Notice to readers

The way in which the following report refers to Family & Community Services (FACS) – Ageing, Disability and Home Care (ADHC), was correct at the time of publication. Any reference in the document to names by which ADHC was previously known (Department of Human Services, Department of Ageing, Disability and Home Care) should now be read as FACS and ADHC. If you are having difficulty accessing any of the content within the report, please contact the Research and Evaluation Unit on 02 8270 2381.

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Transformations of Care: Living the consequences of changing public policies in Australia

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Bringing knowledge to life

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Executive Summary

This report, *Transformations of Care: Living the consequences of changing public policies in Australia* presents the main findings from an ADHC funded research project focussing on NSW care workers. Initially a context for research is provided, with an overview of the findings of international research, followed by a section on the funding of aged care services in Australia. Australian research on the community services industry concludes this review. From this overview it was found that very few studies look in-depth at the details surrounding the everyday life of care from the perspective of the care workers themselves. This study addresses this gap and shows the dimensions of the working lives of care workers and the challenges faced by care workers in NSW.

Presented next are the findings from a 2010 survey of NSW care workers. In summary, the study identifies that most care workers are older and very experienced workers, most having come to care work as older workers. These care workers state that they enjoy their work, however, consistently report that they have too many tasks to attend to and not enough time to complete these tasks.

These findings from the NSW survey are then compared with the findings from a survey of Swedish care workers conducted in 2005. A surprising finding was that the comparison revealed that while the NSW care workers are experiencing difficulties with not enough time to complete allocated tasks, they actually spend more time with their clients. In addition they report that they able to exercise more control over their working day and the nature of the care they are delivering in comparison with their Swedish counterparts.

Also reported are the findings from the observation studies that were carried out as part of this project. The daily working lives of two care workers are scrutinised in depth. This is followed by a discussion of the promising practices that are being implemented by care providers, care managers and care workers in NSW, albeit unevenly across the state.

1. International Research into Care workers

International studies of paid care workers date back to the 1980s. A theme that emerges from this work is that care workers consistently state that they enjoy their work and report very high levels of job satisfaction (McLean 1999, Twigg 2000, Szebehely 2005). Care workers draw most satisfaction from the aspects of their work over which they have the most control; activities that produce reward for effort such as improving their clients' quality of life, making people happy, ensuring that they feel part of the community, keeping older people comfortable and seeing them make progress (McLean 1999, Fleming and Taylor 2006). What care workers liked most about their jobs was the autonomy and freedom of working alone and the opportunity to exercise judgements in relation to how they could best meet the individual needs of the elderly with whom they are working (Szebehely 2005, Twigg 2000). Rasmussen (2004) also found that care workers' sense of self as caring

individuals and their commitment to their elderly clients' well-being, were for many care workers central features of their personal and work identities.

While reporting consistently that care workers enjoy their work, the research also found that care work is consistently devalued. For instance, Waerness (1984) found that the care workers enjoyed their work and were committed to providing good care to those they were caring for. But, while they enjoyed caring, they were acutely aware that the values they brought to their work and the skills they drew upon were devalued in the public sphere. Several later studies have confirmed these findings. Aronson and Neysmith (2006) and Szebehely (2005) for example, found the frontline knowledge that care workers possess particularly regarding the centrality of relationships in supportive home care was devalued by employers.

What care workers like least about their work are those aspects over which they have little control, for example, working under conditions where there is little flexibility to change the care they are providing, for instance, where there is not enough time to complete tasks and where there are insufficient resources available to them to provide the care they would like to provide. Under these conditions care workers will do all that they can to provide what they consider to be good care even if it means breaking the rules and working unpaid overtime. Job satisfaction and enjoyment decline when care workers have limited time to spend with older people and as tasks become more instrumental (Aronson and Neysmith 2006, McLean 1999, Szebehely 2005). Care workers also express legitimate concerns about how this is reflected in poor rates of pay and the generally held view that care work is a low status profession (Fleming and Taylor 2006, McLean 1999; Szebehely 2005).

An important theme emerging from this work are findings that indicate that the relational and emotional labour central to care work has been further sidelined in recent years in favour of managerialism and market models of care. Adoption of market models has resulted in increased standardisation of services in many countries. Canadian and Swedish care workers, for example, report facing increasing difficulties in meeting the varying needs of care recipients (Aronson and Neysmith 2006, Szebehely, 2005). Further, these researchers have found home care workers themselves bearing the costs as they strive to respect relationships while attempting to offset the impact of efficiency-driven care (Aronson and Neysmith 2006, Rasmussen 2004, Szebehely 2005).

Care workers involved in the provision of care have a firm idea of the meaning of quality. Stone's (2000) research, for example, found that people in care-giving jobs derive their standard of good care from an image of the care provided in good family relations. The care workers in this study emphasised emotional over physical tasks and the moral value of the work rather than its technical quality. This and other research confirm that emotional fulfilment, what one might term 'the intrinsic reward', is very important for the psychological well-being of the carer.

However, there are a paucity of studies that focus on the details of the 'everyday life of care' from the perspectives of those most involved in this care; the persons needing care, their informal carers, and care workers. Of these three groups, care workers have been the least studied. (Szebehely, 2007). This research project, *Transformations of Care: Living the*

consequences of changing public policies in Australia bridges this knowledge gap and provides details of the day-to-day working lives of care workers in NSW; as well as enabling a comparison between the NSW care workers and their Swedish counterparts. However, before discussing the findings of this research project it is important to contextualise this project and provide an overview of the relevant Australian context, how aged care services are funded and the research that has been done to date.

2. Funding of Aged Care Services in Australia

The Commonwealth government contributes the bulk of the funding for aged care services. This system has developed over time to the point where the provision of community care services comes with high levels of government regulation through a system of 'managed markets' (Davidson, 2009). Davidson argues that 'This enables government to dictate how these markets operate in ways that go well beyond the powers of government in most conventional markets. In turn, government action shaping the particular form of each managed market will substantially influence the types of service provider organisations that operate in that market' (Davidson, 2009:43). The government controls key aspects of aged care by: allocating aged care places to approved providers, assessing client, eligibility, funding services, setting prices and controlling quality (Productivity Commission, 2008:20).

For instance, for every 1000 people aged 70 years and over and 50 years and over for Aboriginal and Torres Strait Islander people, the framework aims to provide 40 residential high care places; 48 residential low care places; and 20 community places (Department of Health and Ageing (2007:17)

Government subsidised community care is provided through two main programs, the first, the Home and Community Care (HACC) and Veterans Home Care (VHC), (this is a program of community services for eligible veterans of the armed forces and their families and provides support similar to the support provided through the HACC program) and the second, the CACP (Community Aged Care Package) programs including EACH (Extended Aged Care at Home) and EACHD (Extended Aged Care at Home Dementia).

The largest program by far in terms of funding and the number of clients receiving services is the HACC program. HACC is funded by the Commonwealth, the States and Territories, with the States and Territories contributing around 40 percent and the Commonwealth 60 percent. The HACC program provides specialised services, including home nursing, domestic assistance (this includes home cleaning, showering and dressing) other personal care services, home maintenance and modification, community transport, day care, neighbour aid and counselling services. HACC services are frequently (although not necessarily) task specific and are often provided by small, locally based organisations (Fine, 2007:270). The number of hours of service delivery is quite low with a national average of only 2 hours of services provided per person per week (Table 1 below).

The HACC program is administered by the States and Territories. In NSW the Department of Ageing, Disability and Home Care (ADHC) makes decisions about who will provide the services. Services are delivered by the government providers NSW Home Care Service (HCS) or Non Government Organisations, most NPOs (Not for Profit Organisations) and some FPOs (For Profit Organisations) (Davidson, 2009:71).

CACPs, EACH and EACHD packages were introduced as 'an alternative for older people with complex care needs who wish to remain living in their own homes and are able to do so with the assistance of a care package'(AIHW, 2007:126). Community Aged Care Packages (CACPs) provide a bundle of services averaging 7 hours a week as an alternative to low level residential care. Extended Aged Care at Home (EACH) programs target older people eligible for high level residential care by providing an average 23 hours of packaged care a week. EACH Dementia (EACHD) packages are designed to provide the highest level of community care for those with complex cognitive, emotional or behavioural needs (Productivity Commission, 2008:13).

Packages are provided for those over 70 and over 50 for Indigenous Australians, assessed as needing this support by an Aged Care Assessment Teams (ACATs). The ACAT assesses care recipients' needs and provides information about and/or referral to a provider (Department of Health and Ageing, 2007:18). Organisations tender annually for these packages, as for HACC funding and the services are coordinated, organised and delivered by either government providers, (for example, NSW HCS), NPOs (Not for Profit Organisations) and some FPOs (For Profit Organisations) (Davidson, 2009:71).

These care packages are then managed by a care manager who arranges the services. These can be personal care, domestic assistance, social support, assistance with meal preparation and other food services, respite care, rehabilitation support, home maintenance, delivered meals, linen services and transport (AIHW, 2007:126).

The following table shows the number of people receiving services under the Commonwealth programs, the average hours per week of service provided to clients, the amount of government subsidies, per day, (CACP, EACH and EACHD), reimbursement for per person or package year and the overall government funding allocated to the programs.

Table 1. Government funding of community care programs

Programs	Number of people receiving services	Average hours per recipient per week	Government Subsidy for Packages per day as at 1st July 2008	Reimbursement per package (or person for HACC and VHC) per year	Overall Government Funding, State and Commonwealth
EACH and EACHD	3578	23 hours	$116.16 $128.11	$32,000	$248,000,000
CACP	32,983	7 hours	$34.75	$11,100	$381,000,000
HACC	642,650	90% <2 hours, 97%< 4.5 hours		$1500	$1,151,000,000
VHC	72,100				$93,000,000

Figures drawn from Productivity Commission 2008:12, 13, 22

As can be seen from Table 1 the bulk of government funding goes to the HACC program. This program also services the largest numbers of clients. Only 36,000 people receive packages compared with 642,650 receiving HACC services. However, HACC services are spread sparsely. There are tight limits on the hours and dollars available per person and long waiting lists, with ninety percent of those who receive HACC services receiving less than two hours assistance per week (Productivity Commission 2008:12). The CACPs are far more expensive. Those receiving packages receive many more hours of care per week and the packages are funded per person at a much higher rate, with far fewer people in receipt of these services. It is worth noting however that the programs have very different target populations and eligibility. The Home and Community Care Program provides vital support to frail older people, younger people with a disability and their carers to support them to remain in their own homes, enhance their independence, and prevent their premature admission into residential care.

Many older people are not receiving the services that they need and services often overlap. There is no centralised organisation or coordination of services and the demand for services far outstrips the supply (Gray,M and Heinsch,M, 2009:111).

Another option for older people is to purchase services from for profit providers. There is growing number of providers offering services to those who can afford to pay. These services are not subsidised, funded or regulated by government. There is no data available on these service providers or the extent, size or take up of these services (Productivity Commission, 2008).

3. The Community Services Industry in Australia

At present we have limited information on the workforce in the community services sector. National datasets have collected limited, irregular and inconsistent information about community service organisations and their workers. Further, not a great deal of research on this workforce has focused on New South Wales (Hilferty, et al, 2010).

However, we do know that the community services workforce is one of the fastest growing sectors of the workforce in Australia. It has been estimated that the number of care workers in the social and community services sector increased by a massive 66.2% between 1996 and 2006 compared to a 26.3% growth in nursing homes, 23.2% in child care and 19.2% in the economy overall (Meagher and Cortis, 2010: 2). Employment in non- residential care services expanded faster than any other community services industry between 1996 and 2001 (Meagher and Healy, 2005).

A high level of growth is expected to continue well into the future, as in recent times much caring has shifted from the realm of informal, usually familial, relationships to the public realm of formal arrangements involving paid carers. As King and Martin observe: 'Caring for the old and the young involves the paid labour of an increasing number of Australians and there is every reason to believe that the ranks of paid carers will grow in coming years' (King and Martin, 2007: 131). The next section of this report focuses on what we do know from the Australian research about characteristics of this workforce, gender, age, working conditions, hours worked, levels of education and training, and pay.

The community care industry is a subset of the community services industry. Care workers in child care and 'non-residential care services' make up a significant proportion of the workforce. 'Approximately 1 in 42 employed Australians report that their main job was in a caring occupation in a community services industry such as child care or non-residential care services' (Meagher and Healy, 2006: 7).

Martin and King (2008) estimate that nationally 77% of providers of community care are operated by non-profit agencies. Twenty per cent are operated by organisations administered by state and local governments; for example, state based organisations including NSW HCS, with a small percentage - approximately 3% - operated by profit making enterprises (Martin and King, 2008: 98). Martin and King stress that these figures are estimates, that there is no accurate list of service providers. A similar point is made by Meagher and Cortis (2010: 6), who observe that 'consistent data on the workforce, organisation and operation of the community services industry in general, and on the subset known as the social and community sector (SACS) in particular, is not easy to come by'. What do we know of this workforce?

Despite the efforts of researchers, no accurate numbers of care workers in Australia are available. One extensive effort has been made by Meagher and Healy, who in their two reports set out to draw a detailed profile of the community services sector, including home care workers, utilising data collected by the Australian Institute of Health and Welfare

(AIHW) and the Australian Bureau of Statistics (ABS) (Meagher and Healy, 2005 and 2006). But, due to the classifications used by these data collection agencies, they found it was not actually possible for them to extract detailed data on particular sectors of the community services workforce. Basic information, such as the number of care workers providing community care to older people and those with disabilities, could not be accurately determined. Despite these obstacles, the reports contain useful information about care workers which is summarised below.

Martin and King (2008) surveyed all of the service outlets receiving funding from Commonwealth programs supporting community based aged care. As well, they surveyed the care workers employed by these community-based providers (Martin and King, 2008: i). Included in their research were service providers funded by one of six programs: the Community Aged Care Packages (CACPs) program, the Extended Aged Care at Home (EACH) and EACH Dementia (EACH-D) packages/programs, the Home and Community Care (HACC) program, the Day Therapy Centres (DTCs) program and the National Respite for Carers Program (NRCP). A substantial majority of the outlets surveyed were funded through the HACC program. This survey is focused upon paid care workers providing services to the elderly and upon those providing services to both the elderly and to people with disabilities (Martin and King, 2008). Martin and King estimate that approximately 87,500 people are employed by organisations providing community care, 74,000 (85%) as direct care workers. Of this 74,000, approximately 60,500 deliver community care services, with about 9,500 nurses (mostly Registered Nurses) and 4,000 Allied Health workers employed alongside them (Martin and King, 2008: 59).

However, despite their efforts, Martin and King were also unable to provide either an accurate or complete list of community care providers in Australia or an accurate count of care workers; hence the estimates above. For example, the methodology they employed did not enable them to track those providers receiving government funding, who in turn broker or contract out the actual provision of service to other organisations, either to non-profit or profit-based enterprises.

What we do know from these studies is that care workers are predominately female and mature aged, work predominantly part time, and are poorly paid, although most have some training relevant to their work (Meagher and Healy, 2005 and 2006, King and Martin, 2007, Meagher and Cortis, 2010). Care workers are generally mature aged workers with 70% of community based workers older than 45. This is considerably older than the workforce as a whole, where only 37% of all workers are older than 45. Care workers also tend to commence work in this sector as mature aged workers (Martin and King, 2008: i). This finding is reinforced by Meagher and Cortis, who found that not only do older workers predominate but that the proportion of care workers in Social and Community Services (SACS) industries, who are 45 years or older, increased by 6.4% between 2001 and 2006, compared to an increase of 3.8% in the workforce overall (Meagher and Cortis, 2010: 21).

A relatively high proportion of care workers work part time compared to the rest of the workforce. Fifty five per cent of all care workers in community service industries were working part time compared with 30% of workers in similar occupations in the labour market overall (Meagher & Healy 2006: 62). Martin and King found that ‘among care

workers, 60% of community based care workers [were] permanent part-time employees and 29% were in casual employment' (Martin and King, 2008: i).

Meagher and Healy report that on average, care workers earn lower hourly incomes than those they work beside in non-caring occupations in community service industries and male care workers receive, on average, a higher hourly rate of pay than female care workers (Meagher & Healy, 2006: 92). Low rates of pay tends to undermine care workers' status and living standards, prefiguring disincentives to work in the sector and undermining the capacity of government and non-government agencies to provide services that meet the people's needs. Survey and focus group data confirms that community service workers in NSW, particularly those employed by NGOs, consider low pay a distinct disadvantage and that the prospect of public sector pay, conditions, job security, career paths and development opportunities present powerful incentives to leave the industry (Meagher and Cortis, 2010: 32). Care workers report that not only are they dissatisfied with pay rates but that they see low pay as inadequate recompense given the 'social importance of the work they do' (Martin and King, 2008: iv).

Care workers are not required to have any formal training or educational qualifications and there are few opportunities for promotion for care workers. In 1996, a significant minority (44.3%) of all care workers reported having no qualifications at all: this rate fell to 38.5% in 2001. However, in 2001, 13,871 or 7.3% of care workers in the community services industry held a Bachelor's degree or higher but worked in an occupation classified as an associate profession or as intermediate service work. Meagher and Healy conclude that 'some workers are formally overqualified for their jobs, indicating a lack of employment opportunities in higher skilled job categories in caring occupations' (Meagher and Healy, 2006: 36–37).

Martin and King report that in their study, most of the workforce (residential and community care) reviewed had post school qualifications appropriate to the work they were doing, with only 20% of direct care staff having no post school qualifications. Twenty five per cent of recently appointed staff were currently studying some post-school qualification, as were approximately 20% of all staff. As Martin and King claim: 'This is an impressive proportion, especially given the age structure of the workforce, and it indicates both workers' and their employers' commitment to skill development' (Martin and King, 2008: 67). Further, care workers reported that they were generally confident that they had the skills they need to do their work, and that they believed that they use their skills effectively in doing the job (Martin and King, 2008: i).

Meagher and Cortis also report that increasing numbers of care workers in the community service industries have formal qualifications. They found that '[a]mong care workers in all community service industries (includes SACS) 64.6% had a post-school qualification in 2006, compared with 53% in 2001' (Meagher and Cortis, 2010: 3).

This brief overview of international and the Australian context and research on care workers contextualises the study *Transformations of Care: Living the consequences of changing public policies in Australia*. In summary, care workers report high levels of job satisfaction; in particular that they like the autonomy care work provides and become dissatisfied when this autonomy is challenged, leaving them little control over their work. Furthermore, in recent

times, moves to managerialism and marketisation, and increasing standardisation, have decreased the autonomy of care workers. The review of the Australian literature focuses on the characteristics of the care workforce. We know that most care workers are female, are mature aged, work part time, and are poorly remunerated: the majority have some basic training. However, we have little in depth understanding of the work of care workers from the perspective of care workers. This research breaches this gap in our knowledge and provides a more in-depth understanding by directly seeking the views of a large number of care workers in NSW.

4. Research Background

This research is part of an international research program titled *Transformations of Care: Living the consequences of changing public policies in Canada, Australia and Sweden.* The overall focus of this cross national research is on the responses by these three countries to global challenges regarding care provision. In 2008 a partnership was formed between researchers in Sweden, Canada and Australia and led by Professor Marta Szebehely (University of Stockholm, Sweden), Professor Sheila Neysmith (University of Toronto, Canada) and Associate Professor Jane Mears (University of Western Sydney, Australia). The main aims of this research partnership are: (1) to examine the experiences of care workers and of older people receiving care and their families, and (2) to seek out the qualitative differences between the three countries in the organisation and provision of care.

This three country study was initiated because there are very few comparative studies on the everyday life of care from the perspectives the paid care workers. Very little is known about whether there are national (or welfare regime specific) differences in the working conditions of careworkers (Szebehely 2007:2). Consequently very little is known about differences in working conditions of care workers across different countries.

The Swedish component of the research project was funded by the Swedish Council for Working Life and Social Research (SEK 2 million per year 2007-2012 awarded May 23, 2007), while the Canadian research was funded through an SSHRC Grant of $117,000 over 3 years from June, 2008. The first stage of the ongoing Australian research component was funded in 2009 by a NSW Ageing, Disability and Home Care grant.

This research project focuses on care workers, comparing the organisation of care and the provision of care by home care workers in NSW and Sweden. This survey of home care workers has not yet been completed in Canada. Therefore at this point in time it is not possible to include a comparison with Canadian home care workers.

The methodology adopted for this Australian study is based on the NORDCARE study, conducted in 2005. As part of the NORDCARE study, a mail questionnaire was sent to 5000 care workers working with older people and those with disabilities, both in the home and in residential care settings in Sweden, Denmark, Finland and Norway. In Sweden the survey was mailed out to a random sample of members of the municipal workers union (Kommunal). At the time of data collection around 80 per cent of all Swedish care workers

were members of this union. Of the entire Swedish sample of 735 care workers, 448 worked in residential care and 287 worked in clients' homes. Seventy five of these care workers worked only with people with disabilities under the age of 65, mainly as personal assistants. These 75 care workers have been excluded from the analysis below, as the prime focus of this research was on the aged care sector. In 2009 to supplement this survey, interviews were conducted with home care workers, care managers, informal carers and older people in receipt of care, as well as participant observations, where the researcher followed a care worker throughout the working day.

5. Research aims

The aims of this research are consistent with the overall aim of the larger study *Transformations of Care: Living the consequences of changing public policies in Canada, Australia and Sweden* that is, to compare policies, organisational arrangements and the delivery of home based community care services with a particular focus on identifying promising policies and practices in each of the countries involved.

The specific aims of this Australian component research, *Transformations of Care: Living the consequences of changing public policies in Australia,* as set out in the original proposal were to:

1. Explore and analyse the impact of recent social, historical and political changes on the organisation, management and delivery of care across three categories of service provider, state funded and administered agencies, for-profit providers and not-for profit providers.

2. Collect and analyse detailed in-depth data on the working conditions, the organisation of care and the nature of care provided by paid care workers and care managers.

3. Compare the findings to investigate differences (if any) in the working conditions, organisation of care and the nature of care provided by paid care workers and care managers across the three categories of service provision.

4. Identify promising practices and policies in care management and provision and the conditions which enable and support these promising practices.

5. Compare the findings from this research with findings from research in Canada and Sweden on transformations of care and documentation and analysis of promising practices (Mears, 2009).

While this research has achieved its aims, there were some unanticipated limitations, requiring the original aims to be slightly modified. For instance, we discovered that there is no comprehensive documentation on care provider organisations in Australia and no clear way of differentiating not for profit organisations (NFPOs) from for profit organisations (FPOs). While we were given access to useful data from the NSW Home Care Service (HCS), such as the number of care workers employed by HCS, we were unable to source similar

information from the NGO sector. Unfortunately, the publically available information that exists for the NGO providers is fragmentary and incomplete. These same limitations have been noted by Martin and King (2008), Simpson-Young and Fine (2010), and Meagher and Cortis (2010).

There were also some challenges encountered regarding the 'official' conceptualisation and terminology. For example, the distinction between provider organisations as for-profit or not-for-profit is not a distinction that is commonly made in this sector. One of the advisers to the project commented that the 'abbreviations NFPO and FPO are very new to ADHC'. She suggested we use the umbrella term Non Government Organisation (NGO) instead of trying to differentiate between for-profit or not-for-profit. We took this advice. The sample of service providers is therefore made up of the NSW HCS, the state provider and large and small NGOs.

Lastly, as the Canadian survey of home care workers has not yet been completed inclusion of a comparison with Canadian care workers in this report was not possible. Therefore aims 1, 3 and 5 were slightly modified as follows:

1. Explore and analyse the impact of recent social, historical and political changes on the organisation, management and delivery of care across *two* categories of service provider, *state (NSW HCS) and NGO providers.*

3. Compare the findings to investigate differences (if any) in the working conditions, organisation of care and the nature of care provided by paid care workers and care managers across the *two* categories of service provision.

5. Compare the findings from this research with findings from research in Sweden on transformations of care and documentation and analysis of promising practices.

The next section focuses on the methodologies devised to undertake this research project.

6. Methodologies

This research centred on care workers working with elderly clients and/or clients with disabilities in the clients' homes who are currently employed by service provider organisations receiving relevant Home and Community Care (HACC) and/or Commonwealth Community Aged Care Packages (CACP), including Extended Aged Care at Home (EACH) and Extended Aged Care at Home Dementia (EACHD) Packages. Day-centre and residential care staff are not part of the target group for this project.

Consistent with the methodology employed in the Swedish study outlined above, three methods were used to collect the data: the first was a large scale survey of approximately 1000 care workers in NSW; the second involved in-depth interviews with care workers, care managers, those receiving care and informal carers; and, the third involved researchers' observation of an average working day of care workers. Ethics approval to conduct this

research was granted by the University of Western Sydney Ethics Committee HR No.H7339. Ethics approval was also granted by Baptist Care, Uniting Care Ageing, Sunnyfield and The Benevolent Society of NSW.

7. The Survey

In total, 1093 surveys were distributed: 362 to 17 small NGOs; 365 to three large NGOs and 374 to HCS, including to the specialist Aboriginal and Torres Strait Islander (ATSI) care workers in HCS. These provider organisations were drawn from five Ageing, Disability and Home Care (ADHC) Local Planning Areas (LPAs): Central Coast; Far North Coast; Orana/Far West; Sydney Inner West and Northern Sydney. The packages posted out to organisations that agreed to participate (Appendix 1) contained an Information Sheet (Appendix 2), the survey (Appendix 3) and a reply paid envelope for each individual survey form addressed to the researchers at the University of Western Sydney.

Out of the surveys distributed, 537 surveys had been returned by 8 July 2010, a response rate of 49%. For this analysis to be consistent with the Swedish analysis we have excluded 22 respondents, who were working only with people with disabilities under 65. This left 515 surveys, 210 (40.8%) from the HCS and 305 (59.2%) from the NGOs. The data from these surveys was coded and entered into an Excel file and then imported into and analysed using SPSS.

In the following two sections, Section 8 and Section 9, the findings from the survey of the NSW care workers are presented along with a comparison of these findings with the findings from the Swedish study. In Section 8 the responses of the NSW care workers to the survey are analysed. Where relevant the responses of care workers from NSW HCS (n=210) are compared with those of care workers employed by the NGOs (n=305). Incorporated into this section are the care workers responses to the open ended questions in the survey (Appendices 4, 5, 6 and 7). In section 9 all NSW care workers (n=515) are compared with the Swedish care workers responses (n=212) to the same survey. This is followed by Section 10, the findings from the observation studies.

8. The Findings from the survey of NSW care workers

In this section the findings from the NSW survey are documented, comparing the responses from those employed by the state provider, Home Care Service (HCS) (n=210) and the Non-Government Organisation (NGO) (n=305) providers. The focus of this analysis is on work-force characteristics: employment conditions; consequences of employment conditions; the clients serviced and the tasks care workers perform in their daily work.

8.1 Workforce characteristics

The care workforce characteristics are presented in Table 2 below. This Table documents gender, age, place of birth, ATSI (Aboriginal Torres Strait Islander), LoTE (Language other Than English), use of LoTE at work, training, time working in the sector and informal caring responsibilities, past and present.

Table 2. Workforce characteristics of HCS and NGO employees, gender, age, place of birth, ATSI, LoTE, use of LoTE at work, training, time working in the sector and informal caring responsibilities, past and present 2010

	HCS (%) (n=210)	NGO (%) (n=305)
Female	90.4	89.5
Age:		
Under 25 years	0	1.7
25-34	3.5	8.1
35-44	16.9	22.1
45-54	41.3	36.2
55-64	33.3	28.9
65 and over	5.0	3.0
Born outside Australia	25.4	36.4
Aboriginal or Torres Strait Islander (ATSI)	2.0	1.3
Speak a language other than English (LoTE)	21.5	30.4
(of which use LoTE at work)	44.2	51.7
Length of training:		
None	15.6	15.0
Less than 1 month	3.7	6.8
1-5 months	6.8	7.7
6-11 months	10.8	10.1
1-2 years	19.7	10.1
More than 2 years	43.4	50.2
Time working in care of elderly or people with disabilities:		
Less than 1 year	6.3	9.3
1-5 years	33.3	48.2
6-9 years	21.4	21.7
10-19 years	22.8	16.0
20 or more years	15.9	5.1
Has had informal care role in the past	69.0	62.2
Currently has informal care responsibilities	45.9	39.5

The care workers in this study were predominately female, with no significant differences in this regard between the HCS and NGO sector**:** 90.4% of the HCS and 89.5% of the NGO care workers were women (Table 2). This is consistent with other studies of care workers and of the community service industry as a whole (Martin and King, 2008 and Meagher and Cortis, 2010).

They were on average older workers. Those working for the HCS were significantly older than their colleagues in the NGO sector. A massive 80% of HCS care workers were 45 and over compared to 68% of those employed by NGOs (Table 2). This makes this group of care workers older than those in the Social and Community Services (SACS) sector in NSW (which includes home care workers) where 50% are 45 and over and considerably older than the labour force overall where only 38% are 45 and older (Meagher and Cortis, 2010: 2).

Only a small percentage of the respondents were from ATSI backgrounds: HCS, 2%, NGOs 1.3%. The slightly higher percentage of ATSI respondents working in the HCS may be attributed to the fact that the NSW HCS has a distinct Aboriginal Home Care Service that employs predominately ATSI care workers.

Turning to the percentage of care workers born outside Australia, the HCS employed a significantly lower percentage of care workers born outside of Australia, that is, 25% compared to the NGO sector where 36% of the respondents were born outside Australia (Table 2).

With more care workers born overseas in the NGO sector, it is not surprising that a larger proportion (30%) of the NGO workers spoke a language other than English compared to the HCS, where 22% spoke a language other than English. Of those who spoke a language other than English, it was also somewhat more common among the NGO workers to use a LoTE in their paid care work (52% of those working for NGOs compared to 44% of the HCS workers, see Table 2).

There were only minor differences with regard to specialised training for work with elderly or people with a disability. The majority of care workers in both sectors reported having one year or more specialised training for work with elderly or people with a disability: 63% of HCS workers and 60% of NGO workers. At the other end of the spectrum, 19% of HCS workers and 22% of NGO workers had either less than one month of specialised training or no training at all for this work (Table 2).

About half of those surveyed had worked for six or more years in paid care caring for the elderly and people with a disability. HCS workers were more experienced, 39% having worked in the sector for ten years or more compared to 21% of those working for NGOs. Of those employed by HCS, 16% had worked 20 years or more in the sector compared to just 5% of those employed by NGOs (Table 2).

A striking finding from this analysis was that 65% of care workers had in the past cared for ill or elderly relatives or friends with a disability, while 47% reported that they were currently caring for one or more relatives or friend who was ill or had a disability. There was no marked difference between NGO and HCS care workers in this regard. However, 12% of those at present working and caring reported that their informal care responsibilities had impacted negatively on their working lives and that their employment or working hours had been affected by this care work (Table 2).

8.2 Employment conditions

The employment conditions of care workers in NSW are presented in Table 3. This Table compares the employment conditions, of employees in the HCS and the NGO sector in regard to the form of employment, shifts worked, combination of shifts, and working split shifts.

Table 3. Employment conditions, HCS and Non-governmental sector 2010

	HCS (%) (n=210)	NGO (%) (n=305)
Form of employment:		
Casual	14.8	25.2
Permanent full-time	17.2	7.5
Permanent part-time	59.3	66.2
Fixed-term contract full-time	3.3	0
Fixed-term contract part-time	5.3	1.0
Shifts worked:		
Weekdays, days	97.6	97.4
Weekdays, evenings	34.3	14.1
Weekends	49.5	21.3
Nights	15.7	2.3
Combination of shifts (weekdays day; weekdays evenings; weekends; nights):		
One shift only	47.4	76.4
Two shifts	20.6	13.8
Three shifts	18.7	8.2
All four shifts	13.4	1.6
Work split shifts:		
Never	31.7	46.8
Rarely	25.5	29.9
Often	23.6	15.9
Almost always	19.2	7.3

As can be seen from the table above, most of the care workers reported that they were employed as permanent part time workers: 66% of the NGO workers and 59% of those employed by the HCS. Permanent full time care workers were more likely to work for the HCS, with 17% of HCS care workers in this form of employment compared to the NGO sector where less than 8% were employed as permanent full time workers (Table 3).

Also, NGO care workers were far more likely to be employed as casuals, with a quarter (25%) of NGO care workers employed as casuals compared to 15% of the Home Care workforce (Table 3).

In regard to the shifts worked, the overwhelming majority, that is, 98% of the NSW care workers who participated, work weekdays and during the daytime. However, those working for the HCS were far more likely to work weekends also, with 50% reporting that they worked weekends compared to 21% in the NGO sector. Also, evening work was more common among the HCS workers: 34% compared to 14% of NGO workers (Table 3).

HCS care workers were also more likely to work a combination of different shifts (weekday evenings or weekends and sometimes nights in addition to weekday days). Thirty two per cent reported that they usually worked three or four different types of shifts, compared to 10% from the NGO sector (Table 3).

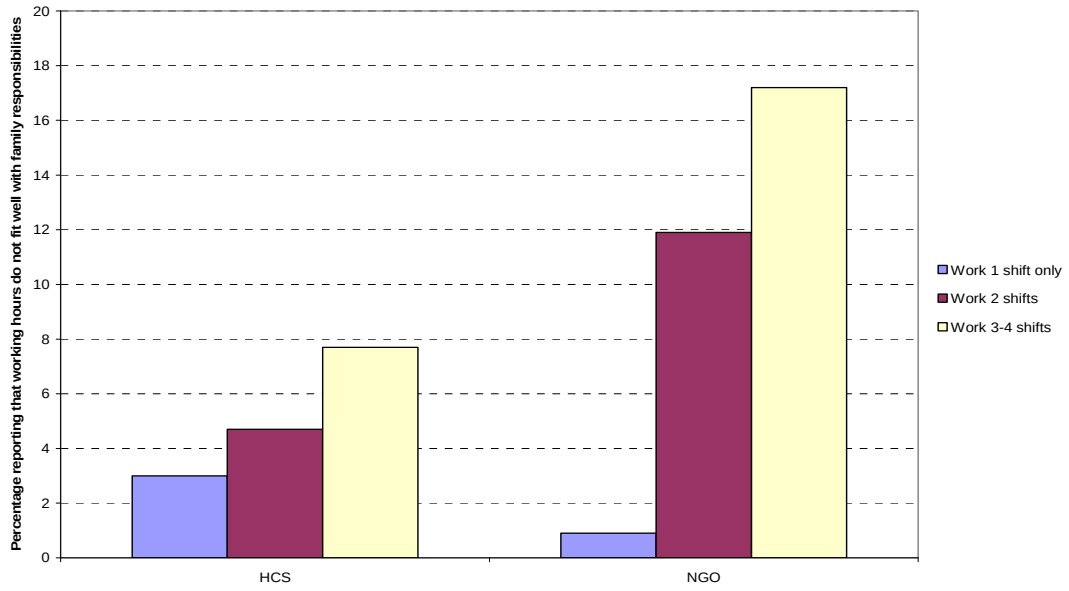
A striking finding was that those working for the HCS were far more likely to work split shifts, with almost twice as many (43%) HCS workers reporting that they often or always worked split shifts compared to 23% of those working for NGOs (Table 3).

The analysis of the data revealed no significant difference in the average hourly rates of pay between those employed by the HCS and those employed by NGOs. The mean pay rate reported by the care workers was $A19 per hour. However, there were differences between the providers in regard to the ways in which working hours were calculated. Some providers calculated the working day from the time the care workers set off to work, to the time they finished caring for the last client of the shift. Other providers calculated the hours the care workers were paid by calculating the time spent with each of the clients plus travel time between clients. Lastly, were those providers who only paid the care workers for the time they spent with clients, that is, they were not paid for the time they spent travelling between the clients. There were also different policies and practices adopted between providers in regard to mobile phones, insurance and whether or not care workers could transport clients in their own cars. All the care workers used their own cars to travel between clients and all were paid a mileage allowance.

8.3 Consequences of employment conditions

8.3.1 Combining family and social commitments

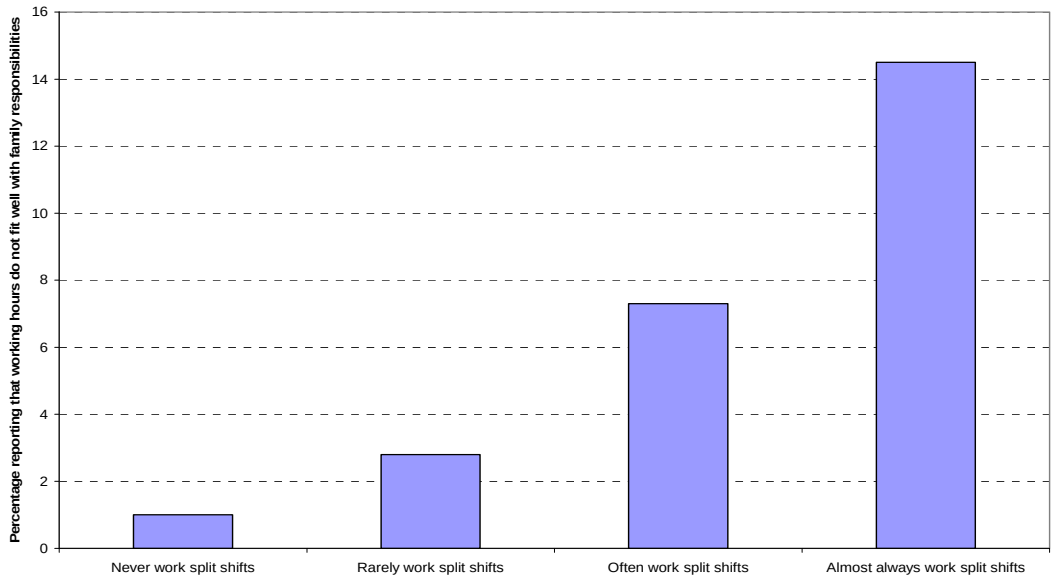
Most care workers reported that their working hours fit quite well with their family or social commitments. Only 4% of NGO workers and 5% of HCS workers reported that their working hours fit ‘not very well’ or ‘not at all well’ with their commitments outside of work. However, further analysis demonstrated that the number of shifts worked impacts significantly on the ‘fit’ between working hours and family and social commitments.



Graph 1. *Percentage of care workers reporting that their working hours fit 'not very well' or 'not at all well' with their family and social commitments outside of work, by number of shifts worked per cent, employed by HCS and NGO.*

Graph 1 illustrates percentage of care workers reporting that their working hours fit 'not very well' or 'not at all well' with their family and social commitments outside of work by the number of shifts worked employed by the HCS and NGOs. Of the care workers who work only one shift (usually day only), almost all said that their working hours fit in fairly well or very well with their family and social commitments. Only about 2% of HCS and less than 1% of NGO care workers reported that working hours 'fit not very well' or 'not at all well' with family and social commitments. As the number of shifts increases, the proportion reporting that their hours do not fit well with their other commitments also increases, significantly more so among the NGO workers. Of the NGO workers working three or four shifts, 17% responded that their working hours do not fit well with their other commitments, compared to less than 8% of HCS workers working the same number of shifts.

When the focus shifts to those working split shifts, a similar pattern is evident. Those who always work split shifts are much more likely to report a conflict between work and family and social life than are those who never work split shifts (Graph 2).



Graph 2. *Percentage of care workers both NGO and HCS reporting that their working hours fit 'not very well' or 'not at all well' with family and social commitments outside work, by frequency of working split shifts..*

8.3.2 Further insights regarding consequences of employment conditions.

A number of those responding to the survey also provided further written comments on some aspects of their employment conditions. A small number (n=28) stated that problems regarding their working conditions, such as working hours, were leading them to think about quitting care work. They made the following comments. 'The hours are not consistent' (NGO) and 'Not enough hours [are] available' (NGO). 'I cannot do more hours. Random hours eat [away at] my days and energy and I have difficulty making a regular income' (NGO). In addition, low pay (n=39), dissatisfaction with the balance between domestic assistance, personal care and social assistance (n=14), the impact of policy changes - cost cutting in particular (n=14) and lack of promotion opportunities (n=10) were among the factors that prompted care workers to consider resigning (see Appendix 4).

On the positive side, other care workers (n=64) stated that particular aspects of the job such as flexible working hours underpinned their continued commitment to care work (see Appendix 4) Flexibility of working hours was seen by many care workers as an important feature of care work. 'This job suits [my] family life' (NGO). Another respondent observed that: 'The job is usually quite flexible around family life and there are clients that make you feel [much] appreciated' (NGO). A very small number of care workers (n=12) reported 'opportunities to advance' as a reason for their continuing commitment to care work.

8.4 The clients

This section looks at the profiles of the clients for whom care workers provide care. Table 4 below sets out the percentage of workers who work with one or more clients who have an intellectual disability, a mental illness, need assistance to move or are bed bound, have issues with addiction, or who suffer from dementia.

Table 4. Care workers who work with one or more clients who have an intellectual disability, a mental illness, need assistance to move or are bed bound, have issues with addiction or who suffer from dementia

Work with one or more clients who...	HCS (per cent) (n=210)	NGO (per cent) (n=305)
Have an intellectual disability	76.0	29.2
Have a mental illness	74.5	47.8
Need assistance to move or are bed bound	77.9	55.9
Have issues with addiction	29.7	16.3
Suffer from dementia	83.5	87.0

Table 4 illustrates that HCS workers have a larger proportion of clients with special needs compared to workers in the NGO sector. This was particularly marked in regard to those with an intellectual disability. The differences were also significant for clients with a mental illness and HCS workers were considerably more likely to be assisting clients who needed assistance with mobility. The difference was slightly less in regard to caring for those with an addiction. The vast majority of care workers in both groups work with clients suffering from dementia: 84% of workers for the HCS and 87% in the NGO sector (Table 4).

A significant number of survey respondents observed that the clients' social support needs are not being addressed due to insufficient time. Care workers reported that they were frequently the only people visiting these homes and their clients were often lonely and in need of social support. Care workers expressed their concern as follows: 'We need more time to provide companionship for elderly and invalid clients who are on their own' (HCS); 'Lots of my clients really want to have a chat – I feel really bad sometimes when I have to rush off and leave [in] the middle of a conversation' (HCS) (see Appendix 5). The care workers making these comments clearly saw the social support and social connectedness they were providing as central to their work. Nevertheless, they reported that they have less and less time to allocate to this central component of their work.

8.5 The tasks

The survey asked the care workers for detailed information about the tasks they perform on a daily basis. Table 5 shows percentages of care workers who regularly perform the following tasks: cleaning, assisting with personal hygiene, lifting or assisting to move a person, accompanying a client on an errand, participating in recreational activity, shopping for groceries, preparing meals and having a cup of coffee with a client.

Table 5. Tasks performed by care workers in HCS and NGO

Tasks	HCS (%) (n=210)	NGO (%) (n=305)
Cleaning (several times a day)	70.8	34.2
Assisting with personal hygiene (several times a day)	67.0	31.8
Lifting or assisting in moving a person (several times a day)	28.2	10.7
Accompanying a client on an errand (during the last month)	31.6	86.0
Participating in a recreational activity (during the last month)	17.7	57.6
Shopping for groceries (several times a day)	4.5	34.0
Preparing meals (several times a day)	28.0	43.9
Having a cup of tea or coffee (several times a day)	5.3	15.5

As illustrated in Table 5 above, workers employed by the HCS were significantly more likely than care workers from NGOs to be cleaning, assisting with personal hygiene and lifting their clients. Part of the explanation for this difference could be attributed to the difference in the client groups. As illustrated in Table 4, HCS care workers were working with a greater proportion of clients with special needs, for example, those who need assistance to move or who are bedbound (Table 4). In such cases, it would be expected that more personal care would be needed. This finding could also be related to the capacity of the HCS to take on the more complex aspects of community care. Many of the NGOs do not have this capacity.

There were also significant differences between the HCS and the NGO care workers in regard to tasks such as accompanying a client on an errand, participating in a recreational activity, shopping for groceries, preparing meals and/or having a cup of tea/coffee with a client. The HCS care workers were significantly less likely to be carrying out these tasks with their clients (Table 5). Some of this difference could be attributed to the smaller percentage of HCS clients who were able to participate in these activities.

8.5.1. Further Insights regarding Tasks

The care workers took up the opportunity to expand on their answers to the questions regarding tasks and provide more detailed responses by answering the following open ended questions: 'Please state if there are any tasks you feel you should have more time for' (Question C8a) and 'Please state if there are any tasks that you currently do that you feel should not do' (Question C8b) (see Appendix 3).

In their written responses the care workers reported overwhelmingly that they wanted more time for some tasks, particularly social support and personal care. Represented here are the voices of 129 care workers (24% of the total number of care workers who completed the survey) who identified a total of 173 tasks that needed more time.

Top of the list were tasks that centred on social support (n=53), followed by tasks focussing on personal care (n=38). Other tasks identified were shopping (n=20), domestic assistance (n=15), appointments (n=13), meal preparation (n=10), respite for carers (n=10), admini-

strative work (n=9), meetings with managers (n=3) and, finally, palliative care (n=2) (for more details see Appendix 5).

Care workers wrote of needing time to enable them to be flexible in the delivery of care and to take into account the individual differences between clients: they wanted sufficient time allocated to provide individualised and flexible care. 'Some clients can take up to 10 minutes longer than the time allocated especially during winter – due to extra layers of clothing' (HCS). Concern was also expressed about the consequences of recent cutbacks, which further diminished the time care workers could spend with their clients. One care worker reported that 'Travelling time between clients has recently been removed so staff have to leave one client early and get to the next client late (NGO). Of a half hour shift allocated to do a shower and tidy the house, we get 20-25 minutes. It is not enough, by the time you cut out travel' (NGO). These examples do not even remotely exhaust the list of tasks identified as needing more time. Nevertheless, they do provide support to the most strongly identified theme of this research, that of care workers needing more time to care. Here, it can be concluded that, in the main, care workers reported that they have too much to do and not enough time to do it.

8.6 Insights regarding changes to the community care sector

The final question of the survey asked: 'If you had the power to decide, what changes would you recommend regarding care for the elderly and those with disabilities?' (Question F) (see Appendix 3). Three hundred and forty three care workers (64%) responded to this question providing over 400 recommendations. Overall, the answers to this question reinforced the findings presented above. The same themes emerged again. Overwhelmingly, the care workers were saying that they wanted more funding and resources allocated to the sector to enable them to spend more time with their clients and provide what they judged to be quality care.

At the top of the list were recommendations for more funding for additional services to enable more time to be spent with clients (n=146 recommendations). Following in descending order, were recommendations for improving the quality of services, providing sensitive assessment, monitoring and responding proactively to people's needs (n=54 recommendations), funding for higher wages and additional care staff (n=48 recommendations), opportunities to enhance community connections, more day centres and excursions (n=39 recommendations), ways to improve working conditions (excluding pay and wages) and recommendations in regard to training and Occupational Health and Safety (n=35 recommendations). There were also recommendations (n=24) suggesting community and public awareness campaigns to raise awareness of the services available to older people and calling for greater recognition of care work.

Twelve care workers reported that they felt that the system works well in its present form (n=12 recommendations). Forty four recommendations did not fit into the above categories.

8.6.1 Funding for additional services and time spent with clients

One hundred and forty six recommendations were made for additional services and funding to enable care workers to spend more time with clients. Typical responses included: 'More funding is needed for the elderly' (HCS) and 'We need more government funding. The packages, only 5 hours per week, are nowhere near enough time to care for an elderly client, especially those with dementia. A doctor's visit can take two to two and a half hours alone. Personal care and adequate support and socialisation are not possible' (NGO). Several responses alluded to what they viewed as unacceptably long response times: 'More funding is needed for elderly for help at home. A quicker service response is required, cutting the long waiting period for the elderly who desperately need services. This means more accessibility for the ACATs (Aged Care Assessment Teams), more providers and more government funding' (NGO).

Again, care workers reported that they found loneliness and isolation a serious problem for many of the older people they were working with: 'We need more time to talk as loneliness is one of the biggest causes of unhappiness' (HCS); and, 'I would recommend more staff particularly with support and the comforting side of things. They all need their showers, but there doesn't seem to be time for what they really need, that is, someone to listen to them. We seem to be or should I say the government seems to be unaware of how much care people need, not only the person with disabilities but the person who looks after them' (HCS). This was especially the case for those with no family support: 'Some people have no one. They look forward to our visits. They need more visits with family or social support. I sometimes want to help more in my own time' (NGO).

Many reported that they felt pressured when they did not have enough time to meet their clients' needs and spoke of feeling that they were abandoning their clients: 'Most of the clients I visit really need extra time spent with them. Sometimes I feel like I'm leaving prematurely because they want you to stay or talk or just be with them. It sometimes feels like a 'hit and run visit' leaving them abandoned' (NGO). Care workers spoke of recent changes in policies that made their work more difficult, of how new rules made it impossible to provide what they judged to be good care: 'A lot more caring (is needed)'. The word 'caring' has gone out of home care. I was taught to care more in my job and then someone comes along and tells us we shouldn't. I have seen lots of changes in this job, some are not good. Some rules were made to be broken though' (HCS). Attention was also drawn to the fact that caring relationships could lead to the development of friendships, leading care workers to break the rules and to visit clients outside working hours: 'I am assisting a client outside of working hours as there is no family. I do not tell work because this is not allowed. This person is terminal and has no one. I have known them for two years and I feel the need and friendship to help. There is not enough help from the care team' (NGO).

Finally, care workers wanted more emphasis to be placed on social support and enhancing community connections: 'More emphasis on alleviating loneliness and isolation (no one likes to eat alone). More time for social support – encourage connections with the broader community. There needs to be more emphasis on older persons' mental health' (NGO).

Some care workers wanted to be able to take clients on outings: 'To be able to take the elderly or the person with a disability out for shopping or lunch or cup of tea because some elderly and disabled people stay in their homes day after day and the only person they see is the care worker that comes to see them each week or fortnightly' (HCS).

8.6.2 Quality of services provided

The 54 recommendations in this category included ways to improve assessment, monitoring and continuity of services and to respond more sensitively and flexibly to individual and changing needs. Conducting assessments over the telephone was consistently identified by care workers as bad practice that significantly affected the quality and appropriateness of the care: 'The assessment of new clients (should be) given back to supervisors of each branch so that they have personal contact with clients to allow them to see the needs of each client. The elderly do not understand the questions when the assessment is carried out over the phone and, if the assessment of their needs is not correct, they miss out on the service. Each supervisor should spend time visiting each client so the client can feel they are important and they put a face to voice over the phone. This is very important to the elderly and those with disabilities' (HCS).

Another respondent stated: 'Before agreeing to give the new client their service, it is very important that the case manager must personally visit the place to interview and assess the true condition of the place. I don't agree with simply assessing someone over the phone' (HCS.

Care workers also noted the importance of continuity of care for their clients, having perhaps one or two care workers consistently caring for the same client: 'Give more continuity of staff. Clients don't like having multiple carers, they like to have their regular carers be it domestic or personal care' (NGO); and 'If I had the power I would definitely set up a program to assist the matching of carers to clients personalities – as we all know, we are all very different and not everyone gets along with everyone. Some clients relate better to older carers or maybe a particular sex. I think when you are entering a client's home the client has the right to feel one hundred per cent confident and relaxed with the carer looking after them. Clients comment that having a number of different carers attending to them can be very unsettling. A lot would prefer just a couple of carers' (HCS).

Furthermore, care workers reported that there is a need for more open and direct communication between all parties in order to respond more quickly to the changing and/or real needs of clients: 'I would recommend that changes should be devised with a lot more listening and a lot less unsubstantiated assumptions made' (HCS); and 'We should be quicker to adapt to changing needs. More communication between agencies, care providers and care workers would assist here' (HCS).

Finally, these care workers recommended more involvement by other healthcare professionals, specifically Registered Nurses (RNs) and General Practitioners (GPs): 'Ensure that a RN is employed in all [areas of] community service. We used to have one until her

position was made redundant. I feel that a RN is needed to give care workers back up in the field' (NGO); and 'More GP involvement and follow up needed after seeing client' (NGO).

8.6.3 Funding for higher wages

Once again, the low levels of remuneration for care workers featured prominently (48 recommendations). 'Care workers should be paid more money for what they provide to the elderly' (HCS); 'If I had the power to I would raise both the aged care and disabilities services pay rate to a fair hourly rate that reflects the work we do' (NGO); and 'Make pay rates more respectable to encourage dedicated caring people to stay in the industry. Carers tend to get burnt out especially in nursing homes. Put more staff on and give staff the hours they want instead of keeping hours to a minimum. For the care we provide we should get more money' (NGO).

These suggestions were made alongside recommendations for more time and more care workers to meet the needs of clients: 'We need more time and staff per ratio of clients to staff to do our jobs properly' (NGO). Another respondent argued similarly: 'Increase staffing numbers to give clients the help and services they need and to stop burn out in staff. Increase wages so staff will feel they are paid what they are worth and take pride in their jobs, be able to afford education so they can help their clients with the right knowledge' (NGO).

8.6.4 Enhance community connections

Thirty nine recommendations were made regarding ways to enhance community connections. Recommendations included the following: 'I would have visits to the elderly more frequently just as social visits. Arrange with neighbours or family to check [on] client as often as possible. If elderly live alone make sure they are confident to get help from someone/organisation if they need to 24/7 (anytime)' (NGO); as well 'There should be more funding directed to respite for aged care as this will provide social recreation for people at home and keep their lives more occupied' (NGO).

8.6.5. Suggested improvements regarding working conditions

Thirty five recommendations were made regarding improved training, qualifications, promotion opportunities and working hours. Regarding training, one survey respondent recommended the following: 'More training for everyone from field staff to office staff, also office staff should, once a year, go into the field for a day working with the clients. More team building' (HCS); another recommended the following: 'Hands-on training by properly qualified experts would lift the work rate and increase the carer's confidence, especially in relation to high need clients such as quadriplegics, cerebral palsy sufferers, autistic clients and motor neurone disease clients' (HCS). It was also stated that: 'The aged care workforce should have appropriate formal qualifications to maintain standards of care' (NGO).

As regards promotion, recognition and career prospects the following was recommended: 'Employees should be given more status and recognition. There should be more opportunities to be promoted and achieve a sense of growth and develop within the industry' (NGO). Recommendations were also made regarding the working hours: 'I would also recommend that carers be allowed to work 2,3,4 days per week not made to work 5... I really hope some positive changes may occur as most care staff burn out quickly and find better paying less stressful jobs' (NGO).

8.6.6 Community/Public awareness of services available

In this category there were twenty four recommendations, suggesting community education programs. 'Community programs to introduce elderly residents to younger neighbours and children, especially those living near or next door to each other. School programs to include elderly in story, reading, verbal history groups (NGO); 'Everyone to have experience supporting disabled people as a compulsory part of secondary education and [spend] time interacting with elderly people as part of primary education. Cultural studies to include cultures of disabilities. Community attitudes to ageing changed to value experiences and history. Interest in difference to be cultivated by inclusive, integrated opportunities' (NGO).

One recommendation was for education programs for older people around support services, 'Compulsory self-education upon the start of retirement on the topic of aged care and/or membership of a program that maintains client health and well being, minimising the risks of self neglect and isolation' (NGO);

As mentioned above, forty four recommendations did not fit readily into the above categories. These recommendations included ways of challenging ageism; providing alternative accommodation; and the upgrading of residential care facilities. 'Society should respect the elderly for their wisdom. Age and disability should be more normalised' (NGO) and the need for inclusive education: 'Cultural studies to include cultures of disabilities. Community attitudes to ageing changed to value experiences and history, with an interest in difference to be cultivated by inclusive, integrated opportunities' (NGO), and 'More education and awareness in schools is needed, so that young people grow up with the thought of caring for older people in the community. Teach children to respect/care for older citizens in our society. This will make for a better society' (NGO).

In regard to the provision of alternative accommodation, the following recommendations were made: 'I would like to see affordable respite home-like environment cottages in all communities near or attached to residential facilities, providing day respite, overnight respite and assisting in gentle transition into permanent placement if and when necessary. Provision for pets and pet care, e.g., dogs, cats, chooks, chickens, sheep, lambs also important (NGO); 'More flexible models of care and innovation for elderly people who live in rural areas. It's a big change to move to hostel care in large towns away from family and friends. I would suggest building dwellings on rural properties and have them funded to provide care needs for people' (HCS).

Finally, several care workers were concerned about the conditions in residential care facilities and singled out the need for more staff in aged care facilities. 'More nurses and assistants needed in aged care facilities. I left (working in residential care) after 22 years as the pressure was getting too great. I have been working casually in community care and it seems less stressful as demands on time are less' (NGO). Another care worker stated: 'I also work in a nursing home and we need more staff! That would give us time to let the residents do more themselves as well as enabling us to meet more of their needs, particularly social needs' (NGO).

8.7 Summing up: Care workers in NSW

To summarise, the care workforce surveyed is predominately female and comprises mostly older workers. Those working for the HCS are older, on average, than those working for the NGOs. Most were working part time and, for the majority, their working hours fitted well with their family responsibilities, with the notable exception of a small percentage, mostly HCS care workers, who were working split shifts. These care workers had considerable informal care experience. Nearly half of all the care workers were caring for older family members or those with a disability.

Overall, there is a slightly higher proportion of those with LoTE in the NSW care workforce compared to the Australian care workforce. About half of these care workers use a language other than English in their work. While the majority of the care workers in NSW had at least a year of formal training working with older people and those with disabilities, approximately 20% of these care workers had less than one month's training or no training at all.

The most significant differences between the two groups were in the needs of the clients they were caring for and the tasks they performed. Those working for the HCS had a much larger proportion of clients with special needs and were far more likely to be doing more intensive work, such as cleaning, assisting with personal hygiene, and lifting and moving people. By contrast, those working for NGOs cared for clients with less intensive needs and were able to spend more time on tasks such as having cups of coffee, shopping for groceries, accompanying client's on errands and participating in recreational activities.

9. Comparing NSW and Sweden

As outlined above, one of the aims of this research was to compare the findings of the survey of NSW care workers with the findings from the Swedish survey (Szebehely, 2006). The methodology and data collection, the survey, the interviews and the observation studies were specifically designed to enable this comparison.

This section compares the findings from the NSW survey of care workers with the findings from the Swedish survey conducted in 2005. The comparison between the NSW and Swedish care workers follows the same structure as the comparison between HCS care workers and NGO care workers reported above. The focus is on workforce characteristics, employment

conditions, consequences of employment conditions, the clients and the tasks. An additional section here includes comparisons of data on work intensity. There were 515 respondents in the NSW sample and 212 respondents in the Swedish sample.

9.1. Workforce characteristics

Table 6 compares the workforce characteristics of the NSW care workers and the Swedish care workers. Characteristics compared are gender, age, whether they were born outside of Australia/Sweden, the length of their training, the length of time they have been working as carers of the elderly or people with disabilities and their informal caring responsibilities.

Table 6. Workforce characteristics NSW 2010 and Sweden 2005.

	NSW (%) (n=515)	Sweden (%) (n=212)
Female	89.8	96.2
Age:		
Under 25 years	1.0	2.9
25-34	6.2	17.8
35-44	20.0	27.4
45-54	38.3	29.3
55-64	30.7	19.2
65 and over	3.8	3.4
Born outside Australia /Sweden	31.9	9.8
Length of training:		
None	15.3	14.5
Less than 1 month	5.0	2.4
1-5 months	7.2	7.2
6-11 months	10.6	7.2
1-2 years	15.7	43.0
More than 2 years	46.2	25.6
Time working in care of elderly or disabled people:		
Less than 1 year	8.1	2.9
1-5 years	41.9	16.2
6-9 years	21.5	16.7
10-19 years	18.8	38.1
20 or more years	9.6	26.2
Currently has informal care responsibilities	42.0	27.2

The care workforces in both NSW and Sweden are female dominated: in the NSW sample, 90% were female compared to 96% of the Swedish sample. The NSW care workers were considerably older than their Swedish counterparts: 73% of the NSW care workers were 45 and over compared to 52% of the Swedish care workers. However, the Swedish care workers had been caring for older people and people with disabilities for longer. Half of the NSW care workers had worked for 6 or more years in the sector compared to 81% of the Swedish

care workers: 26% of the Swedish care workers had worked 20 years or more in the sector compared to 10% of the NSW care workers.[1] (Table 6)

The NSW sample had a far higher percentage of care workers born outside of the country: 32% compared to the Swedish care workers, where only 10% were born outside of Sweden (Table 6). However, this difference is not so large if we contextualise this finding by examining the percentage of overseas born in each country. The ABS reports that 27% of Australians overall are overseas born (ABS, 2010:45): Statistics Sweden reports that 12% of the Swedish population were overseas born in 2005 (Statistics Sweden, 2006: 107). When contextualised in this way it would appear that care workers born outside of the country are over-represented in the care workforce in NSW, whereas in Sweden they are slightly underrepresented.

The NSW care workers had longer training periods in specialised courses on ageing and disability than their Swedish counterparts. A larger percentage of NSW workers had more than 2 years training, 46.2% compared with 25.6% of the Swedish workers (Table 6). There was little difference between the percentage of the care workforce in both countries with no training, 15.3% in NSW and 14.5% in Sweden.

The NSW care workers were far more likely than the Swedish workers to be carrying informal care responsibilities while working. Of the NSW care workers surveyed 42% reported that they had informal caring responsibilities for one or more adults, which they were juggling alongside their paid care work, compared to 27% of the Swedish care workers. As informal caring responsibilities increase with age and since the NSW workforce is older, we would expect that caring responsibilities are more common among this group. However, this does not totally explain this difference, as the NSW care workers were also more likely to have informal care responsibilities at younger ages.

9.2. Employment conditions

Table 7 compares the employment conditions of the NSW and Swedish care workers, their forms of employment, the shifts they work and the combinations of shifts.

[1] This difference probably reflects the history of the sector in the two countries. Sweden has a much longer history of developed home care services than NSW.

Table 7. Employment conditions, NSW 2010 and Sweden 2005

	NSW (%) (n=515)	Sweden (%) (n=212)
Form of employment:		
Casual	21.0	6.8
Permanent full-time	11.5	34.3
Permanent part-time	63.4	52.7
Fixed-term contract full-time	1.4	0
Fixed-term contract part-time	2.7	5.3
Shifts worked:		
Weekdays, day	97.5	78.3
Weekdays, evenings	22.3	68.2
Weekends	32.8	81.0
Nights	7.8	14.7
Combination of shifts (weekdays days; weekdays evenings; weekends; nights):		
One shift only	64.4	16.6
Two shifts	16.5	30.3
Three shifts	12.5	46.9
All four shifts	6.4	6.2

Home care work is mainly part time work in both NSW and Sweden. Most of the NSW care workers who responded to this survey reported that they are employed as permanent part time workers: 63% compared to 53% of the Swedish sample. The NSW workers were more likely to be employed as casuals than their Swedish counterparts, 21% and 7% respectively. The Swedish workers were more likely to be employed on a permanent full-time basis: 34% compared to only 11.5% of the NSW sample (Table 7).

The overwhelming majority, that is, 98% of NSW care workers work weekdays during the daytime, compared to 78% of the Swedish care workers. The NSW care workers work less on weekday evenings (22%) and far less on weekends (33%) compared to the Swedish care workers, of whom 68% reported working weekday evenings and 81% worked weekends (Table 7).

As a consequence, it is much more common among Swedish care workers to work a combination of shifts. More than half of the home care workers in Sweden work three or four different types of shifts, 53%, compared to 19% of the NSW care workers (Table 7).

9.3. Consequences of employment conditions

Table 8 provides comparative data on the percentage of care workers in NSW and Sweden wanting to work more hours.

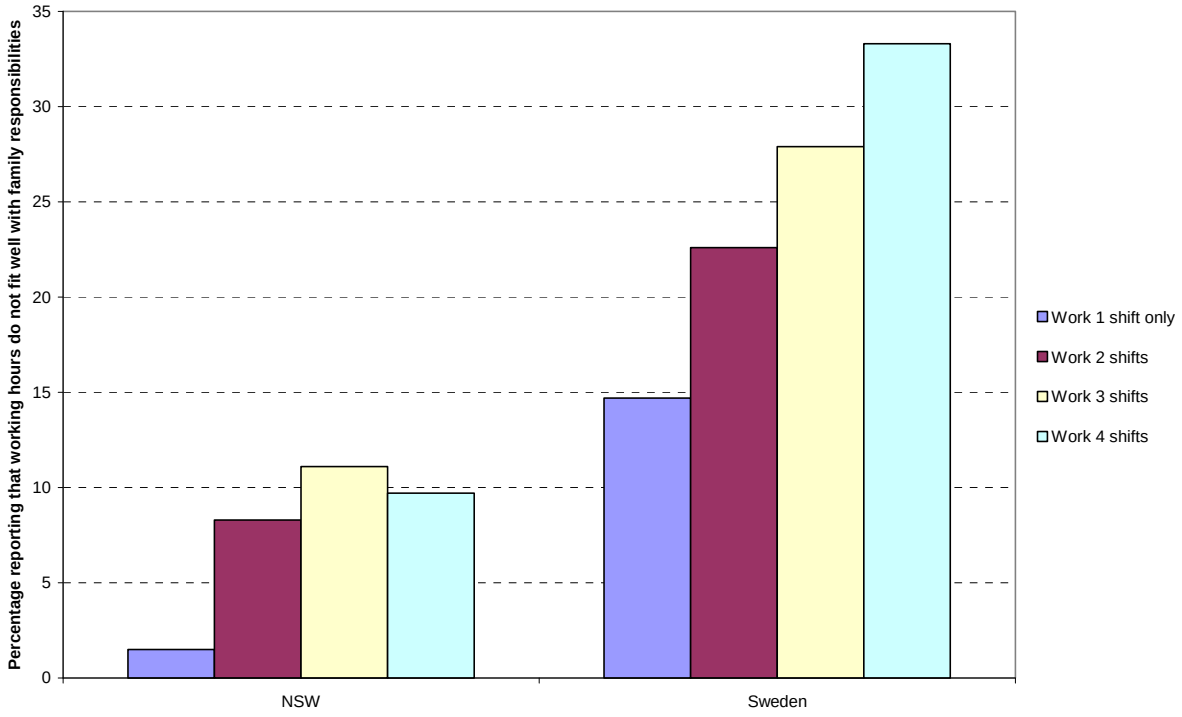
Table 8. Care workers wanting to work more hours NSW 2010 and Sweden 2005

	NSW (%) (n=515)	Sweden (%) (n=212)
'Would like to work *more* hours'; per cent of all workers	29.7	17.2
'Would like to work *more* hours'; per cent of part-time workers	30.3	24.9
'Would like to work *more* hours'; per cent of full-time workers	25.0	3.6

As noted above,(Table 7) part-time work is more common among the NSW workers. However, Table 8 shows that in many cases, working part-time is not voluntarily chosen. In NSW, with nearly 30% of all the care workers reporting that they would prefer to work more hours, 30% of the part-time workers and surprisingly, 25% of those working full-time. By contrast, in Sweden, 17% of all care workers would like to work more hours; 25% of those working part-time but only 4% of those working full-time (Table 8).

9.3.1. Combining work, family and social commitments

The Swedish care workers have more difficulty combining work and family life than the NSW care workers. When asked how well their work fitted with their family commitments, a very small percentage of NSW care workers, only 4%, reported that their working hours did not fit with family or social commitments outside of work compared with 25% of Swedish workers.



Graph 3. *Care workers reporting that their working hours fit 'not very well' of 'not at all well' with their family and social commitments outside work by combination of shifts worked (weekdays days; weekdays evenings; weekends; nights)*

The graph above breaks this down into a relationship between the shifts worked and responses from the care workers in the two countries on the fit between their working hours and their family and social commitments. The graph shows that in both countries the more shifts worked, the less did working hours fit with the workers' commitments outside of work. However, independently of the number of shifts worked, the Swedish care workers find it more difficult to combine their paid work with their family and social commitments. This cannot be explained by the fact that more Swedish care workers work full time.

9.4. The clients

Table 9 provides comparative data on the clients comparing NSW and Sweden.

Table 9. The clients, NSW, 2010 and Sweden, 2005, per cent

Work with one or more clients who…	NSW (%) (n=515)	Sweden (%) (n=212)
Needs/need assistance to move or is/are bed bound	65.2	93.3
Has/have a mental illness	59.3	84.7
Has/have issues with addiction	22.2	58.2
Has/have an intellectual disability	50.0	28.9
Suffers/suffer from dementia	85.5	93.4

Table 9 shows that Swedish care workers have a larger proportion of clients with special needs: 93% of Swedish workers compared to 65% of NSW care workers work with at least one client who is bedbound; 58 % of Swedish care workers have clients with issues with addiction compared to 22% of NSW care workers; 85% of Swedish care workers work with at least one client with a mental illness compared to 58 % of NSW care workers. Slightly more Swedish care workers work with clients suffering from dementia (93% compared to 86%) while it is more common for NSW care workers to work with clients who have an intellectual disability.

9.5. The Tasks

There were significant differences between NSW and Sweden in regard to the nature of the work, specifically the tasks performed. The following section looks at tasks performed weekly, then tasks performed monthly. A comparison is made between the NSW and Swedish care workers.

Table 10. The tasks NSW, 2010 and Sweden, 2005

Do the following tasks at least *once a week*:	NSW (%) (n=515)	Sweden (%) (n=212)
Clean a client's home	91.0	75.6
Prepare a meal	66.5	45.5
Shop for groceries	66.6	70.8
Assist with personal hygiene	86.8	98.6
Lift or assist in moving a person	52.2	90.3
Have a cup of coffee or tea with a client	69.1	36.6
Provide support or comfort to a client	89.1	94.1
Accompany a client on a walk	50.8	48.5
Do administrative tasks	40.7	65.5
Do the following tasks *at least monthly*		
Mobility or speech training/rehabilitation work	12.2	57.1
Hand out medicine from a dispenser	49.1	86.8
Give an injection	1.6	38.4
Set a client's hair, give a manicure or pedicure	22.5	72.9
Accompany a client on an errand outside of home	63.7	52.4
Participate in recreational activity with client(s)	41.1	12.8
Get in touch with health care system	22.0	67.0
Contacted (or was contacted by) a client's relative	34.9	64.9

The NSW care workers were more likely than the Swedish care workers to clean a client's home, prepare a meal, have a cup of coffee, accompany a client on an errand outside of the home and participate in recreational activity with clients. There was little difference between the NSW and the Swedish care workers regarding the percentage of care workers who shopped for groceries, provided support or comforted a client, or accompanied a client on a walk (Table 10).

The Swedish care workers were far more likely to assist with personal hygiene, lift or assist in moving a person, set a client's hair, give a manicure or a pedicure, do administrative tasks and undertake mobility or speech training or rehabilitation work. They were also far more likely to be doing medically oriented tasks such as handing out medicines, giving injections or being in touch with the health system and the clients' relatives (Table 10).

9.6. Work intensity

Table 11 provides comparative data of the intensity of work that care workers undertake in NSW and Sweden with particular focus on the number of visits per shift.

Table 11. Work intensity NSW, 2010 and Sweden, 2005, per cent

	NSW (%) (n=515)	Sweden (%) (n=212)
Too many visits, weekdays daytime	2.4	40.6
Too many visits, weekdays evenings	8.6	48.2
Too many visits, weekends	3.2	50.6
Too many visits, nights	5.9	32.1

This Table illustrates the striking differences in work intensity between the Swedish and NSW workers. The Swedish workers consistently reported that the number of visits they were required to make during any one shift was excessive. This was reported across all of the shifts, but was most marked among those working weekends (Table 11).

Table 12 below, provides comparative data on the intensity of work as described by the care workers. The focus here is upon the overall workload ('I have too much to do in the job all or most of the time'); feelings of inadequacy do to inability to provide sufficient care ('I feel inadequate because clients are not receiving the care they should: all or most of the time'); physical demand of the care work ('I carry, lift or pull heavy loads or people: weekly or more often'); and, staffing issues ('My workplace is short-staffed due to illness, vacation or unfilled vacancy: weekly or more often').

Table 12. Statements about the work

	NSW (%) (n=515)	Sweden (%) (n=212)
Have too much to do in the job *all or most of the time*	7.5	35.3
Feel inadequate because clients are not receiving the care they should: *all or most of the time*	5.7	23.2
Carry, lift or pull heavy loads or people: *weekly or more often*	20.6	70.0
Workplace is short-staffed due to illness, vacation or unfilled vacancy: *weekly or more often*	21.4	51.2

Just over a third, 35%, of Swedish workers reported that they 'have too much to do in the job' all or most of the time, compared to only 8% of NSW workers. The Swedish workers are also more likely to report that they feel inadequate because clients are not receiving the care they are entitled to, 70% of the Swedish workers reported that they carry, lift or pull heavy loads or people every week or more often, compared to only 21% of NSW workers (Table 12).

There is also a far greater likelihood that the Swedish workers will find their workplace short-staffed due to illness, vacations or unfilled vacancies: just over half (51%) of Swedish care workers reported this a weekly or more often issue, compared to 21% of NSW workers (Table 12).

9.7. Summing up: Comparing NSW and Swedish care workers

The care workforce is predominantly female in both countries. Whereas NSW care workers are considerably older than their Swedish counterparts, Swedish care workers have been working in the sector longer. The NSW workers had more specialised training in working with the aged and the disabled and were more likely to be combining their paid care work with informal care.

Part time work was the predominant form of employment in both countries: Swedish workers were more likely than their NSW colleagues to have full time work. Most NSW care workers worked weekdays during the daytime. The Swedish care workers were more likely to work weekends and a combination of different shifts over any given week. A larger percentage of the NSW care workers reported that they want to work more hours. The Swedish workers have far more difficulty combining work and family responsibilities than their colleagues in NSW.

The Swedish care workers have a larger percentage of clients with special needs, including a far higher percentage of clients who are bed bound. They also do more intense and physically demanding work, such as lifting and moving clients.

Overall, it would appear that the NSW care workers have less demanding working conditions than their Swedish colleagues. The Swedish home care workers report that they are required to make too many visits per day, that they often feel stressed and feel that they cannot provide enough help. Further analysis is needed to interpret and better understand these important differences in the working and employment conditions in NSW and Sweden.

10. The Observation Studies

A central component of the methodology for this project was the observation studies, where a researcher followed or shadowed a care worker throughout her working day. These observation studies added considerably to our understanding of the day to day work of care workers in NSW and enabled us to put a human face to the findings from the survey. This was a very intensive process, both for the researcher, who spent four full days following these care workers and for the care workers, who opened themselves to many hours of scrutiny from the researchers.

To conduct such an intensive study requires a high degree of trust and goodwill, as well as commitment and support from the provider organisations and the individual care workers. It also required a large amount of forward planning. The major weight of this planning was carried by the care worker herself. The process was as follows: The care managers employed by three provider organisations, the HCS and two NGOs, were approached by the researcher with the request that they invite care workers to volunteer for this phase of the data collection. The researcher was advised by the care managers of the care workers who expressed an interest in participating. The researcher then approached the care worker,

spoke to her about the aims of the study and if she agreed to participate, she signed a consent form and a mutually convenient day for the observation to take place was negotiated. The next stage of the process required the care worker, the week before the observation study was to take place, to provide an information form and a consent form to each of the clients being visited on the nominated day to obtain their permission for the researcher to enter their homes to observe the care worker. Four observations were completed, two with care workers from the NSW HCS and two with care workers from two (different) NGOs.

The findings from these observation studies were consistent with the findings from the survey of care workers. On a typical working day care workers would attend to the needs of three to six clients and were caring for between ten and twenty five clients in a week.

The hours the care workers worked varied depending on the needs of the client and the availability of the care worker. All four of the care workers who participated in this stage of the research worked part time. Indeed for these care workers, as reported in the survey, it was the part time nature of this work, where the care workers could to some extent, control their hours of work to fit with their family responsibilities that was one of the major attractions of this work.

The names and details of the care workers and the clients have been changed to preserve confidentiality and privacy. The scenarios document, firstly, a day in the working life of Tracey, who works for an NGO and secondly, a day in the working life of Helen, who works for the HCS. Both Tracey and Helen lived close to where they worked (the homes of their clients) and drove their own cars, leaving home and going straight to work from their homes to the home of the first client of the day. The visits they made were within a 10-15 kilometre radius of their homes and it generally took them between 5 and 15 minutes to drive from the home of one client to the next. They generally only called into the central office every couple of weeks, to attend staff meetings, training days or supervision sessions.

10.1 A Day in the Working Life of Tracey Employed by an NGO

Tracey, aged 45, has worked for the same NGO as a care worker for 6 years. Prior to working as a care worker, she had worked as a hairdresser. She has a TAFE hairdressing qualification and a Certificate 3 in Aged Care. She is divorced and her children, aged 8, 12 and 14, live with her. She had been caring for her 80 year old mother for approximately 10 years. After her divorce, 4 years ago, she and her mother jointly purchased a house and moved in together. Her mother has had a mild stroke and has severe arthritis and requires assistance and support from Tracey. Her mother supports Tracey also, assisting in getting the children off to school and being at home when they come home from school in the afternoons. On the working day documented below, Tracey worked from eight until about one, a working day of 5 hours. She made 4 home visits to 4 clients during that time. She works five days a week, 25 hours per week, repeating a similar pattern each day. Some of her clients she visits each day, some she visits twice a week and some she visits once a week.

She started work at eight, visiting Mrs M, who lives alone. She assisted Mrs M to get out of bed and get showered and dressed for the day. She did some washing and cleaning for Mrs M.

At nine she visited Mr G, who is severely debilitated with Parkinson's disease and is cared for by his daughter. She assisted Mr G with showering and some personal care. At about ten she visited her third client of the day, Mr A, who lives in a self contained unit in a retirement complex, cared for by his wife. He has had a debilitating stroke and is virtually bed bound. She spent all the time on this visit attending to personal care, getting him out of bed, showering him, changing his pyjamas, then assisting him back to bed. The fourth client was Mr X, who lives alone, in an apartment in a large block. He is physically quite fit, but suffers from Alzheimer's disease and his memory, particularly his short term memory, is very poor. Tracey arrived at Mr X's home at about eleven, tidied his apartment, changed his sheets, did some washing, then took him grocery shopping and on a visit to the local travel agent, returning him home by about 12.45pm.

What is not in this account are the details of the interactions the researcher observed between Tracey and those she was caring for. It was observed that all the time Tracey was doing the work outlined above, she was continually explaining to the clients what she was doing. She was constantly multi-tasking, for instance asking questions about their health and what they wanted to do that day, while checking the fridge for what food was needed. She was also continually monitoring their health and well being, asking what they needed. She was able to be flexible and often responded immediately to her client's needs.

One example was Mr X, who had a number of tasks he needed assistance with that day, including replacing the batteries in his clock. The batteries were purchased during the shopping trip and the clock fixed by Tracey on our return to Mr X's home. We first visited the local IGA, where Tracey spent time with Mr X enabling him to choose exactly what he wanted, for instance his favourite brand of marmalade. Even though the IGA stocked fruit and vegetables, we went across the road to buy his fruit and vegetables from another shop that Mr X preferred. We also stopped at the local Travel Agency on the way home from shopping as Mr X was planning a trip. We waited outside the Travel Agent for about 10 minutes, while Mr X completed his business. *'Mr X likes to do these things himself. He doesn't like us to know his business' (Tracey)*. On the way home, Mr X asked if we could vary the route slightly and drive past the house he had lived in most of his life. Tracey was happy to do this and Mr X cheerfully related stories about his family and the neighbourhood as we drove home. His short term memory was indeed very poor. He asked Tracey the same question, 'When are you next coming to see me?' every 5-10 minutes throughout the entire time we were with him. She patiently answered him, as if this was the first time he had asked this question and each time drew his attention to a large calendar on the wall, where her visiting times were recorded.

Sometimes it's very, very busy, because each client you go to, it's normally full-on. You've got to get everything you can done for that client in the time you're there and then you're in the car and off to the next client. So, if you've got a few clients in one day sometimes it can be very tiring (Tracey).

Tracey spoke constantly of how much she enjoys the work, *'I love this job. It suits me well. I have no intention of giving up care work' (Tracey).*

10.2 A Day in the Working Life of Helen employed by the HCS

Helen, aged 55, is married with children 25 and 27 who are no longer living at home. She is also an informal carer for her mother, aged 80 and her mother-in-law, who is 92. She has worked as a care worker for the HCS for 10 years. Prior to care work, she worked as a receptionist in a doctor's surgery and in a residential care home. She has a Cert III and IV in aged care and specialised training in Dementia. She is a Grade 3 care worker and is qualified to provide for complex care needs.

On the working day documented below, Helen made 6 visits to 5 clients. She works long days and works split shifts. She worked from 7- 12pm and from 3- 7pm, a total of 9 hours. She works three days a week, 27 hours per week, repeating a similar pattern each day.

Helen started at 7am at the home of Mrs P. Due to a degenerative muscle disease Mrs P cannot get in or out of bed without assistance. Another care worker met Helen at Mrs P's home and the two care workers assisted Mrs P to get out of bed, prepared breakfast, assisted her to shower and dress and assisted her into her electric wheelchair. They left Mrs P at 7.30am, having made sure that everything that Mrs P needed for the day was within easy reach. Then, at 8.45am Helen visited Mrs S, who has severe disabilities and is unable to communicate. She lives with and is cared for mostly by her husband. Helen assists him with showering and feeding Mrs S. Except when Helen and Mr S take her into the shower she stays in bed all day. The next client, at 10am, was Mr J, who is a quadriplegic and like Mrs P requires assistance from Helen to get out of bed in the morning and back into bed at night. She assists him with showering and dressing, tidies the flat and makes him a sandwich for his lunch. Then at about 11am, she visits Ms H who lives alone and has just been discharged from hospital after a minor stroke. She assists Ms H with personal care and some housework, finishing up the morning shift at about noon. At 3pm she returns to work and provides in-home respite care for Ms M, who is 40 and has a severe intellectual disability. Mandy lives with her mother, who works part time. Helen meets Ms M off the bus from her Day Care Program and assists her into the home, then stays for 3 hours, feeding and talking to Ms M, who requires constant supervision and care. Her last visit of the day is back to Mr J, at 6pm, to assist with his dinner, cooking the sausages she has taken from the freezer in the morning, along with some vegetables and assists him into bed, finishing up at about 7pm.

Like Tracey, Helen was working frantically all the time, as well as telling her clients exactly what she was doing, asking questions and moderating her care as appropriate. There were, however, not as many opportunities for Helen to be flexible and to personalise her care in the ways described above for Tracey. Helen's clients had far greater needs and most lived alone, so on each visit, there was simply far more that needed to be done. She reported that, *'I'm tired at the end of the day, but I never want to stop what I'm doing' (Helen).*

She spoke of how she found it difficult to fit all she had to do into her allocated schedule. *'I am allocated 5 minutes to travel between the clients. This is not enough. I take no breaks for morning tea, lunch or afternoon tea. Although DADHC is very good to us, I just wish I could do more for my clients. I'm always rushing. You are always working against the clock - people are waiting for you, sometimes by the door, but if someone makes a mess you're going to be*

late for your next visit. It is very rarely that I finish jobs on time and I'm often working more hours and doing more than I am paid for'(Helen).

Helen also commented on changes that had taken place over the past few years that negatively impacted on her ability to do her job. *'We used to be able to take clients out for coffee and to the pictures, but we can't do that anymore. We are also no longer able to transport clients in our own cars. Sometimes we'll meet them at the shops and help them do the shopping but we can't take them in the car anymore. We used to do all that work but not anymore'.*

She doesn't want to give up care work, but has just finished a management course and is thinking maybe a day or two in the office doing field assessments may suit her in the future.

As the stories of Tracey and Helen illustrate, the working day of a care worker is full of activity. Care workers work from between 3-8 hours a day. Regardless of the hours and the pattern of hours, as can be seen from the scenarios outlined above, the working day of an average care worker is busy and packed with complex tasks, revolving around personal care, health care and social care designed to support older people, those with disabilities and their carers in their own homes, ensuring they are safe, well cared for and experience a decent quality of life.

11. Promising Practices

The findings from this research illustrate that there are many promising practices that care workers, care managers, service providers and policy makers are already implementing, albeit unevenly, across NSW. The most significant promising practice was the building in to care plans a component of social care and providing the time and the opportunity for care workers to provide individualised, flexible care to their clients. In the open ended responses in the survey, care workers also offered many suggestions of ways to enable them to provide more social care for their clients.

In Australia and Sweden the amount of time the care workers have to care for their clients is tied to the funding provided. In NSW, for example, the promising practice of providing social care is only possible if funding is allocated specifically for it. This is the case for those receiving care through the CACPs, the EACH and the EACHD packages where the funding guidelines include the provision of social care.

The care workers and care managers participating in this research also drew attention to other promising practices that are being implemented. These promising practices included:

- Care managers incorporating social care into care plans, thereby acknowledging the importance of professional interpersonal relationships between the care worker and the client and enabling the delivery of individualised personal, health and most importantly, social care.

- Care managers taking into account care workers' skills and preferences when matching care workers with clients, through active involvement by care managers in drawing up care plans and seeking continuous input from care workers in regard to their preferences.

- Care managers supporting and enabling continuity of care by organising rosters so that care workers are able to care for one person over a period of time as far as possible.

- Care managers negotiating and regularly reviewing individualised care plans in face to face meetings with clients with built in opportunities for care workers to deliver flexible, individualised care.

- Care plans that provide the time and opportunity for care workers to talk to and listen to their clients regarding their needs and wishes and to tailor the care accordingly within agreed limits.

- Care managers who organise the work to enable maximum time to be spent on direct care, through strategies such as minimising paperwork and travel time

- Care managers who take the views, knowledge and experience of care workers into account when reviewing and refining policies affecting care workers

- Care managers who hold regular staff meetings with care workers to enable care workers to support each other, exchange ideas and solve problems.

- Care managers who provide regular supervision sessions for care workers to discuss difficulties and challenges.

- Care managers who organise short training courses in response to care workers' requests.

- Care managers who support care workers to gain formal educational qualifications in ageing and disability.

- Care providers and care managers valuing past experience of care workers by a formal recognition of skills and knowledge acquired through past informal and formal work experiences.

- Care providers and care managers creating career paths and promotion opportunities for care workers.

Conclusion

One of the findings from this survey was that care workers in NSW are predominantly older and experienced workers, many taking on care work as older workers (45 and older) having previously worked in a wide range of occupations (Meagher and Healy, 2005 and 2006, Martin and King, 2008). A significant finding, not reported before in Australia, was that the majority of NSW care workers have extensive informal care experience caring for older people and those with disabilities, with as significant proportion of those surveyed still working as informal carers alongside their work as paid care workers. The care workers reported that care work was an attractive option for them, providing flexibility and autonomy.

These care workers are on the whole an older, highly experienced and highly skilled group of workers. The predominance of older workers in this sector is a distinct strength. Not only does the sector benefit from the additional experience and expertise these older workers bring to the job, but care work provides opportunities for older women to work in part time jobs that, for the most part, enable them to successfully combine work and family commitments.

However, in regard to the working conditions of care workers, some findings give rise for concern. There were clear differences between the working conditions of care workers in the HCS and the NGO sector, particularly the split shifts worked by the Home Care Service (HCS) employees and the high proportion of casuals in the NGO sector. There are also concerns in regard to the intensity of the work, particularly for HCS workers, with this group on average undertaking more intense and physically demanding work. These care workers also had a greater proportion of clients with higher needs that those working for the NGOs.

The comparison between the Swedish and NSW workers illustrated clear and rather surprising differences between the two regimes in regard to the working conditions of the care workers, and the outcome of these conditions and the effects on working and family lives of care workers. An important aim of this research was to identify promising practices. Research has demonstrated that the care workers find the most satisfaction and enjoyment from providing flexible individualised care to their clients, being able to exercise judgements and be able to see the results of their work- aspects of their work they can control (McLean 1999, Szebehely 2005, Twigg 2000, Rasmussen 2004, Fleming and Taylor 2006). The findings from the survey and the comparison with the Swedish care workers would strongly suggest that the conditions under which the NSW care workers are working, although far from ideal, do enable them to provide flexible individualised care, spend more time with their clients and exercise judgement with more control over their working day than the Swedish workers.

At the same time, there is no cause for complacency here. We need to build on the promising practices that have already been implemented by innovative service providers, care managers and care workers in NSW. The most significant findings of this research was that despite their apparently favourable working conditions, the NSW care workers still

consistently reported that they have too much to do and insufficient time to complete allocated tasks to provide what they judge to be good quality care, in particular time to provide social, emotional and psychological support to their the clients. These care workers were saying very clearly that they have too much to do and not enough time.

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Appendix 1 Participating Organisations by Service Provider Type

Type of Organisation	Name of Participating Organisation / Branch
Small NGOs	Anglicare
	Australian Red Cross
	Canterbury Multicultural Aged and Disability Support Service Inc
	Casino Neighbourhood Centre
	Coastlink Respite
	Family Resource & Network Support Inc
	Jack Towney Hostel Aboriginal Corporation
	Just Better Care
	Multicultural Home Respite Inc
	Presbyterian Aged Care
	Royal Freemasons Benevolent Institution
	Rozelle Neighbourhood Centre
	RSL Life Care
	Southern Cross Care
	Sunnyfield
	The Benevolent Society NSW
	United Protestant Association
Large NGOs	Baptist Community Services
	Catholic Healthcare Limited (includes Catholic Care)
	UnitingCare Ageing NSW ACT
HCS NSW	Bourke
	Burwood
	Canterbury
	Casino
	Chatswood
	Cobar
	Dubbo
	Gosford
	Grafton
	Hornsby
	Maclean
	Mudgee
	Narromine
	Tweed Heads
	Walgett

Appendix 2 Information Sheet: The Experiences of Care Workers

Care Workers: Would you like to tell us about the work you do?

This is an opportunity for you to participate in a research project focusing particularly on you and your work. To date, little research has been done in Australia focusing on care workers. We are very interested in the work you do, your experiences and ideas. This research project, funded by NSW Human Services Ageing, Disability and Home Care (ADHC), focuses specifically on care workers. The main aim of the research is to explore your ideas and to collect and document your knowledge and understanding of care work. We are interested in issues such as the nature of the work you do, whether it has changed, the demands and the responsibilities and the satisfaction you derive from your work.

You probably know that as Australia's population ages more and more frail older people and those with disabilities will need care and support. As this need for care increases, so will the demand for care workers. We think that caring for people in their homes, maintaining their health and quality of life in a safe and caring environment, is extremely important work. This research will provide a detailed picture of the work you do and the opportunities and the challenges the work provides. Your experiences and knowledge are very valuable to us and we would like to stress just how important and significant your contribution is.

We are conducting a large scale survey of 1000 care workers in NSW to find out more about the work you do. You and some other care workers from your organisation have been randomly selected to fill out this survey. Your name is not on the survey or on the reply paid envelope, your answers will be confidential. Your employer has agreed to participate in the study by letting us ask you if you would like to participate. It is important that you understand that you do not have to participate if you do not want to. There are no consequences if you decide not to participate.

The information collected from these surveys will be part of the final project report presented to ADHC in July 2010, as well as future articles in scholarly journals. We will send a copy of the final report to all organisations that have participated in the study for distribution to their care workers so you will be able to read for yourself the results of this study.

If you decide to help us by participating, please read the first page of the survey for instructions. Your manager or case coordinator will inform you of your options of how to return your questionnaire to us. It is important that you know that by completing and sending us the questionnaire, you are giving us your voluntary consent to participate in this study.

For those of you who have decided not to participate, we thank you for the time you have taken to read this material. For those of you who have decided to participate, many thanks for your important contribution.

Kind regards,

The Research Coordinators:
Associate Professor Jane Mears and Eva Garcia

Jane: Phone: XXXXXXXX Email: j.mears@uws.edu.au
Eva: Phone XXXXXXXXXX Email: e.garcia@uws.edu.au

This study has been approved by the University of Western Sydney Human Research Ethics Committee. The approval number is **H7339***. If you have any complaints or reservations about the ethical conduct of this research, you may contact the Ethics Committee through the* ***Research Ethics Officer (Tel: (02) 4736 0883).*** *Any issues you raise will be treated in confidence and investigated fully and you will be informed of the outcome*