



Human Rights
Commission

Te Kāhui Tika Tangata



Caring counts

Tautiaki tika

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Caring counts *Tautiaki tika* website:

<http://www.neon.org.nz/agedcareinquiry/>

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Part 1

Foreword

As many as 48,000 workers in New Zealand, the vast majority of them women, undertake indispensable but largely invisible employment every day. They care for older people either in their homes, in residential aged care facilities, or in hospitals.

The Human Rights Commission has used its Inquiry powers to examine equal employment opportunities in the aged care sector and has gathered evidence from 886 participants over a 12 month period in 2011-2012. Everyone, bar two participants who were managers for a residential aged care provider, want higher pay and more status for those who work as carers.¹

The Commission extends its immense appreciation to the hundreds of older New Zealanders and their families, carers, nurses, doctors, residential aged care providers, home health care providers, civil society groups, District Health Boards, government agency representatives and Members of Parliament who met with us. A very special thanks to Grey Power, the New Zealand Nurses Organisation, the Service and Food Workers Union and U3A who helped arrange meetings around the country.

A draft of the report was sent back to all those who participated asking for feedback which was incorporated in the final version. The recommendations were developed by the Equal Employment Opportunities Commissioner and the Inquiry team after this feedback and endorsed by the New Zealand Human Rights Commission.

I would like to acknowledge the superb commitment of the very small team of Human Rights Commission staff members who contributed well beyond expectations and who worked long hours to complete the task. In particular I would like to thank Sue O' Shea, Moana Eruera and Emilia Don Silva.

In my time as Equal Employment Opportunities Commissioner there has seldom been the degree of unanimity about a work-related issue than there is about the low pay of carers. The consensus revealed by the Inquiry means that New Zealand has an unprecedented opportunity to address the indecency of poorly paid "emotional labour" undertaken by often marginalised workers looking after vulnerable older people. A much repeated comment up and down the country when the Commission undertook its field work was that the value we place on older people in New Zealand society is linked to the value we place on those who care for them.

¹Carers are often called health care assistants or community support workers, and they include those who work in residential aged care and home-based settings

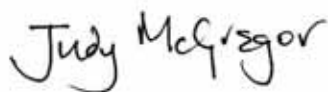
The sense of crisis that surrounds aged care is partly a reflection of our collective knowledge that we are not being fair and that a large group of workers is being discriminated against. Inaction on pay inequality and inadequate compensation for travel are breaches of fundamental human rights. Given their significance, these breaches cannot be justified by affordability arguments.

To address the equal employment opportunities issues there needs to be a defined leadership within government. This should encourage a better developed sense of responsibility and accountability by all of us and particularly those with greatest influence such as the responsible government ministers; the Minister of Health, the Minister of Women's Affairs and the Minister for Senior Citizens; the Ministry of Health; District Health Boards, providers, unions, and their peak bodies. The voice of older people and their families also needs to be legitimised, properly acknowledged and listened to.

The recommendations in *Caring counts, Tautiaki tika* are solutions-focussed. The Commission has modelled the potential costs of a three-step process to restore some measure of equality to carers' wages over three years. The report makes other recommendations aimed at eliminating discrimination and progressing equal employment opportunities.

The Human Rights Commission is committed to supporting the implementation of this Inquiry's recommendations so that equal employment opportunities are properly realised in the aged care sector. It's time for action. In the interest of justice we should not accept further delay in addressing a systemic inequality that is within our power to remedy.

The report is dedicated to all older New Zealanders, and especially our mums and dads, and our grandmothers and grandfathers. *I waihangatia te pūrongo nei mā te hunga kaumātua katoa o Aotearoa, tae ake ki ngā whāea, ngā mātua, ngā koroua me ngā kuia.*



Dr Judy McGregor
Equal Employment Opportunities Commissioner
Kaihautū Oritenga Mahi

Recommendations

1. **Leadership**
 - The Prime Minister ensures that the minister with responsibility for older people has a top ten Cabinet ranking to deliver better services, and to provide leadership and co-ordination across ministerial portfolios.
2. **Pay**
 - The Minister of Health directs District Health Boards (DHBs) to develop a mechanism to achieve pay parity between health care assistants working in DHBs and carers working in home support and residential facilities.
 - DHBs and residential care and home support providers implement pay parity for carers across the government-funded health sector within three years.
3. **Fair Travel**
 - The Ministry of Health and DHBs develop a sustainable and consistent fair travel policy which is annually reviewed and adjusted, and which covers the real and actual costs of travelling including vehicle costs and time spent travelling.
4. **Qualifications**
 - Providers in the aged care sector and the ITO (Careerforce) commit to ensuring all new staff achieve a Level 2 Foundation Skills qualification within six months of starting and that all existing staff achieve this qualification in the next two years. Within five years, Level 3 should become the normal level of qualification for all staff with 18 months service or more.
5. **Safety Standards**
 - The voluntary standard “Indicators for safe aged-care and dementia-care for consumers” should become compulsory to ensure the protection of both carers and older people.
 - The “Home and Community Support Sector” standard must also be compulsory.

6. **Consumer information**
 - A five star system of quality assurance comparing residential facilities, with the aim of improving consumer choice and public accountability, is developed and adopted for use in New Zealand by the Ministry of Health and DHBs with input from the Auditor-General (A-G).
7. **Transparency**
 - District Health Boards provide disclosure in their annual reports that makes explicit expectations about 'passing through' annual funding increases and details the fair travel and equal pay provisions in aged care service delivery contracts.
8. **Migrant workers**
 - Immigration New Zealand ensures information about qualifications and registration requirements is available in countries of origin and develops best practice guidance for migrant workers in aged care.
9. **Diversity of carers**
 - Health Workforce New Zealand provides leadership on the recruitment of men as paid carers, the promotion of 'encore careers' in aged care, and the development of strategies that encourage part-time paid carers to increase their hours of work.
10. **Valuing carers**
 - The Human Rights Commission hosts a stakeholder summit with government agencies, peak bodies, providers, Age Concern and Grey Power, trade unions and community groups to enhance sector cooperation and to promote and celebrate the paid aged care workforce.

Timetable for implementation

Lead responsibility	Action	Year
<ul style="list-style-type: none"> • Prime Minister • Minister of Health & DHBs • DHBs and MoH • Minister of Health • Immigration NZ • Human Rights Commission 	<ul style="list-style-type: none"> • Appointment of high ranked Minister for older people • Development of mechanism for pay parity • Revision and implementation of Fair Travel • Safety standards are made compulsory • Production of guidance for aged care migrant workers • Stakeholder summit 	2013
<ul style="list-style-type: none"> • MoH & DHBs with input from the A-G • DHBs • Health Workforce NZ 	<ul style="list-style-type: none"> • Development of five star consumer information system • Disclosure of provisions in service delivery contracts • Development of workforce plan to increase diversity 	2014
<ul style="list-style-type: none"> • Aged care providers and Careerforce 	<ul style="list-style-type: none"> • All carers have Level 2 Foundation skills at minimum 	2015
<ul style="list-style-type: none"> • DHBs and aged careproviders 	<ul style="list-style-type: none"> • Implementation of full pay parity 	2016



Part 2

Why this Inquiry?

The New Zealand Human Rights Commission's decision to hold this Inquiry was prompted by two significant concerns. The first relates to the low pay, the undervaluing, and the pay disparity for many thousands of New Zealanders, the vast majority of them women, working in the aged care sector. The second relates to the nexus between the value society places on the aged care workforce and on the respect and dignity of older New Zealanders.

While the aged care sector has been subject to a multitude of reviews, reports and inquiries in recent years, there has not been a singular focus on equal employment opportunities issues linked to the human rights of older people. This Inquiry is overdue in terms of giving voice to the serious and legitimate claims of some of New Zealand's most valuable but neglected workers, and the views of the people they care for.

About the Human Rights Commission

A major function of the Human Rights Commission is to provide leadership about equal employment opportunities, including pay equity. Under Section 17 of the Human Rights Act 1993 the Equal Employment Opportunities Commissioner can provide advice and leadership; evaluate the role of legislation, guidelines and codes of practice; monitor and analyse progress and report to the Minister about that monitoring; and liaise with others about the promotion of equal employment opportunities in New Zealand.

The Inquiry was conducted under Section 5 (2)(h) of the Human Rights Act 1993:

“to inquire generally into any matter, including any enactment or law, or any practice, or any procedure, whether governmental or non-governmental, if it appears to the Commission that the matter involves, or may involve, the infringement of human rights.”

Terms of reference

The Terms of Reference for the Inquiry were:

1. The Commission will inquire into equal employment opportunities in the aged care sector in New Zealand and consider the issues as they concern employers and employees, with reference to:
 - (i) The regulatory frameworks in the aged care sector and their impact on progressing equal employment opportunities, including decent work
 - (ii) Workforce supply issues, including recruitment and retention, and their impact on equal employment opportunities
 - (iii) Training and qualifications in the aged care sector and the related equal employment opportunities issues
 - (iv) Conditions of work, including staff to resident ratios and managerial competence, and the implications for equal employment opportunities
 - (v) Wages of nurses, health care assistants and others in the aged care sector, and equal pay, pay parity and pay equity issues
 - (vi) The role of men and women in the aged care sector and the equal employment opportunities issues for both men and women
 - (vii) Equal employment opportunities and migrant workers in the aged care sector
 - (viii) Other equal employment opportunities issues that are raised during the course of the Inquiry by submitters and participants, employers, employees and those receiving care.

2. The Commission will consider, as a result of the Inquiry, whether to make recommendations on:
 - (i) Changes to legislation, regulations, policies, practices, procedures and funding arrangements
 - (ii) The value of promulgating national frameworks, standards, guidelines or codes of practice to ensure equal employment opportunities are progressed in the aged care sector in New Zealand
 - (iii) A timetabled approach with clear benchmarks that relates to the implementation of improved equal employment opportunities in the aged care sector in New Zealand.

How we conducted the Inquiry

Participation

A marked feature of the Inquiry process was the degree of participation by all major stakeholders. All of those approached, bar one agency, met with the Commission and granted either an interview or access. This inclusive approach demonstrated the degree to which older New Zealanders, those that care for them, the residential aged care and home health care industry are in agreement about the critical nature of workforce issues and the need for fair, reasonable and practical action, even if there was not universal agreement about what that should be. Areas of common concern identified by participants whether they were staff, employers or those receiving care included pay levels, training, staff numbers and the quality of care, the image of the sector and government policies relating to funding.

The Inquiry process

A total of 886 people from throughout New Zealand provided information to the Inquiry which allowed for a well-rounded picture of equal employment opportunities issues in the aged care sector. The evidence gathered is both qualitative and quantitative and follows the process adopted by the Commission in other national inquiries. It came from written submissions, from discussion with representatives of organisations and individuals, from public meetings, from field work, from transcribed interviews, from three online questionnaires and from action research undertaken by the Equal Employment Opportunities Commissioner. Financial modelling was undertaken by an academic accountant and the literature review was completed by a public policy academic with expertise in ageing issues who also peer reviewed the content against the written submissions received.

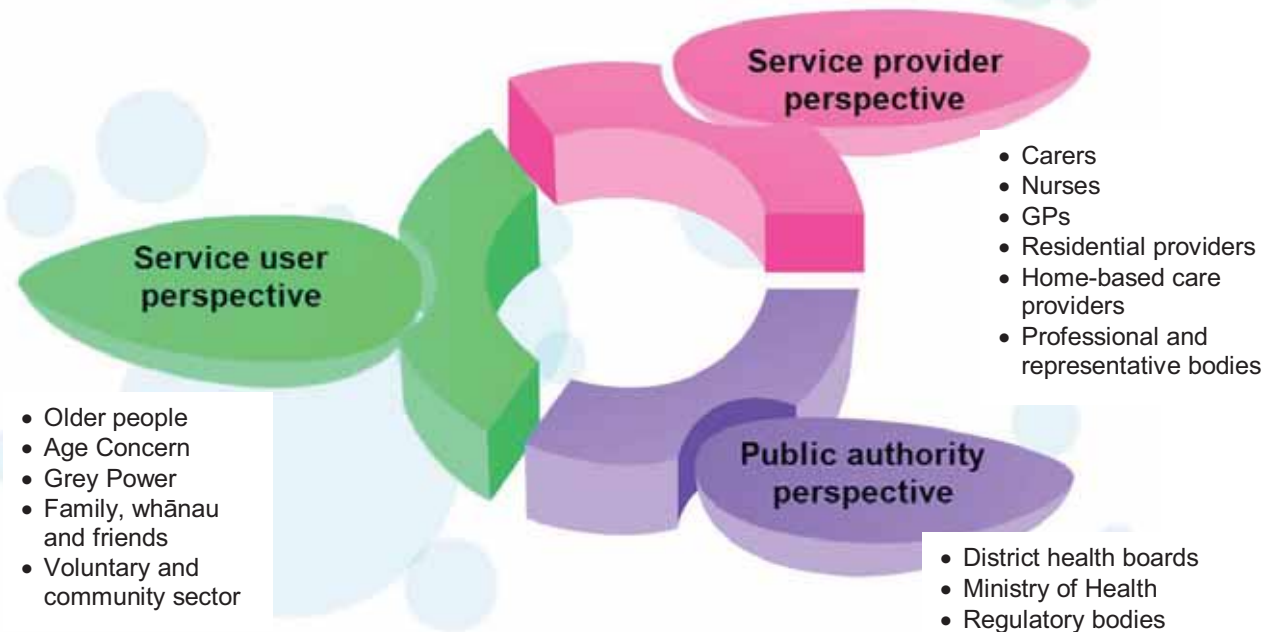
The evidence was collected from older people and their friends and families, residential aged care providers and the New Zealand Aged Care Association, the New Zealand Nurses Organisation, the Service and Food Workers Union and the Public Service Association, home care providers and the New Zealand Home Health Association, Ministry of Health officials, general practitioners and those working in clinical roles in aged care, representatives of District Health Boards, academic experts, and nurses and carers themselves. Much of what the Human Rights Commission saw and heard on its visits to residential aged care facilities verified other sources of information relating to employment issues in the aged care sector produced by other agencies and researchers examining aged care from different perspectives. The EEO Commissioner worked as a carer in the course of this Inquiry.

All of the participants received a copy of the Terms of Reference for the Inquiry and the scoping diagram outlining the issues the Commission wanted to hear about, before meetings were held. A draft copy of the report was sent to every participant and feedback incorporated into the final report before the Commission developed its recommendations.

Action research

EEO Commissioner Dr Judy McGregor responded to challenges that policy-makers should “know” the job that carers were undertaking before speaking about it. The Commissioner’s account of working incognito in a provincial care facility is entitled *Diary of a Carer* and is published later in the report.

Evidence Collection



Written evidence

Over a hundred submissions were received from organisations and individuals. Many individuals made submissions confidentially. Their perspectives have been taken into account and are used in the report. Two peak bodies, the New Zealand Aged Care Association (NZACA) which represents residential providers and the New Zealand Home Health Association (NZHHA) which represents home health care providers, made written submissions.

Public meetings and regional visits

Public or union meetings were held in Warkworth, Central Auckland, Hamilton, Tauranga, Rotorua, Palmerston North, Wellington, Nelson, Richmond, Christchurch, Dunedin and Invercargill. The Commission also visited Blenheim to interview aged care managers and Whakatane to look at a navigator model of home support. The Commission visited Christchurch on three occasions to examine changes to models of care in response to the earthquakes. Grey Power facilitated three of the public meetings in Stoke, Howick and Rangiora, the last with over 120 participants.

Visits to facilities

The Commission visited numerous facilities in different parts of New Zealand. During this field work it often met with managers, staff and residents of facilities. The Commission attempted to visit a variety of models of residential aged care including Kaumatua flats at Whakatu marae in Nelson, the Abbeyfield model also in Nelson, and facilities involved in the Eden Alternative in Palmerston North and Wellington. In addition, we visited newer models of home-based health care including the CREST model in Christchurch and Te Whiringa Ora in Whakatane.

Verified interviews

Sixty-six interviews were conducted with chief executives of major residential providers, with medical and clinical experts, representatives of District Health Boards and the Ministry of Health, carers and nurses, lobby groups, union officials, academics and individual facility managers. All interviews were taped and meeting notes were verified with each participant. Many of the interviews were conducted in residential aged care facilities and one was conducted in a call centre for a major home-based care provider to provide insight into rostering practices.

Financial modelling

Financial modelling was undertaken by Associate Professor Paul Rouse, of the University of Auckland Business School, to assess the fiscal impact of recommended stepped increases to achieve pay parity between home care support workers within and outside of the district health board system.

Literature review

Dr Judith Davey, senior research associate of the Institute of Policy Studies at Victoria University of Wellington, wrote the literature review and peer-reviewed the report as well as ensuring that all the written submissions had been taken account of before the draft was sent back to participants for comment.

Confidentiality

Many of the individuals who made submissions during the Inquiry requested confidentiality and anonymity. The Commission made a commitment to provide a safe, private and accessible process so these voices can be heard.

Using a human rights framework

The Commission's starting point in analysing the evidence is the international human rights framework outlined in the Universal Declaration of Human Rights (UDHR). Article 23 of the UDHR states that everyone has the right to work, to free choice of employment and to just and favourable conditions of work. The Universal Declaration states that everyone, without any discrimination, has the right to equal pay for equal work and that everyone who works has the right to just and favourable remuneration ensuring an existence worthy of human dignity. This underpins the International Labour Organisation's (ILO) Decent Work agenda that New Zealand has made a tripartite commitment to. It involves employers, the trade union movement and the Government.

Lack of decent work for aged care workers will have a direct impact on the realisation of the rights of the older people they care for. While the United Nations Principles for Older Persons adopted in 1991 are not legally binding, they provide a guide as to how the rights of older people should be respected. The UN Principles on the Rights of Older People state that older people should be able to pursue opportunities for the full development of their potential and should be able to live in dignity and security and be free of exploitation and physical or mental abuse. It is a fundamental human rights principle that older persons should be treated fairly regardless of age, gender, racial or ethnic background, disability or other status, and be valued independently of their economic contribution.



Terminology

Acuity: refers to dependency levels. In the context of this Inquiry, increasing levels of acuity refers to greater levels of clinical need among care recipients.

Carers: Various terms are used for the paid workforce who provide care for older people in both residential facilities and in the home support sector. We have used the generic term 'carer', but where participants have used other terms such as caregiver, support worker, community support worker or home support worker we have used that term. The Commission acknowledges the value of the many unpaid carers who are not the focus of this Inquiry.

CREST: Community Rehabilitation Enablement Support Team, a model of working which supports patients to be discharged earlier from hospital by providing short term intensive support in the home. CREST was implemented in Christchurch, earlier than originally planned in response to a shortage of hospital beds after the February 2011 earthquake.

Dementia Units: This level of care is the same as rest home care, except care is provided in a secure environment for residents who may exhibit behaviour likely to cause concern to others, or who may harm themselves.

Eden Alternative: An international organisation which promotes and licenses a model of care developed from the work of Dr William Thomas, "dedicated to transforming care environments into habitats for human beings that promote quality of life for all involved". 'Edenised' homes must progressively meet all ten of the Eden principles. A central value is elder-centred care.

Enable New Zealand: is the biggest provider of equipment and housing modification services for the Health and Disability Sector in New Zealand and is contracted by the Ministry of Health, ACC and some District Health Boards to provide services.

Enrolled nurses: The Nursing Council regulates enrolled nurses, who are required to have completed a Level 5 qualification in enrolled nursing. The scope of practice states that enrolled nurses must practice under the direction and delegation of a registered nurse or nurse practitioner and that the registered nurse maintains overall responsibility for the plan of care.

Hospital level care: Geriatric hospital care is defined in the Health and Disability Services (Safety) (HDSS) Act 2001, at Section 4. They provide care for the sickest and frailest long term residents who are highly dependent and/or have complex care or medical needs that require the presence of a registered nurse 24 hours a day.

InterRAI: The InterRAI assessment tools are a suite of comprehensive geriatric assessment tools designed to assess the medical, rehabilitation and support requirements of an older person.

Managerial competencies: go beyond simple management techniques and, like key capabilities, should be regarded as combinations of organisation-related techniques, attitudes and working methods. The main goal of managerial competencies is to make sure that the key capabilities are tuned in to each other, so that the result becomes more than a sum of the parts.²

Registered nurses: The Nursing Council sets the standards for registration which include a bachelor degree in nursing (or an equivalent qualification). The scope of practice emphasises nursing knowledge and complex nursing judgment. It also emphasises the ability to practice independently and in collaboration with other health professionals.

Regulated and unregulated workforce: The workforce is differentiated into 'regulated' and 'unregulated' groups. The former are subject to regulatory requirements under health legislation such as the Health Practitioners Competence Assurance Act 2003 and the Social Work Registration Act 2003. These Acts mandate registration (including vetting and qualification requirements), ongoing competence requirements, professional standards and limitations and disciplinary procedures. The regulated workforce is subject to scopes of practice. Other workers, including carers, are part of the 'unregulated workforce'.

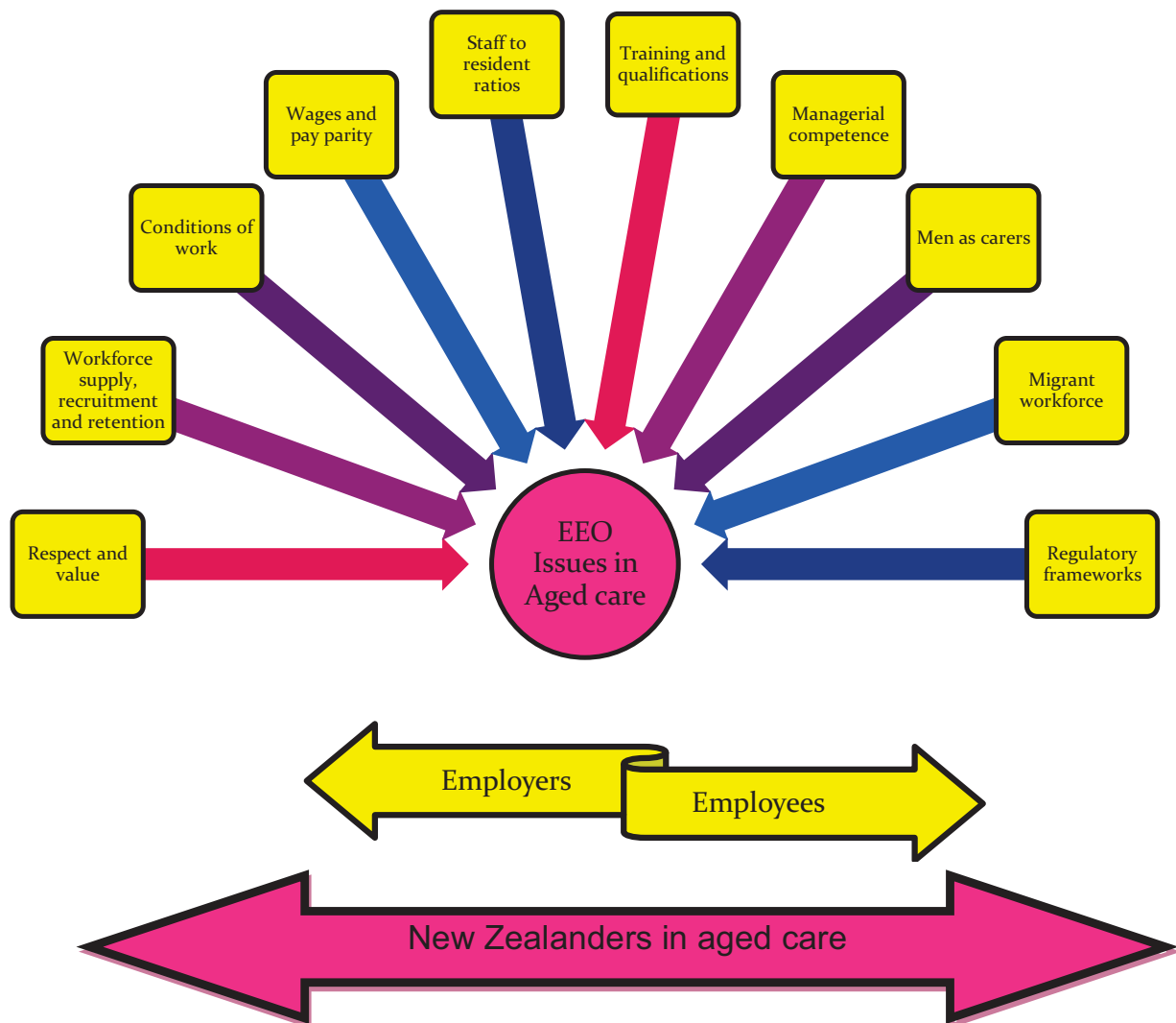
Rest home care: This level of care is defined in the HDSS Act at Section 6 (2). These facilities cater for residents who require residential care because they are frail. The residents have stable medical conditions and care needs that do not require the presence of a registered nurse.

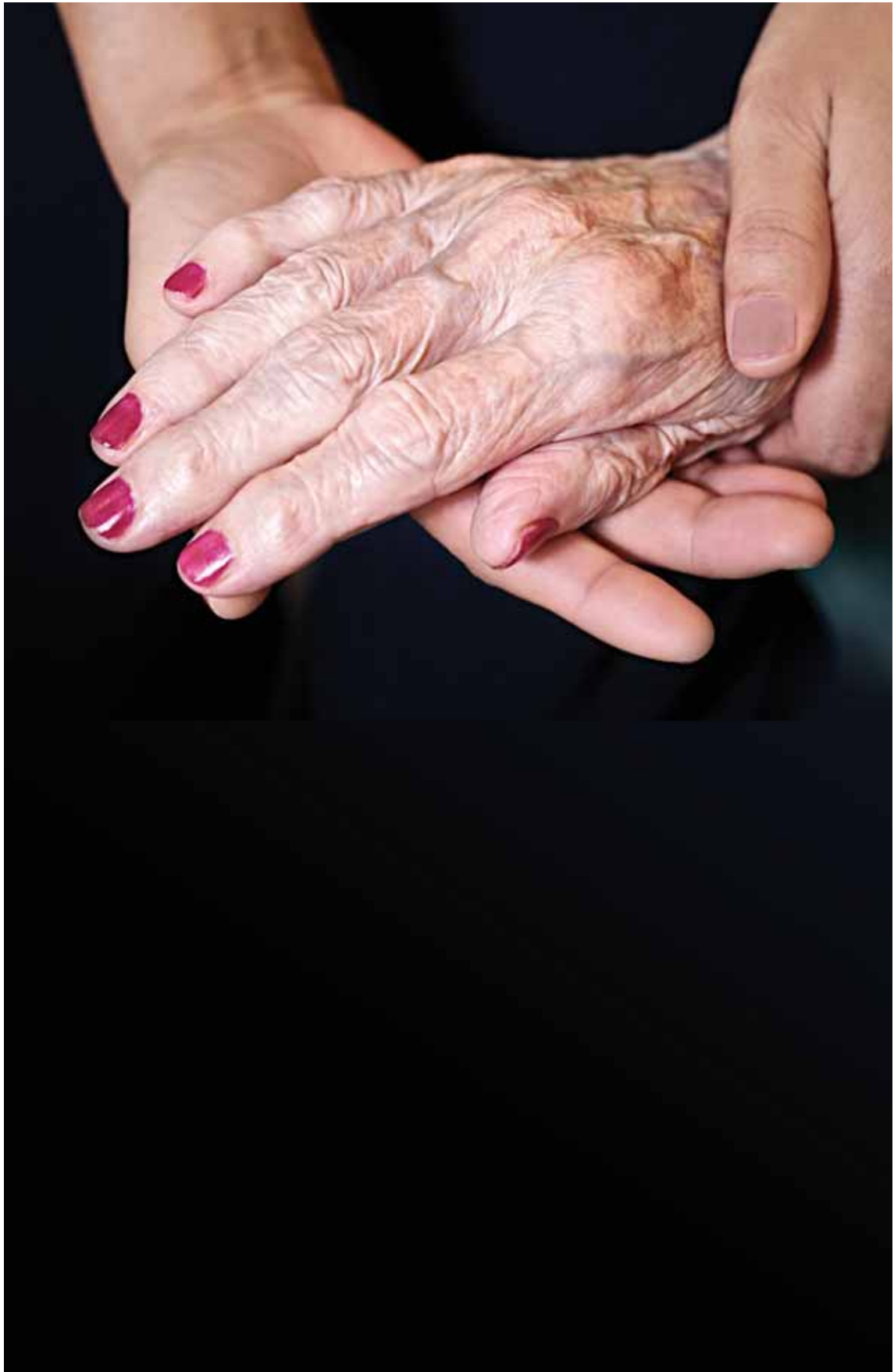
Scope of practice: Definitions of tasks and processes that health professionals are considered competent and safe to perform are known within the industry as scopes of practice. Health professionals are required to act within their scope of practice and by extension are not permitted to practice outside.

²Cobbenhagen, J. (2000). *Successful Innovation: Towards a new theory for the management of small and medium-sized enterprises*. Cheltenham, United Kingdom: Edward Edgar.

Issues looked at in the Inquiry

The focus of the Inquiry was to examine equal employment opportunity issues related to the aged care sector in New Zealand. The following elements were identified by the Equal Employment Opportunities Commissioner prior to the Inquiry. All participants were asked whether the elements identified covered all areas of concern. Many of the issues overlap and are interconnected and need to be read together. Participants' voices and their experiences are included to highlight the issues and concerns.





Part 3

Respect and value

Older persons should have access to social and legal services and to health care so that they can maintain an optimum level of physical, mental and emotional well-being. This should include full respect for dignity, beliefs, needs and privacy. (UN Principles for Older Persons).

Caring for older people requires a unique set of skills, resources and personal relationships. It is understandable why many carers resent the term “unskilled work” to describe their role. The findings of our Inquiry, backed by other research³, showed that for many carers their main priority was to be respected and valued for the work they carried out. The associated priority was pay. Respect and value for the aged care workforce is inextricably linked to respect and value for older persons.

“It is clear that the realisation of the rights of the workforce will have a direct impact on the realisation of the rights of older people using aged care services.”

Social attitudes to older people

In a written submission, the National Council of Women (NCWNZ) asked, “what value does the community place on a service which keeps a relatively well person in their own home and out of expensive and oversubscribed residential care? It is impossible to value how important it is to enable a person to stay in their own home for as long as possible. The dignity and self worth that comes with semi independence, the possibilities of still being able to contribute to their local community –these activities are impossible to accomplish in an institution.”

This link was also expressed by another submitter who said, “the care given to our most frail elderly must be worth more than that given by a vet nurse to my cat or dog.” At a public meeting a participant said, “there needs to be a paradigm shift in respect for the elderly.”

A senior medical specialist said, “the whole of society’s attitude to older people has to change. There are weak signals from political leadership about age issues. Older people should not be out of sight, out of mind. Communities have to accept responsibility. Instead of neighbourhood support (which is about property) it’s about

³Walker, L. (2009). *NZNO Aged Care Survey: an examination of the perceptions, tasks, responsibilities and training needs of caregivers in New Zealand’s aged care facilities*. Retrieved from <http://www.nzno.org.nz/LinkClick.aspx?fileticket=rIP9jQbZ2Zc%3D&tabid=179>

supporting our neighbours (which is about people). We have to address ageism. There are still people that regard dollars spent on older people as dollars wasted.”

Speaking personally, the President of Age Concern, Liz Baxendine observed, “modern life has changed, there’s a lot of ageism. There is a cult of the young, just look at the images on TV. We don’t value older people. The three Rs are rights, responsibilities and respect. We need to think of older people as a resource.”

Disrespect for the elderly is expressed in social attitudes to residential care. The chief executive of a major provider said, “aged care is easy to kick about. Ask the average person whether they would want to go into a rest home and they would say they would only go there when they need to and even so reluctantly.” A union member working in the aged care sector added, “we need to put the care back into the aged care sector. The value and respect for older people is tied to the value placed on those caring for older people. Who’s going to look after these people if we don’t?”

Care recipients’ views

Care recipients and families often expressed explicit and implicit appreciation for the crucial role of carers. At a public meeting hosted by Grey Power the Commission was told, “they (carers) are Mother Teresas as far as I can see. Shame on us (referring to society).” Spontaneous appreciation came in private meetings without management or staff present. In a Dunedin facility three residents in their late eighties said their facility was “very comfortable, the meals are good and the staff are nice.” A long term resident who had been living at a facility for nine years said, “they look after us here, there are good nurses and carers.”

In response to the question ‘Do you feel your carer is paid enough?’ a resident in an aged care facility said, “absolutely not, they should be on much more, they look after those who have paid taxes their whole lives and built the foundations of our society.”

A manager of a home support service said, “I don’t think people have an appreciation of what support workers are faced with every day and what they’re expected to do and what they actually do. From a social point of view it’s always been women’s work to do the caring in the family and it’s always been hidden away behind closed doors what support workers are doing.”

A senior medical practitioner said, “we are blessed as a nation to have so many formal and informal carers who are outstanding. Formal carers are putting in far more hours than they’re paid for. There is essential goodness out there between people.”

Carers’ commitment

Most of the carers, nurses and managers who participated in this Inquiry expressed an emotional commitment to the older people they worked with. They were clearly extremely fond of the people they cared for and felt a responsibility for them. Many people at union meetings, for example, talked about the bond they made with the older people they cared for. One registered nurse said that initially she had a hard

time working in the aged care sector but then “you get to love them.” One carer said that she had looked after her grandparents back home and “it’s what I know how to do”. A number of carers talked about looking after older people “like you look after your own family.”

Another said, “I make a commitment inside my heart to look after them as my own parents, sister or even my own children. I like this job very much.” At a meeting a carer in a rest home said, “who wouldn’t want a job where you get to hang out with the Nanas and Poppas of the world!” The sense of family was a common thread, with another carer making the point, “to those that work full time we are like family, we see them more than their own family, no disrespect meant.”

A carer said that what she enjoyed and valued in her work was “working with elderly and respecting their life and culture. It is a privilege being able to provide positive experiences with residents and their families. It is satisfying to know you have given quality comfort to families’ loved ones in their end of life care.” A registered nurse said that what she enjoyed about her work was, “caring and knowing the elderly are happy and satisfied with the care given.”

Another listed what she valued in the elderly that she cared for. “Their stories, making them laugh when they are down or giving them a hug when needed, holding their hand and reassuring them when they are dying. This is an honour to be with them as they leave as not everyone has a family that cares or wants to be with them or can be with them.” Another carer said, “I love the people I care for, they are part of my life.”

And another valued “the self reward of knowing I’ve made a difference in my resident’s everyday life.” When asked what would improve the job, a social worker in the sector wrote, “enough resources to make sure that every person had access to sufficient care to ensure that they were safe and comfortable.” A carer who had looked after her own parents for ten years said, “if I can make their day better then that is making it all worthwhile.” An enrolled nurse said, “it is rewarding to get a smile from someone who does not normally respond to anything. It is also rewarding to be able to encourage someone who may have lost their confidence through a fall or illness and eventually see that person walk and/or become a happy person again.”

Valuing carers

This attachment to the elderly was seen to be exploited by funders. Older people frequently referred to carers as “saints” for doing the work they did for the pay they received. The link between pay and how society values care work was expressed by a submitter who said, “Australia pays much higher, and somehow this means that such work receives more respect – as being ‘valuable’ work.”

This plays out in a number of ways. Pay for carers working as health care assistants in residential facilities and home support workers is at, or close to, the minimum wage. The “regulated workforce”, predominantly registered nurses working in aged residential care, are paid below their counterparts in hospitals. As one submitter put it, there is “no incentive to pursue a career in aged care, the sector is not promoted or seen as exciting, it’s viewed as the poor relation and an option of last resort.”

This issue is explored in the section on wages and pay parity. Migrant workers who have a culture of respecting older people and those, such as Pacific peoples and others, who have closer ties to grandparents are more likely to be attracted into the sector.

Carers themselves felt undervalued but emotionally rewarded for their work. A support worker who runs an activities department (for \$15 an hour) said, “we feel undervalued by being worked hard and paid little... although most of our residents value and respect us and some of our managers do.” At a public meeting a participant said, “caregiving is not a respected profession.” Another said, “there is a perception that anyone can do it. Part of that perception is no training.” A parallel was drawn with early childhood education. “It was a long process to get across the idea that a teacher was a teacher wherever they worked.”

The chief executive of a home support service said, “I think there’s a perception out there about caring expressed in the common saying that ‘I’m just a carer’. All I’m doing is, that I’m just going out and helping this person to look after themselves and off I go and it is not seen as a profession or a professional role.” At another meeting the Commission was told, “carers are completely undervalued. We do a job that no-one sees. We are a vulnerable workforce looking after vulnerable people.”

Another participant said, “While there are groups who value support workers they’re not spoken about using the same value words that we use when we’re talking about registered nurses or doctors. The whole community health service would fall apart if we didn’t have carers.”

Another theme was that lack of respect for older people results in a low value placed on aged care services including the aged care workforce. A link was often made between society’s attitude to the elderly and the value attached to those who care for them. A carer said, “frankly, if carers are dealing to people’s basic human bodily functions and being paid little money, then that is insulting to the person giving the care and the person getting it.” A culture shift to greater respect for the elderly was called for. Some participants identified the lack of respect for the elderly as ageist. A carer wrote, “our culture tends to be re our vulnerable elderly; ‘out of sight out of mind’ attitude. If it were the vulnerable young, everyone would make sure the standard of care was high and paid accordingly, our elderly are equally important and carers should be respected in their role.”

Carers and nurses working in aged care talked about the negative attitudes they encounter in the community when they talked about their work.

- “The public think because it’s a retirement home, we’re retired too” said a rest home worker.
- “Even other nurses don’t value what we do. They have no idea what we do.”
- “People ask you what do you do and you tell them and they say, ‘oh you wipe shitty bums.’”
- “The sector is invisible. The work we do is too nasty to think about. The things you do are not pleasant. Who in their right mind would do it? It’s assumed that you must be unskilled and you can’t do other things.”
- “We are embarrassed to say carers because no-one has any respect for carers.”

Suggestions about what is needed

Participants in the Inquiry offered some thoughts about what was needed. Ideas included ensuring that the public at large are better informed about what is involved in aged care, celebrating ageing at home with a National Home Care Day, ensuring a higher ranking minister in cabinet for older people and publishing attractive brochures on the complexity of aged care issues. A submission from an employer suggested that there was a need to educate “the public so they can support workers wages and increase the value of aged care in the community.”

Other ideas included better management of negative publicity surrounding the aged care sector. A number of participants observed that people die in hospitals all the time but this tended not to attract the bad press received by one-off incidents in aged care facilities. “Bad publicity takes everyone down. Aged care is very easily picked off by the news media whereas others in the health care area such as DHBs have the ability to put their spin on bad news. A number of reports had been written in the past five years about aged care at a time when the industry had moved forward and this progress needs to be recognised. There is a need for positive advertising about working in aged care.”

One of the models of care which fosters greater respect and community interaction is the Eden Alternative; a philosophy developed by Dr William Thomas “dedicated to transforming care environments into habitats for human beings that promote quality of life for all involved”. Residential facilities visited by the Commission, which have adopted Dr Thomas’ approach, exhibit a strong sense of connection with the local community, for example with local schools. One of the Eden principles is “an elder-centred community creates opportunity to give as well as receive care. This is the antidote to helplessness.”⁴ It is also an antidote to the invisibility of older people in the community.

Conclusion

The respect and value shown to older people in New Zealand is linked to the respect and value shown to their carers. While society continues to devalue older people, the aged care sector will remain marginalised in terms of both status and in adequacy of resourcing. Alzheimers Eastern Bay of Plenty spoke for many the Commission heard from in its Inquiry. “The challenge is for the people of New Zealand to value older people, kuia and kaumatua and those who care for them. This requires that the business of caring for older people is one which has quality of care as a high priority and for which we as a country are prepared to pay accordingly.”

⁴The Eden Alternative. (2012). *Eden principles*. Retrieved from <http://www.edeninoznc.com.au/About-Us/Eden-Principles/Eden-Principles.asp>



Workforce supply, recruitment and retention

“There’s a perception that aged care is not seen as sexy.” (Comment from a participant).

Success in recruiting and retaining the aged care sector workforce is important to every family in New Zealand. All of us will require care and assistance at some point in our lives. However, there are huge challenges to be overcome in attracting people to work in the aged care sector, incentivising them to build on their expertise and relationships and remain in the workforce. The challenges are acute as the workforce itself ages and carers seek to retire just as demand for their services increases.

Future predictions

Statistics New Zealand predicts that by 2031 one in five New Zealanders will be over 65 years.⁵ Longevity is predicted to increase and the proportion of New Zealanders in the 85+ age brackets is growing very rapidly. Many of these older people will require care and support services.

A Department of Labour study found that the demand for labour in health and disability services will grow by between 40 and 69 percent by the year 2021 (depending on the scenario used). The same study estimates that around 48,200 paid carers will be needed in 2036 to care for older disabled New Zealanders requiring high levels of care and support, a trebling of current numbers.⁶ If present trends continue, there may only be 21,400 aged-care workers available at this time, leaving a huge shortfall and giving rise to serious concerns around workforce supply.⁷

This projected long term increase in the demand for care services and workers will significantly impact on the issues discussed in this Inquiry report including workforce supply, recruitment and retention, training and the evolving skill sets required by the aged care sector workforce. The equal employment opportunity issues relating to both the highly skilled health professional component of the aged care workforce (the regulated workforce) as well as the critically important less trained carer workforce (unregulated) are brought into sharp relief by New Zealand’s shifting demography and the need to consider how services can be delivered that respect the human rights of everybody.

⁵Statistics New Zealand. (2009). *National Population Projections: 2009 (base)–2061*. Retrieved from http://www.stats.govt.nz/browse_for_stats/population/estimates_and_projections/NationalPopulationProjections_HOTP09base-61.aspx

⁶Department of Labour (2009b) *The future demand for paid caregivers in a rapidly ageing society* Retrieved from <http://www.dol.govt.nz/services/LMI/workforce2020/ageing/paid-caregivers/index.asp>

⁷Badkar, J., Callister, P. and Didham, R. (2009). *Ageing New Zealand: The growing reliance on migrant caregivers*. IPS Working Paper 09/08. Wellington, Institute of Policy Studies.

In her 2007 aged care discussion paper, the Minister for Senior Citizens, Hon Jo Goodhew (then National Party Associate Health Spokeswoman) said, “the present funding system is not meeting the demand for carers.”⁸

The New Zealand Aged Care Association (NZACA) in its submission observed that, “in terms of workforce supply issues, currently the sector employs many caregivers and nurses from overseas... However, in future as competition for foreign health staff increases New Zealand may have to find a solution to labour shortages from within its own borders.” NZACA suggest that the most likely outcome is to move activities and responsibilities from the regulated to the unregulated workforce, an idea also advanced in the Grant Thornton report, which identifies “substitution of cheaper labour for expensive labour” as a means of achieving productivity gains through lowering workforce demand.⁹

Turnover

The 2010 NZACA survey¹⁰ reported an annual turnover rate of 27 percent for both registered nurses and caregivers with an overall turnover rate of 26 percent for all staff in residential aged care facilities. The survey reported a very high turnover rate for inexperienced staff, at 46 percent for nurses in their first year and 56 percent for caregivers. In a study published in the New Zealand Medical Journal it was found that staff turnover in the 845 long term residential care facilities surveyed was 22 percent annually and that greater continuity is desirable.¹¹ Where a high turnover of staff exists there will be a disincentive to invest in staff development and training and an impact on quality of care. Age Concern states that where temporary agency staff are used due to high turnover, they will be less well informed about the needs of residents and their care plans as well as the facilities’ policies and procedures potentially leading to poorer quality of care.¹²

The New Zealand Medical Journal report considered that addressing high staff turnover requires “a career structure for healthcare assistants within the industry associated with training, increased involvement with care planning for residents, increased involvement in therapeutic care for older residents, and flexibility of working times for workers with families.”¹³ A survey conducted by the New Zealand Home Health Association (NZHHA), from the providers’ point of view, suggested that the ability to work autonomously and possessing person-centred values are the two most important abilities required of support workers.¹⁴

⁸Goodhew, J,P. (2007). *Choice not chance for older New Zealanders*. Retrieved from http://www.national.org.nz/files/NZNP_Aged%20Care_Discussion%20Paper_low%20res.pdf

⁹Grant Thornton New Zealand. (2010). *Aged residential care service review*. Retrieved from <http://www.grantthornton.co.nz/Assets/documents/home/Aged-Residential-Care-Service-Review.pdf>

¹⁰New Zealand Aged Care Association. (2011). *2010 NZACA member profiling survey*. Wellington: New Zealand Aged Care Association. <http://nzaca.org.nz/>

¹¹Kiata, L., Kerse, N. & Dixon, R. (2005) Residential care workers and resident: the New Zealand story. *Journal of the New Zealand Medical Association*, 118(1214),8-11.

¹²Age Concern New Zealand. (2010). *Updated briefing to the Minister of Senior Citizens*. Retrieved from <http://www.ageconcern.org.nz/acnz/policy>

¹³Supra at note 11.

¹⁴Haggie, J. (2011). *Valuing our Workforce*. InSite June/July 2011

The manager of a residential facility observed that absenteeism occurred in cycles. “They start off keen for 6 to 9 months, work really hard and turn up, then one day they’ve had enough.” The manager is now using a different recruitment strategy. Care managers do the interviews and “we have a resident on the interview panel” and a Registered Nurse (RN). She said that this had made a big difference. She also has a formal arrangement with Work and Income New Zealand (WINZ) which “seems to be working in terms of recruitment.”

NZHHA noted in its submission that policy setting and health workforce planning is framed through a medical and nursing lens, rather than being seen from the point of view of the non-regulated workforce. This resulted in “insufficient national planning to ensure retention of current non-regulated staff and continuity of supply.”

Ageing workforce

The current aged care sector workforce is itself ageing. Figures from the New Zealand Nursing Workforce reported by Kai Tiaki Nursing New Zealand¹⁵ show that more than 40 percent of registered nurses (RNs) and 72 percent of enrolled nurses (ENs) and nurse assistants are aged 50 years or more. While many of these carers will work longer in their lifetimes than previous generations, there is nevertheless concern that there are not enough young workers attracted into the profession to meet demand.¹⁶

Talking about RNs, a Human Resources Manager said, “they come after their life at the DHB. They are coming to us in their fifties, even bordering on sixties.”

Support workers are also ageing. NZHHA, in its submission, said that 75 percent of the workforce is over 36, 40 percent is over 51 and 10 percent is over 65. “It is not an attractive career for younger people because there is no guarantee of hours, it is low paid and workers must operate independently without direct supervision.”

Des Gorman, Professor of Medicine at the University of Auckland and executive chair of Health Workforce, also observed that gerontology was not seen as a sexy speciality and cautioned that providing financial incentives to enter the field in isolation sends the wrong message. “If the only cues you are sending are financial then you are sending the message that this job is undesirable.”

“There is a perception that aged care nursing is not sexy. There isn’t the latest whizz-bang technology or leading edge medicine. You don’t have a collegiate body around. Instead you have a handful of RNs in a facility. Often too, it’s a palliative care service, for the last fifteen months of a person’s life. It’s the non-sexy end of nursing.”

Manager, large provider

¹⁵Research changes practice, (November 2010) Kai Tiaki, Nursing New Zealand,

¹⁶Fujisawa, R. & Colombo, F. (2009), “The Long-Term Care Workforce: Overview and Strategies to Adapt Supply to a Growing Demand”, *OECD Health Working Papers*, No. 44, OECD publishing, © OECD.

However, a general manager from a major residential care provider thought this was changing. “We are seeing a change in the perception that nursing in the sector is not seen as ‘sexy’. The development of nurse practitioner roles in the aged care sector will go a long way to addressing that. The changes in direction of residential aged care will also help. The care is going to become more acute, and it’s the acuteness that registered nurses find sexy. The registered nurses that come to us get a bit of a surprise at the nature of the decision-making they’re responsible for. DHBs are looking at how they can reduce admissions and are looking to residential care to contribute to that. So we have got some younger registered nurses, we do take some new RNs in their first and second years who are coming out in their supported programmes through the DHBs.”

An employer submitted that for both RNs and carers “demand outweighs supply again due to the negative media and public discussions.”

Geoff Hipkins, former chief executive of Oceania Group said, “we’re concerned with the perception that aged care has particularly for RNs and ENs, which is that it provides an almost end of career job for them. When we looked at our RNs they were definitely skewed towards older ages.”

Corina Montgomery, manager of Whare Aroha observed that New Zealand RNs in the sector were older and the younger RNs were from other nationalities.

Carers working in residential facilities and in home support were also predominantly older than other groups of medical workers. Concern was expressed about the impact of retirement on the workforce. A rest home manager said she was facing a looming problem as her management team were all approaching retirement age. “If we all left on our 65th birthday my entire management structure would go within 15 or 16 months.”

“I think it’s a head thing not a chronological age thing. My oldest RN is 73. She’s still learning, she surfs the net for all sorts of stuff, she reads journal articles. She works 3 or 4 days a week, work is her salvation, it is what keeps her going....she’s clinically safe so for me it’s about performance.”

Rest home manager

While some providers report that “less people are retiring at 65 years”, the physical demands of the job mean that older workers are less likely to work full time in their later working life. An older support worker said, “in five years I won’t be in this industry. It’s a physical job. With my husband and my own health I probably won’t be able to do this work.”

The Commission heard about the contribution of older workers, with reports of people in their seventies and older continuing to work in the sector. Some workers in the older group are employed in managerial and administrative work while others continue to work “on the floor”. A group of carers said that they had colleagues who continue to work into their 60s and 70s because “they like to have a reason to get up in the morning, but also because on low wages they haven’t saved enough for retirement.”

The general manager of a home support and residential provider, with 1800 staff, estimated that 50 percent of the staff were over 55 years and 30 percent were over 60 years. “Most of our managers are 60ish. We have staff in their 70s and one who is 84 and is a community support worker.”

The average age of General Practitioners (GPs) is also trending upwards and this is impacting on the availability of GPs to service the ageing population. As the profession becomes more feminised, retirement patterns may change. The College of GPs told the Commission that the number of GPs has increased but not enough to support the ageing population with their complex needs and multiple morbidities. New Zealand will “hit the wall” in five to ten years when the needs of an ageing population collide with an ageing workforce. New Zealand is a reasonably attractive country for overseas trained doctors but whether they can be retained long term is questionable.

Younger workers

The aged care sector attracts few young people and once recruited, retention is low. The Commission was told that there is “greater churn” (i.e. turnover) with young staff. The pay and the nature of the work were both seen as barriers to the recruitment and retention of younger carers.

At both public meetings and with meetings of carers, participants commented that caregiving was not a career that they would encourage young people to join. One carer talked about the advice she gave to her daughter, who she admired as having the attributes of a great carer of the elderly and who was interested in the work. “But I said, ‘if you want to travel or own your own home, don’t go there,’”. The issue of low pay for caregivers is traversed in the section on wages and pay parity.

Many of the younger carers who participated in this Inquiry aspire to be nurses. Some are in training while others do not have the pre-requisite academic qualifications or the income to train to be nurses and see caregiving as an alternative. One young carer said, “I’m a young Mum. I dream of being a nurse but can’t afford it.”

Global recession

While the global recession and higher unemployment rates have reduced turnover and increased the supply of both the regulated and unregulated workers¹⁷ in the aged care sector, a number of employers, providers and funders predict that as unemployment trends down, supply and turnover difficulties will intensify again.

In terms of workforce supply the picture varies from region to region, from large urban centres to provincial and rural New Zealand, and also between providers. Some providers in provincial centres report stable staffing and have no difficulty recruiting staff while others report chronic difficulties attracting the right staff. A significant factor is the local availability of alternative employment, especially of the unregulated workforce.

¹⁷The regulated workforce in this context are typically nurses and other health professionals subject to the Health Practitioners Competency Assurance Act and regulated by professional bodies. The unregulated workforce are typically support workers, care assistants who are not regulated. See the section Regulatory Frameworks.

A home support manager said, “I think when employment is high, it’s harder for us to get good staff because people have other options. We often have people approaching us for work every week and that varies depending on what the job situation is like at the time.” Another manager said, “the economic climate has been positive for aged care. We haven’t had the same level of turnover as previously. In Te Puke the kiwifruit disease has affected the kiwifruit picking work and carers are looking for extra hours. As soon as the economy picks up we’ll need to get ready for an upswing of demand for staff.” Employers also talked about “seeing a shift in those looking for work now” and “we get lots of people knocking on our doors asking for work, I think that’s part of what is going on.” However, supply is still an issue. “In the current economic climate there is not such a drastic supply issue, but turnover is still high.”

Similar patterns were reported for RNs, with a number of employers reporting less difficulty recruiting RNs than in the past. A manager from a major residential provider said, “job security is driving the supply of nurses. DHB budgets are constrained and there are no new programmes that might attract nurses. Young nurses are not going overseas, and older nurses are staying in the workforce.” However, other providers reported difficulty in finding skilled staff, in particular experienced registered nurses.

A DHB manager told the Commission that, “shortages (for RNs and home support workers) are now happening in parts of Otago and Southland that are not rural. Providers have to take what comes through the door. The aged care sector deals with our most vulnerable population, it’s scary.”

New models of care

The new models of care being specified in DHB contracts with the home care sector require a certain skill set from support workers. Peter Hausmann, managing director of Healthcare of New Zealand said that building this workforce should have started five years ago. “You need to build the workforce that keeps people in their homes.”

Mr Hausmann believes three tiers of support workers will be required in response to the new model. “We are going to have people at the top who are managing complex people, like Te Whiringa Ora. They’ll be trained to the level of an enrolled nurse, level 3, Level 4 national certificates. Then there is a group in the middle, working with people with semi-complex needs, and then you are going to get basic home support for the elderly. The employment model and the qualification model are going to be different for each layer.”

Staff with the increased skill levels necessary to meet higher acuity levels were difficult to find, a residential provider submitted. “Our staff all do their best for our residents but the complexity of care now is a huge issue and the inability to find and fund well trained staff is a huge problem.”

A manager with responsibility for services for Māori said, “recruiting skilled Māori staff is also proving to be a challenge. Māori providers find it difficult to find a Māori workforce. There is a shortage of Māori staff. We need more Māori RNs. The relationship with the person delivering the service is the most critical element.”

Possible solutions

A 2009 OECD report recommends three avenues for meeting the increased demand for carers for older people. The first is to increase the supply of carers by making their jobs more attractive to under-represented or unemployed groups in the population by addressing training, pay and conditions at work. A study from 2004 found that about one third of the support workers in New Zealand were economically inactive prior to taking jobs in the sector, of which 40 percent had been “housewives” and 46 percent had been unemployed.¹⁸ The second is to make better use of the available carer workforce by improving staff retention, again through training, wage rates and conditions of work as well as supporting informal carers. The third is to reduce the need for carers through increased use of technologies and changing the skill mix required for different tasks.¹⁹

One of the major residential providers is entering into formal arrangements with WINZ. Oceania is piloting a programme in which it trains a number of young unemployed people with an option to employ. A chief executive of another provider said the company was philosophically attracted to recruitment from WINZ but noted there was some stigma attached to WINZ placements. The company had met with mixed success in recruiting from WINZ. Another major provider said that they did not tend to recruit from WINZ. A rest home manager had an arrangement with her local WINZ office to look through curricula vitae (CVs) which she said, “provides me with opportunities to email them to consider them for employment.” She was “keen to get the right staff with good spoken English and who want to work in aged care, not just working in aged care because they need a job and this is the only avenue they’ve got.” Recruiting unemployment beneficiaries from WINZ tended to be treated somewhat cautiously by the industry.

Working part-time is one of the responses to retaining older staff past traditional retirement age, but for the regulated workforce, professional regulation requirements can be a barrier. Requirements for maintaining an Annual Practising Certificate and CPD (continuing professional development) are expensive and time consuming. Currently it is easier and less expensive for doctors to retire than to semi-retire.

The College of General Practitioners (GPs) is working on career progression models for GPs that will help to address retention. This might include portfolio careers, advanced skills and different ways of working such as third age careers.

Professor Gorman agrees, “one of the answers to the workforce supply issue is third age/encore health careers. Instead of nurses walking off the job at 40, let’s find another way to give them a job that keeps them in the workforce another ten–fifteen years. Even if it means reinventing themselves. Rather than doctors hanging up their shingle and going fishing what would they like to do that is constructive and meaningful in some district health board? We invest all this training in twenty year olds and here are all these fifty year olds. We are trying to reconfigure medical careers, so there is sufficient general skills and knowledge at the beginning so they are retrainable at the end. They specialise too early, so that when they reach their late fifties and they no longer have the eye hand co-ordination to do corneal

¹⁸Ministry of Health/University of Auckland (2004) *Disability Support Services in New Zealand The Workforce Survey*

¹⁹Supra at note 16.

transplants, they are useless to us because they have to take them back to scratch. We have to pre-programme them for some diversity of role or at the least recognise that the investment in retraining is greater than what we think. They could be involved in a training mentoring role. Just because they can't do a corneal graft doesn't mean that they cannot decide who needs them. ”

Graeme Titcombe Chief Executive of Access Homehealth said, “the biggest problem we've got in terms of support workers is not the number of support workers but encouraging support workers to work full-time. The average hours for a support worker is 20 hours a week. If we can get them to work full-time double our output without the need for massive increase in numbers. Why don't they work? Because they don't get paid enough.”

Conclusion

New Zealand, like other developed nations, faces critical health workforce shortages. Over and over the Commission heard that working in aged care is a “heart and mind” type of role, that people had to have “the right attitude” that, “you don't just want anyone – you have to want to work with the elderly”. However, the increasing complexity of caring requires evolving skill development. There is a projected increase in the demand for carers, nurses and doctors, and for carers to have increasing levels of skills appropriate for greater numbers of more dependent older people. Current turnover of carers is high, which suggests that reducing turnover would assist in meeting the demand for labour. While many carers are women with families, a proportion of those working part-time could be encouraged to increase their hours of work thereby reducing the churn of new entrants. However, a significant barrier to attracting carers into the aged care industry is poor and unattractive conditions of work. This is one factor inhibiting the recruitment of more men as carers. In New Zealand little attention has been paid to third age and ‘encore’ careers, despite the increasing number of 65+ who are choosing to, or have to, remain in the workforce. A more strategic, sustained approach to the carer workforce is urgently required.





Conditions of work

Everyone has the right to work, to free choice of employment, to just and favourable conditions of work and to protection from unemployment.

Article 23(1) Universal Declaration of Human Rights

Dignity at work is important to every New Zealander and is a basic human right. Caregiving is inherently demanding but too often conditions at work for carers can lead to unnecessary pressure and a lack of dignity for both the worker and those being cared for. Limitations to hours of work are enshrined in international human rights instruments and in domestic law. Minimum pay legislation also provides a floor for workers on low wages. While there is no suggestion that carers are being paid below the minimum wage in their hourly rate, the issue of what is counted as work time does raise questions of compliance with minimum wage provisions.

While the issue of whether or not driving between clients constitutes work has not been tested in court, the recent conclusion of what is referred to as the ‘sleep over’ case²⁰ provides useful guidance on defining “work”. The case involved payment for the sleepover shift, from 10pm-7am, when disability support workers are allowed to sleep but at the same time are responsible for the health and safety of the house residents and must be available to assist when necessary. Both the Employment Court and the Court of Appeal decided that each hour of a sleepover shift should be paid at the minimum wage at least. One of the factors taken into consideration was constraints placed on the freedom of the employee. In the case of driving between clients, it could be argued, the carer is not free to undertake other activities.

There are differences in working conditions between home care workers and those working as carers in residential facilities and in hospitals. The latter have problems around night shifts, broken shifts and insecurity of employment. In home based services there is insufficient contract time for travel time between clients, writing reports, team meetings and performance appraisal and training. Home care workers also tend to use their own vehicles in the course of their work and are often inadequately compensated.

In the course of the Inquiry, two issues featured prominently. One was hours of work and the other was travel. Travel concerns included unpaid travel time and underpayment for vehicle costs in the course of providing home based care. Health and safety issues related to exposure to infection were also raised. Work intensity and worker supervision is covered in the staff–resident ratio section.

Hours of work

Hours of work issues included: unsociable hours (for example nights and weekends); insecure hours (both for casual staff and permanent staff); unsafe hours; and unpaid hours of work.

²⁰Idea Services Ltd v Dickson [2011] 2NZLR 522

The views of employers and managers on hours of work tended to focus on supply issues. Managers spoke of difficulty in covering weekends and of short shifts when work demands were high. One rest home manager said, “the short afternoon shift is hard to fill; 4:30-8:30pm and 3:30-10:30pm. Who wants to work those hours? We employ student nurses for those shifts.” Another rest home manager said that one of her major human resources issue was people not turning up to work at the weekends. Carers said that when people call in sick, other staff are asked to work additional hours because using agency staff to fill in is too expensive.

Home-based care

The New Zealand Home Health Association (NZHHA) in its submission said that one of the labour supply issues was the low level of income security because the “work is frequently part time or casual and dependent upon a steady supply of clients in the area that the worker covers.” NZHHA asked, “why would an employee be interested in a job that has:

- No guaranteed income per week (as this depends on which clients needs are serviced and whether clients are in hospital)
- No benefit financially if NZQA training is undertaken
- No guaranteed working hours.”

A manager talked about the insecurity of hours for a new carer. “Normally people would start with relief work or if we had new clients they would pick up those or if someone leaves they pick up some of that work. It’s very bitsy. It’s so unpredictable. It’s hard to maintain a consistent level of work.”

Managers were aware that insecure hours were a factor in recruitment and retention difficulties but that the fee for service funding model made guaranteed hours unsustainable. A carer said, “if a person dies your hours are cut, but you still have to pay the rent.”

The general manager of a home support and residential care provider said that with the move to bulk funding her organisation was considering moving to shifts, “where we have a confirmed density of clients.” She said that the organisation was likely to offer three types of employment. “One will be regular shifts, another will have guaranteed hours, which means they’ll be guaranteed hours per fortnight, and then there will be piece meal work.”

A service manager said, “support workers have a different raft of tasks, with no set hours. They may have gaps in their day and work an eight hour day between 8:00am and 9:00pm. I put people on fixed people hours for a while but it was untenable financially.”

The National Council of Women (NCWNZ) outlined their concerns about casualisation. “Our members’ comments on this topic ranged from concerns about the punitive effects of secondary tax rates as a result of having more than one employer, through to the effect of broken shifts on a worker’s day and pay and also the resultant lack of consistency for clients who experience a confusing chain of different people coming through their homes.”

NCWNZ included the following comments from a community support worker, “recently I was working 35 hours a week then within a few weeks, four people passed away giving a total loss of around 15 hours per week which still has not been replaced. There needs to be guaranteed hours per employee so that gaps that appear are filled prior to new workers being handed jobs.”

The Commission spent time with the placement co-ordinators of a large home support provider. This is their story:

Lisa’s day starts at 7:30 am and will finish at 4pm, “or until the job is done.” Her task for this particular Friday is to match up forty carers and clients on the Kapiti Coast for the weekend. It’s a busy day for the six care co-ordinators managing the rosters at Access Homehealth Wellington region. Each has a list of unassigned home visits: clients whose carer is on leave, new clients and other clients who do not have permanent carers. The co-ordinators work the phones, talking to carers about picking up an extra hour or two at the weekend and talking to clients about what is being proposed. Maintaining relationships is critical to the job.

Lisa is responsible for a total of 450 clients and has about 100 carers to call on. Carers work between 15 – 50 hours a week supporting clients with personal support and home management. Most of the carers have regular rosters. Carers do not have guaranteed hours, but must be available for a minimum of fifteen hours a week. “We try to give them a minimum of fifteen to twenty hours.” New carers start out relieving and then build up a more regular roster when clients express a preference for them.

The co-ordinators juggle multiple schedules. Each client and each support worker has a schedule. Both groups have their preferences. This client wants to be showered in the early part of the morning, this carer doesn’t work weekends. Travel time needs to be factored in. Travel time is unpaid time for carers so scheduling can make a difference to income.

Each client has a support plan and it is the job of the co-ordinator to match the skills of the carer to the needs of the client. One co-ordinator said, “you match the correct person for the correct client for the correct job. If you get it right no-one complains.” Client choice is always respected, if a client doesn’t want a particular carer in their home for whatever reason, the co-ordinator will assign a different carer. “It’s their home.” Some clients are reluctant to accept a male carer. One co-ordinator tells me that she asks clients if they mind a male carer. She suggests they give it a try – no matter what the neighbours might say. When a client requests someone from a particular cultural background the co-ordinators accommodate it if they can. The same choice is available to carers. We don’t leave anyone in unsafe situations; we tell our carers “If you don’t feel safe, walk out.”

Most co-ordinators have been support workers and share the same commitment to their clients. Co-ordinators come in early and leave late or take work home to ensure that support for their vulnerable clients is maintained. “One more call and I’m right for the weekend,” says one of the co-coordinators, mid afternoon. “One more person to grease up,” she says smiling. It’s all about relationships.

The funding manager of Auckland District Health Board (DHB) talking about the changes the DHB had made to the way home services were funded and delivered said, “the workforce were transient, underpaid and non-engaged, which lead us to question the quality of care. One of the significant changes was creating a sustainable workforce which was 100 percent non-casualised. Employment contracts provide guaranteed hours with clients known to the carer. There are fewer workers and training to Level 2 with health professionals doing the assessment is mandatory. Carers have fewer clients and work under the direction of a case manager who has accountability for a group of clients. That’s an extra layer.”

Newer service models such as CREST, Te Whiringa Ora and other variants of restorative care and the Auckland DHB model provided more certainty of funding and increased security of hours.

Residential care

While workers in residential aged care understand that the nature of the work is ongoing and in many instances 24/7, the Commission heard about shift allocation practices and lack of penal rates which workers felt were unfair. But arguably of most concern to support workers was that insecure hours of work at minimum wage rates added up to extremely precarious income.

One carer said that every Sunday he worked different hours. At a union meeting the Commission was told that most collective agreements in the sector are hours of work dependent and part time hours were variable (anything under 40 hours). This made for insecure work time and insecure income. An RN said that she worked part time on night duty, but did not have set hours in her employment contract despite asking for them.

“CREST support workers are rostered for an eight hour day and usually work either the morning shift or afternoon. The service requires services to be available between 7am - 9pm with the volume of the work being between 10am and 2pm. Generally CSWs work a six week roster, working one weekend in three and a mix of morning and afternoon shift. No-one works longer than eight hours start to finish on any given day.”

CREST manager

Migrant workers who depend on a specific employer for a work visa feel obliged to work whatever shift they are asked to do, without negotiation. Worryingly, this sense of obligation also includes agreeing to double shifts (i.e. 15-16 hour days). This is described further in the section on migrant workers. A number of submitters have expressed concern about the safety implications of this, let alone rights to decent work which include the right to rest and leisure and “reasonable limitation of the working day” enshrined in the Universal Declaration of Human Rights.

The Commission is in no doubt that some carers seek part time work and that is one of the attractions of working in the care sector. However, it would be wrong to conclude that income from the work should be regarded as “pin money” and that casualised hours and therefore variable income is acceptable to all workers.

Employers value 'flexibility' to meet the variable demands of the day and of the work. The New Zealand Aged Care Association said, "in terms of work security, currently just under 40 percent of the caregiver workforce is employed full time and the remaining part time. The reasons for this relate to the nature of the work, where facilities require more staff in the mornings and evenings due to the nature of work involved in caring for elderly people. We understand that some part time caregivers would like additional hours and more guaranteed work. However, the way in which aged care providers are funded and the changes that can occur in a facility make this difficult to achieve. For example, aged care providers are paid on a daily basis for an occupied bed and when occupancy changes a facility's income reduces, thereby staffing levels must be re-evaluated. To change this causal link would require a change to the current legislative and contractual framework by which the aged care sector is funded. Clearly, addressing this issue and reducing the need for a flexible workforce would also require aged care providers to accept more inefficiency in their staffing rosters and government funding would have to increase to cover these financial inefficiencies."

Working for free

Unpaid work was another issue raised by employees. Both nurses and carers talked about expectations of working on days off or after hours. This usually involved preparation and paper work done in unpaid time. Carers in home health and Community Support Workers (CSWs) said that there were some tasks that were required out of hours such as checking rosters and tasks, planning and phoning clients. A registered nurse said in her submission, "I work 32 hours a week and have no issues with my pay. However, there is an ongoing expectation that RNs will work more hours (unpaid) or give up meal breaks to attend meetings, complete compulsory education material, etc. I do not have time to complete computerised nursing care plans during a normal day's workload and it has been suggested to me several times that I come in on days off to do this."

Other instances of unpaid work have been the result of recent cuts to home health hours. A number of carers told the Commission that the time allocated for tasks is insufficient and that they are pushed to complete tasks in the time given. A manager from a home support agency said, "as the scope and expectation on carers are increasing the time allocated to do them is being cut down. This creates an emotional strain as carers are leaving a person's patient care half done or rushing out." Some carers respond by completing the tasks in their own time.

Travel

Travel reimbursement is a major issue in the home support sector and support workers, concerning the adequacy of reimbursement for both time spent travelling and vehicle expenses.

In meetings with community support workers, whether or not time spent travelling between clients was paid or not, was unclear, with carers reporting mixed messages about this issue from their employers.

The Aotearoa New Zealand Association of Social Workers (ANZASW) submitted that, “community based workers are not currently paid for travel time or any time when they are required to wait for professional assistance such as an ambulance to provide professional care for their client. In this respect it could be argued that the low paid workforce is subsidising the companies and NGOs (not for profits) that are providing the aged care services.”

Another very experienced carer said she found the 15 minutes allocated to travel between clients was the most stressful part of the job.

Reimbursement of vehicle expenses varies. One method of reimbursement is to load 77c an hour (with a cap of three hours per assignment) onto client contact time to pay travel expenses. Another is to pay a mileage rate (typically 30c a kilometre) with the first ten kilometres of each day subtracted. Another variation of this is to exclude travel to the first client from home and travel from the last client of the day in the daily mileage calculation.

Peter Hausmann, managing director of Healthcare of New Zealand said, “some DHBs pay a travel component of \$1.50 an hour. We take a five percent slice for administration and pass the rest through to our staff on a staff reimbursement model. Other providers use that as a top up to the hourly rate, less tax. The variability in the sector is enormous.”

The New Zealand Home Health Association (NZHHA) said that Fair Travel needs to be reviewed and costings done to reflect the actual cost of travel. The Fair Travel’s policy was developed between providers and the DHBs in 2008 when the cost of 91 octane petrol was \$1.33 per litre compared to 2012 prices (when this information was collected) of \$2.12 per litre. Carers told us repeatedly that travel reimbursement did not meet their costs and managers and providers told us that the terms and conditions of Fair Travel had been set some time ago (2008) and “so there is nothing for us as a provider to pass over to them.”

One barrier to full reimbursement was said to be the cost at which reimbursement was taxed.

“My understanding is that the time allocated to a client is based on assessment/estimation by the community nurse co-ordinator as to the fairest and most accurate time required to complete the tasks in the Support Plan. For the most part this works well. Depending on the day and the tasks required at the time, you may finish slightly early and are therefore able to move on to your next client. However, this is not always the case as the support plan may be tight and/or the next client may live far away. In addition, some clients expect you to stay for the allocated time exactly. Which I can understand. Where this is the case, there is no time set aside, to travel to the next client. This means either the support worker ends up travelling in their own time, unpaid or the travel time is taken out of another client’s allocation. Neither of which is fair.”

Support worker in an email submission

One of the carers interviewed estimated that she was reimbursed for about half of the petrol used to fulfil her caring role. Another community support worker clocks up 115km on average per week but has driven up to 230km a week. She is reimbursed at 30 cents a kilometre after the first 10km each day. That is, in an average week she would be reimbursed for 65km of travel at 30 cents a kilometre, in total \$19.50 while travelling 115 kilometres. In a written submission a support worker advised that when she started work at her present employer “we received 30 cents per kilometre for petrol, losing the first ten kilometres each day and it is still 30 cents a kilometre 16 years later.” (Emphasis in the submission)

The Inland Revenue Department (IRD), as at Dec 1 2011, suggests that “a reasonable estimate of the costs likely to be incurred by an employee, reflecting on the average cost of running a motor vehicle, including the average fuel prices for the 2011 income year” is 74 cents a kilometre. This figure is based on the assumption that the overhead costs of running a car are met during the first 5,000km. The Automobile Association estimate that the operating costs for a small (below 1500cc) petrol fuelled car is 52.7 cents a kilometre, and for a compact car (1500cc-2000cc) 63.1cents a kilometre. However, employers are not obliged to pay this rate, and instead can pay the actual cost of running a vehicle.

Graeme Titcombe, Chief Executive of Access Homehealth, said rural home health care workers are even more disadvantaged and he provided the following analysis.

Up until 2005 support worker travel was not funded by MoH or DHBs and providers reimbursed travel costs in the best manner that they were able. However, this was only achieved at the expense of wage levels. Following two Parliamentary Health Select Committee hearings into support worker wages and salaries the Government decided to ‘work towards a fair travel’ policy. In Budget 2005 the Government provided additional funding to DHBs who were required to increase pricing by a percentage; all providers were then required to gain funder approval for policies that ensured that this was passed on to support workers.

As this increase was based on a percentage of the existing individual DHB price the dollars figures varied by funder. It was also based on a ‘per hour of service delivery’ (the average was approximately \$1.38 per hour); it had no relationship to the distance actually travelled by individual support workers. Provider organisations took differing approaches to this ‘pass-on’. Some introduced an hourly tax free travel allowance while others introduced a per kilometre based payment.

Access is the major rural provider to the New Zealand market. As such, we needed to institute a ‘per kilometre’ payment if we were to have any hope of retaining rural delivery staff. Although the dollar value received for travel differed per funding agency, the total amount we received equated to \$0.19 for every support worker kilometre travelled within our organisation. Access instituted a national policy of paying \$0.30 per kilometre with a daily deductible of 10 kilometres per day. Given the current costs of running a vehicle this payment is acknowledged as inadequate and is particularly disadvantageous to support workers servicing the rural sector.

Impact on Support Workers

The varying impact on support workers of the varying rates of wages and the inadequacy of the travel funding can be illustrated below (assuming the true cost of running a vehicle is \$0.60 per kilometre and both are delivering personal care):

Rural worker on lowest pay rate (1 hour of personal care service to a client):

Wages	13.23	
Travel Time (15 minutes)	0	
Less PAYE (approx)	<u>1.80</u>	
Net Pay	11.43	
Travel Reimbursement	<u>3.60</u>	(6 kilometres each way to client)
Total Received	15.03	
Travel costs (12km's@\$0.60)	<u>7.83</u>	
Total net received after travel costs		\$7.20 for 1hr 15 minutes of 'work'

Urban worker on highest pay rate (1 hour of personal care service to a client):

Wages	15.35	
Travel Time (5 minutes)	0	
Less PAYE (approx)	<u>2.24</u>	
Net Pay	13.11	
Travel Reimbursement	<u>1.20</u>	(2 kilometres each way to client)
Total Received	14.31	
Travel costs (4km's@\$0.60)	<u>2.40</u>	
Total net received after travel costs		\$11.91 for 1hr 5 minutes of 'work'

While both workers are inadequately reimbursed for their time and costs, the rural worker is substantially disadvantaged and receives only 60 percent of the urban worker reimbursement for exactly the same task.

Note: Lower paying DHBs tend to be those servicing rural areas.

Another provider, who pays 55 cents a kilometre, talked about how they calculated travel reimbursement. "We make assumptions about people having a car no bigger than two litres, of a certain age and that it runs on petrol and in addition to that formula, we put in the co-ordinates of what the current cost of petrol is, and run a schedule to make sure the current 55 cents covers it. And certainly the four times we've done it when I've been in this organisation it's been a completely absorbed fixed cost. Your warrant and your rego etc is covered by the 55 cents. Often you have to take that to staff and assure them that the 55 cents covers everything, insurance the lot. This does not include community carers going to their first client of the day and going home from their last client. This is on the basis that if you were going to a fixed place of work you would incur those costs."

Although the rate of reimbursement is fairly consistent, if inadequate, the actual cost of travel to carers is very different from centre to centre, between urban and rural areas and between providers. In Auckland carers do not have far to travel because providers service a geographically compact area. In the Wellington region carers face a lot more travel. In rural areas travel distances can be very high. A special case has been made for Queenstown as there were significant supply issues without adequate travel reimbursement. The National Council of Women summed up the

majority feeling when they said, “we believe the travel allowance should be enough to cover real and actual costs, especially when one is required to travel outside the caregiver’s own suburban living area and taking into account the huge distances between clients required of caregivers in rural areas.”

The Ministry of Health advised the Commission, “at the request of the Minister of Health, the Ministry is currently conducting an inquiry into DHB policies and practices regarding recognition of exceptional travel by support workers, with a view to ensuring greater consistency and transparency across the sector. The Minister has asked to be kept advised of progress in this area.”

Health and safety

Carers in both residential and home based settings also raised safety concerns related to exposure to infection. Some of these relate to inadequate infection control and others relate to sick leave provisions that do not take into account the particular nature of the work.

Carers talked about poor infection control that put both them and care recipients at risk. Examples included having inadequate equipment such as examination gloves, boots and aprons. In one instance a doctor advised that carers should be fully gowned, masked and gloved when caring for a patient with MRSA²¹ and other super-bugs such as ESBL²², yet this equipment was not available. At another meeting the Commission heard that, “infection control is not well understood by some managers, for example one pinafore was left behind the door of a resident with a super bug for each carer to use when they cared for that person.”

Carers said that in some workplaces they had to pay for their own screening for super bugs MRSA and ESBL, even though these bugs are “quite contagious and we can take them home with us.” At one facility clients were tested for a super bug infection but not staff. Concern was raised about discharge notes from a public hospital which alerted the facility of the presence of a superbug a couple of days after a resident arrived. “It’s scary, we’ve all got families”, a carer said.

In another instance a sign on a door warning of the presence of MRSA (in effect a hazard notice to staff and visitors to take precautions) was removed to preserve patient confidentiality. Carers also felt that immunisation should be paid for by employers.

Another issue was the provision of sick leave. The sector typically allows 10 days sick leave a year. The work environment in aged care exposes workers to greater risk of ill health because they are likely to be in the presence of infectious organisms. Secondly, it is an environment in which there is a heightened obligation for workers who are unwell to absent themselves from work in order to protect the health of their clients. At low wages and low levels of sick leave provision this is a significant cost to carers. The New Zealand Nurses Organisation agreement in DHBs has a provision

²¹Methicillin-resistant staphylococcus aurea, a ‘super bug’.

²²The Extended-Spectrum Beta Lactamase (ESBL) strain of e-coli is another superbug which is resistant to several antibiotics. Patients develop urinary tract infections, which can develop into dangerous septicemia (blood poisoning).

that nurses sent home with an illness that poses a risk to patients do not lose sick leave.

One carer said, “I don’t know how much longer I will be able to do the job I love due to all the heavy lifting and just the constant physical nature of the job. My shoulder is very bad and in need of an operation, but because I cannot specifically put a date on when I hurt my shoulder, I have been told I would be out of work for up to 3 months. Well, on my pay, I can’t afford the time off.”

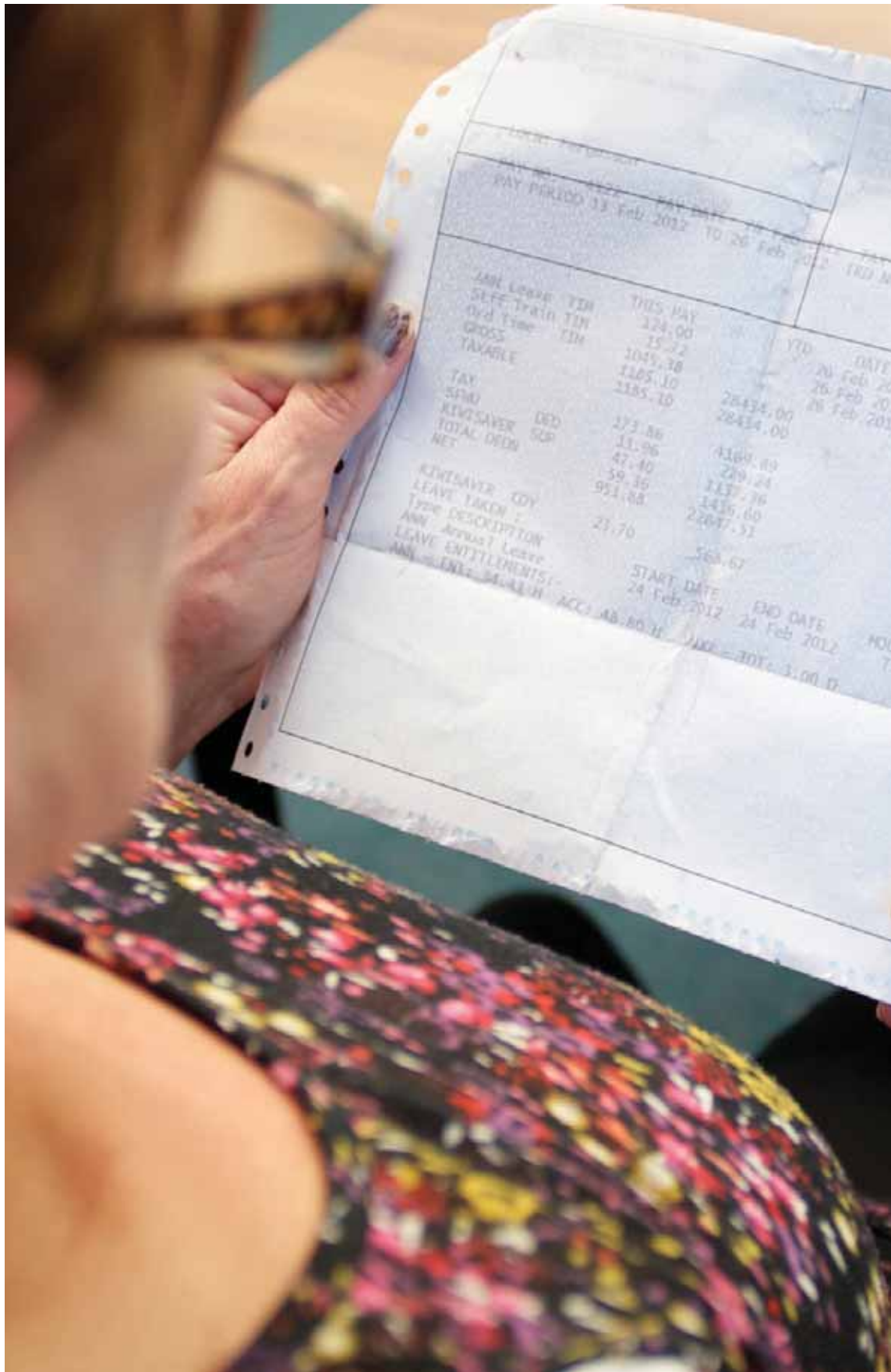
Inadequacy of equipment was also described by another employee, a cleaner, who said she had bought her own mop and vacuum cleaner because the equipment supplied was so inadequate (the hose was too short, it kept banging into her leg, vacuum cleaner bags were not supplied) Carers said that hoists have improved workplace injury related to lifting. But, the “biggest time consumer was locating the hoist”. However, transfers still require physical strength. Some residents are very heavy, for example 120 kg and that is a challenge even for two carers.

Conclusion

The issue of travel costs and the shortfall in payments to carers working in the community constitutes injustice and possibly warrants legal intervention to remedy. Inadequate reimbursement for the travel costs of carers working in home support was a constant theme. Support workers, care recipients, employers and other groups all raised the issue of Fair Travel. Employers apportioned the blame on the funding system they operate under. The evidence presented to the Commission also shows that many home support workers (and some residential carers) have uncertain hours resulting in precarious income. New models of care with a different funding system partly addresses the hours of work issue and these may increasingly become the norm.

Health and safety issues and physical degradation will require increasing attention as the caring workforce gets older. While technological improvements will help they are likely to be a partial answer only to the physical demands of the job.





PAY PERIOD 13 Feb 2012 TO 26 Feb 2012		END A	
ANN LEAVE TIN	THIS PAY	YTD	DATE
SEFF Train TIN	124.00		26 Feb 2012
Ord Time TIN	15.72		26 Feb 2012
GROSS	1045.38	28434.00	26 Feb 2012
TAXABLE	1165.10	28434.00	
TAX	235.10		
SFMO		4189.69	
KINGSAYER DED	173.86	289.24	
KINGSAYER SCP	11.96	2117.36	
TOTAL DEDN	47.40	1436.60	
NET	59.36	22077.51	
KINGSAYER CDY	951.88	568.67	
LEAVE TAKEN :	21.70		
Type DESCRIPTION			
ANN Annual Leave			
LEAVE ENTITLEMENTS:			
ANN - ENR - BUREAU			
ACC: AB-80 H			
START DATE	24 Feb 2012	END DATE	24 Feb 2012
MO:			
NO:			
DO: TOT: 3.00 D			

Wages and pay parity

Everyone, without any discrimination or distinction of any kind, has the right to equal pay for equal work.

Article 23 (2) Universal Declaration of Human Rights

The ability to earn a living wage which can support the basic necessities of life for an individual and their family is a fundamental human right. Carers are one of the lowest paid groups in the country, many receiving the minimum wage for physically, mentally and emotionally demanding work. The workforce is predominantly female and the pay scales reflect the historic systemic under-valuation of the roles played by women in society.

A 2009 survey carried out by the New Zealand Nurses Organisation (NZNO) found that the average wage per hour for carers was \$14.40, ranging from \$12.55- \$19 an hour.²³ The New Zealand Home Health Association (NZHHA) reports that support workers in the home care sector earn \$13- \$14.50 per hour.²⁴ As the Inquiry report was being completed the minimum wage rose to \$13.50 an hour to take effect from April 1, 2012. A study from 2004 found that 17 percent of carers, particularly the lower skilled workers, hold multiple jobs, often care related²⁵ which is likely to reflect the low wages, part time and irregular nature of care work.

As well as chronically low wages paid to carers there are also inconsistencies in pay between different parts of the sector. These include pay disparities between community support workers and carers and healthcare assistants and nurse aides working in a public hospital.²⁶ There are also variations between individual District Health Boards (DHBs), the Ministry of Health and Accident Compensation Corporation (ACC) as to how services are purchased, provided and funded which are reflected in the hourly rate paid to providers. The New Zealand Home Health Association (NZHHA) reports that hourly contract rates have barely shifted over the past 5 years while the costs of providing the services have increased dramatically.

The Ministry of Health affirmed DHB responsibilities to be good employers, including having an Equal Employment Opportunity programme and to addressing gender inequities which extend to their responsibility when outsourcing services (see Appendix 2).

Since 2005, a number of Cabinet Minutes²⁷ have directed DHBs to “continue to address and respond to any identified gender inequities as part of good management practice and being a good employer, consistent with pay and employment commitments. DHBs are also required to have regard to the

²³Supra at note 3.

²⁴The New Zealand Home Health Association. (2011) *Making the most of home support services*. Wellington: New Zealand Home Health Association.

²⁵Supra at note 18.

²⁶Supra at note 3.

²⁷CAB Min (05) 42/5 dated 19 December 2005; CAB Min (07) 16/2 dated 14 May 2007; CAB Min (09) 5/5A dated 16 February 2009; and EGI Min (09) 16/12.

Government's Pay and Employment Equity Responsible Contracting Policy when entering outsourcing contracts for services that DHBs have an operational obligation to ensure are provided."

As part of its function of monitoring Equal Employment Opportunity reporting by Crown Entities, in late 2009, the Human Rights Commission surveyed DHBs to determine the progress they were making on implementing their pay and employment equity response plans. All DHBs were part of the state sector wide pay and employment equity plan of action and were required to produce response plans to address pay and employment inequities. Only seven of the twenty one DHBs responded. Six reported they did not have a pay gap and the seventh did not know. The Commission found this information surprising and at odds with the findings of the 2009 Pay and Employment Equity Unit (PEEU) Overview Report which states, "there is a significant gender pay gap in this [health] sector".

Carers – community and residential facilities

There is a remarkable consensus that the remuneration of workers in the aged care sector is inadequate. As one submitter put it, in response to the question in the Commission's website questionnaire, "do you feel your carer is paid enough for the job? 'The answer is an unequivocal NO.'" With the exception of a couple of managers from one of the smaller residential providers, everyone the Commission met with acknowledged the undervaluing of carers. This included chief executives and senior managers in DHBs, representatives of peak bodies, to nurses and carers.

Here are some typical viewpoints:

"I fundamentally believe that care workers should be paid more. What that more is, is difficult to say. They are significantly undervalued. In an absolutely ideal world they'd be paid \$20.00 an hour. That's probably what the job is worth. Registered nurses in the sector would get double what they are currently paid," said Brien Cree, chief executive of Radius Residential Care.

An employer submitted, "We need to value the work our carers perform and pay them appropriately. This work is not valued and we are not paid well by the DHB and therefore can not afford to pay our staff well."

A geriatrician said, "we need to pay carers decently, the other option (older people receiving less than acceptable care) is untenable. That's the moral issue. You need to pay a reasonable sum of money to ensure an acceptable level of care. Carers are not unskilled people. People looking after people have to be skilled and paid appropriately."

The National Council of Women submitted that their members considered pay rates for home carers and retirement home workers were "too low for the skills and quality of care required of a care worker."

The Aotearoa New Zealand Association of Social Workers (ANZASW) submission said that the aged care workforce either had to work long working hours or "hold alternative employment in order to be able to earn a sustainable wage to meet day to

day living costs. This has the potential to compromise the ability to provide high quality care.”

A support worker who had worked in the sector for many years said, “we need a fair deal for the work we do and better wages. It’s all very well we being told we do a great job etc, etc.”

When asked what a fair hourly rate of pay would be for carers, two responses emerged. One was to suggest a minimum hourly rate, and the other was to propose parity with similar or equivalent jobs in DHB (public) hospitals.

“Carers working in homes without oversight need a high level of expertise to keep people safe at home in the community. Around \$18 an hour would be a fair wage for a good carer. Support workers are the eyes and ears of the home care service. Eighty percent of support workers can accurately predict who is going to be in hospital in the next fortnight. They need to be able to make the decision about when to escalate care and they need education and training to do that.”

Senior DHB manager

Fair minimum hourly rates identified by participants in the Inquiry ranged from \$15-20 with the majority at \$18 per hour.

“In an ideal world setting aside the funding model the pay for a Level 2 qualified support worker should be \$16-17 and that’s where we are pitching our Level 3. But ideally I’d like the Level 2s to be there and the Level 3s to be nearer the \$20 mark. And we’d like to be able to recognise the really high performers, the ones providing the really significant care, to pay them a little higher, \$21-\$22 an hour. There are some really complex cases out there and that should be recognised,” said a manager of a home support provider.

Many participants were outraged by the low level of pay and used words such as “abysmal”, “unacceptable” “terrible” and “inadequate”. “It is a national disgrace how all these companies treat hard working women and men in the care industry and, of course, the “gold” residents of our country. A lot of hospitals were also employing the cheapest staff they could get in the door,” said one.

An enrolled nurse wrote, “the care these girls (carers) give to our residents is well over and above the call of duty and all they get in return is a measly \$14-15.98 per hour. They are so much worth more! Even after being there for more than 10 years! Some have been working here for 15 years, now that’s dedication.”

The pay was not considered to provide a living wage and carers either had to work long hours or have other sources of income, such as a benefit. The Aotearoa New Zealand Association of Social Workers (ANZASW) argued that community based workers were “subsidising the companies and NGOs (referring to the not-for-profits) that are providing the aged care services. Care employment is often supplementing another low paid role or is supplemented by a second job.”

An enrolled nurse said, “some staff at the facility I work at do double shifts and six day stretches to earn enough money to support their family. We need to keep these skilled passionate people from burning out and leaving aged care.”

The Commission conducted a number of public meetings, in most cases hosted by local branches of Grey Power and in one case by University of the Third Age. Older citizens made up the majority of these meetings. Some were direct recipients of care services, some were partners of care recipients and others knew friends who received care. These groups are very supportive of the carer workforce and are vocal in advocating for decent remuneration. An older person at a large public meeting hosted by Grey Power in Rangiora said, “carers should be paid a respectable wage because they do a respectable job caring for respectable people.”

Many make the link between the low pay of people caring for the elderly and the value placed by society of the elderly themselves. A submission from Alzheimers Eastern Bay of Plenty put the case succinctly, “in the home care industry the hourly rate, coupled with insecurity of hours, of regular hours per week, demeans the value of people trusted to work independently with vulnerable clients.” This issue is discussed in the section on respect and value.

Many older citizens have direct experience of the work of carers and the difference good caring can make in the quality of a person’s life. The partner of a woman receiving home care support said, “it’s slave labour. The money she was getting is absolutely ridiculous, it should never happen in this day and age in New Zealand. It’s criminal.”

The only dissenting voices were two managers of a smaller residential provider who emphasised the absence of qualifications needed for the job. “Carers are not massively paid but that pay also recognises that the underlying job doesn’t require any qualifications. Carers are paid adequately for people without qualifications. Having said that, it is a personally responsible job - for example, if you shower someone you can’t drop them.”

The argument for parity with Health Care Assistants (HCAs) in public hospitals was that the work was very similar but with some differences in the home health sector, such as degree of responsibility and autonomy and access to direct supervision which arguably makes caring in the community harder. This could suggest a premium for carers in the community. As a registered nurse wrote, “it is an irony because we receive the same funding from the government.”

Senior managers at one DHB were candid about the lack of fairness in these disparities. They told the Commission, “DHBs pay more than the private sector and have no trouble recruiting. Is that fair? No.” This group thought that one of the causes of the disparity was union power. “HCAs are far more unionised in public hospitals compared to those in the private sector.” An employer asked for “funding to be on a level playing field with the DHBs to allow staff to be remunerated equally.”

A number of carers quantified the hourly pay differential between working for DHBs and working for the private sector at \$4 an hour. However, an enrolled nurse said that “untrained hospital aides are on about \$6 an hour more than our hardworking

carers and time and a half in weekends. The government NEEDS to provide pay parity with the DHBs to retain good staff in aged care.”

Peter Hausmann, managing director of Healthcare of New Zealand compared a home support worker on \$14.50 and someone in the hospital on \$17 with overtime. He observed that carers providing home support had to work ten hours to get the same as someone in a hospital working eight hours. He continued that it was unacceptable to “pay people who are managing people with chronic disease and complex conditions in the community on these (current) kinds of terms and conditions. You have people at Level 4, and in terms of experience they are starting to overlap at the bottom of the competencies of an RN and they are on \$40-42K range. That’s another conversation about equity.”

Staff at a residential facility said, “we should get \$20 an hour, the same as the DHB – we don’t want to bankrupt the Government.” The manager of an aged care facility told the Commission, “the Multi-Employer Collective Agreement (MECA) for Health Care Assistants in the DHBs pay a lot more than we can afford in our sector. We’ve got caregivers who are more qualified and who are doing a wider range of basic hands-on care than they are in the DHBs.”

Residents in an aged care facility the Commission visited said, “this is a very good rest home, well run by dedicated people. The carers say they do not do the job for money but because they like working with the frail elderly. The work they do is more than equivalent to that of a nurse aide in a hospital working with drugs, people with dementia who need a lot of care; which nurse aides do not have to do. The difference in remuneration of the nurse aides and our care workers could be up to \$4 an hour. Where is the justice here?” In a submission from Access Homehealth, the lowest rate for equivalent staff in DHBs was 23.2 percent “above our lowest rate, and their highest rate is 16.5 percent above our highest rate (including our highest skill margin).”

Professor Matthew Parsons, Chair of Gerontology at the University of Auckland, is more cautious. “Comparisons between health care assistants and community support workers are difficult. Support workers in the community may have more autonomy and they don’t work under supervision but they do different work. Some or most of what they do is housework. The problem with the parity argument is around the housework component. You reach equity if you take out the housework component entirely. So long as you have housework in there you will never achieve equity.”

But carers, nurses and community members dispute this view of the work. A nurse talking about carers said, “The pay is appalling. It’s not just the workload. We rely on these people, they are our eyes.”

A home support worker told the Commission that, “in-house kitchen assistants and cleaners at the DHB get paid more than home based support workers.” This view was also expressed at a public meeting in a different region. “There are pay differentials between the DHB and community residential facilities. At the DHB the rate for health care assistants is \$20 an hour plus shift allowance. Cleaners, laundry and kitchen assistants at the DHB are paid \$16 an hour.” Care workers at an iwi-

based service said of home support workers, “they do more than clean the home. They can watch out for signs of depression, empty pill bottles, and identify mats that might be a hazard.”

Another home support worker paid just above the minimum wage at \$13.50 talked about her work. “Some clients are very active, but there are many clients who are struggling to accept the ageing process and experience pain, isolation and depression. For these clients, the support worker’s visit is often the highlight of their week. For some, it is their only social interaction. As part of my role, I attempt to lift their spirits, encourage them to become/remain socially active, listen to their concerns, and provide positive reinforcement and so on. Support workers also have the significant responsibility for observing and reporting any changes in client’s health. In order to do this, it is necessary to establish a close and mutually trusting relationship with clients. Again, this highlights the community work aspect of the position and the high level of responsibility, which should be reflected in increased levels of pay.”

Another carer said she had responsibility for monitoring someone with brittle diabetes at night for \$13 an hour. Supervision was an RN at the end of a telephone, but “you have to know what to look for, \$13 is ludicrous.” The Commission was told about the situation of a care recipient in the community. The man’s Filipino carer was catheterising and bathing him every day “and she was getting the minimum wage. He required full hospital care yet was living at home supported by home help at the minimum wage.”

A distinction was made between carers in rest homes and hospital level care. Professor Parsons said that care workers working in hospital level care should have parity with health care assistants providing hospice care. He makes the point that with the gradual shift away from the rest home level care, which is increasingly being provided in the home, residential care provision is now predominantly hospital level/end-of life care.

Researcher, Dr Michal Boyd who is a Gerontology Nurse Practitioner and a Senior Lecturer with the Department of Geriatric Medicine at the University of Auckland also referred to carers providing a high level of care. “Psycho-geriatric and dementia care occupancy is 96 percent. They are full, you can never get enough beds. So they go into rest home care and private hospitals and you have carers providing end of life care, providing high needs dementia care and that makes the undervaluing of their job even worse.”

The low value placed on care work and consequent low remuneration is undoubtedly gendered. Care work is predominantly done by women, is seen as women’s work and has traditionally been unpaid work.

The gendered nature of caring

Des Gorman, Professor of Medicine at the University of Auckland and executive chair of Health Workforce said, “the pay parity issue is historical. It used to be that women would become nurses or teachers until they could find a good husband. Vocational history is the baggage that those particular professions carry.”

NZACA in its submission said, “society sees the function of caring as more suited to women. At a historical level, the occupation of caregiving was often seen as a secondary job for a wife to supplement a family income as it was part time and flexible. At a business level it is important to employ women, and they prefer their personal care being delivered by women.” The general manager of a home support and residential care provider said, “most of the staff are women which is why they’re paid so badly.”

A recent Australian case has involved discussion of the effect of gender in low paid community work.

Early this year, Fair Work Australia ordered the wages of approximately 150,000 workers in the community and disability sector to be increased by between 19 and 41 percent. The highest paid workers would receive a \$24,000 pay rise and the lowest \$6,000 per annum. Fair Work Australia found that workers in the community and disability sectors were underpaid compared to public service workers doing similar jobs. It found that gender was one of the reasons for workers being undervalued. The new rates are to be phased in over an eight year period. The decision²⁸ is instructive in explaining the gendered rationale for undervaluing care work. After determining that the workforce is predominantly female, the court then considered and agreed that the work bears a “female characterisation”.

- a) Much of the work in the industry is “caring work”
- b) The characterisation of work as caring work can disguise the level of skill and experience required and contribute, in a general sense, to a devaluing of the work. and
- c) The evidence of workers, managers and union officials, in the SACS (Social, community and disability services) industry, again in a general sense, is undervalued to some extent, and
- d) Because caring work in this context has a female characterisation, to the extent that work in the industry is undervalued because it is caring work, the undervaluation is gender-based.

²⁸Equal Remuneration Case [2012] FWA 1000

The NZACA salary survey data shows that maintenance staff/gardeners who are generally male are paid at a higher rate than carers.²⁹

Staff category	Pay per hour 2010
Kitchen hand	\$13.75
Diversional therapist	\$16.59
Cleaning staff	\$13.85
Registered nurse	\$25.64
Caregiver	\$14.37
Laundry staff	\$13.98
Nurse/clinical manager	\$30.77
Office administration staff	\$19.44
Cook (unqualified)	\$15.68
Enrolled nurse	\$18.65
Facility Manager	\$35.37
Gardening/maintenance staff	\$16.56

A researcher at Auckland University of Technology said that this was indicative of the gendered nature of the work. “Changing a light bulb or pulling weeds is paid at a higher rate than caring for older people.” A nurse said, “it’s about gender. I call a plumber to come to the house and I pay him \$70 an hour. I’m an experienced nurse and I get \$21”. Other participants said, “the wages are a hangover from the old days – it’s seen as women’s work” and “the reason why the job is not valued is partly because it is done by women. They are treated like servants.”

The emotional bond carers feel toward their elderly clients is frequently commented on, and is described elsewhere. A number of participants, from community members in public meetings, to union organisers and to the chief executive of a major home care provider thought that this bond was exploited. At a public meeting, the Commission was told that carers were emotionally blackmailed into providing more care than was paid for.

A care recipient wrote to the Commission from a rest home in support of carers. She said that carers at the home she lived in had not had an increase in wages for three years, despite the service provider receiving funding increases from the DHB. Noting that the hourly wage was currently 11c an hour above the minimum wage she said, “each day becomes harder for them to make ends meet as the cost of living rises such as petrol.”

Staff at a residential facility put the case, “we’re expected to do a lot more than we used to. We do a lot more: checking teeth and gums, weights, drugs, insulin, bandages that were done by qualified nurses. We’re undervalued. New carers are on the same rate as those of us with experience. My son gets more working at the checkout at Kmart. The wages aren’t reflective of what we do. We should start at \$16 and then go to \$18-20. We should get at least more than (supermarket) checkout rates.”

²⁹Source: 2010 NZACA Member Profiling Survey provided in NZACA submission

A health care assistant said in her submission, “we have to care for the elderly, do personal cares, dressing, weights, toileting, lifting, the senior care assistant does blood pressure readings, giving out medications, we also clean the resident if they soil themselves. Yes, it is part of our job and we are willing to do these tasks as that is what we are there for, to look after the elderly in our care. But for \$13 an hour, I don’t think so!” (Emphasis in submission.)

Pay issues

The comparisons between caring and other types of work often mentioned the lack of responsibility and stress of similarly or better paid jobs. “You can stock shelves for that money with none of the stress” and “you get that money at Cadbury’s or any factory without the responsibility” and “a friend’s son works at Burger King he’s 18 and gets \$16 an hour, we’re looking after people’s lives.” A carer at the top of the scale (at \$15.50) said, “it’s frustrating. I give medication, treatment, hands-on personal cares and hospital carers get \$16-17 an hour and a twenty-seven year old I know has just started in a dress shop and gets \$17.50 an hour.”

Various participants at meetings with the Commission said the following jobs are paid better or the same (but with less responsibility).

Bus Drivers	Shelf stackers
Checkout operators	Fish factory
Factory workers	Prison officer
Rousing and tailing	Retail assistant
Stop Go road works	Vineyard worker
Glass handler in pub	Cleaners
Flipping burgers	Waiters and waitresses
Home based educators	Rubbish collector
Handymen	Kiwi fruit pruner
Gas station attendant	Supermarket cashiers
Vet nurse	Hotel housekeeper
Baby sitter	Apple picker
Van drivers	

A submission received from a Grey Power branch said, “the hourly rate, must be raised, it is unethical to be paying a minimum wage to this group of workers whose goodwill is being imposed upon.” Another submitter was adamant that the answer was not in increasing the minimum wage. “This misses the point entirely – the work these staff undertake is worth far more than the minimum wage.”

In addition to the low wages, carers delivering home based services face a great deal of uncertainty about hours of work, so income is insecure. One of the appeals of the move to service models such as CREST and START is that hours of work are guaranteed and income is much more secure.

The CREST model is on a different funding basis than that normally used for home /community support services. The funding is on a capacity basis rather than a fee for service basis. This funding means that providers like Healthcare NZ can advertise for full time or part time community support worker positions with guaranteed hours and therefore secure and consistent pay from week to week. CREST support workers work 40 hours a week regardless of the number of clients or their needs.

Professor Parsons argues that fixing up the pay should not be done in isolation from a package of reforms designed to improve employment in the sector. The income of support workers is not just determined by the hourly rate, but also security of hours, travel and training costs.

The extent to which support workers meet their own travel costs, both in terms of vehicle costs and time spent travelling, is discussed fully in the section on conditions of work. The relevance to wages is travel costs incurred in providing the service reduce the net income of support workers which is already at or near the minimum wage. Training costs also erode net income and are discussed in the section on training and qualifications.

Lack of pay progression was also of concern to experienced carers who said that there needs to be “opportunity incentives within the industry to stimulate long serving staff, e.g. differences in levels of pay between new and experienced long serving staff is only \$1.50 cents an hour.

Affordability/Adequacy of funding

The chief executives of the major providers frequently identified affordability as a barrier to achieving pay parity between the private providers (of publicly funded services) and public providers (i.e. hospitals).

Graeme Titcombe, Chief Executive of Access Homehealth said, “it will be a big figure to correct the wage rates of those working in aged care, no matter how you step it.” A manager of a residential care facility said, “it would be nice to pay \$18 per hour to health care assistants in our industry but this would mean many more millions of dollars to get us from where we are, to where that is.” Dwayne Crombie, Chief Executive of BUPA Care Services said, “carers need to have parity with health care assistants in DHBs (indeed their roles probably require more autonomous practice in the community based setting) before we even start to consider parity with male dominated occupations. But aged care is a big sector and that makes it expensive to achieve parity.”

The Ministry of Health have advised the Commission that some work has been started on job evaluations across DHBs and the aged care sector, but it is unclear whether this was confined to nursing positions or included health care assistants and carers and what priority has been accorded this work.

Financial modelling

One of the arguments advanced in favour of parity is that it is morally wrong for DHBs to pay their own staff at higher rates than they are prepared to fund private providers of public services to ensure their workers are paid decently and equitably. This gross anomaly is well recognised and the Commission believes that it cannot be

allowed to continue or to be defended in light of New Zealand’s ratification of international treaties around equal pay. The good employer, social responsibility and ethical obligations of DHBs are also relevant here. The Commission is aware that the current climate is one of fiscal constraint and that parity between carers may well be dismissed as unaffordable.

For that reason the Commission asked Associate Professor of Accounting Paul Rouse at the University of Auckland Business School to model the cost of parity between the carers working in home support and residential facilities in the community and health care assistants working in public hospitals. The modelling commissioned for this Inquiry puts the cost of parity between \$139 and \$141 million per annum, less than one percent of the Health budget.

The estimates of pay include annual leave and statutory holidays and on-costs were estimated initially as 3.5 percent on top of these base rates and include ACC and Kiwisaver. After consultation with a major provider, on-costs were recalculated at 4.56 percent to include time and a half for working statutory holidays.

Detailed modelling, including a three year roll out assuming a one third cumulative increase each year to demonstrate how addressing pay parity could be implemented, and an explanation about the assumptions on which the modelling is based is appended later in this report. The following summary table indicates the net increases as forecasted.

Pay parity between carers outside DHBs and health care assistants inside DHBs

Cost summary assuming on-costs of 3.5%

	Estimated FTEs	Estimated current total pay inc on-costs	Estimated increased total pay inc on-costs	Net increase
Homecare support workers	7,500	\$ 227,837,821	\$ 280,916,181	\$ 53,078,360
Residential facility workers	12,500	\$ 382,008,079	\$ 468,193,635	\$ 86,185,556
Totals	20,000	\$ 609,845,900	\$ 749,109,816	\$ 139,263,916

Cost summary assuming on-costs of 4.56%

	Estimated FTEs	Estimated current total pay inc on-costs	Estimated increased total pay inc on-costs	Net increase
Homecare support workers	7,500	\$ 230,171,232	\$ 283,793,197	\$ 53,621,965
Residential facility workers	12,500	\$ 385,920,432	\$ 472,988,662	\$ 87,068,229
Totals	20,000	\$ 616,091,664	\$ 756,781,859	\$ 140,690,194

Community funding

Caring for older people in the community, done well, has the potential to keep people out of the secondary health system, to minimise the number of hospital admissions and to shorten hospital stays. This moves money from the hospital system to the community sector. These efficiency gains can only be made, however, if the workforce supporting older people in the community are 'fit for purpose' and remunerated accordingly.

The submission from Access Homehealth said, "transferring resource to the community will assist to reduce both primary and secondary health care costs. However, providers need to be resourced to provide these home based services; the continual withholding of funding from home based services is damaging the sustainability of the sector at the very time it should be enhancing its capabilities to meet new challenges."

The NZHHA submission said, "DHBs should fund providers to provide the same levels of training, travel reimbursement (and vehicles), continuity of work and reasonable pay rates that other DHB employees receive, and which they avoid by contracting the service at rates under which those incentives cannot be provided." The NZACA submitted, "wages in the aged residential care sector will not markedly change unless the subsidy rates paid by the government are substantially increased."

Brien Cree, chief executive of Radius Residential Care said, "it's all very well for Government to complain about people's pay rates, but they pay them. We just funnel the cash. Government could pay better if they wished to ensure decent wage rates. People need to realise that we are underfunded and it's on purpose."

An employer in her submission said, "funding from the DHB/Government per resident has not increased to match inflation for the last three to four years therefore facilities income is decreasing as costs for food/supplies increase and we continue to try and maintain high quality standards and conditions for residents and staff."

NZHHA submitted, “traditionally home support for older citizens has been seen as a social service, and the work given a very low value. There appears to be unstated support within many DHBs for funding the work at the minimum wage level. However, they are now also demanding additional training and skill levels, and that providers deliver services such as restorative care.”

Glenys Stilwell, general manager of Enliven in the home support sector said, “they (DHBs) are in charge of the funding. Is it because they don’t value the work of the community health sector? What is it that would make a DHB say we’ll fund our own workforce in this way but the exact same job or maybe more difficult job in the community doesn’t deserve that amount of money?”

Transparency and consistency

Compounding the funding issue is the plethora of rates paid to providers. DHBs all have different rates, the Ministry of Health and the Accident Compensation Corporation fund services differently and the move away from fee for service funding to other models all add to the opaque nature of funding flows.

Peter Hausmann, managing director of Healthcare of New Zealand said, “another big discrepancy is the different rates paid by the various DHBs. The variability between them is about 25 percent. A number of them know we are going to have to top up wages or they are below the minimum wage. The DHBs are funding us below the minimum wage. Healthcare NZ is a localised provider so we pay staff variable rates according to the DHB rate in that locality or whether the funder is the ACC or the Ministry of Health. That ensures that we survive in each locality. But in terms of Whanganui we subsidise every hour of government service. A support worker can be getting a different rate for the same work depending on who is the funder. Access is a national provider and uses overs and unders to pay a national rate. The response of the DHBs is to increase the service specifications. The Ministry of Health is much better, they’ve made a commitment to provide an increase that we pass through each year. In terms of addressing the pay parity issue there is also a problem in that DHBs are moving away from an hourly rate to a bulk funding arrangement. There is no transparency in their behaviour. In the government you’d hope that transparency would be best practice.”

In the area covered by the Whanganui DHB, funding to the three home care providers is insufficient to meet the cost of the service. “All of us are making losses and we were making losses two years ago. We’re saying we should pull out and just let the service collapse but morally we’re not able to do so,” said Graeme Titcombe, chief executive of Access Homehealth. The Commission is clear that it is not just the care workers who feel the moral responsibility to maintain a service to their vulnerable clients. Providers, too, believe the sector is at a tipping point.

Transferring resources

Providers explained that increased funding to meet pay parity between DHBs and the aged care sector would also have to include “on-costs”. These costs did not just include “something for your administration” but the cost of providing leave, public holiday provision and other features of the pricing structure of the industry. A chief executive of a home support service said, “if this organisation is to survive, the funding model has to recognise provider costs as well as salary costs.”

Graeme Titcombe puts the on-costs at a high 20 percent on top³⁰ but others say it should be between 3 – 5 percent.

Graeme Titcombe is concerned that funding is falling further behind. “Since 2007 when some of them (carers) started to get to reasonable rates in relation to the minimum wage basically the increases we’ve had since then haven’t even covered the inflation costs of our non-wages let alone our wages. Everyone slips backwards.”

A residential provider said, “currently in excess of 60 percent of our revenue is paid out in wages. The Grant Thornton report shows we’re not making an adequate return and this is the conundrum we have and the issue which is going to hit this country like a brick, particularly with the changing demographics. The sector is underfunded. There’s very little investment because there’s just not enough return. So we agree that we’d love to pay our people more but given the current funding model we can’t.”

Access Homehealth submitted, “any meaningful attempt by providers to bridge the pay and travel disparities without additional funding would result in the insolvency of the organisation.” Another employer said, “we only received a 1.72 percent increase in DHB funding and therefore could only pass that percentage onto our employees as an increase in wages. Fundamentally funding is a main concern to pass on a reasonable income.”

Simon Challies, chief executive of Ryman Health Care said, “the return to capital on rest homes is very slim. The profit margin of selling in the village funds the rest home.” He argued that residents of hospitals and rest homes would pay more to fund more pay for caregivers and that “the government has to publicly mandate premium fees.”

While chief executives acknowledge the injustice of carers’ pay, one researcher who participated in the Inquiry noted that they do not necessarily publicly lobby for wage increases in negotiations with DHBs. She said, “while employers, managers and owners may have views that caregivers don’t get enough money, they are not lobbying on their behalf for increased funding for caregivers. They’re not saying ‘no’ and nor are they using their power to improve low pay.” She suspects the only way of achieving greater employee representation is through NZNO and SFWU, union-based mechanisms. However, many carers are not union members and this raises the question of how they are represented.

Professor Gorman makes the point that small shifts in salaries have big costs in health funding, but says there are two strong counter-arguments to the issue of affordability. “One is the productivity argument and the other is that a skilled happy well paid and engaged individual will deliver more health care in a productive way and reduce morbidity etc. Quality of care is around safety, efficiency and patient satisfaction. There is very little evidence that driving quality up does anything but drive costs down. So a properly engaged, properly trained, properly employed adequately supported health worker will pursue a quality agenda that has positive knock on effects.”

³⁰Graeme Titcombe includes the cost of annual leave, sick leave, ACC levies, Kiwi saver and statutory holidays in this figure. These costs are included in the modelling undertaken for the Commission, see Part 5.

Pay issues for registered nurses and other workers

Pay inequity between nurses in the aged care sector and in public hospitals tends to be focussed on penal rates. A manager from one DHB said, “community providers have to compete with DHBs for nurses. It’s possible to achieve parity on base salary but not on penal rates.” A nurse said she’d “earn as much in three days over the weekend working as an RN in a hospital as I do here as manager of a large aged care facility in a week.” Difficulties in retention of nursing staff were one of the consequences of lack of parity. A residential care provider said, “we need to pay people the equivalent hospital rate, i.e. parity. Otherwise you train up people and they leave. The biggest issue in human resources is losing nurses to the DHBs.”

Margins for undertaking additional responsibility were also an issue. “In weekends I’m in sole charge. There is no other RN, no manager, and limited cleaning and laundry staff on. I get \$1.13 an hour extra for that responsibility. Soon another RN will be employed; she’ll be on-site to do care plans. This won’t lessen my load but I’ll lose the \$1.13,” said an RN.

Pay relativity in aged care was also discussed. A residential care manager asked, “if you push caregivers up to \$18 per hour where do you then place Registered Nurses (RNs) and Enrolled Nurses (ENs) for their skill base, their care base and the requirements under legislation? There needs to be relativity between the pay of a qualified workforce and an unregulated workforce to retain high quality nurses in aged care.”

Another participant said that parity of conditions also had to occur. “For example nurses in the DHBs get a day off a year to do their Professional Development and Recognition Programmes (PDRP), and a paid day to do their portfolios for the Nursing Council. There is the same requirement on a nurse to do a portfolio in an aged care facility as in a hospital. They get study leave they get higher rates on a public holiday, unsociable shift rates. Bringing up the basic pay rates is a start but you need to bring up the conditions of work as well.”

Social workers submitted that pay equality and pay equity were issues for them. In one workplace, clinical assessors could come from a social work background or a registered nurse background. However, “clinical assessors who are social workers do exactly the same work as clinical assessors who are RNs yet they are paid less.”

Other work undertaken by both social workers and nurses was not exactly the same but very similar. “Risk assessments are completed jointly (either together or sequentially) with RNs doing the assessment of physical factors and SWs looking at family issues. However the pay is different.”

Conclusion

Low wages and pay inequality and inequity are three issues which dominated the Inquiry. The fact that thousands of (mainly women) are caring for vulnerable older people for barely the minimum wage is an injustice grounded in historical undervaluation of the role. It is an indignity New Zealand can no longer afford. Pay inequality between home and residential based caring and those doing much the same work in public hospitals cannot continue to be condoned when it is publicly funded. Quite simply it is a fundamental breach of human rights.

The traditional invisibility and lack of public voice of many working in aged care has helped sustain the squeeze on carers' pay over the years. However, there are now indications that carers feel they have nothing to lose by withdrawing their labour as shown in the recent industrial action.

The Commission has provided financial modelling to show how New Zealand could progressively realise pay parity in the aged care sector stepped over three years. It believes that affordability arguments can no longer trump the importance of the right to equal pay. The United Nations Committee on Economic, Social and Cultural Rights states, "a failure to remove differential treatment on the basis of lack of available funds is not an objective and reasonable justification unless every effort has been made to use all resources that are at a State party's disposition in an effort to address and eliminate the discrimination, as a matter of priority."³¹

³¹General Comment No 20 of the Committee on Economic, Social and Cultural Rights: Non Discrimination in economic, social and cultural rights (art. 2, para.2 of the International Covenant on Economic, Social and Cultural Rights) E/C 12/GC/20 (2 July 2009) at [13]

Staff to resident ratios

“The critical factors for optimum care of aged clients, is empathy, TIME and knowledge”.

Submission from Grey Power Horowhenua.

The concept of mandatory staff to resident ratios was one of the most contentious issues in this Inquiry. However, considerable consensus emerged on some basic concerns and issues including:

- levels of dependency and care needs have clearly risen among rest homes residents in recent years and care needs have become more complex
- different skills are required for people with different levels of need
- staffing levels must be responsive to the higher needs of care recipients, often referred to as increased acuity
- staff require the training and skills necessary to meet the needs of those they are caring for
- increasing the scope of caregivers’ practice may lead to stress
- increased managerialism in some residential settings is placing pressure on the time available for staff to interact socially with the older people they care for
- the need for adequate supervision and support for care workers, including both the regulated and unregulated workforce.

There are studies which show that the dependency levels of people living in rest homes and private hospitals in Auckland have increased considerably and that while twenty years ago 36 percent of this group were assessed as of high dependency, in 2008 56 percent of residents had high dependency³². This increased level requires more time per person carrying out more complex tasks.

Not only has the volume of work increased but the tasks and skills required to complete those tasks have also become more complex and demanding. This issue plays out not just in staff to care recipient numbers but in the mix of staff and the level of skill required for caring for people at varying levels of acuity. Linked to this is the issue of scopes of practice and “scope creep” as carers are asked to do more in their daily work.

There was no unanimous support for mandated staffing ratios per se. But the positions of New Zealand Nurses Organisation (NZNO) and the Service and Food workers Union (SFWU) are unequivocal. While no-one who participated in the Inquiry disputed that the acuity threshold has increased, how that plays out in contractual obligations is highly disputed. The NZNO and SFWU are campaigning for mandatory staff–resident ratios and providers are asserting their right to determine how staff are deployed. The unions’ position is detailed in their aged care charter launched in 2011.

³²Boyd, M. et al. (2008) *Changes in aged care residents characteristics and dependency in Auckland 1998 to 2008. Findings from Older Persons’ Ability Level Census 10/9/8*. Auckland: University of Auckland.

The charter asked for “Government to properly fund aged care services in New Zealand” and included as one of the four platforms of reform: “Compulsory safe staffing levels and skill mix so that every resident gets the care they need, when they need it. One of the biggest problems in aged care is not having the right staff with the right skills working at the right time. When the mix isn’t right it makes it much more difficult (sometimes even impossible) to care for the elderly safely and with dignity. We need clear regulations so that all aged care facilities are always safely staffed.”

There is considerable agreement on the need for appropriate staffing levels which reflect the higher needs of care recipients. The skill mix of the workforce is linked to the complexity of need. How appropriate staffing levels are determined and subsequently assured is the critical issue. Affordability impacts significantly on staffing levels too.

The Commission notes the work of the Ministry of Health Safe Staffing Unit which is currently refining the Care Capacity Demand Management tool which measures patient acuity and needs and matches staffing to those needs. The New Zealand Nurses Organisation (NZNO) advised the Commission that this model is being implemented in a number of DHBs and could be adapted for residential aged care.

Inadequate staffing levels will impact on the dignity and conditions of work for carers as well as the quality of care that is provided to older people. Given the labour intensive nature of the sector, staffing levels also have significant cost implications.

Age Concern is frequently told of situations where there are insufficient staff available to meet the needs of residents in a timely manner³³ and that inadequate staffing levels are frequently cited in cases of institutional abuse that are referred to its Elder Abuse and Neglect Prevention Services.³⁴

Contractual requirements

The Ministry of Health advised the Commission that “staff numbers in aged residential care are based on the requirements to safely meet the needs of the consumer.” These are contained in Appendix 3.

How this works in practice was described by the manager of a large rest home, “we have a higher level of staffing than contracted. Staffing levels are reviewed on a daily basis. We have discretionary shifts, staffed by casuals. These are used to inflate or deflate staffing levels according to need. There is a minimum number of staff on the floor.”

However, participants in the Inquiry described different practices which suggested that “staffing up to meet need” may not be a robust measure and that they often worked “short.”

³³Supra at note 12.

³⁴Labour/Green/Grey Power. (2010). *A report into aged care: What does the future hold for older New Zealanders*. Wellington: New Zealand Labour, Green Party of Aotearoa New Zealand in conjunction with Grey Power New Zealand.

The manager of a rest home said, “managers have to manage staff-patient ratios. When patients come in and require a lot more time you can’t just put on another staff member because of funding levels. A number of not-for profit organisations have pulled out of the residential care sector. Our wage bill is huge.”

A common concern was the non-replacement of staff taking sick leave. A nurse said in her experience, “the replacement of staff in all the areas I have worked relate strongly to the patient numbers.” She explained that if the resident numbers “in house” are not at the recognised ceiling, then the first, call-in-sick staff member is not replaced. “The acuity of resident care and needs are not factored into this decision.” A group of migrant nurses working as carers observed that managers did not call in bureau carers or did not replace carers if someone called in sick. “Management divides up the clients among the carers”. Calling in staff was discouraged. “We are really scared of ringing in sick because of our manager. She tells us off.” Carers at a union meeting said that short staffing is rife, and is increasing. “Management are happy to run short. Two or three days a week we’re short staffed.”

The New Zealand Standard Indicators for Safe Aged Care and Dementia Care for Consumers SHNZ HB 8163:2005 are voluntary and sets a higher threshold than the Age Related Residential Care (ARRC) agreement. A member of the working group who developed the handbook for the Indicators with Standards NZ said that the workbook is a guideline rather than a prescribed standard which includes recommended hours per consumer per week. However, she told the Commission, funding constraints mean that if the guidelines became a prescription then the options for many facilities would be to cut staff or pay less. This residential facility manager said that many good recommendations were made in the Grant Thornton report but the industry and DHBs jointly needed to get on with the implementation. Mandated hours would constitute ratios of hours per staff per day and /or week.

Noeline Whitehead, a health researcher with considerable experience in the sector, said that the OPAL study³⁵ showed that increased dependency levels had not been matched by an increase in minimum staffing levels. “In light of this it is difficult to understand the rationale for the reduction in the minimum registered nurse staffing requirements in residential aged care.” She says prior to 2002 and the introduction of certification, high level dependency (hospital) level facilities were staffed at a ratio of one nurse to five beds.

Therefore a 45 bed geriatric hospital would have nine full time nurses – a ratio of 1.14 hours per resident per day. Now, providers develop their own staffing levels as long as they meet the requirements of the ARRC Services Agreement. This requires one registered nurse on at all times, a minimum of 0.5 hours per resident per day in a 45 bed hospital level facility. The standards (SNZ HB 8163:2005) recommend “a registered nurse on duty at all times and a minimum of 1.14 hours per resident per day increasing to two hours per resident per day when levels of acuity amongst residents are high.”

³⁵Supra at note 33.

A senior manager from a DHB said, “when the regulations changed and became guidelines a number of providers went to the minimum required.” A carer told the Commission, “facilities are staffed at the bare minimum prescribed by the DHB contract. It only takes change in the condition of one or two residents or someone to call in sick to end up “working short.” The Commission was told at a nurses union meeting about the difficulty that adherence to contractual agreements and staffing levels caused. The guidelines were said to be very complicated and “there are continual arguments about what they mean.”

A registered nurse working in the residential care sector wrote, “the staffing levels are always kept at an absolute minimum, often below the standard ratios, with increased work loads and rising dependency levels of residents. It would be nice to feel I had time in the day to complete all tasks and have some quality time with residents, but at the moment only getting the bare minimum done each day... feels like a ticking time bomb, an accident waiting to happen, a battery farm for elderly folk. Basic nursing cares are being missed, and although ultimately the RNs carry the responsibility for their practice, I think we are being set up to fail. Carers are treated even worse... they deserve more pay and much better conditions.” An enrolled nurse advocated for the “ratio of staff to residents to be allocated according to the amount of care needed not on the number of beds in the facility.”

Increased acuity

Nurses and care workers who participated in the Inquiry reported increasing levels of acuity, involving higher dependency needs among older people, an observation borne out by research undertaken by Dr Michal Boyd from the University of Auckland and cited above. This is a complicating factor in workload issues.

A major residential care provider said, “the DHB controls and determines resident assessment acuity which in turn dictates the staffing and safety levels of facilities. The DHBs use this assessment to control cost which effectively means that people who should be categorised at hospital level get assessed at rest home level as it is a cheaper rate per day. This is a real issue for our facilities.”

Nurses and carers at an NZNO meeting told the Commission, “people who used to be looked after in hospitals are now being looked after in rest homes, and those who used to be in rest homes are now in retirement villages. Carers are doing far more than they used to. Care is far more complex and expectations are higher.” At a meeting of migrant nurses, increased workloads were related to “heavier clients” (both in terms of weight and demand) and an increase in paperwork.

Managers also referred to increased acuity levels and consequent staffing implications. One told the Commission, “it’s heavy work. Seven out of nine people needing PEG feeding³⁶ are now assessed as rest home level care. Historically they would be assessed as hospital level care. Small boutique care facilities are struggling with the staffing component needed.”

³⁶Percutaneous endoscopic gastrostomy, (PEG) feeding is tube feeding directly into an incision in the stomach.

Another manager agreed that staffing levels are a big issue. “Facilities need to be able to staff adequately for residents with high dependency needs. A floating pool of additional staff for that purpose would take the stress off existing staff. When we opened the facility, clients could walk down the corridor now there are people who require three or even four people to turn them. We need to fund for the right number of people and the right kind of support when people are bigger.”

A carer explained that people moved to hospital level care at a much more advanced state of need. “People stay at home or in rest homes longer so by the time they get into hospital care the level of acuity is much higher, for instance higher levels of dementia, not ambulant and people have mixed illness and conditions. When they fail (i.e. at home or in rest home care) they fail fast and hard. Also people are living longer and with increased medical interventions.”

Work intensification is not unique to the aged care sector, but the characteristics of the sector are exceptional because they involve the care of human beings. Hurrying care tasks are seen not only as compromising dignity for the client but also minimising opportunities for the additional less defined tasks of observation and interaction so critical to the role of carers as the eyes and ears of the workforce. A carer in a residential care facility said, “quality care needs quality time to be administered. Therefore patient ratios should be taken seriously”.

Grey Power Horowhenua said, “much work has been done by the nursing profession on client–staff ratios and needs to be taken cognisance of. The critical factors for optimum care of aged clients, is empathy, TIME and knowledge. (The ageing process slows our reaction times.)” The submission then pleaded, “if aged clients are to receive personalised care rather than being ‘warehoused’ it is imperative that staff client ratios are legislated for.” A care recipient living in a residential facility wrote, “the staff had too many people to look after and too short a time.”

Time to care

Both carers (nurses and support workers) and aged care recipients and their families expressed concern about insufficient time to provide adequate care. This applied both in the home care sector and in the residential care sector. The Commission heard that staff “working short” meant that critical care tasks were hurried and sometimes missed.

Staff at a residential facility made the following comments, “when there are only one or two RNs on the floor you can’t get to everybody. Observing is part of the job. Picking up subtle things and taking the extra time to sort things. Sometimes they want to tell you stories. Talking and reassuring is important and can work better than medicine. We report to the nurses ‘so and so is not herself today’ or report any changes we observe.”

A nurse observed that taking extra time to allow people to tell their story made them more settled and then they needed less medication. “The first choice is to talk. Ideally, RNs should shower people for their first three days so they could do observations etc, however, this is not possible due to their workloads.”

Other comments by carers about time constraints included:

- “You can’t sit and talk, it’s too rushed. It feels like you are processing people – like a production line.
- There are 12 residents per carer. That’s a lot. Once we have more than 46 residents we’ll get another carer. I can handle 10. You miss a lot of bits and pieces when you are rushing, you can’t fit in things like fingernails and having a chat. If someone is sick we get staff in and on the odd occasion we call an agency.
- The time restraints are a constant battle and to have more staff on duty to cope with the stress of rushing (would help) as I refuse to rush my residents through their personal cares so as I finish on time, as I do not get paid for working longer.
- Having more staff in each shift which would give the carers some time to spend with our patients and make them feel at home.”

Nurses and carers said that manual handling was particularly challenging when working short. “If two people are required to lift, and one carer phones in with a sick child and you don’t have a pool you can access then you end up below the minimum.” A carer from another rest home said, “with manual handling you cannot do it alone. Sometimes people get confused, shouting, yelling, spitting. You need a pair of workers. Every time you want to use a hoist you’d have to call someone.”

An activities assistant wrote that she was the only person in the facility in that role and that it was not possible to “provide quality care to 70 residents in the three wings by myself.”

A Grey Power member, with power of attorney for a number of people in rest homes, wrote of her concern about insufficient staff including physiotherapy time to provide rehabilitation on release from hospital. “When they get to the rest home there are not enough staff to even get the patients who may have had a stroke, for example, even take them for walks up and down the corridors a few times a day. One of the ladies I now look after could walk with the aid of a frame and a staff member in attendance when admitted to the home about three years ago. She can now not walk at all and never will. So much for rehabilitation.” She also talked about the unnecessary use of incontinence products because there was insufficient time to get to residents when they asked for assistance to go to the toilet.”

A carer, in her submission described the mix of dependency.

“I have 21 residents to oversee and attend to with one other staff member. I am team leader 4 pm shifts and 2 am shifts per week. Of the 21 residents in my area, four are independent. The rest are full assists! Their conditions range from Dementia, brain injury (accident and brain aneurisms), Huntington's, Cerebral Palsy, Spina bifida, alcohol dementia etc. The work load has tripled in the last year but the staffing levels have not changed which means stress levels are extremely high and residents are not getting the care they are paying for. I'm constantly spending time off the floor to attend to wandering residents and time spent attending to this means duties fall behind.

On my shifts alone I am responsible for:

- *Medication dispensing*
- *Wound cares*
- *Meal preps and setting of tables and clearing tables/washing dishes*
- *Showers and shaves (personal cares)*
- *Laundry and rubbish collecting*
- *Mopping toilets and shower rooms*
- *21 Resident reports/handover sheets/incident reports*
- *Dealing with falls and safety issues and behavioural issues plus many other issues.*

As well as the above duties the demands of these residents are very high.”

However, the peak body for residential providers, (the New Zealand Aged Care Association) claims there is little research evidence to support the need for mandatory staff-resident ratios. “In relation to staff to resident ratios, these are set by a facility’s clinical manager (who is an RN) to ensure the care needs of the residents are being met. To date there have been no reports or research from HealthCert or DHBs to show a problem with current practices and procedures in how nurse managers set rosters in the aged residential care sector. We do note that the NZNO and SFWU have been advocating for the past ten years to establish mandated staffing ratios based on an argument about caregivers working too hard and poor care outcomes, but as yet have never produced any robust research to back up their claim. Many people would argue that they work too hard, and that they could do better if they were not pressed for time... In the aged care sector a claim of the work being too hard can only be justified if the required amount of care to be delivered under the contract is not delivered. To date there is no evidence from HealthCert or DHBs that there is a systemic failure to deliver the level of care they are required under contract to provide.”

Nurses said that their advice about necessary staffing levels was not always heeded. One RN said that if people talked about unsafe staffing levels they were asked, ‘what are you doing wrong?’ It was important that the advice of registered nurses and carers was accepted by managers and co-ordinators in each department. The Commission heard that staff felt unsafe in raising concerns about this issue. “You are not allowed to say you are understaffed,” a carer said.

Researcher Noeline Whitehead argues that there is a reasonable body of international research that indicates that there is a point when quality of care is likely to be compromised by care staff time. She pointed out that, “people tell me they can’t afford good staffing levels. I disagree, quality care saves on costs. When I was a facility manager, with decent staffing levels I saved on incontinence products and all sorts of things like the laundry bill because staff were doing what’s required of them. I didn’t have major issues with incontinence or pressure ulcers and there were less falls and skin tear problems. This is supported by research.”³⁷

³⁷Hicks, L. L., Rantz, M. J., Petroski, G. F., & Muka, D. B. (2004). *Nursing home costs and quality of care outcomes*. *Nursing Economics*, 22(4), 178(115).

An RN wrote to the Commission saying, “aged care must have regulated staff to resident ratios. But there needs to be flexibility in these ratios, so staff can deliver the right level of care for every resident.” She summed up the issue from a carer’s perspective. “Staff should be able to give the appropriate care to each resident each and every day. They should not feel that they need to work unpaid time to try and meet their residents’ immediate needs. They also should not be ending their shift feeling absolutely physically and mentally drained.”

Mandatory staffing ratios – the providers’ viewpoint

Chief executives of the large residential providers and senior managers including CEOs of DHBs were wary of the idea of mandatory staffing ratios. A number of participants said that mandatory staffing had been problematic in other jurisdictions and other parts of the health sector. The campaign for mandatory staffing in the early childhood sector, specifying staff to children ratios and staff skill levels, was referenced by both proponents and opponents of mandatory staffing ratios in the aged care sector.

Dwayne Crombie, chief executive of BUPA said, “I am not a fan of staffing ratios, I don’t want to lose the ability to manage.” However, he did support standard setting, “there are voluntary New Zealand standards which need to be redone to reflect rising acuity and provide reasonable workloads.” A senior manager from a DHB said, “there is a need to take the emphasis off ratios onto acuity. The learnings from Melbourne were that ratios just about broke the health services. In New Zealand we’ve had a bad experience with mandated ratios in mental health.”

The Ministry of Health said, “this method (proscribed staff ratios) has been tried in aged residential care and subsequently rejected for a variety of reasons. First and foremost, positive outcomes as experienced by residents, are arguably more important than any input measure and should be given greater priority. Further locking in a particular mode of service stifles innovation and creates barriers to possibly more effective ways of improving older people’s experiences.”

Geoff Hipkins, former chief executive of Oceania Group said, “internationally, Canada, United States, Australia, where they’ve tried to grapple with this issue of staff to resident ratio they’ve come unstuck. Health is not an industry where you can hold everything else equal. It is such a dynamic industry and you’re dealing with so many people issues. It’s very hard to be prescriptive about any sensible staff to resident rations. I just look at our funding now and, for example, dementia, we have people who are assessed as dementia sufferers and that can be anything from someone who may need some help putting milk in their coffee to a D5 who is literally borderline psycho-geriatric requiring permanent restraint, needing one on one. All that is encompassed within our dementia funding - we have this broad brush approach to funding that doesn’t really address acuity levels, dementia levels...it is a complete and utter farce to try and work in that system as the Grant Thornton report indicated.”

Simon Challies, chief executive of Rymans Healthcare said, “Australia is heavily regulated but they don’t have mandated staff ratios. The onus is on the provider to deliver not how to get there. Not having staffing indicators doesn’t make a jot of

difference. Getting sanctioned or getting a bad reputation which leads to low occupancy makes a difference.”

A senior DHB manager said, “ratios are a blunt instrument. You need the right mix according to different needs. InterRAI³⁸ works on a proper assessment and results in a case mix. The individual care plan should drive the care provided.”

Other rest home providers were concerned that current ratios relied on a mix of low dependency residents and high dependency residents. A manager explained that “easier, low dependency clients balance out the heavy, high dependency clients but if this balance is thrown out it’s difficult to manage. For example, it costs an additional \$57 per week per client to peg feed someone. This expense cuts into the money available to pay carers.”

Senior managers from a DHB agreed with this analysis, “within rest home care there are clients with low dependency and high dependency. There is a risk that providers will skim off those with low dependency needs.”

Nurses’ workloads

The demands on lone registered nurses were of concern. The ARRC agreement requires a registered nurse to be onsite at all times. Nurses told the Commission that it was common practice for a retirement village to have one RN to cover a rest home and village. Technically, the nurse was not allowed to leave the rest home, but in practice if they were required to attend someone in the village they would assist.

A registered nurse working in aged residential care said, “in large facilities that include hospital rest home and villas there may be only one RN on the whole site. The RN must leave the hospital if there is a problem somewhere else on site. The whole facility is at risk in this circumstance.” Another registered nurse wrote, “I work from 15:15-23:15 myself having full responsibility for 50 hospital and rest home residents also apartments and 100 villas.” Another submitter said, “one registered nurse is meant to supervise a 30 bed hospital, a 30 bed rest home and a dementia unit as that is what the regulations allow. Not good enough.”

A registered nurse returning to the sector after some years away wrote in saying she would “cut all responsibility for village residents out of all job descriptions for Registered Nurses and carers working in care facilities... From what I’ve heard and observed this would boost morale no end.” She advocated for an RN in rest homes even if it was for a shift a day and a maximum of twenty hospital level patients per RN “with no responsibility for village and rest home residents.” (emphasis in submission). This submitter believed that “if you improve the RN’s situation a lot of the caregiver issues will resolve (provided their numbers do not get cut in between time) as they will get more input and supervision.” In response to this issue a funding manager from a DHB told the Commission, “an RN cannot leave the hospital. I don’t mind them taking a phone call; I don’t have a contract with the village.” Senior staff at a DHB noted that there are currently minimum standards for the number of RNs and that the drivers continue to trend toward the minimum

³⁸InterRai is an clinical assessment tool being rolled out across New Zealand. It is designed to help staff assess the medical, rehabilitation and support requirements of the older person.

standard. This was linked directly to the health outcomes of care recipients. “We can track this by noting the rate of hospitalisation.”

Researcher, Noeline Whitehead cites “a large volume of research that indicates the importance of registered nurses in providing quality care to high dependent residents”. In New Zealand and internationally she says, the “positive relationship between nurse staffing levels and the quality of nursing home care has been widely demonstrated to such a level that it is difficult to ignore the evidence.”³⁹ “It’s frustrating when people say to me they can’t afford reasonable staffing I just raise my eyebrows and say, ‘you are talking to the wrong person.’”

Delegation of tasks to carers

We heard that in the case of very high resident to nurse ratios, nurses were restricted to a very limited range of tasks. For example, the Commission was told “one RN to 60 patients, all they are doing is administering medication.” Other participants, both workers and families, were concerned that in the absence of sufficient nurses, support workers were given the task of distributing medication. This was seen as a risk. “This is nurses’ domain and it is high risk to work outside scope of competence.” Concern was expressed about accountability in a situation like this. One participant stated “it seems outrageous to me that healthcare assistants are giving medication- that’s high risk. Giving someone the wrong meds could kill them.” Community support workers were noticing “scope creep” with more tasks demanded of them and on top of that, less time to do them.

A major home health provider identified the competencies required of community support workers at Level 3 include the following nurse supervised tasks.

Medication	Urinary catheter care
Manual bowel evacuation	Nasogastric tube insertion
Suppository insertion	Intermittent catheterisation
Urodome management	Blood glucose monitoring
Management of hyper and hypo glycaemia in diabetics	Diabetic medication
Suppository and enema administration	Nebuliser administration
Administering eye drops	Peg care
Suctioning airways	Tracheotomy

Community support workers are in people’s homes, so any nurse supervision is invariably off site. The submission from the New Zealand Home Health Association (NZHHA), the umbrella body for home support service providers argued that staff-to client ratios should focus on levels of supervision available to care workers. They propose that the ratio of support workers (i.e. the unregulated workforce) to registered professionals be established and made mandatory.

³⁹Whitehead, N. (2010) *The importance of a nursing strategy for residential aged care*. College of Nurses Aotearoa NZ Inc.

Conclusion

The bottom line in aged care must be ensuring quality of care and the right of older people receiving care either in the home or in residential services to be treated with respect and dignity. For that to happen the Commission has come to the view that the voluntary standards developed by the sector (SNZ HB 8163:2005) relating to staffing should become compulsory.

The demands on carers and nurses in the aged care sector have increased as the dependency needs of care recipients have intensified. Their work has increased in complexity and in the level of skills required to safely meet the needs of the older people they care for. As a number of participants have submitted, quality care takes time. At the same time mandated staffing ratios have reduced.

Minimum levels are set by DHBs in the ARRC Agreement but the New Zealand Standards (SNZ HB 8163:2005) in relation to staff–resident ratios are voluntary. Many of the providers are reluctant to support mandatory staffing, other than levels contracted for on the basis that they want to retain the ability to determine the level and mix of staffing to meet the needs of the people they care for. The Commission believes that flexibility can be achieved on top of the minimum levels set in the standards but that a basic floor is required to protect older people, their families and the workforce. A minimum floor does not defeat the employers' requirements for flexibility. Staffing issues in the home based sector relate to levels and access to supervision. Standards for adequate and appropriate supervision in the home based sector should also be mandatory.



Training and qualifications

“A range of qualifications is needed to reflect the degree of skill and competency of workers and workers who have completed training courses should receive higher pay rates.”

Submission from the National Council of Women of New Zealand.

The realisation of decent work relies upon a number of factors, one of which is the prospect for personal development within the workplace. The provision of training at both induction level and on a continuing basis is essential for an individual's own development, job satisfaction and duration of employment, as well as for improving the quality of care being provided. Furthermore, looking forward, appropriate training and qualifications, particularly for carers supporting people in the community, will be essential as new models of care focussing on home and community based prevention and rehabilitation services are introduced and the acuity of needs increases. This shift will necessitate a renewed focus on training a workforce which is fit for purpose.

It is essential then, for all of the above reasons, that caring is recognised as a career. It must have a structure, with an appropriate qualifications and training framework and career progression in order to meet the needs of carers, encourage recruitment and retention and to meet the needs of older people requiring support.

It has been found that 61 percent of community support workers have no formal qualifications of any kind, and in the residential care workforce, 46 percent have no qualifications. While most workplaces offer some in-house induction training and others actively encourage formal qualification programmes, workers are not incentivised to take up training opportunities as providers are unable to reward staff through pay increments as their competency increases.

While the Health and Disability Services Standards stipulate staff qualification and training requirements in residential care, including induction training, it is reported anecdotally that many facilities do not meet this.⁴⁰

Changing service models and developing skill sets

The introduction of new integrated service models and investment in preventative and rehabilitative services in community settings will require new skill sets from the caregiver workforce and blur the distinction between the roles of the “unregulated” workforce and enrolled nurses. For health and support workers to provide increased community and primary care a transfer of expertise will be required from clinical specialists to other carers working in these settings.⁴¹

This highlights the need for “scope of practice” issues to be worked through and more clearly defined. Any changes must be linked to a targeted training and

⁴⁰Supra at note 12.

⁴¹Health Workforce New Zealand (February 2011) *Workforce for the care of older people Phase 1 report*.

qualifications framework. Pay parity issues which are addressed earlier in this report are also part of this.

More investment in training for carers would allow them to offer a broader range of services. This has the potential to reduce demands on secondary care and specialist services. Some progress has been made by home support organisations to build up relevant expertise for example in assisting people to manage chronic conditions, working in co-ordinated teams on specific health issues and managing district nursing services.⁴² The New Zealand Home Health Association (NZHHA) report of 2011 outlines the increase in breadth and depth of care provided to people in their homes from traditional domestic and personal support services to a range of services dealing with chronic conditions, support for those with disabilities and aged care.

The Ministry of Health said, “developing the non-regulated workforce will be essential for maintaining people with high and complex health and disability support service needs in their own homes. A more skilled non-regulated workforce will also help reduce hospital admissions and re-admissions and reduce length of stay in hospital settings.”

Nicola Turner, general manager of Presbyterian Support Central's Enliven services, has been instrumental in introducing the Eden Alternative to residential services in New Zealand. The main barrier to implementing Eden is cost, most of which is training expenses. The training involves shifting staff “from a task focus to supporting residents to be independent. This can be a challenge.” She explained that the majority of staff were not regulated health professionals and therefore follow instructions with a focus on completing tasks. And that’s some of the struggles we have.” For example, at one facility a group of residents started up a bridge club and would sometimes play until one in the morning. “The afternoon staff have struggled with that because they’re not in bed before they go off duty.” Afternoon staff were concerned that they were letting down “the night staff because these people are still up.” Staff need considerable reassurance and training to accept the shift in mindset from “what the staff prefer to what residents would like.”

Setting aside the changing nature of care delivery, appropriate training is an essential component of delivering quality and safe care to older people at all times. Our findings that a range of tasks and procedures such as those detailed in the section on the regulatory framework are routinely carried out by carers without direct supervision signals the need for a review of training requirements for safe practices. Given the impracticality of direct oversight in the older person’s home, adequate training to safely carry out these tasks is necessary.

Minimum training levels for support workers

Numerous reports recommend minimum training requirements for carers (typically Level 2 Foundation level) as well as a general up-skilling of the workforce to meet new demands. Support workers, providers, funders, care recipients and their families and the public agree in their statements to the Commission. As a support worker said, she wanted “sufficient training so that you knew you were doing a decent job.”

⁴²Supra at note 3.

Graeme Titcombe, Chief Executive of Access Homehealth New Zealand said, “if you’d asked me six months ago I would have said you don’t need a minimum until you’re doing personal care. But I think the boundaries are becoming more blurred and a lot of domestic assistance has been cut anyway. Domestic assistance is being delivered in conjunction with personal care. The minimum is probably Level 2.”

The manager of a residential service run by a community trust said, “I support mandatory training. We have to do a lot of our training in-house. It’s important to have the basic skills before they get here. I’d like to see staff complete a six week foundation course at Waiariki Institute of Technology before they start. It should include: infection control; restraint; holistic health; dementia care; cognitive impairment and challenging behaviour.”

The New Zealand Home Health Association (NZHHA) supports a regulatory framework for training and qualification in the home care sector. “Level 2 on the National Qualification Framework is the bare minimum for domestic care and Level 3 qualifications are becoming increasingly necessary for those providing personal care for people who have higher needs. The NZHHA has set as a goal that 80 percent of the workforce reaches Level 2 qualification in five years. Currently it is 40 percent”.

The report, *Workforce for the Care of Older People*,⁴³ identifies key changes needed in the delivery of health services in the future, all of which have a training component. The call to mandate minimum qualifications was supported by Age Concern in their briefing to Incoming Ministers in 2011; by the NZHHA; by the National Council of Women (NCWNZ) who also emphasise the personal qualities needed for the job; and by Peter Hausmann, Managing Director of Healthcare of New Zealand. The latter suggests that “minimum training requirements as part of increased quality standards within contracts would do more than anything else to develop a workforce that delivers quality healthcare and disability services in the community.”

A submission from Alzheimers Eastern Bay of Plenty urged that staff have “training in dementia and the application of that understanding to person centered care particularly for people with dementia. A submission from Grey Power Horowhenua said, “national standards are an imperative. All carers must receive a basic training, which focuses on outcomes, which are measurable, one national basic course. Local areas may then add on courses for specific needs.”

A submission from the Aotearoa New Zealand Association of Social Workers (ANZASW) thought that “the bar had been set too low. These (Level 2 and Level 3) are very low level qualifications and provide little in the way of career path opportunities.” ANZASW regards this level of qualification inadequate for a workforce providing care services for the elderly. Another submitter said, “I think caregiving needs to be regulated across the board with Level 3 certificate at least.”

But not everyone was in favour of mandatory qualifications. The chief executive of one major residential provider, BUPA’s Dwayne Crombie, said he was not in favour of regulating training, “God forbid, you’d be like the pre-school sector although I

⁴³Supra at note 40.

strongly believe in organisations taking responsibility for training their staff appropriately.”

A number of providers, for example Enliven group, Te Whiringa Ora, Rymans and Summerset advised the Commission that they are aiming to have all their care workers at Level 2 qualifications at least. To that end induction and orientation programmes are being integrated into a Level 2 qualification. Carers also support Level 2 qualifications being undertaken in the first few months of starting, rather than prior to entrance.

Glenys Stilwell, General Manager of Enliven said, “we are just embarking on trying to integrate our induction and orientation programme to meet Level 2. Careerforce⁴⁴ are facilitating this. Having the induction/orientation programme as a Level 2 qualification, means that a new staff member will be qualified within eight weeks of starting work.”

Rymans Chief Executive Simon Challies said, “all our care staff have Level 2 qualifications or better. The foundation course is undertaken at induction. It is an internal KPI (key performance indicator) for us. We target national certificate completion.” And senior managers from Summerset said, “we are aiming to have all caregivers at Level 2. We are embedding the Level 2 Foundation Course into induction training. For many of our staff it is the first qualification they have.”

Staff at a residential facility visited by the Commission spoke about the commitment to training which was “part of the requirement of working here. We are contractually required to commence the ACE care qualification within 3 months of starting here, and to finish the core programme within one year of commencement.” The staff trainer provides tuition and there are study groups towards the National Certificate in Community care, which includes dementia training. “It is hard but in the end it is good. It’s good for the industry. We also have an eight hour core study day that all staff must attend annually; we also get other opportunities to undertake courses of relevant study.”

Carers also talked about how training was “respected and acknowledged” by being incorporated into workplace practices. “The workplace is open to how can we incorporate what we’ve learnt.”

Metlifecare senior managers talked about the support structures they have put in place to encourage training. “We recruit for the right attitude and train them. We have a robust training programme and want our staff to keep improving themselves. Support for training includes orientation training at the outset, career progression and pay linked to completion of Level 3 and 4 qualifications. Training sessions are provided for groups of staff within a facility doing the same module. They are encouraged to work together to get themselves through. Support workers are given “some hours to assist them with each module. Those who get stuck (at Level 2, without progressing) are actually quite skilled caregivers and they are not being remunerated because they won’t do the exam. It’s not a matter of numeracy or literacy it’s ‘I don’t want to do this, ‘I just want to come to work.’ We’ve had to do

⁴⁴The Industry Training Organisation (ITO) for the sector

things like buddy them with someone else who has done it recently to help them work it through. We've got most of them over the line."

Increasingly DHBs are specifying minimum staff qualifications in new contracts. Where new models of care, such as the restorative model are being implemented, DHBs are requiring Level 3 qualifications in their service specifications.

However, the Commission was told that "the degree of compliance is uncertain and is not necessarily monitored by DHBs. They tend to turn a blind eye." The submission from NZHHA also sounded a note of caution, "whilst some DHBs have been rewriting contracts to include the requirement for staff to hold a Level 2 qualification, they have not allowed for this by increasing their contract rate. The rates do not allow providers to give financial incentives for staff to receive training."

Progress has been made in several DHBs as reported by managers. "We are rolling out training across the home care sector. There is a commitment to achieving Level 3 training via Careerforce." Within the hospital itself, health care assistants are required to have Level 4 qualifications and "we're moving toward having Level 3 training requirements in our contracts with other providers. We plan to take a time-tabled approach to this." "Training to Level 2 with health professionals doing the assessment is mandatory". "The CREST workforce is required by contract to be at Level 3."

The unit standards of the compulsory section of Level 2 (Foundation Skills) cover⁴⁵

Consumer rights	Role of a support worker
Maintaining a safe and secure environment	Applying a service plan

Unit standards in the elective section of Level 2 cover:

Communication	Continence	Restraint
Eating and drinking	Impact of change	Safety
Infection control	Infectious conditions	Key comfort cares
Observing and reporting	Quality of Life	Medication
Report writing	Response to death	

⁴⁵www.careerforce.org.nz

**Unit standards for Level 3 include:
All three compulsory standards (9 credits):**

Abuse	Advocacy
Code of Rights	

One of the following two standards: (6 credits)

Ethnicity	Māori values
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And between 23 and 42 credits of the following Level 3 credits and up to 17 credits from Level 2

Ageing	Assistive feeding
Breastfeeding	Challenging behaviour
Community	Culture
Dementia	Disability
Ethics	Falls
Independence	Loss and grief
Mental Health	Pacific values
Personal cares	Risk management

It is also possible to choose up to 10 credits from:

Injury prevention	Listening
Writing.	

As well as linking qualifications to remuneration, there is also considerable support for qualifications to be portable across the sector and nationally recognised. A participant at a regional public meeting hosted by Grey Power observed, “there is no standard across the country, no consistency. The level varies.” Another participant said, “there should be a single national training programme, on the New Zealand Qualification Authority framework.”

Union members said, “qualifications within a recognised career pathway should be portable across the sector. The pathway could be caring, advanced caring, enrolled nurse, registered nurse.” A group of community based nurses drew a “parallel

between the early childhood sector and the aged care sector. There needs to be a career pathway and ratios too. The sector needs a fundamental shift.”

A support worker submitted that, “along with a nationwide remuneration plan needs to go an education plan that is also recognised nationwide. The lack of an education plan, linked to a nationwide remuneration plan can be used by employers to “disadvantage qualification in one care facility to another.” A carer said that having to repeat training (when moving between jobs) penalises the employee (again) in their remuneration package with resulting additional costs (again) to do the current employers’ package just to get a pay rise.” Some carers were concerned that if they gained a qualification that was exclusive to one employer then that would “tie you to them.”

The Ministry of Health advised that the intent of the Disability Support Services Workforce Action Plan 2009 will be to:

“promote and support effective self-care through improved training and development opportunities for unregulated workers. There are two immediate objectives:

- a) To align the education framework and funding structures to support the strategic intent of the Plan.
- b) To establish career pathways based on agreed competencies and qualifications.

Work to progress these objectives has already started. A Māori Unregulated Health and Disability Workforce Wānanga will consider these issues from the Māori perspective. A Māori workforce and service forecast is about to get underway and the workforce and service forecast for Pacific has begun.

Further work needs to be developed by Health Workforce New Zealand working across the Ministry of Health and with DHBs and the ITO in order to maximise the ability of the unregulated workforce to meet the challenges of the ageing population. This work will need to address the increased prevalence of multiple or complex long term conditions and aim to keep people in their own homes wherever possible.”

Qualifications and rewards

It is clear from what carers told the Commission, and from the literature, that minimal financial rewards are a powerful disincentive to train and a signal that increased skills are not valued in monetary terms. A registered nurse writing in support of carers said, “they are encouraged, even contracted, to do extra curricular studies and having completed these, seem to get minimal recognition for the qualification.”

Some employers, but not all, pay a one-off bonus on completion of qualifications. A manager of a residential facility said, “carers have five steps and pay/bonuses are linked to completion of training.” The chief executive of a major residential provider said that carers get paid a \$200 bonus on completion of the Foundation course (Level 2) and that completion of other courses attracts pay increases. “We encourage every staff member to do a refresher and have upped our incentives for Level 3.” A home support worker told the Commission that her employer, a major home support provider paid a \$100 lump sum on completion of Level 2 for support

workers who worked twenty hours or more a week and \$50 for those who worked less than twenty hours.

But other carers were less positive. A support worker wrote, “when I finish Cert 3 I will get the princely sum of 50 cents an hour more. It (the training) has cost me petrol and time to go to the courses and for 50 cents. It is quite insulting.”

At a meeting of Service and Food Worker Union members, concerns were expressed about qualifications not being indexed to pay rates and that carers were being required to pay for their own training. However, this was not true for all providers.

Value of training

Training is itself intrinsically rewarding for those who undertake it, promoting enhanced self esteem and a sense of achievement. “When you start at a certain level and work yourself up, that’s another positive outcome,” said a carer. A health researcher observed, “there has been some very good education for caregivers in recent years. That’s been positive. For someone who hasn’t had any formal education to become a senior caregiver is transformational. When people are affirmed in their work, given praise for doing a good job, they just beam. They do this work because they love it. You say, you guys are doing a great job. This is what dementia looks like, have you thought about doing this, would this work for you? – conveys respect. “

The chief executive of a major home health provider talked about attending graduation ceremonies, “it’s helluva humbling to go to a training graduation where these women turn up with their whole families dressed to the nines because it’s the first time they’ve ever got a qualification at all. It’s humbling when they are getting \$14.00 something an hour and you hear the hours they’ve put in.”

Career path

The 2011 report “Workforce for the care of older people” called for “more work to support formal and informal caregivers, especially in helping older people to maximise their own potential. The workforce recommended that specific training and development be provided to these groups with a “career path” for formal caregivers who make up the bulk of the aged-care workforce.”⁴⁶

The National Council of Women (NCWNZ) in its submission called for the elder care work force to have a structured career path comparable to that of nurses. A range of qualifications is needed to reflect the degree of skill and competency of workers and workers who have completed training courses should be given higher pay rates and responsibilities. They would as a result become “well-trained professionals.”

The manager of a rural residential facility said, “if a person came into the sector as a carer then moved to enrolled nurse, then registered nurse, she’d know this system backwards. You could identify good leaders and train them up for management roles. You’d end up with a responsible manager with a clinical background. This

⁴⁶Supra at note 41.

would be a staged approach and someone wouldn't have to leave a particular employer or a rural area.”

A health researcher said, “if someone comes in they should do Level 2 within 3 months and complete it within six months and they shouldn't take a full resident load until they have completed it. It should be sharp and short and easy to complete. Then you create a career pathway and the pay is linked to the levels. So if you are Level 5 then you are reasonably well paid.”

Peter Hausmann, managing director of Healthcare of New Zealand who has identified three levels of caregiving roles within the unregulated workforce, with each role requiring different training and qualifications, says that the different groups would have different expectations of employment. “The employment model and the qualification model are going to be different for each layer. Before this, we had a fairly ubiquitous hourly rate type employment model.” At the top “we have to pay them full-time. It's an hourly wage but they tend to have 8 hour days no matter what. The next level down tend to want to work part-time 20 – 25 hours a week.”

A submission from an employer said that increased pay in the sector needs to be linked to career pathways rather than length of service. “Facilities can develop career pathways for carers who are Healthcare Assistants and Registered Nurses linked to an appropriate pay scale (once the funding issue has been addressed) rather than length of service.”

Challenges

There are numerous barriers to the provision of appropriate training. They include the fact that it is not funded through contracts, the high turnover of part-time staff which is seen to increase the cost and limit long term benefit and poor literacy among some workers.⁴⁷ Poor motivation is also cited as a limitation.

As already noted, funding is a major challenge, even among those who support mandatory training. Providers point out the fiscal implications of career progression. “There's not a career progression pathway at the moment because the government funds the providers so poorly.” Disputes between funders and providers about what is included in the contract price and whether or not this is adequate for the purpose is a critical issue in the sector and is further developed in the section on the regulatory framework. The funding manager at one DHB said, “the DHB are now looking at setting aside funding for training. The current workforce can't meet the demands made of them. The current draft restorative care specifications include training and levels of training required.”

The cost to carers is also a barrier to training uptake. Costs include time spent training, travel costs and also training fees. A home support worker who met with the Commission said that she paid for her own first aid certificate and underwent the training in her own time because the DHB no longer required it.

Professor Matthew Parsons, Chair of Gerontology at the University of Auckland said that a number of providers are still not routinely paying for training, for example the

⁴⁷Supra at note 3.

cost of travel time to training. “It’s the perception of the DHB that providers are paying for that, so they are not going to give them additional funds.” NCWNZ submitted, “training needs to be within work time, and fitted in with the family lives of care workers, most of whom are women, so child care help might be needed.”

High turnover rates in the aged care workforce is seen to jeopardise the return on investment in training. The chief executive of a major residential provider said, “the economic rationale for training needs to be addressed. There is no incentive to train people if others can steal your trained people.” Another chief executive said that his organisation “spent a million dollars a year training people and if it could ‘stop the spin’, it would be less of a cost.” NZHHA in its submission gave an example, “of the 150 people trained by one provider to Foundation Level Two in the period 2007-2009, 23 are still working in home care.” High turnover of staff is threatening NZHHA’s target of 80 percent of the home support workforce attaining Level 2.

Mr Hausmann said, “first we have to stabilise the workforce. If you have 20-30 percent turnover and you are required to train your workforce and it costs you \$1500 a person to train them, and on top of that is advertising, there are significant savings for stabilising the workforce.”

A manager from Summerset said, “we are comfortable about people moving on once they have their qualification because people can say in the community that ‘Summerset is a good employer and trained me’. Not all providers bother with training because of the turnover. We at Summerset aim to develop them and keep them. You have to pay for the cost of churn or the cost of training. Training equips caregivers to do the job.”

Another submitter pointed to immigration practices that increased turnover and consequently impacted on training budgets, saying, “the employers’ investment in training may be of limited value because of the risk of applications for renewal of visas being declined.”

The manager of a new service, CREST which requires support workers with Level 3 qualifications, said there was not a workforce out there ready to go “unless you are pinching them from another provider.” They solved the issue by recruiting and training support workers to the necessary standard. She said, “the CREST capacity base funding supports the learning environment. Staff have time during the working day to participate in training and also to meet with nurses and other staff, such as occupational therapists and physiotherapists. There is an issue within the sector of training up staff and losing them to residential providers – they don’t tend to go the other way. The reason is that home care providers can’t provide regular hours and better pay for those with qualifications.”

Another barrier identified by providers arises from changes to the way government funds Industry Training Organisations. A chief executive applauded the structure and flexibility of the qualifications being developed by Careerforce to meet different providers’ needs, but said, “we still have a major issue about the non-funding of training and that it costs a fortune to utilise Careerforce.”

The New Zealand Aged Care Association (NZACA) also identifies changes to the way ITOs are funded as a challenge to training provision. “In 2012 ITOs are required to achieve 30 percent industry contribution. The employer-led model used by the sector results in significant financial commitment by employers. However, as the majority of costs are indirect and do not generate an external invoice they cannot be included in the industry contribution. Indications are that Tertiary Education Commission (TEC) will reduce Careerforce’s funding in 2012 if the 30 percent industry contribution is not achieved. The TEC also requires minimum and maximum training timeframes. The rules regarding the minimum timeframes are inconsistent with the ARRC contract requirements. Employers could complete the Level 2 inductions/orientation qualification in under six months, however, the minimum time TEC will allow is eight months. The outcome is again reduced funding to the sector.” Other changes required by TEC, which means that employers must reconfigure their training programmes may also “result in reduced funding in 2012. Changes made by TEC and the timeframe for change do not support employers to increase the amount of training they offer to their employees.”

Funding to Careerforce is contingent on completion rates, and the ITO will be required to return funding unless an 80 percent completion rate is achieved over the next two years. In an industry with a high turnover, this is likely to be a significant challenge. A residential provider expressed concern about Careerforce’s lack of control over the quality of trainers. “The employer can delegate whoever they wish to teach the caregivers. I suspect there are no checks from Careerforce to ascertain if the employer’s choice of trainer is a good sound practising Registered Nurse.”

Literacy difficulties and negative experiences of formal learning are barriers for support workers in undertaking qualifications. The Commission was told that literacy difficulties are identified in the training via a literacy assessment, but the details of support for workers struggling with literacy are less clear. Careerforce has developed a comprehensive package to support employers to meet their trainees’ literacy and learning needs, including funding to employers for online literacy assessments, free professional development for training teams, free educator resources and networking support. One residential service offered a solution. “Literacy can be an issue. We peer support people to pass their qualification requirements and even put on night classes so they can help each other.” Another strategy is to improve the use of recognition of prior learning (RPL). Currently establishing RPL is onerous and so streamlining and standardising recognition would assist those in the workforce who have completed qualifications not recognised at present and also may assist long term carers have their skills and experience acknowledged.

A funding manager from one of the DHBs said, “training is scary for many caregivers. When the training is written or on-line it can drive people away. Well-designed training makes it worthwhile.” This point was echoed by a support worker who wrote to the Commission saying, “a lot of support workers are not well educated and the thought of doing training terrifies them.” NZHHA said, “training requirements are increasing with added complexity of tasks and a higher level of critical thinking required. This is a challenge with 61 percent of staff having no formal qualifications.”

The NZACA also identify low levels of literacy and fear of failure as challenges, noting that 46 percent of carers in residential care have no previous qualification.

Grey Power Horowhenua submitted, “opportunities for those with limited literacy and numeracy skills should be available.”

There may also be resistance from staff to delivering care in different ways and this may make training more difficult. One participant said, “they’re very difficult to convince that they should be doing certain things in new ways. One of the things we’re constantly battling is that support workers often have a fixed focus on what they think they should be doing out there.”

One chief executive said, “where we have tried to attract the workforce to take advanced training and to look at more clinical risk management, the traditional workforce is not that interested. They tend to be more itinerant, part time, older women.”

And a residential provider said, “we have caregivers who have been with us for many years. They are now struggling with the complex medical conditions that we are expected to care for. Their previous training does not meet the needs of our residents now. Our long term faithful caregivers are now out of their depth and lack the ability to recognise the complexity and multiple problems being admitted to us.”

Another barrier to training uptake, according to the NZACA, is opposition by unions to wage increases based on training and performance. “One issue which needs to be raised is the inflexibility in some union negotiations around the distribution or allocation of wage increases according to training and performance. While this is an anecdotal comment, and therefore lacks any sort of robust research basis, members have raised with me the resistance in collective bargaining with unions to paying higher increases to those people with qualifications and who are seen to be high performing caregivers.”

Qualifications, training and the regulated workforce

Submissions on qualifications and training in the regulated workforce focus on the need for specialisation in gerontology and additional training in facility management.

The need for registered nurses to have skills in staff and facility management will be discussed in the section on managerial competence.

There were calls for gerontology to be a specialised field for registered nurses (RNs). “We have to make it sexy.” A registered nurse talked about her concern about the lack of experience and comprehensive knowledge of safe aged care among new staff. Members of New Zealand Nurses Organisation (NZNO) said that lack of training in dementia care was an issue. “People who have never been oriented to dementia are put on night duty in a dementia ward. RNs are being employed with no experience of elder care.”

“Specialist training should be available in geriatric and psycho-geriatric nursing care so there is an equitable level of care available in all situations,” said NCWNZ. “RNs employed in aged care institutions need the minimum of a post basic gerontological course,” said Grey Power Horowhenua.

In-service training for registered nurses is a requirement of the Nursing Council to maintain a practising certificate. An RN said she paid for her own in-service training and did this on an off-duty day. She is required to complete 20 hours in-service training a year. "In the DHB this training is free. Some organisations pay for in-service and some don't. Aged care providers are paid to provide this training."

And this view was supported by researcher, Noeline Whitehead, who cited research that showed, "RNs working in Residential Aged Care do not access post graduate education to the same extent as their colleagues working in the public sector. The reasons for this include: feeling supported; family/work life balance; and cost."

Participants also referred to the lack of training in the aged care field for doctors. A DHB manager said, "medical students are not required to do a rotation through older person's health." The College of General Practitioners also identified a gap in training, "the complexity of working with older people is that they present with multiple co-morbidities. The problem is we think about them in silos; diabetes, cardiovascular disease and high blood pressure. Teaching is struggling to catch up with multiple system failure. The College is helping general practitioners understand complex populations. Teaching needs to have a multi-organ focus."

Another aged care specialist decried the limited amount of age-related issues in medical training and argued that the problem was not confined to doctors training. "In the US all medical specialists have to have six months training in the health of older people. We don't have that here. Our medical training has two weeks plus some lectures on the health of older people. I agree that we need mandated training, not just for home based services but across the health training curricular. Physiotherapists' training is predicated on sport. Occupational Therapists have become the dispensers of raised toilet seats, rather than rehabilitation. Speech Language Therapists are much better but they need to know more about aphasia."

The Physiotherapists Association in their submission said that although Level 2 and 3 qualifications for support workers included a physiotherapy component, "very few workplaces encourage their physiotherapy assistants, many of whom work part time, to gain qualifications. Of greater concern to the profession is the lack of provision for adequate supervision of physiotherapy assistants by registered physiotherapists. Many assistants are working beyond their allowed scope with no supervision, putting patients at risk."

A geriatrician talked about the need for specialists to take an increased educative function in their role. "There needs to be a cascade of knowledge, not just in the aged care sector but to the whole of health services. Experts should be educating and teaching and providing a transformational role for carers, rather than focussing on one-to-one clinical input. They should be spending 50 percent of their time on clinical one-to-one and 50 percent on teaching the teachers or the deliverers of services. That is, a transformational approach. The knowledge goes up and down between specialised knowledge (for example medical staff) and those providing context (for example carers and the older person themselves)"

Conclusion

Variable training programmes; a lack of portability; inadequate recognition indexed to reward systems and historical problems with the industry training organisation are just some of the issues identified in the Inquiry. As Hon Jo Goodhew, Minister for Senior Citizens has previously noted, “one way to increase morale in the sector is to provide improved training for carers. This will allow them to complete qualifications that are appropriate to their caregiving roles, and then be remunerated for the skills they have acquired.”⁴⁸

The wisdom of having an adequately skilled and trained workforce is self evident. What constitutes adequate training is debateable, but at minimum, Level 2 qualifications for support workers and specialist training for the regulated workforce is required. It is also apparent that the necessary supports for training need to be in place. These include nationally recognised and therefore portable qualifications, financial incentives for both support workers and providers to encourage training uptake, career pathways, and the availability of literacy and numeracy courses for those who need it.

Changing models of community delivery such as restorative care programmes, and District Health Board contracting is helping to “push up” the level of qualifications and training required. More work is needed to convince carers themselves of the imperatives of life long learning. The Commission believes the aged care sector must commit to the attainment of Level 2 within the first six months as a minimum qualification.

There is a risk that experienced and competent carers with significant literacy issues will leave the sector in response to such a requirement. The Commission suggests that the ITO Careerforce working with providers and carers develop strategies to accommodate the needs of carers with learning difficulties. The ITO already offers support for literacy programmes.

⁴⁸Supra at note 8.





Managerial competence

A good manager is transparent, fair and democratic, open-minded and doesn't operate on gossip. (Comment made at a trade union meeting).

The successful management of aged residential care facilities is a complex and demanding task. The sector is rapidly expanding at the same time as acuity levels of residents are increasing. People with the right blend of clinical and managerial expertise, medical and social skills, organisational and leadership skills, emotional intelligence and intellectual skills are needed. This multi-dimensional skill set is evolving at a time when people management has been identified as weak in New Zealand in terms of global practice.⁴⁹

“Managerial competencies can be regarded as the glue which keeps it all together and the catalyst for achieving competitive advantage”. (Jan Cobbenhagen).⁵⁰

Managerial competencies go beyond simple management techniques and, like key capabilities, should be regarded as combinations of organisation-related techniques, attitudes, working methods and so on. The main goal of managerial competencies is to make sure that the key capabilities are tuned in to each other, so that the result becomes more than a sum of the parts.

Employees and employers differed in their emphasis in responses to questions about managerial competence. Employees focussed on what qualities made a good manager for them and employers and managers talked about the challenges of developing managerial competence. A common theme related to the professional isolation of nurse managers in residential care facilities.

Employees: What makes a good manager?

During the course of this Inquiry, over a hundred staff employed in aged care facilities were asked about the characteristics of a good manager. The responses were remarkably consistent, with good communication at the top of the list. There was agreement that a good manager was crucial to achieving a good facility and a happy workplace.

The staff of a rest home listed the following attributes of a good manager:

- communication
- someone you can go to and who will always listen
- the door is always open
- approachable (workers are “not afraid to knock on her door”)
- has a calm personality; doesn't flap

⁴⁹Green, R, and Agarwal, R (2011) *Management Matters in New Zealand: How does Manufacturing Measure up?* Ministry of Economic Development Occasional Paper 11/03 and Le Pla, R, *Lifting the performance of New Zealand's managers* New Zealand Trade Enterprise downloaded 06/03/12 <http://www.nzte.govt.nz/features-commentary/Features/Our-economy/Pages/lifting-the-performance-of-new-zealands-managers.aspx>

⁵⁰Supra at note 2.

- follows up right away
- very organised
- good networks.

Comments like, “a good clinical leader with some nursing knowledge and a good manager with an understanding about what pressures her staff are under” were common from carers. At a union meeting a good manager was described as “transparent, fair and democratic. They are open-minded and don’t operate on gossip. They are leaders.”

Having an open door, understanding the work and being prepared to support staff in practical ways are highly valued attributes across the sector. Comments from carers included:

“She (a manager) had a uniform in her office, when someone was sick she’d jump in and do the work.”

“We get support from our CEO, the door is always open and she’ll jump into any role from the laundry to a caregiver. Our nurse managers also give us support.”

Conversely, when talking about poor management a carer said, “you have to make an appointment to see them.” Staff who identified bad management talked about being discouraged from reporting incidents and feeling vulnerable when something went wrong. “If something happens someone will be punished”. Disciplinary action ranged from dismissal and unwanted changes to shifts and rosters. “Rostering is a form of revenge,” the Commission was told. Bullying occurred in some workplaces, but, “it goes under the radar.”

Another concern raised by carers was a focus on finance over people, with a bad manager being characterised by being “so involved with money and saving dollars”. This criticism included the observation that accountability to shareholders drove decision-making at the expense of quality of care.

Employers and managers: What makes a good manager?

One provider acknowledged the tension between financial management and clinical management by separating out care and facility management. Metlifecare managers explaining their organisational structure, “our nurse manager reports to the village manager. The village manager is accountable for the site. The nurse manager is accountable for the performance of the care facility that includes staffing, direct costs and some indirect costs including maintenance but in practice the village manager is actually supporting them in that aspect of the work. Why that comes about is that nurse managers are interested in clinical care they are not necessarily interested in facilities management. If they are going to be torn one way or the other then it is always going to be to the care.”

The chief executive of a large residential care provider identified the mix of management and leadership as critical in a good manager. “Management is about organisation and leadership is about team building, communication and coaching. You need emotional intelligence people skills.”

Managers themselves identified the competencies and the commitment required to do the job. A group of managers said, you have to have “an open mind, a sense of humour and leadership ability.”

The manager of a 62 bed residential facility that included a hospital, rest home and dementia unit, who also manages another 45 bed rest home, said, “I don’t think in all my jobs in health management I have ever struck a job that is so intense, where there’s no money and so many complaints. You’re trying to do the best you can and then you have to deal with District Health Boards, the Ministry of Health and the Health and Disability Commissioner. So it was a culture shock!

I think you have to be really resilient on a personal level. You needn’t take everything onboard, it’s not about you, it’s about a lot of different things. You learn that after your first complaint. You also need to have leadership qualities because you want to take the staff where you’re going, but as the manager of a facility you also need to develop a senior team around you that is going in the same direction. And that’s one of the hardest things. You need to have human resources understanding in terms of employment law.

You need to have compassion. You need to be a go-getter, which I don’t see a lot in the aged care sector. I didn’t come from it so I looked up the positive ageing strategy and where government wants to go with it. And I think that that’s what’s lacking because sometimes care managers have to be facility managers and they haven’t had the breadth of experience. I’ve also had lots of training in leadership and management because I was Chair of a national health organisation so they sent me to directors training through the Institute of Directors and I also did papers through the Institute of Management.”

The breadth and the demands of the job are significant. The Commission heard that in one region (with 37 facilities) there had been a 50 percent turnover for managers in the previous year. A manager said, “the burnout rate is high”. She recommended mentorships at a regional level to support other managers.

Nurse managers

Concerns about the demands made on nurse managers in residential facilities were frequently raised. In many rest homes managers are registered nurses (RNs). The Commission was advised that this was in part to fulfil contract requirements for registered nurse numbers in the facility. “RNs are managers to bring up the numbers of nurses.” However, there was considerable consensus about the need for medical or health expertise. The chief executive of a large residential provider said, “we have one village manager and a clinical manager RN per site. Where at all possible we grow our own. It’s quite hard going to a sector you don’t know. It’s hard to come cold to this sector. If managers are not RNs they have had health exposure.” He went on to say that the company had “very rigid systems” around organisation such as rosters to ensure “they are not being administrators, instead they have great personal skills.”

A senior clinician working at a DHB said, “failures in care of the elderly are due to a failure of RN leadership. Nurses work in complete isolation and lack of support. Aged care failures are our problem and our responsibility. You can’t contract out of accountability.”

Another chief executive said, “managerial competence is a huge issue. I think there is a view that just because you are a registered nurse you therefore have the appropriate managerial skills to run a very large small business. There might be a residential village over the fence with people issues, a vast raft of legislation re compliance and there was the idea that a RN could just step up.” Another participant said, “we put nurses into leadership roles for which they don’t have the experience or competence. These nurses are accountable. It’s a steep learning curve from ward nurse to leadership of an aged care facility.”

Another point of agreement was the need for management training for nurses who step into the management role. A challenge is attracting registered nurses with enough clinical experience and management skills to lead a largely unregulated workforce. The placement of new graduates and recently registered migrant nurses in leadership positions is viewed across the sector as highly risky for both the nurses and clients. A participant said in regard to managers, “some are very good. Some have hardly got the background.” This issue is being addressed in some areas with management training being offered by the New Zealand Aged Care Association, DHBs and universities.

The general manager of a service that provided both residential and home support services said that “we’d probably always choose to have an RN manager if we can but they must have management qualifications and ability – ideally degree level ones. The service is currently supporting two managers through a postgraduate diploma in aged care management.” She told the Commission that “our managers need to have property skills, HR skills, finance, marketing, networking, clinical skills – there’s hardly any management jobs that would expect to have everything. They’re probably the most complex management roles you’ll get anywhere.”

A health researcher with considerable experience in the sector said, “I don’t think facilities are that well organised. We had managers with a lot of experience; it takes a lot of leadership experience to set those systems up and running (for example, to cope with staff calling in sick). I think the industry is sick at the leadership level. That is not to say we don’t have good people out there. There is no succession planning and there are no leadership frameworks. There is no leadership qualification. In the United States facility administrators have to have a degree. In Australia people are expected to show they have experience. But with the pay rates so poor it’s really difficult for facilities here to attract good leadership. Some of the organisations are starting to realise that they have to develop their own leadership from within.”

“There needs to be a career pathway for nurses in residential care. In the hospital we have RNs, associate clinical charge nurses, nurse specialists, nurse practitioners. But in residential aged care we don’t have that. It used to be that the manager had to be an RN but they took that out two or three years ago.” A post graduate paper called Clinical Leadership in Residential Care is now being offered at the University of Auckland to meet the training needs identified.

Nurse managers in rest homes are professionally isolated and may not have ready access to professional advice and supervision. The isolation is even more acute in rural towns. An employer said that RNs in aged care have a much larger supervisory and management role than counterparts in the public sector. In public hospitals the RNs have collegial support around them at all times. In aged care RNs are often on their own.

Mentorship networks are being developed. Several of the providers who contributed to the Inquiry said that one-on-one support on site is a particularly effective support method. Management competence and access to support for managers would make a big difference to the sector. The Commission was told that a small pool of expert managers to mentor new managers for two to three weeks was needed. In order to participate in leadership courses managers need to be released by their employers. Bigger organisations have the ability to move an experienced manager to support a newer manager.

The cost of this was discussed by a group of managers and providers. The consequences of not putting management supports in place need to be considered. A senior DHB manager observed that managers were “not putting up their hand when they’re in trouble so they can get assistance. Getting in a temporary manager once it goes wrong is difficult. Temporary managers are like hens’ teeth and expensive.”

A residential care provider observed that a person can be a great nurse clinician but not a great leader of an unregulated workforce. He went on to say that leadership must be combined with control. “The manager has to be able to stand up to a strong un-regulated workforce. You need to have the skills to be fair and assertive and embed that to make it happen. It’s a core competency. Managers can be fearful that if they’re tough on someone they’ll leave and that fear can over-ride common sense performance management.” This point was also made by Noeline Whitehead in a paper published in the College Of Nurses magazine. “This (the residential care facility team) will require the registered nurses working in this industry to be skilled in the human resource practices necessary to delegate care to, and direct, this workforce,”⁵¹ she wrote.

A manager from the residential provider, Metlifecare, said that there were challenges, “when a nurse transitions to a nurse manager position. They need to grow in their ability to manage rosters effectively, to understand the financial implications of bringing an extra person onto the shift because you have a heavy load on a particular day. We have an implemented time target which is an electronic time sheet which comes with a rostering module to assist this. It enables us to budget and benchmark against the NZ Standard, the voluntary standard first developed in 2003. How they work out the mix, the shifts, is all within the nurse manager’s responsibility. The nurse manager is responsible for all clinical care across the site. It’s geared to the strengths of a nurse manager rather than the weaknesses.” Managing Director Alan Edwards said, “these structures are an investment in our business. It costs us more but long term the outcomes are better for our residents.”

⁵¹Supra at note 38.

The Commission also heard that registered nurses do not have a supervision model or peer review as part of their practice. “Allied health professionals do peer review well. Facility managers need the same process. Where can they talk about the problems they are facing? It’s incumbent on individuals. How do you bring people together? Tear them away? They need to prioritise time to talk to someone.”

Another group of managers said, “managerial competence is dictated by the big companies. Training is not there. Managers are getting no support to increase their competency. Safe staffing ratios are dictated to them. Managers are just as impotent in the sector. They face the same issues as the rest of the workforce in this regard.”

The issue has been addressed at Oceania group and its approach may be a useful model for the sector. Oceania is using something called (Four Quadrant Leadership). Oceania has also offered a more senior NZQA qualification to its facility managers. The senior qualification is at a NZQA diploma level underpinned by the National Certificate in Business which in 2011 has graduated approximately 30 senior facility managers. The qualification specifically targets the needs of the aged care sector. More specifically it focuses on management skills, financial, legal and human resources skills that are required and aimed for aged care. The qualification is being offered to the wider aged care sector.

Other participants emphasised the need for managers to first and foremost have a health professional background. Grey Power Horowhenua said, “an understanding of the industry is essential. We believe that managers with a health professional background comprehend the full gamut of the vulnerability and safety of the elderly (risk management) as opposed to financial management and other management principles.” The submission said that “not infrequently nurse managers are put under extreme pressure by owners to reduce costs which results in compromising care. Owners, boards may wish to provide quality care but often do so from a point of benevolent ignorance.”

Conclusion

A new breed of health professional manager is required in aged care that meets the changing, complex demands of care and facility operation requirements. The issue of responsibility to ensure managers are competent needs to be resolved. One option is to mandate management qualifications; another is to ensure roles are separated so that competence is assured. The consequence of not addressing quality management in the sector cannot be overstated. High turnover of managers (in one region as high as 50 percent in 2011), burn out and systemic failures in care have all been attributed to managerial incompetence by both employers and staff.

The extraordinary managerial qualities required in the aged care sector were identified for the Commission up and down the country by managers themselves, by carers, by older people and their families and by providers. Most participants called for a mix of experience as a health practitioner, management and leadership skills with financial, human resources, legal competences as well as clinical understanding. This requires training beyond health registration qualifications.

INDEPENDENT CARE

VILLA AVAILABLE

ENQUIRE AT



RECEPTION



Men as carers

“Men would be attracted by more money, better hours and recognition. The aged care sector needs men.” Comments made by a group of managers.

“Men are not attracted into caring because it is low paid and has that nursing tinge to it,” said one Inquiry participant. Globally the caregiver workforce is overwhelmingly female – 92 percent in New Zealand.⁵² An OECD study shows that there has been little change over time in the gendered nature of the workforce with female employment mostly restricted to practical care work while managerial jobs tend to be held by men.⁵³

Many carers work part time especially in home-care settings. Care work often appeals to women with children who perceive a value in “flexible working hours”. Recent figures show that almost half of the country’s active nurses work part-time, most (34.5 percent) giving their responsibilities as parents as the primary reason for this. A total of 15.1 percent said they worked part time as a personal choice; 10.4 percent because they worked casually; and 9.3 percent said they had reduced hours because of high work loads.⁵⁴

Women outnumber men as residents in aged care facilities. An Auckland study reported that in rest-homes the gender split is 71/29 female/male, in hospital level care it is 69/31, in dementia care it is 66/34 and in psycho-geriatric care it is 61/39.⁵⁵ But the life expectancy gap between men and women is closing and we may see a more even balance between the sexes in future. Aged care must meet the needs and preferences of both men and women.

At all the meetings when the role of men as paid carers was raised the Commission heard that men were few and far between and that more men would be a welcome addition to the workforce. Despite this there are significant barriers to men’s participation in the aged care sector which include: low pay, low status, gender expectations and client preferences.

There was no discernible difference between the views of employees and employers on this issue. Some care recipients have a preference for female carers but this is not universal.

Value of male carers

One manager said she was keen to build a team with a male and female mix. However, she has found that male registered nurses are “as rare as hens’ teeth”, and community registered nurses even more so.

⁵²Supra at note 7.

⁵³OECD (2011) *Help Wanted? Providing and paying for long- Term Care*. Paris: Organisation for Economic Co-operation and Development.

⁵⁴Kai Tiaki (November 2010) *The New Zealand Nursing Workforce*, 16, No. 10

⁵⁵Supra at note 32.

One male carer, a nurse in his country of origin, said he had worked in health care for ten years, “I’ve worked with a lot of women and I don’t think gender is a problem. Sometimes it helps to have men, especially when working with people with dementia. If a client is aggressive our presence can help. Women carers can get scared.” At another meeting the Commission heard that male carers were viewed as very caring and “stronger than slips of girls.”

A geriatrician said, “there is a need for more men. Male residents don’t fit in well in the typical rest home environment. Male residents don’t enjoy a gender appropriate environment. They need things like men’s sheds and gardening activities.” In one centre visited, a major provider had made a men’s shed available to its male residents. Other participants observed that it was good for elderly men to be cared for by men.

A submission from Alzheimers Eastern Bay of Plenty also emphasised the need for gender appropriate activities. The sector needed to, “encourage men to engage in working with older people. Frequently our members say, ‘The staff at X facility are all very good, but they are all women and the activity programme does not meet the needs and interests of men very well.’ “

A rest home manager, whose workforce included ten men, agreed, “men make the most amazing carers.” She then observed, “it’s easier to get male registered nurses than care assistants.”

Low wages a disincentive

The usual reason given for the dearth of men in the aged care sector was low wages.

- “Better wages” would attract more men.
- Men wouldn’t put up with this in their industry.”

At several meetings the Commission heard that carers’ wages were seen as supplementary income and that men who had a family to support would not accept such low wages. A manager of a home support service said that the guaranteed income available in new service models would make caring more attractive to men, as they were often the main earners in a family. One male carer said, “you need a passion for this work. I wouldn’t be working here if my partner wasn’t working, because this money wouldn’t sustain us.” A group of elderly women residents in a rest home said positive role modelling and publicity would be one way of encouraging men into the sector. “Improving the money would definitely have something to do with it because most are married men.”

Low status of caregiving

A rest home manager said that it was not the low pay per se but the low status of the caring. “I don’t think it’s the pay. Men work at McDonalds. It’s the lack of understanding and knowledge and the lack of value attached to the job that’s the problem.”

Another common reason was the perception that caregiving is women’s work and as one participant put it, “not manly.” The low status of caregiving was also referred to.

“There is huge stigma attached to being a male carer in New Zealand. There would have to be a helluva attractive pay rate,” one participant said. A service provider said, “seventy percent of our clientele are women and we receive negative feedback about men as carers. If men train as nurses it is somehow perceived as okay.”

A group of managers said, “there is no kudos in the job. Men would be attracted by more money, better hours and recognition. The aged care sector needs men.” A manager from a DHB suggested there are very few men in the industry because “it is seen as a dead end street with no career progression.” The Commission was told that a male registered nurse on resigning from his job in a residential aged care facility said, “I’ve got a real job now in the hospital.”

An employer said that there “were not a lot of New Zealand-born male carers and nurses”, but a high number of migrant men. She was optimistic that there were more men training as carers and as registered nurses. Caring worked well for women because the hours often suited women with family commitments.

Barriers

One barrier to the acceptance of men in caring roles is the reluctance of older women to have a man provide personal and intimate care for them. Gender was an issue for some older men as well. At one meeting we heard that elderly clients found it particularly difficult to be cared for by younger men. A male carer said that initially he was very unconfident in the role especially around dressing and undressing people, but that after a while became comfortable with it.

Some older residents feel discomfort with men working in non-traditional roles. “There’s some residents who don’t want a male carer, yet they have a male doctor or a male nurse”, said one participant. A rest home manager said, “for many older people, men are doctors and nurses are women. Aged care is very feminised, the majority of our clients are female.” A carer working in home support observed that some elderly clients did not like to have a man make their bed, let alone provide personal care.

Providers, especially in the home care sector accommodated elderly clients’ preferences for female carers. A senior manager from a DHB said, “providers do attempt to give choice and make sure the client is happy.” One participant talked about the need for vulnerable elderly people to feel safe in their home and to have a choice about who came into it.

This view was echoed by a rest home owner who said that the fear of being accused of harassment put a lot of men off. A residential care provider said, “men in caring roles face the same issues as men in early childhood and teaching; the risk of accusations of abuse and their sexuality and intent being called into question.”

Another participant said, “it’s important to be culturally sensitive on this issue. It would depend on the man and on the client.” The submission from Grey Power Horowhenua also argued that the “aged clients or where necessary, relatives, are given the choice to refuse to be cared for by males.”

A rest home manager explained the dilemma, “we have some really compassionate men. We need to be absolutely certain as the employer to ensure our residents are safe and our employees are safe and males providing care are safe because it is very easy for accusations to be made by people with dementia. Men have a right to be employed and our residents have a right to safe care. It’s how you manage that.”

Other participants said that they were comfortable with men as carers and one elderly care recipient said that she had a male nurse in hospital. “It doesn’t worry me, all my pride and modesty has gone”. She also said, “in our day we were very modest, things are different now.” A staff member at one rest home said, “residents don’t mind who’s showering them. Some really like having male carers.” Six elderly female residents in a Dunedin residential facility said the male carers they had experienced were “absolutely marvellous” and they would not mind more men in the role.

Conclusion

The absence of men in paid caring work is primarily due to pay, status and societal stereotyping that it is “women’s work”. If increasing numbers of men require aged care services it is important to provide male carers and to provide a gender appropriate service. Boundaries in relation to personal care are breaking down and society needs to become more encouraging of men in caring roles. The sector should consider an active recruitment campaign for men such as that undertaken in education and, in particular, early childhood education. The proportion of men attracted to caring will rise only if the status of the work and pay improves. The aged care industry has a real opportunity to meet the demographic trends of increasing male longevity with positive recruitment campaigns aimed at increasing the number of male carers.





Migrant workforce

“Diversity in the population should be reflected in the workforce”.
(Comment from an Auckland District Health Board manager)

The domestic New Zealand labour market is unlikely to meet the growing demand for carers, given the rapidly ageing population. The World Health Organisation estimates the global shortfall of health workers at 4.5 million. The perception and the reality of the work as low status and underpaid exacerbate labour shortages. Migrant workers already make up a significant proportion of the aged care workforce and it seems both likely and necessary that this trend will continue.

The role of migrant carers is substantial across many OECD countries. In New Zealand figures from 2004 show that 24 percent of nurses were foreign trained⁵⁶. The care sector in New Zealand has recruited heavily in recent times from the Philippines and the Pacific⁵⁷ but also from a range of other places such as China. In the course of the Inquiry we met carers from countries such as Nepal, India, the Solomon Islands, Cook Islands, China, South Africa and Japan.

Internationally the phenomenon known as de-skilling is frequently observed. Foreign-born carers are qualified nurses in their country of origin, but may not have their qualifications recognised in their host country.⁵⁸ For some nurses who come to New Zealand seeking employment, working at a level lower that they are qualified for is a transitional phase. But others are unable to gain employment or registration due to unrecognised qualifications or English language requirements. These, as the Inquiry found, may end up taking up long term care jobs.⁵⁹

An increase in low skilled migration raises equal employment opportunity issues. There are numerous reports illustrating how foreign-born carers often work with shorter contracts, more irregular hours and broken shifts, for lower pay and lower classified functions than non migrant carers.⁶⁰

Across the globe millions of women move across borders, attracted by the demand for cheap labour in destination countries and pushed by the lack of job opportunities in home countries. As a result of gendered labour patterns in destination countries, migrant women are often “restricted to traditionally female occupations – such as domestic work, care work, nursing, working in the domestic services and sex work.”⁶¹

Labour legislation and other laws across the world often discriminate against domestic workers which increases their vulnerability. This Inquiry includes discussion about the current gaps in protections available to workers in the domestic sphere in New Zealand.

⁵⁶Supra at note 52.

⁵⁷Supra at note 7.

⁵⁸Supra at note 52.

⁵⁹Supra at note 7.

⁶⁰Supra at note 52

⁶¹Antonopoulos, R. (2009). *The unpaid care work –paid work connection*. ILO Working paper No 86.

Concerns about the protection of migrants in New Zealand have been raised by many of the international treaty monitoring bodies and migrant's workers rights were raised in the context of New Zealand's Universal Periodic Review in 2009. Members of the Human Rights Council recommended New Zealand ratify or consider ratifying the Migrant Workers Convention.

As at the 2006 Census, a quarter of carers in the aged care sector were born overseas.⁶² The principal source countries were the Pacific Islands, (one in three) and the United Kingdom and Ireland (one in four). Recent research suggests that the age of carers is roughly the same for both locally born and overseas born carers. This is not true for nurses in the aged care sector, as overseas born nurses are younger.

Des Gorman, Professor of Medicine at the University of Auckland and executive chair of Health Workforce said that more than 40 percent of the medical workforce in New Zealand is overseas trained, the result of "many years of quite deliberate government policy of under-training doctors in the belief that a way of managing the cost of health was to restrict the number of doctors. And doctors groups facilitated that because it maintained private practice incomes." Professor Gorman is of the view that "15 percent of the workforce being overseas trained is desirable, in terms of different points of views and vitality. Forty percent is too much."

The majority of migrants to New Zealand enter as skilled migrants. Low skilled migrants (except for certain Pacific peoples) are only able to enter as temporary workers. People from the Cook Islands, Tokelau and Niue have free entry into New Zealand as do those from Australia. Other Pacific peoples, from Kiribati, Tuvalu and Tonga are able to migrate permanently to New Zealand if they meet character, health and age requirements, and have basic English language skills and a job offer.

In the course of this Inquiry it was apparent that many care recipients and their families were very appreciative of migrant carers and in turn migrant carers expressed their respect and fondness for their elderly clients, often rooted in cultural traditions. However, cultural misunderstandings and difficulties in communication were raised, particularly in relation to the care of elderly clients with dementia and/or cognitive impairment. This posed a dilemma for employers.

Other issues raised included the difficulty experienced by migrant nurses in meeting English language requirements in order to register in New Zealand and the vulnerability of migrants employed on work visas who are dependent on employers and managers for positive references.

Migrant workers in the aged care sector

At a meeting of twenty nurses and care assistants, in the Waikato, the Commission was struck by the diversity of those who attended in addition to Māori and Pakeha staff. People from Asia and the Pacific predominated, although some were from Africa. We noted the following countries of origin: Solomon Islands, Nepal, India, Fiji,

⁶²Supra at note 7.

Tonga, Papua New Guinea, China, Scotland, Samoa, South Africa, Gambia and Thailand.

The chief executive of a major aged care provider, along with other participants, observed that migrant workers are younger and they bring the average age of carers down. Participants also observed that there were regional differences with a smaller percentage of migrant workers in the South Island and a bigger percentage in Auckland. The Commission was also told that the men coming into the aged care sector are often younger migrants.

A number of managers and providers talked about how aged care relied on migrants with one saying, “the aged care workforce would collapse without migrant workers. In my facility the majority are migrant workers.” Another made the point that the migrant workforce was key to managing the demand for carers. A senior manager at a District Health Board (DHB) said, “the DHB does not have an issue with the Kiwi first policy. However, it would have difficulty running a whole lot of services without migrants. There is such a shortage (of Kiwi health workers).” However, providers and migrant workers report difficulties in renewing work visas because there is an expectation that New Zealand workers are available to do the work.

Overseas trained nurses

One senior DHB manager estimated about a third of the registered nurses in the aged care sector were migrants. She said, “it is difficult to attract New Zealand registered nurses (RNs) to the sector and so Filipino nurses fill that gap. The DHB is not supportive of overseas trained RNs when New Zealand registered nurses are out of work. The problem is that New Zealand RNs are not attracted into the aged care sector and it is hard to be a new practitioner in the community aged care sector.” The chief executive of a large provider said that previously the company could not attract New Zealand graduate nurses because of pay differentials compared to the DHBs. Employing New Zealand new graduates was problematic because of their lack of practical experience. “New graduates have to be supernumerary (i.e. they need to be employed as an additional member of staff above the regular staffing level) and need to be mentored, otherwise you might discourage them.” Consequently the company absorbs a limited number of RNs each year. Therefore they must rely on migrant nurses.

Residential providers consulted by the Commission said they recruited foreign trained nurses and employed a limited number of New Zealand registered foreign trained nurses. A chief executive of a major residential care provider said, “we sponsor a limited number each year. Even when people have signed off on the International English Language Test System (IELTS) and nurse training there are still cultural differences. We treat them like a new or close to new graduate. We have an experienced RN on a shift and the second RN is less experienced. You need to be careful with your mix.” Another chief executive said, “we have brought migrant workers who are RNs or aiming to be RNs. Now we can only absorb ten new graduates a year.”

A senior manager in a large DHB explained the moral dilemma inherent in overseas recruitment. “We don’t have mass campaigns to recruit internationally. We have an ethical responsibility to the developing countries not to poach their health workforces.

Doctors should be working in their own communities.” The manager believes that recruiting health professionals from countries that have significant gaps in their health workforce deprives that country of desperately needed health provision.

Some migrant nurses are bonded – BUPA (the employing organisation) pays for the cost of completing the Competency Assessment Programme (CAP) in return for a specific period of employment. However, BUPA says this does not tie the nurse to the organisation. “Some bonded nurses are lost to DHBs and the DHBs pay off the CAP. Alternatively the migrant nurse can fund the CAP themselves.”

Oceania have a strategic alliance with a Chinese university. Geoff Hipkins, former Chief Executive said, “the university has a 5 year nursing degree taught in English and we have access to their graduates. Interestingly our Chinese graduates typically pass with an 8.5 score on IELTS which is better than most here. We’re offering on average half a dozen each year to come and work with Oceania in NZ and we’re finding that not only are they highly skilled and highly educated but they also have a greater empathy with our residents.

This is probably arises from Chinese cultural respect for the elderly. They don’t actually see working with the elderly as a negative; they see it is as a positive. Yet I would say working with some of the youth employment schemes we’ve been involved with we had that stigma, that barrier. The Chinese graduates are bonded in a loose sense in that they’ve given a commitment to work for Oceania for a two year period and at the end of that two year period we’ve basically said ‘look, it’s your call’, by then you will have been in New Zealand for two years, you can choose to stay and go down the residency route or arguably you have other options, whether it is here or other Commonwealth countries.”

English language requirements for registration

Migrants wanting to register as nurses must pass IELTS or the Occupational English Test (OET). This has proved a significant barrier to many migrant nurses. Until migrant nurses are registered as nurses in New Zealand they are not recognised as skilled migrants.

A large residential care provider puts overseas trained nurses through a six week course to prepare them for Nursing Council requirements. However, the provider and migrant nurses have advised the Commission that achieving the English language requirement is problematic. A chief executive said that the IELTS standard is academic rather than practical.

At a union meeting the Commission was told, “they (migrant nurses) can’t pass their English exams and then they get sent home.” A union organiser said “migrant nurses with experience were brought to New Zealand, and their families spent \$20-30K to get them here, with the expectation of earning \$60K a year. They are currently working for \$13 an hour because they fail the language requirements for nursing registration. New Zealand nurses (with English as a first language) who want to work in the UK also struggle with IELTS to the level required”.

The chief executive of a major residential care provider said, “the IELTS exam is incredibly tough and I would suggest half of our New Zealanders would fail. I would

suggest, particularly after discussions with the Nursing Council, that it is used as a barrier to protect their own. It's almost like a professional body excluding competition. When I look at IELTS papers, conversational English, day to day speech and jargon is not dealt with, it's very academic, and I don't think the outcome is what they are really driving for." The English language requirements for registration are at the same level in New Zealand, Australia and the United Kingdom.

A geriatrician was of the opinion that "there needs to be more flexibility in passing English language tests. But, communication with the people being cared for is essential." She was concerned that English as a Second Language education funding had been cut and advocated for continuing adult education.

At a meeting of migrant nurses and carers in Christchurch, the cost of achieving English language qualifications was raised. Many of those at the meeting were nurses from the Philippines who were not registered in New Zealand and who worked as carers. "We are not just carers we are nurses in the Philippines". These people left the Philippines with the expectation that they would work as nurses in New Zealand. "I wouldn't call it false advertising. To be fair it's not the Government's fault". Filipino nurses said that they didn't anticipate how difficult or expensive it would be to pass the English requirements. One carer had sat and failed English language tests multiple times. Carers in Rotorua also indicated that a local educational institute was benefitting financially from migrant carers having to repeat courses to achieve qualifications.

At another meeting the Commission heard that overseas qualified nurses come to New Zealand with the expectation that they will gain their nursing certificate while working. Working full time and studying is challenging. "You need to work full time to live, but then you don't have time to go to school to get your nursing certificate, so I'm stuck," said an overseas qualified nurse working as a health care assistant.

Work visas – the union view

The vulnerability of migrants with respect to work visas was highlighted at meetings of nurses and carers hosted by unions. "For a migrant worker the employment relationship is a bit different because you rely on the employer for a work permit which is attached to the employer," said one participant. The Commission was told that "work permits are used as a threat" to gain compliance on work conditions such as hours of work and pay. Another fear was the possibility of not getting a good reference when changing employment. The Commission was told migrant workers were also vulnerable when they sought residency. "They have to stay in line with management to stay in the country." A union member said that employers have got migrants in these situations "by the short and curlies." The Commission was also told of a migrant worker who applied to have her visa renewed and was turned down and given 48 hours to leave New Zealand.

A number of people said they were tied to their employers because of the nature of their visa. "You can't complain because you are on a work visa." Migrant workers would like more choice in their workplace. "In my passport I can only work in one place." One person said that this threatened freedom of expression. "Pakeha don't want to work on the weekend or night time or the afternoon shift, so people on work

visas have to work those shifts.” The Commission was also told that some migrant workers were doing double shifts.

Union members the Commission spoke to were seeking national standards about how migrant workers are employed, better monitoring by Immigration New Zealand of migrant staff after arrival and that information about rights for migrant workers in the aged care sector should be available in countries of origin and in appropriate languages.

Work visas – the employers’ view

BUPA, a large residential care provider, with 390 staff on work visas, has Approval in Principle (AIP) from Immigration New Zealand to employ migrant workers. BUPA do not recruit off-shore but employ migrant carers if they are already in New Zealand on a one or two year work visa. The chief executive said that the company spends a huge amount of energy explaining to Immigration New Zealand that migrant workers meet a need. “We’d regard this job as semi skilled plus.”

Waitemata DHB said that it has a good process for managing the visas of migrant staff. “We have the only recruitment consultant in the country (among DHBs) signed off by Immigration. We can bypass a lot of red tape.”

A rest home manager said that she was asked by migrant workers to write to Immigration New Zealand in support of visa applications. “I can’t do that in good faith because if I advertise I’m going to get 80 people apply for a position. And you have to show that you can’t find New Zealanders for the job.”

Another employer talked about the “excessive” time required for managers to assist with visa renewal applications. Within this process time was also required to “advertise and sift through applications from many people clearly unqualified for the role.” She asked for changes to immigration policy so that “once an immigrant worker has been employed, the job doesn’t have to be re-advertised every year and they don’t have to reapply every year.”

Professor Gorman said that there had been a disconnection between immigration and regulatory behaviour. He noted that the Medical Council was providing an assessment for registration on arrival for new migrant doctors. “There are three paths for them: forget it, you are so far from being registerable; you are registerable almost immediately and here is the training and upskilling available to you to get you over the line; or you are immediately registerable, you can be working tomorrow. It should be available in the country of origin, before they even get here.”

Discrimination

Migrant nurses and carers at the meeting of migrant workers had experienced occasional hostility and rudeness from co-workers. One nurse said that she had experienced insubordination, bullying and bossing from co-workers (mainly European) even though as their senior they take instruction from her.

A health care assistant said that her contract was an individual employment agreement and found out that other people working the same shift as her got a night rate. “Advantage is taken of people with English as a second language.” Another

care worker, who was a nurse in her country of origin said that she was currently being paid \$14 an hour “although according to the provider’s pathways criteria, I already fall under Level 4, the rate I am getting is just Level 2.” The carer said she was scared to approach her manager regarding this and asked to remain anonymous when she wrote to the Commission.

Cultural and language differences

There is a need for culturally appropriate aged care. Cultural sensitivity is particularly important when working with people with dementia and cognitive impairment. Some older people have difficulty understanding migrant carers. A combination of less tolerance, impaired hearing and speed of speech all contribute to language difficulties between carers and clients.

As an RN wrote, “it is very hard for those elderly with dementia to be cared for by staff who have limited English, despite having passed an English test, and have no idea what the older adult is talking about.”

A submission from Grey Power Horowhenua said, “culture is a critical aspect for both the worker and the clientele being served, in this case frail, dependent elderly with complex health needs. This group of elderly have poor health status, varying, but usually advanced hearing and visual impairments, limited to zero mobility, along with other disabilities. The impact on the frail elderly when large numbers of migrant workers are employed on any one shift, (and in some situations they may form the majority of care staff), is catastrophic for the elderly. A key area is language, in terms of proficiency in English, and accent. This frequently creates enormous confusion and frustration. As a society it is important that serious consideration is given to having culturally appropriate aged care staff of similar cultural and linguistic background to those being cared for. A balance of staffing is a priority, i.e. a mix of staff and ethnicities on any one shift.”

Rest home staff wondered if this would change as a new cohort with greater experience of diversity came into residential care. One carer said, “a small number of residents don’t like to be cared for by migrants. It’s a generational thing as well as people with dementia (being careless about what they say). Sometimes there’s a clash between residents and carers and we just swap personnel.” Another observed that “these prejudices will go out with our generation”.

The manager of a home support service explained the dilemma. “Six or seven years ago the company experienced problems with clients objecting to being cared for by Asian staff, in particular Japanese staff. This related to the war experiences of clients. It is the company’s philosophy to respect client’s wishes, although it did have an impact on employees. It was necessary, for example, to explain to support workers that some clients may have a problem with being cared for by someone wearing the hijab so that they were prepared for a possible reaction. The manager referred to the Code of Health and Disability Services Consumers’ Rights and the fact that a client “can refuse any of us to be in their home”.

Another home support service manager said, “it’s quite hard enough for someone from a different country to manage any job but to manage in a Kiwi home and know what is expected and how to behave and what’s normal is quite a big ask. And sometimes it doesn’t work. Sometimes it’s about us matching people like that appropriately. Some client’s really enjoy that – having someone interesting from another country and to talk about travel. Some just find it doesn’t work.”

A rest home manager also identified the issue. “We have a problem in that we have to be mindful that residents here relate more to Europeans. We’ve had a problem in the past of residents being dismissive of other cultures and quite harsh, and we’ve had to support the staff through that. Sometimes with age comes confusion and they say inappropriate things.” A home support worker said, “there is no-one else in their home, they feel vulnerable and they may not know why. They want to feel as safe as possible.”

The importance of good communication was emphasised, with a manager of a home support service saying that it was important to match clients with people that they could communicate with. “The more ethnically diverse support workers were, the greater the pool of different language skills. It’s hard to communicate if a client has very little English.” As New Zealand’s increasingly diverse population ages, so too will the demand for ethnically diverse support workers. Alzheimers Eastern Bay of Plenty submitted that it was important that clients had the opportunity to communicate in their first language, “be that Māori, Cantonese, Samoan, Dutch etc.”

Managers from Auckland District Health Board also emphasised the need for culturally appropriate services, “diversity in the population should be reflected in the workforce. We are constantly looking for people with community languages.” Another submitter pointed out that when carer and care recipient were from different backgrounds, “residents and staff are less able to relate about shared cultural experiences and values.”

Language and cultural difficulties between staff of different ethnic backgrounds was also identified as a potential problem. An employer submitted, “migrant registered nurses do not necessarily understand our predominantly Pacific health care assistants and this can cause difficulties.” Another said, “with too many staff from different ethnicities for whom English is a second language, miscommunication risk is high.”

Conclusion

New Zealand like other developed nations is reliant on migrant workers in aged care. However, their employment protections are often weak – they express misgivings about the mismatch between their work aspirations and the reality of working in New Zealand and their work is precarious. Many feel regulation and English-as-a-second language education and professional training is expensive and exploitative. While many migrant workers in aged care are respectfully employed and supported by the older people they care for, others are working too hard, for too long and for too little, and have no public way in which they can air their concerns.

Carers from different cultures are needed in aged care, to reflect the increasingly diverse older population, as well as to meet labour shortages. There is a need to

strengthen the protection for migrant workers in the sector, to ensure that their visa status does not leave them vulnerable to working excessive hours, and that they have the same employment conditions as co-workers. Some streamlining of immigration processes is required given the number of migrant workers employed in the sector and the number whose job status is insecure.

Information about registration requirements must be made available to qualified migrant workers in their country of origin, in forms that are readily accessible. Language requirements are a vexed issue. Assessment of language skills and the level of language skills required should be fit for purpose, which is to ensure that communication skills are not a barrier to quality care. Given the intensely relational nature of aged care, good communication and client choice are critical.

Regulatory frameworks

Regulation of the workforce would compel the Government to recognise the value it plays within the sector. (Submission from New Zealand Home Health Association)

Aged care services look after some of the most vulnerable and at risk members of society and employ some of the most marginalised workers. It is of critical importance therefore that appropriate measures of monitoring and accountability are in place to ensure the human rights of both groups are protected. Appropriate regulatory frameworks will become increasingly important as the scale, demographic make-up and skill mix of the workforce undergoes change and aged care is increasingly provided in home care settings.

In New Zealand where aged care services are provided by both non government organisations (NGOs) and for profit organisations, the responsibility for human rights protection remains primarily with the State. Last year the United Nations Human Rights Council endorsed the Guiding Principles for the Implementation of the UN "Protect, Respect and Remedy" Framework which provide an authoritative global standard for preventing and addressing the risk of adverse impacts on human rights linked to business activity.

One of the principles is that, "States should exercise adequate oversight in order to meet their international human rights obligations when they contract with, or legislate for, business enterprises to provide services that may impact upon the enjoyment of human rights." ⁶³ This oversight will require appropriate policies, legislation, regulations and enforcement measures.

Regulation related to the workforce is focussed on registered nurses, (the regulated workforce) and service specifications include mandatory minimum levels of nurses within a facility. Carers are referred to as the "unregulated workforce", that is, those who are not subject to regulatory requirements under health legislation such as the Health Practitioners Competence Assurance Act 2003. This Act mandates the registration (including vetting and qualification requirements), ongoing competence requirements, professional standards and limitations and disciplinary procedures. The regulated workforce is subject to scopes of practice which define what a particular health professional can or cannot do.

According to the Ministry of Health⁶⁴ a profession may not be regulated where there is:

- a low level of risk of harm;
- practitioners work with, or under the supervision of a regulated profession

⁶³ *Guiding Principles on Business and Human Rights: Implementing the United Nations "Protect, Respect and Remedy" Framework*, A/HRC/17/31, 21 March 2011.

⁶⁴ Downloaded on 30.01.2011 <http://www.health.govt.nz/our-work/regulation-health-and-disability-system/health-practitioners-competence-assurance-act/non-regulated-health-professions>

- employment arrangements provide an appropriate form of regulation outside the Act to minimise risk of harm to the public
- self-regulation by the profession can provide an appropriate form of regulation.

Other forms of regulation outside the Act can adequately address the competence and fitness to practice of a number of professions, according to the Ministry of Health. For example, an employer such as a District Health Board (DHB) may have in place education and training qualification requirements for employees in non-regulated health professions.

In recent years, contracts, at least in the residential sector and increasingly in the home support sector, are specifying minimum qualifications (Level 2) for all support workers. New models of home based care are requiring qualified staff.

In the aged care sector, the regulated workforce supervise the unregulated workforce and this raises issues of accountability and scope of practice boundaries. New Zealand Home Health Association (NZHHA) has advocated for mandatory supervision ratios for home support workers, an issue discussed in the staff to resident ratio section of the report. The responsibility of registered nurses as supervisors of the unregulated workforce is in the managerial competence section.

Residential facilities must be certified by the Director General of Health, and to remain certified they must be audited (usually every three years) to check whether they meet the criteria set out in the Health and Disability Services Standards (the Standards⁶⁵). Six areas are covered: consumer rights; organisational management; continuum of service delivery; safe and appropriate environment; restraint minimisation and safe practice. The Ministry uses designated auditing agencies to carry out audits of facilities. There is also further monitoring of delivery and performance by DHBs where there is an Age Related Residential Care (ARRC) Services Agreement in place with the local DHB.

Home support services, however, do not have the same certification requirements as residential facilities. The Home and Community Support Sector Standard (NZS 8158) is a voluntary standard which covers service users' rights, organisational management and activities supporting good quality service. NZHHA estimates that there are approximately 125 providers of home care of which 80-100 may hold DHB contracts. NZHHA also estimates that between half and two thirds of providers with current DHB contracts hold voluntary certification. NZHHA advise that the government has given an undertaking that all DHBs will require providers to be certificated. Funding agencies do not have a consistent approach to auditing for quality, or to auditing at all, leading to inconsistency across New Zealand. NZHHA advocate a mandatory Home and Community Support Sector Standard and that inconsistencies of auditing and collaborative funder action to reduce the audit compliance burden be looked at.

⁶⁵The revised Health and Disability Services Standards 2008 are made up of four sets of Standards- NZS 8134.0:2008 Health and Disability Services (General) Standard; NZS 8134.1:2008 Health and Disability Services (Core) Standards; NZS 8134.2:2008 Health and Disability Services (Restraint Minimisation and Safe Practice) Standards; NZS 8134.3:2008 Health and Disability Services (Infection Prevention and Control) Standards

The Auditor General published a performance audit report “Effectiveness of arrangements to check the standard of services provided by rest homes” in 2009.⁶⁶ This report suggested that improvements to the current arrangements for auditing, certification, and monitoring of rest homes should be considered.

Age Concern in a briefing to incoming Ministers and Members of Parliament in 2011 asked that the Government, “make the Home and Community Support Sector Standards mandatory; require home support staff to complete nationally recognised training; commission a review of staffing ratio policies and of the application of the standards relating to staffing levels; incorporate the Indicators for Safe Aged-care and Dementia-care for Consumers (SNZHB 8163:2005) into mandatory requirements of aged residential care provision and; continue to progress the implementation of a robust audit regime.”⁶⁷

Linked to regulation and contractual obligation is monitoring. The findings referred to above suggest that while standards might be set in the residential sector, monitoring of those standards has a way to go. This is also true of standard setting for the workforce. A number of participants and submissions argued for greater transparency in quality assurance activities.

Regulation of the workforce

During the course of the Inquiry, views on whether the aged care support workforce should be regulated or not, or to what extent, were mixed. The argument against regulation was based on difficulties in implementation and the need to focus on more pressing issues. On the other side were positions ranging from full regulation to simply increasing quality assurance structures. The role of carers in sustaining the regulated workforce and the implications of this was discussed by a number of participants.

Professor Matthew Parsons, Chair of Gerontology at the University of Auckland said that, “while increasing professionalisation ultimately ends up with a regulated workforce, it’s important to sort out things like travel and training and the nature of the work first. There are more important fish to fry.”

Graeme Titcombe, Chief Executive of Access Homehealth, thought that with the level of turnover, regulating the workforce was impractical. Another difficulty he anticipated was scope of practice. “In this environment you are reacting to the client’s needs in their homes, which is completely different to reacting within a residential or hospital setting.” He said, “if you are saying that unless it is included in the scope of practice you can’t do it that would be a problem.”

Participants at public meetings and union organised meetings expressed concern at the level of work now being demanded of support workers and felt that regulation would assist in defining what they were safe to do, that is defining a scope of practice for their work.

⁶⁶Auditor General. (2009). *Effectiveness of arrangements to check the standard of services provided by rest homes: Performance audit report*. Wellington: Office of the Auditor General.

⁶⁷Age Concern New Zealand. (2011). *Briefing to Ministers and MPs on what matters to older people*. Wellington: Age Concern New Zealand Incorporated.

Definitions of tasks and processes that health professionals are considered competent and safe to perform are known within the industry as scopes of practice. Health professionals are required to act within their scope of practice and are not permitted to practice outside. Professional bodies, such as the Nursing Council are required by legislation to define scopes of practice. This can be done, according to New Zealand legislation, by reference to names or forms of words commonly understood by people in the sector, reference to an area of science or learning, tasks commonly performed or reference to illnesses or conditions to be diagnosed.⁶⁸

NZHHA advised the Commission that the current review of the Home and Community Support Sector Standard refers to a 'scope of practice' for carers. However, there is no definition of what that scope is.

Currently, as the manager of a residential facility said, "health care assistants don't have a scope of practice. The people that have a scope of practice are the enrolled and registered nurses. Health care assistants through no fault of their own are an unregistered, unlicensed workforce. And they're a huge workforce so I think we need to work towards getting them some recognition as a body. So there's protection for them and those who are vulnerable that they work with. We need legislation that says health care assistants do this and do that. We undervalue aged care when we undervalue health care assistants."

At a public meeting hosted by Grey Power a participant said, "carers are now doing enrolled nurse work: doing blood sugars, blood pressures, and giving out medication. Carers are now caring for people with motor neuron disease, Alzheimers, providing palliative care. They are the cheaper option. It's quite scary." Union members at a combined union meeting said, "we need a scope of practice round what caregivers can do. They are not protected. The workforce should be regulated."

This raises the question of how support workers are supervised to deliver these services. The issue of supervision of home support workers who deliver services by and large on their own in the community, is particularly of concern. But the adequacy of supervision of residential care support workers was also raised with the Commission. An RN working in an aged residential care facility wrote, "they (carers) are working on an RN's practicing certificate yet the RN cannot supervise them constantly to ensure delegated tasks are carried out correctly as asked...I have found they do not always understand the reasoning or importance of a task, thus they skip corners as they are very busy and think it won't matter but I believe it does so the patient can receive the best care."

In a comprehensive submission, the Aotearoa New Zealand Association of Social Workers (ANZASW) urged the Inquiry "to set realistic standards in relation to the aged care support workforce including:

- Setting minimum qualifications required for the aged care workforce who provide services such as residential care staff, home help, personal care, carer support and socialisation services, and a clear career pathway.

⁶⁸Health Practitioners Competence Assurance Act (2003) s 11

- Establishing a realistic wage for the workforce to facilitate the development of a long term and sustainable workforce who will be able to provide quality care.
- The development of a set of service delivery frameworks including Codes of Ethics, Practice Standards and assessment of minimum competencies on a regular basis. For greater independence this could be by way of the establishment of a professional membership body or could be established by the industry.”

Without this, ANZASW submitted, the workforce does not have supporting quality assurance structures apart from the Health and Disability Code and employment contract requirements.

NZHHA submitted that, as support workers take on increasingly complex care and support tasks/activity in the home, there was a need to introduce levels of regulation of the workforce. “Regulation of the workforce would compel the government to recognise the value it plays within the sector and make real investment in sustainability.”

While NZHHA were explicit in not supporting full registration they recommended that the following forms of regulation were needed:

- Safe ratio of supervision by a registered professional for non regulated staff
- Guidelines on activities that can be undertaken safely in the home, with proper training
- Required minimum level of training within a period of working (say first six months)
- Additional training required for workers providing care for clients with high and complex needs (as assessed by InterRAI).

A senior manager of a home support service identified the need for more rigorous quality standards in contracts and consequent monitoring of home support workers and said that funders only check the quality of workers every six months and on the phone. “Older people are terrified that their help will be cut so they will tell you they are fine.”

A participant with experience in the health sector at the governance level said that carers were doing a professional job with professional responsibilities that did not have the legal and regulatory framework that protected both them and the people they cared for. “They are terribly exposed” she said.

Regulation of services

Adequacy of audits

Several participants in the Inquiry advocated for a range of accountability mechanisms, arguing strongly that just one, namely audits, was insufficient to assure quality. The funding manager from a DHB said, “mechanisms for assuring quality of care are wider than the ‘snapshot ‘audit. Health visitors (e.g. District Nurses, Allied Health, GPs and Needs Assessors) are all able to give feedback. Staff themselves can raise awareness, (as can) consumers and their families. The introduction of InterRAI Long Term Care assessment tool will also provide information on quality of

care across the age residential care sector. DHB contract managers also do provider visits.”

This view was also put by the chief executive from one of the largest residential providers. Dwayne Crombie, Chief Executive of BUPA said, “auditing is highly overrated as a means of quality improvement. It may detect a few bad apples, but by itself is not that helpful. The current certification process is OK. It moves the bottom 5 percent but doesn’t address the bottom 50 percent. Quality drivers are training and setting quality improvement processes. A lot of hospitals benchmark and use pride as a driver. Eighty percent of people don’t want to be in the bottom twenty percent. You need to take a long term quality improvement approach, the same as mental health or maternity (services).”

A health researcher also expressed misgivings about audits as a quality assurance mechanism, “my experience of people working in care is that they are completely dedicated so, the moment we put this auditing stuff on them, basically they spend their time making sure their auditing stuff is correct. They then don’t get on the floor. We don’t want to make the facilities the victim. So how do we not do that, how do we stop people saying ‘oh those horrible rest homes’?” This was echoed in a submission by an employer who said, “the level of bureaucracy/compliance takes staff off the floor, away from residents. So much time is being spent on paperwork for auditors and the Ministry of Health.”

A general manager implementing Eden Alternative principles in numerous residential facilities described some challenges in promoting facilities as the home of residents. She said, “our auditors have been through the journey with us. We have animals in some of our homes and the infection control police struggle with a lot of it, because we have cats and dogs and chickens and who knows what else. We’ve become so regulated and hooked on compliance that now we’re trying to loosen that up.”

As the Chief Planning and Funding Officer from Auckland DHB put it, “you can only ever audit against the contract.” Auditing occurs in the context of contractual agreements and quality standards. Another health researcher said, “the problem with our standards are they are very generic because they apply to all health care facilities. They don’t include standards for the basics of care. For example they don’t describe the standard for oral care. Because of that, facilities are basically required to write their own standards using evidence. The problem the facilities have, and in particular the RNs, is accessing good evidence. You don’t know how to do it and you don’t know how to read it. There is a great variety in beliefs and practices which make it really difficult for the staff on the floor to know whether they are doing good or bad.”

Another Chief Executive, Simon Challies of Ryman Healthcare said that, in his view, “getting sanctioned or getting a bad reputation which leads to low occupancy, makes a difference.”

A number of participants and submitters said that unannounced (spot) audits of residential facilities were required, a view that indicates either a lack of awareness that these audits happen or a lack of confidence in this process.

For example, at an NZNO meeting, members talked about the need for spot audits but disagreed about who might do this. One person suggested an independent company. Another said, “you need someone who is kosher in the community and linked to government.” Another participant told the Commission that unannounced audits were undertaken within a known three month period, so annual leave for instance, would be cancelled during this period. At another union meeting, the Commission heard that, “there needs to be spot audits by an independent agency.” The National Council of Women (NCWNZ) recommended that, “registration of residential aged care homes and facilities should be compulsory with regular oversight of their services including staff.”

The issue of who should conduct the audit was a recurring theme. A registered nurse from a residential facility said, “it needs to be done by someone who has the power to make change or even close a facility. They need to know what to look for and can spot covert practices.” A funding manager said, “certification audits are three yearly and surveillance audits are unannounced. Audit agencies are selected by the provider. They should be independent.” Staff from a nursing agency suggested a Commissioner to undertake random visits.

The idea of a Care Commissioner was raised elsewhere and is a recommendation of the Labour/Greens/Grey Power report⁶⁹. A manager with many years experience in the industry said there needed to be formalised training and upskilling and annual competency checks. She said that the caring industry needed to be regulated. There also needed to be a Care Commission or like body/person who could advocate for older people and with the power to conduct audits of the quality of care including unannounced audits. “We’ve got to change things where there is a ‘shut your mouth or leave’ philosophy.”

NZHHA submitted that the home support sector needed better auditing and pointed to the residential sector as an example of what needed to happen. “Quality assurance processes from the DHB are very variable as reported in the Auditor General’s report. There should be more consistent regulation through quality assurance auditing, as happens in the residential aged care sector.”

The Ministry of Health informed the Commission that it is “currently undertaking a project which will result in the following improvements in home-based support services:

- a) Mandatory application of a revised quality standard for home-based support services (NZS 8158:2012)
- b) A national cross-agency audit framework, with publication of audit results
- c) A national framework for complaints and consumer satisfaction measures.

This work is consistent with recommendations of the Office of the Auditor General, as communicated in their report: *Home-based Support Services for Older People* (July 2011).”

Follow up audits are important when problems are identified. Professor Parsons suggested, “if a provider fails an audit, they should be audited again within six

⁶⁹Supra at note 34.

months and if they fail that, go to monthly audit. The provider would then be paying for the audit but would not have a choice about who was auditing them, this would be directed by the DHB. The model is similar to putting in a statutory manager.”

Whether unannounced or expected, auditing against industry standards is an important mechanism by which standards are embedded in practice. Where standards are not mandatory, membership organisations such as NZHHA require compliance with the Home and Community Support Standard as a condition of membership. Similarly residential facilities that are registered with the Eden Alternative are required to progressively realise and be assessed against the ten Eden principles before they can claim to be ‘edenised’. A senior manager from the home support sector told the Commission that funders should be required to specify quality standards in contracts, that is, minimum quality standards.

Complaints’ procedures and transparency

Audits are just one of a suite of quality assurance methods. Complaints procedures are another. Mechanisms include complaints to the Health and Disability Commissioner, to the Ministry of Health or to the DHBs. The chief executive of one of the major providers said, “staff can complain anonymously to the DHB or the Ministry of Health.” A submission from Grey Power Horowhenua expressed concern for the safety of complainants. “Whistleblower protection needs addressing in this industry.”

Transparency is another critical accountability mechanism. Comments focussed on lack of transparency in the funding process and on consumer friendly audit reporting.

The funding manager at Auckland DHB said, “over the last three years Auckland DHB have changed the way home support services are funded and delivered. We were without any doubt that there was enough money; it just wasn’t getting to the right place. One of the drivers was to ensure that service users and those employed in the sector received a better chunk of the funding.” The DHB were also motivated by lack of transparency and collaboration in the funding–delivery process. “Costs were going up and we didn’t know why.”

A researcher in the aged care sector said she would like to see greater transparency in the annual reports of DHBs relating to the funding received for aged care services by providers. Contract details should be specified and described given that it is public funding.

Lack of transparency about funding impinges on the debate about how decent wages in the sector could be implemented. The submission from Access Homehealth stated, “many of the inquiries around support worker wages have been derailed by ‘selective information’ by funding agencies.” Funders often reply to “requests for information around increase in rates by providing information on the total ‘spend’ on support services. In an environment when the policy is to keep people in their homes the total ‘spend’ is increasing but that has absolutely no effect on the hourly rate paid and therefore on the ability of providers to pay higher wages – it merely means the number of workers that are being underpaid is increasing.”

The profits posted by some of the larger residential providers have been cited as evidence that providers could pay staff more without additional funding from DHBs. The counter argument given to the Commission is that almost all these profits come from the property side of the businesses. This issue is traversed in the wages and pay parity section. Greater transparency about where public funding is spent would be extremely helpful in resolving this issue, in encouraging the debate and breaking the impasse surrounding responsibility for delivering decent wages. The need for transparency is more pronounced, when the public voice of disadvantaged employees is neither heard nor well organised in a sector dominated by lobbying from peak bodies.

The Ministry of Health provided information on the funding model in Appendix 4. The Ministry said, “aged care services are generally funded from Vote Health under the population-based funding formula, which is used to bulk fund DHBs. Resource allocation and service delivery decisions are then made at a local level by individual DHBs. This is a relatively common funding model. This means that difficult trade-offs regarding resource allocation can be informed by local circumstances, rather than centrally. It also reduces transaction costs. In the Ministry’s view, there is nothing inherent in this funding approach that necessarily introduces unfair pay discrimination.”

Another accountability mechanism, consumer choice, relies on readily accessible, user friendly and reliable information. Consumer magazine has published two articles in recent years on aged care facilities and said, “much greater transparency is needed. The lack of adequate information makes it harder for consumers facing the task of finding a rest home either for themselves or a family member who needs long term care.”⁷⁰ Consumer says that quality indicators available to the public should include staffing ratios and negative health indicators such as the presence of pressure sores, infections, weight loss, depression, and decreased mobility.

“Limited access to audit and inspection reports means it is still extremely difficult for consumers to find out about problems at rest homes and whether they've been adequately dealt with. In June 2009, the Ministry of Health began publishing summaries of the reports. However, these summaries frequently fail to record whether the home has been the subject of a complaint investigation,” it said. One carer said she appreciated that the audit was put on the notice board at the facility where she worked.

Consumer magazine reports that “Ombudsman David McGee has criticised the information provided in the ministry’s summary reports as incomplete because they don’t specify in any detail what standards haven’t been met and what steps are required to resolve problems. ‘They do not contain the detail which would enable consumers to be more confident that they are making a decision about the suitability of a particular facility for themselves or a family member with as much information as possible,’ he says. Consumers must have access to comprehensive and transparent information about quality of care, including information about complaints.”⁷¹ Carers

⁷⁰Wilson, J. (2009) Failing to Care, *Consumer*, p31-33.

⁷¹ Wilson, J. (2011). Resting easy, *Consumer*, p.29

were appreciative of the reports published in Consumer and welcomed greater transparency, “we don’t get told about it otherwise.”

Researcher Noeline Whitehead, who has extensive experience working in the sector, recommends that New Zealand adopt the five star quality rating system developed by the Centres for Medicare and Medicaid Services, which is being rolled out this year in the United States.

This system was developed to help consumers, their families, and caregivers compare residential facilities. People are able to go to the Nursing Home Compare Web site⁷² and view the rating for any nursing home. Each facility is rated between one and five stars, with five stars considered to be well above average quality and one star well below. The rating is determined on three variables: health inspections (aggregated over a period of three years); staffing ratios (including the staff mix adjusted for acuity of need); and quality measures (physical and clinical measures related to the health of the residents of the home). For each facility the star rating on the Nursing Home Compare site is supplemented by separate indicators for each of the three variables.⁷³ This system was also supported in the Labour/Greens/Grey Power report on aged care.⁷⁴

The Ministry of Health said, “Audit summary reports of certification audits have been published on the Ministry’s website since July 2009. In order to achieve this, the Ministry worked closely with consumer representative groups (Age Concern and Grey Power), providers and designated auditing agencies to agree a suitable format and process. Along with the summary reports, additional information is available on the Ministry website to increase consumer awareness of the audit process and availability of audit report summaries. A “traffic light” approach is used in the UK and this was adopted in New Zealand.”

In October 2009, a survey was undertaken by Age Concern and Grey Power about the effectiveness of the publications. Recommendations for improvements were accepted and the format further revised in 2010. In 2011, a traffic light system was also introduced for the mid-point unannounced audit visit website summary.

Integration and co-ordination of services

The Commission heard from a number of participants and submitters about the need for better integration of services, including the need for better information flows.

The manager of Te Whiringa Ora, which is piloting a navigator programme in the delivery of home support services in Eastern Bay of Plenty said, “one of the major barriers to overcome has been communication between various services and professionals. Shared client records have been one of the breakthroughs.”

The need for better information flows were also identified by the National Council of Women (NCWNZ) in its submission, “our members commented that, at times, communication between the caregiver and their supervisor is unreliable with a resulting lack of co-ordination in services. Concern was expressed over lack of

⁷²www.medicare.gov/nhcompare/

⁷³<http://www.cms.gov/CertificationandCompliance/Downloads/consumerppt.pdf>

⁷⁴Supra at note 34.

continuity/co-ordination when several care workers, perhaps from different agencies, are dealing with a single client, each care worker providing a separate service/carrying out separate tasks. We suggest a monitoring system with each care provider recording notes on her visit for the next care worker to read.” NCWNZ suggested that observation skills and record-keeping be included in care worker training.

Access Homehealth said, “one of the key concepts for services for Older People will be the integration of services and supports into a continuum of care. International research and trends suggest that the effective treatment of older people with chronic conditions is best provided through integrated health care and community support. Co-ordinated care is achieved through defined clinical and client care pathways and the focus is on facilitating older people to remain in their usual residence with ongoing support as required.”

In her Aged Care discussion paper in 2007 the Minister for Senior Citizens, Hon Jo Goodhew (then National’s Associate Health Spokeswoman) said that the quality of care and the choices available to older people could be improved. In particular, there was a failure for many older people and their families in the co-ordination of care.⁷⁵

Another issue raised was access to community health services by residential care providers. A geriatrician said, “those in residential care are disenfranchised from the health sector. The contract specifies that residential providers will provide everything including expert care. This places a high burden on providers to provide all services. For example, community occupational therapists and physiotherapists are not allowed to go into rest homes, neither are primary care services and most of allied health.

The sickest, frailest most co-morbid people are concentrated into rest homes, with limited access to community services and primary health care. Twenty percent of medical admissions to the hospital come from that sector. There needs to be a review of national contracts that addresses the inequitable access to community services. There should be multidisciplinary teams available to those in community and residential facilities.”

This was echoed by the manager of a residential facility, “aged care facilities have reduced access to services provided by the DHB such as ENABLE (a disability equipment and information service) equipment, incontinence products, and access to expertise such as dieticians and occupational therapists. These services are all supposed to be built into the contract value of the contract (and therefore are required to be supplied by the facility).”

The College of General Practitioners (GPs) said, “there are significant issues of continuity of care when people move into residential aged care facilities. GPs don’t get to see their patients anymore as the DHB contract with residential facilities includes medical support. There is a need for more integrated care. Residential facilities should contract with doctors directly.”

⁷⁵Supra at note 8

Hon Jo Goodhew, in her 2007 report said, “aged care provision needs to allow for this increasing diversity of living arrangements. For example, Aged Residential Care (ARC) providers are not allowed to contract to provide publicly funded home-based services to people who live in retirement villages. Nor are rest-homes permitted to deliver publicly funded home-based care to people outside their facility.”

The practice of not allowing aged care village operators to be contracted by DHBs to provide home support services was seen as inefficient and leading to poorer outcomes. Metlifecare is contracted by Bay of Plenty DHB to provide home support services to residents in its villages in Tauranga. Instead of a support worker providing one hour’s support a day, “we can have a support worker walking to residents’ own homes within our village four times a day for fifteen minutes at a time. It is much better for residents as they have more touch points in a day. In our villages where we are not the provider of home support services we have quality issues such as continuous turnover of support workers, the lack of regularity with which they come, (i.e. no-one comes if the support worker is sick) and the fact that their hours are restricted. In this model we are able to support people in their own homes for significantly longer than those supported in their own homes out in the community.”

Another participant pointed out although the DHB is responsible for the health of the community, this has not permeated to primary health. “A lot of GPs are still on the private practice model, income-generation model. Community health is not as embedded in that sector as it should be.”

The need for long term integrated planning was identified as critically important by Age Concern’s Liz Baxendine, speaking personally, “I’d like to see a summit to discuss aged care. The three year government cycle inhibits long term planning. There’s not nearly enough cross talk. I agree that we need a champion of older people at cabinet ministerial level.”

Better co-ordination was advocated at a public meeting hosted by Grey Power where the Commission was told about a lack of co-ordination between funders for example ACC and the DHBs. The funding manager from a DHB said there needed to be better co-ordination between DHBs and residential facilities. “People from rest homes are coming into EDs (emergency departments) in a state that indicates rest home staff aren’t managing. EDs are an avenue to hospital care. At discharge they are not well supported. There are not good notes and information flowing between facilities.”

NCWENZ said, “at times communication between the caregiver and the supervisor is unreliable with a lack of co-ordination of services. Concern was expressed over lack of continuity/co-ordination when several care workers, perhaps from different agencies, are dealing with a single client, each care worker providing a separate service/carrying out separate tasks.”

Conclusion

The funding model and its impact on equal employment opportunities

While the funding model is clearly driving the employment model in the aged care sector, it cannot be used to absolve those responsible for ensuring that human rights and equal employment opportunities are protected.

A remarkable feature of the Inquiry was the sense of “delegated responsibility”, almost a “not me” and “buck-passing” mindset, around issues such as pay inequality and fair travel costs in the aged care sector where it is not public hospital-based.

Ministry of Health officials talked of the Ministry’s “arms length” or “twice removed” relationship with employment issues because the DHBs are the contracting party with private or not for profit providers for home and community service support and for residential care services for older people, and not the Ministry itself. The providers then enter into employment relationships with their employees either through collective agreements with unions or through individual employment contracts. However, the “not me” cultural norm that the Commission observed is at odds with the intention of the New Zealand Public Health and Disability Act 2000 which has as one of its purposes s3 (1) (a) (iii) the “best care or support” for those in need of personal health services, public health services, and disability support services.

The current funding and financing path has a built in systemic pay inequality that is discriminatory and breaches domestic law and international human rights obligations. Carers, working within DHBs, are paid at approximately 16 percent more than those undertaking similar work in residential aged care facilities and in home-based community support.

However, because the Ministry or the DHBs are one-step or two steps removed from actual employment relationship, pay inequity is systemic and entrenched. This contravenes the spirit of section 22 relating to DHB objectives of the New Zealand Public Health and Disability Act 2000 which states that every DHB should:

- be a good employer in accordance with s118 of the Crown Entities Act 2004
- uphold the ethical and quality standards commonly expected of providers of services and of public sector organisations
- exhibit a sense of social responsibility by having regard to the interests of the people to whom it provides, or for whom it arranges the provision of services.

The State cannot “contract out” of equal pay, pay equity and equal employment opportunities through privatisation of service delivery. *The Guiding Principles on Business and Human Rights*⁷⁶ which were adopted by the United Nations General Assembly last year state: “States should exercise adequate oversight in order to meet their international human rights obligations when they contract with, or legislate for, business enterprises to provide services that may impact upon the enjoyment of human rights.”⁷⁷

⁷⁶Supra at note 63

⁷⁷Supra at note 63, at par 5.

States do not relinquish their international human rights law obligations when they privatize the delivery of services that may impact on the enjoyment of human rights. Failure by States to ensure that business enterprises performing such services operate in a manner consistent with the State's human rights obligations may entail both reputational and legal consequences for the State itself. As a necessary step, the relevant service contracts or enabling legislation should clarify the State's expectations that these enterprises respect human rights. States should ensure that they can effectively oversee the enterprises' activities, including through the provision of adequate independent monitoring and accountability mechanisms."⁷⁸

Regulating the unregulated workforce

The practice of formalising induction and orientation programmes so that a nationally recognised, portable qualification is gained in the first few months of working as a carer is essential and is supported by the workforce. This, coupled with the trend in District Health Boards towards requiring all carers to have at least Level 2 or undertake minimum qualifications moves the "un-regulated" workforce closer to regulation. The Commission's view is that all carers should have completed Level 2 qualifications within the first six months of working and the industry should commit to ensuring the total workforce (new plus existing staff) are at the minimum Level 2 by 2014.

Assuring that carers in the sector are competent and capable of delivering safe, quality care for older people will inevitably lead to caregiving becoming professionalised. This will also improve their leverage in employment negotiations and legitimise their representation. Current staffing ratios and the service models mean that carers must frequently act independently and autonomously. It is unreasonable to hold registered nurses accountable professionally for the actions of the unregulated workforce which they may only be nominally supervising.

Transparency

Other quality assurance methods need considerable development. The work on quality assurance mechanisms in the home care sector currently underway within the Ministry of Health needs to be progressed as a matter of urgency. In the residential sector voluntary standards should become compulsory. Transparency is a critical element of ensuring quality. Care recipients and their families need to have access to reliable and easily understood comparisons on the quality of residential facilities. The current audit information available on the Ministry of Health's website lacks sufficient specificity for consumers to understand if a facility does not meet the required standards.

Transparency of the funding chain from the Ministry of Health, through to District Health Boards and on to providers is needed to tighten accountabilities and to inhibit the "not me" culture observed during this Inquiry. Greater transparency in the funding chain is also important in order to make progress on issues such as carers' pay.

⁷⁸ibid at par 5.

Integration and co-ordination of care

Reform is required to ensure that ageing-in-place approaches and practices actually improve the quality of care and provide real choice for older people and their families. New models of restorative care call for better integration of services and coordination between health and care professionals. But many current policies and practices act as barriers to these aims. These include the way in which older people in residential care are blocked from access to publicly funded expert care. If the continuum of care promised in the Health of Older People Strategy is to become a reality, omissions, inefficiencies, duplications and silo effects need to be eliminated.

Part 4

Diary of a carer

by Dr Judy McGregor, EEO Commissioner

If you haven't done it, you don't get it

You can't imagine it, you cannot understand it, and you don't get it, if you haven't done it. Two organisations recently challenged decision-makers and influencers to personally experience working as a carer for a shift, or a day, or a week in a bid to gain support for decent pay for carers. The New Zealand Home Health Association in its submission to the Human Rights Commission's Inquiry recommended the following as a way of improving the low pay in the aged care sector. *Encouraging funders, health ministers and health planners to each do a week of home support.* In the 2011 debate between the New Zealand Nurses Organisation (NZNO) and the New Zealand Aged Care Association (NZACA) about what was the real crisis in residential age care - quality or quantity - the NZACA chief executive officer was challenged to go and work in residential aged care. He said he would.

ILO expert Guy Standing notes the neglect of care work by mainstream policy makers, economists, statisticians and the social sciences generally was a shameful failure for most of the twentieth century. This shameful failure continues into the twenty first century, but with added complexity, intensity and pressure.

Investors, employers, CEOs, politicians, policy analysts, Treasury experts and those who speak for them, routinely use the serious fiscal impact of pay parity for residential and home based carers with District Health Board-employed carers as their longstanding defence against the payment of decent wages for private residential age caring. They do so from a basis of profound ignorance of actual "doing". As professionals they have probably never received an hourly rate as low as \$14.62 after 12 years working in the same facility, in their entire lives even as long ago as their student days in short-term hospitality or retail. They have probably never stood for a six to eight hour shift, bending, hoisting, lifting, toileting, sponging, dressing, or feeding frail old people. The closest they may have come to age care is arranging for elderly parents, grandparents or relatives to move into a rest home or hospital care environment and visiting. But they haven't actually done it. They don't know it. But they sit in judgment of its value.

Undercover as a trainee carer

In January 2012 I worked in a residential aged care hospital facility over several days doing a variety of six hour shifts with a half an hour's break. The facility's clients were predominately frail and very frail elderly, many of them stroke victims in their eighties and nineties who were unable to talk, men and women, all of them individuals. They were the "old, old" of our aged care system.

I was on unpaid buddy duty and was attached to an experienced health care assistant on each six hour shift. Basically I watched and learnt, helping with hoisting, feeding, showering, toileting, pushing to the dining room, laying out clothing for the day's wear and undertaking tasks that posed no safety risks or quality of care issues to client patients or staff. I wore a buddy's uniform smock over black trousers and black flat shoes. No one knew who I was. I worked outside of Wellington so no one would recognise me. I will not identify the facility. My presence was not exploitative, intrusive or voyeuristic. I was there to learn and help, to answer the challenge of "doing" by "doing." As part of the normal buddying protocol of the facility, each patient/client was asked if they were comfortable with my active presence in their room and in their daily routines. Those who were capable of consent gave it freely and willingly.

Some shocking stories are told about the quality of elder care. Bad news media events- the use of tie-down restraints, rationing of incontinence pads, hoist falls, shortages of equipment, working "short" so morning showers became afternoon showers, and quite horrible commode stories. I saw none of that in the facility in which I worked. There were no equipment shortages, the food was varied (fresh fruit and fresh vegetables and salads, variety etc). There was one wry *Oliver Twist* moment when a patient/client asked for more ice cream before all the residents had been served. Overwhelmingly, there was a culture of positive caring from the registered nurses through to the carers. The most difficult, the most perverse, the seemingly ungrateful and the utterly unresponsive, were treated with kindness, with respect. That is not to say that quality of elder care issues don't exist in New Zealand. But my feeling is that the random is not the norm. There is, however, a straight-line nexus between the quality of patient care and healthcare staff levels and staff mix. No one should deny that.

What do carers do?

Now I have undertaken hour after hour of caring shift work, I can reel off the routines. On a daily basis they are the same, as unrelenting as night and day. There may be cycles and patterns of personal health and mobility improvements and setbacks, there may be critical clinical incidents, there may even be death. But the routines are inevitable and unchanging. Arriving early, ten to fifteen minutes before the shift starts for handover (unpaid time for carers). Handover means sitting and listening to the registered nurse who is signing off duty, running through the patient/clients individually and reporting progress, medication change, patient stability, to the incoming rostered registered nurse. "Please can we watch X's skin and use the cortisone cream, Y is peg feeding so ensure he sits up, Mrs M has surprised us all and appears to be maintaining weight, please watch her nutritional intake etc."

The caregiver staff are largely silent during this handover. The muteness reflects the hierarchy of caring.

In my first shift my buddy instructor was an experienced, thoughtful Māori grandmother in her fifties who taught me the strictly adhered-to hygiene routine, the sluicing room protocols, the collection bins (one for resident's dirty washing, one for towels and linen, one for faeces and urine type messes, and one for incontinence pads.) Rubber gloves went into the rubbish tin in the sluicing room. She was meticulous. I was meticulous. Next was a guided circuit of six patients' rooms with

basins, flannels, towels, incontinence pads to streamline the waking, dressing, showering and toileting regimes. Get the routine right and you didn't have to waste time retracing your steps to the storeroom. Time management skills.

Hoists triumph in a carer's working life. Patients are lifted by hoist from bed onto wheelchairs, into ensuite toilet rooms, onto toilets, off toilets, into wheelchairs for pushing to the showers, and into wheelchairs for the push to the dining room, the physio or the TV lounge. They are hoisted in a reverse cycle back into bed at the end of the day. The fear of dropping or hurting a frail, patient/client is a constant stress. It is a very physical job, even with hoisting technology. Sliding a patient higher up in bed, turning someone over, all take strength. A second buddy instructor showed me her bruising on her leg where she inadvertently caught herself on a wheelchair. Manoeuvring hoists and wheelchairs in small confined spaces is a dodgem technique.

But these are just some of the physical tasks. Mostly caring is about the fabled "human capital" and social relationships. It is about trust, affection, mutual respect and dignity, obligation, guilt, and reciprocity to name a few of the moral sentiments that are in play. Age care may be defined as the work of looking after the physical, emotional and restorative needs of older people.

Having now done it, the following equation is realistic⁷⁹.

Care work = Time (Actual and "stand by", both paid and unpaid) + Effort + Technique + Physical stamina + Social Skills + Emotional inputs such as empathy, compassion, encouragement + Stress (pressure from family members, fear of failing employers, the regulatory environment.)

In my working life I have worked as a book store attendant, a waitress, a petrol pump attendant, a forestry worker, a journalist and newspaper editor, a publishing manager, an academic and currently as a human rights commissioner. Care work has more dimensions than many of my previous jobs. Here are some of my observations working as a carer.

Feeding Ethel

The day after I finished my shifts I woke up in the motel room and Ethel was instantly in my mind. Who was feeding her breakfast this morning? Patiently spooning in her porridge, judging when to encourage the next mouthful, urging her to swallow and not just shunt the food into the sidings of her cheeks. Between mouthfuls Ethel would drift off into a private, inwards, abstracted solitude. Tolstoy once described a female character; "She ate, drank, slept, sat up, but she did not live. Life left no impression upon her." I would bring Ethel back from her private land by approaching her mouth with the next spoonful, conscious of the time it was taking to get through the porridge before the strawberry yoghurt and that five clients still had to have breakfast. Ethel would look at me and once gave me a little girl smile. Complete trust. She is old, very old, ancient, in fact. She does not talk. Her frailty is evident in the yellow and purple bruising on her arms, her sensitive red rash bottom, and her papery skin.

⁷⁹ Adapted from Guy Standing's equation in *Care work: overcoming insecurity and neglect*. In Mary Daly (Ed) (2001) *Care Work: the quest for security*. International Labour Office, Geneva, p.18.

I fed Ethel over several days. She made me realise why carers never go on strike or seldom take direct industrial action. Goodness knows, they have grounds. It has little to do with union representation, collective agreements or individual employment contracts, employers' power or even their own personal circumstance or employment options. They wouldn't do it to Ethel.

Supporting Brian

When older people go into residential age care, their space and the way in which they live folds into a box. In the ward where I worked the patient/client's rooms were now their whole life experience, apart from memories. Older frail hospital patients are frozen by both their immobility or loss of sensibilities and cognisance or both to the smallest of neighbourhoods-their room and en suite toilet, the proximate corridors and the dining room. In some cases it narrows down to just the bed.

The lucky ones have loving partners, spouses, friends and families who call often daily, some with the family pet. Occasionally the elderly frail person has a big day out. Almost every room had special photographs. The pictorial poignancy of previous robustness, of brightness, of activity and of humour. The patient before this happened looking alive, looking connected, a social actor, a citizen of the world. The span of lifetimes covering babies, children, family portraits, weddings, graduations, birthdays, anniversaries, special moments on holiday, favourite cats. American writer Susan Sontag says all photographs testify to time's relentless melt. There is a special sadness, though, when the photographs speak to visitors in a way that their subjects cannot.

One family had assembled a wall of photo montage with brief captions for an elderly male stroke victim. He'd been a scientist, a father, a grandfather, he'd owned a house, he'd come from a farm, he'd tramped, climbed and enjoyed the outdoors. He had friends and work colleagues. He has a loving wife who arrived to take him out to the movies in a special mobility taxi. What would he see and understand of the movie? How would we know? Trapped now within a cocoon of silence by his stroke five years ago, the occasional grunted "no" being his only speech, he lives by this family love and the continuous and continuing nurturing of his carers- three rotating shifts of supporters waking, washing, toileting, dressing, hoisting, toileting as he has no bowel autonomy, and putting to bed. Next day, ditto. For all the rest of his days, ditto.

Is there a right to care? Of course everybody has a human right to be cared for. Care is part of the human condition, part of our basic need, a demographic imperative and a fundamental human right. What mark would Brian give his own quality of life if he was able to? And what would that mark be, without the extraordinary commitment and compassion of his carers who nurture, chatter, engage and cajole him "try and sit forward for me, Brian, as we put on your shirt", and simply love their patient/clients regardless of who they have been, or what they have become?

Occasional reflections on my caring experience

Feet

Day One. My feet. The dull pain I associate with the last hour of a tramping expedition. They were two Panadol feet or they would have been if I'd had time to go

to the staff room and find water. Six hours straight on concrete floors. The uniform requirement demanded navy blue shoes. I searched Wellington for tasteful, navy blue lace ups. Kirk's almost satisfied but they didn't have my size. All the rest were nasty. Navy blue is not a hot colour this summer. I settled for Banks half price sale and a pair of black Lacoste suede and leather trainers, nuggeting out the Lacoste crocodile logo so it wasn't visible. Despite walking them in the weekend prior, they were hell. The next day and every other day I put on my old New Balance trainers with ripple soles and comfortable stretch black pants. No style, no pain... vanity kicked for touch.

Television

In child parenting, the use of pacifiers in baby's mouth is done with the knowledge that baby will grow up and begin to talk, thereby vocalising hunger, discontent, pain and demand. The pervasive use of wide screen television in lounges and small box sets in rooms is an electronic, old-age pacifier, a substitution for human contact and conversation, a semblance of activity when nothing is happening at all. Day time reality cooking and contests, the Antique Road Show, quizzes all competing for vacant passivity up and down the ward corridors.

Incontinence pads

Take 40,000 aged care residents in New Zealand and multiply by 365 days a year by three incontinence pads each a day = 43,800,000 incontinence pads in NZ 100% Pure's land fill depots annually. Surely technological innovation, ingenuity must begin here? Sam Morgan, where are you?

Weight

We are all citizens of age. The heavier we are, the harder it is to be cared for. Will I be a one-carer, a two-carer or a three-carer lift when I need it? There is an essential indignity and inhumanity in being hoisted, functional and necessary though it may be and no matter how carefully it is done.

Mozart

One of my buddy instructors defied stereotypes. She had worked at the same facility for 12 years. She was 52 years old and she cared for her elderly father at home when she was off duty from caring at work. She had all of her ACE qualifications and had trained in dementia. She felt her pay, \$14.62 an hour, was "disgusting." She had tried to rejuvenate the union in the facility but felt pressured by management not to organise members. While we were in a room with the television blaring out the forced tension of answers in a celebrity quiz she said if she won anything like a lottery or a money prize "this place wouldn't see me for dust." She turned to the patient/client. "But I'd miss you darling, very, very much." She was a classical music buff with Mozart her favourite.

The staffroom hierarchy

I was a trainee under buddy duty. No pay. Lowest status of the lot. General staff room indifference. The same power relations as every workplace. Perhaps carers have exhausted their stocks of compassion before their half hour breaks, rigorously enforced?

Time for change

Lived experience can give anger a new intensity. From my privileged and elite position as EEO Commissioner sitting in The Terrace offices of the New Zealand Human Rights Commission, I have objectively felt throughout this inquiry that it is grossly unfair that the state pays district health boards who pay their carer employees several dollars per hour more than people doing the exact same job down the road in private facilities which the DHBs, and therefore the state, also funds. It offends against human decency. The arguments used to defend the pay disparity are morally defective. Now my anger is subjective as well. The reliance of New Zealand, of all of us, on the emotional umbilical cord between women working as carers and the older people they care for at \$13-14 an hour is a form of modern day slavery. It exploits the goodwill of women, it is a knowing exploitation. We can claim neither ignorance nor amnesia.

Ageing is not just some bad habit, and nor is it an unpredictable risk. Caring used to be called the “gift relationship”. Not any more. Increasingly commentators note the right to care is advancing as is the right to receive care. But perhaps the right not to be obliged to provide care is also relevant, particularly to women, as caring is women’s work, 90 percent of the time. If that is the case, we have to pay for it. Aged care needs to move from the margins and shadows into sharp relief with a modern public policy focus. There needs to be a national conversation about rights and responsibilities, family responsibilities included. We need to talk quickly and seriously about who pays.

Peak bodies have a significant role in fostering constructive public voice and considered public policy. For too long their spokespeople have played oppositional, warrior politics slinging arrows of self interest about quality, commodification, the bad news media stories, multi-national profiteering, bed shortages, increasing scope of practice etc etc. They have often undermined the very genuine attempts by bodies such as Greypower and Age Concern to bring into play sensible discussion. A key challenge lies in determining the relative roles of the State, the market, the workers, the family and concerned groups. If they can’t talk to each other, division grows. How we provide aged care and how we pay for it are seriously hard questions. They may be among the hardest of our times. Oppositional lobbying and the distraction of old-fashioned confrontational styles, suit politicians of all persuasions. The fighting is letting them off the hook.

New Zealanders recognise gross unfairness at five paces. They will want to work through how we as a civil society in the best sense of the words improve the material and social value of a carer’s work. The imperatives of ageing mean we have no choice.

I urge everyone to work as a carer. To do is to know. To know is to get angry.





Māori in aged care

During visits to aged care facilities the Commission was struck by the absence of Māori as residents. Conversations with providers suggest that residential care residents are predominantly female and Pakeha, although providers have noted increasing diversity in recent years. Data from the OPAL study (2008) based on Auckland figures, show that two percent of rest home residents were Māori, compared to 92.4 percent European and 4.5 percent Pacific Island. Of those in hospital level facilities, 2.6 percent were Māori, 89.1 percent European and 6.4 percent Pacific.⁸⁰

Professor Des Gorman, Chair of Health Workforce NZ attributes this to two trends. One, is Māori life expectancy. The other is cultural practice in which whānau care for kuia and kaumatua at home, with or without home support services. A director of Māori health at a District Health Board (DHB) said, “there are cultural barriers for Māori being cared for in rest homes. Elderly Māori find it hard to be seen unclothed by another person and to be dressed by someone else. It’s quite an adjustment.”

Commission visits included the kaumatua flats attached to Whakatu marae in Nelson. These provided supported housing but are not a residential care facility as such. Māori men were also resident at Whare Aroha in Rotorua, which is a residential facility on the edge of Lake Rotorua run by a community trust.

Whakatu marae in Nelson provides cultural awareness education in rest homes with kaumatua in them. The need for cultural awareness was discussed in Rotorua, when the manager of a residential facility with a high proportion (50-60 percent) of Māori residents said, “it can be hard to reconcile the desire of Māori families for more Māori staff. That’s difficult for us. There are not a lot of skilled Māori staff available, while the facility retains a core of Māori staff. Yet it is important because only Māori staff understand the cultural and spiritual dimensions of the experience of older Māori. For example recently an elderly Māori woman couldn’t sleep. She believed that spirits were coming to get her. One of the Māori staff understood this and could get her back to sleep.” A director of Māori health also noted a difficulty in recruiting Māori. “Māori providers find it difficult to find a Māori workforce. There is a shortage of Māori staff. We need more Māori RNs. The relationship with the person delivering the service is the most critical element.”

Another residential facility manager, herself Māori, said that there is a “marked absence of Māori managers in aged care, even at regional management level.” She also stressed the importance of integrating Māori carers into the sector. In her facility, an Eden Alternative home, she noted that four residents out of a total of 62 were Māori and she felt that the whānau concept inherent in the Eden principles was attractive to Māori. For example, the second Eden principle states, “an elder-centered community commits to creating a human habitat where life revolves around close and continuing contact with plants, animals, and children. It is these

⁸⁰Supra at note 3.

relationships that provide the young and old alike with a pathway to a life worth living.”

Whakatu marae also provide a navigator service – linking people to services and taking them to clinics and treatments, and co-ordinating appointments. This role complements the registered nurse (RN) role and provides for people who need time to talk and someone to take them out. The service is mainly provided to women, “they tend to have a partner or they are supported by family.” Te Whiringa Ora in the Bay of Plenty has a similar co-ordination focus and works with many older clients who have complex, long term health needs and who are high users of hospital services. The contract identifies people who have the most severe needs (the top 5 percent). The average age of the client group is seventy years, with ages ranging from 26 to 92 years. About 40 percent of the clients are Māori.

Using a navigator model, RNs and kaitautoko (who have social work backgrounds) work with clients to co-ordinate and navigate a web of care that enables the client to self manage their own conditions. While the more usual home support role is task-focussed, navigators work with the clients to motivate them to achieve their own goals. The job of the navigator is to “get the client into a head space where they can identify their own barriers.”

Listening is a key element of the navigator model being used at Te Whiringa Ora. With the client’s permission the Commission accompanied an RN to visit an older client on the outskirts of Whakatane. The meeting was characterised by information exchange and autonomous decision-making. From the client’s perspective she told the nurse about her unusually bad back pain. The nurse then outlined some options including speaking to the 80 year old’s GP and practice nurse about medication. From the nurse’s perspective during the meeting she provided information about a community day programme run in town for senior citizens that would help with loneliness and social isolation during the week.

The client set her own goal in relation to her back pain, aiming to be well enough to go on a family expedition to Rotorua, including going fishing with family members. The visit demonstrated the benefits of face-to-face social interaction with an older person using support to age in place, and the empathy and clinical skills required of an RN undertaking this role in the community. The older client made her own decisions from information provided, was able to have a conversation about the All Blacks in the World Cup, her past working life, her contact with neighbours, and the home health care help she received. The navigator model applies to both Māori and non-Māori clients.

While there are few Māori in conventional aged care residential facilities, the carer workforce both in rest homes and in the community is heavily reliant on Māori women.

Bonnie Maxwell-Ritchie is a Māori carer in her 70s who exemplifies Dr Merimeri Penfold’s observation about Māori attitudes to retirement and is one of the many hundreds of Māori women working in aged care. Dr Penfold said, “the concept of retirement is not in the thinking of many Māori elders of my age (eighty-five). We’ve

been taught how to survive, how to cope with our responsibilities and a sort of separation between work and retirement isn't in our way of viewing the world."⁸¹

This is Bonnie's story.

Twelve years on from gold card eligibility Bonnie Maxwell-Ritchie is more active than many people half her age. On top of managing a large garden, an active social life and grandchildren Bonnie is still working four days a week, supporting her clients, whose ages range from 40-90 years of age, in their own homes. After a brief period of 'retirement' for two months at seventy after the rest home in she was working was closed, Bonnie decided to return to work. She says she will "keep working while she is fit and healthy", motivated by her philosophy that "we should all keep contributing to our society for as long as we can."

Bonnie is a home support carer, working between 20 -30 hours a week. Now 77, Bonnie has worked in the aged care sector for 25 years, 19 of them in a rest home on night shift and more recently providing home based support. She says that she is not the oldest carer of her colleagues. As a teenager, Bonnie trained as a nurse but did not complete her training. In those days students were not granted dispensation to marry and then complete their training. Bonnie has worked all her life, unpaid when she had her children and in paid work after that.

Bonnie has regular clients and is also called on to relieve other carers who are on leave. Her hours have increased in recent times from twenty hours, to respond to the demand for experienced carers. "The co-ordinator rings and asks me if I can do such and such and I'm afraid that if I say no she may not ring me again."

Bonnie works unsupervised. She receives on-going training four times a year, "when a registered nurse takes us through our paces." Bonnie says that refresher courses are worthwhile. "When you feel something is amiss you contact the co-ordinator." Bonnie identified the qualities that make her employer a good employer: "They communicate well, listen to you, let you have your say, and are very approachable and this is a reciprocal process."

The physical demands of the job do not faze Bonnie. As a young nurse she learnt how to position her body safely and that of the person she was caring for, to avoid injury. She is fit, healthy and strong and says that she will know when it is time to stop, perhaps when she is 80. In the meantime she has a lot to offer. Bonnie attributes her good health to her hobbies, which include a regular scrabble group, being active and good genes. "Ninety-nine percent of my clients don't have hobbies, and they rely on television. It's important to keep active." She knows of one person who retired and put her feet up. "She just sat back, did nothing and watched TV, she's now immobilised and seized up with arthritis."

⁸¹McGregor, J. (2005) *Lifeswork: Celebrating older workers in New Zealand*. Wellington: Dunmore Publishing.

On the four days that she works, Bonnie starts at 8:00am and finishes at 5:00-5:30. She is allocated 15 minutes to drive between clients and this, she says, is the only stressful part of the job. If traffic is heavy there is not enough time to get to each client on time. Travel reimbursement doesn't cover her costs, but, she says, "It helps and pays at least half of my petrol." In the course of her work-week Bonnie drives between 40-70 kilometres. Bonnie says that a fair hourly rate for the work would be \$20-25 an hour. "Our clients deserve us."

Carers see a lot of people who are socially isolated. Bonnie described one woman's situation: "Without carers and volunteers such as St Johns and Age Concern she would see no-one. She has no-one in this country. We are her life-line, her link to sanity." Elderly men in particular can be very lonely. "Men don't socialise as well as females, many men don't encourage friendships. Men want to be king of the castle and don't want to share the castle." Women on the other hand are more self sufficient, "older women live on their own better". That said Bonnie is very supportive of the ageing in place policy. All her clients say "I don't want to go into care." Their ultimate aim is to live and die at home, in their own bed. Having a supportive neighbourhood helps. Bonnie lives in a friendly neighbourhood in which people look out for each other, but not every neighbourhood is like that. "People close their doors, they drive rather than walk and this leads to isolation."

"Without us, (home support carers) the elderly would be in care. We are saving the government and the taxpayer money." Bonnie believes that governments don't value our elderly people. "They are not given the respect due to them." She believes that the lack of respect starts in the home. "Most of our clients are in the older age group, they are seen as past their use by date, and this leads to a low value placed on carers."

Conclusion

As increasing numbers of Māori age and require support, the importance of developing culturally responsive services is necessary. The small proportion of Māori in residential care require care and support that is appropriate to their needs and the kind of service provided by Whakatu marae could be provided in other locations. It is also necessary to recruit Māori into the health workforce at all levels.

Home based services, which appear to be the preferred model for older Māori will also need to be delivered in a different way, with greater emphasis on supporting families to care for their kaumatua. (The concept of whānau ora). Te Whiringa Ora in the Bay of Plenty is a model of that different way of delivering services.





Impact of Christchurch earthquake

The effect of the Christchurch earthquakes of September 4, 2010 and February 22, 2011 on the aged care sector has been profound. Christchurch has the largest percentage of older people of all New Zealand cities at 15 percent. Christchurch lost 600 residential care beds in total. Older people in residential facilities were displaced, with seven aged care facilities fully evacuated, two partly evacuated and a number of residential facilities closed and 300 residents relocated to various parts of the country.⁸² Hospital wards for stroke and dementia patients were evacuated and older hospital patients had their care disrupted. Affected older people who wanted to return to Christchurch have now done so and occupancy of aged residential care facilities stands at 98 percent with little room for flexibility. Like most of the Canterbury population, carers were in the “front line” and are still coping with their own family stresses as they provide assistance to their clients.

Older people living in their own homes were made homeless or had to live in damaged houses. Some such as Margaret, in our story below, were injured in the earthquake.

CREST

Services had to quickly adapt. The Canterbury District Health Board (CDHB) brought forward its plan to implement a new integrated model of supporting people in their home. Faced with a hundred fewer hospital beds, the CREST model was implemented earlier than planned incorporating existing home care delivery providers. This freed up hospital beds by reducing the duration of hospital stays and supporting people at home. In general people are now able to leave hospital two or three days earlier than they would without the intensive support available through CREST. A manager said, “it is a cheaper alternative to hospital, and the CDHB are investing in primary and community care.”

One of the features of CREST is to assist people in a way that restores independence, “doing with, rather than doing for”. This can be a very different way of working which required “quite a mind shift for staff.” Carers need to stand aside and support and encourage independence. “The focus is on getting people up and running” and that provides greater job satisfaction as carers can see that they are “really making a difference.”

Integrated care is another feature of the CREST model. In practice this happens at three levels: integration at the client level, i.e. at their home; integration at the service level; and integration at the funder level. Clients receive support from CREST for up to six weeks, but usually support is provided for three to four weeks. Support can be

⁸²Carswell, S. (2011). *What we have learnt: Aged care provider learnings on responding to the February earthquake in Canterbury*. Christchurch Eldernet with funding support from the Canterbury District Health Board.

quite intensive, at least initially, and some clients are visited up to four times a day. The purpose is to make a success of staying at home and to have a shorter admission time in hospital.

Funding is on a capacity basis rather than the usual fee-for-service basis which is the norm in community support services. This funding means that a provider can advertise for full time or part time community support worker positions with guaranteed hours and therefore secure and consistent pay from week to week. The funding model also enabled carers to gain the qualifications needed to deliver the service. All support workers delivering CREST services are required to have a Level 3 NZQA community support qualification or be in training to complete their Level 3 qualification. There was no workforce out there ready to go “unless you are pinching them from another provider”. One CREST provider said it recruited carers and then trained them to Level 3.

CREST from a client perspective

Margaret has been receiving support for two weeks now after her discharge from Burwood Hospital. She was injured in the February earthquake and is glad to be home. She thinks the CREST service is brilliant and also thinks highly of the support workers. “The girls are wonderful, they are kind and caring”. Margaret says that she would still be in hospital without the support of CREST support workers. “Each day I’m mentally and physically stronger. I wasn’t anxious about going from hospital to home.” At 79 years old, Margaret says she is not used to being “useless”.

Margaret’s goals include being able to use her computer to play games, surf the net and Skype with her grandchildren, “My brain is a lot clearer, I’m getting the fuzz out of it.” Another goal is to get out and about, for example, going out to lunch with friends and family.

Margaret currently has support workers coming four times a day, but that will reduce and it is anticipated that she will not require CREST support at all in a couple of weeks. “I don’t think I’ll need six weeks.” Before the earthquake she was receiving one hour a week support from Nurse Maude.

“It’s wonderful being in your own home, being able to stretch out, no-one shining a torch in your face. I probably would have gone into respite care and I’m not ready for that, I wouldn’t fit in, I have too much to say.” Margaret thinks people are better off at home. “I’ve never flatted” she says. “I like living in my own space. I can eat bacon butties at 11 o’clock at night. You can’t do that in a rest home.”

Another service, Totalcare was launched in 2011. This service is “effectively a response to the loss of so many residential care beds. So we are now delivering residential care services in the person’s own home – seven days, invariably four visits a day, putting other types of services in place around the client” , said Fran Cook, General Manager of clinical services at Nurse Maude.

Impact on carers

Carers “stepped up” after the earthquakes by continuing to look after people while also coping with upheaval in their own lives. Some lost their jobs, including migrant workers who had been working in the residential facilities that were closed. Dr Sue Carswell, the researcher who evaluated the sector’s response to the earthquake, in a 2011 report states that “the total number of redundancies is not known but would be significant”, given that 96 staff were made redundant at one facility and 70 at another. She also notes that there has been “considerable staff movement” as some facilities make staff redundant while other places have hired new staff.⁸³ A number of providers also had to relocate their administration offices.

Ongoing stress is reported by a number of review participants. A Christchurch manager said, “staff are quite exhausted, some of the support workers were secondary income earners prior to the earthquake but they are now the primary income earner because of the loss of businesses in the CBD. This means there is a greater financial burden on some of our staff than there was previously so they need as much work as we can give them, but they are very tired and what goes with that.”

Another said, “they are going from their own home where there is family stress into someone else’s home where there are significant levels of stress, because they are also dealing with the health burden as well. We’re asking them to do an awfully big job and a lot of them do not want to take that on. Support workers are not only getting tired, they’re also getting sick and they want to keep working but they don’t want to pass it on. We’d had more sickness than normal this time of the year and people’s resilience and reserves are down. People are tired and the recovery is a long drawn out process.”

Liz Baxendine, President of Age Concern, speaking personally, reflected on the impact on the whole community, “the increase in social capital was like a candle in the dark. There’s a lot of grief and anger and there has been a huge increase in telephone counselling services. There’s nowhere to go – libraries, art galleries, swimming pools for people to be together.”

A national provider reflected on its learning from the earthquake. “What were the lessons around Christchurch? It’s all about people. Not the equipment and procedures, it’s all about how people manage with the equipment and resources. The procedure stuff was minor. The critical thing is how do you support the staff. Our buildings were fine but the staff’s buildings (their homes) weren’t fine. Some staff had homes destroyed and were coming in to work. We needed to support them at an enormously emotional time.”

Travel costs have escalated for caregivers who must meet the additional cost of wear and tear on their vehicles caused by driving to their clients over potholed and broken roads. The additional cost of driving older cars over roads “torn up” by the Christchurch earthquakes was raised at several of the Christchurch meetings.

The general manager of a home support organisation summed up the issue. “We’re seeing people’s cars that can no longer cope with the roads. The maintenance costs

⁸³ibid

become so high that they exit work. They can't maintain the suspension and the tyres so we have had some leave because they can no longer afford to run their cars. We've also got support workers who are less willing to travel. In the Eastern area we've got a real shortage of support workers but we still have a group of clients in the red zone areas who haven't yet been able to relocate, so they are still in their homes and they still need quite a bit of care. The support workers are very reluctant to travel into those areas so we have shortages (and have) to manage those challenges. A lot of people who work for us don't have the most modern vehicles, they don't stand up to earthquake conditions."

Conclusion

Natural disasters are traditionally seen as situations creating challenges related to the provision of humanitarian treatment and, increasingly, to the need for human rights protection. This Inquiry has as its focus equal employment opportunities issues related to aged care. The Christchurch earthquakes impacted both on the dignity and human rights of older people and the rights and responsibilities of those that provide for them and who care for them on a daily basis. At the same time many of those providing care were coping with their own job losses and housing and with the family and community stresses that accompany severe natural disasters.

The Human Rights Commission is monitoring the effects of the Christchurch earthquakes on the realisation of human rights by those affected, in particular vulnerable groups such as older people. It is using the human rights approach outlined in the IASC (Inter-Agency Standing Committee) Guidelines on the Protection of Persons in Situations of Natural Disasters.⁸⁴ The guidelines that relate to older persons include non-discrimination, participation and consultation, special attention during evacuation and family re-unification, among other issues.

In terms of equal employment opportunities issues, the earthquakes accelerated the introduction of new models of community aged care services that provide better job security and pay for carers, greater integration of services, and restorative models for older people. What should not be under-estimated, however, is the continuing stress on older people and those that care for them in hospital, residential facilities or in their homes, as a consequence of the Christchurch earthquakes. The effect on the implementation of equal employment opportunities, job loss, changed work conditions and emotional stress as a result of the Christchurch earthquakes require ongoing scrutiny beyond this Inquiry.

⁸⁴Inter-Agency Standing Committee. (2011). *Operational Guidelines of Human Rights and Natural Disasters*.

Part 5

Financial modelling

One of the arguments advanced in favour of parity is that it is morally wrong for DHBs to pay their own staff at higher rates than they are prepared to fund private providers of public services to ensure their workers are paid decently and equitably. This gross anomaly is well recognised and the Commission believes that it cannot be allowed to continue or to be defended in light of New Zealand's ratification of international treaties around equal pay. The good employer obligations of DHBs are also relevant here. The Commission is aware that the current climate is one of fiscal constraint and that parity between carers may well be dismissed as unaffordable.

For that reason the Commission asked Associate Professor of Accounting Paul Rouse at the University of Auckland Business School to model the cost of parity between carers in community support and residential aged care services and health care assistants working in public hospitals. The result puts the cost of parity between \$139 and \$141 million per annum. This is less than 1 percent of the Health budget. A three year roll out is modelled to demonstrate how addressing pay parity could be implemented.

Figures for the home support workforce have been estimated by taking the total headcount, subtracting the workers who deliver services to people under age 65 and calculating full-time equivalents (FTEs), based on the assumption that the average carer works half time. This process was necessary because headcount data was available for this group, but not FTEs. The FTE numbers for carers in the residential sector were obtained from Health Workforce NZ data. Total FTEs are assumed to include relief workers.

Salary information was based on rates of pay from the major providers and from the New Zealand Aged Care Association survey data. Numbers at each level were estimated and reviewed by a major provider. Total hours per annum are calculated at 52 weeks (which includes annual leave and statutory holidays) multiplied by 40 hours. On-costs were estimated initially as 3.5 percent on top of base rates and include ACC levies and Kiwisaver contributions. After consultation with a major provider, on-costs were recalculated at 4.56 percent to include time and a half for working statutory holidays. Both figures are included in the modelling.

The modelling does not include penal rates for overtime, shifts, weekends and on call, long service leave, progression through the rates based on length of service or mileage reimbursement. The following tables provide the calculations used to determine the likely total cost of parity.

Data

Support workers generic	Homecare			Residential Home			Adjust to NZACA (\$)	Parity with HCAs in DHBs	
	Lower bound (\$)	Current (\$)	Upper bound (\$)	Lower bound (\$)	Current (\$)	Upper bound (\$)		Homecare (\$)	Residential Home (\$)
Step 1	13.00	13.55	13.76	13.00	13.55	13.76	13.63	16.28	16.28
Step 2	13.39	13.94	14.07	13.39	13.94	14.07	14.02	17.30	17.30
Step 3	13.91	14.51	14.69	13.91	14.51	14.69	14.60	18.46	18.46
Step 4	14.21	14.98	15.39	14.21	14.98	15.39	15.07	18.79	18.79
Step 5	14.63	15.45	16.22	14.63	15.45	16.22	15.54	18.79	18.79
Mean		14.49			14.49		14.57		
NZACA est. average 2011							14.57		

Adjustment factor 1.006

Homecare support workers	A	B	C	D	etc
Step 1	35%				
Step 2	30%				
Step 3	20%				
Step 4	7%				
Step 5	8%				

100%

Mean	Std Dev	Estimated Percentage Labour Force in Home care
35%		35%
30%		30%
20%		20%
7%		7%
8%		8%

100%

Estimated FTE	Oncosts	Year	Phasing in stages of increase
7500	3.50%	1	33%
	3.50%	2	66%
	3.50%	3	100%
	3.50%		

Residential facility workers	A	B	C	D	etc
Step 1					
Step 2					
Step 3					
Step 4					
Step 5					

100%

Mean	Std Dev	Estimated Percentage Labour Force in Home care
		35%
		30%
		20%
		7%
		8%

Estimated FTE	Oncosts	Year	Phasing in stages of increase
12500	3.50%	1	33%
	3.50%	2	66%
	3.50%	3	100%
	3.50%		

Working hours per week

40

On-Costs

3.50% Choice

1

Total weeks per annum

52

4.56% Choice

2

Working weeks per annum

45.8

Forecast

Homecare support workers	Nos.	Current Rates			Using Parity with HCAs in DHBs							
		Estimated %	Current Base \$	Including On-Costs \$	Estimated Total Hours Per Annum	Estimated Total Base Pay \$	Estimated Total Pay including On-Costs \$	Parity with HCAs in DHBs \$	Parity incl On-Costs \$	Estimated Total Base Pay Including On-Costs \$	Increase in Base Pay excluding On-Costs \$	
Estimated FTES	<u>7,500</u>											
Step 1	2,625	35%	13.55	14.02	5,460,000	73,983,000	76,572,405	16.28	16.85	88,888,800	91,999,908	14,905,800
Step 2	2,250	30%	13.94	14.43	4,680,000	65,239,200	67,522,572	17.30	17.91	80,964,000	83,797,740	15,724,800
Step 3	1,500	20%	14.51	15.02	3,120,000	45,271,200	46,855,692	18.46	19.11	57,595,200	59,611,032	12,324,000
Step 4	525	7%	14.98	15.50	1,092,000	16,358,160	16,930,696	18.79	19.45	20,518,680	21,236,834	4,160,520
Step 5	600	8%	15.45	15.99	1,248,000	19,281,600	19,956,456	18.79	19.45	23,449,920	24,270,667	4,168,320
	<u>7,500</u>	<u>100%</u>			<u>15,600,000</u>	<u>220,133,160</u>	<u>227,837,821</u>			<u>271,416,600</u>	<u>280,916,181</u>	<u>51,283,440</u>

Residential facility workers	Nos.	Current Rates			Using Parity with HCAs in DHBs							
		Estimated %	Current Base \$	Including On-Costs \$	Estimated Total Hours Per Annum	Estimated Total Base Pay \$	Estimated Total Pay including On-Costs \$	Parity with HCAs in DHBs \$	Parity incl On-Costs \$	Estimated Total Base Pay including On-Costs \$	Increase in Base Pay excluding On-Costs \$	
Estimated FTES	<u>12,500</u>											
Step 1	4,375	35%	13.63	14.11	9,100,000	124,044,830	128,386,399	16.28	16.85	148,148,000	153,333,180	24,103,170
Step 2	3,750	30%	14.02	14.51	7,800,000	109,384,392	113,212,846	17.30	17.91	134,940,000	139,662,900	25,555,608
Step 3	2,500	20%	14.60	15.11	5,200,000	75,904,712	78,561,377	18.46	19.11	95,992,000	99,351,720	20,087,288
Step 4	875	7%	15.07	15.60	1,820,000	27,427,182	28,387,133	18.79	19.45	34,197,800	35,394,723	6,770,618
Step 5	1,000	8%	15.54	16.09	2,080,000	32,328,816	33,460,325	18.79	19.45	39,083,200	40,451,112	6,754,384
	<u>12,500</u>	<u>100%</u>			<u>26,000,000</u>	<u>369,089,932</u>	<u>382,008,079</u>			<u>452,361,000</u>	<u>468,193,635</u>	<u>83,271,068</u>

Combined support workers generic	Nos.	Estimated %	Current Rates			Using Parity with HCAs in DHBs						
			Current Base \$	Including On-Costs \$	Estimated Total Hours Per Annum	Estimated Total Base Pay \$	Estimated Total Pay including On-Costs \$	Parity with HCAs in DHBs \$	Parity incl On-Costs \$	Estimated Total Base Pay Including On-Costs \$	Increase in Base Pay excluding On-Costs \$	
Estimated FTES	<u>20,000</u>											
Step 1	7,000	35%	13.60	14.08	14,560,000	198,027,830	204,958,804	16.28	16.85	237,036,800	245,333,088	39,008,970
Step 2	6,000	30%	13.99	14.48	12,480,000	174,623,592	180,735,418	17.30	17.91	215,904,000	223,460,640	41,280,408
Step 3	4,000	20%	14.56	15.07	8,320,000	121,175,912	125,417,069	18.46	19.11	153,587,200	158,962,752	32,411,288
Step 4	1,400	7%	15.04	15.56	2,912,000	43,785,342	45,317,829	18.79	19.45	54,716,480	56,631,557	10,931,138
Step 5	1,600	8%	15.51	16.05	3,328,000	51,610,416	53,416,781	18.79	19.45	62,533,120	64,721,779	10,922,704
	<u>20,000</u>	<u>100%</u>			<u>41,600,000</u>	<u>589,223,092</u>	<u>609,845,900</u>			<u>723,777,600</u>	<u>749,109,816</u>	<u>134,554,508</u>

Phasing of introduction over three years

Homecare support

Year 1			Year 2			Year 3		
Parity with HCAs in DHBs \$	Estimated Total Base Pay Including On-Costs \$	Increase in Base Pay including On-Costs \$	Parity with HCAs in DHBs \$	Estimated Total Base Pay Including On-Costs \$	Increase in Base Pay including On-Costs \$	Parity with HCAs in DHBs \$	Estimated Total Base Pay Including On-Costs \$	Increase in Base Pay including On-Costs \$
14.96	81,663,481	5,091,076	15.89	86,754,557	10,182,152	16.85	91,999,908	15,427,503
15.58	72,893,377	5,370,805	16.72	78,264,183	10,741,611	17.91	83,797,740	16,275,168
16.37	51,064,954	4,209,262	17.72	55,274,216	8,418,524	19.11	59,611,032	12,755,340
16.81	18,351,721	1,421,026	18.11	19,772,747	2,842,051	19.45	21,236,834	4,306,138
17.13	21,380,146	1,423,690	18.27	22,803,835	2,847,379	19.45	24,270,667	4,314,211
	<u>245,353,680</u>	<u>17,515,859</u>		<u>262,869,538</u>	<u>35,031,718</u>		<u>280,916,181</u>	<u>53,078,360</u>

Residential care

Year 1			Year 2			Year 3		
Parity with HCAs in DHBs \$	Estimated Total Base Pay Including On-Costs \$	Increase in Base Pay including On-Costs \$	Parity with HCAs in DHBs \$	Estimated Total Base Pay Including On-Costs \$	Increase in Base Pay including On-Costs \$	Parity with HCAs in DHBs \$	Estimated Total Base Pay Including On-Costs \$	Increase in Base Pay including On-Costs \$
15.01	136,618,837	8,232,438	15.92	144,851,274	16,464,875	16.85	153,333,180	24,946,781
15.63	121,941,364	8,728,518	16.75	130,669,882	17,457,036	17.91	139,662,900	26,450,054
16.43	85,422,190	6,860,813	17.75	92,283,003	13,721,626	19.11	99,351,720	20,790,343
16.87	30,699,638	2,312,505	18.14	33,012,142	4,625,009	19.45	35,394,723	7,007,590
17.20	35,767,284	2,306,960	18.30	38,074,244	4,613,920	19.45	40,451,112	6,990,787
	<u>410,449,313</u>	<u>28,441,233</u>		<u>438,890,546</u>	<u>56,882,467</u>		<u>468,193,635</u>	<u>86,185,556</u>

Homecare support and residential care

Year 1			Year 2			Year 3		
Parity with HCAs in DHBs \$	Estimated Total Base Pay Including On-Costs \$	Increase in Base Pay including On-Costs \$	Parity with HCAs in DHBs \$	Estimated Total Base Pay Including On-Costs \$	Increase in Base Pay including On-Costs \$	Parity with HCAs in DHBs \$	Estimated Total Base Pay Including On-Costs \$	Increase in Base Pay including On-Costs \$
14.99	218,282,318	13,323,514	15.91	231,605,831	26,647,027	16.85	245,333,088	40,374,284
15.61	194,834,741	14,099,323	16.74	208,934,064	28,198,647	17.91	223,460,640	42,725,222
16.40	136,487,144	11,070,075	17.74	147,557,220	22,140,151	19.11	158,962,752	33,545,683
16.84	49,051,359	3,733,530	18.13	52,784,889	7,467,061	19.45	56,631,557	11,313,728
17.17	57,147,430	3,730,650	18.29	60,878,080	7,461,299	19.45	64,721,779	11,304,999
	<u>655,802,992</u>	<u>45,957,092</u>		<u>701,760,084</u>	<u>91,914,185</u>		<u>749,109,816</u>	<u>139,263,916</u>

Pay parity between carers outside DHBs and health care assistants inside DHBs

Cost summary assuming on-costs of 3.5%

	Estimated FTEs	Estimated current total pay inc on-costs	Estimated increased total pay inc on-costs	Net increase
Homecare support workers	7,500	\$ 227,837,821	\$ 280,916,181	\$ 53,078,360
Residential facility workers	12,500	\$ 382,008,079	\$ 468,193,635	\$ 86,185,556
Totals	20,000	\$ 609,845,900	\$ 749,109,816	\$ 139,263,916

Cost summary assuming on-costs of 4.56%

	Estimated FTEs	Estimated current total pay inc on-costs	Estimated increased total pay inc on-costs	Net increase
Homecare support workers	7,500	\$ 230,171,232	\$ 283,793,197	\$ 53,621,965
Residential facility workers	12,500	\$ 385,920,432	\$ 472,988,662	\$ 87,068,229
Totals	20,000	\$ 616,091,664	\$ 756,781,859	\$ 140,690,194

Human rights framework

The right to work, to equal pay for equal work and the right to a decent income and working conditions are rights enshrined in the Universal Declaration of Human Rights (UDHR) and elaborated on in subsequent human rights treaties. Decent work is an essential component of the realisation of many other human rights, such as the right to an adequate standard of living, and can pave the way for broader social and economic advancement, strengthening individuals, their families and communities. In short, decent work is fundamental to the dignity of all human beings.

The equal employment opportunities issues discussed in this Inquiry report relate to some of the key international human rights framework protections which have been ratified by New Zealand. There are also a number of un-ratified treaties, such as the International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families, the ILO Convention on Domestic Workers, and principles such as the UN Principles on the Rights of Older People which provide an important guide to the international standards that New Zealand should strive to meet.

Aged care in New Zealand is funded primarily by government through District Health Boards, the Ministry of Health and the Accident Compensation Corporation who contract with a range of service providers from both the private and voluntary sectors. They, in turn employ care workers. Regardless of the funding or institutional arrangements in place for the provision of care however, there are positive obligations on the state, at an international level, to protect the human rights of both workers and of older people. This state duty to protect human rights from the abuses of third parties, including private entities, is a core principle of international law which is further explored as part of the UN Secretary General's Special Representative for Business and Human Rights "Protect, Respect and Remedy" framework⁸⁵ and Guiding Principles⁸⁶ endorsed by the Human Rights Council. Under this framework private providers also have a free standing responsibility to respect human rights and there should be access to remedy, judicial or non-judicial for victims of human rights violations.

While this Inquiry is primarily concerned with the equal employment opportunities in the aged care sector it is clear that realisation of the rights of the workforce will have a direct impact on realisation of the rights of older people using aged care services. If for example, a workforce is underpaid and undertrained then they will be less well equipped to do their job to the highest possible standards. It is for this reason that we also set out in this report the most relevant human rights standards relating to older people using aged care services such as the

⁸⁵ Protect, Respect and Remedy: a Framework for Business and Human Rights Report of the Special Representative of the Secretary-General on the issue of human rights and transnational corporations and other business enterprises, John Ruggie, A/HRC/8/5, 7 April 2008

⁸⁶ Supra at note 63.

international treaty rights provisions relating to the right to health and the right to be treated with dignity and respect.

The employment rights of aged care sector workers

The aged care workforce is predominantly female with numbers of migrant workers and large numbers of people employed to provide domestic home-based care. As the preamble to the ILO Convention on domestic workers states “...domestic work continues to be undervalued and invisible and is mainly carried out by women and girls, many of whom are migrants or members of disadvantaged groups, including the disability community, and who are particularly vulnerable to discrimination in respect of conditions of employment and of work, and to other abuses of human rights.” The same marginalisation and lack of protections exist in relation to migrant workers, while the systemic undervaluation and low pay which is characteristic of carers’ roles carried out by women remains prevalent.

The international instruments outlined here are intended to reflect the profile of workers in the aged care sector. Employment rights applicable to everyone are included in the lists below as well as specific rights for vulnerable groups employed in the sector, such as migrant workers and domestic workers.

The right to work

Everyone has the right to work, to free choice of employment, to just and favourable conditions of work and to protection against unemployment, regardless of race, colour, national or ethnic origin and appropriate steps must be taken to safeguard this right.⁸⁷

Equal pay

Everyone, without any discrimination or distinction of any kind, has the right to equal pay for equal work. In particular women must be guaranteed the right to equal remuneration, including benefits, and to equal treatment in respect of work of equal value, as well as equality of treatment in the evaluation of the quality of work.⁸⁸

Living wage

Everyone who works has the right to just and favourable remuneration ensuring for themselves and their family an existence worthy of human dignity, and supplemented, if necessary, by other means of social protection. This includes the right to social security, particularly in cases of retirement, unemployment,

⁸⁷ Universal Declaration of Human Rights (UDHR) 23 (1); International Covenant on Economic Social and Cultural Rights (ICESCR) 6 (1); International Convention on the Elimination of Racial Discrimination (CERD) 5(e) (i); Convention on the Rights of Persons with Disabilities (CRPD) 27 (1)

⁸⁸ UDHR 23 (2); ICESCR 3 & 7 (a); CERD 5 e i (i); Convention on the Elimination of Discrimination Against Women (CEDAW) 11 (d); International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families (ICPRMW) 25 (1); ILO C189 Domestic Workers Convention (DWC), 2011 (This Convention has recently (June 2011) been adopted by the ILO and is yet to be ratified. New Zealand voted for adoption of the convention and for the accompanying recommendations.); 11; ILO C100, Equal Remuneration Convention, 1951; ILO C111, Discrimination (Employment and Occupation) Convention 1958; CRPD 27 (1) (b)

sickness, invalidity and old age and other incapacity to work, as well as the right to paid leave.⁸⁹

Right to organise

Everyone has the right to freedom of peaceful assembly and association and the right to form and to join trade unions for the protection of their interests. There is also a right to effective recognition of collective bargaining.⁹⁰

Working hours, right to rest and leisure

Everyone has the right to rest and leisure, including reasonable limitation of working hours and periodic holidays with pay, as well as remuneration for public holidays and overtime compensation.⁹¹

Right to non-discrimination

All of the above rights in respect of employment and occupation must be guaranteed without discrimination of any kind to disability, race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status. It is necessary to address prejudices and discrimination based on stereotypes of roles for men and women.⁹²

Access to training

The right to work includes the right to receive technical and vocational guidance, placement services and recurrent education, training and re-training programmes.⁹³

Safe and healthy work environment

Everyone has a right to safe and healthy working conditions. In the case of home based aged care it will also be important that there is regard to the specific characteristics relating to the occupational safety and the health of domestic workers.⁹⁴

Equal opportunities

Everyone has the right to equal opportunities in relation to the criteria applied to selection as well as to promotion opportunities based on seniority and competence.⁹⁵

Dignity at work

When at work everyone should be treated with dignity and respect. This means that everyone's life and liberty will be respected and no one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment. There should

⁸⁹UDHR 23 (3); ICESCR 7 (a) (ii) (ii); CEDAW 11 (e); CRPD 28 (2).

⁹⁰UDHR 20 (1) & 23 (4); ICCPR 21; CERD 5 (e) (ii); ILO C189 DWC 3 (2) (a); CRPD 27 (1) (c); ICRMW 26 & 40; ILO C 87- Freedom of Association and Protection of the Right to Organise Convention, 1948; ILO C 98- Right to Organise and Collective Bargaining Convention 1949.

⁹¹ UDHR 24; ICESCR 7 (d); ICRMW 25; ILO C189, DWC, 10.

⁹² ICESCR 2 (2); CEDAW 5 (a); ILO C189, DWC 3 (2) (a); ICRMW 7, 25, 43 (documented workers); CRPD 27 (1) (a).

⁹³ ICESCR 6 (2); CERD 5 (e) (v); CEDAW 11 (c), 11 (f); ICRMW 43 (documented workers); CRPD 27 (1) (d).

⁹⁴ ICESCR 7 (b); CEDAW 11 (f); ILO C189, DWC, 5, 6 & 13 (1); CRPD 27 (1) (b).

⁹⁵ ICESCR 7 (c); CEDAW 11 (b); CRPD 27 (1) (b).

be measures in place to ensure that workers, and particularly domestic workers, enjoy effective protection against all forms of abuse, harassment and violence and have living arrangements which respect these rights. The right to privacy, family life, religion and freedom of expression must also be respected.⁹⁶

Transparent contracts

It is expected that there should be measures to ensure that domestic workers, working in people's homes, are informed of their terms and conditions of employment in an appropriate, verifiable and easily understandable form. There should also be national laws and regulations which require that migrant domestic workers who are recruited in one country for domestic work in another, receive a written job offer, or contract of employment that is enforceable in the country in which the work is to be performed.

Finally, in relation to domestic workers, but particularly migrant domestic workers, consideration should be given to the conditions governing the operation of private employment agencies recruiting or placing domestic workers, in accordance with national laws, regulations and practice. It should be ensured that individuals can complain and there is proper investigation of complaints where there are alleged abuses and fraudulent practices concerning the activities of private employment agencies.⁹⁷

Rights of older persons in aged care settings

In many circumstances poor adherence to the decent work issues of care sector employees will have a direct impact upon the realisation of the rights of the older people they care for.

There are currently no human rights instruments relating specifically to older people, although this gap in protection and the feasibility of a new instrument or measure is being explored at an international level by a UN Open-Ended Working Group on Ageing.⁹⁸ Nevertheless, all of the rights contained in the existing international treaties and particularly the UN Convention on the Rights of Persons with Disabilities are relevant to older people using caring services.

The United Nations Principles for Older Persons⁹⁹ are not legally binding but are a guide as to how the rights of older people should be respected. The 18 principles are grouped under five themes of Independence, Participation, Care, Self-fulfilment and Dignity. The existing binding legal standards can also be broadly categorised in alignment with these themes as set out below.

⁹⁶ UDHR 3, 5 & 12; CRPD 15 (1), 16,17, 22, 23; ICCPR 17;ICRMW 10,11,12,13,14; ILO C189 DWC 5& 6

⁹⁷ ILO C189 DWC 7, 8 &15

⁹⁸ Established by the General Assembly by resolution 65/182 on 21 December 2010. <http://social.un.org/ageing-working-group/>

⁹⁹ The United Nations Principles for Older Persons(UN Principles) which were adopted by General Assembly resolution 46/91 of 16 December 1991. These Principles are not legally binding but are based on many of the other international treaties.

Independence

Older people should be supported to live independently and be included in the community.¹⁰⁰ In relation to the UN Convention on the Rights of Persons with Disabilities, this means having the choice over where to live on the same basis as other people and having access to a range of in-home, residential and other community support services, including personal assistance necessary to support living and inclusion in the community to prevent isolation or segregation.¹⁰¹

The UN Convention on the Rights of Persons with Disabilities also recognises the right to personal mobility with as much independence as possible which includes not only access to mobility aids but also the provision of training in mobility skills to persons with disabilities and to specialist staff working with persons with disabilities.¹⁰²

Participation

Older people have the right to participate in their communities as well as in the decisions that affect their lives. Older persons should remain integrated in society and participate actively in the formulation and implementation of policies that directly affect their well-being.¹⁰³

Self-fulfilment

Everyone has the right to freedom of thought, conscience and religion as well as freedom of opinion and expression including access to information and the right to seek, receive and impart information and ideas of all kinds.¹⁰⁴

The UN Convention on the Rights of Persons with Disabilities also enshrines the right to habilitation and rehabilitation, which means measures must be put in place to enable persons with disabilities to have maximum independence, full physical, mental, social and vocational ability, and full inclusion and participation in all aspects of life. As part of this right there is a duty to promote the development of initial and continuing training for professionals and staff working in habilitation and rehabilitation services.¹⁰⁵

The UN Principles on the Rights of Older People state that older people should be able to pursue opportunities for the full development of their potential and have access to the educational, cultural, spiritual and recreational resources of society.¹⁰⁶

Dignity

Older persons should be able to live in dignity and security and be free of exploitation and physical or mental abuse. It is a fundamental human rights principle that older persons should be treated fairly regardless of age, gender,

¹⁰⁰ UN Principles 1- 6

¹⁰¹ CRPD 19, Living independently and being included in the community

¹⁰² CRPD 20, Personal mobility

¹⁰³ UDHR 27(1); ICESCR 15; CRPD 29, 30; UN Principles 7- 9

¹⁰⁴ UDHR 18, 19; ICCPR 18,19; CRPD 21, 24 & 28

¹⁰⁵ CRPD, 26

¹⁰⁶ UN Principles 15 & 16

racial or ethnic background, disability or other status, and be valued independently of their economic contribution.¹⁰⁷

Older people have the right to life, liberty and security of person and the right not to be subject to cruel, inhuman or degrading treatment. Older people's physical and mental integrity must be respected on an equal basis with others.¹⁰⁸ There are also rights to privacy including the protection of personal, health and rehabilitation information. Home and family life must be protected and there should be no discrimination in matters relating to marriage, family, parenthood and relationships.¹⁰⁹

The UN Convention on the Rights of Persons with Disabilities states that persons with disabilities should be free from exploitation, violence and abuse. It is recognised in this Convention that in order to prevent all forms of exploitation, violence and abuse, there should be appropriate forms of gender and age-sensitive assistance and there is also a need to support individuals, their families and caregivers, including through the provision of information and education on how to avoid, recognise and report instances of exploitation, violence and abuse. The Convention also recognises the importance of effective monitoring by independent authorities of all facilities and programmes in order to prevent, identify and where appropriate prosecute, the occurrence of abuse.¹¹⁰

Importantly for this Inquiry, the UN Convention on the Rights of Persons with Disabilities explicitly recognises that there needs to be training for professionals and staff working with persons with disabilities so as to better provide assistance and services. We believe the same should be true for all older people in line with the UN Principles on the Rights of Older Persons.¹¹¹

Care

Everyone has the right to an adequate standard of living for their health and well-being and to security in old age. Older persons should benefit from family and community care as well as having access to health care to help them to maintain or regain their optimum level of physical, mental and emotional well-being and to prevent or delay the onset of illness.¹¹²

There is an internationally enshrined right to the highest attainable standard of physical and mental health. This includes a system of health protection with health facilities, goods and services which are available, accessible, acceptable and of good quality. An aspect of quality services will require, among other things, skilled and trained medical personnel.¹¹³

¹⁰⁷ UN Principles 17 & 18

¹⁰⁸ UDHR Article 3,5, CRPD 15 (1), 16, 17

¹⁰⁹ CRPD 22, 23, ICCPR 17

¹¹⁰ CRPD 16

¹¹¹ CRPD 4(i), UN Principles 17 & 18

¹¹² UDHR 22, 25 (1); ICESCR 12 (1); UN Principles 10-14

¹¹³ ICESCR 12 (1); Committee on Economic, Social and Cultural Rights, General Comment 14 (2000) on the right to health elaborates that the right to a system of health protection will include health facilities, goods and services which are available, accessible, acceptable and of good quality.

There must not be any discrimination against women or persons with disabilities in attaining the highest attainable standard of health.¹¹⁴ In relation to persons with disabilities, the UN Convention on the Rights of Persons with Disabilities says that health professionals must provide care of the same quality to persons with disabilities as to others which means raising awareness of the human rights, dignity, autonomy and needs of persons with disabilities through training and understanding of ethical standards for public and private health care.¹¹⁵

Home health care workers and the Human Rights Act

To clarify the position of carers working in peoples' private homes, the following legal analysis was undertaken.

Section 22 of the Human Rights Act 1993 prohibits discrimination in employment. Although antidiscrimination law usually only applies to activity in the public sector, section 27(2) provides an exception to section 22 for the purposes of authenticity and privacy. The exception is designed to permit employers some leeway in choosing domestic employees where the job may involve the employee living in a private home and there is a degree of physical or social contact with the employer. This is consistent with the title of the section which refers to "privacy".

Section 27(2) states that:

Nothing in s.22 of this Act shall prevent different treatment based on sex, religious or ethical belief, disability, age, political opinion, or sexual orientation where the position is one of domestic employment in a private household.

Section 27(2) has been interpreted by the Commission as applying to a person doing any type of work in a domestic residence¹¹⁶. Other agencies have also argued that a person has the right to choose from whom they receive a service in the home.¹¹⁷ If this is correct then anybody working in a domestic household falls within the exception and is not protected by the HRA in the employment context. The person to whom they are providing services could say, for example, that they do not want them to provide them with care because they disapprove of their sexual orientation or don't like people of a particular ethnicity¹¹⁸.

Whether s.27(2) applies to workers providing home based health care and support under a contract with providers such as Healthcare of New Zealand or Access Homehealth, appears to have never really been addressed by formal complaint to the Commission. It seems logical, however, that whether or not people fall within the exception should be determined by the nature of the work they perform rather than where it is carried out.

¹¹⁴ CEDAW 14 12(1)

¹¹⁵ CRPD 25.

¹¹⁶ Human Rights Commission. (2008). *An A to Z for Employers and Employees: Pre-Employment Guidelines*.

¹¹⁷ See, for example Lazonby, A. (2007). *The changing face of the Aged Care Sector in New Zealand*. Retirement Policy and Research Centre.

¹¹⁸ Section 27(2) technically allows householders to discriminate positively in favour of someone belonging to one of the identified groups.

In *Cashman v Central Regional Health Authority*¹¹⁹ the Court of Appeal held that workers who provided care for old and/or disabled people living in their own home who were unable to look after themselves, were “homeworkers” and, therefore, employees for the purposes of the Employment Contracts Act 1991. It was necessary to bring them within the Act because if they were treated as independent contractors they could not benefit from the protection of the legislation even though it was recognised that they were “vulnerable and susceptible to manipulation” [at p.11 line 44]. When the ECA was replaced by the Employment Relations Act in 2000 it specifically provided cover for people working in someone’s home for a third party.

Some groups of people working in the domestic sphere will clearly be classified as workers for the purposes of the Employment Relations Act 2000 - and therefore the HRA - but it is worth noting that the ERA does not cover people who are working for a homeowner in a direct contractual relationship. Given the synergy between the ERA and the HRA, arguably the same could be said to apply to the HRA. Against this it can be argued that as legislation such as the Injury Prevention, Rehabilitation & Compensation Act 2001¹²⁰ and the Income Tax Act applies to domestic workers, it would be anomalous if they were denied the protection of the HRA while being required to pay tax and meet their ACC levies. Such an interpretation would also be consistent with the large and liberal interpretation in human rights legislation that is universally preferred and compatible with the general principle that exclusions in human rights legislation should be narrowly construed because of the importance of the rights protected.

Reasonable accommodation

The combination of the fact that carers and nurses are older and the physical nature of the work, highlight the need for better information around disabilities in the aged care workforce. Article 27 of the CRPD refers to the need to ensure that reasonable accommodation is provided to persons with disabilities in the workplace. Reasonable accommodation can entail modifications or adjustments which will, for example, allow a job applicant with a disability to participate more equally in the workplace.

¹¹⁹ [1997] 1 NZLR 7

¹²⁰ The ACC defines a “private domestic worker” as someone employed by any other person where –

- (i) the employer is the occupier or 1 of the occupiers of a dwelling house or other premises used exclusively for residential purposes; and
- (ii) the employment is for the performance of work in or about the dwelling house or premises or the garden or grounds belonging to the dwelling house or premises; and
- (iii) the employment is not in relation to any business carried on by the employer or to any occupation or calling of the employer; and
- (iv) the employment is not regular full-time employment

Literature review

This literature review, which examines Equal Employment Opportunities (EEO) issues in the aged care sector, was carried out by Dr Judith Davey, on contract with the Human Rights Commission. The focus is on recent New Zealand literature – published reports and other documents from agencies in the public, private and voluntary sectors – as well as academic material. Overseas sources of special relevance, from countries to which New Zealand compares itself, are also covered. While every effort was made to find useful information, the review does not claim to be totally comprehensive. The picture is not fully clear because of gaps in the New Zealand material and sometimes a lack of specificity about the coverage of the information. Gaps are evident in the home support area and include topics such as men as paid carers, the social and cultural aspects of care work, and finding a balance between assuring quality care and economic constraints.

The review highlights numerous areas where research in the New Zealand context would be valuable and would help to plug the gaps. The replication of overseas studies in New Zealand can often highlight useful initiatives, while taking local conditions into account. The following is a selection of potential research topics:

- Exploring new approaches to aged care, taking a “client-centre” focus, giving a voice to client needs and wishes.
- The implications of a greater emphasis on home-based care for older people with significant disabilities – incorporating the actual experiences of home care workers and their clients.
- How better training and upskilling for carers can be provided and funded, building in incentives for workers to improve their career prospects.
- Improving health and safety for workers in aged care and reducing the stresses inherent in the work.
- Exploring new areas for the recruitment of aged care staff and improving the image of the work (this could include ways to even the gender balance in aged care work).
- How regulatory systems in aged care can be improved to the benefit of clients, workers, management and funders.
- Exploring the inter-relationship of paid and unpaid caring work to arrive at policies which promote shared responsibility for aged care.
- How to improve communication within aged care and how this links to managerial competence.
- The implications of using migrant workers in aged care in New Zealand.

Background – factors affecting the demand for aged care services

The demand for aged care services is driven by population ageing, disability trends and factors from the social and policy environment.

Population Trends

Population ageing, driven by increased life expectancy and falling birth rates, is a global trend. At the time of the most recent New Zealand Census in 2006, there were 495,600 people aged 65 and over (Badkar, 2009). This figure had doubled

from 1970. The trend is set to continue into the future. Between 2006 and 2026 the population is expected to grow by almost 20 percent, from 4.2 to 5 million. The number of people aged 65 plus is estimated to increase by 84 percent, from 512,000 to 944,000. Growth will be even more marked in the 85 plus age group, which is expected to more than double, from 58,000 to 116,500 (Grant Thornton, 2010, 78).

Statistics New Zealand (SNZ) produces a variety of projections, adopting different assumptions about fertility, mortality and migration (www.statistics.govt.nz). Series 5 is a medium projection, which is widely used, assuming medium fertility and mortality and annual net migration of 10,000. The nine alternative projections for 2026 and 2061 do not vary greatly in terms of ageing. All suggest that 19 percent of the population will be aged 65 plus by 2026, and between 23 percent and 27 percent by 2061. Assumptions about mortality rates are influential; the lower the rate, the higher the growth in the older age groups. Assumptions about fertility rates are less important. High rates of in-migration are associated with high growth rates for 65 plus, but have less effect on the 85 plus group.

Dependency and disability trends

From 2031, according to SNZ's Series 5 projection, the proportion of the population aged 65 plus will be greater than the proportion under 15. The proportion of "working age" – 15-64 – will fall from 66 percent in 2011 to 58 percent in 2061. The 65 plus "dependency ratio" (the number of people aged 65+ years per 100 people aged 15–64) stood at 20 in 2011. This will increase to 42 in 2061 and could be as high as 53 with very low mortality.

The incidence of disability increases with age. According to the 2006 Household Disability Survey (quoted in Badkar, 2009, 14-15), 32 percent of people aged 65-74, 51 percent of those aged 75-84 and 71 percent of people aged 85+ reported some form of disability, mainly physical or sensory.

Assuming the prevalence of disability continues as at present, Badkar (2009, 16) estimates that the group with high support needs, meaning daily assistance, is likely to increase from 54,700 to 147,700 between 2006 and 2036. Numbers in the 85+ age group will increase from 18,800 to 66,800. People with high support needs from chronic disabling conditions are likely to require long-term care, either in an institutional setting or in the community.

Other factors influencing demand

A variety of social, economic and policy factors also influence the demand for aged care services. These include changes in family structure and trends which differ by ethnicity. The availability of informal carers has reduced, linked to rising labour market participation by women and declining family size (Fujisawa & Colombo, 2009; Cornwall & Davey, 2004; Stone, 2000).

Public policies on the provision and funding of care services will affect their configuration and the balance between types of institutional and home care (Cornwall & Davey, 2004). Government is responsible for monitoring and

regulation of care services and can influence labour supply through immigration policy.

Advances in health practices and technology are difficult to predict, but improvements in the prevention and treatment of dementia, for example, will be influential in the demand for aged care. Tele-monitoring is already being trialled and may allow more self management at home. Strategies aimed at healthier ageing could reduce levels of impairment and hence the demand for care (Lazonby, 2007).

A further set of factors affecting the size and nature of demand for aged care are workplace and management practices, for example, consolidation of facilities and economies of scale, improved processes and working practices, including the use of information technology. At the same time as expectations for more responsive and better quality care systems are growing, fiscal constraints are creating pressures to improve value for money, leading to cost-cutting. These trends impact significantly on the workforce of this highly labour-intensive sector, exacerbating difficulties of recruitment in what is physically and mentally demanding work.

Future demand for aged care services and workforce

Over the last decade, several exercises have attempted to project the future demand for aged care services and workers in New Zealand, often in the context of the health and disability services sector as a whole. The Health Workforce Advisory Committee reported on the current capacity of the sector in 2002 and looked to the future in their 2003 report. Cornwall and Davey (2004) were commissioned by the Ministry of Health to examine the impact of population ageing on the demand for health and disability support services and workforce implications. These reports were quoted by the New Zealand Institute for Economic Research (NZIER) (2004) in *Ageing New Zealand and Health and Disability Services: Demand projections and Workforce Implications*. Subsequent work has focussed more narrowly on aged care. The Department of Labour study (Badkar, 2009), *The future demand for paid caregivers in a rapidly ageing society*, was followed by the Grant Thornton review (2010) and the Health Workforce New Zealand (HWNZ) Phase 1 Report – *Workforce for the care of older people* – published in 2011.

All this work points to an increasing demand for aged care services and signals a likely shortfall in supply, especially in the available workforce. NZIER (2004) suggested that the demand for health and disability service labour would grow faster than the population. In the absence of productivity increases or a fall in demand, both of which could not be foreseen, the conclusion was that “attention needs to focus on how the health and disability services workforce should be educated, trained, developed and deployed” (NZIER, 2004, iii). Badkar (2009, 19) suggested that, given estimates of older disabled people needing care, and assuming a ratio of one care giver per three disabled people, the number of care workers needed would rise from 17,900 in 2006 to 48,200 in 2036. Current growth trends produce a total of 21,400, clearly not enough.

The Aged Residential Care Services review (ARCSR) (Grant Thornton, 2010) also pointed to a large increase in demand. Using a starting point of 34,000 beds in 2010, and assuming no change in service delivery patterns, the report predicts that demand will rise to between 44,000 and 52,000 beds in 2026. This represents an additional 12,000 to 20,000 residents. These projections assume that current staff-to-resident ratios are appropriate and do not try to establish ideal staffing levels. The conclusion is that workforce demand in the sector will increase between 50 percent and 75 percent between now and 2026 (on a FTE basis).

Looking more widely, HWNZ (2011, 13) estimate that from 2011 to 2026 the demand for aged care services will double. The numbers of people receiving home support and residential care will increase by 61 percent and 54 percent, respectively, representing an extra 290,000 people. HWNZ suggest that funds for aged care will increase by 30 percent, enough to provide for 240,000. A significant shortfall is predicted.

This picture is reflected in other OECD countries (Fujisawa & Colombo, 2009). Workforce shortages are predicted for the UK (Wanless, 2001), the USA (Stone, 2000); and Australia (Gibson & Lui, 1994). The sources call for a shift in the balance of care from institutions to home care; better training for the professional and paraprofessional health workforce; and renewed efforts in retention and recruitment.

Aged care workforce supply and characteristics¹²¹

Numbers and categories

Numbers quoted for the New Zealand aged care workforce vary according to date, coverage and source. Most of the information relates only to institutional care. Using the 2006 Census, Badkar (2009, 18) gives a total of 17,900 aged care workers. HWNZ (2011, 39) used a variety of sources and, on a headcount basis, arrived at the data summarised in the following table.

¹²¹The New Zealand characteristics, in terms of age, gender and hours of work, are similar to those found among the aged care workforce in other countries (Korczyk, 2004). The ratio of carers to trained nurses, however, varies considerably, being especially low in New Zealand, both in home and institutional care (OECD, 2011).

The New Zealand aged care workforce¹²²

Occupation	Headcount
Geriatricians	37
Nurse practitioners, specialising in or serving mainly in aged care	60
Nurses working in continuing care	636
Nurses in aged residential care	4,705
Therapists in aged residential care	1,284
Managers and non-care staff in aged residential care	9,295
Carers in aged residential care	18,150
Unpaid carers for people of all ages (estimate 50 percent care for people 65 plus)	420,000

Surveying their members in 2010, the New Zealand Aged Care association (NZACA) arrived at a total of 17,503 employees, of which 73 percent were carers. Grant Thornton (2010, 107) estimated that 34,450 people were employed in aged residential care services in 2008 (including vacancies). Of these, 16 percent were nurses, 57 percent carers and 4 percent occupational and diversion therapists, plus 20 percent non-care workers (kitchen, laundry and other support) and 3 percent managers. In the home support sector 86 percent of the workforce are support workers, 6 percent are co-ordinators, another 6 percent are nurses and 10 percent are managers.

Age

Reflecting the population as a whole and overseas trends, the aged care workforce is itself ageing and is older than the New Zealand workforce as a whole (Grant Thornton, 2010, 109). Many current health professionals are part of the baby boom generation. The average age of registered nurses (RNs) was 42.6 in 1998 and has now risen to about 48 (Walker, 2009). The average age of carers is estimated to be well over 40. NZACA data shows a “distinctive bulge” of carers aged between 40 and 59 (Grant Thornton, 2010, 109). The modal age range in the New Zealand Nurses Organisation (NZNO) survey of carers (Walker, 2009) was 51-60.

Ethnicity

Grant Thornton (2010, 109) compares the New Zealand European proportion of aged care residents – 85 percent – with that of residential care employees – 56 percent. The latter compares to 68 percent European in the NZNO survey of carers (Walker, 2009) and 77.8 percent from 2006 Census data (Badkar, 2009, 30). Māori and Pacific Islanders each comprise 10 percent of the residential aged care workforce, according to Grant Thornton (12 percent Māori and 9 percent Pacific Island, in the NZNO survey; 14.8 percent Māori and 7.7 percent, Pacific from 2006 Census figures). Workers of Asian ethnicity are a growing proportion of the workforce. Between 2001 and 2006, their proportion rose from 3 percent to 7 percent, while the Māori and Pacific Island shares remained constant.

¹²²However, HWNZ did not include home support workers estimated by the New Zealand Home Health Association (NZHHA) at 18,000.

Full-time/Part-time work

A high proportion of aged care staff work part-time. In the Grant Thornton report (2010, 108), the proportions varied from only 6 percent part-time for managers, to 55 percent for nurses, 66 percent for carers and 75 percent for non-care staff. International comparisons are complicated by different definitions of part-time work (OECD, 2011, 161). According to this source, home care workers in New Zealand were more likely to be part-time than workers in aged care institutions. The differences are much greater in other countries, for example, in Japan 84 percent of home care workers are part-time.

Community/Institutional work

According to the OECD (2011, 161), even though most aged care recipients are served in their homes, most long-term carers practise in residential settings – over half in most OECD countries, including New Zealand. The exceptions are Japan and Korea, with much higher proportions in home care. Accurate statistics and information on characteristics are harder to find for home care workers.

Gender

Aged care workers, both in the residential and community sectors, are overwhelmingly female, with estimates over 90 percent in New Zealand and international sources. In OECD countries the female proportion ranges from 87 percent in Japan to 96 percent in Denmark, with New Zealand at 92 percent (OECD, 2011, 162). Caring work, including care for older people is a major source of female employment throughout the world, but women are concentrated in direct care work – managerial jobs tend to be held by men.

Concern about the situation of female homecare workers was expressed in a Ministry of Women's Affairs report in 1999 (Burns et al., 1999). In 2010, the National Advisory Council on the Employment of Women (NACEW) conducted research to identify the characteristics, pay and working issues for prime age (25-54) female employees who work under 37 hours a week in low paid jobs (2/3 of mean hourly wage for all workers)¹²³. NACEW found that 39 percent of women and 40 percent of men working part-time are low paid. Most women in this category are salespeople, cleaners and carers, occupations where lack of recognised skills is associated with low pay. These workers are also less likely to receive employer-funded training and more likely to be temporary. Workers in personal care are especially likely to fall into the low paid category. There was little evidence of advancement into better paid jobs and lack of financial rewards reduced motivation for training. NACEW concluded that the situation represented a significant wastage of women's skills and potential.

The International Labour Organisation (ILO) (2009, 25), examining the connection between paid and unpaid care work, came to similar conclusions. Paid "social reproduction" work, associated with the traditional roles of women and often in sex segregated environments, is generally assumed to be unskilled, with low pay, slender options for promotion and scant social protection. In all

¹²³ Source material came from the Survey of Working Life and the Household Labour Force Survey in 2008. NACEW hoped to identify firms with good practices in supporting low paid, prime-aged women to advance to better paid jobs. None were found.

countries low pay predominates in services where jobs replicate unpaid activities done by women at home.

Conditions of work

Concerns about the Equal Employment Opportunities (EEO) situation and workforce supply in aged care often focus on wage levels, but other factors are also relevant. These include working conditions, health and safety, job content, training, career opportunities and sector image.

Allocation of tasks

The aged care sector shares with health services in general a hierarchy of positions, from doctors through to nurses and general assistants or carers. The highest levels of professional skills are usually located in acute hospitals. There have been suggestions that medical, clinical and nursing skills should be accessed more directly at the community level in aged care (HWNZ, 2011, Initiative 4; Parsons et al, undated), but the scarcity of geriatricians, nurse specialists and allied professionals working with older people makes this difficult to achieve. The trend towards management of chronic conditions at home gives a higher role to general practitioners (GPs) as part of care teams, although their training often contains little geriatric medicine (HWNZ, 2011, Initiative 3).

In the non-acute sector, the care workforce is composed mainly of nurses and carers, in residential and home care. As cost and labour supply pressures have mounted, the allocation of tasks between nurses and carers has become blurred. The NZNO survey of carers who are members of their organisation (Walker, 2009), showed that most had received training for tasks within their usual ambit. But some are being called upon to perform what are usually nursing tasks, under what may be inadequate supervision (also noted in the Labour/Greens/Grey Power report, 2010, 34). These include giving medication (insulin and morphine), blood glucose monitoring and catheterisation. Walker (2009, 8) found that 26 percent of carers “very frequently” gave medication with no RN supervision and over half sometimes did this. The NZNO are calling for agreement on consistent guidelines for the roles and tasks of RNs, enrolled nurses and “unregulated” carers. The organisation suggests that lines of responsibility, delegation and oversight are not clear or consistent. HCNZ (2011, 33) have also called for “scope of practice” issues to be better defined. There are calls for constructive reallocation of tasks within residential care, with adequate training and supervision, consistent with the needs of older people who are increasingly frail on admission.

In the home care sector, workers face additional challenges as they are working in isolation with much less supervision, and less nurse support. Their schedules are often tight, giving little time for report-writing, team meetings, performance appraisal and training.

The OECD report (2011, 179) raises the issues of self-employed and agency care workers, who are often employed in residential and home care to deal with shortages. There may be some advantages in this, but there is the risk of “grey” care services developing. These are difficult to regulate and standards of training and care quality cannot easily be ensured.

Staff/care recipient ratios

There are clearly issues around both the ratio of care staff to supervisors and the ratio of staff to care recipients in both residential and home care. The Labour/Green/Grey Power report (2010, 19) points out that, before deregulation, minimum staffing requirements and regulations were imposed by legislation; for example one full-time RN was required per five hospital residents. Currently care facilities may decide how many staff they employ and develop their own staffing rationale, provided they have an RN on duty at all times. The Grant Thornton report admitted to huge variations in staff/resident ratios, which are also reported in home care services. Data in this report show that a rest home resident receives between 2.3 and 2.9 hours of nursing staff time per week and 10.6 to 11.5 hours of care giver time (Grant Thornton, 2010, 110 and 117). The same source shows that, in 2008, there were about 11 FTE nurses and managers per hundred beds in aged residential care, and 34 carers. The NZNO are campaigning actively for mandatory staffing levels and staff to patient ratios; a call echoed by Age Concern (Age Concern, 2010).

Union representation

Commentators in New Zealand and overseas agree that union membership is low or variable among aged care workers. The Joseph Rowntree Foundation study on home care (Wild, Szczepura and Nelson, 2010, 37) found that care staff had little knowledge about or interest in union representation for either individual or professional matters. The report suggested, however that unions could develop supportive structures for new approaches to aged care and new roles for carers, as well as encouraging training.

In New Zealand, the NZNO speaks out for its care giver members on staffing levels, fair pay, and nationally recognised training. Other care workers are represented by the Service and Food Workers Union who with NZNO organised stop-work meetings of nurses, carers and service workers from 20 Radius Residential facilities across New Zealand in December 2011 (Stylianou, 2011).

Health and safety

While many aged care workers find their jobs meaningful and rewarding, taking satisfaction from the dignity they can give to their clients, ultimately “care work is demanding and burdensome” (OECD, 2011; Martin & King, 2008).

The physical impacts show themselves in work-related injuries, often back problems from lifting (Stone, 2000). In the USA, care workers report the highest levels of work accidents after truck drivers and labourers. This situation may be made worse by understaffing, lack of communication and collegial support. Where relationships with management are not good, lack of trust may prevent workers from reporting incidents. The possibility of violence is another risk. Quoting a University of Auckland study, the OECD (2011) reported that half of residential care workers in New Zealand feared violence from their clients, and a quarter of workers in home care.

The increased dependence of clients and staff shortages also increases mental stress among workers, which can lead to mistakes, elder abuse and burnout (OECD, 2011, 169). Psychological pressures are especially high in dementia care and night shifts. Home care staff, working in isolation, may face different,

but also high rates of stress. The authors of the Labour/Green/Grey Power report (2010, 6) believe that pressure from staff shortages “is the main reason behind many of the shocking stories of neglect and abuse we heard.” On the other hand, Stewart (2008, 29) commended support workers for the positive responses of the majority of her respondents, and noted that complaints of abuse are rare.

Martin & King (2008) found quite high levels of job satisfaction among carers and nurses in Australia, except with pay. Job satisfaction was higher when aged care workers felt they use their skills and have some autonomy in their jobs. They found that community based workers were generally more content than those in residential settings, because they spend more of their time in direct care work, are under less pressure, and have more autonomy.

On the other hand, in the UK, the Equality and Human Rights Commission (EHRC, 2011, 41) reports frustration among home care workers “at not being able to take a ‘common sense’ approach and use their initiative in their work.” Not having enough time to deliver care to an appropriate standard and time pressure in travelling between service users added to their stress. This also appears to be the case in New Zealand.

Wages and pay parity

Local and international literature concurs that aged care work is low-paid, linking this with its gendered nature and under-valuing of work traditionally done by women. Funding shortages are frequently linked with low pay and low pay with staff shortages and difficulties in recruitment and retention (Korczyk, 2004). The ability to earn a living wage, however, remains a basic component of decent work and workers rights.

Parity within the sector

Variations in pay between workers in different roles and settings point to inequities within the aged care sector. The Labour/Green/Grey Power report (2010, Chapter 6.2) points out that carers and nurses in residential homes have a much greater role in care than those in public hospitals, but are paid less and also lack on-site support from doctors and other professionals. They add that nurses in rest homes do not have parity with District Health Board (DHB) employees, or the same opportunities for career advancement. The residential care sector is fragmented in ownership, leading to considerable variations in pay. Collective agreements may not survive changes of ownership. As well as inconsistencies between the hospital, rest homes and community services, there are differences in pay and conditions between DHBs, and between funding from the Ministry of Health and ACC.

Carers in all settings are generally among the lowest paid workers, often attracting only minimum wage levels. Community support workers earn less than healthcare assistants in public hospital or nurse aides, with pay rates reported to be 20 percent lower, and often have no guaranteed hours of work (NZHHA, 2011; HCNZ, 2011, 28). They have no compensation for non-contact time, for penal rates or other benefits received by DHB staff. They are also not fully reimbursed for travel time between clients or mileage. This represents a significant disadvantage for home care workers in rural areas. Calls for greater

pay parity within the sector have come from NZNO and the Labour/Green/Grey Power report. The latter calls for a national contract for home care and aged residential care workers.

Pay levels

Several reports document pay levels for aged care workers in New Zealand. These vary in their date and coverage. A selection of the most recent, illustrates differences within the sector:

- HCNZ (2011): DHB pay rates for home management are \$20 per hour upwards and \$22 plus for personal care. Community support workers earn \$13 – \$15.50 per hour, with travel allowances of 77c to \$2.97 per visit. Hospital support workers are paid \$16-19 per hour.
- NZACA (2011): Hourly rates for residential care are - RN \$25.64, care giver \$14.37, kitchen hand \$13.75.
- NZHHA (2011): Community support workers earn \$13-14.50 per hour.
- Department of Labour (undated): The average minimum hourly rate for community support workers is \$13.23, with a maximum of \$16.20.
- Walker (2009): Mean hourly rate for care giver members of NZNO was \$14.40, with a range from \$12.55 to \$19 (the latter for a night shift).

Wage trends

There is some disagreement about trends in pay for aged care workers. The authors of the Labour/Greens/Grey Power report (2010, 35) quote NZACA, saying that carers' wages have gone up 25.6 percent in the last five years, while residential care funding has increased 23 percent. NZNO says many carers have had no increases for over 10 years and wages have gone up 5 percent in that time. HCNZ (2011, 9) report that DHB funding strategy means that, in many regions, only government employees in the health sector have received increases in recent years.

NZACA suggest that the main criteria for pay levels are years of experience, qualifications and performance, but a Department of Labour case study of community support workers (undated) came to the conclusion that wages are determined by funding, not skill level. The NZNO survey (Walker, 2009) found that qualifications made little difference to salaries. Looking at women workers in low paid care positions, NACEW (2010) found that longer tenure workers received much the same pay as those newly employed.

According to employers' statements, they share concerns about low pay in the sector, recognising that the wages they offer provide no incentive for training, that skills are undervalued and that low pay makes recruitment and retention difficult. However, they assert that while demands made on aged care workers and the costs to service providers have increased, contract rates for their services have barely shifted (NZHHA, 2011, 41). Similar concerns were expressed to the human rights investigation in the UK. Providers said that they could not provide services of an acceptable or safe standard at the low rates paid by some local authorities (EHRC, 2011, 47).

Wider parity

Taking a wider view, the 2011 OECD report points out that wages in aged care are generally low, but may be higher than average for low skilled workers. Martin's Australian study of aged care workers (2007) concluded that their earnings were comparable with those of other women with limited formal qualifications. Carers may even have better tenure prospects. But, compared with men with similar low levels of education, these workers earned 30 percent less. Heavily gender-segmented labour markets for people with limited qualifications continue to sustain significant pay inequities. Nurses may be better off because of their professional status and professional organisations. The EHRC investigation reached similar conclusions (2011, 73). In 2009, hourly pay rates in the private care sector were 50p less than for retail workers.

The New Zealand Human Rights Commission (2011, 26) point out that the right to equal pay for work of equal value is not in contention. The issue is the determination of work of equal value and the selection of comparator groups, which can be identified using a gender-neutral job evaluation tool. However, up to now, anti-discrimination legislation has been insufficient to make equal pay a reality. The Human Rights Commission is calling for a new approach and a review of the Equal Pay Act 1972, which will provide an effective legal regime to ensure that the right to equal pay is implemented and enforced. The commission has promoted a new Pay Equality Bill covering both the public and private sectors.

Training and qualifications

The OECD (2011) points out that training standards in the aged care sector overall are highly variable and curricula are under-developed in many countries. Most physicians have no training in long-term care, especially in understanding the inter-relationships between patients' health conditions and their physical, social and psychological needs (Stone, 2000). HWNZ (2011) called for more education and training in gerontology (sic) for nurses and for junior hospital staff in relating to older people and the management of their care.

The lack of formal qualifications is one of the main reasons why aged care work is of low status and is low paid. The conundrum is that low pay does not encourage taking up training opportunities, but low qualifications lead to low pay. The most important and overlooked dimension of long-term care policy is the adequacy and availability of a trained workforce, according to Stone (2000). Developing appropriate and effective training programmes is fundamental to ameliorating the poor image of many long-term care jobs, thereby attracting more people to the sector and, in addition, helping to guarantee quality standards (Fujisawa & Colombo, 2009). HWNZ (2011, summary) reached a similar conclusion - "It is recommended that specific training and development be provided to (formal and informal carers) with a career path for formal carers who make up bulk of the aged care workforce."

Training is required at several stages in the work cycle - before taking up a paid position, at induction into work, and ongoing education to offer a career structure and individual progression.

The present situation in New Zealand

Lack of standardisation in qualifications is especially acute for carers. There is no minimum training requirement except in dementia care. This contrasts with requirements for formal qualifications in the case of carers of younger disabled people (Age Concern, 2011). Community care workers are less likely to hold qualifications than institutional workers. There is also unease about the quality of training and lack of standard accreditation.

Figures confirming the low qualification levels of workers in the aged care sector in New Zealand are provided in several recent reports from care providers, although they also report some improvement. Most workplaces offer some in-house induction training and many are actively encouraging the acquisition of formal qualifications (HCNZ, 2011, 34). NACEW (2010) conceded that there is more employer-provided training for low-paid aged care workers than for their sales or cleaning comparators. This is only to be expected, given the quality and safety factors involved in caring for frail older people. Among caregiver members surveyed by NZNO (2009), 80 percent have nursing or caregiving qualifications, mainly through ACE Training, and there are high levels of in-house training, covering occupational safety and health, handling and lifting.

Other sources suggest that about half of carers in residential care have no formal qualifications and the same is true for about 60 percent of home support workers. The Labour/Greens/Grey Power report claims that take-up of New Zealand Qualifications Agency (NZQA) and Careerforce¹²⁴ courses is limited (2010, 32). The Service and Food Workers union estimates only 20 percent of their members have any relevant qualifications.

In their consultations on health and disability services, NZIER (2004, 50) concluded that the current approach to training and development of the aged care workforce was unsustainable (2004, 50). The Auditor General's investigation of home support services (2011) also found that quality of supervision and training of providers' staff posed a significant risk for future service delivery.

There is general agreement among providers, DHBs, worker groups and interest groups advocating for older people, on the need for improved training. NZNO, NZHHA and the SFWU are calling for mandated minimum qualifications, suggesting Foundations (NZQA Level 2) as a minimum. NZNO is currently developing and consulting on recommendations for nationally accredited transferable training career pathways for carers. HWNZ is working with the Tertiary Education Commission to increase the aged care content of core health training qualifications (2011, 40).

Barriers

Despite widespread agreement on the importance of improving training standards in the aged care workforce, numerous barriers stand in the way,

¹²⁴ Careerforce is the industry training organisation for the health, disability and aged support workforce, offering courses for Levels 1-8 on the National Qualifications Framework. <http://www.careerforce.org.nz/Workplace-Health-and-Disability-Training-about.html>.

including the low pay conundrum. Support workers are reluctant to undertake training if providers cannot reward them for competency increases. Employers may resist calls for training as they anticipate a rise in labour costs, and claim that their own funding is insufficient. Low-paid current and prospective employees are unlikely to be willing to invest their own funds to acquire qualifications (Korczyk, 2004). As a result, there may be few alternatives to public sector funding and encouragement.

Being available for training may be a problem for nursing staff in aged care, as was found in a rest home pilot study, mainly concerned with medication, in the Counties Manukau DHB (Sankaran et al., 2010). Carers who attended appreciated the training and felt that it resulted in their being more valued by the organisation.

As a result, while there is easy access to lower skilled occupations in aged care, there is little vertical or horizontal mobility once workers are in the profession (Korczyk, 2004). This lack of career mobility can make care work a dead-end occupation, both in the perception of potential employees and in fact.

In addition to lack of funding, staff turnover, poor literacy of workers, family commitments and overall lack of incentives act as barriers to training in the aged care workforce (Jorgensen et al., 2009). Wild, Szczepura and Nelson (2010, 28) listed the key motivators for further learning, as reported by British care staff. These were led by personal and professional growth and increased personal pride based on achievement. The list continued with greater inclusion in decision making/planning and praise/recognition from managers. Increased pay was an important incentive, but workers accepted that this was not necessarily available.

Ideas to improve training

Suggestions for improved training for care workers were listed by Livingstone (2008), who asked workers in the USA to recommend items to be incorporated into initial training. The top topics were: more hands-on experience, communication skills and teamwork, and how to deal with residents' problem behaviours. Wild, Szczepura and Nelson (2010, 12) called for a "person-centred" approach to care, with more responsive work schedules to meet fluctuating needs among residents. Upskilling care home staff, enabling them to provide fundamental nursing activities in-house, supported by a nursing team, would help ease staff shortages. Suggestions in the New Zealand environment include Age Concern's (2010) call for staff training in how to recognise and prevent elder abuse; and Kerse's (2011) emphasis on the need to educate care staff about the behavioural and psychological symptoms of dementia.

Healthcare models that aim to promote community based service delivery for older people with high care needs, trialled in New Zealand through the ASPIRE project, bring with them demands for much higher training levels (Parsons et al., undated). In the Promoting Independence Programme, after residential rehabilitation, care is passed on to home care providers, with a tailored education programme for formal and informal carers. The Community FIRST approach entails a multidisciplinary team of health professionals devising a support plan,

delivered by support workers. Such approaches entail very high expectations of carers and demand higher levels of training.

Recruitment and retention

New Zealand and overseas commentators are in agreement that the aged care industry faces significant recruitment and retention problems, especially where rates of population ageing are high (OECD, 2011). Examining the situation in Australia, Martin (2007) points out the interconnectedness of factors affecting whether people stay in aged care work. They include employment arrangements – wages and non-wage benefits, contracts, flexible working hours – organisational characteristics, the extent of alternative work opportunities and personal characteristics. Holloway et al. (2009) add to this involvement in care planning, job security and approaches to intercultural caring. In New Zealand, Stewart (2008) found that attracting skilled and unskilled workers was one of the barriers to DHB's implementing the Health of Older People Strategy.

Turnover

Estimates for labour turnover rates in New Zealand aged care vary according to their coverage – types of worker and their location. The Labour/Greens/Grey Power report quotes 40-50 percent per annum for the sector (2010, 36). NZACA suggested an annual turnover of 25 percent in 2010, an increase on the 2009 figure. Jorgensen et al. (2009) found a staff turnover of 29 percent in residential care, 39 percent in community services. Generally, turnover rates for carers are higher than for nursing staff.

Turnover is especially high for workers who have been in their jobs for less than a year – 56 percent for carers, 46 percent for RNs, according to the NZACA (2010, 62), although turnover declines with years of experience. The Auditor General (2011) quotes a 2006 study of the community support workforce in which there was a 50-80 percent turnover in first year, and a 40 percent turnover for staff who had worked longer than one year. The conclusion was that the transient nature of the workforce and its working conditions posed a considerable risk to delivery of home base support.¹²⁵ High turnover will also exacerbate problems with training.

Ways to improve recruitment and retention

The literature includes numerous suggestions to help retain the current labour supply and assist recruitment, many of which have already been noted. They include better wages, training and opportunities for career advancement, changed content of work (including flexibility of hours and a greater ability to work autonomously) and improved safety standards (Badkar, Callister & Didham, 2009; Booth, Miller & Mor, 2007; NZNO 42; HCNZ, 2011). Some sources suggest that as important as, or perhaps more important than, wages, are work environments that value and respect worker contributions and involve them in care planning. Livingstone (2008) adds practical suggestions from the *Better Jobs, Better Care* exercise in the USA, relating to direct care workers. These

¹²⁵These figures compare to turnover rates of 20% for nurses and 25% for carers in Australia (Martin, 2007).

include consistent assignments to individual residents/clients and their families, which strengthen relationships, and designating a retention specialist or a retention team within a facility. Korczyk (2004), looking across five countries, quotes the example of Denmark which has relatively high-paid care workers and strong unions, but fewer staffing shortages than other countries. In Denmark, training is integrated with employment, offering aspiring professionals a chance to earn income and gain on-the-job experience as they study, and creating career paths that can reward further training.

Several initiatives are suggested to reduce the demand for carers and help to stave off the predicted shortfalls. Badkar, Callister and Didham (2009) call for initiatives to promote self care and healthy ageing; greater support to informal carers, possibly including financial benefits; greater use of information and communication technologies to improve efficiency in organising and planning services, and improved co-ordination. NZIER (2004, 39) took a more pessimistic view. They pointed out that regulated labour in health care is internationally mobile, so recruiting and training local professionals “becomes like filling a leaking bucket”. Technology breakthroughs leading to productivity improvement cannot be relied on and may have a perverse effect in increasing demand for a wider range of treatment options. Improved health education and monitoring might reduce the need for services, but the reverse could be true – it might uncover conditions previously untreated, and make people more self aware and demanding.

Applied research and demonstration projects in the USA aim to reduce turnover rates and improve workforce quality (Livingstone, 2007; Stone & Dawson, 2008). In the UK, Wild, Szczepura and Nelson (2010) showed how innovative residential care homes can provide opportunities for a learning environment for multi-disciplinary students and hence attract staff.

Possible areas for recruitment

Quoting an Australian study, Badkar (2009, 8) suggests way to extend participation in the aged care workforce (also Fujisawa & Colombo, 2009; Livingstone, 2007).

- Several commentators recommended recruitment among older workers. Livingstone (2007) found that workers aged 55 plus were interested in residential and home care work and employers favoured older workers as more stable than younger workers and better able to provide quality care. Livingstone goes on to advise how mature workers could be attracted – advertising in less traditional places, such as church notice boards; restructuring jobs to appeal to older people; and flexible assignments. In New Zealand, the Waitemata DHB (2008 and 2011) conducted focus groups and workshops aimed at attracting and retaining mature workers. The initiatives suggested were similar to Livingstone’s, with the addition of health care benefits, retirement, career and succession planning.
- Badkar, Callister and Didham (2009) suggested drawing in workers currently disengaged from the workforce, including the early retired, unemployed people and volunteers. Quoting New Zealand data, the OECD (2111) stated that one-third of carers had been economically inactive before taking the job; 40 percent had been housewives and 49 percent unemployed. Livingstone

points out that people who have been informal carers may be recruited into paid care work when no longer needed by family members. This may also apply to women re-entering the workforce after bringing up children. Recruitment could be helped by timely information, stressing the altruistic elements of the job. A majority of aged care workers are women who often have significant non-work responsibilities and demands and require flexible conditions of work compatible with these (Martin & King, 2008).

- Recruitment among groups traditionally under-represented in the long-term care workforce, such as men, although this would require additional spending to subsidise training and wages.
- Encouraging the immigration of low skilled workers (considered in the next section).

Migrant workforce

In many countries, the response to shortages of workers in aged care services has been to employ immigrants. Tens of thousands of nurses, aides, and carers leave their homelands in Asia, Africa, the Caribbean, Eastern Europe, and the Pacific Islands each year to provide services to ageing populations in developed countries (Redfoot & Houser, 2005). The 2011 OECD report found that foreign-born workers play a substantial and growing role in many European countries, the USA, Australia and New Zealand. Between 1980 and 2000, the proportion of Asian nurses in long-term care in the USA increased from 29 percent to 38 percent. Most of these migrant workers are women, willing to take on work which is unattractive to local people despite its often uncertain and sometimes illegal status. They are sometimes recruited through specialised job agencies. Foreign workers often have shorter contracts, more irregular hours, lower pay and lower classified functions, and may have to work with the least favourable recipients. Hence there are concerns about their rights as workers, even though some of these characteristics may be shared by local care workers.

Some migrant workers enter under general immigration conditions, attracted by work opportunities, existing migrant communities, and education and training opportunities. Some countries, for example Canada, have targeted recruitment schemes for health professionals and care workers who can become eligible for permanent residence (Badkar, Callister & Didham, 2009, 20-22). Filipino nurses and carers work in Japan under an agreement between the two countries. Singapore has schemes to raise skill levels for migrant domestic workers, including courses on elder care. But their working conditions and labour rights are less than would be expected for local citizens and they cannot gain citizenship or residency.

Some of these schemes lay migrant workers open to exploitation and abuse, as documented by Human Rights Watch (Badkar, Callister & Didham, 2009). In addition to the adverse conditions typical of the aged care sector as a whole, they may also be subject to discrimination and racial abuse from clients, fellow professionals, and administrators (OECD, 2011).

There are therefore consequences for the migrants and the individuals whose lives they support. International agreements and national policies should deal with the aspirations and needs of both groups. The net effects of immigration on

economic development are not uniform or entirely clear. Among the positives are economic opportunities and independence for women (ILO, 2009, 20). Their remittances are an important source of revenue to developing countries, but they come at the expense of losing better educated workers, creating potential problems for the health care systems of their home countries (Redfoot and Houser, 2005).

Several reports suggest that migrant care workers can be over-qualified. Trained nurses may act as carers while working towards recognition of their qualifications, towards language proficiency, or an opportunity to have their families join them (NZACA, 2010; Badkar, Callister & Didham, 2009). Anna L. Howe (2009), reviewing the Australian experience, asks whether this is a case of migrant care workers or migrants working in long term care?

The New Zealand situation

New Zealand has highest proportion of migrant doctors in the OECD (foreign-born doctors were 52 percent of the total in 2005/6) and one of highest for nurses (29 percent) (Zurn & Dumont, 2008; OECD, 2011, 174).

New Zealand's growing reliance on migrant carers is documented by Badkar, Callister and Didham (2009, 20), despite the absence of any formal immigration scheme. These workers can come as skilled migrants, but also as partners of migrants, refugees and students (allowed to work for up to 20 hours a week). The Pacific Islands have been a significant and consistent source of carers, mainly from Samoa and Fiji, but assisted by free entry from the Cook Islands, Tokelau and Nuie (Badkar, Callister & Didham, 2009, 19). Between 2001 and 2006 the proportion of Asian carers increased from 3 percent to 7 percent, represented mainly by workers from the Philippines, India and Sri Lanka. Overseas-born carers represented 25 percent of the workforce in 2006. The Grant Thornton report (2010, 109) suggested that 56 percent of rest home carers are of non-European descent.

Implications and prospects

Many questions arise. Will New Zealand continue to attract overseas care workers to supplement local supply, when it cannot compete with the wages and lifestyle attractions of other countries? Should existing family ties and historic links with Pacific countries be used to develop immigration schemes along with training opportunities? What are the impacts on the local labour market, given competition for jobs during economic downturns? How can quality of care be assured? What are the integration challenges and the potential for cultural clashes? Will workers be able to bring in partners and children and what are the social consequences if they are not? Browne and Braun (2008) ask what responsibility developed countries have for the impacts of emigration on source countries. Will migrants depress wages and working conditions and counteract efforts by unions and professional associations to improve wages and working conditions for nurses and aides? Will this contribute to the continued devaluation of eldercare as a profession? Fujisawa and Colombo (2009) point out concerns about the flow of low-skilled workers through unmanaged migration routes, such as overstaying, fraudulent entry or illegal border crossing. National policies on long-term care financing, based on assumptions about service delivery models

and traditions of family responsibility, affect the demand for various types of international workers. Education and credentialing requirements aimed at ensuring quality of care can also be used to limit the admission of health and care workers, especially nurses.

The commentators conclude that meeting the long-term care needs of older populations in more developed nations, as well as the economic development and health care needs of less developed nations, will require more engagement across international boundaries.

Men as carers

Aged care is a female-dominated industry and the implications of this have been spelled out. Low wages and low job status make it unattractive to men. The environment of caregiving is clearly not men-friendly. There is also the question of appropriateness. Women outnumber men in the older age groups and the imbalance grows with age. There is scope, however, for higher male participation in aged care as male life expectancy increases. Many older women feel uncomfortable if their personal needs – washing, toileting – are being attended to by men, although the reverse is less likely to be the case as personal care is seen as a “natural” female role. Male carers form a higher proportion of non-European and immigrant care workers (Badkar, Callister & Didham, 2009, 15). In 2006, Māori represented 19 percent of female and 28 percent of male carers who were New Zealand-born. Men represented 10 percent of overseas-born carers and 7 percent of New Zealand-born.¹²⁶

Managerial Competence

Most of the issues already discussed which relate to working conditions and EEO in the aged care industry, are directly influenced by the culture of organisations and managerial competency. The latter, defined as “ability to perform successfully in a particular job or position” is not rated highly in New Zealand, according to Management Magazine’s Management Capability Index, created in 2003 and now adopted internationally (Matheson, 2009). Management shortcomings and instability (turnover among management) can undermine the sustainability of recruitment and training programmes as well as the confidence and commitment of workers. Staff turnover may be a symptom of poor management. In rest homes where turnover is high, Booth, Miller and Mor (2007) found that there were greater costs associated with vacancy, recruitment and replacement, lost productivity, poor service quality and lack of morale.

Information from the NZACA (2011), which represents 79 percent of aged care homes, gives the average size of facility at 52 beds. The Grant Thornton report (2010) suggests that the financially viable size is 80 beds, so that 83 percent are less than this. The conclusion drawn by the providers is that management is under stress in achieving optimum quality of care and staffing through under-funding. The negative effect of cost cutting on care for dependent older people is illustrated in the Labour/Greens/Grey Power report (2010). In an industry with a high proportion of unqualified staff, more supervision is required, rather than less,

¹²⁶ Literature on men as carers is hard to find. Fursman & Callister (2009) cover male participation in unpaid care only.

which is a result of the “squeeze” on nursing staff. Contributors to this report (2010, 19) suggest that focus on cost-cutting and securing profit margins through rationalised and uniform services (which are cheaper to provide than small scale, individually tailored services) can undermine the ethic of care. Some suggest that this is related to the trend for a reduction in the proportion of aged care beds in the charitable/religious/welfare sector and an increase in privately owned facilities, including homes run by commercially motivated multi-national firms.

Management culture

There are frequent calls for a change in management culture in aged care, which the providers maintain is difficult to achieve due to inadequate funding. Booth, Miller and Mor (2007, 7) suggest:

Rather than treating clients as clinical entities, downplaying their psychosocial and spiritual needs, advocates for culture change believe that systems of care should be adopted that accommodate individuals’ choices rather than forcing them to adhere to the routines of the provider. Patient participation, client autonomy and shared decision-making are emphasised.

Such change would require a rethink of caregiving to de-emphasise top-down authority, adopting a home-like environment that respects clients’ privacy, autonomy and preferences and empowers care workers through self-managing work teams and organisational adjustments. Stack (2003) suggests that an emphasis on new public management principles, especially the use of narrow performance indicators, leads to over-emphasis on continuous reporting and documentation. This increases the administrative component and eats into time for hands-on care, not only reducing client satisfaction but also leading to burn-out, absenteeism and turnover among staff. In order to cope, carers may distance themselves from patients, dehumanise them and treat them in demeaning ways. The EHRC (2011) also found that over-emphasising accountability for outcomes and performance monitoring reduces clients’ consumer sovereignty and their representation in matters of quality. If care homes are structured as bureaucratic medical caregiving organisations, this depersonalises the labour process in the interests of speeding it up and making it cheaper.

Comments on supervision in aged care settings are relevant to management competency. Livingstone (2008) suggests that the training of supervisors should focus on “coaching” rather than “command and control.” The shift of basic clinical activity from RNs to the unregulated workforce requires providers to develop more sophisticated governance procedures (NZHHA, 2011). The same is true in models of home care delivered to higher needs recipients.

Research has shown that many carers feel they are not being respected or valued by management (Walker, 2009). In Australia, Martin & King (2008) found that job satisfaction among carers and nurses was higher when they felt that they could use their skills and feel that they had some significant autonomy. They found that the most important predictors of satisfaction relate to how work is organised in care settings and this is directly under the control of facility

managers. Job satisfaction is clearly threatened by the pressures of job intensification. Korczyk (2004) reached similar conclusions in the five countries studied. Carers were often not considered members of their clients' long-term care teams, despite their extensive contact with them and understanding of their needs. If carers are not included in care planning, this can reduce the workers' job satisfaction as well as the quality of care.

Regulatory frameworks

At present rest homes must be certified by the Director-General of Health and audited against Health and Disability Service Standards, 2008. Designated agencies carry out audits of rest homes against these standards, which cover consumers' rights, protecting the right to information, privacy and non-discrimination, and ensuring a safe and appropriate environment. Home-based support services are not formally regulated, but undergo self-regulation through a voluntary code of practice. District Health Boards (DHBs) monitor performance where they have a contracted agreement with providers. There are no audit requirements in non-contracted care or individualised funding (Ministry of Health and ACC). Measures of monitoring and accountability are important to ensure the human rights of vulnerable people and marginalised workers, especially given expected growth in the aged care sector.¹²⁷ This includes policies, legislation, regulation and enforcement of care standards and workforce conditions.

Need for improved integration

Several bodies have made recommendations about changes in the regulatory framework in aged care. Booth, Miller and Mor (2008) canvassed experts' views on long-term care in New Zealand and identified the main challenges facing the sector, all of which relate to policy and regulation. High on the agenda were better integration and planning of services.

Criticism of siloed purchasing and contracting methods has come from HWNZ (2011) and the Labour/Greens/Grey Power report (2010), seeing these as barriers to change. A whole of system approach is required and a model which focuses on interaction between the needs of older people, service configuration and the workforce. Fujisawa and Colombo (2009) see lack of co-ordination arising from the multiplicity of services catering to long-term care recipients and perverse financial incentives faced by providers. Several commentators agree on the need for co-ordination and active management of care plans (HWNZ, 2011; HCNZ, 2011; Stewart, 2008). Such initiatives are beginning to be taken up in some OECD countries, using care managers or assessment teams to plan and co-ordinate services, and emphasising the importance of communication among providers and recipients. Greater flexibility in funding and a focus on supporting and incentivising desired outcomes is called for by HWNZ (2011). NZHHA (2011) also suggest that there has been little strategic intent in investment in the aged care sector, resulting in inconsistencies in service delivery and pricing.

¹²⁷Providing that these are not taken to extremes, as noted on p.179.

Current regulation – as it impinges on the workforce

The New Zealand Auditor General carried out performance audit reports of rest home services in 2009 and of home based support services for older people in mid 2011.

The Auditor General concluded that auditing of rest homes was inconsistent and sometimes of poor quality and that monitoring by DHBs was not well co-ordinated with the work of the Ministry of Health. Certification has improved quality and safety, but the rate of improvement has slowed. The 2010 Age Concern briefing endorsed all the Auditor-General's recommendations and called for unannounced audits in residential care.

In the home care sector, the Auditor General noted different issues. "There is no mandatory standard for home-support service providers and DHBs do not have a consistent and robust approach to managing quality. I am therefore unable to give positive assurance about the quality and consistency of services throughout the country (2011, 3)." The NZHHA (2011) reported that, of 125 providers, 50 were not certificated. In 2010, ACC did its first audit of home care services and found no consistency. The report recommended strengthening management contracts to ensure that home-based support staff provide high-quality services and are well trained and supervised.

This situation has led to many calls for the mandating of standards, especially in home care services, for reliable, transparent and nationally consistent systems of monitoring and supervision, spot audits, inspection and regulation to protect workers and service users. There was overwhelming support for such initiatives in the NZNO carers survey (Walker, 2009). These calls have implications for the workforce. "DHBs have recognised that one of the biggest risks they need to manage is the ability of their service providers to supply a suitably qualified and well-supervised workforce (Auditor General, 2011, 3)."

The authors of the Labour/Greens/Grey Power report (2010, 10) recommend the appointment of an Aged Care Commissioner, tasked with developing and trialling new models of care and new funding models¹²⁸.

New approaches

Fujisawa and Colombo (2009), reviewing available data and published literature, conclude that there is a dearth of information on what works and what does not in providing long-term care for older people. Nevertheless the growing and changing needs of the sector call for a new approach and new systems of regulation. As HWNZ (2011, 6) points out – "More of the same will not meet the challenge. It will also be necessary to innovate, to provide for some needs in ways which are significantly different to current services." As well as increased client numbers and a wider range of providers, there had been a shift away from residential care (OECD, 2005). This means that home support clients have higher health needs and that home-based care is increasingly being used to

¹²⁸Concerns about regulation of the aged care sector are reflected in other countries. In the UK, private and voluntary organisations providing home care are not subject to Human Rights Act. The EHRC (2011, 89) recommend a single regulatory body to oversee the sector.

support acute recovery and chronic disease management. Emphasis is shifting towards preventing and delaying loss of function among older people and restoring function where such potential exists. This means that needs assessment and care planning should aim to optimise potential rather than simply assessing eligibility for services. This change will require better workforce planning and training, with changes in workforce orientation and skills, leaving behind outdated models of care, a call reinforced in the Labour/Greens/Grey Power report (2010). Future development may include short-stay care facilities and the development of community-based multi-disciplinary team (as recommended in the ASPIRE project). These initiatives have implications for training, improving clinical leadership in primary and community settings to support health care assistants and informal carers. Kerse (2011) also calls for a greater role of general practitioners in residential care, which, she claims, would reduce costs and probably decrease admission to hospitals.

There is the potential for information and assistive technologies to support these new approaches (HWNZ 2011; NZHHA, 2011). HWNZ (2011, Initiative 7) suggests that the integration of information could have workforce benefits in terms of job satisfaction, recruitment and retention. The use of information and communication technologies (ICTs) in long-term care, such as telemedicine and electronic health records, could empower older people to be more autonomous in daily living and improve efficiency in organising and planning formal carers' services (Fujisawa & Colombo, 2009). This would help to address shortages of care workers and improve productivity in long-term care jobs. The authors point out, however, that the uptake of ICTs has been slow to date.

Respect and value

Dignity at work is a basic human right – unfavourable conditions can lead to lack of dignity for workers and poor quality of care for users. This section links to earlier ones on health and safety and also to management competence and culture.

Respect for clients and the effect on quality of care

Treating older people in receipt of care with respect is a major determinant of the quality of care. Quality of care in turn arises from management and workforce issues. There is a tendency for older people to be viewed as passive recipients of care. Routines become taken-for-granted by staff unaware of discomfort for the recipients. Age Concern (2010) called upon care staff to respect and promote the human rights of rest home residents. Producing a compassionate and respectful attitude cannot be legislated for or required by standards, but the tone can be set by owners and managers. If residents do not receive the quality of care they need, Age Concern (2011) considers this institutional abuse. The solution is the development of a culture of respect, empathy and person-centred care and a management regime which fosters this.

The EHRC (2011) considers that age discrimination is the main risk to the human rights of older people, which links with Age Concern New Zealand's call for ageist attitudes to be challenged. The UK Dignity in Care Campaign and Care about Rights, a Scottish training and awareness programme, are examples of helping care workers to use a human rights approach (Scottish Human Rights

Commission, 2011). In care settings, human rights are related to the concept of dignity, which embodies the ability of care recipients to communicate with staff, feel listened to, have a sense of independence, control and privacy, being involved in decisions which affect them. But respect for dignity in care cannot be taken for granted and will depend on the environment, staff attitudes and behaviour. The EHRC explore the role of care workers in promoting and protecting human rights for older people. This is especially important for home care workers, who may be the older people's only contact with outside world. "The combination of frequent lone working and high levels of individual responsibility, coupled with the need for highly developed communication and practical skills required by good home care workers are found in few other jobs afforded such low value in our labour market (EHRC 2011, 27)." Similar concerns have been expressed in New Zealand in the Labour/Green/Grey Power report and by Age Concern.

In the UK, Joseph Rowntree Foundation reports (Bowers et al., 2009; Bowers et al., 2011; Wild, Szczepura & Nelson, 2010) explore ways of empowering older people and enhanced care approaches. Wild, Szczepura & Nelson (2010, 4) conclude that the rhetoric of person-centred care is undermined by a climate of ageism. "Upskilling care staff can produce benefits for residents in terms of improved quality of life, increased activity and stimulation, more positive interactions and relationships between residents and staff, as well as more appropriate and directed care (ibid, 19)."

To achieve these outcomes, a culture change is called for. In their survey of New Zealand opinion leaders in long-term care, Booth, Miller and Mor (2008) found that less than a third were familiar with the concept of client-centred care, which would allow residents more choice and autonomy and promote better relationships between older people, their families, staff and the community. The authors suggested that the main barriers to culture change of this type were cost and resistance from rest home leadership and staff.

Several commentators discuss the concept of cultural competence in aged care, including Kiata and Kerse (2004) in New Zealand (pointing out how cultural differences affect care practices) and Livingstone (2008) in the USA. Livingstone shows that awareness of cultural differences goes beyond language to non-verbal communication, religious observances and customs at the end of life. These aspects of care deserve greater emphasis in training and practice. Cultural competency programme initiatives should involve care recipients, family members and staff. With growing ethnic diversity among the older population, aged care services in New Zealand will need to respond (Davey, Keeling & Zodgekar, 2009).¹²⁹

Respect for aged care staff

Throughout this literature review the ways in which care staff are devalued, the lack of incentives for improving their status and the deleterious effects of cost containment have frequently been highlighted. The use of terms such as

¹²⁹ An initiative in Auckland to provide culturally appropriate rest home services for South Asian immigrants has recently been announced (North Shore Times, December 6, 2011, page 2).

“unskilled” and “unregulated” do not help. All these impinge upon respect for and valuing of care workers.

Good management of aged care services and professional leadership, especially by RNs, is essential to ensure the success of new approaches. Unions could also play a part. A professional body, a robust training and qualification system and improved pay would do much to attract people into aged care and enhance its image with the general public.

Wild, Szczepura and Nelson (2010, 44) point out the importance of care staff feeling valued, confident, adequately resourced and clear about boundaries and levels of accountability if they are to take on new roles and responsibilities. New approaches to aged care are essential, not only to ensure the sustainability of services, but also to improve continuity of care, quality of life and security for older people and also job satisfaction for carers, more manageable workloads for health staff and greater efficiency in health care.

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Appendix 1 – Online questionnaire

Here's a sample of the online questionnaire for carers. Two similar questionnaires were developed for employers/owners/managers and for those being cared for.

Are you: A Carer

Being Cared For

An Employer/Owner/Manager

2. What work you do in the aged care sector and how many hours do you work?
3. What training you had and continue to have for your work?
4. What do you enjoy and value about your work in the aged care sector?
5. What would improve your job in the aged care sector?
6. Looking at the issues we have identified in our diagram which are the most important for you and why?
7. Do you work full-time or part-time?
8. If part-time, how many hours do you work?
9. Do you work part-time by choice?
 - Yes
 - No
10. Do you work for more than one employer?
 - Yes
 - No
11. If yes, how many employers do you work for?

Appendix 2 - Good Employer obligations

“DHBs have good employer obligations under the New Zealand Public Health and Disability (NZPHD) Act and the Crown Entities (CE) Act. These obligations are outlined annually to DHBs in the Operating Policy Framework. The current inserts regarding DHBs as good employers and Pay and Employment Equity are detailed below.

DHBs as Good Employers

Section 22(1)(k) NZPHD Act and section 118 CE Act refer

- Each DHB is required to be a good employer as indicated by section 22(1)(k) of the NZPHD Act, and as defined under section 6(1) of the NZPHD Act and under section 118(2) of the CE Act
- DHBs are required to include ‘Good Employer’ statements, in their Statements of Intent and in their Annual Reports.
- DHBs are required to operate human resource policies that comply with being a good employer and maintain overarching policy for employment and workplace relations based on demonstrating good faith, natural justice, human rights, good employer practice and meeting all statutory requirements in accordance with s118 of the CE Act and s22 (1) (k) of the NZPHD Act. Such policies should include an equal employment opportunities programme (EEO).

Appendix 3 – Staffing standards

i). The Health and Disability Services Standards 2008 (SNZ 8134:2008)

Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation (Standard 2.7).

ii). Age Related Residential Care Services: Agreement between the District Health Board and the Provider for the Provision of Age Related Residential Care

Section D17.3 specifies the human resource requirements for rest homes. Requirements of section D17.3 relating to staffing standards are set out below:

a. In every Facility where there are:

- i. 10 or fewer Subsidised Residents, there must be a Care Staff member On Duty at all times;
- ii. up to (and including) 30 Subsidised Residents, there must be one Care Staff member On Duty and one Care Staff member On-call at all times;
- iii. more than 30 Subsidised Residents, at least two Care Staff members shall be On Duty at all times;
- iv. more than 60 Subsidised Residents, at least three Care Staff members shall be On Duty at all times.

b. Despite clause D17.3(a), where (having regard to the layout of the Facility, the health and personal care needs of Residents and the ease with which the Residents can be supervised) the Registered Nurse or Manager at any time considers that additional staff are required to meet the needs of all Subsidised Residents, you shall ensure that those extra staff are On Duty for the period of time that the Registered Nurse or Manager recommends.

c. Where you provide more than one category of Services at your Facility one of the staff members may, if qualified, provide On-call assistance in respect of another category of Service...

d. Manager

- i. Every Rest Home must engage a Manager who holds a current qualification or has experience relevant to both management and the health and personal care of older people, and is able to show evidence of maintaining at least 8 hours annually of professional development activities related to managing a Rest Home; and
- ii. The role of the Manager includes, but is not limited to, ensuring the Subsidised Residents of the Home are adequately cared for in respect of their everyday needs, and that services provided to Subsidised Residents are consistent with obligations under legislation and the terms of this Agreement.

e. Registered Nurse: You must employ, contract or otherwise engage at least one Registered Nurse to be responsible for working with staff.

Section D17.4 specifies the human resource requirements for Hospitals, and essential requirements are set out below:

In every Hospital:

- i. at least one Registered Nurse shall be On Duty at all times;
- ii. the distribution of Care Staff over a 24 hour period shall be in accordance with the needs of the Subsidised Residents as determined by a Registered Nurse. A minimum of 2 Care Staff are required to be On Duty at all times;
- iii. the layout of the Facility must also be taken into consideration when determining the number and the distribution of Care Staff required to meet the needs of the Subsidised Residents under clause D17.4(a)(ii).

iii). Guideline: New Zealand Handbook Indicators for Safe Aged-care and Dementia-care for Consumers SNZ HB 8163:2005

This Guideline recommends staffing levels to ensure care is delivered by sufficiently experienced and suitably skilled staff. The Guidelines recommend that the direct care hours per consumer per day be used to determine whether the requirement of Standard 2.7 of SNZ 8143 Health and Disability Services Standards 2008 is met.”

Funding models utilised to publicly fund health and support services for older people

In New Zealand, the following funding model generally applies to all services funded for older people by District Health Boards (DHBs):¹³⁰

The Crown transfers funding to DHB baselines via the Ministry of Health based on a population-based funding formula (PBFF) that takes into account the size and characteristics of a DHB's population. The PBFF also includes what is called a Contribution to Cost Pressures (CCP), which is an additional component that assists DHBs to meet increased costs of funding and providing health and support services.

Funding and financing path

Once the Crown has transferred money to DHB funder arms (as above), a DHB then:

- contracts with providers and/or transfers funds its provider arm to provide home and community support services, and
- contracts with providers for residential care services for older people.

Accountability framework and contract types

It is largely up to the DHB to determine how much of the funding that it receives is spent on services for older people.

DHBs are required to provide at least the range and level of services specified in the Service Coverage Schedule (SCS); and in a way that accords with the business rules stipulated in the Operational Policy Framework (OPF).

The provision of residential care is also legislated for under Part 4 of the Social Security Act 1964 (the Act).

In terms of residential care, the Age Related Residential Care (ARRC) national contract requires DHBs to agree the price that will be paid (the 'set price') for providing services to older people with provider representatives on an annual basis. Once an older person has a needs assessment and is assessed as requiring long-term residential care, the DHB must then pay the provider the set price for the DHB area.

There is no national contract, on the other hand, for home and community support services. This allows DHBs to choose their approach to funding providers of home and community support services; and also the contract price.

The two main approaches used by DHBs when purchasing home and community support services from providers are:

- a fee for service (hourly price); and
- flexible funding arrangements including a price for an agreed package of care and bulk funding for providing services to an agreed client population.

The Ministry of Health expects each DHB to provide for the residential care and home and community support service needs of its population.

¹³⁰ Primary care and pharmacy dispensing also utilise, respectively, the following funding models: capitation payments, fee for services items and fee for services co-payments; and, payment from person to provider. See Appendix 4 for an overview of publicly funded health and support services for older people.

Appendix 4: Overview of funding models for publicly funded health and disability support needs for older people

Service	Purchaser	Funding Model	Funding and financing path	Contract type	Providers
Residential care services	DHB funder arm	PBF DHB baseline	Crown → DHB funder arm → Providers	Fee for service	DHBs charitable organisations private for profit
Home help and personal health services	DHB funder arm	PBF DHB baseline	Crown → DHB funder arm → DHB provider arm Crown → DHB funder arm → Providers	National Agreement with providers Fee for service, with a very small number of bulk contracts DHB individual contracts with providers (no national agreement)	Private providers (not the same providers as residential care)
NASC	DHB funder arm	PBF DHB baseline	Crown → DHB funder arm → DHB provider arm Crown → DHB funder arm → Providers	Bulk	Mix. Some DHB provision, some private providers
Acute hospital	DHB funder arm	PBF DHB baseline	Crown → DHB funder arm → DHB provider arm	Service Level Agreement (generally price/volume)	DHBs provider arm
Primary care	DHBs PHOs (act largely as an admin conduit for first contact services) Patients	PBF DHB baseline Capitation Other Fee For Service items, e.g. remote prescribing Fee For Service (co-payment)	Crown → DHB funder arm → PHO → Providers Patient → Provider	National PHO Agreement Multiple funding streams that include some which are capitation based and others with variety of contract types Flexible funding pool for BSMC alliances	Private providers (typically GPs)
Pharmacy dispensing	DHB funder arm	PBF DHB baseline Fee For Service	Crown → DHB funder arm → Providers	Pharmaceutical Services Agreement Fee for item National fixed price for provider and co-payment (formula based)	Private providers

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The Human Rights Commission welcomes your feedback about Caring counts *Tautiaki tika*. The Commission intends holding a stakeholder summit with government agencies, peak bodies, providers, Age Concern, Grey Power, trade unions and community groups to enhance sector cooperation and to promote and celebrate the paid aged care workforce. Feedback will be incorporated in the summit to be held in 2012.

Comments can be made to:
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