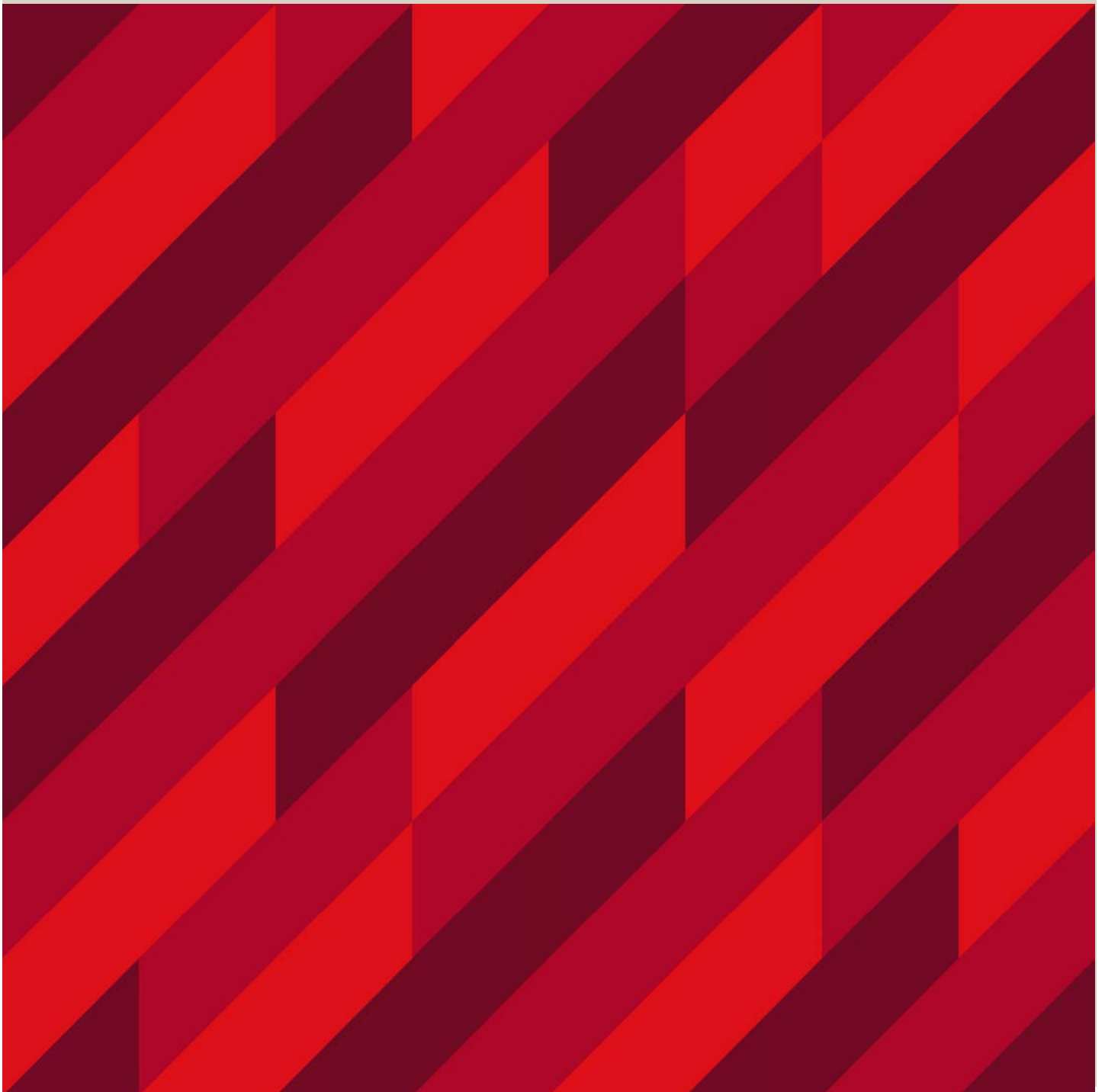




# Research Report

## VALUING CARE WORK AND CARE WORKERS: WORKFORCE AND EQUAL PAY ISSUES IN NZ AGED RESIDENTIAL CARE

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**This report was prepared for E tū, in relation to an equal remuneration case.**

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## Executive Summary

This report presents the findings of research on the characteristics of the care workforce in aged residential care services in New Zealand, and the nature and valuation of care work in this sector. The focus is on the non-professional workforce, called health care assistants (HCAs) or caregivers. The research is based on analysis of data from Statistics New Zealand, primarily from the Census of Population and Dwellings, research and public policy documents from New Zealand, and a survey of international research.

### **1. The aged residential care workforce in NZ: Structure, characteristics, development**

The first section of the report presents a profile of the workforce in aged residential care, including its occupational composition, demographic characteristics (including sex, age and ethnicity), and the education levels and incomes of care workers.

- Aged residential care employs a total of around 25,000 people, of whom approximately two thirds work in direct care roles.
- Health care assistants comprise half the aged residential care workforce, and nearly three quarters (73%) of the total care workforce (which includes nurses and other health and welfare professional and para-professional workers).
- Health care assistant is a female dominated occupation: 93% of all HCAs in aged residential care are female, as are more than 90% of all other care occupations. Non-care occupations in aged residential care are also female dominated to a similar extent, including those in hospitality-related or domestic occupations.
- Care workers in aged residential care are older, on average, than workers in the New Zealand labour market overall. Of HCAs, 43% are 50 years or over, compared to 35% in the NZ workforce overall.
- The health care assistance workforce has a diverse ethnic profile. Among HCAs, 59% identify as European, 12% as Maōri, 11% as Pacific peoples, and 22% as Asian. This profile diverges considerably from the profile of the NZ population as a whole, and from the population of aged residential care facilities, in which 93% identify as European, 4% as Maōri, 2% as Pacific peoples, and 2% as Asian.
- Approximately one third of HCAs have a post-school qualification; 21% have a skilled vocational qualification or a diploma or advanced diploma, while 8% has a bachelor degree or higher. The proportion of HCAs with qualifications has increased in recent years, with much of the growth being in the share with a bachelor degree.
- A majority of HCAs (62%) works full-time (defined as 30 hours per week or more). This is slightly less than the female workforce overall (66%). HCAs have a lower rate of full-time work than registered nurses in aged residential care, of whom 76% works full-time.
- Although a majority of HCAs work full-time hours, almost all report personal incomes below median earnings in New Zealand, and more than half had incomes below 60% of the median. HCAs also have low earnings relative to women in New Zealand: 57%

of all women in NZ reported personal incomes at or below \$40,000 per year compared to 96% of carers and aides reported.

- In collective agreements, health care assistants are categorised along with kitchen and laundry occupations, and paid within the same pay scales. As the next section shows, this categorisation fails to recognise what is distinctive about *care* work in aged residential care.

## **2. The nature of care work in aged residential care**

Aged residential care services deliver assistance with activities of daily living, and nursing care. Thus, they are labour intensive, and the workforce is the key ‘instrument’ of service delivery. While the skill demands of care carried out by nurses are recognised, the social and practical skills of HCAs are less well understood and recognised. Further, several developments within the ARC field in recent years have increased the scope and intensity of skill demands on professional and non-professional care workers. These developments include:

- *Increasing frailty among residents of ARC facilities.* A majority of residents have cognitive impairments and the proportion with moderate or appreciable dependency has grown in recent decades. Aged care facilities in New Zealand are increasingly functioning as *de facto* hospices for older people – with significantly fewer and less well trained staff than those who carry out end-of-life care in designated hospices.
- *New models of care.* Reorientation of aged care provision towards home-based care contributes to increasing frailty in residential care. Increased emphasis on individualised care means that front-line services as delivered by HCAs are expected to be tailored individual needs, including those arising from cultural difference. It is not possible to recognise and respond to individual needs with a routinized, task-based approach to care, delivered by unskilled workers.
- *The growth of service quality monitoring.* The growth of an audit apparatus to monitor care quality is a positive development aimed at ensuring that providers fulfil their obligations. However, quality assurance in ARC makes additional demands on the work and skills of people employed to provide care: to ensure their work aligns with these standards, care workers need to understand the standards and how their practice enacts/maps to them, and to know how to assess whether or not their practice has met the standards. Further, monitoring protocols can create new problems, by focusing time-pressured care workers’ attention on documentation rather than care, and on what can be monitored rather than important things that cannot.

## **3. Equal pay issues in aged residential care**

The characteristics of the aged residential care workforce and aged residential care services have affected the valuation of care work in the sector, resulting in low relative pay. The valuation of care and rates of pay are also affected by the status of old people in society and by the ownership structure of the ARC sector.

- *Occupational sex-segregation.* The aged residential care workforce is female dominated. International research has shown that female dominated occupations tend to be paid less than male dominated occupations, taking into account

educational requirements and other factors that objectively influence worker productivity.

- *The gendered undervaluation of care work.* Research has shown that jobs involving interacting with other people (which tend to be female-dominated) are generally paid lower wages than comparable jobs, especially where caring or nurturing activities are performed. The undervaluation of caring occupations arises because of the pervasive cultural association between care work and the traditional roles of women. As these traditional roles are not accorded economic or monetary value in society more broadly, the skills associated with them are also devalued or rendered invisible.
- *Worker motivation and preferences.* Explanations of gender pay inequity in terms of the preferences of female workers for care-related jobs or family-friendly working arrangements are not convincing. Research has found that these preferences are themselves affected by other social and economic circumstances that shape women's acceptance of poor quality jobs in care.
- *The social status of old people and recipients of aged residential care.* Most old people in residential care are not able to fund the services they receive, and rely on collective resources in the form of public subsidies. Yet these subsidies are constrained by the low priority given to old people and aged care in policy and society. Constrained subsidies limit the resources available to pay care workers.
- *The ownership profile of the aged residential care sector.* International research has shown that facilities run for-profit have significantly lower levels of staffing overall, higher proportions of less-trained staff, and lower quality care than those operated on a not-for-profit or public basis. Staff costs are the largest share of expenditure in aged residential care. Reducing staff costs via lower staffing levels and/or reducing pay and working conditions for care staff is one clear means, among others, of making profit.

## **Conclusion**

Positioning the occupation of health care assistant as a low skilled job that requires only low pay is problematic for two reasons.

- *First*, it does not recognise the range of skills required to undertake *high quality* daily care of older people. This lack of recognition means that those who exercise these skills are not rewarded for them. This is an issue of fairness, and was identified by the NZ Human Rights Commission in its report on aged care (2012).
- *Second*, by not recognising these skills, and so not requiring them in the recruitment process, the aged residential care sector is likely to hire many workers who lack the necessary skills. This risks undermining the quality of care and makes residents vulnerable to poor quality care.

Equal remuneration orders, that better recognise the impact of sex-segregation and gendered undervaluation of care on the recognition and remuneration of care workers, are one clear method by which these injustices and risks can be addressed.

## Introduction

Care work involves face-to-face service that helps recipients meet their daily physical, psychological, emotional and developmental needs (Standing, 2001) and develop their human capabilities (England, Budig, & Folbre, 2002). This report presents the findings of research on the nature and valuation of care work in aged residential care services, and the characteristics of the care workforce in this sector in New Zealand. The research is based on analysis of data from Statistics New Zealand, primarily from the Census of Population and Dwellings as well as research and public policy documents from New Zealand. The findings are discussed in the context of international research on the nature of care work in aged residential care, and the valuation of care work, specifically on gendered factors that lead to low pay in caring occupations such as health care assistant.

In 2013, just under 30,000 people aged 65 and over lived in aged residential care (ARC) facilities in New Zealand and, of these, more than half were 85 years of age or older (Statistics New Zealand, 2015). At any time, around one in twenty, or 5% of older New Zealanders reside in an aged care facility. However, this 'snapshot' vastly underestimates the extent of use of aged residential care in the population. A recent study takes a lifetime perspective, and finds that almost half (47%) of all New Zealanders aged 65 or more will enter aged residential care at some time in their later years, rising to two thirds of those who live to be 85 or over (Broad et al., 2015). Since most people live to be 65, this lifetime perspective gives a different and important understanding of the reach of residential care for older people. Further, it is expected that population ageing will significantly increase the number of older people needing support, and hence the demand for care workers to assist them (New Zealand Department of Labour, 2009)

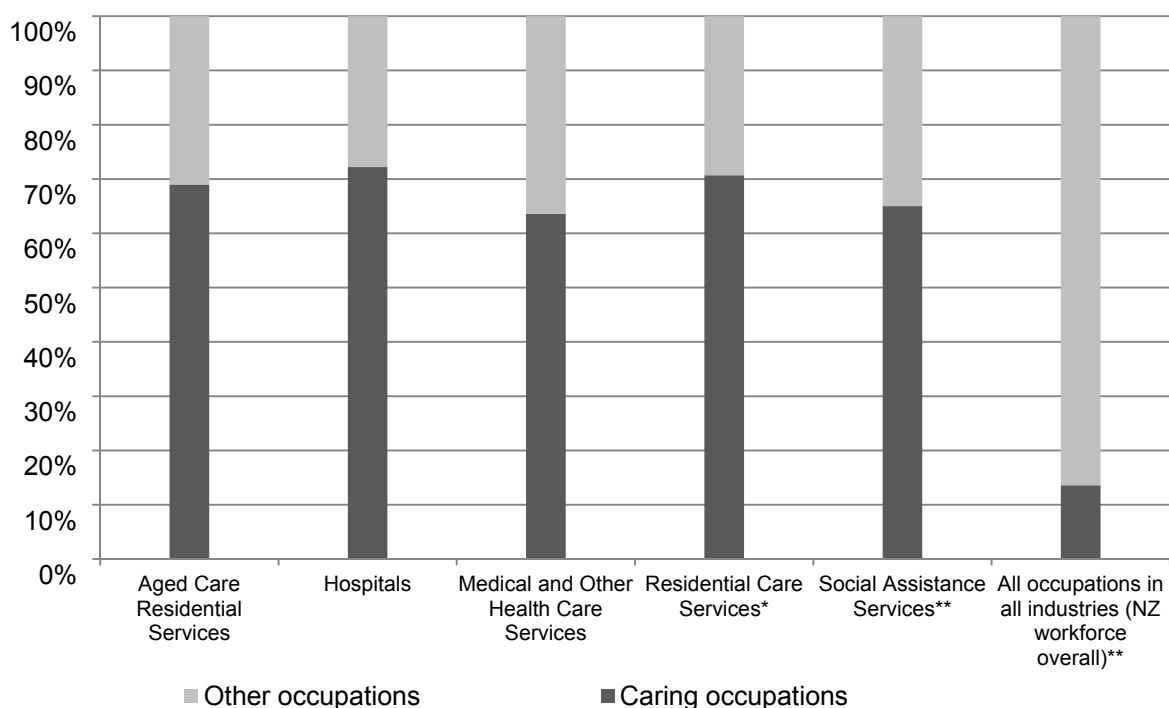
Aged residential care employs a total of around 25,000 people, of whom approximately two thirds work in direct care roles (Statistics New Zealand, 2013). The first section of this report presents a profile of the workforce in aged residential care. The occupational profile of the workforce, its demographic characteristics (including sex, age and ethnicity), education levels and incomes of care workers are all discussed. The characteristics of the workforce in aged residential care are compared with the workforces of other sectors in health care and social assistance and the workforce overall. Where comparable data are available, change in the ARC workforce over time is also discussed. The second section discusses the nature of aged residential care work, and the factors that are shaping and changing this work. The third and final section discusses the findings of international research on the valuation of care work.

# 1. The aged residential care workforce in NZ: Structure, characteristics, development

This section provides an overview of the structure, characteristics and development of the workforce in aged residential care in New Zealand. Where relevant and useful, aspects of the workforce profile in aged residential care are compared with the workforces of other industries or with the NZ workforce overall. Unless otherwise specified, the analysis is based on data collected by Statistics New Zealand in the New Zealand Census of Population and Dwellings for the years 2001, 2006 and 2013. Although reported in the past tense, the data for 2013 are likely to be a very good representation of the current situation in New Zealand.

Aged residential care is a sub-sector within the health care and social assistance industry. In each of the four major industry sub-divisions – hospitals; medical and other health care services; residential care; and social assistance services – at least three fifths of the workforce is employed in direct service or ‘care work’ occupations (see Figure 1). These industries also employ staff in managerial, administrative and other service capacities and in the trades, but their orientation toward delivering care gives these industries, and their workforces, a distinctive character.

**Figure 1: Distribution of the workforce between caring and non-care occupations, selected industries, New Zealand, 2013**



\* Note that this industry sub-sector includes Aged Residential Care Services. \*\* Pre-primary, special education and school teachers included among caring occupations in these industries for completeness.

## ***Size of the workforce, occupational structure and change over time***

Aged residential care services are a sub-division within the industry health care and social assistance services. Figure 2 shows the major sub-divisions of this industry, and where employment in aged care residential services fitted in 2013. Nearly one in ten (9.6%) New Zealand workers were employed in health care and social assistance, and of these, more than one in eight (13.1%) was employed in residential aged care services. Overall, 1.3% of the New Zealand workforce was employed in residential aged care services.

Figure 1 above showed the broad distribution of workers between caring occupations and non-care occupations in aged residential care, other subdivisions within the health care and social assistance industry, and within the NZ labour market overall. Within the broader category of care work, it is useful to make a further distinction between *professional occupations* such as nurse and social worker (for which a bachelor degree or higher is required); *associate professional occupations* such as welfare support worker (requiring a diploma or higher); and *non-professional* or 'unregulated' occupations, such as caregiver/health care assistant (for which vocational qualifications are deemed appropriate, where they are required). Table 1 shows the occupational structure of the aged residential care workforce in more detail, for the years 2006 and 2013.

The table shows that the ARC workforce as a whole grew by 15% during the seven year inter-census period, compared to 1% in the New Zealand labour force (as measured by the Census).<sup>1</sup> Care workers were 70.1% of the ARC workforce in 2006, and 68.8% in 2013. The largest occupational group was 'carers and aides', known in the ARC sector as caregivers or health care assistants (HCAs), who formed half the sector's entire workforce in both years.

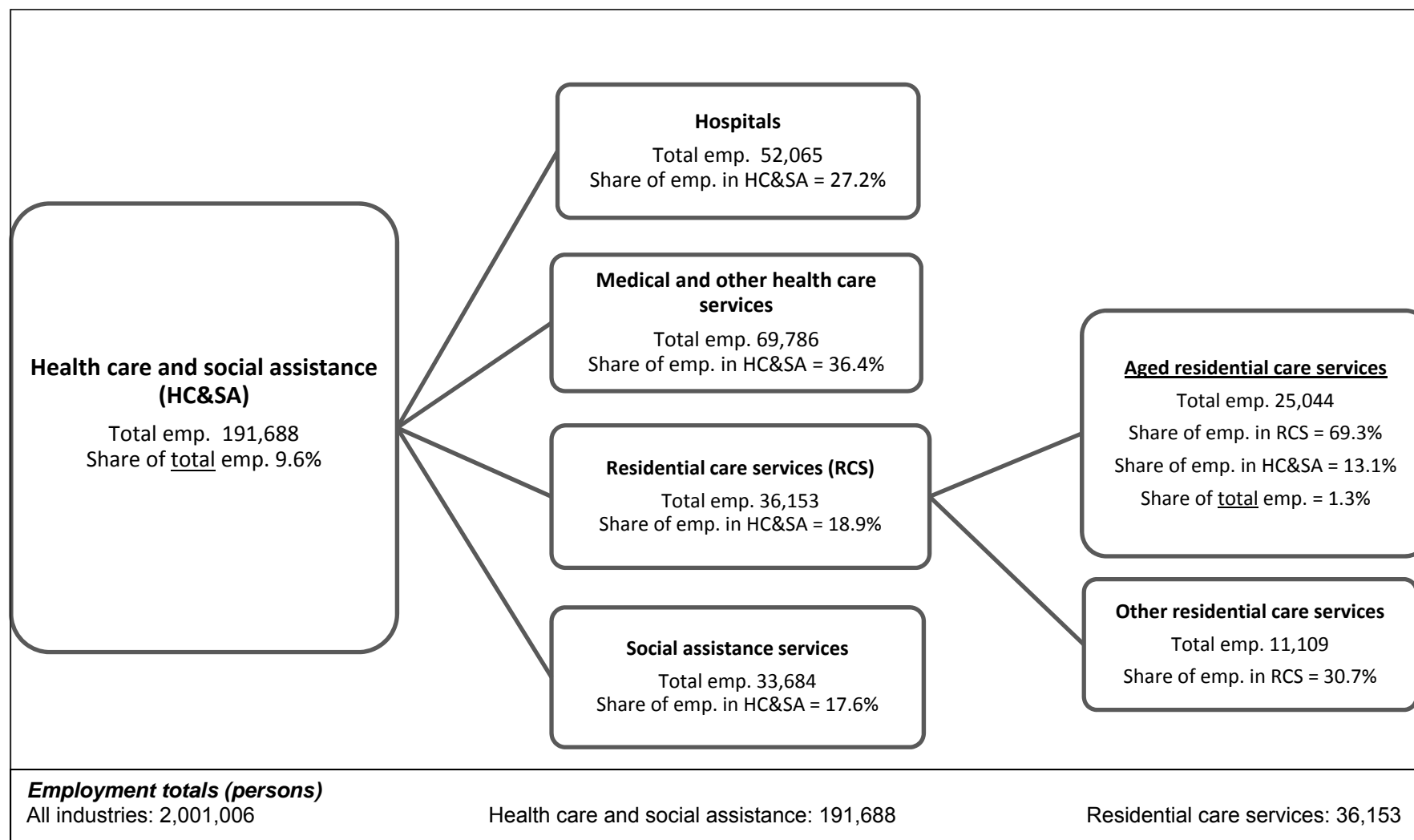
While the absolute number of workers employed in each occupational group grew, not all groups grew at the same rate. Consequently, the distribution between professional, associate professional and non-professional care workers shifted slightly, with an increase in registered nurses and a fall in the share of both other health and social professionals and of carers and aides. The share of non-care occupations increased slightly more than the average increase for the ARC sector overall. These are 'head count' measures, change in which may not directly reflect any changes in the equivalent full-time distribution of staff between occupational categories. It is therefore not possible to determine whether there has been an absolute increase in the relative hours of nursing versus care assistance in nursing homes. However, postulating such a change would be warranted by evidence of increasing frailty among residents.

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<sup>1</sup> The total number of employed persons recorded by the Census of Population and Dwellings in 2013 was 2,001,006. This is lower than 2,204,100 reported in Statistics NZ's labour force series as the number of all employed persons for the March quarter in 2013. Using data for both time points from the *labour force* series, the growth in total employment between 2006 and 2013 was 4%. This is greater than 1% found in the Census but considerably less than the 15% growth in the ARC workforce found in the Census. Overall, the conclusion that employment in ARC grew considerably faster than employment in the labour market overall seems warranted (See <http://nzdotstat.stats.govt.nz/wbos/Index.aspx?DataSetCode=TABLECODE7080>.)



**Figure 2: Where aged care residential services fits within the New Zealand health care and social assistance workforce, 2013**



**Table 1: Occupational structure of the aged residential care workforce, NZ, 2006 and 2013<sup>2</sup>**

	2006		2013		% change in persons, 2006-2013
	Persons	% share of total	Persons	% share of total	
<b>Professional care workers</b>					
Registered nurses	2,094	9.6	2,697	10.8	28.8
Other health and social professionals	837	3.8	852	3.4	1.8
<b>Associate professional care workers</b>					
Health and welfare support workers	1,068	4.9	1,281	5.1	19.9
<b>Non-professional care workers</b>					
Carers and aides	11,247	51.7	12,399	49.5	10.2
<b>Non-care occupations</b>					
Cleaners, laundry workers and food preparation assistants	2,472	11.4	3,066	12.2	24.0
Other non-care occupations	4,044	18.6	4,749	19.0	17.4
<b>All occupations in ARC</b>	<b>21,762</b>	<b>100</b>	<b>25,044</b>	<b>100</b>	<b>15.1</b>

Table 2 shows the occupational and gender structure of the aged residential care sector in 2013. The clear finding in this table is that aged residential care is a female-dominated sector. Overall, 88.5% of the ARC workforce is female, and in every caring occupation, the share of women exceeds 90%. Female workers also dominate hospitality services in ARC facilities: 85.4% of food trade workers and 89.5% of cleaners, food preparation assistants and laundry workers are women.

**Table 2: Occupational structure of the aged residential care industry by sex, NZ, 2013**

Occupation/Occupational group	Employed persons	% Female	Occ. as % of ARC workforce
<b>CARING OCCUPATIONS</b>			
Registered nurses	2,697	90.8	10.8
Other health and social professionals*	912	91.1	3.6
Health and welfare support workers	1,281	95.8	5.1
Carers and aides	12,399	93.5	49.5
<b>TOTAL (Caring occupations)</b>	<b>17,229</b>	<b>93.1</b>	<b>69</b>
<b>NON-CARE OCCUPATIONS</b>			
Clerical and administrative workers	792	96.2	3.2
Food trades workers	945	85.4	3.8
Food preparation, cleaning and laundry workers	3,066	89.5	12.2
Other occupations	2,952	59.2	11.8
<b>TOTAL (Non-care occupations)</b>	<b>7,815</b>	<b>78.2</b>	<b>31</b>
<b>TOTAL (All occupations in ARC)</b>	<b>25,044</b>	<b>88.5</b>	<b>100</b>

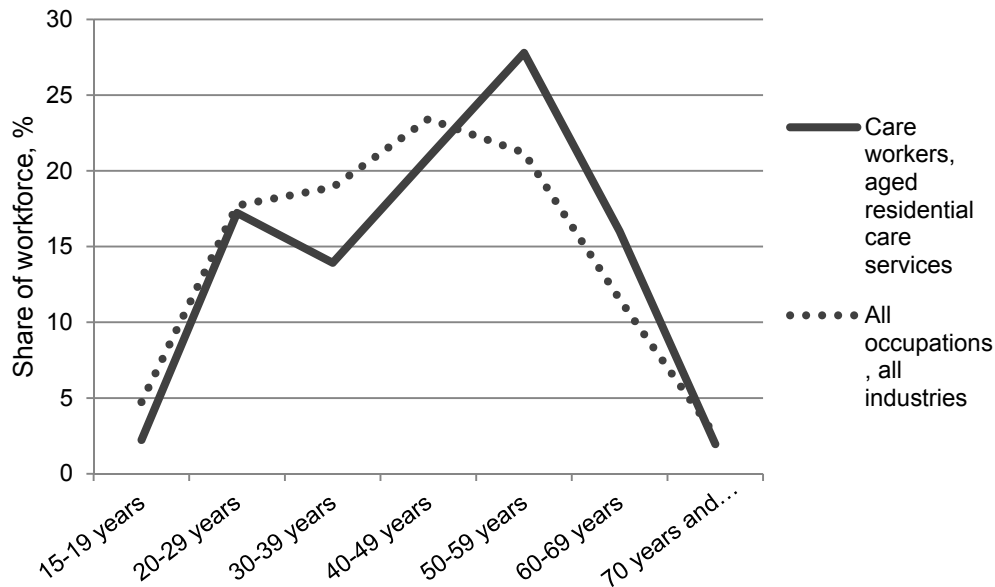
\* These occupations are counted in a slightly different way than in Table 1 resulting in a small difference in the totals in the two tables.

<sup>2</sup> Differences in the occupational classifications used to code the 2001 and 2006 censuses mean that it is not possible to extend the analysis back to include 2001.

### The age profile of the aged residential care workforce

Care workers in residential aged care services are older, on average, than the New Zealand labour force. In 2013, 46% of care workers in ARC services were 50 or over, compared to 35% of the workforce overall (see Figure 3).

**Figure 3: Age distribution of care workers in aged residential care and all occupations in all industries, 2013**



Figures 4 and 5 compare the age structure between occupational groups within the aged residential care workforce. Figure 4 compares care workers with non-care workers in the ARC sector. While the care workforce is somewhat older on average than the New Zealand workforce in general, non-care workers in aged residential care are, on average, older than care workers, such that 57% of employees in non-care occupations are 50 and over, compared to 45% among care workers.

**Figure 4: Age distribution of care workers and non-care workers in aged residential care, 2013**

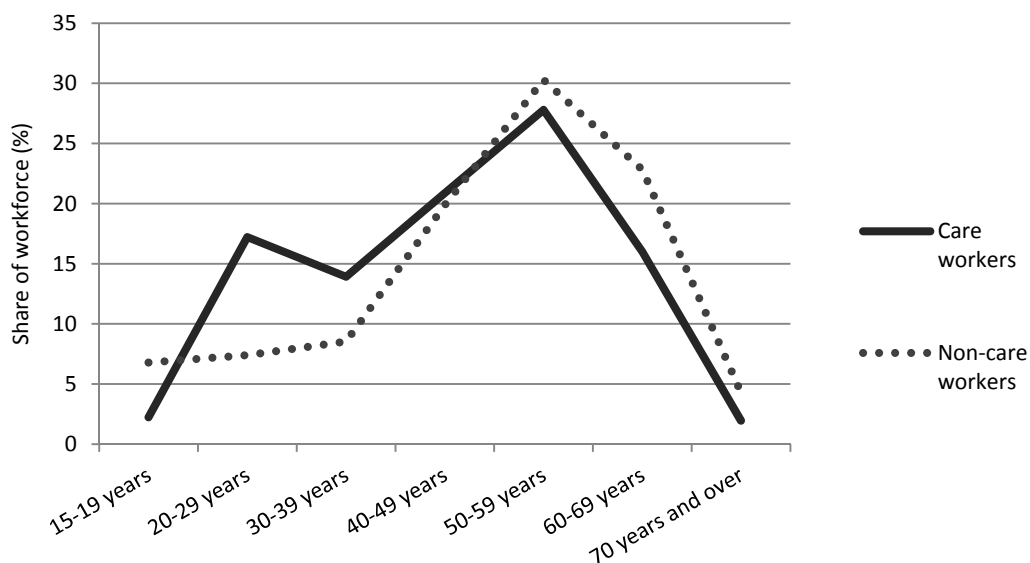
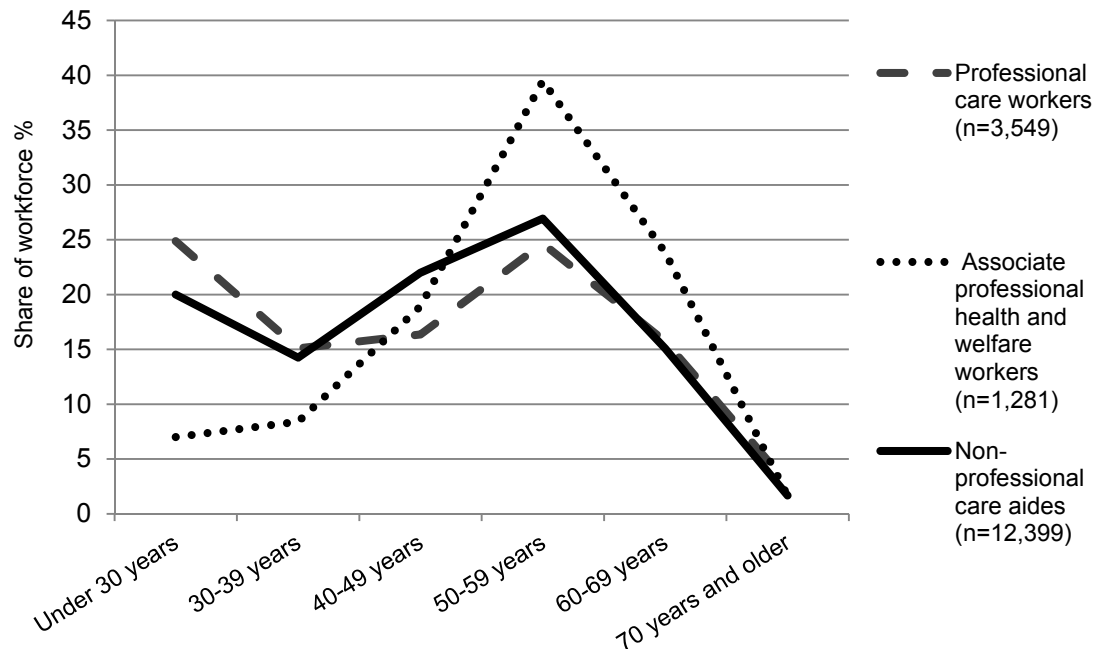


Figure 5 compares broad occupational groups within the care workforce in aged residential care: professional, associate professional and non-professional care workers. It shows that

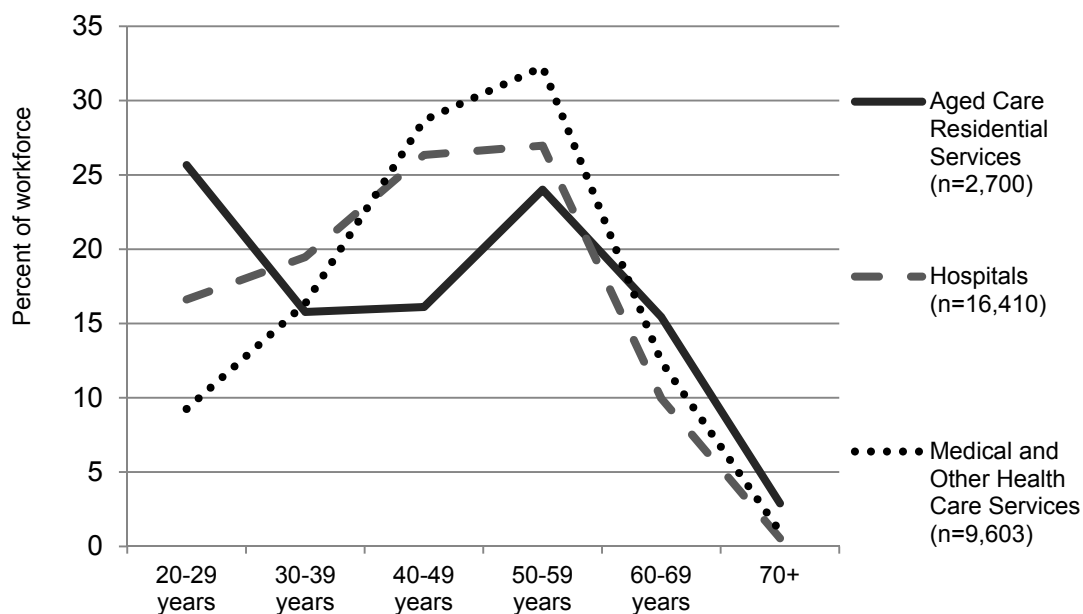
the (relatively small) associate professional care workforce is the oldest, on average. The age distribution of the care workforce in ARC services could suggest the withdrawal of female workers during the child-bearing years (Figures 3 and 4), particularly within professional (primarily RNs) and non-professional caring occupations (primarily HCAs) (Figure 5).

**Figure 5: Age distribution of professional, associate professional and non-professional care workers in aged residential care, 2013**



Further, this pattern seems to be somewhat specific to aged residential care: Figure 6 shows the age distribution of registered nurses in aged residential care, compared to registered nurses working in hospitals and other medical and health care services.

**Figure 6: Age distribution of registered nurses in three health sub-sectors, 2013**



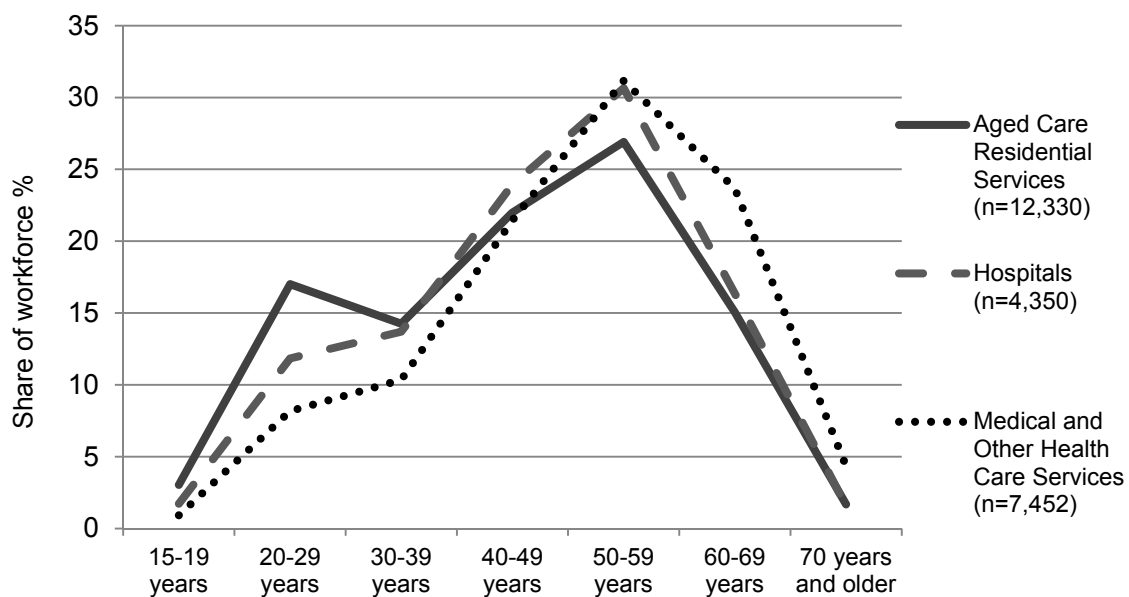
While a minority of nurses work in aged residential care (8%, compared to 50% in hospitals and 30% in medical and other health care services<sup>3</sup>), a much higher proportion of nurses in ARC is under 30 (more than a quarter) compared to less than a fifth in hospitals, and less than a tenth in medical and other health care services. Further, the ‘dip’ in the childbearing years is not evident in the age pattern of nurse employment in the other health care sectors. It seems rather that the rate of participation is lower in the child-bearing years for nurses in the non-ARC sectors, climbing towards middle age.

There is another interpretation of these data, which relates to the preferred clinical practice setting of graduating nurses. Data on these preferences is collected in the Nursing Advanced Choice of Employment (ACE) system, which is used by District Health Boards to recruit graduating nurses (Ministry of Health, 2015). Aged residential care was the least preferred of the sixteen fields offered, with only 1.3% of graduates giving ARC as one of their three choices. It may be that graduates take employment in ARC when they graduate, and move on as quickly as possible.

There are some similarities with nurses in the age distribution of non-professional care workers across the main sectors of health care (see Figure 7). There is no corresponding study of these workers that would enable further discussion of the reasons for this pattern.

These findings suggest that strategies to retain workers in the two largest care occupations could address specific concerns of women in their 30s and 40s (registered nurses) and in their 30s (health care assistants).

**Figure 7: Age distribution of carers and aides in three health care sub-sectors, 2013**



<sup>3</sup> The remaining 12% of registered nurses work outside health care, in, for example, education and social assistance services.

## ***Ethnic diversity in the ARC workforce***

Ethnic diversity in the care workforce is important for at least two reasons. One relates to cultural competence in care provision, such that the workforce has the relevant knowledge and understanding to provide culturally appropriate care to various ethnic and cultural groups within the service-receiving population (New Zealand Human Rights Commission, 2012; Pacific Perspectives, 2013). The second relates to the distribution of labour market opportunities, specifically access to higher skilled, higher paid jobs (Flippen, 2014; New Zealand Human Rights Commission, 2012). In New Zealand, ethnic diversity arises both from colonisation, which brought European people to land belonging to the indigenous Maōri people, and from immigration, which has brought many people from the Pacific region, Asia and elsewhere to New Zealand, particularly in more recent decades. Both Maōri people and immigrants from non-European countries, most particularly Pacific peoples, face disadvantages in the NZ labour market, including higher rates of unemployment and segregation into lower skilled occupations (Ministry of Business, 2015; Sutherland & Alexander, 2009). The NZ Human Rights commission's report on equal opportunity in the aged care sector pointed to two kinds of problems for immigrant care workers. One is that those with qualifications in, for example, nursing may have difficulty having those qualifications recognised, and so are obliged to take up occupations, such as health care assistant, that do not require qualifications. The second is that migrants with lower levels of education find employment in aged care because qualifications are not required, where they may be subject to poor working conditions (New Zealand Human Rights Commission, 2012). Immigrants from the Pacific are particularly vulnerable to the second problem.

The ethnic composition of the aged residential care workforce is presented in Table 3, with selected further data presented in Figure 8. The table compares the profile of professional, para-professional and non-professional care workers in ARC with two groups of non-care workers (clerical and administrative workers and workers in hospitality service occupations). The table also includes the distribution of the entire New Zealand workforce by ethnic group, and some data about the age structure of the New Zealand population and the ARC resident population by ethnic group.

The panels in Figure 8 show the different ways particular ethnic groups are engaged in the aged residential care system. People who identify as European are relatively *under*-represented among ARC care workers (at 61.1%), compared to their share of the workforce overall (77.3%), and relatively *over*-represented among the population of people over 65 (87.8%) and among residents of aged care facilities (92.5%). Maōri New Zealanders are somewhat under-represented both in the ARC care workforce (10.1%) relative to their share of the labour force overall (11.3%), and within the ARC resident population (at 4.0%), relative to their share of the older population (5.6%). Pacific peoples are over-represented among ARC care workers (8.6%) relative to their share of the NZ workforce overall (5.0%), and under-represented among residents in ARC (1.7%). People who identify as Asian are significantly over-represented among ARC care workers (23.3%) relative to their share of the workforce overall (11.0%), and under-represented among older people (4.7%) and ARC residents (2.3%).

**Table3: Ethnic identification of care and non-care workers in ARC, all NZ employed persons, ARC residents, all NZ population and population 65 and over, 2013**

Ethnic self-identification	Care workers, ARC				Selected non-care occupations, ARC		All NZ employed persons	Population distribution			
	Professional (primarily RNs)	Associate professional	Non-professional (primarily HCAs)	All care workers	Clerical workers	Hospitality workers*		Proportion of group that is aged 65+	Share of group in total NZ population	Share of group's 65+ members in all 65+	Share of residents in ARC
European	54.7	84.2	59.0	61.1	90.1	71.3	77.3	17.1	74.0	87.8	92.5
Māori	5.1	8.5	11.7	10.1	7.6	15.6	11.3	5.4	14.9	5.6	4.0
Pacific Peoples	3.5	3.3	10.6	8.6	1.5	6.8	5.0	4.7	7.4	2.4	1.7
Asian	36.8	7.3	22.4	23.3	4.2	12.6	11.0	5.8	11.8	4.7	2.3
Middle Eastern /Latin American /African	1.9	0.0	1.5	1.4	0.8	1.1	1.0	3.3	1.2	0.3	0.2
Other Ethnicity	1.1	1.6	1.1	1.1	1.5	1.2	2.0	11.5	1.7	1.3	0.4
Total	100	100	100	100	100	100	100	--**	--***	--	--

\* Cleaners, laundry workers and food preparation assistants

\*\* Note that this column would not be expected to sum to zero; it measures the proportion of each ethnic group that is over 65.

\*\*\* These columns do not sum to 100 because respondents are allowed to choose more than one ethnic identification.

The occupational skill profiles of the various ethnic groups also differ markedly. Maōri and Pacific people working in ARC are much more likely to be employed in non-professional occupations than professional ones, while the reverse is true for people who identify as Asian. This latter group forms a large minority (36.8%) of the professional care workforce, and a significant, but smaller share of the non-professional workforce (22.4%).

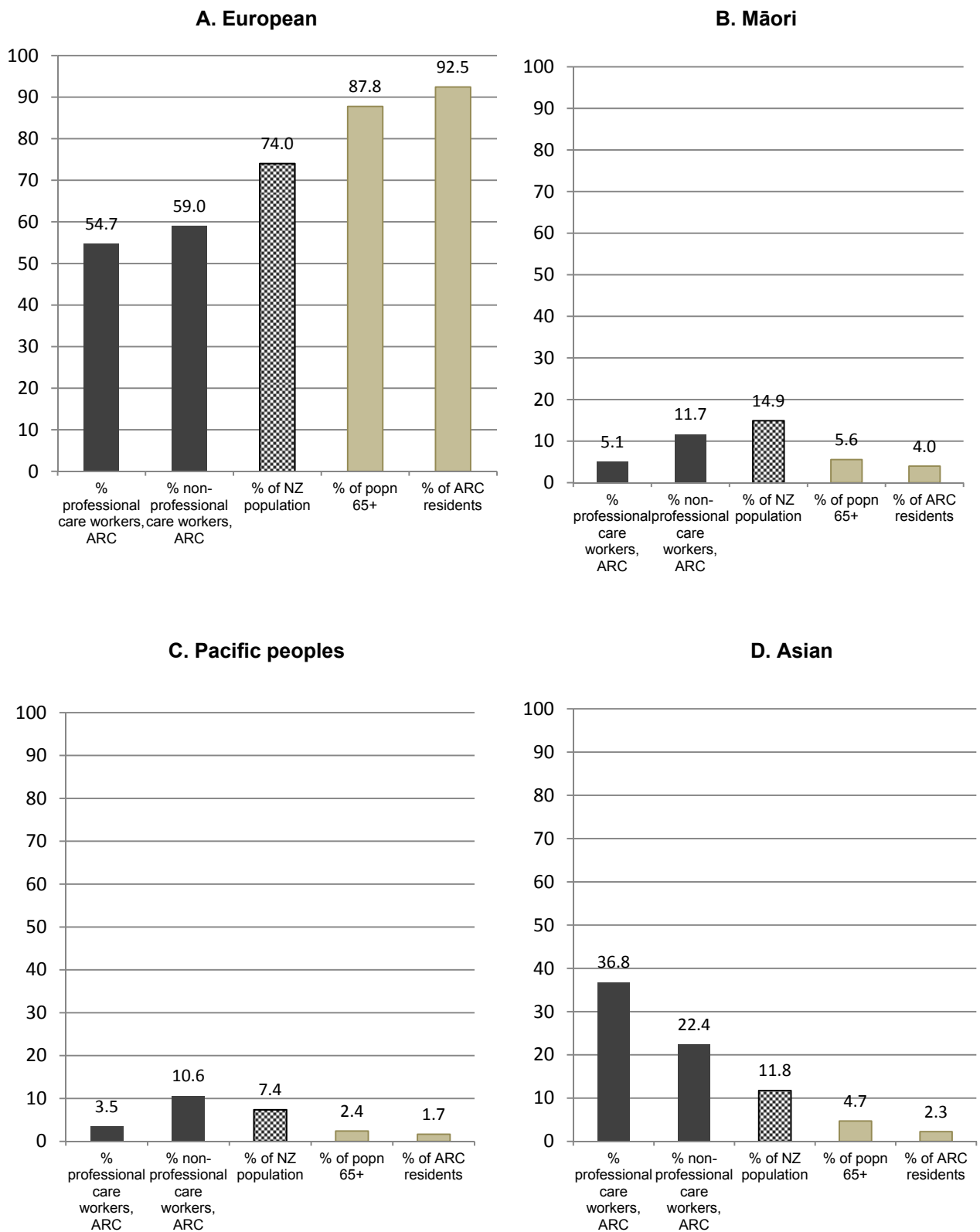
In summary, the vast majority of residents identifies as European (92.5%), while more than two thirds of care workers identify as Maōri, Pacific, Asian or another ethnicity. This pattern points to two kinds of risk in ARC. One risk relates to managing cultural difference in the relationships between workers and residents: the demands of care work are likely to be higher for the large proportion of workers who work with residents with a cultural background that differs from their own (discussed in more detail in Section 2).

The other is the risk of labour market inequalities, as suggested by the relatively low rates of participation in professional occupations among Maōri and Pacific peoples. Occupations such as health care assistant, into which it is relatively easy to enter, may be more available to these groups, particularly to Pacific peoples. Further, international research shows that care work, especially jobs designated as low skilled, often rely on migrant workers, and that the low barriers to entry and the lack of social and market power of minority groups contribute to the continuing low relative pay and poor conditions of these jobs (Flippen, 2014; Hussein & Manthorpe, 2014; Manthorpe et al., 2012; Walsh & Shutes, 2012).

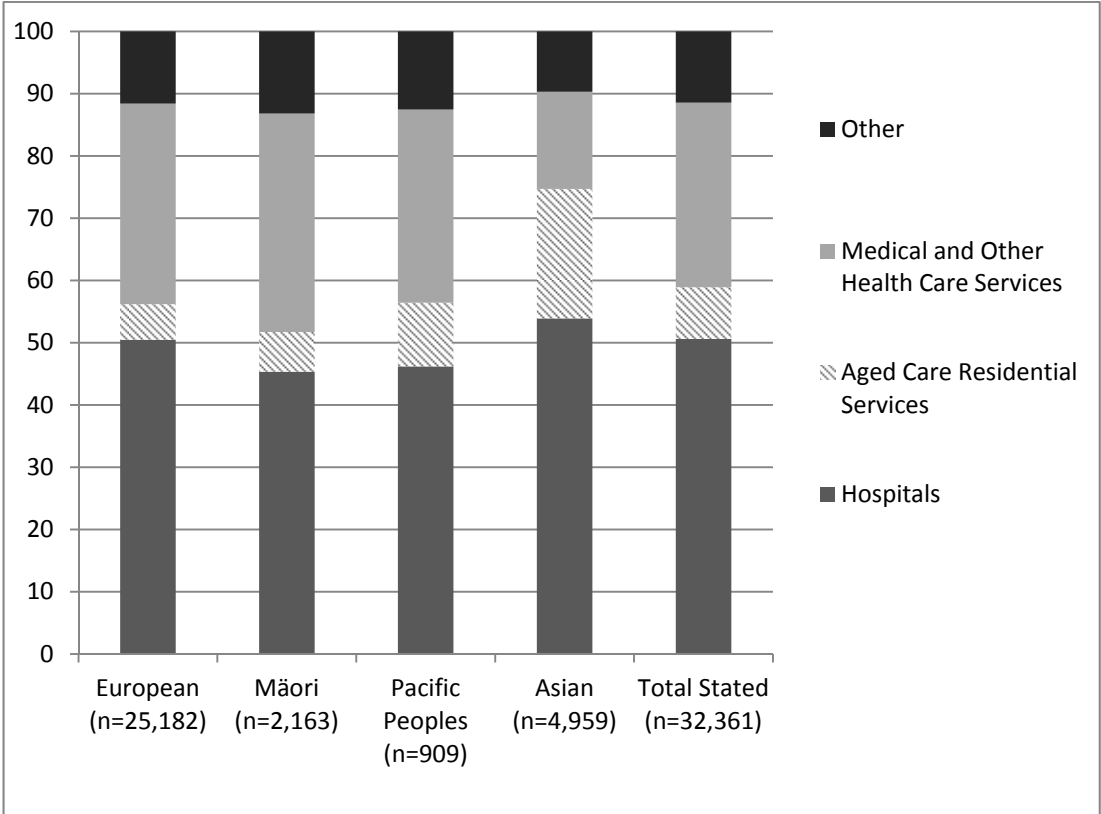
The high proportion of people who identify as Asian among professional care workers is also notable in this respect. As discussed earlier, aged residential care is not considered a highly desirable working environment by graduating nurses. While registered nurses who identify as Asian work in hospitals at a similar rate as registered nurses from other ethnic groups, Asian RNs are much more likely than nurses of European or other ethnicities to work in aged residential care than to work in medical and other health care services, as Figure 9 shows. Whether this relates to fewer opportunities in non-ARC health sectors or to positive discrimination towards Asian nurses in ARC requires further research.



**Figure 8: Ethnic distribution of care workers in ARC, population comparators, and ARC residents, 2013, New Zealand**



**Figure 9: Industry distribution of registered nurses by ethnic identification, New Zealand, 2013**



## Education and qualifications of health care assistants

The care workforce in aged residential care is divided mainly between registered nurses (16%) and non-professional health care assistants (72%), with the remainder in other health professions (5%) and health and welfare associate professional roles (7%). While registered nurses are required to hold the qualifications to support their registration, members of the largest occupational group, health care assistants, are not. Qualifications for these workers are increasingly used/expected, but are not required. Indeed, no formal qualifications beyond three years of high school are required to enter this occupation. Table 4 shows the highest qualifications of carers and aides working in aged residential care in 2013, compared with those working in other health care subsectors. More than one third of those working in ARC have a post-school qualification (37.6%), with similar findings for other health care sub-sectors.

**Table 4: Highest qualification of carers and aides in aged residential care and other health sub-sectors, NZ, 2013, percent**

	Aged residential care	Hospitals	Medical and other health care
No post-school qualifications	62.4	61.4	62.7
Basic vocational qualification	10.4	7.5	7.7
Skilled vocational qualification	9.1	13.1	13.2
Diploma or advanced diploma	7.3	7.6	8.1
Bachelor degree or equivalent	10.1	9.5	7.5
Higher degree	0.7	0.9	0.8
Total*	100 n=11,349	100 n=4,353	100 n=9,078

\* Includes only those who reported their highest level of education

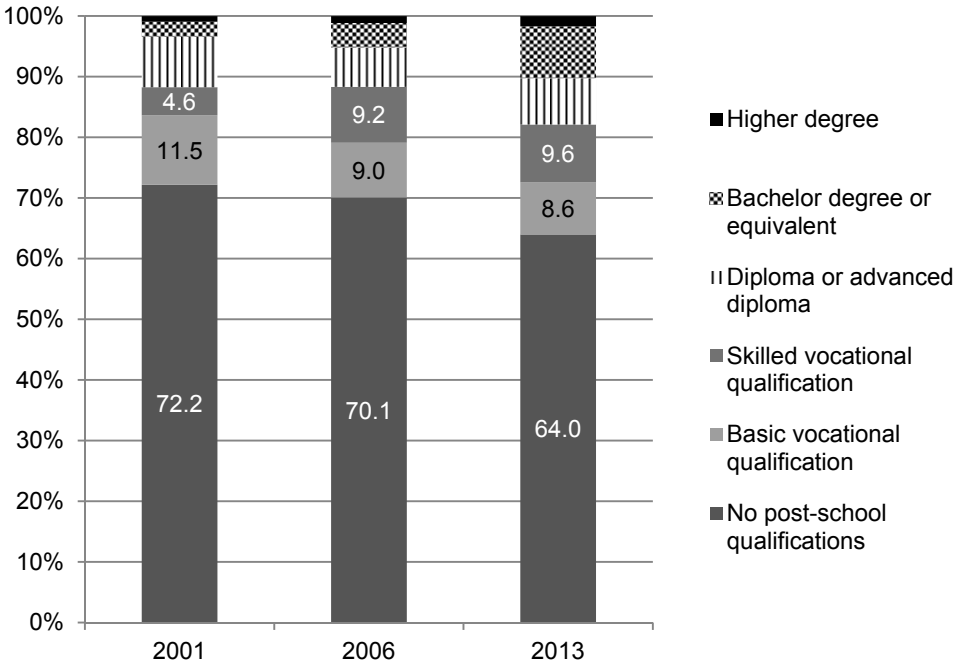
Further, nearly one-fifth (18.1%) has a diploma or higher, including one in ten with a bachelor degree. How these workers' training relates to their work cannot be inferred from this data alone. More information about how their fields of study relate to their work and the extent to which they use their skills at work would be useful. However, some possibilities can be inferred from these data. One is that there is some degree of functional underemployment among those with higher qualifications; that is, they have skills that remain *unused* (and unrewarded) in their work. Another is that these workers have qualifications that enable them to undertake their tasks with a higher level of skill than is recognised by their designated occupation in a care home. In other words, they may be employed in the occupation 'health care assistant' (for which qualifications are neither required nor rewarded) but *perform work* at a higher skill level, which benefits both care home owners and residents, without the corresponding remuneration for workers.

The proportion of notionally unskilled care workers who have post-school qualifications has been growing in New Zealand in recent years. Data that enable direct comparison with that presented in Table 4 are not available. However, it is possible to look at the highest qualification of carers and aides across the New Zealand workforce for the years 2001, 2006 and 2013 (see Figure 10).<sup>4</sup> The trend over time is clear: the share of workers without post-school qualifications has been falling and, since 2006, this is largely due to the growing share of care aides with bachelor degrees.

<sup>4</sup> The qualifications profile of carers and aides in ARC shown in Table 4 is broadly congruent with the profile of personal care assistants in 2013 shown Figure 10 (62.4% compared to 64% with no post-school qualifications).

On one hand, this is a welcome development from the perspective of the increasing complexity of care work in aged residential care (discussed in Section 2 of this report), and the concerns expressed by the NZ Auditor General and others that care workers in aged residential care may not have the skills they need. On the other hand, the skills of the formally over-qualified workers may not be adequately recognised by the designation of their work as unskilled. Overall, it seems that the low formal qualification demands of the occupation of health care assistant is a problem that needs addressing.

**Figure 10: Highest qualification of personal care assistants, NZ, 2001, 2006 and 2013**



Sources: Statistics New Zealand, *Census of Population and Dwellings*, tables 2001\_table608a.xls, 2006\_table608a.xls and 2013\_table608.xls. Notes: in 2001, the occupational title was 'caregivers'; cases coded as 'not elsewhere included' have been excluded from the calculations.

## ***Hours of work of care workers in aged residential care***

This section presents a brief overview of what can be learnt from NZ Census data about the hours of work of care workers in aged residential care. Figure 11 shows the hours of work reported by registered nurses and carers and aides (health care assistants) employed in aged residential care, compared to the other health care sub-sectors and for these occupations in all industries. Panel A shows that nurses have a similar pattern of working hours across different sub-sectors, and that the norm is full-time employment (defined as 30 hours per week or more). In aged residential care, less than a quarter of registered nurses worked part-time (1-29 hours per week). By contrast, the pattern of working hours for carers and aides, shown in Panel B, differs considerably between different health care sub-sectors, with a majority of those employed in medical and other health care services working part-time hours, compared to the majority working full-time hours in ARC and hospitals. It is also noteworthy that the rate of part-time work is higher among HCAs than among RNs: 37% compared to 24%. Further, nearly one in six (16%) HCAs reported working short part-time hours, compared to one in ten RNs (10%).

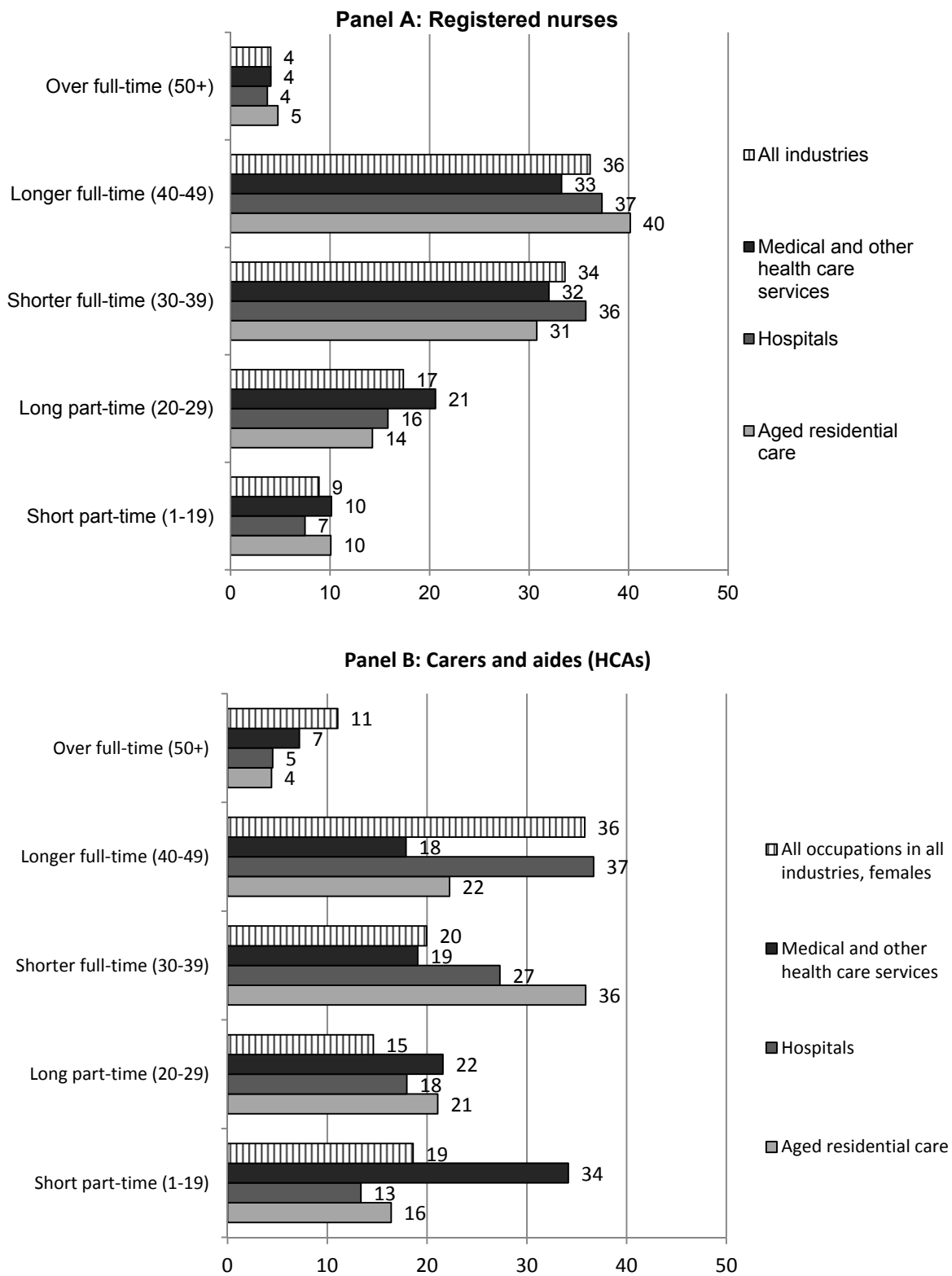
One small difference between the two panels of Figure 11 is that, in the second panel showing the working hours of carers and aides, a comparison with the working hours of all female workers is included (all occupations in all industries, females). This addition makes clear that HCAs reported working part-time in similar proportions as women workers in general (37% compared to 34%), but were much less likely to report working longer or over-full-time hours (26% compared to 47%)

Figure 12 compares the working hours of care workers (in professional, para-professional and non-professional occupations) in aged residential care with the remainder of the ARC workforce employed in non-care occupations. To give a clearer sense of industry and occupational differences, the ARC workforce is also compared with the distribution of working hours for all *female* employees, and for *all* employees in New Zealand (both sexes, all occupations, all industries).

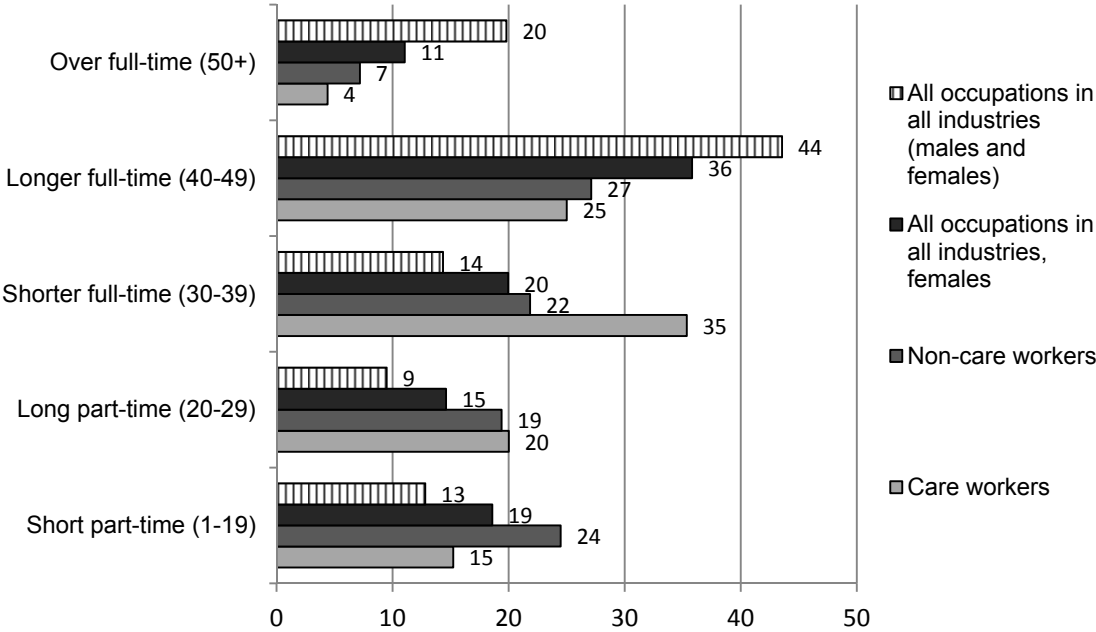
The figure shows that care workers in aged residential care are employed part-time at a similar rate as women workers in general (35% compared to 34%), although the share of workers employed for short part-time hours is lower among care workers in ARC than among women workers in general (15% compared to 19%). The proportion of care workers in ARC who work long full-time hours (40 hours per week or more) is also lower than the proportion of female employees in general (29% compared to 47%). A considerably higher proportion of non-care workers than care workers in ARC works short part-time hours (24% compared to 15%), but a larger proportion of non-care workers than care workers also works 40 hours or more (34% compared to 29%).

Overall, more than a third of care workers (and more than two-fifths of non-care workers) employed in ARC would unlikely to be economically independent. In other words, care workers in ARC would not be able to live on their labour market earnings alone, because they work too few hours weekly to generate a living income. The next section examines available data on the incomes and rates of pay of non-professional care workers (HCAs) in ARC.

**Figure 11: Hours of work of registered nurses and carers and aides in aged residential care and other health sub-sectors, New Zealand, 2013, percent**



**Figure 12: Working hours of care workers and non-care workers in aged residential care, all female employees and all employees, New Zealand, 2013, percent**



## ***Incomes of care workers in aged residential care***

The Census provides some data on the personal incomes of care workers in aged residential care. Figure 13 shows the distribution of personal incomes for carers and aides in ARC compared with all those reporting a personal income in 2013 (Panel A) and with all females reporting a personal income (Panel B).<sup>5</sup> Note that these data relate to income from all sources, not just labour market income. However, they are useful for ascertaining where the personal incomes of non-professional care workers in aged residential care fit within the income distribution in New Zealand.

The figure shows that carers and aides are concentrated in the lower part of the income distribution, and are much more likely to have low incomes compared to all persons and to females in general. More than half (57%) of all non-professional care workers in ARC reported an annual personal income of \$25,000 or less, compared to a quarter of all those reporting a personal income in the Census (25%) and less than a third (32%) of females reporting a personal income. The vast majority of HCAs (96%) reported annual personal incomes of \$40,000 or less, compared to 47% of all those reporting a personal income, and 57% of females reporting an income. Lower average working hours for HCAs are part of this picture, but are unlikely to explain the entire discrepancy.

The Census findings can be indicatively compared with income data collected by Statistics New Zealand,<sup>6</sup> which also help situate care workers' personal incomes in the broader distribution of earnings. Median annual earnings for all employees in 2013 were approximately \$43,680,<sup>7</sup> which supports the inference that almost all non-professional care workers in ARC had earnings below the median, while more than half had earnings below 60% of the median.<sup>8</sup>

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<sup>5</sup> Only those who reported a positive income are included in the calculations underlying the chart. All carers and aides (both male and female) are included in the comparison, since 1) the vast majority of carers and aides in ARC are female (93.5%), 2) the pattern of male incomes in this occupation is broadly similar to the pattern of female incomes (for example, 53.1% of males reported earnings of \$25,000 or less, compared to 57.4% of females, and 57.1% for both males and females), and 3) the aim of this report is to examine the occupation as a whole.

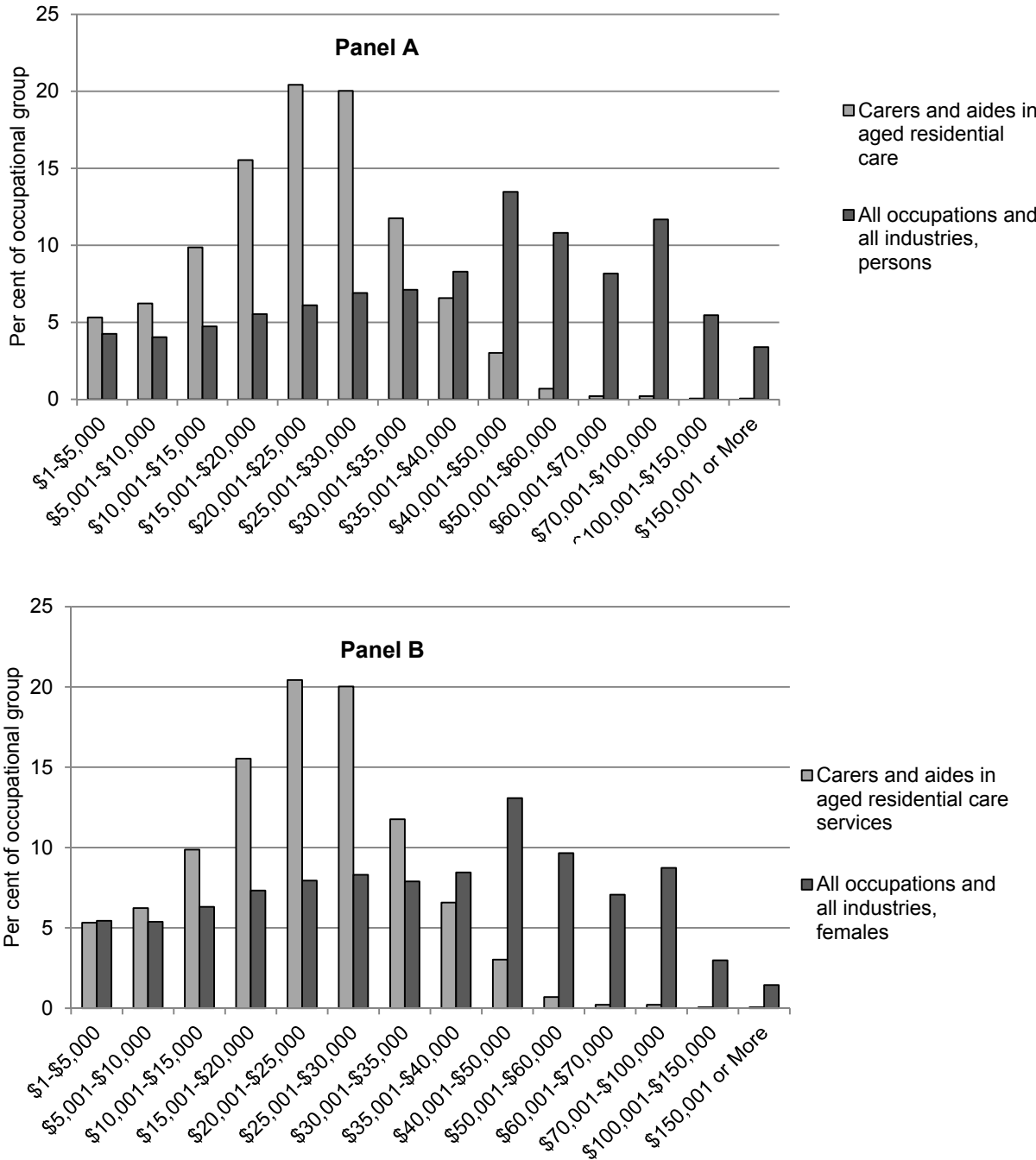
<sup>6</sup> See: [http://nzdotstat.stats.govt.nz/OECDStat\\_Metadata/ShowMetadata.ashx?Dataset=TABLECODE7452&ShowOnWeb=true&Lang=en](http://nzdotstat.stats.govt.nz/OECDStat_Metadata/ShowMetadata.ashx?Dataset=TABLECODE7452&ShowOnWeb=true&Lang=en). These data are not strictly comparable, because the Census reports income from all sources, while the earnings data refers to labour market income only. Because of this, the Census data is likely to *overestimate* the labour market earnings of care workers.

<sup>7</sup> Calculated by multiplying by 52 the median weekly earnings (both sexes and all ages) as reported by Statistics New Zealand at the URL reported in fn 5.

<sup>8</sup> Here, the median weekly earnings for all employees in 2013 (both sexes and all ages) were multiplied by 52, and 60% of this sum was calculated:  $\$840 \times 52 = 43,680$ ;  $60\% \text{ of } \$43,680 = \$26,208$ .



**Figure 13: Distribution of personal annual income, carers and aides in ARC compared with all persons reporting personal income (Panel A) and all females reporting personal income (Panel B), New Zealand, 2013, percent**



Census data, however, is not useful for comparing incomes of specific occupational groups at a more detailed level.<sup>9</sup> Again, income data from Statistics New Zealand is useful here. This data provides a guide to the relative pay of broad occupational groups that supports inferences about the low relative pay of care workers in New Zealand. Table 5 shows the median hourly earnings for broad occupational groups, along with the share of females in each occupational group. The occupational group ‘community and personal service workers’ includes health care assistants in aged residential care, alongside child care workers and education aides. The median represents the level of earnings at which half all employees earn less, and half more per hour. A measure of hourly earnings has been chosen because weekly earnings are affected by different average working hours of women (lower) and men (higher).<sup>10</sup>

**Table 5: Median hourly earnings, major occupational groups, New Zealand, 2015**

	Median hourly earnings (\$)		Female hourly earnings as % of female C&PS workers' earnings
	Females	Males	
Managers	29.08	33.13	173%
Professionals	30.00	36.77	179%
Technicians and trade workers	19.16	23.37	114%
<i>Community and personal service workers</i>	<i>16.80</i>	<i>23.96</i>	<i>100%</i>
Clerical and administrative workers	23.81	27.31	142%
Sales workers	18.10	21.58	108%
Machinery operators and drivers	18.00	21.00	107%
Labourers	16.50	19.32	98%
All occupations	23.01	26.85	137%

The table shows that median hourly earnings for female community and personal service workers, who comprise almost 70% of this occupational group, were \$16.80 in 2015, and *this was lower than median hourly earnings for females in every other occupational group, with the exception of labourers*. Median hourly earnings for female community and personal service workers were lower than earnings for all male occupational groups, and male labourers had median hourly earnings 15% higher than female community and personal service workers (\$19.32 compared with \$16.80).

The final column shows female median hourly earnings in each occupational group as a percentage of median hourly earnings for female community and personal service workers. This shows that women in all other occupational groups have higher median hourly earnings than female community and personal service workers, with the exception of labourers, whose earnings were 2% below (at 98%). The median earnings of female sales workers were, average 8% more per hour than female community and personal service workers, while median earnings of female clerical and administrative workers were 42% more per hour.

The table also shows that women’s hourly earnings are lower than men’s in every occupational

<sup>9</sup> This is because income data are reported in broad bands only, and all sources of income are reported together. Further, because working hours are *also* reported in bands, cross-tabulation is not a viable strategy for fine-grained comparison. Finally, confidentiality issues mean many cells are obscured when detailed occupation and industry classifications are used to identify specific groups.

<sup>10</sup> For a more detailed discussion of different earnings measures, see Meagher (2014).

group. One important reason for this is gender segregation in employment: men and women tend to work in different sub-occupations in different industries, and these differences are not evident in available data, which is reported at a higher level of aggregation (Coelli, 2014; Meagher, 2014). In general, female dominated or ‘women’s’ occupations pay less, on average, than men’s – a point that will be discussed in detail in the final section of this report.

Census income and labour market earnings data from Statistics New Zealand show, in different ways, that non-professional care workers in aged residential care have relatively low earnings. These broader comparative data can be supplemented by information gathered from collective agreements that set out pay rates for different classifications of workers to give quite a precise picture of their relative rates of pay.

A selection of collective agreements was sourced from the New Zealand Nurses Organisation’s website,<sup>11</sup> and pay rates were compiled from these agreements (see Table 6). Table 6 also includes New Zealand’s minimum wage in 2015.

**Table 6: Rates of pay for health care assistants in aged residential care, New Zealand, 2014-15**

Collective agreement	Occupations covered*	Hourly rates <sup>#</sup>
New Zealand minimum wage 1 April 2014 <sup>^</sup> 1 April 2015		\$14.25 \$14.75
Oceania Group Collective Agreement 1 July 2014 – 30 June 2015 (p. 30) <ul style="list-style-type: none"> <li>rates given applicable from 29 August 2014</li> <li>progression is ‘a combination of training and development, performance review and service’.</li> </ul>	<u>Healthcare Assistants</u> Kitchen Assistant / Kitchen Hand Cleaner and Laundry Physio Assistant Recreational Assistant / Activities Officer Receptionist Maintenance / Gardener	1 \$14.46 2 \$14.83 3 \$15.37 4 \$16.26
Bupa Care Services (NZ) Limited Collective Agreement 1 July 2014 – 30 June 2015 <ul style="list-style-type: none"> <li>rates expired 30 June 2015</li> </ul>	<u>Carers</u> Support Workers [which appears to include kitchen hands and cleaning and laundry workers] Physio Assistants Activities Officers	Step 1 entry level \$14.56 with life experience \$14.72 Step 2 \$15.00 Step 3 \$15.57 Step 4 \$16.44 Step 5 \$17.33-\$19.52
Howick Baptist Home & Hospital Aged Care Services Employees Collective Employment Agreement 2013– 2014 <ul style="list-style-type: none"> <li>rates expired 31 March 2014</li> </ul>	<u>Care givers</u> Service workers (‘general cleaning and domestic duties, laundry and sewing work, kitchen duties with limited or little cooking responsibility, porter / orderly duties, routine maintenance and other supportive duties’ p. 21).	1 \$15.17 2 \$15.55 3 \$15.98 4 \$16.41 5 \$16.66

\* Occupations covered by the specific pay scale, collected together in the agreement under a single category

<sup>#</sup> Does not include ‘merit’ rates or rates for ‘special responsibility’

<sup>^</sup> <http://employment.govt.nz/er/pay/minimumwage/previousminimum.asp>

<sup>11</sup> [http://www.nzno.org.nz/support/collective\\_agreements](http://www.nzno.org.nz/support/collective_agreements). A wider search did not reveal further agreements.

The *first* point to note is that rates of pay are at, or very close to, the minimum wage in New Zealand. Indeed, to remain within the law, Oceania and Bupa would have needed to raise entry level rates for HCAs during the life of their collective agreements.

The *second* point to note in the table is that health care assistants/care givers are classified along with a range of hospitality and other occupations *which are paid the same rates*. In other words, rates of pay for work that involves caring for frail older people are not differentiated from rates for work that involves (for example) basic food preparation or laundry work.<sup>12</sup> Further, while only one of the agreements, the Bupa agreement, included rates for clerical and administrative employees, this agreement provides some grounds for comparison between rates of pay for care work and entry level administrative work. 'Entry' level rates of pay for 'administrator support' roles were listed in bands, with the lowest set at \$14.57-17.65, while the highest 'Merit' rates for this group were set at \$19.38-20.72. The lowest rate for administrative support workers, then, is 1 cent per hour higher than the HCA rate, while the highest rate for administrative support workers is \$1.20 per hour higher than the HCA rate. Note that the upper point of the *entry* level band for administrative support workers, at \$17.65, falls within the range of the *top* (step 5) of the HCA rates (\$17.33-19.52).

The *third* thing to note is the opportunities for pay progression within the health care assistant/care giver occupation are limited, particularly in two of the three agreements (Howick and Oceania). There are few steps in these classifications (4-5), and pay increases with progression are generally low. Under two of the agreements, the highest step is paid no more than 10% (Howick) or 12% (Oceania) more than the rate paid to the lowest step. In the Bupa agreement, step 5 is presented as a range, with the lower point 19% higher than the entry level step 1 rate, and the upper point 34% higher. Further, in both the Oceania and Bupa agreements, progression is subject to performance appraisal, not annual progression by years of service, as in the Howick agreement.

Evidence from the three sources compiled here: the Census, Statistics New Zealand's earnings data, and collective agreements covering non-professional care workers in aged residential care confirm that these workers have relatively low total personal incomes (Census), labour market earnings (Statistics NZ) and occupational rates of pay (collective agreements).

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<sup>12</sup> A similar observation applies to physiotherapy assistants and activities officers, who, to do their jobs well, need to pay careful attention to the individual needs of frail older people.

## 2. The nature of care work in aged residential care

Work in aged residential care, along with work in other health and social assistance industries, has specific characteristics. As shown in Figure 1, the majority of workers in these industries provide direct care and support of some kind to service users, many of whom are vulnerable because of age, illness or disability.

Because aged residential care services are primarily oriented toward delivering assistance with activities of daily living and nursing care, they are labour intensive. The workforce is the principle means of service delivery and, as such, the quality of services depends on a combination of 1) the skills and dispositions workers bring to their interactions with service users and 2) the resourcing and organisation of their work. The resourcing and organisation of care workers' work are determined at the industry level by government policies on employment relations and aged care services and at the organisational level by management practices. For employers and funders, the essential role of care workers in service delivery means that labour costs are significant, comprising around 70% of totally operating costs in NZ aged residential care (Grant Thornton, 2010).

Research in New Zealand and internationally has found that care workers in aged residential care value the opportunity to make a positive difference in the daily lives of residents. Yet while work involving care is potentially satisfying, it is also physically and psychologically demanding, and low pay is a source of dissatisfaction with jobs in the sector (King et al., 2012; New Zealand Human Rights Commission, 2012; Ravenswood et al., 2014).

The skill demands of care carried out by nurses in aged residential care, which are related to the medical needs of residents (such as managing medications and complex wound dressings) are broadly recognised. The social and practical skills needed for health care assistants (HCAs) to provide good care are less well recognised. These workers are employed in the care occupation that is represented as the least skilled in aged residential care, and are the focus in the remainder of this section.

Older people in residential facilities are experiencing a major transition from relative independence to relative dependence in life in general, and in the activities of daily living in particular. A significant proportion of residents also have evolving cognitive problems. Thus, as HCAs offer support in activities of daily living, they work closely with these older people in their most vulnerable and exposed moments of waking, eating, toileting and bathing. Care staff are also members of the community formed within the facility where residents are attempting to make their new homes. Providing high quality care demands sensitivity from workers at all skill levels, as residents adjust to the psychological, physical, social and locational changes they undergo (Jaye et al., 2015).

Caring for older people in aged residential care is a demanding occupation, the skills of which are poorly recognised. Moreover, several developments within the ARC field in recent years have further *increased* the scope and intensity of skill demands on care workers at all levels, including HCAs. These include increasing frailty of residents, new models of care and the growth of an audit apparatus to oversee care quality.

### ***Increasing resident frailty***

One important development has been that the characteristics of the population of older people who live in aged residential care in New Zealand has changed in recent years, such that residents are frailer, on average, now than they were in the past. One driver of this increasing frailty in the resident population is the trend towards lengthening older people's time in their own homes, to minimise growth in the more expensive residential care system (Health Workforce New Zealand, 2011). Thus, today older people tend to enter aged residential care in a frailer condition than in the past. This is confirmed by a unique New Zealand study, which has shown that between 1998 and 2008, the proportion of residents with 'moderate' or 'appreciable dependency' or who needed 'hospital level care' increased from 59% to 79%, with 'dependency in mobility, toileting, urinary and faecal incontinence, dressing, and orientation to time demonstrate[ing] a steady and statistically significant increase' (Boyd et al., 2011). The same study found a prevalence rate of two thirds for cognitive impairment, and one fifth for challenging behaviour in aged care facilities. A related recent study by the same team found that one-fifth of older New Zealanders died within six months of entering residential care (Connolly et al., 2014). The authors argue that aged care facilities in New Zealand are increasingly functioning as *de facto* hospices for older people – with significantly fewer and less well trained staff than those who carry out end-of-life care in designated hospices. Both studies noted the importance of specially trained staff for the delivery of high quality care for older people in their final months.

### ***New models of care***

The second development relates to two trends in models for the care of older people. One is the reorientation of aged care provision towards home-based care and preventative re-ablement of older people; as discussed, for example, in the report *Workforce for the care of older people* (Health Workforce New Zealand, 2011). Service reorientation *away* from long-term residential care has, nevertheless, profound implications *for* the profile of ARC resident populations, and for the daily work of ARC workers. Specifically, this reorientation is likely to accelerate the trend towards increasing dependency and complexity of need among residents of aged care facilities because only the most frail older people will enter residential care permanently, and temporary care will be used for people normally cared for at home who experience a spike in their needs, and are offered additional short-term support.

The other trend in care models for older people is an increased emphasis on the individualisation of care. While older people must necessarily adapt to their changed circumstances when they enter an aged care institution (Jaye et al., 2015), contemporary models of care reject the 'institutionalisation' of older people. Thus, instead of being required to conform to the norms and routines of a residential institution, under contemporary care models, each older person living in ARC should receive personalised care in a home-like environment. The requirement for care to be individually adapted is established in the Health and Disability Services (Standards) Act 2001, which governs the accreditation of providers and the quality of services in aged residential care. Older people living in ARC have rights as 'consumers' under the Act and associated Standards, under which they must be afforded privacy and respect, and be free from discrimination and coercion, among other things (Health and Disability Commissioner, 2014).

More specific requirements for individually adapted care are set out in the service agreement made between each ARC provider and the relevant District Health Board(s) (DHB Shared

Services, 2015). These agreements require providers to offer services which are, for example, 'relevant to the health, support and care needs of each [resident], recognising their cultural and/or spiritual values, individual preferences and chosen lifestyles'. Providers must 'ensure that support and care is flexible and individualised, focusing on the promotion of quality of life' and that the staff 'build a supportive relationship' with residents. Each resident must have a care plan that is available to all staff, who are required to use these plans to guide care delivery according to their level of responsibility.

Since HCAs form the bulk of the care workforce (discussed in detail below), they necessarily interact most intensively and extensively with residents in ARC facilities. Further, many of the requirements of individually adapted care, such as relevance to the spiritual values and chosen lifestyles of residents, and respectful treatment, cannot be reduced to a prescribed set of tasks that HCAs simply carry out as directed. Indeed, research has shown that, even in 'basic' care issues such as continence management, significant ethical challenges arise as nurses and care assistants attempt to enable residents to maintain their autonomy and dignity in the process of continence management, given that requirements were sometimes internally contradictory and competed with other demands (Ostaszkievicz et al., 2014).

Further, as discussed earlier in this report, the ethnic profile of residents in aged residential care in New Zealand is quite different from the ethnic profile of the workforce. This means that ARC providers cannot assume that their staff will have the relevant cultural competences, which could be expected to derive from a shared cultural background, in relation to the resident profile. This suggests that staff need to learn about cultural differences between themselves and residents, which adds cultural competence to the skills expected of care workers.

### ***The growth of service quality monitoring***

A third development is the growth of the audit apparatus that monitors the quality of aged residential care in New Zealand. This is a positive development aimed at ensuring that providers fulfil their obligations under the Health and Disability Services Standards. However, like all systems for monitoring compliance with standards, quality assurance in ARC makes additional demands on the work and skills of people employed to provide care, and creates some new problems.

Some demands relate to change in the content of daily work, such as the requirement for increased documentation. However, to achieve the goal of assuring that services meet required standards, audit systems also seek to change how practitioners approach their work through mandated quality standards. Accordingly, to ensure their work aligns with these standards, care workers need 1) to understand the standards and how their practice enacts/maps to them, and 2) to know how to assess whether or not their practice has met the standards. As the professional care workers, nurses are expected to provide clinical leadership in ensuring quality care practice by HCAs. However, HCAs' care practice is made up of many small decisions in their moment-by-moment work with older people; decisions about who to respond to, in what order, and how. Such decisions require judgment that cannot be fully codified or routinised.

Other challenges arising from increased audit relate to the potential for negative impacts of monitoring on behaviour in organisations, as shown in forensic detail by Braithwaite and colleagues (Braithwaite et al., 2007). Audit systems tend to focus the attention of practitioners, managers and auditors on the arrangements and practices that are monitored, and away from those which are not. This can put time-pressured care workers in the difficult situation of

choosing between undertaking care tasks and documenting them. In such situations, the ethical demands are particularly challenging, which demonstrates how defining front-line care work as relatively unskilled underestimates the nature of the work.

It is also very difficult to establish systems that go beyond assessing whether documentation is in order, to ensure that the actual quality of care is high (Office of the Auditor General, 2012). In New Zealand, the Office of the Auditor General assessed the quality of oversight of care in aged residential care in 2009 and 2012 (Office of the Auditor General, 2009, 2012). The 2009 report found serious concerns with audit processes. The 2012 report noted considerable improvement in these processes, but also that ‘the effect of changes on quality of care is less certain’ (Office of the Auditor General, 2012).

### ***Conclusion: The skill demands of high quality aged residential care***

This section has sought to show that the skill demands of providing individually adapted, high quality care in residential facilities for frail older people are considerable, and this includes the skills demanded of health care assistants, who undertake the vast bulk of the daily care work. Residents are very frail; a majority has some cognitive impairment and a significant minority exhibits challenging behaviours. Care models are increasingly demanding, with the expectation that each resident receives individually adapted care. To support increasing social expectations of care quality, systems of audit have been implemented and strengthened.

There is evidence that not all care workers in ARC facilities currently have the skills required to deliver care of the standard expected by New Zealand society today (Office of the Auditor General, 2012). However, a wide range of voices has pointed out that recognising and improving the skills of care workers, and increasing their career opportunities and pay are essential for reaching the quality goals of the system, for the benefit of both residents and workers (Careforce New Zealand, no date; O'Halloran, 2011; Report into Aged Care, 2010; SFWU & New Zealand Nurses Organisation, 2012)



### **3. Equal pay issues in aged residential care**

This section examines how some of the characteristics of the aged residential care workforce and aged residential care services have affected the valuation of care work in the sector, by reference to research on the connections between care work, occupational sex-segregation and low pay. The connections between low pay and the status of old people in society, and the ownership structure of the ARC sector are also discussed.

Consistent with other reports (Grant Thornton 2010; Ravenswood, Douglas & Teo 2014), the Census data presented in Section 1 showed that aged residential care is female-dominated in New Zealand. This is also the case in comparable countries, including Australia (King et al., 2012), the United Kingdom (Hussein & Manthorpe, 2014) and the United States (England et al., 2002). Further, income data gathered from several sources confirms that non-professional care workers in aged residential care have low relative pay. This report has also presented Census data that show that people who identify as Māori, Asian or Pacific peoples form a large minority (45%) of the non-professional care workforce in aged residential care. As suggested above, the ethnic composition of the workforce may also affect pay rates, as these workers suffer systematic disadvantage in the NZ labour market.

Low pay undermines aged residential care workers' status and living standards and presents disincentives to work in the sector. Low pay has been associated with a series of challenges facing aged residential care services, including attracting and retaining appropriate staff. Significantly, the rates of pay of health care assistants/caregivers who look after frail older people do not appear to be differentiated from the rates paid to staff who undertake unskilled work in the kitchens and laundries of aged residential care facilities.

Researchers in economics and sociology have identified a range of reasons for low relative pay in aged residential care. These include occupational sex-segregation, the gendered undervaluation of care work, worker preferences and motivations, the characteristics of care recipients, and funding arrangements and the organisational composition of the aged care industry. Several of these reasons overlap; for example, caring occupations are disproportionately undertaken by women. This section considers the arguments and evidence presented in a range of international research.

#### ***Occupational sex-segregation***

Occupational sex-segregation refers to the differential distribution of women and men between occupations in the labour market, such that some occupations are dominated by men and others by women. (Some also have a relatively even distribution of the two sexes.) Researchers have found that female dominated occupations tend to be paid less than male dominated occupations, taking into account educational requirements and other factors that objectively influence worker productivity, and that occupations in which women increase their share of workers, pay rates decline (Mandel, 2013). An early American study by Kilbourne and colleagues (1994) show that some occupations are paid less than others with equivalent job content simply because they employ mostly women or involve skills associated with women – a point to which I return in relation to the undervaluation of care work. A recent Australian study showed that occupational segregation contributes substantially to gender pay inequality, explaining between 39 and 51% of the gap, depending on the method of estimation (Coelli,

2014).<sup>13</sup> Coelli's findings suggest that the gaps shown in Table 5, which presents median hourly earnings of major occupational groups in New Zealand in 2015, are likely to be underestimates of gender inequality in earnings.

Occupational sex segregation is a pervasive labour market phenomenon. In New Zealand, Census data reports on employment in just over 1,000 detailed occupational categories. Of these occupations, 22% are female-dominated (defined as 65% or more female composition), 30% are male-dominated (65% or more male composition), and the remaining 48% are mixed (defined as between 35% and 65% male and between 65% and 35% female composition). However, workers are not distributed evenly among these occupations. Around half all women workers are employed in female-dominated occupations (52%), while nearly two thirds of all men are employed in male-dominated occupations (62%).<sup>14</sup> As the analysis presented in this report has shown, some occupations are largely confined to a narrow range of industries: in the final bar in Figure 9 it can be seen that nearly 90% of all registered nurses work either in hospitals (51%), aged residential care (8%) or medical and other health care services (30%). In the same vein, a majority (around two thirds) of carers and aides work in health and social assistance services. Thus, there is a correspondence between *occupational* segregation and what can be called *industrial* sex-segregation.

### ***The gendered undervaluation of care work***

The correspondence between occupational and industrial sex-segregation is particularly relevant when it comes to industries in which care and assistance are the main activities. As discussed earlier, it is the orientation toward delivering care that gives work in residential aged care (and in other health care and social assistance industries) its distinctive character. Research has shown that jobs involving interacting with other people (which tend to be female-dominated) are generally paid lower wages than comparable jobs, especially where caring or nurturing activities are performed (Barron & West, 2013; England et al., 2002; Kilbourne et al., 1994). In other words, the gendered undervaluation of care work means that care occupations attract a wage penalty.

Studying the United States, England and colleagues (2002) found that 'nurturing' work (defined broadly to include all those who work with people to develop or maintain their capabilities, such as doctors, nurses and teachers as well as health care assistants) attracts lower hourly pay than would otherwise be received, based on qualifications and other job characteristics (including skill demands, educational requirements, and sex composition). The wage penalty for performing nurturing work found in their empirical study was significant. While the penalty affects both men and women performing paid care work, occupational segregation means there are disproportionate numbers of women performing care work. Thus, lower pay for caring jobs contributes to gender pay inequity (England et al., 2002).

In a large study of the British labour market, using data over 17 years, Barron and West found 'clear evidence of a statistically significant wage penalty associated with working in some caring occupations. Those occupations requiring lower levels of educational qualification, *such as*

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<sup>13</sup> This study was a breakthrough in the field, since it used much more disaggregated data than is usually used to measure the effect of occupational segregation on pay. Previous studies – which had more equivocal findings on the relation of gender segregation to gender inequity -- had used broad occupational groups. Coelli's estimator employed 'the detail that women are over-represented in the relatively low-paying carer and aide occupations and under-represented in the higher paying protective services occupations. Both these occupations fall within the middle-paying community and personal services occupational group' (2014: 50).

<sup>14</sup> These figures are derived from the author's calculations based on data from the New Zealand Census for 2013.

*nursing assistants and auxiliaries*, are particularly hard-hit by the wage penalty' (2013, emphasis added).

A further study of the effect of care work on earnings in twelve countries, which also defined care occupations broadly, found that care employment frequently entails wage penalties (Budig & Misra, 2010). The study found that these penalties are independent of differences in worker attributes such as age, education and experience. The authors show that while both sexes are economically disadvantaged for performing care work, wage penalties tend to be larger for women than men.

These studies establish that care work faces a wage penalty, but it is also important to understand why this penalty exists. One reason for the undervaluation of caring occupations arises is the pervasive cultural association between care work and the traditional roles of women. Because work such as that in aged residential care involves care and because the workforce is female dominated, it is often thought about as an extension of women's traditional roles and dispositions, involving 'body work' (Twigg et al., 2011) and personal, emotional contact. An Australian interview study with aged residential care home employers found that they actively constructed the care work and care workers within a 'familial logic', which offered them two benefits:

- (a) it justifies the notion that aged care work needs little or no professional nursing skills and (b) it shapes the assumption that quality aged care work is done in return for emotional rewards rather than for pay, which in turn is used to defend low pay rates (Palmer & Eveline, 2012).

As these female roles are not accorded economic or monetary value in society more broadly, the skills associated with them are also devalued or rendered invisible. Instead of being recognised as skills that some have or have learnt, they are assumed to be natural, feminine capacities – that is, they are associated with *love* rather than with *skill* (Palmer & Eveline, 2012). These cultural assumptions are grounded in the division of labour in society. Paid care work is associated with, or replaces care tasks that are also offered, unpaid, by women within the family (or by volunteers within religious or voluntary organisations), on the basis of love, altruism or duty rather than money. This means that the tasks and skills are consequently valued and paid less than skills associated with male roles (England et al., 2002; Folbre & Nelson, 2000; Kilbourne et al., 1994).

Significant skill is demanded for the delivery of high quality care by HCAs in aged residential care, as documented in Section 2. However, the skills of care work continue to be undervalued across the economy and society as deserving reward commensurate with comparable levels of skill in other kinds of work. Further, as also documented in Section 2, the skill set required for high quality aged residential care is expanding to encompass new demands, driven by new models of care and new accountability requirements, among other things.

### ***Worker motivations and preferences***

Explanations of the undervaluation of care that point to cultural association of care work with women and domestic sphere are made at the *social* level – society and culture shape how the work in occupations such as aged residential care are seen, evaluated and hence remunerated. A further set of explanations for the undervaluation of care work is at the *individual* level, and focuses on worker preferences and motivations. Here the argument is that certain types of work may be paid less because workers choose to trade off pay and conditions (extrinsic rewards) in

order to perform work they prefer because it gives personal satisfaction, such as the satisfaction of helping others (intrinsic rewards).

There is certainly ample evidence that aged residential care workers derive intrinsic rewards from their work with older people (Bjerregaard et al., 2015; King et al., 2012; New Zealand Human Rights Commission, 2012). However, arguments that justify lower pay for these workers on the basis of a trade-off between pay and the satisfaction derived from caring are not convincing. The main reason is that they are one-sided: that is, applied to women's caring occupations, but not to men's jobs.<sup>15</sup> As England and colleagues (2002) point out, the argument that workers' altruistic motivations and care work's intrinsic rewards offset wages could be applied to any job, on the basis that in all occupations and industries are 'self-selected' by workers who derive some fulfilment from that field of work. Yet a male engineer who is good at mathematics and enjoys problem-solving is not expected to take low pay because he has this aptitude and likes these aspects of his job.

Another preference that is cited to justify low pay in care occupations is the organisation of work. Easy entry and the frequent availability of part-time employment attract women workers who find occupations with such arrangements compatible with their unpaid caring responsibilities (Palmer & Eveline 2012). However, women's responsibilities for unpaid caring work in the family are also a product of the social division of labour, and are affected at least as much by policy settings as by women's preferences. In countries where high quality, publicly-funded services for the care of children, people with disabilities and frail older people are available, women have significantly higher rates of full-time work and economic independence (Meagher, 2014). In other words, 'preferences' for jobs that fit with family responsibilities are themselves partly shaped by the availability of good supports for working families.

Further, a recent British study has found that motivations and preferences are themselves socially shaped in fundamental and encompassing ways that mean it is mistaken to take them for granted as an expression of individual free will and desire (Hebson et al., 2015). The authors show how inequalities in access to and experience of education and the labour market combine to shape people's motivations, preferences and orientations – and their sense of their opportunities. From this perspective, women who have few qualifications and few job opportunities, especially those who come from minority groups that experience discrimination, are influenced by cultural scripts about women's roles, dispositions and responsibilities to take care sector jobs, in the expectation they will be more meaningful than other available jobs, such as catering and cleaning. In this way, 'specific economic, family and labour market circumstances combined to shape women's acceptance of many of the poor quality aspects of care jobs' (Hebson et al. 2015, p. 14). These findings further challenge the argument that women simply self-select into care jobs, trading off job quality against wages and conditions to fulfil their individually-determined preferences.<sup>16</sup>

The relationship between care work and the domestic roles of women has already been noted, along with its roots in the opposition of love and skill. However, the idea that workers are motivated by non-pecuniary factors also arises because work in aged residential care, as in other social services, has roots in *voluntarism* (as well as its associations with women's work in

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<sup>15</sup> In fact, compensating differentials in male-dominated occupations are typically hypothesised as offering *additional* remuneration to compensate for unattractive elements of jobs, such as danger and dirt – which, incidentally, are also characteristics of aged residential care (Palmer and Eveline 2012, p. 268-69). See Dorman (2009).

<sup>16</sup> An analogous argument has been made by Nobel Laureate Amartya Sen in his account of 'adaptive preferences', which holds that people whose set of viable options is limited adapt their preferences to fit the options they have.

the home). As such, there has historically been tension around whether care work is a *vocation* on the one hand, or an industry requiring industrial regulation and fair wages on the other.<sup>17</sup> This tension has been encapsulated as *love versus money* (Folbre & Nelson, 2000; Palmer & Eveline, 2012). The argument that care is a vocation has given rise to concerns that care work should *not* be better paid because higher pay might attract workers with less altruistic motivations, thereby ‘crowding out’ the genuine caring motivations that are critical to service quality. This logic has been convincingly refuted (Nelson & Folbre, 2006). Nelson and Folbre point out that good wages and conditions – that *recognise* the contributions care workers make to the well-being of care recipients, their families, and society more broadly – can ‘crowd in’ highly motivated care workers. Low wages can actually drive away well-motivated workers for whom the opportunity costs of choosing a caring occupation are too high, relative to their financial needs, while higher wages may attract such people to care work, and affirm and enhance their professionalism and commitment to care (Nelson & Folbre, 2006; Palmer & Eveline, 2012).

### ***The social status of old people and recipients of aged residential care***

The status of *recipients* of aged residential care services – specifically their limited purchasing power and low social status – also contributes to the undervaluation of care work. Recipients of social care services, including aged residential care, require assistance most at those times in their lives they are least able to earn money, live and work independently, or purchase services on their own behalf (England et al., 2002: 456). Because those who need services have limited capacity to pay, social care services need to be partly or wholly paid for by from society’s collective resources, typically in the form of public funding from government budgets. In New Zealand, a large majority of people living in aged residential care facilities do not have the resources to fund their own care, and so receive a partial or full subsidy (Broad et al., 2014). This has direct implications for staffing levels and the wages and conditions of care workers, because these are determined by the extent of public subsidies for aged residential care (Hussein & Manthorpe, 2014). The NZ Human Rights Commission’s report, *Caring Counts* (2012), links the lack of recognition and respect for older people in New Zealand society to the low priority aged care services receive in public debate and government budgets, and the poor wages and working conditions of the care workers who provide these services.

### ***The ownership profile of the aged residential care sector***

International research shows that the ownership profile of the aged residential care sector has implications for the quality of care, the staffing profile and the level of staffing, and the earnings of care workers. In particular, facilities run for-profit, especially by for-profit chains, have been found to have significantly lower levels of staffing overall, higher proportions of less-trained staff, and lower quality care than those operated on a not-for-profit or public basis (Comondore et al., 2009; Geraedts et al., 2015; Harrington et al., 2012; Harrington et al., 2015). Studies have consistently shown that higher staffing levels are associated with higher care quality (Comondore et al., 2009) and, as noted above, staff costs are the largest share of expenditure in aged residential care. Thus, reducing staff costs via lower staffing levels and/or reducing pay and working conditions for care staff is one clear means, among others, of making profit (Harrington, 2013). The connection between private ownership and lower earnings has been shown in a British study of the structure of wages within the long-term care sector (which includes care for people with disabilities as well as older people, and care in both home and

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<sup>17</sup> This tension was recognised by Commissioner Fisher in her decision on the Queensland Equal Remuneration case of 2009.

residential settings). The study found that care workers employed by for-profit companies had significantly lower earnings than those employed by public or non-profit providers (Hussein & Manthorpe, 2014). These findings are likely to be relevant to the New Zealand situation, since the share of for-profit ownership in aged residential care is high at more than two-thirds (68% in 2010) (Grant Thornton, 2010), and there is no industry-wide award to protect workers across different ownership types.

### **Conclusion**

Positioning the occupation of health care assistant as a low skilled job that requires only low pay is problematic for two reasons.

*First*, it does not recognise the range of skills required to undertake *high quality* daily care of older people. This lack of recognition means that those who exercise these skills are not rewarded for them. This is an issue of fairness, and was identified by the NZ Human Rights Commission in its report (2012). Indeed, the combination of low relative pay in care occupations and the growing share of care occupations in the labour market overall has been found to be a significant contributor to rising income inequality in the United States (Dwyer, 2013). The same dynamic may be evident in New Zealand, and is worthy of further research.

*Second*, by not recognising these skills, and so not requiring them in the recruitment process, the industry is likely to hire many workers who lack the necessary skills. This risks undermining the quality of care and makes residents vulnerable to poor quality care. If residential care for frail older people is seen as an entry level job without skill requirements, the quality of aged residential care will not be able to adequately meet the needs of older people.

Equal remuneration orders are one clear method by which these injustices and risks can begin to be addressed. From a broader policy perspective, consideration could also be given to the level of funding for aged residential care, the effectiveness of quality regulation, and the ownership structure in the sector.

## References

- Barron, D. N., & West, E. 2013. The financial costs of caring in the British labour market: is there a wage penalty for workers in caring occupations? *British Journal of Industrial Relations*, 51(1): 104-123.
- Bjerregaard, K., Haslam, S. A., Mewse, A., & Morton, T. 2015. The shared experience of caring: a study of care-workers' motivations and identifications at work. *Ageing & Society*, DOI: doi:10.1017/S0144686X15000860.
- Boyd, M., Broad, J. B., Kerse, N., Foster, S., von Randow, M., Lay-Yee, R., Chelimo, C., Whitehead, N., & Connolly, M. J. 2011. Twenty-year trends in dependency in residential aged care in Auckland, New Zealand: a descriptive study. *Journal of the American Medical Directors Association*, 12(7): 535-540.
- Braithwaite, J., Makkai, T., & Braithwaite, V. 2007. *Regulating aged care: Ritualism and the new pyramid*. Cheltenham: Edward Elgar Publishing.
- Broad, J., Ashton, T., Lumley, T., Boyd, M., Connolly, M., & Kerse, N. 2014. Biases in describing residents in long-term residential aged care. *The New Zealand Medical Journal*, 127 (1402).
- Broad, J. B., Ashton, T., Gott, M., McLeod, H., Davis, P. B., & Connolly, M. J. 2015. Likelihood of residential aged care use in later life: A simple approach to estimation with international comparison. *Australian and New Zealand Journal of Public Health*, 39(4): 374-379.
- Budig, M. J., & Misra, J. 2010. How care-work employment shapes earnings in cross-national perspective. *International Labour Review*, 149(4): 441-460.
- Careforce New Zealand. no date. *Literature Review for the New Zealand Qualifications Review - Aged Care, Disability, Health and Social Services Sectors*: Careforce New Zealand.
- Coelli, M. B. 2014. Occupational differences and the Australian gender wage gap. *Australian Economic Review*, 47(1): 44-62.
- Comondore, V. R., Devereaux, P. J., Zhou, Q., Stone, S. B., Busse, J. W., Ravindran, N. C., Burns, K. E., & et al. 2009. Quality of care in for-profit and not-for-profit nursing homes: Systematic review and meta-analysis. *British Medical Journal*, 339(b2732).
- Connolly, M. J., Broad, J. B., Boyd, M., Kerse, N., & Gott, M. 2014. Residential aged care: The de facto hospice for New Zealand's older people. *Australasian Journal on Ageing*, 33(2): 114-120.
- DHB Shared Services. 2015. *Age Related Residential Care Services Agreement*. Wellington: DHB Shared Services <http://www.dhbshareservices.health.nz/includes/download.aspx?ID=140115>.
- Dorman, P. *Markets and mortality: economics, dangerous work, and the value of human life*. Cambridge University Press, 2009.
- Dwyer, R. E. 2013. The care economy? Gender, economic restructuring, and job polarization in the U.S. labor market. *American Sociological Review*, 78(3): 390-416.
- England, P., Budig, M., & Folbre, N. 2002. Wages of virtue: The relative pay of care work. *Social Problems*, 49(4): 455-473.
- Flippen, C. A. 2014. Intersectionality at work: Determinants of labor supply among immigrant Latinas. *Gender & Society*, 28(3): 404-434.
- Folbre, N., & Nelson, J. A. 2000. For love or money--or both? *Journal of Economic Perspectives*, 14(4): 123-140.
- Geraedts, M., Harrington, C., Schumacher, D., & Kraska, R. 2015. Trade-off between quality, price, and profit orientation in Germany's nursing homes. *Ageing International*: DOI: 10.1007/s12126-015-9227-1.
- Grant Thornton. 2010. *Aged Residential Care Service Review*. New Zealand: Grant Thornton.
- Harrington, C. 2013. Understanding the relationship of nursing home ownership and quality in the United States. In G. Meagher, & M. Szebehely (Eds.), *Marketisation in Nordic eldercare: a research report on legislation, oversight, extent and consequences*: 229-240. Stockholm: Department of Social Work, Stockholm University.

- Harrington, C., Olney, B., Carrillo, H., & Kang, T. 2012. Nurse staffing and deficiencies in the largest for-profit nursing home chains and chains owned by private equity companies. *Health Services Research*, 47(1, pt1): 106-128.
- Harrington, C., Ross, L., & Kang, T. 2015. Hidden owners, hidden profits, and poor nursing home care: A case study. *International Journal of Health Services*, 45(4): 779-800.
- Health and Disability Commissioner. 2014. *Code of Health and Disability Services Consumers' Rights*. Auckland: Health and Disability Commissioner.
- Health Workforce New Zealand. 2011. *Workforce for the care of older people: Phase 1 report*. Wellington: Ministry of Health.
- Hebson, G., Rubery, J., & Grimshaw, D. 2015. Rethinking job satisfaction in care work: looking beyond the care debates. *Work, Employment & Society*, 29(2): 314-330.
- Hussein, S., & Manthorpe, J. 2014. Structural marginalisation among the long-term care workforce in England: evidence from mixed-effect models of national pay data. *Ageing & Society*, 34(1): 21-41.
- Jaye, C., Hale, B., Butler, M., McKechnie, R., Robertson, L., Simpson, J., Tordoff, J., & Young, J. 2015. One of us: Stories from two New Zealand rest homes. *Journal of Aging Studies*, 35: 135-143.
- Kilbourne, B. S., England, P., Farkas, G., Beron, K., & Weir, D. 1994. Returns to skill, compensating differentials, and gender bias: Effects of occupational characteristics on the wages of white women and men. *American Journal of Sociology*, 100(3): 689-719.
- King, D., Mavromaras, K., Wei, Z., & et al. 2012. *The Aged Care Workforce, 2012*. Canberra: Australian Government Department of Health and Ageing.
- Mandel, H. 2013. Up the down staircase: Women's upward mobility and the wage penalty for occupational feminization, 1970-2007. *Social Forces*, 91(4): 1183-1207.
- Manthorpe, J., Hussein, S., & Stevens, M. 2012. Communication with migrant workers: The perspectives of people using care services in England. *Practice*, 24(5): 299-314.
- Meagher, G. 2014. Persistent inequalities: the distribution of money, time and care. In S. Schroeder, & L. Chester (Eds.), *Challenging the Orthodoxy: Reflections on Frank Stilwell's Contribution to Political Economy*. 79-100. New York: Springer.
- Ministry of Business, Innovation and Employment, 2015. *Fact Sheet: Pacific People in the Labour Market*. In Ministry of Business Innovation and Employment, Wellington.
- Ministry of Health. 2015. *Recruitment of new graduate registered nurses*. Wellington.
- Nelson, J. A., & Folbre, N. 2006. Why a well-paid nurse is a better nurse. *Nursing Economics*, 24(3): 127-130.
- New Zealand Department of Labour. 2009. The future demand for paid caregivers in a rapidly ageing society, *Workforce 2020: Demographic shift*. Wellington: New Zealand Department of Labour.
- New Zealand Human Rights Commission. 2012. *Caring counts*. Wellington: New Zealand Human Rights Commission.
- O'Halloran, J. 2011. Submission to the Workforce Service Review: Workforce for the care of older people. Wellington: Royal New Zealand College of General Practitioners.
- Office of the Auditor General. 2009. Effectiveness of arrangements to check the standard of services provided by rest homes, *Performance Audit Report*. Wellington: Controller and Auditor General.
- Office of the Auditor General. 2012. Effectiveness of arrangements to check the standard of rest home services: Follow-up report, *Performance Audit Report*. Wellington: Controller and Auditor General.
- Ostaszkiwicz, J., O'Connell, B., & Dunning, T. 2014. Ethical challenges associated with providing continence care in residential aged care facilities. *Australian and New Zealand Continence Journal*, 20(4): 179-186.
- Pacific Perspectives. 2013. *Pacific Health Workforce Service Forecast*. Wellington: Pacific Perspectives.
- Palmer, E., & Eveline, J. 2012. Sustaining low pay in aged care work. *Gender, Work & Organization*, 19(3): 254-275.



- Ravenswood, K., Douglas, J., & Teo, S. 2014. *The New Zealand Aged Care Workforce Survey 2014: A Future of Work Programme Report*. Auckland: New Zealand Work Research Institute, Auckland University of Technology.
- Report into Aged Care. 2010. *A Report into Aged Care: What does the future hold for older New Zealanders?* Wellington: New Zealand Labour, the Green Party of New Zealand and Grey Power.
- SFWU, & New Zealand Nurses Organisation. 2012. Submission to the Health Select Committee on Petition 2008/148: Quality care for older New Zealanders (Aged Care Charter). Wellington.
- Standing, G. 2001. Care work: Overcoming insecurity and neglect. In M. Daly (Ed.), *Care Work: The quest for security*. Geneva: International Labour Office.
- Statistics New Zealand. 2013. *Census of Population and Dwellings, 2013*. Wellington: Statistics New Zealand.
- Statistics New Zealand. 2015. *Living outside the norm: An analysis of people living in temporary and communal dwellings, 2013 Census*. Wellington: Statistics New Zealand.
- Sutherland, H. J., & Alexander, W. R. J. 2009. The occupational distribution of Maori 1997-2000 *University of Otago Economics Discussion Papers*, Vol. No. 0204. Dunedin: University of Otago.
- Twigg, J., Wolkowitz, C., Cohen, R. L., & Nettleton, S. 2011. Conceptualising body work in health and social care. *Sociology of Health & Illness*, 33(2): 171-188.
- Walsh, K., & Shutes, I. 2012. Negotiating user preferences, discrimination, and demand for migrant labour in long-term care. *Social Politics*, 19(1): 78-104.



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