

Working in Residential Aged Care: A Trans-Tasman comparison

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Abstract

Residential aged care has become an issue of critical interest in developed countries, including Australia and New Zealand, due to an ageing population and workforce. The ageing population has contributed to concerns about ensuring a sustainable labour supply to the sector. A key barrier to a sustainable workforce in residential aged care in Australia and New Zealand is the physically and emotionally demanding work, which is undervalued and low paid. This article compares the regulatory frameworks for residential aged care in New Zealand and Australia, and considers why, despite different environments, the outcomes for residential aged care workers are very similar. There is scant comparative research in residential aged care, particularly between New Zealand and Australia. This article provides an important overview of the regulatory environment in a sector that is increasingly important to the public, policy makers and researchers.

Introduction

Across the developed world, governments are contending with the policy challenges associated with an ageing population. The extent of the problem is starkly illustrated in OECD figures, and its impact of workforce and retirement policy in general (OECD, 2006). These demographic trends are reflected in Australia and New Zealand where government-sponsored reports have delineated the extent of demographic change and the implications of this change for the provision of social services, specifically aged care services (Badkar, 2009; Commonwealth of Australia, 2004; 2010; Grant Thornton, 2010; Productivity Commission 2008; 2011).

In Australia and New Zealand, particular attention is being paid to the issue of attracting and maintaining a suitable workforce to deliver services to the aged, either in their own home or in residential care facilities (Grant Thornton, 2010; Productivity Commission, 2008; 2011). The demand for aged care is, of course, underscored by the same ageing population that is predicted to leave both countries with critical labour and skills shortages, particularly in aged care (Badkar, 2009; Carryer, Hansen & Blakey, 2010; Kiata, Kerse & Dixon, 2005; Lazonby 2007; Productivity Commission, 2011).

Aged care services are publicly funded on both sides of the Tasman; consequently, the growth in demand for services raises two important public policy questions. The first about the sustainability of the aged care sector, and the second about the responsibility of national governments to guarantee the quality of care provided to the aged. Although key concerns are to prevent escalating cost to governments and public, poor work conditions of employees have been associated with lower quality care. Research has established some connections between poor work conditions, such as stress amongst employees (Bonias, Bartram, Leggat & Stanton, 2010; Schmidt & Diestel, 2010), workload and ensuing lack of time to provide non-physical care (Carryer et al., 2010; Duffield et al., 2011; King & Meagher, 2009; Palmer & Eveline, 2012) and job dissatisfaction created through lack of recognition of the skill

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required and low pay (Bach, Kessler & Heron, 2012; (Badkar, Callister & Didham, 2009; Kaine 2009; Kiata & Kerse, 2004; King & Meagher, 2009; Lazonby, 2007; Martin, 2007; Mears, 2009; Nishikawa, 2011; Palmer & Eveline, 2012; Provis & Stack, 2003; Ryosho, 2011) and lower care outcomes. A critical component in the provision of quality care relates to the supply of appropriately trained workers (Productivity Commission, 2011).

In order to understand how to ensure an appropriate labour supply to the sector, it is necessary to identify and comprehend the characteristics of the aged care sector, in particular, how aged care funding and regulation impacts on the existing, and potentially future, workforce. Funding of the sector is inextricably linked to the wage rates of the workers. As low waged workers in a feminised sector and often on part-time contracts, this group of workers is one that would immediately benefit from a living wage. This article compares the workforce characteristics and regulatory framework for residential aged care in Australia and New Zealand. In doing so, it enables some explanation of how different regulatory systems result in similar working conditions.

Trans-Tasman Comparisons

Researchers have pointed out the benefits of a comparative approach to industrial relations (IR) because it facilitates both a greater understanding of our own IR context, and highlights both positive and negative aspects of the IR system in relation to the comparative country (Bamber & Lansbury, 1998). There have also been calls for increased comparative research between Australia and New Zealand (Markey, 2011), in part because of similar shared union and regulatory environments between the countries during the twentieth century (Ellem & Franks, 2008; Markey, 2011). Although New Zealand and Australia have followed similar IR patterns, for a period of the 1980s and 1990s, there was considerable divergence in formal IR policy (Barry & Wailes, 2005). Despite this divergence, the 2000s saw the two countries align much more in IR policy than the previous two decades (ibid).

This current Trans-Tasman comparative study is particularly fruitful because, despite differences in IR policy in the residential aged care sectors, there are considerable similarities in the increasing demand for labour, and the continuing low wages paid to non-nurses in residential aged care. The poor work conditions in both countries have been the subject of separate research by both authors and by other researchers in Australasia (Kaine, 2012; Ravenswood, 2011; McGregor, 2012; King & Meagher, 2009). Indeed, while this article focusses on residential aged care, Barry and Wailes (2005) also noted similar labour market outcomes from different institutional frameworks.

Through examining the two regulatory systems and where they differ or are similar, it is proposed that systems perpetuating the current poor work conditions will be revealed and potential remedies discovered. This is an important tenet of comparative IR research that is noted by several scholars in the field (Bamber & Lansbury, 1998; Barry & Wailes, 2005). Furthermore, comparing two countries with similar historical IR trajectories enables a focus on the functions of institutions more than comparative national cultures, and strengthens the results where they are similar in both countries, suggesting that they may be more generalisable to other IR contexts than a single nation study.

The similar historical frameworks for IR between these two countries mean that any differences can provide a substantial background for examining, and learning from, the differences and similarities in an increasingly significant sector. Our approach, looking as much at the functions of institutions as the

institutions themselves, answers the critique of an overly institutional approach to comparative industrial relations (Barry & Wailes, 2005; Bamber & Lansbury, 1998; Markey, 2011).

This current article arose through comparison of the results of two earlier studies that were undertaken separately in Australia and New Zealand by the authors. Each study comprised of analyses of three residential aged care organisations in each country. The original projects were conducted with slightly different purposes, one focussing more on regulation in Australia, the other on employee participation and wellbeing in New Zealand. Comparison of results confirmed that, despite differences in regulatory frameworks, the outcomes for workers in residential aged care were very similar in both countries. This current article proposes to outline the workforce characteristics and regulatory frameworks in both countries, offer some explanation for the similar outcomes for workers, and suggest alternative means of regulating residential aged care for employees.

Section one contains an overview of workforce characteristics and issues in residential aged care in Australia and New Zealand. Section two outlines the regulatory context within which residential aged care in both countries is delivered. The penultimate section then considers these regulatory contexts and comparative workforce issues, and suggests potential remedies to address these in both countries. The final section provides some concluding observations about the nature of work in aged care and the impact of regulation on workplace outcomes. It also suggests directions for future research.

Residential Aged Care in Australia and New Zealand

Residential aged care is a growing sector in terms of employment in Australia and New Zealand. Australia had 2773 facilities providing care to 163,000 people in residential aged care facilities in 2010, and New Zealand providers had approximately 34,000 beds in residential aged care facilities in 2011 (NZACA, 2012; Productivity Commission, 2011). Table 1 illustrates how many of the workforce characteristics are similar between New Zealand and Australia: the majority of residential aged care workers are in direct care positions, women, employed on a part-time basis, and increasingly in the age group of 45 years and older.

Table 1: Workforce characteristics

Australia	New Zealand
202,344 RAC workers	Approx. 33,000 RAC workers
73% in direct care roles	77% in direct care roles
89% women	92% women
72% working part-time	64% working part-time
55% aged 35-55	Majority 45 years or older
Increasing use of agency staff	Increasing use of migrant labour
Turnover of approx. 25%	Turnover of approx. 25%

Source: Badkar, 2009; Grant Thornton, 2010; Kiata et al., 2005; Martin & King, 2008; Miller, Booth & Mor, 2008; King et al., 2013; NZACA, 2010.

The workforce issues are similar in both Australia and New Zealand, characterised by a growing sector with constraints on funding. How future workforce demand will be met is a key concern in both countries. It is predicted that workforce demand may increase by 50 to 75 percent by 2026 in New Zealand (Grant Thornton, 2010). In Australia, it is anticipated that the workforce will need to grow to four times its current size to meet demand in 2050 (Commonwealth of Australia, 2012).

One means of reducing demand for workforce is, of course, increasing the workload and intensification of existing employees. There is evidence of this in both countries where research documents a decreasing ratio of employees to residents (Productivity Commission, 2011; Carryer et al., 2010; Haultain, 2011; Kiata et al., 2005). Furthermore, complex tasks are often delegated to lower skilled employees (such as from nurses to caregivers) as a cost cutting measure (Networkers, 2005; Productivity Commission, 2011). These types of efficiency measures may impact on both quality of care as workers have less time to carry out care tasks, but also pose issues for employee health and safety, and, therefore, may increase costs to organisations through injury, accidents, and lost time (Ravenswood, 2011). In Australia, research has shown that increased workload/low staffing levels have contributed to increased staff turnover, and poorer care outcomes (Productivity Commission, 2011). Another factor relevant to workload is the relatively high use of agency staff in Australia to cover absences and shortfalls in staffing levels (King et al., 2013). This, too, impacts on quality of care because, generally, agency staff are not as familiar with residents' needs, but also has on-flow effects on the workload for other staff who may have to compensate for an agency staff member's lack of familiarity with the facility. New Zealand, in contrast, relies on agency staff less, with managers employing existing staff on extra shifts, or allocating more work to individuals on a shift (NZACA, 2010; Ravenswood, 2011).

Wages are relatively low in both countries with residential aged care workers not only on low wages, but low compared to those in similar positions in public sector hospitals (ANF, 2012; McGregor, 2012; Ravenswood 2011). In New Zealand, wages for residential aged care have tracked at the minimum wage or slightly above, with the only increases really being in adjustment with increases to the national wage (McGregor, 2012; Ravenswood 2011). It must be noted that wages are higher in general in Australia than New Zealand, but residential aged care wages in Australia still are low compared to other industries (Productivity Commission, 2011).

Regulatory context – Funding and Quality of Care

Funding of the sector is via public funding, and to a mixture of private (and in Australia some public) providers of residential aged care. Although there are different mechanisms, to be detailed below, both countries regulate the amount individuals pay for residential aged care and by how much they are subsidised. Both countries also regulate the licensing of residential aged care providers, and provide some minimum standard of care guidelines. The patterns of ownership of residential aged care providers differ significantly, with the majority in Australia owned by not-for-profit organisations, and the converse in New Zealand (see Table 2).

Table 2: Ownership of Residential Aged care facilities

	Australia	New Zealand
Profit	35%	68%
Not-For-Profit	59%	32%
Public	6%	0%

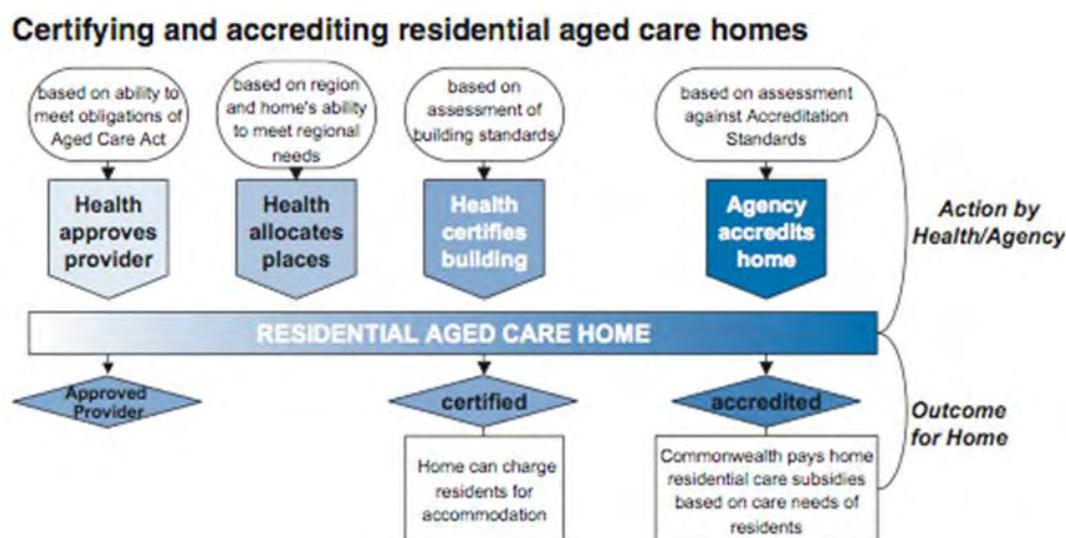
Source: DoHA, 2010 as cited in Productivity Commission, 2011; NZACA, 2010.

The aged care sector in Australia is highly regulated by the state in recognition of the vulnerability of residents and clients (Hogan, 2004), and due to the large amount of public money it attracts. Formal state regulation of residential aged care is complex. It extends to quality of care, location and quantity of services provided, and price controls stipulating the maximum a provider may charge its clients (Productivity Commission, 2011). These regulations are largely enforced as a consequence of the need for a 'managed market'. A key characteristic of this managed market for aged care services in Australia is that the federal government provides the majority of funding for the provision of services within the sector, allowing it to constrain or regulate the actions of non-government (both for-profit and not-for-profit) providers by placing conditions on the granting of subsidies (Howe, 2006). In the case of aged care, those conditions are expressed through the Aged Care Act 1997 (Cth).

The Aged Care Act 1997 (the Act) is the over-arching legislation articulating the goals of the sector, establishing the funding framework and detailing the responsibilities associated with the acceptance of such funding by service providers (Nicoll, Jackson & O'Hanlon, 2003). Specifically, the Act outlines the regulatory mechanisms with which the government controls the allocation of beds, limits service prices and accommodation bond charges, allocates funding and assesses the eligibility of clients to attract subsidies (Productivity Commission, 2008). These mechanisms and their inter-relationships will be explored in more detail below.

Figure 1 illustrates the relationship between the regulations and funding. It shows the regulatory process from the initial approval of a provider by the Department of Health and Ageing to the annual allocation of beds for which the provider applies, through to building certification and accreditation, all of which contribute to the eligibility for funding. The funding of aged care facilities is distributed through subsidies for each resident, which is based on care needs. Given the direct link between the level of care required for a resident and the amount of government funding a facility attracts to care for that resident, government validation through Aged Care Assessment Teams (ACAT) occurs to ensure appropriate care levels are being declared and claimed by providers. The federal government also determines the price paid by residents for subsidised services and the cost of accommodation bonds (Productivity Commission, 2008).

Figure 1: Regulatory Process



Source: Nicoll et al., 2003 as cited in Braithwaite, Makkai & Braithwaite, 2007: 192)

Similarly to Australia, the New Zealand government, via District Health Boards, is the major funder of residential aged care. All aged care residential providers, who provide care to subsidised people, are funded through contracts of service with their District Health Board. The Social Security Act 1964 governs the maximum contributions made by individuals towards their care in residential aged care (Ministry of Health, 2012). Subsidies are granted dependent on the elderly person's dependency levels and means testing of income and some assets (Lazonby, 2010; NZACA, 2010). While the contract of service with aged care providers and District Health Boards is negotiated nationally, compliance with the agreements is monitored by the local District Health Board with which the agreement is made (Office of the Auditor General, 2009).

New Zealand is starkly different from Australia in its lack of current specific legislation governing aged care. Historically, residential aged care was governed by specific regulations: the Old People's Homes Regulations covered minimum standards of accommodation, licences, and the duties of licensees. The latter section outlined the minimum number of hours to be worked by staff (including the manager) per facility according to the number of residents. This regulation was revoked in 1993 and replaced with the Hospital Regulations which also has been superseded. The Health and Disability (Services) Act 2001 currently guides minimum standards for quality of care, and the accreditation of providers. Quality of care is regulated to some extent through this Act (Lazonby, 2007).

The Act provides the basis for standards that must be met to gain certification. These include general and core standards, restraint minimisation standards, infection prevention, and control standards (see Table 3). Within each standard, several specific criteria are included. Table 3 shows some of the standards and how they are audited. According to the Health and Disability (Services) Act 2001, providers must be audited by independent assessors every five years. This process has been called into question because the provider appoints and remunerates the auditor themselves. Furthermore, the standards are for the health and disability sector overall, and it is up to auditors to assess how the standards apply in the residential aged care sector (Office of the Auditor General, 2009).

Table 3: Standards and auditors' requirements

Standard	Example of what the auditors check
Organisation management	Enough staff with the necessary qualification on duty at the rest home. Checked by staff rosters and interviews with manager and staff. Auditors will check records to ascertain that staff receive adequate orientation and training. Check that risk management systems are in place and that rest home service is monitored.
Continuum of service delivery	Residents receive care that is safe and appropriate to their needs. Residents receive medication in a safe way.

Source: Adapted from Office of the Auditor, 2009: 19

Regulatory context – employment conditions

Two recurring key issues for employment conditions are low pay and also workload, with increasing intensification of work in both countries. In New Zealand, there is little regulation governing workload or, indeed, required training for caregivers, with neither the Aged-Related Residential Care agreements or the Health and Disability (Services) Act 2001 providing detailed guidelines for minimum numbers of non-nursing staff nor minimum numbers of hours worked per week.

In Australia and New Zealand, the traditional mechanism for increasing wages in residential aged care has been through centralised instruments, either Awards (in Australia) or through movements in the Minimum Wages Act 1983(New Zealand). The reliance on both of these instruments to alter wages highlights the difficulty faced by caregivers in the sector to collectively bargain. This difficulty is threefold: first the casual/part-time nature of care work in dispersed workplaces has made the sector difficult for unions to organise and, consequently, bargain for (Cooper, 2010). Second, centralised wage determination has been subject to the historical undervaluing of women's work, such as caregiving (Baird, 2003; Kaine, 2012; Palmer & Eveline, 2012). Third, the public funding of aged care in both countries has imposed budgetary constraints, with aged care providers frequently citing inadequate funding as a barrier to improving the wages and conditions of caregivers (Catholic Health Australia, 2013; NZACA, 2011). The cumulative effect of these barriers to bargaining is the continuing reliance of aged care workers on centralised instruments, which only ensure minimal wages and conditions are received.

In Australia, recent changes to labour laws have resulted in a mechanism embedded in the Fair Work Act 2009, which is designed to facilitate collective bargaining amongst low paid workers known as the Low Paid Bargaining Stream (LPBS) (see Naughton, 2012). While the LPBS contains the capacity to include third parties, such as funding bodies in the bargaining process, it cannot compel third parties (such as governments) to increase funding. Unions representing aged care workers applied to access the LPBS in 2010, but the case faced a significant hurdle early on. Fair Work Australia determined that, while aged care workers were indeed 'low paid', it also deemed ineligible to access the LPBS any workers in organisations that had previously only been involved in what might be described as 'defensive'¹ bargaining, effectively splitting the sector in half.

As a consequence of the LPBS excluding significant numbers, aged care unions diverted efforts attempting to influence a review of the sector being undertaken by the federal government. The resulting policy document, *Living Longer, Living Better: Aged Care Reform Package*, was released in 2012. As part of this package of reforms, the then federal government quarantined \$1.2 billion of the \$3.7 billion new funding to the sector, overall, to be used for the improvement of wages and conditions. The receipt of these funds by aged care providers was conditional to particular labour outcomes being agreed upon and met. Specifically, this funding process involved the development of a workforce ‘Compact’ (the tripartite commitment between government, unions and aged care providers), which set out the broad parameters for the disbursement of the additional funding in accordance with goals concerning the improvement of labour standards. Outcomes, thus far, are mixed. While some aged care providers agreed to participate in bargaining under the conditions of the Compact, employer peak bodies have argued that the Compact is “poor public policy” and a break with “established and respected industrial relations practices” (Maher, 2013). Furthermore, the election of a conservative federal government has put in doubt the future of the ‘Compact’ in any form.

There is no obvious parallel in New Zealand, however, the EEO Commissioner of the Human Rights Commission has formal responsibilities, including the evaluation of the role that legislation, guidelines, and voluntary codes of practice play in facilitating and promoting best practice in equal employment opportunities; leading the development of guidelines and voluntary codes of practice to facilitate and promote best practice in equal employment opportunities, and monitoring and analysing progress in improving equal employment opportunities in New Zealand (Human Rights Amendment Act, 2001). The EEO Commissioner has reported on inequalities in aged care for both the older people being cared for and for employees in aged care. This has not led to changed regulations, but has, in October 2012, been the impetus for a summit between some providers, unions, government and other interested parties in aged care with a view to increasing wages and conditions across all types of aged care in New Zealand (McGregor, 2012). Furthermore, a case has been taken by a female aged care worker under the Pay Equity Act 1972, arguing that it is discrimination that aged care workers are paid less because the work is in a female-dominated occupation. This argument tests the interpretation of the Act and is currently awaiting the Judges’ decision (Slade, 2013).

Comparing ‘remedies’

A common outcome of enduring low pay for caregivers in New Zealand and Australia is the likely impact on the quality of care for recipients of aged care. While outcomes are hard to measure in terms of non-physical care, research does indicate that quality of care is impacted on by the workload and wellbeing of caregivers (Bonias et al., 2010; Carryer et al., 2010; Clarke & Hill, 2012; Ravenswood, 2011; Schmidt & Diestel, 2010). As competition among providers increases, reputation for care will become increasingly important. It would, therefore, seem crucial for work conditions to be integral to the regulation and funding of this significant industry. Long term, perhaps radical, ‘blue skies’ ideas are necessary to ensure a skilled, sustainable workforce that provides quality care. What we propose here, however, is more practical medium term solutions that could work with current regulation as future innovations are developed. We propose these as a result of the comparative strengths and weaknesses of both the Australian and New Zealand frameworks.

One weakness of both regulatory frameworks is the lack of assurance for work conditions in the accreditation standards for aged care providers. The national accreditation of aged care providers is central to the funding and regulatory frameworks. The accreditation standards focus on outcomes of care

and overlook the role that employment has in providing quality care. While, currently, these systems are not providing the necessary stimulus for improved working conditions, enhancing the accreditation standards would necessitate greater focus on employment conditions, and the ensuing effect on quality of care. Given the increase in workload, skill and demand for aged care workers, a 'sensible' remedy could be to address these factors more precisely in accreditation standards. Including components of work conditions, such as staffing levels, maximum hours, training and other work conditions in the accreditation standards would indicate their importance for, and connection with, quality of care and, therefore, organisational outcomes for providers. While Australia has specific aged care accreditation standards, New Zealand has very few, and this is one remedy that could be taken from a Trans-Tasman comparison. New Zealand could benefit from standards and audits that refer to the specific conditions of aged care, as opposed to generic health provision guidelines, which existed under the previous legislation in New Zealand briefly outlined earlier.

Furthermore, in comparison to Australia, New Zealand has limited industry and national instruments for aged care workers to collectively take action on wages. In Australia, the LPBS and the Aged Care Compact both represent recent attempts to address wages nationwide. Changes may eventually occur in New Zealand depending on the current case under the Pay Equity Act 1972. One possible solution for New Zealand in the shorter term is the inclusion of employee representation in the negotiations for the national aged care service agreements, strengthening employee voice at an industry level (Ravenswood, 2012). Indeed, a combination of more aged care specific standards for work conditions in accreditation with increased employee voice at a national level could provide substantial improvements for aged care workers. While not exactly the same, this process would mirror the Australian example of linking funding to the development and implementation of a Workforce Compact. We acknowledge, however, that changes to the process of the national service agreements would require considerable change in employers' acceptance of the inclusion of work conditions in their service contract, which has been contested in the past (Healthcare Providers New Zealand Incorporated and New Zealand Association of Residential Care Homes Incorporated vs District Health Boards of New Zealand, 2007), and is, indeed, proving controversial in the Australian equivalent.

Future Research

Palmer and Eveline (2012) highlight the role that a rhetoric of vocation and low-skill has in enduring low wages for aged care work. This is, undoubtedly, a strong underlying factor in the similar outcomes for workers from different regulatory frameworks in New Zealand and Australia. Indeed, as has been argued, both countries have similar IR histories (Bray & Walsh, 1998; Wailes, 2011), which will have been influenced by gendered notions of care work and its value (Frances & Nolan, 2008). However, any change to that rhetoric will be through social change, which is not likely to provide quick solutions to a growing problem. It could be that we may, in both countries, reach a 'tipping point' where the sheer number of baby boomers approaching residential aged care will prompt a rethinking of society's value of care work. This is a complex issue which could provide endless avenues for the exploration of what the societal influences on the value of care work are.

One stimulus to social change could be through changed regulation of the work conditions in the industry in both countries. The question of the role of regulation versus managerial prerogative is an enduring debate, but in the context of aged care, in particular, the role of government not as formal regulator but as the procurer of a service is an area of research that deserves further consideration.

Should our ‘remedies’ of more closely linked work conditions with clinical outcomes be included in accreditation standards, where does this leave the role of unions as representatives of aged care workers? Unions in both countries have been instrumental in the use of current regulation in trying to secure increased wages. In environments of at best stagnating unionisation (OECD, 2013), could our proposed remedy push unions in aged care further to the edges? What would the effects of this be, and could it, in the long term, erase some of the benefits of increased regulation?

While we have focussed on formal regulation, social change could well provide faster moving progress with relation to wages if, for example, the living wage campaign in New Zealand continues to gain social acceptance and employer uptake. While the living wage campaign does not address the general work conditions of residential aged care (such as staffing levels and work load), low pay is a primary concern for workers in the sector. Furthermore, the philosophy underlying the living wage campaign that encourages the respect for and valuing of workers as people could well lead to other improved conditions and recognition of the work that residential aged care workers undertake. The role of unions, managerial prerogative and the living wage campaign will be of future interest in this sector.

Our comparison of aged care regulation in Australia and New Zealand has highlighted some key differences, mainly in the lack of specific attention to aged care in New Zealand. However, the comparison also indicates common weaknesses in accreditation of aged care providers that could provide an avenue for improvement in an industry that is in a state of ‘urgency’. These ‘simpler’ remedies, however, do not preclude the need for long-term planning and thought which looks beyond the ‘simple’ to innovative, perhaps challenging change that may be required.

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Notes

¹ In Australia, the change from state-based industrial relations systems and legislation required workers in aged care to transition from state-based industrial instruments to federally-based instruments. In an attempt to save more favourable provisions contained in the state-based instruments, unions opted to quarantine these conditions in collective agreements.