Still working for love? Recognising skills and responsibilities of home-based care workers

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Abstract

Purpose - The purpose of this paper is to focus on care workers employed in clients' own homes, recognising the skills and responsibilities of home-based care workers.

Design/methodology/approach - Interviews and focus groups with domiciliary care workers in New Zealand centred on what these employees actually do during their working day.

Findings - Home-based care workers require the same skills as residential care workers, but they also have greater responsibilities and receive less supervision and support, as they work largely in isolation. In addition, they must spend a large part of their working day traveling between clients: this time is unpaid, and brings their average hourly pay below the minimum wage.

Practical implications - Although the home-based care workers who took part in this project love and are committed to making a positive difference to their clients, they also want the government, employers and the public to recognise their skills, efforts and their challenging working conditions.

Originality/value - In earlier days of deinstitutionalisation, Graham described caring work as a "labour of love". More than three decades years later, a New Zealand government minister described paid care workers as working partly "for love". Care work is also currently perceived as unskilled. Both these perceptions depress the pay and working conditions of care staff, and in future may undermine the quality of care delivered to vulnerable clients.

Keywords Gender roles, New Zealand, Care work, Emotional labour, Professional skills, Home-based

Paper type Research paper

Introduction

Care of frail elderly, sick and disabled adults in their own homes is expanding in English-speaking countries. This is partly a response to restricted government budgets, since home-based care is cheaper than hospitals and residential care homes. The proportion of adults in the population requiring care is increasing, with a growing proportion of people aged over 85 (New Zealand, Human Rights Commission, 2012).

It is vital to ensure the social care workforce is able to deliver high-quality care services. However, at present relatively little is known about how home care workers themselves experience and negotiate their labour on a daily basis (Stacey, 2005, p. 831). This paper aims to address this.

The work of home-based care workers is low status, regarded as unskilled, and has very limited career prospects. Pay is low, with few opportunities for pay progression. Despite this, this project finds that domiciliary care workers require a range of professional skills, including relationship-building, problem solving and coordination. The work demands high levels of responsibility for the wellbeing of clients and the ability to work largely unsupervised, in isolation,
with little support. Staff are required to work under constant pressure because of often inadequate time allocations for each client. There is an additional requirement to travel between jobs, but employees are not paid for this. They also describe working additional hours unpaid in order to safeguard clients’ safety, health and wellbeing.

For the participants in this study, the only attractive feature of the job is the relative autonomy they enjoy, which enables them to utilise their years of experience for the benefit of clients. However, high levels of demands and responsibilities, combined with poor remuneration and low status make care work unattractive to new recruits, with low retention of younger staff (Human Rights Commission, 2012). In addition, most older and experienced care workers retire as soon as they reach pension age. Consequently there is a looming staffing crisis in care work. Because of this it has been claimed that: “care workers’ experiences of frustration, and strategies to alleviate them, are worthy of further investigation” (King, 2012, p. 52).

An obstacle to valuing the skills needed in care work is the view put forward by the New Zealand Minister of Senior Citizens, Jo Goodhew (Higgins, 2012), who claims that care workers are compensated in non-monetary ways because they “love their jobs”. Participants in this study did not agree that satisfaction and pride from performing a difficult job should be used as a justification for poor pay and conditions.

The paper is organised in the two parts. It begins with a description and analysis of a small in-depth study of domiciliary care work in New Zealand. It details the daily activities of an experienced domiciliary care worker, in her own words. This is followed by a discussion of some of the complex skills required by this worker and others doing the same work. The skills required tend to be tacit and hard to see (Junker et al., 2009a; Hempton and Junior, 2003; Guy and Newman, 2004, p. 290; Palmer and Evaline, 2012, p. 271). It then looks at the working conditions of home-base care workers, which differ in some respects from those in residential care work.

Part I of the paper documents the challenging employment conditions under which home-based care staff are working. Part II critically examines some of the explanations that have been advanced for the under-recognition of home-based care workers’ skills described in Part I. We look at the effects of gender and class on the value placed on care work. Finally we conclude by briefly exploring possible ways of improving recognition, retention and transmission of these skills. This includes recent legal challenges to the undervaluation of skills in female-dominated occupations and at whether there may be a case for professionalisation of care work.

**Methodology: about this project**

The research draws on two focus groups: one with eight women, and the other with six. The focus groups were conducted by a professional facilitator. Her notes from the debriefing sessions following the focus groups are included below. Nine of these women subsequently agreed to be interviewed by telephone and the interviews were professionally transcribed. Participants were based in a number of provincial towns across New Zealand[1] and recruitment took place with the support of a service workers union. All of these participants were providing home-based care for clients with disabilities.

Most of the workers were over 50 years old, just one in her late 30s and were female. Most had been involved in this sort of work for over ten years, some for 15-20 years and one for over 25 years. The names of all the women quoted have been changed and the names used are all pseudonyms.

Although the women who took part were working long hours, they were keen to participate because they were concerned about the lack of recognition of their skills, responsibilities and efforts. Upon publication one of the authors will reconvene the focus group to thank the participants.

Each focus group discussion and interview was asked open-ended questions asking the group or the interviewer to describe how they became a care worker. Supplementary questions had the care workers describe a normal day. The interviews provided rich data and the focus groups allowed participants to raise issues that were elaborated by other participants.
Both authors read the transcripts and manually coded them thematically developing four broad themes: the workers’ background, their day to day responsibilities, their working conditions and how they described care work as skilled work. Together these forms generated a body of evidence about care work, adding to job analysis interview data such as that reported by Junor et al. (2009a, b), and Hampson and Junor (2010) and Briar and Junor (2011).

Part I: skills, responsibilities and working conditions

A day in the life of a domiciliary care worker

Staff who took part in this study are well aware of the demands and complexity of their jobs. As one expressed it, "I just wish people would value what we do". Sylvia, an experienced care worker currently aged over 60, worked this typical Monday shift:

I don’t start till 8.30 am. I shoot down and do a 1) colostomy bag lady and monitor her. Then I go on from her to 2) a shared care one with another home based care worker at 9 am which is the stroke lady and it's two persons' care. She is a large lady who won't use a hoist so it is a bit dodgy and she takes an hour. At 10 o'clock 3) I go up to a cerebral palsy man for 2 hours. Give him a quick spruce up and do his cleaning and his cooking. I've gone to him for over 2 years. I've got the key and I am basically his house carer really. I do his cooking and I also do 2 hot meals a week and pop that into the freezr for him. At 12 o'clock I see 4) a very frail elderly lady who lives with her family but they work. I just see if she needs a wee toilet trip and make sure she has something to eat. She’s a half hour. At 1 o'clock 5) I go to a shared care man, he's got dementia so we do his hoisting and toileting. [She paused] and then where do I go on Monday? Um oh yes then 6) I go to a young man who is not 30 and has dystonia. Bright as a button, and I also do his cooking. Then at 4 pm 7) I go to my little boy who has cerebral palsy and he's been in and out of a cast and I shower him and feed him, help with his homework and all the rest. Then at 6 pm 8) I go and do a women's support stockings. She suffers from anxiety. That's 8.30 pm. I'm starting to get a headache [remembering all this], And then 9) I go and do the shopping for the man I should do on Tuesday, I usually do it on Monday night because I have a got a gap. And then 10) I go back to the dystonia man because he can't actually self-medicate because he can’t get the wee pills out of the wee things, so I go to him. Then I go to - oh yeah at 8 o'clock-ish 11) I go and put the old man I saw at 10am to bed. That's shared care with another carer. And then 12) I go back to the dystonia man and give him his second lot of pills and then 13) I go to a women who has post-stroke and she's a standing hoist and we just get her into bed and that's it. So that's Monday, Saturday, Sunday, Monday, Tuesday are just insane and then the rest of the week is quite civilised.

Sylvia has a long working day, under constant pressure. She also works unsocial hours – evenings and weekends. She is out working for 13 hours a day, but is only paid for nine hours. Because of the variety of clients’ ages and conditions she needs a wide and detailed practical knowledge base and skill sets. Some of the techniques she uses would also be used in hospitals.

Skills used in home-based care work

Building a body of knowledge. Although an understanding of the job’s procedures, responsibilities and boundaries can be acquired in a relatively short time, clients with long-term and chronic conditions undoubtedly benefit from the in-depth knowledge held by experienced care workers. For example, Tanya had already built up a body of knowledge about the client’s family circumstances and her dementia. In this example her knowledge protected a client from missing a main meal. She said:

[You might say to the client], look I'll do your lunch. “No, no you don’t have to do my lunch, my daughter is coming”. And you think: “I know you don’t have a daughter, she died eleven years ago”. Most of the carers who took part in this study had been in their current roles for a many years, and had accumulated knowledge about the clients and their families.

Skills of assessment. In addition, experienced care workers generally have built up the capacity to quickly assess new clients’ needs. At times workers are sent to a new client's home with little information about the person. Carol described one instance:

After meeting the client for the first time I called the coordinator manager and asked: “now tell me, has this lady got slight dementia”? She looked up the notes and said “yes she has”. I said “fine, that’s all I needed to know: so now I know why she was repeating herself”. But I was not told that.
They need to start by making keen observations. They may then need to sit down with the client and/or the family and ask a series of follow-up questions. These care workers realised that a new recruit to their occupation would not have the body of knowledge that enabled them to do this as effectively. Janice said:

The first thing you do when you go to a client is you look and that look gives you mostly all that you need to know and from that look you know if you need to sit down or not. You couldn’t teach anybody that but I believe that new carers should have to go with old carers for a while.

As Janice points out, experienced staff can pass on practical skills of assessment to newer employees, in ways that could not occur on formal courses.

Fruently dealing with complex issues. Because of the ageing population, an increasing proportion of the people that the home-based workers care for are older clients. Older people requiring care often have multiple health issues: for example, hearing loss, dementia, difficulties with mobility and/or problems following a stroke, such as speech loss.

Some health professionals dislike working with elderly patients, because of their complex mental and physical health conditions and the fact that, ultimately, there is no cure for old age. “Tanya” shrewdly noted that:

A dear frail old lady […] is practically immobile. She has paper skin; she had breathing difficulties – I mean that’s why the GPs don’t like the old people do they? It is quite complex the care of the elderly and the monitoring of them and reporting back the changes in their condition (Tanya).

Coordination and time management skills. Excellent time management and professional skills of smoothly sequencing and combining activities are all vital when working in a tight time frame. Staff need to keep re-prioritising, and maintaining and restoring the workflow, because if one client’s level of need causes the visit to go over time, or they are delayed in traffic between visits, they must find ways of catching up.

Here Tanya describes her tasks and responsibilities during a half-hour visit to a stroke victim:

My next client […] I took him from the dining table, wheeled him down to the bathroom, got him shaved, got his teeth cleaned, got him into the shower – he has had a stroke but you have really got to watch him when he stands up to walk and all that jazz. You can get him into the shower but he can’t get himself under the shower because he can’t move his legs. Then you have to get him out of the shower, so you tell him each time, move your left leg, move your right leg, move your left leg and then you kind of grab him and put him back onto the wheelchair so you can dry and dress him. Then you put him onto the toilet. So after you fix him all up you have to wipe his bottom and wash it all you know all over again, get him back into the lounge. Then clean up the bathroom, whatever else […] put the washing out. Then I pop across town to a lady.

Some of the clients are “shared care”: that is their care requires two people to be present. In these instances, care workers needs to coordinate being present at the same time and then the use of teamwork skills.

Working safely alone. Other skills involved include awareness of client safety: for example, the above client cannot walk safely. The care worker has to know how to assist an adult who cannot control their limbs in and out of a wheelchair and the shower without injury to herself or the client.

Negotiation, tact and diplomacy. The need to preserve the client’s dignity is paramount. The care worker exercises control over her natural reactions to the care of clients like the one above, disguising negative reactions and remaining cheerful when he needs a bowel motion just after his shower. She is under pressure because the next client will be waiting across town, but must suppress her anxiety because the current client must not be made to feel rushed.

Home-based care workers operate within the private world of the home and family. This can mean care workers learning to skilfully negotiate complex webs of family dynamics, emotions, resentments and rivalries. Sylvia explains:

When you are in their homes you are stepping into their marae [It’s their territory] and you have to be so careful. Not just to the client but the whole family dynamic and I’ve been caught out. You know one daughter will stamp in and say, why are you doing this for mum? She is absolutely capable of doing that. And the next daughter will say poor mum, and she really does need more help.
Participants take responsibility for clients’ health and wellbeing, but as Lydia explained, this has to be balanced with tact and diplomacy to avoid offending some family members:

I've actually taken one woman whose daughter lives out of town to the doctor a couple of times and picked up her prescription from the chemist but I know it might be a problem (with the daughter).

**Relationship-building skills.** Providing intimate personal care requires maintaining a delicate balance between being friendly and being professional. Some disabled clients had been cared for by the same workers for many years. Each of the nine interviewees described how they built special relationships with those in their care, for example Fitia described finely balancing these relationships in order to be genuinely warm and friendly whilst maintaining professional boundaries:

I just treat them [the client] like a friend of mine. I try to avoid any time with them out of work (but) if I run into them on the street or in town I will stop and talk, that sort of thing.

However, employers can be task-focused rather than recognising the need for humanity. The care workers who took part in this project were discouraged from forming relationships with clients, were told to use only their first names and not disclose their home phone numbers to the clients. Lydia outlined the restrictions:

We are not allowed to get close to them or anything like that, but a lot of people say well how can you not when you are a carer?

**Problem-solving skills.** Because they are working alone in clients’ homes, without supervision, these care workers have learned to solve problems and crises as they arise. They sometimes have to think quickly on their feet. Here Teresa responds innovatively to relieve the terror of a client tormented by demons:

I showered him and for the first five minutes he was screaming that there were people in the ceiling, and I could not pacify him. I didn’t know what to do so in the end I turned around. I thought well maybe I will get sacked but I just stood there and said to [the demons] “for god’s sake will you just bugger off”. And then there was dead silence from him and he turned and said, well that worked didn’t it?

Frequently, carers need to be able to independently work out causes of problems, and wherever possible put solutions in place. They may also need to make adjustments to their own responsibilities. For example, Sylvia said:

[One man] was losing weight but I knew he gets meals on wheels. So I looked in the fridge and there were the meals, stacked. He was getting meals on wheels but he wasn’t actually eating them. That is half our job, supervising that; he was eating the meals. After that he perked up considerably [laughs]. He just thought that the lady gave them to him and just put them in the fridge. He missed out the middle bit [laughs].

**A strong sense of responsibility.** The participants showed a keen awareness of what could go wrong if they did not do their work. Some clients have no family help and could see no one if it was not for the care workers’ visits. For example, Sylvia reported that when she did her visit on the Monday, the client’s previous visitor had been on the preceding Thursday.

Clients are often dependent for their health and safety as well as their wellbeing on the care workers. Lydia knew the consequences of not caring could be extremely serious or even fatal:

If one of my clients hasn’t had her pills delivered I’d whip down and pick them up from the chemist. I don’t do a lot of that sort of stuff because I know you can get into a lot of trouble with families. Or the client needs to go to the doctor and the family just avoid taking her to the doctor till it suits them.

Because of they felt a commitment to maintaining standards for their clients, these care workers were working additional hours unpaid.

**Maintaining professional standards.** In most nations (other than the Republic of Ireland), care work is not regarded as a profession. Nevertheless, these participants were doing their utmost to maintain professional standards, using experience and observations to try and promote the best outcomes for clients. Sometimes this was at their own expense.

For instance when the agency changed one of her client’s visits from weekly to fortnightly, Carol knew this would be disruptive. She observed that change is disturbing for vulnerable clients,
especially those with mild to moderate dementia. And for some weeks she kept doing her weekly visit, unpaid, although she also felt exploited by the employer who had cut her hours of paid work with the client. She said:

I mean [the client] didn’t know what week it was, I just kept going, what the heck. But this is what they do to us cause we are caregivers, because we love the work, they screw us (Carol).

Other informants told stories of doing something extra that was out of the care-plan job description, such as picking up milk or washing clients’ hair, or liaising with family members to maintain positive relationships. Lydia recalled:

I might stay for a cup of tea at lunchtime. If her daughter’s come down I might stay and have a yak to them and that sort of thing.

Lydia continued describing the amount of ongoing commitment that stems from the relationship with clients:

If she went into a [rest] home I would probably visit her. Quite a few have gone into homes and I’ve visited them. Yeah I do until they die and then I go to their funerals if I can fit it in.

*Working conditions in home-based care work*

Working conditions in home-based care work differ from care work in hospitals and residential care. Participants described both positive and negative features of home-based care work. They stated that there is more variety in home-based care work. Clients are of all ages, with a range of health conditions.

Participants enjoyed the challenges and variety. In home-based care there is no danger that staff will be routinely assigned one “assembly line” task such as washing hair, making beds or doing laundry. Respondents also appreciated having opportunities to provide a better service to clients in home-based care, where there can be greater scope for meeting clients’ needs and wishes. Sylvia said:

It’s variety which I just thrive on. If you were in the rest home it would be “go shower some people”.

Participants also prized the relative autonomy and independence. For instance:

We get the chance to say what clothes would you like to wear, and that talcum is nicer than that one, let’s use that one. You know, you can put some of yourself in it (Sylvia).

However, home-based care workers also have greater responsibility and less supervision and contact with co-workers than residential care workers. Because they work mainly in isolation, their skills, efforts and responsibilities are even less visible than those of residential care workers. This can fuel a sense of being unsupported and undervalued.

*Feeling valued by clients and their families.* Feeling valued by clients and/or their families makes a positive difference to these home-based care workers. Rita said that most clients valued her work:

Nine out of ten of your clients are just lovely and they really appreciate what you do for them.

Rita also said that most family members are extremely appreciative:

I get a lot of family members saying “if it wasn’t for you I don’t know where my mum would be, she just loves you coming here each week”. We get lots of thanks from the families and that’s really good to know that they appreciate what you do.

Recognition from the clients and some of the clients’ families was welcome, but the focus groups spoke of needing more formal recognition.

*Management, supervision and support.* For a time the focus group became a forum in which shortcomings in management were discussed and in her debrief the focus group facilitator gave this summary:

The group were very critical about their organisations. I don’t think I heard anything positive. They obviously are very hierarchical and they are at the bottom of the heap, and the coordinators have a very powerful role.
None of the workers interviewed for this project felt that their employer took the time to value and thank them for their commitment. For example Lydia disclosed:

The manager sent an email telling us that instead of a Christmas party they were sending a donation to a local charity on our behalf.

The yearly site visits by managers giving the carers’ tasks a cursory glance exemplify the lack of detailed feedback. Rita said:

Once a year the coordinating nurses come out and assess us. They ask us what we do and how we do it or watch us do it. And yeah, just sort of pass us or fix us up on different things as we go […] they would just come to a job where we have a shower and pretty much they stay while you do that shower and yeah, leave and that passes for another year. We get something in the mail saying, I am very confident and have a fabulous rapport with my clients and they are very happy with me.

Vulnerability to false accusations. The requirement to work alone and unsupervised in clients’ own homes demonstrates a high level of trust in the integrity of these care workers. At the same time, this same lack of supervision leaves domiciliary care workers open to allegations of dishonesty which can be difficult to disprove … Sometimes family members complain about the care workers, and this can make them feel under surveillance. For example, some clients with dementia may be prone to losing precious possessions. Lydia said being accused by a family member of stealing was a particular threat for home-based care workers:

I was accused of pinching a table cloth. Half an hour after I left the house I got a phone call from the supervisor to tell me I had pinched the table cloth and would I mind bringing it back to them. And it was pegged out on the clothes line.

Hours of work: no time for love?. The workers who took part in this study were keen to discuss issues surrounding their working hours. Most of the participants worked between 20 and 50 hours a week, but were not paid for all the hours they worked. Some are on “zero hours” contracts. It was pointed out that clients’ needs are variable; one size does not fit all, so half an hour may be enough for one client but not another:

|Our employers| will give you half an hour for a shower for one old lady and half an hour for a shower for another old lady. One is absolutely well organised and you can do it in half an hour. You go to the next one and you say where’s your clean knickers? Knickers? What are knickers?

One of the difficulties facing home-based care workers is that the amount of time allocated to clients and/or frequency of visits is being increasingly cut back. It is difficult or impossible to provide a quality service with very short or infrequent visits from carers.

Travelling between clients. At present, in keeping with cost-cutting considerations, workers who provide home-based care are paid close to the minimum wage. The steady shift from residential to domiciliary care work means the time spent getting from one client to the next has been increasing very significantly. Time they spend travelling between clients is unpaid.

Whereas staff felt they had some degree of choice whether to do extra unpaid work for their clients to maintain professional standards, travel time between clients is an essential part of the job for domiciliary care workers. The requirement to travel unpaid in their own time between clients brings average hourly pay down below the minimum wage. This phenomenon is known as “wage theft” (Workers’ Action Centre, 2011).

Health and safety. Risks to care workers included injuries from lifting clients onto and off wheelchairs, beds, showers and toilets. As obesity becomes more common, care staff are meant to use hoists to help avoid injury. However, Sylvia reported working with “a large lady who won’t use a hoist”. Care staff are also at risk from infections as a result of dealing with bodily fluids.

Another risk not discussed by these respondents but common in care work as a whole, in New Zealand and overseas, is of being violently assaulted by the people being cared for (Brier, 2008; Armstrong et al., 2009). In some male-dominated occupational groups such as the police and prison officers the level of pay is higher to take account of risks such as violence.

The stress of working under constant pressure, in isolation and feeling undervalued and unsupported can also undermine physical and mental health and wellbeing.
Working in isolation. The home-based care workers who took part in focus groups for this project were delighted to meet other care workers in their locality and in similar circumstances to themselves. They normally work in isolation, so this was a rare opportunity to share and compare experiences. The focus group facilitator said in her debriefs:

They obviously got a lot out of meeting today and just being able to compare notes and say, "Oh does your organisation do that, oh yes the same thing happens for us" and being able to talk about those risks and joke about things in this way.

Some of these women work in the same occupation, for the same service providers in the same region, and yet they did not know one another. At present these employees work alone most of the time(2) except when they work with "shared care" clients. When staff exchange ideas about clients it can be a valuable source of support, guidance and informal peer supervision which improves the quality of services.

The participants said they would like regular staff meetings from now on. However, at present home-based care workers are actively discouraged from meeting and forming supportive relationships with co-workers, as these two examples show. The focus group facilitator reported:

They talked about the need for support and how their organisations don’t provide it and in fact discourage contact [...] They said their organisation doesn’t want us to get together [...] and how they formed a social network site where they could communicate with each other just within that group but the employer found out about it and they were reprimanded.

In her telephone interview Lydia told a story that revealed the lengths her employer went to keep employees apart. She said:

I had some apricots here and she [another care] said she would love some. I didn’t get her phone number and I picked the apricots and rang work and asked for her number. And they said, no we will not ring her and get her to ring you.

Part II: discussion

Clients are entitled to receive care that maintains their dignity and sense of self-worth, caters to their individual needs and wishes and is provided with compassion and good humour. Care work requires both emotional labour (Hochschild, 1983) and a group of skills sometimes referred to as "emotional intelligence". In this section we discuss whether these typologies capture the demands and complexities of care work.

Undervaluation of care work: links to emotional labour

Hochschild (1983) developed the notion that many service sector workers are required as part of their job to perform superficial “emotional labour”, using smiles and stock phrases, to keep the customers happy. Many studies have centred on the use of women’s emotional labour (Hochschild, 1983; Tibbals, 2007; Valdez, 2011; Wharton, 2009) and particularly on the ways this has been exploited by employers (Colley, 2006, p. 15; Herd and Meyer, 2002, p. 666). It has also been suggested that emotional labour is the link that produces lower wages for jobs held primarily by women (Guy and Newman, 2004, p. 296).

Clearly there are links between requirements for the performance of emotional labour and the notion of "working for love". In both cases potentially positive and potentially satisfying human feelings are being undervalued and exploited. This can give rise to complex and conflicting emotions.

Hochschild (1983) argued that employees can become alienated from their own emotions through the job to perform emotional labour. Tolich (1993) expanded and adapted Hochschild’s original concept of alienated emotional labour, arguing that emotional exchanges based on genuine care, compassion and empathy can form “liberating autonomous emotion management” and so become a source of liberation and job satisfaction. However, Tolich’s thesis of liberating autonomous emotion management is only partially borne out in these interviews. For emotional labour to be liberating it requires external validation. As we have seen,
most clients and their families validate the care workers but their employers and politicians generally do not. Working in isolation prevents also validation from co-workers.

The care staff who took part in this study do genuinely care for and about their clients, and obtain satisfaction from being able to make a difference. They do so autonomously, even to the extent of doing extra work for their clients unpaid and in their own time. In occupations that already have professional status it is not uncommon to expect staff to show initiative and go the extra mile. However, these workers have a professional attitude but currently not the training, status and other rewards that would be found in a profession. Consequently they say they feel their professional skills are under-recognised.

As well as engaging in genuine emotional exchanges with clients and building positive and trusting relationships with them, care workers must also disguise their emotions, in order to calm clients and preserve their dignity. In the process they minimise situations such as “little accidents”, concealing their natural reactions to difficult, disgusting, disturbing or dangerous situations behind a matter-of-fact efficient cheeriness. Therefore, care staff need to use interpersonal relationship-building skills which utilise both genuine and disguised emotions.

The term “emotional labour” may therefore be too broad-brush to capture the complexity of all the professional skills required in care work. Other hidden skills of care workers include: assessment, awareness of consequences, problem solving, negotiation, tact and diplomacy, coordination and time management. Some work has been done on a vocabulary for describing these skills and stages for acquiring them over time (Junior et al., 2009a) and there is scope for developing this further in relation to care workers.

Gender, class, age, power and privilege

There is a strong gender dimension to being expected to work fully or partially “for love”. Most caring work is still done “for love”, unpaid, at home, mainly by women bringing up children or looking after sick, elderly or disabled family members. In both unpaid care and low-paid care, there is still an assumption that caring and emotional labour come naturally to women.

The pay and value attached to home-based paid care workers suffers from association with work done at home by family members, especially women: work that “counts for nothing” (Waring, 1988). Even though home-based care workers are dealing with strangers whose needs are too great to be met by family, the skills required and demands are not recognised. It is primarily women who are employed as care workers (Anderson, 2003; Lopez, 2006).

Sylvia pointed out that people who are unable to get better paid, higher status work with better working conditions, typically perform care work[3]:

I'm not talking class but it's not successful people who do this job. Rolling people and hoisting people and cleaning up faces. A certain class of girl, of women that will do it. Most of them have been through the school of hard knocks and they have got the empathy and maturity to deal with all these people.

Is it the work or the worker that is stigmatised? It has been argued that association with “dirty work” (Stacey, 2005) taints workers. The skills required in maintaining client dignity when performing personal care with adults are considerable (Wellin, 2007; Lawler, 1991) but largely overlooked. Yet at no time do the participants self-report their work as dirty work or as stigmatising in terms of what Boris and Klein (2012, p. 8) call the devaluation thesis:

Cleaning bodies as well as rooms, home care workers engage in intimate labor, a kind of toil that is at once essential and highly stigmatised, as if the mere touching of dirt or bodily fluids degrades the handler.

However, it is also likely that skills are undervalued and overlooked because of the stigmatised identity of the people performing the work. A relatively unexplored aspect of the undervaluation of care work is its association with the care of elderly people by mainly older workers. In addition, overseas studies have noted that recent migrants often take up care work due to the lack of alternative opportunities. In care work, inequalities based on gender, age, class and ethnicity/migration all coincide and contribute to making skills invisible. However, the most obvious and
overarching inequality is that based on gender and assumptions about gender roles; and in particular about activities and attributes that come "naturally" to women.

Contesting the undervaluation of care work

Shortly after this study took place in 2013 the Service and Food Workers Union brought a successful court case under the 1972 Equal Pay Act on behalf of a group of residential aged care workers, on the basis that they are paid less than if they were not a female-dominated group[4]. Many of these workers were paid only the National Minimum Wage, whilst others earned very little more. The previous year Australian Services Union won a similar case in front of a full bench of Fair Work Australia on behalf of community sector care workers[5]. Further steps are needed. Love is not enough.

Conclusion

The care workers who took part in this project are able to judge the impact of their own work, and know what could go wrong if it was not done. They have developed keen observation, awareness of unfolding situations and the ability to quickly assess clients’ needs. The challenge now is for politicians, employers and the public to recognize the knowledge and skills of care workers. Making emotional labour more visible is a first step towards making it compensable (Guy and Newman, 2004, p. 286).

Love is a gift that has no price, but working “for love” becomes an excuse for exploitation. The notion of working for “love” has been used in the past in attempts to oppose the professionalisation of occupations such as nursing.

The care workers who took part in this project do love their jobs. They know they are making a huge difference to the lives of the people they care for. However, they feel exploited, and want to be valued for their experience, complex skills and committed, professional attitude. The focus groups did not agree with the Minister of Senior Citizens statement that “love” is an adequate substitute for fair pay[6]. When one participant read an early draft of this paper she said its recognition of her story made her weep.

Home-based care workers have to work under challenging conditions: in isolation, with very little supervision and no team meetings, but at times feeling under surveillance from clients’ family members. They are discouraged from consulting or meeting with co-workers.

At present their financial rewards are slight. The already low average hourly pay is reduced below the minimum wage, through absence of payment for travelling between clients and through doing extra work unpaid to safeguard clients’ wellbeing despite shrinking budgets. This is not a group of workers that can afford to donate their labour.

There is a case for larger-scale and more detailed analysis of the professional skills needed in home-based care work. Ways need to be found of passing on these skills from experienced staff to newer recruits. And there needs to be a pay and career structure that recognises this skill and knowledge base.

A caring profession?

This small project suggests that home-based care workers have their own body of knowledge, skills and responsibilities. The workers interviewed have the skills and experience that could help in sharing solutions with others. Potentially they could also work effectively as part of a team. Currently, because they work in isolation they do not often have opportunities to do so.

This is the time to explore options for the professionalisation of the occupation, with the creation of a code of practice, clear guidelines, peer support, supervision, learning and development opportunities and a career structure. Participants also identified to redress gaps in the information they were given about new clients and their needs.

At the moment employers are resisting any moves towards professionalisation because of the implications for pay. Employers prefer to focus on tasks and responsibilities such as showering clients, toileting them, using hoists correctly and meal preparation. Use of skills of
relationship-building are actually discouraged. If this was really what the care workers did for clients, this kind of mechanical approach would constitute degrading and inhuman treatment. In fact, carers do more than is asked, more than is measured and sometimes more than they are really allowed to do, in order to produce quality of life for clients.

However, there is potential for the professionalisation of care work. This is an international phenomenon. In Ireland since 2005, social care work has been a designated profession (Irish Statutes, 2005; Share, 2005), although registration of care workers is still pending. There may be scope for professionalisation of care work in other English-speaking countries, including New Zealand. In order for this to be done research needs to classify the body of knowledge and professional skills more precisely. This would help to safeguard standards of care for the future.

At present there are changing patterns of service provision, with negative implications for the working conditions of care staff and for quality of services. There is pressure on staff to increase the numbers of visits during a shift and reduce the numbers of visits and/or amount of contact time with each client. The workers who took part in this study reported doing additional hours unpaid, trying to maintain quality of services. Any reduction in the time spent with each client makes it impossible for staff to do a good job. This also destroys the quality of working life. A better way would be to learn more about the under-recognised professional skills already used by experienced care workers, including but not confined to those that are referred to as “emotional intelligence”, “emotional labour” or “behavioural competencies”.

Government funding constraints pose the largest obstacle to recognising, promoting and rewarding care skills, and this is affecting all of health and social care provision to some degree. However, valuing care workers’ skills would not only help protect standards of care. There is also potential for it to be more cost effective. For example, allowing sufficient time for visits, so that clients’ needs are met would reduce hospital admissions and re-admissions. Continuity in care also makes a positive difference to the quality of clients’ lives (UNISON, 2012). It is difficult for clients to maintain their dignity if they receive personal care from a series of strangers. This means it is vital that working conditions encourage staff retention. Employees who feel valued, respected and believe they are being treated fairly are more committed and less likely to leave their jobs. Staff turnover is very high in New Zealand care work, especially amongst the newer recruits, with over half leaving less than a year in the job (Human Rights Commission, 2012).

Team meetings could provide a culture of facilitating a reciprocal sharing of knowledge. The Japanese model of continuous improvement (Kenney and Biggart, 1999) would be a starting point. Regular staff meetings and opportunities for training, development and mentoring would also lead to lower staff turnover and would lead to significant savings.

Payments to staff for their time spent on travel between clients are currently not made because of the associated costs. However, paying for travel time would potentially lead to more efficient rostering, save staff time and allow more of that time to be spent with clients.

Ways need to be found of ensuring that important skills and knowledge are passed on rather than wasted. This could include a panel of home care workers to act as advisors, help train new employees and safeguard standards. Whilst a professional approach to caring should include warmth, empathy and love, it is not tenable to expect care workers to work “for love”.

Notes

1. Ethics approval 12/285 gained from the Otago University Human Subjects Ethics Committee.

2. Working in isolation is also an issue in the UK, where over half of care workers surveyed (43 per cent) do not see co-workers more than once a week, and nearly a third hardly ever see colleagues (UNISON, 2013, p. 31).

3. In the UK a high proportion of new recruits to the adult social care workforce are recent immigrants and members of ethnic minority groups.

4. Under New Zealand’s 1972 Equal Pay Act s 3(1)(b) work which is exclusively or predominantly performed by female employees, should have the rate of remuneration that would be paid to male employees with the same, or substantially similar, skills, responsibility and service performing the work under the same, or substantially similar, conditions and with the same, or substantially similar, degrees of effort.
Previously the Equal Pay Act had not been used to determine whether rates of pay in female-dominated occupations were affected by sex discrimination.

5. The basis of this case was that skills mainly used by women have been historically undervalued due to sex discrimination (Joner and Briar, 2012).

6. A larger scale by the report by the New Zealand Human Rights Commission (2012, p. 20) also found that carers feel undervalued.

References


**Further reading**


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