33%) while a similar proportion of CCWs work in casual contracts.

The forms of employment used for ENs and AH workers have changed. In 2007 nearly a quarter of ENs were employed on a permanent full-time basis with a similar proportion on casual contracts (Martin & King, 2008); by 2012 the proportion of ENs in these employment arrangements had decreased and two-thirds now work under permanent part-time arrangements. AH workers have seen a similar shift since 2007, when nearly one-third worked in permanent full-time jobs compared with 27 per cent in 2012.

In community aged care, a higher proportion of direct care workers are on casual contracts (27%), compared with those in residential aged care (19%). However, a similar proportion (10–11%) is employed under permanent full-time arrangements across the two sectors.

Table 5.17: Form of employment of the community direct care workforce, by occupation: 2012 (per cent)

Occupation	Permanent full-time	Permanent part-time	Casual or Contract	Total
Registered Nurse	32.6	53.3	14.2	**100**
Enrolled Nurse	17.0	67.2	15.8	**100**
Community Care Worker	6.7	62.9	30.4	**100**
Allied Health	27.4	60.0	12.5	**100**
All occupations	**10.6**	**62.1**	**27.3**	**100**

Source: Census of community aged care outlets.

The majority of community direct care workers are employed on regular daytime shifts (Table 5.18). There has been very little change in the patterns of shifts for AH workers since 2007. For Nurses and CCWs there has been a move away from working on an irregular schedule; Nurses have moved towards being on rotating shifts while there has been an increase in the proportion of CCWs working regular daytime shifts.

Table 5.18: Work schedule of the community direct care workforce, by occupation: 2007 and 2012 (per cent)

	Nurse		CCW		AH	
Work schedule	**2007**	**2012**	**2007**	**2012**	**2007**	**2012**
A regular daytime shift	84.2	82.4	75.4	79.5	95.9	96.0
A regular evening shift	1.1	1.7	0.9	0.7	0.0	0.0
A regular night shift	1.3	0.8	0.5	0.4	0.0	0.0
A rotating shift	6.6	10.4	3.2	2.1	0.0	0.8
Spilt shift	0.5	0.6	3.4	2.5	0.0	0.0
On call	0.5	0.2	0.8	1.0	0.5	0.4
Irregular schedule	5.5	2.5	15.3	11.9	3.1	1.6
Other	0.2	1.4	0.5	1.9	0.5	1.2
Total	**100**	**100**	**100**	**100**	**100**	**100**

Source: Survey of community aged care workers.

One of the issues that workers have previously raised in interviews (e.g. Martin & King, 2008) is whether they are able to work their preferred hours. This is often associated with the ability to achieve their required level of financial security, and also their capacity to meet their non-work responsibilities. In 2007, we saw that there was evidence of excess capacity in the direct care workforce with over 40 per cent of workers seeking longer hours. The following two tables (5.19 and 5.20) examine this issue for workers in 2012.

If we look first at the actual hours worked in Table 5.19, we see that the majority of workers work between 16–34 hours per week. Although this was also the case in 2007, there has been a decrease in the proportion of direct care employees working these hours from 61 to 54 per cent, with a corresponding increase in the proportion working full-time or long hours (from 22 to 30%).

There are occupational differences in the hours worked; more than half of the Nurses and AH workers work 35 hours or more per week, whereas only a quarter of CCWs do so. CCWs are the major occupational category working 1–15 hours, although the majority of CCWs work 16–34 hours per week. However, since 2007 there has been an increase in the proportion of CCWs working full-time or longer (from 17 to 25%).

Turning now to the hours that workers would prefer, we see that there is a tendency for lower proportions of workers to want to work in either the 1–15 hours or >40 hours categories, with a higher proportion of workers preferring to work 35–40 hours per week. The preference to work shorter hours is particularly noticeable for RNs and ENs, while the preference for longer hours relates mainly to CCWs. Of all the occupational groups, RNs are the only one in which the proportion of workers wanting to work short hours (1–15 hours) is greater than the proportion that currently work these hours.

Table 5.19: Actual working hours and preferred working hours of direct care workers in the community direct care workforce, by occupation: 2012 (per cent)

	Actual hours per week				Preferred hours per week			
Occupation	**1–15**	**16–34**	**35–40**	**>40**	**1–15**	**16–34**	**35–40**	**>40**
Registered Nurse	2.3	41.1	38.0	19.0	4.0	52.6	40.8	2.6
Enrolled Nurse	4.7	39.1	39.1	17.2	2.5	51.9	39.5	6.8
Community Care Worker	18.5	56.4	20.2	4.9	12.2	53.0	32.0	2.8
Allied Health	9.2	40.5	39.3	10.7	7.5	44.7	44.7	3.5
All occupations	**16.2**	**53.6**	**23.4**	**6.8**	**11.0**	**52.4**	**33.7**	**2.9**

Source: Survey of community aged care workers (Row totals)

To further investigate these preferences in working hours, we now look more closely at the direction of preferred change (more or less hours) and the extent of the preferred change in terms of the number of hours workers want to increase or decrease by. The preferences are compared with those of workers in 2007.

There has been virtually no change between 2007 and 2012 in the proportion of workers happy with the hours they currently work. However, there has been a slight change in the desired direction of change, with 15 per cent of workers seeking fewer hours in 2012 compared with 11 per cent in 2007. Of those workers who do want to change their hours, the majority are looking to increase their hours, with about half looking for an increase of 1–5 hours per week.

Table 5.20: Preferred change in working hours of the community direct care workforce: 2007 and 2012 (per cent)

Desired change in hours	2007	2012
10+ hours less	3.5	4.7
1–9 hours less	7.6	10.6
No change in hours	47.3	48.7
1–5 hours more	23.1	19.9
6–10 hours more	12.6	10.4
11+ hours more	6.0	5.8
Total	**100**	**100**

Source: Survey of community aged care workers.

5.2.2 Wages

In Table 5.21 we present the gross median earnings for each direct care occupation by the number of hours worked per week.[13]

The median wage for RNs is $1081 per week, reflecting their longer working hours. They also have the highest median wage across all of the hourly categories, which is to be expected given their qualifications. AH Professionals, who have a similar level of qualification to that of RNs, have a slightly lower median wage than RNs, and this is particularly noticeable in the 1–15 hour and >40 hour categories. AH Professionals are the only occupational group that earns more in community than in residential aged care across all categories.

13 The alternative would be to calculate the hourly rate for each occupation. We have used the medians earnings to maintain comparability with previous reports.

For ENs, CCWs and AH Assistants the median wages are similar across both sectors of aged care. For any of these occupations, if they work full-time or longer in community aged care they will have a higher median wage than their counterparts in residential facilities. However, a higher proportion of workers are part-time in community aged care, especially in the 1–15 hours category. Of these workers only CCWs have a lower median wage than similar workers (i.e. PCAs) in residential facilities.

Table 5.21: Median earnings of the community direct care workforce, by occupation and working hours: 2012 ($ per week)

	Hours per week				
Occupation	**1–15**	**16–34**	**35–40**	**>40**	**All hours**
Nurse Practitioner	*	*	*	*	**750**
Registered Nurse	500	830	1268	1516	**1081**
Enrolled Nurse	372	650	966	987	**750**
Community Care Worker	269	596	835	900	**600**
Allied Health Professional	337	766	1180	1112	**940**
Allied Health Assistant	287	566	850	847	**668**
All occupations	**275**	**600**	**876**	**1000**	**617**

Source: Survey of community aged care workers.
* As the numbers of Nurse Practitioners are small, the wages earned have not been reported for individual categories

5.2.3 Multiple Job Holding

In the broader Australian workforce, approximately 5.4 per cent of employees hold more than one job (ABS, 2011c). Given that the majority of community direct care workers are part-time, and 45 per cent want to work more hours, there is scope for them to hold more than one job. Indeed, as we see in Table 5.22, 14 per cent of community direct care workers hold multiple jobs. Of these, over one-third has jobs in aged care. Where workers have another job in aged care, a higher proportion of ENs than other occupational groups work in residential aged care; while 4 per cent of CCWs and 6 per cent of AH workers have another job in community aged care.

Table 5.22: Prevalence of multiple job-holding among community direct care workers, by occupation: 2012 (per cent)

Jobs held	**RN**	**EN**	**CCW**	**AH**	**All occupations**
Only have one job	88.4	83.2	85.9	86.2	**86.0**
Other job in residential aged care	2.0	5.4	2.1	1.5	**2.2**
Other job in community aged care	1.1	1.8	3.6	6.1	**3.5**
Other job not in aged care	8.5	9.6	8.5	6.1	**8.4**
Total	**100**	**100**	**100**	**100**	**100**

Source: Survey of community aged care workers.

5.2.4 Training

We have seen already that a high proportion of the community direct care workforce had formal qualifications and had demonstrated a preparedness to undertake further study. In this section we focus on the training and continuing professional development (CPD) undertaken 'on the job' or to maintain these qualifications. Within aged care, training is an important element of the work. New questions about training were asked of workers in 2012 to establish their participation, the aims of the training undertaken and the areas in which they would

like further training. This last aspect of training was also asked of outlets in relation to training required for CCWs, the largest component of their workforce.

As shown in Table 5.23, 53 per cent of the direct care workforce engaged in CPD and 78 per cent did some training during the previous 12 months. As with residential aged care, mandatory training was the most common type of training undertaken, with 69 per cent of the workforce having participated in this type of training. A lower proportion of CCWs than workers in other occupations undertook non-mandatory training. As with the residential sector, a higher proportion of Nurses and AH workers than CCWs engaged in CPD over the past 12 months because it is often required by their professional associations.

Table 5.23: Participation in training and/or continuing professional development (CPD) by community aged care employees in the past 12 months, by occupation: 2012 (per cent)

CPD/Training	RN	EN	CCW	AH	All occupations
CPD	89.8	73.8	46.5	75.1	**52.5**
Training:					
No training	20.6	23.7	22.5	21.7	**22.3**
Mandatory training	67.9	58.9	69.6	67.7	**69.0**
Non-mandatory training	36.7	33.7	19.2	31.2	**21.8**

Source: Survey of community aged care workers.
Note: Multiple response allowed, totals will not sum to 100

Workers engage in training for a variety of reasons, as illustrated in Table 5.24. The most commonly selected reasons were to improve or develop skills. A high proportion of workers, particularly RNs (76%), selected 'to maintain professional/occupational standards' as one of their aims. Although meeting accreditation requirements was a relatively popular reason for undertaking training, this was not viewed as important as it was in residential facilities.

A quarter of CCWs and 21 per cent of AH workers nominated safety/health concerns as an aim of the training they had undertaken within the last 12 months. A relatively low proportion of workers viewed training as having direct relevance to being able to secure a job or promotion or to help get started in their job.

Table 5.24: Stated aims of training undertaken by the community direct care workforce during the last 12 months, by occupation: 2012 (per cent selecting)

Aim of training	RN	EN	CCW	AH
Improve skills in current job	58.9	70.5	68.8	59.0
Develop skills generally	45.2	58.1	45.2	43.4
Maintain professional/ occupational standards	76.4	55.8	50.4	52.0
Meet accreditation requirement	41.2	32.8	43.0	44.4
Safety/health concerns	12.1	11.7	24.6	20.5
Prepare for future job/promotion	8.2	7.0	7.3	7.8
Help get started in job	6.1	7.0	7.5	12.7
Other	5.7	4.7	4.0	6.3

Source: Survey of community aged care workers.
Note: Multiple response allowed, totals will not sum to 100

As is evident in Table 5.25, workers identified numerous areas in which they thought additional training was needed. The relatively high proportions of workers that identified multiple areas suggest that they believe their skills could be improved in a range of areas. For all occupations except for RNs, dementia training was viewed as the most needed. As with residential aged care, a higher proportion of RNs than workers in other occupations wanted training in management and leadership.

Outlets also identified areas of training most needed for CCWs. When compared with the responses from CCWs we see that although the proportions are different, the priorities are the same. The top three areas of training are dementia training, mental health and palliative care.

Table 5.25: Areas of training identified as most needed in the next 12 months for the community direct care workforce, by occupation, comparing outlet and worker responses: 2012 (per cent)

	RN	EN	CCW		AH
Area of training	**Workers**	**Workers**	**Workers**	**Outlets**	**Workers**
Dementia training	32.1	52.1	47.9	64.1	62.4
Palliative care	31.3	39.1	28.4	21.4	14.1
Management and leadership training	38.0	23.4	23.4	16.2	29.3
Wound management	36.9	40.2	21.1	17.5	6.5
Mental Health	17.2	32.7	32.7	34.0	25.5
Allied health	2.8	6.5	12.3	7.7	32.7
Other	16.6	10.1	12.9	25.5	17.1

Source: Survey of community aged care workers and Census of community aged care outlets
Note: Multiple responses were allowed, columns do not sum to 100.

5.3 Career Paths

We have seen that the community direct care workforce is growing, so the sector needs to continually attract people into aged care and retain them once they are employed. This section examines the pathways into aged care and the current jobs held by workers, before looking at their intentions to stay or leave their jobs. When discussing the mobility of the workforce we distinguish between workers who want to leave aged care and those who want to leave their current job, but stay in aged care.

5.3.1 Into Aged Care

Aged care is the first occupation for between 4 and 7 per cent of the direct care workforce. Nurses have a clear pathway into aged care, with 77 per cent of RNs and 45 per cent of ENs having previously worked in a different health or social care setting. In comparison, a relatively high proportion of CCWs have worked in quite different occupations, with 38 per cent having a background in sales, hospitality, cleaning or clerical work. As noted in 2007, these are areas of work that are dominated by women and often do not require post-school qualifications. AH workers also have diverse backgrounds, with a quarter coming from other health or social care jobs and just over a quarter from professional or management jobs. For CCWs and AH workers, then, there is no clear pathway into aged care work. Attracting these workers into aged care will therefore require a variety of strategies that emphasise the benefits of this work compared with their current jobs.

Table 5.26: Activity prior to first job in aged care of the community direct care workforce, by occupation: 2012 (per cent)

Last occupation before first aged care job	RN	EN	CCW	AH
No previous paid employment	4.5	7.3	6.6	4.3
Nurse, acute care	50.9	28.2	1.7	1.6
Nurse, community	18.1	1.8	0.9	0.4
Other health care	6.5	12.5	4.0	14.6
Carer in other setting	0.9	2.4	9.1	7.5
Salesperson	1.4	6.6	8.6	6.7
Clerical worker	2.6	6.0	11.0	6.7
Hospitality worker	2.0	6.6	8.8	4.7
Cleaner	0.3	1.2	9.1	1.6
Professional (other than nurse)	0.9	3.6	3.3	24.0
Manager	6.0	2.4	3.5	3.9
Other paid employment	6.0	21.5	33.3	24.0
Total	**100**	**100**	**100**	**100**

Source: Survey of community aged care workers.

Understanding the age structure of the workforce is necessary when planning for the future because it could impact on issues such as turnover due to retirement or the need to take measures to accommodate the needs of older workers. Most direct care workers have worked in other jobs before coming into aged care, which partially explains their relatively high median age of 50 years (Table 5.6).

Compared with direct care workers in residential facilities, a high proportion of community direct care workers start working in the sector at a later stage in life (Table 5.27). More than 50 per cent of direct care workers are 40 years or older when they first start working in community aged care. There is variation between the occupational groups, with 57 per cent of CCWs compared with 26 per cent of ENs starting after the age of 40 years. Just over 40 per cent of RNs, ENs and AH workers began working in aged care before the age of 30 years, compared with just 20 per cent of CCWs.

Table 5.27: Age at which began working in aged care of the community direct care workforce, by occupation: 2012 (per cent)

Age (years)	RN	EN	CCW	AH	All occupations
21 or under	14.6	25.0	9.0	13.6	**10.2**
22–29	25.5	17.9	9.7	29.5	**12.4**
30–39	22.3	31.0	24.0	19.8	**23.9**
40–49	27.2	16.7	34.9	24.8	**33.1**
50+	10.3	9.5	22.4	12.4	**20.4**
Total	**100**	**100**	**100**	**100**	**100**

Source: Survey of community aged care workers.

Not surprisingly, the age at which workers first begin working in aged care will influence the total time they remain in the workforce. Table 5.28 shows that over a third of RNs and ENs, for example, have been in aged care for 20 years or more, which is quite reasonable given they begin working in aged care at a younger age than other occupational groups. The majority of RNs, ENs and AH workers have been working in community

aged care for 10 years or more, demonstrating that once people come into aged care, they often stay for a considerable length of time. A lower proportion of CCWs has been in aged care for a similar time and this can be explained by their older starting age, with two-thirds being 40 years or older when they first start working in the sector.

Table 5.28: Total time spent working in aged care of the community direct care workforce, by occupation: 2012 (per cent)

Total time in aged care (years)	RN	EN	CCW	AH	All occupations
1 or less	5.7	7.4	11.6	7.7	**10.7**
2–4	3.7	0.7	5.7	4.3	**5.3**
5–9	23.3	16.1	39.3	28.1	**36.3**
10–14	19.3	22.1	20.8	26.2	**21.1**
15–19	13.2	14.8	9.9	10.9	**10.4**
20 or more	34.5	38.9	12.6	22.9	**16.1**
Total	**100**	**100**	**100**	**100**	**100**

Source: Survey of community aged care workers.

5.3.2 Into their Current Job

One of the concerns expressed by employers of care workers is the difficulty of recruitment and retention. The previous section indicates that the majority of workers are committed to working in aged care, often staying for 10 years or more. However, there is mobility within the community sector. This section looks at pathways into the current job held by direct care workers and finds out the extent of, and reasons for, job mobility.

About half of the direct care workers had worked in aged care prior to getting their current job. There were occupational differences, with a lower proportion of CCWs (38%) than workers in other occupations (61–75%) having done so (Table 5.29). While the proportion of workers who had worked in aged care on a voluntary basis was low, it appears that it is a more important pathway for CCWs and AH workers than for Nurses. It is not clear from the information provided whether this voluntary work was undertaken specifically to get paid work, or whether people start off as volunteers and then apply for paid work when it becomes available.

Table 5.29: Whether had worked in aged care prior to current job of the community direct care workforce, by occupation: 2012 (per cent)

Whether had previous work in aged care	RN	EN	CCW	AH	All occupations
Yes, paid	65.3	75.0	37.6	61.2	**42.4**
Yes, unpaid	2.3	1.2	6.3	5.4	**5.7**
No	32.5	23.8	56.1	33.5	**51.9**
Total	**100**	**100**	**100**	**100**	**100**

Source: Survey of community aged care workers.

Table 5.30 focuses on workers who had been in aged care for less than 5 years to show the extent to which churn is occurring among the newer cohort of employees in an outlet. It shows a similar picture to that in the previous table, wherein a higher proportion of Nurses than CCWs have worked in the outlet previously; and where CCWs and AH workers are more likely to have done unpaid or voluntary work in the outlet.

Table 5.30: Whether had worked in current outlet prior to obtaining current job of community direct care workers employed in the last five years, by occupation: 2012 (per cent)

Whether had previous work in current outlet	RN	EN	CCW	AH
Yes, paid work	23.7	25.3	7.9	16.3
Yes, unpaid or volunteer work	1.0	1.3	4.4	5.2
No	75.3	73.4	87.7	78.4
Total	**100**	**100**	**100**	**100**

Source: Survey of community aged care workers.
N=2,644 (weighted)

Workers who had previously worked in aged care, whether in their current outlet or elsewhere, were asked why they left that job. Their responses to this question, reported in Table 5.31, show that management decisions within an outlet have some capacity to influence the retention of staff.

There are, of course, some reasons that are not amenable to being influenced by management and these stem from the ways in which workers' personal lives intersect with their work. For example, just under a third (between 29 and 32%) of workers cited personal reasons such as moving house, fulfilling care responsibilities or wanting a job closer to home. These reasons are embedded in the characteristics of the workforce. It is female dominated and therefore workers are more likely to bear the majority of domestic (day-to-day) responsibilities; and it is largely part-time or casual and therefore workers are less likely to be primary wage earners. These factors provide the context within which workers have to make decisions about their work.

On the other hand, some factors are amenable to management intervention. After moving house, the five most important factors that were cited for leaving their previous aged care are to do with work conditions and work roles: higher pay, challenging work, get preferred hours, avoid managers, relief from stress. Together these account for more than 40 per cent of the reasons why workers left their previous job. There were some differences between the occupational groups in the proportions of workers citing each of these factors. Of these reasons, RNs were most likely to leave for higher pay; ENs and CCWs to get their preferred shifts or hours and to find more challenging work; and AH workers to find more challenging work.

While there are some differences between residential and community direct care workers in the extent to which they nominated different reasons, there is also overlap. The top four reasons given by community direct care workers were moved house, achieve higher pay, find more challenging work and get preferred shifts/hours. For residential direct care workers they were moved house, find more challenging work, get preferred shifts/hours and avoid managers. It seems, then, that both sectors could address at least some of their retention issues through the implementation of different management strategies.

Table 5.31: Main reason for leaving prior aged care job of community direct care workers with previous experience in sector, by occupation: 2012 (per cent)

Most important reason	RN	EN	CCW	AH
Moved house/location	20.7	18.2	18.9	18.0
To find more challenging work	10.1	19.8	12.1	16.8
To get shifts or hours of work I wanted	7.0	17.4	12.7	3.7
To avoid managers/management I did not get along with or like	7.0	1.7	5.0	6.2
To achieve higher pay	13.2	8.3	6.9	9.3
To be closer to home	5.7	9.1	4.5	5.6
The job was too stressful	7.9	4.2	4.5	3.7
To fulfil care responsibilities (including having a baby)	6.2	4.2	6.2	5.6
Made redundant/retrenched	2.6	0.8	2.5	2.5
Not able to spend sufficient time with residents	2.6	5.0	4.6	3.7
To avoid workmates/colleagues I did not get along with or like	1.3	0.8	1.3	1.2
To find easier work	1.3	0.8	2.9	0.0
Other	14.5	9.9	18.1	23.6
Total	**100**	**100**	**100**	**100**

Source: Survey of community aged care workers.
N= 1,977 (weighted)

Returning now from those workers who had worked in aged care previously to all direct care workers, Table 5.32 shows the proportion of the workforce that has worked in their current jobs for different lengths of time. We see that half of the community direct care workforce has been in their job for less than 5 years which is the same as that reported by residential direct care workers. However, a slightly lower proportion of workers in community outlets has been in their jobs for 10 years or longer (20%) than direct care workers in residential facilities (24%). Overall, however, there is little difference in the pattern of tenure between the two sectors.

If we compare workers' tenure in their current job to their tenure in aged care (Table 5.28) the mobility of the workforce is evident, with a proportion of this mobility being related to churn between aged care employers.

Table 5.32: Tenure in current job of the community direct care workforce, by occupation: 2012 (per cent)

Tenure in current job (years)	RN	EN	CCW	AH	All occupations
1 or less	23.8	15.4	15.4	19.7	16.3
2–4	29.6	28.4	34.6	32.4	33.8
5–9	24.3	29.6	31.2	27.8	30.4
10 or more	22.3	26.6	18.8	20.1	19.5
Total	**100**	**100**	**100**	**100**	**100**

Source: Census of community aged care workers.

5.3.3 Into the Future

So far throughout this section we have focused on the career paths of direct care workers in terms of how they came to be in their current jobs. Here we change the focus to look at the future. For how long are direct care workers planning to stay in their current jobs and what do they think they will do if they are seeking a change? As intentions to leave can have a significant impact on actual turnover, these questions are important (King et al., forthcoming).

As shown in Table 5.33, around 8 per cent of direct care workers were actively seeking work at the time of the survey. This varies slightly across occupational groups, with higher proportions of ENs and AH workers seeking work than other occupations. The length of time a worker has been in a job has little bearing on intentions to leave for RNs or CCWs, although across the whole workforce intentions to leave are lowest for workers who have been employed in their current job for 10 years or more. In contrast, relatively high proportions of ENs who have been in their jobs for 5–9 years, and AH workers who have been in their jobs for 2–4 years, are actively seeking work.

Table 5.33: Proportion of the community direct care workforce actively seeking work by occupation and tenure in current job: 2012 (per cent)

	Actively seeking work				
Tenure in current job (years)	**RN**	**EN**	**CCW**	**AH**	**All occupations**
1 or less	8.5	3.8	7.9	13.7	**8.2**
2–4	9.8	12.5	8.5	19.0	**9.3**
5–9	8.3	22.0	5.7	6.9	**6.5**
10 or more	6.5	2.2	5.0	7.7	**5.2**
Total	**8.4**	**10.7**	**6.9**	**12.4**	**7.5**

Source: Survey of community aged care workers.

Responses from the question asking workers what they thought they would be doing in 12 months' time indicate that the vast majority (82%) expect to be working for their current employer (Table 5.34). Indeed, around 76 per cent of RNs and AH workers and 83 per cent of ENs and CCWs thought they would be staying in their current job. Of the remaining workers, just over half did not know what they would be doing. This leaves about 8 per cent of the current workforce who have given some thought to where they will be in 12 months. About half of these will leave aged care, either because they have retired or for a job in a different sector; just under a third expect to go to work in a different outlet, while the remainder will work in residential aged care. A relatively small proportion of the existing workforce is therefore intending to leave aged care completely (although 10 per cent of direct care workers did not know where they would be), reinforcing previous comments about the relative stability of the direct care workforce.

Table 5.34: Expected activity in 12 months' time of the community direct care workforce, by occupation: 2012 (per cent)

Expected activity in 12 months	**RN**	**EN**	**CCW**	**AH**	**All occupations**
Working in Aged Care, this outlet	75.7	83.4	83.0	76.9	**82.2**
Working in Aged care, different outlet	2.3	1.8	2.1	3.5	**2.1**
Working in residential aged care	1.1	1.8	0.8	0.8	**0.9**
Working, but not in aged care	5.6	5.3	3.0	4.6	**3.3**
Not working for pay	1.7	0.6	1.1	1.2	**1.1**
Don't know	13.6	7.1	10.1	13.1	**10.4**
Total	**100**	**100**	**100**	**100**	**100**

Source: Survey of community aged care workers.

5.4 Experiences of Working in Community Aged Care

Direct care employees work in the sector for a variety of reasons: they need a wage, they want to combine their work with other commitments, they want to make a difference in people's lives or they enjoy the type of work that 'caring' entails. In this section we investigate whether their work is meeting their expectations and the extent to which they are satisfied with their jobs.

Throughout this section responses to questions were based on information ordered in scale form (i.e. respondents were asked to respond on a scale from 1–7 or 1–10). Before discussing the data, several caveats have to be noted. We discuss these in relation to the job satisfaction data (Table 5.35), but the same principles apply to Tables 5.36, 5.39 and 5.40.

First, in Table 5.35 many of the differences in average satisfaction levels at any point in time between different occupation groups will be too small to be of statistical significance, hence they should not be over-interpreted. Differences in averages will typically also conceal the more informative differences across the whole distribution of the reported values from 1 to 10. Second, changes in averages over time for any occupation group (i.e. between the 2007 and 2012 data sets) will depend on the characteristics of the workforce being constant over time, which we know to not be the case in all aspects of the data. This is always a problem when comparing single cross-section data sets and can only be satisfactorily handled through the use of multivariate regression. Finally, it should be noted that satisfaction measures are ordinal measures, that is, they tell us if someone likes something more than an alternative, but they do not tell us by how much. This naturally limits the interpretation we can give to responses. More specifically, it means that when we observe two survey respondents, the first of whom is satisfied enough to be ticking the box with value 4, and the second the box with value 6, this does not mean that the second person is 1.5 times more satisfied than the first person because 6 is 1.5 times higher than 4. It only means that the second person is more satisfied than the first person. The same limitation applies to the same person becoming more satisfied, but this type of comparison is not feasible in our data, because we do not identify individuals over time. The discussion that follows will need to be interpreted according to these caveats and limitations.

5.4.1 Job Satisfaction—The Conditions of Work

Job satisfaction is a reliable predictor of intentions to stay or leave a workplace, both directly or as an intervening variable in which it mediates the effects of other variables on intentions to leave (for example, satisfaction with their work may offset any disadvantages of being employed on casual contract) (King et al., forthcoming). In this section we examine the range of factors that contribute to job satisfaction. We asked workers to rate their satisfaction with aspects of their work on a 10-point scale where 1= totally dissatisfied, and 10=totally satisfied. Average scores from these responses are shown in Table 5.35, with the distribution of responses (for each level of each statement) reported in Appendix C, Tables A20 to A28. Table A29 reports on the average scores from 2007; these have been recalculated to be comparable with 2012.

The overall job satisfaction score for 2012 is 8.2, indicating widespread job satisfaction with direct care work, and with CCWs being slightly more satisfied than Nurses or AH workers. There has been no change in overall satisfaction since 2007, however satisfaction with most other aspects of work has increased slightly with the exception of total pay, with which satisfaction has decreased from 5.8 in 2007 to 5.6 in 2012 (see also Table A29). As in 2007, we see that community direct care workers are more satisfied with their work than those in residential facilities. This is the case both for overall satisfaction, which was 7.9 for direct care workers in residential facilities, and for each measure of job satisfaction apart from hours worked. Discussion of each area of job satisfaction is below.

Table 5.35: Average scores for responses from the community direct care workforce to statements about job satisfaction, by occupation: 2012 (range 1–10)

Satisfaction with	Nurse	CCW	AH	All occupations
1. Total pay	6.0	5.5	5.8	**5.6**
2. Job security	7.8	7.6	7.4	**7.6**
3. The work itself	7.9	8.3	7.9	**8.2**
4. Hours worked	7.5	7.5	7.8	**7.6**
5. Opportunities to develop abilities	7.3	7.8	7.0	**7.7**
6. Level of support from your team/service provider	7.6	8.2	7.8	**8.1**
7. Flexibility to balance work and non-work commitments	7.7	8.2	7.7	**8.1**
8. Match between work and qualifications	7.6	7.6	7.7	**7.6**
9. Overall satisfaction	7.8	8.3	7.8	**8.2**

Source: Survey of community aged care workers.
Scale used is 1(totally dissatisfied) to 10 (totally satisfied)

1. Total pay. Satisfaction with pay among direct care workers in both residential and community sectors has been comparatively low in each of the surveys that have been conducted. This is widely recognised as an issue for recruitment and retention, with both the Productivity Commission and the Department of Health and Ageing indicating that higher wages need to be considered (DoHA, 2012; Productivity Commission, 2011). The decision by Fair Work Australia to uphold a pay equity claim based on the gendered nature of work in community services was made just prior to the survey being conducted and may have had a bearing on how community direct care workers responded to this question. Just over 50 per cent of community direct care workers expressed some level of satisfaction with their pay. A higher proportion of Nurses than workers from other occupations were satisfied with their pay, but satisfaction for Nurses and CCWs has decreased since 2007. Only AH workers registered an increase in satisfaction with pay, from 46 per cent in 2007 to 55 per cent in 2012. These findings indicate that pay remains an issue for workers in community aged care.

2. Job security. Given that around a quarter of the community direct care workforce is employed on casual contracts, satisfaction with job security is relatively high. While it has remained virtually unchanged since 2007 for CCWs, it has increased from 7.4 to 7.8 for Nurses and from 7.2 to 7.4 for AH workers (Table A29). Nearly a quarter of direct care workers in 2012 were totally satisfied with their job security (Table A21).

3. The work itself. Qualitative research shows that many workers come into aged care because they want to do something worthwhile and they value the opportunity to make other people's lives a little better (Martin & King, 2008). Satisfaction with the work itself is therefore likely to be linked to whether they will stay in aged care. Ranging from 8.3 (CCWs) to 7.9 (Nurses and AH workers), the average scores for satisfaction with the work are higher than for other aspects of the work apart from overall satisfaction. As in 2007, 91 per cent of CCWs and nearly the same proportion of AH workers are satisfied with the work itself (Table A22). Of the occupational groups, however, Nurses have increased their average scores the most, going from 7.5 in 2007 to 7.9 in 2012 (Table A29).

4. Hours worked. As shown in Table A23 around 80 per cent of all direct care workers expressed some level of satisfaction with their hours, with a nearly quarter being totally satisfied.

5. Opportunities to develop abilities. As discussed in Section 5.4.2, high proportions of the community direct care workforce believe that they have the skills to do their work and are provided with adequate training in the workplace. Satisfaction with the opportunities to develop their abilities reinforces these earlier findings: 82 per cent of workers expressed satisfaction, ranging from 76 per cent of AH workers to 84 per cent of CCWs (Table A24). Only CCWs increased their satisfaction in this area since 2007. In comparison, the level of increase in the residential direct care workforce between 2007 and 2012 was much greater and went across all occupations.

6. Level of support. Community direct care workers often work by themselves when providing care services and while this autonomy may suit many people, there may be specific circumstances where support is required. The high average scores given for satisfaction with the level of support provided indicates that workplace relationships are working effectively in enabling direct care workers to perform their tasks. Although there has been no change in the satisfaction score for CCWs since 2007, Nurses have increased from 7.2 to 7.6 while AH workers have gone from 7.3 in 2007 to 7.8 in 2012 (Table A29).

7. Flexibility to balance work and non-work commitments. Details about how workers manage their work and non-work commitments are explored in Section 5.6, below. Here we focus specifically on their satisfaction with the level of flexibility they have in combining work with other responsibilities. Workers in all occupational groups have relatively high average scores for this aspect of their work, with CCWs scoring more highly (8.2) than Nurses and AH workers (7.7). Nevertheless around 30 per cent of direct care workers were totally satisfied with the flexibility their work gave them to combine their work and non-work commitments (Table A26). These findings show a slight increase in satisfaction across all occupational groups since 2007 (Table A29).

8. Match between work and qualifications. In 2012 we asked workers whether they were satisfied with the match between their work and their qualifications for the first time: in essence, did their qualifications prepare them adequately for the work they were doing? Indeed, 84 per cent of workers expressed satisfaction with the match between work and qualifications, with little variation between occupational groups (Table A27). Similar results were found in residential facilities, suggesting that direct care workers are generally confident in their preparation and ability to do the work required.

9. Overall satisfaction. There has been no change in the average score for overall satisfaction since 2007, however the score of 8.2 indicates that satisfaction remains high. Small changes in the average scores for Nurses and AH workers were recorded, going from 7.6 in 2007 to 7.8 in 2012 (Table A29). However, there has been no change in the proportion of Nurses or CCWs indicating overall satisfaction, and only a small increase for AH workers (Table A28).

5.4.2 Doing the Work

Workers responded to a number of statements about 'doing' care work. For each statement, they were asked the extent to which they agreed this was the case for them, and they could give a score on a scale of 1 (totally disagree) to 7 (totally agree), with 4 being considered the midpoint. Although subjective, these assessments of their work are important indicators of what they would like changed and their confidence in performing the work.

Table 5.36 reports the average scores for each statement, by occupation. The distributions of responses to the statements (i.e. the percentages for each level of response in each statement) are in Appendix C (Tables A30 to A38). As with residential workers, we see that community direct care workers agree most strongly with statements about having skills, using them and receiving adequate training. Overall, community direct care

workers had higher average scores than residential workers for all statements except for those about pressure/stress. Responses to individual statements are discussed below the table.

Table 5.36: Average scores for responses from the community direct care workforce to statements about their work, by occupation: 2012 (range 1–7)

Statement	Nurse	CCW	AH	All occupations
1. I am able to spend enough time with each care recipient	4.6	5.2	5.0	**5.1**
2. I have the skills and abilities I need to do my job	6.2	6.2	6.2	**6.2**
3. I use many of my skills and abilities in my current job	5.8	6.1	6.0	**6.1**
4. Adequate training is available through my workplace	5.2	5.9	5.3	**5.7**
5. I have a lot of freedom to decide how I do my work	5.3	4.9	5.5	**5.0**
6. I feel under pressure to work harder in my job	4.0	3.0	3.7	**3.2**
7. My job is more stressful than I had ever imagined	3.8	3.1	3.3	**3.2**
8. Considering all my efforts and achievements I receive the respect and acknowledgement I deserve	4.9	5.3	5.0	**5.2**
9. Management and employees have good relations in my workplace	5.0	5.5	5.1	**5.4**

Source: Survey of community aged care workers.
Scale used is 1(strongly disagree) to 7 (strongly agree)

1. Time to care. In 2007, we noted that given direct care workers are employed primarily to deliver care services to clients, having enough time with each care recipient was likely to impact on their sense of achievement and satisfaction. At that time, 70 per cent of direct care workers agreed that they had enough time to provide this care. The picture is very similar in 2012 (Table A30). Again 70 per cent of direct care workers agreed with the statement, with some variation between occupations; just over half of RNs, for example, agreed with the statement. However, this is a higher proportion of RNs than in 2007, when 43 per cent agreed that they spent enough time with care recipients.

In comparison with residential direct care workers where only one-third of direct care workers thought they had enough time to spend with clients, those in the community sector appear to have their work structured to optimise the amount of time they spend in direct care tasks. However, if we compare the results in Table 5.37 with those of the residential sector (Table 3.37), a slightly different interpretation may be required. Table 5.37 shows that 59 per cent of direct care workers in community outlets spend more than two-thirds of their shift actively caring for care recipients, with CCWs being the dominant occupational group in this category. Less than a third of Nurses and AH workers spend this much time with clients. Indeed, for any of the occupations a lower proportion of workers than in residential facilities spend more than two-thirds of their shift actively caring. This suggests that direct care workers in residential facilities spend more time actively caring, but less time with each care recipient, than direct care workers in community outlets. It is, therefore, not just the amount of time spent 'doing care', but also the extent to which this time allows workers to provide adequate services to each care recipient that informs satisfaction with this aspect of their work.

Table 5.37: Responses of the community direct care workforce to the question 'In a typical shift, how much time do you spend actively caring for care recipients?', by occupation: 2012 (per cent)

Time spent caring	Nurse	CCW	AH	All occupations
Less than one-third	41.5	19.6	31.4	**22.7**
Between one-third and two-thirds	34.9	15.2	37.6	**18.8**
More than two-thirds	23.4	65.2	31.0	**58.5**
Total	**100**	**100**	**100**	**100**

Source: Survey of community aged care workers.

Community direct care workers may also provide care to younger people with a disability, especially if funded under particular programs. As Table 5.38 shows, for around half of Nurses and AH workers and 60 per cent of CCWs, all of their clients are aged. The remaining workers have more variety in their client base, which could impact on the amount of time they spend on caring for each person, or on other aspects of their satisfaction with their work.

Table 5.38: Distribution of the proportion of aged clients cared for by community direct care workers, by occupation: 2012 (per cent)

% of aged clients	Nurse	CCW	AH	All occupations
Less than 50	2.0	2.1	3.5	**2.2**
50–74	6.3	6.0	8.6	**6.2**
75–99	42.9	33.0	40.3	**34.5**
100	48.8	59.0	47.7	**57.2**
Total	**100**	**100**	**100**	**100**

Source: Survey of community aged care workers.

2, 3 & 4. Skills, abilities and training. The community direct care workforce is comprised of high proportions (86%) of people with post-school qualifications and propensity for undertaking training with the goal of improving their skills further. The high levels of agreement regarding statements on skills, abilities and training show that, overall, workers believe they have the skills, use them and can upgrade them as required. The proportion of workers agreeing that they (a) have the skills and (b) use them in their jobs has increased since 2007 to the point where 94 per cent of workers believe they have the skills and 91 per cent believe they use them (Tables A31 and A32). This is relatively consistent across the occupational groups. In contrast, while a high proportion of CCWs believe they receive adequate training (85%), fewer Nurses (70%) and AH workers (74%) agree with this statement.

5. Freedom to do the work. In interviews with community direct care workers, autonomy has been cited as a reason for working in the community rather than residential sector (King, forthcoming). From the average scores we see that Nurses and AH workers believe they have more freedom than CCWs and the distributions reinforce this picture (Table A34). While three-quarters of Nurses and AH workers agree they have a lot of freedom to do their work, this compares to two-thirds of CCWs. However, as in 2007, CCWs are more likely to believe they have autonomy (65%) than PCAs (50%) in the residential sector.

6 & 7. Pressure and stress. The relatively low average scores for these statements indicate that, overall, workers are not feeling particularly stressed or pressured in their work. There are occupational differences however, with Nurses having a higher average score than AH workers or CCWs for both of the statements. If we compare the distribution of responses to those given in 2007 (Tables A35 and A36) we see that although

there has been little change in responses regarding stress, the proportion of CCWs and AH workers who feel under pressure has increased slightly. On either measure, though, the proportion of community direct care workers feeling stressed or under pressure is lower than that in residential facilities.

8. Respect and acknowledgement. Compared with Nurses and AH Workers, a higher proportion of CCWs feel that they receive the respect and acknowledgement they deserve (Table A37). This contrasts with responses in residential aged care in which PCAs were least likely to agree with this statement. However, since 2007 the proportion of CCWs who believe they receive these rewards has decreased from 76 to 72 per cent, while for Nurses it has increased from 57 to 65 per cent, and AH workers from 60 to 69 per cent.

9. Workplace relationships. The quality of workplace relationships is particularly important in community aged care given that individual workers may often have little face-to-face contact with colleagues or managers. This could impact on the development of trust and respect between managers and workers. With an average score ranging from 5.0 (Nurses) to 5.5 (CCWs), it would appear that most workers (76%) think that the relationship between workers and managers in their workplace is generally good (see also Table A38). However, a lower proportion of Nurses than CCWs agreed with the statement. The same pattern was noted in 2007, but since then the proportion of Nurses stating that management and employees have good relations has increased from 57 to 67 per cent, indicating that the situation has improved for a substantial group of Nurses.

In addition to the general statement about workplace relations we also sought information from workers about relationships between themselves and management, and themselves and colleagues. Responses to these questions are reported in Tables 5.39 and 5.40. As we see, even when personalising the relationships, workers generally think they are good. While there is hardly any difference between occupational groups in the quality of relationships between themselves and colleagues, CCWs were more likely than Nurses or AH workers to view relationships between management and themselves as being good.

Table 5.39: Community direct care workforce assessment of the quality of workplace relationships 'between management and yourself', by occupation: 2012 (range 1–7)

	Nurse	CCW	AH	All occupations
Bad	7.5	5.4	7.6	**5.7**
Neither good nor bad	10.4	7.4	10.6	**7.9**
Good	82.1	87.2	81.7	**86.3**
Total	**100**	**100**	**100**	**100**

Source: Survey of community aged care workers, 2012
Scale used is 1(very bad) to 7 (very good)

Table 5.40: Community direct care workforce assessment of the quality of workplace relationships 'between workmates/ colleagues and yourself', by occupation: 2012 (range 1–7)

	Nurse	CCW	AH	All occupations
Bad	2.4	2.6	3.5	2.6
Neither good nor bad	6.1	6.0	5.0	5.9
Good	91.5	91.5	91.5	91.5
Total	**100**	**100**	**100**	**100**

Source: Survey of community aged care workers, 2012
Scale used is 1(very bad) to 7 (very good)

5.4.3 Job Demands

In 2012 we asked outlets questions about the prevalence of unusual job demands that may be made of workers. The demands listed were based on research conducted on care workers by Rubery et al. (2011) and broadly align with issues raised by care workers in the interviews conducted in 2007 as an extension of the census and survey. In residential aged care we saw that the most prevalent unusual job demand was working with aggressive service users, although variation to hours or working longer than scheduled were used by a high proportion of facilities in exceptional circumstances.

The responses for direct care workers in community outlets are reported in Table 5.41. Of the five unusual job demands listed, the most widely made demand is to work longer than scheduled (82%), while working alone late at night was only required by 17 per cent of outlets, mostly in exceptional circumstances.

As with residential facilities, in community outlets the most prevalent job demands are related to unanticipated changes in work patterns: working longer than scheduled or varying hours or location at short notice. While the majority of outlets who make these demands indicated that it was only done in exceptional circumstances, nearly a third of outlets vary hours or location at short notice under normal circumstances and 17 per cent ask employees to work longer than scheduled hours because of unanticipated needs of residents. These demands create an element of uncertainty in working hours for employees and may make it difficult for them to plan their workload or meet their non-work responsibilities.

More than two-thirds of outlets ask their direct care employees to work with aggressive service users, with 16 per cent doing so under normal circumstances. This reflects the increasing numbers of older Australians with dementia and mental illness who are electing to stay in their homes. Given that most community direct care workers work alone, the need to visit aggressive service users could raise concerns about safety issues.

Although less prevalent than other demands, 29 per cent of outlets asked employees to work in very unsanitary conditions (compared with only 4 per cent of residential facilities) and 5 per cent indicated that this was a routine demand in the work. Again this raises the issue of occupational health and safety for workers who may enter these situations unknowingly and may have limited power to rectify them once there.

Table 5.41: Prevalence of unusual job demands made on the community direct care workforce: 2012 (per cent)

Job demand	Under normal circumstances	In exceptional circumstances	Never	Total
Working longer than scheduled because of unanticipated needs of residents	17.0	65.0	18.1	**100**
Variations in hours or location at short notice	32.3	47.7	20.1	**100**
Working in very unsanitary conditions	4.7	24.4	70.9	**100**
Working with aggressive service users	16.4	52.6	31.0	**100**
Working alone late at night (after 10 pm)	5.7	11.6	82.7	**100**

Source: Census of community aged care outlets.

5.5 Work-related Injury and Illness

In community aged care the type of work performed and the conditions in which it is undertaken is quite different to what occurs in residential aged care. Workers often work alone rather than in teams; they work in the private homes of service users rather than in a managed facility; and they can only influence the health and well-being of service users for short periods of time rather than being able to have them under constant surveillance. As discussed above, community direct care workers are exposed to risks in their work that could impact on their health and safety. In 2012 we asked additional questions about workplace injuries and illnesses in both the census and survey. In this section we compare findings from both sources.

In Table 5.42 we compare the types of work-related injuries and illnesses reported by outlets and workers. We see that about half of all outlets reported one or more type of injury or illness in the 3 months leading up to the census. Of those who had incidents, the most commonly reported injuries were sprains and strains, superficial injuries, chronic joint or muscle conditions and stress or other mental condition.

If we now turn our attention to worker responses, we see that 12 per cent of workers reported having a work-related injury or illness in the last 12 months. The most commonly reported incidents (for those who had reported them) were similar to those of outlets: sprains and strains, chronic joint or muscle conditions, and stress and other mental condition. However, a further 2 per cent of all workers, and 20 per cent of workers who reported an incident, indicated they had 'other' (unspecified) injuries or illnesses as a consequence of their work.

Table 5.42: Types of reported work-related injuries and illnesses, comparing outlets and workers: 2012 (per cent)

	Outlets (last 3 months)		Workers (last 12 months)	
Type of injury/illness	All outlets	With any incidents	All workers	Who reported incidents
None reported	49.4	n/a	88.3	n/a
Fracture	1.7	4.7	0.3	2.4
Chronic joint or muscle condition	9.4	26.0	2.8	26.0
Sprain/strain	20.3	56.1	4.7	43.2
Cut/open wound	5.1	14.0	0.6	5.6
Crushing injury/internal organ damage	0.2	0.7	0.1	1.2
Superficial injury (minor)	11.1	30.6	0.7	6.4
Stress or other mental condition	7.3	20.2	1.4	12.6
Amputation	0.0	0.0	0.0	0.0
Burns	2.1	5.8	0.1	1.2
Other	3.1	8.7	2.1	19.8

Source: Census of community aged care outlets.
Note: Multiple response allowed, columns will not sum to 100

Table 5.43 shows the causes of reported work-related injuries and illnesses for outlets and workers. For outlets that had any incident in the last 3 months, the four main causes are: lifting, pushing, pulling and bending; a fall; hitting or being hit or cut by a person, object or vehicle; and repetitive movement. These were similar to the causes identified by workers: lifting, pushing, pulling and bending; a fall, repetitive movement; vehicle accident; and exposure to mental stress. While there was similarity in the main causes, the extent to which

they were nominated differed. We also noted this in relation to residential direct care workers, but are unable to determine the reason from the information provided. Contributing factors might be the different reporting periods; the withdrawal from the workforce of workers who experience work-related injuries; statistical error (e.g. from weightings) and difficulties in accurately recalling incidents over the designated period.

Both outlets and workers indicated that a substantial minority of work-related injuries and illnesses were due to 'other' causes. With 14 per cent of outlets reporting an incident and 20 per cent of workers reporting an incident selecting 'other', it is possible that the standard measures of workplace safety by Safe Work Australia may not be adequate to identify the problems associated with working in community aged care. Further investigation into the causes and the types of work-related injuries and illnesses in community aged care may be warranted.

Table 5.43: Causes of reported work-related injuries and illnesses, comparing outlet and worker responses: 2012 (per cent)

Cause of injury/illness	Outlets (last 3 months)		Workers (last 12 months)	
	All outlets	With any incidents	All workers	Who reported incidents
None reported	49.4	n/a	88.3	n/a
Lifting, pushing, pulling, bending	18.3	50.6	3.4	31.8
Repetitive movement	5.7	15.7	1.1	10.6
Prolonged standing, working in cramped or unchanging positions	0.3	0.9	0.0	0.2
Vehicle accident	4.4	12.2	0.5	4.8
Hitting, being hit or cut by person, object or vehicle	6.4	17.8	0.4	3.8
Fall	9.1	25.1	1.4	12.6
Exposure to mental stress	4.9	13.4	0.5	4.8
Long term exposure to sound	0.0	0.0	0.0	0.0
Contact with chemical of substance	0.5	1.3	0.1	0.8
Fatigue	2.3	6.4	0.3	2.4
Other	5.1	14.2	2.1	19.6

Source: Census of community aged care outlets.
Note: Multiple response allowed, columns will not sum to 100

The extent to which Workcover is used by outlets and workers provides an indication of the seriousness of reported work-related injuries and illnesses. Table 5.44 shows that 24 per cent of outlets had one or more employee on Workcover in the designated fortnight, an increase from 17 per cent in 2007. These outlets had an average of 2 workers on Workcover, although this differed in relation to the occupational groups of the workers. For example, the 20 per cent of outlets that had CCWs on Workcover used it for an average of 1.9 workers; while the 2 per cent of outlets using Workcover for RNs had an average of 1.3 workers on it during the designated fortnight.

Table 5.44: Proportion of outlets with employees on Workcover (per cent) and, of these, the mean number of employees per outlet on Workcover during the designated fortnight: 2012

Occupation	Facilities Using Workcover (%)	Employees (average per facility)
Registered Nurse	1.7	1.3
Enrolled Nurse	2.2	1.3
Community Care Worker	20.1	1.9
Allied Health	1.6	1.5
All occupations	**23.5**	**2.0**

Source: Census of community aged care outlets.

5.6 Work and Non-work Responsibilities

In 2012 we used a measure of work–life interference called AWALI: the Australian Work and Life Index. Information about how this index is used and what it measures is given in Section 3.6 and is not repeated here. To summarise, however, AWALI measures perceptions of work–life interference focusing on:

- 'General interference' (frequency with which work interferes with responsibilities or activities outside work)
- 'Time strain' (frequency with which work restricts time with family or friends)
- Work-to-community interference (frequency with which work affects workers' ability to develop or maintain connections and friendships in their local community)
- Satisfaction with overall work–life 'balance'
- Frequency of feeling rushed or pressed for time.

National AWALI surveys have been conducted since 2007. Consistent patterns have emerged with regard to the groups most likely to experience high work–life interference, as defined by particular social or employment characteristics. This report examines how community and residential sector care workers' work–life interference varies by these characteristics. Care workers' scores on the work–life index are also compared with the national average from the AWALI 2012 survey, to examine whether care workers have better or worse work–life outcomes than the Australian average. In each of these tables, lower numbers equate to lower work–life interference.

Parental status

As Table 5.45 shows, work–life interference did not vary with parental status for community direct care workers overall. There was, however, a significant effect for men, with fathers reporting higher work–life interference than men without dependent children aged less than 18 years. In contrast, women's work–life interference did not differ with parenting status.

Compared with the national average, community direct care workers consistently report lower levels of work–life interference, whether they have children or not. Furthermore, in the national AWALI surveys it is consistently observed that parenting is associated with higher work–life interference. This was only observed for men in community direct care work. This suggests that female community direct care workers who are combining work with child care are less likely to experience work–life strains and pressures compared with Australian women in general.

Table 5.45: AWALI work–life index scores of the community direct care workforce and Australian workforce, by gender and parenting status: 2012

	Direct Care Workers	AWALI 2012
	Men	
Child < 18 years	39.6	48.3
No child	32.3	38.1
All	33.6	42.9
	Women	
Child < 18 years	35.2	47.1
No child	35.0	39.8
All	35.1	43.1
	All	
Child < 18 years	35.5	47.7
No child	34.7	38.9
All	34.9	42.8

Source: Survey of community aged care workers; AWALI 2012

Work hours—part-time and full-time work

Work hours, particularly the contrast between part-time and full-time work, is a consistent and strong predictor of work–life interference. This is observed in the national AWALI surveys and is a well-established finding in other Australian and international research.

As Table 5.46 shows, community sector workers working full-time consistently report higher work–life interference than their part-time counterparts.

Compared with Australian workers in the AWALI 2012 survey, part-time and full-time workers in the community sector report lower work–life interference, and this was the case for both men and women. The contrast is most evident for full-time workers, especially women working full-time in the community sector. This is an important observation, because in the AWALI surveys it is women with children and women working full-time who are consistently identified as the workers most likely to experience high work–life interference. These findings suggest that working in the community sector has a particularly positive effect on women's work–life balance.

Table 5.46: AWALI work–life index scores of the community direct care workforce and Australian workforce, by gender and work hours: 2012

	Direct Care Workers	AWALI 2012
	Men	
Part-time	30.7	33.8
Full-time	38.7	45.0
	Women	
Part-time	32.3	36.0
Full-time	41.7	50.7
	All	
Part-time	32.2	35.3
Full-time	41.3	46.9

Source: Survey of community aged care workers; AWALI 2012

Occupational role and employment contract

Work–life interference also varies within the community sector between workers with different occupational roles, and for those on different types of employment contract (Table 5.47).

CCWs report the lowest work–life interference compared with all other occupational groups[14] with a work–life index score of 34.9, which is equivalent to the average for this sector. RNs and ENs report the highest work–life interference, at a level equivalent to the average for Australian workers in 2012 (with no difference between these two groups). Nurses' work–life interference is higher than that reported by CCWs and AH workers. In turn, AH workers report higher work–life interference than CCWs.

Levels of work–life interference also vary with employment contract. Casual workers report lower work–life interference than those on fixed term or continuous contracts. This most likely reflects the lower work hours reported by casuals compared with workers on other employment contracts. Casual workers' work–life index scores are comparable to the national average, whereas direct care workers on fixed term or continuous contracts report lower work–life interference than the national average.

14 Bonferroni post-hoc tests have been conducted on these contrasts, and all other contrasts of 3+ groups ($P < .05$) where contrast is noted in the text.

Table 5.47: AWALI work–life index scores of the community direct care workforce and Australian workforce, by occupational role and employment contract: 2012

	Direct Care Workers	AWALI 2012
Occupational role		
Registered nurse	44.9	-
Enrolled nurse	44.0	-
Community care worker	33.4	-
Allied health worker	39.6	-
Employment contract		
Casual	32.6	35.7
Fixed term	35.5	45.9
Continuous	35.9	44.3

Source: Survey of community aged care workers; AWALI 2012
Note. '-' indicates data not available from the national AWALI survey.

Participation in education or training

The addition of study commitments to paid work, family, social and other commitments can create the potential to increase work–life conflict and time pressures. This is the case for workers in the community sector. As Table 5.48 shows, work–life interference is higher for workers who are combining work and study compared with those who are not, and this is the case for men and women.

The 2009 AWALI survey examined the association between participation in education and training and work–life interference (Pocock et al., 2009). The AWALI data in Table 5.48 shows the work–life index scores of respondents who indicated they were studying for a university, vocational education or other type of qualification.

Nationally, there is little difference in work–life interference between those who are studying compared with those who are not. Although studying has a negative work–life effect for workers in the community sector, it should also be noted that their work–life index scores are lower than the national average, regardless of whether they are studying or not.

Table 5.48: AWALI work–life index scores of the community direct care workforce (2012) and Australian workforce (2009), by gender and engagement in study

	Direct Care Workers	AWALI 2009
	Men	
Currently studying	36.8	42.4
Not studying	30.1	42.8
	Women	
Currently studying	37.0	45.5
Not studying	32.4	42.9
	All	
Currently studying	37.0	44.1
Not studying	32.2	42.9

Source: Survey of community aged care workers; AWALI 2009

Comparing work–life interference for residential and community direct care workers

Overall, residential direct care workers report higher work–life interference than direct care workers in the community sector, and this is the case for workers with or without children, for workers on different types of employment contract and for workers who were or were not studying. This pattern of higher work–life interference in the residential sector is also the case for men, whether they are working part-time or full-time. For women, only part-time workers in the community sector report lower work–life interference than their counterparts in the residential sector. Women working full-time in the community and residential sectors report equivalent work–life interference.

Combining work and parenting is associated with an increase in work–life interference for all direct care workers in residential facilities, whereas this effect is only observed for men in the community outlets.

The work–life index scores of most residential direct care workers are closer to the national average, whereas direct care workers in community outlets consistently report lower work–life interference than the national average, across various social and employment categories. For RNs in residential facilities, however, their work–life interference is above the national average for all Australian workers.

5.7 Cultural and Linguistic Diversity

Cultural and linguistic diversity in the direct care workforce is not surprising given that over a quarter of Australia's population was born overseas (ABS, 2012). Some workplaces can actively use the linguistic skills and cultural knowledge that migrants bring to their work. For example, better care might be provided to some older migrants if they have a care worker who can speak their primary language and is familiar with their cultural norms around ageing, gender and care. In contrast, having a culturally and linguistically diverse workforce can present challenges for managers, workers and clients.

In this section we focus on the experiences of workers from culturally and linguistically diverse backgrounds in community aged care. In Section 5.1.4 we saw that just over a quarter of the workforce was born overseas and that a majority of these were from countries in which the primary language is not English. In addition, the direct care workforce also includes second generation migrants who may speak a language other than English, and workers who are fluent in Aboriginal or Torres Strait Islander languages. In total, 24 per cent of the direct care workforce is fluent in a language other than English. Of these, a relatively high proportion is

most fluent in English although this varies by occupation (Table 5.49). The majority of RNs and ENs are most fluent in English, although a substantial minority speak both English and their primary language equally well. About half of the AH workers are most fluent in English, with another 37 per cent speaking both English and their primary language equally well. For CCWs, 39 per cent speak both languages equally well, with a similar proportion being most fluent in English. Of all the occupational groups, CCWs have the highest proportion that is most fluent in LOTE.

Table 5.49: Fluency in a language other than English (LOTE) of the community direct care workforce, by occupation: 2012 (per cent)

Speak LOTE, most fluent in	RN	EN	CCW	AH
English	59.5	73.9	38.5	50.8
LOTE	9.6	4.4	22.2	12.3
Both equally well	30.9	21.7	39.3	36.9
Total	**100**	**100**	**100**	**100**

Source: Survey of community aged care workers.
N= 995 (weighted)

Approximately 41 per cent of outlets provide services to specific cultural or ethnic groups (see Table 6.11), thereby providing opportunities for some workers to use their language skills. Given the distribution of older Australians throughout society it is likely that even those outlets not providing specialised services are still required to meet the needs of clients who come from culturally and linguistically diverse backgrounds. In Table 5.50, we see that 67 per cent of workers who are fluent in a language other than English use it in their work. Of the occupational groups, a higher proportion of CCWs (70%) than other occupations use these language skills in their work. This proportion has remained the same since 2007.

Table 5.50: Use of language other than English (LOTE) by the community direct care workforce, by occupation: 2012 (per cent)

Speak LOTE and	RN	EN	CCW	AH	All occupations
Use LOTE in job	31.6	32.0	70.1	59.7	67.0
Do not use LOTE in job	68.4	68.0	29.9	40.3	33.0
Total	**100**	**100**	**100**	**100**	**100**

Source: Survey of community aged care workers.

In 2012, for the first time we asked workers who were fluent in a language other than English to assess their skills in reading, writing and speaking English. This type of self-assessment provides an indication of whether workers think they may need assistance in understanding instructions or training. Of the three areas of English literacy, workers are most confident in their ability to speak and read in English (Table 5.51). As in residential aged care, writing was viewed as the area in which they are least fluent. A quarter of direct care workers who speak a language other than English assessed their fluency in writing in English as 'not very well'; with a very small proportion indicating that they could not write in English at all. This suggests that in community aged care there is a significant minority of workers for whom writing in English is a problem.

Table 5.51: Subjective assessment of English literacy for community direct care workers most fluent in a language other than English (LOTE): 2012 (per cent)

English literacy	Not at all	Not very well	Well	Very well	Can't say	Total
Speaking	0.0	10.8	65.8	23.4	0.0	**100**
Reading	0.0	14.9	44.9	40.1	0.0	**100**
Writing	0.5	25.3	55.0	19.2	0.0	**100**

Source: Survey of community aged care workers.

The following tables focus on information provided by outlets about the CCWs they employ who come from culturally and linguistically diverse backgrounds. We focus on CCWs because they are the largest occupational group in community aged care, both generally (82%) and of the proportion of the workforce who were born overseas (92%).

Table 5.52 shows that just over one-third of all outlets had no CCWs from culturally and linguistically diverse backgrounds. Another one-third of all outlets indicated that CCWs from diverse backgrounds comprised between 1 and 33 per cent of their CCW workforce. This indicates that the employment of CCWs from culturally and linguistically diverse backgrounds is widespread and goes beyond those outlets that provide specialised services to particular groups. However, the employment of these CCWs is not as widespread as in residential facilities. This is the case in terms of their proportion of the workforce generally and in terms of their distribution across the workforce.

Table 5.52: Distribution by proportion of community care workers (CCWs) from culturally and linguistically diverse (CALD) backgrounds in community outlets: 2012 (per cent)

% of CALD CCWs per outlet	Outlets
Zero	35.0
1–33	33.4
34–66	12.3
67–100	19.3
Total	**100**

Source: Census of community aged care outlets.

Following the outcomes of a small qualitative study conducted as part of the 2007 census and survey, we added a question to the 2012 census about the benefits of employing CCWs from culturally and linguistically diverse backgrounds. As we see in Table 5.53, the vast majority of outlets (97%) indicated that there were benefits. Of these benefits, the opportunity to enhance cross-cultural understandings and the use of language (other than English) skills were cited most frequently. However, the majority of outlets selected a range of benefits indicating they viewed the employment of CCWs from culturally and linguistically diverse backgrounds as beneficial to their clients and to the organisation.

Table 5.53: Stated benefits of employing community care workers (CCWs) from culturally and linguistically diverse backgrounds in community outlets: 2012 (per cent)

Benefits	Outlets
No benefits	3.2
Stated benefits	
Enhance cross-cultural understandings	88.1
Offer different cultural activities	67.0
Language (other than English) skills	78.4
Link clients to ethnic communities	65.5
Link outlet to ethnic communities	51.1
Other	9.9

Source: Census of community aged care outlets.
Note: Multiple response allowed, column will not sum to 100

We now narrow our focus to the employment of CCWs who speak a language other than English. We asked outlets to nominate the most common ethnic or cultural background of CCWs from linguistically diverse backgrounds. Table 5.54 shows that just over half of all outlets employed CCWs who spoke a language other than English. Of those that did, the most common languages spoken were Italian and Chinese.

In outlets that had CCWs who spoke a language other than English, the most common languages were again Italian and Chinese, however, 10 per cent of outlets said that Filipino was the main language group for CCWs from diverse backgrounds. The picture is only slightly different for outlets with more than a third of CCWs speaking a language other than English. In these outlets, Filipino was replaced by Eastern European languages as the third most widely spoken language group in these outlets.

Table 5.54: Proportion of community outlets that employ community care workers (CCWs) from linguistically diverse backgrounds: 2012 (per cent)

Ethnic group	All outlets	Outlets with any CCWs speaking LOTE	Outlets with >33% CCWs speaking LOTE
None	48.3	n/a	n/a
Italian	8.6	16.9	11.7
Chinese	6.6	12.5	21.7
Filipino	5.3	10.2	6.1
Eastern European[1]	4.2	8.1	10.3
Indian[2]	3.1	6.0	4.3
German	3.1	5.9	5.3
Greek	2.5	4.8	4.7
African	1.7	3.4	2.4
Pacific Islands	1.7	3.2	0.5
Aboriginal / Torres Strait Islander	1.4	2.7	4.7
Other	13.6	26.4	28.4
Total	**100**	**100**	**100**

Source: Census of community aged care outlets.
1. Includes Croatian, Serbian, Slovenian, Russian, Slovakian, Romanian and Slavic language groups
2. Includes Hindi and other languages spoken in India and Sri Lanka

Despite 97 per cent of outlets nominating benefits from employing CCWs from culturally and linguistically diverse backgrounds, we see in Table 5.55 that managing a multilingual workforce can present challenges. Indeed, just under 30 per cent of outlets indicated one or more area of difficulty in employing CCWs who speak a language other than English. As in residential aged care, the main concern focused on communication, especially with management/staff (68%) and with clients (64%). Although other difficulties such as occupational health and safety and communicating with clients' families were identified by fewer outlets, they still presented difficulties for over 40 per cent of them.

Table 5.55: Stated difficulties of employing community care workers (CCWs) who speak a language other than English in community outlets: 2012 (per cent)

Difficulties	Per cent of outlets
Outlets identifying difficulties	29.2
Stated difficulties	
Occupational health and safety	41.9
Communication with management and/or other staff	68.3
Communication with clients	64.0
Communication with client's families	43.0
Other—written communication	10.6

Source: Census of community aged care outlets.
Note: Multiple response allowed, column will not sum to 100

6. The Census of Community Outlets

In this chapter we use data from the census of community outlets to provide an overview of what they do, how they are structured in relation to other aged care services, their recruitment needs and strategies and their use of non-PAYG workers and volunteers in providing services to older Australians. We sent surveys to 4,178 community outlets and received valid responses from 33 per cent or 1,357.

Community outlets provide a range of aged care services, with many outlets providing at least two types of service. In this report we cover specific services, divided into two groups: packages and programs. The address lists provided by the Department were for CACP, EACH, EACH-D, HACC, DTC and NRCP services. While outlets providing ACHA and DVA programs were not part of the original sample, it was recognised that some 'in-scope' outlets also provided services under these programs and they were included in the questionnaire on advice of the project reference group. A brief description of each of these services is provided below (DoHA, 2011b, 2012b, 2012c).

Packages

Community Aged Care Packages (CACP): a planned and managed package of community care for complex low-level care needs. It includes help with personal care such as bathing and dressing, domestic assistance such as housework and shopping, or possibly participating in social activities.

Extended Aged Care at Home (EACH): meets high care needs through an individually tailored package to assist older Australians to remain living in their home for as long as possible. It includes nursing care as well as the types of care listed under CACP.

Extended Aged Care at Home Dementia (EACH-D): provides similar services to those under the EACH program, but focused on the needs of older Australians with dementia

Programs

Assistance with Care and Housing for the Aged (ACHA): helps frail, low income older people who are renting, have insecure housing or who are homeless, to remain in the community.

Day Therapy Centres (DTC): offer physiotherapy, occupational and speech therapy, podiatry and other therapy services to older people in a community setting.

Home and Community Care (HACC): meets basic needs in the home by providing maintenance and support services that promote independence such as domestic assistance, personal care, safety-related home and garden maintenance and respite care. HACC services are primarily undertaken by not-for-profit and charitable organizations.[15]

15 As part of the aged care reforms funding and operational responsibility for basic community aged care services currently delivered through the HACC program was transferred to the Commonwealth in late 2011, just prior to the National Aged Care Workforce Census and Survey

National Respite for Carers Program (NRCP): arranges respite care for relatives and friends caring at home for people who are unable to care for themselves because of disability or frailty.

Veterans Home Care / Dept of Veteran Affairs (DVA): provide HACC type services (see above) to eligible veterans and war widows/widowers.

Throughout the chapter when we refer to a particular type of service we use their acronym for ease of reading.

6.1 A Profile of Service Outlets

The community direct care workforce is distributed roughly proportional to the distribution of the population of older Australians (ABS, 2011b). Table 6.1 shows that the states with the greatest share of the community direct care workforce are NSW, Victoria and Queensland. This is similar irrespective of whether we consider the distribution of the whole direct care workforce or only direct care employees.[16]

Between 2007 and 2012 there has been a change in the distribution of the workforce across States and Territories. This is particularly noticeable for NSW, which has increased its share of the direct care workforce by 10 percentage points, and Victoria which has decreased its share by 7 percentage points. The reasons for this shift are not clear. However, the current distribution is more in line with States' share of the population more generally, and older persons specifically, in Australia.

The distribution of the workforce in different locations for 2012 remains similar to that in 2007. Metropolitan outlets employ half of the workforce, with the remaining workforce distributed across Regional (29%), Rural (19%) and Remote (2.2%) locations.

When examine by facility type, we see that in 2012 not-for-profit outlets employ three-quarters of the workforce in community aged care, a slight increase since 2007. For-profit outlets employ 6 per cent of the workforce, which is a small increase since 2007; while publicly owned outlets decreased their share from 22 per cent in 2007 to 17 per cent in 2012.

Community outlets offer a variety of services, making comparisons of the workforce between different types of service difficult. One measure of the overall size of outlets, irrespective of the services they offer, is by the number of their PAYG and direct care employees (Table 6.2).

Very small outlets employing between 1 and 5 people account for 20 per cent of all PAYG employees and 26 per cent of direct care employees. This suggests that these small outlets have a lower proportion of employees in non-direct care roles (i.e. in administration or management). In contrast, large outlets, employing more than 40 people, account for 23 per cent of all PAYG employees, but only 18 per cent of the direct care workforce. As outlets get larger, the proportion of staff required to administer the services provided increases.

16 This is not surprising given that direct care employees are a subset of all PAYG employees. Basic information about non-direct care employees is in Tables 5.4.

Table 6.1: Distribution of community direct care workforce (per cent) by State/ Territory, location, and ownership type: 2007 and 2012

		All PAYG employees		Direct care employees	
		2007	2012	2007	2012
State/Territory	ACT	1.2	2.1	1.2	2.0
	NSW	20.5	31.2	22.7	32.9
	Victoria	30.5	22.6	27.6	20.9
	Queensland	20.3	16.9	22.3	19.1
	SA	9.0	10.7	9.4	9.5
	WA	11.3	13.1	10.7	11.1
	Tasmania	6.2	2.5	4.9	3.0
	NT	1.0	1.0	1.3	1.4
Location	Metropolitan	51.3	51.2	49.5	50.6
	Regional	26.2	25.5	26.8	28.5
	Rural	20.6	21.2	21.8	18.7
	Remote	1.8	2.1	1.9	2.2
Ownership Type	Not-for-profit	70.0	74.4	72.9	76.1
	For-profit	7.6	5.2	4.7	6.7
	Public	22.5	20.4	22.4	17.1

Source: Census of community aged care outlets.

Table 6.2: Distribution of community direct care workforce (per cent) by size of community outlet, by number of PAYG and direct care employees: 2012 (per cent)

Number of employees	All PAYG employees		Direct care employees	
	2007	2012	2007	2012
1–5	22.3	19.8	24.0	26.1
6–10	21.0	21.3	22.3	19.2
11–20	20.5	16.9	20.3	16.2
21–40	16.8	18.7	16.9	20.9
More than 40	19.3	23.3	16.4	17.6
Total	**100**	**100**	**100**	**100**

Source: Census of community aged care outlets.

The following tables focus on the distribution of community outlets (as opposed to workers) that offer particular types of services. We have divided the services into two groups: those that are measured by the number of packages received such as CACP, EACH and EACH-D, and those that are measured by the number of clients such as ACHA, DTC, DVA HACC and NRCP.

We turn first to the distribution of CACP, EACH and EACH-D packages. As illustrated in Table 6.3, more than 50 per cent of outlets offer CACP packages, 29 per cent offer EACH packages and 20 per cent offer EACH-D packages. The distribution of outlets offering CACP packages across States/Territories is relatively even. The exceptions are the ACT and Tasmania where around 65 per cent of outlets offer packages; and SA which, with 41 per cent of outlets offering CACP packages, is lower than other States/Territories. The other variation relating to CACP packages is in ownership type, where a higher proportion of for-profit outlets (82%) offer CACP packages than not-for-profit outlets (54%) or publicly owned outlets (36%).

The distribution of outlets offering EACH and EACH-D packages has a similar pattern. There is some variation in distribution across States/Territories. This most obvious for the outlets in the ACT and NT, however the small proportion of outlets in these Territories suggests caution in interpreting the findings. Outlets in WA and Queensland have a lower proportion of EACH-D packages than for outlets in general. For EACH and EACH-D packages the proportion of outlets offering these in Rural and Remote locations is relatively low. Variation also exists in ownership type, with for-profit outlets offering a much higher proportion of packages than not-for-profit or publicly owned outlets.

While the proportion of outlets offering CACP packages has decreased slightly, from 55 to 52 per cent since 2007, the proportion of outlets offering EACH packages has increased from 15 to 29 per cent and those offering EACH-D packages has increased from 8 to 20 per cent. This reflects a shift toward providing increased levels of care for older Australians in their own homes, even when they have complex needs such as those associated with dementia.

Table 6.3: Proportion of community outlets offering CACP, EACH, and EACH-D packages in the designated month, by state, geographical location and ownership type: 2012 (per cent)

		CACP	EACH	EACH-D
All outlets		51.6	28.9	19.8
State/Territory	ACT	64.9	57.4	43.8
	NSW	51.4	28.3	21.8
	Victoria	52.1	32.5	20.6
	Queensland	53.0	26.3	17.1
	SA	41.6	33.3	23.4
	WA	47.7	26.7	13.4
	Tasmania	68.8	26.7	21.6
	NT	55.4	15.0	3.8
Location	Metro	48.8	29.4	19.8
	Regional	54.6	36.5	27.5
	Rural	51.6	21.8	12.8
	Remote	50.0	8.5	5.1
Ownership Type	Not-for-profit	54.0	31.6	23.0
	For-profit	81.5	58.3	34.1
	Government	35.5	11.9	2.9

Source: Census of community aged care outlets.
Note: Outlets can offer more than one type of package, rows do not total 100

The distribution of outlets in relation to the number of packages they offer provides an indication of the size of the outlet. The findings in Table 6.4 illustrate that many outlets offer only a small number of packages, especially for EACH and EACH-D providers with more than half of the outlets offering these packages providing 10 or less per month. CACP providers are more evenly spread with over a quarter of these outlets offering more than 50 packages per month.

Table 6.4: Distribution of community outlets (per cent) by number of CACP, EACH, and EACH-D packages delivered by outlets in designated month: 2012

Number of packages	CACP	EACH	EACH-D
Zero	48.4	71.1	80.2
1–10	12.6	16.1	14.3
11–25	12.2	6.9	4.8
26–50	11.7	4.9	0.5
51+	15.2	1.0	0.2
Total	**100**	**100**	**100**

Source: Census of community aged care outlets.

In Table 6.5 we direct our attention to the average number of packages offered by outlets across different locations. Overall, outlets offer more CACP packages on average than EACH or EACH-D packages. If we compare the findings for the average number of CACP packages per outlet (51) with the distribution of CACP across outlets in the above table, we see that only about a quarter of outlets deliver more than 50 packages per month. This suggests that some of these outlets deliver a large number of packages, thereby driving up the overall average.

The average number of packages provided per outlet remains relatively similar across the mainland States, with outlets in Tasmania having lower averages across all package types. Outlets in Queensland have the highest average for CACP, but relatively low averages for EACH and EACH-D; while outlets in SA also offer fewer EACH and EACH-D packages. Outlets in the Territories also tend to offer lower numbers of CACP packages than the overall average.

As might be expected given the distribution of the population generally, outlets in Rural and Remote areas provide fewer packages on average than those in Metropolitan or Regional areas. Outlets that are publicly owned also offer fewer packages than those in other ownership categories.

Table 6.5: Average number of CACP, EACH, and EACH-D packages offered by community outlets, by state, location and ownership type: 2012 (mean number of packages)*

		CACP	EACH	EACH-D
All outlets offering packages		51	16	11
State/Territory	ACT	44	18	8
	NSW	51	17	12
	Victoria	56	17	11
	Queensland	60	15	9
	SA	52	9	7
	WA	43	29	22
	Tasmania	23	5	7
	NT	18	8	10
Location	Metro	60	20	15
	Regional	76	17	9
	Rural	22	8	6
	Remote	11	10	8
Ownership Type	Not-for-profit	57	17	11
	For-profit	34	12	12
	Public	21	9	5

Source: Census of community aged care outlets.
* Average is for outlets providing these packages only

The next two tables refer to outlets that provide programs, i.e. ACHA, DTC, DVA HACC and NRCP. Table 6.6 shows that of these services, HACC programs are the most widely offered with 66 per cent of outlets providing these services. In contrast, less than 4 per cent of outlets offer ACHA services to clients; however, this may be explained by sampling differences between ACHA and other types of programs.[17] The following discussion of the data will therefore focus on DTC, HACC and NRCP programs because these formed the basis of our sample.

Turning attention to the distribution of outlets providing these services to clients, we see that there is some variation. This is particularly noticeable for the locations in which there is a smaller proportion of services—the smaller States/Territories and Remote areas. However, we need to bear in mind that the small number of respondents from these locations may skew findings so caution is required in interpreting the results. Of the remaining States/Territories, we see that Queensland has a relatively low proportion of outlets offering DTC and NRCP services, but a higher proportion offering HACC services.

Across geographical locations, we see variation in the Rural and Remote areas, particularly in the proportion of outlets providing HACC services. For ownership types the variation is primarily associated with the lower proportion of for-profit outlets that provide HACC or NRCP services.

17 The address lists from which the samples were drawn did not include ACHA or DVA services. It is therefore likely that these are under-represented in the findings.

Table 6.6: Proportion of community outlets offering DTC, HACC, NRCP, ACHA and DVA services to clients in the designated month, by state, geographical location and ownership type: 2012 (per cent)

		DTC	HACC	NRCP	ACHA	DVA
All outlets		13.1	66.1	28.1	3.5	38.8
State/Territory	ACT	46.2	66.7	41.7	0.0	57.8
	NSW	12.9	63.3	31.7	3.4	38.7
	Victoria	12.8	58.9	24.8	4.0	38.8
	Queensland	7.8	74.0	22.9	3.8	45.7
	SA	19.4	65.5	31.1	3.1	27.1
	WA	15.7	73.7	30.6	1.2	35.7
	Tasmania	12.5	54.4	26.7	2.8	42.9
	NT	21.6	74.7	25.7	8.1	8.1
Location	Metro	14.7	63.5	28.8	3.9	30.1
	Regional	13.0	61.5	30.4	3.3	44.1
	Rural	11.3	71.2	26.4	2.7	49.8
	Remote	11.1	88.0	20.2	5.2	26.0
Ownership Type	Not-for-profit	13.4	65.1	30.0	3.7	38.4
	For-profit	11.4	22.5	9.8	2.3	41.7
	Government	12.4	78.5	23.3	2.7	39.5

Source: Census of community aged care outlets.
Note: Outlets can offer more than one type of package, rows do not total 100

Table 6.7 provides an indicator of the size of outlets in relation to the number of DTC, HACC, NRCP, ACHA and DVA services to clients provided in the designated month. About half of the outlets offering DTC services have 50 or fewer clients per month, with only a small proportion having more than 250 clients. A relatively high proportion of outlets offering NRCP services have 50 or less clients per month, with two-thirds of outlets falling into this category. In contrast, the size of outlets offering HACC services has a wider distribution, with about one-third having 50 clients or less and one-quarter having more than 250 clients.

Table 6.7: Distribution of community outlets by number of DTC, HACC, NRCP, ACHA and DVA services to clients, by service outlets in designated month: 2012 (per cent)

Number of clients	DTC	HACC	NRCP	ACHA	DVA
Zero	86.8	34.0	71.9	96.5	61.2
1–50	7.6	23.4	22.3	3.0	28.5
51–100	2.8	15.6	1.8	0.1	3.2
101–250	1.2	11.0	3.4	0.3	4.7
251+	1.5	16.0	0.5	0.1	2.4
Total	**100**	**100**	**100**	**100**	**100**

Source: Census of community aged care outlets.

Table 6.8 shows the distribution of the average number of clients for each of the different programs. For all outlets, the average number of clients in the designated month for DTC was 108, for HACC services it was 242 and for NRCP it was 44.

Although some variation was identified in Table 6.6 in the distribution of outlets providing these services, the extent of this variation is even more apparent when considering the distribution of clients. For example, Victoria has a relatively low proportion of outlets offering HACC services (Table 6.6), but as we see below, these outlets provide services to more clients (374) than outlets in other States. In contrast, while the proportion of outlets that provide DTC and HACC services in NSW was about average, they tend to have fewer clients (with 80 DTC clients and 175 HACC clients) than outlets in other States/Territories. Other noteworthy variations include the average number of clients for outlets in SA that provide DTC or NRCP services, which is double the average for all outlets; and the differences between the two Territories, in which the number of clients in ACT outlets for NRCP is double the average, while outlets in the NT have a much lower average across all programs. As mentioned previously, however, some caution is required when interpreting the results for these smaller areas. This point is also relevant when considering the lower average number of clients for services in Rural and Remote areas. What is most striking about the differences in location is the average metropolitan outlet has more DTC and HACC clients per month than services elsewhere, while the average regional service has more NRCP clients.

The final distribution compared in this table relates to ownership type. Here we see that outlets that are publicly owned have a higher average number of HACC clients than for other ownership types, while not-for-profit outlets have a higher average number of clients in their DTC program. There are few for-profit outlets offering community aged care, with a low proportion providing HACC or NRCP services. As we see below, even when they do provide these services, the average outlet has fewer clients than other ownership types.

Table 6.8: Average number of DTC, HACC, NRCP, ACHA and DVA clients provided services by community outlets, by state, location and ownership type: 2012 (mean number of clients)

		DTC	HACC	NRCP	ACHA	DVA
All outlets		108	242	44	30	53
State/Territory	ACT	81	251	81	0	57
	NSW	80	175	43	25	44
	Victoria	104	374	39	16	47
	Queensland	108	238	34	59	60
	SA	227	264	88	20	71
	WA	109	317	27	4	74
	Tasmania	88	188	41	19	50
	NT	18	31	15	11	11
Location	Metro	167	348	49	27	84
	Regional	79	259	57	49	56
	Rural	36	126	27	10	22
	Remote	26	47	8	35	27
Ownership Type	Not-for-profit	128	208	45	34	53
	For-profit	13	84	29	23	164
	Public	38	371	36	8	29

Source: Census of community aged care outlets.
* Average is for outlets providing these services only

6.2 Outlets' Relationships with Broader Aged Care Services

Many community outlets provide more than one kind of aged care service. As well as we possibly could, we identified these co-located services from the service lists provided by the Department of Health and Ageing. We estimate that at least one-third of community outlets provide multiple services.

In addition to co-located services, outlets also have relationships with other aged care services. Some outlets are part of a larger provider organisation. Table 6.9 shows that 61per cent of outlets are part of larger groups, a decrease from 65 per cent in 2007. The decrease was not uniform across ownership types with the proportion of for-profit outlets belonging to a larger group increasing from 46 per cent in 2007 to 67 per cent in 2012 (see also Martin & King, 2008).

The proportion of community outlets providing residential aged care services has also decreased since 2007 when just under a quarter of outlets across all ownership types provided these services. By contrast, in 2012 just under 20 per cent of outlets provided residential aged care, with there being more variation between ownership types. The proportion of not-for-profit and for-profit outlets providing residential aged care services decreased, while the proportion of publicly owned outlets doing so increased.

Table 6.9: Proportion of community outlets that are part of larger provider group or provide residential aged care (per cent), by ownership type: 2012

	Not-for-profit	For-profit	Public	All outlets
Part of larger provider group	65.0	66.9	40.5	**60.6**
Providing residential aged care	18.2	13.7	26.4	**19.5**

Source: Census of community aged care outlets.

Focusing on the 19.5 per cent of outlets that also provide residential aged care services, we see that about one-quarter of nurses and CCWs working in these outlets work across both residential and community aged care. Publicly owned outlets have a higher proportion of these employees working across both sectors. A lower proportion of workers in AH roles work in both sectors (10%) and, when they do, they are likely to be in publicly owned outlets.

Table 6.10: Proportion of community aged care employees that work in both residential and community aged care (per cent), in outlets that provide some residential aged care, by ownership type: 2012

Occupation	Not-for-profit	For-profit	Public	All outlets
Nurse	37.6	19.1	45.5	**25.1**
CCW	25.9	22.0	30.4	**23.0**
Allied Health	8.2	20.9	44.0	**9.9**

Source: Census of community aged care outlets.
N=806 outlets (weighted)

6.3 Ethnic Specialisation

The capacity for outlets to meet the needs of older Australians from specific ethnic or cultural groups is an important policy issue. With 41 per cent of outlets providing specialised services in community settings (Table 6.11) it appears that the need for aged care services that are ethnically and culturally appropriate is well recognised. Specialisation is much higher in community outlets than in residential aged care, where it is offered by around one-quarter of all facilities. Nevertheless the rate of growth in specialised services is higher

in residential than community. Between 2007 and 2012, the proportion of outlets that offered specialised services decreased from 47 per cent to 41 per cent of outlets, while the proportion of residential facilities specialising increased from 17 to 25 per cent.

The range of ethnic and cultural groups catered for by outlets was wide although three groups stand out. Together these three groups cover 75 per cent of outlets that specialise. Some 31 per cent of outlets specialise in providing services to older Australians of Polish background; another 30 per cent specialise in services for Aboriginal and Torres Strait Islanders; while 14 per cent cater for people of Italian heritage.

For the first time in 2012, we asked outlets whether they provided specialised services to older Australians who were gay, lesbian, bisexual, transgender or intersex. Just over one per cent of outlets indicated that they offered services that specialised in these areas.

Table 6.11: Community outlets catering for specific ethnic or cultural groups: 2012 (per cent)

Ethnic group	All outlets	% among outlets that specialise
None	58.8	n/a
Polish	12.7	30.7
Aboriginal / Torres Strait Islander	12.5	30.2
Italian	5.8	14.0
Chinese	2.2	5.3
Dutch	0.8	2.0
Greek	0.5	1.3
Gay, lesbian, bisexual, transgender, intersex	0.4	1.1
Other	6.3	15.4
Total	**100**	**100**

Source: Census of community aged care outlets.
N=1,686 outlets (weighted)

6.4 Skill Shortages

The provision of aged care services depends on having the right number of workers with the required skills in the workforce. In recent years the government has invested in developing workforce skills, both for existing and potential direct care workers, so that skill shortages are minimised. The skill shortages (causes and responses) questions we use have been shaped to resemble closely those of the Business Longitudinal Data (BLD) survey of the ABS, which surveyed small to medium sized firms in Australia initially from 2005 to 2007 (see Healy et al., 2012) and subsequently in 2008–2009. The similarity in the questions was intentional in order to allow for statistical comparisons between the Aged Care sector and the broader Australian national benchmark offered by the BLD. The information we collected about the extent of skill shortages, the factors that cause the shortages and the kinds of responses to them will assist in refining existing strategies and planning for the future.

Skill shortages in one or more occupations were experienced by 49 per cent of all outlets (Table 6.12). This compares with 76 per cent of facilities, indicating that while the majority of outlets have skill shortages, this is lower than in residential aged care. In exploring regional differences in the spread of skill shortages, we can see that outlets in Remote areas are more likely to have skill shortages, with outlets in Metropolitan areas also having a higher proportion of skill shortages than outlets in Regional or Rural areas.

Table 6.12 also calculates the proportion of outlets with skill shortages in particular occupations. The summary figure for these (in the right hand column) indicates that shortages of CCWs was the most common (37.2% of outlets), followed by RNs (15.7% of outlets). There were, however, regional differences. Shortages of CCWs were more likely in outlets in Metropolitan or Remote areas, while shortages of RNs were more likely to be reported by outlets in Regional areas.

Further analysis of these data found that although many outlets had skill shortages for one occupation, just 0.2 per cent faced shortages in *all* occupations.

Table: 6.12: Proportion of community outlets reporting skill shortages in 2012 (per cent), by location and occupation affected

Whether had skill shortage	Metro	Regional	Rural	Remote	All outlets
No	48.0	54.3	54.4	38.8	**50.9**
Yes	52.0	45.7	45.6	61.2	**49.1**
Yes, for:					
RN	13.9	18.0	16.4	15.8	**15.7**
EN	6.8	4.5	5.5	8.2	**5.9**
CCW	41.3	34.7	30.7	52.0	**37.2**
AH	11.4	9.0	8.9	6.6	**9.9**

Source: Census of community aged care outlets.
Note: Multiple responses allowed, columns do not sum to 100

Outlets that reported skill shortages (49%) were asked to identify the factors that caused them. Table 6.13 shows that while a diverse range of causes was identified, three stand out. The most frequently reported causes of skill shortages were the slow recruitment process (40%), the geographical location of outlet (37%) and the specialist knowledge required to do the work (31%). These are the same three causes cited most frequently by residential facilities, although in the reverse order of priority.

When we break this analysis down by selected occupation, the slowness of the recruitment process is highlighted even further for outlets with shortages among RNs and CCWs. Outlets were also more likely to nominate 'specialist knowledge required' for their RN shortages than for their CCW shortages. Another difference between these two occupations is that outlets were more likely to indicate that lack of confidence in the 'long term demands for service' was a cause of shortages among CCWs than RNs.

Table 6.13: Proportion of community outlets with skill shortages in 2012 that nominated each cause of that shortage (per cent), by occupation affected

Cause of skill shortage	Outlets that reported skill shortages		
	For any occupation	For RNs	For CCWs
Specialist knowledge required	31.1	42.4	30.7
Geographical location of outlet	37.0	38.5	35.8
Wages or salary costs too high	15.2	19.0	15.4
Lack of availability of adequate training	16.1	18.2	17.5
Unsure of long term demands for service	14.2	10.1	16.8
Recruitment too slow	39.6	44.6	43.1
Aged care not attractive	6.5	5.0	7.2
Leave/sick or maternity leave	0.0	0	0
No suitable applicants	0.0	0	0
Shortage of (experienced) nurses/RNs	0.7	2.3	0.4
Other	6.4	6.3	6.7

Source: Census of community aged care outlets.
Note: Multiple responses were allowed, columns do not sum to 100
N=2,018 outlets (weighted)

The last question about skill shortages asked outlets with skill shortages (49%) what they did in response to having these shortages. A range of strategies was used, with some strategies being used more widely than others. Table 6.14 shows that a majority of outlets (55%) asked their existing staff to work longer hours. This is in line with the most frequent response nominated by residential facilities, and reflects that of businesses in Australia more generally (Healy et al., 2012).

Outlets also responded to skills shortages by providing training for their staff, either on-the-job training (38%) or external training (22%); and by employing non-PAYG staff, either from agencies (30%) or self-employed/ brokered sources (15%). These strategies were also used by residential facilities.

One of the key differences between outlets and facilities in their responses to skill shortages is that outlets were more likely to reduce outputs (i.e. services) with 16 per cent of outlets identifying this response compared with 4 per cent of facilities. This is understandable given the different nature of services offered. Community outlets have somewhat more flexibility in how they structure service delivery and the number of services they provide. However, this does mean that older Australians who have been assessed as requiring services may not be able to receive them.

Table 6.14: Proportion of community outlets with skill shortages in 2012 that nominated each response to that shortage (per cent), by occupation affected

Response to skill shortage	Outlets that reported skill shortages		
	For any occupation	For RNs	For CCWs
External training of staff	22.2	22.2	24.8
On-the-job training of staff	38.1	39.0	42.9
Existing workforce worked longer hours	55.0	63.7	57.3
Greater use of agency staff	29.5	36.6	30.7
Sub-contracted or outsourced services	14.5	19.4	15.6
Employed staff on short term contracts	15.0	19.1	12.9
Wages, salaries and/or conditions increased	11.9	13.3	13.8
Reduced outputs or production	15.9	14.4	15.3
Overseas recruitment	0.3	0.9	0.2
Recruitment/advertising	2.4	1.4	2.3
Other	3.7	4.3	3.8

Source: Census of community aged care outlets.
Note: Multiple responses were allowed, columns do not sum to 100

6.5 Vacancies

Vacancy rates are another indicator of the state of the aged care labour market. Together with the information about skill shortages, we build a picture of the extent to which community outlets have difficulties in recruiting enough staff with the right skills to provide the required services.

We asked outlets to report on the number of vacancies they had at the time of completing the survey for employees in each occupational classification. This information has been used in Table 6.15 to calculate the proportion of outlets with vacancies in each occupation (Panel 1) and the average number of vacancies for these outlets (Panel 2). We exclude outlets that did not report any vacancies.

Community outlets reported FTE vacancies across the range of occupations, but were more likely to have vacancies for CCWs (21.4%) than other occupations. This is understandable given the distribution of the different occupations in community aged care, because CCWs comprise 82 per cent of the workforce. As with residential facilities there has been little change in the proportion of outlets with vacancies between 2007 and 2012. If anything, outlets are currently slightly less likely to have vacancies.

In Panel 2 we see that for those outlets with vacancies, the mean number of unfilled FTE positions ranged from 3.5 for CCWs to 1.4 for RNs.

Table 6.15: Vacancy rate (per cent of all community outlets) and mean number of vacancies (in outlets with vacancies), by occupation: 2007 and 2012

	Full-Time Equivalent	
	2007	2012
Panel 1: % of outlets with any vacancies		
Registered Nurse	6.1	5.5
Enrolled Nurse	2.5	2.1
Community Care Worker	22.2	21.4
Allied Health	5.2	3.8
Panel 2: Mean number of vacancies in outlets with any vacancies		
Registered Nurse	n/a	1.4
Enrolled Nurse	n/a	1.6
Community Care Worker	n/a	3.5
Allied Health	n/a	2.3

Source: Census of community aged care outlets

Probably the most reliable way to assess directly the issues facing outlets in recruiting staff is gained by looking at the time that it takes to fill vacancies for different occupations. Tables 6.16 and 6.17 examine vacancy duration (measured in weeks) with reference to the *most recent* vacancy that outlets advertised.

The results in Table 6.16 show that for all occupations except for CCWs, over half of the vacancies were filled in 2 weeks or less. However, over three-quarters of vacancies for CCWs were filled within 4 weeks. This would suggest that CCW vacancies are somewhat more difficult to fill. However, when comparing occupations that take the longest to fill (i.e. over 5 weeks) we see that there is little difference in the proportion of outlets with vacancies for CCWs, RNs and AH workers. Around 20 per cent of outlets had longer vacancies for these occupations.

The most striking aspect of the results reported in Table 6.16 is the increase in vacancy duration since 2007. This goes across all occupations, but is most noticeable for RNs, ENs and AH workers. In 2007, the majority of vacancies in these occupations (77%, 90% and 83% respectively) were filled within 1 week, whereas in 2012 these figures were 40 per cent for RNs, 63 per cent for ENs and 45 per cent for AH workers. This suggests that it has become more difficult for outlets to recruit these workers since 2007. Vacancy duration for CCWs also increased, but only moderately, indicating that recruiting CCWs has been difficult for several years.

Table 6.16: Weeks required by community outlets to fill most recent vacancy, by occupation: 2012

% of outlets that took	RN	EN	CCW	AH	All occupations
Less than 1 week	39.6	62.7	16.2	45.2	**11.9**
1 week	3.2	5.2	9.8	3.7	**9.9**
2 weeks	8.9	4.3	18.6	6.5	**16.0**
3 to 4 weeks	18.0	12.0	31.9	19.1	**29.6**
5 to 8 weeks	18.4	7.4	16.5	16.4	**21.7**
9 to 12 weeks	6.1	5.3	4.1	5.5	**5.9**
13 to 26 weeks	4.5	2.1	2.1	3.1	**4.2**
More than 26 weeks	1.1	1.0	0.8	0.3	**0.9**
Total	**100**	**100**	**100**	**100**	**100**

Source: Census of community aged care outlets
N=2,939 outlets (weighted)

Another way of investigating any difficulties in recruitment is to measure vacancy duration by the average number of weeks taken to fill a position. This is reported in Table 6.17, where we see that the average vacancy duration is slightly higher for RNs than for CCWs.

It seems that the location of outlets has an influence on vacancy duration for each of the reported occupations. With an average vacancy duration of 4.7 weeks, outlets in NSW and Victoria take longer to fill RN vacancies than outlets in other States/Territories. Problems recruiting RNs appear lower in the smaller States/Territories. For CCWs, the picture is nearly reversed with outlets in SA, NT and Tasmania taking longer on average to fill these vacancies. Not surprisingly, vacancies in Rural and Remote areas take longer than the average to fill. These areas are less likely to have a ready pool of RNs and CCWs to draw upon when vacancies arise. This is more so for RNs than CCWs.

We also estimated the median vacancy duration to see if there were extreme values at either end that *skewed* the mean statistic. For RNs the median vacancy duration is 3 weeks (compared with a mean of 4.3) and for CCWs the median is 2 weeks (compared with a mean of 3.9). This suggests that while there are a few outlets that take a long time to fill vacancies, the majority of outlets would fill them in a relatively shorter period of time.

Table 6.17: Average vacancy duration (weeks) for RNs and CCWs, by State/Territory and location: 2012

		RN	CCW
All outlets		4.3	3.9
State/Territory	ACT	3.3	3.0
	NSW	4.7	4.1
	Victoria	4.7	3.7
	Queensland	4.4	3.5
	SA	3.0	4.7
	WA	3.7	3.4
	Tasmania	3.0	4.2
	NT	4.1	4.5
Location	Metropolitan	3.6	3.8
	Regional	3.9	3.6
	Rural	4.7	4.0
	Remote	8.4	5.5

Source: Census of community aged care outlets

Vacancies can exist for a variety of reasons including growth of an outlet or retirement. We asked outlets the reason(s) for their most recent vacancy for each of the occupations. In Table 6.18 we report on their responses for RNs, CCWs and all occupations. As with residential facilities, the most common reason for a vacancy is resignation, with 59 per cent of outlets nominating this response. However, over a third of all vacancies were new positions that had been created. This indicates that the community aged care sector is growing at a similar rate to residential aged care.

There were some differences in the reasons given for different occupational groups. RN vacancies were particularly likely to be due to the creation of a new position, with 38 per cent of outlets giving this as the reason. In contrast, for CCWs, outlets were more likely to nominate resignation as the main reason for a vacancy (53%).

Table 6.18: Proportion of community outlets giving each reason for their most recent vacancy (per cent), by occupation: 2012

% of outlets stating	RN	CCW	All occupations
New position	38.0	24.9	34.7
Retirement	9.4	11.8	14.4
Injury/illness	7.0	6.1	7.1
Resignation	34.5	52.5	59.2
End of contract	3.5	1.6	3.2
Involuntary separation	0.0	3.3	3.6
Other	10.5	18.9	25.0

Source: Census of community aged care outlets
Note: Multiple response allowed, columns will not sum to 100

Outlets use a number of strategies to recruiting staff to fill vacancies. We asked outlets how they recruited CCWs, and compare their responses with how recently hired CCWs and other workers find out about recruitment opportunities. Table 6.19 summarises their responses.

We see some interesting differences in the use of information from various sources. While more than a third of outlets use traditional approaches to recruitment of CCWs through advertising in newspapers and/or the internet, only 18 per cent of CCWs use these as a source of job information. Instead, CCWs are more likely to find out about jobs by word of mouth (26%) or through job placement programs such as those offered through educational/training institutions (34%). While Nurses and AH workers also find out about jobs through word of mouth, they are much more likely than CCWs to use the internet as a source of information.

Despite the extensive use of agency workers in aged care, fewer than 3 per cent of outlets use agencies to recruit CCWs. In contrast nearly 7 per cent of CCWs find out about jobs through agencies. Of interest also is the proportion of CCWs that find employment through placements from training providers and other education institutions (34%).

Table 6.19: Sources of information about recruitment opportunities used by recently hired* community direct care workers and outlets: 2012 (per cent)

Source of job information	Nurse	CCW		AH
	Worker	Worker	Outlet	Worker
Walk-in	n/a	n/a	3.5	n/a
Word of mouth	28.9	36.1	12.0	34.8
Newspaper job advertisement	26.7	17.6	26.3	21.7
Internet job advertisement	38.9	0.3	15.0	32.6
Both internet and newspaper job advertisement	n/a	n/a	35.2	n/a
Job placement program/career service	0.0	33.8	3.7	0.0
Agency	3.3	6.8	2.6	6.5
Other	2.2	5.4	5.0	4.3
Don't know	n/a	n/a	3.3	n/a

Source: Census of Community aged care outlets, and Survey of community aged care workers.
Note: Multiple response allowed, columns will not sum to 100
* Recently hired workers have been employed for 12 months or less, N=2,868 outlets (weighted)

6.6 Setting of Employment Conditions

The method used by outlets in setting employment conditions provides the framework for determining working arrangements and the degree of flexibility that outlets can maintain. Table 6.20 reports the proportions of employees across all community outlets that are bound by particularly forms of agreement. It should be noted that some of the methods operate in tandem (e.g. awards and agreements) and employers may not recognise the distinctions between them. However, we report the responses as provided by outlets.

As with residential aged care, the most common method of setting employment conditions is Enterprise Agreement. It is not as common as in residential aged care, however, where three-quarters of employees are covered by this method compared with 59 per cent in community aged care. The difference is that a higher proportion of employees in community outlets is covered by Awards (35%) than in residential facilities (24%).

The use of Awards in setting employment conditions for workers in community outlets is much higher than its use for non-managerial employees in the Australian workforce more generally, which is 16 per cent (ABS, 2010b).

Table 6.20: Industrial methods used by community outlets to set employment conditions (per cent), by employee occupation: 2012

% of employees with conditions set by method	Nurses	CCW	AH	All occupations
Award	40.0	32.7	47.8	34.5
Enterprise Agreement	54.0	60.6	47.8	59.0
Common Law Contract	2.9	4.7	1.2	4.3
Individual Flexibility Agreement	1.9	1.4	2.0	1.5
Don't Know	1.2	0.6	1.2	0.7
Total	**100**	**100**	**100**	**100**

Source: Census of community aged care outlets

6.7 Agency, Brokered and Self-employed Staff

In addition to the workforce employed directly by community outlets, workers may also be sourced through nursing or employment agencies, other aged care providers, or through networks of independent care workers. We refer to these 'agency', 'brokered' or 'self-employed' employees as 'non-PAYG'. The traditional use of non-PAYG workers is to fill temporary gaps when permanent or casual staff are on leave or there is an unexpected vacancy. Outlets may also use non-PAYG workers on a more permanent basis and view them as part of their core staff. We asked outlets to provide information about their use of non-PAYG workers so that we could understand the extent to which these workers augment the workforce in community aged care.

Table 6.21 shows that a minority of community outlets, some 27 per cent, used at least one non-PAYG worker in the designated fortnight. Of the three types of non-PAYG workers, outlets were most likely to engage brokered workers (15%), with 11 per cent using agency workers and 6 per cent using self-employed workers.

Outlets employ mainly CCWs via non-PAYG arrangements. About one-fifth of all outlets engaged CCWs using these arrangements, mainly through brokered services (12%) or agencies (8%). Use of non-PAYG workers in RN and AH roles was not as high, at 8 per cent each. We can also see that outlets simultaneously engaged non-PAYG workers from different occupations. For example, the proportion of outlets employing brokered workers across all occupations is 15 per cent which is less than the total for that column (i.e. by adding the proportion for each occupation), indicating a level of overlap.

Table 6.21: Proportion of community outlets (per cent) using non-PAYG workers in the designated fortnight, by occupation and type of worker: 2012

Occupation	Agency	Brokered	Self-employed	All non-PAYG
Registered Nurse	3.7	3.4	1.2	**7.9**
Enrolled Nurse	1.1	1.2	0.1	**2.4**
Community Care Worker	8.3	12.1	3.0	**21.0**
Allied Health	2.3	3.5	3.2	**8.2**
All occupations	**11.3**	**14.5**	**6.0**	**27.2**

Source: Census of community aged care outlets

Table 6.22 focuses attention on the use of non-PAYG workers in two occupations: RNs and CCWs. The most noticeable finding in this table is the increase in the proportion of outlets employing non-PAYG RNs and CCWs since 2007; from 2 per cent to 8 per cent for RNs and from 12 per cent to 21 per cent for CCWs. This contrasts with the findings in residential facilities where the use of non-PAYG RNs had remained constant while for PCAs the proportion had decreased.

There is variation in the distribution of outlets employing non-PAYG RNs and CCWs between the States. Outlets in Victoria are more likely to employ non-PAYG workers in either occupation than outlets in other States/Territories. Relatively high proportions of outlets in the ACT (28%) and SA (28%) employ non-PAYG CCWs, whereas a fairly low proportion of outlets in Queensland (14%) employ these workers. Outlets in SA are the least likely to employ non-PAYG RNs (2%).

Table 6.22: Proportion of community outlets (per cent) using any non-PAYG RNs or CCWs in the designated fortnight, by State/Territory: 2012

State / Territory	RN		CCW	
	2007	2012	2007	2012
ACT	7.7	5.3	15.4	28.1
NSW	7.5	6.9	14.3	21.1
Victoria	1.7	11.9	13.0	26.8
Queensland	3.0	9.9	8.8	14.4
SA	3.3	1.6	13.0	27.6
WA	1.9	5.3	12.1	18.2
Tasmania	0.0	5.0	3.4	21.3
NT	3.0	6.9	6.1	20.7
All outlets	**2.2**	**7.9**	**11.6**	**21.0**

Source: Census of community aged care outlets

Table 6.23 provides an alternative view of the extent to which non-PAYG workers contribute to the community direct care workforce, by reporting on the number of non-PAYG workers outlets had employed in the designated fortnight, and the number of shifts these workers covered.

With respect to the number of workers, non-PAYG CCWs were the most widely used by outlets. There were nearly 20,000 of these workers in outlets in the designated fortnight, representing 87 per cent of all non-PAYG workers in community outlets at that time. The next most widely utilized were non-PAYG AH workers of which there were 1,316 or 6 per cent of all reported non-PAYG workers. This is a change since 2007 when non-PAYG RNs were slightly more likely to be used in outlets.

As discussed above, almost half of all non-PAYG workers were brokered. Nurses were less likely to be self-employed than CCWs or AH workers.

The right-hand column shows the number of *shifts* that non-PAYG workers covered rather than the number of *workers*. This further demonstrates the extent to which non-PAYG CCWs contribute to community aged care. While these workers comprise 87 per cent of the workforce, they worked 95 per cent of all shifts covered by non-PAYG workers. While there are fewer non-PAYG RNs than AH workers, they cover a larger proportion of shifts.

Table 6.23: Number of non-PAYG workers in community outlets in the designated fortnight, and the number of shifts they covered, by occupation: 2012

Occupation	Number of workers				Number of shifts
	Agency	Brokered	Self-employed	Total	Total
RN	445	598	101	1,145	5,047
EN	187	183	12	383	471
CCW	5,349	11,463	3,041	19,853	142,568
AH	293	689	334	1,316	2,422
All occupations	**6,274**	**12,933**	**3,488**	**22,697**	**150,508**

Source: Census of community aged care outlets
N=1,131 outlets (weighted)

Another way of illustrating the contribution of non-PAYG workers in community outlets is to look at the average number of shifts worked by each worker. Table 6.24 summarises the average number of shifts worked by each non-PAYG worker for the different occupations, and then separately by State/Territory and outlet location.

The findings reported in this table reinforce the important contribution made by non-PAYG CCWs in community aged care. With an average number of shifts worked in the designated fortnight of 7.2, this is much higher than the average number worked by RNs (4.4) or by ENs or AH workers who worked 1–2 shifts each. These averages are much higher than the number of shifts worked by non-PAYG employees in residential facilities.

When examined by State/Territory and outlet location, some differences stand out. Not only do higher proportions of outlets employ non-PAYG workers, they do so for more shifts per fortnight than in other states. For example, non-PAYG RNs in Victoria worked an average of 7.3 shifts and CCWs worked 10.1 shifts in the designated fortnight, which is much higher than any in other State/Territory. A similar story is found for outlets in Regional areas, where non-PAYG employees work nearly double the number of shifts compared with the average, and a much higher number compared with non-PAYG workers in other locations.

Table 6.24: Average number of shifts worked in the designated fortnight by each non-PAYG worker in community outlets by occupation, State/Territory and location: 2012

		RN	EN	CCW	AH	All occupations
All outlets		4.4	1.2	7.2	1.8	**6.6**
State	ACT	0.0	0.0	3.6	0.0	**3.5**
	NSW	3.8	1.8	7.7	2.0	**7.2**
	Victoria	7.3	0.8	10.1	2.4	**9.2**
	Queensland	1.5	2.5	6.6	0.9	**5.4**
	SA	1.0	1.0	1.6	1.4	**1.6**
	WA	2.1	0.6	5.7	2.1	**4.9**
	Tasmania	3.4	0/0	8.4	1.3	**7.5**
	NT	0.3	0.0	0.6	1.0	**0.6**
Location	Metro	2.0	0.8	4.9	1.6	**4.6**
	Regional	9.4	1.8	13.5	2.9	**12.4**
	Rural	5.2	2.4	1.6	0.7	**1.8**
	Remote	0.5	1.2	1.7	0.1	**1.0**

Source: Census of community aged care outlets

6.8 Volunteers in Community Aged Care

Volunteers are widely used in community aged care programs and a number of 'volunteer only' services were within the scope of the census (but not the survey which was for paid direct care workers). Some community outlets use volunteers to augment existing services, for example taking older Australians shopping or to appointments, providing a community bus or programs in the community; other outlets only have volunteer services, such as Meals on Wheels and other kinds of food delivery services. Some of these services engage a large number of volunteers, for example, 13 outlets indicated they had 200 or more volunteers providing community aged care services. Information about the number of volunteers and the hours they contributed in community outlets was collected for the first time in 2012.

Table 6.25 shows that outlets responding to this question engaged nearly 57,000 volunteers who provided more than 250,000 hours of service in the designated fortnight. This equates to an average of 27 volunteers per outlet, with each volunteer averaging 4.6 hours for the fortnight. If we extrapolate these hours over a year it comes to more than 6.7 million hours of volunteer service in community aged care.

Table 6.25: Total number of volunteers and volunteer hours worked in community outlets in the designated fortnight: 2012

Volunteer numbers	Volunteer hours	Average hours per volunteer
56,729	258,373	4.6

Source: Census of community aged care outlets.

Table 6.26 shows that 51 per cent of outlets have one or more volunteers. The distribution of volunteers is fairly consistent for all locations except Remote areas, where 34 per cent of outlets had volunteers. The use of volunteers also differs by the ownership type of outlets, with for-profit outlets being much less likely (11%) to engage volunteers than not-for-profit or publicly owned outlets.

Table 6.26: Proportion of community outlets employing volunteer workers (per cent) in designated fortnight, by location and ownership type: 2012

		Volunteers
All outlets		51.2
Location	Metropolitan	53.4
	Regional	49.0
	Rural	53.1
	Remote	34.2
Ownership type	Not-for-profit	53.7
	For-profit	10.8
	Public	46.6

Source: Census of community aged care outlets.

7. Interviews with Direct Care Workers

Interviews with 101 direct care workers were undertaken following the survey. The purpose of these interviews was twofold. Firstly, we sought to understand more about the experience of male workers and that of overseas-born workers from culturally and linguistically diverse backgrounds. These two categories of workers were oversampled so that we could investigate what it was like for them to have jobs in aged care. The issues they raise are pertinent if these categories of workers are to expand further their presence in the direct care workforce. Secondly, we sought to identify or further investigate emerging issues for the sector. In analysing the interviews it was evident that the perspectives of employees in 2012 differed from those we interviewed in 2007: they were more optimistic about their work, sought opportunities for training and professional development and were engaged in thinking about how to improve the quality of care services. In the final part of the chapter, issues raised by care workers are discussed in relation to their impact on recruitment and retention in the sector.

7.1 The Interview Process

Upon completion of the workforce survey, direct care workers were provided with an opportunity to nominate themselves to take part in a deeper discussion about their experience of work in the aged care sector. A randomised sample of these employees was generated and semi-structured telephone interviews were conducted with 101 people.[18] These included 13 RNs, 6 ENs, 56 CCWs/PCAs, 4 AHP, 19 AHA, 1 ancillary care worker, and 2 care coordinator/team leaders.

A purposive sampling strategy used was such that the random sample was stratified to be equally divided between direct care workers in residential facilities and those in community outlets. The sample was further stratified to oversample two target groups: men, and culturally and linguistically diverse migrant workers (hereafter called CaLD migrant workers). The aim was to interview 100 workers comprised of 20 men, 50 CaLD migrant workers, and 30 workers randomly drawn from the total sample (which also included male and CaLD migrant workers). However, following the contact process described below, the final designated sample comprised a total of 20 men, 48 migrant workers, and 33 general workers. Given that the stratification process allowed non-sampled participants to be selected for another category, it did not preclude participants from fitting multiple categories. For example, a participant designated as 'male' might also be a migrant worker, or a participant designated as 'general' might also be a male worker. As many of the general workers also fitted the other categories, the demographic features of the final sample are 33 male, 49 CaLD migrant and 19 female, non-migrant workers. Two-thirds of the CaLD migrant workers in this sample had arrived in Australia since 2001.

The process involved generating an initial sample from the list of respondents to the survey who had provided their contact details. The research team then telephoned potential participants to schedule interviews of approximately 30 minutes at a time that was convenient for the participant. We made three attempts to contact each person and if this was unsuccessful he or she was replaced in the sample using the same purposive sampling strategy discussed above. Those who expressed a desire not to take part in the interview process were also replaced. This occurred until all interviews had been completed. The interviews were conducted in April and early May, 2012. A copy of the interview schedule is in Appendix D.

After obtained each participant's consent, interviews were digitally recorded and transcribed verbatim. The transcripts were then analysed thematically by categorising units of text around the core themes outlined

18 The goal was to interview 100 workers divided equally between residential and community aged care.

by the interview schedule, and identifying response patterns. 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. As is the nature of semi-structured interviews, participants may have provided responses that cover multiple themes and some interviewees may not have addressed all of the questions.

Each interviewee was designated a number which reflects the designated 'group' they belonged to and the sector they worked in. For example, numbers with the prefix R indicate workers from residential facilities, while C indicates a community worker; the suffix indicates the group, M for male, G for general and C for culturally and linguistically diverse migrant. An excerpt numbered R031C is therefore interview number 31 of the residential workers; and as the suffix is 'C', this person migrated to Australia and speaks a language other than English.

7.2 Growing the Aged Care Workforce

Australia's demographic characteristics indicate that the aged care workforce is going to continue to grow for at least the next 30 years. One of the challenges, as most recently pointed out by the Productivity Commission (2011), is to find workers to fill these places. Women, often with little or no post-secondary education and who are returning to work after having raised their children or cared for parents, have been the traditional group from which workers have been recruited. However, Australian-born women now have more education and job options when returning to the workforce or establishing a second career. Although they will remain an important component of the workforce, it is clear that recruitment strategies will need to target other groups to fill vacancies. To a certain extent this is already happening: migrants, for example, now comprise a substantial proportion of the direct care workforce (see Tables 3.8 and 5.8). Another group that is increasing, particularly in residential aged care, is men. These two groups of workers present challenges for a sector that is constructed around care work as a form of 'women's' labour, in which English is the primary administrative and management language.

7.2.1 Male Workers

Men now comprise just over 10 per cent of the workforce in both residential and community aged care. Although small, their share of the workforce has been slowly increasing and has the potential to increase further. Over the past two decades working age men have been withdrawing from the general workforce because of changes in the structure of the labour market (e.g. decline of manufacturing) and the growth of non-standard work arrangements (e.g. part-time, flexible work). In addition, job growth over this period has been particularly noticeable in occupations related to service work and care work, areas which are dominated by women and viewed by some men as 'not appropriate' for them to undertake. In her analysis of the factors influencing men's entry into care work (specifically aged care and child care) by workers with no post-secondary education, Moskos (2011) found that perceptions of masculinity and assumptions about men's skills and traits, held both by potential workers and potential employers, impeded their entry into these forms of work. She argues that if men are to increase their share of the direct care workforce, these perceptions will need to be addressed.

In this section we seek to understand what it is like for men to work in aged care: how do they get into the work? Are they expected to do specific types of work? Did they feel disadvantaged by undertaking work in an area that is traditionally linked to 'women's skills'? We focus on the experiences of men who are currently working in aged care. This provides an important perspective on men in care work, but to gauge fully the potential for men to increase their share of the workforce the perspectives of employers, care recipients and men who have left aged care would also need to be considered. What we provide here is a starting point

to see whether increasing the employment of men in the sector might be a feasible option for addressing workforce shortages.

We interviewed 33 men, 20 of whom had been purposively sampled and the remainder were in the general and migrant categories. Men came into aged care from diverse backgrounds, including previous experience in other care fields such as hospitals or disability care; other forms of service work such as cleaning or being a taxi driver; doing manual labourer as a tradesmen or construction worker; or having experience in management or self-employment. The following excerpt is from a man who had previously been a surveyor's assistant and had moved location for family reasons. As work opportunities in his chosen occupation were limited in the new location he found work in a hospital:

> *I was working at the hospital as a wardsman—it was an excellent job in the public system, better pay and conditions of course, as well—but unfortunately because I was on contract there and the aged care beds were leaving the hospital to go to the private nursing home my position was going to be no longer required as I was only under contract. Basically I applied for the job at the nursing home and got it. [R013M]*

Several of the men moved into aged care after an interruption to their career through redundancy, retirement or a change in location, with only a small proportion—mainly nurses—having an occupational background that closely fitted the profile of an direct care worker. However, some men had personal experience of caring for vulnerable adults which opened up options for them in terms of aged care:

> *I was a logistics manager for 20 odd years and my father-in-law who used to live with us got dementia and we went through a torrid time and there wasn't a lot known about dementia sort of 12 years ago and with my job as logistics manager I was able to get away most days and I fed him. The lady at his nursing home said "You'd be good at it". [The company] finally sold out and I found myself at the ripe old age of pushing 50 and without a job and so I went back to school and became a carer and then I went and done two years nursing. [R046M]*

Aged care was not viewed by many men as a first option for a career, but this is the same for women. As we saw from the survey data, most care workers (other than RNs and AH workers) come into aged care after having other careers and usually after a period out of the workforce to provide childcare (or elder care). For men, however, there appears to be a somewhat serendipitous pathway that relies on either some form of non-work contact with the care system or being introduced into the work by people they know.

> *It wasn't a conscious decision, it was just a matter of chance really. I met someone—a guy at a drawing group and he said that he had this job where he was taking a chap drawing, sketching, a chap with dementia, so I thought that sounded quite—I was looking for some part-time work and that sounded quite attractive so I went and enquired and it started from then. Once I started I went to—and did the Cert Three and Cert Four in aged care because that was sort of like considered a basic requirement, and that's about it. Since then I've been doing it. [C015M]*

The accounts highlighted above indicate that male workers are likely to have a different skill set to those of women when they enter aged care. For some workers it appeared important that these skills were recognised as useful and, even if not directly used in their care work, as having relevance in constructing their identities as workers (in much the same way it is recognised that caring for children provides women with a caring disposition). For example, the men we interviewed would make links between their previous and current

occupations to reinforce both a continuity of work identity and their suitability for care work. The following worker had been a taxi driver and ran his own cleaning business before entering aged care, linking these through his enjoyment of 'helping people':

> *I like the actual caring capacity. The actual helping, assisting people to look after… I spent a year running a cleaning business, I just missed it so much, I had to go back to it. [R018M]*

While women often speak of having a caring disposition as a motivation for entering care work, men mainly spoke of their capacity to help people and do something from which they could derive a sense of satisfaction.

> *It's to do with getting some kind of quality out of the average working day. I feel like I'm putting something back in directly to the people who have spent most of their working life contributing and now that they need a little bit of a helping hand I get a lot of satisfaction out of helping them out. (C017M)*

Moskos (2011) found that men's experience of working in female dominated occupations was often fraught and they had difficulty in adapting to the new environment. The men she interviewed discussed feeling ignored or isolated, having their competence questioned, and having to put up with negative reactions from others. Our interviews reinforced these findings, but also found numerous advantages to being male in aged care. Starting with the advantages, we found that men were often able to carve out a niche for themselves working with specific clients—often those with needs that the men felt they had particular skills in addressing. These included older men generally, but also men who had been identified as having substance abuse issues, mental health problems, dementia or who were known to be 'sleazy'.

> *Yeah. And it's also good for a guy to work in aged care because… a man who will not like for a lady to shower him, and if you are there as a guy you can shower that guy. (R034C)*

> *I'm one of the rare male members in the industry and there's very, very, very few of us, I'm in high demand regarding clients because I've got a lot of male clients who prefer to deal with a male, purely from the point of view that, you know, we can sit down and be blokes. They can fart and swear without offending anybody. And when you are dealing with elderly gentlemen who are like say 70, 80 and in their 90s, it's mateship for them. [C016M]*

> *… he's a bit of a sleazebag, like I wouldn't trust a young lady with him because all he wants to do is just look at the girls and their legs and their backsides and all that and that's not nice. [C013M]*

Men were also asked to do particular tasks such as those requiring physical strength; however, this could be a double-edged sword for some men who resented being asked to do the heavier work just because they were male. Other men identified instances when care recipients respond better to a man. The following narrative from a residential care worker encapsulates both of these approaches, also demonstrating the ways in which emotional labour is used by male care workers:

> *Being male you do get called on to do a lot of different things that if you was a female you probably wouldn't get asked to do. [Interviewer: Okay, what like?] Heavy stuff, not that you're supposed to lift but generally if there's something that's difficult to do they'll call on the male carer and sometimes it's got its advantages; we had a dementia gentleman only yesterday that they were trying to get some blood out of and the pathology was a lady and the carer and the nurse were both ladies and he wasn't going*

> *to have a bar of it and they gave me a ring and I went up to the other unit and walked around the unit with him for five minutes and sat him down and said "We're going to take some blood" and he put his arm out and it was all over with.*
>
> *[Interviewer: So what did you do in those five minutes to make him change his mind?] Just talked to him and walked with him and put my arm around him and consoled him because he was getting a bit agitated and the walking stick was starting to get a bit head height. But at the end of the day some people will adapt to male carers more so than female and that was one instance and that happens quite often actually. Quite often we get called to the dementia unit… [R046M]*

Challenges of working in a female-dominated environment in which the skills and tasks are assumed to be 'best' done by women were identified by the majority of the men we interviewed. Instances of both explicit and implicit discrimination were identified. One of the most difficult issues for male carers was in providing personal care to older women, particularly showering and toileting. Reactions to having a male care worker varied, from acceptance, to concerns about modesty, to fears about the sexualisation of care.

> *Like there's one or two residents, because I'm a male they don't like me to shower them, like they're a female resident, and I respect that. I can actually cop flak from staff about that and they'll say 'well, I'm going to talk to the resident, they're being sexist'. I said 'no they're not, they have rights and I respect that'. There's one lady out there, she said 'I don't care what you do, you can do anything, bring me meals, do whatever but when I'm naked I like a woman to shower me' and fair enough. [R013M]*
>
> *Sometimes residents latch onto the fact that you're a male and they don't want to be showered, they don't want to do this, they will… imply that you're doing something naughty. All, most of it's abusive and I feel really a bit worried about that. [R018M]*

Some men discussed developing strategies for protecting women's modesty and concerns while still providing personal care, while others found it easier to swap tasks with another care worker if a woman expressed concerns. In community care there is more flexibility to match care workers with clients so workers had the option of informing the co-ordinator if a client had problems with having a male CCW and they would be reassigned.

Another challenge faced by men was the need to continually prove themselves—that they were caring enough, that they could clean toilets, and that they could give people showers. This issue illustrates the ways in which gender stereotyping operates at personal, interpersonal and institutional levels. Although this seemed to diminish as people (colleagues and care recipients) came into contact with more men in caring roles, it was raised by several men in the interviews.

> *Yeah it's unnatural; it's not common to see male housecleaners or something like that. Of course the people up here, there are quite a few Italians so that's another thing, it's a bit of a barrier, but after a while you get over it. I used to make a joke, I used to say 'hang on, I'll just go to the car and I'll put a skirt on and I'll knock on the door again and 'oh this is Andrea' and make a joke out of it. It's the same thing with doing showers. I have a few ladies that at one stage they were a bit hesitant having a male do the showers but they get used to it. [C012M]*

In a small number of interviews, men admitted to stereotypical attitudes of their own. While they generally overcame this in the course of doing their work, others chose areas of work within aged care that enabled

them to maintain their perceived gender role. The care worker in the following quote mainly provides transport services in community care because he did not feel suited to personal care work:

> *There are occasions when things go above and beyond the call of duty, like one guy was sick in the bus and that was a joy to clean up! But yeah I couldn't—there's some guys come along who are either studying or have been or are professionally involved in intensive elderly care and I take my hat off to them, I could not do that…. When I think of nursing staff I see women as a better fit—and I'm in danger of being sexist here but I don't mean to be—I see women as a better fit and when it was a male nurse I just—I rarely felt that there was that loving demeanour, that caring demeanour. (C002M)*

For other workers, it was not the gender of the worker that was the problem, but the gendering of the workplace. While this could sometimes work in the men's favour, this was not always the case.

> *I think the industry lacks males, I've got to say, I think there's too many females. I think because there are so few males if you are promoted it's looked on almost as favouritism or something. I haven't been in aged care for that long—well, when I say that it's four and a half years—I find the gossip incredibly overwhelming and the bitchiness of the industry. I find that quite extraordinary actually. Whether that's just where I am I don't know, or whether it's industry wide, I can't comment on that. [R012M]*

> *We have a policy with the organisation that uniforms are issued every six months. However in the office there's always spare second-hand uniforms left over from previous employees—they're all female. The wardrobe's full of female shirts but I had to wait ten months to get my male fitting shirts. Another is when you're in meetings, especially some of the staff meetings, it's all 95/99% women, I might be the only bloke there or maybe one other and they will forget there's a bloke in the room. …I'll give you a classic example; we had to arrange for some fire training and they were going to arrange some fireman to come and do a talk and all the women go "Ooh, I hope they're good looking, I hope they take their shirts off" and I went "Ladies, excuse me". There is reverse sexual discrimination. It's not targeted, it's not deliberate, but it's there because it's a female environment. It just happens. [C016M]*

Stereotypes of what men can and cannot do, or should and should not do, not only constrain opportunities for men but can also be insulting and overtly discriminatory. The interviews contained several accounts of overt discrimination that could be off-putting for men entering aged care workplaces, such as that described by the following care worker:

> *One board member actually said to me 'you only got this job because you're male and we didn't want the numbers to be so out of balance'. I was the only male there at the time so 'oh thanks'. Anyway, so yeah, I've put up with a bit of crap over the years. (R013M)*

While the men interviewed have remained in aged care despite instances of discrimination, it is quite likely that others have left after such experiences. Exit interviews with care workers would broaden our understanding of the impact of discrimination on career choices of men in aged care. Interviews with men who could potentially work in the sector would provide accounts of how perceptions of working in a female-dominated environment, in roles that have been traditionally designated as 'female', impact on their decision about whether or not to apply for jobs. What our interviews with existing workers highlight is that there are opportunities for men in aged care and that when they do get jobs in the sector they try to shape their work

to suit their skills and backgrounds. However, they do this in an environment that has been constructed around norms associated with a female workforce and within which they can find it difficult to create a space in which to be both male and a care worker. The men we interviewed did not sit outside of these gendered norms: they, too, sometimes held stereotyped views of their role and that of the women they worked with. More commonly, though, male care workers had to fend off comments from care recipients, colleagues and supervisors that located them as 'different' and questioned their 'masculinity' and motivation. Men did develop strategies for dealing with these kinds of comments by using humour, calling people to account or even ignoring them but they were a part of their everyday experience of working in aged care. Attracting men into care work may well require some reflection from employers and policy makers about how to construct a workplace that is more welcoming, one that provides opportunities for both men and women to contribute to the care of older Australians.

7.2.2 CaLD Migrant Workers

In 2007, 125 aged care managers were interviewed about the employment of workers from culturally and linguistically diverse backgrounds.[19] Some of the information gained from these interviews was incorporated into the survey for 2012, in particular the types of benefits and problems that employers experience in employing these workers. In the 2012 interviews we sought to investigate the experiences of workers to see if there were issues impacting on them that would affect recruitment of CaLD migrant workers into the workforce in future. With around 23 per cent of direct care workers in residential facilities and 16 per cent of direct care workers in community outlets being both overseas born and speaking a language other than English, this is a significant subset of the direct care workforce. In this section, information from the interviews with CaLD migrant workers is discussed around three issues: pathways into aged care; linguistic diversity and communication challenges; and the experience of workplace discrimination.

The pathways into direct care work for CaLD migrants differed according to their occupational background and reflected differences in the skill level, motivation and commitment to the work. First, of the 22 workers who had previous experience as a health or care professional (including broader care occupations such as teaching), 14 were in aged care because their qualifications were not recognised or because there were visa restrictions on their work. These workers bring with them skills and qualities required for aged care, even if some cultural adaptation to the Australian aged care system is required. However, they often took jobs as PCAs or CCWs, sometimes while they were studying to attain Australian qualifications in their profession, while others planned to stay in their current jobs:

> *Because before I came to Australia I used to work in Kenya as a nurse and I worked as a nurse there since 1999 and… initially when I came here I did hospitality and I was working in another aged care but in the kitchen and now since I'm working, I'm studying for Registered Nurse, I'm working more in the aged care. [R020C]*

The second pathway related to the 25 workers who came from a different occupational area and viewed aged care as an entry level job that was readily available and would provide them with training, exposure to the Australian workforce and work experience.

> *Because when I arrived in Australia about eight years ago—I have a teaching background back from my country—but because my teaching background was in German I just couldn't really find work as a German teacher… so aged care was really the field that interested me simply because of the demand for people so I started looking*

19 Those interviews also covered the employment of Aboriginal and Torres Strait Islander workers.

> *for work even though I didn't have any experience or qualifications in the field, I still was successful in finding a job and then just started doing some training on the job and the first job that I got in aged care was as a support worker but eventually over time I did some extra study and now I work as a co-ordinator, so yeah I've been quite successful. [C025C]*

The third pathway was more pragmatic: ten workers selected aged care because it fitted in around other commitments or because there were no other jobs available to them.

> *My background is in accounting and finance actually where I come from. I did not be recognised for what I had, the skills and my diplomas and stuff. …I actually started working as a volunteer for one of the aged cares here, in the admin side… [but] I was juggling between kind of the three jobs through the week. I didn't have the flexibility. My kids were growing kind of—I left home seven o'clock and I was home seven o'clock and it wasn't my lifestyle. …so I actually turned again to the aged care where I was a volunteer, so I established something in my mind and they actually welcomed me and they proposed me why are you doing a volunteer, why do you not work for money? [C006C]*

However, nearly half of the CaLD migrant workers (even those working for pragmatic reasons) had made a conscious decision to work in aged care because they were interested in working with the elderly:

> *I used to be in HR and I like people and after I lost my mother I wanted to work with elderly people, just wanting to give back a bit to the community. It was a simple, plain reason. [C031C]*

CaLD migrant workers therefore have different skill levels, occupational experiences, and motivations which require specific management strategies if they are to be fully utilised in the workplace. Although there has been a focus on assisting workers to get previous aged care qualifications recognised, such as nursing, it is likely that people with skills in teaching, human relations, accounting and even engineering could use these skills in the aged care workplace, especially with the administrative aspects of care work being so important.

One area that limits some workers from contributing more fully is their English language skills. Others, however, are able to benefit from their linguistic diversity by using their language skills and cultural knowledge in their work. This has been recognised in the survey data, where about one-third of residential aged care and two-thirds of community direct care workers who speak a language other than English use it in their jobs (Tables 3.49 and 5.50), and it was evident from the interviews that workers viewed this as making a significant contribution to the quality of care for older Australians. According to 12 interviewees, they have an advantage over Australian workers in having the required skills to work with clients who either never spoke English or who have reverted to their native language as a result of dementia, and in being better able to understand the cultural nuances relevant to care recipients from a similar background:

> *Well for our work it's necessary because our clients they don't speak English, so you know we need to communicate with them in their own language, that's why we need people who are bilingual and who come from the same background and you know it's, language is not the only thing because they actually have to come from the same cultural background to be able to connect and relate to the client well. (C025C)*

However, just under a quarter of the CaLD migrant workers interviewed identified poor English language skills and a lack of cultural knowledge of Australia as a disadvantage in working in the aged care sector. In particular they viewed it as making it difficult to communicate with care recipients, and to understand the training courses. Both of these are significant issues for the provision of quality care and impact on the management of care workers, as is evident in the following excerpt:

> *For example, like there's sometimes like language, communication issues because this is my second language and sometimes it's really hard to communicate with the old people. They won't understand properly; and like our supervisor and other people, they think we are not doing the right things, but we're—because of the lack of communication but it's not that we are not doing the right thing, they won't understand the thing, the lack of communication, they just think things, oh we are not doing the things, what we have to do. [R005C]*

While workers recognised the need to improve their language skills and familiarity with Australian ways of providing aged care, they also sought support from their employers in order to gain this knowledge:

> *I'm from different culture. Sometimes some of the things, I don't know. But if there was senior staff there teaching us how to use this type of things, how we can help them, that's really great help for us as well, because when we are coming from India, we don't know about the culture or the rules and regulations in here. But if somebody's teaching us very nicely, then it will a great model for us. [R028C]*

The issues surrounding English language competence and cultural knowledge are widely recognised in the aged care sector. It is evident from the interviews that workers are also aware of the problem and seek ways to improve these skills through their work. There may be ways in which this could be done more formally, as part of the training process (see, for example, Wallis & Sanchez, 2008). Other industries have experienced similar issues: in one university, academics teaching pharmacy recognised the problems created when the majority of their graduates spoke English as a second language and had difficulties communicating with customers to assess their needs. Subsequently, the development of English language skills was built into the training program so that students had to meet particular requirements by the end of their degree. This type of approach would require both employees and employers/trainers to take mutual responsibility for developing the language skills and cultural knowledge required to work in aged care. In the broader interviews, some care workers indicated that their workplace had implemented measures such as visual learning and establishing work groups to facilitate the development of these skills.

Like the male workers discussed in the previous section, CaLD migrant workers experienced discrimination in the workplace. However, because they also experienced it in the community more broadly, most did not view it as a particular problem with working in aged care:

> *I think it's a normal part of a migrant to go in another country. Yeah, there can be lots of discrimination, but I didn't take it seriously. [R037C]*

The discussions about discrimination suggested that skin colour was likely to cause more discrimination than language when dealing with care recipients, but that language creates more problems when dealing with co-workers or supervisors. One of the more frustrating aspects of workplace discrimination appeared to be not being taken seriously or not being consulted by other employees:

> *I don't know. If I complain they won't listen to us. Another thing is, you know, 'you are Asian. You've got a language barrier' so they don't listen so I can't do anything. [R025C]*

Some workers also felt they had to justify why they (and other migrant staff) were working in the sector, in response to comments from colleagues:

> *…. I've heard some of my former Australian colleagues being not very nice in the way that they were talking about international nurses and I still hear some of them asking questions as to why there are so many international nurses or assistant nursing working in aged care where they don't realise that maybe the Australians don't really want the jobs and so that's why there are so many. (R023C)*

In addition to the discussion around the experience of discrimination by CaLD migrant workers, interviews with Australian born workers revealed that 10 workers held concerns about communication and the impact that poor language skills and a lack of cultural knowledge have on the ability to perform caring work. Another two workers expressed concerns about discrimination from care recipients, i.e. employing young Asian women for men who went through World War II or the Korean War. However, there was also some discussion around the fact that the ability to be a good care worker is not linked to one's ethnicity, and the fact that CALD workers relate better to CALD clients even if not from the same background.

Again, it is not possible from this interview data to ascertain the extent to which discrimination or the lack of English language skills creates turnover among CaLD migrant workers, or even deters them from entering the workplace. However, they are substantial issues and even though they are recognised within the aged care sector they are worth reiterating. These appear to be longstanding issues that impact on the quality of work and the quality of care. If CaLD migrant workers are to continue to be a core cohort from which aged care agencies recruit new workers then a sector-wide response to these issues is likely to be required. Currently the focus is on providing services to older Australians from diverse backgrounds (DoHA, 2012a); these interviews indicate that there also needs to be a focus on the provision of services to older Australians *by workers* from diverse backgrounds.

7.3 Working in Aged Care

In contrast to the interviews conducted in 2007, the workers we interviewed in 2012 appeared more optimistic about their work and more likely to discuss their work in 'professional' terms. Many accounts of direct care work highlight the intrinsic rewards of caring, and these certainly featured widely in the interviews. Overall, workers described their experience of working in aged care positively. When asked to describe their most important achievement in their work, 59 interviewees discussed their joy in being able to help others or make people happy. However, we also noted a new emphasis on what workers contribute to the well-being of care recipients and to their employer in terms of their skills and knowledge. When asked about their most important achievement, workers regularly identified programs or strategies they had introduced or used in their work to 'improve' the care provided:

> *I just think it's, for me, putting in something different, different strategies to improve the quality of care we give to our clients. Having come in new and introduced a few fresh ideas, that's probably something I find—that's my achievement anyway or my contribution to my workplace. [C018M]*

Approximately one-fifth of the interviewees also highlighted the personal achievement in getting to the stage they felt they could provide good care:

> *I think being able to complete the Master's degree while I was still working because that was actually hard, I spent the last five years working nearly full time, 0.8 full time equivalent and at the same time studying at uni. Unfortunately two years of that were wasted on a nursing degree that didn't eventuate although it did give me lots of useful background for my current role as well; and luckily the last two years I spent studying gerontology which was very relevant to my work, but still I had to put a lot of effort into doing all that, working, studying and I also had the family so, yeah, I've done quite well really. [C025C]*

This shift in the ways interviewees discussed direct care work reflects not only increased perceptions of aged care as being more 'professional', but also of them adding value to (and being valued in) the workplace. Some of this has stemmed from changes in management approaches. In 2007, interviewees were somewhat critical of management and this motivated us to ask specific questions about management processes in 2012. Their responses to these questions indicate a desire for management to listen to their ideas for improving the quality of care.

7.3.1 Improving Care Services

Overall participants described having a good relationship with the organisation that they worked for, with 41 participants describing their organisation as being good to work for and only 7 participants indicating that their organisation was not a good employer. Workers who liked their organisation perceive that management both understands their work and is open to ideas.

> *They're very hands on. They are involved with everything. We have regular meetings which the managers do attend. We have meetings where we talk about possible clients that are coming towards the end of maintaining themselves in their own home and we have a meeting with the residential facilities, like a general meeting for the network area, so they get involved in that. … They have regular monthly catch ups with leaders so they'll have one with myself, the clinical leader and our operational leader so they're always, again, involved with what's going on and keeping up to date with everything. No they're very well attuned. [I: How would you take new ideas to management?] … Sometimes we have away days where we do a lot of planning for the future so we could do that then. We have the catch ups, we have the meetings and like I said they're very approachable and they've got an open door policy so we can just do it that way or through an email. [C028C]*

Although not all managers were as 'well attuned' as the one mentioned above, many interviewees could give concrete examples of what managers did to build productive relationships with care workers.

> *They are a really, really open management group of people; they're really open with us. We have meetings once a month normally and we do spend two hours altogether; it's a fun time. I've never been bored in those meetings. I'd never do something, you know 'I'm spending my time but I'll sit here because it's money time', you know what I mean? You go there and you have fun because they make it fun. They make it good, they make it interesting. They make it around you; they don't make it around themselves. Every time when we do have meetings we have something to talk about. We talk about clients, we talk about ourselves. We have time to talk about them. We have time for something new, we have time for joy so for everything. I don't know. [C006C]*

Where this didn't occur, the problem was either that managers were viewed as 'hopeless' in terms of their management skills; or that they did not have institutional support, in particular around the time allocated to providing good management:

> *They understand it [what is involved in care work] but they can't cope with their own workload so they can't stretch out to mine. [I: To what extent is management open to you suggesting new ways to improve services?] They're very open but they're incapable of embracing it because they're only just—I think they've just got their nose above water and able to breathe but their mouth is under. [C030G]*

Workers also distinguished between direct line management and the senior management or owners. Mostly they discussed their line managers, but there was a perception that senior management were more concerned with finances and administration than care:

> *Well, as I said to you we're going through lots of changes, rebranding, reinventing ourselves, we've got a—well, she's called a facility manager that, to the best of my knowledge and the best of everybody's knowledge, doesn't have a nursing background and I just don't think she understands that if—let's say she cuts a shift, the flow on and impact that can have on other staff and residents. Again it's that bottom line all the time. Honestly, I don't really think she knows or has ever taken the time to actually come on the floor and sort of have a look around and see what people do. [R012M]*

Discussions with participants emphasised the perception that managers with experience or knowledge of work in the field (particularly recent experience) are better at understanding the work undertaken by direct care workers. This theme emerged in over one-third of the interviews and is illustrated in the following excerpt:

> *No, our manager here in particular is very good. She's been on the floor herself. She's a Div Two nurse so she's done the caring part and then sort of moved up and is now in the manager's role so she knows where people are coming from, particularly care staff. If they come to her with a particular issue then she understands that particular side of things because she's actually done it herself which, some may not be in that situation to really have that hands on experience, to know what the other staff are talking about. (R049G)*

Having their work understood and recognised by managers helps to create an environment in which care workers feel respected and valued in the organisation. Another aspect of this is whether they are able to take ideas to management about improving care services. Nearly all interviewees said that there was a process for taking ideas to managers, but this was viewed as different to being 'open' to suggestions. Even if these suggestions were not acted upon, it appeared important that workers felt that their ideas had been taken seriously by managers.

> *They are open to that [suggestions] and I certainly think they listen and if it's not implemented then I think it's for legitimate reasons usually, in the sense that you can't do everything for everybody so you have to look at the big picture sometimes. If individuals—you know, something can't be implemented that I think might be a good idea I think usually there's a good reason for it; I think they're quite receptive. [C015M]*

Workers who did not feel listened to were more dismissive of management and, when asked how management could improve, would suggest changes that reflected the need to have their ideas taken seriously. This change was identified by 16 workers:

> *Okay, we have monthly meetings where we do that, we'll bring up suggestions. It falls on deaf ears. We get the nods "Oh yes, that's great and we were just wondering about that" or usual line is "Oh we have to check to see if we can afford that" or "We've got to check with management" and then it kind of disappears and you don't hear about it. [I: Okay, so it's that follow up that's missing?]What follow up? There is no follow up. Now, no offence and this is a generalisation, but it happens a lot and I'm speaking on behalf of a lot of care workers because I knew this interview was going to come along so I asked a couple of my colleagues could I speak on their behalf and they said "Certainly", they know what I'm like. I may come across being kind of firm and harsh but in the last 18 months from the organisation I've received nine staff member of the month awards as recommended by my clients. My client is my focus. Same with the other care workers, our clients, their health and well-being is our only focus, not the management side of things. [I: So are there any other ways or areas that management could improve?] [laughs] I could give you a whole long list but I'll give you one simple solution; they sit down with the grass roots staff from the field, they remove all of their management hierarchical crap and say "Okay, talk to me. What can we do to improve?", take notes and act on it, that's all they've got to do. [C016M]*

Over half of the workers identified areas in which management could improve, with around one-third of the ideas being about ways that services for clients could be improved or that protected worker health and safety; however the need for extra staffing (or more stable staffing) and better working conditions was also raised by nearly one-third of interviewees. Most workers indicated an awareness of the tension between service improvements and cost containment, which some saw as frustrating particularly if they viewed the change as necessary for client well-being (e.g. providing extra incontinence pads).

> *I think they've got restraints by accounts. I think the accounts are too tight, so if something costs nothing, yes. If it's to move residents because their health has deteriorated a bit, yes. If it's got to do with the need for new equipment or different equipment, no. [R018M]*

The frustration was exacerbated if they did not feel valued as a care worker:

> *A few areas they need to be improved, they need to change a few things. They never will listen to us because they think we are carer, we are shit. They treat us like—sorry, I mention the 'sh' thing. [I: That's okay.] We know nothing, we are nothing 'she's only a carer, she knows nothing. She don't know nothing.' Like a new resident came last week; the resident's got scabies. Scabies is really easy to spread. They didn't put it in the handover, they didn't tell us. They didn't let us know. We must wear gloves because this resident's got scabies and things but they didn't let us know so that's not fair, those things. [R025C]*

Workers described three ways of broaching ideas with management: via informal means (i.e. direct discussion), via formal means (i.e. meetings, letters, emails), and via a structured process (i.e. a box, book, or form). In residential facilities and community outlets that were viewed as open to ideas, workers mainly broached ideas through informal means although other strategies were also used. In those that were not seen as open to ideas, workers mainly used formal means of communicating their suggestions. This could mean either that informal approaches to management result in a more open process of consideration thus leading workers to feel as though management is open to their ideas; or it could mean that when management is perceived to be open to ideas, workers feel more comfortable that their ideas will be considered by management and they feel free to use less formal methods to broach their ideas.

Care work is being undertaken in an environment of tight time schedules and an increased focus on client-centred care. As care work professionalises and care workers view themselves as having expertise—particularly in relation to client needs—the need to have productive relationships with managers, in which their ideas and feedback are given due consideration, is important. From the accounts of the care workers who were interviewed it is evident that many managers value their work and are open to ideas. However, a substantial number of interviewees indicated that their relationship with management was not constructive and that they felt that either it was not worth taking ideas to management or, if they did, the ideas would not be considered. Given that many of these ideas are related to the quality of client care or to improving the ways in which services are delivered, there are good reasons for ensuring they are at least considered. Most workers understood the tension between quality care and constraints imposed by budgets or legal requirements (e.g. health and safety), and could accept it if ideas could not be implemented, but thought they should at least receive proper consideration.

7.3.2 Improving Knowledge and Skills

Something that was particularly valued by the care workers interviewed was professional development. When asked 'what do you want to achieve in your work over the next 3–5 years?' 26 participants referred to career progression, and 34 indicated that they intended to increase their knowledge, skills, training, or qualifications. As the following excerpt illustrates, one of the incentives for training was career progression:

> *To do my Division One nursing so I could get more into the management side of it. I know I manage now but more of a management side. [R015M]*

Other incentives included doing a better job of caring—to 'better themselves' as one worker put it [C029G]—to get more pay or to open up new opportunities.

> *Because of my age I would like to get away from nursing but I know there's the opportunity to work in a nursing home doing that sort of thing, especially aromatherapy. I already do some massage work with the physiotherapist. [C044G]*

> *All the same work, sort of more—well I suppose really it's more time for training and also more time to actually teach some skills to other staff members [C035C]*

> *I really want to do the—first of all I have a plan to do Certificate Four and then become a EN but I have to improve myself in this field because I really want to stay in the nursing home and I want to improve my knowledge so that I can give a good assistance to these people. [R024C]*

A more positive attitude was noted in this round of interviews than previously (2007) with regard to the training provided by their organisation. While in 2007 the compulsory training provided by employers was perceived to be 'repetitive or not particularly useful for their work', participants in 2012 expressed the view that despite being repetitive, this compulsory training is important and one can always learn something new from these sessions. Of the 98 participants that discussed their training, 56 expressed the view that all of the training that they had done had been useful, with only 10 participants describing the training that they had undertaken as being repetitive.

> *Well I guess all the updates of training or the revisions, which might be annual or something, are usually quite good because even if you think you know it all there's always something that comes up or you're with a different group of people who might raise a different issue. (C010G)*

> *Not really I think, most of it is really good and even if I've heard it before, it's good to refresh the knowledge and sometimes I've completely forgotten something and it's, I find it's all really helpful. (R033C)*

During the discussions about training, a total of 51 participants described their employer as being good at organising and providing training. According to workers, some employers provided extra assistance which allowed them to undertake training; for example, by providing them with time to undertake training or by scheduling training at appropriate times for staff (i.e. repeated sessions at different times to accommodate shift work); by funding them to do training either by paying for the time taken to do training or paying for the training itself; and by providing more accessible training through in-house or computer/Internet based training. Some interviewees indicated that their workplace had their own trainers (RTOs), which allowed them to respond to identified needs; while other employers incorporated an element of training into regular team meetings.

> *The training here, most of ours is done in-house. If there's anything that comes up outside that we look at and we're interested in we can always apply to do it but we usually have to pay for the course ourselves and they'll pay for us to go; that's how it happens in this organisation and usually that works. [C040G]*

Others identified problems with accessing training: 23 interviewees indicated that they did not have the time for training (this was more of a problem for community direct care workers); 10 said that they were not funded for training (again, more of a problem in the community sector); while 32 interviewees commented on the poor quality of training, either its repetitiveness or irrelevance, or the ineffectiveness of the trainer/RTO.

> *They talk to them about chemicals or they talk to them about incontinence but they don't explain—they need to go a little bit more in depth. And I hate these three or four weeks' fast-tracked Certificate Three people, they get nothing out of it and that's what my big concern is in that area. . . . And then facilities or aged care facilities should be involved in that training rather than some TAFE somewhere doing it or some private company having a group of people and going through all that. You know everybody's trying to make a buck [R008G]*

One of the features of training that over a quarter of the participants commented on was the format in which the training was provided. While the majority of these found 'hands-on' or practical training the most useful, others commented on the accessibility and effectiveness of virtual learning environments: the Internet and the Aged Care channel. This highlights the need to be responsive to different adult learning styles in the provision of training.

What emerges from the questions on training is that the quality and accessibility of training differs throughout the sector, with community direct care workers having particular problems (see also Section 7.4.3 below). Despite this, workers appear genuinely engaged in professional development and training and seek opportunities to improve their knowledge and skills when they are provided with the time and money to do so.

7.4 Emergent Themes

Several issues were raised spontaneously by care workers during the interviews, although many of the themes that emerged had been identified from previous research. Nearly half of the interviewees indicated that working conditions in the sector—low pay, understaffing and time constraints—were the most challenging aspect of their work and were a source of stress. Additionally, around a third of the interviewees discussed challenges associated with dealing with difficult clients and families, and the complexity of the aged care system which they felt sometimes failed to provide appropriate care. Because these issues are well recognised within the sector

and have been explored in other research, they are not discussed further here. Instead, this section focuses on themes that have had less attention and which might be relevant for further investigation. Four themes have been selected for discussion: the importance of social and emotional skills; difficulties of working with 'unsuitable' workers; planning for retirement; and specific issues associated with working in community aged care.

7.4.1 Social and Emotional Skills

Table 7.1 provides an overview of the perceived requirements of a 'good' worker, broken down into four categories: formal skills, informal skills, characteristics and approach to work. As illustrated, when asked what skills and qualities make a good direct care worker interviewees focused more on the social and emotional qualities associated with being a good communicator, rather than on formal skills and qualifications.

Table 7.1: Profile of a 'good' care worker, community and residential aged care (number of interviewees)

Skills and Qualities	Type of Provider	
	Community	Residential
Formal Skills		
Qualifications	9	10
Skills	1	12
Good at time management	8	0
Motivated, passionate, diligent	5	13
Experience & knowledge	9	3
Maintains professional boundaries	1	1
Informal skills		
Empathy & compassion	29	26
Patience	21	15
Caring	11	13
Interacts well with clients	13	7
Good listener/interpersonal skills	7	7
Happy	5	5
Respectful	1	4
Honesty	2	2
Sense of humour	2	0
Communicates well with staff	0	2
Common sense	5	2
Characteristics		
Age	8	4
Physically and emotionally fit	6	2
Literacy or English speaking skills	4	3
Approach to work		
Not in it for the money	5	3
Adaptable or flexible	12	4
Puts in that extra effort	3	3
Willing to raise concerns	2	3
Non judgemental	3	0

A scan of job advertisements for care workers indicates that some employers are aware of the need for good communication and interpersonal skills, but the emphasis is primarily on formal qualifications. While formal qualifications are undoubtedly necessary for working in the sector, care workers provided numerous examples of the difficulties of working with people who lack the social and emotional skills (sometimes called emotional intelligence) to work with older people who have a range of physical and mental needs. Being a good communicator involved empathy, compassion, patience, caring, respect and honesty. Without these skills care workers were viewed as deficient in some way and difficult to work with, often creating frustration and higher workloads for others.

> *Because I like working with people who have dementia it's very frustrating because I—well the other thing too that I didn't say is that they ['unsuitable' workers] often speak very inappropriately. To my mind, I don't like hearing people with dementia spoken to like children and sometimes that does happen. I can't really—it's not my place to say something to people when they do that. I can say something to my supervisor and she can say something to another supervisor but I find it very frustrating and very—I really don't like it, it's very disrespectful I think when people speak inappropriately like that. [C041G]*

Having social and emotional skills is not just about being a 'nice' person or a 'people' person, it allows workers to be more effective and efficient. These skills are often associated with an aspect of work called 'emotional labour' that is well recognised in service work and health care. For example, researchers have identified three ways in which performing emotional labour assists in nursing: *therapeutic* emotional labour improves a client's emotional well-being and may be used, for example, to facilitate client co-operation with a care worker so that tasks such as showering can be undertaken with a minimum of fuss; *instrumental* emotional labour can be used to calm a client during a procedure or intervention and increase the levels of trust and confidence in the care worker; and *collegial* emotional labour helps to facilitate effective communication between co-workers (Theodosius, 2008). The use of emotional labour is therefore productive and should be recognised as a set of skills required for undertaking care work. This contrasts to concerns often expressed about the need for employers to contain emotions in the workplace—to make sure that workers do not 'care too much'. Indeed King (forthcoming) has identified aspects of the work environment that enabled care workers to use emotional management strategies to successfully juggle or synthesise the emotional demands of their work and provide care that was respectful of clients while meeting organisational needs.

Aged care has traditionally relied on employing workers who were perceived to have these types of emotional and social skills, but as an innate quality often having been gained through informal caring. As the need to recruit from outside of the traditional groups increases it may well be necessary to formalise these skills into training programs. Currently training is primarily focused on tasks (e.g. lifting, showering, documentation, safety) or understanding health needs (e.g. dementia, palliative care, falls) rather than developing the required emotional and social skills. One interviewee, a Registered Nurse and educator, discusses the difference between being task focused and being person focused:

> *Well I mean to me, and as I explain to the staff here—and no offence to the staff or anyone else but I mean you can train a monkey to do a good job but to show true compassion, empathy and treat them [care recipients] with dignity and respect is a skill. I mean we get away from the task. Like I can get anyone off the ward and just say 'well that person needs to have a shower' and they go and do it as a task but they need to have that compassion to actually treat them with that dignity and respect. (R001M)*

This interviewee teaches care workers how to work with compassion and empathy and claims to have turned around staff attitudes in the facility. To do this he uses a range of techniques including formal training using

scenarios; informal peer monitoring of behaviour on a non-judgemental basis; and by personally being a constant, active presence on the floor. He believes his approach has enabled him to successfully employ (and integrate) younger workers and men into his team, thereby expanding the potential pool of workers. As the direct care workforce grows and incorporates new employees from different backgrounds, finding ways to teach and develop the required social and emotional skills is likely to become more important. One of the challenges may well be in systematically incorporating this into training programs.

7.4.2 'Unsuitable' Workers

One of the issues raised by employers prior to the 2012 surveys and interviews was the lack of suitable applicants for jobs and the problems caused by workers who are not suited to the work. Interestingly, around 10 per cent of facilities, but no community outlets, indicated that their skill shortages were caused by the lack of suitable applicants (Tables 4.9 and 6.13). Because the interviews were with current care workers we could not investigate the problems associated with attracting the 'right' workers; however, we did discuss what it was like to work with 'unsuitable' workers. Around one-third of the interviewees had experienced working with colleagues they thought were 'unsuitable' and the picture we gained from them is that it is distressing, frustrating and sometimes a health risk to work with people who are not engaged in their work. However, for most of these workers the main problem was viewed as being the impact on the quality of care provided by their organisation.

> *It's just horrendous, dangerous. I've had people on a two-person hoist that'll go and answer their mobile phone. I've worked with people that have left clients on the toilet and gone for their break for 20 minutes and come back and 'oh that's right, I popped them on the loo before I went out and forgot about them'. It's just so inappropriate and I guess it goes on. There's a lot of rorting the system. They start turning up late, they disappear with things, more pilfering goes on… [C039G]*

A theme to come out of these discussions was that although employers had policies in place to report poor behaviour, few employees chose to use them. Instead, they were more inclined to increase their own workload to cover for others and 'bite their tongue' than confront the issue. This response was exacerbated when staff were not permanent and felt they did not have any right to make a judgement or the job security to make a complaint. Where reports were made, it was often done anonymously, and occasionally workers would speak directly to the person behaving inappropriately.

> *You really just don't want to be there but I just grind it out and some of the residents go—you know, one resident will go 'look, I can't stand her' and I just go 'yeah, well, you know, I know what she's like' and give them a bit of a wink and help them out with whatever they need and try and make their day a little bit better. You're kind of limited in that aspect. In some aspects it's pretty funny because if you go and report someone it always seems to get back to them, there's no confidentiality, even with the Director of Nursing. [R013M]*

> *I bite my tongue and ignore it and try and get on with my work. Sometimes I will say 'come on, settle down, let's do this properly and no mucking around' and they're 'oh, what's wrong with you?' I say 'nothing wrong with me' and they change their attitude but it is hard, it's very hard. …But there's a few things that happened at the nursing home that I didn't like and should not have happened, residents should not be treated like that and I had to say something but—they didn't know it was me but it had to be done because it's not right.[C029G]*

When asked to describe the characteristics that made these workers 'unsuitable', interviewees pointed primarily to two factors: they did not have the social and emotional skills (the compassion, empathy) that are required to engage effectively with care recipients in order to fulfil the required tasks with respect and dignity; and they were not in aged care for 'the right reasons', that is, they treated it as just a job rather than meaningful work, resulting in low commitment to client care or their colleagues.

> *They're not interested, they—an example is if the bells ring and they [care recipients] need to go to the bathroom they just ignore it and they don't see that it's that important. Even if they need to be fed they'll give them a couple of mouthfuls and then take their tray away. You have to always be looking and that's not my job but because I've been in this industry for a long time I just feel that I—you know, you know when someone's not getting fed so you keep an eye on it. It's frustrating. [C040G]*

> *Some people refuse to work with dementia specific patients, they just want normal aged care people, so like the day to day rosters in dementia specific houses, they just call up and say they're sick and because they're only casual management like scrambles around to find someone. [R016M]*

While finding suitable applicants is one issue, having to work with someone who is not suited to care work is another. It is evident that some employers (such as the one referred to in section 7.4.1) are proactive in retraining and weeding out workers who are not suited to the work; others, possibly because of the pressure of needing people on the ground delivering services, appear reluctant to take action. On the other hand, some workers are resistant to change, as the following excerpt shows:

> *I have to say the two that I've worked with just recently, don't want to learn, don't want to know, don't want to be any better… they have no interest in the work at all. None whatever. Very difficult to work with people like that because they're resistive to change, they're resistive to instruction, they're resistive to advice, they just don't want to know and sometimes you have to get really tough with them and say "Well you will do this and you will do that and you will follow the instruction and I am the Registered Nurse and I have made a decision based on sound judgment". [R032G]*

Nevertheless, because the issue adversely impacts on both the quality of care provided and the quality of the work environment for good employees, there would be much to be gained from investigating the issue further, in particular in relation to what strategies can help employers address the problem.

7.4.3 Planning for Retirement

Around one-quarter of residential direct care workers and one-third of community direct care workers are 55 years or older. As they near retirement age, planning their work to accommodate their health, family and leisure needs becomes a priority. Of the 101 workers interviewed, 19 participants indicated that they were planning to retire in the next 3–5 years. None of the older workers interviewed indicated a desire to stop working as soon as they reached a certain age. Instead, they discussed trying to find ways of working that would allow them to continue working in the sector for as long as possible. The strategies they discussed differed, but included decreasing the hours worked; having more diversity in their work, for example, mixing care work with administrative roles; shifting toward less intensive work, for example, from nursing to massage therapy; and becoming a 'travelling' care worker, i.e. as a working holidaymaker.

> *I think because I'm getting older and my body's wearing down as it does when we get older, I'd like to still stay in aged care but maybe come off the floor and do more in administration, that type of thing, only because my body's not going to, I can't see myself doing this until I'm 67. So I maybe could get involved in another area that wasn't so taxing physically. [R040G]*

> *I hope I'm retired but I plan to stay in this job until I retire. I will probably work beyond 65 because the work is important to me. I wouldn't work as many days. In three to five years I hope that I'm working fewer days because I work four days at the moment and I would rather be working less, so I would like to be working less. I would like to have less face to face contact. I enjoy it and it's important but it does wear you out. [C041G]*

While retirement is inevitable for older employees, there are opportunities for employers to work with them to maximise their engagement in care work and make the most of their experience and knowledge. It was evident from the interviews that one of the issues was the physical and emotional toll of performing care work; workers needed to be able to protect their health as they moved into retirement because they did not want to retire and be incapable of enjoying it. Perhaps finding ways of giving older workers their preferred hours and opportunities for varying the tasks they do in their work may assist in reducing the health risks that participants discussed as being associated with care work as they get older. The alternative will be to lose workers prematurely, before they are ready to leave. As the excerpt below illustrates, older workers often want to remain in aged care, and will seek out ways of doing this if their current employer cannot accommodate their needs:

> *I started actually looking for part-time work, if I can do at least a couple of days as a co-ordinator and other part I can do the support worker. It's hard to find something like this unless you find it in two different aged cares [sic], which I don't like to, but that is my aim. [C006C]*

7.4.4 Community Aged Care

Although generally very positive about their work, community direct care workers raised three issues around working in the community as opposed to residential aged care. The first is that because the sector is primarily focused on residential care, the training, standards and policies (e.g. around occupational health and safety) are often not relevant to working in the community. The particular issue raised is that the difference between working in an institution and working in someone's home is not recognised. The following excerpt is from a worker who provided numerous examples of the challenges faced:

> *All the training is all based on a residential focus. The training's great, but it means nothing in community, it means absolutely nothing. Like for example it's all under workplace safety laws which is so important; that you're working in an aged care facility and there's this chance of slips and bangs and falls and all those kind of things, they're going to make a workplace safe. In a community your workplace is someone's home, your workplace is your car, your workplace is when you're walking them down the street. …They want me to do personal care, showering people and that, I've got no problem but I've got to be taught how to do it. They sent me to a facility to learn how to do it and I said that's great, how does that equate to someone's home? Why? Well in the facility you've got a proper bathroom with the washing chairs and the showers on hoses, and handrails. We're talking about a domestic home where it's a normal shower recess, a fixed shower on the wall and no room for a chair. [C016M]*

Although only raised by 5 of the 50 community workers interviewed, it points to the issue of how can community aged care be structured so that worker safety and person-centred care can be provided in spaces (i.e. private homes) that are difficult to 'regulate' without losing the benefits of being at home. For example, one worker discussed the problem of rugs in her client's home which she viewed as a trip hazard for both her client and herself. However, she also recognised that it was having items like rugs and personal belongings around them that contributed to the clients' sense of being in their 'own home' and that, if removed, they would make the space less homely and remove some autonomy from the clients. While the tension between regulation and home-based care might be difficult to resolve, acknowledging it in training and policies may allow workers to develop better strategies around how to manage issues when they arise.

The second issue that community workers raised was around the 'hidden costs' of working in this area. Again this was identified as an issue by a minority of participants (8 of the 50 community care interviews); however, it was also raised by workers in the 2007 interviews, suggesting that the problem is longstanding. Two types of hidden costs were discussed: car related expenses (i.e. car insurance, petrol, upkeep of car) and not being paid for their time when travelling between clients. Although workers received reimbursement for car-related costs, interviewees indicated that this was insufficient and they had to subsidise the costs of care out of their own pockets both in terms of petrol and maintenance. In addition, when workers were required to transport clients from one place to another concern was raised about the problems of cleaning the car if seats were soiled or the car was damaged by clients. In addition to reimbursement for out of pocket travel expenses, workers also discussed the problems of 'time' and the pressure on them to rush between clients. They saw this as an issue for their own safety because if they were to meet the job demands they either had to compromise on the time spent with each client or on their road safety (e.g. by speeding):

> *It can be like being a racing—that's the analogy I use—like being a racing car driver and I actually talk to my bosses about this and they were good, they understood what I was saying because as they were going for trying to get us to do more work—again there's all this talk about time management and time and motion stuff so when it got to the stage when I was getting rosters—and this is like travelling from town to town so you might have to do 25ks or something to your next client and it was like—well it got a little too tight so that there was no time to breathe or if anything went wrong like you had to stop because maybe one of your tyres, the air was a bit low or you needed to go to the toilet or road works or something, it became too intense. That's what I mean about the racing car driver. [C014M]*

The third issue relates to concerns about the safety of workers and clients given the individual nature of work in community aged care. There was a sense from some workers that they never knew what they were walking into when they went into a client's home, particularly if the client had behavioural problems or dementia. Workers discussed going into situations that were violent or homes that were particularly insanitary, and that this could be difficult to deal with because they were often alone. Although client issues could be dealt with once reported to the co-ordinator, the worker still had to respond to the immediate situation.

> *I won't give the details but as a result it was a physical confrontation with three, the brother, the son and the father, the father has severe dementia. I had to physically go in there and break them up and in doing that I got punched in the chest by the demented father at one stage, I also got the blow on the chin. This is what it's like in community. In a facility you've got immediate back-up there with you, you've got other staff there. Out in community you're it. You've got to rely on your own wits there and then. Obviously there's been some issues about that regarding my safety which I'm concerned about but I'm more concerned about his safety, the family's safety and I end up having a meeting with the management of that region to come up with a solution for the family.[C016M]*

While workers in the community mostly enjoy their work and value the ability to keep clients in their homes for as long as possible, they did raise some points that have implications for training, budgeting and safety, as well as their capacity to sustain working in community aged care. It is not clear how widespread these issues are, or whether different employers have mechanisms for addressing these challenges that could be disseminated throughout the sector. However, they may be emerging issues for the sector and worth monitoring into the future.

7.5 Summary

To summarise, the findings from the interviews highlight a range of issues that impact on the recruitment and retention of workers and the quality of their work and workplace. In section 7.2 we discussed the experiences of male workers and workers who were overseas born and spoke a language other than English. They had some broad experiences in common, although the specific detail differed. They both sought ways of using their existing skills (e.g. language skills or occupational skills) in the aged care workplace to maintain some continuity in identity. The need to have these skills recognised and their transferability into different contexts was related to their motivation and satisfaction in their work. They were sometimes able to achieve this through creating a niche for themselves in working with specific care recipients: male workers often provided care to men and people with aggressive or difficult behaviours, while migrant workers were sometimes able to work with care recipients from the same linguistic or cultural background. However, while matching of existing skills with current work was sometimes applicable they also had to work with other care recipients, which could involve being subjected to judgements based on stereotypical views of their gender or culture. Both groups experienced discrimination in the workplace, from colleagues, supervisors and care recipients. While most of the CaLD migrants did not view this discrimination as any worse than that they received outside the workplace, men were more acutely aware of it because they were less likely to be subjected to discrimination outside of the workplace. In both cases, however, there is a role for policy and employers to address discrimination in the workplace.

One of the major contributors to the discrimination faced by interviewees is that the stereotypical care worker against which they are judged is an Australian born, mature-aged, English speaking woman. Indeed, the direct care workforce has historically been primarily comprised of workers with these characteristics. Consequently expectations, organisational practices and policies have been constructed with this 'norm' in mind. One of the challenges in broadening the potential pool of workers for aged care is to revisit this view of the 'ideal' care worker so that people who are male or born overseas or young can visualise themselves as care workers and feel as though they have a place in aged care which allows them to feel valued and provides them with opportunities. The discussion about the pathways into aged care indicates that, unless they have selected care work as a primary occupation (i.e. as nurses or AH professionals), the route into the role is somewhat serendipitous for men, and more of an 'entry' level job for CaLD migrant workers. For many interviewees, aged care was not so much a conscious career direction, but an opportunity that came their way. Changing this would require finding ways of making direct care work an attractive option to different categories of workers: what can aged care offer them by way of occupational identity and career paths?

Section 7.3 looked at interviewees' level of engagement and commitment to aged care as demonstrated by their interest in improving care services, both in terms of quality of care and provision of services. One area that was highlighted by the discussion in this section was the importance of having good management strategies that valued input from workers and provided a strong basis for productive work relationships. While nearly all employers had formal strategies for managing feedback, grievances and suggestions, we found that where interviewees indicated they had a mix of formal and informal strategies they were more likely to feel as though they had been taken seriously by management even if the ideas were not implemented. It was also

evident that there was quite marked variation in management practices across the sector, with interviewees differentiating between managers who were open, experienced and attuned to care workers and those who were not. Workers were generally dismissive of managers who did not provide them with support or who were not interested in improving service quality; although some managers were viewed as having little institutional support to help them develop good practices.

Variation within the sector was also identified as an issue regarding the provision of training and professional development. Although interviewees were highly motivated to undertake training, there was concern about the quality of training and their ability to access it. Some employers had moved toward the provision of media-based training (i.e. Aged Care channel or the Internet) which was viewed positively by workers who would otherwise find it difficult to access training. However, the majority of interviewees found that hands-on training was the best. The delivery of training in mixed formats is likely to help workers with different learning styles as well as those who find it difficult to get to formal training programs. It was noted that direct care workers in community aged care were more likely to have problems accessing training or being funded for training than those in residential facilities. This could have implications for the sector as it moves towards increasing the size of the community direct care workforce.

The final section of the chapter identified four themes that emerged as likely to be important to the sector and worthy of further investigation. These were:

- Identifying the social and emotional skills required in direct care work and explicitly incorporating them into training and policies. This is likely to become increasingly relevant as workers are drawn from different occupational and skill backgrounds. It will also provide a mechanism for managing the emotion work involved in aged care.
- Developing strategies for managing 'unsuitable' workers who were viewed by interviewees as being detrimental to their work environment as well as adversely impacting on the quality of care provided.
- Finding ways to maximise the work lives and contribution to aged care of older workers.
- Recognising that community care work occurs within a specific context that has implications for workers. Firstly, care is provided in private homes that are not easily subjected to regulation in the same way as residential facilities. Interviewees indicated that training and occupational health and safety guidelines need to reflect these differences. Secondly, there are hidden costs of providing community care (such as petrol and other car-related costs) that are borne by employees. Thirdly, the individual nature of community care raises safety issues for employees. This is likely to become exacerbated as the range of social, health and behavioural disorders of clients increases.

The issues raised by interviewees as discussed in this chapter are not necessarily new to the sector. However, there is a need to understand these issues in more detail and we highlight them here to flag their importance to workers as they seek to make their work in aged care personally satisfying and publicly useful. As noted throughout the chapter, some of these issues require different approaches to be fully understood. For example, finding ways to maximise the contribution of older workers would require not only surveying the needs of existing workers, but also incorporating workers who have left aged care into the research. The issues therefore serve as 'flags' for further research, as well as identifying areas that may require policy or management action.

8. Conclusion

The National Aged Care Workforce Census and Survey, 2012, provides information about the characteristics of the workforce, their experience of working in aged care and the factors related to recruitment and retention. The National Institute of Labour Studies has now conducted this research three times in the residential sector and twice in the community sector, and we have developed a good understanding of the dynamics of the workforce and the issues being faced as the workforce expands and changes. Throughout the report we have compared the residential and community aged care workforces (with a focus on direct care occupations), the changes over time, the differences between various components of the workforce (occupational groups, recent hires) and, in some instances, the workforce to the Australian population more generally. This concluding chapter provides a summary of the findings and identifies trends and issues that may benefit from further investigation.

In 2012 there were 352,100 PAYG employees working in aged care. Of these, 202,300 worked in residential facilities and 149,800 in community outlets. The report focused mainly on direct care workers: those workers who provide care services to older Australians as a core part of their work. More than 240,000 workers were employed in direct care roles. There were 147,000 in residential facilities (an increase of 10% since 2007) and 93,350 in community outlets (an increase of 25% since 2007). When converted to full-time equivalent employees the growth between 2007 and 2012 in the two sectors is more similar at around 20 per cent, equating to 94,800 employees in residential facilities and 54,500 in community outlets. The corresponding national growth between 2007 and 2012 was 9 per cent in headcount and 7 per cent in FTE. The direct care workforce comprises six occupational groups: nurse practitioners (NP), registered nurses (RN), enrolled nurses (EN), personal care attendants (PCA)/community care workers (CCW), allied health professionals (AHP) and allied health assistants (AHA). Within residential aged care the patterns of change within these groups indicate that all occupations except RNs grew in size, and there was a change in the share of occupation across the workforce. PCAs have grown in both size and share and now constitute 68 per cent of the residential direct care workforce (from 64% in 2007), numbering over 100,000 employees. At the same time the share of the workforce held by RNs, ENs and AH workers (combining both AH groups) has decreased (from 36% in 2007 to 32% in 2012). Numerically, there are now 22,000 RNs, 17,000 ENs, 2,600 AHPs and 5,000 AHAs in the sector. This pattern of reducing the share of the more highly educated workforce was already present between 2003 and 2007. Of note in the residential direct care workforce is that the rate of increase of FTE employees was greater than that of the actual persons, indicating that employees are working more hours than in 2007.

The community direct care workforce has a somewhat different profile. Again, all of the occupational groups increased in size; however this was also unevenly distributed, with RNs decreasing their share of the workforce and most of the increase going to ENs. CCWs are the largest occupational group: the 76,000 employees in this category comprise 81 per cent of the direct care workforce which is very similar to what it was in 2007. The rate of increase of actual workers in the community direct care workforce was greater than that of FTE employees, indicating that the sector continues to rely heavily on part-time workers.

Aged care employers also use other workers to provide services. Of all PAYG employees, just over a quarter in residential facilities and a third in community outlets are non-direct care staff. Within residential facilities, about 70 per cent of these employees provide ancillary care services such as catering, cleaning, laundry and maintenance services. In community outlets, managers (including care managers) and administration staff make up 90 per cent of the non-direct care workforce. The use of non-PAYG workers is also widespread. In the designated fortnight for data collection (last pay period in November 2011), about 40,000 workers were employed through agency, brokered or self-employment arrangements: 17,000 of these in residential facilities

and 23,000 in community outlets, covering 23,000 and 150,000 shifts respectively. For the first time in 2012 we also captured information about volunteers. During the designated fortnight, 79,000 volunteers worked in aged care. There were over 22,000 volunteers in residential facilities who worked an average of 4.8 hours each, and just under 57,000 volunteers in community outlets who worked an average of 4.6 hours each. About 84 per cent of residential facilities and 50 per cent of community outlets used volunteers during the designated fortnight.

8.1 Who Works in Aged Care?

The characteristics of the workforce are generally similar to those in 2007. It continues to be a female dominated, older workforce in which a high proportion of workers hold post-school qualifications and where workers born overseas (and speaking a language other than English) are a growing subset. Key features and trends from the 2012 data collection are:

- The proportion of men in direct care roles has increased in residential aged care and is now over 10 per cent of both the residential and community direct care workforce.
- The workforce is ageing, with the median age now 48 years in residential and 50 years in community aged care. This differs by occupation, with PCAs being the youngest (47 years) group in residential facilities and RNs the oldest (51 years); while in community outlets both CCWs and RNs have a median age of 50 years. In both sectors the proportion of the workforce aged 55 years and over has increased since 2007. Although recent hires have a younger profile, it remains that 40 per cent of PCAs and nearly 60 per cent of CCWs do not enter aged care until after they are 40 years of age.
- In both sectors the workforce enjoys relatively good health with around 60 per cent of direct care workers assessing their health as very good or excellent.
- The proportion of Aboriginal and/or Torres Strait Islander people working in aged care roughly equates to that in the Australian population (around 2.5%). In both sectors, Aboriginal and/or Torres Strait Islander direct care workers were over-represented amongst PCAs/CCWs and under-represented among nurses and AH workers.
- The proportion of the workforce that was born overseas has increased slightly since 2007 and it now comprises 35 per cent of the residential and 28 per cent of the community workforce. The proportions are about 2 percentage points higher for recent hires. One-third of the overseas born direct care workers in residential facilities had been in Australia for 5 years or less and they were coming increasingly from countries in which English is not the primary language (e.g. India, China and the Philippines), nor the language of most older migrant communities. This represents a distinctive change in the composition of the residential direct care workforce. In contrast, overseas born direct care workers in community outlets had been in Australia longer and 75 per cent had been here for 10 years or more; of those coming from countries where English is not the main language, similar proportions were from European and Asian countries.
- By 2012, 80 per cent of residential facilities and 50 per cent of community outlets employed PCAs/CCWs who spoke a language other than English. Just under one-third of the residential and around two-thirds of the community direct care workforce spoke their primary language as part of their job. Despite differences between the sectors in the length of time overseas born workers had been in Australia, their English literacy levels were similar; if anything, direct care workers in residential facilities rated their English literacy slightly higher than their counterparts in community outlets. In both sectors workers identified 'writing' as the area of English literacy in which they were weakest, although the majority still considered their capacity to write in English to be relatively high.

- The workforce has very high levels of post-secondary education with the vast majority of workers (86–88%) having some form of qualification. Two-thirds of RNs have degree level qualifications in nursing; while the majority of ENs had a Certificate IV/Diploma of Enrolled Nursing. The proportion of PCAs/CCWs with relevant Certificates III has remained the same since 2007 at around two-thirds of the workforce. However, the proportion with Certificate IV qualifications has increased to approximately 20 per cent. The majority of residential facilities and community outlets now have more than 50 per cent of their workforce with a relevant Certificate III qualification.
- This workforce is continually upskilling, with around 20 per cent currently studying. While the majority are studying in a health or aged care related area, 12 per cent of direct care workers in residential facilities and 40 per cent of direct care workers in community outlets are studying in 'other' areas (i.e. outside the fields of health, aged care or management). A relatively small proportion of the workforce has a specialised qualification in ageing; the most common areas were palliative care and gerontology.
- In residential facilities, care managers have a similar profile to RNs, but with a greater proportion having management qualifications and a specialisation in ageing. There seems to be clear pathway for RNs into management. In community outlets, where the role of care co-ordinator is not usually clinical, the pathway is not so clear. Care managers have a wide range of educational backgrounds, although they seem more highly educated than the average CCW with a small proportion (10%) also having specialised qualifications in ageing.
- Training is widely undertaken with 80 per cent of workers having engaged in some form of training in the previous 12 months. A further 60 per cent of residential workers and 53 per cent of community workers had undertaken continuing and professional development during this period. In residential facilities, the main areas of training sought by PCAs for the following 12 months were in dementia and palliative care; while dementia and mental health were identified as areas of need in community outlets. A substantial minority of RNs are seeking training in management (nearly half of RNs in residential and over a third in community aged care).
- Direct care workers are also gaining specialised qualifications in ageing and aged care, particularly those in clinical roles. In residential facilities, around a third of RNs and Care Managers have specialised in areas such as gerontology, palliative care or psychogeriatrics; whereas in community outlets just under a quarter of RNs and 11 per cent of Care Managers have these specialisations. Of the remaining direct care workforce, just under 20 per cent in residential facilities and 10 per cent in community outlets had specialised qualifications.
- Multiple job holding is slightly more common among the community direct care workforce where 14 per cent had more than one job compared with 11 per cent of the residential workforce.[20] Nearly half of the 'other' jobs were in aged care, with a small proportion of workers employed in both the residential and community sectors.

8.2 Retaining Existing Workers

Putting measures in place to retain the existing workforce is an important component of any workforce planning strategy. The direct care workforce is relatively mobile, with nearly 50 per cent of residential and 40 per cent of community direct care workers having had a previous job in aged care. About a third of this mobility is because of factors associated with workers' household and family responsibilities, with another third leaving for reasons associated with the organisation of work in their previous workplace. In addition, the

20 Although the difference is noted, some caution is required in interpreting the result given the lower response rate for the community direct care workforce.

age of the workforce means that the proportion of the workforce that will retire each year is likely to be higher than in other industries.

The data shows that there is a difference between retention in aged care and retention in a particular organisation. While 16 per cent of the workforce has been in their current job for 12 months or less, only half of these are 'new' workers to the sector. While the challenge for employers is to retain workers themselves, this is different to the challenge faced by the sector in which retention is less of a problem. Indeed, over a third of direct care workers in residential facilities and a quarter in community outlets have been in aged care for 15 years or more, indicating long-term commitment to the sector by a substantial proportion of the workforce. The commitment of the direct care workforce is also manifested by the highly sector-specific education and training explained in the previous section; we would only expect workers who plan to stay in the sector to make such educational choices. Another indicator of the level of churn in the workforce is in the analysis of workers' intention to leave in the next 12 months. More than 80 per cent of the workforce indicated they will be working for their current employer, while less than 10 per cent are actively seeking work (a further 10 per cent were unsure what they would be doing). Of those seeking work, about half intended to stay in aged care. This means that only 5 per cent of the workforce are certain to be considering leaving the sector and 10 per cent undecided, with some of this total of 15 per cent being of retirement age. On the whole, this is a sector with a highly committed workforce.

Retaining staff requires ensuring that work conditions are sustainable and that they provide the basis for workers to be satisfied enough to want to continue in the sector. There have been few changes in work conditions since 2007. In residential facilities, 72 per cent of the workforce is now employed under permanent part-time arrangements, an increase of 3 per cent, with a corresponding decrease in the proportion of casual workers. In community outlets, proportions remain unchanged with 62 per cent of workers permanent part-time, and 27 per cent casual. About half of the workforce in each sector work between 16–34 hours per week. However, there has been a 7–8 per cent increase in the proportion of employees working 35 hours or more per week. There has also been an increase in the proportion of workers wanting to decrease their hours, yet it is still the case that a quarter of the workforce in residential facilities and a third in community outlets want to increase their working hours. With around 45 per cent of the workforce seeking to change their work hours, this remains a significant issue of imbalance for the sector.

Another longstanding issue relating to work conditions is that of pay. Wages are quite similar across sectors and satisfaction with pay is low across the board. Given that the majority of workers are employed part-time, the capacity to earn sufficient income is an issue that workers appear to be continuously off-setting against other work-related qualities, such as the intrinsic satisfaction with their jobs as was apparent in both the survey data and interviews.

The 2012 data collection expanded the section on work conditions and asked residential facilities about the unusual job demands they placed on workers and extended the questions on work-related injuries and illnesses. The most prevalent job demands were to ask employees to work longer hours than anticipated or to vary their hours at short notice. In the community sector, these demands were viewed as being 'normal' by a third of community outlets. In contrast, for a third of residential facilities it was viewed as 'normal' to ask employees to work with aggressive service users. Although quite different, these demands potentially contribute to the level of stress and/or work-related injuries that workers experience as part of their work.

Three-quarters of all residential facilities and half of the community outlets had employees report a work-related injury in the three months prior to the survey. The most common injuries were sprains and strains,

superficial injuries and chronic muscle or joint pain, however, 20 per cent of community outlets and 13 per cent of residential facilities reported stress or other mental condition. Causes of these injuries were primarily lifting, pushing, pulling, bending; hitting or being hit or cut by a person, object or vehicle; and falls. At the time of the survey, 46 per cent of residential facilities and 24 per cent of community outlets had employees on Workcover, mostly PCAs/CCWs. Given that direct care workers require good health to be able to do their work, injuries have the potential to shorten their careers in aged care and to increase turnover.

On a more positive note, workers' high commitment to aged care is likely to be related to their satisfaction with and experience of doing the work. In residential aged care, levels of satisfaction had increased in all areas since 2007, while in the community sector it remained at similar levels. Overall, workers appeared satisfied with all aspects of their work *except* with pay, with those in community outlets being somewhat more satisfied with their work than direct care workers in residential facilities (apart from with hours worked). Their satisfaction is undoubtedly related to their experiences at work, whether they believe they have the relevant skills, abilities and training to undertake the work; and whether they are generally positive about workplace relations. Differences between occupational groups were noted in some areas, as was variation between sectors. Of these differences, two stand out. In 2007 we noted that CCWs spent more time actively caring than PCAs and that this contributed to their greater satisfaction with their work. However, in 2012, PCAs appeared to be spending more time actively caring than CCWs but still felt that they did not have enough time to 'care'. We surmised from this that PCAs may have been required to spread this time over a larger number of care recipients than CCWs, which meant that they did not feel able to give enough time to each recipient. In contrast CCWs may have had more freedom to structure their time with care recipients to provide the level of care required. The second difference relates to the respect that workers receive. In residential aged care, PCAs reported lower respect than other occupations, while in community outlets, CCWs recorded higher levels of respect than others. This may partially be explained by the different occupational structures in the two sectors, with hierarchical arrangements more prevalent in residential care.

As noted previously, many direct care workers have household and family responsibilities that impact on their mobility, preferred hours of working and satisfaction with their jobs. Their capacity to achieve some balance (or at least minimise the interference) between work and family was the subject of interviews in 2007. In 2012 we incorporated new questions into the survey based on the Australian Work and Life Index (AWALI). Direct care workers in residential facilities reported higher levels of work–life interference than those in community outlets. In the residential sector, scores were close to the national average (i.e. across all industries). However, RNs and part-time workers had higher work–life interference than the national average. In the community sector, scores were lower than the national average. The work–life interference in the residential sector is possibly linked to the proportions of workers who report stress (21 per cent of those reporting a work-related injury) and/or who are seeking a reduction in working hours.

Retaining existing workers is part of an overall workforce strategy. However, the difference between retention in the overall workforce and retention in a particular organisation needs to be acknowledged. While the issues raised below are evident from information gained from the existing workforce, knowledge in this area is still developing. There is scope for a more sophisticated analysis of the data from the existing workforce that may provide further insights into the factors influencing retention. However, there is also a need to obtain information from workers who have left aged care to fully understand what factors motivate workers to leave. If this were done it is entirely plausible that factors such as wages may come to the fore even more than they do for existing workers. Despite their low satisfaction with wages, only a small proportion of existing workers view this as a reason for leaving their jobs. This may indicate that there is an element of selection bias in the sample whereby those for whom wages are a central issue are no longer employed in the sector. In aged care, loss of staff is due to three main factors: prioritising household responsibilities, retirement and management issues.

- *Prioritising household responsibilities:* employers are somewhat limited in their capacity to address this issue. Beyond optimising the preferred hours worked to enable workers to best manage their responsibilities, there is little to be done to keep these workers in a particular residential facility or community outlet. There may, however, be interventions at the industry level. For example, a system which arranges transfers between employers could be initiated; or having a centralised 'job search' system to make it easier for workers within the aged care sector to find suitable jobs in new locations (this, however, would need to be accessible given that many PCAs/CCWs do not use internet strategies to seek work). Although such interventions may increase turnover within the sector, it would also increase the quality of the moves and consequently reduce the permanent exits from the sector, resulting in a better educated and more stable workforce.
- *Retirement:* aged care requires employees to be physically and emotionally healthy. At the same time it places demands on employees' health because of both the day-to-day work required and the exposure to work-related risks. Given the older age profile of the workforce, these health risks are likely to exacerbate the likelihood of losing staff through early retirement. While nothing can be done about the age of the workforce, there is the potential to retain workers for as long as possible by providing options that allow them to remain engaged in the workforce at the level and the type of work that is suited to their capacity. For example, some workers may want reduced hours or the option of working with the more mobile care recipients; others may want to remain in the sector but in an administration or ancillary role.
- *Management issues:* one of the points to come out of the interviews is that good management makes a difference to workers' satisfaction and their intentions to stay in an organisation. While employees and management have relatively good relationships across the sector, it is evident that some employers have problems. Good managers were viewed by employees as people who had experience in the sector, who valued the work done and who made themselves accessible to discuss issues, improvements and care plans. Managers also have control over rosters (and giving employees their preferred hours), ensuring that the work is equitably distributed and challenging enough to keep workers interested and engaged, providing a safe work environment and handling grievances appropriately. There is evidence that the management capacity of the workforce is increasing, and more managers are obtaining appropriate qualifications. However, as the interviews with direct care workers illustrate, there still seems to be scope for improvements in this area.

8.3 Recruiting New Workers

Apart from retaining existing workers, a workforce planning strategy entails finding new workers. This is particularly important in an industry that is growing as rapidly as aged care. The 2012 census and survey included additional questions on skill shortages and vacancies that enable a more comprehensive understanding of these issues. In addition, the interviews were primarily with groups of workers viewed as important for expanding the direct care workforce: overseas born workers and men.

The residential and community sectors have different experiences of recruitment. Among residential facilities, three-quarters identify skill shortages with evidence indicating that there is often shortages in multiple occupations. Although skill shortages were identified across all occupations, a higher proportion of residential facilities reported them for RNs (63%) and PCAs (49%) than for ENs (33%) or AH workers (20%). This compares with half of all community outlets identifying skill shortages, mostly in a single occupational group. Around a third of community outlets identified skill shortages amongst CCWs, with 15 per cent reporting them for RNs.

Both residential facilities and community outlets identified three causes for their skill shortages: a lack of specialist knowledge, recruitment that is too slow and geographical location. Around one-third identified each of these causes. Of the less prevalent causes, low wages were identified by 15 per cent of facilities/outlets. A similar proportion of community outlets indicated that uncertainty of long-term demands made addressing skill shortages difficult; while 10 per cent of residential facilities had problems finding suitable applicants. On the whole, employers try to cover skill shortages from within the existing workforce using strategies such as upskilling or asking staff to work longer hours. In community aged care around 16 per cent of community outlets reduced their outputs, an option that is unlikely to be as feasible in residential facilities which do not have much flexibility (particularly in the short term) regarding client numbers.

In addition to drawing on existing staff, employers also utilise non-PAYG workers (agency, brokered, self-employed) to cover skill shortages. Just over half of all residential facilities and a quarter of all community outlets used non-PAYG staff in the designated fortnight. In residential aged care, the majority (92%) of these workers are from agencies, while in the community sector the majority are brokered (57%). Nevertheless, when community outlets use non-PAYG staff they do so at higher levels than in residential facilities. For example, non-PAYG workers in the community sector worked an average of 6.6 shifts each in the designated fortnight compared with just 1.3 shifts for residential non-PAYG workers. While use of non-PAYG staff has increased for both CCWs and RNs in community outlets, it has decreased for PCAs and remained the same for RNs in residential facilities.

Employers reported relatively high vacancy rates in the designated fortnight. Around one-third of residential facilities reported vacancies for RNs and/or PCAs, with FTE vacancies increasing across all occupational groups since 2007. Residential facilities that had vacancies reported having an average of 3.4 PCA vacancies and 2 RN vacancies per facility. However, it is now quicker to fill vacancies than in 2007 with around one-third of RN and PCA vacancies, half of EN vacancies and two-thirds of AH vacancies being filled within one week. At the other end of the spectrum, just under a third of RN vacancies and only 14 per cent of PCA vacancies took longer than 4 weeks to fill. While the average (mean) time to fill vacancies was 7 weeks for RNs and 3.2 weeks for PCAs, the median time was 2 weeks indicating that a few residential facilities take much longer periods of time to fill vacancies. Residential facilities in Victoria take longer to fill RN vacancies; residential facilities in WA and NT take longer to fill PCA vacancies; while residential facilities in Remote and Very Remote regions took nearly twice as long to fill any vacancy.

The proportion of community outlets with vacancies has stayed the same since 2007 with around 20 per cent of community outlets having CCW vacancies and 6 per cent with RN vacancies. These community outlets averaged 3.5 CCW and 1.5 RN vacancies. In contrast to the residential sector, vacancies in community outlets are now more difficult to fill than in 2007. The proportion of vacancies filled within one week has decreased by approximately one-third for RNs, ENs and AH workers. Vacancies for CCWs continue to take longer to fill, with only 16 per cent being filled within one week and the majority taking 3–8 weeks. The average time to fill vacancies is shorter than in the residential sector at about 4 weeks for both RNs and CCWs, with the median being 3 weeks and 2 weeks respectively. Again there were geographical differences with community outlets in NSW and Victoria taking longer to fill RN vacancies; community outlets in SA and NT taking longer to fill CCW vacancies; while community outlets in Remote areas took nearly twice as long to fill RN vacancies and somewhat longer to fill CCW vacancies than community outlets in other regions.

The picture obtained from this information is that while there is greater need (i.e. in terms of numbers) to recruit PCAs and CCWs, the most difficult group to recruit is RNs. The problems in attracting RNs to aged care are longstanding and some measures to address these, such as introducing clinical training into aged

care, have been recently put in place. Information from the survey about RNs' working conditions can help inform these strategies. Looking explicitly at RNs in the workforce we see that many are working longer hours than they prefer. In residential facilities 29 per cent work more than 40 hours per week while only 6 per cent want to be doing this; in community outlets 19 per cent are working more than 40 hours per week and only 3 per cent have this as their preferred hours. Compared with other occupational groups, nurses (RNs and ENs) are more likely to report feeling under pressure and that their job is more stressful than they imagined. In the residential sector, RNs report high work–life interference: the highest of all occupational groups and higher than that of the Australian workforce more generally. Although about a third of RNs have been in the workforce for 20 years or more, just over 20 per cent have been in their jobs for 12 months or less—the highest proportion of all the occupational groups. To further exacerbate matters, about a quarter of all RNs do not expect to be working for their current organisation in 12 months, with 14 per cent in the residential sector and 8 per cent in the community sector actively seeking work at the time of the survey. These issues point to there being substantial pressure on employers both to retain RNs and continually recruit them from universities and the broader health and social assistance sector.

Two categories of workers were selected for interviews on the basis of their capacity to fill some of the vacancies in the direct care workforce: migrants (who speak a language other than English) and men. Workers in both of these groups discussed difficulties in working in a field that is dominated by and constructed around Australian-born mature-aged women. Many interviewees experienced discrimination from colleagues, supervisors and care recipients. Often this was dealt with through humour and re-education, but some workers indicated frustration with continually having to prove their competence. Opportunities existed within aged care for each group to have a niche: men provided care to other men and care recipients with difficult behaviours, while CaLD migrant workers provided care to culturally and linguistically diverse care recipients. However this 'matching' was not always possible and workers also had to provide services to the broader population of older Australians and deal with any discrimination that this involved. CaLD migrant workers recognised the difficulties they had sometimes in communicating in English and with understanding Australian culture. They viewed their work as an opportunity to improve their knowledge and skills in both of these areas and sought support from the workplace in achieving this. There is the potential for men and CaLD migrants to increase their share of the direct care workplace. The interviews point to some issues that current workers face and that may prevent some people from viewing aged care as an area in which they could work. However, there are also opportunities. As discussed in the analysis, it is likely that more could be done to facilitate pathways into aged care for these groups of workers who, apart from nurses and those with health qualifications, often have a serendipitous pathway into aged care. The industry needs pathways that make direct care work a career choice rather than an opportunistic job.

8.4 Emergent Themes from the Interviews

During the interviews with care workers a number of issues were raised which we discussed in Chapter 7 as areas that might be 'flags' for further investigation or that may require policy or management action. Many of the issues have been raised previously, and we focused on those that have received less attention. These included:

- Variation in management strategies and skills throughout the sector that impact on worker satisfaction, the development of productive working relationships and the level of service quality;
- Variation in the quality and accessibility of training; with community direct care workers finding access to and the relevance of training particularly problematic (because of its emphasis on the provision of care in residential facilities);

- The development of strategies for managing 'unsuitable' workers who were viewed as placing additional pressure on other workers and reducing the quality of services provided;
- The ability to identify clearly the social and emotional skills required for care work and incorporate them into training and guidelines for care workers;
- The need to find ways to maximise the work lives and contribution to aged care of older workers;
- Specific issues associated with community aged care: recognising that providing care in private homes is different to providing it in regulated residential facilities; the hidden out of pocket costs that are borne by workers; and the safety issues associated with working alone and going into private homes.

Appendix A: Technical Note on Data Weighting

Residential Facilities and Community Outlets (Census data)

We constructed basic weights for the residential facility and community outlet responses in order to better approximate their respective populations. In each case, the general approach for calculating these weights was to take the inverse of each facility's or outlet's response probability. In a limited number of cases, it was necessary to modify this general approach as described below, to remove obvious outliers in the data.

We can claim to have achieved a Census of residential facilities. We received useable responses from 2,485 of these facilities, representing an overall response rate of 96 per cent. The weights that we used to inflate these facilities' responses thus differ only marginally from the results obtained by using the raw (unweighted) data. Note, however, that there was a systematically lower response rate from smaller residential facilities. To capture these differences, we used the number of (worker) surveys that each facility received, determined in advance by the number of operational places, as a proxy for the size of the facility's workforce. This allowed us to assign a marginally higher weight to the responses from smaller facilities. The overall effect of this differentiated weighting procedure on the final data remains minor, because the response rate from the smallest facilities in our sample was still very high: 93 per cent. All of the residential facility weights are thus close to 1.

For community outlets, we used the same basic weighting procedure as described above, with two important qualifications. First, our information about the population of community outlets is less complete than for residential facilities. In calculating the community weights, we decreased the total population of outlets by removing those that were known (from their returns) to be out of scope. We have assumed that the remaining, non-responding outlets are in scope. This assumption is likely to overstate the true population of outlets, but we have no reliable basis for further reducing the in-scope population. In the section of the report examining the size of the community aged care workforce, we use the information collected in follow-up telephone calls made by the survey company to non-responding outlets to re-estimate some of results using alternative, lower-bound weights.

A second modification to the community outlet weights was required to reduce the influence of outliers on the results. We undertook a case-by-case inspection of a small number of outlets (N=12) that reported unusually high numbers of direct care workers. In every case, these responses were found to have come from service providers whose information represented employment in multiple outlets located within a wider service area (e.g. the Blue Mountains). For these few respondents, we reset the weight to 1, to recognise that their response constitutes a full enumeration of employment within that particular service area.

Residential and Community Workers (Survey data)

As in previous years, our approach to sampling aged care workers involved distributing survey forms via the workers' facility or outlet. By matching responding workers to their corresponding facility or outlet—which we can do for almost all residential workers and for a majority of community workers—we derive sampling weights that reflect the different probabilities of selection into the final sample for these workers. We asked facilities and outlets to distribute the survey forms randomly to their direct care workers. Unlike in the previous surveys conducted in 2003 and 2007, we did not seek the same number of worker responses from each facility, irrespective of its size. Rather, we attempted to collect more worker responses from facilities that were known in advance (from their number of operational places) to be larger in size, by sending these facilities

packages that contained a higher number of worker survey forms. The majority of residential facilities received packages that contained fewer than 10 worker forms, with the largest number receiving 4 worker forms. Thirty facilities were sent packages that contained 16 worker forms, and another three facilities received packages containing 30 worker forms. Despite these efforts to gather additional worker responses from larger facilities, it is evident from the eventual responses that the probability of selection into the worker sample was still inversely related to facility/outlet size. Hence, workers matched to facilities and outlets that reported a larger number of direct care workers were less likely to complete the worker questionnaire. The sampling weights we have constructed adjust for these different probabilities, assigning a higher weight in the analysis to workers from larger facilities.

Where workers were unable to be matched with a facility or outlet (because no corresponding Census form was returned) we imputed a weight by using the mean value of the weight for workers in facilities that received the same number of worker forms. For workers in facilities or outlets that did not return a Census response, we can tell (from their unique identification code) the number of *worker* forms that were sent to the facility. This information allows us to impute weights for the unmatched workers in our data. The imputation procedure is more consequential for the community data than for the residential data, because a higher proportion of community workers were in outlets that did not return a Census response.

A major benefit of collecting data from both facilities/outlets and workers is that we can compare the occupational composition of the workforce as reported by these two groups. Our approach to sampling aged care workers should, in principle, yield a stratified random sample of these workers that approximates the population. In practice, however, the final worker samples achieved in both the residential and community sectors significantly under-sample particular types of workers. This may occur because facilities and outlets do not always select randomly the workers that are asked to participate. Our judgment about the under-sampling of groups of workers is based on comparing the facility/outlet-reported and worker-reported distributions of the workforce by occupation. Because facilities/outlets are asked to report information for their whole workforce (whereas workers answer only for themselves) we regard the facilities/outlets as being more accurate with respect to the total workforce. Comparing the facility/outlet data to the workers' data suggests that our worker surveys under-sample lower-skilled Personal Care Attendant and Community Care Workers, and over-sample Nurses and Allied Health professionals. We have thus undertaken some further *post hoc* adjustment of the workers' sampling weights, to bring the final proportions of workers within each occupation into line with the occupational distribution reported by facilities/outlets.

In both the residential and community workers data, the above steps used to derive the sampling weights resulted in an excessively wide dispersion of values for these weights. As a final measure, we 'trimmed' the weight variables to obtain a more useable range of values. For the residential workers data, this was achieved by following a standard weight shrinkage procedure described by Longford (2008, p. 82). Its application resulted in a final weight with a range of values very close to that used for analysis of the 2007 Aged Care Census and Survey. For the community workers data, however, the wide dispersion of the weights resulted from a handful of very high outlying values. These were corrected by top-coding the final weight at the 99th percentile value of the post-hoc adjusted weight.

Appendix B: Questionnaires

Available via the Commonwealth Department of Health and Ageing website, www.health.gov.au

Appendix C: Additional Tables

Please note, all tables in the Appendix have column totals.

Ac.1 Appendix to Section 3.4.1

Tables A1 to A9 provide the distributions of the mean scores reported in Table 3.35. The range is from 1–10, with 1 being totally dissatisfied and 10 being totally satisfied

Table A1: Distribution of responses from the residential direct care workforce, to statement about job satisfaction re 'Total pay', by occupation: 2007 and 2012 (range 1–10)

	2007 (%)				2012 (%)			
	Nurse	PCA	AH	All	Nurse	PCA	AH	All
1	10.8	19.2	14.6	15.7	10.3	18.0	15.9	15.7
2	7.0	9.4	6.8	8.3	6.8	10.2	7.7	9.1
3	12.1	13.2	15.0	12.9	11.0	11.7	11.4	11.5
4	9.7	9.4	10.5	9.6	8.8	8.1	9.2	8.3
5	13.1	12.0	11.3	12.3	10.8	11.7	13.2	11.5
6	8.2	7.6	10.5	8.0	9.7	8.7	8.2	8.9
7	12.0	8.6	10.7	10.1	12.1	9.8	10.7	10.5
8	13.5	8.5	7.8	10.3	14.1	8.1	11.4	9.9
9	8.0	6.6	6.1	7.1	9.0	7.7	6.9	8.0
10	5.7	5.5	6.7	5.7	7.4	6.1	6.0	6.4

Source: Survey of residential aged care workers, 2012 (Question A23(a))
Scale used is 1(totally dissatisfied) to 10 (totally satisfied)

Table A2: Distribution of responses from the residential direct care workforce, to statement about job satisfaction re 'Job security', by occupation: 2007 and 2012 (range 1–10)

	2007 (%)				2012 (%)			
	Nurse	PCA	AH	All	Nurse	PCA	AH	All
1	2.2	2.3	1.3	2.2	1.7	2.0	2.0	1.9
2	1.7	2.2	0.2	1.8	1.7	1.7	0.7	1.7
3	3.4	3.2	2.4	3.2	3.2	3.4	4.2	3.4
4	4.3	5.4	3.9	4.9	3.0	3.8	2.5	3.5
5	10.1	10.2	9.3	10.1	8.0	10.3	11.1	9.7
6	8.5	7.9	10.4	8.3	6.6	8.5	6.7	7.9
7	11.0	11.5	9.1	11.1	11.6	12.0	10.6	11.8
8	20.1	18.2	17.8	18.9	19.2	17.5	15.6	17.8
9	18.9	19.2	23.4	19.4	20.2	17.2	22.0	18.3
10	19.8	19.9	22.1	20.0	24.9	23.5	24.5	23.9

Source: Survey of residential aged care workers, 2012 (Question A23(b))
Scale used is 1(totally dissatisfied) to 10 (totally satisfied)

Table A3: Distribution of responses from the residential direct care workforce, to statement about job satisfaction re 'The work itself', by occupation: 2007 and 2012 (range 1–10)

	2007 (%)				2012 (%)			
	Nurse	PCA	AH	All	Nurse	PCA	AH	All
1	0.9	0.9	0.2	0.8	0.8	1.2	0.2	1.0
2	1.6	1.7	0.9	1.6	0.9	1.2	0.2	1.1
3	2.8	2.5	0.9	2.5	2.4	2.2	0.7	2.1
4	4.7	4.0	1.8	4.1	3.3	3.1	1.7	3.1
5	9.1	8.7	5.0	8.6	8.8	7.6	4.5	7.8
6	10.6	9.4	5.7	9.6	7.3	7.7	6.7	7.5
7	15.9	13.1	11.3	14.0	13.5	13.5	9.2	13.2
8	23.2	19.9	25.5	21.6	22.2	19.1	18.9	20.0
9	18.2	19.5	24.2	19.4	22.0	21.6	31.6	22.3
10	13.2	20.2	24.0	17.8	18.7	22.9	25.6	21.9

Source: Survey of residential aged care workers, 2012 (Question A23(c))
Scale used is 1(totally dissatisfied) to 10 (totally satisfied)

Table A4: Distribution of responses from the residential direct care workforce, to statement about job satisfaction re 'Hours worked', by occupation: 2007 and 2012 (range 1–10)

	2007 (%)				2012 (%)			
	Nurse	PCA	AH	All	Nurse	PCA	AH	All
1	1.7	1.5	1.3	1.5	2.4	2.3	1.2	2.3
2	2.3	1.9	2.8	2.1	2.7	1.2	1.5	1.6
3	3.4	3.0	2.6	3.1	4.1	2.7	4.0	3.2
4	4.4	3.9	4.5	4.2	4.7	3.7	2.5	3.9
5	8.1	8.5	6.2	8.2	8.6	7.7	6.7	7.9
6	7.6	8.8	6.7	8.2	6.8	7.4	7.0	7.3
7	11.1	9.2	9.5	10.0	10.4	11.0	7.7	10.6
8	19.6	16.1	13.6	17.2	17.6	15.8	14.5	16.2
9	20.0	19.8	24.1	20.2	18.6	20.1	24.4	19.9
10	22.0	27.3	28.7	25.4	24.2	28.0	30.4	27.1

Source: Survey of residential aged care workers, 2012 (Question A23(d))
Scale used is 1(totally dissatisfied) to 10 (totally satisfied)

Table A5: Distribution of responses from the residential direct care workforce, to statement about job satisfaction re 'Opportunities to develop abilities', by occupation: 2007 and 2012 (range 1–10)

	2007 (%)				2012 (%)			
	Nurse	PCA	AH	All	Nurse	PCA	AH	All
1	2.1	2.1	1.7	2.1	1.6	2.2	1.7	2.0
2	3.6	2.8	2.0	3.0	1.5	1.5	1.0	1.5
3	4.8	4.3	4.3	4.5	3.2	3.2	3.2	3.2
4	4.8	4.8	5.0	4.8	4.7	3.5	2.7	3.8
5	8.6	8.7	8.5	8.6	9.3	8.1	6.9	8.3
6	9.6	9.4	7.4	9.4	7.5	8.3	7.9	8.1
7	13.2	11.9	9.4	12.2	11.8	11.7	8.7	11.5
8	19.5	17.9	16.7	18.4	18.9	17.6	19.1	18.1
9	18.9	18.8	21.7	19.1	20.9	20.1	25.0	20.6
10	14.9	19.3	23.7	18.0	20.6	23.9	24.0	22.9

Source: Survey of residential aged care workers, 2012 (Question A23(e))
Scale used is 1(totally dissatisfied) to 10 (totally satisfied)

Table A6: Distribution of responses from the residential direct care workforce, to statement about job satisfaction re 'Level of support from your team/service provider', by occupation: 2007 and 2012 (range 1–10)

	2007 (%)				2012 (%)			
	Nurse	PCA	AH	All	Nurse	PCA	AH	All
1	2.9	2.1	1.1	2.3	1.7	1.8	1.5	1.7
2	3.0	3.5	2.8	3.3	2.3	2.2	1.0	2.1
3	5.0	4.3	3.0	4.5	3.5	3.4	2.7	3.4
4	4.7	5.4	5.2	5.1	4.1	4.0	2.2	3.9
5	7.0	9.2	8.5	8.3	6.8	9.2	7.9	8.5
6	7.5	8.1	6.1	7.7	6.5	7.5	8.4	7.3
7	10.8	10.5	10.4	10.6	10.6	11.6	8.9	11.2
8	20.4	17.0	15.3	18.2	18.9	18.4	18.8	18.5
9	21.9	20.3	22.9	21.1	23.5	20.3	21.3	21.2
10	16.8	19.7	24.8	19.0	22.3	21.7	27.5	22.2

Source: Survey of residential aged care workers, 2012 (Question A23(f))
Scale used is 1(totally dissatisfied) to 10 (totally satisfied)

Table A7: Distribution of responses from the residential direct care workforce, to statement about job satisfaction re 'Flexibility to balance work and non-work commitments', by occupation: 2007 and 2012 (range 1–10)

	2007 (%)				2012 (%)			
	Nurse	PCA	AH	All	Nurse	PCA	AH	All
1	2.1	1.7	1.7	1.9	2.0	2.5	1.7	2.3
2	3.2	2.4	1.5	2.6	2.3	1.9	1.0	2.0
3	4.4	3.5	2.6	3.8	4.6	3.7	2.5	3.9
4	4.7	5.1	3.4	4.8	4.4	3.3	3.5	3.6
5	10.0	10.3	8.0	10.0	7.8	9.0	4.7	8.4
6	8.4	8.3	7.4	8.3	8.1	8.0	6.4	7.9
7	12.0	11.7	9.1	11.6	11.3	12.0	9.7	11.7
8	18.7	17.4	18.1	17.9	15.8	18.0	19.6	17.5
9	20.7	20.0	23.6	20.5	21.7	19.2	24.3	20.2
10	15.7	19.6	24.4	18.5	22.1	22.4	26.2	22.5

Source: Survey of residential aged care workers, 2012 (Question A23(g))
Scale used is 1(totally dissatisfied) to 10 (totally satisfied)

Table A8: Distribution of responses from the residential direct care workforce, to statement about satisfaction re 'Match between work and qualifications, by occupation': 2012 (range 1–10)

	2007 (not asked in 2007)				2012 (%)			
	Nurse	PCA	AH	All	Nurse	PCA	AH	All
1					1.3	1.6	1.4	1.5
2					0.5	1.5	0.9	1.1
3					1.8	2.0	1.4	1.9
4					2.7	3.4	3.7	3.2
5					7.1	8.3	6.5	7.9
6					9.2	10.5	8.5	10.0
7					13.2	13.5	14.8	13.5
8					26.6	21.0	20.5	22.7
9					19.1	18.2	21.3	18.7
10					18.5	19.9	21.3	19.6

Source: Survey of residential aged care workers, 2012 (Question B9.6)
Scale used is 1(totally dissatisfied) to 10 (totally satisfied)

Table A9: Distribution of responses from the residential direct care workforce, to statement about job satisfaction re 'Overall satisfaction', by occupation: 2007 and 2012 (range 1–10)

	2007 (%)				2012 (%)			
	Nurse	PCA	AH	All	Nurse	PCA	AH	All
1	1.1	1.0	0.4	1.0	0.7	1.0	0.5	0.9
2	1.9	1.5	1.5	1.7	0.9	0.8	0.2	0.8
3	3.4	2.2	0.9	2.5	3.0	1.9	1.7	2.2
4	4.5	4.2	2.4	4.2	2.9	2.8	2.7	2.8
5	7.5	8.0	6.3	7.7	8.4	6.9	4.5	7.2
6	9.1	8.1	5.8	8.3	7.2	7.2	5.7	7.1
7	15.2	14.0	14.7	14.5	12.4	10.9	13.6	11.4
8	22.7	21.2	22.6	21.9	20.4	21.7	18.8	21.2
9	21.1	21.2	22.8	21.3	25.2	25.4	30.7	25.6
10	13.5	18.5	22.8	16.9	18.8	21.5	21.5	20.8

Source: Survey of residential aged care workers, 2012 (Question A23(h))
Scale used is 1(totally dissatisfied) to 10 (totally satisfied)

For comparison with responses reported in Table 3.35, scores for 2007 have been recalculated on a scale from 1–10 and will differ slightly from those previously reported (Martin and King 2008).

Table A10: Average scores for responses from the residential direct care workforce, to statements about job satisfaction, by occupation: 2007 (range 1–10)

Satisfaction with	Nurse	PCA	AH	All occupations
Total pay	5.4	4.6	4.9	**4.9**
Job security	7.4	7.3	7.7	**7.4**
The work itself	7.3	7.6	8.1	**7.5**
Hours worked	7.5	7.7	7.8	**7.6**
Opportunities to develop abilities	7.1	7.3	7.6	**7.2**
Level of support from your team/service provider	7.3	7.3	7.6	**7.3**
Flexibility to balance work and non-work commitments	7.2	7.4	7.8	**7.3**
Overall satisfaction	7.4	7.6	8.0	**7.5**

Source: Survey of residential aged care workers, 2007 (Question A23(a–h)
Scale used is 1(totally dissatisfied) to 10 (totally satisfied)

Ac.2 Appendix to Section 3.4.2

Tables A11 to A19 provide the distributions for the mean scores reported in Table 3.36. The range is from 1–7, with 1 being strongly disagree, 7 being strongly agree and 4 being neither agree/disagree (neutral).

Table A11: Distribution of responses from the residential direct care workforce to the statement 'I am able to spend enough time with each care recipient', by occupation: 2007 and 2012 (range 1–7)

	2007 (%)				2012 (%)			
	Nurse	PCA	AH	All	Nurse	PCA	AH	All
1	18.9	15.9	12.2	16.7	15.0	13.4	12.3	13.8
2	19.1	16.5	18.1	17.6	13.2	12.1	9.3	12.2
3	20.4	18.9	21.7	19.7	19.3	18.2	18.0	18.5
4	18.4	22.8	18.3	20.8	20.8	21.6	20.5	21.3
5	13.7	12.1	15.4	13.0	15.8	16.0	19.3	16.1
6	7.0	8.6	9.2	8.1	9.4	10.3	9.5	10.0
7	2.5	5.2	4.7	4.1	6.4	8.5	11.3	8.1

Source: Survey of residential aged care workers, 2012 (Question A21(a))
Scale used is 1(strongly disagree) to 7 (strongly agree)

Table A12: Distribution of responses from the residential direct care workforce to the statement 'I have the skills and abilities I need to do my job', by occupation: 2007 and 2012 (range 1–7)

	2007 (%)				2012 (%)			
	Nurse	PCA	AH	All	Nurse	PCA	AH	All
1	0.2	0.6	0.4	0.4	0.5	0.4	0.0	0.4
2	0.2	0.7	1.3	0.6	0.3	0.5	0.5	0.5
3	0.5	1.1	0.9	0.9	0.7	0.5	1.0	0.6
4	3.0	4.3	5.0	3.9	3.2	3.7	4.2	3.6
5	9.5	10.6	12.9	10.3	10.8	10.8	9.9	10.7
6	43.1	37.5	41.5	39.9	37.6	32.1	40.1	34.1
7	43.4	45.3	38.1	44.1	46.8	52.0	44.3	50.1

Source: Survey of residential aged care workers, 2012 (Question A21(b))
Scale used is 1(strongly disagree) to 7 (strongly agree)

Table A13: Distribution of responses from the residential direct care workforce to the statement 'I use many of my skills and abilities in my current job', by occupation: 2007 and 2012 (range 1–7)

	2007 (%)				2012 (%)			
	Nurse	PCA	AH	All	Nurse	PCA	AH	All
1	0.5	0.6	0.4	0.6	1.3	0.6	0.5	0.7
2	1.6	0.8	1.9	1.2	1.6	0.8	1.2	1.0
3	3.4	1.0	0.9	1.9	2.7	1.6	0.7	1.8
4	8.6	4.3	5.2	6.0	6.2	3.5	4.0	4.3
5	14.6	11.5	11.6	12.7	12.6	10.8	9.7	11.3
6	38.6	36.2	40.7	37.5	35.4	32.8	37.9	33.8
7	32.8	45.6	39.6	40.3	40.2	49.9	46.3	47.0

Source: Survey of residential aged care workers, 2012 (Question A21(c))
Scale used is 1(strongly disagree) to 7 (strongly agree)

Table A14: Distribution of responses from the residential direct care workforce to the statement 'Adequate training is available through my workplace', by occupation: 2012 (range 1–7)

	2007 (not asked in 2007)				2012 (%)			
	Nurse	PCA	AH	All	Nurse	PCA	AH	All
1					2.4	2.0	1.5	2.1
2					3.1	2.2	3.0	2.5
3					5.9	3.5	5.9	4.3
4					10.4	7.6	10.9	8.5
5					17.5	15.0	15.6	15.7
6					29.4	29.9	29.7	29.7
7					31.4	39.9	33.7	37.2

Source: Survey of residential aged care workers, 2012 (Question A21(i))
Scale used is 1(strongly disagree) to 7 (strongly agree)

Table A15: Distribution of responses from the residential direct care workforce to the statement 'I have a lot of freedom to decide how to do my work', by occupation: 2007 and 2012 (range 1–7)

	2007 (%)				2012 (%)			
	Nurse	PCA	AH	All	Nurse	PCA	AH	All
1	3.5	5.6	1.1	4.5	3.3	6.6	4.0	5.6
2	5.6	8.6	3.0	7.1	5.2	8.5	3.3	7.3
3	8.4	12.4	6.0	10.4	8.3	12.9	6.0	11.3
4	19.8	24.4	13.2	21.8	17.5	23.0	12.8	20.9
5	23.6	21.7	19.6	22.3	22.4	21.6	21.1	21.8
6	25.5	17.4	32.1	21.6	26.0	16.1	28.9	19.5
7	13.6	9.9	25.0	12.4	17.3	11.4	23.9	13.7

Source: Survey of residential aged care workers, 2012 (Question A21(d))
Scale used is 1(strongly disagree) to 7 (strongly agree)

Table A16: Distribution of responses from the residential direct care workforce to the statement 'I feel under pressure to work harder in my job', by occupation: 2007 and 2012 (range 1–7)

	2007 (%)				2012 (%)			
	Nurse	PCA	AH	All	Nurse	PCA	AH	All
1	7.6	10.3	11.4	9.4	9.5	11.9	14.4	11.4
2	12.6	13.6	16.6	13.5	12.0	14.2	14.9	13.6
3	11.8	12.4	14.0	12.3	12.0	13.0	14.6	12.8
4	18.1	18.4	18.1	18.3	16.9	19.1	16.9	18.4
5	16.7	15.8	16.6	16.2	16.7	13.8	14.4	14.7
6	19.5	16.7	11.4	17.4	16.4	15.3	14.4	15.6
7	13.7	12.7	11.8	13.0	16.5	12.5	10.4	13.5

Source: Survey of residential aged care workers, 2012 (Question A21(e))
Scale used is 1(strongly disagree) to 7 (strongly agree)

Table A17: Distribution of responses from the residential direct care workforce to the statement 'My job is more stressful than I had ever imagined', by occupation: 2007 and 2012 (range 1–7)

	2007 (%)				2012 (%)			
	Nurse	PCA	AH	All	Nurse	PCA	AH	All
1	7.9	10.8	10.5	9.7	10.3	13.3	16.4	12.6
2	12.9	13.2	15.4	13.2	13.5	14.4	14.9	14.2
3	13.0	13.3	14.3	13.3	12.7	15.9	16.2	15.1
4	19.4	19.7	18.2	19.5	19.6	18.1	18.9	18.6
5	17.8	15.6	14.4	16.4	15.0	14.3	16.2	14.6
6	15.4	15.4	15.8	15.4	14.7	12.1	9.1	12.7
7	13.6	12.0	11.6	12.6	14.1	11.9	7.8	12.3

Source: Survey of residential aged care workers, 2012 (Question A21(f))
Scale used is 1(strongly disagree) to 7 (strongly agree)

Table A18: Distribution of responses from the residential direct care workforce to the statement 'Considering all my efforts and achievements I receive the respect and acknowledgement I deserve', by occupation: 2007 and 2012 (range 1–7)

	2007 (%)				2012 (%)			
	Nurse	PCA	AH	All	Nurse	PCA	AH	All
1	4.5	4.7	3.2	4.5	4.4	6.3	4.2	5.7
2	6.1	8.0	5.6	7.1	5.7	7.1	5.9	6.6
3	9.1	9.8	6.9	9.3	8.1	9.8	7.2	9.2
4	17.0	18.8	17.7	18.1	15.8	16.2	15.6	16.0
5	20.4	17.9	18.0	18.9	19.2	18.2	19.8	18.6
6	28.0	24.0	30.5	26.0	27.5	23.3	26.7	24.6
7	14.9	16.7	18.2	16.2	19.4	19.1	20.5	19.3

Source: Survey of residential aged care workers, 2012 (Question A21(g))
Scale used is 1(strongly disagree) to 7 (strongly agree)

Table A19: Distribution of responses from the residential direct care workforce to the statement 'Management and employees have good relations in my workplace', by occupation: 2007 and 2012 (range 1–7)

	2007 (%)				2012 (%)			
	Nurse	PCA	AH	All	Nurse	PCA	AH	All
1	4.4	4.3	2.4	4.2	4.2	7.0	4.2	6.1
2	6.2	6.2	5.2	6.1	4.9	5.5	5.7	5.4
3	8.8	9.4	10.4	9.2	7.3	7.9	7.9	7.7
4	17.3	18.1	16.6	17.7	14.2	16.5	14.6	15.8
5	20.7	17.5	20.5	18.9	19.7	18.3	22.5	18.9
6	25.6	22.9	25.9	24.1	29.0	22.8	24.5	24.6
7	17.0	21.7	19.0	19.8	20.7	22.0	20.5	21.6

Source: Survey of residential aged care workers, 2012 (Question A21(h))
Scale used is 1(strongly disagree) to 7 (strongly agree)

Ac.3 Appendix to Section 5.4.1

Tables A20 to A29 provide the distributions of the mean scores reported in Table 5.35. The range is from 1–10, with 1 being totally dissatisfied and 10 being totally satisfied

Table A20: Distribution of responses from the community direct care workforce, to statement about job satisfaction re 'Total pay', by occupation: 2007 and 2012 (range 1–10)

	2007 (%)				2012 (%)			
	Nurse	CCW	AH	All	Nurse	CCW	AH	All
1	8.8	8.0	9.3	8.1	5.2	11.5	8.4	10.6
2	2.7	6.1	10.2	5.9	5.4	7.8	5.7	7.4
3	13.7	8.4	12.0	9.2	10.4	10.0	7.6	9.9
4	8.1	8.7	9.8	8.6	10.4	7.7	10.3	8.2
5	6.3	13.3	12.9	12.3	10.9	11.4	12.6	11.4
6	14.9	10.4	13.3	11.1	7.5	10.4	10.7	10.1
7	12.7	12.0	10.2	12.0	11.5	11.5	11.5	11.5
8	19.5	13.7	11.1	14.3	18.0	13.5	15.3	14.1
9	8.6	10.6	9.3	10.3	12.5	7.9	9.9	8.5
10	4.7	9.0	2.7	8.1	8.4	8.3	8.0	8.3

Source: Survey of community aged care workers (Question A26(a))
Scale used is 1(totally dissatisfied) to 10 (totally satisfied)

Table A21: Distribution of responses from the community direct care workforce, to statement about job satisfaction re 'Job security', by occupation: 2007 and 2012 (range 1–10)

	2007 (%)				2012 (%)			
	Nurse	CCW	AH	All	Nurse	CCW	AH	All
1	1.4	1.9	1.8	1.8	1.0	2.1	1.9	1.9
2	1.4	1.8	0.4	1.7	1.3	2.6	3.4	2.5
3	2.4	2.9	5.8	3.0	3.1	2.5	4.2	2.7
4	5.4	3.3	4.0	3.6	3.3	4.2	2.3	4.0
5	5.4	7.1	9.8	7.0	6.3	8.8	7.6	8.4
6	10.8	6.9	10.7	7.6	6.1	6.9	8.4	6.9
7	12.3	10.9	16.9	11.4	11.5	10.3	11.1	10.4
8	29.2	19.4	13.8	20.4	21.5	18.1	23.3	18.8
9	17.6	24.7	22.2	23.7	22.3	19.9	18.3	20.1
10	14.0	21.0	14.7	19.8	23.6	24.7	19.8	24.2

Source: Survey of community aged care workers (Question A26(b))
Scale used is 1(totally dissatisfied) to 10 (totally satisfied)

Table A22: Distribution of responses from the community direct care workforce, to statement about job satisfaction re 'The work itself', by occupation: 2007 and 2012 (range 1–10)

	2007 (%)				2012 (%)			
	Nurse	CCW	AH	All	Nurse	CCW	AH	All
1	0.5	0.2	0.0	0.2	0.0	0.2	0.0	0.2
2	0.3	0.4	0.9	0.4	0.6	0.4	0.8	0.5
3	0.5	0.7	2.2	0.8	2.7	1.1	0.8	1.2
4	9.1	2.0	3.6	2.9	3.1	1.9	2.3	2.0
5	4.6	6.0	5.8	5.8	6.2	6.0	6.1	6.0
6	13.4	5.6	6.2	6.6	5.2	6.0	9.2	6.1
7	13.9	12.3	20.9	12.9	11.8	10.9	16.0	11.3
8	19.9	19.1	27.6	19.6	24.1	20.3	20.6	20.7
9	23.8	27.9	22.7	27.1	27.4	22.6	22.9	23.1
10	13.9	25.8	10.7	23.6	18.6	30.7	21.0	28.8

Source: Survey of community aged care workers (Question A26(c))
Scale used is 1(totally dissatisfied) to 10 (totally satisfied)

Table A23: Distribution of responses from the community direct care workforce, to statement about job satisfaction re 'Hours worked', by occupation: 2007 and 2012 (range 1–10)

	2007 (%)				2012 (%)			
	Nurse	CCW	AH	All	Nurse	CCW	AH	All
1	0.8	1.6	0.4	1.4	1.0	2.6	0.4	2.3
2	0.7	1.8	0.4	1.6	2.1	1.7	1.5	1.7
3	3.2	4.1	1.8	3.9	6.6	3.2	1.5	3.5
4	10.7	5.8	7.1	6.4	3.5	4.0	4.2	4.0
5	8.8	7.4	4.9	7.5	9.1	8.8	5.4	8.6
6	4.7	7.5	8.9	7.2	4.9	7.5	8.0	7.2
7	10.3	10.8	18.2	11.1	10.1	10.5	12.6	10.5
8	21.7	18.3	16.4	18.7	21.2	18.5	24.1	19.1
9	25.2	22.6	27.6	23.1	21.9	19.5	19.2	19.7
10	14.0	20.2	14.7	19.2	19.8	23.8	23.4	23.3

Source: Survey of community aged care workers (Question A26(d))
Scale used is 1(totally dissatisfied) to 10 (totally satisfied)

Table A24: Distribution of responses from the community direct care workforce, to statement about job satisfaction re 'Opportunities to develop abilities', by occupation: 2007 and 2012 (range 1–10)

	2007 (%)				2012 (%)			
	Nurse	CCW	AH	All	Nurse	CCW	AH	All
1	1.2	1.3	1.3	1.3	1.3	1.1	1.5	1.2
2	0.5	2.1	1.3	1.8	2.5	2.5	3.4	2.5
3	2.0	3.9	3.6	3.7	5.8	2.8	4.2	3.2
4	4.4	3.1	5.8	3.4	5.8	3.0	5.7	3.5
5	15.7	6.8	12.0	8.2	6.5	6.9	10.0	7.0
6	5.4	8.8	14.7	8.6	9.4	6.8	12.6	7.4
7	13.2	10.7	14.7	11.2	10.6	11.3	13.4	11.3
8	23.1	20.1	16.4	20.3	18.7	17.5	16.9	17.6
9	20.1	22.4	22.7	22.1	22.5	21.1	18.4	21.1
10	14.0	20.8	7.6	19.3	17.1	27.0	14.2	25.1

Source: Survey of community aged care workers (Question A26(e))
Scale used is 1(totally dissatisfied) to 10 (totally satisfied)

Table A25: Distribution of responses from the community direct care workforce, to statement about job satisfaction re 'Level of support from your team/service provider', by occupation: 2007 and 2012 (range 1–10)

	2007 (%)				2012 (%)			
	Nurse	CCW	AH	All	Nurse	CCW	AH	All
1	1.4	0.9	0.9	0.9	1.5	1.3	0.8	1.4
2	2.2	1.3	3.6	1.5	1.9	1.3	3.4	1.5
3	7.8	2.8	6.2	3.6	4.6	2.5	3.1	2.7
4	4.4	2.7	4.4	3.0	3.1	2.6	2.3	2.6
5	5.4	4.5	6.7	4.8	7.3	5.3	5.4	5.6
6	5.6	5.2	8.0	5.4	6.2	4.6	5.7	4.9
7	24.7	6.9	14.2	9.5	12.7	8.0	12.6	8.8
8	12.2	17.2	12.4	16.3	17.5	14.8	20.7	15.4
9	20.1	27.6	29.8	26.8	24.8	25.0	24.1	24.9
10	16.2	30.9	13.3	28.2	20.2	34.7	21.8	32.3

Source: Survey of community aged care workers (Question A26(f))
Scale used is 1(totally dissatisfied) to 10 (totally satisfied)

Table A26: Distribution of responses from the community direct care workforce, to statement about job satisfaction re 'Flexibility to balance work and non-work commitments', by occupation: 2007 and 2012 (range 1–10)

	2007 (%)				2012 (%)			
	Nurse	CCW	AH	All	Nurse	CCW	AH	All
1	0.8	0.6	0.4	0.6	1.2	0.8	0.8	0.9
2	1.2	1.0	1.8	1.1	3.3	1.2	1.9	1.5
3	8.8	1.5	3.5	2.5	4.0	1.7	3.1	2.1
4	5.2	3.5	7.1	3.9	3.5	3.0	3.4	3.1
5	5.7	6.1	7.1	6.1	7.9	5.2	6.9	5.6
6	7.1	5.6	9.7	6.0	4.6	5.5	7.3	5.5
7	11.1	8.4	10.2	8.8	8.9	8.6	11.5	8.8
8	14.2	18.2	23.5	17.9	19.5	17.2	19.5	17.6
9	23.0	26.0	25.2	25.5	25.4	24.5	24.0	24.5
10	23.0	29.1	11.5	27.4	21.8	32.2	21.8	30.4

Source: Survey of community aged care workers (Question A26(g))
Scale used is 1(totally dissatisfied) to 10 (totally satisfied)

Table A27: Distribution of responses from the community direct care workforce, to statement about job satisfaction re 'Match between work and qualifications', by occupation: 2007 and 2012 (range 1–10)

	2007 (not asked)				2012 (%)			
	Nurse	CCW	AH	All	Nurse	CCW	AH	All
1					0.4	1.9	1.6	1.7
2					1.2	1.4	1.6	1.4
3					1.4	2.9	0.8	2.5
4					3.4	3.0	4.5	3.2
5					9.4	7.1	5.7	7.3
6					8.0	9.4	6.6	9.0
7					12.6	12.4	13.5	12.5
8					25.1	22.6	29.5	23.4
9					24.8	17.8	19.3	18.8
10					14.0	21.5	16.8	20.3

Source: Survey of community aged care workers (Question B9.6)
Scale used is 1(totally dissatisfied) to 10 (totally satisfied)

Table A28: Distribution of responses from the community direct care workforce, to statement about job satisfaction re 'Overall satisfaction', by occupation: 2007 and 2012 (range 1–10)

	2007 (%)				2012 (%)			
	Nurse	CCW	AH	All	Nurse	CCW	AH	All
1	0.5	0.2	0.0	0.3	0.2	0.7	0.4	0.6
2	0.5	0.7	0.4	0.7	2.3	0.7	0.4	0.9
3	7.7	1.3	0.4	2.1	1.5	1.0	1.9	1.2
4	2.7	1.5	4.0	1.8	3.3	1.3	2.3	1.6
5	5.1	4.9	8.0	5.1	9.4	5.2	5.7	5.7
6	4.8	4.6	11.5	5.0	4.2	5.1	7.6	5.1
7	15.8	10.8	19.0	11.8	12.5	10.3	15.2	10.9
8	22.1	20.4	23.0	20.8	22.3	19.1	24.7	19.8
9	25.0	28.2	26.1	27.7	27.7	26.3	26.6	26.5
10	15.8	27.2	7.5	24.8	16.5	30.3	14.4	27.8

Source: Survey of community aged care workers (Question A26(h))
Scale used is 1(totally dissatisfied) to 10 (totally satisfied)

For comparison with responses reported in Table 5.35, scores for 2007 have been recalculated on a scale from 1–10 and will differ slightly from those previously reported (Martin and King 2008).

Table A29: Average scores for responses from the community direct care workforce to statements about job satisfaction, by occupation: 2007 (range 1–10)

Satisfaction with	Nurse	CCW	AH	All occupations
Total pay	5.8	5.9	5.2	5.8
Job security	7.4	7.7	7.2	7.6
The work itself	7.5	8.2	7.7	8.1
Hours worked	7.4	7.5	7.6	7.5
Opportunities to develop abilities	7.4	7.6	7.0	7.6
Level of support from your team/service provider	7.2	8.2	7.3	8.0
Flexibility to balance work and non-work commitments	7.5	8.1	7.4	8.0
Overall satisfaction	7.6	8.3	7.6	8.2

Source: Survey of community aged care workers. (Question A26)
Scale used is 1(totally dissatisfied) to 10 (totally satisfied)

Ac.4 Appendix to Section 5.4.1

Tables A30 to A38 provide the distributions for the mean scores reported in Table 5.36. The range is from 1–7, with 1 being strongly disagree, 7 being strongly agree and 4 being neither agree/disagree (neutral).

Table A30: Distribution of responses from the community direct care workforce to the statement 'I am able to spend enough time with each care recipient', by occupation: 2007 and 2012 (range 1–7)

	2007 (%)				2012 (%)			
	Nurse	CCW	AH	All	Nurse	CCW	AH	All
1	9.7	2.6	3.1	3.6	5.3	3.4	2.7	3.6
2	13.1	3.6	7.6	4.9	7.8	4.8	4.6	5.1
3	14.9	7.8	15.6	9.0	13.3	7.2	11.9	8.2
4	19.7	14.3	15.6	15.0	19.5	14.4	16.2	15.0
5	13.2	21.2	22.3	20.2	15.6	21.8	21.5	21.1
6	19.9	28.1	25.9	26.9	21.5	23.3	23.1	23.0
7	9.7	22.5	9.8	20.3	17.0	25.2	19.6	23.9

Source: Survey of community aged care workers (Question A24(a))
Scale used is 1(strongly disagree) to 7 (strongly agree)

Table A31: Distribution of responses from the community direct care workforce to the statement 'I have the skills and abilities I need to do my job', by occupation: 2007 and 2012 (range 1–7)

	2007 (%)				2012 (%)			
	Nurse	CCW	AH	All	Nurse	CCW	AH	All
1	0.2	0.6	0.4	0.6	0.4	0.6	0.4	0.5
2	0.0	0.3	0.0	0.3	0.6	0.5	0.0	0.5
3	0.8	1.1	2.7	1.1	0.6	0.6	0.4	0.6
4	1.5	4.2	4.9	3.9	4.8	4.1	3.5	4.1
5	9.0	10.7	14.2	10.6	11.4	11.5	15.8	11.8
6	52.2	36.7	46.0	39.1	38.9	31.5	36.3	32.6
7	36.3	46.4	31.4	44.4	43.3	51.2	43.2	49.9

Source: Survey of community aged care workers (Question A24(b))
Scale used is 1(strongly disagree) to 7 (strongly agree)

Table A32: Distribution of responses from the community direct care workforce to the statement 'I use many of my skills and abilities in my current job', by occupation: 2007 and 2012 (range 1–7)

	2007 (%)				2012 (%)			
	Nurse	CCW	AH	All	Nurse	CCW	AH	All
1	0.3	0.8	0.4	0.7	0.4	1.0	0.8	0.9
2	2.0	0.5	1.8	0.8	1.2	1.2	0.8	1.2
3	1.4	1.8	3.1	1.8	3.7	1.1	2.3	1.5
4	5.1	6.3	8.0	6.2	8.0	4.9	5.4	5.3
5	16.5	11.7	17.7	12.6	14.8	13.3	15.8	13.6
6	48.7	35.8	38.9	37.5	39.6	31.0	36.7	32.3
7	26.3	43.2	30.1	40.4	32.2	47.5	38.2	45.2

Source: Survey of community aged care workers (Question A24(c))
Scale used is 1(strongly disagree) to 7 (strongly agree)

Table A33: Distribution of responses from the community direct care workforce to the statement 'Adequate training is available through my workplace', by occupation: 2007 and 2012 (range 1–7)

	2007 (not asked)				2012 (%)			
	Nurse	CCW	AH	All	Nurse	CCW	AH	All
1					2.7	1.8	3.5	2.0
2					4.3	2.3	3.8	2.6
3					8.3	3.2	6.9	4.0
4					13.6	7.4	11.9	8.4
5					16.3	14.5	19.6	15.0
6					33.1	28.7	28.5	29.2
7					21.5	42.1	26.2	38.9

Source: Survey of community aged care workers (Question A24(i))
Scale used is 1(strongly disagree) to 7 (strongly agree)

Table A34: Distribution of responses from the community direct care workforce to the statement 'I have a lot of freedom to decide how to do my work', by occupation: 2007 and 2012 (range 1–7)

	2007 (%)				2012 (%)			
	Nurse	CCW	AH	All	Nurse	CCW	AH	All
1	0.5	2.3	0.4	2.0	1.6	4.0	1.6	3.6
2	1.9	3.5	1.8	3.2	4.5	6.0	2.3	5.6
3	13.2	7.3	3.1	7.8	7.2	7.8	5.4	7.6
4	8.1	15.7	12.4	14.6	12.2	18.1	12.1	17.1
5	23.9	24.0	24.8	24.0	20.7	24.3	20.6	23.7
6	36.4	28.1	38.9	29.7	30.4	23.2	31.9	24.5
7	15.9	19.1	18.1	18.7	23.6	16.7	26.1	18.0

Source: Survey of community aged care workers (Question A24(d))
Scale used is 1(strongly disagree) to 7 (strongly agree)

Table A35: Distribution of responses from the community direct care workforce to the statement 'I feel under pressure to work harder in my job', by occupation: 2007 and 2012 (range 1–7)

	2007 (%)				2012 (%)			
	Nurse	CCW	AH	All	Nurse	CCW	AH	All
1	7.4	26.1	5.8	22.9	11.0	25.4	14.7	23.1
2	19.2	24.3	20.4	23.5	17.2	22.4	14.3	21.4
3	11.1	16.9	19.1	16.2	13.2	14.4	17.8	14.5
4	18.5	14.8	16.4	15.3	15.1	16.2	21.6	16.4
5	14.7	8.8	17.8	9.9	17.2	8.8	15.1	10.1
6	10.2	5.8	13.8	6.7	16.9	8.1	8.5	9.1
7	18.8	3.4	6.7	5.5	9.5	4.6	8.1	5.4

Source: Survey of community aged care workers (Question A24(e))
Scale used is 1(strongly disagree) to 7 (strongly agree)

Table A36: Distribution of responses from the community direct care workforce to the statement 'My job is more stressful than I had ever imagined', by occupation: 2007 and 2012 (range 1–7)

	2007 (%)				2012 (%)			
	Nurse	CCW	AH	All	Nurse	CCW	AH	All
1	9.2	24.5	9.5	21.8	12.4	24.7	18.1	23.0
2	18.0	25.7	21.6	24.5	18.3	23.1	17.4	22.2
3	15.1	13.4	23.9	14.1	14.2	15.2	21.6	15.5
4	23.0	15.7	18.9	16.8	17.9	14.1	17.8	14.7
5	15.0	8.8	14.4	9.8	17.7	9.7	12.0	10.7
6	17.2	7.2	7.7	8.5	12.4	7.7	7.3	8.2
7	2.4	4.7	4.1	4.4	7.2	5.5	5.8	5.7

Source: Survey of community aged care workers (Question A24(f))
Scale used is 1(strongly disagree) to 7 (strongly agree)

Table A37: Distribution of responses from the community direct care workforce to the statement 'Considering all my efforts and achievements I receive the respect and acknowledgement I deserve', by occupation: 2007 and 2012 (range 1–7)

	2007 (%)				2012 (%)			
	Nurse	CCW	AH	All	Nurse	CCW	AH	All
1	1.0	2.4	3.5	2.3	3.9	3.2	3.5	3.3
2	11.7	3.9	6.6	5.1	7.2	4.2	6.5	4.7
3	10.4	5.3	11.1	6.2	9.1	6.9	8.1	7.2
4	19.7	12.4	18.6	13.7	15.1	13.7	13.5	13.8
5	17.0	18.1	23.5	18.2	19.6	17.5	23.1	18.1
6	28.0	32.8	26.1	31.9	27.3	29.4	29.2	29.2
7	12.2	25.0	10.6	22.7	17.6	25.0	16.2	23.7

Source: Survey of community aged care workers (Question A24(g))
Scale used is 1(strongly disagree) to 7 (strongly agree)

Table A38: Distribution of responses from the community direct care workforce to the statement 'Management and employees have good relations in my workplace', by occupation: 2007 and 2012 (range 1–7)

	2007 (%)				2012 (%)			
	Nurse	CCW	AH	All	Nurse	CCW	AH	All
1	1.2	2.6	0.9	2.4	4.8	2.4	4.6	2.8
2	5.6	2.3	10.2	3.1	5.6	4.2	5.4	4.4
3	9.2	4.7	8.0	5.4	8.1	4.5	7.3	5.1
4	27.6	10.5	13.3	12.8	14.5	11.6	12.3	12.0
5	16.3	14.4	20.4	14.9	17.6	16.7	19.2	17.0
6	22.6	33.7	30.7	32.2	30.9	29.7	28.8	29.8
7	17.5	31.7	16.4	29.2	18.2	30.9	22.3	28.9

Source: Survey of community aged care workers (Question A24(h))
Scale used is 1(strongly disagree) to 7 (strongly agree)

Appendix D: Interview Schedule

1. What is your current role in aged care?

- Do you have more than 1 job? *If yes—probe:*
  - What do you do?
  - If in aged care, with this provider or another?
  - Why do you need to have more than 1 job?
  - How do you manage to combine the jobs?

2. Why did you choose to work in aged care?

  - If male or migrant—probe:
  - Specific pathways (i.e. non-traditional)
  - Specific issues (relating to gender / ethnicity)

- Why this organisation?

3. What qualities or skills do people need to work in aged care?
Probe: for issues re age, gender, appearance, culture, language.

- How would you describe someone who is a 'good' aged care worker?
- Can you describe someone you work/have worked with who has lacked these qualities or skills?
- What is it like to work with people like this?
- How does your organisation deal with people who do not have the right skills or qualities?

4. What has been the most important achievement in your work?

5. What has been the most difficult thing you have dealt with in your work?

- Was support available to help you work through this? *If yes—probe*
  - Was this support used? If not, why not?

6. Is there anything about your work that you find stressful?
If yes,—*probe*

  - What do you find stressful?
  - How does this impact on their work/availability for work?
  - What strategies do they use to deal with the stress?

7. How would you describe your relationship with the older people you care for?

- Can you provide us with an example of a 'good' relationship and a 'difficult' relationship?
- How do you manage your relationships to make sure that both client needs and organisational needs are met?
- *Probe for specific issues relating to working with dementia clients (skills, issues).*

8. How well do you think management understands the work that you do?

- To what extent is management open to you suggesting ways for improving services?
- How would you take ideas to management?
- Are there areas in which management could improve?

9. How are grievances/complaints dealt with in your organisation? Can you provide an example?
Probe for any gender/ethnicity issues

10. Training has a high priority in aged care, is there anything that can be done to make it easier for you to do this training?

- What kinds of training do you find most useful?
- Have you done any training that hasn't been useful? If yes, what kinds?

What would you like to achieve in your work over the next 3–5 years?

References

Australian Bureau of Statistics. (2010a). *Labour Mobility*, Cat. No. 6209.0. Canberra: ABS.

Australian Bureau of Statistics. (2010b). *Employee Earnings and Hours*, Cat. No. 6306.0. Canberra: ABS.

Australian Bureau of Statistics. (2011a). *Australian Social Trends*, Cat. No. 4102.0. Canberra: ABS.

Australian Bureau of Statistics. (2011b). A*ustralian Demographic Statistics*, Cat. No. 3101.0. Canberra: ABS.

Australian Bureau of Statistics (2011c). *Australian Labour Market Statistics*, Cat. No. 6105.0, Canberra: ABS

Australian Bureau of Statistics. (2012). *Reflecting a nation: Stories from the 2011 Census*, 2012–2013, Cat. No. 2071.0. Canberra: ABS.

Australian Institute of Health and Welfare. (2010). *Residential aged care in Australia 2008–09: A statistical overview*. Aged care statistics series no. 31. Cat. no. AGE 62. Canberra: AIHW.

Department of Health and Ageing. (2011a). *Types of care.* Accessed June 2012, http://www.agedcareaustralia.gov.au/internet/agedcare/publishing.nsf/content/Types+of+care

Department of Health and Ageing. (2011b). *What programs are available?* Accessed June 2012, http://www.agedcareaustralia.gov.au/internet/agedcare/publishing.nsf/content/What%20programs%20are%20available

Department of Health and Ageing. (2012a). *Living longer. Living better.* Canberra: Department of Health and Ageing.

Department of Health and Ageing. (2012b). *Day Therapy Centres overview.* Accessed June 2012 http://www.health.gov.au/internet/main/publishing.nsf/Content/ageing-commcare-dayther.htm

Department of Health and Ageing. (2012c). *National Respite for Carers program.* Accessed June 2012 http://www.health.gov.au/internet/main/publishing.nsf/content/ageing-carers-nrcp.htm

Healy, J., Mavromaras, K., & Sloane, P. J. (2012). *Skill shortages: Prevalence, causes, remedies and consequences for Australian businesses.* NCVER Monograph Series 09/2012. Adelaide: National Centre for Vocational Education Research.

King, D. (forthcoming). It's frustrating! Managing emotional dissonance in aged care work, *Australian Journal of Social Issues.*

King, D., Wei, Z., and Howe, A. (forthcoming). Work satisfaction and intention to leave among direct care workers in community and residential aged care in Australia, *Journal of Aging and Social Policy.*

Longford, N. T. (2008). *Studying human populations: An advanced course in statistics.* New York: Springer.

Martin, B. & King, D. (2008). *Who cares for older Australians? A picture of the residential and community based aged care workforce.* Adelaide: National Institute of Labour Studies, Flinders University.

Moskos, M. (2011). Low skilled men's access to low skilled female dominated jobs: An occupational case-study approach. Unpublished PhD thesis, Flinders University, Adelaide.

Moskos, M. & Martin, B. (2005). *What's best? What's worst? Direct carers' work in their own words.* Adelaide: National Institute of Labour Studies, Flinders University.

Pocock, B., Skinner, N., and Ichii, R. (2009). *Work, life and workplace flexibility: the Australian work and life index 2009*, Centre for Work + Life, University of South Australia

Productivity Commission. (2011). *Caring for older Australians.* Report No. 53, Final Inquiry Report. Canberra.

Richardson, S., & Martin, B. (2004). The care of older Australians: A picture of the residential aged care workforce. Adelaide: National Institute of Labour Studies, Flinders University.

Rubery, J., Hebson, G., Grimshaw, D., Carroll, M., Smith, L., Marchington, L., & Ugarte, S. (2011). *The recruitment and retention of a care workforce for older people.* Manchester: European Work and Employment Research Centre (EWERC), University of Manchester.

Safe Work Australia. (2009). *Work-related injuries in Australia 2005–06: Community services and health*. Canberra: Commonwealth of Australia.

Skinner, N., Hutchinson, C., & Pocock, B. (2012). *The big squeeze: Work, life and care in 2012—The Australian Work and Life Index.* Adelaide: Centre for Work + Life, University of South Australia.

Theodosius, C. (2008). *Emotional labour in health care: The unmanaged heart of nursing.* Abingdon, UK: Routledge.

Wallis, S., & Sanchez, L. (2008). No one is an empty vessel: ESL and aged care. *Fine Print*, 31(1), 10–13.

Footootnotes

1 Please note that because of rounding of percentages, the totals do not always sum to exactly 100 throughout the report.

www.health.gov.au

All information in this publication is correct as at January 2013

D1010 Jan 2013