Research Report

Changing aged care, changing aged care work: workforce and work value issues in Australian residential aged care

Prepared by
Dr Gabrielle Meagher
Professor Emerita
School of Social Sciences
## Contents

Executive summary .................................................................................................................. i

Introduction .................................................................................................................................... 1

1. Who lives in residential aged care and how is this group changing? ........................................ 1
   1.1 High levels of care and support needs ................................................................................. 2
   1.2 Increasing care and support needs ...................................................................................... 3

2. Who cares for older Australians in RAC and how is this workforce changing? ......................... 5
   2.1 Gender in the residential aged care workforce ..................................................................... 5
   2.2 The changing occupational structure of the RAC workforce ............................................... 6

3. How is the RAC sector structured and how is this changing? .................................................. 8
   3.1 Larger facilities, fewer providers in residential aged care ..................................................... 9
   3.2 Changing ownership structure ............................................................................................ 11
   3.3 Implications of structural change for care quality ............................................................... 12

4. Current principles of aged care quality and associated regulation ........................................... 14

5. A new ‘household’ model of residential aged care ..................................................................... 17

6. The impact of sector trends on care work in residential aged care .......................................... 18
   6.1 Changing occupational profile, increasing work demands ................................................... 19
   6.2 Unique demands of ancillary work in residential aged care settings .................................. 21
   6.3 Providing person-centred care is a whole-of-staff responsibility ......................................... 23
   6.4 Changing operational environment, changing administrative demands ............................ 24

7. Work value issues in residential aged care ............................................................................... 25
   7.1 Occupational and industrial sex-segregation ....................................................................... 26
   7.2 The gendered undervaluation of care work .......................................................................... 27
   7.3 Worker motivations and preferences .................................................................................... 28
   7.4 The social status of old people and recipients of residential aged care ............................... 30
   7.5 Ownership and funding of residential aged care ................................................................. 31

Conclusion .................................................................................................................................... 32

References ..................................................................................................................................... 32
Executive summary

This report presents research on the nature and valuation of care work in Australian residential aged care, in the context of change in the structure of the sector and in community expectations about aged care. The focus is the care work carried out by employees under the Aged Care Award (2010), who provide direct care and ancillary and administrative support to older people living in residential aged care facilities. The research is based on analysis of a wide range of official data, public policy documents related to aged care, and other national and international peer-reviewed studies about residential aged care.

The work of people employed in residential facilities is shaped by the characteristics of the older people to whom they offer care, assistance and ancillary support, by the organisational environments in which they work, and by community expectations and regulatory requirements about the quality of care.

1. Who lives in residential aged care and how is this group changing?

Residential aged care touches the lives of many Australians. Today, facilities permanently house one in eight Australians 80 years and over. From a lifetime perspective, a third of all older people in Australia will eventually become permanent residents of an aged care facility.

The population of older people living in residential care today is older, sicker and frailer than in the past and needs increasingly high levels of care and support. Older people are also more diverse, across forms of social, economic and geographical disadvantage and various differences in cultural and sexual expression.

Each year, nearly a quarter of all residents pass away, and new residents move in. The average length of stay is falling, and the share of respite (temporary residents) is increasing. The result is higher turnover among residents.

2. Who cares for older Australians in RAC and how is this workforce changing?

The workforce in residential aged care is overwhelmingly female, across direct care, ancillary support and administrative roles.

The occupational structure of the residential care workforce has changed, in two ways. First, among direct care workers, the share of full-time equivalent personal care assistants has grown from 57% in 2003 to 72% in 2016, and the share of nurses and allied health workers has fallen. Second, the share of direct care workers (nurses, allied health, personal care workers) in the total workforce fell from 74% of all employees to 65% between 2012 and 2016, with a corresponding increase in the share of ancillary and administrative workers and managers.

In addition to the falling share of professional care staff, older people have poor access to specialised medical and other health care, including palliative and end-of-life care from people who are not employed by residential care providers.

---

1 This executive summary does not include detailed statistics or references to support its findings; these are all provided in the full report.
3. How is the residential aged care sector structured and how is this changing?

The residential aged care sector has grown and its structure has changed over the last two decades, across dimensions of facility size, provider size and ownership. These dimensions are systematically related to the quality of care.

The number of places in residential aged care has increased over the last two decades, but has not kept up with growth in the population of older people. This contributes to the increasing needs profile among the resident population.

Over the last decade, the average size of facilities has increased, the number of providers has decreased, and the average size of provider organizations has increased. There are fewer providers who own only one facility, and more large providers who own 20 or more facilities.

The ownership structure has also changed: for-profit private ownership of residential care places has grown strongly, non-profit private ownership has grown weakly, and there has been an absolute decline in public ownership.

These trends – more large facilities, more large providers, more for-profit providers – are linked. The average size of for-profit facilities is considerably larger than non-profit and public facilities. The group of large providers formerly primarily comprising church and charitable groups has been joined by several large for-profit corporations, which operate large and growing chains of facilities.

Change in the structure of the sector, notably growing facility size and increasing for-profit ownership, have implications for the quality of care. For-profit providers have lower average quality than public and non-profit providers, and larger facility size is clearly associated with poorer quality.

While for-profit providers are under-represented among higher quality providers and over-represented among lower quality providers, they are over-represented in the top quartile of providers by earnings per resident. Smaller staffing costs may explain this pattern.

4. Current principles of aged care quality and associated regulation

Contemporary models of care reject the ‘institutionalisation’ of older people that require them to conform to the norms and routines of a hospital-like institution. Instead, models of care increasingly emphasise that care should be person-centred, that is, adapted to the needs of each individual older person, and that person-centred care is grounded in caring relationships in aged care settings.

The ideals of person-centred care are embodied in Australia’s aged care policy and associated regulation, for example, in the Aged Care Quality Standards (ACQS) for providers and the related Charter of Aged Care Rights for older people.

The ACQS set out the expectations on provider organisations, and these organisations’ responsibilities to ensure and demonstrate that their entire workforces are able and enabled to deliver high quality care. Other government regulation includes the National Aged Care Mandatory Quality Indicator Program. In addition to government regulation are voluntary codes, such as Aged Care Voluntary Industry Code of Practice.
5. A new ‘household’ model of residential aged care

Some providers are working through a ‘clustered domestic’ or ‘household’ model of care to enact the model of person- and relationship-centred care framed in the Aged Care Quality Standards. Under this model, tasks that would be conducted by ancillary staff in traditional facilities are included in the role of personal care assistants. Personal care assistants work with the older people to prepare meals, clean the unit and launder clothes, in addition providing them with personal care and other forms of assistance.

Facilities organised on the household model employ a higher proportion of personal care assistants relative to registered and enrolled nurses than standard facilities. Personal care workers spend significantly more time in direct care with older people and receive more training but do not get higher pay.

The household model of care offers residents better quality of life and they have better clinical outcomes, as measured by hospitalisations. Older people and their families also rate this model of care better.

6. The impact of sector trends on care work in residential aged care

The skill, judgement and responsibility demands of work in residential aged care have increased because of the trends identified above: high and increasing needs and diversity among older people, the changing staffing profile, change in the organisational structure of the sector, enhanced principles of care quality and care regulation, and new models of care.

Responsibility for meeting increased needs and expectations falls to the staff of residential facilities. To provide person-centred and relationship-based care, a task-oriented approach to aged care work is not appropriate. Instead, residential care staff need to get to know each older person as an individual, and be enabled with the skills, knowledge and work environment necessary to provide care that meets each person’s specific needs.

Increased levels of need and diversity among older people living in residential care have not been reflected in a larger or a more qualified workforce. The same number of workers is caring for a group of people with much higher needs, and so the amount of care work needed is greater, as well as the content of the work being more skilled, complex and demanding.

Because of these changes in the occupational profile of the direct care workforce, personal care assistants are taking on tasks that were previously carried out by nurses. Because of their greater knowledge of the older people they care for, personal care workers are relied upon by registered nurses to monitor and report on the health status of the older people. In doing this work, personal care workers exercise responsibility and high level skills in observation, assessment and reporting of health information.

Families of older people look also to personal care assistants as the first line of communication about their older relative. Here, personal care assistants are called upon to exercise careful judgement about the kind and extent of information they provide, along with sensitivity and compassion during what can be very difficult times.
Under the household model of care, personal care assistants’ work requires additional organisational and relational skills, as well as additional technical skills related to care, maintaining premises and managing food service.

Increased levels of need and diversity among older people living in residential care also affect the work of employees in ancillary and administrative roles.

Food service staff need increasingly specialised technical knowledge of older people’s nutritional needs and special diets. They also need interpersonal and organisational skills to engage older people and colleagues in arranging meals and mealtimes that meet the goals of personal-centred care.

Cleaners in residential facilities have roles in infection control, maintaining the homelike atmosphere of facilities and in offering relational care to residents. They use a range of technical and interpersonal skills beyond those required in non-health care settings and different from those required in acute care settings.

Providing person-centred care is a whole-of-staff responsibility. Principles such as reablement, and increased psychosocial needs among residents, increase the likelihood that all staff in a facility are called upon to exercise judgment, responsibility and assessment skills, as well as strong interpersonal skills, as they interact and respond appropriately to older people.

Frequent changes in regulation and the diffusion of information technology make demands on the care and administrative staff to learn and adapt. Personal care workers and administrative workers also handle sensitive health information about residents, as part of the documentation and reporting requirements of aged care regulation.

The increasing share of for-profit providers and the growing average size of facilities makes additional demands on workers as they seek to meet regulatory and community expectations.

7. Work value issues in residential aged care

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

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.

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.
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 status of recipients of residential aged care services also contributes to the undervaluation of care work. Because of pervasive ageism, older people are not valued, and so neither is the work of caring for them. Further, 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 also affects the valuation of aged care work. On one hand, facilities run for-profit have significantly lower levels of staffing overall, higher proportions of less-trained staff, and lower quality care that 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. On the other hand, for different reasons related to their foundations in voluntarism and altruism, non-profit providers also have a history of low pay weakly related to the value of work. In non-profit facilities, lower pay may subsidise higher quality within limited resources.

Conclusion

In its final report, the Royal Commission into Aged Care Quality and Safety found that Australia has ‘an undervalued aged care workforce’ and that care workers are ‘paid comparatively less than their counterparts in other health and social service sectors’. It further found that ‘[t]he bulk of the aged care workforce does not receive wages and enjoy terms and conditions of employment that adequately reflect the important caring role they play’.

Undervaluation of aged care work is reflected in an industrial instrument that has not been modernised, despite its title. In female-dominated occupations, especially those related to care, outdated perceptions of women’s roles and women’s work have been frozen by institutional inertia into relative wage structures.

The current award does not recognise the range of skills and responsibilities aged care workers exercise in providing high quality care to older people. Lack of recognition means that those who exercise these skills and responsibilities are not rewarded for them.
Introduction

This report presents the findings of research on the nature and valuation of care work in Australian residential aged care, in the context of change in the structure of the sector and in community expectations about aged care. The focus is the care work carried out by employees under the Aged Care Award (2010), who provide direct care and ancillary and administrative support to older people living in residential aged care facilities.

To understand the changing nature of care work in residential aged care requires knowledge about change in 1) the group of people who live in residential care facilities, 2) the structure and characteristics of the workforce employed to provide care and support, and 3) the structure of the residential care sector and 4) regulation and models of care. The report analyses these aspects of the Australian aged care system, and then sets out the implications of the trends identified for work in residential aged care facilities. The research is based on analysis of a wide range of official data, public policy documents related to aged care, and other national and international peer-reviewed studies about residential aged care.

The findings are discussed in the context of international peer-reviewed research on the nature and valuation of care work, specifically on factors that lead to the historical and contemporary undervaluation of work in occupations such as personal care assistant and ancillary roles in aged care.

While the COVID-19 pandemic has had disproportionate impact on older people living residential aged care and on aged care workers, it is not a focus of this report. Although many of the challenges identified in the report have been exacerbated by the pandemic, they were evident before it.

1. Who lives in residential aged care and how is this group changing?

Residential aged care touches the lives of many Australians. On 30 June, 2020, there were 184,000 people living permanently in residential aged care facilities in Australia. More than three quarters of these people were 80 years or older and, at any one time, more than one in eight Australians in this age group live in residential care.³

A snapshot of residents on a single day like this gives only part of the picture. A life time perspective shows that around a third of all older people in Australia will eventually become permanent residents of an aged care facility.⁴

The work of people employed in residential facilities is shaped in important ways by the characteristics of the older people to whom they offer care, assistance and ancillary support.

---

² Main sources of official data are the Australian Institute of Health and Welfare, the Aged Care Financing Authority, annual Reports on Government Services, the National Aged Care Workforce Census and Survey, the ABS Survey of Disability, Ageing and Carers, the Census of Population and Housing, and research conducted for the Royal Commission into Aged Care Quality and Safety.
³ AIHW https://www.gen-agedcaredata.gov.au/www_aihwgen/media/Data-Snapshot/Aged-Care-Data-Snapshot-2020-Release-3-1.xlsx. Among residents, 76% are 80 years and over, and 13% of this age group live in residential care at any one time. The majority of other residents are aged between 65 and 79 (22% of all residents), while a very small proportion is under 65.
⁴ Broad et al. (2015); Forder et al. (2018).
While the number of older people living permanently in residential care is increasing each year, as the population ages, the share of older people using residential aged care is falling over time, in line with many older people’s preferences, and as community-based care is extended. Thus, people who move into residential care now are older, frailer and sicker than in the past, and their average stay is shorter. In relation to age, over the 10 years to 2019, the share of permanent residents aged 90 years or older increased from 27% to 34%.\(^5\)

### 1.1 High levels of care and support needs

There is clear evidence of older people who live residential aged care are frail and that a majority suffers from multiple forms of ill health. The best available data show that:

- In 2015, most older people living in residential aged care had multiple long-term health conditions; more than three quarters (77%) had at least five conditions, and nearly a quarter (23%) had at least nine conditions.\(^6\)
- In 2019, around half had a diagnosis of dementia.\(^7\)
- Older people living in residential aged care are at significant risk of malnutrition. A recent research review found that around half all residents were malnourished,\(^8\) while the final report of the Royal Commission into Aged Care Quality and Safety cites prevalence of between 22 and 50%.\(^9\)
- A study published in 2015 found that 40% of older people living in residential aged care had sarcopenia, which is ‘a progressive loss of skeletal muscle and muscle function, with significant health and disability consequences’.\(^10\)
- Nearly a quarter (23%) of older people in residential aged care had diabetes, which was twice the rate for people living in the community, according to a study published in 2018.\(^11\)
- Older people living in residential care are particularly susceptible to infectious diseases, such as gastroenteritis, influenza\(^12\) and other respiratory infections, not least COVID-19, due to their frailty, close living arrangements and contact with staff and other visitors.\(^13\) In 2017, a severe flu season, there were more than 500 influenza outbreaks reported in residential aged care in NSW alone.\(^14\)

In relation to activities of daily living, the majority of older people living in residential care have high needs for support. According to the Australian Bureau of Statistics’ Survey of Disability, Ageing and Carers, last conducted in 2015, and the best available detailed source:

---

\(^5\) Calculated using data from the ABS and the AIHW presented in Gibson (2020), Table 1.

\(^6\) Gibson (2020), Table 5, based on data from the Australian Bureau of Statistics Survey of Disability, Ageing and Carers; see also Lind et al. (2020), which reports data from 2014-2017.

\(^7\) Gibson (2020), page 823.

\(^8\) Agarwal et al. (2016).

\(^9\) Volume 2, page 115.

\(^10\) Senior et al. (2015).

\(^11\) Farrer et al. (2018). The authors do not state when they collected the data.

\(^12\) Huhtinen et al. (2019).

\(^13\) See Latta et al. (2019).

• Only one in twenty (5%) permanent residents was able to prepare to eat, and to eat, without assistance. Fully three quarters (75%) required physical assistance in eating or preparing to eat, or both.\textsuperscript{15}

• Fewer than one in five (17%) permanent residents had no need of daily assistance with managing incontinence; almost three quarters (74%) needed assistance four times daily or more.\textsuperscript{16}

• More than half all residents needed to use aids or equipment to get out of a chair or bed (55%), and nearly two thirds needed aids or equipment for toileting (63%). Around three quarters needed aids or equipment for moving about the residential facility (75%), for managing incontinence (70%) and for showering or bathing (76%).\textsuperscript{17}

• Overall, nearly three quarters (73%) had at least five impairments in relation to these activities; 38% have at least nine.\textsuperscript{18}

1.2 Increasing care and support needs

The detailed data presented above, which are available for various points in time over the last decade, demonstrate that older people living in residential care have multiple, complex needs. Importantly, in addition to this snapshot picture, there is also \textbf{strong evidence that older people’s care and support needs have increased during the last 10-15 years}. The major trends as follows, with the availability of data determining the time periods reported:

• Between 2009 and 2019, the share of residents with high care needs increased considerably across the three domains measured in the Aged Care Funding Instrument. The share with high needs in:
  - complex health needs quadrupled, from 13% to 52%
  - cognition and behavioural needs increased from 36% to 64%
  - support in carrying out activities of daily living increased from 33% to 60%.\textsuperscript{19}

  Overall, the share who have high care needs across all the three domains of activities of daily living, cognition and behaviour, and complex health care, increased from a tiny minority (4%) to almost one third (31%).\textsuperscript{20}

• The prevalence of mental health disorders among older people living permanently in residential care has also increased significantly in recent years; from 54% to 68% between 2008 and 2016.\textsuperscript{21}


\textsuperscript{17} Data from the 2015 ABS Survey of Disability, Ageing and Carers, https://www.abs.gov.au/ausstats/abs@.nsf/Previousproducts/4430.0Main%20Features1022015?opendocument&tabname=Summary&prodno=4430.0&issue=2015&num=&view=. The most recent SDAC (2018) has not reported data about people living in residential aged care.

\textsuperscript{18} Gibson (2020), Table 5, based on data from the Australian Bureau of Statistics Survey of Disability, Ageing and Carers.

\textsuperscript{19} Gibson (2020), based on data from the Australian Institute of Health and Welfare.

\textsuperscript{20} Gibson (2020), Table 4, based on data sourced from the Australian Institute of Health and Welfare.
One result of these increasing needs is that, at a point in time now, compared to a point in time a decade ago, the cohort of aged care residents is older, frailer and sicker. A related result is that the group of permanent residents in aged care facilities changes considerably each year, as older people pass away, and new people move in.

Each year, between 55,000 and 58,000 older people living permanently in residential care pass away. This represents nearly a quarter of all residents for the year.\(^2\) And each year, around 70,000 people are admitted to permanent residential aged care for the first time, equivalent to around 30% of permanent residents.\(^3\) Further, as a result of older people’s higher needs on entry, their average length of stay has been falling, to two and half years in 2018-19 from nearly three years a few years earlier. Behind this average is great variability: a quarter of residents stay for less than six months, while a quarter stay for more than three and a half years.\(^4\)

In addition to offering permanent residence, aged care facilities also offer short-term, respite care to older people living in the community. In 2019-2020, nearly 66,000 older people lived temporarily in a residential facility as a respite client. Respite clients increased from around 17%, to nearly 22% of share all older people using residential care services over the decade to 2020.\(^5\) This means that in addition to new admissions of around 30% among permanent residents annually, a significant additional number of older people enter and exit respite care in residential facilities each year.

Older people living in residential aged care come from a diverse range of backgrounds and ‘special needs groups’, as identified under the Aged Care Act. Identified special needs groups include people who are: Aboriginal and Torres Strait Islander; from culturally and linguistically diverse (CALD) backgrounds; living in rural or remote areas; financially or socially disadvantaged; veterans; experiencing homelessness or at risk of becoming homeless; care leavers; parents separated from their children by forced adoption or removal; [and] lesbian, gay, bisexual, transgender and intersex.\(^6\)

\(^{21}\) Amare et al. (2020).
\(^{22}\) Data on the total number of permanent residents each year is available in the AIHW’s Aged Care Data Snapshots for 2017-2019, and in the reports on the operation of the Aged Care Act for earlier years. Data about people leaving residential care, most of whom pass away, is available for the years 2013-14 – 2018-19: https://www.gen-agedcaredata.gov.au/Topics/People-leaving-aged-care. Data for 2020 are not yet available.
\(^{24}\) Gibson (2020).
\(^{25}\) Calculated by adding the total number of older clients in permanent and respite residential care for each year, and dividing by the number of respite clients in each year. Data from additional data files for aged care provided with annual Reports on Government Services, 2012-2021; available https://www.pc.gov.au/research/ongoing/report-on-government-services.
2. Who cares for older Australians in RAC and how is this workforce changing?

Residential aged care employs more than 235,000 people in Australia. The majority of these, around 154,000, are the direct care workers (including nurses, allied health workers, personal care assistants), who assist residents with their health care and personal needs. A further 56,800 employees offer ancillary support for daily life and amenity in facilities through food services, cleaning, laundry, maintenance and gardening, while 10,500 provide administrative support. The work of members of these groups – personal care assistants, ancillary and administrative workers – is the main focus of this report. Another 13,600 employees in residential facilities are care managers/coordinators or managers, while a further 1,000 or so provide spiritual or pastoral support.

2.1 Gender in the residential aged care workforce

The workforce in residential aged care is overwhelmingly female, across direct care, ancillary support and administrative roles.

- Of people employed in direct care roles, 87% are women; among the largest group of direct care workers, personal care assistants, 86% are female.

A very similar pattern is evident among the administrative and ancillary workers who form more than four fifths (82%) of the workforce who are not employed in direct care roles, and who also fall under the Aged Care Award 2010. We can divide ancillary workers into three main groups: 1) food services, 2) cleaning and laundry, and 3) gardening, building maintenance and driving.

- Administrative workers are predominantly female (91%).
- Food services employees form the largest group of ancillary workers (55%), and 80% of these workers are female.

---

27 The primary source of high quality data on the residential aged care workforce is the National Aged Care Workforce Census and Survey (NACWCS), most recently conducted in 2016, and published in Mavromaras et al. (2017). NACWCS has been commissioned and funded by the Department of Health, conducted by the National Institute for Labour Studies (NILS), and carried out in 2003, 2007, 2012 and 2016. NILS closed in 2017, and the study scheduled for 2020 has not been conducted. Reports from these studies are the main source on the direct care workforce in this section.

28 Based on data presented in Tables 3.1, 3.4 in Mavromaras, et al. (2017). Latest available data are for 2016; see previous note. Numbers are weighted estimates headcounts of people employed in different occupational groups and rounded to the nearest 100 for ease of reading.

29 Mavromaras et al. (2017), Figure 3.4.

30 These data on the overall number of direct care and non-direct care workers are derived from Mavromaras et al. (2017), Table 3.4. NACWCS does not include data on the gender of workers in ancillary and administrative roles, so basic data on these workers has been sourced from the Census of Population and Housing 2016. Tablebuilder Basic was used to create a table of all employees in the industry subdivision ‘Aged Residential Care’, by occupation at the most detailed (4-digit) level and by gender. Occupations with more than 100 persons employed in them were considered, then selected and grouped as shown. The composition of each group are given in subsequent footnotes.

31 Administration occupations selected were, ranked from the largest to smallest number of persons: General Clerks, Receptionists, Accounting Clerks, Contract, Program and Project Administrators, Payroll Clerks, Human Resource Clerks, Information Officers, Keyboard Operators, Bookkeepers, Sales Assistants (General), Purchasing and Supply Logistics Clerks, Other Miscellaneous Clerical and Administrative Workers, Secretaries. Professional occupations (e.g. accountant) were not included.
• Cleaning and laundry workers are 33% of ancillary workers; 87% of these workers are female.\textsuperscript{33}

• Gardening, building maintenance and driving workers form the remaining 12% of the ancillary workforce, and this smallest group is predominantly male (95%).\textsuperscript{34}

\section*{2.2 The changing occupational structure of the RAC workforce}

The occupational structure of the residential care workforce has changed considerably in recent years, in two ways. There are two ways of measuring this change in distribution of workers between occupations: a ‘headcount’ and ‘full-time equivalents’. A headcount captures the total number of people employed in each occupation, without taking into account the hours they work. (The workforce data presented above are based on headcounts.) A ‘full-time equivalent’ (FTE) measure captures the size of the workforce in terms of the available labour time. The two measures have different strengths and weaknesses. It is preferable to compare occupations and to measure change over time with FTEs, but this data is not always available.

First, the share of personal care workers in the direct care workforce increased from 57\% to 72\% between 2003 and 2016, measured as full-time equivalent employees, while the share of nurses and allied health workers has fallen (see Table 1 and Figure 1). There was also an absolute decline in the number of registered and enrolled nurses and allied health workers on this measure. All the growth in the FTE direct care workforce was in the occupation ‘personal care attendants’.\textsuperscript{35}

\begin{table}[h]
\centering
\caption{Full-time equivalent direct care employees in the residential aged care workforce, by occupation: 2003, 2007, 2012 and 2016\textsuperscript{36}}
\begin{tabular}{lrrrr}
\hline
 & 2003 & 2007 & 2012 & 2016 \\
\hline
Registered Nurses & 16,265 & 13,247 & 14,129 & 14,857 \\
Enrolled Nurses & 10,945 & 9,856 & 10,999 & 9,126 \\
Allied Health Workers & 5,776 & 5,204 & 5,026 & 3,954 \\
\textbf{Personal Care Attendants} & \textbf{42,943} & \textbf{50,542} & \textbf{64,669} & \textbf{69,983} \\
\textbf{Personal Care Attendants (\%)} & 57\% & 64\% & 68\% & 72\% \\
\hline
\textbf{All direct care workers (FTE)} & 76,006 & 78,849 & 94,823 & 97,920 \\
\hline
\textbf{\% change, 2003-2016} & & & & 29 \\
\end{tabular}
\end{table}

\textsuperscript{32} Food services occupations selected included, ranked from the largest to smallest number of persons: Kitchenhands, Cooks, Chefs, Waiters, Cafe Workers.

\textsuperscript{33} Cleaning and laundry occupations included, ranked from the largest to smallest number of persons: Commercial Cleaners, Laundry Workers, Domestic Cleaners, Housekeepers, Labourers (not further defined), Cleaners and Laundry Workers (not further defined).

\textsuperscript{34} Gardening, maintenance and driving occupations included, ranked from largest to smallest: Handypersons, Gardeners, Bus and Coach Drivers, Garden and Nursery Labourers, Greenkeepers, Technicians and Trades Workers, nfd, Carpenters and Joiners.

\textsuperscript{35} This is the term used in the NACWCS.

\textsuperscript{36} Data reported in Mavromaras et al. (2017), Table 3.3.
Figure 1: Occupational structure of the direct care workforce in residential care, 2003, 2007, 2012, 2016, per cent of total full-time equivalent workforce

Second, the share of direct care workers in the total workforce fell from 74% of all employees to 65% between 2012 and 2016, on a headcount measure. Full-time equivalent data are not available for the following comparisons, but the headcount measures available do provide some useful information. Figure 2 shows that the number of non-direct care employees increased much more (48%) than the number of direct care workers (5%).

Figure 2: Direct care and non-direct care employees in residential aged care, 2012 and 2016, headcount

---

37 Mavromaras et al. (2017), Table 3.3.
38 Calculations based on data in Table 3.1 in Mavromaras et al. (2017). Data on earlier years is not available.
Within the group of non-direct care workers, Figure 3 shows that there was strong growth in all occupational groups except pastoral care. The largest group, ancillary care workers, grew by 46% on this headcount measure, while the second largest group, administrative workers grew 51%.39

Figure 3: Employees in non-direct care major occupational groups, residential aged care, 2012 and 2016, headcount

The data about the direct care workforce presented in Table 1 and Figure 1 point to the loss of specialised professional staff employed in residential aged care over recent decades. However, not all the people who provide support and care to older people living in residential aged care are employed within facilities, and the availability of the services of other, non-employed medical and allied health professions is essential to ensuring the well-being of residents. The services of external specialist professions are also undersupplied in residential aged care. The Royal Commission into Aged Care Quality and Safety reports that ‘older people living in residential aged care have less access to specialist health care than their peers in the community, despite them having much higher levels of care needs’.40 Of particular concern is the lack of access to specialist palliative and end-of-life care, given that the vast majority of older people who move into residential care ultimately die there.

3. How is the RAC sector structured and how is this changing?

Each residential care facility that a group of older people lives in is operated by an organisation. These organisations provide the living environment of residents and the working environment for the people employed to care for them. The residential aged care sector has grown and its structure has changed considerably over the last two decades, across dimensions of facility size, provider size and ownership. These dimensions are systematically related to the quality of care.

40 Royal Commission into Aged Care Quality and Safety (2021), Final Report Volume 2, page 79; based on data from the AIHW.
Figure 4 shows the number of operational places in residential aged care facilities in Australia for the last two decades. The number of places increased around 50%, from around 141,000 to 217,000, between 2000 and 2020. However, this growth in residential aged care places has not kept up with growth in the population of older people. The starred line at the top of the figure shows the number of places per 1,000 people aged 70 years or older in the population. This ratio has fallen (with some slight fluctuations) from 84 to 77 over the two decades, in line with the observation above that a smaller proportion of older people live in residential aged care than in the past.

Figure 4: Operational residential aged care places, 2000-2020, ownership and places per 1,000 people aged 70 and over

3.1 Larger facilities, fewer providers in residential aged care

Residential care places (for individual older people) are located within facilities, which are owned by providers. Facilities can be of different sizes, as can providers, and the size of both has increased over time. Table 2 puts trends in places, facilities and providers together for 2011-2019. The table shows that, between 2011 and 2019, while the number of operational places increased by 16%, the number of facilities remained more or less stable, and the number of providers fell by 18%.

---

41 Data derived from annual Reports on Government Services, 2001-2021; data tables provided for the chapter on Aged Care Services.
Table 2: Number of providers, facilities and places in residential care, 2011-2018

<table>
<thead>
<tr>
<th>Year</th>
<th>Operational places</th>
<th>Facilities</th>
<th>Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011-12</td>
<td>184,570</td>
<td>2,716</td>
<td>1,069</td>
</tr>
<tr>
<td>2012-13</td>
<td>186,278</td>
<td>2,718</td>
<td>1,048</td>
</tr>
<tr>
<td>2013-14</td>
<td>189,283</td>
<td>2,688</td>
<td>1,016</td>
</tr>
<tr>
<td>2014-15</td>
<td>192,370</td>
<td>2,681</td>
<td>972</td>
</tr>
<tr>
<td>2015-16</td>
<td>195,825</td>
<td>2,669</td>
<td>949</td>
</tr>
<tr>
<td>2016-17</td>
<td>200,689</td>
<td>2,672</td>
<td>902</td>
</tr>
<tr>
<td>2017-18</td>
<td>207,142</td>
<td>2,695</td>
<td>886</td>
</tr>
<tr>
<td>2018-19</td>
<td>213,397</td>
<td>2,717</td>
<td>873</td>
</tr>
<tr>
<td>% change 2011-2019</td>
<td>16%</td>
<td>0%</td>
<td>-18%</td>
</tr>
</tbody>
</table>

If the number of places is growing, while the number of facilities is stable, then by logic, the **average size of facilities is increasing**. Figure 5 shows the distribution of places in residential aged care by size of facility. In 2003, around a quarter of all places in residential care were in facilities with 40 or fewer places, while less than half (46%) were in large facilities, with 61 or more places. By 2020, only 7% of places were in small facilities of up to 40 places, while 80% were in facilities of 61 places or more. Among the majority of facilities that have 61 or more places is a significant group with more than 120 places. In data reported to the Royal Commission, around one in six (17%) facilities has 121 places or more.

Further, the **average size of provider organisations is increasing**, as some large for-profit corporations, which run chains of facilities, have grown by acquiring other providers, and as some non-profit providers merged or consolidated their operations under a larger, affiliated entity. In 2012-13, there were 667 providers who owned a single facility and a further 307 who owned two to six facilities. By 2018-19, the number of providers with a single facility had declined 16% to 547 and the number of providers with 2-6 homes had declined 19% to 244. The number of providers owning 7-19 homes was more or less stable at about 60 across this period, while the number of providers who owned 20 or more homes increased 40% from 15 to 21. Thus, while the share of single-home providers is fairly stable at around 63%, their share of places has fallen from 24% in 2013-14 to 20% in 2019-2020. Across the same period, providers who own 20 or more facilities have increased from 1.5 to 2% of all providers, while their share of places has increased from 20% in 2013-14 to 33% in 2019-20.

According to the Royal Commission into Aged Care Quality and Safety, ‘This creates regulatory risk as providers become “too big to fail”,’ such that poor providers may be

---

42 Data reported in Table 8.1 (2017) and Table 6.1 (2020) in the Aged Care Financing Authority’s Annual Reports on the Funding and Financing of the Aged Care Industry, 2017 and 2020.
43 See Table 3, page 168 of Royal Commission into Aged Care Quality and Safety, Final Report, Volume 2.
44 The business pages of major newspapers frequently report on mergers, acquisitions, deal-making, sales, stock market floats and entry and exit of private equity investors in residential care providers; see for example, Urban (2012); Tan (2013); Wilmot (2013); Allen (2014); Kitney (2015); Pugh (2015); Cranston (2016); Tasker (2016); Rawling (2017); Boyd (2019); Wilmot (2021).
46 Aged Care Financing Authority (2014, Table 4.14) and Aged Care Financing Authority (2020, page 61).
permitted to continue operating, ‘because failure of a single provider may affect thousands of vulnerable people receiving care across many locations’.\textsuperscript{47}

**Figure 5: Distribution of operational places in residential aged care by facility size, 2003-2020\textsuperscript{48}**

### 3.2 Changing ownership structure

*Figure 4* above also reveals another trend in the residential aged care sector, in the pattern of ownership of care places. The vast majority of providers are private, either non-profit or for-profit. Between 2000 and 2020, the shares of non-profit, for-profit and publicly-owned providers has changed. Measured as a count of places over time, **for-profit private ownership has grown strongly, non-profit private ownership has grown weakly, and there has been an absolute decline in public ownership.** Measured as ownership shares across the same two decades, the share of publicly-owned places fell from 10% to 4%; the share of non-profit, private providers fell from 63% to 55% and the share of for-profit providers grew from 27% to 41%. **Since 2000, more than two-thirds (68%) of all growth in residential care places has been with for-profit providers.\textsuperscript{49}**

These trends – more large facilities, more large providers, more for-profit providers – are linked. One link is between *facility size* and for-profit ownership. The average size of for-profit facilities is considerably larger than non-profit and public facilities. In 2019, the average number of places in a for-profit facility was 95, compared to 75 in a non-profit facility and 36 in a government-run facility. *Provider size* and for-profit ownership are also linked. In the past, the group of very large providers primarily comprised church and charitable groups. These have been joined, over the last decade and a half, by several large,  

\textsuperscript{49} A ‘dealtracker’ report by industry analyst, Grant Thornton (2015), found that ‘almost all (92%) of the buyers of the Aged Care beds in the last 5 years [to to 31 March 2015] have been for-profit organisations’ (p. 3).
for-profit corporations, some privately held by families,\textsuperscript{50} some listed on the stock exchange, and some owned by private equity funds. These corporations operate large and growing chains of facilities.\textsuperscript{51}

\textbf{3.3 Implications of structural change for care quality}

Change in the structure of the sector, notably growing facility size and increasing for-profit ownership, have implications for the quality of care. Research conducted for the Royal Commission on Aged Care Quality and Safety found that \textbf{for-profit providers had lower average quality than public and non-profit providers}. Facilities were allocated to one of three categories by the researchers, who note that the three ‘quality levels reflect the quality found among facilities within the current residential aged care system under current funding levels’.\textsuperscript{52} While the majority of facilities (78\%) fell in the middle category (Q2), there is a clear association between ownership and quality. Very few for-profit facilities (4\%) were higher quality (Q1), compared to 13\% of non-profit facilities and 24\% of government-owned facilities.\textsuperscript{53} As \textit{Figure 6} shows, for-profit facilities are under-represented among higher quality providers (Column 1, Q1) and over-represented among lower quality facilities (Column 3, Q3), relative to the share of for-profit facilities overall (Column 4). These findings are corroborated in earlier Australian research,\textsuperscript{54} and in international studies.\textsuperscript{55}

\textbf{Figure 6: Distribution of providers by ownership type and quality}\textsuperscript{56}

\begin{figure}
\centering
\includegraphics[width=\textwidth]{distribution图表.png}
\caption{Distribution of providers by ownership type and quality}
\end{figure}

\textsuperscript{50} See Ward (2019).
\textsuperscript{51} See Grant Thornton (2015), EY (2019).
\textsuperscript{52} See Research paper 9, page 3 for a description of the quality categories.
\textsuperscript{53} Royal Commission into Aged Care Quality and Safety, Final Report Volume 2, Table 2, page 166.
\textsuperscript{54} Baldwin et al. (2014).
\textsuperscript{55} International studies include major systematic reviews by Comodore et al. (2009) and Bos et al. (2017); and studies of individual countries, e.g. Bach-Mortensen & Montgomery (2019) on Scotland; Barron & West (2017) on England. Studies of countries with very small shares of for-profit provision of RAC are less likely to find quality differences by ownership; on Denmark, see for example, Hjelmar et al. (2018).
\textsuperscript{56} Based on data in Table 2, page 166, Royal Commission, Final Report Volume 2 (2021).
Research conducted for the Royal Commission also found that **larger facility size is clearly associated with poorer quality**.\(^{57}\) Large facilities were underrepresented among higher quality facilities (Q1) compared to those with fewer places, and overrepresented among facilities with lower quality. For example, very large facilities – those with 121 places or more – were 4% of the higher quality facilities and 29% of the lower quality facilities, while being only 18% of facilities overall. *Figure 7* shows the very clear association between facility size and quality. While the majority of facilities in all size groups fell in the middle Q2 quality category, as facility size increases, the share of higher quality facilities falls and the share of lower quality facilities rises. As noted above, the average size of for-profit facilities is considerably larger than among non-profit and public providers.

**While for-profit providers are under-represented among higher quality providers and over-represented among lower quality providers, they are over-represented in the top quartile of providers by earnings per resident** in every year for which data are available from the Aged Care Financing Authority (2011-2019).\(^{58}\) Research by industry analysts suggest one source of superior financial performance. Staff costs constitute around 70% of providers’ total costs, and **providers in the top quartile of earnings have consistently lower staffing time per resident per day than the sector average**.\(^{59}\) The association between better financial performance and worse outcomes for older people and employees is confirmed in a systematic review of 50 studies comparing for-profit and non-profit residential aged care in the United States.\(^{60}\)

*Figure 7: Distribution of providers by size and quality*\(^{61}\)

---

\(^{57}\) International research also finds that quality is higher in smaller facilities, and declines with facility size (Rantz et al. 2004).

\(^{58}\) As measured by Earnings Before Interest, Taxes, Depreciation and Amortisation (EBITDA) and documented in ACFA’s annual Reports on the Funding and Financing of the Aged Care Sector 2013-2020.

\(^{59}\) See Aged Care Sector reports by StewartBrown; for example, Table 4 in the March 2020 report, and Table 7 in the report for the 2019 financial year.

\(^{60}\) Bos et al. (2016).

4. Current principles of aged care quality and associated regulation

Organisations that operate residential care facilities are expected – by governments that regulate them and by the broader community – to meet regulatory requirements and community standards in their operations. These regulatory requirements and community standards, which are underpinned by principles of care quality, should guide the practice of the workers employed to offer care, assistance and ancillary support to the older people who live in those facilities. Thus, understanding these principles, how they are embodied in regulation, and how they are changing, sheds light on the expectations and roles of aged care workers.

Community expectations in relation to the character and quality of residential aged care have increased significantly in recent decades. While older people must necessarily adapt to their changed circumstances when they enter residential aged care, contemporary models of care reject the ‘institutionalisation’ of older people that require them to conform to the norms and routines of a hospital-like institution. Instead, models of care informed by older people’s perspectives increasingly emphasise that care should be person-centred, that is, adapted to the needs of each individual older person, and that person-centred care is grounded in caring relationships in aged care settings. Relationships include those between older people and those who care for and assist them within a facility, but also those between both these groups and the families of older people. There is a large body of research internationally on the benefits of the person-centred approach to care for older people, and of the organisational requirements, including employment and working conditions, that enable the underlying ideals to be realised.

The ideals of person- and relationship-centred care are strongly reflected in the final report of the recently-completed Royal Commission into Aged Care Quality and Safety. The report offers a clear and detailed account of attributes of high quality aged care, drawing on research prepared under the auspices of the Royal Commission and on the testimony of large numbers of older people, their families, and other individuals and organisations engaged in various ways in providing support and care within the aged care system. The Royal Commission’s Recommendation 13 provides an authoritative overview of the characteristics of high quality aged care; see Box 1 below.

The Royal Commission’s recommendations are forward-looking. However, the ideals of person-centred care are already embodied in Australia’s aged care policy and associated regulation, for example, in the Aged Care Quality Standards (ACQS) for providers and the related Charter of Aged Care Rights for older people. The new ACQS and Charter, in force since 1 July 2019, are more comprehensive than those they replaced. Their aims include improving the quality of life of residents by enhancing infection control, catering, cleaning and laundry services in addition to clinical and other forms of personal support.

---

63 For a detailed analysis and review, see Meagher et al. (2019).
Recommendation 13: Embedding high quality aged care

1. The Aged Care Act 1997 (Cth) should be amended to provide that the Australian Commission on Safety and Quality in Health and Aged Care, in setting and amending safety and quality Standards for aged care (under the functions referred to in Recommendation 18), give effect to the following characteristics of high quality aged care:
   a. diligent and skilful care
   b. safe and insightful care
   c. caring and compassionate relationships
   d. empowering care
   e. timely care.

2. ‘High quality’ care puts older people first. It means a standard of care designed to meet the particular needs and aspirations of the people receiving aged care. High quality care shall:
   a. be delivered with compassion and respect for the individuality and dignity of the person receiving care
   b. be personal and designed to respond to the person’s expressed personal needs, aspirations, and their preferences regarding the manner by which their care is delivered
   c. be provided on the basis of a clinical assessment, and regular clinical review, of the person’s health and wellbeing, and that the clinical assessment will specify care designed to meet the individual needs of the person receiving care, such as risk of falls, pressure injuries, nutrition, mental health, cognitive impairment and end-of-life care
   d. enhance to the highest degree reasonably possible the physical and cognitive capacities and the mental health of the person
   e. support the person to participate in recreational activity and social activities and engagement.

The standards set out the expectations on provider organisations, and these organisations’ responsibilities to ensure and demonstrate that their entire workforces are able and enabled to deliver high quality care.

- Standard 1 of the ACQS establishes the principles of dignity and choice for older people in relation to their care and supports. In recognising older people’s dignity and autonomy, their identity, culture and diversity are to be respected, as is their privacy.
- Standard 2 positions older people as partners in ongoing assessment and planning that helps ensure they receive the care and support that they need for their health and well-being. Plans must meet the older person’s goals and preferences, and focus on their abilities. Plans should be regularly reviewed and revised as necessary. They should be documented, and documentation should be available to the older person and those who care for them.
- Standard 3 requires organisations to deliver safe and effective personal and clinical care in accordance with the older person’s goals and preferences, to optimise their health and well-being. Significantly, in the context of the poor performance of some residential care

---

providers during the COVID-19 pandemic in 2020, Standard 3 includes requirements related to infection control.

- Standard 4 relates the ideals of person-centred care to supports for daily living, which explicitly include cleaning, laundry, food service, gardening and maintenance. Under this standard, these supports should respond to individual needs, goals and preferences, and promote each older person’s emotional, spiritual and psychological well-being. When older people are less able than before to manage day-to-day activities, providers are expected to take a reablement approach to delay decline.

- Standard 5 requires providers to offer a welcoming, physically and culturally safe and comfortable service environment that promotes older people’s independence, sense of belonging, capacities and enjoyment.

The remaining standards establish how organisations should arrange their human resources and governance to ensure that the standards are met, as follows:

- Standard 6 requires organisations to seek feedback and receive complaints, as relevant, from all stakeholders and use these to inform continuous improvements for older people and the organisation, in open and culturally appropriate ways

- Standard 7 requires organisations to have a workforce of sufficient size, that is skilled and qualified to provide safe, respectful and quality care. This includes the requirement that organisations ensure that workers’ interactions with older people are kind, caring, and respectful of each person’s identity, culture and diversity.

- Standard 8 requires providers to have a governing body that is accountable for the delivery of safe and high quality care. Older people must be supported to engage in evaluating services and effective organisational and clinical governance need to be in place.

All the aged care standards have requirements related to consultation, documentation, and organisational supports. **All standards specify in detail high expectations of the workforce, across the full range of care, support, administrative and organisational governance activities and roles.** These address the extensive range of skills, attitudes, personal qualities, dispositions, values and knowledge workers in aged care are expected to have, and the actions, interactions and collaborations they are expected to engage in as they work. Staff are expected to be compassionate, knowledgeable and competent; they are expected to be ‘responsive, inclusive and sensitive’ to people from diverse backgrounds and special needs groups. They are expected to engage sensitively and professionally with the families of older people they care for, including engaging them in care planning according to the older person’s wishes. They are expected to contribute to making aged care facilities welcoming to families and friends, and to connect older people to their communities. They are expected to have working knowledge of, and be able to describe how, the standards are met in their workplace and to recognise and respond if the standards are not met.

A further form of government regulatory oversight, in the form of the National Aged Care Mandatory Quality Indicator Program, became mandatory for all residential aged care
providers from 1 July 2019. Under this program, providers are required to report for each resident on pressure injuries, use of physical restraint and unplanned weight loss. From 1 July 2021, providers must also report on any falls and major injuries, and on medication management.

In addition to government regulation, such as the Aged Care Quality Standards, are voluntary codes, such as the recently revised and relaunched Aged Care Voluntary Industry Code of Practice, promulgated by the Aged Care Workforce Industry Council in March 2021. The principles of this code share with the government regulations the high aspirations of person-centred care and associated high expectations of the dispositions, skills, knowledge and personal qualities in the workforce.

While the principles underpinning the regulation of care quality in residential facilities for older people in Australia reflect those of person-centred care, there is currently no regulation of the level of staffing (for example, of the ratio of care workers to older people), no regulation of the occupational mix of staffing (for example, the proportion of registered and/or enrolled nurses relative to personal care workers). There is also no regulatory requirement that providers spend a designated amount of the funds they receive from public subsidies (or older people’s contributions) to provide care and assistance to older people on that care and assistance.

5. A new ‘household’ model of residential aged care

Australia’s aged care policies require providers to deliver person-centred care, but leave them to develop organisational and staffing approaches to doing so. In this context, some providers are working through a ‘clustered domestic’ or ‘household’ model of care to enact the model of person- and relationship-centred care framed in the Aged Care Quality Standards. A recent Australian study categorised this model as operating where facilities meet five of the following six criteria:

1. Small scale (maximum 15 residents per living unit)
2. Residents have independent access to outdoors
3. Continuity of staff assigned to the living units
4. Meals cooked within the living units
5. Self-service of meals by residents
6. Residents can assist with meal preparation

Standard facilities included for comparison met no more than two of these six criteria.

Under the household model, tasks that would be conducted by ancillary staff in traditional facilities are included in the role of personal care assistants. In addition to

69 Both specific staffing requirements and financial regulation requiring acquittal of staffing costs against designated funding were removed with the introduction of the Aged Care Act in 1997. State-based regulation of regulation, specifically of the presence of RNs in facilities not operated by the government, has also been removed in some states, for example, in NSW.
70 Dyer et al. (2018), page 434.
providing personal care and other forms of assistance to the older people living in the facility, personal care assistants prepare meals (ideally engaging older people in the process), clean the unit and launder the older people’s clothes.

**Facilities organised on the household model employ a higher proportion of personal care assistants relative to registered and enrolled nurses** than standard facilities, and provide more total staff time in direct care with older people. Notably, there was significantly more time spent by personal care assistants and significantly less by registered nurses. Facilities’ spending on staff training was significantly higher in those organised on the household or clustered domestic model, but there was no significant difference in staff pay between the two types of facility.\(^71\)

The household model of care offers residents better quality of life and they have better clinical outcomes, as measured by hospitalisations.\(^72\) Older people and their families also rate this model of care better.\(^73\) This is not surprising, given that smaller facility size is associated with higher quality of care. That household model facilities are developed by motivated, primarily non-profit,\(^74\) innovators in residential care may also be relevant for understanding findings on higher quality in such facilities.\(^75\)

### 6. The impact of sector trends on care work in residential aged care

The demands of work in residential aged care have increased because of the trends identified above: high and increasing needs and diversity among older people, the changing staffing profile, change in the organisational structure of the sector, enhanced principles of care quality and care regulation, and new models of care. These trends pull in contradictory directions, and front-line care workers are called upon to negotiate and manage these contradictions in their daily work.

First, there is clear evidence that the needs of older people in residential care have increased considerably over the last decade, both for clinical care and for assistance with activities of daily living. On average, residents require more, and more complex and varied, assistance with multiple aspects of their physical, psychological, social and emotional lives, than did residents a decade ago.

Second, shorter average stays among permanent residents and an increase in respite residents leads to higher turnover in the group of older people in residential care. Care workers now meet, care for, and part from more older people than they did a decade ago. They need to get to know the needs and preferences of more people across any year than previously, which further increases the complexity of their work.

---

\(^71\) Harrison et al. (2019); note that ‘significant’ here refers to statistical significance. 

\(^72\) Dyer et al. (2018). See Ausshöfer et al. (2016) for a scoping review of research on home-like models.

\(^73\) Gnanamanickam et al. (2019). These findings are often replicated in international studies, e.g. Green (2014); Hermer et al. (2017), Morgan-Brown et al. (2013).


\(^75\) Ibrahim (2018).
Third, in addition to higher turnover among residents, **the group of older people in residential aged care has become more diverse.** This diversity among residents has been explicitly recognised in the concept of special needs groups in aged care policy. In 2013, the Aged Care Act was amended to include all special needs groups within the Act itself, and to add further groups with very different needs from each other. More groups are now recognised as having special needs, and the concept of special needs has been broadened, to recognise, for example, gender and sexual expression differences, and the specific challenges faced by people who have been in state care. As discussed in section 4 above, the Aged Care Quality Standards require that staff have and exercise skills and knowledge about a wide range of social groups so they can meet their individual needs.

Fourth, **prevailing regulatory and community standards have increased expectations of the character and quality of residential aged care.** Responsibility for realising increased expectations falls to the staff of residential facilities, who are required to care for and support older people in ways that respond to their individual needs, goals and preferences, and promote their emotional, spiritual and psychological well-being in all aspects of their work. **To provide person-centred and relationship-based care, a task-oriented approach to aged care work is not appropriate.** Instead, residential care staff need to get to know each older person as an individual, and be enabled with the skills, knowledge and work environment necessary to provide care that meets each person’s specific needs.

Fifth, **new regulatory requirements increase the amount and quality of assessment and documentation required in the course of care provision.** These include the mandatory quarterly reporting against the National Aged Care Mandatory Quality Indicator Program. **These changes significantly increase the skill demands and level of responsibility of work in residential aged care, across multiple dimensions and occupations covered by the Aged Care Award.**

### 6.1 Changing occupational profile, increasing work demands

In many ways, the causes of the increasing demands of care work in residential aged care – the changing population receiving care and enhanced expectations for the quality and character of that care – are positive developments. Older people are entering residential aged care later because they are staying home longer. Increased expectations can drive quality improvement. However, residential care workers confront other trends in the system that pull against these more positive opportunities, and this increases the skill and responsibilities they need to exercise in their work.

One challenge is that, as Table 3 shows, **increased levels of need and diversity among older people living in residential care have not been reflected in a larger or a more qualified workforce.**
Table 3: Average ratio of direct care workers (FTE) to operational places in residential aged care, 2003-201676

<table>
<thead>
<tr>
<th></th>
<th>2003</th>
<th>2007</th>
<th>2012</th>
<th>2016</th>
<th>Growth</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Share of residents with high care needs in at least 2 domains (%)</td>
<td>n.a.</td>
<td>22.7</td>
<td>40.8</td>
<td>61.2</td>
<td>170%</td>
</tr>
<tr>
<td>B. Equivalent full-time direct care workers</td>
<td>76,006</td>
<td>78,849</td>
<td>94,823</td>
<td>97,920</td>
<td>29%</td>
</tr>
<tr>
<td>C. Operational places</td>
<td>148,547</td>
<td>169,594</td>
<td>187,941</td>
<td>195,825</td>
<td>33%</td>
</tr>
<tr>
<td>D. Ratio of FTE direct care workers to operational places (B/C)</td>
<td>0.51</td>
<td>0.46</td>
<td>0.50</td>
<td>0.50</td>
<td>-2%</td>
</tr>
<tr>
<td>E. Share of personal care assistants in direct care staff (FTE, %)</td>
<td>57</td>
<td>64</td>
<td>68</td>
<td>72</td>
<td>15%</td>
</tr>
</tbody>
</table>

- In relation to workforce size, there has been no increase in ratio of full-time equivalent (FTE) workers in direct care roles to the number of operational places in residential aged care between 2003 and 2016, the latest date for which data are available (Table 3, row D.). The number of FTE direct care workers increased 29% across this period (Table 3, row B.), while the number of places increased by 32% (Table 3, row C.).

- In relation to the occupational profile of the workforce, increased levels of need among older people in residential care have not resulted in a more highly trained workforce. Rather, the share of personal care assistants among the direct care staff has increased from 57% in 2003 to 72% in 2016 (Table 3, Row E), with a corresponding decline in the share of registered and enrolled nurses and allied health professionals and aides (see also Table 2 and Figure 1 above).

These trends effectively mean that the same number of workers is caring for a group of people with much higher needs, and so the amount of care work needed is greater, as well as the content of the work being more skilled, complex and demanding.

Because of these changes in the occupational profile of the direct care workforce, personal care assistants are taking on tasks that were previously carried out by nurses, including without supervision by nurses.77 Pain management is one example of an area in which personal care assistants now have a major role, which requires them to exercise responsibility, judgement and high level assessment skills. A recent study of pain documentation for people living with dementia in Australian residential care found that personal care assistants were involved in pain documentation at all points in the pain management pathway, and that they were responsible for considerably more episodes of

---


77 Royal Commission on Aged Care Quality and Safety, Interim Report, Volume 2, page 18. Henderson et al. (2017) found that declining nurse numbers meant personal care assistants were called upon to work outside their scope of practice.
assessment than nursing staff (50% vs 18%). Further, in its submission to the Royal Commission on Aged Care Quality and Safety, the Australian Pain Society stated that personal care assistants are the foundation of the multidisciplinary team in residential aged care facilities (along with nursing, medical and other allied health professionals), and that they ‘are uniquely positioned to identify pain in residents with dementia’. Related, in the widespread absence of specialist palliative care supports, personal care assistants are also at the front-line of end-of-life care and support in residential facilities.

More generally, in the context of the declining share of professional care workers (nurses, allied health workers) in residential care facilities, personal care assistants are increasingly essential colleagues because of their greater knowledge of the older people they care for. For example, personal care workers are relied upon by registered nurses to monitor and report on the health status of the older people. In doing this work, personal care workers exercise responsibility and high level skills in observation, assessment and reporting of health information. In a research trial of facilitated family case conferencing for people with advanced dementia living in nursing homes, ‘[i]nvolvement of AINs/personal carers who worked closely with residents every day was considered especially useful in gaining a better understanding of their changing needs’. Other research has found that families of older people look to personal care assistants as the first line of communication about their older relative, and personal care assistants need to manage carefully family expectations with the boundaries of their role. Here, personal care assistants are called upon to exercise careful judgement about the kind and extent of information they provide to families, along with sensitivity and compassion during what can be very difficult times.

Meanwhile, new approaches to organising residential care, such as the clustered domestic or household model, are stretching the scope of personal care assistants’ work in other directions, underpinned by additional training. The broader range of activities within personal care assistants’ work under the household model requires additional organisational and relational skills, as well as additional technical skills related to care, maintaining premises and managing food service. Personal care assistants working in this model are also likely to have additional responsibility for resident welfare, because of the reduced time spent with residents by registered nurses in this model compared to regular facilities.

6.2 Unique demands of ancillary work in residential aged care settings

Increased levels of need and diversity among older people living in residential care also affect the work of ancillary and administrative workers. For example, the Royal Commission cites evidence that food service staff need more increasingly specialised knowledge of older

---

78 Andrews et al. (2019).
80 Omori et al. (2020).
81 O’Neill et al. (2017); Laging et al. (2018).
83 Omori et al. (2019).
84 Harrison et al. (2019).
85 Harrison et al. (2019).
people’s nutritional needs, special diets and the psychology of their social interaction.\textsuperscript{86} As discussed above, a significant proportion of older people living in aged care facilities are malnourished, and residents have twice the prevalence of diabetes compared to older people living in the community. They also have high prevalence of gastrointestinal disorders (including acid-related disorders of the upper GI tract and constipation) and cardiovascular disorders\textsuperscript{87} all of which may require special diets.

In addition to diverse and specialised food needs related to clinical concerns is the emphasis on choice of meals and high quality mealtime experiences in delivering person-centred care.\textsuperscript{88} Research shows that ensuring that older people living in residential aged care are well-nourished requires a holistic approach, which engages food service and care staff along with older people and their families, and which takes into account factors related to food (texture, appearance, nutritional value) and to the social organisation of eating and mealtimes (enabling autonomy and dignity, and including assistance as required).\textsuperscript{89} This means that food service workers increasingly need a broader set of skills to engage older people and colleagues in arranging meals and mealtimes, in addition to greater technical knowledge associated with specialised food preparation.

The knowledge and skills required of food service workers in residential aged care extend well beyond those of food service staff in non-care settings. However, a trade qualified cook in the current Aged Care Award, for example, is currently paid at the same rate as a trade qualified cook in the General Retail Industry Award.\textsuperscript{90} The more complex demands of the work in residential aged care suggest undervaluation of the skills required in that setting.

Cleaning staff can also be conceptualised as part of the care staff. A large international research project in residential facilities, including in Australia, found that cleaning staff played three critical roles that demonstrate how their work was different from, for example, hotel cleaning, and how it therefore demands higher skills.\textsuperscript{91} The first of the three roles is in infection control, given older people’s high level of susceptibility to infection and close living arrangements as discussed above. Cleaners in residential care carry out their work in the context of a mix of private and shared spaces, and a mix of private and organisational property, which makes infection control particularly challenging. Another international study found that cleaners have ‘a unique perspective that might help in the design of workable infection control policies’, because of their understanding of the specialised knowledge of spaces and places in the facility.\textsuperscript{92} This study

\textsuperscript{86} Royal Commission into Aged Care Quality and Safety, Interim Report, Volume 2, page 226.
\textsuperscript{87} Lind et al. (2020).
\textsuperscript{88} Wang et al. (2018).
\textsuperscript{89} Evans et al. (2005), Milte et al. (2017), Wang et al. (2018)
\textsuperscript{91} Müller et al. (2018).
\textsuperscript{92} Van Tiem et al. (2020).
also emphasised how cleaners had to work sensitively and collaboratively with other care staff who may necessarily be working with residents in the same spaces at the same time.

Cleaners’ second role is maintaining the appearance of the home, for residents, but also for family members, who consider a clean environment with an absence of odours to indicate good care and a home-like atmosphere. Cleaners maintain the appearance of homes where many older people live with incontinence and ‘accidents around bodily fluids … happen frequently’.  

Cleaners’ third role is the relational care work they provide, not least during the ‘regular and substantial’ time they work in residents’ rooms. They may talk to the residents, providing psychosocial support, assist with small personal tasks, call for assistance from other staff, and advocate for older people by understanding and communicating their preferences and needs to colleagues.

Overall, cleaners in residential facilities use a range of skills beyond those required in non-health care settings (hotels, offices) and different from those required in acute care settings.

6.3 Providing person-centred care is a whole-of-staff responsibility

The work of personal care workers and ancillary care workers has become more demanding as the profile of residents in aged care and regulatory and community expectations about care quality have changed. But the responsibility to deliver person-centred care goes beyond the specific roles within these two groups.

Enabling and re-enabling older people to maintain and regain their capabilities and to delay decline are also important principles in aged care. As older people move around a facility and engage in various activities and interactions, they are likely to come into contact with many staff members beyond those who are responsible very directly for their daily care. These staff members need to know each older person as a person, and to have the knowledge and skills to respond to them as people with individual and changing needs and capabilities.

Related, higher rates of mental health disorders and behavioural needs and high rates of dementia are evidence of the increased psychosocial needs of older people in residential care. Greater psychosocial needs increase the likely frequency that all staff in a facility are called upon to exercise judgment, responsibility and assessment skills, as well as strong interpersonal skills, as they interact and respond appropriately to older people’s concerns and behaviours.

The changing occupational structure of the residential care workforce is relevant here: there has been more growth in the ancillary care staff than in the direct care staff, which could indicate that ancillary staff are called upon to interact more with older people and their families. More generally, the more complex working environment entailed by the changing resident profile requires judgment, prioritisation and collaboration skills across the full range of tasks and roles in residential care.

93 Müller et al. (2018), page 58.
94 Ludlow et al. (2021).
Under the prevailing regulatory standards, and in line with community expectations, facilities are required to be inclusive, welcoming places not just for older people, but also for their families and friends. **This requirement means the entire staff of a facility, across care, ancillary and administrative functions need to exercise the skills of sensitive communication, respect for dignity and privacy, compassion and so on that are laid out in the Aged Care Quality Standards.** In general, **the current regulatory framework requires the entire workforce in residential aged care to contribute to providing individually-adapted, person-centred care.**

6.4 **Changing operational environment, changing administrative demands**

There has been considerable change in the operating environment for residential aged care in recent years, notably in relation to regulation and information technology. In the regulatory domain, the regulatory agencies that oversee residential aged care have changed twice in less than a decade. The Aged Care Quality and Safety Commission was established in 2019, as noted above. It replaced the Aged Care Quality Agency, established in 2014, which replaced the Aged Care Standards and Accreditation Agency. Associated with each of these changes were **new standards, policies and procedures, which create considerable demands on both the care staff and the administrative staff, to learn and adapt.**

Increasing use of, and changes in, information technology in relation to resident care and health status documentation, business record keeping, business administration and regulatory compliance activities have also occurred. These demand new skills from both care staff and administrative staff.

Further, personal care workers and administrative workers in residential aged care handle sensitive health information about residents, as part of the documentation and reporting requirements of aged care regulation. Administrative workers may also handle sensitive financial information about residents, related to means-tested user charges. Maintaining accuracy and privacy is essential across the information chain.

Comparison with administrative assistant rates in the Labour Market Assistance Industry (LMAI) Award suggests undervaluation of administrative work in residential aged care. Like aged care, labour market assistance is publicly funded and regulated, with a range of documentation and compliance requirements. The rates across the (entry level) classifications for administrative assistants are higher than relevant rates in the Aged Care Award, and any administrative assistant in the LMAI who holds a Certificate III automatically enters the pay scale at pay point 4, which is set at $927.90 (as at 16 February 2021) – considerably more than a aged care employee Level 5 ($907.30 as at 1 March 2021), at which trade level qualifications may be required.95

**Changes in the structure of the residential aged care sector, in relation to ownership and facility size, are also shaping care workers’ working conditions.** As outlined above, the share of for-profit providers is growing as is the average size of facilities. International and Australian research has found that the quality of care is associated with ownership and with facility size, such that, on average, for-profit providers and larger facilities have lower

95 Relevant award pay guides, Fair Work Australia website.
quality. Explanations for these associations often relate to staffing issues, for example, for-profit facilities are more likely to provide fewer staffing hours per resident. In larger facilities, quality is likely to be affected because staff do not have the same opportunities as in smaller facilities to get to know residents, which is an essential precursor to providing person-centred care. Working in these environments makes additional demands on workers as they seek to meet regulatory and community expectations.

Section 6 has shown that the skill demands of providing individually adapted, high quality care in residential facilities are considerable, and have increased appreciably in line with growing frailty and illness among older people and increased regulatory and community expectations. This includes the skills demanded of personal care assistants, who undertake the vast bulk of the daily care work, and of ancillary and administrative staff, who are responsible for various other aspects of the support for older people.

7. Work value issues in residential aged care

Residential aged care is called ‘care’ for a good reason: older people who live in this form of special housing need support and help that is grounded in their human dignity and their human frailty, and that is offered within caring relationships. Thus, the people employed to provide this support and help are doing ‘care work’, a broader category of work which involves face-to-face service that helps recipients meet their daily physical, psychological, emotional and developmental needs and develop their human capabilities. This section examines how characteristics of the residential aged care workforce and residential aged care services have affected the valuation of care work in the sector.

Employment in residential aged care is overwhelmingly female-dominated in Australia, across almost all occupational groups. This is also the case in comparable countries, including New Zealand, the United Kingdom and the United States. Work in residential aged is also low paid, relative to the skills demanded. Low pay undermines residential aged care workers’ status and living standards and presents disincentives to work in the sector. The Royal Commission into Aged Care Quality and Safety found that low pay, poor working conditions and lack of opportunities for progression and of career pathways mean that residential aged care services have difficulty attracting and retaining appropriate staff.

Researchers in economics and sociology have identified a range of reasons for low relative pay in care work, including in residential aged 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

99 Meagher (2016).
100 Hussein & Manthorpe (2014).
101 Kelly et al. (2020).
occupations are disproportionately undertaken by women. This section considers the arguments and evidence presented in a range of international peer-reviewed research.

7.1 Occupational and industrial 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.) 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 pay rates decline as women increase their share of employment in occupations. An early American study showed 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.

Occupational sex segregation is pervasive in labour markets. In Australia, Census data reports on employment in 474 detailed occupational categories. Of these, 20% are female-dominated (defined as 70% or more female composition), 41% are male-dominated (70% or more male composition), and the remaining 39% are mixed. As Figure 8 shows, around half all women workers are employed in female-dominated occupations (51%), while 57% of all men are employed in male-dominated occupations.

Employment in industries is also sex-segregated. Using 70% as the threshold to define female- and male-dominated industries in Australia, 37% of women work in female-dominated industries, and 48% of men work in male-dominated industries.

Some occupations are largely confined to a narrow range of industries: 90% of all registered nurses work either in hospitals (65%), residential aged care (14%) or medical and other health care services (11%). In the same vein, 89% of personal carers and assistants work in industries across health care and social assistance, and 39% work in residential aged care. Thus, there is a correspondence between occupational segregation and what can be called industrial sex-segregation.

103 Mandel (2013); Murphy & Oesch (2016).
104 Kilbourne et al. (1994).
105 Coelli (2014). 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 in Australia. 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, p. 50). The gendered difference between them was obscured when the larger grouping was used in prior analyses.
106 Calculations based on data from the ABS Census of Population and Housing, 2016.
107 Based on data from the Census of Population and Housing.
7.2 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 above, its foundation in delivering care gives work in health care and social assistance industries, including residential aged care, 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.\textsuperscript{108} In other words, the gendered undervaluation of care work means that care occupations attract a wage penalty.

A major American study\textsuperscript{109} found that ‘nurturing’ work\textsuperscript{110} attracts significantly lower hourly pay than non-nurturing work, based on qualifications and other job characteristics, including skill demands, educational requirements, and gender composition. 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.\textsuperscript{111}

Similarly, a large study of the British labour market,\textsuperscript{112} using data over 17 years, 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 nursing assistants and auxiliaries, are particularly hard-hit by the wage penalty’ (emphasis added).

A further study of the effect of care work on earnings in twelve countries found that employment in caring occupations frequently entails wage penalties. These penalties were

\textsuperscript{108} Barron & West (2013); England et al. (2002); Kilbourne et al. (1994).
\textsuperscript{109} England et al. (2002).
\textsuperscript{110} 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 personal care assistants.
\textsuperscript{111} Dwyer (2013).
\textsuperscript{112} Barron & West (2013).
independent of differences in worker attributes such as age, education and experience. While both sexes are economically disadvantaged for performing care work, wage penalties tend to be larger for women than men.\footnote{Budig & Misra (2010).}

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 residential aged 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’\footnote{Twigg et al. (2011).} and grounded in relationships. An Australian interview study with residential aged 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.\footnote{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 \textit{love} rather than with \textit{skill}. 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.\footnote{England et al. (2002); Folbre & Nelson (2000); Kilbourne et al.(1994)}

Significant skill is demanded for the delivery of high quality care by care workers in residential aged care, as documented above. However, the skills and responsibilities of care work continue to be undervalued across the economy and society. They are not seen as deserving the same rewards as comparable levels of skill and responsibility in other kinds of work. Further, as also documented above, the skill set required for high quality residential aged care is expanding to encompass new demands, driven by the shift from institutional to person-centred care and new regulatory requirements, among other things.

\section*{7.3 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 \textit{social} level – society and culture shape how the work in occupations such as residential aged care are seen, evaluated and hence remunerated. A further set of explanations for the undervaluation of care work is at the \textit{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 residential aged care workers derive intrinsic rewards from their work with older people. 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, they are applied to women’s caring occupations, but not to men’s jobs. 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. 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. In other words, ‘preferences’ for jobs that fit with family responsibilities are themselves shaped by the availability of good supports for working families.

Further, motivations and job preferences are shaped by social learning and social experience. Thus, it is mistaken to take them for granted as an expression of individual free will and desire. Inequalities in access to and experience of education and the labour market combine to shape people’s motivations, preferences and orientations, not least 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

---

117 Bjerregaard et al. (2017); Mavromaras et al. (2017); Lightman & Kevins (2019).
118 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 residential aged care, as Palmer and Eveline point out (2012, p. 268-69). See also Dorman (2009).
119 England et al. (2002).
120 Palmer & Eveline (2012).
121 Meagher (2014).
122 Hebson et al. (2015).
poor quality aspects of care jobs'. 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.

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 residential aged care, as in other social services, has roots in *voluntarism* (as well as its associations with women’s work in 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.

This tension has been encapsulated as *love versus money*. 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 essential to good quality care. This logic has been convincingly challenged. Economists Julie Nelson and Nancy 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.

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

The status of *recipients* of residential aged care services also contributes to the undervaluation of care work. The Final Report of the Royal Commission into Aged Care Quality and Safety stated that ‘[a]ttitudes and assumptions about older people and aged care affect the delivery of aged care’, and cited evidence that ‘as a society, we underestimate and devalue older people’s contributions to the community’. If older people are not valued, the work of caring for them is not considered as socially important as it would be if they were accorded full dignity and respect. Research in the UK has also found that employers, care workers and older people ‘explicitly linked low wages to ageism and the low value the society places on looking after older people’.

As well as facing ageism in society, older people also have limited purchasing power, and this too contributes to holding down the wages of the people paid to care for them. People

---

123 Hebson et al. (2015), page 14.
124 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.
125 This tension was recognised by Commissioner Fisher in her decision on the Queensland Equal Remuneration case of 2009.
130 Hussein (2017), page 1823.
living in residential aged care require assistance most at a time in their life that they are least able to earn money, live and work independently, or to purchase services on their own behalf.\textsuperscript{131} Because people need services have limited capacity to pay, residential care needs to be partly or wholly paid for from society’s shared resources, typically government funding. In Australia, around half all people living in residential aged care facilities do not have the resources to fund their own care, and so are partially or fully supported.\textsuperscript{132} 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 residential aged care.

### 7.5 Ownership and funding of residential aged care

International research shows that the ownership profile of the residential aged care sector has implications for the quality of care, the staffing profile and the level of staffing, and the earnings of care workers. There are two distinct issues here, which although coming from quite different directions, foster under-recognition and undervaluation of care work in residential aged care.

One relates to the growing role of for-profit providers, as discussed in section 3 above, which cited evidence that for-profit facilities have lower levels of staffing overall, higher proportions of less-trained staff, and lower quality care that non-profit or public facilities, and that reducing staffing costs is one clear means, among others, of improving financial performance. Further, international studies have found that care workers employed by for-profit companies had significantly lower earnings than those employed by public or non-profit providers.\textsuperscript{133}

The second relates to the continuing large role of non-profit providers in residential aged care, which, for different reasons also have a history of low pay weakly related to the value of work. Non-profit providers have their roots in religious, charitable and community organisations with a long history of voluntarism and altruism as organisational foundations. These roots are associated with the ‘love vs money’ tension discussed in section 7.3 above. In non-profit facilities, lower pay may subsidise their higher average care quality.

However, non-profit organisations have increasingly received public funding to deliver major social programs especially over recent decades, as a substitute for public provision that is or has often been available in other countries. Residential aged care is one such program. As services offered by non-profits have been drawn into government-funded social service provision, workers delivering these services have struggled to gain appropriate industrial recognition for the work they do, as the history of the Social and Community Services Award shows.\textsuperscript{134} This problem was partly recognised in the Equal Remuneration order for this award in 2012.

\textsuperscript{131} England et al. (2002), page 456.
\textsuperscript{132} Aged Care Financing Authority (2020), page 90.
\textsuperscript{133} See, for example, Hussein & Manthorpe (2014).
\textsuperscript{134} Briggs et al. 2007.
Conclusion

The Royal Commission into Aged Care Quality and Safety found that Australia has ‘an undervalued aged care workforce’ and that care workers are ‘paid comparatively less than their counterparts in other health and social service sectors’.135 It further found that ‘[t]he bulk of the aged care workforce does not receive wages and enjoy terms and conditions of employment that adequately reflect the important caring role they play’.136

Undervaluation of aged care work is reflected in an industrial instrument that has not been modernised, despite its title. In female-dominated occupations, especially those related to care, outdated perceptions of women’s roles and women’s work become ‘frozen in by institutional inertia in relative wage structures’.137

The current award does not recognise the range of skills and responsibilities aged care workers exercise in providing high quality care to older people. Lack of recognition means that those who exercise these skills and responsibilities are not rewarded for them. This is an issue of fairness. 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. The same dynamic may be evident in Australia, and is worthy of further research.

Addressing the undervaluation of aged care work is a clear method by which these injustices can begin to be addressed. From a broader policy perspective, consideration could also be given to the level of funding for residential aged care, the effectiveness of quality regulation, and the ownership structure in the sector.

References


135 Final Report, Volume 2, pages 211, 213.


Barron, D. N., & West, E. (2017). The quasi-market for adult residential care in the UK: Do for-profit, not-for-profit or public sector residential care and nursing homes provide better quality care?. *Social Science & Medicine*, 179, 137-146.


