Canadian Home Care Human Resources Study

Technical Report

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Canada

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This point-form technical report contains the detailed results of data collection in Phase II of the Canadian Home Care Human Resources Study. The purpose of this report is to provide the reader with additional details on data collection and analysis that were not included in the overview report for the study entitled*: Canadian Home Care Human Resources Study – Final Report (June, 2003).* It should be noted that this report contains the analyses only. For the appropriate interpretations, conclusions, recommendations, and strategies associated with the integration of analyses, the reader is referred to the overview report. Features of the present technical report include the following.

- The data are presented under general headings to allow the reader to review the detailed findings from the multiple data sources.
- During the course of the key informant interviews and focus groups, stakeholders in the home care sector identified a number of possible themes for human resource (HR) strategies in the sector – particularly ways to improve recruitment and retention in the sector. These are presented throughout the report.

Data sources

Data was collected from a variety of sources. The details of each data collection approach are included in the Appendices. The following sources of data are presented in this report:

- ***Key informant interviews*** with 61 representatives of associations, ministries of education, employers/managers of home care organizations, unions and other service agencies and work-related organizations (Appendix B);
- ***Focus groups*** (36 groups with a total of 324 participants) across the country with consumer groups, informal caregivers and volunteers, and professionals and para-professionals working in home care (Appendix B);
- ***Survey of formal caregivers*** (home support workers, registered nurses, licensed practical nurses, physical therapists, occupational therapists, and social workers) carried out – completed questionnaires were received from 3,388 formal caregivers (Appendices D & G);
- ***Survey of informal caregivers*** with 774 interviews completed with informal caregivers as part of a general population survey (Appendix C);
- ***Analysis of data from Statistics Canada's Labour Force Survey*** that provided information on workers in the Home Health Care Services and Individual and Family Services industries (Appendix E);
- ***Analysis of the National Population Health Survey*** conducted in 1994, 1996 and 1998 that provided information on the use of home care services and the volunteerism in the community (Appendix A); and,
- ***Survey of colleges and universities*** conducted – completed questionnaires were received from 83 post-secondary institutions across Canada (universities, university colleges, community colleges and career colleges) (Appendix F).

Contextual issues with regard to data collection

There are a number of contextual factors that the reader should take into account when reviewing the findings from the data analysis. These include the following.

- ***The purpose of the study was to provide general, national level data to address human resource issues in the sector***. The purpose of the study was to collect general, national level information about the human resource issues that currently affect the home care sector. It just begins to fill the gap in information on home care workers. The data should not be used any other purpose than that for which it was intended. For example, it would be erroneous to use the data to draw conclusions about specific regions, specific employers, or specific sub-groups of workers within the broad occupational groups upon which the survey is based.

- ***The study collected systematic quantitative information on only a subset of occupations that provide home care in Canada***. The scope of the largest quantitative portion of the current study included registered nurses, licensed practical nurses, home support workers, occupational therapists, physiotherapists and social workers. The occupational therapists, physiotherapists and social workers were grouped into one group for analysis due to the overall small numbers of members of these occupational groups who work in the home care setting. While these latter three professional groups have some aspects in common, there are many aspects of their practice and therefore likely some human resource issues that would differ significantly between the groups. While the more qualitative portions of the study (e.g., focus groups and key informant interviews) were broader in their scope, the scope of the formal home care worker survey did not include many of the other occupations such as physicians, psychologists, respiratory therapists, dietitians, etc.
- ***Data is time sensitive and context-bound***. The data was collected during 2001-2002. During this period there were a number of contextual issues in the home care sector that may affect responses. These included: some occupational groups were either on strike or in a position to strike; and there were major changes and/or cutbacks in funding for home care in some regions.

For the data limitations specific to each of the methods used, the reader is referred to the relevant appendix.

Notes for the reader

Notes on terminology

Throughout the report, we have used the term "formal caregiver" or "home care worker" to denote those paid to provide home care services.

In those sections which refer to data collected as part of the survey of formal caregivers, we have defined the groups of formal caregivers as follows:

– Home support workers (HSWs), (also referred to elsewhere as personal aide workers, personal attendants and homemakers);

– Registered nurses (RNs);

– Licensed practical nurses (LPNs) (also referred to elsewhere as registered practical nurses); and,

– Occupational therapists, Physiotherapists, and Social Workers (OT/PT/SW). We have placed these three professionals in the same group for analyses rather than three distinct groups because the sample sizes were insufficient to analyse separately. The reader should be aware that, although there are similarities between these three groups, they are distinct professions that have different roles and different practice patterns, and they may have different human resource issues.

The term "informal caregiver" is used to denote those who provide unpaid care for a family member or friend. Although some people prefer the term "family caregiver", we have retained the term "informal caregiver" as the caregivers can be friends and neighbours, as well as family members.

The terms *public funding* and *publicly funded* refer to services paid for by government. Public servants working in government agencies can deliver these services, staff in regional health authorities, private not-for-profit home care agencies and private for-profit service providers (organizations or individual health care professionals such as physiotherapists, psychologists, and physicians). In this report, we shall refer to organizations providing home care as: public; private not-for-profit agencies; and, private for-profit agencies.

Notes on the tables

With the exception of the data from Statistics Canada, percentages in this report have been rounded to the nearest integer. For Statistics Canada data, the percentages have been rounded to one decimal place.

For the most part, the proportion of "don't know", "not applicable" or "refused" have not been reported in the individual tables, but have been taken into account in the calculation of percentages.

Information for this Section is taken from two primary sources: the National Population Health Surveys (NPHS) for 1994, 1996 and 1998, and the focus groups and key informant interviews conducted for Phase II of this study. The information source is noted where appropriate.

Some information on the use of home care services is available from the National Population Health Surveys (NPHS) conducted in 1994, 1996 and 1998. While the questions varied somewhat across the years, they were reasonably comparable. The following question, used in the 1996 survey, is representative of the question that was posed in each survey:

- Home care services are *health care and homemaker* services received at home, with the cost being entirely or partially covered by government. Examples are: nursing care; help with bathing or housework; respite care and meal delivery.
- Have [has] you [name] received any home care services in the past 12 months?

Unless otherwise noted, the information in this section comes from an analysis of NPHS results from 1994 and 1998.

It should be noted that, since the most recent NPHS results are from 1998, they will not reflect significant changes in the home care sector – notably the availability of services – over the past couple of years.

Characteristics of home care recipients

The people who use home care are most likely to be elderly, live alone, have lower education levels and be less affluent. The following sections provide detailed information on the demographic characteristics of those receiving home care.

Table 2.1 provides a summary of the percentage of people, 20 years of age or older, who said that they had received some home care over the previous 12 months (the past year). Overall, the percentage of people receiving home care was identical in 1994 and 1996 and increased somewhat in 1998. There were moderate increases in the percentage of home care consumers over time in Atlantic Canada and Ontario. Quebec and the Prairies were somewhat mixed and there was a significant drop in British Columbia between the 1994 and 1996 surveys. This drop seems to reflect the impact of a new policy of reducing services to low care need consumers, who were only receiving cleaning services from care in 1995.

The informal caregiver survey provides us with an indication of the percentage of the Canadian population receiving home care services. This survey identified that only 1.9% of the population had received home care services in the past twelve months. However, this number likely includes only those who

Table 2.1: **Percentage of people receiving home care in the past year by region and year, for persons 20 years of age or older**

Region	**1994** (%)	**1996** (%)	**1998** (%)
Canada	2.5[1]	2.5[2]	2.8[3]
Atlantic	2.3	2.4	2.8
Québec	2.1	2.0	2.4
Ontario	2.6	2.7	3.3
Prairies	2.3	2.7	2.5
British Columbia	3.5	2.9	2.6

[1]Total population 20 and older receiving home care in 1994 = 520,912
[2]Total population 20 and older receiving home care in 1996 = 539,986
[3]Total population 20 and older receiving home care in 1998 = 606,787

received medical services at home and would not include those who received housekeeping services.[1]

There was an increase in the proportion of people who received home care services by age. Overall, people 65 years of age or older were approximately ten times more likely to receive home care than people under 65. There was almost twice the percentage of females receiving home care than men (3.3% compared to 1.7% in 1996). (Table 2.2)

Persons who were widowed, divorced or separated were approximately four to five times as likely to receive home care than were people who were single, or married or common law. (See Table 2.3)

With regard to living arrangements, those who lived alone were three to four times more likely to have received home care services in the past year.

Those with lower levels of income and education were more likely to use home care services than those with higher incomes or who are well educated. Caution should be used in interpreting this finding because it relates to use rather than payment. In many jurisdictions home support services are income tested and thus, those with means would pay privately as they would not be eligible for a subsidy. Thus, in looking at government data one cannot be sure if the low proportion of higher-income people is because they are less likely to actually need home care or they are not registered in the public system.

Health status and home care services

Health status of care recipients

Table 2.4 indicates that some 12 to 15% of the people who were hospitalized or used a long term care facility bed also received home care, compared to some 1.5% of people who had not been in institutions. Similarly, the proportion of people who had a disability and received home care was over ten times the rate for people who did not have a disability. The proportion of people who received home care was also clearly related to self-reported health, with 0.05 to 0.08% of people who reported excellent health receiving home care compared to 20 to 26% of the people who rated their health as poor.

Home care services

Home care consumers received a wide range of services. Table 2.5 indicates the percentage of consumers who received different types of services and their relative need for care based on the average number of tasks for which they needed someone else to help them. The main tasks were nursing care, housework and personal care. The proportion of people receiving nursing services was fairly constant over time. The people who received nursing services (people could receive one or more types of service) generally had

Table 2.2: **Percentage of people receiving home care in the past year by age group, sex and year, for persons 20 years of age or older**

Age Group	**1994** (%)	**1996** (%)	**1998** (%)
20-39 Years	0.9	0.9	0.7
40-59 Years	1.1	1.2	1.4
60-69 Years	3.4	3.3	2.8
70-79 Years	9.7	8.0	10.1
80+ Years	22.3	24.0	28.0
Less than 65 Years	1.1	1.1	1.1
65 Years or Older	10.3	9.9	11.8
Sex			
Females	3.3	3.3	3.5
Males	1.7	1.7	2.1

[1] The question about home care services followed the question *"Have you personally received any services from a doctor, hospital, nurse of other health care provider in [province] in the past 12 months?"* Only those who replied in the affirmative were asked if they received home care services. Of those who had received medical services in the past twelve months, 2.2% had received home care services.

Table 2.3: **Percentage of people receiving home care in the past year by socio-demographic characteristics of home care consumers and year, for persons 20 years of age or older**

Socio-Demographic Characteristics	**1994** (%)	**1996** (%)	**1998** (%)
Marital Status			
Married/Common Law	1.8	1.9	2.2
Single	1.5	1.3	1.1
Widowed/Divorced/Separated	7.5	7.3	7.6
Living Arrangements			
Living Alone	7.6	6.3	6.6
Living with Others	1.8	1.9	2.1
Other	1.7	2.1	1.9
Education			
Less than High School	4.9	4.8	6.1
High School Graduate (plus other)	2.0	2.1	2.0
Diploma/Degree	1.3	1.5	1.7
Income (in Quantiles)			
Lowest	6.4	4.0	5.5
Lower Middle	5.6	6.1	8.3
Middle	2.9	3.1	4.0
Upper Middle	1.3	1.3	1.4
Highest	0.9	1.0	1.2

Table 2.4: **Percentage of people receiving home care in the past year by health related factors and year, for persons 20 years of age or older**

Health Related Factors	**1994** (%)	**1996** (%)	**1998** (%)
Home Care consumer who was overnight patient in hospital or nursing home in past year			
Yes	12.6	14.4	15.9
No	1.4	1.4	1.7
Had a restriction of activities in past year			
Yes	9.0	10.1	11.1
No	0.7	0.9	0.8
Self-Reported Health			
Poor	20.5	19.8	26.2
Fair	8.3	8.9	10.5
Good	2.7	2.7	3.0
Very Good	1.1	1.1	1.1
Excellent	0.5	0.8	0.5

Table 2.5: **Percentage of home care consumers receiving different types of home care services and severity score[1]**

	1994		1996		1998	
	Severity Score	**Receiving Services (%)**	**Severity Score**	**Receiving Services (%)**	**Severity Score**	**Receiving Services (%)**
Nursing Care	1.8	39.2	2.1	46.0	2.4	41.2
Housework	2.7	50.8	2.9	42.3	3.0	42.2
Personal Care	2.9	10.6	4.2	24.4	3.8	37.2
Meal Preparation[2]	3.0	7.2	3.7	14.5	3.3	16.1
Shopping	3.3	1.2	3.6	4.3	3.8	5.5
Other	2.6	12.1	N/A	N/A	N/A	N/A
Respite Care	N/A	N/A	N/A	5.3	3.1	5.9
Other Health Care	N/A	N/A	2.7	13.6	2.7	11.4
Other	N/A	N/A	2.2	2.0	1.5	3.7

[1] Severity score is based on whether or not the consumer needed help from someone else with the following tasks: preparing meals, shopping, doing housework, doing heavy household chores, personal care and mobility. The scale is based on scoring one point for each task requiring assistance and ranges from 0 to 6 (Cronbach's Alpha = 0.81).

[2] For the 1996 and 1998 survey the wording was "meal preparation or delivery".

lower needs for assistance with tasks than those receiving most other services. This may be because these people might have been more likely to receive short-term, hospital-replacement home care, such as three to four home visits after surgery. Thus, some may have been fully recovered by the time the survey was conducted and this could account for their greater independence. There was a significant increase in Personal Care (some form of non-professional hands on care, such as bathing) between 1994 and 1998. This may be a reflection of changes in policy that reduced the number of people receiving housework services.

These findings with respect to the shift in types of services are consistent with information in the Labour Force Survey on changes in employment patterns in the Home Health Service Industry. This information suggests that there has been a shift in services away from housekeeping tasks to personal care tasks. The proportion of Nursing Aides who work in the Home Health Services Industry has increased dramatically over the five-year period from 2,600 in 1997 to 13,400 in 2001 and increase of 515%. This huge increase may be at least partially attributable to the changing responsibilities of home support staff and the greater emphasis on personal care tasks and less emphasis on housekeeping tasks. (LFS)

Information on the specific services consumers received from both formal and informal caregivers is provided in subsequent sections – Section 3: Informal Caregivers and Section 5: Formal Caregivers.

Consumer issues

A diverse range of consumers was consulted through a series of focus groups conducted across the country. (See Appendix B for a description of the methodology.)

There was considerable consistency in the issues raised with respect to service delivery and human resources in the home care sector:

- Consumers were very concerned and frustrated about the perceived reduction in home care services. They noted that increasingly, care recipients have to depend on informal caregivers or services from voluntary organizations. These reductions in services were identified as an indication of the low value that is placed on seniors in our society. Home support services are predominantly provided to seniors, many of whom are trying to remain independent in the home for as long as possible; the fact that these services are disappearing or the time available to provide services is being significantly reduced (i.e. time for tasks), only serves to strengthen this perception.

- Consumers expressed concern about the appropriateness of some services that were offered. Although highly valued, home care services were considered not always appropriate to the needs of the consumers and their families; formal home care services should address family needs as well as care recipients' needs.
- They feel that caregivers need to have some degree of flexibility in the services that they are able to provide. This enables them to respond better to the specific needs of consumers and their family members and suggests a more holistic approach to the care and support of home care recipients.
- Consumers universally spoke about the importance of having the same formal caregivers providing care in the home. Consumers and family members are angry, dissatisfied, concerned and stressed-out at the lack of continuity and the effects this has on the provision of care in the home. Many focus group participants shared their experiences with having to reorient "endlessly" it seemed, the "revolving door" of workers coming into the home. They were concerned about the quality of care being provided and having to educate new workers continually as to the specific needs of their family member. To some this was a problem associated with the casualization of the workforce.
- Consumers expressed a desire for increased coordination not only between formal and informal home care services, but also between and among home care, other components of the health system and other social and community services.
- Consumers also provided many more general comments on issues related to the quality of home care services. Details are provided in Appendix B.
- The specific issues identified by focus groups participants with each type of consumer group are identified in Table 2.6.

Table 2.6: **Human resource issues for different consumer groups**

CONSUMER GROUP	COMMON THEMES	SPECIFIC ISSUES
Seniors	Continuity of formal caregiver Casualization of the workforce Need for respite of informal caregivers Flexibility in tasks	Loneliness is a big factor in the provision of home care services. Workers do not have time to sit and talk; yet this is highly valued by seniors.
Chronic needs consumers	Continuity of caregiver Casualization of the workforce Need for respite for informal caregivers Flexibility in tasks	Flexibility for workers to address better the needs of the consumers and their family caregivers. This flexibility included additional time ('five minutes to sit and talk') for more social functions, which contribute to the positive mental health of consumers and families. Some individuals, such as those with schizophrenia, just require companionship and that can make a big difference in their lives. Consumers recognize the fiscal constraints facing the sector but are frustrated that more time cannot be provided to them and that there cannot be more a focus on what needs to be done from their perspective. Links with formal sector – Support for informal caregivers and an understanding of the community organizations and volunteers that are available.
Parents of children with special needs	Continuity of caregiver Casualization of the workforce Need for respite for informal caregivers	Volunteers can help but, because they are volunteers, cannot dictate what needs to be done.

Continued

Table 2.6 (continued): **Human resource issues for different consumer groups**

Persons with physical disabilities	Continuity of caregiver – and need for backup Need for recognition of informal caregivers Flexibility in tasks	Flexibility to address specific needs, particularly social needs. Home care also does not address social needs, which are important to persons with disabilities who may not be able to get out in the community as much as they would like. Stress and burnout of formal and informal caregivers. Importance of self-managed care opportunities – to address varied needs. Provides continuity of caregiver, flexibility, independence and control over the environment. Need to provide supports for the logistics of self-managed care arrangements.
Persons with psychiatric disabilities	Continuity of caregiver (particularly for this group) Need for respite for informal caregivers Flexibility in tasks	Focus on prevention/maintenance functions.
Persons with HIV/AIDS	Need for recognition and support for informal caregivers – particularly need for bereavement support Flexibility in tasks	Need for wide range of services – home supports, pharmaceutical care, supportive physicians – generally, more intensive case management. Home care providers should be asking more questions about consumer needs and routines rather than imposing a set of tasks on the consumer. Home care workers need to have a greater understanding of the illnesses and problems they are encountering.
Multicultural groups	Burden on informal caregivers when language is an issue	Language can be a significant barrier to effective communication and quality home care (with issues related to the timing of visits, the coordination of services and programs for the consumer, the specific and changing care needs of the consumer, and the appropriate responses to concerned family members). Miscommunication about what type of care should be provided, by whom and when, is magnified if the consumer and/or family member is cognitively impaired. Greater reliance is placed on the family caregivers who have the language skills to act as mediator between the service system and the consumer. For older immigrant consumers that came to Canada many years ago, the language barrier is less of an issue as they have learned to speak English or French over time. Many organizations providing or coordinating home care in known areas of ethno-cultural diversity have attempted to address the language issue with workers who speak the language.

Summary

Overall, the percentage of people receiving home care was identical in 1994 and 1996 and increased somewhat in 1998. There were moderate increases in the percentage of home care consumers over time in Atlantic Canada and Ontario.

The profile of consumers who have used formal home care services in the previous year changed little between 1994 and 1998. The people who use home care are most likely to be elderly, live alone, have less education and have lower income levels.

- Overall, people 65 years of age or older were approximately ten times more likely to receive home care than people under 65.
- The percentage of females receiving home care was almost twice that for men.
- People who were widowed, divorced or separated were approximately four to five times as likely to receive home care than those who were single, or married or living in a common-law relationship.
- Those with lower levels of income and education were more likely to use home care services than those with higher incomes and who are better educated.[2]

However, the types of service they access have changed over the same time period:

- The proportion of people receiving nursing services was fairly constant over time.
- However, there was a significant increase in personal care (some form of non-professional hands on care such as bathing) between 1994 and 1998. This may be a reflection of changes in policy that reduced the number of people receiving housework services. This is consistent with information from the Labour Force Survey on a shift in services away from housekeeping tasks to personal care tasks.

There are a number of key consumer issues with respect to home care services and providers:

- Consumers perceive that, while there is an increasing demand for home care services, cutbacks in publicly funded home care across the country mean that these services are less available from formal caregivers and that reliance on informal caregivers and volunteers is increasing.
- The reallocation of public funding for home care has resulted in a focus on formal caregiver services such as nursing (and other professional services) and personal care services, and away from housekeeping services.
- Consumers are indicating that they need to receive home supports as these supports often make the difference in enabling seniors to remain in their own homes. They believe that providers should have the flexibility to be able to provide these services.
- Consumers would like more continuity in home care providers, in order that a relationship can be established between the caregiver and the care recipient. This would improve the quality of care and reduce stress for the informal caregiver. Lack of continuity is attributed, in part, to the casualization in the workforce, but it may also be a management issue related to work scheduling.
- There is a call for better coordination within the home care sector (between formal and informal caregivers) and with other components of the health system and other social and community services.

[2] It should be noted that this is an important finding because it relates to use rather than payment. In many jurisdictions home support services are income tested and thus, those with means would pay privately as they would not be eligible for a subsidy. Thus, in looking at government data one cannot be sure if the low proportion of higher-income people is because they are less likely to actually need home care or because they are not registered on the public system.

INFORMAL CAREGIVERS

Unless otherwise noted, the information in this section is based on final results of a national survey of the general population carried out from December 2001 to May 2002 as part of the Berger Population Health Monitor survey.

The survey included 4,208 (weighted data) Canadians 15 years of age and older.

This survey identified 774 informal caregivers (weighted data). (Details on the methodology are found in Appendix C.)

The sample includes two populations:

- Those who were caring, in the caregiver's home, for "a child or adult who has a long-term physical or mental illness or condition or who is frail or disabled, needs care, attention, errands done for them or similar kinds of help"; and
- Those who were caring, outside the caregiver's home, for "a family member, relative or friend … who is ill, frail or disable or for whom you provide care, attention or help, or do errands for them or visit." (This group does not include those who are living in nursing homes, homes for aged or other types of special housing.)

Profile of informal caregivers

Overall, 19% of respondents indicated that they were providing care, either in their home or in the home of the care recipient. If this figure is extrapolated to the national population, this would indicate that approximately one Canadian in five, 15 years of age or over, is providing informal home care services.

The majority of informal caregivers were providing care in the home of the care recipient. The diagram on the following page illustrates where informal caregivers were providing care. Excluding those providing care only to people in institutions (who were included in the survey, but not included in our analyses):

- Just over one-quarter (27%) were providing care only in their own home;
- Just under two-thirds (62%) were providing care in the care recipient's home only; and,
- Very few (10%) were providing care to people in more than one location.[3]

The survey covered all provinces and territories. Table 3.1 reflects the distribution by region. The provincial distribution of informal caregivers mirrors that of the total sample. The provincial level data are too small to permit any analysis of the results by province, or even region.

Nearly one-quarter (24%) of the informal caregivers are between the ages of 15 and 29. Nearly one-half (44%) are between 30 and 49. Over a quarter (28%) are between 50 and 69. A small percentage (3%) are 70 years of age or older. The average age is 42. The age profile of informal caregivers is comparable to that of the overall sample. (See Table 3.2)

Table 3.1: **Informal caregiver respondents by region**

Region	% of caregivers (n= 774)	% of overall sample (n = 4208)
Atlantic	9%	8%
Quebec	22%	25%
Ontario	41%	38%
Prairies (including Nunavut and Northwest Territories)	18%	17%
British Columbia and Yukon	10%	13%

[3] Due to the way the questions were asked in the survey, we are unable to identify the number of respondents in Group 7 and there may be small discrepancies in the overlapping categories.

Table 3.2: **Percentage of informal caregivers by age**

Age	% of caregivers (n= 774)	% of overall sample (n = 4208)
15 – 29	24%	27%
30 – 49	45%	41%
50 – 69	28%	26%
70 and over	3%	7%

Table 3.3: **Percentage of informal caregivers by sex**

Gender	% of caregivers (n= 774)	% of overall sample (n = 4208)
Male	38%	46%
Female	62%	54%

Table 3.4: **Percentage of informal caregivers by marital status**

Marital status	% of caregivers (n= 774)	% of overall sample (n = 4208)
Married	56%	52%
Common-law	9%	10%
Widowed	2%	4%
Separated/divorced	8%	7%
Single (never married)	24%	27%
Don't know/refused	0%	0%

Nearly two-thirds (62%) of the informal caregivers were females. Females are over-represented among the informal caregivers than in the overall sample. (See Table 3.3)

Nearly two-thirds (65%) were either married or living in a common-law relationship. The remaining (35%) were widowed, separated, divorced or never married. The marital status profile of informal caregivers is comparable to that of the overall sample. (See Table 3.4)

Nearly two-thirds (64%) of informal caregivers were working either full- or part-time (including self-employment). The remaining (35%) were students, unpaid homemakers, unemployed, disabled or retired. The employment profile of the informal caregivers is comparable to that of the overall sample.

The majority of informal caregivers had completed at least their secondary education – 29% have completed high school, 35% post-secondary and 5% post-graduate education. The educational profile of informal caregivers is comparable to that of the overall sample. (See Table 3.6)

Eight percent of informal caregivers who answered the question earn less than $20,000 per year. Over one-third (37%) earn between $20,000 and $49,999 and over a third (39%) earn $50,000 or more annually. The income profile of informal caregivers is comparable to that of the overall sample. (See Table 3.7)

Nineteen percent of informal caregivers indicated that they themselves had a long-term physical or mental illness or condition, were frail, disabled, needed care, attention, errands done for them or similar kinds of help.

Table 3.5: **Percentage of informal caregivers by work status**

Employment status	% of caregivers (n= 774)	% of overall sample (n = 4208)
Working full-time	43%	44%
Working part-time	15%	14%
Self-employed	6%	5%
Going to school (not working)	9%	10%
Homemaker (not paid)	9%	7%
Unemployed	5%	4%
Unable to work – disabled	4%	5%
Retired	9%	13%

Table 3.6: **Level of education of informal caregivers**

Level of education	% of caregivers (n= 774)	% of overall sample (n = 4208)
Less than completed high school	16%	19%
Completed high school	29%	26%
Some post-secondary (includes college and university)	15%	13%
Completed post-secondary (includes college and university)	35%	47%
Completed post-graduate	5%	8%
Don't know/refused	1%	1%

Table 3.7: **Total household income for informal caregivers**

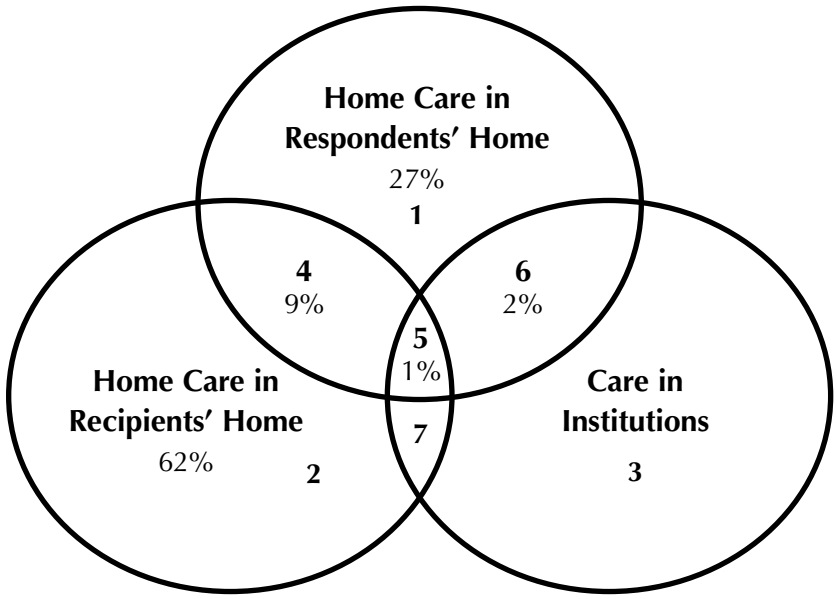
Income	% of caregivers (n= 774)	% of overall sample (n = 4208)
Less than $20,000	8%	10%
$20,000 – $29,999	12%	10%
$30,000 – $39,999	12%	11%
$40,000 – $49,999	13%	11%
$50,000 – $59,999	8%	9%
$60,000 – $69,999	6%	7%
$70,000 – $79,999	6%	6%
$80,000 – $89,999	4%	4%
$90,000 – $99,999	4%	3%
$100,000 or more	12%	12%
Don't know/refused	17%	18%

Table 3.8: **Relationship of informal caregiver to care recipient**

Relationship	% of caregivers (n= 774)
Parent	43%
Other relative	26%
Friend/neighbour	19%
Spouse/partner	13%
Brother/sister	10%
Child	13%

Total is greater than 100% because, if respondents cared for more than one person, they may have indicated more than one relationship.

Figure 3.1: **Location of Informal Caregiving**



1 = Providing home care in respondents' home only

2 = Providing home care in recipients' home only

3 = Providing care to recipients in institutions only

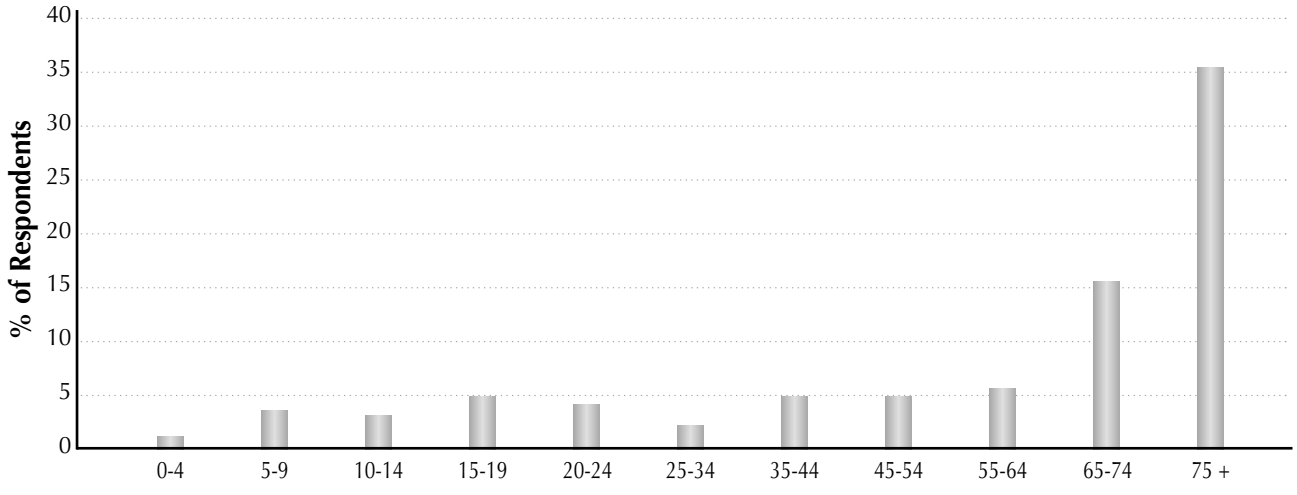
4 = Providing home care both in respondents' and recipients' home

5 = Providing home care in respondents' and recipients' homes and institutions

6 = Providing home care both in respondents' homes and institutions

7 = Providing home care both in recipients' home and to recipients in institutions

Figure 3.2: **Age of Care Recipients**



When asked to compare their general health to other persons their age, 28% of informal caregivers stated their health was excellent, 50% said it was good, 19% said it was fair, and 4% said it was poor. This is comparable to the responses of the overall population sample (30% said excellent, 52% good, 15% fair, and 4% poor).

Over two-thirds (71%) of informal caregivers cared for only one person; 17% cared for two people, and a further 8% cared for between three and eight people.

Two-thirds of the informal caregivers (67%) had been providing care for five years or less. The remaining third (33%) had been providing care for between six and 40 years. The average number of years for which caregivers have been providing care was six years.

Profile of the care recipients

Forty-three percent of informal caregivers were caring for a parent. Just over one quarter (26%) is caring for other relatives (which may include aunts/uncles or in-laws) and 19% were caring for a friend or neighbour. (See Table 3.8)

The age of care recipients is shown in Figure 3.1. Just over one-third of the recipients were under the age of 55. One-quarter (25%) was between 55 and 74 years of age. Just over one-third (36%) was 75 years of age or older.

Profile of the caregiver tasks/services

The focus groups with informal caregivers indicated that there is an increasing level of frustration that families are expected to take on more responsibilities. There was considerable concern and anger at the assumption that families will, and can, readily provide the care and support that the public system can no longer fund. There was a feeling among informal caregivers that there ought to be more recognition of the role they play.

The survey results indicate that there is a range of reasons that informal caregivers are providing care, the most frequent being that the care recipient is elderly or frail, but wishes to remain in his/her home. Reasons why care is needed are listed in Table 3.9.

Caregivers provided varying amounts of care. The frequency of caregiving varied from providing care every day, all day, to providing care only on special occasions. One-quarter (24%) spent at least some time each day providing care (ranging from once a day to every day, all day). Over another third (39%) spent time each week (either once a week or several times a week) providing care. Just less than one-quarter (21%) provided care only at special times.

The amount of time they spent providing care also varied from a few hours a week up to 140 hours a week. The average number of hours of care provided in the seven days prior to participating in the survey was 11 hours.

Informal caregivers carry out a wide range of tasks from housekeeping support to health care interventions. The most frequent task was helping care recipients to get to doctors' or other appointments or to visit friends (76% of all respondents) and the least frequent was helping with home dialysis (1%). (See Table 3.10 for the distribution of all tasks.)

Table 3.9: **Reason care is needed***

Reason: Care recipient…	**% of caregivers (n= 774)**
… is elderly or frail but wants to live in their home	63%
… is not elderly but is physically or mentally ill, disabled or frail in some way	53%
… is receiving rehabilitation services at home after an accident or illness	22%
… has been discharged from hospital and needs short-term care	19%
… is terminally ill and wants to live in the home as long as possible	19%

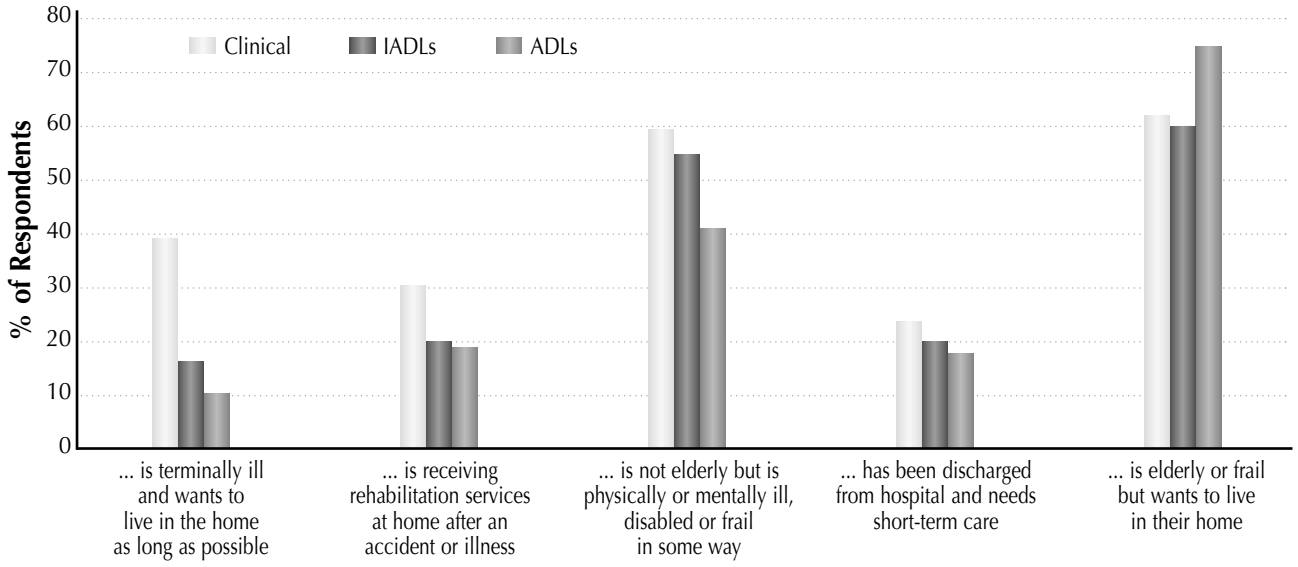
* Respondents may have indicated that they are providing care for more than one reason.

Table 3.10: **Services provided* by formal caregivers**

Service	% of caregivers (n= 774)
Clinical Care	
... clean and bandage pressure or bed sores, infections or wounds	8%
... give needles or take care of intravenous therapy	6%
... help with oxygen, suctioning or other respiratory therapy	5%
... help with bladder catheterization or bowel routines	4%
... help with tube feeding	1%
... help with home dialysis	1%
Instrumental Activities of Daily Living (IADL)	
... make sure they take their medication as required	56%
... get them to doctors' and other appointments or to visit friends	76%
... help them by communicating with others, reading and writing	33%
... help clean house, do housekeeping	61%
... help them with eating or preparing meals	46%
Activities of Daily Living (ADL)	
... help them with dressing, undressing, washing, bathing, help in the bathroom	20%
... help them with mobility problems such as turn them in bed, or move from bed to chair	18%

* Respondents may have indicated that they are providing more than one service.

Figure 3.3: **Reason care is needed, by category of care (n= 705-708)**



* Respondents may have indicated that they were providing care for more than one reason.

Table 3.11: **Informal caregiver challenges***

Respondents indicated that the following were 'almost always', 'often' or 'sometimes' true…	**% of caregivers (n = 774)**
… caregiver has experienced stress as a result of providing care	46%
… caregiver experiences physical pain or discomfort as a result of providing care	14%
… people they care for are verbally abusive to them	12%
… people they care for are physically abusive to them	3%

* These questions were asked only of those providing care in the caregiver's home.

Analysis by category of care

For the purpose of further analysis, the tasks have been divided into three major categories: clinical care, instrumental activities of daily living (IADL), activities of daily living (ADL).

Category 1:

- Clinical care includes any activity requires medical knowledge to address technical aspects of wound care, IV therapy, etc.

Category 2:

- IADLs included the ability to do heavy housework, laundry, meal preparation, grocery shopping, getting around outside, getting to places outside of walking distance, money management, using the telephone, and taking medications.

Category 3:

- ADLs included eating, getting in and out of bed, getting around inside, dressing, bathing and using the toilet.
- 16% of caregivers were fulfilling at least one task from the clinical category of care.
- Females represented a higher percentage (68%) of the caregivers in the clinical category than males (32%).
- This is also true for the IADLs – females represented 64% of the caregivers, while males represented 36% of caregivers. The gender gap changes in the third category of task (ADLs). In this category males represented 52% while females represented 48%.
- Those providing clinical care were less likely to be working full-time (39%) than those providing IADLs (43%) and ADLs (52%).

Figure 3.3 reflects the reasons for giving care, by the category of that care. Those who are in acute care conditions – terminally ill or receiving rehabilitation services after an accident or illness – are receiving more clinical care than IADLs and ADLs. Those in chronic care situations – physically or mentally ill, disabled or frail – receive almost equal amounts of all levels of care. Those who are recently discharged from hospital also receive equal amounts of all levels of care. The elderly or frail who want to remain in their homes receive more IADLs and ADLs, but receive a lot of services at all levels.

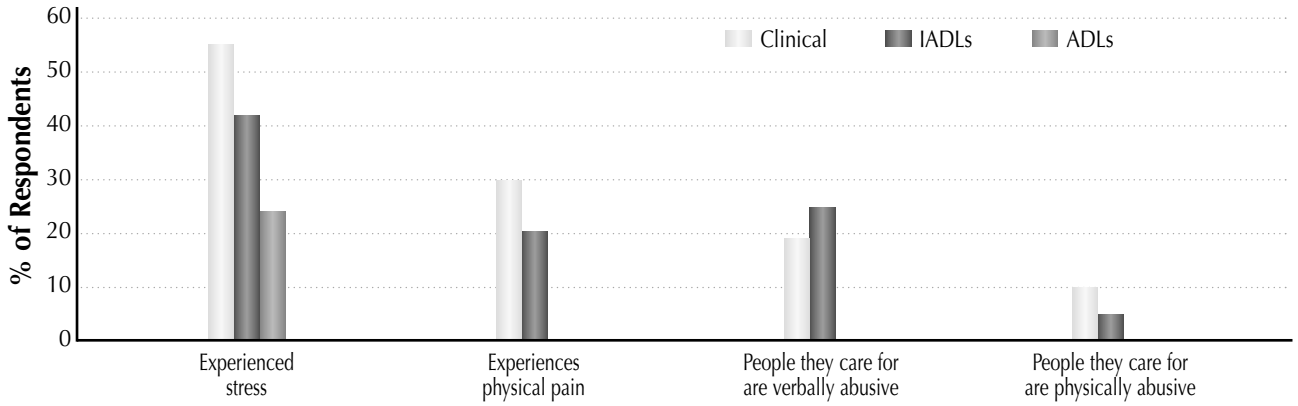
Those providing clinical care were more likely to provide care at least once a day (41%) than those providing IADLs (26%) or ADLs (7%) intensity care.

Conversely, those providing IADLs and ADLs were more likely to do so only at special times (34%) than those providing clinical (14%) care.

Those providing clinical care provided, on average, more hours of care a week (17 hours) than those providing IADLs (11 hours) or ADLs (five hours) intensity care.

Those providing clinical care had, on average, been providing care for a longer period of time (eight years) compared to those providing IADLs (five years) or ADLs (five years).

Figure 3.4: **Informal caregiver challenges (n = 193 – 209)***



* These questions were asked only of those providing care in the caregiver's home.

Informal caregiver challenges and supports

Informal caregiver challenges

In response to a question about the suitability of the house for caregiving, 84% of those caring for people in the caregiver's home indicated that the home was well-suited.

The survey results also identified a number of barriers to home caregiving.

- 41% indicated that there was only occasionally or hardly ever someone in the house to give them a hand when needed.
- 71% indicated that other people in the home are only occasionally or hardly ever cooperative with the informal caregiver.

They also identified burdens placed on informal caregivers. (See Table 3.11)

- Nearly one-half (46%) indicated that they had experienced stress as a result of providing care. One caregiver in ten (12%) indicated that care recipients were almost always, often or sometimes verbally abusive.
- However, the physical burdens are less common: 14% indicated that they had often or sometimes experienced physical pain or discomfort as a result of providing care and 3% of caregivers indicated that the care recipients were almost always, often or sometimes physically abusive to them.

Analysis by level of care

Analysis of the responses to the questions about burdens to the caregiver reflects that those providing

Table 3.12: **Support for informal caregivers from employers (n = 387 – 412)***

Employer was very likely or somewhat likely to allow the caregiver to…	**% of caregivers (n = 774)**
… leave work at short notice because of an urgent situation	84%
… reschedule work to take time for assistance	68%
… use holiday time or sick leave time to help out	60%
… take extended unpaid leave to help with caregiving	60%
… have flexible start and finish times for work days	58%
… take extended paid leave to help with caregiving	32%
… work at home instead of at the office	21%

* These questions were asked only of those providing care in the caregiver's home.

Table 3.13: **Information/advice for informal caregivers (n = 774)**

Informal caregivers indicated they would like …	**% of caregivers**
… somebody to do their duties to give them a break	31%
… emotional or mental health support for themselves	25%
… financial assistance	22%
Informal caregivers indicated they would like advice or support in …	
… information on community services for the care recipients	43%
… information, advice or training on how to provide care	33%
… information on legal issues	22%

clinical care in their own home are more likely to experience these burdens almost always, often or sometimes, than those providing medium or low intensity care.

The only exception is that caregivers providing IADLs (7%) in their own home are more likely to report that care recipients are often verbally abusive to them than other caregivers while both those providing clinical care as well as IADL are more likely to report verbal abuse sometimes or occasionally (9.4%).

Informal caregiver supports

Caregivers indicated varying levels of support from their employers to accommodate their caregiving roles. (See Table 3.12) The majority of respondents who indicated that they were employed, felt that their employer was very likely or somewhat likely to allow them to leave on short notice to respond to an urgent situation. Between half and two-thirds of this group felt that their employer would allow them to reschedule their work, use holiday time, take unpaid leave or have flexibility work hours to accommodate caregiving needs. Only one-quarter felt they would be allowed to take extended paid leave and only one-quarter felt they could work at home instead of at the office. (This may be a reflection of the fact that, in many jobs, working at home is not a feasible option.)

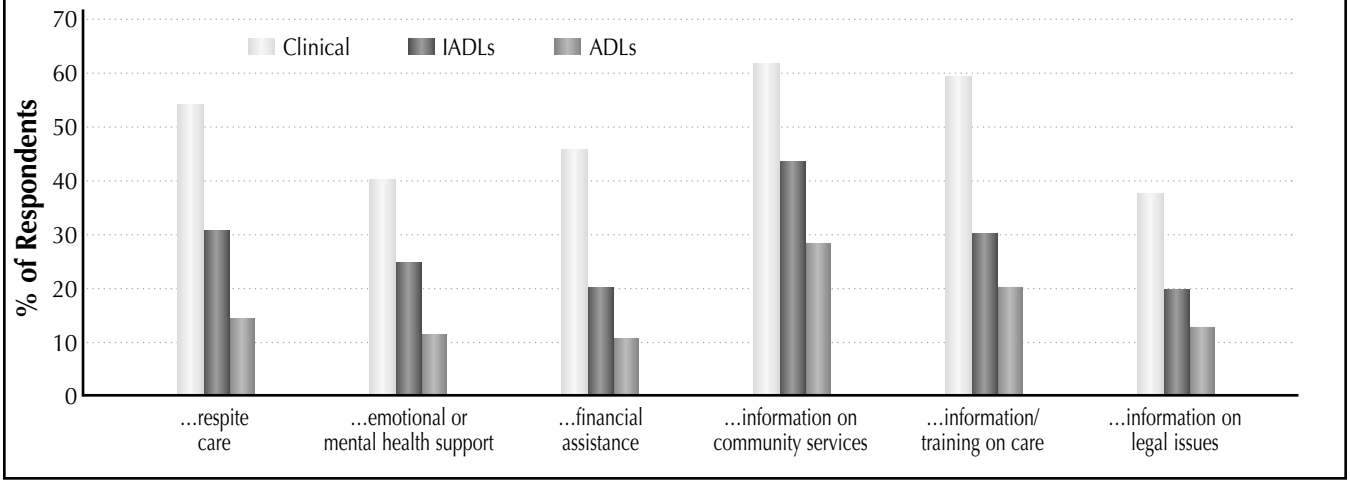
Some informal caregivers indicate an interest in supports for them as caregivers. (See Table 3.13) These were of two types: support for them personally and information to improve their caregiving.

- Almost a third (31%) of the help requested by caregivers was some form of respite care – somebody to do their duties so they could have a break. One-quarter (25%) felt that would like emotional or mental support.
- Four in ten caregivers would appreciate information on community services available for their care recipients. A further third (33%) would like information on how to provide care.

In the focus groups, the supports and assistance that informal caregivers indicated that they would like to receive are consistent with those identified through the survey (FG).

- They would like more respite, particularly night respite and day care centres.
- They would like better integration of services with those of other health and community sectors – for example, better coordination between hospitals and home care (including more information at discharge) and assistance with transportation upon discharge from hospitals. They would also like the formal caregiving sector to be able to address family needs as well support the central role that family caregivers play.
- They would like support to adapt the home to providing home care services, for example with equipment for lifting people.
- They would like more self-help support groups.

Figure 3.5: **Information/advice for informal caregivers, by intensity of care (n = 705 – 707)**



* These questions were asked only of those providing care in the caregiver's home.

The focus groups identified informal caregivers' need for more integration with the formal caregiving sector. However, the formal caregiver survey identified some barriers to that integration. (Formal caregiver survey)

- Not all formal caregivers were paid for time to meet with informal caregivers: only 18% of home support workers are paid for this time. The percentages are higher for the professional caregivers: 68% for RNs, 52% for LPNs and 90% for OT/PT/SWs. This is a barrier (particularly for home support workers) to meeting with informal caregivers to integrate care.
- A second barrier is the limited training that formal caregivers have had in working with informal caregivers. Formal caregivers were asked to identify whether they had had any training in the past 12 months in working with informal caregivers and volunteers. Fewer than two out of 10 caregivers had had this type of training (home support workers – 15%; registered nurses – 15%; licensed practical nurses – 8% and OT/PT/SWs –16%).

Analysis by level of care

The need for information or advice for informal caregivers varied by the category of care being provided. Those providing clinical care were more likely to indicate that they would like advice or support in all areas than those providing IADLs or ADLs. Similarly, those providing IADLs and ADLs were more likely to want advice or support than those providing low intensity care. (See Figure 3.5)

Profile of volunteers

No descriptive information was collected in the study on volunteers in the home care sector, but some information about the voluntary sector is available from the National Population Health Survey (NPHS). There was a single question to identify volunteers in the 1994 and 1996 surveys. The question from the 1996 survey was: "Are you a member of any voluntary organizations or associations such as school groups, church social groups, community centre, ethnic associations or social, civic or fraternal clubs?" Those who responded "yes" were considered to be volunteers.

Table 4.1 indicates that overall, about one-third of Canadians defined themselves as volunteers, but there was a sizeable drop in the proportion of volunteers between the 1994 and 1996 surveys. The proportion of volunteers held fairly steady between 1994 and 1996 in Atlantic Canada and British Columbia. The largest decrease in the proportion of volunteers was in the Prairies (41.3% in 1994 to 34.0% in 1996). The lowest overall percentage of volunteers in 1996 was in Quebec and Ontario at 23.9% and 28.0%, respectively.

In terms of age and sex, the highest percentages of volunteers were among people aged 60 to 79 years of age. In 1996, 37.3% of seniors were volunteers compared to 28.0% of people less than 65 years of age (see Table 4.2). There were relatively even proportions of men and women who were volunteers.

Table 4.1: **Percentage of people who were members of voluntary organizations/associations by region and year, for persons 20 years of age or older**

Region	1994 (%)	1996 (%)
Canada	34.0	29.4
Atlantic	33.7	32.4
Québec	27.9	23.9
Ontario	33.9	28.0
Prairies	41.3	34.0
British Columbia	37.6	36.9

Table 4.2: **Percentage of people who were volunteers, by age group, sex and year, for persons 20 years of age or older**

	Survey Year	
Age Group	**1994 (%)**	**1996 (%)**
20-39 Years	28.3	23.3
40-59 Years	36.3	32.1
60-69 Years	43.1	38.2
70-79 Years	42.3	38.3
80+ Years	39.9	33.2
Less than 65 Years	32.7	28.0
65 Years or Older	41.5	37.3
Sex		
Females	33.9	30.1
Males	34.2	28.8

Table 4.3: **Comparison of the number of volunteers based on the 1996 population distribution compared to the actual age and sex projections**

Year	Projections Based on 1996 Distribution	Projections Based on Estimated Population Distribution	Difference	Ratio of Volunteers to Consumers
1996	6,292,000	6,292,000	0	11.7:1
2006	7,284,200	7,446,000	161,800	9.4:1
2016	8,016,900	8,311,000	294,100	9.5:1
2026	8,519,500	9,006,000	486,500	8.2:1
2036	8,784,200	9,351,000	566,800	7:1
2046	8,850,800	9,407,000	556,200	6.4:1

Projections of volunteer caregivers

The ratio of volunteers to consumers is projected to change significantly between now and 2046. Using the NPHS data for rates of volunteering, we combined the rates of volunteering with projected changes in the composition of the Canadian population according to Statistics Canada. From these analyses, we were able to project the number of volunteers within 50 years and compare that with the projected increase in the number of individuals with need for home care services (according to NPHS data and projections – see Section 5).

The 1996 estimates from the NPHS were used as the base year. The age and sex ratios for the base year were then used to project the number of persons in question in two ways: 1) assuming the same population distribution as the base year for all future years, and 2) applying the age and sex ratios to Statistics Canada population projections (a conservative, mid-level estimate)[4].

Table 4.3 indicates that the overall number of volunteers will increase over time, and will increase at a greater rate than if we were to hold the 1996 population distribution constant. However, relative growth in volunteers is not as strong as it is for home care consumers. This results in the ratio of volunteers in 1996 (11.7 volunteers for each home care consumer) being cut almost in half by 2046 (6.4 volunteers for each home care consumer).

[4] For more complete details on the methods of projection, please refer to Appendix A.

CHAPTER 5

PROFILES AND PROJECTIONS FOR FORMAL CAREGIVERS

This section contains a profile of formal caregivers according to four broad occupational groupings in the home care sector. As well, we present a brief discussion with regard to the issues of supply of, and demand for, formal caregivers within the home care sector.

Sources of information and data

This section uses information and data from multiple sources. The primary sources are listed below.

A national survey of formal caregivers (SFC) which sampled respondents from four occupational groups (details of the survey methodology are included in Appendix D)[5]:

- Home support workers (HSWs) (para-professional workers in the home care sector using a broad definition to include personal aide workers, personal attendants, homemakers, and home support workers);
- Registered nurses (RNs);
- Licensed practical nurses (LPNs); and,
- Occupational therapists, physical therapists, and social workers (OT/PT/SW).

Labour Force Survey (LFS) data from Statistics Canada which includes analysis of (details of the analysis are included in Appendix E):

- Data collected in the 1997, 1998, 1999, 2000, and 2001 surveys;
- Data within the North American Industrial Classification System (NAICS) categories of Home Health Care Services (6216) and Individual and Family Services (6241); and,
- Data collected on the National Occupational Classification System (NOCS) for the occupations of nurses (D112), registered nursing assistants (D233), technical occupations in therapy (D235), nursing aides (D413), aides and assistants in support of health services (D414), and homemakers (G811).

Data from the National Population Health Survey was also analysed for Section 2.0 – Consumers (see Appendix A).

Population projections from Statistics Canada were used based on Census data.

Profiles of formal caregivers

Profiles for each of the primary professional and para-professional groups, namely home support workers (HSWs), registered nurses (RNs), licensed practical nurses (LPNs) and OT/PT/SWs, are below. Caution should be used when interpreting the following tables specific to the survey of formal caregivers, keeping in mind the overall purpose of the data collection, data limitations and contextual issues outlined in Appendix D, and in Section 1.0 of this report.

Number of formal caregivers

No national lists of professionals and para-professionals working in the home care sector exist. As a result, it was necessary to expend considerable effort in developing survey frames for each of the occupational groups. Using this process, we were able to provide an estimate of numbers of formal caregivers that could then be compared with other national estimates.

Number of home support workers

As illustrated in Table 5.1, we identified approximately 32,300 home support workers currently working in Canada through the survey frame development process. This number should be considered an approximate estimate only (most likely an underestimate due to some gaps identified during the process).

The findings from the 2001 LFS data indicate that the number of nurses' aides and homemakers working in

[5] The data presented includes the completed questionnaires returned (HSWs=1135; RNs=918; LPNs=811; OT/PT/SWs=524). At this level, most of the reported proportions according to occupational groups can be expected to be accurate to level of +/- 3% to 4%, 19 times out of 20.

the Home Health Services Industry (NAICS 6216) was approximately 16,700 (13,400 nurses aides and 3,300 homemakers). Another group of workers, of which a portion would likely be working in the home care sector as defined by the current study, is the Individual and Family Services category (NAICS 6241). This group includes an additional 40,600 nurses aides and homemakers. The proportion of this larger group that actually works in home care is unknown. As a result, the 2001 LFS estimates would have the number of home support workers ranging between a low of 16,700 and a high of 57,300.

The Canadian Institute of Health Information (CIHI) does not currently collect data on home support workers.

Table 5.1: **Home support workers in home care**

Province	Survey Frame Total	CIHI	LFS 2001
BC	3,539	—	—
AB	1,707	—	—
SK	1,549	—	—
MB	1,914	—	—
ON	19,801	—	—
QC	2,364	—	—
NB	876	—	—
NS	382	—	—
PE	52	—	—
NL	87	—	—
North	33	—	—
TOTAL	**32,304**	**Not available**	**16,700 – 57,300**

Table 5.2: **Registered nurses in home care**

Province	Survey Frame Total	CIHI Registrar Data[a]	LFS 2001
BC	677	553	—
AB	901	1,164	—
SK	647	607	—
MB	286	285	—
ON	4,789	5,232	—
QC	942	264	—
NB	467	69	—
NS	296	354	—
PE	23	57	—
NL	193	40	—
North	20	19	—
TOTAL	**9,241**	**8,644**	**9,700**

[a] *Supply and Distribution of Registered Nurses in Canada, 2000 – Canadian Institute for Health Information* (Table 6.0, p.75). Estimate based on "place of work" indicated as "home care agency".

Table 5.3: **Licensed practical nurses in home care**

Province	Survey Frame Total	CIHI (3.7% registrants)[a]	LFS 2001
BC	56	185	—
AB	186	161	—
SK	86	76	—
MB	86	94	—
ON	2,160	1,224	—
QC	107	601	—
NB	34	98	—
NS	125	121	—
PE	8	23	—
NL	0	107	—
North	6	7	—
TOTAL	**2,854**	**2,697**	**2,400**

[a] *Health Personnel in Canada, 1991 to 2000 – Canadian Institute for Health Information* (Table 8.3, p.44, 2000 registrants).

Number of registered nurses

Estimates of the number of RNs working in the home care sector were relatively constant ranging from 8,600 to 9,700.

The survey frame collection procedure identified approximately 9,200 RNs working in the home care sector.

Estimates from CIHI nurse registrar data suggest there are approximately 8,600 RNs working in a home care agency[6].

Data from the 2001 LFS indicate that there are approximately 9,700 RNs employed in the Home Health Services Industry (NAICS 6216).

Number of licensed practical nurses

Estimates of the number of LPNs currently working in the home care sector were very similar ranging from 2,400 to 2,900.

The survey frame collection procedure identified approximately 2,900 LPNs working in the home care sector. The distribution according to province is provided in Table 5.3.

CIHI information for LPNs is based on registrants for the year 2000. Currently, place of work is not collected consistently by registrars and transferred to CIHI. For the purposes of the current estimation, we assumed that the proportion of LPNs in homecare would be similar to the proportion of RNs currently working in the home care sector (3.7%). Using this assumption, the estimate would be approximately 2,700 licensed practical nurses currently working in the home care sector, or 3.7% of 73,000. [7]

Data from the 2001 LFS indicate that the number of registered nursing assistants working in the Home Health Services Industry (NAICS 6216) was approximately 2,400. (Statistics Canada uses the term "registered nursing assistant" rather than "licensed practical nurse" in their Labour Force Survey.)

Number of OT/PT/SWs

It is estimated that the number of OT/PT/SWs (i.e., occupational therapists, physical therapists, and social workers) providing home care ranges from 1,600 to 2,600.

As illustrated in Table 5.4, the number of OT/PT/SWs identified by employers was approximately 2,600 according to the survey frame development process.

[6] *Supply and Distribution of Registered Nurses in Canada, 2000 – Canadian Institute for Health Information* (Table 6.0, p.75) Estimate based on "place of work" indicated as "home care agency".

[7] *Health Personnel in Canada, 1991 to 2000 – Canadian Institute for Health Information* (Table 8.3, p.44, 2000 registrants).

Table 5.4: **OT/PT/SWs in home care**

Province	Survey Frame Total	CIHI Registrar Data[a]	LFS 2001
BC	73	196	—
AB	260	238	—
SK	90	62	—
MB	57	54	—
ON	952	438	—
QC	918	396	—
NB	129	69	—
NS	0	75	—
PE	6	10	—
NL	113	47	—
North	15	5	—
TOTAL	**2,613**	**1,591**	**Not available**

[a] *Health Personnel in Canada, 1991 to 2000 – Canadian Institute for Health Information* (Tables 12.2, 16.3, 21.1 – 2000 registrants).

Similar to the process for estimating the number of LPNs in the home care sector using CIHI data, we assumed that 3.7% of all OT/PT/SWs were working in the home care sector. According to CIHI data collected from the various provincial registrars, the number of OT/PT/SWs in the year 2000 was approximately 43,000. Assuming a 3.7% proportion, the number working in home care would be approximately 1,600.

There was no comparable data available from the LFS.

Other groups of formal caregivers

There are many other professionals and para-professionals that work in the home care sector not included in the groups above. For example, we did not attempt to obtain counts of case managers, respiratory therapists, speech therapists, dietitians, physicians, psychologists, or other professional and para-professional groups.

Age of formal caregivers

Respondents to the survey of formal caregivers were asked to report their current age. As demonstrated in Figure 5.1, the home care sector workforce is overall a relatively older workforce.

According to the survey results, approximately one-half of **the home support workers** (45%) reported that they were 50 years of age or older. Approximately one in 10 (9%) reported that they were 60 or older. Only a small proportion (21%) indicated that they were less than 40 years old.

Approximately three-quarters of **registered nurses** responding to the survey (73%) reported that they were 40 years of age or older.

A similar proportion of **licensed practical nurses** (73%) responding to the survey indicated that they were 40 years of age or older.

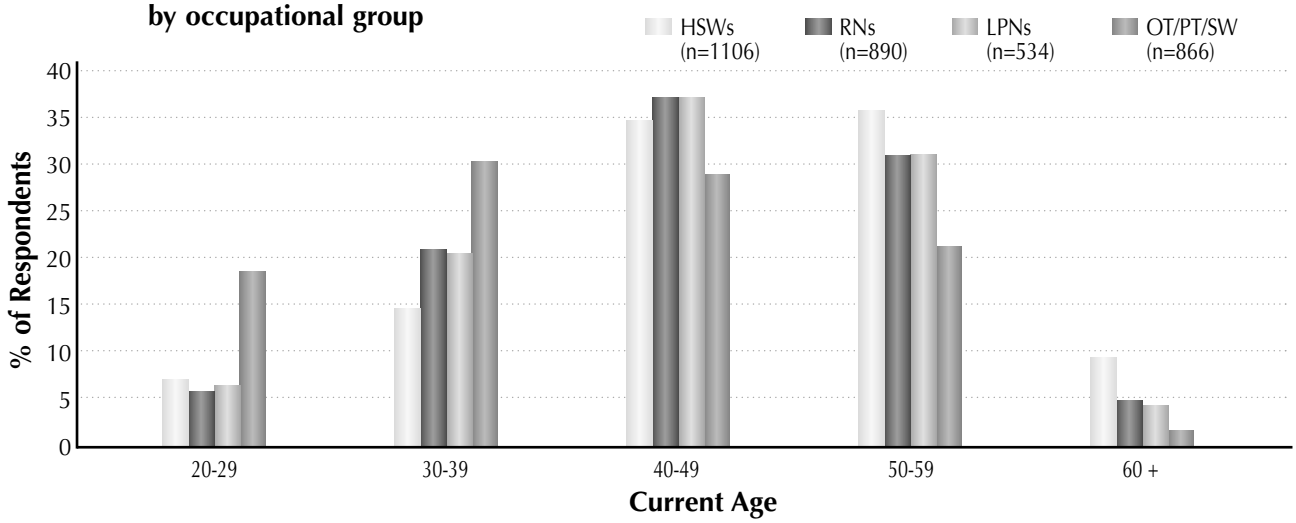
The **OT/PT/SW group** was consistently younger than the other occupational groups with approximately one-half of respondents (49%) reporting that they were under the age of 40.

Comparable data from the LFS collected in 2001 for all occupations in the Home Health Services Industry (NAICS 6216) indicates that over one-half of workers (55%) were in the 35 to 54 year-old age group with an additional 17% in the 55+ age group.

LFS 2001 data indicated a larger proportion of younger registered nurses working in home health services industry (38% under 35 years old) when compared with the survey data.

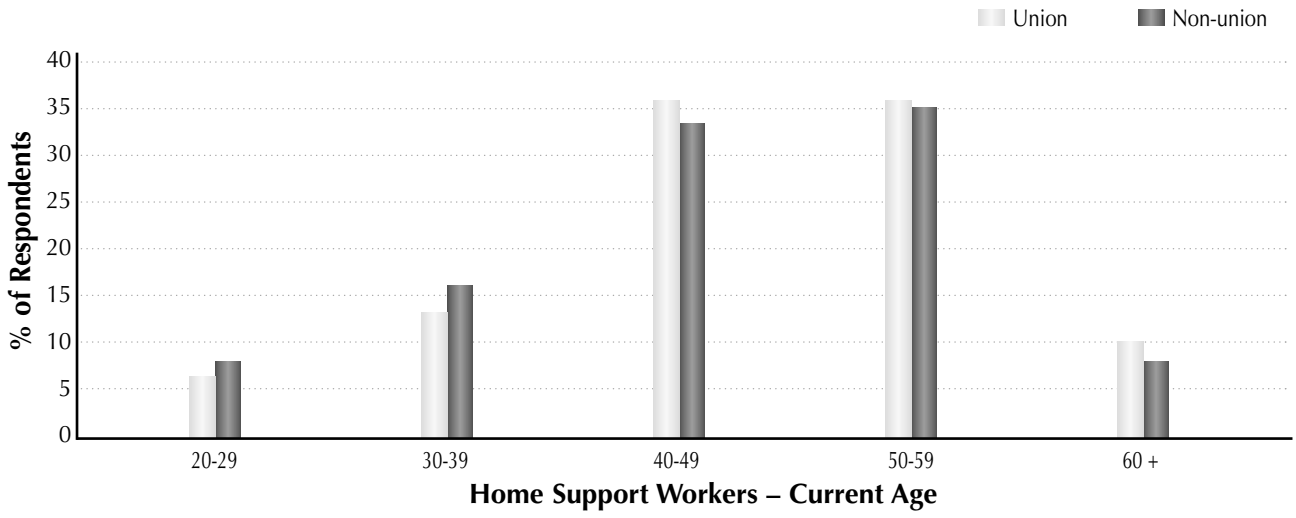
LFS 2001 data for nurses aides working in the home health services industry was comparable with the survey findings with only a small proportion (17%) under the age of 35.

Figure 5.1: **Age of formal caregivers by occupational group**



NOTE: The above data is national in scope. It should be noted that this grouping of data might not reflect important differences that exist by region, province, delivery model, employer type, union status, etc.

Figure 5.2: **Age of HSWs by union status**



NOTE: The above data is national in scope. It should be noted that this grouping of data might not reflect important differences that exist by region, province, delivery model, employer types, etc.

Seventy-two percent of unionized and 68% of non-unionized home support workers are between the ages of 40 and 60.

There is not a large variation (1-3%) of unionized verses non-unionized workers within each age group.

Seventy percent of unionized and 73% of non-unionized registered nurses are between the ages of 40 and 60.

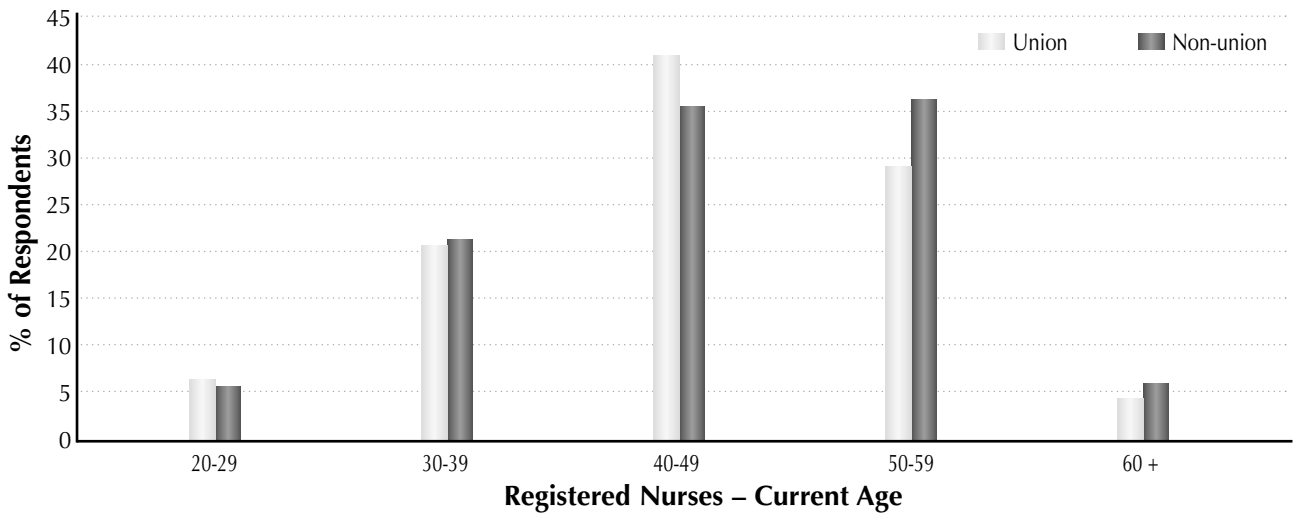
Seventy-two percent of unionized and 65% of non-unionized practical nurses are between the ages of 40 and 60.

Approximately 47% of unionized and 56% of non-unionized OT/PT/SWs are between the ages of 40 and 60.

Education levels of formal caregivers

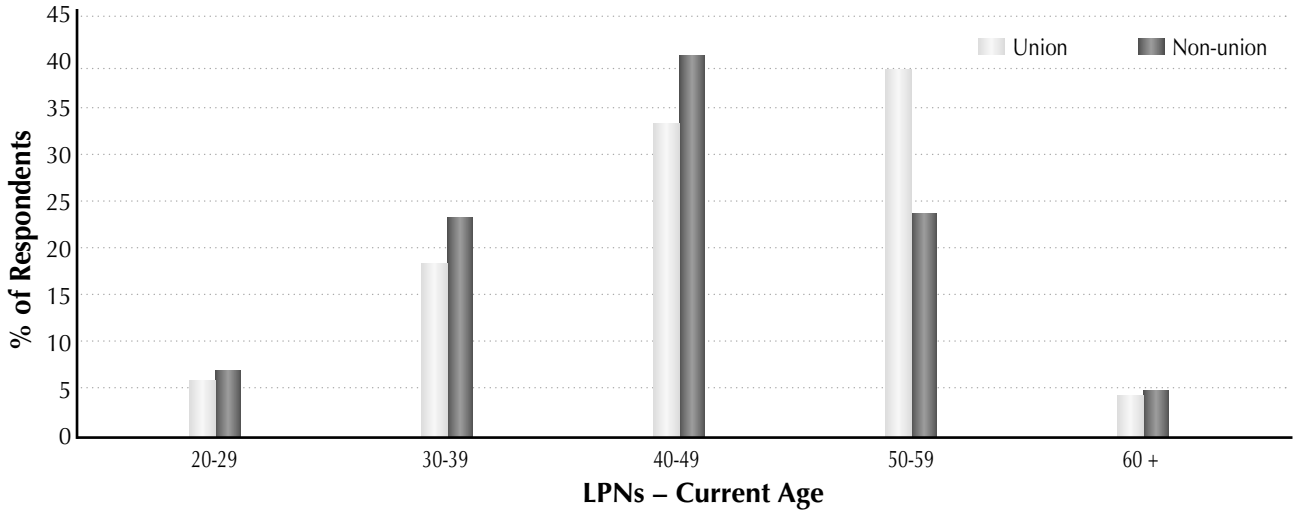
As demonstrated in Figure 5.6, findings from the survey of formal caregivers indicated that most of the workers across the four occupational groups had some post-secondary education. With the exception of the OT/PT/SW group, in which 83% had a university degree, members of the different occupational

Figure 5.3: **Age of RNs by union status**



NOTE: The above data is national in scope. It should be noted that this grouping of data might not reflect important differences that exist by region, province, delivery model, employer types, etc.

Figure 5.4: **Age of LPNs by union status**



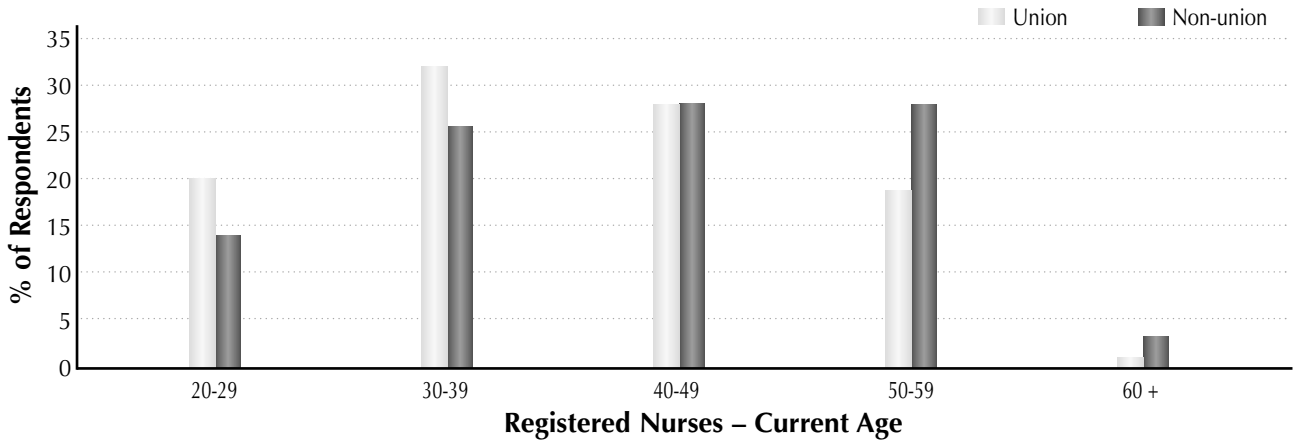
NOTE: The above data is national in scope. It should be noted that this grouping of data might not reflect important differences that exist by region, province, delivery model, employer types, etc.

groups were most likely to have a college diploma. One-third of home support workers (33%) reported having no post-secondary education.

Average number of home care employers

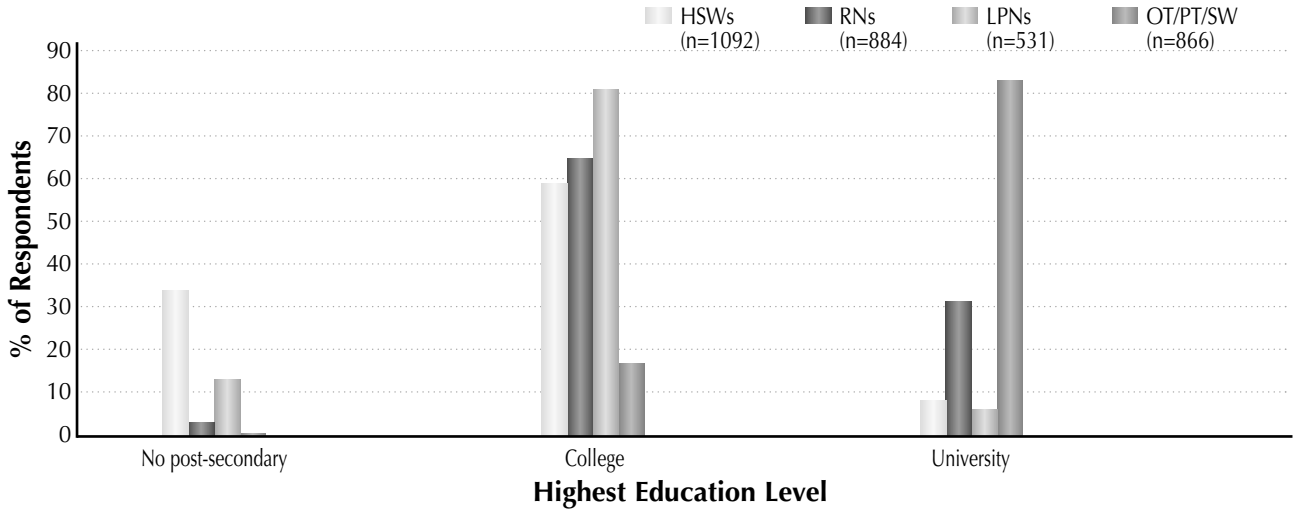
According to the survey of formal caregivers, the median number of home care employers for each of the occupational groups is one.

Figure 5.5: **Age of OT/PT/SWs by union status**



NOTE: The above data is national in scope. It should be noted that this grouping of data might not reflect important differences that exist by region, province, delivery model, employer types, etc.

Figure 5.6: **Education levels of formal caregivers by occupational group**



NOTE: The above data is national in scope. It should be noted that this grouping of data might not reflect important differences that exist by region, province, delivery model, employer type, union status, etc.

Table 5.5: **Average number of home care employers by occupational group**

Group	N	Median	Mean	SD
HSWs	941	1.0	1.2	0.6
RNs	861	1.0	1.1	0.4
LPNs	496	1.0	1.1	0.5
OT/PT/SW	826	1.0	1.1	0.3

NOTE: The above data is national in scope. It should be noted that this grouping of data might not reflect important differences that exist by region, province, delivery model, employer type, union status, etc. SD = standard deviation.

Type of employer

As demonstrated in Figure 5.7, with the exception of OT/PT/SWs who are relatively evenly split, the majority of respondents in each of the occupational groups reported that they worked for a private employer. The proportion working for a public employer varied according to the specific occupational group.

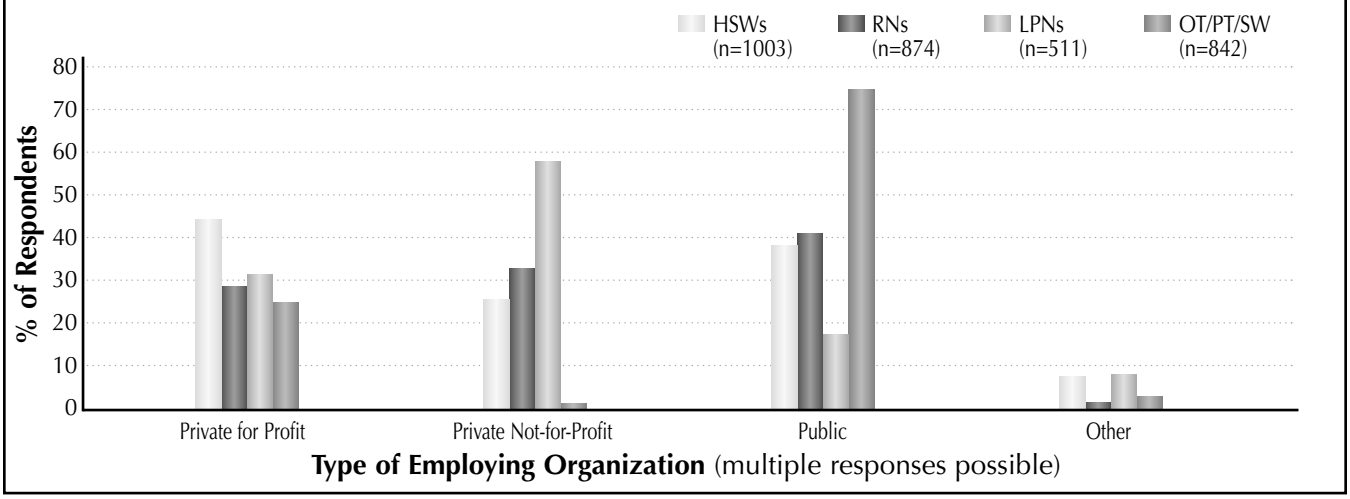
The majority of home support workers who responded to the survey are employed by private employers (70%). Almost one-half (44%) are employed by private for-profit employers, while another 26% are employed by private not-for profit employers. Slightly more than one-third (38%) of respondents reported that they work for a public employer. Interestingly, some respondents indicated that they worked for a different type of employer organization than the one through which they were identified in the frame. This could be because workers work for multiple home care employers, and/or workers who had been identified with a private sector employer might also identify themselves as working with a public employer because the public sector is the source of the actual contract for services. The 2001 LFS data indicate that 89% of nurse's aides and 94% of homemakers in the Home Health Service Industry work for private employers.

Nearly one-half of RN respondents (41%) worked for a public employer (close to frame development finding of 36%). An additional 34% reported that they work for a private not-for-profit employer. Almost one-third of the respondents (29%) indicated that they work for a private for-profit employer. The 2001 LFS data indicates that approximately 23% of RNs working in the Home Health Services Industry work for public employers.

More than one-half of LPNs (59%) indicated that they work for a private not-for-profit employer. Almost one-third (32%) reported that they work for a private for-profit employer. Approximately one in five (17%) works for a public employer. Findings from the survey frame development process were very similar, with 89% of those identified in the frame associated with a private sector employer. The proportion of registered nursing assistants in the LFS 2001 data that worked for private employers in the Home Health Services Industry was also similar at 92%.

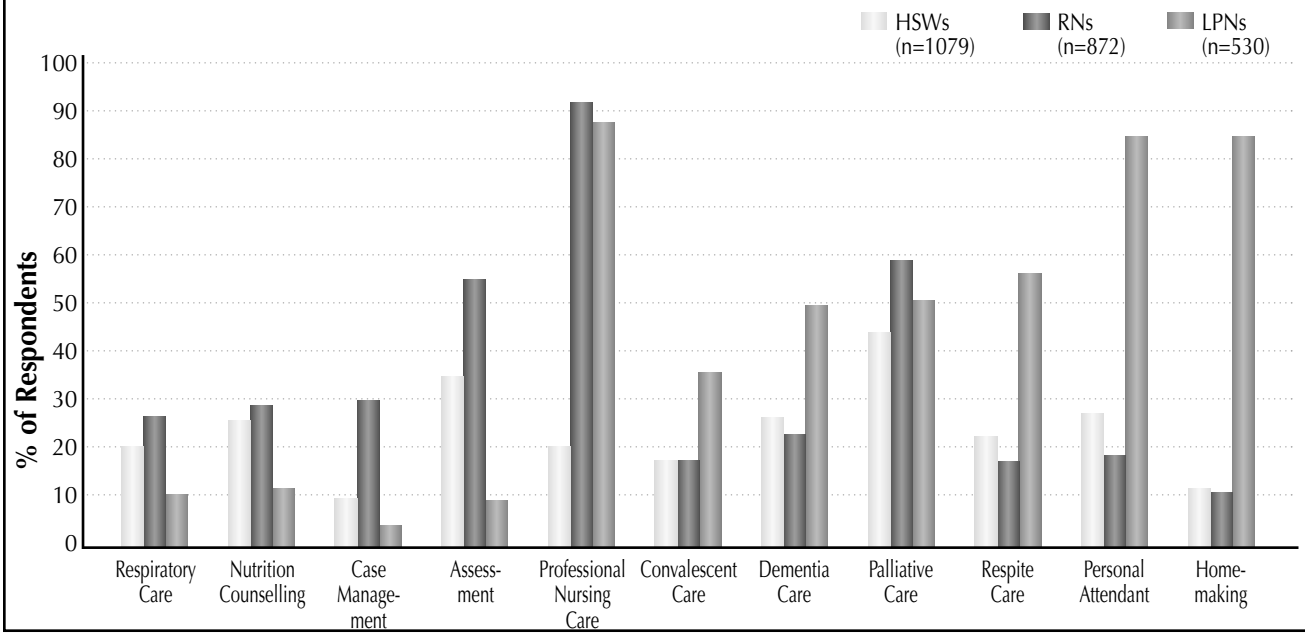
Unlike the other occupational groups, the majority of OT/PT/SWs (74%) reported that they work for a public employer. Another large proportion (25%) reported that they work for a private for-profit employer. Unlike the other professional groups (RNs, and LPNs), very few (2%) reported that they worked for a private not-for-profit employer.

Figure 5.7: **Type of employer by occupational group**



NOTE: The above data is national in scope. It should be noted that this grouping of data might not reflect important differences that exist by region, province, delivery model, employer type, union status, etc.

Figure 5.8: **Groups of services provided by occupational group**



NOTE: The above data is national in scope. It should be noted that this grouping of data might not reflect important differences that exist by region, province, type of employer, delivery model, union status, etc.

Sex and other characteristics

According to the survey of formal caregivers:

- Men are extremely underrepresented in the home care sector across all occupational groups (3% to 9%). LFS 2001 data contains similar proportions.
- A small proportion of home care workers report that they are members of a visible minority group (5% to 14%). According to 1996 census data, approximately 13 percent of the Canadian population self-identified as being a member of a visible minority group.
- A small proportion of home care workers report that they are a person with a disability (1% to 4%). According to the Council of Canadians with Disabilities, 16% of Canadians report that they have a disability.
- A small proportion of home care workers report that they are an Aboriginal (1% to 3%). According to 1996 census data, approximately 3% of the Canadian population indicated they were Aboriginal.

Types of services provided

According to the survey of formal caregivers, when respondents were asked to report on groups of services that they regularly provide in the home care setting, there were, as would be expected, differences between the para-professionals and professionals as demonstrated in Figure 5.8.

- Home support workers most frequently reported that they assisted in homemaking, personal attendant care and respite care. As well, HSWs reported providing dementia care and convalescent care more frequently than the professional nursing groups.
- Palliative care was reported to be given in similar proportions by all three groups.
- Within the professional nursing group, the two groups (RNs and LPNs) showed similar patterns of services. The most frequently reported were professional nursing services, assessment and planning, and palliative care.

As illustrated in Figure 5.9, when respondents[8] were asked to report on *specific services* that they provided in the home care setting, the findings were similar to those from the groups of services. Namely, the professionals and para-professionals differed when they described the specific services that they provided.

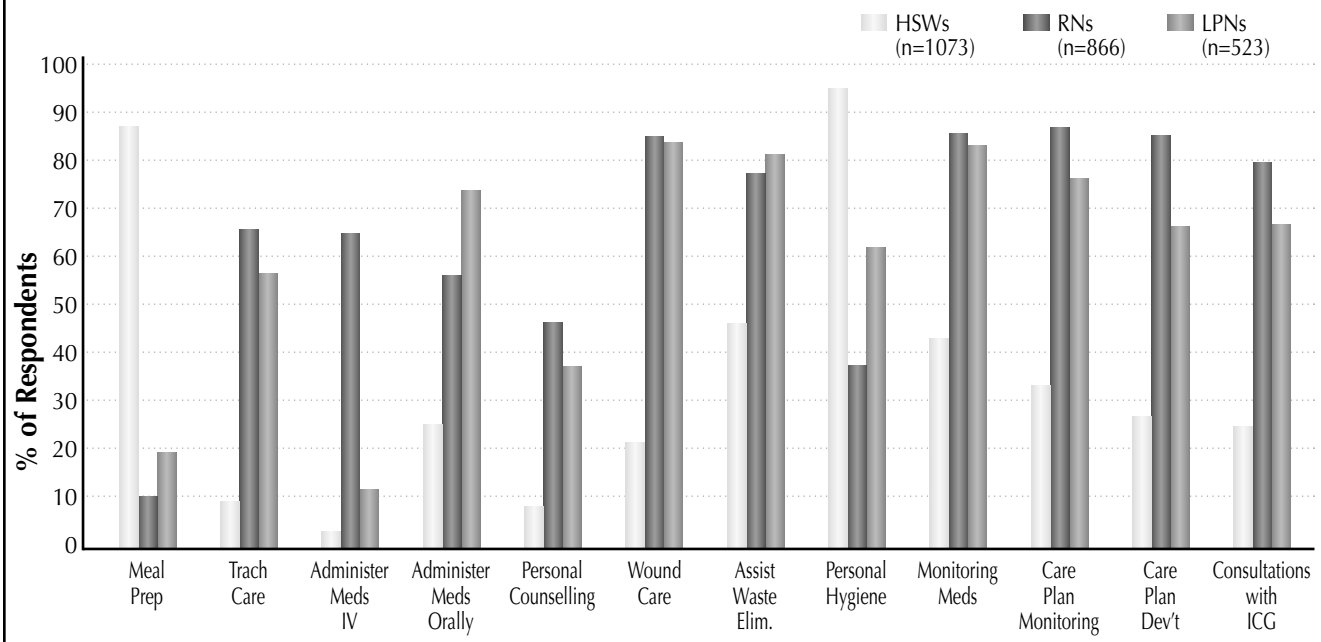
HSWs reported that they provided services in personal hygiene and meal preparation more frequently than the professional nursing groups. Other services frequently provided included assistance with waste elimination, monitoring medications, and monitoring care plans.

The two professional nursing groups reported information showed similar patterns of providing specific services. The two main differences occurred in the areas of administering medications intravenously (RNs = 66% vs. LPNs = 11%) and assistance with personal hygiene (LPNs = 61% vs. RNs = 38%).

Supply and demand issues for formal caregivers

In this section, we provide a brief overview of the supply and demand issues within the home care sector. Given the relative paucity of data on the sector, combined with the instability in the sector during the data collection period, at this point it is not possible to develop more traditional supply and demand models. As research progresses, it is anticipated there will be increased opportunities to work on the development of human resource projection models. However, in the process of conducting the current research, we have collected a significant amount of information with regard to supply and demand issues. Although this information cannot be formulated into supply and demand models, it can be reviewed with respect to ongoing supply and demand issues.[9]

Figure 5.9: **Specific services provided by occupational group**



NOTE: The above data is national in scope. It should be noted that this grouping of data might not reflect important differences that exist by region, province, delivery model, type of employer, union status, etc.

[8] The questionnaire did not ask the members of the OT/PT/SW group to report on specific services relevant to the role played by these professions.

[9] Although we provide an overview of the supply and demand issues in this section, details of the actual methods and approaches as well as more detailed findings can be obtained by reviewing the individual appendices, namely, Appendix A (analysis of NPHS data), and Appendix E (analysis of LFS data).

Current supply and projected supply

Current size of sector

As presented above in the profile of formal caregivers, the estimated current size of the home care workforce for the four occupational groups studied is estimated to be approximately 50,000 with the majority of these (approximately 30,000) working as home support workers. This estimate does not include, of course, the other professional and para-professional groups not included in the survey of formal caregivers but who frequently work in the home care context such as, case managers, dietitians, respiratory therapists, physicians, etc. Currently there are no data available as to the actual size of these other groups of professionals and para-professionals working in the home care sector.

Age of workforce

One important consideration when examining the supply issues for the home care sector is the obvious advanced age of the current workforce. As illustrated in the profile of workers, with the exception of the OT/PT/SW group, the majority of workers are 40 years of age or older.

If the supply of younger workers were to remain constant over the next 10 years (i.e., the same supply of workers aged 20-29 years), then within 10 years approximately 75% of HSWs, 65% of LPNs, and 75% of RNs would be 50 or older with approximately one-half in the 60+ age group.

Age at entry to sector

There may be a tendency for the sector to attract more mature workers. The survey of formal caregivers would suggest this is the case, given the average age of workers contrasted with the amount of time spent working in the home care sector. As a result, entry into the sector would be less likely to occur in the 20-29 year old group like in some other sectors. Rather, we would see the majority of new entrants in the 30-39 and 40-49 year old group. This less traditional career path for the sector would have significant implications for HR strategies with regard to training (particularly for continuing education), benefits, recruitment and retention.

Departures from sector

Reasons for departures from the sector can vary. One that is particularly relevant given the current age of the workforce is retirement. A substantial proportion of the current workforce will retire within the next 10 years.

Another factor that affects the supply of workers is the fact that a proportion of workers intend to transfer to other competing sectors. Given the overall reported shortage of many of the professionals working in the home care sector, particularly among the nursing groups, competing sectors within health care will be obvious alternatives for many workers currently in home care. As reported in the next section (Chapter 6) the percentage of respondents from the survey of formal caregivers who intended to leave their employer within the next 12 months ranged from 17% to 19%. Approximately one-half of these (or 8%-10% of the workforce) reported that they intend to leave the home care sector for another health care sector. Unfortunately, we do not have access to any data that would indicate what is the rate of transfer from other health care sectors into the home care sector.

Projected supply of caregivers based on demographic and population data

Given that we were able to collect some data on the current size of the sector, we used the estimates from the frame development process to estimate the number of professional home care workers and home support workers for Canada through to 2046. The 2001/2002 estimates were used as the base year. The age and sex ratios for the base year were then used to project the number of persons in question in two ways: 1) assuming the same population distribution as the base year for all future years, and 2) applying the age and sex ratios to Statistics Canada population projections (a conservative, mid-level estimate)[10].

We then used the consumer data from the National Population Health Survey (NPHS) to calculate projected ratios of consumers to caregivers within the current base year through to 2046. Table 5.6 indicates that, based on their projected age and sex distribution, the number of professional workers will remain constant and will be less than for the projection in which it is assumed that all future years have the same

[10] For more complete details on the methods of projection, please refer to Appendix A.

Table 5.6: **Comparison of the number of professional home care staff based on a survey of health professional staff (RNs, LPNs and OT/PT/SWs) conducted in 2001 compared to the actual age and sex projections**

Year	Projections Based on 2001 Distribution	Projections Based on Estimated Population Distribution	Difference (Shortfall)	Ratio of Professional Staff to Consumers
2001	14,740	14,740	0	1:37
2006	15,323	15,842	519	1:50
2016	16,365	15,371	(994)	1:57
2026	17,207	14,480	(2727)	1:76
2036	17,608	14,783	(2825)	1:90
2046	17,604	14,548	(3056)	1:100

age distribution as was the case in 2001. Thus, the numbers in the second column are less than in the first column as one progresses from 2001 to 2046. This is due to the fact that we have an aging workforce with the highest proportions of professional workers in home care were in the 40 to 49 and 50 to 59 year age groups. Over time, these groups would have proportionately lower percentages of the population as baby boomers move into their senior years. It is interesting to note that when one compares the projections for home care consumers and professional caregivers, the ratio of caregivers to consumers changes from one worker per 37 consumers in 2001 to one worker per 100 consumers in 2046.

With regard to home support workers, we conducted a similar analysis with similar results. Comparing the ratio of home support workers to consumers, Table 5.7 indicates that the ratio changes from one worker to 17 consumers in 2001 to one worker to 45 consumers in 2046. These findings indicate the potential future pressures on the home care system.

Current demand and projected demand

To characterize current and projected demand for home care services, we had to rely on utilization data, or, an accounting of the services that people actually have used. The main source of utilization data came from an analysis of NPHS data for that portion of Canadians who used home care services. The NPHS provides us with a national level picture of home care use in Canada now and possibly in the future. In this section we present an overview of the findings from these analyses. For more detailed aspects of the

Table 5.7: **Comparison of the number of home support staff based on the survey of home support staff conducted in 2001 compared to actual age and sex projections**

Year	Projections Based on 2001 Distribution	Projections Based on Estimated Population Distribution	Difference (Shortfall)	Ratio of Professional Staff to Consumers
2001	32,304	32,304	0	1:17
2006	33,582	35,030	1448	1:23
2016	35,865	34,906	(959)	1:25
2026	37,710	31,477	(6233)	1:35
2036	38,590	32,876	(5714)	1:41
2046	38,581	32,327	(6254)	1:45

Table 5.8: **Home care consumer projections based on age, sex, and region, and by age and sex**

Year	Age, Sex and Region	Age and Sex
1996	539,988	539,597
2006	788,626	729,930
2016	869,988	874,278
2026	1,095,675	1,093,415
2036		1,335,633
2046		1,460,088

methodology used, additional findings, and projections based on various funding scenarios, please refer to the technical report attached as appendices to the current report (Appendix A – analysis of NPHS data).

National level assessments of current and projected demand

For the national level assessments of current and projected demand, the research team used data from the NPHS combined with population projections from Statistics Canada. Statistics Canada provides detailed population projections to the year 2026 and national estimates to 2050. Table 5.8 presents a comparison of the results of national projections based on age, sex and region compared to age and sex. The results are fairly similar and, thus, the rest of the national projections in this section are based on age and sex forecasts.

In Table 5.9 are estimates of the future potential number of home care consumers. The first column provides projections based on the assumption that the age distribution of the population remains the same as the distribution was in 1996 for all subsequent years. Thus, this is a projection of the number of people who would receive home care if all conditions, other than the overall growth of the population, remain constant. In other words, it is the number of people who would be receiving home care if everything was constant and we 'fast forward' to the year 2046. We present this column to contrast it to column two in Table 5.9 which uses 1996 age and sex ratios of home care consumers and multiplies these ratios against the projected age and sex distribution in future years. As baby boomers become older, the number of home care consumers will increase because of the increased number of people, and their increased age (older people are more likely to use home care services). The difference between columns one and two provides information about the added number of home care consumers related to changes in the demographic structure of Canada. Thus, if everything was the same as it is today, we would have some 760,000 people using home care in 2046; due to changes in the age distribution of the population, we may have an additional 700,000 people using home care. This means that if we had the population distribution today which we will have in 2046 we may need to care for twice as many people with home care as we do today.

Table 5.9: **Comparison of home care consumer based on the 1996 population distribution compared to actual age and sex projections**

Year	National Projection Using 1996 Population Distribution	National Projection Using Projected Population Distribution	Difference
1996	539,597	539,597	0
2006	624,684	729,930	105,246
2016	687,526	874,278	186,752
2026	730,626	1,093,415	362,789
2036	753,324	1,335,633	582,309
2046	759,046	1,460,088	701,042

WORK ENVIRONMENT CHALLENGES

In this section, we focus on formal caregivers and the current work environment challenges that they face. These challenges are: compensation issues; hours and working conditions; career ladders and occupational mobility; and, quality of life issues. In addition to analyses of challenges by union status, work status, and employer type, this section includes analyses by the following delivery models[11].

1) Public-provider model (PP): professional and home support services are delivered mainly by public employees. Examples include Manitoba, Saskatchewan, Quebec, Prince Edward Island, Yukon, Northwest Territories and Nunavut.
2) Public-professional and private home support model (PHS): All professional services are delivered by public employees. Home support services are contracted out to private agencies. Examples include New Brunswick, Newfoundland, and British Columbia.
3) Mixed public-private model: Streamlining functions are provided by public employees. Professional services are provided by a mix of public employees (predominantly) or through contracting out to private agencies. Home support services are contracted out to private agencies. Examples include Nova Scotia and Alberta.
4) Contractual model: Single entry coordinating functions are provided by public employees. Professional services and home support services are contracted out by a public authority to private agencies, which provide the care to clients. This model reflects home care in Ontario as organized through its Community Care Access Centres (CCACs).

Sources of information and data

Multiple sources were used to collect information about the current work environment challenges faced by workers in the home care sector. The primary sources of information and data for this section were the survey of formal caregivers, focus groups, and key informant interviews. As well, we have attempted to validate some of the information collected on compensation issues through the survey of formal caregivers with the data obtained from the LFS 2001.

Compensation issues

Compensation issues are primary concerns identified from the survey of formal caregivers and throughout the focus groups and key informant interviews. We have divided the presentation of data according to wages and benefits. Caution should be used when interpreting the following tables specific to the survey of formal caregivers, keeping in mind the overall purpose of the data collection, data limitations and contextual issues outlined in Appendix D, and in Chapter 1 of this report.

Current wages

As demonstrated in Table 6.1, according to the survey of formal caregivers, the hourly wages of workers within the various occupational groups varied according to whether they were working for a private employer or a public employer.[12]

According to the survey of formal caregivers, OT/PT/SWs enjoyed a statistically significant higher hourly rate if employed by a private employer ($29.05 vs. $27.11). Their average rate overall was the highest among the occupational groups at $27.59 per hour.

RNs reported in the survey a higher hourly wage if working for a public employer ($26.73 vs. $22.38). The overall average hourly wage for RN respondents was $24.00. Data from the LFS 2001 of RNs working in the Home Health Services Industry indicated that the average hourly wage was slightly lower at $20.21. It should be noted that this difference may be explained in part by the higher proportion of younger nurses in the LFS estimates.

[11] Additional detailed tables reporting on various two-way factorial analyses of variance (ANOVAs) using combinations of these variables are contained as a separate appendix (see Appendix G).

[12] Survey respondents were asked to report their hourly wage. There may be inconsistencies in how respondents calculated their hourly wage.

Table 6.1: **Current hourly wage by employer type (2-way split)**

Group	Public Mean (SD)	Private Mean (SD)	Overall Mean (SD)
HSWs***	$14.89 (3.77)	$11.94 (3.34)	$12.60 (3.65)
	n=241	n=842	n=1083
RNs***	$26.73 (3.68)	$22.38 (4.74)	$24.00 (4.85)
	n=323	n=545	n=868
LPNs*	$18.58 (1.93)	$17.42 (3.73)	$17.53 (3.62)
	n=47	n=455	n=502
OT/PT/SW***	$27.11 (5.20)	$29.05 (6.43)	$27.59 (5.59)
	n=603	n=197	n=800

SD = standard deviation

* Statistically significant difference between Public and Private means (p <.05; t-test for independent means)

** Statistically significant difference between Public and Private means (p <.01; t-test for independent means)

***Statistically significant difference between Public and Private means (p <.001; t-test for independent means)

NOTE: The above data is national in scope. It should be noted that this grouping of data might not reflect important differences that exist by region, province, delivery model, union status, etc.

Unlike the other occupational groups, LPNs had similar average wages across private and public sectors. The overall average hourly wage for LPN respondents to the survey was $17.53. Similar to the case with RNs, this wage is higher when compared with that found with the LFS 2001, which reported an hourly average of $15.83 for registered nursing assistants in the Home Health Services Industry.

Across occupational groups, home support workers were the lowest paid at $12.60 per hour on average. Similar to the RN group, the compensation was higher when the home support worker was employed by a public employer ($14.89 vs. $11.94). LFS 2001 data produced a slightly lower average hourly wage of $11.72 per hour for nurses' aides and $10.33 per hour for homemakers working in the Home Health Services Industry.

Table 6.2: **Current hourly wage by employer type (3-way split)**

Group	Public Mean (SD)	Private NFP Mean (SD)	Private FP Mean (SD)	Overall Mean (SD)
HSWs***	$14.52 (3.89)	$11.64 (2.87)	$12.03 (3.71)	$12.60 (3.65)
	n=307	n=197	n=340	n=1083
RNs***	$26.53 (3.97)	$23.24 (4.49)	$21.60 (4.68)	$24.00 (4.85)
	n=327	n=271	n=205	n=868
LPNs***	$18.51 (2.35)	$18.16 (3.70)	$16.60 (3.51)	$17.53 (3.62)
	n=54	n=253	n=115	n=502
OT/PT/SW***	$27.10 (5.03)	$24.49 (5.99)	$28.81 (4.57)	$27.59 (5.58)
	n=586	n=15	n=145	n=800

SD = standard deviation

* Statistically significant difference between employer type means (p <.05; ANOVA)

** Statistically significant difference between employer type means (p <.01; ANOVA)

***Statistically significant difference between employer type means (p <.001; ANOVA)

NOTE: The above data is national in scope. It should be noted that this grouping of data might not reflect important differences that exist by region, province, delivery model, union status, etc.

Table 6.3: **Current hourly wage by union status**

Group	Unionized Mean (SD)	Non-unionized Mean (SD)	Overall Mean (SD)
HSWs***	$13.73 (3.51)	$11.63 (3.53)	$12.62 (3.69)
	n=503	n=565	n=1068
RNs***	$25.11 (4.77)	$21.88 (4.25)	$24.01 (4.84)
	n=564	n=289	n=853
LPNs***	$18.05 (3.40)	$16.95 (3.76)	$17.54 (3.62)
	n=260	n=238	n=498
OT/PT/SW***	$27.00 (4.74)	$29.78 (7.42)	$27.59 (5.53)
	n=628	n=169	n=797

SD = standard deviation

* Statistically significant difference between unionized and non-unionized proportions (p <.05; t-test for independent means)

** Statistically significant difference between unionized and non-unionized proportions (p <.01; t-test for independent means)

*** Statistically significant difference between unionized and non-unionized proportions (p <.001; t-test for independent means)

NOTE: The above data is national in scope. It should be noted that this grouping of data might not reflect important differences that exist by region, province, delivery model, type of employer, etc.

Table 6.2 illustrates the average current wage received by workers according to employer type, as well as an overall average. In all occupations except OT/PT/SWs, the average wage is higher among public sector workers as compared to the private sector. Among the private agency workers, the average wage was higher in not-for-profit organizations for the two nursing groups, and higher in for-profit organizations for HSWs and OT/PT/SWs.

The wage rate is shown increasing in ascending order for home support workers, practical nurses, registered nurses, and OT/PT/SWs.

Table 6.3 illustrates the average current wage received by both unionized and non-unionized workers, as well as an overall average. In all occupations, except OT/PT/SWs, the average wage is significantly higher among unionized workers in comparison with non-unionized workers.

Table 6.4: **Current hourly wage by delivery model**

Group	PP Mean (SD)	PHS Mean (SD)	Mixed Mean (SD)	Contractual Mean (SD)	Overall Mean (SD)
HSWs***	$12.80 (3.19)	$14.83 (4.77)	$11.83 (3.95)	$12.00 (3.12)	$12.60 (3.65)
	n=191	n=178	n=61	n=653	n=1083
RNs***	$25.07 (3.76)	$26.33 (3.37)	$26.38 (5.35)	$22.37 (4.77)	$24.00 (4.85)
	n=173	n=110	n=129	n=457	n=868
LPNs***	$18.29 (2.32)	$15.78 (4.02)	$14.94 (3.12)	$17.84 (3.63)	$17.53 (3.62)
	n=44	n=15	n=49	n=395	n=502
OT/PT/SW***	$26.29 (6.18)	$25.53 (3.31)	$28.91 (3.30)	$29.29 (6.11)	$27.59 (5.58)
	n=322	n=87	n=176	n=215	n=800

SD = standard deviation

* Statistically significant difference between delivery models (p <.05; ANOVA)

** Statistically significant difference between delivery models (p <.01; ANOVA)

***Statistically significant difference between delivery models (p <.001; ANOVA)

NOTE: The above data is national in scope. It should be noted that this grouping of data might miss certain distinctions for which there may be important differences according to region, province, type of employer, union status, etc.

Table 6.5: **Current hourly wage by work status**

Group	Full-time Mean (SD)	Part-time Mean (SD)	Casual Mean (SD)	Overall Mean (SD)
HSWs***	$13.01 (4.12)	$12.11 (2.75)	$13.51 (3.23)	$12.48 (3.39)
	n=398	n=557	n=123	n=1078
RNs***	$25.20 (4.68)	$23.67 (4.86)	$22.58 (4.68)	$24.00 (4.85)
	n=318	n=365	n=184	n=867
LPNs**	$18.32 (3.67)	$17.52 (3.46)	$16.67 (3.63)	$17.54 (3.61)
	n=140	n=240	n=121	n=501
OT/PT/SW	$27.44 (5.10)	$28.19 (5.55)	$25.77 (8.85)	$27.61 (5.58)
	n=461	n=288	n=48	n=798

SD = standard deviation

* Statistically significant difference between work status means (p <.05; ANOVA)

** Statistically significant difference between work status means (p <.01; ANOVA)

***Statistically significant difference between work status means (p <.001; ANOVA)

NOTE: The above data is national in scope. It should be noted that this grouping of data might miss certain distinctions for which there may be important differences according to region, province, delivery model type of employer, union status, etc.

Table 6.6: **Current hourly wage by tenure in sector**

Group	7 Or Less Years Mean (SD)	More Than 7 Years Mean (SD)	Overall Mean (SD)
HSWs***	$12.21 (3.74)	$13.06 (3.54)	$12.62 (3.69)
	n=539	n=527	n=1068
RNs***	$23.14 (4.47)	$24.84 (5.08)	$24.01 (4.84)
	n=419	n=443	n=853
LPNs***	$16.77 (3.23)	$18.16 (3.80)	$17.54 (3.62)
	n=228	n=274	n=498
OT/PT/SW***	$26.72 (5.92)	$28.64 (4.91)	$27.59 (5.53)
	n=431	n=366	n=797

SD = standard deviation

* Statistically significant difference 7 or less years and more than 7 years means (p <.05; t-test for independent means)

** Statistically significant difference 7 or less years and more than 7 years means (p <.01; t-test for independent means)

***Statistically significant difference 7 or less years and more than 7 years means (p <.001; t-test for independent means)

NOTE: The above data is national in scope. It should be noted that this grouping of data might miss certain distinctions for which there may be important differences according to region, province, type of employer, union status, etc.

Table 6.7: **Proportion "satisfied" or "very satisfied" with their current level of pay by type of employer (2-way split)**

Group	Public Proportion (%)	Private Proportion (%)	Overall Proportion (%)
HSWs***	61	31	38
RNs***	65	36	47
LPNs***	55	30	33
OT/PT/SW***	67	44	60

* Statistically significant difference between Public and Private proportions (p <.05; chi-square statistic)

** Statistically significant difference between Public and Private proportions (p <.01; chi-square statistic)

*** Statistically significant difference between Public and Private proportions (p <.001; chi-square statistic)

NOTE: The above data is national in scope. It should be noted that this grouping of data might miss certain distinctions for which there may be important differences according to region, province, union status, delivery model, etc.

The average hourly wage rate is lowest for home support workers followed by practical nurses, registered nurses, and finally, OT/PT/SWs.

Table 6.4 illustrates the average current hourly wage received by delivery model, as well as an overall average. The highest-paid workers were OT/PT/SWs in the contractual model, at $29.29 per hour, while the lowest-paid workers were HSWs in the mixed model, at $11.83 an hour. The highest average pay among the occupational groups varied depending on the delivery model: LPNs were highest paid in the PP model, HSWs in the PHS model, RNs in the mixed model, and OT/PT/SWs in the contractual model.

Table 6.5 shows that there are significant differences in the current hourly wage rate for full-time, part-time and casual workers among all occupational groups except OT/PT/SWs.

Among the professional nurses, full-time workers receive the highest hourly wage, followed by part-time, then casual workers. Casual workers in the registered nurse, practical nurse and OT/PT/SW groups receive the lowest hourly wage. Home support casual workers receive a higher hourly wage than the full-time or part-time home support workers.

Table 6.8: **Proportion "satisfied" or "very satisfied" with their current level of pay by employer type (3-way split)**

Group	Public Proportion (%)	Private NFP Proportion (%)	Private FP Proportion (%)	Overall Proportion (%)
HSWs***	60	22	32	38
RNs***	66	29	44	47
LPNs***	67	29	28	33
OT/PT/SW***	69	40	43	60

* Statistically significant difference (p <.05; chi-square statistic)

** Statistically significant difference (p <.01; chi-square statistic)

***Statistically significant difference (p <.001; chi-square statistic)

NOTE: The above data is national in scope. It should be noted that this grouping of data might miss certain distinctions for which there may be important differences according to region, province, union status, delivery model, etc.

Table 6.9: **Proportion "satisfied" or "very satisfied" with their current level of pay by union status**

Group	Unionized Proportion (%)	Non-unionized Proportion (%)	Overall Proportion (%)
HSWs***	45	32	38
RNs***	53	33	46
LPNs***	34	32	33
OT/PT/SW***	64	51	60

*Statistically significant difference between unionized and non-unionized proportions (p <.05; chi-square statistic)

** Statistically significant difference between unionized and non-unionized proportions (p <.01; chi-square statistic)

*** Statistically significant difference between unionized and non-unionized proportions (p <.001; chi-square statistic)

NOTE: The above data is national in scope. It should be noted that this grouping of data might miss certain distinctions for which there may be important differences according to region, province, type of employer, union status, etc.

Among all occupational groups, there was a significant difference in hourly wage according to how long the person had been working in the home care sector. Those working less that seven years in the sector had a statistically significant lower hourly wage than those working more than seven years in the sector.

Satisfaction with current level of pay

According to the survey of formal caregivers, levels of satisfaction with pay varied only slightly across the occupational groups ranging from a low of 33% among LPNs and a high of 60% among OT/PT/SWs, as shown in Table 6.7. In all occupational groups, there were higher levels of satisfaction with pay among the public sector workers when compared with the private agency workers.

As illustrated in Table 6.8, the government/regional health authority workers are more satisfied with their current level of pay including OT/PT/SWs, who are the only occupation to make more as private for-profit agency workers. Overall, practical nurses are the least satisfied, illustrated in table 6.8.

Between the private groups, OT/PT/SWs and LPNs show little difference in levels of satisfaction with pay. There is more variability in the satisfaction levels of HSWs and RNs between the private for-profit and not-for-profit groups.

Table 6.10: **Proportion "satisfied" or "very satisfied" with their current level of pay by delivery model**

Group	PP Proportion (%)	PHS Proportion (%)	Mixed Proportion (%)	Contractual Proportion (%)	Overall Proportion (%)
HSWs***	56	55	45	28	38
RNs***	61	59	68	32	47
LPNs***	58	50	34	29	33
OT/PT/SW***	68	53	71	45	60

* Statistically significant difference between delivery models (p <.05; ANOVA)

** Statistically significant difference between delivery models (p <.01; ANOVA)

***Statistically significant difference between delivery models (p <.001; ANOVA)

NOTE: The above data is national in scope. It should be noted that this grouping of data might miss certain distinctions for which there may be important differences according to region, province, type of employer, union status, etc.

Table 6.11: **Proportion "satisfied" or "very satisfied" with current level of pay by work status**

Group	Full-time Proportion (%)	Part-time Proportion (%)	Casual Proportion (%)	Overall Proportion (%)
HSWs*	40	34	48	38
RNs	46	47	45	46
LPNs	27	34	38	33
OT/PT/SW	63	56	69	61

*Statistically significant difference between work status proportions (p <.05; chi-square statistic)

** Statistically significant difference between work status proportions (p <.01; chi-square statistic)

*** Statistically significant difference between work status proportions (p <.001; chi-square statistic)

NOTE: The above data is national in scope. It should be noted that this grouping of data might miss certain distinctions for which there may be important differences according to region, province, type of employer, union status, delivery model, etc.

As illustrated in Table 6.9, a significantly higher proportion of unionized workers, with the exception of practical nurses, reported satisfaction with their current level of pay.

Unionized OT/PT/SWs also reported high levels of satisfaction with their pay (64% verses 51%) despite them having a significantly lower average hourly wage when compared with non-unionized OT/PT/SWs ($27.00 versus $29.78).

Home support workers and LPNs in the PP and PHS delivery models reported the highest levels of satisfaction with their current level of pay compared to their colleagues in the mixed and contractual models. Overall, workers in the contractual model are the least satisfied across all occupational groups, as illustrated in table 6.10. Interestingly, OT/PT/SWs in the contractual model reported the highest hourly wage in their occupational group, but the lowest satisfaction with their current level of pay.

Among the PP and PHS models, HSWs and RNs are almost equally satisfied, whereas there is more variability in the satisfaction of OT/PT/SWs and LPN.

Among HSWs, a significantly higher proportion of full-time and casual workers were satisfied with the

Table 6.12: **Proportion "satisfied" or "very satisfied" with their current level of pay by tenure in sector**

Group	7 Or Less Years Proportion (%)	More Than 7 Years Proportion (%)	Overall Proportion (%)
HSWs	38	37	38
RNs	48	45	46
LPNs	35	31	33
OT/PT/SW	62	59	60

*Statistically significant difference between 7 or less years and more than 7 years proportions (p <.05; chi-square statistic)

** Statistically significant difference 7 or less years and more than 7 years proportions (p <.01; chi-square statistic)

*** Statistically significant difference between 7 or less years and more than 7 years proportions (p <.001; chi-square statistic)

NOTE: The above data is national in scope. It should be noted that this grouping of data might miss certain distinctions for which there may be important differences according to region, province, type of employer, union status, delivery model, etc.

Table 6.13: **Proportion that are paid overtime by employer type (2-way split)**

Group	Public Proportion (%)	Private Proportion (%)	Overall Proportion (%)
HSWs***	82	53	60
RNs***	78	60	66
LPNs**	90	65	68
OT/PT/SW***	52	18	43

* Statistically significant difference between Public and Private proportions (p <.05; chi-square statistic)

** Statistically significant difference between Public and Private proportions (p <.01; chi-square statistic)

*** Statistically significant difference between Public and Private proportions (p <.001; chi-square statistic)

NOTE: The above data is national in scope. It should be noted that this grouping of data might miss certain distinctions for which there may be important differences according to region, province, union status, delivery model, etc.

current level of pay than were part-time workers. (See Table 6.11). All other occupational groups showed no significant differences in the proportions of workers satisfied with their current level of pay for the three types of employees.

Satisfaction with pay levels did not differ significantly according to the amount of time that respondents reported working in the home care sector.

Paid overtime

According to the survey results (Table 6.13), with the exception of the OT/PT/SW group, the majority of workers in the occupational groups were paid overtime. For HSWs, RNs, and OT/PT/SWs, statistically significantly lower proportions of workers were paid overtime in the private organizations when compared with the government/regional health authority organizations.

As demonstrated in Table 6.14, the survey results show that, with the exception of private not-for-profit OT/PT/SWs, government/regional health authority workers were more likely to receive overtime pay.

OT/PT/SWs were least likely to receive overtime pay, followed by home support workers.

Table 6.14: **Proportion that are paid overtime by employer type (3-way split)**

Group	Public Proportion (%)	Private NFP Proportion (%)	Private FP Proportion (%)	Overall Proportion (%)
HSWs***	77	56	49	60
RNs***	77	73	45	66
LPNs***	91	75	43	68
OT/PT/SW***	52	53	16	43

* Statistically significant difference (p <.05; chi-square statistic)

** Statistically significant difference (p <.01; chi-square statistic)

***Statistically significant difference (p <.001; chi-square statistic)

NOTE: The above data is national in scope. It should be noted that this grouping of data might miss certain distinctions for which there may be important differences according to region, province, union status, delivery model, etc.

Table 6.15: **Proportion that are paid overtime by union status**

Group	Unionized Proportion (%)	Non-unionized Proportion (%)	Overall Proportion (%)
HSW***	73	47	59
RNs***	76	50	67
LPNs***	77	58	68
OT/PT/SW***	52	16	43

*Statistically significant difference between unionized and non-unionized proportions (p <.05; chi-square statistic)

** Statistically significant difference between unionized and non-unionized proportions (p <.01; chi-square statistic)

*** Statistically significant difference between unionized and non-unionized proportions (p <.001; chi-square statistic)

NOTE: The above data is national in scope. It should be noted that this grouping of data might miss certain distinctions for which there may be important differences according to region, province, employer type, delivery model, etc.

As illustrated in Table 6.15, the survey results show that in each occupational group, a significantly larger proportion of unionized workers received overtime pay when compared with non-unionized workers.

The proportion receiving paid overtime varied between 43% of OT/PT/SWs to 68% of practical nurses.

As illustrated in Table 6.16, the survey results show that HSWs and LPNs in the PHS model were most likely to receive the most overtime pay, as well as RNs and OT/PT/SWs in the mixed model. Contractual model workers were the least likely to receive overtime pay, with the exception of LPNs.

Table 6.17 shows significant differences in the proportions receiving paid overtime for full-time, part-time and casual workers among all occupational groups, with the exception of OT/PT/SWs.

The proportion of workers paid overtime ranges from OT/PT/SWs 43% to practical nurses 68%.

Table 6.16: **Proportion paid overtime by delivery model**

Group	PP Proportion (%)	PHS Proportion (%)	Mixed Proportion (%)	Contractual Proportion (%)	Overall Proportion (%)
HSWs***	73	78	67	49	60
RNs*	70	70	74	62	66
LPNs***	87	100	62	65	68
OT/PT/SW***	42	62	70	19	43

* Statistically significant difference (p <.05; chi-square statistic)

** Statistically significant difference (p <.01; chi-square statistic)

***Statistically significant difference (p <.001; chi-square statistic)

NOTE: The above data is national in scope. It should be noted that this grouping of data might miss certain distinctions for which there may be important differences according to region, province, employer type, union status, etc.

Table 6.17: **Proportion paid overtime by work status**

Group	Full-time Proportion (%)	Part-time Proportion (%)	Casual Proportion (%)	Overall Proportion (%)
HSWs***	66	52	70	59
RNs*	71	66	59	67
LPNs*	67	73	60	68
OT/PT/SW	44	42	38	43

*Statistically significant difference between work status proportions (p <.05; chi-square statistic)

** Statistically significant difference between work status proportions (p <.01; chi-square statistic)

*** Statistically significant difference between work status proportions (p <.001; chi-square statistic)

NOTE: The above data is national in scope. It should be noted that this grouping of data might miss certain distinctions for which there may be important differences according to region, province, employer type, delivery model, union status, etc.

Cancelled shifts

As demonstrated in Table 6.18, the survey results indicate that a minority of workers (11% to 25%) received compensation for shifts that were cancelled by the employer. There were statistically significant differences within occupational groups when the government/regional health authority workers were compared with those working for a private agency, with proportionally fewer private agency workers being paid for cancelled shifts.

As illustrated in Table 6.19, the proportion of workers who received pay for cancelled shifts was higher among public sector workers in all occupations. Among the private agency groups, HSWs and OT/PT/SWs were more likely to receive pay for cancelled shifts if they worked for a private not-for-profit organization as opposed to a private for-profit organization. There was no difference between the two private groups for either of the two nursing groups.

Table 6.18: **Proportion that get paid for employer cancelled shifts by employer type (2-way split)**

Group	Public Proportion (%)	Private Proportion (%)	Overall Proportion (%)
HSWs***	43	19	25
RNs***	32	10	18
LPNs**	29	13	15
OT/PT/SW***	14	3	11

* Statistically significant difference between Public and Private proportions (p <.05; chi-square statistic)

** Statistically significant difference between Public and Private proportions (p <.01; chi-square statistic)

*** Statistically significant difference between Public and Private proportions (p <.001; chi-square statistic)

NOTE: The above data is national in scope. It should be noted that this grouping of data might miss certain distinctions for which there may be important differences according to region, province, union status, delivery model, etc.

Table 6.19: **Proportion that get paid for employer cancelled shifts by employer type (3-way split)**

Group	Public Proportion (%)	Private NFP Proportion (%)	Private FP Proportion (%)	Overall Proportion (%)
HSWs***	40	22	15	25
RNs***	32	9	10	18
LPNs	25	13	13	15
OT/PT/SW***	14	7	2	11

* Statistically significant difference (p <.05; chi-square statistic)

** Statistically significant difference (p <.01; chi-square statistic)

***Statistically significant difference (p <.001; chi-square statistic)

NOTE: The above data is national in scope. It should be noted that this grouping of data might miss certain distinctions for which there may be important differences according to region, province, union status, delivery model, etc.

Table 6.20 shows that the proportion of workers who received pay for cancelled shifts was significantly higher for unionized workers in all occupations, except practical nurses, when compared to non-unionized workers. The proportion that gets paid for cancelled shifts varied between 11% of OT/PT/SWs to 25% of home support workers.

As illustrated in Table 6.21, for HSWs, the proportion of workers who receive pay for cancelled shifts is highest for the PP and PHS models. Workers in the contractual model were least likely to receive pay for cancelled shifts across all occupational groups.

As illustrated in Table 6.22, the proportion of workers that get paid for employer cancelled shifts ranged from OT/PT/SWs at 11% to home support workers at 25%. There were few significant differences when analysed by work status.

Table 6.20: **Proportion that get paid for employer cancelled shifts by union status**

Group	Unionized Proportion (%)	Non-unionized Proportion (%)	Overall Proportion (%)
HSWs***	32	18	25
RNs***	23	8	18
LPNs	17	12	15
OT/PT/SW***	14	3	11

*Statistically significant difference between unionized and non-unionized proportions (p <.05; chi-square statistic)

** Statistically significant difference between unionized and non-unionized proportions (p <.01; chi-square statistic)

*** Statistically significant difference between unionized and non-unionized proportions (p <.001; chi-square statistic)

NOTE: The above data is national in scope. It should be noted that this grouping of data might miss certain distinctions for which there may be important differences according to region, province, employer type, delivery model, etc.

Table 6.21: ***Proportion that get paid for employer cancelled shifts by delivery model***

Group	PP Proportion (%)	PHS Proportion (%)	Mixed Proportion (%)	Contractual Proportion (%)	Overall Proportion (%)
HSWs***	33	40	21	18	25
RNs*	33	16	33	9	18
LPNs***	28	42	26	11	15
OT/PT/SW***	16	6	15	3	11

* Statistically significant difference (p <.05; chi-square statistic)

** Statistically significant difference (p <.01; chi-square statistic)

***Statistically significant difference (p <.001; chi-square statistic)

NOTE: The above data is national in scope. It should be noted that this grouping of data might miss certain distinctions for which there may be important differences according to region, province, employer type, union status, etc.

Other areas of compensation

Other compensation issues addressed in the survey of formal caregivers were whether workers were paid for coffee or meal breaks, paid for preparation and planning time, provided association memberships, paid to attend staff meetings, or paid for meetings with consumers' informal caregivers.

As illustrated in Figure 6.1, HSWs most frequently reported rarely being compensated for staff meetings. Slightly more than one in 10 workers (13%) reported that they received paid compensation for preparation and planning time. Similarly small proportions received compensation for coffee or meal breaks (18%) and meeting with informal caregivers (18%). HSWs working with a private agency were less likely to receive compensation for these areas in comparison with those working in the public sector.

RNs were more likely to receive compensation for staff meetings (79%) and meetings with informal caregivers (67%), than compensation for time spent on preparation and planning (47%) or for coffee or meal breaks (42%). Differences were found between those who work with private agencies and those who work in the public sector.

LPNs reported a pattern similar to that of the RNs.

Table 6.22: **Proportion that get paid for employer cancelled shifts by work status**

Group	Full-time Proportion (%)	Part-time Proportion (%)	Casual Proportion (%)	Overall Proportion (%)
HSWs	29	23	21	25
RNs*	20	16	17	18
LPNs	21	12	14	15
OT/PT/SW	11	10	20	11

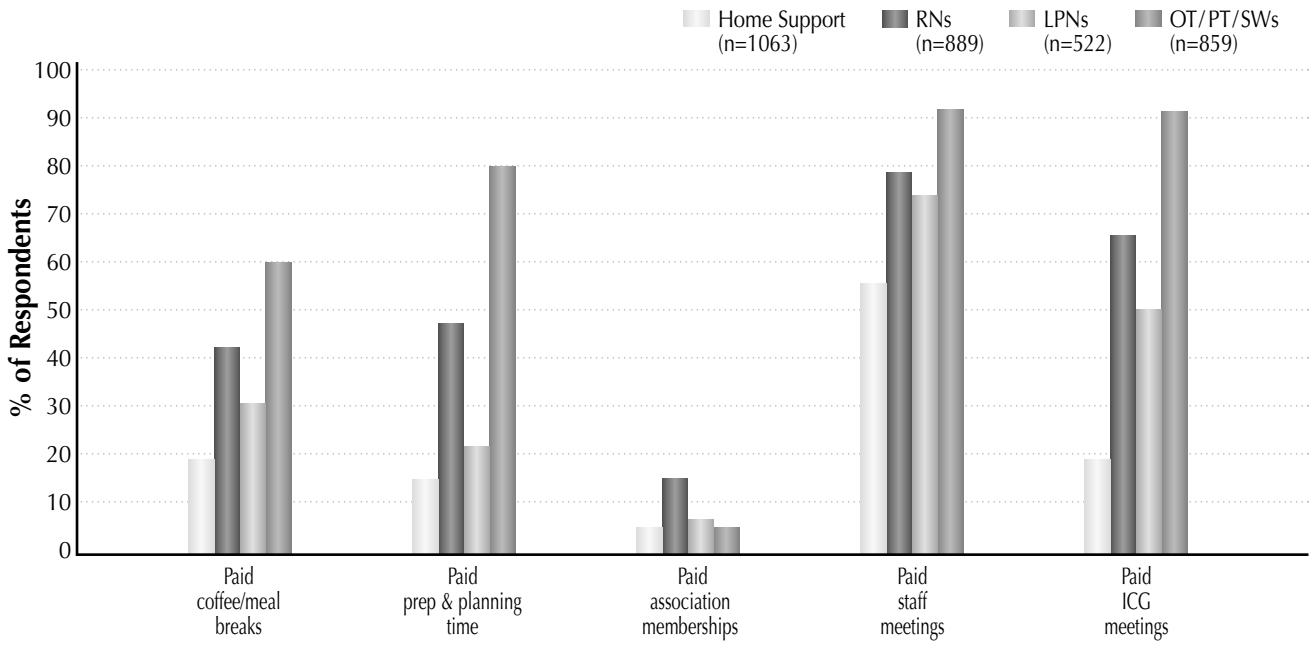
*Statistically significant difference between work status proportions (p <.05; chi-square statistic)

** Statistically significant difference between work status proportions (p <.01; chi-square statistic)

*** Statistically significant difference between work status proportions (p <.001; chi-square statistic)

NOTE: The above data is national in scope. It should be noted that this grouping of data might miss certain distinctions for which there may be important differences according to region, province, employer type, union status, delivery model, etc.

Figure 6.1: **Other areas of compensation by occupational group**



NOTE: The above data is national in scope. It should be noted that this grouping of data might miss certain distinctions for which there may be important differences according to region, province, employer type, union status, delivery model, etc.

The majority of OT/PT/SWs reported that they received compensation for meetings with informal caregivers (92%), staff meetings (92%), and planning and preparation time (80%). Approximately 60% indicated that they received compensation for coffee or meal breaks.

Table 6.23: **Unpaid hours in an average week by employer type (2-way split)**

Group	Public Mean (SD)	Private Mean (SD)	Overall Mean (SD)
HSW	2.2 (5.8)	2.6 (3.5)	2.6 (4.1)
	n=159	n=571	n=730
RNs***	2.1 (4.2)	4.1 (4.4)	3.5 (4.4)
	n=224	n=494	n=718
LPNs**	0.8 (2.1)	3.9 (4.6)	3.7 (4.6)
	n=22	n=351	n=373
OT/PT/SW***	1.8 (3.7)	5.1 (5.5)	3.1 (4.8)
	n=279	n=183	n=462

SD = standard deviation

* Statistically significant difference between Public and Private means ($p < .05$; t-test for independent means)

** Statistically significant difference between Public and Private means ($p < .01$; t-test for independent means)

***Statistically significant difference between Public and Private means ($p < .001$; t-test for independent means)

NOTE: The above data is national in scope. It should be noted that this grouping of data might not reflect important differences that exist by region, province, delivery model, union status, etc.

Table 6.24: **Unpaid hours in an average week by employer type (3-way split)**

Group	Public Mean (SD)	Private NFP Mean (SD)	Private FP Mean (SD)	Overall Mean (SD)
HSWs*	1.8 (4.2)	2.8 (3.6)	2.9 (3.6)	2.6 (4.1)
	n=204	n=149	n=232	n=730
RNs***	2.1 (4.1)	3.6 (4.1)	4.8 (4.5)	3.5 (4.4)
	n=229	n=238	n=198	n=718
LPNs*	1.2 (2.7)	3.6 (4.1)	4.0 (4.7)	3.7 (4.6)
	n=27	n=202	n=86	n=373
OT/PT/SW***	1.8 (3.7)	1.0 (1.2)	5.6 (5.6)	3.1 (4.8)
	n=275	n=12	n=135	n=462

SD = standard deviation

* Statistically significant difference between employer type means (p <.05; ANOVA)

** Statistically significant difference between employer type means (p <.01; ANOVA)

***Statistically significant difference between employer type means (p <.001; ANOVA)

NOTE: The above data is national in scope. It should be noted that this grouping of data might not reflect important differences that exist by region, province, delivery model, union status, etc.

Table 6.25: **Unpaid hours in an average week by union status**

Group	Union Mean (SD)	Non-union Mean (SD)	Overall Mean (SD)
HSWs*	2.6 (4.8)	2.4 (3.4)	2.6 (4.1)
	n=350	n=375	n=723
RNs***	2.4 (3.26)	5.3 (5.33)	3.5 (4.40)
	n=436	n=273	n=709
LPNs**	3.1 (3.6)	4.4 (5.4)	3.7 (4.6)
	n=186	n=182	n=368
OT/PT/SW***	2.1 (3.9)	4.9 (5.6)	3.1 (4.8)
	n=293	n=167	n=460

SD = standard deviation

* Statistically significant difference between unionized and non-unionized means (p <.05; t-test for independent means)

** Statistically significant difference between unionized and non-unionized means (p <.01; t-test for independent means)

***Statistically significant difference between unionized and non-unionized means (p <.001; t-test for independent means)

NOTE: The above data is national in scope. It should be noted that this grouping of data might not reflect important differences that exist by region, province, delivery model, type of employer, etc.

Table 6.26: **Unpaid hours in an average week by delivery model**

Group	PP Mean (SD)	PHS Mean (SD)	Mixed Mean (SD)	Contractual Mean (SD)	Overall Mean (SD)
HSWs	2.2 (5.4)	2.3 (5.2)	2.6 (3.9)	2.7 (3.4)	2.6 (4.1)
	n=111	n=119	n=54	n=447	n=730
RNs***	2.3 (5.0)	2.2 (2.8)	2.0 (3.3)	4.4 (4.5)	3.5 (4.4)
	n=113	n=84	n=103	n=417	n=718
LPNs*	1.1 (1.4)	1.8 (3.2)	2.8 (4.3)	4.0 (4.7)	3.7 (4.6)
	n=20	n=7	n=36	n=309	n=373
OT/PT/SW***	1.9 (5.0)	1.2 (1.9)	1.9 (2.1)	4.9 (5.4)	3.1 (4.8)
	n=124	n=56	n=87	n=195	n=462

SD = standard deviation

* Statistically significant difference (p <.05; ANOVA)

** Statistically significant difference (p <.01; ANOVA)

***Statistically significant difference (p <.001; ANOVA)

NOTE: The above data is national in scope. It should be noted that this grouping of data might not reflect important differences that exist by region, province, type of employer, union status, etc.

Unpaid hours

One issue that respondents to the survey of formal caregivers were asked to comment upon was the number of hours they worked in an average week for which they were *not paid*. As illustrated in Table 6.23, these ranged on average from over two hours for HSWs (M=2.6 hours; SD=4.1) to over three hours for LPNs (M=3.7 hours; SD=4.6). This is approximately 10% of the average hours worked per week (see Table 6.26). With the exception of HSWs, significant differences were found between those who work for a public employer and those who work for a private agency, with private agency workers reporting on average more unpaid hours.

With the exception of OT/PT/SWs working in a private not-for-profit agency, the average number of unpaid hours was lower for workers in the public sector compared with their colleagues in private agencies. Among private agencies, the average number of unpaid hours was higher in the for-profit group compared to the not-for-profit group for RNs. (See Table 6.24)

Within the registered nurse, practical nurse and OT/PT/SWs groups, unionized workers reported on average significantly fewer unpaid hours within a week. With the exception of HSWs, the average number of unpaid hours was significantly higher for workers in the contractual model across all occupational groups.

Issues arising out of the key informant interviews and focus groups regarding wages included the following.

- Wage parity between workers in community settings and those working in institutions was an issue in many parts of the country. According to the interviews and focus groups, lack of wage parity is evident in the eastern provinces and Ontario. It was found that there is also variation in wages between unions, and even within unions in specific areas of a province. This situation is more common for HSWs.
- Overall, there was agreement across stakeholder groups that HSWs are not paid enough considering the work that they do in the home care sector. For example, they are taking on much greater responsibilities overall, play a key role in monitoring, and have higher acuity clients than before. More training is required than in the past.

Current benefits

According to the results from the survey, home support workers reported receiving proportionally fewer benefits when compared with the other

occupational groups. The survey collected information on benefits that were either fully or partially paid for by the employer.

The most frequently cited benefit was annual paid vacation with approximately one-half or more in each group indicating that they received the benefit.

Only one-third of home support workers (34%) reported that they received paid sick leave. About one-third of home support workers (38%) have a pension plan to which the employer makes contributions. Less than one-half (40%) have job-protected maternity leave.

With the exception of job-protected parental leave at 50%, less than one-half of LPNs reported employer contributions to other benefits.

Across all occupational groups, workers with private employers received proportionally fewer benefits when compared with workers with employers in the public sector.

Findings from the key informant groups and focus groups were:

- General agreement that improving benefits for workers is needed; and,
- Adequate compensation for travel time and use of personal vehicles is often an issue raised by unions. In one health region, for example, nurses are given a vehicle allowance but HSWs are not (although in both cases they are paid for kilometres driven). And in many places HSWs are not paid for travelling to their first call or travelling back from their last call.

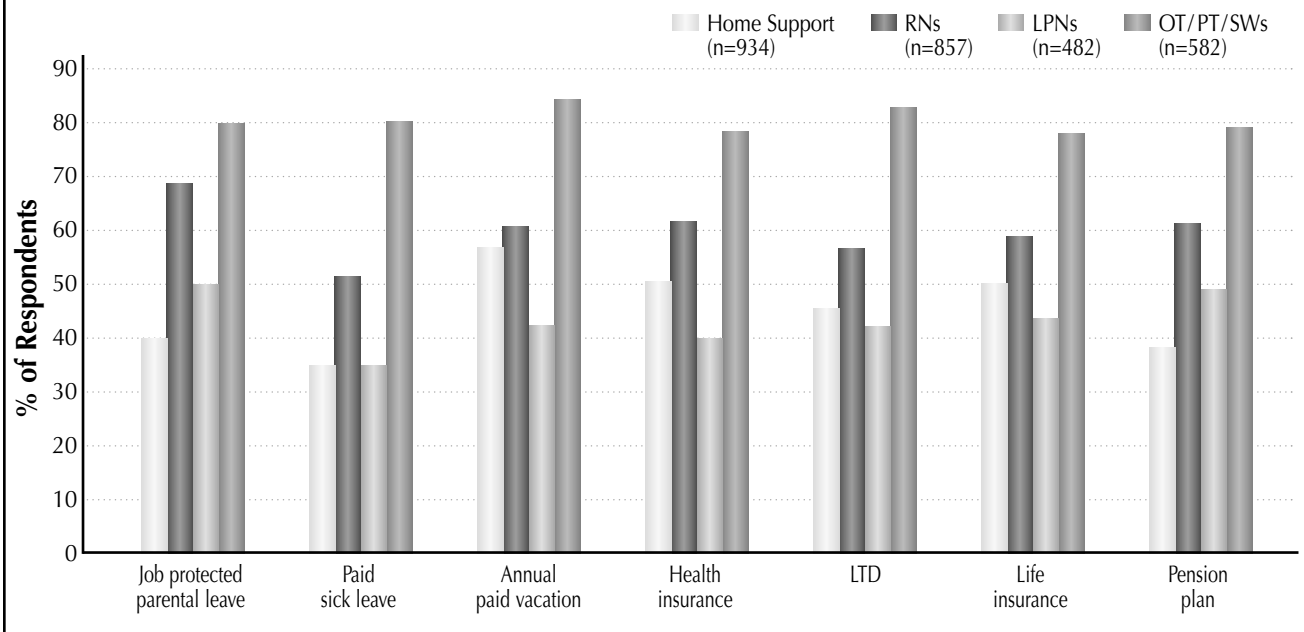
Hours of work and work status

As illustrated in Table 6.27, the average number of hours worked per week was similar across the occupational groups, approximately 30 hours per week.

There were no statistically significant differences between the public and private sectors for the average amount of hours worked per week.

Figure 6.3 shows the percentages of employees working full- or part-time or on casual/substitute status. About one-third of employees in all occupations, except OT/PT/SWs, were working full-time. Between 38% and 52% of the employees were working part-time. A smaller percentage of workers were working as casual or substitute employees.

Figure 6.2: **Current benefits contributed to at least in part by employer by occupational group**



NOTE: The above data is national in scope. It should be noted that this grouping of data might not reflect important differences that exist by region, province, type of employer, union status, delivery model, etc.

Table 6.27: **Average hours worked per week by occupational group**

Group	Mean Hours Worked (SD)
HSWs	27.7 (11.6) n=1092
RNs	29.8 (12.6) n=889
LPNs	28.1 (12.9) n=531
OT/PT/SW	30.6 (10.7) n=859

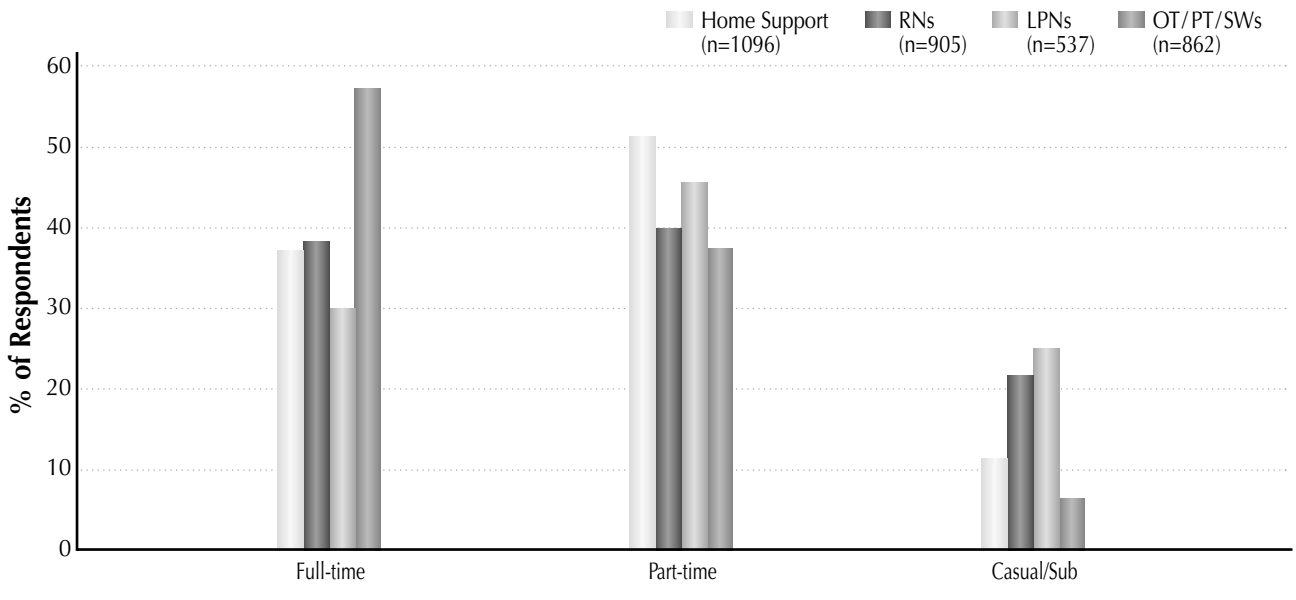
NOTE: The above data is national in scope. It should be noted that this grouping of data might not reflect important differences that exist by region, province, type of employer, union status, delivery model, etc.

In the HSW group, more than one-third of respondents (37%) reported they had full-time work status and an additional 52% indicated that they had part-time status. Approximately 11% reported that they worked as a casual or substitute employee. According to the LFS 2001, the proportion of nurses aides and homemakers working in the Home Health Services Industry (NAICS 6216) with part-time status was 46% and 61% respectively. Findings from the LFS 2001 indicate that approximately one in six nurses aides worked with 'non-permanent' status, similar to the 12% from the survey of HSWs who indicated that they were casual or substitute employees.

Thirty-eight percent of respondents in the RN group reported that they were in full-time positions with an additional 41% reporting part-time status. These proportions are different from those obtained from RNs working in the Home Health Services Industry (NAICS 6216) on the LFS 2001. According to the LFS 2001, approximately two-thirds of RNs (69%) had full-time status, and 31% had part-time status. The LFS 2001 'non-permanent' status proportion of 15% was similar to the survey's proportion of casual/substitution rate of 18% for the RN group.

According to the survey results, approximately one-third of LPNs (30%) had full-time status with an additional 46% working part-time. One in four (24%) of LPNs reported that they worked as casual or substitute employees. The LFS 2001 data for registered nurse assistants working in the Home Health Services Industry (NAICS 6216) only had sufficient data to report that 63% of the group had full-time status.

Figure 6.3: **Work status by occupational group**



NOTE: The above data is national in scope. It should be noted that this grouping of data might not reflect important differences that exist by region, province, type of employer, union status, delivery model, etc.NOTE: The above data is national in scope. It should be noted that this grouping of data might not reflect important differences that exist by region, province, type of employer, union status, delivery model, etc.

Table 6.28: **Hours spent travelling in an average week by employer type (2-way split)**

Group	Public Mean (SD)	Private Mean (SD)	Overall Mean (SD)
HSWs*	4.7 (5.1)	5.8 (6.6)	5.5 (6.3)
	n=211	n=778	n=988
RNs***	5.1 (4.3)	7.0 (7.0)	6.3 (6.1)
	n=315	n=514	n=829
LPNs***	3.6 (2.1)	7.0 (6.9)	6.6 (6.5)
	n=63	n=419	n=481
OT/PT/SW***	4.2 (3.1)	5.8 (4.1)	4.6 (3.5)
	n=593	n=236	n=829

SD = standard deviation

* Statistically significant difference between Public and Private means ($p < .05$; t-test for independent means)

** Statistically significant difference between Public and Private means ($p < .01$; t-test for independent means)

***Statistically significant difference between Public and Private means ($p < .001$; t-test for independent means)

NOTE: The above data is national in scope. It should be noted that this grouping of data might not reflect important differences that exist by region, province, delivery model, union status, etc.

There was insufficient data to report the "non-permanent" rates of employment for this group.

Over one-half of OT/PT/SWs responding to the survey (57%) indicated that they had full-time status. An additional 37% reported part-time status. Approximately one in 20 (6%) indicated that they were casual or substitute employees.

According to the survey results, the number of hours spent travelling in an average work was relatively consistent across occupational groups. As illustrated in Table 6.28, the average number of hours ranged from 4.6 hours (OT/PT/SW) to 6.6 hours (LPNs). This is approximately 18% to 22% of the time spent working per week.

Significant differences were found between the public sector workers and workers with private agencies in the amount of hours spent travelling, with more travel being reported by those working with private agencies.

As demonstrated in Table 6.29, a substantial proportion of the respondents indicated that they were working rotating shifts or doing shift work when providing home care services. More than one-third of RNs (40%), 38% of HSWs, and 41% of LPNs reported working rotating shifts or shift work. Only one-quarter (24%) of OT/PT/SWs indicated working rotating shifts. There were no significant differences between those working for a public employer and those working with a private agency.

Compensation strategies

Participants in the focus groups and key informant interviews identified a number of themes that may point to human resources strategies with respect to compensation in the sector.

Wages

- Increase the wage rate for home support workers. The rate would have to be competitive with other parts of the health system, and indeed, other sectors. What constitutes the "right amount" is

Table 6.29: **Proportion working rotating shifts or shift work by occupational group**

Group	Proportion (%)
HSWs	38
RNs	40
LPNs	41
OT/PT/SW	24

NOTE: The above data is national in scope. It should be noted that this grouping of data might not reflect important differences that exist by region, province, delivery model, union status, employer type, etc.

another issue. It was felt that a higher wage would in any case reflect a greater value placed on the workers role in society, especially since a high proportion of the clients are the senior population. Inter and intra-provincial variation was also identified as an important variable to consider.

- Wage parity does exist in some provinces but in many cases it was identified that there needs to be, at a minimum, wage parity with long term care facilities and the acute care sector. There has been increasing awareness that without parity, workers have moved into facility settings not only for better pay, but also because the working conditions are considered better, with regular hours, no travel, and a consistent workplace environment.
- Provide funding for more positions and to expand the amount of hours of work available. This would reduce job stress by reducing uncertainty of employment and enable workers to spend the time they feel is required with clients, which could also help the system to respond better to client and family needs. Another related suggestion by one key informant was to promote the use of a minimum of three hours pay for workers, regardless of whether they visited just one client for only an hour.

Benefits

- Improve benefits and better reimbursement of travel costs.
- Improving benefits such as family leave was felt by some key informants to be conducive to retaining workers.

Working conditions

The health and safety of workers is a significant issue in home care, especially for unions. It was recognized by the key informants interviewed that major health issues such as preventing back injury must be addressed. Options include limiting the amount of lifting of clients (but that is very difficult when a worker is faced with no other choice but to lift a client), and also to place greater emphasis on devising new technologies to assist workers in their jobs. A research group in British Columbia, for example, has been working with a home support agency to design a portable lift that can be taken from home to home according to the changing needs and indeed clients being provided home care. In any case, it was felt that increased government funding would be required for promoting health and safety issues. Another initiative includes providing safety measures and protocols for working in the home (i.e., giving nurses cell phones).

Working conditions, management practices, recruitment/ retention and quality of care

This section contains the findings from the survey of formal caregivers, focus groups and key informant interviews concerning issues of working conditions, management practices, and finally perceptions of the quality of care that formal caregivers are able to provide as related to working conditions.

Overall working conditions

One aspect of working conditions is the perception of employees as to whether they feel they are able to apply their specific skills and knowledge fully in the workplace. In the survey of formal caregivers, respondents were asked whether they perceived themselves as "*underemployed*", that is, "*working at a job that does not require their level of skill or experience*".

As illustrated in Table 6.30, there was some variation among the occupational groups as to how they answered this question.

One in three HSWs (33%) reported that they felt they were underemployed in their current position. The proportions were significantly different according to which type of employer they worked for, with a higher proportion of workers in private agencies (37%) reporting perceptions of underemployment in comparison with those working for a public employer (17%).

Approximately one in 10 OT/PT/SWs (12%) reported that they were underemployed with a significantly higher proportion occurring among those working in government or regional health authorities.

Twelve percent of RNs reported underemployment with no differences according to type of employer.

Similarly, 21% of LPNs indicated that they felt they were underemployed with no differences found according to type of employer.

As illustrated in Table 6.31, among the private groups, OT/PT/SWs and HSWs were equally likely to report being underemployed. Among LPNs, those working in private for-profit agencies were more likely to report being underemployed when compare with those working in third-party not-for-profit agencies.

Table 6.30: **Proportion who perceive themselves as "underemployed" by employer type (2-way split)**

Group	Public Proportion (%)	Private Proportion (%)	Overall Proportion (%)
HSWs***	17	37	33
RNs	10	14	12
LPNs	28	20	21
OT/PT/SW*	14	8	12

* Statistically significant difference between Public and Private proportions (p <.05; chi-square statistic)

** Statistically significant difference between Public and Private proportions (p <.01; chi-square statistic)

*** Statistically significant difference between Public and Private proportions (p <.001; chi-square statistic)

NOTE: The above data is national in scope. It should be noted that this grouping of data might miss certain distinctions for which there may be important differences according to region, province, union status, delivery model, etc.

Table 6.31: **Proportion who perceive themselves as "underemployed" by employer type (3-way split)**

Group	Public Proportion (%)	Private NFP Proportion (%)	Private FP Proportion (%)	Overall Proportion (%)
HSWs***	19	39	39	33
RNs	11	10	16	12
LPNs***	7	16	25	21
OT/PT/SW	14	7	8	12

* Statistically significant difference (p <.05; chi-square statistic)

** Statistically significant difference (p <.01; chi-square statistic)

***Statistically significant difference (p <.001; chi-square statistic)

NOTE: The above data is national in scope. It should be noted that this grouping of data might miss certain distinctions for which there may be important differences according to region, province, union status, delivery model, etc.

Table 6.32: **Proportion who perceive themselves as "underemployed" by union status**

Group	Unionized Proportion (%)	Non-unionized Proportion (%)	Overall Proportion (%)
HSWs***	26	38	33
RNs	12	13	12
LPNs	22	21	22
OT/PT/SW*	14	7	12

*Statistically significant difference between unionized and non-unionized proportions (p <.05; chi-square statistic)

** Statistically significant difference between unionized and non-unionized proportions (p <.01; chi-square statistic)

*** Statistically significant difference between unionized and non-unionized proportions (p <.001; chi-square statistic)

NOTE: The above data is national in scope. It should be noted that this grouping of data might miss certain distinctions for which there may be important differences according to region, province, employer type, delivery model, etc.

Table 6.33: **Proportion who perceive themselves as "underemployed" by delivery model**

Group	PP Proportion (%)	PHS Proportion (%)	Mixed Proportion (%)	Contractual Proportion (%)	Overall Proportion (%)
HSWs***	21	21	33	39	33
RNs	12	6	15	14	12
LPNs	31	15	18	21	21
OT/PT/SW**	15	6	14	8	12

* Statistically significant difference (p <.05; chi-square statistic)

** Statistically significant difference (p <.01; chi-square statistic)

***Statistically significant difference (p <.001; chi-square statistic)

NOTE: The above data is national in scope. It should be noted that this grouping of data might miss certain distinctions for which there may be important differences according to region, province, employer type, union status, etc.

As illustrated in Table 6.32, non-unionized HSWs were more likely to view themselves as underemployed when compared to unionized HSWs.

As illustrated in Table 6.33, HSWs working in the contractual model were most likely to report being underemployed.

As shown in Table 6.34, a significantly higher proportion of OT/PT/SWs who have a casual work status perceived themselves as underemployed when compared with either their part-time or full-time counterparts.

As demonstrated in Table 6.35, there were no significant differences in the proportion of workers who perceived themselves as underemployed according to the amount of time they had been working in the home care sector.

The survey of formal caregivers asked respondents to report difficulties they had experienced in providing care in the home setting, and how frequently these situations occur. As demonstrated in Figure 6.4, the most commonly reported difficulty across occupational groups was having to provide care in houses with unsanitary conditions.

Table 6.34: **Proportion who perceive themselves as "underemployed" by work status**

Group	Full-time Proportion (%)	Part-time Proportion (%)	Casual Proportion (%)	Overall Proportion (%)
HSWs	29	36	33	33
RNs	10	15	13	13
LPNs	22	19	26	21
OT/PT/SW*	11	13	23	12

*Statistically significant difference between work status proportions (p <.05; chi-square statistic)

** Statistically significant difference between work status proportions (p <.01; chi-square statistic)

*** Statistically significant difference between work status proportions (p <.001; chi-square statistic)

NOTE: The above data is national in scope. It should be noted that this grouping of data might miss certain distinctions for which there may be important differences according to region, province, employer type, union status, delivery model, etc.

Table 6.35: **Proportion who perceive themselves as "underemployed" by tenure in sector**

Group	7 Or Less Years Proportion (%)	More Than 7 Years Proportion (%)	Overall Proportion (%)
HSWs	35	31	33
RNs	13	12	12
LPNs	18	24	22
OT/PT/SW	12	12	12

*Statistically significant difference between 7 or less years and more than 7 years proportions (p <.05; chi-square statistic)

** Statistically significant difference 7 or less years and more than 7 years proportions (p <.01; chi-square statistic)

*** Statistically significant difference between 7 or less years and more than 7 years proportions (p <.001; chi-square statistic)

NOTE: The above data is national in scope. It should be noted that this grouping of data might miss certain distinctions for which there may be important differences according to region, province, employer type, union status, delivery model, etc.

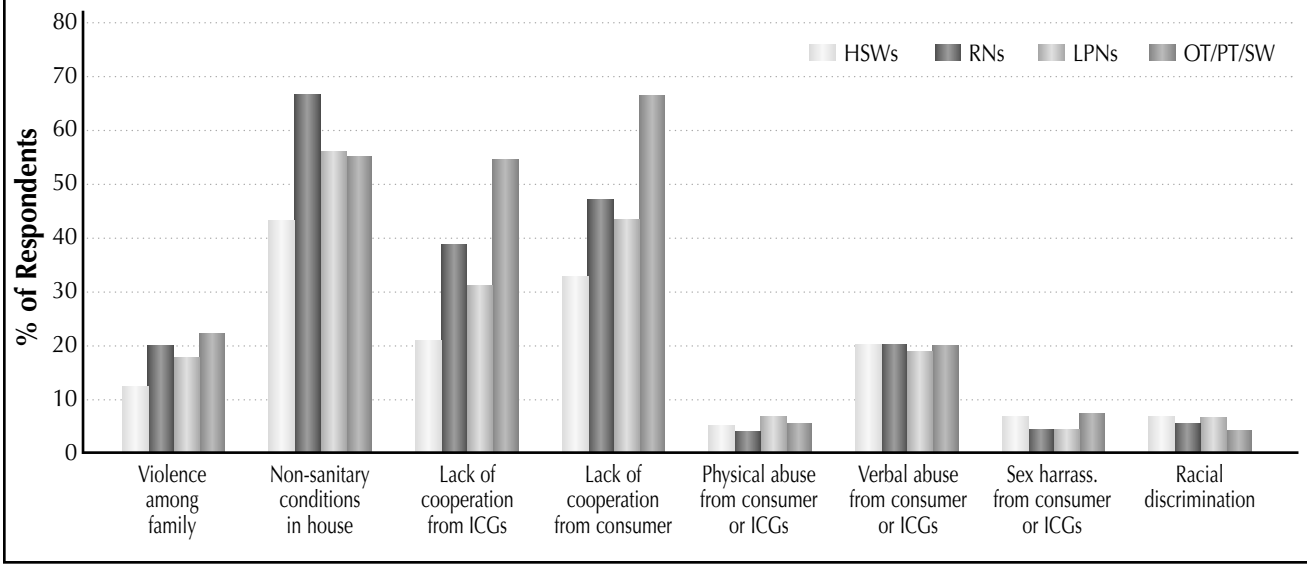
HSWs indicated that the most frequent difficulties they faced were unsanitary conditions in houses (43%), lack of cooperation from the consumer (33%), and verbal abuse from the consumer or the informal caregivers (20%).

RNs most frequently reported difficulties in providing home care in houses with unsanitary conditions (67%), lack of cooperation from consumers (47%), and lack of cooperation from informal caregivers (39%).

LPNs reported a pattern of difficulties similar to those experienced by the RN group. The most frequently cited difficulties were working in unsanitary conditions (56%), lack of cooperation from the consumer (43%), and lack of cooperation from informal caregivers (31%).

OT/PT/SWs most frequently experienced lack of cooperation from the consumer (66%), followed by lack of cooperation from informal caregivers (55%)

Figure 6.4: **Experienced difficulties in providing care in home care setting by occupational group**



NOTE: The above data is national in scope. It should be noted that this grouping of data might miss certain distinctions for which there may be important differences according to region, province, employer type, union status, delivery model, etc.

and unsanitary conditions in houses (55%), similar to the other groups.

Among the nursing and HSW occupations, approximately one in five experienced verbal abuse from consumers of informal caregivers either occasionally or frequently while providing home care. Rates of physical abuse from consumers or informal caregivers ranged from approximately 4% among RNs to 7% among LPNs.

Information on working conditions was also collected from the focus groups and key informant interviews. The main findings were as follows.

- Health and safety is a major issue for unions; however, safety in the workplace is often difficult to ensure. Clients, for example, may have the attitude that it is 'their place' (and as their home, it is), but many workers do not want to work in an environment where smoking is permitted, for example.
- Characteristics of the "workplace" may also be problematic, such as, for example, vacuum cleaners with faulty wiring, animals defecating on the floor, no running water, clients physically and verbally abusing workers, dangerous animals or a lack of outside lighting for evening visits. Some clients meanwhile are insistent on how things should be done (e.g., floors cleaned on hands and knees) while others are much less concerned. In short, there is a need to educate workers regarding their rights and entitlements, and their rights to refuse to work in certain conditions.
- Lifting of clients is a major issue. Although some employers have "zero lift policy", this is almost unenforceable, especially as workers will generally do what the client needs and can hardly stand by and not provide the support a client requires. Unions feel that there should be more mechanical supports available to ensure lifting can be done safely.
- Travel continues to be a safety issue for workers; the safety of long distance traveling in rural areas, especially in winter and at night is a major concern.
- There are concerns about liability, specifically that higher levels of care are required and that HSWs and volunteers could be faced with liability issues if there are negative health outcomes.
- There is often limited interface between workers themselves. Unions commented that the HSWs do not know one another and there is limited peer support.

Management practices

Information on various aspects of management practices was collected from the survey of formal caregivers in addition to the key informant interviews and focus groups. In the survey, respondents were asked to report on issues such as written contracts, written job descriptions, formal complaint procedures, scheduling days off, and flexibility in the work schedule. The key informant interviews and focus groups concentrated on the current constraints and demands made on management as they attempt to deliver home care services in what many have indicated is an unstable environment. We initially present the information from management and union representatives collected through the key informant interviews and focus groups. This is followed by the information obtained directly from the formal caregivers via the survey.

Main findings from the focus groups and key informant interviews with regard to management practices included the following.

- Managers of home care services are working in an uncertain and unstable environment. There is no "master plan" for home care, and there is no integrated human resource strategy in place that would be essential to any strategic direction designed for home care.
- Regardless of the provincial jurisdiction, managers must achieve balance between the fiscal realities of their organization and pressures to maintain a stable workforce, while providing services to an aging and more clinically acute population.
- Difficult decisions are being made with limited budgets, one of the effects being that home support services are being reduced, or are simply not as available as they once were.

Table 6.36: **Employees who have a written contract by employer type (2-way split)**

Group	Public Proportion (%)	Private Proportion (%)	Overall Proportion (%)
HSWs***	73	56	60
RNs***	79	68	73
LPNs*	50	69	70
OT/PT/SW***	73	86	77

* Statistically significant difference between Public and Private proportions ($p < .05$; chi-square statistic)

** Statistically significant difference between Public and Private proportions ($p < .01$; chi-square statistic)

*** Statistically significant difference between Public and Private proportions ($p < .001$; chi-square statistic)

NOTE: The above data is national in scope. It should be noted that this grouping of data might miss certain distinctions for which there may be important differences according to region, province, union status, delivery model, etc.

- While managers express concern regarding these changes they have few options to choose from. CEOs of health authorities and managers within regional entities recognize the pressures facing home care, but point also to the pressures facing the health care system generally. Thus, although there is acknowledgement of the low pay for HSWs and the disparity in wages between workers in institutions and home care in some parts of the country, the capacity for home care managers to address care needs and HR issues seem quite limited when there are competing needs for resources in other parts of the health care system. For example, in Ontario, managers in the Ontario CCACs are under immense pressure. The new *Community Care Access Corporation Act* 2002 has given the government new powers that enable it to control how the CCACs are run. Many of the previous CEOs and Executive Directors have been replaced through the Act, which gives the government the ability to appoint the Executive Directors. Governing boards of all the CCACs are in the process of being replaced with appointed board members. Amid this uncertainty at the senior management level, managers are required to balance the budgets, which has led to significant changes (reductions) in home support services, adopt new common assessment tools (MDS-HC), and implement accountability frameworks that place more fiscal responsibility onto case managers.
- Managers of agencies contracted with publicly funded home care to provide services are faced with pressures to provide care with very small margins. As a result, wages are low, and when there is a competitive environment for contracts there is a disincentive for many agencies to hire permanent staff. The competitive model in Ontario, for example, does not support long-term market stability for provider agencies. Many part-time employees may in fact be working full-time hours.
- Without benefits and long-term stability, there is incentive for the workers to look for other job opportunities that will give them stability and more individual financial security. Indeed, unions were critical of management and government, because they felt that workers are not being fully advised of the unstable and uncertain work environment when they begin working in the home care sector.
- Juxtaposed with the above realities, managers are faced with union demands for better working conditions, more permanent positions, and benefits for workers and better pay.
- Scheduling is a problem that in part is due to the consumers themselves; their health needs may be highly variable, or they may force changes in schedules because of their own needs or desires, in which case the agencies must adjust their

Table 6.37: **Employees who have a written job description by employer type (2-way split)**

Group	Public Proportion (%)	Private Proportion (%)	Overall Proportion (%)
HSWs***	76	57	61
RNs**	84	76	79
LPNs***	58	69	68
OT/PT/SW**	84	81	83

* Statistically significant difference between Public and Private proportions (p <.05; chi-square statistic)

** Statistically significant difference between Public and Private proportions (p <.01; chi-square statistic)

*** Statistically significant difference between Public and Private proportions (p <.001; chi-square statistic)

NOTE: The above data is national in scope. It should be noted that this grouping of data might miss certain distinctions for which there may be important differences according to region, province, union status, delivery model, etc.

workers' time accordingly. This can lead to problems with continuity, especially if client needs or demands change in peak hours without warning to the workers. In rural areas, where relatively low numbers of clients are dispersed over a large geographical area, it is difficult to guarantee hours on a long-term basis for workers. Given this variability, it is important to have the capacity to use available casual staff.

According to the survey of formal caregivers, the majority of workers in each of the occupational groups have a written contract with their employer. As illustrated in Table 6.36, the variability between the groups ranges from approximately two-thirds of HSWs with a written contract (60%) to 77% of OT/PT/SWs. There is a statistically significant difference between the workers in the public sector and those in private agencies for proportions of workers with a written contract. Among HSWs and the nursing groups, there are smaller proportions with written contracts among those working in private agencies. The reverse holds true for OT/PT/SWs.

Similar proportions among the four occupational groups have written job descriptions ranging from 61% of HSWs to 83% of OT/PT/SWs. As illustrated in Table 6.37, employer type differences occurred with the HSW, RN and OT/PT/SW groups; smaller proportions of those working with private agencies had written job descriptions. Only the LPN group had smaller proportions of those working in the public sector with written job descriptions.

The majority of employees indicated that they have access to formal complaint procedures. As demonstrated in Table 6.38, the proportions with access ranged from 70% for HSWs to 89% for OT/PT/SWs. The HSW group was more likely to have formal complaint procedures if they worked for a public employer. Similarly, LPNs were more likely to have formal complaint procedures if they worked for a private agency.

As illustrated in Table 6.39, although the majority of respondents across all occupational groups indicated that they have scheduled days off (ranging from 64% to 84%), there were statistically significant differences according to employer type for each of the four occupational groups. Those working in private agencies are less likely to have scheduled days off when compared those working in the public sector.

The vast majority in each of the occupational groups reported that they enjoy flexibility in scheduling work. As demonstrated in Table 6.40, the proportions ranged from 83% for HSWs to 89% for LPNs. OT/PT/SWs and RNs enjoyed significantly more flexibility if they worked for a private agency in comparison to those who worked in the public sector.

Table 6.38: **Employees who have access to formal complaint procedures by employer type (2-way split)**

Group	Public Proportion (%)	Private Proportion (%)	Overall Proportion (%)
HSWs***	82	66	70
RNs	87	83	84
LPNs***	57	78	76
OT/PT/SW	88	90	89

* Statistically significant difference between Public and Private proportions (p <.05; chi-square statistic)

** Statistically significant difference between Public and Private proportions (p <.01; chi-square statistic)

*** Statistically significant difference between Public and Private proportions (p <.001; chi-square statistic)

NOTE: The above data is national in scope. It should be noted that this grouping of data might miss certain distinctions for which there may be important differences according to region, province, union status, delivery model, etc.

Table 6.39: **Employees who have scheduled days off by employer type (2-way split)**

Group	Public Proportion (%)	Private Proportion (%)	Overall Proportion (%)
HSWs***	87	56	64
RNs***	93	63	74
LPNs***	90	64	67
OT/PT/SW***	95	54	84

* Statistically significant difference between Public and Private proportions (p <.05; chi-square statistic)

** Statistically significant difference between Public and Private proportions (p <.01; chi-square statistic)

*** Statistically significant difference between Public and Private proportions (p <.001; chi-square statistic)

NOTE: The above data is national in scope. It should be noted that this grouping of data might miss certain distinctions for which there may be important differences according to region, province, union status, delivery model, etc.

Table 6.40: **Employees who have flexibility in scheduling work by employer type (2-way split)**

Group	Public Proportion (%)	Private Proportion (%)	Overall Proportion (%)
Home Support	82	83	83
RNs***	78	90	86
LPNs	94	88	89
OT/PT/SWs***	84	98	88

* Statistically significant difference between Public and Private proportions (p <.05; chi-square statistic)

** Statistically significant difference between Public and Private proportions (p <.01; chi-square statistic)

*** Statistically significant difference between Public and Private proportions (p <.001; chi-square statistic)

NOTE: The above data is national in scope. It should be noted that this grouping of data might miss certain distinctions for which there may be important differences according to region, province, union status, delivery model, etc.

Management practice strategies

Participants in the focus groups and key informant interviews identified a number of themes that may point to human resources strategies with respect to management practices in the sector.

Staffing

Most proposed staffing strategies relate to the balance between a permanent and casual workforce. Stakeholders proposed that it is important to determine the appropriate proportion of permanent full- and part-time workers and the extent of a casual workforce. Further research may be required to develop an understanding of the need for services, the available supply of workers, and an effective strategy for scheduling that satisfies client and worker preferences. Determining the desired proportions will assist in creating a more stable environment for the workforce.

Some stakeholders felt there should be a decrease in the casual workforce and an increase in the permanent workforce in order to enhance stability and increase the number of hours of work for a smaller number of workers.

One hiring strategy focused on involving direct field supervisors in the hiring of home support workers. This would show an agency's commitment and faith in the decision-making of the supervisor, and help to establish immediately a bond between the new hire and the supervisor with whom he or she would be working.

Work allocation and scheduling

Many strategies proposed by stakeholders focused on promoting stability and certainty in the workplace. There was almost universal agreement by key informants that workers need a guarantee of more and stable hours of employment. With this certainty, it is believed that there would be less staff turnover.

There were calls for employers to ensure that jobs and the number of hours of work be guaranteed. If workers are not salaried, then at least their contracts, with the hours of work, should be more stable.

However, the issue was not one for employers alone. Stakeholders noted the need to confirm the commitment of workers to work at specific times. For home support workers, given the reality of co-employment and "down time", unions and home care organizations have agreed to post positions that require employees to stipulate the amount of time they are able to commit to the job and to commit to certain days. This is called an "application for relief work".

There is a positive side to the lack of stability, as reflected in stakeholder comments about flexibility in their work. Flexible hours can be responsive to employee needs (i.e., for part-time work at certain times), and can be a factor in building respect for and commitment to the employer. Informally, nurses are working in hospitals and other sectors to increase hours and decrease personal downtime. It appears to work for them. Home care provides workers with flexibility. The question, however, is whether more hours and stable hours in home care would lead to these workers moving out of the other sectors.

To stem the flow of those leaving the workforce, stakeholders suggested that organizations look at those who are retiring and see if there are ways to keep them working longer by better suiting their needs (e.g., smaller workloads, more flexible hours, job sharing). This is important given that experienced workers should be highly valued by organizations.

Another approach to improve retention would be to delegate tasks. With shortages of nurses and other professions, greater attention should be directed towards delegating tasks to other workers such as LPNs and HSWs.

Some stakeholders indicated that developing a slower pace of work-life would enable greater levels of communication and the ability to reflect on practice, and would reduce stress and turnover of the workforce.

Organizational culture

Strategies were proposed that relate to how organizational culture can be changed to improve retention in the sector.

At the organizational level, key informants felt that retention could be improved by fostering organizational commitment, making workers feel more part of the home care organization. This may include, for example, more frequent and regular meetings between management and workers, sharing information about the organization, educational opportunities, and involving employees in research activities. Similarly, the underlying philosophy of an organization can have a strong influence on workers. One agency in British Columbia, for example, with a very low turnover rate, observed; 'The way you treat staff, is the way they will treat clients – with respect and in a democratic environment.'

Stakeholders noted the importance of being responsive to workers' needs. This can include demonstrations of respect for the workers, flexibility if circumstances

permit, and financial support in difficult times (offset against future wages).

A stronger voice in decision-making for workers is required. With more nurses in managerial positions, for example, nurse employees would have someone to speak on their behalf. Workers generally could be more involved in the decision-making processes of the respective agencies.

There was a suggestion that there should be more interaction among workers within the sector, both among professionals (e.g., case managers, nurses and OT/PT/SWs), and between occupational groups (i.e., between professional and paraprofessionals).

Stakeholders felt that organizations should communicate effectively 'best' or 'promising' practices. This could contribute to improving the efficiency and effectiveness of service provision in an organization, and could instill in the workforce a desire to obtain and use new knowledge in their practice and the day-to-day operations of the organization.

Technology

Use of advanced communications technology was advised. As employees are working alone, advanced communications technology may further enhance the home care setting as a more desirable place of work.

Retention and recruitment issues

Information was collected on many different aspects of retention and recruitment in the survey of formal caregivers, focus groups and key informant interviews. First we present the data collected from the survey for issues such as: length of time with current employer; current job satisfaction; length of time working in the home care sector; the projected length of time employees intend to continue working in the home care sector; the proportion who intend to leave their current employer in the next 12 months; the reasons for leaving; and, what they intend to do after they leave. The information from the key informant interviews and focus groups centred on issues of difficulties with retention and recruitment, the role of casualization of the home care workforce as related to retention and recruitment issues, and turnover and instability within the home care workforce.

Results of the survey of formal caregivers did not show strong evidence of either "churning" or rapid turnover within the home care workforce.[13] As illustrated in Tables 6.40 and 6.41, the average length of time with current employers was a large portion of the time that they had spent in working in the home care sector overall.

Table 6.41: **Length of time with current employer (years) by employer type (2-way split)**

Group	Public Mean (SD)	Private Mean (SD)	Overall Mean (SD)
HSWs***	7.9 (5.9)	5.8 (5.0)	6.3 (5.3)
RNs***	8.8 (6.5)	6.6 (6.0)	7.4 (6.3)
LPNs***	22.1 (12.8)	5.4 (4.7)	7.4 (8.3)
OT/PT/SWs***	7.5 (6.6)	3.0 (3.4)	6.2 (6.2)

SD = standard deviation

* Statistically significant difference between Public and Private means ($p < .05$; t-test for independent means)

** Statistically significant difference between Public and Private means ($p < .01$; t-test for independent means)

***Statistically significant difference between Public and Private means ($p < .001$; t-test for independent means)

NOTE: The above data is national in scope. It should be noted that this grouping of data might not reflect important differences that exist by region, province, delivery model, union status, etc.

[13] "Churning" is normally defined as rapid movement between employers within the same sector. Turnover reflects the number of positions for which replacements had to be hired each year. It is usually calculated as the number of new hires within a year divided by the total number of positions.

HSWs had worked for their current employer an average 6.3 years at the time of survey. There was a significant difference between public sector and private sector HSWs, with public sector employees having longer tenure. The average length of time working in the home care sector for the HSW group was 8.2 years. If there were a large amount of churning in the home care workforce, we would expect that the length of time with current employer would be relatively small in comparison with the overall time spent in the sector. Given the age of the HSW workforce and the average length of time in the sector, it is likely that entrance into the home care sector occurs relatively later in the worker's career (i.e., they have worked in other sectors prior to the home care sector, or are re-entering the workforce).

Patterns found within the HSW group were similar for RNs, LPNs, and OT/PT/SWs. The average length of time with their current employers was a relatively large proportion of the average time spent in working in the home care sector. Similarly, significantly longer tenure with current employers was seen among public sector employees when compared with private sector employees for these three groups.

As illustrated in Table 6.43, the length of time with the current employer is significantly higher for workers belonging to unions across all occupational groups.

As illustrated in Table 6.44, the length of time working in the sector is significantly higher for workers belonging to unions with the exception of the OT/PT/SW group.

As demonstrated in Table 6.45, the average number of years with the current employer is similar across all four occupational groups. Within each occupational group, the average number of years worked tended to be higher for the PP and PHS models, as compared to the mixed and contractual models.

As demonstrated in Table 6.46, the average number of years working within the home care sector is similar across delivery models for HSWs and RNs. Among LPNs and OT/PT/SWs there were significant differences according to delivery model.

As demonstrated in Table 6.47, the average number of years with the current employer is similar across all four occupational groups. Private for-profit agency workers reported the lowest average number of years with their employer across all occupational groups.

Table 6.42: **Length of time working in the home care sector (years) by employer type (2-way split)**

Group	Public Mean (SD)	Private Mean (SD)	Overall Mean (SD)	Range
HSWs***	9.5 (6.6)	7.8 (5.7)	8.2 (6.0)	0.1-44.0
RNs	9.5 (6.7)	8.6 (6.3)	9.0 (6.5)	0.2-35.0
LPNs***	16.3 (10.5)	8.1 (6.0)	9.1 (7.2)	0.2-38.0
OT/PT/SWs	8.1 (6.7)	8.4 (7.0)	8.2 (6.8)	0.1-37.0

SD = standard deviation

* Statistically significant difference between Public and Private means ($p < .05$; t-test for independent means)

** Statistically significant difference between Public and Private means ($p < .01$; t-test for independent means)

***Statistically significant difference between Public and Private means ($p < .001$; t-test for independent means)

NOTE: The above data is national in scope. It should be noted that this grouping of data might not reflect important differences that exist by region, province, delivery model, union status, etc.

Table 6.43: **Length of time with current employer (years) by union status**

Group	Unionized Mean (SD)	Non-unionized Mean (SD)	Overall Mean (SD)
HSWs***	7.6 (5.8)	5.1 (4.5)	6.3 (5.3)
RNs***	8.6 (6.5)	5.5 (5.4)	7.5 (6.3)
LPNs***	10.1 (10.1)	4.5 (3.8)	7.5 (8.3)
OT/PT/SWs***	7.1 (6.6)	3.5 (3.7)	6.3 (6.2)

SD = standard deviation

* Statistically significant difference between unionized and non-unionized means (p <.05; t-test for independent means)

** Statistically significant difference between unionized and non-unionized means (p <.01; t-test for independent means)

***Statistically significant difference between unionized and non-unionized means (p <.001; t-test for independent means)

NOTE: The above data is national in scope. It should be noted that this grouping of data might not reflect important differences that exist by region, province, delivery model, employer type, etc.

Table 6.44: **Length of time working in the home care sector (years) by union status**

Group	Unionized Mean (SD)	Non-unionized Mean (SD)	Overall Mean (SD)
HSWs***	9.3 (6.2)	7.2 (5.6)	8.2 (6.0)
RNs***	9.7 (6.6)	7.7 (5.9)	9.0 (6.5)
LPNs***	10.5 (8.2)	7.5 (5.5)	9.1 (7.2)
OT/PT/SWs	8.3 (6.8)	8.1 (6.8)	8.2 (6.8)

SD = standard deviation

* Statistically significant difference between unionized and non-unionized means (p <.05; t-test for independent means)

** Statistically significant difference between unionized and non-unionized means (p <.01; t-test for independent means)

***Statistically significant difference between unionized and non-unionized means (p <.001; t-test for independent means)

NOTE: The above data is national in scope. It should be noted that this grouping of data might not reflect important differences that exist by region, province, delivery model, employer type, etc.

Table 6.45: **Length of time with current employer (years) by delivery model**

Group	PP Mean (SD)	PHS Mean (SD)	Mixed Mean (SD)	Contractual Mean (SD)	Overall Mean (SD)
HSWs	6.9 (5.7)	7.0 (5.4)	5.4 (5.6)	5.9 (5.1)	6.3 (5.3)
RNs	8.2 (6.5)	8.2 (6.3)	7.5 (6.8)	6.8 (6.1)	7.4 (6.3)
LPNs***	22.7 (12.9)	5.5 (4.3)	5.6 (4.2)	5.4 (4.8)	7.4 (8.3)
OT/PT/SWs*	8.6 (7.5)	6.5 (5.8)	5.9 (4.7)	3.3 (3.5)	6.2 (6.2)

SD = standard deviation

* Statistically significant difference (p <.05; ANOVA)

** Statistically significant difference (p <.01; ANOVA)

***Statistically significant difference (p <.001; ANOVA)

NOTE: The above data is national in scope. It should be noted that this grouping of data might not reflect important differences that exist by region, province, employer type, union status, etc.

The length of time HSWs and RNs were with their current employers in the public employer and private not-for-profit agencies were very similar. The length of time with their current employers for LPNs and OT/PT/SWs in the public sector was higher than for their colleagues working for private not-for-profit agencies.

As illustrated in Table 6.48, with the exception of OT/PT/SWs, there were significant differences between employer types when considering the length of time the workers had spent in the home care sector. The length of time HSWs and RNs were in the home care sector was similar among those who worked in the public sector and private not-for-profit agencies.

As illustrated in Table 6.49, the average number of years with the current employer was similar across all occupational groups with significant differences in full-time, part-time and casual positions among all occupational groups.

The proportion of years worked with the current employer was significantly higher for full-time employees for all occupational groups, except OT/PT/SWs.

Table 6.46: **Length of time working in the home care sector (years) by delivery model**

Group	PP Mean (SD)	PHS Mean (SD)	Mixed Mean (SD)	Contractual Mean (SD)	Overall Mean (SD)
HSWs	8.0 (6.3)	8.8 (6.1)	9.2 (9.0)	8.0 (5.5)	8.2 (6.0)
RNs	9.1 (6.7)	10.0 (6.9)	7.9 (6.4)	8.9 (6.2)	9.0 (6.5)
LPNs***	16.6 (10.7)	10.2 (4.6)	8.9 (7.1)	7.9 (5.9)	9.1 (7.2)
OT/PT/SWs*	8.7 (7.5)	7.5 (6.3)	7.1 (5.4)	8.5 (6.8)	8.2 (6.8)

SD = standard deviation

* Statistically significant difference (p <.05; ANOVA)

** Statistically significant difference (p <.01; ANOVA)

***Statistically significant difference (p <.001; ANOVA)

NOTE: The above data is national in scope. It should be noted that this grouping of data might not reflect important differences that exist by region, province, employer type, union status, etc.

Table 6.47: **Length of time with current employer (years) by employer type (3-way split)**

Group	Public Mean (SD)	Private NFP Mean (SD)	Private FP Mean (SD)	Overall Mean (SD)
HSW***	7.5 (5.7)	7.0 (5.9)	5.3 (4.5)	6.3 (5.3)
RNs***	8.5 (6.5)	8.9 (6.7)	4.2 (3.7)	7.4 (6.3)
LPNs***	16.6 (13.4)	6.4 (5.2)	3.8 (11.1)	7.4 (8.3)
OT/PT/SWs***	7.5 (6.6)	4.4 (7.2)	2.8 (2.9)	6.2 (6.2)

SD = standard deviation

* Statistically significant difference (p <.05; ANOVA)

** Statistically significant difference (p <.01; ANOVA)

***Statistically significant difference (p <.001; ANOVA)

NOTE: The above data is national in scope. It should be noted that this grouping of data might not reflect important differences that exist by region, province, delivery model, union status, etc.

Table 6.48: **Length of time working in the home care sector (years) by employer type (3-way split)**

Group	Public Mean (SD)	Private NFP Mean (SD)	Private FP Mean (SD)	Overall Mean (SD)
HSWs***	9.1 (6.5)	8.3 (5.9)	7.3 (5.3)	8.2 (6.0)
RNs***	9.3 (6.7)	10.2 (6.6)	6.8 (5.3)	9.0 (6.5)
LPNs***	10.3 (5.9)	8.5 (5.7)	7.4 (6.1)	9.1 (7.2)
OT/PT/SWs	8.1 (6.8)	7.3 (8.8)	8.3 (6.5)	8.2 (6.8)

SD = standard deviation

* Statistically significant difference (p <.05; ANOVA)

** Statistically significant difference (p <.01; ANOVA)

***Statistically significant difference (p <.001; ANOVA)

NOTE: The above data is national in scope. It should be noted that this grouping of data might not reflect important differences that exist by region, province, delivery model, union status, etc.

Table 6.49: **Length of time with current employer (years) by work status**

Group	Full-time Mean (SD)	Part-time Mean (SD)	Casual Mean (SD)	Overall Mean (SD)
HSWs***	7.2 (5.6)	5.9 (5.1)	4.4 (4.2)	6.2 (5.3)
RNs***	9.1 (6.9)	7.0 (6.0)	5.1 (4.9)	7.4 (6.3)
LPNs***	10.3 (9.3)	7.3 (8.6)	4.2 (4.5)	7.4 (8.3)
OT/PT/SWs***	6.7 (6.6)	6.4 (5.8)	1.9 (1.9)	6.3 (6.2)

SD = standard deviation

* Statistically significant difference between work status means (p <.05; ANOVA)

** Statistically significant difference between work status means (p <.01; ANOVA)

***Statistically significant difference between work status means (p <.001; ANOVA)

NOTE: The above data is national in scope. It should be noted that this grouping of data might not reflect important differences that exist by region, province, delivery model, union status, employer type, etc.

One main component of retention and also recruitment into home care positions is overall job satisfaction. As illustrated in Table 6.50, the overall proportions of those either "satisfied" or "very satisfied" with their current position were similar across occupational groups ranging from 73% for HSWs to 78% for RNs. There was little difference across employer type, with the exception of the RN and LPN groups who were likely to be more satisfied if working in the public sector.

As demonstrated in Table 6.51, RNs were least likely to be satisfied with their job if they were working in a private not-for-profit agency.

HSWs were least likely to be satisfied if they were working in a private for-profit agency.

As demonstrated in Table 6.52, there is no significant difference in the proportions of job satisfaction for unionized and non-unionized workers.

Table 6.50: **Proportion "satisfied" or "very satisfied" with current job by employer type (2-way split)**

Group	Public Proportion (%)	Private Proportion (%)	Overall Proportion (%)
HSWs	76	72	73
RNs***	84	74	78
LPNs***	93	73	75
OT/PT/SWs	77	74	76

* Statistically significant difference between Public and Private proportions (p <.05; chi-square statistic)

** Statistically significant difference between Public and Private proportions (p <.01; chi-square statistic)

*** Statistically significant difference between Public and Private proportions (p <.001; chi-square statistic)

NOTE: The above data is national in scope. It should be noted that this grouping of data might miss certain distinctions for which there may be important differences according to region, province, union status, delivery model, etc.

Table 6.51: **Proportion "satisfied" or "very satisfied" with current job by employer type (3-way split)**

Group	Public Mean (SD)	Private NFP Mean (SD)	Private FP Mean (SD)	Overall Mean (SD)
HSWs*	78	74	69	73
RNs***	84	71	79	78
LPNs	89	74	75	75
OT/PT/SWs	77	87	74	76

SD = standard deviation

* Statistically significant difference (p <.05; chi-square statistic)

** Statistically significant difference (p <.01; chi-square statistic)

***Statistically significant difference (p <.001; chi-square statistic)

NOTE: The above data is national in scope. It should be noted that this grouping of data might miss certain distinctions for which there may be important differences according to region, province, union status, delivery model, etc.

Table 6.52: **Proportion "satisfied" or "very satisfied" with current job by union status**

Group	Unionized Mean (SD)	Non-unionized Mean (SD)	Overall Mean (SD)
HSWs	73	72	73
RNs	78	78	78
LPNs	76	74	75
OT/PT/SWs	75	78	76

SD = standard deviation

*Statistically significant difference between unionized and non-unionized proportions (p <.05; chi-square statistic)

** Statistically significant difference between unionized and non-unionized proportions (p <.01; chi-square statistic)

*** Statistically significant difference between unionized and non-unionized proportions (p <.001; chi-square statistic)

NOTE: The above data is national in scope. It should be noted that this grouping of data might miss certain distinctions for which there may be important differences according to region, province, employer type, delivery model, etc.

As illustrated in Table 6.53, overall satisfaction tended to be lowest for the contractual model with the exception of the OT/PT/SW group, which reported the lowest levels of job satisfaction in both the mixed and contractual models.

Respondents to the survey of formal caregivers were also asked how long they intend to continue working in the home care sector. Across occupational groups, there was only a small proportion that had a definite timeframe as to when they intended to leave the sector (see Table 6.54). The proportion with a definite timeframe ranged from 15% of RNs to 20% of LPNs. Among those with definite timeframes for departure from the sector, departure was not imminent on average. The average length of time they intended to continue working in the sector ranged from 5.0 years for LPNs to 7.1 years for HSWs.

In order to estimate the amount of turnover within a one-year period, survey respondents were asked if they intended to leave their current employer within the next 12 months. As demonstrated in Table 6.55, the anticipated rate of turnover was similar across occupational groups ranging from 14% to 18%. There were significant differences between anticipated turnover rates for those working in the public sector, and those working for a private agency.

Significantly larger proportions of HSWs, RNs and LPNs working for a private agency intended to leave their current employer within the next 12 months when compared with the same groups working for the public sector. Approximately one in five RNs (22%) working for a private agency were intending to leave their current employers within the next 12 months, compared with one in 11 who worked in the public sector (9%).

Table 6.53: **Proportion "satisfied" or "very satisfied" with current job by delivery model**

Group	PP Proportion (%)	PHS Proportion (%)	Mixed Proportion (%)	Contractual Proportion (%)	Overall Proportion (%)
HSWs*	79	77	77	70	73
RNs***	84	84	84	72	78
LPNs***	94	100	82	70	75
OT/PT/SWs	79	78	73	73	76

* Statistically significant difference (p <.05; chi-square statistic)

** Statistically significant difference (p <.01; chi-square statistic)

***Statistically significant difference (p <.001; chi-square statistic)

NOTE: The above data is national in scope. It should be noted that this grouping of data might miss certain distinctions for which there may be important differences according to region, province, employer type, union status, etc.

Table 6.54: **Length of time intend to continue working in home care sector by occupational group**

Group	Indefinitely Proportion (%)	Uncertain Proportion (%)	Definite Proportion (%)
HSWs	35	49	16
RNs	39	46	15
LPNs	36	45	20
OT/PT/SWs	37	46	18

NOTE: The above data is national in scope. It should be noted that this grouping of data might miss certain distinctions for which there may be important differences according to region, province, employer type, union status, delivery model, etc.

Similar proportions of public and private sector OT/PT/SWs reported intending to leave their current employer within the next 12 months (14% and 13%, respectively).

As illustrated in Table 6.55, of those intending to leave their employers within the next 12 months, HSWs and the two nursing groups reported most frequently that their reasons for leaving were that their current wage is too low, or they had poor job security or insufficient benefits with their current employer. For the OT/PT/SW group, the two top reasons for leaving their current employment situation was that the job was too stressful or the working conditions were not good.

Of those who intended to leave their current employer within the next 12 months (14% to 18%) 40% to 50% of those (across all occupational groups) intended to find another position in the health care sector, but not in home care.

As demonstrated in Table 6.56, overall, approximately one in six respondents intended to leave their current employer within the next 12 months.

The proportion of workers who intended to leave their current employer within the next 12 months was significantly higher for non-unionized workers in the HSW and RN groups.

Table 6.55: **Proportion that intend to leave current employer within next 12 months by employer type (2-way split)**

Group	Public Proportion (%)	Private Proportion (%)	Overall Proportion (%)
HSWs***	8	18	16
RNs***	9	22	17
LPNs***	2	20	18
OT/PT/SWs	14	13	14

* Statistically significant difference between Public and Private proportions (p <.05; chi-square statistic)

** Statistically significant difference between Public and Private proportions (p <.01; chi-square statistic)

*** Statistically significant difference between Public and Private proportions (p <.001; chi-square statistic)

NOTE: The above data is national in scope. It should be noted that this grouping of data might miss certain distinctions for which there may be important differences according to region, province, union status, delivery model, etc.

Table 6.56: **Proportion that intend to leave current employer in next 12 months by union status**

Group	Unionized Proportion (%)	Non-unionized Proportion (%)	Overall Proportion (%)
HSWs**	12	19	16
RNs**	14	22	17
LPNs	15	21	18
OT/PT/SWs	14	14	14

*Statistically significant difference between unionized and non-unionized proportions (p <.05; chi-square statistic)

** Statistically significant difference between unionized and non-unionized proportions (p <.01; chi-square statistic)

*** Statistically significant difference between unionized and non-unionized proportions (p <.001; chi-square statistic)

NOTE: The above data is national in scope. It should be noted that this grouping of data might miss certain distinctions for which there may be important differences according to region, province, employer type, delivery model, etc.

As illustrated in Table 6.57, HSWs and RNs were more likely to leave their current employer if they were working under the contractual model.

LPNs were more likely to leave their current employer if they were working under the PHS model.

OT/PT/SWs were more likely to leave their current employer if they were working under the mixed model.

As illustrated in Table 6.58, the proportion of workers who intended to leave their current employer within the next 12 months was significantly higher for casual workers than part-time and full-time workers within the RN group.

In addition to the survey, the research team addressed issues of retention and recruitment with the focus group and key informant participants. The main findings from focus groups and key informant interviews were:

- Improving recruitment and the retention of staff is important for several reasons:
  - Enables care to be provided. (Without an adequate supply of providers clients will not receive services, even if funding is available.)
  - Promotes continuity of care for clients and families.
  - Reduces costs. (Training new workers has an explicit cost dimension. Agencies ideally do not want to hire inexperienced staff.)
  - Enhances and promotes a stable workplace environment, in order to provide a more rewarding career, both personally and professionally for home care workers.
  - Enables long range planning for matching the anticipated need for home care services with the appropriate supply of formal care providers.
- Turnover and instability in the workforce is in part attributable to the large proportion of casual labour. Addressing the proportion of casual labour will also address the need for continuity of the formal caregiver.
- With nursing shortages, personal support workers are replacing health care aides in nursing homes, so there are retention and recruitment problems among the HSW group.
- A major concern of unions is to reduce the extent of the casual workforce. The perceived casualization of the workforce has contributed to a perceived decline in the quality of care (with less continuity of care provider through more and more workers entering a home, many inadequately trained), and has contributed to instability for the sector. There is a perception that HSWs who are casual staff have a different mentality to part-time staff; that while part-time staff may hope for a full-time position, casual staff are more likely to treat the job as short term and move on if better opportunities arise. This, in part, both contributes to and is a result of, the instability in the sector.[14]

Table 6.57: **Proportion that intend to leave current employer in next 12 months by delivery model**

Group	PP Proportion (%)	PHS Proportion (%)	Mixed Proportion (%)	Contractual Proportion (%)	Overall Proportion (%)
HSWs***	9	9	15	20	16
RNs***	6	15	10	23	17
LPNs***	2	36	12	21	18
OT/PT/SWs**	10	14	22	13	14

* Statistically significant difference ($p < .05$; chi-square statistic)

** Statistically significant difference ($p < .01$; chi-square statistic)

***Statistically significant difference ($p < .001$; chi-square statistic)

NOTE: The above data is national in scope. It should be noted that this grouping of data might miss certain distinctions for which there may be important differences according to region, province, employer type, union status, etc.

[14] It should be noted that the perceived pattern of casualization of the workforce is not evident in the past five years of the Labour Force Survey Data. For example, the proportion of "non-permanent" employees across all occupations employed in the Home Health Services Industry (NAICS 6216) has been remained at approximately 14% since 1997 (ranging between 10% – 1999 and 15% – 2000). This rate is also relatively consistent across occupational groups.

Table 6.58: **Proportion that intend to leave current employer in next 12 months by work status**

Group	Full-time Proportion (%)	Part-time Proportion (%)	Casual Proportion (%)	Overall Proportion (%)
HSWs	14	17	19	16
RNs**	13	15	25	17
LPNs	14	18	23	18
OT/PT/SWs	14	14	18	14

*Statistically significant difference between public and private sector proportions (p <.05; chi-square statistic)

** Statistically significant difference between public and private sector proportions (p <.01; chi-square statistic)

*** Statistically significant difference between public and private sector proportions (p <.001; chi-square statistic)

NOTE: The above data is national in scope. It should be noted that this grouping of data might miss certain distinctions for which there may be important differences according to region, province, employer type, delivery model, union status, etc.

- Although in the short term, casualization of the workforce may be viewed as way to reduce costs (lower wages and no benefits), in the long term it may well increase costs as new workers always require some level of training and orientation and client care may suffer. Unions observe that a more permanent workforce would also require benefits such as family leave, which they feel, would help to reduce the turnover of staff. These are the sorts of issues being discussed at collective bargaining negotiations.
- Unions are concerned that the front-line workers are not being given greater involvement in the decision-making processes for developing recruitment and retention strategies. HSWs in the focus groups indicated that they would like more involvement. The HSWs and the union representatives who were interviewed felt that HSWs were undervalued and not recognized fully for the role they play in the lives of home care clients and family members.

Table 6.59: **Reasons for wanting to leave current employer (of those intending to leave within next 12 months) by occupational group**

	Occupation Group – Proportion % (Rank)			
Reason	**HSW**	**RN**	**LPN**	**OT/PT/SW**
Wage is too low	70 (1)	64 (1)	65 (1)	27 (3)
Poor job security	54 (3)	54 (2)	62 (2)	26 (4)
Not sufficient benefits	55 (2)	46 (3)	43 (3)	17 (6)
Job is too stressful	27 (5)	43 (4)	31 (6)	55 (1)
Working conditions not good	21 (6)	30 (6)	34 (5)	36 (2)
Want to change work status	49 (4)	39 (5)	40 (4)	19 (5)

Recruitment and retention strategies

Participants in the focus groups and key informant interviews identified a number of themes that may point to human resources strategies with respect to recruitment and retention in the sector.

- To facilitate recruitment into the home care sector, focus group participants suggested that the advantages of work in home care should be emphasized, compared to other sectors.
- Promote the flexibility of the workplace – One strategy identified for recruiting nurses and OT/PT/SWs was to promote the flexibility of the work (i.e., for nurses, Speech Language Pathologists (SLP)). The difficulty with recruiting SLPs, however, is there are many jobs in other sectors, and not enough currently available in home care. Retention is an issue as well, as it is relatively easy for SLPs to leave home care for other sectors in order to attain more work stability. The flexibility the job provides nurses should be further promoted by home care organizations. Nurses can have a degree of flexibility in terms of when they see clients and how they interact and provide the care and support required. Depending on the model of care in the province or territory where they are employed, they can have higher levels of flexibility in determining the nature of the care provided, which enhances job satisfaction. (Conversely, the model may also dictate what care can be provided,e.g., in Ontario, and flexibility is reduced.) In some places, especially in rural areas, there is considerably more flexibility and autonomy. If retention and recruitment strategy reflected the growing level of stress that comes from working in the hospital environment (where there are demands for working many hours overtime due to shortages, less flexibility, irregular hours, less autonomy and less client and family interaction), the home care sector might be more attractive to new workers.
- Emphasize the full scope of practice in home care. There are more opportunities in home care to use a wider range of skills compared to other settings. And with more and more acute care clients, the skills once considered as hospital-based are now moving beyond the hospital walls. Indeed, this was one of the cornerstone points when the Extramural program (EMP) was established in New Brunswick. Nursing jobs in the EMP are the most sought after in the province. The EMP also provides nurses with government cars to visit the clients, and so the issue of compensation for travel in many parts of the country is not a concern.
- Emphasize autonomy in the workplace. Each home setting is different and, unlike a hospital where there are peer and institutional supports at hand, each home care setting presents its own unique challenges (location, travel, quality of the home, family pressures, animals, health and safety issues).
- Promote home care as a place of employment in universities and colleges. Key informants felt that home care was not adequately promoted in universities and colleges as a career or place of employment. For example, marketing a nursing career in high schools (e.g., videos on nursing), and nurses associations working with guidance counsellors to promote nursing should include information on home care.

Quality of care issues as related to working conditions

Issues of quality of care were presented to respondents in the survey of formal caregivers as they related to specific working conditions. Respondents were asked whether they were satisfied with the quality of care they provided to consumers, whether they had sufficient time to provide appropriate levels of care, whether they had adequate supplies, adequate information about the care plan, or adequate contact with the case supervisor or case manager.

As illustrated in Table 6.60, the majority of workers in each of the occupational groups indicated that they were either “satisfied” or “very satisfied” with the quality of care they are able to provide to consumers.

- Approximately four out of five HSWs (79%) were satisfied with the quality of care they were able to provide. Similar proportions were found among the RNs (78%) and the LPNs (81%).
- Of all the occupational groups, the OT/PT/SW groups had the lowest proportion of respondents satisfied with the quality of care they provided to consumers (61%). The proportion of OT/PT/SWs

Table 6.60: **Employees who are "satisfied" or "very satisfied" with quality of care they are able to provide to consumers by employer type (2-way split)**

Group	Public Proportion (%)	Private Proportion (%)	Overall Proportion (%)
HSWs	78	79	79
RNs	76	79	78
LPNs**	93	79	81
OT/PT/SWs**	58	69	61

* Statistically significant difference between Public and Private proportions (p <.05; chi-square statistic)

** Statistically significant difference between Public and Private proportions (p <.01; chi-square statistic)

*** Statistically significant difference between Public and Private proportions (p <.001; chi-square statistic)

NOTE: The above data is national in scope. It should be noted that this grouping of data might miss certain distinctions for which there may be important differences according to region, province, union status, delivery model, etc.

satisfied was significantly lower among those who worked in the public sector (58%) when compared with the private agency employees (69%). The opposite pattern was observed in LPNs: the proportion of LPNs satisfied was significantly lower among the private agency employees (79%) when compared with those in the public sector (93%).

As illustrated in Table 6.61, many respondents to the survey of formal caregivers indicated that they occasionally or frequently did not have sufficient time to provide an appropriate level of care to consumers. The proportion ranged from 55% of LPNs to 68% of OT/PT/SWs. OT/PT/SWs, RNs and LPNs working for governments or regional health authorities were more likely to indicate that they often did not have sufficient time when compared to their colleagues in the private sector.

In the survey of formal caregivers, respondents were asked to report how frequently they experienced having inadequate supplies to be able to provide an appropriate level of care to consumers.

- As illustrated in Table 6.62, approximately one-half of OT/PT/SWs (51%) reported that they either occasionally or frequently did not have adequate supplies. Similar responses were found among the

Table 6.61: **Employees who have insufficient time to provide appropriate level of care by employer type (occasionally, frequently) (2-way split)**

Group	Public Proportion (%)	Private Proportion (%)	Overall Proportion (%)
HSWs	60 *(32,28)*	59 *(27,32)*	59 *(28,31)*
RNs*	63 *(32,31)*	55 *(31,24)*	58 *(32,26)*
LPNs***	75 *(18,57)*	52 *(27,25)*	55 *(26,29)*
OT/PT/SWs**	71 *(31,40)*	61 *(32,29)*	68 *(32,37)*

* Statistically significant difference between Public and Private proportions (p <.05; chi-square statistic)

** Statistically significant difference between Public and Private proportions (p <.01; chi-square statistic)

*** Statistically significant difference between Public and Private proportions (p <.001; chi-square statistic)

NOTE: The above data is national in scope. It should be noted that this grouping of data might miss certain distinctions for which there may be important differences according to region, province, union status, delivery model, etc.

Table 6.62: **Employees who have occasionally or frequently had inadequate supplies to provide appropriate level of care by employer type (occasionally, frequently) (2-way split)**

Group	Public Proportion (%)	Private Proportion (%)	Overall Proportion (%)
HSWs***	46 *(34,12)*	35 *(26,9)*	37 *(26,11)*
RNs**	40 *(29,11)*	49 *(34,15)*	46 *(32,14)*
LPNs***	18 *(16,2)*	46 *(36,10)*	43 *(34,9)*
OT/PT/SWs	51 *(34,17)*	50 *(37,13)*	51 *(35,16)*

* Statistically significant difference between Public and Private proportions (p <.05; chi-square statistic)

** Statistically significant difference between Public and Private proportions (p <.01; chi-square statistic)

*** Statistically significant difference between Public and Private proportions (p <.001; chi-square statistic)

NOTE: The above data is national in scope. It should be noted that this grouping of data might miss certain distinctions for which there may be important differences according to region, province, union status, delivery model, etc.

RNs (46%) and LPNs (43%). RNs and LPNs working for a private agency indicated more frequently than their colleagues in the public sector that occasionally or frequently did not have adequate supplies.

- Among the HSWs, approximately one in three (37%) reported that they occasionally or frequently did not have sufficient supplies to provide an appropriate level of care to consumers. A significantly higher proportion of these HSWs worked for a public employer.

As illustrated in Table 6.63, similar proportions of the occupational groups reported that they either occasionally or frequently had inadequate information about a consumer's care plan. The proportions ranged from 36% of LPNs and HSWs to 45% of OT/PT/SWs. There were no significant differences when employer types were compared.

Slightly more than one-quarter of the respondents in each of the occupational groups reported that they had inadequate contact with the supervisor or case manager on an occasional or frequent basis. There were no significant differences in frequencies between the different employer types.

Table 6.63: **Employees who occasionally or frequently had inadequate information about the care plan by occupational group**

Group	Overall Proportion (%)
HSW	36 *(25,11)*
RNs	43 *(32,11)*
LPNs	36 *(29,7)*
OT/PT/SWs	45 *(33,12)*

NOTE: The above data is national in scope. It should be noted that this grouping of data might miss certain distinctions for which there may be important differences according to region, province, union status, delivery model, etc.

Table 6.64: **Employees who occasionally or frequently had inadequate contact with supervisor or case manager by occupational group**

Group	Overall Proportion (%)
HSW	26 *(16,10)*
RNs	28 *(19,9)*
LPNs	28 *(19,9)*
OT/PT/SWs	29 *(20,9)*

NOTE: The above data is national in scope. It should be noted that this grouping of data might miss certain distinctions for which there may be important differences according to region, province, union status, delivery model, etc.

Career ladders and mobility

Information about career ladders and career mobility was collected from the survey of formal caregivers as well as from the focus groups and key informant interviews.

In the survey of formal caregivers, respondents were asked their level of satisfaction in a number of areas including overall job satisfaction, satisfaction with pay, and satisfaction with opportunities for advancement in the home care sector. Of these three areas, 'opportunities for advancement' was where the proportion of employees satisfied was lowest. As illustrated in Table 6.65, the main findings were:

- Only one-third (32%) of HSWs were either satisfied or very satisfied with their opportunities for advancement in the home care sector.
- Approximately one-quarter of LPNs (23%) and RNs (28%) were either satisfied or very satisfied with their opportunities for advancement. There were significantly higher proportions of the RNs working in the public sector satisfied than those working in a private agency.
- Among the OT/PT/SW group, approximately one-quarter (22%) was satisfied with opportunities for advancement in the sector. There were no differences by employer type for the OT/PT/SW group.

One aspect of career development is identification with a profession or para-profession, which can be indicated by membership in professional or para-professional associations.

- As demonstrated in Table 6.66, the rate of membership was substantially higher among the professional groups (RNs, LPNs, and OT/PT/SWs) than the para-professional group (HSWs).
- Among the nursing groups, the proportion that reported being members of a professional association was significantly higher among those working in the public sector, compared with those working for a private agency. In contrast, the proportion of OT/PT/SWs who reported being professional association members was significantly higher among those working for a private agency compared to their colleagues working in the public sector.

One aspect of developing a career ladder involves determining to what extent levels of responsibilities can increase within a given profession. For the survey of formal caregivers, those who had worked with their current employer for at least three years (approximately 64% of the total sample) were asked whether they had assumed increased responsibilities over the past three years. As illustrated in Table 6.67, approximately one-half of home support workers (44%) reported an increase in responsibilities during this

Table 6.65: **Employees who are "satisfied" or "very satisfied" with opportunities for advancement in home care sector by employer type (2-way split)**

Group	Public Proportion (%)	Private Proportion (%)	Overall Proportion (%)
HSWs	29	33	32
RNs*	33	26	28
LPNs	24	23	23
OT/PT/SWs	22	23	22

* Statistically significant difference between Public and Private proportions ($p < .05$; chi-square statistic)

** Statistically significant difference between Public and Private proportions ($p < .01$; chi-square statistic)

*** Statistically significant difference between Public and Private proportions ($p < .001$; chi-square statistic)

NOTE: The above data is national in scope. It should be noted that this grouping of data might miss certain distinctions for which there may be important differences according to region, province, union status, delivery model, etc.

Table 6.66: **Membership in professional or para-professional association by employer type (2-way split)**

Group	Public Proportion (%)	Private Proportion (%)	Overall Proportion (%)
HSW	26	31	30
RNs***	95	69	78
LPNs***	99	67	71
OT/PT/SWs***	86	98	90

* Statistically significant difference between Public and Private proportions (p <.05; chi-square statistic)

** Statistically significant difference between Public and Private proportions (p <.01; chi-square statistic)

*** Statistically significant difference between Public and Private proportions (p <.001; chi-square statistic)

NOTE: The above data is national in scope. It should be noted that this grouping of data might miss certain distinctions for which there may be important differences according to region, province, union status, delivery model, etc.

time. Slightly higher proportions within each of the professional groups also experienced increased responsibilities (58%-64%).

Findings from the focus groups and key informant interviews on the issue of career ladders and career mobility included the following:

- Ongoing training and education could be the catalyst for development of a career path for home support workers, who could then train for and move into LPN roles and subsequently RN roles (with higher levels of pay). Comments included that this idea:
  - Would be realistic with the appropriate incentive structure and promotion of the sector;
  - Can happen on an individual basis, but from a strategic sectoral approach it hasn't yet; and,
  - Needs to have incentives in place to encourage this. Ultimately will fall to the government to fund because a) it is larger than the employers and b) the employers say they cannot afford this because margins, if any, are so minimal already when compensating workers.

Table 6.67: **Proportion reporting increase in responsibilities over past 3 years by employer type (2-way split)**

Group	Public Proportion (%)	Private Proportion (%)	Overall Proportion (%)
HSW*	52	42	44
RNs	66	63	64
LPNs***	83	58	62
OT/PT/SWs	59	56	58

* Statistically significant difference between Public and Private proportions (p <.05; chi-square statistic)

** Statistically significant difference between Public and Private proportions (p <.01; chi-square statistic)

*** Statistically significant difference between Public and Private proportions (p <.001; chi-square statistic)

NOTE: The above data is national in scope. It should be noted that this grouping of data might miss certain distinctions for which there may be important differences according to region, province, union status, delivery model, etc.

- There is an under-utilization of HSW skills. In PEI, for example, the PEI Union of Public Sector Employees observes that HSWs are able to do tasks that RNs are currently doing, and at a lower cost. This reflects a waste of skilled training for some HSWs (who are licensed nursing assistants or were formerly residential care workers).

Quality of life issues

The primary quality of life issues addressed in the survey of formal caregivers were: work-related stress; work-related injury; shift work; amount of time spent travelling; number of hours worked; and experiencing difficulties while providing care, such as verbal and physical abuse. As many of these areas have been covered in earlier sections of the report, we concentrate primarily on work-related stress and injuries in this section.

In the survey of formal caregivers, all respondents were asked to indicate if they had lost time from work as a result of a work-related injury or illness in the past 12 months. The main findings were as follows:

- Approximately one in eight HSWs (13%) reported that they had missed work in the past 12 months as a result of a work-related injury with the average length of lost time at 1.3 months (or 26 days). LPNs reported similar rates of missing work (15%) with similar lengths of lost time (1.9 months on average; or 38 days).
- Approximately one in 10 RNs indicated that they lost time in the past year due to a work-related injury or illness. The average amount of time lost from work was 1.5 months (or 30 days).
- Of OT/PT/SWs, 6 % reported that they lost time from work as a result of a work-related injury or illness. The average reported time lost was 1.9 months (or 38 days).

Respondents were asked to report as well whether they had lost time due to work-related stress in the past 12 months. As illustrated in Table 6.68, when compared with work-related injuries, similar proportions of respondents indicated missed time due to work-related stress (7% – HSWs to 15% – LPNs). Average amounts of time lost at work ranged from approximately 0.7 months to 1.2 months (or 14 to 24 days).

Findings from focus groups and key informants regarding quality of life issues included a focus on stress and frustrations in attempting to deliver quality care in the current home care environment. Comments included the following.

- Workers are experiencing higher levels of stress because of increased complexity of cases.
- There are increased levels of stress for case managers. Morale is very low for case managers (CMs) in Ontario and British Columbia due to lay-offs and no re-hiring for attrition in some places. The perception is that many CMs would like to leave their jobs.
- The professional groups find it difficult to match the needs of clients with the resources in the community, which creates increased levels of stress.

Table 6.68: **Lost time from work (months) due to work-related injury or illness within past 12-months by occupational group**

Group	Overall Proportion % (M,SD)
HSWs	13 (M=1.3, SD=1.8)
RNs	10 (M=1.5, SD=2.6)
LPNs	15 (M=1.9, SD=2.2)
OT/PT/SWs	6 (M=1.9, SD=2.5)

NOTE: The above data is national in scope. It should be noted that this grouping of data might miss certain distinctions for which there may be important differences according to region, province, union status, delivery model, etc.

Table 6.69: **Lost time from work (months) due to work-related stress within past 12-months by occupational group**

Group	Overall Proportion % (M,SD)
Home Support	7 (M=0.8, SD=0.2)
RNs	9 (M=0.7, SD=0.1)
LPNs	15 (M=1.2, SD=0.2)
OT/PT/SWs	10 (M=0.9, SD=1.7)

NOTE: The above data is national in scope. It should be noted that this grouping of data might miss certain distinctions for which there may be important differences according to region, province, union status, delivery model, etc.

- There is a lack of service integration among sectors, and limited perspective on the service system.
- The situation is perceived to be worse in hospitals where there are staff shortages and workers are forced to do overtime.
- In Quebec, professionals in the CLSCs commented that in the community, despite an overwhelming and frustrating requirement for paperwork, there is richness in the team approach and more autonomy for workers in the community. 'Working together as teams is great, it's the limitation of what we can provide that is frustrating.'
- Increased levels of stress among workers because of:
  - Gaps in service resulting in decreased quality;
  - Over-emphasis on acute care substitution, and rehabilitation and support services in the community are disappearing as a result; and,
  - Insufficient training.

Improving working conditions

Formal caregivers were asked to respond on how helpful various activities would be in helping improve the working conditions in the home care sector. Respondents were asked to indicate whether each of the activities were 1 – *not helpful*, 2 – *slightly helpful*, 3 – *somewhat helpful*, 4 – *very helpful*, or 5 – *extremely helpful*. The four tables below include the average responses (mean) according to each of the occupational groups.

Table 6.70: **Improving working conditions in the home care sector – HSWs**

Item	Mean (SD)
Providing compensation for travel time	4.4 (1.0)
Promoting more respect for home care workers in today's society	4.4 (0.9)
Providing ongoing or continuing education and professional development	4.2 (0.9)
Providing better wages	4.1 (1.0)
Improving benefits	4.1 (1.0)
Providing better equipment and supplies to assist in the provision of home care	3.9 (1.1)
Identifying ways to advance in the home care field	3.9 (1.0)
Providing staff with greater decision-making role in providing care	3.9 (1.0)
Providing regularly scheduled preparation time (not overtime)	3.6 (1.2)
Providing regularly scheduled time to consult with family members and informal caregivers	3.5 (1.1)
Providing regular breaks	3.4 (1.3)
Reducing the caseloads for workers	2.8 (1.4)
Reducing the time required for administrative tasks	2.7 (1.2)

SD = standard deviation

Respondents were asked to indicate whether each of the activities were 1 – not helpful, 2 – slightly helpful, 3 – somewhat helpful, 4 – very helpful, or 5 – extremely helpful. Number reported in table is mean rating from 1 to 5.

NOTE: The above data is national in scope. It should be noted that this grouping of data might miss certain distinctions for which there may be important differences according to region, province, union status, delivery model, etc.

Table 6.71: **Improving working conditions in the home care sector – RNs**

Item	Mean (SD)
Providing ongoing or continuing education and professional development	4.3 (0.8)
Providing compensation for travel time	4.1 (1.1)
Promoting more respect for home care workers in today's society	4.1 (1.0)
Providing better wages	3.9 (1.1)
Improving benefits	3.9 (1.1)
Providing regularly scheduled preparation time (not overtime)	3.9 (1.0)
Providing better equipment and supplies to assist in the provision of home care	3.9 (1.0)
Identifying ways to advance in the home care field	3.7 (1.1)
Providing staff with greater decision-making role in providing care	3.7 (1.0)
Reducing the caseloads for workers	3.5 (1.2)
Reducing the time required for administrative tasks	3.5 (1.1)
Providing regularly scheduled time to consult with family members and informal caregivers	3.5 (1.1)
Providing regular breaks	3.4 (1.2)

SD = standard deviation

Respondents were asked to indicate whether each of the activities were 1 – not helpful, 2 – slightly helpful, 3 – somewhat helpful, 4 – very helpful, or 5 – extremely helpful. Number reported in table is mean rating from 1 to 5.

NOTE: The above data is national in scope. It should be noted that this grouping of data might miss certain distinctions for which there may be important differences according to region, province, union status, delivery model, etc.

Table 6.72: **Improving working conditions in the home care sector – LPNs**

Item	Mean (SD)
Providing compensation for travel time	4.4 (0.9)
Providing ongoing or continuing education and professional development	4.4 (0.8)
Promoting more respect for home care workers in today's society	4.3 (0.9)
Providing better wages	4.2 (1.0)
Improving benefits	4.1 (1.0)
Providing better equipment and supplies to assist in the provision of home care	4.0 (1.1)
Providing regularly scheduled preparation time (not overtime)	4.0 (0.9)
Identifying ways to advance in the home care field	3.9 (1.0)
Providing staff with greater decision-making role in providing care	3.8 (1.0)
Providing regularly scheduled time to consult with family members and informal caregivers	3.7 (1.1)
Providing regular breaks	3.4 (1.2)
Reducing the caseloads for workers	3.2 (1.3)
Reducing the time required for administrative tasks	3.2 (1.2)

SD = standard deviation

Respondents were asked to indicate whether each of the activities were 1 – not helpful, 2 – slightly helpful, 3 – somewhat helpful, 4 – very helpful, or 5 – extremely helpful. Number reported in table is mean rating from 1 to 5.

NOTE: The above data is national in scope. It should be noted that this grouping of data might miss certain distinctions for which there may be important differences according to region, province, union status, delivery model, etc.

Table 6.73: **Improving Working Conditions in the Home Care Sector – OT/PT/SWs**

Item	Mean (SD)
Providing ongoing or continuing education and professional development	4.4 (0.7)
Providing compensation for travel time	4.0 (1.2)
Providing better equipment and supplies to assist in the provision of home care	4.0 (1.0)
Reducing the caseloads for workers	3.9 (1.1)
Reducing the time required for administrative tasks	3.9 (1.0)
Promoting more respect for home care workers in today's society	3.9 (1.0)
Providing staff with greater decision-making role in providing care	3.7 (1.0)
Improving benefits	3.6 (1.1)
Identifying ways to advance in the home care field	3.6 (1.1)
Providing regularly scheduled preparation time (not overtime)	3.5 (1.2)
Providing better wages	3.5 (1.1)
Providing regularly scheduled time to consult with family members and informal caregivers	3.4 (1.2)
Providing regular breaks	2.9 (1.2)

SD = standard deviation

Respondents were asked to indicate whether each of the activities were 1 – not helpful, 2 – slightly helpful, 3 – somewhat helpful, 4 – very helpful, or 5 – extremely helpful. Number reported in table is mean rating from 1 to 5.

NOTE: The above data is national in scope. It should be noted that this grouping of data might miss certain distinctions for which there may be important differences according to region, province, union status, delivery model, etc.

SKILLS AND SUPPORT CHALLENGES

Information and data was collected from various sources to determine the specific challenges that currently exist concerning skills and support in the home care sector. Sources included a survey of formal caregivers, information collected through the focus groups and key informant interviews and a survey of colleges and universities. In this section, we initially focus on training needs and requirements for workers in the home care sector. This is followed by information on the current availability of training and supports.

Training needs and requirements

Across the occupational groups, there was a relatively large proportion of respondents to the survey of formal caregivers who indicated that they would like to receive more opportunities for training. As illustrated in Table 7.1, the proportions that indicated they would like additional opportunities ranged from 76% of the HSW group to 83% of RNs. A significantly higher proportion of HSWs, RNs and OT/PT/SWs working for the public sector indicated they wanted additional training opportunities, in comparison with those working for a private agency. Conversely, there was a significantly higher proportion of LPNs working for private agencies that would like to receive more training opportunities compared to their colleagues working in the public sector.

In the survey of formal caregivers, those respondents who indicated that they were interested in having additional training opportunities were also asked to identify which types of training they would prefer. As illustrated in Table 7.2, the most frequently cited area for additional training was working with specific care needs. This training need was identified as the most frequent choice across all occupational groups. For LPNs and OT/PT/SWs, the second most frequently reported training need was in the area of assessment and treatment planning, while for RNs the second most frequent choice was the use of technology in providing home care services. The second most frequently stated area in the HSW group was working on a multi-discipline home care team. For the LPNs, OT/PT/SWs and HSW groups, the third most frequently cited training need was the use of technology in home care. For the RNs, the third most frequently reported training need was in the area of assessment and treatment planning.

The focus groups and key informant interviews also produced information on the training needs and

Table 7.1: **Proportion who would like to receive more training opportunities by employer type (2-way split)**

Group	Public Proportion (%)	Private Proportion (%)	Overall Proportion (%)
HSWs*	82	75	76
RNs***	88	80	83
LPNs***	39	84	78
OT/PT/SWs***	84	66	79

* Statistically significant difference between Public and Private proportions (p <.05; chi-square statistic)

** Statistically significant difference between Public and Private proportions (p <.01; chi-square statistic)

*** Statistically significant difference between Public and Private proportions (p <.001; chi-square statistic)

NOTE: The above data is national in scope. It should be noted that this grouping of data might miss certain distinctions for which there may be important differences according to region, province, union status, delivery model, etc.

Table 7.2: **Most frequently cited areas for additional training by occupational group**

Group	Most frequent	Second most frequent	Third most frequent
HSWs	Working with specific care needs (66%)	Working on multi-discipline home care team (49%)	Use of tech in providing home care (44%)
RNs	Working with specific care needs (62%)	Use of tech in providing home care (51%)	Assessment and treatment planning (49%)
LPNs	Working with specific care needs (57%)	Assessment and treatment planning (51%)	Use of tech in providing home care (43%)
OT/PT/SWs	Working with specific care needs (71%)	Assessment and treatment planning (43%)	Use of tech in providing home care (38%)

NOTE: The above data is national in scope. It should be noted that this grouping of data might miss certain distinctions for which there may be important differences according to region, province, union status, delivery model, etc.

requirements for workers in the home care sector. The main findings from these sources included the following.

- It is difficult to anticipate training needs in the sector because there is not yet a clear sense of direction for the home care sector.
- In the focus groups with consumers and providers, similar information was provided on the desirable personal qualities of home care workers. These included:
  - Compassionate, helpful
  - Physically capable (e.g., lifting)
  - Co-operative, willing
  - Trustworthy, reliable, dependable
  - Flexible
  - Not mothering
  - Uses common sense with a problem-solving approach
  - Enjoys their job
  - Outgoing, friendly, willing to "sit down and talk with you for 15-20 minutes before they do anything."
- There is a need for specialized training to address higher acuity consumers and the use of specialized technologies. Without this training there is the potential for stress and burnout, leading to high turnover rates. An example that was provided was the technological expertise needed to assist with ventilators.
- Some groups and key informants indicated that there is a need for training in early identification of illness, thus allowing them to play a larger role in health monitoring than is currently the case.
- Similar to results from the survey of formal caregivers, the focus groups and key informants identified the need to provide training on specific populations such as severe mental illnesses, children's needs, or people living with HIV/AIDS.
- Some participants identified the need for increased training in the ergonomics for lifting.
- Counselling experience was also identified as a training need.
- Some participants in the focus groups and key informant interviews reported that legislation requiring home support workers to have obtained a certain level of education would assist in developing standards of care and raising the profile and expectations of the workers.
- According to the focus groups and key informants, there is an increased delegation of tasks from RNs to LPNs to HSWs – e.g., suctioning, tube-feeding, catheterization, giving medications, and applying elastic stockings. If this level and frequency of delegation continues, there will be an increased need for more specialized skills among HSWs.

Availability of training opportunities and supports

Respondents to the formal caregiver survey were asked if they had received any training within the past 24 months. As illustrated in Table 7.3, approximately three-quarters of workers within each occupational group reported receiving training during this period.

Table 7.3: **Proportion who received training in past 24 months by occupational group**

Group	Overall Proportion (%)
HSWs	74
RNs	78
LPNs	76
OT/PT/SWs	74

NOTE: The above data is national in scope. It should be noted that this grouping of data might miss certain distinctions for which there may be important differences according to region, province, union status, delivery model, etc.

As illustrated in Table 7.4, the most frequently reported types of recent training were somewhat dependent on the occupational group.

- Among HSWs who reported training in past 24 months, the most frequently reported types of training included first-aid (71%), specific care needs for special populations (69%), and working on a multi-disciplinary team (48%).
- RNs reported most frequently having training in specific care needs for special populations (69%), assessment and treatment planning (57%), and the use of technology (55%).
- LPNs most frequently reported having had training in specific care needs for special populations (58%), first-aid (56%), and assessment and treatment planning (49%).
- OT/PT/SWs reported that they received training in specific care needs for special populations (66%), and in assessment and treatment planning (58%).

According to respondents to the survey of formal caregivers, there were similar patterns to the perceived barriers to training across occupational groups. As demonstrated in Table 7.5, the most frequently

Table 7.4: **Type of training received training in past 24 months by occupational group**

	% within Occupational Group			
Type of Training	**HSWs**	**RNs**	**LPNs**	**OT/PT/SWs**
Specific care needs for special populations	69	69	58	66
First aid	71	55	56	37
Working on a multi-disciplinary team	48	40	31	39
Self-managed care	24	15	19	7
Use of technology	37	55	42	23
Computers	17	27	14	44
Assessment and treatment planning	24	57	49	58
Working with informal caregivers and volunteers	16	16	9	16
Working with children and youth	11	8	18	15

NOTE: The above data is national in scope. It should be noted that this grouping of data might miss certain distinctions for which there may be important differences according to region, province, union status, delivery model, etc.

Table 7.5: **Perceived barriers for additional training (percentage endorsing)**

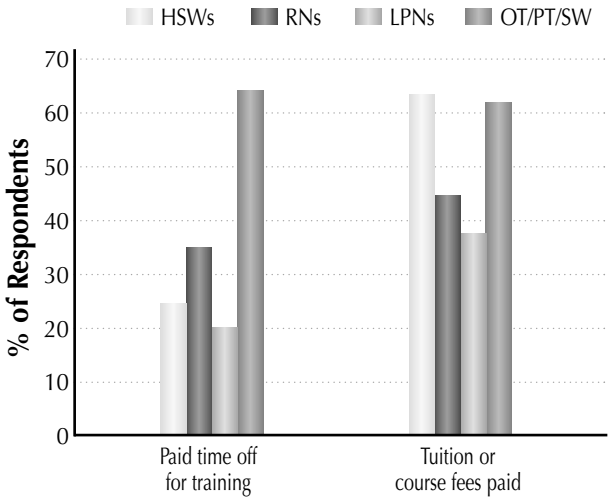
Group	Training is too expensive	No time for training	Training is not available
HSWs	48	39	24
RNs	61	59	29
LPNs	60	50	25
OT/PT/SWs	71	70	33

NOTE: The above data is national in scope. It should be noted that this grouping of data might miss certain distinctions for which there may be important differences according to region, province, union status, delivery model, etc.

endorsed perceived barrier to training in each of the occupational groups was that training was too expensive (48% of HSWs to 71% of OT/PT/SWs). Similar proportions also indicated that there was not enough time for training (39% of HSWs to 70% of OT/PT/SWs). Finally, a smaller proportion reported that training was not available (24% of HSWs to 33% of OT/PT/SWs).

The respondents to the survey of formal caregivers were also asked to indicate if they received paid time off for training, and whether they received at least partial payment from their employer for the tuition or course fees paid for training. Figure 7.1 illustrates that approximately one-fifth of LPNs (21%), one-quarter of HSWs (25%), and one-third of RNs (35%) reported receiving time off for training in comparison with nearly two-thirds of OT/PT/SWs (64%). Similar proportions of HSWs (63%) and OT/PT/SWs (62%) reported that tuition or course fees were at least partially paid by their employers. Approximately 45% of RNs received at least partial payment for tuition or course fees, while 37% of LPNs reported paid tuition or course fees.

Figure 7.1: **Employer contributions to training by occupational group**



Findings from the survey of colleges and universities with regard to availability of formal training opportunities were divided according to information received about delivery methods, the content of programs that have some home care content, and student characteristics:

Delivery Methods

- Among colleges, approximately one-quarter (23%) of programs were offered part-time in addition to full-time.
- Among universities, one-half of programs (50%) were offered part-time in addition to full-time.
- Colleges reported that 12% of their programs were offered via distance education delivery methods.
- Universities reported that 17% of their programs were offered via distance education delivery methods.

Program Home Care Content

- Colleges reported that 15% of the programs that had some home care content had their main program focus on home care. None of the universities indicated that they had programs that had a main focus on home care.
- Approximately one-quarter (27%) of college programs that have some home care content, have courses dedicated to home care. Universities report 11% of their programs that have some home care content have home care courses.
- 45% of college programs that have some level of home care content have individual courses with some home care content. Universities reported that 65% of their programs had courses with some home care content.
- Slightly over one-half of college programs (55%) offered practica opportunities in home care. Approximately three-quarters of university programs (78%) had practica opportunities in home care.

Student Characteristics

- Colleges reported that the proportion of female students was on average 91% in programs that had some home care content.
- Universities reported that the proportion of female students was on average 87% in programs that has some home care content.
- 42% of universities reported that the proportion of women in programs with some home care content had increased in the past five years. They reported on average that the proportion had increased by three percentage points. Approximately 13% of university respondents reported that they had noticed a decrease in the proportion of female students within the past five years. They reported on average that the proportion had decreased by approximately nine percentage points.
- 28% of colleges reported that the proportion of female students had increased in the past five years in programs with some home care content. The average reported increase was three percentage points. Those who indicated that the proportion decreased (21%) reported that the decrease was approximately 12 percentage points within the past five years.
- The age distribution differed according to type of institution. Higher proportions of students were 30 years old or younger among the university students (80%) in comparison with colleges (59%).

Focus groups and key informant interviews provided information on training availability, barriers to training, formal training issues, and issues on ongoing continuing education opportunities. These included the following points.

- Unions are insisting that more training should be provided to HSWs to enable them to do their jobs more effectively. Of interest is the development of national standards for training of HSWs, and financial assistance for workers for training. Regardless of whether this would be a national or provincial program, it is clear that unions feel workers should not have to sustain the costs for receiving such training.
- Nurses' unions and associations observed that the budgets for education and training are typically the first to be hit when there are budgetary concerns. Yet these contribute to job satisfaction and are critical for providing care in the sector given the higher acuity levels of consumers. Nurses' unions and associations also reasserted the need to address training issues as an integral part of developing human resources in the sector, but couched these observations within the context of developing an integrated human resource strategy more generally for the health care system.
- Some participants identified that the cost of training opportunities is often too high for HSWs.
- According to participants, the amount of training and education cannot be improved without either an infusion of funding, or a redirection of funding away for consumer services directly to training of formal caregivers. The latter would cause a reduction of services. The only other option is to require workers to pay for their own training.
- Some participants cited that there are potential ongoing learning opportunities available with co-workers; however, to do this type of training without funding support to increase the number of staff and reduce consumer caseload, would either lead to workers training on their own time or fewer services to consumers.
- Incentives identified by participants included pay raises to reflect higher levels of education and training, increased number of hours if available and desired, and paid leave to attend training programs.

- Participants report that the home care sector needs to create or enhance working environments that encourage 'life long learning'.
- Some participants indicated that the nursing schools need to be better informed about what home care agencies do. This could include recruitment approaches that incorporate the positive aspects of the job in the home such as autonomy, flexible hours, and being able to use a full scope of practice.
- Employers in focus groups and interviews reported that when HSWs become better trained, they often leave the home care sector. With training that focuses on the personal care needs of consumers, HSWs leave the sector and move into the acute care hospitals and long-term care facilities. The attraction is higher pay, stable, ongoing employment, regular working conditions, no travel and availability of peer support.
- According to the interviews with provincial Ministries of Education, trends and issues in formal education include the following.
  - There is a recognition of the relationship between the changing home care sector and the role that the education sector plays.
  - It is still challenging to develop accurate models for ensuring capacity in the sector.
  - This challenge is further compounded by the instability in the sector and the changing demand for workers (both professional and para-professionals).
  - What complicates the "frail" modeling of projected need even further is that it is difficult to determine what the needs for positions will be when the private sector is factored in. Although districts may give some sense of projected need for publicly funded home care services, there is no benchmark of the needs of the private sector.
- There are many variables to consider in the planning process for training opportunities in the sector. Resources are allocated on the basis of forecasted needs. For example, in Saskatchewan these needs are determined through a series of steps from the government to the colleges within the various health districts. The health districts notify and justify to the colleges their anticipated needs. These are then incorporated into the colleges' forecasted needs and communicated to the government. If there is demand for additional spaces, instead of requesting more funds from the government a college will typically go to the private sources for the funding required (e.g., the specific home care agency).
- Participants in the focus groups and key informant interviews reported the value of on-the-job training that adds an experiential element to the learning.
- Some participants indicated that when and where training is of a general nature, it should be shared and accessed by all provider groups (e.g., general training regarding dementia, mental illness, seniors mental health, training in cultural differences and so on).

Among participants, there was a request for more web-based education programs. This would provide agencies and workers flexibility with regard to accessing learning opportunities. In particular, this would provide more opportunities for training and education for workers in rural and remote areas. (e.g., telehealth continuing nursing education program). Suggestions were also made for e-learning, distance education, self-directed learning, access to Web conferencing, and access to online courses offered through correspondence either through a university or a college. To follow-up on these suggestions, some participants reported that home care workers need greater access to computers so they can access web-based education programs.

- Some participants discussed the importance in coordinating training. For example, in rural areas, various health sectors could coordinate their training to offer courses for HSWs and LPNs. This may reduce the costs for individuals and agencies.
- In the focus groups and key informant interviews, some participants reported that there is a need to utilize the new knowledge from research. Evidence-based practice is not encouraged enough. Nurses need to know how to understand research, to share the information with others and use it in practice within the home care context.
- Identified training opportunities that were offered by employers and associations mostly related to the changing care needs or specific needs of certain population groups such as severe mental illness, HIV/AIDS, children, etc.
- Associations and unions do less "clinically-focused" training and concentrate more on workplace development and health and safety issues.
- Professional associations, because they have more than just home care representation, do professional development including ethics and decision-making, how to set rates (e.g., if private).