



## REPORT

# Improving the health of older aged care workers

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As part of the [Working Well, Working Wisely study](#), researchers from the Brotherhood of St Laurence and the University of Melbourne investigated the health concerns of older workers in the aged care sector. We focused on ‘pink-collar’ workers, that is, care-related roles requiring less than a bachelor’s degree qualification.

## Key points

Our findings suggest that the health of older aged care workers can be improved—and in some instances, working lives extended—through three measures:

- mandatory minimum hours of care per client in residential facilities
- employment conditions to improve ‘time and income capability’
- a professionalisation agenda with three elements:
  - professional registration to enhance autonomy and care quality
  - clinical supervision to address emotional depletion
  - training and supervision for specialist roles.

Our findings point to a lack of balance between the interests of service providers and the needs and entitlements of people who give and receive care. This imbalance has had unintended social and economic consequences, including compromises in the quality of care

and in the longevity of the workforce. Other jurisdictions such as New Zealand and Sweden have made different choices that have resulted in preferable conditions for workers and people in care.

## Background

This study is situated at the confluence of three policy concerns.

The first arises from a push to extend the working lives and the participation of older adults in the labour force. Policy makers have argued that this is a justified response to the cost of supporting an ageing population (Department of the Treasury 2015).

The second concern is with the effects on workers when aged care is conceptualised as a marketplace in which consumers make informed decisions about the care they wish to receive.

Our third concern is with the crisis in the aged care workforce. Maintaining and developing this workforce is critical, and requires a focus on job quality and employment conditions. The rollout of NDIS (the National Disability Insurance Scheme) is likely to drive increased competition for personal care workers (Isherwood et al. 2018; Tunc 2017). Overall, employment in the health care and social assistance sector is forecast to grow by a further 16.1 per cent over the next five years (Department of Jobs and Small Business 2019).



## Working longer is hard for aged care workers

While longer working lives might be healthy and viable for some, health deteriorates more quickly for people on lower strata of economic and social hierarchies (Curryer, Gray & Byles 2018). Historically treated as women's work, care work is often regarded as low-skilled and performed for altruistic reasons (Macdonald, Bentham & Malone 2018) so pay and conditions tend to be poor (Hayes 2017).

Involuntary and earlier retirement tends to be more common among women, informal carers and (perhaps surprisingly) those with lower retirement savings and household incomes (Irving et al. 2017). Older workers may suffer from compounding negative health effects if they are forced to continue to work because they have little alternative (McGann et al. 2015).

Women outnumber men in the Australian aged care workforce by nine to one (Mavromaras et al. 2017). Twenty-seven per cent of the residential workforce and 39 per cent of the home care workforce are aged at least 55 years—older than comparable feminised industries (Isherwood et al. 2018). Most pink-collar workers in aged care are employed as personal care assistants (PCAs) in residential aged care or as home care workers (HCWs). These roles tend to involve physically demanding work.

Most older aged care workers have informal care responsibilities which limit the hours they can work and the time they have for self-care (Mavromaras et al. 2017). Strategies to support older workers to stay in the industry might help them avoid involuntary retirement, as well as shoring up workforce numbers.

## Employment conditions are affected by marketisation and demand for flexibility

A sustained shift towards a governing logic of consumers and markets has seen employment conditions eroded within aged care.

In home-based aged care, elements of consumer-directed care have been introduced and the resulting variable demand has created instability and uncertainty, some of which has been transferred from employers to workers. Work in private homes is often fragmented, with short periods of work interspersed with periods of unpaid waiting or travel (Macdonald, Bentham & Malone 2018; Mavromaras et al. 2017). These dynamics have been linked to widespread worker underpayment (Charlesworth & Malone 2017).

In residential aged care, the increase of private operators has contributed to a cultural change in the sector, with the introduction of profit-oriented management. This has led to

some providers gaming the level of care criteria to increase the subsidies collected, and the government has responded by introducing savings measures in the 2012–13 and 2016–17 budgets. As a result, aged care workers have endured waves of austerity measures. The proportion of sector funding dedicated to wages has diminished (Applied Aged Care Solutions 2017). Workers express concerns about the future sustainability of their employers and their own employment (Mavromaras et al. 2017).

## Job quality is linked to care quality

Despite the many compromises in their employment conditions, workers are frequently reported as saying that caring for older people is meaningful and important to them. Some aged care workers state that money is not their primary motivation for work: 'instead the love of helping others and making a difference were their primary motivators' (George, Hale & Angelo 2016, p. 1107). Standing (2001) has argued that 'care work is intrinsically a social relationship, in which moral sentiments such as affection, altruism, mutual respect and dignity and deeply meaningful reciprocities come into play' (p. 21). However, qualitative studies have shown that short staffing and restricted autonomy often compromise the intrinsic rewards of this work (Banerjee et al. 2015; Evesson & Oxenbridge 2017).

## The research

This study forms one component of a larger Australian Research Council Linkage Project entitled *Working Well, Working Wisely*, which contributes to an understanding of the impacts of policy changes related to the employment of older workers and their workplaces. This report relates to one cohort (pink-collar workers) in Study 2.

This study was designed and data were gathered during 2018. We step out our methodology in the sections below.

### Aims

In designing our study of pink-collar workers, we chose to focus on the aged care sector due to our interest in progressing systemic change in that industry. We are also interested in the gendered nature of care work, which has implications for the Brotherhood of St Laurence as an aged care and NDIS provider, as well as for the nation. This study contributes to our research about gender, age and economic security, and the need to reconcile the rights and needs of those who rely on and work in aged care services.

Our study was animated by two research questions:

- What job characteristics are significant for the health of older workers in the aged care industry?
- What are the policy options to improve job quality?

### Sample and recruitment

Our sampling frame was aged care workers aged 50+ years in positions requiring less than a bachelor's degree qualification. After we advertised the study in trade publications, 92 potential participants completed an online

screening survey. From this pool, we recruited 20 participants (17 women and 3 men) to approximately reflect the characteristics of the older home care and residential aged care workforce (Irving et al. 2017; Mavromaras et al. 2017). Participants resided in Victoria (15), New South Wales (3) and Queensland (2). Nine were PCAs, seven were HCWs and four performed other roles.

### Data gathering

Our data gathering was designed to examine the intersecting relationships between employment and health, and life circumstances such as care responsibilities; full-time, part-time or casual employment contracts; cultural background; housing tenure; relationship status; and gender. While these dimensions have been reported as having significant relationships with work and health in quantitative literature, little qualitative work has investigated them.

Semi-structured interviews were conducted face to face (11) or by phone (9). Each took about 60 minutes and asked about work and family biographies, care responsibilities, work and money, and health. Transcripts were altered to change names and potentially identifiable information before being analysed thematically using NVivo qualitative software. The resulting coding frame arranged 14 nodes among four primary themes: biography; supervision and workplace culture; professional conditions and temporal quality; and statements defining good care and its connections with worker health.

Our findings pointed three priority areas for policy reform, presented on the following pages.



**Our data gathering was designed to examine the intersecting relationships between employment and health, and life circumstances.**

## Mandatory minimum hours of care in residential facilities

Our first finding points to the need for staffing levels that allow care workers to spend sufficient time with the people in their care.

Frictions between competing time priorities caused feelings of shame, guilt, frustration and anger among the workers we interviewed. When describing their preferred care practices, workers told us that they liked to take time to develop an understanding about the people in their care. They used stories and questions to identify individual preferences and situations. They tried to keep up morale, especially when it seemed as if the older people felt hopeless. They were aware that dignity was at stake in their intimate bodily care work, and they used the language of kinship and common humanity to describe it. This helped them overcome the de-humanising language of ‘consumers’ and ‘services’. All these approaches are consistent with research on good care practice (Mol 2008).

Good care takes the time that it needs (Davies 1994). However, workers in residential care were unanimous in telling us that their work often felt hurried and impersonal. They felt neglectful when there was not enough time to listen and people were left to their own devices.

The time available and the factory-like sequencing imposed on daily ablutions in residential care was a sore point for many workers. Robyn (52, regional Victoria) explained:

***Most people in aged care are depressed badly because they are missing all those things [from their life before moving into care] and we run into a room and go ‘I’m here to give you your shower’. All they want to do is talk ... All they want is your time. I think it’s in between four to six minutes and a shower should not take any longer than that. How is that practical? How can you say to someone that moves slowly, that’s 102 years old, everything aches ‘Can we move it along, can we move it along? I’ve got to get this shower done?’***

Hannah (61, Melbourne) described a common occurrence in the nursing home where she worked:

***there [are] a few with a stroke and they can manage in the wheelchair by using the one hand but a lot of times the [personal care assistants] will just push them ... if you constantly do that for them, it is showing that they have no real independence ... it is the time factor.***

Hannah explained that these conditions adversely affected her wellbeing:

***You only have a short amount of time to facilitate your job ... I don’t feel like I am carrying out the job well, I get a little bit stressed ... My husband has noticed that I am a little bit [grumpy] if I don’t have a break in between my shifts.***

Such responses suggest that not being able to do one’s job well creates stress. Public health research also tells us that adverse physical, mental and self-reported health effects result from work that is too taxing, not done in a manner of one’s choosing and unfair (Siegrist & Wahrendorf 2013).

Data collected by industry accountants suggest that the hours of care available for each resident in 2018 were about 25 per cent below an international benchmark of 4.3 hours per day (StewartBrown 2018). Although Australia’s policy framework emphasises the role of ‘consumers’ making well-informed choices of residential care providers, staffing data are not collected by government and comparisons between providers are not available.

In the USA, staffing data adjusted for patient care needs are routinely collected and published (Centers for Medicare & Medicaid Services 2018) although research has shown that consumers seldom use these data (Werner et al. 2012). A parliamentary committee has recommended that a similar data system be introduced in Australia (House of Representatives Standing Committee on Health Aged Care and Sport 2018).

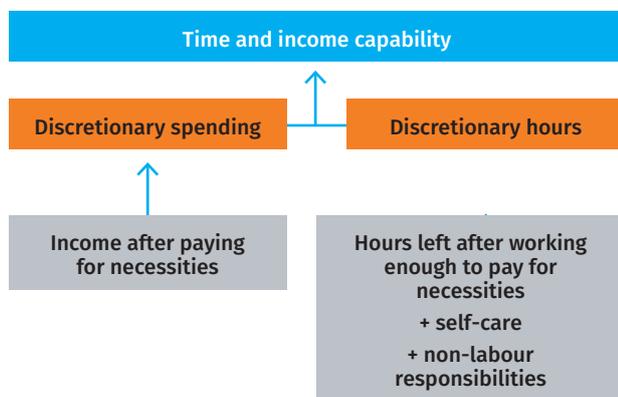
Whether or not staffing data are made available, mandating a minimum number of care staff hours for each person in care is necessary to counter the logic of economic efficiency that drives neglectful practice. The Australian Nursing & Midwifery Federation (ANMF) have advocated the staged introduction of mandated minimum hours of care per resident, starting from a minimum average of 3.5 hours of care in July 2019 and increasing to a minimum average of 4.3 hours in 2025 (2019). These proposals are grounded on international evidence (Willis et al. 2016) and backed by a costing study (Burgan, Spoehr & Moretti 2017) which suggests that increased costs would be more than offset by savings on other social costs. In the light of our findings, we suggest that the ANMF proposals are reasonable and warranted.

## Employment conditions to improve ‘time and income capability’

Our second policy focus is employment conditions. To make this point we employ the concept of time and income capability (Burchardt 2010), illustrated in Figure 1.

Figure 1

### Understanding time and income capability



In the capabilities approach developed by Sen (2004), it is not so much what people actually do that has value, but what they have the opportunity to do. In Burchardt’s notion of time and income capability—which draws from Sen—the freedom or constraint that people have in choosing how to spend their time results from interactions between their discretionary income and discretionary hours.

A well-paid worker with no informal care responsibilities might work long hours, but could choose to work fewer hours and still have an adequate income. This person would have comparatively high time and income capability. On the other hand, someone who has low pay and informal care responsibilities might have few spare hours and little spare money. Because they have a very narrow range of freedom over how they spend their time, this person would have low time and income capability.

Time and income capability affects worker health. For example, research indicates that cognition in later life is associated with interests outside work (Gupta 2018; Health and Retirement Study 2017) and manual workers participate in these kinds of activities less often (Seitsamo & Klockars 1997). In some cases, this is likely to be the result of lower time and income capability.

## Drivers of low time and income capability

Most of our study participants had low time and income capability. About one-third of them had informal care responsibilities. Further eroding their position was the time it took to recover from a physically demanding shift. This was especially true for the oldest workers who had been in the industry longest.

Unpaid hours that were not available for non-work activities were particularly constraining. Home care participants often reported unpaid periods between shifts. The award covering these workers does not require travel time to be paid (Charlesworth & Heron 2012; Fair Work Commission 2018b) and about one-third receive no travel allowance (Mavromaras et al. 2017). Some residential workers—who work under a different award (Fair Work Commission 2018a)—told us that they often performed direct care tasks throughout their entire shift, so paperwork could only be completed without pay after they had clocked off.

The need to be ‘on call’ for potential extra shifts also diminished the value of participants’ non-work time (Facey & Eakin 2010). Three-quarters were on permanent part-time contracts, and these tended to allow for fewer hours than participants needed to earn sufficient income. As a result, many relied on employers to offer additional hours to make ends meet, and held themselves available for a wider envelope of work than they were rostered for.

Some workers explained that they were at pains not to displease their employers lest they miss out on extra shifts. According to industry census figures, about one-third of PCAs and 40 per cent of HCWs want more hours (Mavromaras 2017). The relevant awards do not specify minimum hours for part-time contracts or require penalty rates for hours in addition to those contracted. Research has shown that these arrangements deny workers predictable and regular hours, create difficulties for workers claiming means-tested government welfare benefits, and give employers an extra mechanism for controlling their workers (Charlesworth 1997). In contrast, part-time workers in blue-collar industries tend to have penalty rates attached to work above their regular hours (Charlesworth & Heron 2012).

## Measures to improve time and income capability

In light of these analyses, possible policy measures that are likely to extend worker time and income capability, and hence improve their health, include:

- wage increase
- penalty rates for flexed-up hours
- written notice of roster changes
- minimum shift hours
- sufficient paid hours to perform role
- minimum contract hours
- paid transit time between home care sites.

Recent reform in New Zealand provides a progressive reference point for aged care employment conditions (New Zealand Ministry of Health 2018).

## A professionalisation agenda

Finally, we propose a professionalisation agenda to shift the demarcations between professional and unskilled work. We argue that this can improve care quality and job quality and make roles more sustainable for older workers. We introduce the three interrelated elements of this proposal below.

### Professional registration for autonomy and care quality

Care practice is often understood as unskilled, feminine, private and familial (Theobald 2003). Personal care roles are much less formalised within health sector regulation than other positions. While they are identified in the ANZSCO system, and vocational courses for the roles have been accredited, these roles are less regulated than comparable positions in child care or other social care.

Sociological literature understands professionalism as a power structure projected from a set of institutional arrangements. According to Freidson (2001) these:

- enforce standards of technical skill and ethical conduct
- authorise peer scrutiny and evaluation
- align the agendas of the profession with the public good
- entrust individual practitioners with autonomy.

Research into the demarcations between professional and unskilled care has seen ongoing disputes along gender, class and discipline lines (Abbott 1994; Dahle 2003). It shows that, under different institutional conditions, the designations of labour might be quite different from the

current ones. For example, different demarcations in Sweden result in their personal care workers having more qualifications, more autonomy and a wider range of relational care practices than those in other countries (Daly & Szebehely 2012).

Many of our participants reported feeling disrespected and disempowered by their place in the staff hierarchy, and that their status as 'unskilled' diminished care quality and job quality. Jing Yi (50, residential care, Melbourne) said:

*But I do what I need to do. Yeah. If you say oh, just give it [medication] every day, I said, 'Why, it's not on the job chart?'. [The supervisor's response is] 'No time. Don't tell me, just give it.' So, I get the instruction from the in-charge person. I know what I need to do. This is enough.*

In this instance, Jing Yi's position in the hierarchy undermined her knowledge and sense of good practice. Margaret (57, HCW, Melbourne) also experienced a lack of professional standing that compromised her ability to serve the best interests of those in her care:

*To [people in the office] we're just cleaners and people that give [older people] showers ... A professional is a professional. It's a doctor. But we deal with [people who receive care] more often. If I say this person should be in a nursing home, it should be ... We see that person every day so we know that person should be in a [nursing] home.*

Despite doctors' professional skills, Margaret's sense is that they lack the opportunity to make the more detailed and situated observations available to a personal carer. Margaret's lack of professional status means that important details are lost, jeopardising the wellbeing of those in her care. Jing Yi and Margaret both describe being at the frontline of care practice and the bottom of the professional hierarchy.

Workers in our study were often confronted with the effects of neglectful practice while being denied the opportunity to do anything about it, and the effects on their own health were strongly negative. These observations are in line with research demonstrating that those who lack autonomy and respect at work tend to have poorer health outcomes (Siegrist & Wahrendorf 2013).

We suggest that formal registration of personal care would improve worker health and employment conditions, and the quality of care they are able to provide. Here we are suggesting that aged care workers could join with similar roles in the NDIS under their own category within the National Registration Accreditation Scheme. At present, this system regulates health professions such as occupational therapy, optometry, osteopathy, pharmacy, physiotherapy and podiatry. To register in these professions, individuals need to demonstrate accredited course completion, language proficiency, clean criminal record and recent practice. Ongoing professional development is also required to maintain registration. Adding personal carers to this scheme would recognise their place within the landscape of professional carers.

### Clinical supervision for emotional depletion

Supervision is commonly part of allied health practice (for example, social work, clinical psychology). Several participants spoke of the emotional toll of aged care work without such support. For example, Jenny (55, residential care, rural Victoria) told us:

***People dying, people falling and breaking things and all that. There's never any debriefs. Nobody ever asks, 'Are you okay?'... But some of it is really traumatic and there is no debriefing, there is no, 'How did you handle that, how did you feel?' Nothing. Zero. We have to deal with it between ourselves ...***

Clinical supervision could help sustain workers emotionally, while also building their status as professional carers. We are not suggesting 'supervision' as a managerial tool for discipline or control, but rather as a space for critical reflection on practice and learning. According to Lyth (2000, p. 728):

***Clinical supervision is a support mechanism for practicing professionals within which they can share clinical, organizational, developmental and emotional experiences with another professional in a secure, confidential environment in order to enhance knowledge and skills.***

Supervision has three functions: restoring, norming and forming (McDonald 2011; Proctor 1986). We suggest that all three functions might offer benefits for care workers' job quality, and that the restoring function would be an appropriate response to the concerns workers raised with us about the emotional toll of their work. Supervision can be one-on-one or group-based. Group supervision might be particularly important for home care workers who have little other contact with their teams.

### Supervision and training for role specialisation

Many participants were concerned that their bodies would not last the distance if they stayed with heavier tasks involved in personal care work. Some had negotiated lighter duties with their employers but others could not see a clear way to transition. One year prior to the interview, Jackie (50, home carer, Sydney) had both knees reconstructed. She was concerned that 'my knees will wear down again' if she remained in physically demanding personal care roles. She was completing a leisure and lifestyle course in her own time at her own expense, so she could become an activities officer.

Many of the possible role transitions desired by workers required training that was not made available by employers. To pursue another role, or just to improve their skills, some participants had undertaken training independently and without their employer's knowledge. Topics of study had included dementia, sign language, death and dying, a bus licence, English language, and leisure and lifestyle.

We think there are opportunities to combine workers' enthusiasm for study and for role transition by developing specialist roles across care teams. Such specialist roles might include continence; falls prevention; occupational health and safety; podiatry; induction of new workers; manual handling; peer support and staff wellbeing; wounds and skin integrity; procurement; waste management; and IT. Some roles could be supervised by senior personal carers and others by registered nurses or allied health practitioners. Accredited courses could be developed, and pay rates could be tiered accordingly.



**Clinical supervision could help sustain workers emotionally, while also building their status as professional carers.**

## Implications

Our findings underline the need to increase the value and status of pink-collar jobs in order to close the gender gap, build economic security and make longer working lives more viable. This means professionalisation, improving remuneration and codifying better entitlements into awards. In the case of aged care, it also means requiring employers to provide supervision for workers. Failing to take such measures may result in more older workers being caught in poverty and economic insecurity (McGann et al. 2016). While some service providers and industry bodies will resist these measures, it seems clear that a better balance needs to be struck between the costs of providing services and the needs and entitlements of people who give and receive care.

The history of care as private and familial obscures the specialist skills that are already practised by pink-collar care workers. Closing the gender gap will require formal recognition of these skills by employers and governments, and within the institutional structures that confer professionals with their status. Other jurisdictions such as New Zealand and Sweden offer models of preferable conditions for workers and people in care.

Finally, our findings underline the need to improve the accredited training offers. While many employers may favour in-house training, accredited training will allow workers to specialise and or to move across care industries. We suggest that the COAG-mandated Australian Health Practitioner Regulation Agency and the Australian Industry Skills Committee need to work with care providers to build a comprehensive suite of credentials for personal care workers in aged and disability care. Using this system of credentials, the Aged Care Quality and Safety Commission could work with providers to ensure that each had an appropriate suite of skills among their staff.

## About the project

This study forms one component of a larger Australian Research Council Linkage Project entitled *Working Well, Working Wisely*, which contributes to an understanding of the impacts of policy changes related to the employment of older workers and their workplaces. The project comprises five interrelated studies; and this report relates to one cohort (pink-collar workers) in Study 2, a qualitative component of the broader Linkage project. Study 2 investigates how blue, white and pink-collar industry settings shape workers' experiences; and examines how work, health and participation risks are generated among older workers in these sectors. The blue-collar and white-collar components of Study 2 are being conducted by researchers at Australian National University.

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## For further information

For more detail about this study, see <<https://www.bsl.org.au/research/projects/older-workers-health-and-work/>>

For further information about the broader project, see <<https://rsph.anu.edu.au/research/projects/working-well-working-wisely>>

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