Health and Community Services Industry Profile

ACIL Tasman
September 2008
Colmar Brunton Social Research
August 2008

Report commissioned by the
Australian Fair Pay Commission, 2008
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1. Health and community services industry profile – quantitative overview

ACIL Tasman
September 2008
1.1 Executive summary

This report provides a detailed profile of the Health and community services industry. The report aims to inform the Australian Fair Pay Commission's (Commission's) minimum wage reviews by providing statistical information on the industry, which has a relatively high prevalence of employees covered by the Commission's wage decisions.

Industry structure and characteristics

The industry comprises two subdivisions: Health services and Community services. These subdivisions are broken down further into the following industry classes:

- Hospitals;
- Medical services;
- Pathology and diagnostic imaging services;
- Allied health services;
- Other health care services;
- Residential care services;
- Child care services; and
- Other social assistance services.

The industry comprises a diverse group of classes with different revenue streams, skill requirements and wage rates. The Health services subdivision contains classes that generally employ more highly qualified employees with higher hourly wage rates relative to those employed in the Community services subdivision.

While the industry contains a large public sector component, many indicators presented in the report are for the private sector only. More specifically, all industry-level financial information excludes the public sector. The sections covering employment, occupations, wage rates and earnings include data from both the public and private sector.

The Health services subdivision comprises 79.8 per cent of all the revenue generated by the entire industry in 2005–06. The remainder was generated by Community services (20.2 per cent of revenue). Community services are further split between Community care services (72.9 per cent of revenue) and Child care services (27.1 per cent).

Health and community services is characterised by moderate levels of industry concentration. Income in the industry is generated predominantly from the sale of services (76 per cent in 2005–06), while an additional 16 per cent was generated by government funding for operations. Wages and salaries are by far the most significant operating expense among businesses operating in the Health and community services industry. Wages and salaries accounted for approximately 40 per cent of total operating expenses. At the industry subdivision level Community services are more labour intensive than Health services.
Industry performance

The Health and community services industry has demonstrated growth close to the average across all industries. Between 2001–02 and 2005–06 total income in Health and community services grew at an annual rate of 9.1 per cent.

Future demand for Health and community services will be underpinned by a number of factors:

- As incomes rise, and wealth increases, people allocate a larger proportion of their spending on services over manufactured goods, including health services.

- Furthermore, demand for Health and community services is going to be driven by a combination of population growth and the ageing of the population.

- The increasing incidence of obesity and physical inactivity within the population is likely to lead to an increasing prevalence of diseases such as diabetes and cardiovascular disease.

- The costs and availability of health care can also drive demand, with government funding of schemes such as Medicare and private health insurance reducing the direct cost of medical care to patients and increasing the demand for such care.

- Increasing female participation in the labour force can result in increasing demand for child care services.

Operating profit margins are significantly higher in the Health and community services industry than the average across all industries. Moreover, there is also significant variation in operating profit margins between classes within the industry. Given the high labour cost bills of businesses operating in these parts of the industry, wage rises in Hospitals and nursing homes, Child care services and Community care services are expected to have a proportionally larger impact on profitability than on other parts of the industry.

Characteristics of employment

Employment in the Health and community services industry has grown strongly over time, from 658,000 people in May 1990 to 1.12 million in May 2008. Over the last 15 years, employment growth in the industry has averaged 3.3 per cent per annum against employment growth of 2.2 per cent across all industries.

In October 2007 the Australian Government projected above-average annual employment growth in the Health and community services industry of 3 per cent per annum to 2011–12. Within the industry the fastest-growing industry class is projected to be Child care services (3.7 per cent per annum). Hospital and nursing homes and Community care services are projected to show employment growth of 3 per cent per annum and 2.8 per cent per annum respectively to the year 2011–12.

Employment in the Health and community services industry shows a higher than average prevalence of part-time workers, with about 43 per cent of workers classified as part-time in May 2008. The prevalence of casual workers across in Health and community services is 4.3 percentage points lower than the average of all industries.
Employment in Health and community services is dominated by female workers, who comprise 77.7 per cent of the workforce in Health services and 82.8 per cent of the Community services workforce.

The age distribution of the Health and community services industry shows that the workforce is relatively older compared to other industries. Labour mobility in the industry also tends to be lower than average. Data indicates that workers are more likely to remain in the industry for three to 10 years compared to workers in other industries.

**Occupational profile, productivity and wage bargaining**

The four largest employing occupations in the industry are Registered nurses, Child care workers, Special care workers and Receptionists. Occupations in the industry tend to be classified either at the very top end or at the bottom end of the Australian Bureau of Statistics' (ABS) Australian and New Zealand Standard Classification of Occupations (ANZSCO). Thus, there is a dichotomy between highly skilled and well-remunerated Registered nurses and General and Specialist medical and health practitioners, and large numbers of Child care workers and Special care workers who are low-skilled and earn below-average wages.

In 2006, three-quarters of the workforce in the Health and community services industry held a non-school qualification, with close to 40 per cent having completed a bachelor’s degree or above. A quarter of the workforce had Year 12 or lower qualifications.

In terms of wage bargaining, the majority of employees in the industry (55.8 per cent) are covered by state and federally registered collective agreements. About a quarter of employees rely on an award only as a method for wage-setting. The high reliance on collective agreements within Health and community services is largely a result of the large public sector institutional component of the industry.

**Hours worked, wages and earnings**

In May 2006 the average full-time hours (including overtime) worked in the Health and community services industry was slightly lower than the average across all industries. Hours worked in Health services were higher (39.1 hours) than in Community services, where employees worked 38.2 hours per week on average.

Part-time workers in the Health and community services industry worked more hours on average than those in other industries. In May 2008, part-time employees in the industry worked an average of between 17.7 and 20.1 hours per week depending on the class within the industry, while part-time employees across all industries averaged 17.2 hours per week.

Hourly wage rates vary quite widely in the Health and community services industry, with the higher-skilled employees in Health services earning an average hourly wage rate of $28.60 compared with $25.11 across all industries of the economy as at May 2006. Employees in Community services earned a below-average hourly wage of $22.00. Within Community services, the lowest-paid workers are in Child care services, where average full-time hourly wages were $18.20 per hour in May 2006.

Full-time average total earnings in Health and community services were $1,115 per week in May 2007, compared with $1,136 across all industries. Despite overall earnings in the industry being close to the average across the entire economy, there are significant differences in earnings between the parts of the industry. While Health services workers
are highly skilled and enjoy higher than average incomes, their counterparts in Community services tend to be employed in lower-skilled occupations with lower rates of pay. This is particularly true of Child care workers.

The differences in wage rates between permanent and casual employees, as well as between junior and adult employees, are smaller in the Health and community services industry than in other industries. While permanent employees in Health services and Community services respectively earn $1.10 and $0.60 per hour more than casuals, the difference in earnings across all industries is $4.60 per hour. Similarly, adult employees in Health services and Community services earn $13.40 and $10.60 per hour respectively more than juniors, compared with a difference of $14 across all industries.
1.2 Introduction

This report has been prepared in response to a request by the Australian Fair Pay Commission (Commission) to provide a detailed profile of the Health and community services industry. The study aims to inform the Commission's minimum wage reviews by providing statistical information about an industry with a high prevalence of employees covered by the Commission's wage decisions.

1.2.1 Study objectives

The Commission is responsible for making minimum wage decisions that affect low-paid workers across the economy including:

- workers on junior rates of pay;
- workers on training wages;
- casual and piece rate workers;
- adult workers on the Federal Minimum Wage; and
- workers receiving Australian Pay and Classification Scale wages.

The objective of this study is to provide a detailed analysis of the Health and community services industry to inform the Australian Fair Pay Commission’s decision-making.

The study focuses on:

- profitability and performance;
- industry characteristics such as cost drivers and output prices;
- characteristics of employing firms;
- characteristics of employees such as hours worked, earnings and wage rates;
- employment conditions; and
- productivity of labour and capital.

1.2.2 Report structure

The report is structured as follows:

Chapter 1.3 defines the industry. Chapter 1.4 outlines the characteristics of the industry. Chapter 1.5 looks into industry performance and trends. Chapter 1.6 analyses the level and growth of employment. Chapter 1.7 looks at occupational profile, productivity and wage bargaining, while Chapter 1.8 outlines hours worked, wages and earnings in the industry.
1.3 Industry definition

1.3.1 Industry classification

The industry classifications applied in this report are the Australian and New Zealand Industrial Classification (ANZSIC) 2006 and 1993.

The Health and community services industry division under ANZSIC 1993 has been renamed as Health care and social assistance in ANZSIC 2006. It includes organisations that are predominantly engaged in the provision of human health and social assistance.

1.3.2 Industry segments

The industry division comprises a number of industry groups, which are further divided into industry classes.

840 Hospitals

The Hospitals industry group comprises two industry classes at the 4-digit ANZSIC level:

- **8401 Hospitals** consists of hospitals engaged in the provision of facilities and services such as diagnostic, medical or surgical services.
- **8402 Psychiatric hospitals** are engaged in the provision of psychiatric, mental or behavioural disorder services.

851 Medical services

This industry group is split further into the following industry classes:

- **8511 General medical practitioner services** engaged in the independent practice of general medicine, such as registered medical practitioners operating in private or group practice.
- **8512 Specialist medical services** engaged in the provision of specialist medical services such as obstetrics, psychiatry, dermatology, etc., but not including pathology or diagnostic imaging services.

852 Pathology and diagnostic imaging services

This group is primarily involved in providing pathology laboratory or diagnostic imaging services such as ultrasound or x-ray services.

853 Allied health services

The Allied health services industry group is further subdivided into the following industry classes:

- **8531 Dental services.**
- **8532 Optometry and optical dispensing.**
- **8533 Physiotherapy services.**
- **8534 Chiropractic and osteopathic services.**
- **8539 Other allied services**, consisting of units that are unable to be classified elsewhere, such as:
Health and community services industry profile

- acupuncture;
- audiology;
- midwifery services;
- podiatry services;
- dieticians;
- naturopathic services;
- occupational therapy; and
- speech pathology.

859 Other health care services

The Other health care services group consists of the following industry classes:

- 8591 Ambulance services.
- 8599 Other health care services not elsewhere classified including health assessment services and blood bank operations.

860 Residential care services

The Residential care services group is comprised of:

- 8601 Aged care residential services including accommodation for the aged and nursing homes.
- 8609 Other residential care services engaged in the provision of residential care but not including aged care. Examples include:
  - children's homes;
  - crisis care accommodation;
  - hospices; and
  - community mental health hostels.

871 Child care services

The Child care services class includes those operations involved in providing day care for infants or children.

879 Other social assistance services

This class is involved in the provision of a wide variety of social support services, but does not include accommodation services. Examples of services falling under this category include:

- adoption services;
- Alcoholics Anonymous;
- marriage guidance services;
- youth welfare services; and
- disabilities assistance services.

1.3.3 Changes to ANZSIC classifications between 1993 and 2006

Changes between the ANZSIC 1993 and ANZSIC 2006 classifications pertaining to Health and community services are shown in Table 1 below.
Table 1: Changes between ANZSIC93 and ANZSIC06

<table>
<thead>
<tr>
<th>ANZSIC 1993 class description</th>
<th>Action</th>
<th>ANZSIC 2006 class description</th>
</tr>
</thead>
<tbody>
<tr>
<td>8611 Hospitals (except Psychiatric hospitals)</td>
<td>No change</td>
<td>8401 Hospitals</td>
</tr>
<tr>
<td>8612 Psychiatric hospitals</td>
<td>No change</td>
<td>8402 Psychiatric hospitals</td>
</tr>
<tr>
<td>8613 Nursing homes</td>
<td>Class removed, activities moved</td>
<td>The activities moved to the following ANZSIC 2006 classes: Nursing or convalescent home operation to 8601 Aged care residential services, Hospice operation to 8609 Other residential care services</td>
</tr>
<tr>
<td>8621 General practice medical services</td>
<td>No change</td>
<td>8511 General practice medical services Includes locum doctor services from ANZSIC 1993 class 8639 Health services n.e.c.</td>
</tr>
<tr>
<td>8622 Specialist medical services</td>
<td>Activities moved</td>
<td>8512 Specialist medical services Excludes: pathologist and radiologist (own account) to ANZSIC 2006 8529 Pathology and diagnostic imaging services</td>
</tr>
<tr>
<td>8623 Dental services</td>
<td>No change</td>
<td>8531 Dental services</td>
</tr>
<tr>
<td>8631 Pathology services</td>
<td>Name change, activities added</td>
<td>8520 Pathology and diagnostic imaging services, Includes: Diagnostic imaging operation and x-ray clinics from ANZSIC 1993 8639 Health services n.e.c.; Pathologist and radiologist (own account) from ANZSIC 1993 8622 Specialist medical services</td>
</tr>
<tr>
<td>8632 Optometry and optical dispensing</td>
<td>No change</td>
<td>8532 Optometry and optical imaging</td>
</tr>
<tr>
<td>8633 Ambulance services</td>
<td>No change</td>
<td>8591 Ambulance services</td>
</tr>
<tr>
<td>8634 Community Health Centres</td>
<td>Class removed, activities moved</td>
<td>Activities moved to the following ANZSIC 2006 classes: Community health centres to ANZSIC 2006 8790 Other social assistance services, Nursing services — on account of government or non-profit organisation to ANZSIC 2006 8599 Other health care services n.e.c.</td>
</tr>
<tr>
<td>8635 Physiotherapy services</td>
<td>No change</td>
<td>8533 Physiotherapy services</td>
</tr>
<tr>
<td>8636 Chiropractic services</td>
<td>Name change</td>
<td>8534 Chiropractic and osteopathic services</td>
</tr>
<tr>
<td>8639 Health services n.e.c.</td>
<td>Split into 2 classes, activities added, activities moved</td>
<td>8539 Other allied health services, Includes: Independent allied health services except dental, optometry, physiotherapy, chiropractic, and osteopathic services, Nursing services — on account of government or non-profit organisation from ANZSIC 1993 8634 Community health centres, 8599 Other health care services n.e.c.</td>
</tr>
<tr>
<td>8640 Veterinary services</td>
<td>Class moved</td>
<td>Class moved to Professional, scientific and technical services division</td>
</tr>
<tr>
<td>8710 Child care services</td>
<td>No change</td>
<td>8710 Child care services</td>
</tr>
<tr>
<td>8721 Accommodation for the aged</td>
<td>Name change, activities added</td>
<td>Includes: nursing or convalescent home operation from ANZSIC 1993 class 8613 Nursing homes</td>
</tr>
<tr>
<td>8722 Residential care services n.e.c.</td>
<td>Name change, activities added, activities moved</td>
<td>Includes: Hospice operation from ANZSIC 1993 class 8613 Nursing homes, Excludes: Juvenile correction centres to the Public Administration and safety division</td>
</tr>
<tr>
<td>8729 Non residential care services n.e.c.</td>
<td>Name change, activities added, activities moved</td>
<td>Includes: Community health centres from ANZSIC 1993 class 8634 Community health centres, Excludes: Welfare fundraising to Other services division</td>
</tr>
</tbody>
</table>


There has been a degree of movement between the ANZSIC 1993 and ANZSIC 2006 classifications.
First, a large number of the ANZSIC 1993 classes have remained unchanged. These are Hospitals, Psychiatric hospitals, General practice medical services, Dental services, Optometry and optical dispensing, Ambulance services, Physiotherapy services and Child care services.

The major changes to the classification occurred with the 8640 Veterinary services industry class which was moved to the Professional, scientific and technical services division. Two other industry classes within ANZSIC 1993 that were removed are 8613 Nursing homes and 8634 Community health centres. In the case of 8613 Nursing homes, activities within this class were moved to the industry class 8601 Aged care residential services and 8609 Other residential care services. Activities within the ANZSIC 1993 class Community health centres were split between 8790 Other social assistance services, 8539 Other allied health services, and 8599 Other health services not elsewhere classified (n.e.c.).

The ABS produces various statistics under both the ANZSIC 1993 and ANZSIC 2006 classification systems. This is an added complication. We adopt a number of strategies to deal with this difficulty. Where time series data is presented in this report, the data has been constructed under the ANZSIC 1993 classification to ensure consistency. In some cases, where point in time data is shown, it has been produced under ANZSIC 2006. In general, there has been very little movement in or out of the Health and community services industry division between ANZSIC 1993 and ANZSIC 2006, with most of the movement resulting in a reorganisation of some industry classes within the industry division only.
1.4 Industry structure and characteristics

1.4.1 Industry summary statistics

Industry division-level summary

The Health and community services industry comprises two subdivisions: Health services and Community services (see Table 2). As explained previously, each of these are further divided into industry groups.

While the industry contains a large public sector component, the financial indicators presented in both section 1.4 and section 1.5 of this report are for the private sector only. This is a key deficiency in the data presented in these sections. Except where stated otherwise, data presented in these sections excludes the public sector.

As a whole, the private sector of the industry generated total income of $65.3 billion in the 2005–06 financial year, compared with $45.3 billion in 2001–02. This represents an annualised growth in income of 9.1 per cent.

The Health and community services industry generated 3 per cent of the total income generated by all industries, making it the eighth largest industry in Australia by income in 2005–06. By comparison, the three largest industries by income were Manufacturing (16.9 per cent), Wholesale trade (16.7 per cent) and Retail trade (15 per cent). The Health and community services industry was of similar size to Agriculture, forestry and fishing (2.9 per cent) and Communication services (2.3 per cent) and considerably larger than Personal services (0.8 per cent).

The industry generated $37 billion in value added and operating profits before tax of $9.7 billion in 2005–06. Profit growth over the period has averaged a robust 14 per cent per annum.

Table 2: Health and community services (private sector) – summary statistics, 2001–02 to 2005–06

<table>
<thead>
<tr>
<th></th>
<th>Employment at end of June '000s</th>
<th>Wages and salaries $m</th>
<th>Sales and service income $m</th>
<th>Total income $m</th>
<th>Total expenses $m</th>
<th>Operating profit before tax $m</th>
<th>Industry value added $m</th>
<th>Profit margin %</th>
</tr>
</thead>
<tbody>
<tr>
<td>2001–02</td>
<td>16,515</td>
<td>34,104</td>
<td>45,375</td>
<td>39,874</td>
<td>5,525</td>
<td>25,741</td>
<td>16.2</td>
<td></td>
</tr>
<tr>
<td>2002–03</td>
<td>18,160</td>
<td>38,108</td>
<td>50,634</td>
<td>44,162</td>
<td>6,501</td>
<td>28,863</td>
<td>17.1</td>
<td></td>
</tr>
<tr>
<td>2003–04</td>
<td>19,272</td>
<td>41,592</td>
<td>54,858</td>
<td>47,544</td>
<td>7,356</td>
<td>30,738</td>
<td>17.7</td>
<td></td>
</tr>
<tr>
<td>2004–05</td>
<td>729.1</td>
<td>20,162</td>
<td>46,324</td>
<td>60,013</td>
<td>51,094</td>
<td>8,984</td>
<td>33,203</td>
<td>19.4</td>
</tr>
<tr>
<td>2005–06</td>
<td>751.5</td>
<td>22,231</td>
<td>51,832</td>
<td>65,344</td>
<td>55,784</td>
<td>9,654</td>
<td>37,002</td>
<td>18.6</td>
</tr>
</tbody>
</table>


Industry group-level summary

As can be seen in Table 3, Medical and dental services generated the highest total income ($24.2 billion) among the groups within the industry division in 2005–06. This was followed by Hospitals and nursing homes ($14.9 billion) and Other health services ($11.4 billion). Veterinary services and Child care services generated the least total income ($1.7 billion and $3.6 billion respectively).
Table 3: Industry breakdown (private sector), 2005–06

<table>
<thead>
<tr>
<th>Industry</th>
<th>Wages and salaries</th>
<th>Total income</th>
<th>Total expenses</th>
<th>Operating profit before tax</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health services (private sector)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospitals and nursing homes</td>
<td>6,902</td>
<td>14,848</td>
<td>14,050</td>
<td>837</td>
</tr>
<tr>
<td>Medical and dental services</td>
<td>5,540</td>
<td>24,187</td>
<td>18,574</td>
<td>5,626</td>
</tr>
<tr>
<td>Other health services</td>
<td>3,568</td>
<td>11,360</td>
<td>9,628</td>
<td>1,761</td>
</tr>
<tr>
<td>Veterinary services</td>
<td>426</td>
<td>1,737</td>
<td>1,549</td>
<td>192</td>
</tr>
<tr>
<td>Total health services</td>
<td>16,437</td>
<td>52,133</td>
<td>43,801</td>
<td>8,416</td>
</tr>
<tr>
<td>Community services (private sector)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child care services</td>
<td>1,553</td>
<td>3,585</td>
<td>3,127</td>
<td>459</td>
</tr>
<tr>
<td>Community care services</td>
<td>4,241</td>
<td>9,626</td>
<td>8,855</td>
<td>779</td>
</tr>
<tr>
<td>Total community services</td>
<td>5,794</td>
<td>13,211</td>
<td>11,982</td>
<td>1,238</td>
</tr>
<tr>
<td>Total Health and community services</td>
<td>22,231</td>
<td>65,344</td>
<td>55,784</td>
<td>9,654</td>
</tr>
</tbody>
</table>


Economy-wide health expenditure

According to the Australian Institute of Health and Welfare (AIHW),¹ spending on Health services across the entire economy, from private and public sources, reached a total of $87 billion in 2005–06 and represented 9 per cent of GDP.

Of this total, about two-thirds of this expenditure was made by government and the rest is funded by private individuals, private health insurance and other non-government sources. The Federal Government spent $37 billion on health in 2005–06, and an additional $22 billion was provided by state/territory and local governments.

In the 10 years to 2005–06, Federal Government health funding grew in real terms by an average of 4.9 per cent per annum. State/territory and local government funding grew by 6.2 per cent per annum in real terms over the same period.

1.4.2 Industry composition

Industry composition by revenues

Within the Health and community services industry, Health services was responsible for generating almost 80 per cent of the industry’s revenue, compared with 20 per cent for Community services (see Figure 1).

Within Health services, Medical and dental services were the largest contributors of revenue in 2005–06 (46 per cent), followed by Hospitals and nursing homes (29 per cent) (see Figure 2).

As can be seen in Figure 3, Community care services generates more than twice as much revenue as Child care services (72.9 per cent versus 27.1 per cent of the subdivision’s revenues).
Industry composition by wages and salaries

As in the case for revenues, total wages and salaries in the Health and community services industry are dominated by the Health services subdivision (74 per cent, compared with 26 per cent for Community services) (see Figure 4).

**Figure 4: Industry composition by wages and salaries (private sector) as a percentage, 2005–06**

![Pie chart showing industry composition by wages and salaries.]


Within Health services, Hospitals and nursing homes accounted for the largest share of wages and salaries in 2005–06 (42 per cent), followed by Medical and dental services (34 per cent) (see Figure 5). Recall from section 1.4.2 that Medical and dental services generated greater revenues than Hospitals and nursing homes. This suggests that Hospitals and nursing homes are more labour-intensive than the providers of Medical and dental services.

**Figure 5: Composition of Health services by wages and salaries (private sector) as a percentage, 2005–06**

![Pie chart showing composition of Health services by wages and salaries.]


Within Community services, wages and salaries paid out by Community care service providers were almost three times that paid out by Child care service providers in 2005–06 (see Figure 6).
1.4.3 Number of businesses

The number of private business operating in the industry has increased steadily in the last five years, rising from 108,816 businesses in 2001–02 to 130,268 businesses in 2005–06 (see Figure 7).

At the industry level, most of the businesses are small ones that employ fewer than 20 employees or do not have any employees, that is, they are sole proprietorships (see Table 4). In 2005–06, such businesses made up 97 per cent of the industry.
Table 4: Number of operating businesses by size (private sector), 2001–02 to 2005–06

<table>
<thead>
<tr>
<th>Year</th>
<th>Small (&lt;20 employees)</th>
<th>Medium (20–100 employees)</th>
<th>Large (&gt;100 employees)</th>
<th>Non-employing</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2001–02</td>
<td>47,774</td>
<td>4,312</td>
<td>398</td>
<td>56,333</td>
<td>108,816</td>
</tr>
<tr>
<td>2002–03</td>
<td>47,998</td>
<td>4,306</td>
<td>333</td>
<td>57,727</td>
<td>110,363</td>
</tr>
<tr>
<td>2003–04</td>
<td>49,602</td>
<td>3,973</td>
<td>339</td>
<td>63,564</td>
<td>117,478</td>
</tr>
<tr>
<td>2004–05</td>
<td>50,375</td>
<td>3,644</td>
<td>343</td>
<td>68,858</td>
<td>123,219</td>
</tr>
<tr>
<td>2005–06</td>
<td>51,531</td>
<td>3,230</td>
<td>371</td>
<td>75,137</td>
<td>130,268</td>
</tr>
</tbody>
</table>


1.4.4 Geography

As can be predicted by their relative population sizes, New South Wales had the largest Health and community services industry in Australia in 2005–06 (by wages and salaries, total income, total expenses, operating profit, and pre-tax earnings), followed by Victoria and Queensland (see Table 5).

Table 5: Industry statistics by state/territory (private sector), 2005–06

<table>
<thead>
<tr>
<th>State</th>
<th>Wages and salaries</th>
<th>Total income</th>
<th>Total expenses</th>
<th>Operating profit before tax</th>
<th>Earnings before interest, tax, depreciation and amortisation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$m</td>
<td>$m</td>
<td>$m</td>
<td>$m</td>
<td>$m</td>
</tr>
<tr>
<td>NSW</td>
<td>7,661</td>
<td>23,040</td>
<td>19,591</td>
<td>3,461</td>
<td>3,353</td>
</tr>
<tr>
<td>Victoria</td>
<td>5,609</td>
<td>16,255</td>
<td>13,936</td>
<td>2,331</td>
<td>1,896</td>
</tr>
<tr>
<td>Queensland</td>
<td>4,411</td>
<td>12,291</td>
<td>10,895</td>
<td>1,432</td>
<td>1,689</td>
</tr>
<tr>
<td>South Australia</td>
<td>1,499</td>
<td>4,838</td>
<td>3,887</td>
<td>956</td>
<td>1,002</td>
</tr>
<tr>
<td>Western Australia</td>
<td>1,927</td>
<td>5,957</td>
<td>4,915</td>
<td>1,048</td>
<td>1,068</td>
</tr>
<tr>
<td>Tasmania</td>
<td>502</td>
<td>1,275</td>
<td>1,101</td>
<td>194</td>
<td>217</td>
</tr>
<tr>
<td>Northern Territory</td>
<td>100</td>
<td>297</td>
<td>252</td>
<td>46</td>
<td>55</td>
</tr>
<tr>
<td>ACT</td>
<td>523</td>
<td>1,391</td>
<td>1,207</td>
<td>186</td>
<td>159</td>
</tr>
<tr>
<td>Australia</td>
<td>22,231</td>
<td>65,344</td>
<td>55,784</td>
<td>9,654</td>
<td>9,439</td>
</tr>
</tbody>
</table>


Figure 8 shows the share of turnover in the Health and community services industry by jurisdiction. New South Wales’ share is 35 per cent, while Victoria’s and Queensland’s are 25 per cent and 19 per cent respectively.
Figure 8: Industry size by jurisdiction (private sector) as a percentage, by turnover

<table>
<thead>
<tr>
<th>Jurisdiction</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tasmania</td>
<td>2</td>
</tr>
<tr>
<td>ACT</td>
<td>2</td>
</tr>
<tr>
<td>Western Australia</td>
<td>9</td>
</tr>
<tr>
<td>South Australia</td>
<td>7</td>
</tr>
<tr>
<td>Queensland</td>
<td>19</td>
</tr>
<tr>
<td>Victoria</td>
<td>25</td>
</tr>
<tr>
<td>NSW</td>
<td>35</td>
</tr>
<tr>
<td>Northern Territory</td>
<td>1</td>
</tr>
</tbody>
</table>


Total employment in the industry (including both private and public sector employees) by state between 1990 and 2008 is shown in Figure 9. Among the states and territories Queensland has experienced the fastest employment growth in the Health and community services industry, reflecting the population growth experienced by the state (particularly in older interstate migrants).

Figure 9: Total employment by state, 1990 to 2008


1.4.5 Industry concentration

As a whole, Health and community services appears to exhibit moderate industry concentration. The income of large businesses (those employing more than 100 workers) as a proportion of total income in the industry was 32 per cent in 2005–06.
In 2005–06, small Health and community service providers (those employing fewer than 20 workers) generated $22.3 billion in income, medium-sized providers (those employing between 20 and 100 workers) generated $10.5 billion, and large businesses generated $20.8 billion (see Figure 10). In that year non-employing businesses generated $11.7 billion in income.

Figure 10: Total income by business size, 2001–02 to 2005–06

Between 2001–02 and 2005–06 the total income of small businesses grew by an average of 8 per cent per annum, while that of medium-sized businesses, large businesses and non-employing businesses grew by 4 per cent, 11.8 per cent and 12 per cent per annum respectively.

1.4.6 Industry income sources and cost structure

Sources of income

The major sources of income for Health and community service providers are shown in Table 6. By far the largest source of income for these providers is income from services (76 per cent in 2005–06), while government funding for operations accounted for 16 per cent of total income that year (see Figure 11).
Table 6: Sources of income (private sector), 2001–02 to 2005–06

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>$m</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sales of goods</td>
<td>2,024</td>
<td>2,175</td>
<td>1,790</td>
<td>2,309</td>
<td>1,846</td>
</tr>
<tr>
<td>Income from services</td>
<td>31,353</td>
<td>35,497</td>
<td>39,268</td>
<td>43,542</td>
<td>49,554</td>
</tr>
<tr>
<td>Rent, leasing and hiring income</td>
<td>727</td>
<td>435</td>
<td>534</td>
<td>473</td>
<td>432</td>
</tr>
<tr>
<td>Funding from government for operational costs</td>
<td>8,998</td>
<td>9,731</td>
<td>9,833</td>
<td>10,158</td>
<td>10,499</td>
</tr>
<tr>
<td>Interest income</td>
<td>336</td>
<td>360</td>
<td>330</td>
<td>556</td>
<td>517</td>
</tr>
<tr>
<td>Other income</td>
<td>1,938</td>
<td>2,436</td>
<td>3,103</td>
<td>2,975</td>
<td>2,496</td>
</tr>
<tr>
<td>Total income</td>
<td>45,375</td>
<td>50,634</td>
<td>54,858</td>
<td>60,013</td>
<td>65,344</td>
</tr>
</tbody>
</table>


Figure 11: Income sources as a proportion of total income (private sector) as a percentage, 2005–06

Total expenses for the Health and community services industry rose from $39.9 billion in 2001–02 to $56.8 billion in 2005–06, or by an average of 8.4 per cent per annum (see Table 7). Labour costs (which include wages and salaries as well as other items such as superannuation) over the same period increased by an average of 7.9 per cent per annum, from $18.6 billion in 2001–02 to $25.5 billion in 2005–06. Similarly, the cost of sales rose from $18.6 billion to $26.5 million.

Table 7: Sources of expenditure (private sector), 2001–02 to 2005–06

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>$m</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Selected labour costs</td>
<td>18,629</td>
<td>20,687</td>
<td>22,032</td>
<td>23,061</td>
<td>25,539</td>
</tr>
<tr>
<td>Cost of sales</td>
<td>18,598</td>
<td>20,586</td>
<td>22,326</td>
<td>24,219</td>
<td>26,450</td>
</tr>
<tr>
<td>Depreciation and amortisation</td>
<td>1,289</td>
<td>1,488</td>
<td>1,501</td>
<td>1,741</td>
<td>1,892</td>
</tr>
<tr>
<td>Interest expenses</td>
<td>535</td>
<td>618</td>
<td>740</td>
<td>803</td>
<td>906</td>
</tr>
<tr>
<td>Other operating expenses</td>
<td>799</td>
<td>754</td>
<td>904</td>
<td>1,205</td>
<td>902</td>
</tr>
<tr>
<td>Total expenses</td>
<td>39,874</td>
<td>44,162</td>
<td>47,544</td>
<td>51,094</td>
<td>55,784</td>
</tr>
</tbody>
</table>

As Table 8 shows, wages as a proportion of total expenses in the Health and community services industry declined slightly from 41.4 per cent in 2001–02 to 39.9 per cent in 2005–06. This proportion is much higher than the average across all industries, which rose marginally from 15.5 per cent in 2001–02 to 15.8 per cent in 2005–06.

**Table 8: Wages as a proportion of total expenses (private sector), 2001–02 to 2005–06**

<table>
<thead>
<tr>
<th>Year</th>
<th>Health and community services</th>
<th>All industries</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Wages and salaries</td>
<td>Expenses</td>
</tr>
<tr>
<td></td>
<td>$m</td>
<td>$m</td>
</tr>
<tr>
<td>2001–02</td>
<td>16,515</td>
<td>39,874</td>
</tr>
<tr>
<td>2002–03</td>
<td>18,160</td>
<td>44,162</td>
</tr>
<tr>
<td>2003–04</td>
<td>19,272</td>
<td>47,544</td>
</tr>
<tr>
<td>2004–05</td>
<td>20,162</td>
<td>51,094</td>
</tr>
<tr>
<td>2005–06</td>
<td>22,231</td>
<td>55,784</td>
</tr>
</tbody>
</table>


Industry cost structure

The cost structures for Health services and Community services are shown in Figure 12 and Figure 13 respectively.

**Figure 12: Health services cost structure (private sector) as a percentage, 2005–06**

- Cost of sales: 50.1%
- Selected labour costs: 43.5%
- Depreciation and amortisation: 2.8%
- Other operating expenses: 1.8%
- Interest expenses: 1.6%


While labour costs make up 43.5 per cent of total costs among Health service providers, the proportion for Community service providers is higher, at 54 per cent. Conversely, the cost of sales is a higher proportion of total costs for Health providers than Community service providers (50.1 per cent versus 37.4 per cent). These figures suggest that Community services are even more labour-intensive than Health services.
Figure 13: Community services cost structure (private sector) as a percentage, 2005–06

Selected labour costs 54.0
Other operating expenses 1.1
Depreciation and amortisation 5.6
Interest expenses 1.8
Cost of sales 37.4


The proportion of wages to total costs or expenditures by groups within Health services is shown in Figure 14. The proportion is highest in Hospitals and nursing homes (49.1 per cent), reflecting the labour-intensive nature of their operations, and is much lower in Veterinary services (27.5 per cent) and Medical and dental services (29.8 per cent).

Figure 14: Wages and salaries as a proportion of total Health service expenses (private sector), 2005–06

<table>
<thead>
<tr>
<th>Health Service</th>
<th>Per cent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospitals and nursing homes</td>
<td>49.1</td>
</tr>
<tr>
<td>Medical and dental services</td>
<td>29.8</td>
</tr>
<tr>
<td>Other health services</td>
<td>37.1</td>
</tr>
<tr>
<td>Veterinary services</td>
<td>27.5</td>
</tr>
</tbody>
</table>


In Community services the proportion of wages to total costs is 49.7 per cent for Child care services and 47.9 per cent for Community care services.
Figure 15: Wages and salaries as a proportion of total Community service expenses (private sector), 2005–06

Per cent

50.0

<table>
<thead>
<tr>
<th></th>
<th>Per cent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child care services</td>
<td>49.7</td>
</tr>
<tr>
<td>Community care services</td>
<td>47.9</td>
</tr>
</tbody>
</table>

1.5 Industry performance

1.5.1 Current and historical performance

Table 9 presents a number of key indicators for the Health and community services industry.

The industry generated total income of $65.3 billion in 2005–06, up from $45.4 billion in 2001–02. This represents an average annual growth rate of 9.1 per cent. Over the same period expenses rose by 8.4 per cent per annum to $55.8 billion. Operating profits before tax was therefore $9.7 billion in 2005–06.

In 2005–06 the industry generated $37.0 billion in industry value added, up from $25.7 billion in 2001–02.

Wages and salaries paid by the Health and community service providers also grew over the same period, from $16.5 billion to $22.2 billion, an annual rise of 7.4 per cent.

Table 9: Key statistics of the Health and community services industry (private sector), 2001–02 to 2005–06

<table>
<thead>
<tr>
<th>Year</th>
<th>Sales and service income $m</th>
<th>Wages and salaries $m</th>
<th>Total income $m</th>
<th>Total expenses $m</th>
<th>Operating profit before tax $m</th>
<th>Industry value added $m</th>
</tr>
</thead>
<tbody>
<tr>
<td>2001–02</td>
<td>34,104</td>
<td>16,515</td>
<td>50,619</td>
<td>39,874</td>
<td>5,525</td>
<td>25,741</td>
</tr>
<tr>
<td>2002–03</td>
<td>38,108</td>
<td>18,160</td>
<td>56,268</td>
<td>44,162</td>
<td>6,501</td>
<td>28,863</td>
</tr>
<tr>
<td>2003–04</td>
<td>41,592</td>
<td>19,272</td>
<td>60,864</td>
<td>47,544</td>
<td>7,356</td>
<td>30,738</td>
</tr>
<tr>
<td>2004–05</td>
<td>46,324</td>
<td>20,162</td>
<td>66,486</td>
<td>51,094</td>
<td>8,984</td>
<td>33,203</td>
</tr>
<tr>
<td>2005–06</td>
<td>51,832</td>
<td>22,231</td>
<td>65,344</td>
<td>55,784</td>
<td>9,654</td>
<td>37,002</td>
</tr>
</tbody>
</table>


Figure 16 compares growth in these variables for the Health and community services industry against all industries between 2002–03 and 2005–06. The data indicates that the industry has performed quite similarly to the average over this period. Total income has slightly outpaced total expenses, leading to annual growth in pre-tax operating profits of approximately 13 per cent.
In comparing income growth in the Health and community services industry, non-employing and large businesses have exhibited the strongest growth between 2001–02 and 2005–06, achieving an annualised growth rate of 12 per cent. Incomes of small businesses grew by 8 per cent per annum, while that of medium-sized businesses grew by only 4 per cent per annum.

1.5.2 Drivers of industry growth

Population growth and an ageing Australian population

Demand for Health and community services is going to be driven by a combination of population growth and the ageing of the population. Population growth will have an impact on overall demand for health services and the extent of this will depend on the size, composition and distribution of that growth. For example, population growth that is dominated by migration rather than natural increase will result in a smaller increase in demand for health services in the short to medium term than it otherwise would because of the high usage of health care services by infants in the first year of life.

The ageing of the Australian population is expected to lead to greater consumption of health services. Increased life expectancy may also increase demand for particular types of health services and aged care services.

**Figure 18: Australians’ projected life expectancy, 2007 to 2047**

<table>
<thead>
<tr>
<th>Years</th>
<th>78</th>
<th>80</th>
<th>82</th>
<th>84</th>
<th>86</th>
<th>88</th>
<th>90</th>
<th>92</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2017</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2027</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2037</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2047</td>
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<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


Increasing incidence of obesity

The consumption of health services is also expected to increase due to the rising incidence of obesity and physical inactivity in the population, leading to increasing prevalence of diseases such as diabetes, hypertension, cardiovascular disease and cancer.

Rising incomes and affluence

It is a well established fact that as real incomes increase in developed economies, households allocate a larger proportion of their disposable income to services instead of manufactured goods, of which Health and community services income is a significant component. The Productivity Commission (1999) observes that as incomes rise, spending on health services increases more than proportionately, so that health care expenditures expressed as a percentage of GDP tend to increase over time.
Health and community services industry profile

Higher incomes due to steady and uninterrupted economic growth in Australia from the early 1990s onwards mean people expect and are prepared to pay for sophisticated but expensive medical and health treatments. They may also substitute privately provided services for publicly funded ones.

ABS household expenditure surveys have shown that higher income households tend to spend considerably more on specialist medical services. For example, in 2003–04, while the lowest 20 per cent gross income quintile spent 58 per cent less than the average weekly amount spent by all households on specialist doctors’ fees, the top 20 per cent gross income quintile spent 94 per cent more than the average household.

Technological advances in medicine

Advances in medical technology and pharmaceuticals increase the complexity and cost of medical treatment and increases revenues for hospitals and medical practitioners.

Technological advances have increased the capacity to treat illness and a variety of disabling conditions. According to the Productivity Commission (1999), technological advancements have increased the demand for health services by providing new treatments and by improving the safety and likelihood of success of existing treatments. Apart from offering new and improved treatment, technological advances have also made it possible to treat a wider range of patients.

Community attitudes to health care and health care education

The demand for health care will be affected by improving community attitudes to health care and education. Health care education can help people monitor and improve their state of health. In some cases, health education campaigns such as anti-smoking campaigns encourage people to adopt healthier lifestyles, thus reducing the future demand for health services, while in other cases they may encourage people to seek treatment for conditions, resulting in an increase in demand for health services.

Cost and availability of health care

Government funding of schemes such as Medicare, veterans’ healthcare, workers’ compensation, traffic accident compensation and private health insurance may reduce the direct cost of medical care to patients and consequently increase the demand for such care.

Increasing female labour force participation

Increasing participation of females in the labour force and prevalence of dual-income households is likely to result in increasing demand for child care services, particularly in instances where grandparents and other extended family members do not support or assist parents.

The rate of female participation in employment has been increasing steadily over the last 25 years. Moreover, the rise in female participation is expected to continue to increase. As a result, an increasing number of mothers with young children in the workforce will drive an increase in demand for child care services. Moreover, in the last few years there has been an increase in the female fertility rate. Although still significantly below historical highs, this has the effect of adding to the demand for child care services.
1.5.3 Profitability

The total pre-tax operating profits of the Health and community services industry has increased steadily and significantly from $5.5 billion in 2001–02 to $9.7 billion in 2005–06 (see Figure 19). This corresponds to an average growth rate of 14 per cent.

Of the $9.7 billion total in 2005–06, small businesses contributed $3.1 billion, medium-sized businesses $0.8 billion and large businesses $1.7 billion. In that year, non-employing businesses were the largest contributor to the industry's operating profits at $4.1 billion. The corresponding figures in 2001–02 for the four business size categories were $2 billion, $0.5 billion, $0.6 billion and $2.4 billion respectively.

Between 2001–02 and 2005–06 the average annual growth rate in the pre-tax operating profits of large businesses (25 per cent) was more than twice that of small businesses (10.9 per cent).

Figure 19: Operating profit before tax (private sector), 2001–02 to 2005–06

$ million

<table>
<thead>
<tr>
<th>Year</th>
<th>Pre-tax Operating Profits (million)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2001–02</td>
<td>5,525</td>
</tr>
<tr>
<td>2002–03</td>
<td>6,501</td>
</tr>
<tr>
<td>2003–04</td>
<td>7,356</td>
</tr>
<tr>
<td>2004–05</td>
<td>8,984</td>
</tr>
<tr>
<td>2005–06</td>
<td>9,654</td>
</tr>
</tbody>
</table>


The average operating margin in the Health and community services industry has varied between 17.1 per cent and 19.4 per cent from 2001–02 to 2005–06 (see Figure 20).
As can be seen in Figure 21, pre-tax operating margins vary significantly between groups within the Health and community services industry. The margin ranges from 5.6 per cent (Hospitals and nursing homes) to 23.3 per cent (Medical and dental services). Within Community services, Child care service providers are considerably more profitable than Community care service providers (12.8 per cent versus 8.1 per cent).
Figure 22 shows the proportion of businesses in Health services that made a profit or loss, or broke even between 2001–02 and 2005–06. In any given year, between 17.1 per cent and 20.5 per cent of such businesses sustained losses.

**Figure 22: Proportion of Health service businesses that made a profit, broke even or made a loss (private sector), 2001–02 to 2005–06**

<table>
<thead>
<tr>
<th>Year</th>
<th>Made a profit</th>
<th>Broke even</th>
<th>Made a loss</th>
</tr>
</thead>
<tbody>
<tr>
<td>2001–02</td>
<td>77.5</td>
<td>3.3</td>
<td>19.2</td>
</tr>
<tr>
<td>2002–03</td>
<td>81.0</td>
<td>1.5</td>
<td>17.5</td>
</tr>
<tr>
<td>2003–04</td>
<td>78.7</td>
<td>0.8</td>
<td>20.5</td>
</tr>
<tr>
<td>2004–05</td>
<td>79.3</td>
<td>1.0</td>
<td>19.7</td>
</tr>
<tr>
<td>2005–06</td>
<td>81.2</td>
<td>1.7</td>
<td>17.1</td>
</tr>
</tbody>
</table>


Figure 23 shows the proportion of businesses in Community services that made a profit or loss, or broke even between 2001–02 and 2005–06. In any given year, between 21.2 per cent and 25.2 per cent of such businesses sustained losses. This is consistently higher than that for Health services.

**Figure 23: Proportion of Community service businesses that made a profit, broke even or made a loss (private sector), 2001–02 to 2005–06**

<table>
<thead>
<tr>
<th>Year</th>
<th>Made a profit</th>
<th>Broke even</th>
<th>Made a loss</th>
</tr>
</thead>
<tbody>
<tr>
<td>2001–02</td>
<td>72.8</td>
<td>2.0</td>
<td>25.2</td>
</tr>
<tr>
<td>2002–03</td>
<td>74.2</td>
<td>3.5</td>
<td>22.2</td>
</tr>
<tr>
<td>2003–04</td>
<td>76.1</td>
<td>2.7</td>
<td>21.2</td>
</tr>
<tr>
<td>2004–05</td>
<td>73.4</td>
<td>3.3</td>
<td>23.3</td>
</tr>
<tr>
<td>2005–06</td>
<td>75.6</td>
<td>1.4</td>
<td>22.0</td>
</tr>
</tbody>
</table>

1.6 Characteristics of employment

1.6.1 Employment level and growth

The employment statistics presented in this section include workers in both the public and private sectors. The same is true of data presented in section 1.7 and section 1.8.

Employment growth in the Health and community services industry has been robust over the last two decades, rising from 658,000 in May 1990 to 1.12 million in May 2008 (see Figure 24). This reflects an average annual growth rate of 3 per cent.

Figure 24: Total employment in Health and community services, 1990 to 2008

Employment (’000s)

<table>
<thead>
<tr>
<th>Year</th>
<th>Employment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1990</td>
<td>658,000</td>
</tr>
<tr>
<td>1991</td>
<td>691,000</td>
</tr>
<tr>
<td>1992</td>
<td>715,000</td>
</tr>
<tr>
<td>1993</td>
<td>737,000</td>
</tr>
<tr>
<td>1994</td>
<td>756,000</td>
</tr>
<tr>
<td>1995</td>
<td>775,000</td>
</tr>
<tr>
<td>1996</td>
<td>794,000</td>
</tr>
<tr>
<td>1997</td>
<td>813,000</td>
</tr>
<tr>
<td>1998</td>
<td>824,000</td>
</tr>
<tr>
<td>1999</td>
<td>836,000</td>
</tr>
<tr>
<td>2000</td>
<td>848,000</td>
</tr>
<tr>
<td>2001</td>
<td>861,000</td>
</tr>
<tr>
<td>2002</td>
<td>875,000</td>
</tr>
<tr>
<td>2003</td>
<td>889,000</td>
</tr>
<tr>
<td>2004</td>
<td>903,000</td>
</tr>
<tr>
<td>2005</td>
<td>917,000</td>
</tr>
<tr>
<td>2006</td>
<td>931,000</td>
</tr>
<tr>
<td>2007</td>
<td>946,000</td>
</tr>
<tr>
<td>2008</td>
<td>1,120,000</td>
</tr>
</tbody>
</table>


Figure 25 shows that, despite a steady rising trend in the level of employment in the Health and community services industry, annual changes in employment can be quite volatile. For example, an increase in employment of 52,100 in 1998 was followed by a 10,500 decline in employment the following year and a rebound of 44,700 in 2000.

Figure 25: Change in employment in Health and community services, 1990 to 2008

Employment (’000s)

<table>
<thead>
<tr>
<th>Year</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>1990</td>
<td>21,400</td>
</tr>
<tr>
<td>1991</td>
<td>21,400</td>
</tr>
<tr>
<td>1992</td>
<td>25,000</td>
</tr>
<tr>
<td>1993</td>
<td>28,600</td>
</tr>
<tr>
<td>1994</td>
<td>32,200</td>
</tr>
<tr>
<td>1995</td>
<td>35,800</td>
</tr>
<tr>
<td>1996</td>
<td>39,400</td>
</tr>
<tr>
<td>1997</td>
<td>43,000</td>
</tr>
<tr>
<td>1998</td>
<td>46,600</td>
</tr>
<tr>
<td>1999</td>
<td>50,200</td>
</tr>
<tr>
<td>2000</td>
<td>53,800</td>
</tr>
<tr>
<td>2001</td>
<td>57,400</td>
</tr>
<tr>
<td>2002</td>
<td>61,000</td>
</tr>
<tr>
<td>2003</td>
<td>64,600</td>
</tr>
<tr>
<td>2004</td>
<td>68,200</td>
</tr>
<tr>
<td>2005</td>
<td>71,800</td>
</tr>
<tr>
<td>2006</td>
<td>75,400</td>
</tr>
<tr>
<td>2007</td>
<td>79,000</td>
</tr>
<tr>
<td>2008</td>
<td>82,600</td>
</tr>
</tbody>
</table>

Total employment growth in the Health and community services industry is shown in Figure 26 against growth across all industries.

**Figure 26: Annualised growth rates of total employment in Health and community services (to May 2008)**

<table>
<thead>
<tr>
<th>Per cent</th>
<th>1 year</th>
<th>2 year</th>
<th>5 year</th>
<th>10 year</th>
<th>15 year</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2.4</td>
<td>2.2</td>
<td>3.9</td>
<td>3.2</td>
<td>3.3</td>
</tr>
</tbody>
</table>


Over a 15-year period, annualised growth in employment in Health and community services has been 3.3 per cent per annum versus 2.2 per cent across all industries (that is, 50 per cent higher). However, in the last two years employment growth in Health and community services has not out-performed the economy-wide average.

Figure 27 presents the level of employment in Health and community services by state/territory between 1990 and 2008. All states and territories experienced positive average employment growth in Health and community services over this time period.
The main regions where Health and community services jobs are located are shown in Figure 28. As expected, most of the jobs in the industry are found in the major capital cities. Employment is also substantial in regional areas such as the Hunter region and the NSW North Coast, Western Victoria, and Central and North Queensland.
As can be seen in Figure 29, employment growth in Health and community services in the last decade has been strongest in Victoria (averaging 3.4 per cent per annum), closely followed by Queensland (3.3 per cent), South Australia (3.2 per cent) and New South Wales (3.1 per cent). In the last five years, employment growth across states/territories has been more divergent, ranging from 0.3 per cent per annum in the Northern Territory to 5.7 per cent per annum in Tasmania. Over a 10-year period employment growth has been most consistent in New South Wales and most volatile in the Northern Territory.
1.6.2 Projected employment growth

Projections released by the Australian Government in October 2007 of employment growth to 2011–12 are shown in Figure 30.

Employment in Health and community services is projected to grow by 3 per cent per annum between 2007–08 and 2011–12, compared with 1.3 per cent for all industries. Of the various groups in the Health and community services industry, Child care services are projected to produce the fastest employment growth, at 3.7 per cent per annum. These projections suggest that the Health and community services industry will be a significant creator of jobs for the Australian economy in the next three to four years.
1.6.3 Full-time versus part-time

Figure 31 shows the breakdown of employment in the Health and community services industry by full- and part-time employment. Overall, in May 2008, 57.3 per cent of employment in the industry was on a full-time basis, compared with 71.2 per cent across all industries. Conversely, part-time employment is more pronounced in Health and community services than in most other industries.

Examining the split between full-time and part-time employment in Health and community services across states and territories, the Northern Territory appears to stand out in having a much greater proportion of full-time workers.

Full-time and part-time employment by industry group in May 2008 is shown in Figure 32. Hospitals are by far the largest employers in the Health and community services industry, with nearly 230,000 full-time employees and more than 120,000 part-time employees. Part-time work is prevalent in the industry, particularly in Medical services, Child care services, Residential care services and Other social assistance services. In the last two of these industry groups, part-time employees currently outnumber full-time employees.

Figure 32: Employment by industry group and work mode, May 2008

Permanent/fixed-term versus casual employees

Figure 33 shows the breakdown of the Health and community services workforce into permanent/fixed-term and casual employees. As at May 2006, 16 per cent of employees in the industry were employed on a casual basis. This compares to 20.3 per cent of workers across all industries, and indicates that casual employment in Health and community services is lower than the average across all industries.
Figure 33: Permanent/fixed-term versus casual employees – proportion of all employees, May 2006

<table>
<thead>
<tr>
<th>Per cent</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>All industries</td>
<td>Health and community services</td>
</tr>
<tr>
<td>90</td>
<td>84.0</td>
<td>79.7</td>
</tr>
<tr>
<td>80</td>
<td></td>
<td>16.0</td>
</tr>
<tr>
<td>70</td>
<td></td>
<td>20.3</td>
</tr>
</tbody>
</table>

Source: ABS, Employee Earnings and Hours, Catalogue No. 6306.0, Canberra, ABS, 2007.

1.6.4 Gender

As can be seen in Figure 34, female employees (both full-time and part-time) heavily outnumber their male counterparts in Health services, forming 77.7 per cent of the workforce in this part of the industry.

Female employees are roughly evenly split between full-time workers and part-time workers, while the majority of male employees in Health services work full-time. However, full-time male employees form only 18.4 per cent of the Health services workforce, compared to the average of 46.4 per cent across all Australian industries.
Figure 34: Employment share by gender – Health services

Employment shares by gender and the full-time/part-time split in Community services are shown in Figure 35. The gender bias is even more pronounced here than in Health services. Full-time and part-time female employees constitute 82.8 per cent of all employees in this part of the industry. Among female employees, part-time workers outnumber full-time ones (42.5 per cent versus 40.3 per cent).

Figure 35: Employment share by gender – Community services
In the last decade female employment has increased by 170,300, compared with only 35,900 for male employment (see Figure 36).

**Figure 36: 10-year growth in employment – Health services**

![Figure 36](image)


In Community services, female employment grew by 75,600 over the last decade, compared with 10,100 for male employment (see Figure 37).

**Figure 37: 10-year growth in employment – Community services**

![Figure 37](image)


At the industry class level, as can be seen in Figure 38, the dominance of female employment is particularly striking in Residential care services and Child care services (where females outnumber males by more than 10 to one).
1.6.5 Age profile

The distribution of workers by age in the Health and community services industry is shown in Figure 39. The 45–54 age group is the largest, with 306,600 workers, followed by the 35–44 age group, with 258,100 workers.
As can be seen in Figure 40, there are relatively more older workers in the Health and community services industry compared with other industries. This age profile may reflect multiple factors, such as the value of experience and qualifications in the industry, or work in the industry being relatively less physically challenging than that in primary industry and manufacturing.

**Figure 40: Distribution of workers by age in comparison to all industries**

The relatively older age profile of the Health and community services industry is further reflected by the proportion of the industry’s workforce that are classified as junior versus adult workers. Figure 41 shows that only 1 per cent of employees in the industry are comprised of junior workers compared with 6.1 per cent across all industries.
1.6.6 Duration of employment

The degree of industry attachment for Health and community service workers compared with those in other industries is shown in Figure 42. The data indicates that Health and community service workers are more likely to remain in the industry for three to 10 years than their counterparts in other industries.
1.6.7 Unemployment

Figure 43 shows the number of unemployed persons who were previously employed in the Health and community services industry. This number has fluctuated considerably, but shows a slight downward trend between 2001 and 2008, perhaps reflecting a robust economy that was showing increasing signs of labour and skills shortages.

![Figure 43: Unemployed persons previously employed in the Health and community services industry, 2001 to 2008](image)

**Number of persons (’000s)**

<table>
<thead>
<tr>
<th>Year</th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>2001</td>
<td>24</td>
<td>23</td>
<td>22</td>
<td>21</td>
<td>20</td>
<td>19</td>
<td>18</td>
<td>17</td>
</tr>
<tr>
<td>2002</td>
<td>16</td>
<td>16</td>
<td>15</td>
<td>15</td>
<td>15</td>
<td>15</td>
<td>15</td>
<td>15</td>
</tr>
</tbody>
</table>

1.7 Occupational profile, productivity and wage bargaining

1.7.1 Occupations

The major occupations in the Health and community services industry by level of employment are shown in Figure 44. Registered nurses are by far the largest group, totalling 158,000 in February 2007, followed by Child care workers (75,800), Special care workers (70,300), Personal care and nursing assistants (62,300) and Receptionists (62,000). There were 38,500 Generalist medical practitioners and 28,800 Enrolled nurses in the industry in February 2007.

**Figure 44: Top 20 employing occupations in Health and community services, year to February 2007**

In Table 10 we rank the same occupations by skill level. The ANZSCO assigns occupations to five skill levels on the basis of required qualifications and experience, with a rating of 1 indicating the highest skill level and a rating of 5 the lowest. A skill level of 1 is commensurate with a bachelor’s degree or higher qualification. A skill level of 2 is a level of skill commensurate with an associate degree, associate diploma or diploma. Skill levels 3 and 4 are occupations with a skill level commensurate with a certificate II and certificate III. Finally, an occupation with skill level 5 is a level of skill commensurate with a certificate I or the completion of compulsory secondary education.

The top 20 occupations in the Health and community services industry are split between very highly skilled medical occupations such as Registered nurses and medical practitioners, with a skill level of 1, and low skill occupations such as Children's and Special...
care workers, Receptionists and Personal care and nursing assistants, with skill levels of 4 or 5. There were 271,000 and 106,400 skill level 1 and skill level 2 workers respectively in the Health and community services industry in 2007. This is compared with 294,200 workers with a skill level of 4 and 47,800 employees with a skill level of 5.

Table 10: Top 20 employing occupations ranked by ANZSCO skill level

<table>
<thead>
<tr>
<th>Occupation</th>
<th>Thousands</th>
<th>ANZSCO skill level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Registered nurses</td>
<td>158.0</td>
<td>1</td>
</tr>
<tr>
<td>Generalist medical practitioners</td>
<td>38.5</td>
<td>1</td>
</tr>
<tr>
<td>Specialist medical practitioners</td>
<td>20.0</td>
<td>1</td>
</tr>
<tr>
<td>Medical technical officers</td>
<td>17.5</td>
<td>1</td>
</tr>
<tr>
<td>Physiotherapists</td>
<td>13.0</td>
<td>1</td>
</tr>
<tr>
<td>Dental practitioners</td>
<td>12.0</td>
<td>1</td>
</tr>
<tr>
<td>Registered midwives</td>
<td>12.0</td>
<td>1</td>
</tr>
<tr>
<td>Enrolled nurses</td>
<td>28.8</td>
<td>2</td>
</tr>
<tr>
<td>Office managers</td>
<td>25.0</td>
<td>2</td>
</tr>
<tr>
<td>Welfare and community workers</td>
<td>22.3</td>
<td>2</td>
</tr>
<tr>
<td>Dental assistants</td>
<td>16.8</td>
<td>2</td>
</tr>
<tr>
<td>Welfare associate professionals</td>
<td>13.5</td>
<td>2</td>
</tr>
<tr>
<td>Children’s care workers</td>
<td>75.8</td>
<td>4</td>
</tr>
<tr>
<td>Special care workers</td>
<td>70.3</td>
<td>4</td>
</tr>
<tr>
<td>Receptionists</td>
<td>62.0</td>
<td>4</td>
</tr>
<tr>
<td>Personal care and nursing assistants</td>
<td>62.0</td>
<td>4</td>
</tr>
<tr>
<td>Secretaries and personal assistants</td>
<td>12.3</td>
<td>4</td>
</tr>
<tr>
<td>General clerks</td>
<td>11.8</td>
<td>4</td>
</tr>
<tr>
<td>Kitchen hands</td>
<td>25.3</td>
<td>5</td>
</tr>
<tr>
<td>Cleaners</td>
<td>22.5</td>
<td>5</td>
</tr>
</tbody>
</table>


1.7.2 Qualifications

In 2006, 75.1 per cent of the workforce in the Health and community services industry had a non-school qualification (see Figure 45). More specifically, 37.8 per cent had a bachelor degree or above, 14.5 per cent had an advanced diploma or diploma, 14.8 per cent had a certificate III or IV, and 4.7 per cent had a certificate I or II. By contrast, 24.9 per cent of the Health and community services workforce had Year 12 or lower qualifications.
1.7.3 Training

According to the National Centre for Vocational Education Research (NCVER (2008)), the majority of employers in the Health and community services industry provide some form of training, with most of it provided on an informal and on-the-job basis. While 54 per cent of employers in all industries are engaged in some way with the VET system, the proportion in Health and community services is above average, with 59 per cent of employers engaged with VET. Overall, 94 per cent of employers in the Health and community services industry provide some form of training to their employees.

Figure 46 shows the number of hours of training conducted by industry in 2005. In 2005, 16.7 million hours of training were conducted in Health and community services, compared with an average of 7.9 million hours across all industries. This is significantly above the average across all industries and reflects the highly skilled nature of employment in the industry, requiring continuing up-skilling and professional development.

Figure 46: Total training hours completed by industry, 2005

<table>
<thead>
<tr>
<th>Industry</th>
<th>Hours ('000s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Industries</td>
<td>21,808</td>
</tr>
<tr>
<td>Personal and other services</td>
<td>2,397</td>
</tr>
<tr>
<td>Government administration and defence</td>
<td>12,009</td>
</tr>
<tr>
<td>Health and community services</td>
<td>12,903</td>
</tr>
<tr>
<td>Education</td>
<td>21,808</td>
</tr>
<tr>
<td>Finance and insurance</td>
<td>16,662</td>
</tr>
<tr>
<td>Communication services</td>
<td>9,014</td>
</tr>
<tr>
<td>Transport and storage</td>
<td>7,871</td>
</tr>
<tr>
<td>Accommodation, cafés and restaurants</td>
<td>10,078</td>
</tr>
<tr>
<td>Retail trade</td>
<td>5,093</td>
</tr>
<tr>
<td>Wholesale trade</td>
<td>10,066</td>
</tr>
<tr>
<td>Construction</td>
<td>4,984</td>
</tr>
<tr>
<td>Manufacturing</td>
<td>2,591</td>
</tr>
<tr>
<td>Electricity, gas and water supply</td>
<td>2,842</td>
</tr>
<tr>
<td>Mining</td>
<td>931</td>
</tr>
<tr>
<td>Agriculture, forestry and fishing</td>
<td>2.6</td>
</tr>
</tbody>
</table>


Figure 47 presents the number of training hours per employee by industry. The number of training hours completed per employee in the Health and community services industry was 16.4 hours in 2005. This is about 22 per cent higher than the number of training hours per capita across all industries. In 2005, each employee across all industries completed an average of 13.4 hours of training.

Figure 47: Training hours completed per employee by industry, 2005

<table>
<thead>
<tr>
<th>Industry</th>
<th>Hours per person</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Industries</td>
<td>13.4</td>
</tr>
<tr>
<td>Personal and other services</td>
<td>8.5</td>
</tr>
<tr>
<td>Government administration and defence</td>
<td>17.9</td>
</tr>
<tr>
<td>Education</td>
<td>47.3</td>
</tr>
<tr>
<td>Health and community services</td>
<td>18.4</td>
</tr>
<tr>
<td>Cultural and recreational services</td>
<td>8.5</td>
</tr>
<tr>
<td>Transport and storage</td>
<td>21.6</td>
</tr>
<tr>
<td>Communication services</td>
<td>11.7</td>
</tr>
<tr>
<td>Property and business services</td>
<td>25.8</td>
</tr>
<tr>
<td>Finance and insurance</td>
<td>11.0</td>
</tr>
<tr>
<td>Construction</td>
<td>31.3</td>
</tr>
<tr>
<td>Wholesale trade</td>
<td>11.7</td>
</tr>
<tr>
<td>Retail trade</td>
<td>5.8</td>
</tr>
<tr>
<td>Electricity, gas and water supply</td>
<td>6.7</td>
</tr>
<tr>
<td>Manufacturing</td>
<td>23.0</td>
</tr>
<tr>
<td>Agriculture, forestry and fishing</td>
<td>2.6</td>
</tr>
</tbody>
</table>

Figure 48 shows the total expenditures on training made where the cost was incurred by the participant, in 2005. Expenditure in the Health and community services industry was found to be the highest across all industries by a significant margin, with total expenditures of $44.5 million, compared with the average across all industries of $9.8 million.

In addition, the ABS estimates that the amount spent on training by employers in the Health and community services industry amounted to $383 per employee compared with the all-industry average of $458 per employee in 2001–02. This is below the industry average and is surprising given the significantly above-average training costs incurred by employees in the industry.

**Figure 48: Total training costs incurred by participants by industry, 2005**

<table>
<thead>
<tr>
<th>Industry</th>
<th>Dollars (‘000s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agriculture, forestry and fishing</td>
<td>1,183</td>
</tr>
<tr>
<td>Mining</td>
<td>2,019</td>
</tr>
<tr>
<td>Manufacturing</td>
<td>6,681</td>
</tr>
<tr>
<td>Electricity, gas and water supply</td>
<td></td>
</tr>
<tr>
<td>Construction</td>
<td></td>
</tr>
<tr>
<td>Wholesale trade</td>
<td>4,877</td>
</tr>
<tr>
<td>Retail trade</td>
<td>2,816</td>
</tr>
<tr>
<td>Accommodation, cafes and restaurants</td>
<td>9,771</td>
</tr>
<tr>
<td>Transport and storage</td>
<td>3,279</td>
</tr>
<tr>
<td>Communication services</td>
<td>5,381</td>
</tr>
<tr>
<td>Finance and insurance</td>
<td>1,043</td>
</tr>
<tr>
<td>Property and business services</td>
<td>7,493</td>
</tr>
<tr>
<td>Government administration and defence</td>
<td>28,441</td>
</tr>
<tr>
<td>Health and community services</td>
<td>15,780</td>
</tr>
<tr>
<td>Cultural and recreational services</td>
<td>44,547</td>
</tr>
<tr>
<td>Personal and other services</td>
<td>4,807</td>
</tr>
<tr>
<td><strong>All Industries</strong></td>
<td>8,813</td>
</tr>
</tbody>
</table>


Figure 49 presents the same information as in Figure 48, but on a per employee basis.

The figure shows that the average employee in the Health and community services industry spent $43.80 on training. This is the highest level of training expenditure by employees among all industries.
1.7.4 Labour productivity

The provision of the Health services industry involves the use of physical and intellectual resources (inputs) to produce goods and services (outputs). Inputs include the health workforce (staff and their skills), buildings, land, technology, medical supplies, food, bed linen, office supplies and utilities. As noted in Gabbitas and Jeffs (2007), the outputs of the health industry are numerous and vary substantially in character, encompassing consultative and procedural services delivered in a range of community and institutional settings. They include general practitioner consultations, acute care treatments (such as hip replacements, cataract operations, organ transplants and oncology treatments), immunisations, staff training and scientific research. These outputs bestow benefits upon individuals and society (outcomes).

Productivity is the quantity of goods and services produced by the health industry per unit of input. As such, it incorporates the technical efficiency with which inputs are turned into outputs. Technical efficiency can be measured as the extent to which the same output can be produced using fewer inputs or the extent to which output can be increased using the same inputs.

The ABS measure of labour productivity in Health and community services – gross value added (GVA) per hour worked – grew at an average rate of 1.2 per cent per year between 1985–86 and 2006–07. While positive, this growth rate is lower than the 1.6 per cent average across all industries. In particular, the growth in labour productivity in the industry appears to have stalled since 2002–03 (although the slowdown in productivity growth has also been evident in other Australian industries). The 1.2 per cent growth rate for Health and community services is a consequence of the 4 per cent growth in GVA exceeding the 2.8 per cent growth in hours worked.
Figure 50: Health and community services labour productivity, 1985–86 to 2006–07

Index (2004–05 = 100)

The ABS measure of labour productivity indicates changes in GVA per hour worked and, as such, reflects the contribution of all factors of production and not just labour. For example, an increase in output from capital deepening – an increase in the capital intensity of production – would show up as an increase in measured labour productivity even though labour is not any more productive per hour worked. Because some of the ABS estimates of outputs and inputs within the health industry are not independently derived, the ABS classifies the Health services in its ‘non-market’ sector. The ABS does not measure capital services in the non-market sector. Consequently, the ABS series, as presented, do not allow measured changes in labour productivity for Health and community services to be decomposed into its constituent parts such as capital deepening and multifactor productivity growth.

The ABS does not explicitly adjust health outputs in the Australian National Accounts for changes in quality over time. As noted in Productivity Commission (2005), some aspects of health care quality are difficult to measure, such as the impact of illness and the resulting treatment on patient well-being (morbidity) or the contemporaneous skill of medical staff in operations.

1.7.5 Unionisation of the workforce

As Figure 51 shows, union membership in the Health and community services industry has been steadily declining. In Health services, union membership declined from just above 40 per cent in 1994 to just below 30 per cent in 2007. In Community services, membership fell from approximately 23 per cent in 1994 to below 15 per cent in 2007.
While union membership has declined throughout the Health and community services industry, the level of membership continues to vary significantly between groups within the industry (see Figure 52). For example, union membership in Hospitals was 43.5 per cent in 2007, compared with 13.2 per cent in Medical and other health care services and 13.8 per cent in Social assistance service. Union membership in Residential care services was 26.6 per cent in 2007.
1.7.6 Wage bargaining

Figure 53 shows the proportion of workers in Health and community services under various types of labour market agreements. Compared with other industries, Health and community service workers are more likely to enter into a state registered collective agreement rather than an unregistered individual agreement. They are also more likely to be on an award containing minimum terms and conditions of employment.

Figure 53: Type of agreement in wage bargaining, May 2006

1.8 Hours worked, wages and earnings

1.8.1 Hours worked

As can be seen in Figure 54, average hours worked per week in the Health and community services industry in the May quarter of 2008 was 38.1 for full-time employees and 19.1 for part-time workers. The average across all industries was 41 and 17.2 respectively. This indicates that full-time employees in Health and community services work fewer hours than their counterparts in most other industries, while the reverse is true for part-time employees.

However, the average hours worked in Health and community services masks considerable variations within the industry. For example, full-time Child care employees worked an average of 35.7 hours per week, compared with 41 hours in Allied health services. Part-time Child care employees worked an average of 17.7 hours per week, compared with 20.1 hours for Hospital workers.

Figure 54: Average hours worked, full-time versus part-time, May 2008

As can be seen in Figure 55, full-time male employees in Health and community services tend to work longer hours a week than their female counterparts, particularly in Child care services. On the other hand, in Residential care services, full-time male employees tend to work slightly fewer hours per week than their female counterparts.

Health and community services industry profile

Figure 55: Average weekly hours worked by full-time employees, May 2008

<table>
<thead>
<tr>
<th>Industry</th>
<th>Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health care and social assistance industry</td>
<td>37.1</td>
</tr>
<tr>
<td>Hospitals</td>
<td>40.7</td>
</tr>
<tr>
<td>Medical services</td>
<td>36.5</td>
</tr>
<tr>
<td>Pathology and diagnostic imaging services</td>
<td>37.1</td>
</tr>
<tr>
<td>Allied health services</td>
<td>35.7</td>
</tr>
<tr>
<td>Other health care services</td>
<td>39.0</td>
</tr>
<tr>
<td>Residential care services</td>
<td>36.5</td>
</tr>
<tr>
<td>Child care services</td>
<td>34.6</td>
</tr>
<tr>
<td>Other social assistance services</td>
<td>37.9</td>
</tr>
<tr>
<td>All industries</td>
<td>38.4</td>
</tr>
</tbody>
</table>

On the whole, average hours worked per week in the Health and community services industry are lower than that for all other industries except Education (see Figure 56).

Figure 56: Average total hours of work paid for per week by industry, full-time employees, May 2006

<table>
<thead>
<tr>
<th>Industry</th>
<th>Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mining</td>
<td>45.5</td>
</tr>
<tr>
<td>Manufacturing</td>
<td>41.2</td>
</tr>
<tr>
<td>Electricity, gas and water supply</td>
<td>40.0</td>
</tr>
<tr>
<td>Construction</td>
<td>42.1</td>
</tr>
<tr>
<td>Wholesale trade</td>
<td>40.1</td>
</tr>
<tr>
<td>Retail trade</td>
<td>39.3</td>
</tr>
<tr>
<td>Accommodation, cafes and restaurants</td>
<td>40.1</td>
</tr>
<tr>
<td>Transport and storage</td>
<td>43.2</td>
</tr>
<tr>
<td>Communication services</td>
<td>39.1</td>
</tr>
<tr>
<td>Finance and insurance</td>
<td>38.4</td>
</tr>
<tr>
<td>Property and business services</td>
<td>39.4</td>
</tr>
<tr>
<td>Education</td>
<td>36.5</td>
</tr>
<tr>
<td>Health and community services</td>
<td>38.3</td>
</tr>
<tr>
<td>Cultural and recreational services</td>
<td>38.7</td>
</tr>
<tr>
<td>Personal and other services</td>
<td>39.5</td>
</tr>
<tr>
<td>All industries</td>
<td>40.2</td>
</tr>
</tbody>
</table>


Source: ABS, Employee Earnings and Hours, Catalogue No. 6306.0, Canberra, ABS, 2007.
As can be seen in Figure 57, within the Health and community services industry, as at May 2006 average hours worked per week were 39.1 in Health services and 38.2 in Community services. Within Community services, average hours worked per week were 38.1 in Child care services and 38.2 in Community care services (compared with an average of 40.2 across all industries).

**Figure 57: Average hours worked by industry subdivision, full-time employees, May 2006**

Not only is part-time work more prevalent and average hours worked shorter in the Health and community services industry than in many others, but ABS data suggest that underemployment is more prevalent (7.3 per cent) than in many other industries, with the exception of Cultural and recreational services (10.7 per cent), Accommodation, cafés and restaurants (13.2 per cent) and Retail trade (11.2 per cent). An underemployed worker is one who wishes to work more hours per week at the prevailing wage rate than he or she is currently working. The underemployment rate is defined as the number of workers who would like to work more hours as a proportion of the entire workforce.

**Figure 58: Underemployment rate in various industry divisions, May 2008**


1.8.2 Wages and earnings

Wage rates

As Figure 59 shows, the average hourly wage rate in the Health and community services industry in May 2006 was $27.30, which is 8.7 per cent higher than the average across all industries. However, there is significant variation in wage rates within the Health and community services industry. The average hourly wage rate was $28.60 in Health services and $22.00 in Community services.

In addition, there is considerable variation in the hourly wage rate within Community services. The rate was $18.20 for Child care services and $23.20 for Community care services (see Figure 60).

Figure 59: Average total hourly wage by industry group, full-time employees, May 2006

![Bar chart showing average total hourly wage by industry group, May 2006.](chart1)

Source: ABS, Employee Earnings and Hours, Catalogue No. 6306.0, Canberra, ABS, 2007.

Figure 60: Average total hourly wage by industry class, full-time employees, May 2006

![Bar chart showing average total hourly wage by industry class, May 2006.](chart2)

Source: ABS, Employee Earnings and Hours, Catalogue No. 6306.0, Canberra, ABS, 2007.
Figure 61 shows a comparison of average hourly wage rates for permanent and casual workers. Interestingly, the wage gap between permanent and casual Health services workers ($1.10 per hour) and Community services workers ($0.60 per hour) is much smaller than that averaged across all industries ($4.60 per hour). The data includes all ordinary time cash earnings including any casual loading or penalty rates that may apply.

**Figure 61: Average ordinary time hourly cash earnings – permanent versus casual workers, May 2006**

The difference in average hourly wage rates between adult and junior Health and community service workers is shown in Figure 62. Adult workers in Health services earn $27.70 per hour on average, compared with $14.30 for junior workers. Adult employees in Community services earn $21.20 per hour, while junior workers earn an hourly rate of $10.50. Averaged across all industries, the corresponding figures are $25.20 per hour and $11.20 per hour. The gap is thus smaller in Health services ($13.40) and Community services ($10.60) than the average across all industries ($14.00).
Figure 62: Average ordinary time hourly cash earnings – adult versus junior workers, May 2006

Dollars

<table>
<thead>
<tr>
<th>Industry</th>
<th>Adult</th>
<th>Junior</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health services</td>
<td>27.70</td>
<td>14.30</td>
</tr>
<tr>
<td>Community services</td>
<td>21.10</td>
<td>10.50</td>
</tr>
<tr>
<td>All industries</td>
<td>25.20</td>
<td>11.20</td>
</tr>
</tbody>
</table>


Figure 63 shows the difference in hourly ordinary time cash earnings for males and females in Health services and Community services, compared with hourly rates across all industries. The data shows that the difference between male and female hourly cash earnings is higher in Health services ($6.70) and Community services ($3.00) than it is across all industries ($2.80), and may at least partly reflect differences in the gender balance within certain professions in the industry.

Figure 63: Average ordinary time hourly cash earnings – male versus female workers, May 2006

Dollars

<table>
<thead>
<tr>
<th>Industry</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health services</td>
<td>32.90</td>
<td>26.20</td>
</tr>
<tr>
<td>Community services</td>
<td>23.40</td>
<td>20.40</td>
</tr>
<tr>
<td>All industries</td>
<td>25.90</td>
<td>23.10</td>
</tr>
</tbody>
</table>

Figure 64 shows the differences in ordinary time hourly cash earnings for Health services and Community services by the method of wage bargaining. The figure shows that the highest average hourly wage rate in Health services is earned by those workers on federally and state registered collective agreements, who earned an hourly wage rate of $29.30 and $29.20 respectively. The lowest hourly wage rates earned by workers in Health services were those who were on the award only, who earned $22.60 per hour. In Community services, the highest hourly wage was earned by those on federally registered collective agreements, earning $24.20 per hour while those on the award earned $19 per hour.

**Figure 64: Average ordinary time hourly cash earnings by method of setting pay, May 2006**

- **Collective agreement (Federally registered)**
- **Individual agreement (Federally registered)**
- **Collective agreement (State registered)**
- **Individual agreement (unregistered)**
- **Collective agreement (unregistered)**
- **Award only**
- **Total**

Data presented in this section relies on both published and unpublished data from the ABS Employee Hours and Earnings (EEH) survey. While the information is presented at the industry division and industry class level, the group of employees that are primarily of interest in this study are low-paid workers. To some extent, their characteristics are obscured by the inclusion of all employees in the statistics. This is a weakness in the data. One solution might be to utilise purchased unit record data, although the smaller sample sizes of low-paid employees will lead to less reliability and accuracy in the results.

**Earnings**

Figure 65 presents average full-time adult weekly total earnings in the Health and community services industry for males and females between 1990 and 2007. Average weekly full-time earnings for males increased from $696 in 1990 to $1,475 in 2007, reflecting an average annual nominal growth rate of 4.5 per cent. Average weekly earnings for females grew by an average of 3.6 per cent per annum in nominal terms, from $526 in
1990 to $959 in 2007. In 2007, average weekly earnings of females in the industry were 65 per cent that of males.

After adjusting for the effects of inflation, growth in real terms in average full-time adult weekly earnings was 1.9 per cent per annum for males and 1 per cent per annum for females.

**Figure 65: Average adult full-time weekly total earnings – males versus females, 1990–2007**

Average weekly earnings for males and females in the Health and community services industry are shown in Figure 66 and Figure 67 respectively. They indicate that average weekly earnings for males in the industry are considerably higher than that across all industries ($1,476 versus $1,222 in May 2007), while average weekly earnings for females in the industry have dipped below the average across all industries in recent years ($959 versus $983 in May 2007).
Figure 66: Average adult male full-time weekly total earnings – Health and community services versus all industries, 1990–2007

Dollars


Figure 67: Average adult female full-time weekly total earnings – Health and community services versus all industries, 1990–2007

Dollars


As can be seen in Figure 68, average weekly earnings in Health and community services in May 2007 were slightly lower than the average across all industries ($1,115 against $1,136, or 1.8 per cent lower). However, they were higher than that for Accommodation, cafés and restaurants ($868) and Retail trade ($857).
Figure 68: Average adult full-time weekly total earnings by industry, May 2007

Figure 69: Industry breakdown of private sector full-time average weekly total earnings, May 2006

Source: ABS, Employee Earnings and Hours, Catalogue No. 6306.0, Canberra, ABS, 2007.

The above figure shows that average full-time incomes in Health services exceeded those in Community services by nearly 33 per cent in May 2006. This is not surprising, considering that Health services comprises largely of highly trained and well-remunerated health care professionals.
Within Community services, Community care services workers earned considerably more than Child care workers (see Figure 70). As at May 2006, Community services workers earned about 28 per cent more than those employed in Child care services.

Figure 70: Average adult full-time weekly total earnings – Child care services and Community care services, May 2006

Dollars

<table>
<thead>
<tr>
<th>Dollars</th>
<th>1,000</th>
<th>889</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community care services</td>
<td>889</td>
<td></td>
</tr>
<tr>
<td>Child care services</td>
<td>694</td>
<td></td>
</tr>
</tbody>
</table>

Source: ABS, Employee Earnings and Hours, Catalogue No. 6306.0, Canberra, ABS, 2007.

Figure 71 plots the distribution of income in the Health and community services industry against that of all industries. The figure shows that a significant number of workers in the industry earn between $600 and $1,000 a week. The median weekly earnings in the industry was $914 in May 2006, compared with $926 for all industries.

Figure 71: Distribution of weekly full-time income – Health and community services versus all industries, May 2006

Per cent

<table>
<thead>
<tr>
<th>Dollars</th>
<th>20</th>
</tr>
</thead>
<tbody>
<tr>
<td>16</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
</tr>
<tr>
<td>0</td>
<td></td>
</tr>
</tbody>
</table>

Source: ABS, Employee Earnings and Hours, Catalogue No. 6306.0, Canberra, ABS, 2007.
In a report prepared by McGuinness et al. (2007), entitled *Characteristics of Minimum Wage Employees*, data are presented (and reproduced in Figure 72) showing the percentage of full-time employees who are classified as low-paid by industry. In this study, workers were classified as low paid if they earned within 10 per cent of the Federal Minimum Wage.

**Figure 72: Percentage of low-paid full-time employees by industry**

<table>
<thead>
<tr>
<th>Industry</th>
<th>Per cent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agriculture</td>
<td>19.7</td>
</tr>
<tr>
<td>Manufacturing</td>
<td>7.4</td>
</tr>
<tr>
<td>Mining</td>
<td>4.0</td>
</tr>
<tr>
<td>Electricity, gas and water supply</td>
<td>4.5</td>
</tr>
<tr>
<td>Construction</td>
<td>8.7</td>
</tr>
<tr>
<td>Wholesale trade</td>
<td>12.2</td>
</tr>
<tr>
<td>Retail trade</td>
<td>19.6</td>
</tr>
<tr>
<td>Accommodation, cafés and restaurants</td>
<td>10.3</td>
</tr>
<tr>
<td>Transport and storage</td>
<td>6.8</td>
</tr>
<tr>
<td>Communication services</td>
<td>1.2</td>
</tr>
<tr>
<td>Finance and insurance</td>
<td>5.8</td>
</tr>
<tr>
<td>Property and business services</td>
<td>1.7</td>
</tr>
<tr>
<td>Government administration and defence</td>
<td>2.5</td>
</tr>
<tr>
<td>Education</td>
<td>2.0</td>
</tr>
<tr>
<td>Health and community services</td>
<td>10.3</td>
</tr>
<tr>
<td>Cultural and recreational services</td>
<td>14.2</td>
</tr>
<tr>
<td>Personal and other services</td>
<td>13.4</td>
</tr>
<tr>
<td>All industries</td>
<td>7.2</td>
</tr>
</tbody>
</table>


The data show that 10.3 per cent of full-time employees in Health and community services are classified as low-wage employees, compared with 7.2 per cent across all industries.
References


Australian Bureau of Statistics (2007), Information paper: experimental estimates of industry multifactor productivity, Australia, Catalogue No. 5260.0.55.001, ABS, Canberra.


Australian Bureau of Statistics (2007), Labour Mobility, Catalogue No. 6209.0, ABS, Canberra.


2. Health and community services industry profile – qualitative overview

Colmar Brunton Social Research
August 2008
2.1 Executive summary

2.1.1 Introduction

A series of targeted focus groups were conducted covering the Health and community services (HaCS) industry across four states with current low-paid employees, employers (owners and senior managers), and employees who had recently left the industry. The purpose of the research is to build on the Australia Fair Pay Commission's knowledge of labour market issues by profiling the employers and employees of the Health and community services industry and to explore how changes in minimum wages impact this industry.

This report presents the views and experiences of low-paid employees and employers of the low paid within the Health and community services industry. There is significant diversity across the industry in terms of the range of services provided and the employees who deliver them. The industry comprises a large number of low-paid employees across Australia, including a large proportion who are reliant on annual wage-setting decisions for adjustments to their basic rate of pay. The majority of contributions to this research are from the aged care, disability care and child care divisions of the industry where a large number of low-paid workers are employed. Furthermore, emphasis was placed on including the opinions and experiences of employers and employees from the private sector of the industry, though the public sector is also represented.

Unlike other low-paying industries analysed by the Commission, the Health and community services industry includes a large proportion of employees who are highly skilled and consequently highly paid – for example, medical practitioners. These highly paid employees were deliberately excluded from this qualitative research, as their opinions and experiences are of limited relevance to the Commission's understanding of minimum wage issues.

2.1.2 Key findings

Industry overview

Participating employers reported rapidly growing demand for the services offered by their organisations. This was also considered to be the trend across the industry as a whole. This finding was consistent across metropolitan and regional locations, and across the four states included in this research. The reported growth in demand for services was attributed to a number of factors, including:

- the ageing of Australia's population;
- an increase in levels of government funding to Health and community services; and
- an increase in government allowances for parents (e.g. Baby Bonus, Child Care Tax Rebate and Child Care Benefit).

Many organisations included in this research reported struggling to keep up with growing demand. Across the range of service providers there were numerous accounts of long and growing waiting lists. The most commonly reported challenge of meeting service demand is securing suitably experienced and qualified staff to deliver the service. A number of service providers also indicated that they do not have the facilities to meet the current demand and have no room to expand their operations within their current premises.

Organisations operating in the Health and community services industry are required to comply with a range of quality assurance and accountability measures. While considered
necessary by most of the research participants, the rules and regulations that organisations (and consequently, the employees delivering the service) need to adhere to are seen as a significant burden. All government-subsidised care services are evaluated on criteria including safety and security, staffing levels and care ratios, whether staff have the specified training and qualifications, and thorough background checking of newly appointed staff. The numerous compliance requirements create tight operating conditions. Therefore, while many service providers in this industry are experiencing significant growth in demand for their services, profitability and even financial viability continue to be challenges due to compliance requirements as well as increasing levels of competition.

Business operations

Employers reported that their organisations functioned under relatively formal and/or structured management and operational approaches. They highlighted the need to be clear about the expectations and requirements of service delivery within their organisation, while also fostering a pleasant environment for employees (one that is not overly strict or regimented). However, increased procedural and compliance requirements appear to have negatively impacted on the workplace environment for many employees.

Organisations tend to employ a relatively small core team of full-time permanent staff who are more highly skilled, experienced and qualified. These permanent full-time positions are generally held by staff between the levels of senior management and supervisory roles. The staff responsible for the majority of service delivery tend to be employed on a permanent part-time or casual basis, and are generally lower skilled. Juniors, apprentices/trainees and people with disabilities tend to only be employed by medium to large operators.

Employers prefer employing the majority of staff on a permanent part-time or casual basis because this allows for a greater total number of staff to be employed by the organisation, which provides greater flexibility in rostering, and is also more affordable. Limiting staff hours also offers health benefits for staff by helping to prevent 'burnout'. Staff burn out through being consistently stressed due to the physically and emotionally demanding nature of the work.

Labour costs for organisations in the Health and community services industry form a high proportion of total operating expenses, both in absolute terms and relative to other low-paid industries. Therefore, employers monitor their wages bill on a regular basis (weekly or even daily) as there are serious cash-flow risks if they do not pay attention to this major cost. Having flexibility in the workforce for rostering purposes helps employers avoid using agency staff, which can have a significant impact on an organisation's wages bill.

Most employers advised that pay rates in their organisation are set at the minimum specified in the relevant award, Pay Scale or workplace agreement for the specified skill or qualification level. Not-for-profit operators were most commonly reliant on an award or Pay Scale. However, salary packaging arrangements were usually available to supplement the income of employees in not-for-profit organisations.

Employers reported that attracting candidates for unskilled positions was not difficult. Many had experienced a large volume of interest in advertised positions. However, employing a suitable candidate for an unskilled position was more difficult.

The recruitment of skilled staff presents a significant challenge for all employers in the industry. Demand for appropriately qualified employees is increasing as qualifications are becoming the minimum standard in the industry; it seems that the number of experienced
and qualified personnel is decreasing in proportion to the growing demand for services. Further, attracting skilled staff is difficult as employers are not able to greatly differentiate their employment offering from that of their competitors.

A frequently reported issue for employers was the turnover or ‘churn’ within their workforce. This includes the loss of highly valued long-term staff, but more often the loss of shorter term staff. Churn appears to be relatively high across the industry, particularly for organisations in the metropolitan areas of Sydney and Melbourne. Employers reported that although some poorly performing staff may be pushed out of employment, most often it is staff who pull themselves out by leaving their current employer, and sometimes by leaving the industry.

Employee profile

The employee participants in this study were predominantly female and of varying ages. Compared with figures for all industries combined, younger workers are under-represented in the Health and community services industry, and mature-aged workers are over-represented. The majority of employees reported that they see their current employment as a ‘career’, but for some it is simply a ‘job’.

Employee participants reported they were currently earning between $14 and $18 per hour (before tax was deducted) as their standard rate of pay. (Note that low-paid employees were deliberately targeted for this research). Casual employees typically worked between 12 and 20 hours per week. Part-time employees worked between 20 and 37.5 hours per week. Full-time employees worked 38 hours per week or more.

Passion is the primary driver for most employees in the Health and community services industry. They believe what they do is meaningful and benefits the community. However, the majority of employees felt that currently their income dictates their lifestyle, and all participating employees were focused on their wages as a point of dissatisfaction with their current employment. In many cases, income for employees provides just enough to pay the bills. A number of employees discussed the lifestyle sacrifices they have made (because their income only covers the necessities) as a result of working in this industry.

Impact of increased minimum wage

There was very low awareness and limited understanding of the mechanisms for determining federal minimum wages among both employer and employee participants. Many employers and employees hypothesised that any change to minimum wages in Australia was an adjustment for inflation that would be incorporated under the relevant award or collective agreement. Very few participants were able to articulate the name, the role or the functions of the Australian Fair Pay Commission. However, once the role and functions of the Commission were explained to research participants there was strong endorsement for both the existence of the Commission and the process for determining federal minimum wages in Australia.

For employees, most felt the increase in minimum wages would not have an obvious positive impact on their lifestyle. Their recollection of increases to their pay rates in the past were of small increases that didn’t keep up with inflation. They felt that at best any increase in minimum wages would just allow them to maintain their existing lifestyle, rather than improve it in any meaningful way.
Many employer representatives commented that their income sources were limited and if minimum wages increased then they would have to make adjustments to their expenditure and/or income levels. As labour costs form such a significant proportion of operating expenditure, and most organisations are currently operating under tight conditions, many employers discussed a range of options for responding to an increase in wages.

Almost all employers reported that their organisation received some sort of government funding. This funding generally increased each year in line with the Consumer Price Index (CPI). Alternatively they had the opportunity to put forward a revised unit price (i.e. cost per client). All organisations receiving government funding advised that they would seek to cover their increased labour costs through a request for additional funding. Beyond requesting additional funding, the most commonly mentioned and top-of-mind response to an increase in minimum wages was to increase the price of services.

Many employers felt that they had limited options in responding to increases in pay rates due to the highly regulated nature of the Health and community services industry. Attempting to maintain labour costs at the pre-implementation level was difficult as government funding is conditional upon employers having appropriately qualified staff (i.e. minimum of Certificate III for certain duties) and filling specified staff-to-client ratios (care ratios).
2.2 Introduction

2.2.1 Background and purposes of the research

The Australian Fair Pay Commission is an independent agency responsible for adjusting federal minimum and classification wages to promote the economic prosperity of the people of Australia. In adjusting pay rates for around 1.3 million workers in Australia, the Commission plays an important role in the management of the Australian economy. In a similar fashion to other key bodies such as the Reserve Bank of Australia, the Commission has been established as independent from government and makes decisions of major social and economic importance based on consultation, submissions, and research.

The Commission operates under a cycle of information gathering, decision making, communication and monitoring. The Commission consults widely to explore the impact of previous decisions with those most affected, and also to inform future decisions. As the Commission evolves, information is gathered from a broadening range of target audiences and industries, providing cumulative knowledge of minimum wage issues.

The Australian Fair Pay Commission Secretariat estimates that nationally around 12 per cent of Pay and Classification Scale–reliant employees are currently working in the Health and community services industry. That is, across Australia around 143,000 workers in this industry rely on the Commission for adjustments to their rate of pay. A priority for the Commission, therefore, is to understand more about these employees and their employers, and to explore how changes in minimum wages impact the industry.

2.2.2 Research process

The Secretariat engaged Colmar Brunton Social Research to conduct a series of targeted focus group discussions with employers of the low paid and low-paid employees in the Health and community services industry. Focus groups were conducted across a number of locations nationally, including metropolitan and regional areas, and involved employers and low-paid employees, as well as employees who had worked in the industry on low rates of pay, but who had recently left the industry.

Research audiences

The recruitment of research participants focused on reaching employers and employees most affected by the Commission’s minimum wage-setting decisions, including:

- Owner/operators and managers of organisations employing staff on a standard rate of pay at or below what the Secretariat classifies as ‘low wages’ for the purposes of research recruitment ($18.42 ph, $700 pw, $36,400 pa)
- Employees currently paid at or below what the Secretariat classifies as ‘low wages’ for the purposes of research recruitment ($18.42 ph, $700 pw, $36,400 pa)
- Employees who had recently left the industry, but had previously held a position within the industry that paid at or below what the Secretariat classifies as ‘low wages’ for the purposes of research recruitment ($18.42 ph, $700 pw, $36,400 pa)

Note: For analytical purposes the Secretariat often defines ‘low-paid’ as up to 120 per cent of the Federal Minimum Wage. This measure is not adopted for research recruitment purposes, where a round figure of $700 per week is used.
Employers

A range of organisations were purposefully targeted in this research. These included health care, child care, residential care, disability, welfare, housing, legal and counselling services. Emphasis was placed on approaching employers from the private sector within the Health and community service industry, though public sector employers were also included. The majority of employers included in this research were from three divisions of the industry: aged care, disability care and child care services.

The composition of employer groups was as follows:

- The businesses were of varying sizes (measured by number of employees: micro, small, medium and large).
- The businesses employed staff beyond family/friends.
- There were a limited number of organisations from the public sector of the industry.
- The participating employers are responsible for recruitment and/or setting pay rates in their organisation.
- The majority have tried to recruit in the past six months, are currently trying to recruit, or will be recruiting in next six months.
- The minority have a stable workforce (no recruitment in the past six months, and no intention to recruit).
- The majority employ low-paid staff according to an award/Pay Scale (i.e. they are directly affected by the Commission’s wage-setting decisions).
- A limited number of participating businesses employ staff on workplace agreements (i.e. the Commission’s wage-setting decisions are of less relevance to these employers).

Note: This research targeted employers of the low paid in the Health and community services industry. The opinions and experiences of focus group participants in this report do not necessarily represent the views of all employers in the Health and community services industry. Rather, they represent findings from the Commission’s target audience of employers in this industry.

Employees

Employee participants were targeted to ensure representation across the range of employment arrangements, including permanent/non-permanent, and full-time/part-time/casual hours. Employees paid junior rates of pay and apprentice/trainee employees were also targeted. Recruitment sought to include representation according to length of service in the industry – more than five years and less than five years – as well as those who have left the industry within the past 12 months. A range of Health and community services employees are represented in this research, though the majority of employees currently work in aged care, disability care, and child care services.

The composition of employee groups is as follows:

- Employees are currently in paid employment (excludes volunteers), or have worked in the Health and community services industry within the last 12 months (as specified in the following section, ‘Locations and group structure’).
- Employees have a mix of demographic characteristics including: age, gender, have dependants/do not have dependants.
A minimum number of participants are employed directly in the public sector (e.g. in local government).

Note: This research targeted low-paid employees in the Health and community services industry. The opinions and experiences of focus group participants in this report do not necessarily represent the views of all Health and community services industry employees. Rather, they represent findings from the Commission's target audience of employees working in this industry.

Locations and group structure

A total of 16 focus groups were conducted across four states in May and June of 2008. The groups were held in metropolitan and regional locations in Victoria, Western Australia, South Australia and New South Wales. Locations were selected to reflect diversity (economically and geographically) across the industry. Seven focus groups were conducted with employers, seven with current Health and community services industry employees, and two with employees who had recently left the industry. The fieldwork structure is shown on the following page.
Table 11: Focus group structure

<table>
<thead>
<tr>
<th>Participant</th>
<th>Group structure</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employees</td>
<td>Apprentices and trainees (inc. school-based and mature-aged)</td>
<td>Vic: Melbourne</td>
</tr>
<tr>
<td>Employers</td>
<td>Child care, residential care, health and disability services, NGOs etc</td>
<td>Vic: Melbourne</td>
</tr>
<tr>
<td>Employees</td>
<td>Part-time and casual (in the industry shorter term)</td>
<td>Vic: Bendigo</td>
</tr>
<tr>
<td>Employees</td>
<td>Those who have recently left the industry – not in employment or employed in another industry</td>
<td>Vic: Bendigo</td>
</tr>
<tr>
<td>Employers</td>
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</tr>
<tr>
<td>Employees</td>
<td>Those who have recently left the industry – not in employment or employed in another industry</td>
<td>WA: Perth</td>
</tr>
<tr>
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<td>Child care, residential care, health and disability services, NGOs etc</td>
<td>WA: Perth</td>
</tr>
<tr>
<td>Employees</td>
<td>Part-time and casual (study, other employment, lifestyle decision)</td>
<td>WA: Bunbury</td>
</tr>
<tr>
<td>Employers</td>
<td>Child care, residential care, health and disability services, NGOs etc</td>
<td>WA: Bunbury</td>
</tr>
<tr>
<td>Employees</td>
<td>Part-time and casual (study, other employment, lifestyle decision)</td>
<td>SA: Adelaide</td>
</tr>
<tr>
<td>Employees</td>
<td>Emphasis on ‘Juniors’ (including young adults)</td>
<td>SA: Adelaide</td>
</tr>
<tr>
<td>Employers</td>
<td>Child care, residential care, health and disability services, NGOs etc</td>
<td>SA: Adelaide</td>
</tr>
<tr>
<td>Employees</td>
<td>Full-time (mix of long term and shorter term in the industry)</td>
<td>SA: Port Pirie</td>
</tr>
<tr>
<td>Employers</td>
<td>Child care, residential care, health and disability services, NGOs etc</td>
<td>SA: Port Pirie</td>
</tr>
<tr>
<td>Employees</td>
<td>Full-time (in the industry at least five years)</td>
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<td>Child care, residential care, health and disability services, NGOs etc</td>
<td>WA: Perth</td>
</tr>
</tbody>
</table>

The research process

Employers and employees who met the specified recruitment criteria were invited to attend a focus group discussion. In Melbourne, Perth, Adelaide and Sydney, professional qualitative research facilities were used. These venues are equipped with audiovisual facilities and one-way mirrors allowing for observation of the discussion from an adjacent
room. In Bendigo, Bunbury and Port Pirie, the focus groups were convened in conference rooms and, where appropriate, the discussion was observed in the room.

Upon arrival at the focus group venue, participating employers and employees were asked to complete a profile sheet. The employer profile sought information about the employer’s role in the business, how long the business had been in operation, business performance, workforce structure and the composition of total business costs. The employee profile sheet sought information on the employee’s age, gender, occupation, hours worked and income. It also posed questions about why they work, whether they see their employment as a ‘job’ or ‘career’, and explored whether they felt their income dictated their lifestyle or if their lifestyle dictated their income. The employer and employee profile sheets are appended.

Discussion guides for both the employer and employee audiences were developed by the Australian Fair Pay Commission Secretariat in consultation with Colmar Brunton Social Research. Discussion guides are appended to this report.

Observation by the Commission

Many of the focus groups were observed by Secretariat staff who also took the opportunity to address participants and answer questions about the Commission at the conclusion of the discussion. At the time of recruitment, and again prior to the session commencing, participants were informed that the discussion would be observed.

2.2.3 Reporting approach and structure

Report style and presentation

The primary objective of this research project was to gather opinions and experiences of those employers and employees in the Health and community services industry who are most affected by the Commission’s wage-setting decisions. Relative prevalence of opinion and experience are noted throughout the report in order to highlight the more frequently expressed views. However, this report also presents the range of different opinions and experiences articulated in the focus groups, rather than simply focusing on the main or repeated themes. That is, any diversity observed within and across the focus groups is reflected in this report. Accordingly, a larger number of quotes than is typical for a qualitative research report are presented in the body of the text to demonstrate this range of opinions and experiences.

How to use this report

As outlined in Section 2.2.1, this research purposefully sought to include the opinions and experiences of participants representing a range of circumstances. These opinions and experiences have been presented across the structure outlined below:

- **Section 2.3 Industry overview** – This section highlights factors currently impacting the industry and business performance. Attractive aspects of working in the Health and community services industry are outlined as well as negative aspects.

- **Section 2.4 Business operations** – This section covers business performance and the processes and procedures used by organisations in the Health and community services industry. More specifically, issues such as recruitment and retention, workforce structures, labour costs and wage-setting arrangements are examined.
• **Section 2.5 Employee profile** – This section covers the characteristics and experiences of participants who work in the Health and community services industry. The complex relationships between work, income and lifestyle are explored, as well as employees’ views on whether their current role is a ‘job’ or a ‘career’.

• **Section 2.6 Impacts of increased minimum wage** – This section outlines awareness and understanding of statutory minimum wages and perceptions of how these are determined. The perceived impacts of increases in minimum wages from both the employer and employee perspective are addressed.
2.3 Industry overview

There is significant diversity within the Health and community services industry in terms of the range of services provided and the employees who deliver these services. Across Australia, the industry comprises a large number of low-paid employees, including a large proportion who are reliant on annual wage-setting decisions for adjustments in their standard rate of pay. However, unlike other low-paying industries analysed by the Commission, the Health and community services industry also includes a large proportion of employees who are highly skilled and consequently highly paid – for example, medical practitioners. These highly paid employees have been deliberately excluded from this research as their opinions and experiences are of limited relevance to the Commission's understanding of minimum wage issues.

This report therefore presents the views of low-paid employees and employers of the low paid within the Health and community services industry. The contents of this report do not necessarily represent the views of all employers and employees in the industry, and caution should be taken when interpreting the contents of this report. It should also be recognised that the majority of contributions are from the aged care, disability care and child care divisions of the industry, where a larger proportion of low-paid workers are employed. Furthermore, emphasis was placed on including the opinions and experiences of employers and employees from the private sector of the industry, though the public sector is also represented.

2.3.1 External influences

Strong demand driving growth

Participating employers reported rapidly growing demand for the services offered by their organisations. This was also considered to be the trend across the industry as a whole. This finding was consistent across metropolitan and regional locations, and across the four states included in this research. The reported growth in demand for services was attributed to a number of factors, as presented below.

Demand for aged care services is reportedly being driven by the ageing of Australia's population and increasing life expectancy:

‘Definitely growing in this area. We’ve got a high proportion of aged and ageing population.’ [Manager, aged care, Port Pirie]

‘Hugely increasing in aged care of course because of [the] ageing population. We're in a rapid growth area.’ [Manager, aged care, Bunbury]

Increased government funding of disability services over recent years is driving growth in demand for these services. Disability care service providers are now being utilised by a greater number of clients to assist in caring for a disabled family member:

'It's a lot better in disability. The funding levels are a lot better and a lot more consistent as far as longer term funding for programs.' [Service manager, disability services, Sydney]

As a result of increased cost-of-living pressures, many formerly single-income families now require income from both parents to meet their financial obligations. This has increased the number of mothers entering or re-entering the workforce, which has resulted in strong demand for child care services:
"We’re basically inundated – we definitely don’t struggle to find clients … When a child reaches a certain age the mother needs to be out there working." [Manager, child care, Sydney]

Participating employers reported that government initiatives such as the Baby Bonus, Child Care Tax Rebate and Child Care Benefit have made it more viable for parents to use child care services:

‘Child care is growing with the Baby Bonus and increasing focus on child care.’
[Owner/manager, child care centre, Sydney]

Challenge of meeting increasing demand

Many organisations included in this research reported struggling to keep up with the growing demand. Across the range of service providers there were numerous accounts of long and growing waiting lists:

‘My place is constantly full and I’ve got a waiting list that’s growing. I don’t know if all centres in the area are full, but I think quality centres are definitely full with very long waiting lists.’ [Manager, child care, Perth]

A number of service providers do not have the facilities to meet the current demand and have no room to expand operations in their current premises:

‘Our problem at the moment is more space. We haven’t really had any room to run more programs so we can’t really fit much more than what we’re already providing.’ [Manager, child care, Bunbury]

The most commonly reported challenge of meeting service demand is securing suitably experienced and qualified labour to deliver the service. It appears that while the number of service providers is increasing in response to strong demand, the number of suitably experienced and qualified staff is not increasing at the same rate:

‘My particular area is very hard to staff. We’re never fully staffed. I don’t know of a time we have been.’ [Nurse manager, health services, Sydney]

‘… the demand for on-call staff in aged care facilities is higher than the staffing levels that agencies have. As an example, we’re cancelling 50 per cent of our bookings that come from aged care facilities throughout Adelaide due to lack of staff. And the problem in the previous company I worked for was even greater.’ [Manager, aged care, Adelaide]

Many employers expressed concern about the ageing workforce in the industry. With the exception of child care employees, large numbers of employees in Health and community services are nearing, or have reached, retirement age. Most of these employees have been working in the industry long-term and are highly valued for their skills, experience and strong work ethic. Some leave the industry when they retire from the paid workforce; however, there are many who continue working in the industry (at a reduced capacity) on a voluntary basis. The impending retirement of the more reliable and experienced members of their workforce was of great concern to many employer participants:

‘I’ve been there 13 years and we don’t really lose staff, they retire at about 65. Because a lot of our workers are 55-plus even, a lot of our care workers are quite mature, so [we] are losing them out the end due to retirement.’ [Manager, home and community care program, Bunbury]

‘It’s an ageing population, the workforce. There’s going to be a skill shortage of those workers eventually.’ [Manager, health services, Bendigo]
Compounding the issue created by the impending retirement of mature-aged employees is a shortfall in the number of appropriately qualified employees seeking to enter the industry:

‘The other thing I’d like to say about the recruitment situation is that we have to get less well-trained, less experienced people … what we’ve noticed over time is [that] it’s putting a lot more stress on our senior staff. And they're now talking about the fact that they're unhappy and want to leave. Whereas we’ve never had that situation before … [now] we don’t have the backup of people coming through so it’s affecting our stability.’
[Manager, youth services, Bunbury]

A number of other factors are collectively responsible for the shortage of skilled labour in the industry. Further details of this are covered in Section 2.4.6, ‘Recruitment and retention’.

Compliance and conditional government funding

Organisations operating in the Health and community services industry are required to comply with a range of quality assurance and accountability measures. While considered necessary by most of the research participants, the rules and regulations that organisations (and consequently, the employees delivering the service) need to adhere to are seen as a significant burden. All government-subsidised care services are evaluated on criteria including safety and security, staffing levels and care ratios, whether staff have the specified training and qualifications, and thorough background checking of newly appointed staff. The numerous compliance requirements produce tight operating conditions for operators in the industry:

‘On the downside, you’ve got goals and criteria that you have to meet to maintain funding.’ [Owner, aged care, Sydney]

‘It’s becoming harder and harder to actually qualify for a job. Rules and regulations just kill everything.’ [Owner, aged care and disability services, Port Pirie]

‘There are a lot of conditions and requirements and police checks involved in the industry.’ [Manager, aged care, Sydney]

Most, if not all, service providers were receiving some sort of government funding. There was much speculation about funding becoming increasingly conditional on organisations ensuring that the staff providing services are appropriately qualified (i.e. with TAFE Certificate III or IV, a diploma or similar tertiary qualifications). This requirement was of great concern to a large number of employers involved in this research:

‘I've got nearly 400 staff that are unsuitable sitting on my books that could do those tasks if there wasn't a qualification required. So if you need someone to mop a floor I could get 400 people to do it, but they don't suit the qualifications required for the other jobs. So it is very hard.’ [Recruitment consultant, aged care, Adelaide]

‘There is a lot of pressure from our funding bodies to employ qualified people. It's part of our funding conditions to employ a certain person with certain skills.’ [Manager, aged care, Sydney]

Tight operating conditions

While the Health and community services industry is experiencing significant growth, financial viability continues to be difficult, especially for smaller service providers in the more competitive metropolitan areas. In the highly competitive metropolitan areas of Sydney and Melbourne, smaller service providers being ‘swallowed’ by larger providers, particularly in the area of disability services, is a growing trend:
‘I agree the demand is certainly growing. But it's getting much more difficult for organisations, particularly small ones. A small facility is just not viable. Though I'm in a large organisation, I have a small facility within it. We are looking at [our] options because we are in a huge deficit at the moment. That's just getting worse. So the minimum number of beds to make a facility viable keeps going up.’ [Manager, aged care, Sydney]

‘There is increasing consolidation in the disability industry of larger organisations taking over the small.’ [Manager, disability services, Sydney]

Both commercially operated businesses and not-for-profit organisations reported tight operating conditions. A number of factors are contributing to this, many of which stem from the need to secure government funding and the cost of complying with funding requirements. Further detail on compliance issues and the impact of these on operating conditions is covered in Section 2.4.1, ‘Business performance’.

2.3.2 Attractive aspects of the industry

Passion is the primary driver

For many employer and employee participants it was important to work in an industry that is not strictly profit-driven, but rather is focused on providing services to people in need. They believe what they do is meaningful and benefits the community. Employees working in aged care and disability care have a passion for helping their clients. Those working in the field of child care find satisfaction in watching and assisting children's development:

‘The not-for-profit industry and aged care are where my values are.’ [Manager, aged care, Melbourne]

‘I work for an Aboriginal agency, so passion for the culture, certainly not the wage. It was just passion for the people, for the culture, the homeless industry.’ [Manager, accommodation services, Adelaide]

‘I'm just passionate about kids and seeing them grow up.’ [Trainee child care worker, child care, Melbourne]

‘I do the job because I absolutely love the kids. I can’t see myself doing anything else.’ [Preschool teacher, child care, Sydney]

Some participants reported that they ‘fell’ into the industry and grew to love it. Some were advised about work available in the industry and others mentioned that it was the first job they obtained after leaving secondary school:

‘I fell into the job. Once I had a child my husband said I had to get a job and a friend recommended to me to become a personal care assistant. I like what I do and I enjoy working with the old residents. I love them.’ [Personal care assistant, aged care, Bendigo]

‘I left school and didn’t know what to do and got a traineeship in a private child care centre. I enjoy the job and I'm passionate about working with kids and parents are thankful. The only negatives are that I have to travel a long way to work and the traineeship has low pay. But long term, I want to do a teaching degree.’ [Child care assistant, child care, Melbourne]

For many participants, in spite of all of the negative aspects of working in the industry, including relatively low pay (see Section 2.3.3 for further details), it's their passion for the work they do that keeps them going.
Flexibility

A relatively large proportion of the workforce in Health and community services is employed on a casual or part-time basis. Some employees reported that this arrangement affords them the flexibility they require to meet other demands on their time. Many utilised the flexibility of their employment to maintain a healthy work–life balance:

‘I focus on my lifestyle because I have a great balance of work for three days one week and four days the next week, and I enjoy doing things I like to do.’ [Administrative officer, health services, Adelaide]

The most commonly mentioned reasons for needing flexibility were to care for children and to spend time with family:

‘I work because I want to be part of a happy, child-focused community, and to be valued and of value. I work and choose to work part-time and spend more time with my family.’ [Child care assistant, child care, Melbourne]

‘I am focused on lifestyle. The job I do and the hours fit into my lifestyle with my children.’ [Residential aide, disability services, Bunbury]

Some participants were studying at university or TAFE and arranged their work hours around their class times:

‘I work because I need the money and I also enjoy helping people. The job is useful because I need the money for my lifestyle and studying.’ [Personal care assistant, aged care, Melbourne]

There was evidence of some employees using the flexibility available in their employment arrangement to balance their income from paid work with their income from government allowances. Further details on this are given in the section ‘Income’ (page 115).

Employers expressed a preference for a casual and part-time workforce as this affords flexibility in their operations. Employing staff is more affordable under this arrangement, and if business demand declines or increases, there is the flexibility to allocate hours accordingly. Furthermore, covering annual leave, sick leave, and the departure of staff members is manageable with a larger part-time workforce, which can be more flexible to meet the organisation’s requirements.

The seasonality of child care services means that child care organisations require flexible workforces. Client numbers fluctuate during school holiday periods, which affects the number of hours available to staff. Hours of operation for child care service providers are fewer than those of other Health and community services providers, as child care services generally do not operate on weekends or at night. Some operators servicing before-school and after-school child care can only offer their staff part-time hours:

‘Child care is seasonal, so the first half of the year we have vacancies and the latter half we don’t. And that doesn’t seem to change.’ [Owner, child care, Bunbury]

‘Our service is only run for very short hours – before- and after-school care. So it’s only for two hours in the morning and from 3 pm to 6.30 pm at night.’ [Director, not-for-profit child care, Adelaide]

Training and progression

For employees willing to undertake the appropriate training to move to the next level, there are progression opportunities within the industry and defined pathways to follow. As a result, many employees consider their work in the industry a ‘career’:
‘I see my current employment as a career because it will be ongoing and long-term where I will earn and move on to better things.’ [Advocacy officer, disability services, Bunbury]

‘I see my employment as a career because I can see this being long-term employment for me.’ [Youth case worker, youth services, Port Pirie]

The pursuit of further qualifications (TAFE certificates, diplomas and/or tertiary qualifications) was reported by employees to be strongly encouraged within the industry. Employers are up-skilling their existing workforce to fill vacant positions rather than attempting to recruit qualified staff. Current employees are encouraged by this commitment and, for some, this is an incentive to remain in the industry:

‘Well, it was a job, but now with encouragement, it’s more than a job. One of the girls is doing her diploma – she gets time off to study. Yeah, lots of encouragement.’ [Child care assistant, child care, Adelaide]

‘There’s a shortage of nurses in aged care and the only way they can get them is to educate their current staff.’ [Personal care assistant, aged care, Bendigo]

The Health and community services industry is generally accepting and welcoming toward mature-aged employees, particularly when compared to other industries. Some employers felt that investing in training their mature-aged employees was an appropriate use of resources:

‘There are opportunities. I mean, I’m 62 and I got a job offer.’ [Personal care assistant, aged care, Bendigo]

‘We wouldn’t care less how old they are. They can do the work and get paid.’ [Owner, aged care, Perth]

Salary packaging

Salary packaging (salary sacrificing) arrangements were mentioned by almost all participants working in not-for-profit organisations. Most employers from not-for-profit organisations considered salary packaging to be a positive ‘selling point’ as it allows them to offer more competitive remuneration. While other businesses can pay qualified and/or highly valued employees above the minimum rates, not-for-profit organisations are restricted to paying at the minimum level as a result of the tight operating conditions related to funding arrangements. The salary packaging arrangement allows employees to spend up to $16,000 using their pre–income tax wages without incurring fringe benefits tax, which means that they do not pay income tax or fringe benefits tax on these earnings. There was much speculation and discussion in the focus groups about the possibility and impact of the Australian Tax Office withdrawing this arrangement for the not-for-profit service providers. This issue was subsequently resolved in June 2008:

‘We sell it by salary packaging. Because we’re not-for-profit, we can salary package a large portion. [For] somebody else’s wage who’s getting the same award somewhere else, we’ll give them quite a bit more in their hand.’ [Manager, aged care, Perth]

‘It’s a selling point that the private sector doesn’t have. Salary sacrifice is a real bonus.’ [Manager, aged care, Adelaide]

High demand for employees

Most employees reported that it was easy to find their current job, and believed it would be easy to find another position if necessary. All employees were aware of the staff shortages in the industry, and consequently felt secure in their current roles:
'They’re always crying out for carers in Bunbury, always.' [Carer, aged care, Bunbury]
‘Yeah, I think it was [easy], because no one wants to do it and they’re really desperate for those workers. So they pretty much take anyone.' [Aged care worker, aged care, Adelaide]

Some managers recognised the opportunities in aged care services due to the ageing population and the likelihood of increased funding for this area in the future:

‘I’m looking at focusing on aged care. I’m moving from disabilities to aged care because in the next 10 or 15 years the aged care industry is going to be huge – with the baby boomers ageing. So I think community services or welfare services will lead into the direction where a lot of funding will go. I’m going to go where there is going to be opportunities for me, so I think aged care will be the way to go.’ [Manager, aged care and disability services, Sydney]

A recurring theme across all focus groups was the difficulty of recruiting and retaining suitably qualified and experienced staff. It was rare for an employee to be pushed out of their employment, and most felt that it is easy for employees to move around within the industry. Some participating employers felt that employees currently have more power in the relationship:

‘They think they can walk out and walk into a job the next day. They’ve got the upper hand at the moment.’ [Owner, aged care, Perth]
‘Twelve months ago I went through an agency because I couldn’t fill positions.’ [Manager, aged care, Sydney]

2.3.3 Negative aspects of the industry

Low pay

Overwhelmingly, the foremost negative issue for both employers and employees was low rates of pay. This was mentioned by almost all employees across all focus groups. The low pay available to employees is the underlying issue that exacerbates other negative aspects of working in this industry:

‘The low wages is a negative issue. You need to love the job. The love of the job keeps you in the job.’ [Bus driver, disability services, Bunbury]
‘I find child care to be a good job because I enjoy working with kids. But the negative is the low pay rates. I can only receive $14.57 per hour on permanent part-time rates and only $16.90 per hour on casual rates. That is why I work two jobs.’ [Before- and after-school child care worker, child care, Adelaide]

Some employees suggested that they may leave the industry because of the low pay. A large proportion of those who had left the industry cited low rates of pay as a significant factor:

‘The dollars you earn as an early childhood worker are pathetic. I am now doing a Bachelor of Teaching to qualify me as an early childhood teacher, but I will go overseas for a job such as [to] the UK where you get better pay.’ [Early childhood worker, child care, Sydney]
‘I spent four years working in disability accommodation services. I enjoyed the work and the clients, but the pay wasn’t good enough. Now I am looking for a job in graphic design or printing.’ [Ex–disability worker, disability services, Bendigo]
‘I moved out of aged care because the pay is very poor and you were expected to be available 24 hours a day.’ [Ex-carer, aged care, Perth]

A major reason for organisations continuing to offer low rates of pay, even where there is difficulty securing qualified staff, is that government funding contracts often provide no scope for employers to offer above-award rates of pay. This problem is compounded by a growing expectation among qualified staff for above-award wages, in recognition of the demand for their skills.

Underemployment

Some employees were frustrated because the casual or part-time hours they were working did not generate their required income:

‘I have given thoughts about leaving aged care because you don’t get enough hours. I can only work 20 hours per week on casual rates. Unemployed people earn more than me. But I want to work 35 hours at a higher rate.’ [Home support worker, aged care, Adelaide]

Some employees reported that the limited number of hours available to them was compounding the issue of having a low rate of pay. They had little choice but to take on a second job:

‘I can only receive $14.57 per hour on permanent part-time rates and only $16.90 per hour on casual rates. That is why I work two jobs.’ [Before- and after-school child care worker, child care, Adelaide]

‘I love the job. But it is low pay and people leave or have to take two jobs. It is too hard to pay household rents or mortgages.’ [Preschool teacher, child care, Sydney]

Some employers indicated that limiting staff hours was related to funding restrictions. Other employers felt that because of the physically and emotionally demanding nature of direct care, limiting the number of hours each employee works provides health benefits to staff:

‘Well, mostly they’re part-time because we find that full-time drains them out.’ [Human resource consultant, health services, Bendigo]

Difficult working conditions

Employees reported that delivering their services can often be difficult. Many employer participants recognised that their staff, particularly those in aged care, are being pushed to their limit, and that many are considering their employment options outside the industry:

‘The catchcry that you hear across all members of the staff in aged care now is it’s all just getting too hard, we work too hard, we’re not appreciated and our pay rate is not in accordance.’ [Manager, aged care, Adelaide]

‘I’m actually considering changing at the moment. I’ve also got a degree in primary teaching so I’m considering a career change. Life is really, really tough in aged care in every way – [not enough] funding, the workload, the responsibilities, just everything.’ [Manager, aged care, Sydney]

Working conditions described by employees included: being required to do heavy lifting, experiencing verbal and physical abuse by patients, suffering the emotional toll of patients being ill or dying, and cleaning up after patients or children:
‘…children have a lot of energy, they’re constant. You have to give them your total self when you’re working with them and that takes a lot of energy out of you.’ [Owner, child care, Perth]

‘I thoroughly enjoyed my role in aged care, but it was the continual heavy lifting and wheelchair pushing which got me down. It is a big issue.’ [Ex–aged care coordinator, aged care, Bendigo]

The issue of ‘burnout’ was raised in all focus groups. In most instances participants referred to reaching a physical and/or emotional threshold in providing direct care services. Some participants also referred to this experience as ‘compassion fatigue’:

‘In the disability sector … if the client has challenging behaviours or is dual-diagnosis – what I mean is that they have mental health issues as well as a disability – the [care] roles aren’t just physically demanding but they are mentally demanding.’ [Manager, aged care and disability services, Sydney]

‘If you put your all into it you’re bound to have a burnout situation. I believe burnout is when you’re no longer able to cope with your own stress. I see burnout as being “I don’t care about what I’m doing any more.”’ [Operations manager, aged care, Perth]

Some participants in supervisory and middle-management roles spoke about the difficulty of disengaging from work in their own time. Many of these participants expressed their dissatisfaction at being ‘on-call’ after-hours, and with working unpaid overtime:

‘… the pay is totally crap and when you leave the job you’re still contacted at home; you’re expected to be available. So if someone’s given someone the wrong medication they’ll ring you up. The boundaries just weren’t there.’ [Ex–personal care attendant, aged care, Perth]

‘I don’t think the government sort of realises … like, from my point of view, I’m on-call 24 hours, seven days a week. Managers are 24/7.’ [Manager, aged care, Adelaide]

‘The aged care industry is propped up by huge numbers of staff who work past their rostered hours, and don’t get paid any overtime. If everybody in aged care [just] worked the hours that they’re rostered then the industry would implode on itself. We weren’t getting paid for time off and leave. My boss had to work 60 hours one week to get the stuff done. She’s now passed them on to me and I’m working over my 38 hours and I can’t claim over that either.’ [Manager, aged care, Adelaide]

Both employers and employees frequently commented that their workplaces are short-staffed. Employers recognised that this puts additional pressure on their employees. In some cases this was a temporary issue; however, many employees felt they were being consistently overworked:

‘I left the aged care centre because I needed to study to finish my final year nursing degree. But I would have left anyway. It was exhausting and tiring because of the heavy lifting and rush, rush. There was insufficient staff and a high workload. Only did it for the money because I needed money as a student.’ [Ex–personal care assistant, aged care, Perth]

‘I love working with older people and hearing their stories, and working with dementia groups is also positive. But the negative issue in aged residential care is the high rate of staff being absent and this increases the workload. Also paperwork required is increasing.’ [Aged care worker, aged care, Adelaide]

‘There was no employer support and you had to deal with difficult patients who spit and yell. That’s why I work in a supermarket now.’ [Ex–aged care worker, aged care, Perth]
Administration

Increased levels of accountability have led to increased paperwork for employees in the industry. This is a source of great dissatisfaction for many, particularly among more skilled and experienced employees. The increased administrative burden has resulted in employees either working longer hours (including unpaid overtime) or spending less time providing direct care. The primary reason many work in the industry is because they want to provide assistance; however, much of their time is now spent on paperwork:

‘Doing the required paperwork is a big problem. The paperwork involved in programs and accreditation is annoying and it increases your stress levels.’ [Child care worker, child care, Bunbury]

‘I found my job to be very rewarding and I loved working with little kids. But I didn’t like the company I worked for. It was too large and corporate and my job involved too much paperwork.’ [Ex–child care worker, child care, Bendigo]

‘We’ve had staff leave because they haven’t been able to cope with change, because they’ve been in the role for so long. They haven’t had to have accountabilities and then suddenly it’s too hard for them.’ [Manager, disability services, Melbourne]

Management

Many employees expressed considerable frustration with high-level management in their organisation. A distinct ‘us and them’ theme emerged across many of the groups. These comments were most prevalent in regional locations:

‘You get burnt out and you also get sick of the poor management. Poor management is a key issue causing problems.’ [Aged care worker, aged care, Bendigo]

‘The organisation and management where I work are very unprofessional.’
[Care assistant, disability services, Bunbury]

The care of their patients or children is the highest priority for employees in this industry. However, many believe that ‘care’ is not always the first priority for high-level management. There is a perception that management sometimes places hitting targets and profit ahead of care. Many employees hold high-level management responsible for the difficult working conditions they experience, including staff shortages:

‘I dislike management making poor decisions such as allowing good youth workers to leave and then going and recruiting new inexperienced youth workers. I don’t get any encouragement from my managers to become a support worker.’ [Administrative assistant, youth services, Port Pirie]

‘Management is disorganised, and I am learning on the job and I need to rely on my busy colleagues. But everyone is overworked, understaffed, and overstretched.’
[Youth case worker, youth services, Port Pirie]

Lack of appreciation

Some employees felt undervalued by their employers, by their clients and by society generally. Most believe that they are low paid relative to employees in similar industries, such as teaching, and don’t understand why. They feel they are working just as hard, if not harder, and have similar qualifications and experience to those in other industries. Some employees believe their clients see their work as that of a ‘glorified babysitter’ or ‘just a carer’, and do not recognise the skills and experience they have worked hard to achieve:
‘I chose to work in child care and I like it. But you are low paid even though you are performing a substantial service. You are treated as a babysitter by parents.’ [Long day care chef, child care, Sydney]

‘We are also seen by parents as babysitters despite the credentials we have.’ [Child care assistant, child care, Adelaide]

‘The industry needs to be regarded highly. People drop out of the industry because of low pay and because they are not well regarded.’ [Registered nurse, health services, Melbourne]

There was discussion about the value that society (including government) places on providing services to the community, and the costs involved in providing these services. Some felt that society values ‘wealth creation’ over ‘service to the community’, and that therefore, society believes people working in Health and community services deserve lower pay rates than those working in industries that create wealth for the country:

‘Until the government places some value on people who are looking after our children and our old people, the wages aren’t going to change.’ [Manager, youth services, Bunbury]

‘The biggest issue for us will be people wanting to continue to do the caring work. I think the value the community has for carers is minor. That’s our biggest problem. If people can recognise the value of what we do then things might turn around.’ [Manager, aged care, Perth]

‘Well, I read somewhere that they have a very good community and residential system in ... I think it’s Denmark, simply because the public expect to pay the taxes to support them [people in aged care]. You have got to have that in mind – that attitude change here.’ [Manager, aged care, Adelaide]
2.4 Business operations

2.4.1 Business performance

Employer participants were involved in the provision of services including child care, disability care, aged care, mental health, general health (hospitals), drug and alcohol rehabilitation, and counselling services. This research included participants from commercially operated businesses and not-for-profit organisations, and a small number from the public sector. Participating employers’ workforces varied in size, from as few as three staff to more than 2000.

Most employers indicated that revenue for their organisation was increasing. This finding was consistent across both metropolitan and regional Australia, and was also true across the range of service providers.

Most participants from commercially operated businesses reported that their profit levels were increasing; this was particularly true among small and medium-sized businesses outside of Sydney and Melbourne. Most commercially operated businesses in Sydney and Melbourne reported stable profit levels.

Both commercially operated businesses and not-for-profit organisations reported tight operating conditions. A number of factors contribute to this, many of which stem from the need to secure government funding. Fulfilling administration requirements and complying with service-delivery standards have led to an increased number of hours required to deliver services. Increasing minimum qualification levels then increases the rate payable to staff who deliver these services. To summarise:

- Increased administration tasks and record-keeping requirements leads to an increase in the number of hours required to deliver services.
- A higher number of qualified staff now required to deliver services leads to:
  - higher hourly rate of pay for service delivery
  - increased recruitment costs to attract qualified staff, due to current shortage
  - increased training costs to qualify existing workforce.

As a high proportion of total costs for operators in this industry (approximately half of all costs to the organisation) are labour-related, the impact of increased compliance measures can be significant. Therefore, while many service providers in this industry are experiencing significant growth in demand for their services, profitability and even financial viability continue to be a challenge due to tight operating conditions.

Like most industries, Health and community services comprises a high proportion of small operators. Smaller providers tend to deliver one core service, whereas larger providers offer a variety of services. Compared to larger operators, smaller service providers have limited opportunities for improving their margins. These smaller organisations don't have the flexibility, the numbers in their workforce, or the facilities to diversify their business by providing additional services within their existing market:

‘The residential aged care industry is growing but the viability financially is hard. We are in financial deficit. You need to increase the number of beds to ensure viability due to the increasing number of compliance visits.’ [Manager, aged care, Sydney]

Larger operators have the capacity to diversify their offerings, or to focus their efforts on the service(s) delivering the highest margins. On a per-unit basis, larger operators can
provide services at a lower cost than smaller providers and have the advantage of better buying power:

‘We’re looking at closing. We’re lucky we’re part of a big organisation that’s been covering our deficit. We’re trying to expand and buy another site, but if we can’t do that, we’re very close to closing.’ [Manager, aged care, Sydney]

Larger operators have the added advantage of being able to dedicate (or at least partially dedicate) staff to the procurement of government funding. Larger providers tend to have a more sophisticated approach to this method of securing income than smaller operators:

‘Larger organisations can employ specialists who help them reduce risk.’
[Service manager, disability services, Sydney]

‘A lot of smaller organisations don’t have the people skills to do funding submissions correctly, whereas big organisations can employ a lot more experienced people to do the funding submissions.’ [Manager, aged care and disability services, Sydney]

‘I’ve certainly found a lot of bigger organisations are absorbing some smaller ones based on economies of scale and things like that, and [then] providing a larger range of services than they ever have in the past.’ [Disability support manager, disability services, Sydney]

It was noted by a participant from a larger organisation that smaller operators may be undervaluing their services intentionally to secure funding. This strategy is reportedly not sustainable:

‘I just want to touch on something you said about smaller organisations struggling. I tend to notice when it comes to funding and grants that a lot of the time, small organisations tend to undervalue their services and will underestimate a cost in order to secure any level of funding. And then they are in a position that they only have a deficit and it snowballs from that. I’ve seen a lot of organisations do that.’ [Service manager, disability services, Sydney]

### 2.4.2 Business processes

Employers reported that their organisations functioned under relatively formal and/or structured management and operational approaches. Formal processes are necessary to ensure compliance with guidelines and quality accreditation processes, including guidelines concerning:

- safety and security of employees and clients
- staff training and qualification
- thorough background checks of candidates
- service delivery documentation.

Employers highlighted the need to be clear about their expectations and the requirements of service delivery within their organisation, while also fostering a pleasant environment for employees, one that is not overly strict or regimented:

‘We are structured in our operations, but friendly with our staff to ensure quality and requirements are met.’ [Manager and owner, child care, Sydney]

‘There’s certainly structure. I don’t think you can run a business without it. People need to know the rules and regulations, but I certainly think we have a very relaxed and friendly approach that people can be comfortable with.’ [Manager, aged care, Perth]
However, increased procedural requirements appear to have negatively impacted on the workplace environment. As discussed in 'Administration' (see page 95), increased accountability through documentation of service delivery is a major source of dissatisfaction for many employees, as much of their time is now spent on paperwork.

The section 'Recruitment process' (see page 103) covers the sometimes protracted process of recruitment experienced by many employers in the Health and community services industry.

### 2.4.3 Workforce structure

Employers operating in the Health and community services industry tend to employ a relatively small core team of full-time permanent staff who are more highly skilled, experienced and qualified. These permanent full-time positions generally comprise staff between the levels of senior management and supervisory roles.

The staff responsible for the majority of service delivery tend to be employed on a permanent part-time or casual basis, and are generally lower skilled. These employees will have some qualifications, usually a Certificate III. The experience these employees have ranges from almost none to more than 30 years in the industry. There is evidence, therefore, of current employees remaining in low-paid service delivery positions up to retirement age.

Juniors, apprentices/trainees and people with disabilities tend to be employed only by medium to large operators. These employees are often seen as a cheaper source of labour for unskilled tasks. However, most apprentices and trainees are employed in the hope they will undertake further training (often at the employer’s expense) and go on to become permanent, skilled employees in the future.

Employers purposefully structure their workforces to include high proportions of permanent part-time and casual positions, as a large percentage of the total costs to organisations in the industry are labour-related. These costs need to be tightly controlled. Employing the majority of staff on a permanent part-time or casual basis is preferred by employers, because it allows for a greater number of staff in total to be employed by the organisation, and is more affordable. Limiting staff hours also offers health benefits for staff by helping to prevent ‘burnout’ through overwork:

‘… when putting them on part-time it’s for a minimum of whatever hours, but then you can add up and give them extra hours, so you are putting them on the basic rate which comes into the flexibility thing again. And for the staff member as well. They choose to be part-time. They like to have four days off. So it’s a flexibility thing all round.’ [Manager, aged care, Sydney]

For some employers, part-time staff with other priorities and commitments can be inflexible and may not be available for full-time hours:

‘Our part-timers are very inflexible. They come back from maternity leave and say, “I’ll work Tuesday afternoon only”. And if they don’t get that, they threaten to leave. I think that’s why a lot of them go to part-time – for flexibility. It’s actually our full-time staff that are most flexible.’ [Nurse manager, health services, Sydney]

### 2.4.4 Labour costs

Labour costs for organisations in the Health and community services industry form a high proportion of total operating expenses, both in absolute terms and relative to other low-
paid industries. Therefore, employers monitor their wages bill on a regular basis (weekly or even daily) as there are serious cash-flow risks if they do not pay attention to this major cost. As discussed in 'Compliance and conditional government funding' (page 88), to meet and document service delivery standards now requires a greater number of staff hours worked by a greater number of qualified staff, who are paid higher rates. Thus, conditional government-funding arrangements mean that labour costs are consistently increasing, as the proportion of qualified staff must increase:

‘We are stuck between a rock and a hard place because in aged care we have standards of care to meet, and we have to pay the costs required.’ [Centre coordinator, aged care, Port Pirie]

Penalty rates and allowances are payable to staff beyond the standard hourly rates of pay. According to award conditions, which a large number of organisations reference, shift allowances are payable for early starts, for late finishes, on weekends and on public holidays. As aged care and disability care services often require work outside of normal business hours, many of the shifts allocated to staff attract additional labour costs to the employer. Several employers viewed this positively, recognising that it brings the pay rates closer to those offered for low-skilled positions in other industries. Although it creates challenges for managing the wages bill, employers felt that as long as this is accounted for in their funding arrangements, penalty rates help keep workers in the industry:

‘The penalty rates are what brings them up to the [rate of] the checkout chick who is getting significantly more, as that would be a flat rate when they do work overtime, on weekends and that sort of thing. [The penalty rates in this industry] bring wages up and they [employees] can justify it for their weekly budgeting. If they lose those penalty rates, then [maybe] they can’t afford to work in this sector any more.’ [Nurse manager, health services, Sydney]

Having flexibility in the workforce for rostering purposes helps employers avoid using agency staff. The cost of using agency staff can have a significant impact on an organisation's wages bill:

‘I find that even the existing staff have difficulty actually completing their roster. One minute [they] tell us what they want – you know, you’ve picked the perfect roster [for them] and then they still call in sick at the whim. Then you’re looking for a replacement and it’s just always continuing – have you got enough staff on your books so you can cover shifts? It costs money to put in agency staff and we can’t do that a lot because our agency costs have gone through the roof, and that’s very frustrating from a manager’s perspective.’ [Manager, aged care, Adelaide]

An additional labour-related cost for many not-for-profit operators is the administrative cost of salary packaging arrangements. Some organisations outsource this to specialist consultants, while some larger operators have in-house arrangements. Salary packaging occurred in a variety of different ways. For some, salary packaging is specifically available for work-related items such as cars, petrol and laptops. Others mentioned credit cards that can be used for whatever they choose, including utility bills or loan repayments:

‘I pay my rent that way. I end up paying no tax because I’ve paid my rent and some other things through it.’ [Care assistant, disability services, Bunbury]

‘There’s a number of different options. They can package their mortgage, vehicles, laptops …’ [Service manager, disability services, Sydney]

‘Yeah, I think we have three or four different way we can do it. Credit card is one of them.’ [Manager, aged care, Port Pirie]
Salary packaging was most frequently mentioned as an option for permanent part-time and full-time employees in disability services and aged care. Not all not-for-profit organisations offered salary packaging and not all employees took up salary packaging opportunities when available. Some employees did not understand the arrangements, or felt the hours they worked were too low or too variable to provide much benefit, or that the inconsistency of their work hours would make it difficult to keep track of income. The administrative cost of offering salary packaging to staff was a barrier for some organisations, who therefore did not offer this benefit to their workforce:

‘I think there’s a lot of scepticism from the younger ones. They can’t get their head around it initially and you have to do a lot of talking and education and have the reps come out a few times and do a lot of one-to-one. But once they get their head around it they become the best advocates for it. It’s very interesting to see that sort of change.’ [Manager, aged care, Adelaide]

‘I usually recommend when I’m employing staff that they listen to the information and once they actually have a baseline of permanent shifts, and they have a core wage coming in, then it’s good to think about the salary sacrificing then. But while they’re on casual and just going from roster to roster, then perhaps it’s a difficult thing to do.’ [Manager, aged care, Adelaide]

2.4.5 Determining wage rates

Most employees were not sure whether they were being paid according to an award or Pay Scale, a workplace agreement, or some other arrangement. Many ‘take it on trust’, knowing that there is a legal requirement for employers to pay them at least a minimum rate, or else they simply assume that they are being paid correctly.

However, some employees advised that they regularly check what hourly rate they should be paid, and always review their payslips, because they don’t trust management to pay them correctly:

‘You don’t trust the management. The management won’t go out of their way to advise how much you should be paid. In some cases they won’t even tell you when you ask.’ [Youth case worker, youth services, Adelaide]

‘The problem is that management won’t tell you what you are entitled to receive in sick entitlements and how my pay rate is set. The management seems to keep changing the rules.’ [Personal care assistant, aged care, Bendigo]

Employees were aware that younger workers receive lower pay, and that people with qualifications and/or greater responsibility are paid a higher rate according to their classification. However, there was little understanding of how these different rates and classifications are determined.

Most employees had not negotiated their rate of pay prior to accepting their current role. Very few employees had negotiated a pay increase outside of the annual increase they automatically received. Employees could recall receiving pay increases in the past 12 months, but could not attribute the increase to anything specifically.

Most employers advised that pay rates in their organisation are set at the minimum specified in the relevant award, Pay Scale or workplace agreement for the specified skill or qualification level:

‘Child Care Award rate and not a cent over, is what it is. Because our funding is Commonwealth, we’re under the award that says that if you’re working with clients and doing case work, you’re entitled to level-three pay.’ [Manager, aged care, Adelaide]
‘We don’t have a choice. We just have to do what we have to do, like we have to go by the award or what the budget says.’ [Assistant director, child care, Adelaide]

However, as with employees, there was limited understanding of how Pay Scales are formally determined according to level of qualifications, skills and experience:

‘It involves a union, if that helps.’ [Manager, aged care, Perth]

‘I know that we negotiate with the union, not me per se, but I know that happens.’ [Manager, child care, Perth]

‘It’s about talking to others in the industry and asking how much they pay.’ [Owner, child care, Perth]

Commercially operated businesses were often paying qualified staff above the relevant minimum rates:

‘To attract staff we’re paying them at a level that if you put it against the award [classifications] it makes absolutely no sense to what the responsibilities are against an award. And I find that a little tricky. We don’t have workplace agreements but we’re trying. We do it via award but we’ve got to pay way over-award to attract the staff and I find that frustrating.’ [Director, child care centre, Bendigo]

Not-for-profit operators were most commonly reliant on an award or Pay Scale. However, salary packaging arrangements were usually available to supplement the income of employees in not-for-profit organisations.

As highly skilled and qualified employees currently have more power in the employment relationship, due to a high demand for qualified staff, some employers indicated that they need to keep track of what their competitors are paying above the minimum rates. This keeps employees’ expectations in check, while also ensuring an employer’s offering is competitive. It was noted that these competitive rates of pay make attracting and retaining staff more challenging for those organisations paying exactly the minimum rate:

‘We usually ask for the payslip from the previous organisation [where they were employed]. One agency is paying [level] 4.1 for carers, so we’ll match that and we may look at paying them 20 or 30 cents more. So it’s very competitive. The more agencies that have got their rates up, the more every other agency goes up … and the worst problem that does occur – which I personally have an issue with, but it’s just the industry – is as much as the agencies are fighting between rates [and pushing up wages], no one actually considers what the facilities have to end up paying. Because as [agency rates] go up so do the [pay rates] in facilities.’ [Human resources recruitment consultant, nursing and carers agency, Adelaide]

An exercise was undertaken with both employees and employers to determine what factors they felt were most important to consider when setting an individual’s pay rate (not what is currently considered, but rather what should be considered). Overall, considerable importance was placed on the employee’s skills, qualifications and experience. Interestingly, employers and employees were consistent in their views. A breakdown for each group is presented on the following page.
## Health and community services industry profile

### 2.4.6 Recruitment and retention

#### Recruitment process

The formality of the recruitment process varied from 'generally we just interview in the kitchen' to 'we have nine stages'. Employers reported that their business operations and recruitment processes were becoming increasingly formal because of a greater need for accountability and documentation to secure government funding. Legislative requirements such as police checks, working-with-children checks, and medical fitness tests are part of the recruitment process for many employers:

’We have nine stages and we do a pre-interview questionnaire based on a fair bit of research we did. From the interview process we may use a combination of group [interviews] or one-on-one or two-on-one. After the interview process, they get police checks and we’re looking for specific criteria there. Then a two- or three-week probationary period.’ [Manager, disability service provider, Melbourne]

Some participating employers advised that formalised processes can make it difficult to recruit the most suitable applicant because of the response times involved. The increased length of time required to follow the formal process often resulted in employers missing out on the best candidate:

### Table 12: Employers – important factors to consider in setting pay rates

<table>
<thead>
<tr>
<th>Melbourne</th>
<th>Bendigo</th>
<th>Perth</th>
<th>Bunbury</th>
<th>Adelaide</th>
<th>Port Pirie</th>
<th>Sydney</th>
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<tr>
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<td>✓</td>
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<tr>
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<tr>
<td>What the business can afford</td>
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<tr>
<td>What the law says</td>
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</table>

### Table 13: Employees – important factors to consider in setting pay rates

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<tr>
<th>Melbourne</th>
<th>Bendigo 1</th>
<th>Bendigo 2</th>
<th>Perth</th>
<th>Bunbury</th>
<th>Adelaide 1</th>
<th>Adelaide 2</th>
<th>Port Pirie</th>
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<td>Value to the business</td>
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<td>Required workload</td>
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<td>Demand for skill set</td>
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<tr>
<td>Commitment</td>
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<tr>
<td>Involvement in on-the-job training</td>
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<tr>
<td>Cost of living</td>
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</table>
Health and community services industry profile

‘We have to use the management [a local government council authority] requirement to recruit and fill positions using the human resources officer. Now we find the positions are slow to advertise, shortlist, select and recruit, and by the time you offer the person the job they have taken another job elsewhere. It used to be faster when we did it ourselves.’ [Manager, aged care, Bunbury]

‘We also have the problem of increasing HR accountability which is slowing down recruitment. It is a big issue because you miss the best applicant and you get stuck with the fifth or sixth best.’ [Manager, youth services, Bunbury]

Unskilled recruitment

Employers reported that attracting candidates for unskilled positions was not difficult. Many had experienced a large volume of interest in positions they had advertised. Most employers also reported proactive approaches from applicants either in person or via email:

‘It isn’t really a problem. We get plenty of telephone calls and CVs and sift through them. It’s not hard. We also get good results from recruitment ads placed in local newspapers.’
[Owner, aged care, Perth]

‘We get some résumés – maybe two a week. That’s quite a lot.’ [Assistant director, child care, Adelaide]

However, employing a suitable candidate for an unskilled position was more difficult. Many employers reported going through a large volume of applications and interviews to find the right people – those who have a positive attitude toward providing care and assistance:

‘They have to have the right attitude and values. You can’t teach people values.’
[Manager, aged care, Melbourne]

Employers also highly regard a strong work ethic, as well as a caring nature, in potential employees:

‘It is hard to find people who want to work. They don’t turn up when required. Some employees are not loyal or don’t care. This means key staff have to take the load.’
[Owner, aged care, Perth]

‘It is extremely hard to find people who really like the children and realise it is hard work.’
[Director, child care, Sydney]

A few employers talked about cultural and ethnic barriers to employing certain candidates. The background and appearance of those providing the care was reportedly a practical consideration in terms of impact on the team dynamics, as well as on the clients (particularly those in aged care):

‘No-one’s wishing to be discriminatory but there has to be some practicalities and the particular cultural backgrounds need to be matched in order to get the synchronicity.’
[Manager, aged care, Adelaide]

Several employers reflected their frustration with receiving applications for entry-level positions from people who are fulfilling job-search requirements to receive government allowances, rather than genuinely looking for work:

‘It fluctuates. People apply but they don’t turn up for interviews.’ [Owner, child care, Perth]

‘There’s a lot of people out there looking for jobs, but they don’t want to work. That’s a problem.’ [Manager, health services, Bendigo]
Wherever possible, employers will delay recruitment if they have not found a candidate with the qualifications, skills and experience required for a particular role. However, over time employers become more likely to accept lower quality candidates if positions have proved particularly difficult to fill. Some participating employers had also employed junior staff to fulfil staffing requirements, where they would not have done so in the past:

‘Although we say that we prefer our staff to have Certificate III, we actually find it really hard. If we actually said that our staff had to have Certificate III, we’d have people [clients] at risk because we wouldn’t be able to provide services.’ [Coordinator, aged care, Port Pirie]

‘… we have to accept less well-trained, less experienced people.’ [Manager, youth services, Bunbury]

‘We employ more junior staff to fill spaces. That is where the interest is and we employ a high proportion of those to fill our numbers rather than having no-one.’ [Nurse manager, health services, Sydney]

It was acknowledged that accepting untrained and unqualified staff puts pressure on existing staff and management in the short term, due to training and supervisory requirements. However, this was sometimes the only option available. All employers reported that they will not compromise on certain essential qualities for potential employees: strong values, a positive attitude and willingness to work hard.

Skilled recruitment

The recruitment of skilled staff presents a significant challenge for employers. Attracting skilled staff is difficult, as employers are not able to greatly differentiate their employment offering from that of their competitors. The demand for appropriately qualified employees is increasing as qualifications are becoming the minimum standard in the industry, and it seems that numbers of experienced and qualified personnel are decreasing in proportion to the growing demand for services:

‘Finding applicants with Certificate IV qualifications is difficult. The problem is that regulations prescribe that staff need to have Certificate IV, but it is also important for the applicant to have favourable attitudes and values relevant to this industry.’ [Manager, disability services, Melbourne]

“We need child care leaders who have the TAFE diploma and with two years’ experience.’ [Manager, child care, Perth]

Some employers reflected on times when they sourced the best graduates for entry-level positions via arrangements with local colleges. These arrangements are now uncommon due to increased competition for qualified staff among a larger number of operators, and decreased levels of interest in training in a field that offers low rates of pay:

‘We went through a much more formal process this time, and in fact I was personally away, but the HR person and my assistant manager interviewed and chose four and lost them, before they even started, to other agencies. We responded in a timely manner. We did get back to them, so you know … they’ve got a choice of ten places to take, so they took somewhere else.’ [Manager, home and community care program, Bunbury]

“They’re doing two years of college and they’re coming out for a job that pays them $19 an hour and they’re finding it not worth their while. They can work at a supermarket and make more money, so they’re just not doing it [obtaining qualifications].’ [Director, child care, Bendigo]
Several employers reported engaging the services of specialist recruiters or agencies to find suitably qualified employees. This was most prevalent among larger operators, particularly in aged care, and was less common among child care service providers. It was recognised that this process is costly and far from ideal when operating conditions are tight. There were a number of examples of employers having their valued staff 'headhunted' and some examples of recruiters 'poaching' staff from competitors. The intra-industry turnover or ‘churn’ of more highly qualified and skilled employees is currently less of a concern than inter-industry churn of employees, but it is becoming increasingly apparent:

‘We have to use an agency to fill the places because we can’t recruit.’ [Manager, aged care, Melbourne]

'It's very hard to get qualified staff. It's very easy to get the young girls in, but finding qualified [people] to work for the money that they're on is really, really difficult. We've actually got a recruitment agency now that does that [finds suitable candidates] but we do the interviews.' [Director, child care, Bendigo]

‘… you can fill them via headhunting. Aged care has become very competitive and you have to use recruitment agencies.’ [Manager, aged care, Bunbury]

Training

To meet the challenge of finding suitably qualified staff, many employers now hire unqualified staff and train them. Employers facilitate training for new staff members, so staff gain the required qualifications once they have entered the industry, rather than prior to entering it (as employers would prefer):

‘In recent times we’ve been employing people who may have some experience but not necessarily the qualifications. We employ them and train them. So we’re paying for their training to be qualified enough to do the job that we’ve employed them to do.’ [Manager, disability services, Bendigo]

Several employers highlighted the risk of investing in training new staff, who may leave the organisation before the skills they acquire can be appropriately utilised:

‘You train them and then they don’t come, they don’t turn up.’ [Manager, child care, Adelaide]

‘… we’ve got a fairly high turnover at the moment, which is a little frustrating … We’re putting a lot of money into training [them] and then they move on.’ [Director, child care, Bendigo]

Some organisations are now funding the training of existing employees rather than attempting to recruit highly qualified staff. Training is generally offered to long-serving members of staff to recognise their loyalty, rather than to new recruits. Many employers look for government-funded training opportunities for their staff, while most strongly encourage their workforce to obtain further qualifications by providing flexible working arrangements, but do not offer any financial assistance:

‘We push for them to do Certificate III. Sometimes the government might pay or the Southern Development Board might pay.’ [Coordinator, aged care, Port Pirie]

‘We have traineeships. Funded, not for profit, but if we can’t get the funding we normally don’t sponsor them. They do it outside of work.’ [Manager, disability services, Melbourne]

‘It is very hard to find good staff, and often it is easier to train staff in-house or encourage staff to undertake qualifications study.’ [Manager, child care, Melbourne]

‘In my centre I put them on traineeships and I’ve got two of them nearly qualified.’ [Owner, child care, Perth]
Several employers commented on providing training as a strategy for retaining staff. If employers facilitate training and qualification of new staff, then they can be confident that the employee will stay for a minimum period of time:

‘… once we get them and offer the training, they’re with us a while.’ [Owner, child care, Perth]

Retention

A frequently reported issue for employers was the turnover or ‘churn’ within their workforce. This includes the loss of highly valued long-term staff, but more often the loss of shorter term staff. Churn appears to be relatively high across the industry, particularly for organisations in the metropolitan areas of Sydney and Melbourne. Employers reported that although some poorly performing staff may be ‘pushed’ out of employment, most often it is staff who ‘pull’ themselves out by leaving their current employer, and sometimes the industry.

Discussion explored how long lower paid employees typically stay with any one organisation in the industry. Employers reported that length of service has been declining. In the past, staff would work for an organisation for around 10 to 15 years, or longer in areas with few employment alternatives (usually regional areas). More recently, new employees typically remain with an employer for up to three to four years before moving on. Younger staff employed in child care services generally work for up to one to two years with any one employer:

‘I've got the young girls that will come in and they'll work for a year but they're only saving so they can go overseas. And then they're gone. I get that a lot.’ [Director, child care centre, Bendigo]

Employers indicated that many of their experienced and highly valued long-term employees stay with them until retirement. These long-serving employees are not easily replaced, as their commitment and loyalty is not often matched by that of new recruits. The general consensus among employers was that around half of their recent recruits stayed for a relatively long term (three to four years, sometimes longer), and the other half were with them for a short term (a number of months):

‘Half of my staff have been there seven to twelve years, and the other half continually leave.’ [Manager, disability services, Melbourne]

‘It's the unskilled, casual staff who leave.’ [Owner, aged care, Perth]

‘I've got a handful of girls that are good workers, that I can rely on no matter what, but there’s others — you just wonder if they're going to turn up. And I think we all experience that.’ [Owner, aged care, Perth]

The most common explanation for employees leaving after a short period was failure to understand how challenging the role would be, particularly in the area of child care:

‘They think it's something they can do and they have the impression that if you’re working with children, you sit down and you watch them. They don’t realise you’ve got to work and it's really, really hard work. It’s hard work physically and mentally.’ [Director, child care, Sydney]

‘The younger staff are the hardest to hold. The long hours … and the energy involved in caring for children take it out of you. You also need to have discipline.’ [Owner, child care, Perth]

‘The problem is that every 15-year-old who can’t do well at school thinks that going into child care is lovely: “I love kids. I babysit my niece”. But they’re not suited for what’s
actua...od work. They're princesses. Like, “How do I use a mop?” Oh my God! Yeah, so a complete misunderstanding in the community of what child care work actually is.' [Owner/operator, child care centre, Bunbury]

The low rate of pay compared to other industries was also frequently cited as a reason for newer recruits considering leaving their current employer, or leaving the industry. Many employees provided examples of higher pay rates they received from working in low-skilled positions in other industries, or from a second job:

‘I used to work at Coles as a checkout operator and earned $22 an hour. But even working for an agency as a personal care attendant I can only earn between $17 and $20 an hour.’ [Personal care attendant, aged care, Melbourne]

‘I get paid more in my second job where I do telephone marketing and promotions. As a 20-year-old I get paid $20 an hour in the second job, and as I get older I can earn $25 an hour. But as a personal care assistant [working in aged care] I only earn around $15 an hour, and you need to do harder work.’ [Personal care attendant, aged care, Melbourne]

Some employers expressed concern about employees leaving to take up positions in the public service (e.g. with the Department of Human Services), where they are paid significantly higher wages:

‘I think it’s hard to get good quality staff at any given time, but I do have various entry points that they can come in and we can train them up. But the hardest part for me is I do train them up, give them the opportunity, and then they go off. And what they tend to do is they go off into government positions that are being paid [higher rates]. There’s no wage parity, so they’re going to go up $15,000 more than they just got for doing the same thing.’ [Manager, accommodation services, Adelaide]

‘The hospitals are used to paying a higher salary than aged care.’ [Manager, aged care, Melbourne]

Most employers reported that they would prefer to pay their valued staff a higher rate of pay than they do currently. This was not just to retain their services, but to reward them for their commitment and hard work. Employers were asked to share their ideas and individual approaches to retaining their workforce. A number of initiatives to ensure staff understand they are appreciated and valued were shared, most commonly by owners of commercially operated businesses. These employers had the most scope to offer higher rates of pay, incentives and favourable conditions:

‘I don’t think the industry pays enough money for what the job is, but I’ve been lucky enough to get people who are passionate about what they do and are prepared to work for less money. I keep them happy at the job by offering them little extras, like I send them to the hairdresser, things like that. That’s what I do for the staff so that they feel valued, because I realise I can’t pay [higher wages]. She could go and earn more at the local primary school as a preschool teacher but she’s working for me instead for less money because she likes the age group.’ [Owner, child care, Perth]

‘We have a flat rate but we give bonuses for exceptional work, or when we have staff functions we’ll give gifts. You’ve got to give rewards.’ [Owner, catering for the elderly service, Perth]

‘I can’t speak for every agency but I’m pretty sure we offer as part of our incentive – and I know others do too – gift cards. If candidates work hours over on top of their wages, which is not put through the tax system, they get incentives to do that.’ [Manager, accommodation services, Adelaide]
For longer term employees a frequently reported reason for pulling themselves out of their employment, or considering this option, was ‘burnout’. In this instance, most employees leave the industry to pursue employment that is less physically and emotionally demanding and/or more appealing to them. Other employees take up employment with an agency and work casually. Agency work is less demanding, as there is less paperwork and accountability. Employees also find it is easier to disengage from work when not caring for the same patients consistently:

‘I suppose with our accreditation staff, it’s easier working for the agency as you don’t have to keep the records and documentation.’ [Manager, child care, Melbourne]

Most employees also cite a lower-than-acceptable pay rate for the duties they carry out as compounding the effects of burnout. Both employers and employees frequently commented on being short-staffed and the additional pressure this places on employees. This pressure exacerbates the effects of the physically and emotionally demanding work, and causes staff to reach their threshold for stress significantly faster:

‘It is hard work in the caring industry, and my 16-year-old son earns more than me. Working in aged care and disability centres weighs on you with the responsibilities involved, such as giving out medication to the clients. You also get attacked and verbally abused, and you have to put up with it.’ [Carer, disability services, Bunbury]

‘I had a long time in the industry as an occupational health nurse. But you get burnt out because of understaffing, and all of the physical and mental health issues.’ [Ex–occupational health nurse, health services, Bendigo]

‘For myself, I’m on 24/7, seven days a week, holidays, whatever. And to get those highly qualified people to do that, it’s almost [impossible]. They’re there, but they want to be paid for it, and I don’t blame them.’ [Manager, aged care, Adelaide]

Many employers discussed the challenge of attracting and retaining the younger generation, and why they feel younger people are less interested in building a career in the industry. Many felt that the generation currently entering the workforce has a weaker work ethic, and a lower level of commitment; that younger people are deterred by the amount of work involved, particularly in providing direct care services. Others felt they are not willing to take entry-level positions and work their way up, despite not having any qualifications or experience:

‘We’re constantly being challenged about “Generation Y” and how we have to dazzle them and the only way we’re going to attract any of them is the big song and dance. And you need to talk to them completely differently than anybody else. I’ve often found that “Gen Y” comes from the expectation they’re going to start at this level and not work their way up. I think that’s been a really difficult thing for me to understand – why their expectation would be there.’ [Recruitment officer, health services, Bendigo]

‘It’s hard to find people who just want to work. I’ve had girls that have come in and do one day. Some don’t turn up; that’s the hardest part. I’ve got a handful of girls that are good workers that I can rely on no matter what, but there are others, you just wonder if they’re going to turn up. And I think we all experience that. They’ve got the upper hand and at the moment … it’s the workforce that’s got the upper hand.’ [Owner, meals for the elderly business, Perth]

A range of other factors contribute to the retention challenges in the Health and community services industry. These include increased administrative requirements, underemployment, staff dissatisfaction with management, and staff's feelings of underappreciation. These issues are discussed in further detail in Section 2.3.3, ‘Negative aspects of the industry’.
2.5 Employee profile

2.5.1 Who works in the industry?

In this study, the employee participants working in the Health and community services industry were predominantly female and of varying ages. Compared to figures for all industries combined, younger workers are under-represented in the Health and community services industry, and mature-aged workers are over-represented, particularly compared with other low-paying industries such as the Accommodation, cafés and restaurants industry, and the Retail industry. The majority of employees reported that they see their current employment as a ‘career’, but for some it is simply a ‘job’.

The age of the employees and their perception of their current employment as a ‘job’ or a ‘career’ provide effective dimensions for demonstrating the range of employees working in this industry. This is represented in Figure 73 below.

Grouping participating employees in this way is not intended to pigeonhole people who work in the industry; rather, Figure 73 is a basic representation of the different employees involved in this research. There is diversity within each of the broad segments and this diversity is discussed further below.

Figure 73: Segmentation of different types of low-paid employees in the industry

Younger people who see their employment in the industry as just a job.
‘I need money to live, that is why I work. I also enjoy this field of work, but I see it as a job and receiving an income is important’

Younger people who see their employment in the industry as a career.
‘I work because I love my job and I need the money. I see it as a career because it is a passion in my life’

Older people who see their employment in the industry as a career.
‘I work because I enjoy my job looking after disabled people. I see my current employment as a career because I feel that I am very experienced in what I do.’

Older people who see their employment in the industry as just a job.
‘I work because I have a mortgage. It is just a job’

Younger people who see their current employment as a ‘job’

As younger workers are under-represented in the industry, and most participating employees perceived their current employment as a career, this segment was the smallest of the four.

This segment mostly comprises employees working in aged care or child care services – it was rare for younger people to be working in disability, or other high-level care services.
Most employees in this segment were unqualified or held the minimum qualification required to perform their role. Most were employed on a permanent part-time or casual basis. Many were employed straight out of school or following the completion of a TAFE course to achieve the minimum qualification for their role (e.g. Certificate III). Most had been in the industry for less than two years and were unsure about remaining in the industry.

As income and financial commitments seem to be primary drivers for employees in this segment, employees' passion for working in the industry appears to be weaker than that of those employees who view their current employment in the industry as a career. Despite this, many employees in this segment were genuinely attracted to the industry. Examples of responses from this segment include:

- Female, 20 years, Melbourne, employed as a personal care attendant in aged care. She works 20 hours per week at $15.83 per hour:
  
  ‘I need money to live. That is why I work. I also enjoy this field of work, so the experience I receive is also very important to me. But I see it as a job and receiving an income is important.’

- Female, 26 years, Sydney, employed as a child care worker. She works 37.5 hours per week at $14.13 per hour:
  
  ‘I need to pay the bills, a mortgage and car loans. It’s a job – something I had to do.’

- Male, 20 years, Adelaide, employed as a wardsman in aged care. He works 20 hours per week at $15 per hour:
  
  ‘I work because I need the money and like being independent. I’m working through uni. The more I travel, the more I need to work.’

Older people who see their current employment as a ‘job’

Older employees who viewed their work in the industry as a job formed a relatively small segment. These employees were most likely to be employed on a part-time basis, and were employed across the Health and community services industry. Most often they were unqualified or held the minimum qualification to perform their role.

These employees generally entered the industry at a more mature age. Many had entered the industry on a voluntary basis before gaining a paid position, or had personal experience caring for a relative. It was also common for these employees to have experienced difficulties finding employment in other industries. Thus, they appreciated the opportunities offered to mature-aged workers in this industry. The majority of employees in this segment plan to stay in Health and community services until they retire.

While employees in this segment were primarily focused on their financial commitments and consequently their (relatively low) income, they were also genuinely interested in, and passionate about, their work. In many cases, the main reason these employees did not see their current employment as a career was because they were ‘slowing down’ as they neared retirement. They were not looking for advancement opportunities. Most often, the employees in this segment were working the minimum hours required to maintain their livelihood.

- Female, 51 years, Bendigo, employed as a personal care attendant and kitchen worker in aged care. She works 37.5 hours per week at $15.75 per hour:
  
  ‘I work because I have a mortgage. It’s just a job.’
Female, 45 years, Bunbury, employed as an assistant in child care services. She works 17 hours per week at $14 per hour:

‘I work because I need to help pay off my mortgage, and because I enjoy working with children. I see my employment just as a job. I need the income.’

Female, 41 years, Sydney, employed as an enrolled nurse in disability services. She works 38 hours per week at $18.40 per hour:

‘I enjoy working in an industry that helps people. I enjoy mental health. It’s just a job. [It] could be a career if I got paid better.’

Younger people who see their current employment as a ‘career’

This was a relatively large segment, as most workers in the industry saw their employment as a career. Many participants in this segment felt their current employment would lead to a career, as they were using their role as a ‘stepping stone’ by gaining experience relevant to their plans for the future.

These employees predominantly work in aged care or child care; it was less common for them to be working in disability or other high-level care services. They were most likely to be employed on a permanent part-time basis while they studied, or on a full-time basis – many as trainees. These employees were generally employed in the industry straight out of school or following the completion of a TAFE course to attain the minimum qualification for their role (e.g. Certificate III).

Many employees in this segment were in the process of obtaining qualifications to advance from their current role. There were several examples of employees looking to advance in their current field of employment, including child care assistants with Certificate III in Children’s Services pursuing diplomas in order to progress to supervisors or room leaders. There were also numerous examples of employees who were using their current employment as relevant experience towards entering different roles in the industry, for example, working as personal care assistants in aged care while studying to become nurses. There were also some examples of employees who were gaining transferable skills in the Health and community services industry in order to work in other industries, including participants who were working as child care assistants while studying to become teachers.

Most of the employees in this segment have been in the industry for less than five years and are confident they will remain in the industry for the long term. Employees in this segment were genuinely passionate about their work.

Female, 20 years, Bunbury, employed as an assistant in child care services. She works 37 hours per week at $16.26 per hour:

‘I work because I enjoy working with children. I view my current employment as a career because I wish to complete my diploma in child care and continue in child care as a career.’

Female, 21 years, Melbourne, employed as an assistant in child care services.

She works 35 hours per week at $13.50 per hour:

‘I am passionate about my job and I wish to become a room leader or a teacher, and I see this job as leading to a career.’

Female, 23 years, Melbourne, employed as a personal care attendant in aged care.

She works 15 hours per week at $16.40 per hour:

‘I enjoy working in health care and aged care and I also work for the money. I see it as a career and this job as a stepping stone into nursing.’
Older people who see their current employment as a ‘career’

Older employees who viewed their work in the Health and community services industry as a career formed the largest segment. These employees were employed across the spectrum of Health and community services, usually on a permanent basis, working full-time or part-time. Most held all of the qualifications required for their role. Very few of these employees were pursuing further training, apart from that required to maintain their accreditations and qualifications.

Participating employees in this segment were generally very experienced and had initially been employed in the industry from a relatively young age. Most of the employees in this segment have been in the industry for a minimum of 10 years; many had been in the industry for more than 20 years.

There were, however, some employees in this segment who had entered the industry at a more mature age. This was usually after their children had become independent, or no longer required intensive parenting. Many of these employees were in the process of obtaining further qualifications to in order advance their careers.

Most employees in this segment plan to continue their work in the industry until they retire. They are genuinely passionate about their work. Many reported being satisfied with their current role. However, some aspire to move into more highly paid management positions or to start their own business, for example, to open a new child care centre.

- Female, 65 years, Bendigo, employed as a personal care attendant in aged care and disability services. She works 35 hours per week at $18.50 per hour:
  ‘I work because I love the clients I work with. I enjoy working with people with disabilities. It’s a career because the position allows ongoing training and personal development.’

- Female, 42 years, Bunbury, employed as a residential aide in disability services. She works 18 hours per week at $16.40 per hour:
  ‘I work because I do enjoy my job in looking after disabled people. But I also need the extra money. I see my current employment as a career because I feel that I am very experienced in what I do.’

- Female, 49 years, Adelaide, employed as a child care worker. She works 21 hours per week at $17.38 per hour:
  ‘I work because I enjoy my job. I see my employment as a career because I am currently doing my child care diploma to advance my position in child care.’

2.5.2 Work, income and lifestyle

Why employees work

As discussed throughout this report, employees are passionate about working in the industry and most find their work extremely rewarding. However, the majority of employees also reported that income is a primary driver for them. They need to cover their basic day-to-day expenses, so they have to work, but the Health and community services industry is where they choose to be. For many, their financial commitments – rather than lifestyle factors like study or parenting – dictate the income they require, and therefore the number of hours they need to work:

‘I work because I have to. It is a job and I have to live within my means.’ [Personal care attendant, aged care, Bendigo]
‘I work because I have to contribute to the household expenses. My current employment is just a job.’ [Child care assistant, child care, Bunbury]

For some employees, wages from work in this industry may be supplementing government allowances, income from a partner, or wages from other paid employment. These employees appreciate the flexibility offered through their employment in this industry. Casual or part-time working hours can fit around and support their lifestyles, enabling them to focus the remainder of their time on other priorities or commitments. For many, their time at work is important for social interaction and personal development:

‘My income helps my lifestyle. I am working to help pay for my children’s education. I don’t have to work. It is because I want to work.’ [Customer service officer, counselling services, Bunbury]

‘I am focused on lifestyle. The job I do and the hours fit into my lifestyle with my children.’ [Residential aide, aged care, Bunbury]

‘I work because it is something I enjoy and it fulfils my life.’ [Long day care chef, child care, Sydney]

Several participants were encouraged by family members to build a career in Health and community services. Many had parents or other relatives already working in the industry, and their employment was a key connection with these family members:

‘My mother was a registered nurse in aged care and I managed to get a part-time job in aged care.’ [Activities coordinator, aged care, Port Pirie]

‘My mum was a nurse and influenced me.’ [Trainee nurse, health services, Melbourne]

‘Well, I did heaps of different jobs and most of my family work in the field, so I just kind of fell into it and really enjoyed it.’ [Child care assistant, child care, Adelaide]

Many of the employees who entered the industry at a mature age had personal experience caring for a family member, and then chose to pursue paid employment in the industry. Many felt they had valuable skills and experience to offer that were acquired through life experience rather than formal training:

‘I helped care for my grandmother when she had Alzheimer’s and this experience attracted me to work in aged care after I had my two children. I love working in aged care.’ [Case worker, aged care, Bunbury]

‘I cared for both my mother and mother-in-law during their aged care and I also had a disabled child. As a result of this experience I decided to work in aged care and I have completed my Certificates III and IV in Aged Care.’ [Home support worker, aged care, Port Pirie]

‘My dad had dementia and my mother cared for him, and this encouraged me to enter aged care and do Certificates III and IV nursing qualifications. Yes – I will stay in aged care and I will continue increasing my qualifications.’ [Assistant nurse, aged care, Sydney]

There were a number of examples of employees viewing and using their employment in low-paid entry-level positions as stepping stones to more highly paid positions within the industry. Some employees aspired to remain in their current division of the industry, aiming to eventually operate their own business. Some employees were gaining relevant, transferable experience to be utilised in other areas of the industry, or in other industries, including teaching:
‘I love kids and making a difference for the kids. You feel like a mum getting kids skilled. I will be staying in child care because I want to set up my own child care centre.’ [Preschool teacher, child care, Sydney]

‘I see my current employment as a career because it can lead into undertaking study to become a registered nurse.’ [Aged care worker, aged care, Adelaide]

Income

Many employees commented that their low rates of pay did not deliver the income they desire or even require. A number of these employees were currently exploring, or intending to explore, their options for securing employment that will provide a greater income:

‘The pay is low in child care. I only earn $14.09 an hour and I don’t think it will go up when I turn 21. If I stay in child care I would like to work my way up the ladder to be a team leader. I would like to stay in child care but I cannot afford to unless I work more hours. The hours are low, as I can only work 12:30 pm to 6:30 pm every day. I want more hours to get my pay up. If I cannot I will look for a new job such as a real estate receptionist, where I have worked before at $19.90 per hour. But I do love the job in child care and I love working with kids. But at the moment I just see it as a job.’ [Child care assistant, child care, Adelaide]

As discussed in ‘Retention’ (page 107), the low rates of pay and consequently low income levels offered to employees are a major barrier to retaining staff in the industry. Many comparisons were made between wage rates in the Health and community services industry and other industries, particularly industries where employees are generally low-paid due to the unskilled nature of tasks undertaken. Most employers and employees commented on the rates of pay being too low in the Health and community services industry for the amount and intensity of the work, and the responsibilities involved in service provision (a work value argument). Many employers in the industry felt that staff should be paid at a higher rate for the work they do:

‘What’s very sad for our employees is that they see a checkout chick get $19.00 just to scan [items] and it [pays] more than what they are getting paid.’ [Manager, aged care and disability services, Sydney]

‘Everyone knows about child care centre rates … [If] you go to McDonald’s you’d get more money.’ [Manager, child care, Melbourne]

‘Our [staff] do dementia-specific, high-[level] care. It’s very hard work and most of the staff are [paid] under $18.00 [per hour]. I don’t think that the rate of pay that our staff get is fair. I think it is far too low for the work that they do … but we can’t afford to pay more, that’s the crime. So unless the government funding increases we can’t afford to pay more, but that doesn’t mean I think it’s fair, because I don’t.’ [Manager, aged care, Sydney]

Employees reported that they currently earn between $14 and $18 per hour (before tax is deducted) as their standard rate of pay (low-paid employees were deliberately targeted for this research). Casual employees typically worked between 12 and 20 hours per week. Part-time employees worked between 20 and 37.5 hours per week. Full-time employees worked 38 hours per week or more.

Casual employees were receiving a higher hourly rate of pay to compensate for not being entitled to annual and personal leave. Generally casual loading was approximately 20 per cent. Some casuals preferred this arrangement, as they were focused on the higher hourly rate, while others would prefer the security of a permanent full-time or part-time position if it were available.
Many employees reported that, to their knowledge, they were not receiving any penalty rates beyond their standard hourly rate of pay. Some aged care and disability care employees working on a casual or part-time basis reported receiving penalty rates or shift allowances for working very early in the morning, late at night, on weekends, or on public holidays. Typically, these penalty rates increased their income by $50 to $100 per week. Employees working in child care services reported that as they do not work on weekends or public holidays, they do not receive penalty rates.

A number of employees who had left positions in disability and aged care services commented that payments for overnight stays with clients were insufficient. Where employees were required to stay with a client overnight they were paid a flat rate of $30 to $45, rather than being paid by the hour. This was justified because there was limited or no direct care provided during this period when the client was asleep:

‘… an overnight shift wasn’t paid an hourly rate; it was paid on a stand-by rate. You actually sleep in their house, so from 4 pm till 8 am [16 hours] you got a standard $30 [for the responsibility of the client's welfare, not often having to provide direct care].’
[Ex–personal care assistant, disability services, Perth]

Attractive salary packaging arrangements were mentioned by participating employees and employers working for not-for-profit organisations. The salary packaging arrangement allows employees to spend up to $16,000 using their pre-income tax wages without incurring fringe benefits tax, which means they do not pay income tax or fringe benefit tax on these earnings. This ultimately reduces income tax and increases take-home pay for eligible employees.

Salary packaging occurred in a variety of different ways, but all participants who were eligible for the arrangement reported that it was a great boost to their income:

‘Salary packaging greatly reduces my taxable income.’ [Midwife, health services, Melbourne]

Salary packaging was most frequently mentioned as an option for permanent part-time and full-time employees in not-for-profit disability services and aged care. However, not all employees took up salary packaging opportunities, either because they did not understand salary packaging arrangements, or because their hourly pay rates or hours worked were too low to provide much benefit.

There was evidence some participating employees received additional income through government allowances. These employees used the flexibility available in their employment to minimise their hours of work, in order to balance their income from paid employment and their income from government allowances. Examples of this include the following:

- A male child care assistant restricted himself to working two days per week to ensure that he continued to receive NewStart payments.
- A female personal care attendant restricted herself to working two days per week to ensure she continued to receive Youth Allowance.
- A mature-aged female carer in Bendigo receiving the Age Pension was working casually, and restricted the number of hours she worked each week to ensure that she did not owe income tax at the end of the financial year. It was discussed that more than half of her wages from her paid employment, which she wants to supplement her pension payments, was lost through income tax. This seemed to be of concern to other employees nearing retirement who do not currently have sufficient superannuation to support themselves when they eventually retire.
A number of examples of mature-aged employees salary sacrificing large portions of their income into superannuation were shared in the focus groups. For some employees transitioning into retirement, their entire wages were going into superannuation and they were not paying income tax on these earnings:

‘We’ve got one staff member that salary sacrifices her whole pay into super.’
Owner, aged care services, Perth

Non-cash benefits

Many participating employees reported that their employers provided some form of non-cash benefits, usually in the form of meals, tea and coffee. Some employees had undertaken training and qualifications paid for by their employer, while a small number of employees had access to fleet vehicles.

Participating employers mentioned providing a range of additional non-cash benefits to their employees. Employers from the private sector seemed to have more scope to provide non-cash benefits, including free or subsidised physiotherapy, massage, counselling, child care or accommodation. A small number of participating employers also reported that they provide additional paid leave to their employees as a preventative measure against ‘burnout’:

‘… [staff] are dealing with other people’s [clients] huge personal issues … we’ve got to watch out for burnout and things like that because [the clients are] generally people with very high needs. And so you’ve got to give extra care [to your staff] like extra leave and things like that, otherwise they burn out. We find that we’ve got to pay staff to have extra leave for self care and things like that. Mostly they’re part-time because they find that full-time drains them out. And often we’re finding that four weeks annual leave isn’t enough for them so we offer special leave and extra leave. [We’re] trying to make the job more attractive and to keep them.’ [Manager, counselling services, Bendigo]

‘We don’t pay dollars over the award; we pay conditions over the award, if you like. If the award for a particular job was $18 we wouldn’t offer them $19 … We offer them a nine-day fortnight instead of one rostered day a month.’ [Manager, child care, Melbourne]

Further details on non-cash benefits and incentives are discussed in ‘Retention’ (see page 107).

Income and lifestyle

The majority of employees felt that their income dictates their lifestyle. In many cases, their income provides just enough to pay the bills. Participating employees mentioned the lifestyle sacrifices they have made because their income does not support life beyond the necessities:

‘My income dictates my lifestyle, because I am not receiving enough to do everything I want.’ [Aged care worker, aged care, Adelaide]

‘I need the income. I only just get by and I can’t go on holidays or enjoy things like going out for coffee!’ [Carer, youth services, Port Pirie]

‘I work to get income. I am definitely not paid enough to have or sustain the lifestyle I would like.’ [Early childhood education worker, child care, Sydney]

‘Income is most important because I find it difficult to pay bills and to have any savings by the end of the week.’ [Assistant child care worker, child care, Bunbury]

‘I don’t get paid enough to have a lifestyle.’ [Enrolled nurse, disability services, Sydney]
Underemployment

Some participating employees’ income is not sufficient to cover their basic living expenses. Some have taken on a second job because of the low pay and/or the fewer-than-desired hours. Underemployment is a prevailing concern among those casual and part-time employees who did not choose this employment arrangement:

‘I can only receive $14.57 per hour on permanent part-time rates and only $16.90 per hour on casual rates. That is why I work two jobs.’ [Before and after-school child care worker, child care, Adelaide]

‘I love the job. But it is low pay and people leave or have to take two jobs. It is too hard to pay household rents or mortgages.’ [Preschool teacher, child care, Sydney]

Unlike other services across the industry, most organisations offering child care services do not operate on weekends. Therefore, employees working in this division of the industry do not have access to weekend work, which often attracts a higher rate of pay. Further, hours of operation for some child care service providers are limited to before school hours and after school hours, thus limiting the number of hours available to staff:

‘Our service is only run for very short hours: before- and after-school care. So it’s only for two hours in the morning and from 3 pm to 6:30 pm.’ [Director, not-for-profit child care, Adelaide]
2.6 Impact of increased minimum wages

2.6.1 Awareness and understanding

There was very low awareness and limited understanding among both employer and employee participants of the mechanisms for determining Federal Minimum Wages. Many employers and employees hypothesised that any change to minimum wages in Australia was an adjustment for inflation that would be incorporated under the relevant award or collective agreements. Very few participants were able to articulate the name, the role or the functions of the Australian Fair Pay Commission:

‘I have heard of the Australian Fair Pay Commission but I don’t know much about it.’ [Child care assistant, child care, Melbourne]

Discussion identified a common view that a ‘safety net’ for wages and employment conditions is available through industrial laws and industrial courts:

‘[For employees] in disability [services] it [the pay increase] came through into the private sector. They just went through the industrial courts to get a pay rise, through disability not-for-profit coming together and not signing contracts with DHS.’ [Manager, disability services, Melbourne]

However, once the role and functions of the Commission were explained to research participants there was strong endorsement for both the existence of the Commission and the process of determining Federal Minimum Wages in Australia. Top-of-mind responses focused on the importance of having a social safety net. A number of participants spoke about competitiveness, and measures to prevent exploitation of workers:

‘It is imperative to protect marginalised people.’ [Manager, aged care, Bunbury]

‘It is important to have a minimum wage to avoid social problems and people struggling to survive, and it is important to have a base level to avoid exploitation.’ [Home support worker, aged care, Bunbury]

‘It is a good idea to look at the minimum wage level. People in this position are vulnerable and as a societal issue it is important to address.’ [Manager, youth services, Bunbury]

‘People have to be protected because there’s plenty of sharks out there who would sort of take advantage.’ [Owner, aged care, Perth]

Most employers were aware that minimum rates of pay are adjusted regularly. Annual increases were commonly referenced by employers, though few could attribute the increase to the Commission:

‘Only when the government said in July you get another $10 extra, and that’s what we get.’ [Owner, child care, Perth]

‘The last one for the health services was 1 October 2007.’ [Owner, child care, Adelaide]

‘For] the child care workers and teachers awards there’s been set times over the last three years where they’ve increased.’ [Manager, child care, Melbourne]

‘We had a pay rise; it was 18 months ago – 46 cents.’ [Child care assistant, child care, Adelaide]

Some operators paying above the minimum rates required tend to keep to their own timings. They implement their own annual increases at the beginning of the financial year when it is convenient for them. They are made aware of changes to minimum wages;
however, the date of announcement and implementation are of limited relevance to these employers:

‘We just automatically pay them [our staff] increases at the start of the new financial year.’ [Owner, aged care, Perth]

Most organisations paying exactly at the minimum levels would implement the increase on the specified date, while a number of operators with larger volumes of staff were slow to implement the increase to wages. Several employees referred to being back paid several months post-implementation:

‘We always get back paid, every year when something goes up. It takes ages. I got a huge amount of back pay just recently but somebody whose surname started with “A”, they got theirs six months ago. And she [accounts] said, “Yeah, you’ll get one, but please don’t hold your breath.”’ [Recruitment manager, aged care, Perth]

2.6.2 Impact for employers

Many employer representatives commented that their income sources were limited and that if minimum wages increased they would have to make adjustments to their expenditure and/or income levels. As labour costs are such a significant proportion of operating expenditure, and most organisations are currently operating under tight conditions, many employers discussed exploring a range of options. However, a few employers advised that increases had been anticipated and accounted for in their budgeting and funding submissions. Therefore, for these employers, no immediate responses are required to maintain operating costs through any adjustment variables when minimum wages increase:

‘We investigate the award that we are under and what the pay rates are. As that usually increases … we budget for those within the process of completing grants when we are planning for the next financial year.’ [Service manager, disability services, Sydney]

Overwhelmingly, the most commonly mentioned and top-of-mind response to an increase in minimum wages would be to increase the price of services:

‘If our wages go up the parents feel it because we have to look back at the budget and then raise our fees and they have to pay more.’ [Owner, child care, Adelaide]

‘We will have to pass on costs which can not be absorbed.’ [Manager, disability services, Sydney]

‘Parents will be unhappy but our fees to parents will increase.’ [Owner, child care, Melbourne]

‘We would have to increase residential care fees.’ [Manager, aged care, Adelaide]

Almost all employers reported that their organisation received some sort of government funding. This funding generally increased each year in line with the Consumer Price Index (CPI), or alternatively they had the opportunity to put forward a revised unit price (i.e. cost per client). All organisations receiving government funding advised that they would seek to cover their increased labour costs through a request for additional funding. However, most conceded that this response may not be timely in relation to implementation deadlines for minimum wage increases, and preparation of funding submissions. Therefore, many would also increase their prices, and the gap between the increase in government funding and the increase in labour costs would be passed on to clients:

‘We do a submission once a year on our unit costs. So I would raise the unit cost for that service delivery and submit that as part of my funding round.’ [Manager, aged care, Bunbury]
‘We get a CPI increase. If that doesn’t cover it we will just put up our co-payments.’
[Director, disability services, Adelaide]

‘Increase the fees based on the gap between staff members’ wages and the funding we get from the government for looking after the children.’ [Assistant director, child care, Adelaide]

Many employers felt that they had limited options in responding to increases in pay rates due to the highly regulated nature of the Health and community services industry. Attempting to maintain labour costs at the pre-implementation level was difficult as government funding is conditional upon employers having appropriately qualified staff (i.e. minimum of Certificate III for certain duties) and filling specified staff-to-client ratios (care ratios). Therefore, responding by reducing staff hours overall, or by reducing the hours of more qualified and higher-paid employees, would lead to a reduction in service delivery to clients. This would then reduce income to the organisation from both clients and government funding:

‘We can’t reduce staff numbers because we wouldn’t be compliant with the regulations.’
[Manager, disability services, Melbourne]

‘We can’t reduce staff numbers or shifts or anything like that, because we have to have a minimum number per client.’ [Service manager, aged care, Sydney]

‘The applicable one for us would be to increase prices. We can’t do anything with the staff because there is a staff–child ratio and we have to have it one-to-five.’ [Director, child care, Sydney]

‘… the fact is that the manager’s job is the weekly review – the hours and the delivery of service. So you are running a fairly efficient service anyway. You know you can’t reduce hours.’ [Manager, aged care, Adelaide]

‘If we reduce staff we’ll have to reduce client numbers. That reduces our funding, which is a vicious circle.’ [Disability support manager, disability services, Sydney]

Several employer participants in managerial positions indicated that increased pay rates may simply put additional pressure on staff to work beyond their paid hours, that is, to work unpaid overtime in order to maintain required service levels. This was seen to be an unfortunate (but realistic) short-term measure for some operators until the appropriate level of government funding could be secured. Another response for community service organisations could be to press volunteers to work increased hours:

‘I will personally work increased hours.’ [Manager, aged care and disability services, Bunbury]

‘… add more volunteers instead of hiring staff, paid staff.’ [Manager, aged care, Perth]

Many owner/operators reported that if minimum wages increase, they may have to increase the hours that they personally work. These employers felt that in the short term, this would allow client-to-staff ratios to be maintained at lower cost:

‘Increase prices and work personally myself. They’re the only openings that exist.’
[Owner, child care, Perth]

‘Personally, my wife and I would work more hours. We don’t want to cut corners.’
[Owner, child care, Melbourne]

‘I would work longer hours.’ [Owner, health services, Bunbury]

Some employers reported that they would increase or prioritise the training of existing staff in response to increasing pay rates. They felt that the increased productivity levels that
result from a more skilled workforce may offset the increased labour costs associated with increased minimum wages:

‘The only other way I could work as a manager would be to increase or prioritise training of existing staff to improve productivity. Prioritise training so that I have the best skilled workforce.’ [Manager, aged care, Adelaide]

‘Increase the amount of training and productivity of your staff. Prioritise training and staff to cope with that, and to increase productivity, hopefully.’ [Manager, aged care, Perth]

Other employers considered reducing non-essential training to reduce costs to the organisation. For example, organisations currently sponsoring staff to undertake further training may reconsider this commitment. Others referred to limiting in-house training:

‘Basically, if we can increase prices we’ll hopefully cover the cost. [Otherwise] also reduce number of hours, and cut down training.’ [Owner, child care, Melbourne]

Some employers, whose organisations were providing more than the essential health or community services for which they were funded, mentioned that they may reduce or discontinue the non-essential services if necessary:

‘We wouldn’t be able to grow as an organisation. We wouldn’t be able to develop new projects or programs or things like that.’ [Assistant manager, welfare services, Melbourne]

‘We’ll have to reduce what we do. Just can’t do it.’ [Manager, aged care, Bunbury]

‘Service delivery will have to be changed or reduced but this will have negative outcomes.’ [Owner, child care, Sydney]

Other organisations considered obtaining a greater amount of income through donations:

‘We just need to be more proactive and go out and get donations and things like that – public relations. We work very hard.’ [Manager, health services, Melbourne]

There were a few employers who recognised that the increase in wages could be an opportunity to gain a competitive advantage. Operators with higher margins are in a position to absorb the additional labour costs, rather than increase their prices. They can then continue growing their business offering to clients:

‘As long as [gross profit] is increasing, then you’re happy with that. Why push your product up that’s selling and growing? You leave it alone. People say, “Why don’t you put your prices up at that time?” but if we can afford to leave it, then it knocks out our competitors as well, so we keep growing and can keep our prices down. The reason why our business has grown is because we are different to the rest of them, the quality that we put in. We’ve held our prices for about eight years, just increase the volume of business.’ [Owner, aged care, Perth]

### 2.6.3 Impact for employees

Employees felt the increase in minimum wages would not have an obvious positive impact on their lifestyle. Their recollection of increases to their pay rates in the past were that very small increases generally didn’t keep up with inflation. They felt that at best any increase in minimum wages would just allow them to maintain their existing lifestyle, not improve it in any meaningful way:

‘But when you look at it, the increase each year isn’t keeping up with inflation.’ [Support worker, disability services, Bendigo].
The top-of-mind response from many employees was that very little would change. Their current employment arrangements in terms of number of hours and shift allocation would be consistent. After some reflection, many employees considered that organisations may attempt to cut costs, or perhaps increase the price of services to clients.

Some employees expressed concern that employers may implement cost-saving strategies (in order to reduce or maintain labour costs) that would negatively impact on employees' income. Some suspected that employers may decrease the number of hours overall, resulting in fewer shifts available to staff. That is, their increased pay rate may be offset by a reduction in the number of hours they work. Some were concerned that their employers may cut back on overtime payments. Others felt that their employers may reduce the number of staff. However, most cited the limitations of this approach, due to the current shortage of appropriately qualified staff and the fact that organisations are already operating at the minimum staff capacity allowed under funding arrangements:

‘They might try to cut hours, but it depends on where you’re working and what you’re doing because most of the time they can’t cut hours. Well, you can’t in aged care.’ [Personal care attendant, aged care, Bunbury]

‘Staff get cut. That’s where they cut back first – it’s the staff.’ [Recreation activity officer, aged care, Sydney]

‘They can’t skim off any more workers – they’ve done that.’ [Support officer, disability services, Bendigo]

Many employees mentioned that fees and charges to clients would probably be increased, but that this would not have any impact on employees:

‘To cover our wages they’ll have to put up the child care fees.’ [Child care worker, child care, Bunbury]

‘Unless they put the fees up, they’re not going to make more money.’ [Recreation activity officer, aged care, Sydney]

A minority of former employees commented that the some operators may lower standards, or the level of service provided to clients:

‘They would sacrifice the care of the person to make sure that there was money for the wage. Things would be sacrificed, like nappies, soap powder or food.’ [Ex–child care worker, child care, Perth]

‘A couple of years ago when the pay was less, there were actually more resources.’ [Ex–disability support worker, disability services, Perth]

Very few employees commented on increased wages resulting in an increase in training opportunities (in order for staff to become more productive). There were, however, assumptions about increased workload, or increased pressure in the workplace. This was a consistent theme across the focus groups – that this industry relies heavily on workers going ‘above and beyond’ in their commitment to their clients. Employers, and the wider community, rely on the ‘caring’ nature of Health and community services employees, their goodwill and their ethos of putting others’ interests ahead of their own to achieve the required levels of service.
Appendix A: Discussion guides

The employer discussion guide followed the broad structure outlined below:

**Introduction:** The facilitator introduced the broad topic and explained the session structure and rules. Participants were asked to introduce themselves and the organisation they were representing (as an owner/operator or manager).

**Business and employment practices:** Discussion centred on current trends and challenges for the industry. General business processes and procedures were discussed, with emphasis on employment practices.

**Wage rates and wage decisions:** Participants were asked to comment on how wage rates are determined for the different types of employees in their organisation. Detail was sought on what they considered important when deciding how much employees should be paid. Participants were given a worksheet which listed a wide range of attributes and factors that may be considered when determining pay rates for employees. Participants were also encouraged to share any other ideas they had that were not covered in the worksheet. They were asked to indicate all important considerations, and then highlight the three most significant considerations.

**Minimum wages and impact of changes:** Participants were asked to comment on the impact of changes in minimum wages for their organisation. They were asked to consider any potential changes to the operation of their organisation as a result of increased labour costs through increased pay rates. Participants were given a worksheet which listed a broad range of potential adjustments that organisations could make in response to increased labour costs. Participants were also encouraged to share any other ideas they had that were not covered in the worksheet. They were then asked to indicate all adjustments they would consider implementing in response to increased labour costs. Where participants had actually made adjustments, they were encouraged to provide details of the change.

**The Commission and minimum wages:** The focus group session concluded by exploring awareness of wage-setting mechanisms in Australia, changes to Pay Scales, and knowledge of the Australian Fair Pay Commission and its role.

The employee discussion guide followed the broad structure outlined below:

**Introduction:** The facilitator introduced the broad topic and explained the session structure and rules. Participants were asked to introduce themselves and provide details of their current employment.

**Lifestyle and work choices:** Discussion explored the relationship between income and lifestyle. Participants were asked about the positive and negative aspects of their employment in the industry. In the groups where participants had recently left the industry, the reasons behind this decision were explored in depth.

**Wage rates and wage decisions:** Participants were asked to comment on their perceptions of how wage rates were determined in their workplace. They were then asked what factors they believed should be considered when setting pay rates in their workplace. Participants were given a worksheet which listed a wide range of attributes and factors that may be considered important when determining pay rates in their workplace. Participants were also encouraged to share any other ideas they had that were not covered in the
worksheet. All participants were asked to indicate all the important considerations, and then highlight the three most significant considerations. Participants were asked about the practice of negotiating wage rates with their employers. Additional sources of income beyond standard hourly wages (including shift allowances/penalty rates and bonuses) were detailed by participants.

**Minimum wages:** Discussion focused on any recent pay increases employees had received and what these increases were attributed to. Participants were asked to comment on the perceived impacts of changes in minimum wages.

**The Commission and minimum wages:** The focus group session concluded by exploring awareness of wage-setting mechanisms in Australia, and knowledge of the Australian Fair Pay Commission.

**Discussion guide: Employer groups**

This discussion guide is intended as an outline only. There will be considerable scope within the discussion for exploring issues as they arise. Questions are indicative only of subject matter to be covered and are not word-for-word descriptions of the moderator’s questions.

1. **Introduction to the session**  
5 minutes

The CBSR moderator will introduce participants to the study (about business and employment activities) and explain the purpose of this discussion group – to have participants to talk about their employment and business decisions, and their experiences and business perspective relevant to employing people relevant to their sector.

The moderator will explain role of CBSR as an objective third party researcher with no hidden agendas, and encourage participants to be open and frank during their discussion.

The CBSR moderator will explain the confidentiality issues which will apply – audio and/or video taping of the session, and client viewing (if applicable).

The CBSR moderator will also explain that the study has been commissioned by a national statutory body and that specific details of that agency will be explained as the discussion proceeds. The moderator will also explain that some people may be observing who are from that organisation.

The moderator will also explain the session structure which will include discussion and activities, such as writing notes or private questionnaire completion, followed by a chance to discuss issues with the client at the end of the session.

Finally, the moderator will explain the facilities being used, ask everyone to turn off mobile phones, encourage participants to talk one at a time, and endorse participants to agree or disagree (and not necessarily to gain consensus).

2. **Getting started**  
up to 10 minutes

Begin by going around the table asking participants to introduce themselves and ask them:

- to talk about the business they have/work for: what sector, number of employees they have.
- to indicate the make-up/structure of their workforce, how many:
3a. Business and employment practices 10 minutes

Now the moderator will ask participants to discuss:

- general business trends in their sector and/or the local economy (and any issues or trends in business and pressures being faced)

Every participant's opinion will be covered to canvass the following:

- Generally how easy or hard it is to fill positions? (Ask each participant to give a rating out of 10.)
  - How challenging is it to fill low-skilled (low-paid) position with limited experience/qualifications?
  - How challenging is it to fill higher skilled (higher-paid) position with experience and/or qualifications?

- Probe for any discrepancy between the ratings. Discuss which types of positions are easier/more challenging to fill: permanent/temporary roles, full-time or part-time/casual.

- How has the recruitment experience changed over time?

- Probe for anyone having to compromise on the quality of staff they employ. Or does it take longer to fill positions?

- Ask for a couple of interesting examples of recent recruitment where there have been challenges, or where it was surprisingly straightforward.

- Probe on whether these were newly created positions or replacements, and what employment status they were offering – permanent/casual or full-time/part-time.

Every participant's opinion will be covered to canvass:

- How they run their business. Is it a formal approach or informal approach in their operations? (If informal methods are used, ask participants for their definition of ‘informal’.) Explore why the specific approach is used. Then probe on their recruitment practices (formal or informal).

3b. Business and employment practices – incl. Wages 15 minutes

Briefly discuss how they determine the pay rates in their business. Ask for examples of a position they are recruiting for.

Probe if necessary on whether they go by market rates, what is in the award (state award or Pay Scales, formerly the Federal Award) or if they pay above these rates.

Do they advertise a pay rate the business has decided on or do they make a judgement based on quality of applicants? Do they include the applicant in negotiations?
Identify if any participants have experienced difficulty in finding labour and needed to increase the pay rate on offer – for higher skilled or lower skilled positions.

Probe on whether they have flexibility to offer income beyond hourly rate of pay (salary sacrificing/salary packaging) or any non-cash benefits (food, accommodation etc) – just YES/NO at this stage.

Briefly discuss the impact of being short of staff due to recruitment difficulties – how much of a ‘problem’ is it to overcome. (E.g. is the burden on current employees to work more productively, work long hours, or do service levels drop and impact on revenue etc.)

Identify how long staff usually stay with their business. Discuss the differences by permanent/casual, full-time/part-time, higher-skilled/lower-skilled. Ensure you ask everyone how long employees would generally stay. (Do they have a stable workforce?)

Probe to uncover if staff are pushed out of employment (because of slow business or poor quality performance) or pulled out (because other options were available, there was better pay/conditions elsewhere, etc). If so, where are they losing them to – another employer in the sector or another sector, or to study etc?

Have participants consider and discuss what they do to retain their workforce. Probe on anything they do to make their employees feel valued. Or is steady turnover just the way it is?

If not already covered, ask if their lower-skilled staff have opportunities to learn/train and progress through the business to higher pay with increased skills and experience (e.g. move up).

4. Wage rate decisions 15 minutes

The moderator will now have participants discuss exactly how wages are determined in their workplace:

- award rate – reference it, use it as a guide, or pay the minimum required
- Pay Scale – reference it, use it as guide, or pay the minimum required
- workplace agreement
- AWAs
- market rates
- individual negotiations.

Explore different arrangements by different types of employees: low-skilled vs. higher-skilled/permanent vs. casual/full-time vs. part-time.

Discuss the actual mechanisms used to set pay rates in their business and why they use this mechanism/system for determining the pay rate.

If participants are paying above what they legally have to, probe on the extent of paying above the minimum rate they need to for particular staff. Understand how they decide how much, and why they pay above the minimum rate required by law.

(Ensure you understand why, how much and determination of pay rates if they are paying above the minimum required by law).
Now encourage participants to consider what kinds of things should be considered when deciding how much to pay people. Hand out Sheet 1 to prompt their consideration:

**Show Sheet 1** showing different drivers – skills, attitude, supply, worth/value to the business, experience, age, wage rate/labour cost, government subsidy available, length of service, level of commitment, long-term prospects, what I can afford, what I am required to pay by the award, education levels, age, seniority, experience, social justice, training fair and reasonable, what other employers pay, training, juniors, incentives for retention.

Clarify that by ‘market rates’ we mean that we are interested to know the importance of what competitors are paying when they make decisions about setting wage rates.

Ask participants to mark on the sheet all considerations, and then the top three considerations from their perspective.

The moderator will now probe on attitudes and perceptions about what factors are important, and the reasons why.

Probe to clarify if any of these factors are currently taken into consideration when setting pay rates in their business. This is more likely for those paying staff above the minimum wages required by law.

Ask each participant about any income employees receive beyond an hourly rate or non-cash benefits:
- penalty rates (for overtime, or for working public holidays/weekends)
- performance-based payments (including bonuses or commissions)
- salary packaging/sacrificing (what is included, what is the limit)
- tips
- non-cash benefits (food, accommodation, drinks, transport, etc.)

Ask participants to think back to the structure of their workforce (discussed at the beginning). Discuss if this is deliberate and if it is related to labour costs/pay rates for different staff in their business.

Are they managing a wages bill or monitoring labour costs on a regular basis – weekly or fortnightly, monthly, or perhaps more often?

Ask participants about the impact of penalty rates on their wages bill.

Lastly for this section, ask participants if any of their staff are:
- working more than one job
- receiving government allowances, and if this impacts on how much they are paid or how many hours they work.

5. Minimum wages and impact of changes  20 minutes

Now the moderator will prompt employers to consider real examples of reactions to increased labour costs.
Ask all participants to advise how often wages go up in their business. Clarify whether this is a business decision or if it is imposed by an external body.

Ask participants who have had increases imposed on them (most likely those who pay award wage rates or use Pay Scale rates) to remember a time when wages went up for their employees.

Give an example of when an increase was imposed, rather than a business decision. Ask these participants to explain why pay rates increased (the circumstance), how many staff this affected and whether they were low-paid or higher-paid. Then describe what happened as a result of the increase (i.e. how their business reacted to it).

Probe on whether they make changes or if they absorb the increase and accept a reduced profit level.

Changes to probe on include:

- prices
- employment strategies, e.g. employee rosters, hours, employment type, worker classification
- business strategies including your operating (opening) hours
- business offering – products or your services.

Now have any other participants describe the circumstances and reactions of their business to any recent (in the last 12 months) increases in labour costs (pay rates for staff).

**Show Sheet 2** showing potential changes to business operations as a result in increased labour costs through an increase in pay rates.

Ask participants to mark (with an X) any changes that they would make to their recruitment strategies or broader business strategies as a result of an increase in staff wages (or the factors they would consider).

Encourage participants to provide some detail about the changes in the space provided.

Ask for examples to be discussed and probe for details.

Probe on how many/what percentage of the workforce was affected by the changes to give context to the level of change required.

Does their business plan for changes in pay rates for staff (budget for increases), or are they reactive to changes imposed on them or demanded/expected by staff?

6. The Commission and minimum wages 15 minutes

Ask about participants' sources of awareness about wage-setting decisions, and information sources relied upon.

Probe on specific sources of awareness of Federal Minimum Wage decisions and consequent changes to Pay Scales and information sources relied upon.

If not raised already, the moderator will ask, 'Before today, had you heard of the Australian Fair Pay Commission?'
Please read this to participants to ensure accuracy of info:

The Australian Fair Pay Commission is an independent body responsible for adjusting Federal Minimum Wages (Pay Scales).

The last decision was announced in July 2007, which was an increase from $13.47 to $13.74. Businesses were given until the first pay period in October to implement the increase.

The next decision will be announced in early July this year, with an implementation date of October.

Ask participants whether or not they were aware of the July 2007 decision that took effect in October 2007.

Were they aware that the Commission will announce a decision in July this year, with an implementation date of October 2008?

The moderator will also probe and explore the participants’ views on the possible impact of the minimum wages adjustment on their business.

For participants whose businesses are directly affected by the adjustment (follow Pay Scales):

- Ask about the likelihood of making any of the changes discussed earlier.

Clarify with participants who are affected by changes in minimum wage rates:

- When do you adjust pay rates for your employees – when it is announced or by the deadline for implementation (first pay period in October)?

For participants whose businesses are not directly affected by the adjustment in July (workplace agreement/AWAs/paying above the minimum wages required by law):

- Do you review and perhaps adjust your pay rates in response to the increase in Pay Scales?

- If yes, clarify by how much – similar percentage/amount to the Pay Scale increase, or smaller, or larger [Note: They would be likely to be doing this to retain staff by ensuring their competitive advantage over other businesses in the local economy, not just within the sector, but in other sectors].

Finally, gauge opinions on whether increases in minimum wages are a positive thing for:

- their businesses’ growth prospects
- their employees/workers across the sector generally
- the community (concept of a safety net, so that people are not exploited).

Thank and close

Thank participants for their time today and the useful views and ideas expressed.

Explain that the Commission uses a combination of commissioned research, meetings with stakeholders, public consultations and written submissions to inform its wage-setting decisions.
The Commission operates under a cycle of information-gathering, then decision-making, communication of decision, and then monitoring of impacts. This research is addressing the monitoring of impacts on particular sectors. We are conducting focus groups across the country.

Hand out incentives and letter from the Commission.

**Discussion guide: Employee groups**

This discussion guide is intended as an outline only. There will be considerable scope within the discussion for exploring issues as they arise. Questions are indicative only of subject matter to be covered and are not word-for-word descriptions of the moderator’s questions.

1. **Introduction to the session  5 minutes**

The CBSR moderator will introduce participants to the study (about employment and decisions which people make in their work and life) and explain the purpose of this discussion group, which is to have participants talk about their employment and experiences and their perspective relevant to working in their sector.

The moderator will explain the role of CBSR as an objective third-party researcher with no hidden agendas, and encourage participants to be open and frank during their discussion.

The CBSR moderator will explain the confidentiality issues which will apply, audio and/or video taping of the session, and client viewing (if applicable).

The CBSR moderator will also explain that the study has been commissioned by a national statutory body and that specific details of that agency will be explained as the discussion proceeds. The moderator will also explain that some people from that organisation may be observing the session.

The moderator will also explain the session structure, which will include discussion and activities such as writing notes, or private questionnaire completion, followed by a chance to discuss issues with the client at the end of the session.

Finally, the moderator will explain the facilities being used, ask everyone to turn off mobile phones, encourage participants to talk one at a time, and endorse participants to agree or disagree (and not necessarily to gain consensus).

2. **Getting started  up to 10 minutes**

Begin by going around the table asking participants to introduce themselves and ask them:

- to talk about the type of work they do (their position and also the activities of the business or organisation they currently work for)
- to indicate the type of working situation they have (full-time/part-time, permanent or contract) and who determines the hours they work – their employer or themselves
- to indicate their length of time with their current employer
- to indicate the type of ‘lifestyle’ they have (family/life circumstances, e.g. have partner/ don’t have partner, have children/don’t have children). Determine if independent or dependent on parents/partner, and
- to indicate where they live (the area) and if they’re currently renting, or have a mortgage.
3. Lifestyle and work choices  40 minutes

Brief discussion on how the participant feels about working at the moment, and their views on being employed generally (positives and negatives), and the extent to which paid employment fits in with their lifestyle.

Every participant's opinion is to be canvassed.

Discuss responses from the pre-group sheet, particularly the income or lifestyle response. Probe on what constitutes their current income. How much is from their standard hourly pay rate, and then what other sources, e.g. wages from this job, tips/bonuses, government allowances, their partner's wages, etc.

Discuss current lifestyle and what, if anything, they feel they are missing out on (e.g. owning a home, having [more] children, socialising, going on holidays etc).

Discuss what attracted them to work in the sector under review.

Discuss how long they have worked in the sector, and what other positions they have had in the sector.

Discuss what other sectors have they worked in and why they left.

Probe on how long they expect to be in their current employment, then how long they would like to be in their current employment.

Probe on how long they expect to be working in the sector, and then how long they would like to be in working in the sector.

Ask participants to refer to responses from the pre-group sheet completed about current employment being a 'job' or 'career' and determine whether they will remain in the sector long-term, or if their employment is short-term.

Now canvass opinions generally across the group on:

- the positives and negatives of working in the sector
- whether it was easy or hard to find the job they currently have, and probe why
- the decisions they made or considered before taking their current job
- if their current job is a 'stepping stone' to other opportunities in the sector, or elsewhere (receiving formal or on-the-job training to up-skill themselves)
- whether they would consider leaving their current job (and if not, what are the motivations for staying in the current job)
- probe for anything that specifically their current employer is doing to retain them in their workforce (cash-related benefits, or non-cash benefits. Are they doing anything to make them feel valued, etc.)
- identify reasons for such considerations for leaving or staying in their current job
- whether they perceive it would be difficult to move out of their current job (in the sector under review), and whether they perceive it would be challenging to find another job in the sector or outside the sector; the impact of perceptions on how the sector is performing on this decision; and
• whether they have considered leaving the paid workforce.

The moderator will explore further considerations not already covered with prompting to cover:
• pay rates (hourly rate or weekly wage)
• payment method, including cash (in hand) at the end of the shift, weekly, fortnightly, monthly etc., and the importance of this
• working hours
• worksite location and transport issues
• availability of accessible childcare (and associated costs)
• requirements of the job and skills required (what is involved in undertaking the role, and whether it is an unskilled or skilled position)
• attitude/environment of the potential employer (such as formal processes or informal, the atmosphere of the workplace, etc.); and
• the impact of having paid employment on income from any government allowances or concessions received (e.g. health care card).

Now the moderator will encourage discussion to cover if participants have ever been pushed out of employment (because of slow business or poor-quality performance, etc.) or pulled out (because other options were available, there was better pay/conditions elsewhere etc.).

4. Wage rates and wage decisions  20 minutes

The moderator will now have participants discuss how wages are perceived to be determined in their workplace:

Explore:
• different types of employees and different types of jobs in their workplace
• perceptions that participants have about their wage rate compared to other people of the same age or people doing similar jobs.

Probe for:
• younger (junior wages)/older
• casual (temporary)/permanent
• part-time/full-time
• skilled/unskilled
• qualified/no qualifications
• relevant experience/limited experience

Now the moderator will have participants discuss:
• how they know how much they are (legally required) to be paid
• the rate of pay they expect for the work they do/how much their labour is worth. Probe on whether they are over-skilled or under-skilled for their current position
- the rate of pay they require to meet their lifestyle needs and commitments
- the extent they have negotiated any pay increases
- the impact of the pay rate they receive relative to non-hourly rate benefits (such as penalty rates and bonuses)
- for permanent staff, the importance of sick leave, annual leave and so on
- for those working casually, the impact on their budgeting of having a variable wage; and
- the impact of their pay rate received relative to receiving non-cash benefits (such as meals, accommodation, etc.).

Now encourage the participants to consider what kinds of things they consider important when deciding how much they should be paid. Hand out Sheet 1 to help prompt their consideration:

**Show Sheet 1** showing different drivers – skills, attitude, worth/value to the business, experience, age, wage rate/labour cost, length of service, level of commitment, long-term prospects, the relevant award, education levels, age, seniority, experience, being trained or skilled, what other employers pay, juniors vs. seniors rates, incentives for retention.

The moderator will now probe fully on attitudes and perceptions held by participants about what factors are important – and the reasons why. Ask participants to mark on the sheet ALL considerations, and then the TOP 3 considerations from their perspective.

5. Minimum wages  10 minutes

The moderator will now explore minimum wage issues by asking:

- Have they received pay increases in the past 12 months? If yes, what was the impact of this for them personally, and for their colleagues and the business they work for/worked for at the time?
- Who/what did they attribute the increase(s) to?
- Who sets the minimum wage (if this hasn't come up already), or what authority/authorities adjust pay rates for wages in the sector?

The moderator will also probe and explore the participants’ views on the possible impact of minimum wage increases on:

- their current employment
- their current employer’s decisions to employ new staff, or retain existing staff, the allocation of hours across the workforce, penalty rates or overtime, training, and so on.

Probe also for future possible employment prospects, particularly decisions participants would consider if they lost their job or suffered reduced hours. Would they consider different employment structures to what they currently have (such as full-time, part-time, casual employment structures/temporary, and permanent)? Would they change their lifestyle to fit in with work on offer?

Probe to gauge opinions on whether increases in minimum wages are a positive thing for:

- their income/lifestyle
- their prospects to up-skill and move out of lower-paid employment, and
- their longer-term employment prospects.
6. The Commission  5 minutes

The moderator will now explore participants’ awareness of the Australian Fair Pay Commission:

If not raised already, the moderator will ask, ‘Before today had you heard of the Australian Fair Pay Commission?’

Please read this to participants to ensure accuracy of info:

The Australian Fair Pay Commission is an independent body responsible for adjusting Federal Minimum Wages (Pay Scales).

The last decision was announced in July 2007, which was an increase from $13.47 to $13.74 in the Federal Minimum Wage. Businesses using pay scales to determine pay rates for their employees were given until the first pay period in October to implement the increase.

The next decision will be announced in early July this year, with an implementation date of October 2008.

The moderator will also ask the participants whether or not they were aware that a Minimum Wage Decision was announced in July 2007 and took effect in October 2007.

Are they aware that the Commission will announce a decision in July this year, with an implementation date of October 2008?

Thank and close

Thank participants for their time and the useful views and ideas expressed.

Explain that the Commission uses a combination of commissioned research, meetings with stakeholders, public consultations and written submissions to inform its wage-setting decisions.

The Commission operates under a cycle of information-gathering, then decision-making, communication of decision, and then monitoring of impacts. This research is addressing the monitoring of impacts on particular sectors. We are conducting focus groups across the country.

Hand out incentives and letter from AFPC.
# Appendix B: Handouts

## Employer worksheet 1

Things to consider in setting pay rates for your business

<table>
<thead>
<tr>
<th>age of employee</th>
<th>person’s flexibility to work</th>
<th>skills of the person</th>
<th>provision of on-the-job training</th>
<th>market rates for your sector</th>
</tr>
</thead>
<tbody>
<tr>
<td>their employability</td>
<td>their experience</td>
<td>length of service</td>
<td>person’s attitude</td>
<td>cost and availability of childcare to assist ability of people to be employed</td>
</tr>
<tr>
<td>cost of living</td>
<td>scarcity of skills</td>
<td>what other businesses pay</td>
<td>demand for the person’s skill set</td>
<td>person’s seniority</td>
</tr>
<tr>
<td>comparison with receiving government benefits</td>
<td>person’s long-term prospects</td>
<td>your concern about cost of working (travel, petrol etc)</td>
<td>your view on what is fair and reasonable</td>
<td>price of housing in your area</td>
</tr>
<tr>
<td>how many applicants for the job</td>
<td>their qualifications</td>
<td>what the business can afford</td>
<td>person’s education level</td>
<td>person’s improvement in skills</td>
</tr>
<tr>
<td>life experience of employee</td>
<td>level of their commitment</td>
<td>person’s value to the business</td>
<td>what the law says</td>
<td>recognition and respect for others</td>
</tr>
<tr>
<td>integrity / responsibility of employee</td>
<td>their practical life (non-job specific) skills</td>
<td>their ability to adapt quickly</td>
<td>person’s people / relational skills</td>
<td>impact on social / community harmony</td>
</tr>
<tr>
<td>your concern about gap between the ‘haves’ and ‘have nots’</td>
<td>market rates for your local economy</td>
<td>Other (please specify):</td>
<td>Other (please specify):</td>
<td>Other (please specify):</td>
</tr>
</tbody>
</table>

## Employee worksheet 1

Your views on things to consider in setting pay rates

<table>
<thead>
<tr>
<th>person’s age</th>
<th>person’s flexibility to work</th>
<th>work skills of the person</th>
<th>person’s involvement in on-the-job training</th>
<th>market rates for the sector</th>
</tr>
</thead>
<tbody>
<tr>
<td>their employability</td>
<td>their experience</td>
<td>their length of service</td>
<td>their ‘attitude’</td>
<td>cost and availability of childcare</td>
</tr>
<tr>
<td>cost of living</td>
<td>scarcity of skills</td>
<td>what other businesses pay</td>
<td>level of demand for the person’s skill set</td>
<td>seniority</td>
</tr>
<tr>
<td>comparison with receiving government benefits</td>
<td>long term prospects</td>
<td>cost of working (travel, petrol etc)</td>
<td>what is fair and reasonable</td>
<td>price of housing in the area</td>
</tr>
<tr>
<td>how many applicants for the job</td>
<td>person’s qualifications</td>
<td>what the business can afford</td>
<td>person’s education</td>
<td>person’s improvement in skills</td>
</tr>
<tr>
<td>person’s life experience</td>
<td>person’s level of commitment</td>
<td>person’s value to the business</td>
<td>what the law says</td>
<td>recognition and respect for others</td>
</tr>
<tr>
<td>person’s integrity / responsibility</td>
<td>their practical life skills</td>
<td>their ability to adapt quickly</td>
<td>person’s people / relational skills</td>
<td>impact on social / community harmony</td>
</tr>
<tr>
<td>closing the gap between the ‘haves’ and ‘have nots’</td>
<td>Other (please specify):</td>
<td>Other (please specify):</td>
<td>Other (please specify):</td>
<td>Other (please specify):</td>
</tr>
</tbody>
</table>
## Employer worksheet 2

Potential changes to your business operations as a result of increased labour costs (via increases to pay rates)

<table>
<thead>
<tr>
<th>Potential changes implemented</th>
<th>If applies, mark X</th>
<th>Can you provide brief details of the change?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increased prices</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Changed operating (opening) hours</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reduce overall staff numbers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reduce the number of staff per shift</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Change in staff classifications</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Substitute between different types of employees or machinery/automation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Apply junior rates of pay for staff under 21 years of age</td>
<td></td>
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<tr>
<td>Reduce staff hours</td>
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<tr>
<td>Reduce overtime, rates with penalties</td>
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<tr>
<td>I will personally work an increased number of hours</td>
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<tr>
<td>Hiring freeze will occur</td>
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<tr>
<td>Diversify business operations</td>
<td></td>
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<tr>
<td>Change / reduce service delivery</td>
<td></td>
<td></td>
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<tr>
<td>Used cheaper components, ingredients or other inputs</td>
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<tr>
<td>Hire new staff at lower pay grades</td>
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<tr>
<td>Increase or prioritise training of existing staff to increase productivity</td>
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<td></td>
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<tr>
<td>Increase or prioritise training of existing staff</td>
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<tr>
<td>Decrease training of existing staff</td>
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<tr>
<td>Hire more experienced workers to increase productivity</td>
<td></td>
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<tr>
<td>Something else (please specify)</td>
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</tbody>
</table>
Employee profile

(Note: Your information will be treated in strict confidence)
Please circle your answer

Q1. a) How old are you? __________ years
Q1. b) And are you … Male  Female

Q2. What type of work do you do? Please specify: __________________________________________

Q3. What is your job title or occupation? ______________________________________________

Q4. How many hours to you typically work per week: __________ hours

Q5. How much do you earn usually: per hour: $ ________
(Your best estimate will be sufficient) or per week: $ ________

Q6. a) Do you receive penalty rates, bonuses or tips? (circle one) Yes  No  Unsure

Q6. b) If ‘Yes’ in Q6.a), How much would you usually earn from:
(Please circle what you receive) Penalty rates  Bonuses  Tips?
per week: $ ________
or per month: $ ________

Q7. Do you receive any non-cash benefits (e.g. meals) from your employer? Yes  No

Q8. Please finish this sentence: ‘I work because … ’: ______________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Q9. Do you consider your current employment as a ‘job’ or a ‘career’?
Job  Career
Please explain this response: ______________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Q10. Would you say that your current income dictates your lifestyle, or does your lifestyle currently dictate your income?
Income  Lifestyle
Please explain this response: ______________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
Employer profile

(Note: Your information will be treated in strict confidence)
Please circle your answer

Q1. What’s your role in the business? Owner Manager/HR Manager
Other (please specify): ____________________________________________

Q2. If you are the owner, did you establish the business or take over from previous owner? Established the business Took over the business

Q3. How long has the business been in operation? _______ years _______ months

Q4. What was the approximate turnover of your business 3 YEARS AGO (if applicable)? $ _______

Q5. What was the approximate turnover of the business LAST YEAR? $ _______

Q6. Do you expect the business’s turnover to decrease, remain the same or increase THIS YEAR? Decrease Remain the same Increase

Q7. What was the approximate PROFIT level of your business LAST YEAR? _______ % or $ _______ increase

Q8. Do you expect your PROFIT to decrease, remain the same or increase THIS YEAR? Decrease Remain the same Increase Other (please specify): ____________________________________________

Q9. How many PERMANENT members of staff do you employ? Number: _______
How many TEMPORARY members of staff do you employ? Number: _______

Q10. Your workforce profile. State the number of employees who are:
Full-time: _______ Part-time: _______ Casual: _______ Juniors: _______
Trainees/Apprentices: _______ Employees with a disability: _______

Q11. Thinking about the TOTAL COST your business faces THIS YEAR, approximately what percentage of costs are:

Your best estimate will be sufficient
Labour-related costs: _____ %
Wages and salaries (including superannuation contributions): _____ %
Purchases: _____ %
Rent leasing and hiring, utilities, insurance, repairs, maintenance: _____ %
Other costs, specify any of note: _____ %
TOTAL _____ %
Notes