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The Role of Care Paradoxes in Maintaining Precariousness: A Case Study of Australia's Aged Care Work

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ABSTRACT

The paper examines why despite many inquiries and government reforms, the working conditions of aged care workers have remained precarious. The study draws on an analysis of Australian workforce survey data, government documents, and hearing transcripts from a recent Royal Commission into the sector's workforce and care practices. The results paint a complex and nuanced picture of how the government and providers rely on older or culturally and linguistically diverse women to carry out high standards of quality care with minimal worker benefits and protection while devaluing their work as unprofessional. The analysis also highlights the coexistence of four types of precariousness in aged care work: precariousness as a social category, a shared experience, a set of work practices, and management. Further, I find that a series of paradoxes rooted in cultural perceptions of care and older and/or diverse women maintain precariousness at work by constructing workers as the problem, entrenching disadvantage borne from intersectionality and shifting the burden of responsibility and part of the cost of caring for older people onto workers. I suggest that little improvement is possible until the systemic and sociocultural issues around care and the workers engaged in the transaction of care are tackled together as a whole.

1 | Introduction

Aged care workers in Western countries play a crucial role in providing care and support to older people as they become more dependent on others for everyday life activities and age-related health issues (Khan and Saidu 2017). These workers are employed in various settings, including residential aged care facilities, nursing homes, home care services, and community-based programs. The work they do ranges from clinical care to emotional support and ensuring quality of life to providing end-of-life care.

Direct care work carries an expectation that aged care workers will perform sensitive tasks and shoulder enormous responsibilities to deliver quality care even without adequate training, limited resources, and support (Hannan, Norman, and Redfern 2001; Sheehy, Crawford, and River 2024). These conditions are exacerbated by chronic crisis levels of workforce shortages and a lack of appropriate recognition of the social value of their work (Hugo 2009; Morrison-Dayan 2019). Research has found that, together, this has created a precarious work environment characterized by low wages and insecure positions that negatively impact workers by constraining their access to opportunities, employment and life choices and outcomes (Avgar et al. 2020; Olley 2022). In addition, these work conditions have rendered such positions unappealing to future workers and made it difficult to attract staff and replace the aging workforce (King, Wei, and Howe 2013; Villamin et al. 2023; Xiao et al. 2021).

Broadly speaking, precariousness can be characterized as "insecurity and vulnerability, destabilization and endangerment" (Lorey, 2–15, p. 10). Precariousness is a global challenge that tends to be defined as a socio-economic phenomenon or a subjective experience (Valenzuela et al. 2023). Although many studies have emphasized the critical need to improve the status and precarious employment conditions of aged care workers (Banday, Bishop, and Hyde 2023; Galanti 2024; Savy, Hodgkin, and Conway 2023), some studies have highlighted instances of improvement but pointed out that change has been extremely slow if not ineffective (Avgar et al. 2020; Berwick, Nolan, and Whittington 2008). The lack of significant improvement is problematic for several reasons. One, because precarious work produces inequality and creates unsustainable strain on the workers and the sector in delivering care to older people (Hugo 2009; Morrison-Dayan 2019; Negin et al. 2016; Overgaard, Withers, and Mcdermott 2022; Sutton et al. 2022). Second, precariousness has persisted despite many reforms seeking to address this issue (Simonazzi 2010).

In this study, I draw on the work of Campbell and Price (2016), Lorey (2015) and Anderson (2010) to conceptualize precariousness as a four-dimensional phenomenon: a social category (precariat), a shared experience (precarity and precarious workers), a set of work practices (precarity in employment and precarious work), and the structural and regulatory mechanisms that underpin employment conditions (governance and management of precariousness).

The Australian context provides a rich case study to better understand how and why the working conditions of direct care workers (DCWs) in the aged care sector have remained precarious despite the many commissions, inquiries, and scholarly work describing the issues, calling for reforms and proposing solutions to improve workers' conditions (Hugo 2009; Productivity Commission 2011; RCACQS 2021; Commonwealth of Australia 2023). Poor working conditions for aged care DCWs have been a long-standing major issue in Australia, as made evident by the COVID-19 healthcare crisis, a Royal Commission into Aged Care Quality and Safety (RCACQS 2021), and a case for increased wages put forward to the Fair Work Commission (FWC 2020).

The Federal Government subsidizes public (8%) and private aged care organizations (92%) (BPA Analytics 2023). This includes dedicated aged care services delivered in RACFs—which represents the bulk of the service delivery (84%)—and in people's homes through its Home Care Packages Program (HCPP) and Commonwealth Home Support Program (CHSP). The subsidies are regulated by complex federal and state laws. Over the years, the regulatory system has been expanded through a series of reforms and the introduction of standards and policies aimed at improving the quality of care delivered. Compliance with the system is monitored through a time-consuming reporting process on a set of clinical quality measures (i.e., pressure injuries, physical restraint, unplanned weight loss, falls and major injury, and medication management) called Star Ratings (MyAgedCare 2023).

To understand the reasons for the lack of improvement to the working conditions of aged care workers despite a series of government reforms designed to improve precariousness, I analyzed publicly available Australian datasets, including national census and survey data and the testimonials gathered through the RCACQS. To more clearly identify these conditions, if and how they constitute precariousness and why they might have persisted despite the government's attempts to improve them, the analysis focused on who does the work, how the work is done and expected to be performed, and under what conditions.

By bringing together national workforce statistical data, government documentation, and hearing transcripts from a range of stakeholders (e.g., government officials, aged care sector executives and workers, health practitioners, older people in care, their families, and carers) the study offers a more comprehensive understanding of precariousness. Focusing on the "who", "how", and "what" of direct care work, I find that: (1) the sector relies heavily on women who are older, a migrant, and/or from culturally and linguistically diverse (CALD) backgrounds to deliver care; (2) DCWs shoulder the burden of responsibilities despite being perceived as lacking the essential professional skills and knowledge, and (3) DCWs are expected to absorb the cost of meeting quality and safe care standards through low wages and unpaid overtime. The analysis also surfaces the dynamic relationships at play between precariousness as a social category, a shared experience, a set of practices, and management and control mechanisms. It also reveals a series of paradoxes around the notion of care that further serves to produce and reproduce precariousness and limit the possibilities of improvement for the aged care sector DCWs.

This contribution to the literature on the working conditions of direct care aged care workers is structured as follows. I first review the literature on DCWs' employment conditions. I outline the mixed method used to analyze the national, institutional and personal level data. Then, the results are presented with a focus on key findings about who does the work, how the work is expected to be done, and under what conditions. Finally, I discuss how precariousness has become intractable because of its persistence across the four dimensions of precariousness and a series of interconnected care paradoxes. I suggest that little improvement will be achieved without a sector-wide systemic and cultural change.

2 | Literature Review

Many studies have focused on the factors that contribute to precariousness in aged care work and workers' experience of it (e.g., Overgaard, Withers, and Mcdermott 2022), but few provide explicit definitions of the concept. Those who do have defined precariousness concerning work as "low-wage, low-skilled, and unattractive" (Kalemba 2023, 614), an emotional manipulation (Allard & Whitfield, 202) or a form of vulnerability that results from insecure positions and the silencing of workers (Galanti 2024; Anderson 2010). The lack of consistency highlights how the same concept is used to describe a wide range of situations and experiences.

With a focus on the mechanisms linked to precariousness, some researchers have examined how regulatory systems through

their policies, standards, and low levels of funding have been instrumental in creating precarious conditions (Avgar et al. 2020; Farris and Bergfeld 2022; Ranci et al. 2021; Savy, Hodgkin, and Conway 2023). For example, studies have highlighted the role government-regulated migration schemes, introduced to address the chronic shortage of staff, play in creating and maintaining precariousness. They have found that by controlling the access to skilled and low-skill care workers from across national borders, the schemes tend to result in undervaluing and limiting these workers' capacity to access better employment conditions (Galanti 2024; Hugo 2009; Kalemba 2023; Morrison-Dayan 2019; Olasunkanmi-Alimi et al. 2022; Overgaard, Withers, and Mcdermott 2022; Sheehy Crawford, and River 2024).

Such mechanisms also exist in Australia as the regulatory system controls and ties together the wage conditions, migration status, levels of qualifications, and quality of care standards (Olley 2022). Further, however, some studies have found that Australian aged care providers have used these regulatory systems to their advantage. For example, providers have used the need to comply with regulated controls and the limitation these impose on the viability of their business to justify maintaining their practices of not paying above the low minimum wages (Braithwaite, Makkai, and Braithwaite 2007; Brown et al. 2022).

Outside of its relationship with the regulatory systems, the aged care labor market constraints have also been closely linked to precariousness at work because of how they result in unmanageable and unsustainable workloads, low wages, and/or the casualization of the workforce (Charlesworth and Isherwood 2021; OECD 2020; Olasunkanmi-Alimi et al. 2022; Xiao et al. 2021). More specifically, researchers have pointed to the role of the commodification and import of labor from the Global South in maintaining cheap labor conditions (Coe 2019; Glenn 2010; Wichterich 2019). Their studies have shown how Western countries have relied on importing female care workers, often from the Global South, for the delivery of aged care. The import of workers is seen as an efficient and cost-effective practice because it meets the needs of families of older people, migrant workers, and the government. It is argued that it supports middle-class people's desire to provide more dignity to their older family members through in-home care, which they could not afford with local workers. It is rationalized on the grounds that the practice supports countries of the Global South to grow their economy by receiving foreign currency from workers sending part of their wages "back home". Finally, it is justified on the premise that it helps the Western country address its chronic workforce shortage.

The import of workers is problematic because it shifts the workforce shortage of Western countries to the Global South; it locks workers into underpaid and undervalued care work; and it creates prejudicial interactions between older people and paid—mostly female—carers with different cultural backgrounds. The strong work culture and/or expectation of volunteering and performing unpaid overtime care work for the good of the community is also problematic. Studies show how this practice has become common across most Western countries (Baines and Amstrong 2019; Wichterich 2019). However, when care is performed as a vocation, the distinction between professional practice and family relation is often blurred, further preventing workers from lodging official complaints and/or joining unions (Giordano 2021; Allard and Whitfield 2023).

In addition, precariousness in aged care work and its relationship with low-paid positions have been linked to low levels of qualification and a lack of workplace training and professional development opportunities (Farris and Bergfeld 2022). This situation is compounded by the low levels of traction unions and advocacy groups have had until recently in influencing better wages and workers' rights. The low levels of unionization of the workforce and their limited capacity to be represented by unions to advocate on workers' behalf for better conditions have provided some explanation for the maintenance of poor wages and compensations is a substantial contributing factor (Howe and Charlesworth 2018; Simonazzi 2010).

Precariousness has been examined with a focus on the workers themselves. Some studies have demonstrated the influence of gender and diversity on aged care workers' conditions and the value ascribed to care. The gendered nature of the workforce has been offered as an explanation for these poor working conditions (Das and Das 2021; Fotaki, Islam, and Antoni 2019; Wichterich 2019). Research shows how in this highly feminized sector, there is a disproportionate number of men in management and leadership positions, especially in the United States and the United Kingdom (Braithwaite, Makkai, and Braithwaite 2007; WHO 2019), and how the work is undervalued and under-rewarded (PM & C 2023; Ai Group Workplace Lawyers 2022; Negin et al. 2016).

Combining gender with cultural background, research has explained how these forms of difference become key contributing factors to the unequal treatment of workers (Adebayo et al. 2023; Coe 2019; Glenn 2010; Wichterich 2019). Some scholars refer to this phenomenon as the ethnicization or racialization of care (Coe 2019; Cognet 2010; Glenn 2010; Pelzelmayer 2016; Ranci et al. 2021). These concepts highlight how Western countries' discourses and assumptions that associate the competence to perform certain tasks to cultures from non-Western countries help justify poor work conditions, and at times racism, because the dominant perception is that "these" women are naturally inclined to perform unpaid care duties (Coe 2019; Cognet 2010; Glenn 2010; Olasunkanmi-Alimi et al. 2022; Pelzelmayer 2016; Ranci et al. 2021). With these concepts, we also see how "import" workers and those, more broadly, with diverse backgrounds are coerced into performing the work that others would otherwise not choose to do (Baines and Armstrong 2019; Giordano 2021; Glenn 2010; Overgaard, Withers, and Mcdermott 2022; Wilkinson, Ressia, and Mowbray 2023).

Although not explicitly referring to intersectionality, many of these studies highlight "intersectionality", which Crenshaw (2005) defines as the complex structural and relational aspects of society that intersect and compound each other to create a specific form of discrimination against people with multiple labels of difference, for instance, across gender, ethnic background, and class.

The body of work on precariousness at work often points to the role deficit discourses have in shaping and reflecting the negative

social constructs and vulnerability of aged care workers and their care work. For example, Dahl (2021) and Latimer (2013) discuss how constructing workers as vulnerable bodies helps to justify the stripping of their dignity and agency and reinforce their position at the margins of society. On the other hand, vulnerability is also seen as the opportunity for workers to enact change and address experiences of precariousness. Although some researchers have argued that the most efficient driver of change is policy reforms and alternative models of funding and management (e.g., Simonazzi 2010), others have argued that workers' mobilization around their shared vulnerability is the neglected element needed to bring about the change (e.g., Dussuet et al. 2023; Ori and Sargeant 2013).

Although many studies have explored a wide range of factors—regulation, management, union membership, education and training, and sociocultural—central to precariousness at work for aged care workers, the literature reviewed highlights several research gaps. The gaps in methods include longitudinal, comparative, and interdisciplinary studies. The gaps in topical focus include examining different types of precariousness, the range of experiences of precarity, and the organizational and temporal factors at play (Carnemolla et al. 2022; Sutton et al. 2022). More specifically, there is a need to explore the relationship between precariousness and specific management practices, workplace culture, and work settings. There is also a need to investigate the specificities of various forms of insecure and unstable work conditions, why they have endured despite reforms, how they are experienced by workers, and the implications on workers' health, wellbeing, and career trajectories in the short to long term. This means, for example, examining agency workers, workers with multiple casual contracts, and those whose identities sit across several marginalized categories of differences. Finally, there is a need to identify how these findings compare across metropolitan, rural and remote areas, and residential and home care settings. This study sought to address the gaps in understanding the specificities of various forms of precariousness at work and why they have persisted despite regulated changes using Australia as a case study.

3 | Materials and Methods

3.1 | Data Sources and Collection

A mixed method approach was used to identify the forms of precariousness that exist in the Australian aged care sector and better understand why they persevere. The study draws on three sources of data: national workforce surveys, hearing transcripts, and government documents.

Survey data consisted of two sets: The Australian Government Department of Health and Aged Care's (DOHAC) 2020 Aged Care Workforce Census (ACWC) and BPA Analytics' Aged Care Census Database (ACCD). The surveys were used to provide an overview of the workforce. ACWC collects data every four years about the aged care workforce, facility, and provider characteristics. The 2020 ACWC survey was completed by 49% of all residential aged care facilities (RACF) (1329), 47% of HCPP providers (616), and 38% of CHSP providers (505) (DOHAC 2021). ACCD is a survey that captures data about staff's working life, management styles and practices, and staff's perceptions about the quality of care delivered. It also provides workforce views about their working conditions, including on attracting, retaining, and turnover rates for staff. Over the years, the ACCD has captured the views of 171,572 aged care workers (BPA Analytics). ACWC and ACCD were used as a major set of empirical evidence about the working conditions of DCWs. These sets were searched and reviewed to establish the demographic of the aged care workforce, and to identify trends in work arrangements, perceptions of work conditions, and intentions about future engagement with the work.

Qualitative data were extracted from testimonials about the quality and safety of aged care in Australia collected by the RCACQS between 2019 and 2020 through hearings and workshops held across the country. In this study, the testimonials were used to better understand the survey trends and provide richer perspectives of DCWs' experiences. The dataset included 628 witnesses who were experts (e.g., clinicians and academics), older people, family members, informal carers, managers, and executives from aged care organizations, members of advocacy, and peak bodies representing providers, consumers and workers, government employees and senior civil servants, and all level of aged care workers. Although the legal processes and formal structures around the RCACQS limited direct engagement with the full range of caregiving workers and care-receiving people, some of the marginalized voices were represented through the testimonials of professional bodies and advocacy groups, such as workers' unions and cultural associations. The RCACQS transcripts were downloaded and then coded using NVivo 12.

The two datasets were supplemented by a review of various government documents, including policies and reports produced by the Aged Care Workforce Taskforce Strategy (ACWTS), the RCACQS's final report and recommendations, and the Fair Work Commission's Aged Care Work Value Case.

3.2 | Data Analysis

All datasets, from the national workforce statistics, the voices of the workers, and the policies that shape the work were initially clustered around the themes of "who" does the work; "how" their work is framed and the associated expectations; and under "what" conditions. Following Saldaña (2021), the themes drawn from the study's sub-questions were used as a generic structuring approach to help reflect on and analyze the datasets.

To understand the reasons for the lack of improvement to the working conditions of aged care workers, the datasets were analyzed using a "precariousness framework". The framework conceptualizes precariousness as a four-dimensional phenomenon: (1) a social category (precariat), (2) a shared work and life experience (precarious workers and precarity), (3) a set of work practices (precarity in employment and precarious work), and (4) the structural and regulatory mechanisms that control employment conditions (governance and management of precariousness). The four-dimensional framework of precariousness is

based on my synthesis of Campbell and Price (2016), Lorey (2015), and Anderson's (2010) work.

Campbell and Price (2016) distinguish between five types of precariousness: precarity in employment, precarious work, precarious workers, precariat, and precarity. Precarity in employment refers to the employment conditions that are characterized by "low level of regulatory protection, low wages, high employment insecurity and a low level of employee control over wages, hours and working conditions" (Campbell and Price 2016: 315). Precarious work is a type of work that is considered inherently "bad" (e.g., rubbish collector). The concept of "precarious workers" refers to the workers affected by precariousness. The precariat is a social class that has emerged from socio-political studies, which is used to describe a group of people with shared social and political values and characteristics. Precarity refers to the experience of vulnerability and sense of insecurity and instability that affects all parts of life beyond employment.

In addition to being understood as the outcome of a particular dynamic or an experience, precariousness can also be seen as a structural and relational way of managing and governing (Anderson 2010; Lorey 2015). For Anderson (2010), precariousness can be institutionalized and legitimized through a series of mechanisms of control, such as immigration regulatory practices and processes. For Lorey (2015), precariousness is more broadly a characteristic of current western-style democracies. The government and management of precariousness is defined as the regulation and institutionalization of minimum levels of protection and welfare that spill into social spheres traditionally perceived as secure and stable to negatively impact people's general way of life. These mechanisms initially established to protect against insecurity, ultimately, serve to further destabilize employment and constrain self-determination.

4 | Results

The analysis of the datasets reveals that the sector relies heavily on women who are older, migrant, and/or from CALD backgrounds to perform direct care work. It also shows that although DCWs are entrusted with the responsibility of delivering high-quality care to vulnerable older people, their work is often devalued and perceived as lacking professionalism. Finally, the analysis highlights that DCWs are not fully compensated for their training and overtime work, and, thus, are expected to absorb some of the providers' cost of meeting quality and safe care standards.

4.1 | Older and CALD Women

The aged care workforce in Australia is composed of DCWs, nondirect care, and allied health workers. DCWs include registered nurses (RNs), enrolled nurses (ENs), assistants in nursing, personal care workers (PCWs), and health care workers. The nondirect care workers include practitioners who manage and run diversional, lifestyle, and/or recreation activities. The allied health workers are professionals and assistants employed in a wide range of health practices such as physiotherapists, occupational therapists, speech pathologists, and podiatrists. Across the sector, the largest proportion of nurses (i.e., RNs, ENs, and nurse practitioners) and PCWs worked in permanent part-time positions and the second largest as part-timers employed through agencies or as subcontractors (DOHAC 2021).

The workforce includes close to 88% of women (DOHAC 2020). Although the workforce is highly feminized, 49% of senior managers and executives are men. In addition, there is a significant pay gap of 22.8% that disfavor women (WGEA 2023). A majority (52%) of the workers are 41 years old and over—which includes 19% of workers aged 56 years and over (BPA Analytics 2023). The workforce also includes a large proportion of DCWs from diverse backgrounds. For example, 37% are from a non-English speaking background, 48% are born outside of Australia (BPA Analytics 2023), and on average 31% identified as CALD (DOHAC 2021). These statistics do not account for the 2% of DCWs who identified as Aboriginal and/or Torres Strait Islander people (DOHAC 2021).

Although a significant number of DCWs are born overseas, this group of workers includes Australian citizens, permanent residents, and non-residents. Today, DCWs born overseas may have migrated to Australia with or without the intention of working in the aged care sector under the permanent settlers and primary visa holders' program, as the family members of primary visa holders, or as humanitarian migrants. But aged care sector workers are also intentionally recruited by the Australian government under specific visa schemes.

The specific migration programs apply to the recruitment of aged care workers because of its crisis-level shortage of staff. At one end of the workforce spectrum, a skilled migration program seeks to recruit RNs or licensed nurses from English-speaking countries, such as the United Kingdom, Canada, the Republic of Ireland, South Africa, and the Philippines, on a permanent basis (DOHAC 2023). At the other end, a temporary migrant workers program recruits DCWs from the Oceania region. The temporary migrant workers program was designed to fill low-skilled and low-paid positions. The current version of the program is called the Australian Pacific Australia Labor Mobility (PALM 2023) and is for:

> for seasonal jobs for up to 9 months or for longer-term roles for between one and 4 years in unskilled, low-skilled and semi-skilled positions [...] offering employers access to a pool of reliable, productive workers. It also allows Pacific and Timor-Leste workers to take up jobs in Australia, develop their skills and send income home.
>
> (PALM 2023)

This temporary visa program, which is part of de facto labor migration and recruitment policies, should not be confused with the ad hoc recruitment of DCWs among international students on temporary visas—for which there are no definite statistics.

The Australian government sees the PALM scheme and skilled migration program of expedited visa application as the best immediate solution to address the dire shortage (Senate

Committee 2023). The justification for the PALM program is that it seeks to address the crisis level shortage of staff. Yet, as the intention of these visas is for migrants to stay in Australia only for a short period, people who come to work under temporary visa conditions are often under-employed and over-qualified, and/or unable to upgrade their visa status even if work is available for them on a permanent basis. These issues were raised by an RCACQS witness, Prof Charlesworth, a socio-legal scholar whose work focuses on employment inequality for women:

> We do know that there is a number of people that arrive from India and the Philippines and they will have nursing qualifications which are not recognised in Australia, and they could apply for permanent residency if they were able to have their qualifications recognised and trade up and be then going into a nursing job, that's possible. But as long as they are an aged care worker and they want to stay as an aged care worker, they will find it increasingly hard to achieve permanency.

Another issue associated with the employment of DCWs with diverse cultural and ethnic backgrounds includes the prejudice they face. For example, Ms Patetsos (an RCACQS witness), the Chairperson of the Federation of Ethnic Communities Councils, explained how this "incredibly diverse" workforce "experiences levels of racism for a variety of reasons that are complex, and working conditions that are poor. It's a very vulnerable group of people". This issue was reinforced by the ACWTS (2018, 58) who noted that issues of inclusion for CALD and First Nations workers had remained current since their 2012 survey: "Although there is a diverse workforce, almost a third of employees do not feel they are treated with respect regardless of personal characteristics or background".

The analysis of who the DCWs are highlighted a complex picture of a gendered sector where the direct care work is not only largely undertaken by women but also by women who are older, from CALD backgrounds, and/or with various migration backgrounds and residency statuses, including temporary workers from the Pacific islands and international students. It also showed how structures, political framing, and representations work together to create a recurring form of discrimination that is specific to people with cumulative forms of differences, such as older migrant women.

4.2 | Perceived Lack of Professionalism

DCWs are "employees in the aged care sector covered by the [National Minimum Wage] Awards in caring roles" who perform "a non-exhaustive list of specific roles" (Commonwealth Government 2022, 8). DCWs include nurses (RNs and ENs) and PCWs. PCWs represent the largest proportion of DCWs. For instance, in RAFS, 70% of the DCWs are PCWs, 23% are nurses, and 7% allied health professionals (DOHAC 2020). In practice RNs and ENs are responsible for the medical and clinical care. PCWs' role is to assist with daily living care that does not require a qualification. RNs are required to hold a Bachelor's degree, ENs need to be in the process of securing their Bachelor qualifications, and PCWs are not required to hold a qualification. Yet, most PCWs (70%) hold or are enrolled in a Further Education Certificate III or higher (ACWTS 2018).

In the absence of requirements for formal qualifications for low-paid PCWs, expectations about how the work is done have been couched in discourses of professionalization. With the lack of professionalization presented as jeopardizing providers' capacity to meet required standards (Senate Standing Committee on Community Affairs 2017), it became a recommendation of the RCACQS (2021) for the sector to invest in building an "aged care profession" through training and professional development programs in a "cost-effective way". The government ratified this recommendation in its 2023 Draft National Care and Support Economy Strategy (PM & C 2023).

The families of older people have also echoed this call for professionalization, at times overlaying this with discourses of excellence. For example, Ms Backhouse (RCACQS witness reading her written submission) whose older parent lived in a RACF stated: "The workforce must be professionalized to improve standards and quality of care and, yes, that means regulation and appropriate funding and remuneration. It means developing proper career pathways to attract and retain the *best* employees" (italics added by the author).

These discourses coexist with discourses of lack of professionalism and often link low-qualified workers, with poor skills and competencies, and migration status. For example, Ms Butler (RCACQS witness), the Federal Secretary of the Australian Nursing & Midwifery, one of the main unions in the sector, stated: "there are many people who don't have English as a first language, that they also tend to be—they're a transient workforce. They're low paid and gendered—they're very much a female workforce. [...] They tend not to be IT-literate".

That comment highlights the fact that the professionalization discourse not only depicts workers as a problem but also points to a hierarchy of skills—and therefore workers—that fails to recognize the value of a wide mix of competencies required to deliver quality and safe care. Professionalization discourses help justify the need to meet quality standards in cost-effective ways. Yet, they tend to ignore DCWs' actual skills and competence, the low provision of training, and unrealistic expectations to deliver quality and quantity of care.

These discourses add pressure on DCWs to perform and affect their capacity to care for themselves, which, in turn, affects their capacity to care for others. The comment by Mr Mathewson, the Executive Director-Services of Aged & Community Services Australia, a provider representative group, illustrates this point well:

> We need to respect the work of our carers [...] and without minimum safe staffing practices, we can't have a safe workforce. And I'm convinced that we will

> potentially have a death in residential aged care unless we address occupational health and safety seriously.

The pressure and responsibility placed, in particular, on PCWs to meet high standards of quality while being devalued in what they do allows for workers not to be compensated fully for the caregiving they provide and with minimal provision of training. The analysis of government documents, national workforce data, and the RCAQCS's evidence shows how aged care workers are expected to carry out tasks with high responsibilities and deliver high standards of quality care with little to no consideration of the fact that their performance relies on overtime that is unpaid, and their professional practice made invisible by a range of assumptions and discourses, which I examine next.

4.3 | Underpaid Work

As part of its recommendation for the professionalization of the workforce, the RCACQS (2021) proposed an aged care worker registration and accreditation scheme that requires a Certificate III qualification and participation in ongoing professional development activities to ensure PCWs are up to date with the complex clinical needs of caring for older people. This recommendation signals a shift of responsibility for undertaking some of the better-paid RN and EN work toward the lesser-paid PCWs. It also points to a shift in the cost of ongoing professional development to PCWs, especially those employed on a part-time or casual basis or through agencies.

Such a lack of concern for shifting the cost of care work onto workers is also apparent in the work culture and common practice of expecting DCWs to volunteer and perform unpaid overtime for the good of the community. This was highlighted by an RCACQS witness, Ms Wilson, a PCW, who stated:

> most times, most nights I don't leave at a 9 o'clock finish, I will stay back. If there's a resident we're halfway looking after you just don't leave; you stay there and you finish caring for them.

Witnesses' statements also showed how care duties were organized by employers in such a way that they routinely saw overtime work go without pay. The answers of an RCACQS witness, Ms Walton, a PCW, to Counsel, Mr Bolster's questions illustrate this point:

MR BOLSTER: what time do you start work?

MS WALTON: I'm not supposed to start till 11 but I go in early, usually about quarter past 10, 10.30. You're supposed to finish at 7.30 if you can.

MR BOLSTER: And why do you go early?

MS WALTON: It's handover, we have a problem with handover between shifts. We don't actually get to see the registered nurse for a handover when we start our shift.

Additional evidence of how underpaid work is designed into aged care work can be found in how the time required to travel between clients for DCWs delivering in-home services is not part of the paid time allocated per client. That is problematic as Ms Alcock, an Industrial Officer with the Health Workers Union, explains:

> There are women right now, sitting in their cars, waiting to go into someone's home and not being paid for that time. And that isn't their time. So, they're not paid for kilometres travelled. They're not paid to travel between homes.

Workers' tendency to carry out their duties beyond their paid hours reinforces the assumption that workers will accept the responsibility of meeting high standards of quality of care for poor working conditions. This has significant implications for workers as Mr Hayes (RCACQS witness) explains:

> It means they go to work tired. They get to work frustrated. They try to do as much as they can knowing what they can do is just not enough because they don't have the resources to be able to do it. They have an issue of higher workers' compensation from physical injuries, from mental health injuries. Again, when people are dying, you know, every week that they love and then the next step is that before they're dying, they can't get to them to help them to get them to the bathroom on time and things like that. So, the incredible stress that gets put onto aged care workers on a daily basis, whether it's an RN, whether it's a carer, whether it's an allied health professional, this is what these people live with every day and we don't talk about it enough.

The reasons for this acceptance are largely unquestioned and multifaceted, including the complexity of how wages are calculated, as highlighted by an RCACQS witness, Ms Hilton, a PCW (reading her submission):

> When I started with my current employer, we got a pay rise. It was long overdue. our Union has helped us with our new enterprise bargaining agreement and subsequent incremental pay rises. our pay doesn't keep up with the cost of living so we're attracting the wrong sort of people into the positions now. Now, I mostly get domestic assistance work so I don't get paid at the higher level for grade 3 work but I'm not just doing domestic assistance. When people come straight out of hospital they have high needs. Sometimes they burst into tears. Even if I'm rostered for domestic assistance, I need to help them in the situation they're in. However, I don't get paid for that. [...] My pay fluctuates each fortnight, but it's difficult to understand and to monitor. The pay can vary on whether

> you see a grade 2 or grade 3 client and the amount of travel you do.

Another reason for this acceptance may also be found in how the perception of poor conditions depends on workers' backgrounds. National survey data show that aged care workers born overseas and for whom English is not their primary language tend to be more satisfied with the level of remuneration (59.9%) than their counterparts born in Australia and for whom English is their first language (44.2%) (BPA Analytics 2023).

Although there is an acknowledgment of the poor work conditions, it seemed that no DCWs tended to complain. Some RCACQS witnesses suggested that this was because of the lack of bargaining power workers have through the union representation. PCW, Ms Hilton, makes this point:

> Very few [social-and-community home care workers] are covered by enterprise agreements, and the enterprise agreements that do exist are zombie agreements, agreements that were created under work-choice legislation; so they're quite old collective agreements. They provide very few terms and conditions, very low rates of pay under the social-and-community award. They're really invisible workers. It's really hard, to organise them, because they don't have a central location.

Other witnesses argued that this was because of the lack of response from hierarchies. For example, Prof Ibrahim, the Head of Health Law and Ageing Research Unit at Monash University, explained:

> having a predominantly female nursing workforce who look to solve problems and make do means that people—that they don't get the support they need or the support that they deserve. [...] if it was a group of doctors, the AMA [Australian Medical Association] would be banging on about the need for resources, more pay for doctors, more—more resources for residents, and the situation is not good enough. When the ANF [Australian Nursing Federation] say the same thing, they're predominantly met with silence.

Another explanation for the acceptance of underpaid work might be linked to workers' motivation to do this work. For instance, Ms Backhouse (an RCACQS witness reading from her submission) commented that:

> The vast majority of carers are loving, compassionate and diligent people who bring a wealth of pride to their work. They have extremely hard jobs and they do it well under the circumstances.

These quotes also hint at the idea that the care provided to maintain older people's quality of life is a "gift" that cannot be fully financially recompensed.

Regardless of the reasons, the normalization of under paid work further "intensifies" or "degrades" DCWs' work conditions, which makes it difficult to attract and retain staff. Indeed, building unpaid overtime into work further entrenches low pay, which in turn leads to attrition and lack of appeal to work in the sector. This is well described by RN RCACQS witness Ms Murphy:

> unless you are passionate about it and you do love providing the care, then it's probably not something that people would tend to stay in. And I do find that there is quite a large staff turnover in aged care because it is such a demanding and stressful industry.

These results show how the devaluing of DCWs and their work serves to shift the responsibility and cost of meeting quality and safe care standards onto workers. They also show that by employing women who are older, CALD, and/or migrant and have low expectations of working conditions, providers can secure cheap labor.

5 | Discussion

The study sought to understand the reasons for the lack of improvement in the working conditions of DCWs despite a series of government reforms designed to address issues of precariousness in aged care work. My analysis of who does the work, how the work is done, and under what conditions shows how the structures, political framing, and representations of older and/or migrant women secure cheap labor, and that DCWs are burdened with the responsibility and extra cost of delivering high standards of quality and safe care. These key aspects of Australia's aged care sector play a critical role in the persistence of precariousness at work for DCWs. Specifically, I find that the lack of significant improvement is linked to a series of tensions and conflicts that produce and reproduce precariousness by simultaneously valuing and devaluing care and the older and/or diverse women who deliver it. Smith and Lewis (2011) conceptualize such conflicts and tensions as paradoxes. Paradoxes operate within and across various levels and are experienced differently by the various members of a group, organization or industry. In addition, paradoxes are persistent, morph, and adapt overtime.

Precariousness as a social category that defines a group of people around specific socio-political values and characteristics was evident in how older, CALD, and/or migrant women were constructed as ideal caring workers while also being undervalued and underpaid. The tension between the competing values and roles of the actual and perceived identities of older and/or CALD women DCWs is reminiscent of Dahl's (2021) work on the stranger or foreigner, who is central to the delivery

of aged care in Western countries, and, at times, perceived as a threat depending on their distance from a family or community and their position on the periphery of society.

In the Australian aged care sector, precariousness as a social category materialized in the paradox between DCWs being described as skilled and essential, and at the same time as untrained and disposable. For CALD female DCWs a more specific form of precariousness as a social category was also evident in the conflicting views between the assumption that, on the one hand, CALD or migrant female workers are more tolerant of poor working conditions or less vocal about their rights as they come from cultures perceived as less-progressive at a social and organizational level, and, on the other hand, the idea that their cultural background has equipped them with greater capacity to care. That raises the additional conflicting perspective that these women are seen as different while at the same time attributed to the universal value of care. CALD female DCWs, therefore, find themselves simultaneously represented in conflicting ways: a caring person central to the delivery of aged care; and a "stranger" relegated at the bottom of the hierarchy of service delivery. These findings align with other research (Banday, Bishop, and Hyde 2023; Eagar et al. 2019; Latimer 2013; Navallo 2022; Murphy 2015; Overgaard, Withers, and Mcdermott 2022) that explains that these tensions exist because of the values we ascribe to care at a sociocultural level, where care is constructed around notions of gender, social class, age, and sexuality; largely perceived as of the female realm and (pre)occupied with the intimate, affective and embodied interactions.

In addition, precariousness as a social category was apparent in how low-skilled, older, and/or CALD PCWs were placed at the bottom of the aged care workforce hierarchy. As a settler-colonial nation built on the assumed superiority of British rule and civilization (Tavan 2005), there are clear social stratifications at play that still inform social interactions and migratory priorities in Australia today, with Aboriginal and Torres Strait Islander people located at the bottom, White Anglo-Celtic and Europeans at the top, and other new and former migrants in between according to their skin tones and perceived cultural ancestry (Kalemba 2023). The hierarchies are maintained by government policies and regulations to achieve particular social, political, and economic goals (Levi-Faur 2017).

Precariousness as a set of work practices surfaced in the use of discourses that amalgamated the need for increased professionalization of PCWs and concerns of de-professionalization (or de-skilling) of RNs and ENs (Hodgkin and Mahoney 2020). The professionalization of aged care practices coincided with the increased shortage of nurses and the resulting shift toward relying on less qualified PCWs to take on the medical or clinical duties that were previously the responsibility of RNs. As Wichterich (2019) discusses, the professionalization of care (including aged care) has been subjected to the process of rationalization on the grounds of providing quality care. Because of the driving forces of capitalism (i.e., growth, productivity, and efficiency), rationalization is implemented through processes of "modularization and standardization similar to industrial labor" that turns care into a practice that is "fragmented, taylorised, and scheduled into time units" and results in a disembodied relational conceptualization of care (Wichterich 2019, 10).

The rationalization process not only dehumanizes care but also renders the work unsustainable. The work then becomes inherently "bad" because it is devalued and underpaid. This is evident in how the regulation frames and dictates the type of workers required, their qualifications, minimum wages and number of hours on duty. Although the laws, policies, and standards were introduced to ensure safe quality care, providers have also used the regulatory environment to justify the maintenance of substandard employment practices (Brown et al. 2022), including the disadvantage borne from intersectionality, and shifting the responsibility and cost of delivering quality and safe care onto DCWs. Such a justification can be explained by a study of RACFs that found significant parts of the sector to be characterized by high levels of ritualism (Braithwaite, Makkai, and Braithwaite 2007). The authors argued that providers used the legitimacy of needing to comply with institutional goals, such as implementing standards and seeking accreditation, to evade close examination of actual practices and avert attention away from failings and/or rejection of associated cultural goals, such as quality of care (Braithwaite, Makkai, and Braithwaite 2007).

The dehumanizing and unsustainable work and the tension between professionalized care (i.e., a specific set of skills and knowledge) and nonprofessional care (i.e., emotion-based and low-qualified basic tasks) are how the disadvantage borne from intersectionality manifests for the older, migrant, and/or CALD women DCWs. The experience of being devalued in who they are and what they do is then compounded into being silenced when they find their vulnerability pitted against the vulnerability of the older people they care for (Galanti 2024; Strachan 2023). In this context, intersectionality becomes a form of precariousness as shared experience, where the vulnerability and sense of insecurity and instability permeate all parts of DCWs' work and life.

The rationalization and commodification of care are also evidence of precariousness as a form of management and control. As Latimer (2018) found elsewhere, in the Australian sector, the push to professionalize care as a medical or clinical practice usurps and devalues the past idea of care as a relational and affective practice by rendering these aspects mundane, out of the realm of efficiency. That highlights the tension between care as a trait and care as work (Gherardi and Rodeschini 2016). The tension between care as a trait and care as work can be seen as rooted in how the sector has shifted from aged care being mainly delivered by not-for-profit church-based organizations (Gallet 2016; Hughes 2013; Swain 2005) to for-profit businesses (Brown et al. 2022). This is problematic for workers as a care ethic of "self-sacrifice" dominant in church-based organizations is expected to remain the norm in the for-profit delivery of care (Allard and Whitfield 2023).

The tension between care as a trait and care as work can also be linked to the delivery of aged care in the home that turns private personal spaces into professional spaces (i.e., DCWs place of work) and/or as a "public" service in an organizational setting (e.g., RACF) that seeks to mimic a private space. This clash

between private and professional further reinforces and encourages a form of precariousness that increases insecurity at work and limits workers' agency and capacity to enact change (Eagar et al. 2019; Lorey 2015).

The presence of precariousness as a social category, shared experience, set of work practices, and form of management and control reveal how precariousness is produced and reproduced through ongoing and interconnected conflicts and tension between values, practices, management, and regulation of care and care workers. Specifically, precariousness for DCWs has persisted despite the government's attempts to improve working conditions because of the paradoxes that underpin how care, care work, and workers are constructed. The intractable tensions between the construct and practice of care as female, mundane, and private trait/quality opposed to professional, skilled, and public service work are a plausible explanation for the persistence of precariousness in aged care work.

The COVID-19 pandemic—with the associated emergence of "front line" and "essential worker"—and the RCACQS enquiry that made visible public workers, older people and their families' vulnerabilities allowed for the revaluation of DCWs' wages (FWC 2020). In November 2020, the Health Services Union (HSU) with support from the Australian Nursing & Midwifery Federation and the United Workers Union successfully put forward a case to increase the wages of DCWs. And, in 2023, the Australian government approved an increase of 15% of wages—10 percentage points lower than the 25% argued for by HSU—by cementing it in their budget (Senate Committee 2023). These reforms are promising as research shows that better pay is part of the solution to better work conditions (Charlesworth and Isherwood 2021; Farris and Bergfeld 2022). But will pay increases alone be enough to improve the overall work conditions that will finally help to retain and attract more DCWs?

In the meantime, a lack of significant change remains the reality for most DCWs. This can be explained by the fact that reforms have tackled to change one element at a time and in isolation from each other. It can also be explained by the fact that the sector has been operating in crisis mode, waiting for the government to subsidize the work, not investing in their staff and aspiring to be employers of choice. This study provides an additional explanation that the lack of change is linked to the reproduction of different forms of precariousness through a series of paradoxes that construct workers as the problem, entrench disadvantage borne from intersectionality and shift the responsibility of meeting high standards of quality onto workers without full compensation for the hours worked.

The study's findings have implications for policy, employment, and care practices, and for the wellbeing of DCWs in Australia and in countries where aged care is similarly regulated. The analysis points to some of the reasons why policy change that only targets isolated aspects of the sector's aged care work conditions has not resulted in significant improvement. The competing choices and contradictory elements at the heart of the paradoxes are based on interrelated advantages and disadvantages, and enabling and hindering factors, which means that the situation cannot be resolved through the integration of the opposing values. Therefore, to make the working conditions and the sector's operating model sustainable and ensure older people receive quality care, there is a need to address the systemic, relational, and cultural issues as a whole, and build on the solidarity between the caregiving workers and with the care-receiving older people and their families.

Solidarity can be built around the tensions expressed through differences in language and embodied ontology and epistemology, including shared experiences of precariousness and vulnerability (Smolović Jones et al. 2021). Such mobilizing means resisting and rejecting the deficit discourses, reclaiming the place of the mundane, and instating a more integrated understanding of care (Butler 2016; Latimer 2018). Some of the answers may also lie in understanding care as a situated political practice grounded in relationality and reciprocity—especially between care workers, older people, and their families—and care ethics as sitting outside the polarizing views and paradoxes that confine people to social categories and hierarchies of difference (Gherardi and Rodeschini 2016; Mandalaki and Fotaki 2020; Raghuram 2019; Robinson 2020).

6 | Conclusion

This study makes two contributions to the research on precarious work. It offers a "precariousness framework" based on a conceptualization of precariousness as a four-dimensional phenomenon: a social category (precariat), a shared experience (precarity and precarious workers), a set of work practices (precarity in employment, precarious work), and the structural and regulatory mechanisms that underpin employment conditions (governance and management of precariousness). The study also contributes a more complex and nuanced picture of how female workers who are older and/or from diverse cultural, ethnic, and migratory backgrounds are relied on to care for older people under precarious conditions. The results reveal how the poor working conditions have become intractable because of a combination of socio-historical developments, assumptions about care, and women who are older and/or CALD and regulatory reforms that have shaped the sector and limit workers' choices into accepting insecurity and uncertainty. In addition, the analysis shows that the coexistence and persistence of the four dimensions of precariousness—social category, shared experience, work practices, and management—are linked to a feedback loop fueled by a series of care paradoxes that construct workers as the problem, entrench disadvantage borne from intersectionality, and shift the responsibility and the costs of meeting high standards of quality care onto workers.

Although the findings provide insights into the working conditions and experiences of DCWs in Australia and the lack of significant improvement, they are based on data from a time in history on the cusp of change. This limitation to the study means that additional work is needed to examine the consequences of the recently approved increased wages on precariousness in the sector. Further research is needed to understand what it will take to reject the sector's deficit discourses and reclaim vulnerability as a strength and source of solidarity, shift negative perceptions of low-skilled carers and their work, and

value the plurality of voices and complexity of needs of DCWs, providers, and clients.

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Conflicts of Interest

The author declares no conflicts of interest.

Data Availability Statement

All datasets are freely available online.

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