

For Love, Not Money!

A study of health-related decision making in a group of female healthcare assistants who work in residential aged care and who live in low-income households

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Abstract

Issues of social inequality have increasingly featured in public debate in New Zealand and around the world, as the widening gap between rich and poor, both within and across countries, is highlighted and becomes more unacceptable. In New Zealand there has been considerable debate around issues of social inequality and a call to lift the minimum wage has been part of that.

Concern about hardship experienced by low-wage employees in New Zealand was highlighted with the recent Pay-Equity Settlement affecting health-support workers and caregivers; and the very recent announcement of an increase in the minimum wage rate. This thesis was initiated prior to these changes and sought to explore the impact of low income on health-related decision-making among healthcare assistants (i.e. caregivers) working in residential aged-care.

The primary research question for this study was: How do female healthcare assistants employed in residential aged-care and who live in low-income households, think about and attend to their personal health concerns? The literature review provided the contextual framework for this, drawing on literature regarding social determinants of health, particularly low-income and gender, and individually-focussed theories of health decision-making and behaviour change.

To ground this theoretical context in lived experience eight semi-structured interviews were conducted with women who were employed as healthcare assistants in residential aged-care facilities in Dunedin, New Zealand. Participants were obtained using a purposive sampling strategy and they represented a range of ages and worked in different aged-care facilities. One participant was born outside of New Zealand.

Thematic analysis of the interviews revealed two overarching themes which were: “It’s a struggle” and “It’s good to work and it’s good work”. These themes reflect findings from previous studies with this workforce. Mediating these two aspects of the women’s experience were key health beliefs that deeply influenced the women’s confidence and ability to achieve and maintain good health. The study’s

findings are further explicated using the Constrained Choices framework and the Health Capability Model.

The main recommendations to emerge from this research are:

- That mechanisms be adopted to support HCAs constructing themselves as professional carers rather than pseudo-family members
- That adequate staffing levels be maintained to protect the health and wellbeing of HCAs
- That a cohesive team culture be fostered in the workplace that includes all staff
- That appropriate and targeted support be offered to migrant workers
- That a health capability framework be adopted to inform policy and practice in RAC

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List of Abbreviations and Acronyms

ACC	Accident Compensation Commission
DHB	District Health Board
DPB	Domestic Purposes Benefit
HCA	Healthcare Assistant
NGO	Non-governmental organisation
NZ	New Zealand
NCACA	New Zealand Aged Care Association
RAC	Residential Aged Care
SDH	Social Determinants of Health
WINZ	Work and Income New Zealand

CHAPTER ONE: Introduction

Introduction

Insufficient income and poverty have long been identified as being associated with poor health outcomes (Charlton & White, 1995; Ecob & Davey-Smith, 1999; Elo, 2009; Lynch et al., 1997). These findings are seen across several measures of social status, for example, education, occupation and income; which although interrelated, describe different dimensions of social inequality (Kristenson, 2006). Within these dimensions the individual's subjective perception of both their relative status and the amount of power and control they have over their lives, seems to be important for understanding social differentials in health (Kristenson, 2006; Marmot & Wilkinson, 2007).

In the last 10 or so years, a small but growing number of peer reviewed published papers have appeared drawing attention to the issue of the particularly low wages being paid to healthcare assistants (HCAs) working in New Zealand (NZ) residential aged-care (RAC) facilities (George et al., 2016; Hewko et al., 2015; Kaine & Ravenswood, 2013; Palmer & Eveline, 2012; Ravenswood & Douglas, 2017; Ravenswood & Harris, 2016). HCAs, also known as 'caregivers', make up the bulk of the aged-care workforce. Historically they have been a largely invisible group of mostly women, generally considered unskilled, yet responsible for much of the direct 'hands-on' care delivered to residents. Until recently this meant they were sustained on very low wages (at or around the minimum wage) and their experiences and needs were largely being ignored. Little or no attention was given to understanding the health consequences this low-wage situation had for HCAs and their families and it was this awareness that led to the development of this research project.

Thesis aims and structure

Research Questions

The aim of this study was to understand something of how women working as HCAs in RAC and who live in low-income households make health-related decisions for themselves and their families. It aims to explore HCAs' perspectives about how they

achieve and maintain health while negotiating their multiple work and personal demands with few financial resources.

The study set out to explore the following research questions:

- How do participants respond to their own health needs vis-à-vis the needs of others, especially those who depend upon them?
- How does financial constraint impact this process?
- How does a 'caring ethic' manifest/influence and/or complicate health-related decision-making for this group of women?
- What supports are available for the women when they experience diminished health capability due to financial constraints and which do they utilise?
- What compromises do they make in relation to perceived health needs?

Key characteristics

To answer these questions semi-structured interviews were conducted with eight women who were employed as HCAs in different RAC facilities around Dunedin. To be included in the study they also had to live in a low-income-households (i.e. where the total household income was less than \$34,100 per annum (before tax)¹. A qualitative methodology was chosen to facilitate understanding of the significant complexity involved in making health decisions.

A thematic analysis of the interviews revealed two main themes: Firstly, "It's a struggle", and secondly, "It's good to work and it's good work". These dual themes counter-balanced each other determining the women's wellbeing, however the delicate balance was readily upset by health need and concern. Having little or no money rendered the women more vulnerable to this upset.

¹ This figure represents the lowest quintile of the population in terms of income (http://archive.stats.govt.nz/browse_for_stats/people_and_communities/Households/HouseholdEconomicSurvey_HOTPYeJun15/Definitions.aspx.) RAC caregivers typically earned within this lowest quintile.

Thesis outline

In the following chapter, I set the scene for this study by outlining the RAC context, the role of the HCAs within that context, and the history of the recent pay rise awarded HCAs. Following this, I review the literature concerning the influence of gender in RAC, and the role of social determinants, especially low-income, in determining health outcome. This is followed with a review of the literature concerning individual-focussed theories of health decision-making and finally chapter two is concluded with a brief introduction to Health Capability Theory which potentially offers a middle way between a social determinant view of health and an individual health-agency view.

Chapter three summarises the methodology used in this research including the rationale for the approach that was chosen. This is followed with a description of the methods employed in the study and finally chapter three concludes with a reflexive discussion of the research process.

Chapters four, five and six present the main research findings from the thematic analysis of the data. These findings are presented alongside initial discussion to contextualise and explore them further.

The final chapter – chapter seven – presents further discussion, drawing together the multiple threads that are evident throughout the study. The thesis concludes with a brief consideration of the implications of the research and offers some recommendations for RAC and for future research

CHAPTER TWO: Literature Review

Literature Review Strategy

Introduction

The objective of this literature review is to contextualise my research within a framework that acknowledges the complexity and challenge faced by HCAs, who work in RAC, on a daily basis as they strive to achieve good health in their lives. This framework highlights the central importance of gender in health-related decision-making, and summarises how social determinants, including living on low income, are understood to impact health. The review then focuses on literature concerning individual health agency and decision-making paying particular attention to the role of values and beliefs in this. It concludes with a brief introduction to the notion of 'health capability' as a possible middle-way, between social determinants and individual agency, for thinking about health outcomes.

Goals

In order to meet this objective, the following literature review goals were set.

- To summarise the current RAC structure in New Zealand and the outline the work situation generally experienced by HCAs.
- To review literature concerning the influence of gender in this workplace.
- To review current understanding of how social determinants influence health.
- To summarise current models for thinking about how individuals make their health-related decisions.

Scope

Relevant literature for this review was located using multiple key word searches of the following electronic databases: Web of Science, Scopus, PubMed, and CINAHL and Google Scholar databases; and as well using the snowball approach to identify articles from the references of relevant articles. The following keywords were used to direct the search.

Keywords

Healthcare Assistants (caregiver; healthcare assistant; nurse(ing) assistant(s); nurse aid; careworker) AND **Age(d) Care** (residential aged-care, elder care, nursing

home, rest home, aged-care facility, residential care, housing for the elderly, gerontologic care; [Social Determinants of Health](#) (social determinants of health, low income, poverty, socioeconomic position(status), working poor, gender, ageing workforce, migrant, work-life) AND [Health](#) (mental health, perception, health indicator (outcome), injury, chronic health, disease, stress), [Health Agency](#) (agency, self-efficacy, empowerment, choice, decision, capability), [Health Capability, Self-Efficacy](#).

[Inclusion Criteria](#)

Papers published since 2000 in academic peer-reviewed journals were included in this review along with a small number of papers published prior to 2000 that were identified from reference lists of the more recent papers. This was approach was taken because aged-care has changed a lot over the last two decades and prior to this time very few papers were published that addressed the concerns of the HCAs (or caregivers as they were then called). Studies found with a primary focus on the health and wellbeing of HCAs were assessed individually as were papers discussing the conversion factors mediating low socio-economic position and health outcome.

[Parameters](#)

Due to the large volume of material concerning social determinants of health this review focusses on presenting a summary narrative examining the shifting trends in understanding of how low income (or socio-economic position) impacts health. The literature concerning gender and health is also substantial. For the purposes of this review, I focused on the influence factors associated with caring, such as 'doing caring work', family, self-care and social support, had on health choices.

[Review Structure](#)

The literature review is structured in four sections, moving from the more concrete details of the RAC sector and its workforce, through social scientific conceptual understandings of gender and social determinants of health, to conclude with a review of literature concerning individual health decision-making and behaviour.

[Section 1: Setting the Scene](#)

[Introduction](#)

The last 10-20 years has seen an increase in research into aged-care in line with a growing concern about the likely impacts of an ageing population. Until recently

the experiences of HCAs in this sector have largely been ignored. Over the last 5-10 years however a small but growing number of peer reviewed published papers have appeared drawing attention to the issue of the particularly low wages generally paid to this group of mostly women (George et al.,2016; Hewko et al., 2015; Kaine & Ravenswood, 2013; Palmer & Eveline, 2012; Ravenswood & Douglas, 2017; Ravenswood & Harris, 2016). Few of these papers however have examined specifically the health impact of this situation.

I begin this review by setting the scene with an outline of the RAC sector in NZ and an introduction to the HCAs. This is followed with a summary of the pay equity agreement which came into being during the course of this research and which directly impacts HCAs in RAC in NZ.

Residential Aged-care

RAC in NZ is currently experiencing a period of rapid growth, change and development as it attempts to prepare for a projected ballooning in the need for its services. As is the case internationally a major demographic transition is underway with a burgeoning ageing population impacting societies in a myriad of ways. In NZ the number of people in the 65+ age group is expected to increase from 0.7 million (15 percent of the total population) in 2016 to 1.32-1.42 million (21-25 percent of the total population) in 2043, with the number of people in the 85+ age group expected to increase from 83,000 in 2016 to around 250,000 in 2043 (New Zealand Department of Statistics, 2016). As an increasing number of people are living well into their 80s and 90s, and are often frail in their later years, it is clear that the aged-care sector will need to develop its capacity to accommodate and care for the increasingly diverse needs of this group.

Historically, RAC in NZ has been provided by not-for-profit operations run by charitable and religious organisations alongside government-run facilities (Bland, 2007; Lazonby, 2007; Swarbrick, 2018). Over the last three decades however a sea change occurred in health care generally and in aged-care in particular, to the point where it is now privately-owned, profit-driven businesses that are dominating the sector. This business model exacerbated the historic undervaluing of caring work as it intensified pressures to keep wage costs low in order to maximise profits (Lazonby, A., 2007; Ronald et al., 2016).

RAC in NZ includes rest home level care, dementia care, psychogeriatric, and hospital level care. The sector is publicly-funded through individual service contracts between District Health Boards (DHBs)² and a mix of public, charitable and private providers of care. While these contracts are negotiated at a national level, DHBs are responsible for monitoring compliance within their respective regions (Ministry of Health [MoH], 2013). In 2010, there were approximately 670 RAC homes in New Zealand, 61 % of which were in private ownership. Twenty percent were owned by charitable/religious/welfare organisations, 19% were publicly-listed and 1% have 'other' types of ownership. Eight of these care homes were being managed by DHBs (Grant Thornton New Zealand Limited, 2010). There are estimated to be a total of around 38,000 beds held within the sector. By 2026 it is estimated that around 52,000 beds will be required. The average RAC care home has 57 beds. In 2017 a trend toward larger facilities offering multiple levels of care was becoming evident with 77% of all aged-care providers offering specialised services (Burrow et al., 2017).

Government funding supports the care of people who meet certain eligibility criteria. This is based on their level of dependency and the means testing of income and some assets³ (Lazonby, 2007; MoH, 2012). Those who fail to meet the thresholds for eligibility are required to fund or partially fund their own care⁴. The government is ultimately responsible for developing appropriate policy and regulatory frameworks to ensure sufficient care of good quality is available for this particularly vulnerable population. In the face of the approaching tsunami of need the question of sustainability for all parties is paramount.

² The New Zealand Health Care System operates through a number of these regionally-based entities known as District Health Boards. These Boards are responsible for providing health care to the population within their region.

³ To be eligible for the Residential Care Subsidy (RCS), a person must be a NZ citizen or resident, aged over 65 years or 50-64 and single with no dependent children. They must undertake a needs assessment to judge the necessary level of care and they must have assets less than the asset threshold that is set out in part four of the Social Security Act 1964. The threshold is currently \$210,000^[1]. Under schedule 27 of the Act the asset threshold increases by \$10,000 each financial year until 2025/26 (MoH, 2012).

⁴ Provisions of The Social Security Act 1964 govern the maximum contributions that can be made by individuals toward their care (MoH, 2012 quoted in Kaine and Ravenswood, 2013).

In RAC this concern has to extend to employment of the HCAs who constitute the bulk of the workforce. They are generally considered low skilled or untrained but it is the HCAs who provide most of the hands-on care for elderly residents (MoH, 2017; Shannon & McKenzie-Green, 2016). The role of HCAs is essential in RAC, is variable in its scope and is set to expand significantly in the coming years (Burrow et. al., 2017).

Healthcare Assistant Workforce

The size of the HCA workforce in RAC is considerable though it is difficult to ascertain exact numbers because numerous titles exist for the role, including caregiver, carer, support worker, nurse aid, health assistant and kaiawhina⁵. In 2008 there were estimated to be 18,150 caregivers in the aged-care sector in New Zealand (Grant Thornton NZ Limited, 2010). Drawing from the 2013 Census however, the economic consultancy firm, Business and Economic Research Limited (BERL), identified 13,000 as carers or support workers (The Salvation Army Social Policy & Parliamentary Unit, 2017). The New Zealand Aged-Care Association (NZACA) website (NZACA, 2018)⁶ reports that 12,131 caregivers were employed in RAC representing 71% of the workforce. New Zealand government data⁷ shows that as at January 2018 there were around 22,000 caregivers working in RAC facilities. This variability in the data is problematic especially given the changing demographic of the workforce and the need for careful policy and planning (Hewko, et al., 2015).

Two features of particular concern are an ageing workforce and the large number of migrants working in the sector (Callister et al., 2009). Kaine and Ravenswood (2013) identified that in NZ, 92% of the RAC workforce is female, 64% work part-time and the majority are 45 years or older. Around a third of the RAC workers are migrants with an increasing number of these being 'temporary migrants' mostly from the Asia-Pacific region especially from India and the Philippines (Callister et al., 2014).

⁵ Kaiawhina is a Maori word which translates as "helper, assistant, contributor, counsel, advocate" (maoridictionary.co.nz)

⁶ These figures based on a 2017 survey of a sample of RAC facilities (n=423 or 63% of the RAC industry).

⁷ Retrieved from www.newzealandnow.govt.nz/resources/working-in-aged-care Accessed on 05/08/2018.

In a recent workforce survey⁸, Ravenswood and Douglas (2016) highlighted some of the major issues concerning HCAs in RAC in NZ. The most salient issue was clearly the inadequate level of pay. At the time of this survey, 73% of respondents were earning less than \$17 per hour, with 21% of these earning exactly the minimum wage. Considering that more than half the respondents reported that they were the main earners in the family, it is clear that many households are under considerable financial stress (Ravenswood & Douglas, 2016).

As this workforce survey updated a previous one published in 2014, comparisons can be made which show a general decline in job satisfaction, although not in relation to the work itself. (Ravenswood & Douglas, 2016). A majority of respondents (65.8%) reported that they felt pressure to work harder in their jobs and that the work was more stressful than they had expected. Staff turnover among caregivers was 27% in 2017 an increase from 21% in 2014 (NZACA, 2018). A total of 427 incidences of work-related injury and illness were reported by 327 respondents in the 12 months prior to the survey, most of which resulted from injuries such as back injuries, bruises and sprains and strains. In the majority of instances (58.8%) no time off work was taken (Ravenswood & Douglas, 2016).

Female dominated professions in the health care sector are associated with risks of infections, musculoskeletal injuries, and burnout (World Health Organisation, 2009) as well as stress injuries (Gustafsson & Szebehely, 2001). Prevalence of neck, shoulder and backpain is higher among health workers, especially nursing aids. Muscular pain, fatigue and exhaustion were shown to be frequent health problems among employees in Swedish elder care (Hasson & Arnetz, 2008). Work -related exhaustion was also shown to be a strong (inverse) predictor of work satisfaction (Hasson & Arnetz, 2008).

Statistics obtained from the Accident Compensation Corporation show that for the period from 2011 to 2015 the total number of new and accepted work-related injury claims for aged-care services in NZ increased from 2,888 in 2011 to 3,259 in

⁸ The 2016 New Zealand Aged Care Workforce Survey was an online survey encompassing health care assistants, nurses and managers working in home and community care as well as residential aged care. It follows a similar survey undertaken in 2014. In 2016 a total of 327 RAC HCAs participated in the survey from across the country.

2015. Of particular note was the steady year on year increase in injuries seen in RAC homes with rest home or hospital facilities, from 629 in 2011 to 800 in 2015 (personal communication, August 5, 2016).

It was clear in 2017 that a crisis was unfolding in aged-care in New Zealand. The demand for care was increasing as was the complexity of care required. The workforce demographic was changing, remuneration was inadequate and staff morale was low.

[The Government Response - Pay Rise!](#)

At the time this research project commenced in early 2017 concern about the extremely low wage being paid to HCAs did not appear to be at the forefront of people's minds. Five years earlier though it was a different story. In 2012 the Equal Opportunities Commissioner at the Human Rights Commission had the following to say:

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

(Quoted in Callister et al.,2014, p.2)

The pay issue was brought to the fore in 2012, in what came to be known as the TerraNova court case, when the Service and Food workers Union (now part of the E tū⁹ workers union) filed a case in the Employment Court on behalf of Kristine Bartlett, a care worker employed by Terra Nova Homes and Care Limited. The substance of the claim was that care and support work was being systemically undervalued because it was performed by women.

⁹ E tū is a Maori term meaning 'stand up'.

On the 18th April, 2017, the then Minister of Health, Dr Jonathan Coleman, announced in a Media Release “a \$2 billion pay equity settlement for 55,000 health care workers”. In June 2017 the Care and Support Worker (Pay Equity) Settlement Act was passed with unanimous support from across the House (of Parliament). From the 1st July, 2017 when the settlement was enacted caregivers in RAC received pay rises from between 15 and 50% depending on their qualifications and experience (MoH, 2018).

This settlement was a game-changer for caregivers in RAC and a significant step toward achieving pay equity across sectors. As well as this, the new qualifications-based pay structure has the potential to improve the quality of care.

The settlement however has also brought pressure to bear on other elements in the system creating some concerning consequences. Firstly, the NZACA has expressed concern that the rapid implementation of the settlement put considerable pressure on RAC providers who had little time to adjust their business models (NZACA, 2018). They state this precipitated the closure of some facilities and is threatening the viability of others, especially smaller and regional facilities. This in turn affects both the ability of some elderly to access the care they need and it diminishes job security/options for caregivers (NZACA.2018). The NZACA also states that there remains a funding shortfall which has necessitated an increase in fees for the 25% of residents who do not meet the government asset and income criteria for fully subsidised rest home care. The NZACA are concerned about the injustice this represents. Another concern that is being voiced (anecdotally) is that some registered nurses working in RAC are now paid only around \$5 per hour more than the highest paid caregiver. There is a sense of unfairness to this which is exacerbated by the fact that this group of nurses has historically been paid significantly less than their counterparts in the public health system.

This pay rise coincided with the commencement of the data collection phase of this study causing some initial concern given the research was predicated on the HCAs earning around the minimum wage. In consultation with my supervisors however we decided the project was still worth pursuing due to the study participants’ long and recent association with managing life “on the breadline”. The effects of this would by and large still be imprinted on their health decision-making and given the

characteristic time lag between health choice/behaviour and health effect we thought it likely that the women would be still living the consequences of earlier health decisions. We also considered there to be some value in having the women consider how the pay rise might impact their health and wellbeing given they continue to receive a relatively low wage.

Conclusion

It is evident that RAC in New Zealand is on the cusp of significant development as the government and RAC providers respond to the changing needs of a rapidly growing number of older people in the community. In this climate HCAs can no longer be regarded as voiceless handmaidens as the recent employment court proceedings and pay award have shown. The dominance of private business in this sector carries certain risks for staff and residents stemming from market forces which will continue to put pressure on employment and conditions. It is important that the government manages these risks carefully and transparently.

Section 2: The Gendered workplace

Introduction

In the previous section I outlined the current situation of HCAs in RAC. It is clear that these (mostly) women have comprised a large, invisible, very low paid workforce in what has been until now a relatively hidden sphere of health care. Gender inequality is at the root of this situation and has been identified as one of the social determinants of health (Iyer et al., 2008). However, the influence of gender on health is nuanced and the literature inconclusive (Schulz & Mullings, 2006).

Women's work

Historically care of the elderly, whether in private homes or in an aged-care facility has been the work of women and as such it has largely been invisible, unregulated and poorly paid (Sewko et al., 2015; Ravenswood & Harris, 2016). The domestic and familial history of care work, with its expectation that it is performed for love and not money, supported the belief that it is best performed by women, not educated but experienced as mothers or in other family care (Palmer & Eveline, 2012). This attitude assumes that carers are not the primary providers in their families and that any money they receive is supplementary (Ravenswood & Harris, 2016). It also implies that an increase in wages would lead to a decrease in the

quality of care by supplanting the intrinsic motivation of love and caring with the extrinsic motivation of money (Palmer and Eveline, 2012).

That care work is perceived as unskilled is a gendered view based on the traditional assessment which privileges mechanical or technical skills over and above the 'soft' skills of communication, empathy, relationship building, observation and judgement (Bourgeault & Khokher, 2006; Ravenswood & Harris, 2016). The coupling of 'women's work' with a perceived low skill level has cemented the low value placed on care work. It carries a high level of strain and positions carers with little control (Elwer et al., 2010). This situation is aggravated by our negative social construction of ageing as a time of disability, dependence, invisibility and marginalisation (Banks, 2018). In Banks' view this confluence of factors flows through to HCAs ultimately undermining their self-confidence, self-respect, self-esteem and self-realisation (Banks, 2018). From this perspective the recognition afforded HCAs by the recent pay rise is a major step toward deconstructing this vicious circle of devaluation.

Family

Associated with this gendering in the workplace is the explicit use of the familial model to promote good care of residents. Using this model, the residents become pseudo-family members with the expectation that carers will care for each of them as they would their own parents or grandparents. Many HCAs value this fictive kin relationship and it is strongly associated with job satisfaction (Dodson and Zincavage, 2007; George, et al., 2017; Henley, 2015; Ravenswood and Harris, 2016) but it can also be a vehicle for their exploitation as they feel forced to rush and strain to fulfil the needs of 10-15 grandparents (King, 2012). Dodson & Zincavage (2007) and others, alert to this, call instead for structural change and an ethic of reciprocity in the workplace which values equally the needs of residents and the needs of their carers (Elwar et al., 2012; King, 2012; George et al., 2017).

Gender, health and wellbeing

The health, injury or illness experience of women working in this environment is directly affected by this gendered workplace structure (Elwer et al., 2010, 2012) which inevitably conditions HCA's choices and responses to their personal health concerns (Elwar et al., 2012). In their study Elwar et al. (2010) identified two central themes in relation to HCA's health. The first of these: "working against the

odds” highlights the high demands of the job that lead to experiences of exhaustion, powerlessness and exploitation, all of which pose significant health risk. However, they also show potentially meaningful rewards available in the work that are “making the work count” (Elwar et al., 2010).

These factors alongside coping and social support moderate the negative health effects of stress (Pearlin et al.,1990). HCAs experience this balance between stress and reward individually but the gendered nature of the workplace previously described, pressures women to sacrifice their health and wellbeing for the sake of their elderly residents and colleagues.

As well, work-related health is influenced by other aspects of life such as family, social class, ethnicity, and education; and gender inevitably flows through each of these as well. Health experience is therefore an expression of the whole-of-life situation of individuals and is constrained by the social structures one finds oneself subject to (Bird & Rieker,2008).

Conclusion

It is clear that gender has been and will continue to be a significant element in aged-care. Identity and social connection needs are both extremely influential in women’s health-related decision-making, and aged-care, for better or worse institutionalises the meeting of these needs.

Section 3: Social Determinants of Health

Introduction

Understanding the effects of prolonged low income, hard physical work and ageing in the contexts of women’s lives is an important task. Past research concerning HCAs has tended to focus on establishing the need for a pay rise. In NZ this has recently been achieved but questions remain as to the ongoing effect of having lived for an extended period of time on low income, how caring work may ameliorate or exacerbate these problems and how much having more money influences health decision-making.

Low income and poor health

People living in low socio-economic situations in general have poorer health outcomes compared to those living in higher socio-economic situations (Lynch, et al., 2000; Wilkinson & Marmot, 2003; Marmot & Wilkinson, 2007; Raphael, 2006).

The association between low socio-economic status and health is evident across a variety of measures including education level, ethnicity or minority status, occupation and income (Marmot & Wilkinson, 2007).

Factors such as poverty, housing quality, employment status, overcrowding, working conditions, substance abuse, food access, transport and social support, all directly impact the health of individuals through material or physical means (Benzeval & Judge, 2001; Ecob & DaveySmith, 1999; Guneskara et al., 2013; Lynch et al. 1997) and they coalesce to define the social determinants of health (SDH). Marmot and Friel describe SDH as: “The circumstances in which people are born, grow, live, work and age; and the inequitable distribution of power, money and resources that are drivers of those circumstances of daily life” (Marmot & Friel, 2008, p 1096).

These contribute to premature disease and death especially in vulnerable groups such as women, children, the elderly and minority groups. (Marmot, 2005; WHO,2008). Social disadvantage tends to be concentrated among the same people, with their effects accumulating and compounding to produce serious health inequality (Wilkinson & Marmot, 2003).

These factors are likely to be interrelated, leading researchers to try and identify the mechanism they share that mediates the relationship between them and health and this has led to some considerable debate (Lynch et al., 2000; Marmot & Wilkinson,2001; Herd et al., 2007; Canning & Bowser,2010; Marmot & Bell, 2012; Pickett & Wilkinson, 2015).

But why?

Explanations for this apparent relationship tend to fall within three dominant frameworks: the materialist, the neo-materialist and psychosocial approaches (Raphael, 2006).

The materialist view

The materialist position holds that it is primarily material conditions that determine health by influencing individuals’ exposure to harmful or beneficial agents or circumstances. These material conditions essentially predict the likelihood of disease, injury or illness leading to differences in psychosocial distress (Brunner, 2009) and consequent health effects. Recent developments in genetics

continues in the materialist frame focusing on individuals' genetic predisposition to risk of illness.

The neo-materialist view

The second explanation for the SDH is the neo-materialist position which focuses on the conditions of living and social infrastructure as determinants of health (Raphael, 2006). This approach focuses attention on the distribution of economic and social resources and the effects of living conditions on the SDH and is the position strongly held by Lynch et al. (1997).

Lack of material resources, limited educational opportunities and reduced access to health services undoubtedly impact health outcomes however, those who adhere to the third explanatory framework for SDH believe that it is social inequality that is the key determinant of health outcome within any given society (Marmot & Wilkinson, 2001; Babones, 2009; Brunner, 2009; Marmot & Bell, 2012; Pickett & Wilkinson, 2015).

The Social-Inequality View

Marmot observed that a socio-economic gradient exists in and across all societies and that it is this that closely maps the health outcomes in those societies (Marmot, 2006). It seems that irrespective of the wealth of a nation those who reside at the lower end of the socio-economic gradient exhibit worse health outcomes than those further up the gradient. In a review of the literature Pickett and Wilkinson (2015) found support for this view sufficient enough to assert that the relationship between wider income differences and poorer health outcomes is indeed a causal one.

Marmot, Wilkinson and others believe that those who live at the lower end of the social gradient compare themselves (their status, possessions and circumstances) unfavourably in relation to others, leading to feelings of anxiety, shame, worthlessness, envy, depression and reduced social affiliation (Marmot & Wilkinson, 2001; Adler & Snibbe, 2003). They argue that these negative psychosocial factors explain the health gradient. This psychosocial comparison is also understood to be occurring at the communal level where widening inequality decreases social cohesion which is itself a determinant of health (Kawachi & Kennedy, 2002; Raphael, 2006).

Exploring further the impact of social-inequality on health Calara et al. (2016) compared income-related health inequality in Australia with that experienced in Great Britain and found that inequality increased primarily because the health losses over the study period (2001-2006) were concentrated among those who were initially poor and who were significantly more likely to die (Calara et al., 2016). Blakely et. al. (2007) corroborated this finding using NZ MoH data from 1981-2004. They found that low income young adults showed no reduction in mortality over a 25 year period (from 1981 - 2004) whereas their high income counterparts showed a steady improvement, thus widening income inequality in mortality among young adults (Blakely et al., 2007). Blakely et al. estimated that socio-economic mediation accounted for at least half of the Māori: European/Other inequality in mortality (Blakely et al.,2007).

Canning and Bowser (2010) suggest instead that the association between low income and poor health may be an expression of reverse causality where it is poor health that predetermines socio-economic disadvantage. Benzeval and Judge (2001) on the other hand believe that it is the persistence of socio-economic disadvantage over time that is key to understanding this relationship. Based on longitudinal data from NZ Guneskara et al. (2011, 2013) cautiously agree with Benzeval and Judge, but they highlight that it is difficult to gather sufficient evidence free from time-invariant confounding.

An important development in SDH research is the 'lifecourse' perspective which recognises the accumulated effects of health experiences across the lifespan (Raphael, 2006; Corna, 2013). Three areas of health effect are of particular concern. Firstly, the latent effects of early biological or developmental exposures to harmful agents or situations; secondly, the pathway effects which refer to the trajectories that influence health and wellbeing over the life course and finally the cumulative effects which represent the duration or accumulation of exposures over time (Raphael. 2004; Corna, 2013). Corna goes on to emphasise that it is the clustering of exposure over time that is critical in determining health outcomes over the lifespan (Corna, 2013). Adopting this approach, Corna emphasises the importance of addressing the structural determinants of socioeconomic inequality (Corna,

2013) and very importantly challenges the assumption of gender neutrality implicit in SDH research.

Conclusion

Clearly the jury is still out as to the exact mechanism mediating low socio-economic position and poor health. What this debate does reveal however, is the complex web of constraint operating around women's health-related decision-making. Within this web, women are faced with choices, they weigh up their options and make their 'best' decision given their personal resources at the time. In the next section of this review, I will examine literature exploring this process in relation to health behaviour.

Section 4: Individually-focussed theories of health behaviour

Introduction

Multiple theories have been proposed, that attempt to describe health decisions and behaviour from an individual perspective. These tend to emphasise either the process of change, most often conceptualised as a series of stages a person passes through to achieve the desired change (e.g. The Transtheoretical Model - also known as the Stages of Change Model - of behaviour change (Prochaska et al., 2008)); or they emphasise elements of actual health decision-making, for example, the Theory of Planned Behaviour (Ajzen, 1991); the Theory of Reasoned Action (Fishbein 2007); and the Health Belief Model (HBM) (Strecher & Rosenstock, 1997). The value of these theories is that they recognise the individual as an agent in his/her own health. They are similar in that they recognise the key role of beliefs in health-related decision-making and behavioural change. Together the theories identify the most influential beliefs as being those around expectancies, including: a) perceived susceptibility (to illness); b) perceived severity; c) perceived benefits of taking action and d) perceived barriers to undertaking desirable action; and also normative expectancies and self-efficacy beliefs. The latter beliefs refer to confidence in one's ability to take appropriate health-related action (Glanz et al., 2008).

Associated with these categories of health belief is the notion of locus-of-control (Grotz et al., 2011; Holm et al., 2011; Strecher et al., 1986), which refers to perceptions around the level of control an individual believes they have over their health and whether that control is predominantly internally or externally

referenced. Studies have shown that higher age, low socioeconomic status and migration background, are associated with perceived lower levels of control over health; as well as a greater involvement of chance in health outcome (Ajzen, 2006; Berglund et al., 2014; Grotz et al., 2011). These variables are all important features in the HCA workforce in NZ.

A significant shortcoming of both decision and stage theories is that they tend to be rather linear and unidimensional. They privilege the rational element of human cognition over and above the emotional or spiritual dimensions and their focus on the individual fails to account adequately for the powerful influences arising from environment or cultural milieu.

Social Cognitive Theory (SCT)

Recognising the significant involvement of the environment in behaviour led, in part, to the development of SCT (Bandura, 2001). SCT extends beyond the individual to incorporate environmental factors through the principle of “reciprocal determinism”.

Environmental factors influence individuals and groups, but individuals and groups can also influence their environments and regulate their own behaviour” (Glanz et al., 2008, p. 171)

This expresses the two-way interaction between people and their environment (Glanz et al., 2008) linking the two almost as a unity through reciprocity. In their agentic transactions, people are producers as well as products of social systems (Bandura, 2001).

SCT posits that health-related behaviour is a function of three expectancies: situation-outcome, action-outcome and self-efficacy (Conner & Norman, 2005). The first of these represents a belief about what will happen if things are left to go their own course without interference, for example, the likelihood of getting a particular illness; the second, refers to expectations that a particular outcome will occur as a result of taking a particular action, and the third expectation refers to one’s belief about one’s own ability to perform the desired action. These ‘expectancies’ are closely aligned with the health beliefs outlined previously.

Strecher et al. point out that together, outcome and efficacy expectations are what determine capability. They also emphasise that these perceptions are not necessarily the same as actual or “true” capabilities but are really beliefs (Strecher et al., 1986).

Self-efficacy (affects)...the amount of effort they will expend on a task, and the length of time they will persist in the face of obstacles. Finally, self-efficacy affects people’s emotional reactions, such as anxiety and distress, and thought patterns (Strecher et al.,1986, p74-75).

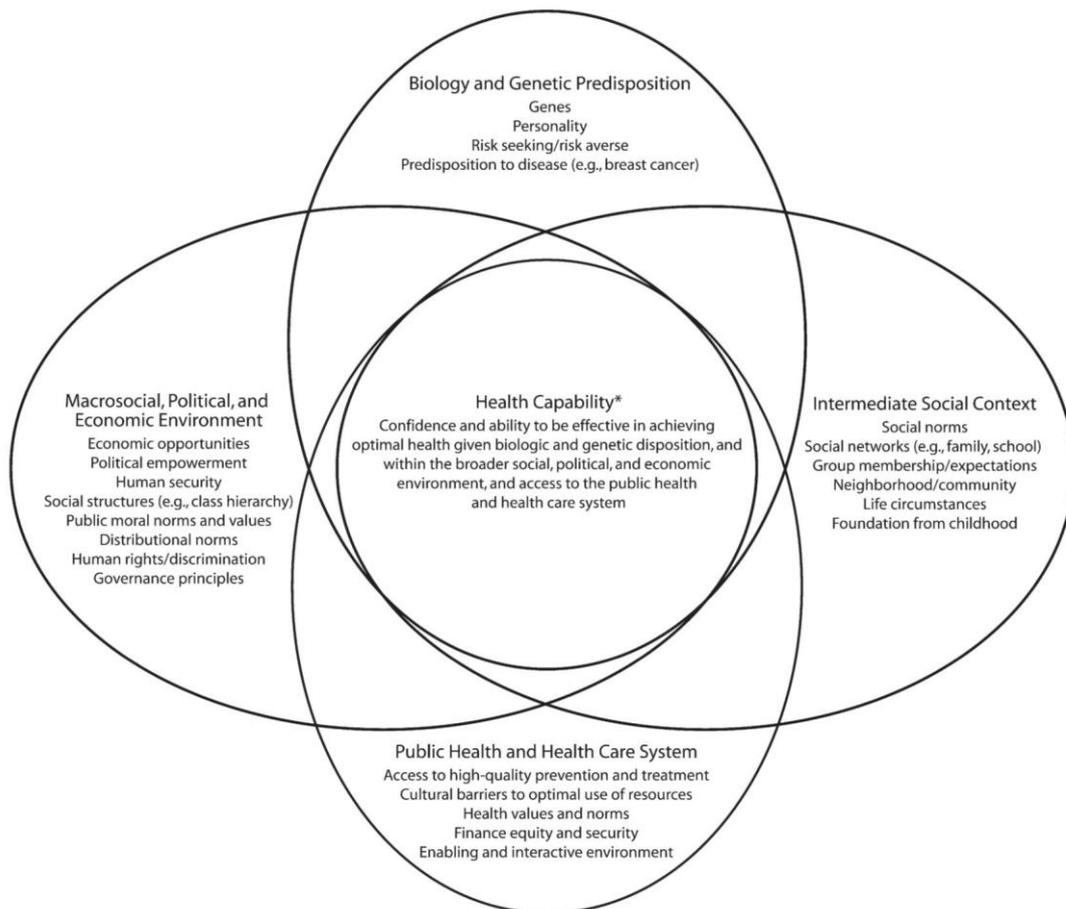
Importantly, self-efficacy is situation-specific and does not describe a global personality trait that operates independently of context (Strecher et al., 1986).

Health Capability

The notion of capability in relation to health decision-making is a useful one in that it provides a way of navigating between the socially determined view of health and the individual responsibility or agency view. It forms the cornerstone of Health Capability Theory (HCT) (Ruger, 2004), which emerged in the last 10-15 years as global awareness of health inequity, both across and within countries, has become more acute. Ruger asserts that any discussion about health has to acknowledge two fundamental realities: firstly, that people seek good health and secondly, that they also seek the means to achieve it (Ruger, 2004). On this basis, Ruger challenges us to care about health inequity, and argues for a model of health capability that incorporates both health agency and the impact health care resources (or lack thereof) have on individuals’ health capability. Thus, the strength of this model is in its accommodation of a social determinant view of health, recognising the impact socio-economic systems have on individuals’ health and wellbeing without losing sight of individual agency in regards to the same (Ruger,2010).

In 2010, Ruger emphasised and valued the intersectionality of health capability; that is, it exists at the intersection of [many] disciplines including “public health, health policy, medicine, health psychology, decision theory, behavioural economics, theories of addiction, social epidemiology and broader social scientific theory” (p.3, 2010). She expressed this intersectionality in the following diagram:

Figure 2.1: Intersectionality of Health Capability



(Ruger, 2010)

Ruger states that:

To measure health capability at the individual level, one must identify how well individuals can act as agents in their own health... (But also) ... health capability is not just a set of individual skills, [but] it is also a set of situations or conditions that enable optimal health (p5, 2011).

This model recognises that health is more than a factor of individual features such as physical functioning, self-efficacy, decision making and motivation; and that it is not captured by social determinants, epidemiology or health economics either (Ruger, 2011). As Ruger states “In this paradigm, group level factors may have individually heterogenous effects, and require evaluation in terms of their direct contextual effect in impairing or enhancing individuals’ ability to be healthy” (Page

5, 2011). Using this model, therefore, the individual is the appropriate level of analysis.

Having created a conceptual model of health capability Ruger then proceeded to develop a health capability profile for measuring capability deprivations. This profile is very detailed and extensive possibly to the point of being unusable (Lorgelly et al., 2010). However it addresses both the internal and external factors defining health capability and as Ruger suggests it provides a starting point for further discussion and refinement.

The Health Capability Model (HCM) was included as part of the conceptual framework for this study for a number of reasons. Firstly, it facilitates a complex and nuanced analysis of health-related decision-making among study participants. Secondly, the HCM's focus on the individual as the point of analysis acknowledges the uniqueness of each women's situation as well as allowing for some exploration into the sometimes far-reaching, implications of choices they make. Thirdly, it recognises the heterogenous effect on the women of external forces such as work situations, low income, transport availability, immigration situation, or child care availability. Fourthly, the HCM's democratic quality seems appropriate in a multi-cultural workforce where it is likely that the individuals' valuing of capabilities will differ. Fifthly, the HCM can accommodate the trade-offs people make to achieve highly valued capabilities and finally, it can speak to people's resourcefulness and creativity as they find novel ways to achieve health capability.

Conclusion

This literature review has provided a rich contextual framework for thinking about the study's findings which are presented in the chapters four, five and six. In the chapter that follows I discuss the methodology chosen for the study and describe in detail the methods used to examine the research questions.

CHAPTER THREE: Methodology

Introduction

This chapter starts with an outline of the methodological theory that informed my research approach. This is followed by a description of the actual research methods used.

I realised that each participant would have their own story to tell and I wanted to capture this individuality. I therefore chose to examine this topic using qualitative methods, an approach that also seemed important to counter the invisibility more characteristic of this group. I also wanted study participants to feel validated and affirmed through the research process, which the personal approach of the interview allows.

It is hoped that insights gleaned from this research will contribute to understanding the association between low income and poor health, and also that the study will raise some important considerations for the RAC sector as it adapts to increasing demand for its services.

Research Question

The primary research question underpinning this study was:

How do HCAs, employed in RAC and who live in low-income households, think about and attend to their personal health concerns?

To answer this, I addressed the following questions:

- How do participants respond to their own health needs vis-à-vis the needs of others, especially those who depend upon them?
- How does financial constraint impact this process?
- How does a 'caring ethic' manifest/influence and/or complicate health-related decision-making for this group of women?
- What supports are available for the women when they experience diminished health capability due to financial constraints and which do they utilise?
- What compromises do they make in relation to perceived health needs?

Ontological and Epistemological Position

Establishing ontological and epistemological positions at the outset is critical to understanding the knowledge generated by the research “because they are precisely about what it means to be scientific and what is allowed to be classed as evidence” (Davidson & Tolich, 2003: 25). These theoretical positions articulate the set of assumptions about social reality within which research tools operate. The basic ontological question in health research is to what degree does research phenomena embody ideas about things (idealism) as opposed to the things in themselves (realism) (Giacomini, 2010). Where we stand on this continuum is significantly influenced by our values and beliefs.

The next layer of theory addresses the question of epistemology, that is, how researchers can empirically investigate phenomena (given the ontological assumptions about what phenomena are) (Giacomini, 2010). Giacomini maps the range of epistemologies on a continuum from the objectivist/positivist position at one end through the pragmatic to the critical/ideological¹⁰ stance at the other. The process of knowledge generation within each position is also mapped and ranges from falsificationist at the positivist end through to critical, creative at the ideological end. The task for the researcher is to consider where they might position their research on this spectrum.

Interpretive – Phenomenological Orientation

I chose to adopt an interpretive orientation, which is located in the middle ground of Giacomini’s map. This is to understand the world foremost as one of ideas, whether about society, ourselves, or nature (Giacomini, 2010). This position is considered particularly suitable for researching social phenomena and socially shared meanings, and it recognises the principle of *Constructivism* which reflects the belief that people mentally construct, rather than receive their ideas of the world (Giacomini, 2010). Different constructivist theories make different assumptions about this process. The interpretive orientation I chose is the phenomenological position with its roots in the work of Edmund Husserl (1859-

¹⁰ In this context *ideological* refers to the construction of new knowledge ideologically or creatively i.e. challenging hegemonic interests that have constructed the prevailing account (Giacomini, 2010).

1938), who introduced the concept of the *life-world* with its attention to individuals' lived experience.

Husserl's phenomenology was expanded further by philosophers such as Heidegger, Sartre and Merleau-Ponty but across all perspectives there are common threads: a) attention to the lived experiences of persons, b) that these experiences are conscious, and c) that the focus is on understanding the essence of these experiences, not on explanations or analyses (Cresswell, 2012). Phenomenology focuses on describing the meanings of lived experience for several individuals and according to Cresswell it is primarily concerned with understanding the commonalities in their experiences (Cresswell, 2012).

Hermeneutic phenomenology

There are three main schools of phenomenology: descriptive phenomenology, hermeneutic phenomenology and existentialist phenomenology. Hermeneutic phenomenology was the framework chosen for this piece of work because it moves beyond description to the interpretation of experience and it incorporates the location of the interpretation within a specific social and historical context (Bryman, 2012, p560). There is some variation in the detail of how this is achieved, but fundamentally, hermeneutic researchers seek to understand how individuals create and sustain the subjective, personal meanings they use to make sense of their context and their experiences (Van Manen, 2016). Centrally assumed in this model is the notion of intersubjectivity which means that in order to understand another's experience, one must draw upon one's own subjective, phenomenological knowledge (Giacomini, 2010).

The Hermeneutic Circle

Hermeneutic interpretation follows a cyclic path which begins with the researcher's initial interaction with the phenomenon from the position of his/her pre-understanding and history. It proceeds through multiple cycles of engagement through which successive new interpretations are negotiated and the new understandings merged with what is already known (Chang, 2010). This describes the interpretive process utilised in this study.

Reflexivity

When undertaking qualitative research, it is important to acknowledge the role of the researcher in generating and interpreting data. This is because they are the

“primary instrument or medium through which the research is done” (Xu & Storr, 2012, p. 1). Inevitably the researcher is intimately present in the research through their methods, values, biases, decisions and attendance in the social world under investigation (Bryman, 2012). The implications of this for the knowledge that is generated must therefore be as explicit and transparent as possible. One way to begin to achieve this is through *reflexivity*.

Reflexivity involves turning one’s attention onto oneself in order to investigate the process of knowledge production (May & Perry, 2014). It describes the way a researcher’s thinking influences their action which in turn influences the situation under investigation and the subsequent interpretation of responses to that situation (Connolly & Harms, 2015). This reflexive cycle is central to the research process and enables more sophisticated critical analysis. As Fook states it is an essential ability

... to locate oneself in a situation through the recognition of how actions and interpretations, social and cultural background and personal history, emotional aspects of experience and personally held assumptions and values influence the situation (Fook, 1999, p. 12).

Adopting a reflexive stance requires the researcher to acknowledge her/his own background and life experiences and consider the impact this might have on the research process and findings. This is discussed below.

Personal Statement

My development as a researcher has been shaped by my experience in a number of health-related roles including nursing, addictions counselling and public health. Theoretically I have been strongly influenced by social science literature especially the cognitive, humanistic and transpersonal psychological strands. I therefore chose to attend to my growing concern about the plight of HCAs in NZ from a qualitative viewpoint, seeking to gain understanding about how these women perceive and live in their worlds, thereby illuminating their ‘lived experience’ (Morse & Field, 1995).

Prior to commencing my research, I was employed for six months as a caregiver in a local residential aged care facility and was quickly struck by the awareness that I had never in my life worked so hard for so little recognition and remuneration.

When I looked around me I saw women running households and maintaining families and I could not help but wonder how they were managing living as they were on or around the minimum wage. What was clear to me was that no two women were the same in either themselves or their situations so it made sense to take a qualitative approach to examine this phenomenon.

From this starting point, I felt it appropriate to take the following path:

- a. to study the descriptive data for what it conveyed about participants' lived experience;
- b. to pay particular attention to the language used as a means of gaining insight into how they made/found meaning in their experiences, primarily through their expression of values and beliefs;
- c. to find commonalities across the interviews without losing the variation between them;
- d. to allow social scientific literature to inform my data (but not filter it);
and finally
- e. to convey my findings in a cohesive narrative.

Throughout this project I was mindful of offering the women a safe space in which they could speak freely of their life experience and I hoped feel validated in themselves and for their work.

Presumptions

Reflexivity requires me, the researcher, to identify my underlying assumptions about the research topic (Green & Thorogood, 2009). Initially I assumed that the women would be happy to participate in the study as they would be given an opportunity to 'have a moan' about being undervalued. This arose from my own experience of the hard work and living on the minimum wage, and not from the complaints of colleagues which were remarkably infrequent in the workplace. I would hear my colleagues speaking of the challenges they were facing, and more often than not, come away with admiration for their sense of purpose, their resourcefulness and their coping.

Another assumption I brought to this study was that despite their shared experience of life as an HCA on low income, each participant would bring with them

a unique set of circumstances and life-demands that they coped with more or less well. I also assumed that they would want things to be better, easier or different but that they had minimal power to effect change in their lives. I imagined they would be focused on what they were not able to be or do with their health or in their lives because of their financial situation.

I considered my experience as an HCA as an advantage in this research for the following reasons:

- first-hand experience of this work gave me credibility in the eyes of study participants;
- it enabled me to establish rapport relatively quickly and proceed to deeper conversation with greater ease;
- I understood the rewarding aspects of the work and the job satisfaction that was regularly expressed and which held the women to the work despite its apparent disadvantages;
- I was also hopeful that my HCA experience would go some way to balancing perceptions of difference in social status.

I considered that my age, gender and ethnicity (i.e. middle-aged pākehā woman) would aid me in establishing rapport with the women as I fit the demographic of the bulk of the aged care workforce. I felt this would help minimise perceptions of social difference between myself and participants, and as younger interviewees interacted daily with their older colleagues this interaction would not in itself be a novel experience.

Acknowledging these assumptions helped me to bracket¹¹ my own experiences and focus on what participants were communicating.

¹¹ Bracketing refers to the method used to constrain the potential influence of the researcher's own experience and preconceptions on the research process.

Methods

In the following sections of this chapter I describe the research methods I used in this project.

Sample

A generic purposive sample

In a generic purposive sample, the researcher identifies and selects study participants with his/her research goals in mind (Bryman, 2012). In this study participants were recruited in the Dunedin area primarily for the convenience it afforded for both myself and the participants. With their shift work commitments and my own other work commitments this was essential. I planned to recruit a maximum of 12 women employed as HCAs across multiple RAC facilities located in different areas in the city. Although I hoped to obtain a range of ages and ethnicities to reflect the demographic characteristics of this workforce I decided to include all women who responded to my advertisement and who fit my inclusion criteria.

Inclusion criteria

To be included in this study respondents had to be:

- Female
- Working as an HCA/caregiver in a RAC facility
- Living in households with a total income of less than \$34,100 p.a. (before tax).

Study members were recruited via two avenues.

1. An advertisement (Appendix 1) was placed in the free local newspaper which is delivered to all households in Dunedin and Mosgiel¹². This included a request for participants and a statement that they would be given a \$30 voucher in appreciation for their involvement. This approach yielded seven calls, four of which met my inclusion criteria. The other two calls were from a home-based carer and a mental health support worker (also paid at minimum rates).

2. I sent a letter (Appendix 2) to 12 RAC facility managers informing them of the study and requesting permission to make a short presentation about the research

¹² A substantial satellite town close to Dunedin.

at a staff meeting, as well as advertise on the staff bulletin boards (Appendix 4). This was followed with a phone call requesting a personal meeting with the manager to discuss my proposal. Of the 12 managers I called 11 agreed to meet with me¹³ and all 12 agreed to a notice being placed on a bulletin board. Two providers who operated four of the facilities also offered to place a short article about the research (Appendix 3) in their staff newsletter. From these approaches three managers agreed to me making a short presentation about the research at a staff meeting¹⁴ where I also informed the HCAs of my ethical responsibilities regarding their involvement and that they would receive a \$30 supermarket voucher in appreciation. This yielded a further four study participants.

The final sample was comprised of eight women aged between 19 and 62 who worked across seven different RAC facilities. One woman was Indian, one a NZ Māori, and the remaining six women were NZ European. A more detailed breakdown of the sample is provided in chapter 4 (Table 4.1).

Initially I indicated that there would be a shorter follow-up interview, to occur at a later date, with a view to checking the veracity of my data. Time pressures on both the participants and myself prevented this occurring. However, each interview concluded with a summary of what had been discussed and any changes or amendments they offered were noted and included in the analyses.

Ethical Approval

Potential participants were fully informed about the study and that their participation would be kept confidential. They were assured that I had no ongoing relationship with any RAC facilities and that their comments would not be conveyed to their employers. I affirmed that their employer would not be named in connection with them and would only be identified as to the nature of the services they offer e.g. rest home or hospital. The University of Otago Ethics Committee

¹³ The one exception said that it was a 'bad' time because her facility was in the middle of switching from a paper-based to an electronic system and that stress levels were too high to even think about a study.

¹⁴ The remaining RAC facilities said that speaking to staff in this way was untenable in terms of logistics citing the following reasons: staff meetings were infrequent, agendas were already set, given the nature of shift work only a small number of women would be available at any given time. Each RAC had a distinct way of operating and it was clear that many of the managers were feeling the pressure.

consented the study In May 2017 (Appendix 5) and the information and consenting process was followed with each participant prior to their interview.

Data Collection

Semi-structured Interview

Data for the study were generated through individual interviews conducted during July, August and September, 2017. These were done at a time and place chosen by the women. Four of the women chose to be interviewed in their homes and four preferred to meet at the Marsh Study Centre, a quiet, accessible off-campus University facility.

A semi-structured interview format (Appendix 8) was used to guide the interview but the conversation was largely led by the interviewee. This was done:

- a) to avoid distracting the participant from her story, with my questions and responses being used more to stimulate conversation than control it;
- b) to enable me to focus specifically on 'her' story as told;
- c) to avoid objectifying the participant by corralling her individuality to fit with my goal;
- d) to allow an inductive approach where knowledge and insights gained from previous interviews could be used to help clarify emergent issues;
- d) to minimise interpolating my own experience.

It was quickly evident that my understanding of the work facilitated rapport with the women and served to reduce the need for my direct involvement in the conversation.

All interviews were conducted face-to-face and recorded using a digital voice recorder (with the participant's consent). The average interview time was around 40 minutes with two interviews taking 80 minutes due to the respondents being particularly distressed with their current situations. In both of these instances, after the interview, I facilitated the women accessing appropriate support services. Six interviews were transcribed verbatim by the researcher with the remaining two done by an external transcription service. These were carefully checked for accuracy. Field notes were recorded after each interview.

I commenced the interview with a brief introduction about myself and the study. I discussed consent with the participants ensuring they understood they could request me to stop recording at any time, and stop the interview if they wished. I started the conversation with a general question about what had led them to respond to my advertisement. I then followed the approach outlined in the Interview Guide (Appendix 8). Included in the interview was a small number of questions about participants' level of confidence in their ability to perform a desired health action for the purpose of achieving a desired health goal. These questions were designed specifically to explore notions of health agency or self-efficacy in relation to health. The interview concluded with a brief strengths-based summary of the interview, which I hoped left them feeling empowered rather than diminished by the research. They also received a \$30 voucher at the end of the interview.

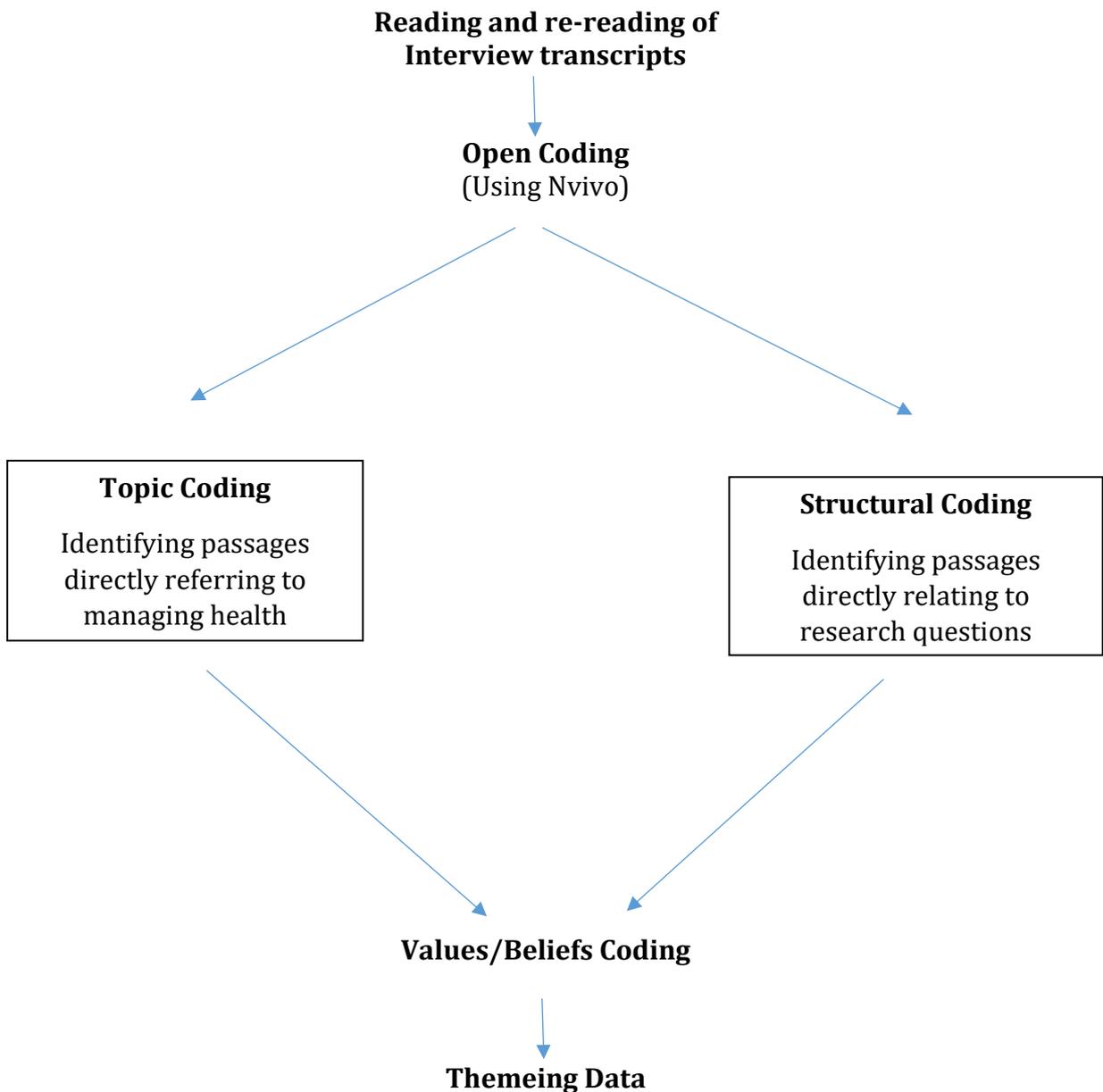
Upon reflection, the decision to use a semi-structured interview approach was appropriate as it accommodated the women's respective situations and concerns. This format allowed me to meet the women where they were in their lives and ultimately yielded some rich narrative and insightful data. My concern about over-directing the conversation to fit with my paradigms was perhaps unwarranted as the women responded well to the questions I asked and actually seemed more secure speaking of personal matters when there were clear hooks to hang their experiences on. Finding the balance between structure and openness was clearly the key and varied between participants.

Data Analysis

Analytical Approach

A mix of different coding strategies was used to analyse the data from multiple perspectives. Figure 3.1 outlines the analytical approach I used to explore the data beginning with the first step of familiarising myself with the transcripts and audio recordings.

Figure 3.1: Analytical Approach



Coding

My first step was to read the transcripts and listen to the recordings several times with the intention of understanding the content of what was said. Then progressing slowly through the text and recordings simultaneously, using Nvivo I systematically identified meaning units and assigned codes to these. Codes were then grouped into preliminary sub-categories and categories. Table 3.1 Provides an example of how this proceeded.

Table 3.1: An example of coding process

Meaning Units	Code	Sub-category	Category	Theme
"I handled it okay for the first year And then I found I couldn't get a proper sleeping habit so my weight went up. My cholesterol is quite high. I am now borderline diabetes"	Diet Over time	Health Effects	Poor health	Struggle
"...and I think just...personally I think I'm at the end of my...I don't think I can do night shift anymore"	Demanding shift work	Feeling overwhelmed	Exhausted	Struggle
"...I don't want to say no because I want to spend some time with her...instead of saying 'no, I'm tired and I'm sleeping' I will just drag myself out of bed , get dressed and go..."	Tired	Rest vs social	Inner conflict	Struggle

The resulting codes, sub-categories and categories from two transcripts, were initially compared and discussed with a supervisor until agreement was reached and the coding manual developed. The remaining transcripts were coded using this manual.

The open coding and topic coding phases were done using this approach in Nvivo whereas the structural coding and values/beliefs coding were done manually using the framework method (Gale et al., 2013) as well as physically highlighting relevant transcript text. I found the framework approach facilitated a focus on actual

language used and with the highlighting method I was more sensitive to contextual elements.

The open coding phase initially resulted in what I found to be an unwieldy number of codes and it was this that led me to pursue more focused methods. I found Saldana's 'generic approach' a useful guide in this (Saldana, 2013, p. 64).

Approaching the data from these different perspectives yielded categories that constituted two themes (Table 3.2). The first of these focused on the women's health and wellbeing concerns and largely centred around the notion of 'struggle'. The second theme represented something of the *Why?* that lay behind their health-related choices and spoke of what the women valued when thinking about their work and their health concerns.

Attending to the more interior experience of the "lifeworld" of the women, aligned with the phenomenological objectives of the study which aim to gain deeper understanding of the nature or meaning of everyday experiences (Van Manen, 1990).

Table 3.2: Coding Framework

CODES	SUBCATEGORIES	CATEGORIES	THEMES
<p>Dependence/Independence Stressful life events Tight budget – keeping up with things Thinking ahead Transport</p> <p>Heavy and fast pace of work Tiredness/mental strain Staffing pressures Emotional demands of caring</p> <p>Health challenge</p> <p>Low pay Migrancy</p> <p>Workplace bullying Demanding shiftwork</p>	<p>Financial exhaustion</p> <p>Physical exhaustion High demands Difficult situations Not coping</p> <p>Health/illness</p> <p>Lack of appreciation Low status</p> <p>Insufficient support and cooperation</p>	<p>Exhaustion</p> <p>Constant demands</p> <p>Health effects</p> <p>Under valued</p> <p>Conflict</p>	<p>It's a Struggle!</p>
<p>Caring for colleagues</p> <p>Caring for residents</p> <p>Feeling competent Being independent Being resourceful Caring for one's own family</p>	<p>Sense of mutuality/team</p> <p>Rewards from residents</p> <p>Work pride</p> <p>Self esteem Self efficacy Sense of purpose</p> <p>Sense of responsibility Finding balance</p>	<p>Good relationships</p> <p>Caring</p> <p>Work</p> <p>Self reliance</p> <p>Own health and wellbeing</p>	<p>It's good to work and it's good work!</p>

Conclusion

My approach to this study involved a literature review and qualitative interviewing. This allowed me to examine the research question: “How do HCAs, employed in RAC and who live in low-income households, think about and attend to their personal health concerns?”. The methodological theory informing this study guided my engagement with participants and framed my personal reflections on the process. The resulting coding framework is derived from the multiple readings of the data. In the following chapter I present the initial findings of the analysis.

CHAPTER FOUR: Findings 1

The Struggle

Introduction

This chapter presents the research findings derived from thematic analyses of the coded data. The two overarching themes that emerged in this process were a) that life as an HCA on low income was a struggle and b) 'it was good to work' and 'it was *good* work'. The latter of these themes indicated the importance of values in the women's decision making. It was evident that each participant's wellbeing was a function of the balance that existed between these two aspects.

This chapter summarises how the 'struggle' is manifest in the women's lives and how it largely determined their current and future ability to care for themselves and others. It will be considered from three overlapping perspectives: firstly, the 'struggle' that arises from managing a life lived on low income in NZ; secondly, the 'struggle' of working as a HCA in RAC and thirdly, the 'struggle' that results from the emotional demands of caring per se. Following this I will outline some particular struggles faced by a migrant caregiver in NZ.

In Chapter five I examine how values and work came together to ameliorate or exacerbate the struggle. I then consider the impact this confluence has on health-related decision making.

The study participants

Until the recent pay rise, it seems fairly clear that caring for the elderly in a residential setting was a low status, low value occupation, accessible mainly to women with no formal qualifications. The degree to which the pay rise will shift this perception yet remains to be seen. The women in this study were a small local subset of the female RAC workforce in NZ. However, their stories reveal a variety of experience and a foreshadowing of their future health and wellbeing. Table 4.1 summarises the work experience of the group.

Table 4.1: Work experience of study participants

Participant	P1	P2	P3	P4	P5	P6	P7	P8
Age	55	46	19	54	53	30	62	31
Experience in Aged Care	3-5 yrs	2 mths	4 yrs	3yrs	4yrs	1yr	2yrs	10yrs
Education	Level 3	Level 3	Level 2	Level 4	Level 3	RN (Currently not Practicing)	RN (Currently not Practicing)	Level 4
Hours Worked	28 hrs across 2 Caring jobs	Casual - wanting permanent hours. Usually works 12 - 18 hours per week.	Just dropped HCA work to casual & started as physio assistant in RAC to be able to get better pay and manage physically	40	40	40	40	20
Number of jobs	1	1	2	1	1	1	2	2

The women in this study had varying degrees of experience in the aged-care sector and most had already taken advantage of opportunities to achieve formal work-related qualifications. Until July 2017 however, this had minimal impact on pay rates or job prospects. The perception of the women in this study as to how much impact the pay rise has had or will be likely to have in their lives, varied depending on their individual situations. For one it was “life changing” with her pay rate increasing by \$6 per hour because she had her Level 4s.¹⁵ Given that **P4** was a solo parent with three dependent teenage children and had been trying to manage on around \$16 an hour, one can appreciate why.

P4: It is. It is (life changing) I mean, my family assistance has gone down a bit, and I don't get accommodation allowance anymore, but still, I'm still better off.

P4: And when you've experienced being on a really low income, and having to struggle, when it gets better, it just ... I don't know, life just ... at the moment, life is just, yeah, financially way easier.

¹⁵ This is currently the highest level of qualification for caregivers.

All but one of the participants lived in some form of rental accommodation with two of them living in rooms with shared facilities. Five of the women lived alone, two lived with dependent children (no partner) and one lived with her partner and his family.

All of the women spoke of their struggle to live lives that fully honoured their health and wellbeing needs.

Table 4.2: Participants' most salient health concerns

Physical Health Concerns	Mental Health Concerns
Knee replacement / Head injury from a fall related to diabetes	Post head-injury confusion and memory problems Addiction Issues
Concern about lump on neck (past history of thyroid cancer) / Diabetes / Hypertension	Anxiety/Depression
Shoulder and knee injury	Stress & anxiety about finances
Prolapses/ Arthritic changes in hands/ General stiffness	Exhaustion/no time for self
Pre-diabetic/Hypertension	Depression/Exhaustion/ Addiction history
Multiple serious health issues exacerbated by intense stress	Excessive stress from immigration concerns
Repetitive Strain Injury	Nil reported
Back pain/ Ankle and knee pain and weakness	Anxiety disorder and general stress

It's a Struggle!

...for independence

Following her statements above **P4** goes on to say that the best thing about the pay rise is the increased sense of independence it gives her. This emerged as an important theme in a number of the interviews, especially among the women for whom their caregiving work provided a means for transitioning off the Work and Income benefit.

P4: Because at that point... Yeah, I was still on the DPB¹⁶, partly, so then I could get off the DPB and go on to family assistance...So it's been ... I mean, for me, being independent is hugely important.

The transition from benefit dependence, to supporting themselves more was mostly experienced by the women as being a very difficult transition, but positive in the long run.

¹⁶ Reference to the *Domestic Purposes Benefit*. This was the state welfare benefit available for sole parents prior to July 2013, when benefits were re-structured and *DPB* became part of *Sole Parent Support*.

It was difficult for the most part, because the variable part-time nature of the work coupled with the 'Work and Income New Zealand' (WINZ)¹⁷ regime of varying deductions depending on fortnightly earnings, made budgeting on what was still a very low income nigh on impossible.

P2: It's (the pay rise) made a bit of a difference but it's taken... because I've got to declare everything that I make with WINZ and it takes a big chunk out of that. Like all I get at the moment from WINZ is \$230 so I've got to make up the difference from that for my rent. So what's left out of that and what I get from pay that goes to part of my rent and then I pay all the bills that I need to pay...There's normally not enough food. Its normally, it's just getting like enough to be able to get a...to be able to buy bread or sometimes...

The vision of living out from under WINZ control strongly motivated the women to persevere and endure this difficult time.

P8: My choice was keep sticking with it, keeping working with it, look for another job at the same time and if you get another job, go or leave now and go on a benefit, which I had done at one point. I was on a benefit and unemployed for 10 days. 10 days was as long as I could manage being ... Because I found being answerable to WINZ more stressful than being, than age care. I found it more stressful than that. I felt guilty for being there.

P5, chose permanent nightshift over benefit support and is now suffering negative health consequences which are, at least in part, due to the consequent exhaustion.

P5: When I was first offered the opportunity - there are only 3 caregivers at FH that work 40 hours. The rest are around about 35 hours and night shift is one of them. And I didn't think about it. I thought I just want a fulltime job and go off the benefit and that was it. That's why I took it.

P2 spoke with some passion about having to comply with WINZ demands all the time:

P2: ... got no idea what I have to put up with, with WINZ on my back all the time saying I need to get work, I need to get work. I get work and they're still on my back. Like I've rung up asking them if I could get a food grant, not so long ago

¹⁷ The government agency that distributes welfare assistance to those in need

“What do you want that for?” “What do you need that for?” You get paid 200 and something dollars. I said well that pays the rent. I said that doesn’t even cover half the stuff I need. So yeah...

Making matters worse is the fact that **P2** has diabetes and has to meet extra costs associated with that:

P2: At the end of it by the time I tell them (WINZ) how much I make a week, how many hours I’ve done at the rate I’m at, they take a big chunk of that off. That goes. And of course, me being a diabetic I’m on medication for the rest of my life. I’ve got to pay for that. And its \$32 to see a doctor and then I’ve got all my prescriptions that I have to have. It damn near works out damn near \$100 every three months.

For virtually all the women in the group, the income derived from caregiving (with a top-up from WINZ in some instances), was all they had to come and go on, and this rendered them vulnerable to economic shocks for example due to unexpected bills, rent rises.

...dealing with stressful life events

Major life events come in many guises and are often unexpected. While they may differ greatly in nature and magnitude, they invariably require some degree of extra resource, financial or otherwise, in order for them to be managed well.

The major life events spoken about by the women in this study included the death of family members, serious health issues and relationship breakdown. In all cases, the impact on personal finances, work and home life was significant and long lasting.

P4: That actually meant I had to, yeah, that's where I had to go into debt because my sister got cancer, and she only had...they gave her ten days to live. So I had to go up there and say good-bye. And then I had to come home, and then go back up two weeks later for the funeral. So that put me in debt. And then last year ... that was two and a half years ago. And then last year April, my mum died, so I had to go up for the funeral. So that put me, yeah. That was when I struggled.

P3: I hurt my shoulder, sprained it, so I had a bit of time off work and then I found out because I only had a week off work I’m not covered and I don’t have

any sick leave because I've only just started at the physio job, so that's cut my fortnightly pay in half. So it's really hard.

The debt that tended to result from these life events created obligations and re-payment pressures adding extra stress to what were already extremely tight budgets.

P3: Yes.. like even my physio...she kind of knows...cause I've kind of talked to her about it and she says "if you ever short that week you can kind of just build up and pay it off as you go" which is good...but I don't like having to ask people... and be like saying "Oh I don't have any money this week can I pay like in the next...like I just don't want to have that on me...

It is during these times particularly that individuals, especially those with limited resources, have to make some hard health decisions weighing up their options more (or less) carefully. **P1** for instance stated that it was having to pay for things that pushed her to gambling.

P1: Then I started getting really bad at paying stuff, and I got into a lot of trouble, gambled, they don't ... When you talk about gambling, I started off originally trying to pay for stuff.

...living on a tight budget with no reserves (and maybe some debt)

Despite the very clear relief the pay rise brought the women, most if not all were still in the position of having to budget very carefully. **P4** for example who was a woman very experienced at budgeting, still needed to take close account of things as she prepared to meet the future needs of her family.

P4: And also there's bus fares. I mean, (and) uniforms. I just have to put money away every week. I mean, I do everything, like money goes into their school accounts every fortnight, and I have to have money, just little bits that go into an account every fortnight so that ... I do that with my Christmas club account, so that by the time Christmas comes, I don't have to think about buying, you know- And I've had to be like that. Because I mean, I've done this for a long time. And I've been poorer, even before the pay rise came in because I only worked part-time. So, yeah...

The increase in income however, has enabled **P4** to, at least in part, prepare for a period away from work when she has surgery. Previously she had to rely on material and financial support of friends and family to get through such events, repaying the debt incurred later once she returned to work.

In contrast, **P8** lives alone but is only able to work for around 20 hours a week, so even with the pay rise she still has to manage her finances very carefully.

P8: ... I don't so much budget my money as have a list of what needs to be paid that fortnight. I have rent, car insurance, petrol, groceries. I write a list of the things that I need to pay that week - if I know what the cost of it was going to be like the rent obviously is a fixed cost. The insurance payment was a fixed thing. Write that down. As soon as that money hits my account, I go, "Right, this is how much money I've got. This is how much money is coming out." Subtract all the things I know the cost of straight away. Just subtract that off and go, "Right, this is how much money I've got left to cover the petrol and groceries." Then 99% of the time, that was enough. I'd buy groceries, get the petrol. I might have \$30. I might have \$40. ...

The women's life situations were, generally speaking, quite singular, each having its own unique set of pressures and circumstances. What was clear however was that on a low income the tipping point into crisis was easily reached.

P3: All up I think it cost me about \$80 just to go there (the Urgent Doctor's) and that's like a large chunk of my pay...just to go there...like the amount of times...like I work out my pay every fortnight, so okay I can do this this week because I have car problems and then I've got rent and then petrol and living costs and I just got to work it out and then something catches me off guard like this week and I'm completely stuffed.

When living close to the bread line like this it is little wonder that health gets knocked down the priority list when it comes to making decisions about how the money is going to be spent. In most cases the short-term view necessarily prevailed; for example, deferring health measures or treatment in order to pay bills or meet other obligations.

P5: so it wasn't consistent at one point so budgeting became really difficult, so I don't want to be evicted so my rent will be paid, I don't want to have a bad credit

rating so my bills will get paid, my cats got fed before I did...I got noodles (laughing).

...keeping up with things

Problems associated with persistent or long-term poverty were evident as the women struggled to meet the demands of unexpected events, work obligations, family needs and their own self-care needs. For example, the need to have or be able to obtain petrol to run a car arose in several of the interviews, perhaps most acutely expressed by **P1**:

P1: I would have had to sell stuff to get petrol. That was a priority, I had to have petrol to go to work.

Feelings around any debt or other costs associated with needing and running a car were often made worse by what else was happening in the women's lives. **P8** for example had a daily battle with an anxiety disorder and feelings of indebtedness, in this case relating to her car, were particularly difficult for her to manage.

P8: The car is very important to me. That is one area where I'm really lucky that my parents live in town and have a spare car because my car died. It just gave up the ghost completely out of nowhere a few months ago. I was able to borrow my parents' family van for a couple of weeks until I could find another car within my price range and I was able to borrow money from my parents to get a new car... I feel very guilty about it...

Despite working only about half time, **P8** was insistent about needing to repay any money owed anyone and would put herself under some pressure to do so, because the ongoing existence of a debt created more anxiety for her.

P8: I can, (ask parents for financial assistance) but again I try very ... I try really hard not to because with my anxiety and things, I feel really guilty being in debt to anybody even my mum. My mum will give me ... I'll say, "Mum, can I just borrow \$20 to top up my phone. I don't get paid for another week. Can I just have \$20 just to top up my phone?" She'll put through 50 and say, "That'll keep you going," but then I feel guilty owing her \$50. For quite a number of years, I had an automatic payment going to the doctors, paying off the doctor's bill, but I also had an automatic payment going to my mum paying off money that I had borrowed.

P2, on the other hand, was still trying to find her feet emotionally and financially after a marriage breakup that occurred three years ago. She had suffered a dramatic loss of income, been forced by the Family Court¹⁸ to move away from her support network to a town where she knew no one, was living in real poverty and coping with serious health issues. The impact of her situation was gravely impacting her nine year old son who was experiencing migraines and talking about wanting to die and while this was a complex and difficult situation and having inadequate income was clearly making it worse.

...meeting the need for transport

Transportation and issues associated with it arose in virtually all of the interviews as being costly and difficult to manage on such tight budgets.

P6: I didn't drive and there was no transportation from where I lived to the place I worked so... the person I was staying with does a job where he has to report at 5.30 am. So I'll get up at 4.45 and get ready and reach my place by 5.15 and wait there until 7 o'clock every morning to start work. So I will be doing 1.30 to 10 shift the previous day and then be getting up at quarter to five and be there at 5.15 again. Even with my health (issues).

For **P4** it was the costs of meeting her children's needs for transportation that were a major source of stress: "... One gets a taxi, two of them get buses. I think the biggest struggle is the bus fares. Because for me at the moment, it's \$50 a week", and for **P5** who did not own a car the prospect of walking to work at 10.30 pm or walking home after her shift at 7 am was too much to face. The night-time walk was scary and the morning was too exhausting when all she wanted to do was get to bed. She chose therefore to spend around \$80 per week to use taxis.

P5: Now it's like I'll finish my shift and it's like I can't be bothered walking home I'm just going to call a taxi which means I'm spending money that I don't really have but I just don't want to walk. I just want to get home.

¹⁸ The Family Court is a court of law that hears cases involving domestic issues such as divorce and child custody.

...dealing with the physical demands of caring

Heaviness and fast pace of work

All of the women in this study mentioned the heaviness and the fast pace of their work, especially when providing hospital level care.

P4: Because where we worked, allocation lists are a lot bigger than anywhere else. I mean, one person might have eight to 10 people, whereas in other facilities, it's only five or six. So it is a very heavy workload at the moment because we've got such a large percentage of hospital care.

P6: ...and then somebody who is working so hard...I mean it's more physical...you are handling a person who is five or six times bigger than you... hoisting and they say you should have two people to hoist but that's often neglected because you can't always get a person to do it and we are always more or less short staffed. And then turning them, rolling them, changing pads, showering, lifting them, oh my God your back is always in strain and that money. That's not really good.

P8: (You get)... pulled in every direction and you have five people. It's become worse now that we have more residents, less staff. The staff have got more things to do. You've got one resident over here saying, "Please make me a cup of tea." Then someone over here, "I want this. I want that." You have four or five people. You have your co-workers pulling you in one direction because they need you to help with something. You've got residents pulling you in another direction. You've got yourself knowing what you need to get done and thinking, "If I do this and this, then that's going to mean I'm later doing that."

Together these factors, the heaviness of the work and the fast pace, increased the risk of the women suffering from stress and sustaining injuries.

P3: ...don't like caring at hospital level. It's so hard. I actually, recently just had some time off work because I hurt my shoulder at work... um...they have got Lazyboys (chairs) that you have got to push down on the back of to get the feet to go out...and I had quite a big resident and I pushed down and I hurt my shoulder, sprained it, so I had a bit of time off work and then I found out because I only had a week off work I'm not covered and I don't have any sick leave because I've only

just started at the physio job¹⁹, so that's cut my fortnightly pay in half. So it's really hard.

The nature of the injuries varied but unsurprisingly sprains and strains were most commonly reported. Back and joint pain was also widely experienced by the women causing them some concern.

P8: Yeah the joint problems, back problems, shoulders, all that sort of thing...I can see... How it progresses. Two or three of them (colleagues) have got really badly arthritic knuckles and fingers just from general wear and tear. There's a lot of arthritic joints going, backs. Really bad backs, shoulders, necks. Chronic pain things that are from 20 plus years of caregiving and I look at it and go, "I've only done 10 years. What's it going to be like in another 10 years?"

P5: As a caregiver one of the main problems is your back. We are always constantly having back educations...we don't do hoist work but we do lift people up and stuff like that...I've had a lumbar spine injury from lifting a resident so if anything that may go as I get older...and also I suffer from arthritis and so that might as I get older that might...(goes on to discuss father's arthritis).

P4: Like I'm finding with my hands, things are changing. Like I wake up and they're all, my joints are sore. I had a problem ... this thumb locked up, and I had to go to the osteopath. That was another issue with money because that cost me. I couldn't get that through ACC or anything, so that was hugely expensive.

Discreet health events tended to be met as challenges and dealt with in whatever way possible but the concern around the chronicity of the back and joint pain was deeply felt. The women were generally very aware of the long-term implications of continuing in this work and it was perhaps the factor about which they were most proactive in trying to ameliorate. Three of the women budgeted as best they could to have regular massage. The cost of this was to varying degrees prohibitive. **P4** found that going to a yoga class twice a week was both affordable and very beneficial.

P4: And I was having massages. That was very irregular because it is very expensive...And the amount (of times) you go, it doesn't end up being that

¹⁹ Prior to the pay rise announcement **P3** had recently taken on nine hours work a week as physiotherapy assistant at a rest home in an attempt to boost her income.

beneficial because you go, you know, you might feel okay afterwards for that moment, but- it's three months before you get back there again, or six months... So yoga is a cheaper and more effective alternative to... So I just go twice a week any two days that I want- so it's great. It's a bit more casual. It's great.

Such proactiveness however was sometimes shadowed by an accompanying sense of *fait accompli* in that the physical damage has already occurred.

P8: I think it does sort of encourage me, it leads me to consider that maybe signing up for some sort of health insurance would be a good idea now in order to... that I'm covered for future things. It also makes me look at the fact that maybe I should not be doing caregiving and go and do something that's not going to ... Stop doing it now before all the damage is done...Yeah, but then I also look at it and think, "It's been 10 years already. I've probably already done enough damage now that it doesn't really make a difference if I stay or not.

Tiredness/Mental Strain

Feeling tired was a perennial state for all of the caregivers in this study. At 19 years of age **P3** was really concerned about this:

P3: I sleep a lot. On my days off I'll sleep until like 11. I know I shouldn't I don't like getting up at my normal time I find myself getting like a tired headache. It's just easier. And when I work, like if it's in the morning I have a nana nap. Like I'm only 19 and I have a nana nap but I just get so tired and I get headaches. Just so tired...

P5's conversation was dominated by this theme. The issue of tiredness was front and centre when she thought about managing her health. **P5** loved her work and expressed a desire to continue doing it until she retired, but she knew that her sensitivity coupled with the demands of doing night shift was having a very deleterious effect on her health and wellbeing.

P5: People misconstrue nightshift... think(ing) everybody is in bed asleep and they're not. We still have to do pill rounds, we still have to do turns, we still have to do toilets, still have to answer bells, we have to pick people up when they fall, we have to prepare the bodies when they've died, you know and as I said there's only two of us on (*for around 50*) people in the resthome, and then of course you've

got (*people in the apartments*) and they can ring an emergency bell during the night and you still have to go over and see what's wrong with them and sit with them until an ambulance has arrived and then there's paper work and we very rarely have a break at night...I handled it okay for the first year, um and then I found that I couldn't find a proper eating habit so my weight went up. My cholesterol is quite high. I am now borderline diabetes and um sleep wise it's just finding a pattern. Yeah, you think you've got it under control but...um I think just personally I think I'm at the end of my, I don't think I can do night shift much more.

P5 was in a bind, rendered particularly vulnerable because of her age, health and financial status. Her manager was reluctant to move her to day shift and **P5** didn't want to do any other type of work. She was exhausted but felt she had few other options.

P8 on the other hand worked a different regime with the caregivers at her workplace also having to complete various housekeeping tasks.

P8: ... I am responsible for most things. Me and my colleagues, we do the breakfast. We do the morning tea. I serve it up, dish it up and serve it. We have a cook, but we have no kitchen hands so we do all the dishes, all the serving of the food and things. We also do the medication for the rest home level residents. The registered nurses do for the hospital, but we do all the rest home residents' medications, all their cares, beds, put the washing out for them, things like that. All the personal cares we do and we also do quite a bit of the cleaning, removing the rubbish and I guess what you would call servicing the rooms in a way...um and vacuuming the common areas and things like that. We're very multi-tasking carers... So it can get a little bit tight for time at times, and then we have to of course do all the paperwork, the notes and recording, all that sort of thing as well...It is an awful lot of work to fit in the amount of time we have.

Tiredness inevitably increased the risk of accidents and injuries in particular.

P3: I reckon that's why I did my shoulder (injury). I was just tired and it was my last day that I knew I was on and I guess I kind of just wearing out a wee bit and it happened which sucks.

...coping with staffing Pressures

Insufficient staff, demanding rosters and high staff turnover exacerbated the stress and tiredness experienced by caregivers.

P6: There should be five caregivers in the morning and in the evening. Most of the mornings we will have five people or at least four but in the evenings we are even working with only three people...I had new staff with me who are orientating, who have no idea what's happening with the residents or what food they eat or what drink they like. So I apparently have to go to every single person, and dish everybody's food and do everybody else's cares. So think about that, one person is taking care of 31 people and I have done that many a time, with all my health issues and some Filipino nurses especially, if they are not ...we are not fully staffed, a few of them at least will come and ask do I need help.

Covering other carers' holidays and sick leave put significant strain on the remaining caregivers, especially when facilities did not use casual or agency staff to meet unusual or unexpected staff demands.

P3: ...over Christmas I think I worked like 12 days in a row or something, some of them six hours, some four hours and a couple like 4-11(pm). They were not like the same shift. Some were like 6-12 or 9-2.30 or 4-11. All over the place so you couldn't get into a routine. It was just like wake up go to work, wake up go, come home sleep, go sleep. Ridiculous. I remember when it happened I'm like I'm never working this many days in a row again. When I work seven days in a row and then they asked me to work the weekend as well and I'm just like I can't, I'm too tired - they weren't the same shifts as well they were just all over the place. If it was a routine I would have been fine for those seven days but the fact that it was different hours, different times, different residents.

P4: At the moment there is. Just. Yeah, there have been times when it's been really hard. I don't do many extra shifts anymore, but there are a lot of carers that have worked, like especially when I was off having surgery, and time off, yeah, there were a lot of carers around last Christmas that did loads of shifts.

Staffing pressures also increased tension among the staff as each person struggled to meet their own work demands. Three of the women spoke specifically about how much

better the work goes when they worked as a team, helping each other with tasks as they go.

P3: Like with that incident I told you about, when another carer came on and I told her about it she was like “oh let’s just team up for the night. We’ll just help each other do...instead of having six residents each we’ll have 12 together and we’ll work through them together, and then it’s safer” and I’m like “oh thank you so much (with a big sigh), that was just a weight lifted off my shoulder instead of having to find a carer every two minutes that I needed. It was just so much nicer...

P8: ... We're working with people who you care about. You don't have to get on with everybody, but often you really care about the other person you're working with... you have to become close with them and become ... You have to become close with them because you're going through the same things together. ...You grieve for the residents together. You're invested in the residents' lives, but in each other's lives as well. To do the work you've got to help each other.

Interestingly this experience of supportive teamwork, at least for **P6** who was from another country, seemed to be more prevalent among the non-Kiwi caregivers.

P6: Yeah...and not the Kiwi nurses. I mean where I worked. I don't say that all the Kiwi nurses are like that, but where I worked they have...it’s usually the Filipino nurses. I think it’s the culture in the Philippines and in India. We have...are similar. We are still in the stage where NZ was 50 years ago so the kind of family values and morals and dedication and commitment.”

Be that as it may, the benefit of working in a supportive team was considerable.

P3: If someone is behind or say it’s getting close to lunch time and they’ve still got say three residents then I just ask “do you want me to do this? pick up this for you? or like I’ll be like I’ll shower them. I’ll get them down there and I’ll make the bed as well coz then they start stressing out and you’re sitting round doing your notes when you could be helping out trying to finish the load. It’s really nice when you work – like there is one team I really enjoy working with in the morning because the whole shift they’re just like “are you ok?” “do you want me to help you with anything”. Just helping, offering to help and then there is another group, another team where it’s just like one for all, like they are just like “you need to do this”, I

can't do this and they're just offloading...I hate it and I'm like "I'm getting there in a minute, give me a chance". And like if you, like with the good team if you forget to take the washing out of the shower they'll do it, oh yeah and they'll just be like "I've done this for you. Just so you know, just so you're not looking for it" where some of the other teams are like "your washing's still in there – get it out! (grumpily)". Like it's definitely a workplace where you need to work together. Like you can't work on your own. You have to be a team even if you don't want to be.

When this was not the prevailing environment it was sometimes very difficult for the carers to persist in obtaining the necessary support from other staff members for managing things like hoisting residents.

P3: ...Definitely. Like, I don't like to say it but there definitely is like there are times when I say to myself "I'm not going to ask this person or I'll do it quicker by myself, or they're not going to give me attitude..." and with being young and I primarily work with people, the carers are about 50 kind of thing. I get looked down on quite a bit and I get pushed around and bossed around because I am younger and I find that really hard as well...But um...yeah I definitely find the whole colleague thing...like I do go to other people because they are a lot nicer.

Poor staff relations were frequently cited as *the* main source of work stress.

P4 I found that the hardest part of the job.

... was just, yeah, some people think they know, you know...Yeah, we've had bullying. Oh, yeah, I think that's probably ... and people who just bring their stuff to work, they are not very nice... So you have to ignore all that. I found that the hardest thing about work. I just have to now, you just don't buy into anything. You don't really, you don't bitch and you don't talk about other people behind their backs. And if you've got a problem, you just go to your boss."

All of the women in this study expressed their dedication and commitment to providing the best care they could for their residents and were aggrieved if colleagues failed to meet their expectations.

P3: Yeah like when someone says "the resident always says this" and I'm like "I don't care, they obviously want it if they're asking" and like ...one of them is always

asking to go to the toilet and I'm like "if that was me and I want to go to the toilet I want to go to the toilet!". (repeated with emphasis) I don't care how many times I ask I would want to go to the toilet. That's the point of the job. They are there relying on you. When they ask for something you have to give it to them. You can't deny it to them...it's like, it's about quality of life.

...dealing with the emotional demands of caring

Dealing with mortality

All of the women in this study attested to the emotional demands of caring for the elderly. Daily they were confronted with the harder realities of human existence, that of ageing, sickness, debility and death and were tasked to do what they could to alleviate the discomfort of these states for the residents and their families. Attachments were formed and lost as residents died and a number of women in the study commented that they found this part of their job difficult.

P6: Even when I hear that somebody has passed away I still cry. I still feel bad because I've taken care of them and I had that kind of attachment with them.

For **P8** her experience of loss on top of more general stress precipitated a crisis which required a period of time off work:

P8: From working as a caregiver and from everything that comes with that, not just the day-to-day stress, but that you become attached to them, they pass away. It's hard. It is like losing a family member sometimes. With ones that you're particularly close with, it's really difficult. That became more and more ... I had a really good patch where I was really good for a while, and then there was just a breaking point at a certain point, where I broke.

As in other helping professions caregivers are expected to get on and process such life/death experiences with little if any, preparation or support. This can prove very challenging especially if one feels liable to be judged negatively for 'not coping' or feels vulnerable to losing their job. **P8**, for example, perceived what she called a veiled threat of job loss:

P8: Two weeks down the track, when I saw the psychologist again and he said, "I think you still need more time" When I rang her back to tell her, "look, he's given me another two weeks", her response to that was, "I can't keep your job open for you forever", something to that effect...Something to the effect that I can't hold

your job open for you forever, which when you're already in a pretty low state of mind is not helpful. That job is all I've got. That's my livelihood. That's all I've got to support myself. That's not at all helpful.

P5 also struggled with this:

P5: Like as I said the other night we had an unexpected death and you need to kind of come home and you need to unwind and I can't handle the death side of it very well and I got into a lot of trouble so I tend to keep that to myself.

(Interviewer) ... a lot of trouble?

P5: We had six deaths in the space of three months at one point and each death was different, some was quite tragic and others were you know go to sleep and that was that and I kind of, I flipped my lid. I basically said in the middle of – I thought my supervisor was ok with it and I said “I've had enough I wish everyone would just stop fucking dying!” and she went and reported it to the manager and the manager then said “do you think this is the right job for you?” you know this is a rest home, they do die, so I've had to keep those feelings bottled up now and deal with it and then I come home...

...caring for residents

For the women in this study, caring for residents was not generally seen to be part of the struggle that concerned them. It was their job and by and large they “loved” it, speaking freely of the pleasure they experienced knowing that “their” residents' lives were made a bit easier and more comfortable through their efforts. Speaking of this brought light to the women's eyes and enthusiasm to their voices. Witnessing the delivery of less than ideal care however was generally very distressing to the study participants.

P3: I actually had an incident at one of my workplaces where one of them wasn't giving a 100 percent and someone was a two person transfer and his family was outside and I had to wait 20 minutes for her to come. The RNs (Registered Nurse) were in handover so I couldn't interrupt them and she was the only one on with me and he was crying and sobbing. It was the most heart-breaking thing ever and I ended up in the manager's office a couple of days later because I was like “I don't know what to do”. Like I want to write an incident form but then I don't want to because I don't want to get on the wrong side of this carer.

P3...And the other carer was like “oh the RN had asked me to do this” and I said like “no he didn’t” and like you’re in a meeting and the manager, didn’t blatantly say it but she was kind of putting it into the perspective that I was lying about it and they dropped the whole complaint. And that’s the side of the job I don’t like. When I’m giving a hundred percent and someone is giving only like say 50 percent. That is really heart-breaking. Because I think I give a hundred percent because if I was in care I would want the same...I wouldn’t want this half-hearted, you know...

P6: I observed that some days the cares are not done for some residents...thinking about them being in the same urine or faeces for 24 hours is really bad. So the nurses have to be more involved.

Stress and tension also emerged when the women had to work with inadequate resources which was not an uncommon occurrence. For example

P8: It is your problem in the moment when you've got an 80 year old yelling at you that..."I can't eat it," and people who have dietary issues, where they can't eat certain things. We have people with colostomy bags. They can't have beans or peas or whatever. When the tea meal is baked beans on toast, what are you supposed to give the poor guy? Toast? That's all he would get. If the meal is a pork stew or something, we have someone who's allergic to pork..."

In this situation the caregivers often bore the brunt of the resident’s ire and in turn felt powerless to remedy the situation.

...caring for one’s own family

Two of the women in this study had direct responsibility for the care of dependent children. Their situations were in some ways quite different although both were sole parenting. Despite their differences, a couple of common themes emerged. Perhaps the main one was the experience of simply not having any space or time to take care of one’s own mental wellbeing. Physical health issues were more insistent and managed in whatever way possible, but mental health was mostly pushed aside as an impossible luxury.

P4: But ... yeah, it's okay. I mean, I've got kids to deal with. You can't... You can't...You've got to move on.

P4: ... but mentally, I think I need to realise that I need to have time to myself to just relax. Because that's the hardest thing, is just to be able to wind down. Because once you finish work, you come home from work, and I usually shower straight away because that's what you feel like you need to do. And then you've got to think about dinner, get the kids organised, and then you've got to get them all, bed, whatever, situation, homework, all that sort of stuff. And I might get an hour a night to myself. And then before I know it because I get up at half past five in the morning. So yeah.

P4 had three teenage children at home, one with learning difficulties and was working 7:00 am to 3:30 pm five days a week. As a way of managing her dual responsibilities as mother and caregiver she had gone to some lengths to teach her children to be independent, getting themselves off to school and such like.

P2 was in a much less resilient position. She was still actively grieving for a lost way of life, was depressed and struggling to find a way forward.

P2: I just feel that sometimes I just don't want to, you know. He (her son) came in one night and seen me crying in bed. And he asked why I was crying and I just said to him "it's alright". He doesn't need to know at his age (something indecipherable)... stress and no money. So I know he asks for things that I can't afford to give him...And I know I went through (something indecipherable) depression not so long ago and I know my son went through it as well at the same time and I couldn't help him because I was going through the same thing (**P2** was very upset and crying right through this speech)

Lack of money meant that **P2** had forgone adequate nutrition for herself in order to ensure her son had sufficient food. All the while she had her own pressing health concerns, including the discovery of a lump in her neck. At the time of the interview though, her main concern was to get her son an important surgical procedure that he needed, and to be able to care for him post-operatively. In her mind this had to take priority.

P2: It's just either me and my boy. If he's sick I've got to, you know half the time I've got to ring work and say look I can't come in because he's sick.

For the other mothers in the study whose children were grown up and living elsewhere, with or without children of their own, this role conflict continued to feature. **P5's** daughter, for example, was living with a serious chronic illness and her mother felt she needed ongoing financial as well as psycho-emotional support.

P5: ...and as I say I have a twenty-four year old daughter and she unfortunately was diagnosed three years ago with endometriosis, stage four, so she's quite riddled with it and can't work full time so I kind of slip her 50 bucks every now and again to help her out.

Oftentimes **P5** could ill afford to gift money like this but as she said "it's just what you do..." (as a mother).

...caring for self

Given all this it is hardly surprising that caring for oneself was often seen as a bit of a luxury. A number of the caregivers in this study spoke of how they would, initially in their caregiving career, habitually put others' needs before their own, saying yes to extra shifts, taking on too heavy a work load, not saying no when it would have been better to. Eventually though they seemed to work out that this approach was on the whole counterproductive and unsustainable.

P8: That's the other thing I've had to do is for a long time I wasn't putting my own self first and only this year have I started saying, "Actually, you know what? Stuff you. It's more important for me to take care of myself than it is to take care of other people." Because I'm just that kind of person. I'm a caring person that's why I look after my residents. That's why I wanted to do this job. I've always been about helping other people and I guess putting other people first and not taking care of myself. Now I'm taking care of myself more and trying to balance it more.

The promise of having a little more money in the pay packet did loosen the bonds around things like buying food or getting the much needed massage, but more commonly the notion of caring for self, meant having more time. The effects of tiredness and demanding work regimes tended to combine and lead to a strongly felt need for solitude, rest and recuperation; time to gather one's energies in order to face another day's caring.

The choice between sleep and socialising was sometimes a difficult one to make:

P5: like my daughter will ring at maybe 1 or 2 o'clock and say oh mum I'm going to the Warehouse would you like to come and I'm sitting there and I'm like thinking well I haven't seen her for a couple of days and I don't want to say no because I want to spend some time with her and um going out with friends and not saying no to these people and instead of just saying no, I'm tired and I'm sleeping I will just drag myself out of bed, get dressed and ...

P5 was particularly protective of her days off

P5:...(it)is my day off (laughing) and I get really brassed off if I've got to go anywhere like if um if I think oh bugger I've run out of milk I've got to go to the market then I am really peeved off that I've got to leave my house to go and because its my day off and I shouldn't have to go anywhere and do anything unless I really want to (laughing). So I stay locked in my little house and that's it (laughing)... you know and if someone says oh we're going for a drive do you want to come its like Oh no I think I'll stay home I've got a couple of chores to catch up on and in my mind I'm thinking "like hell I have I'm staying home, I'm not going anywhere" (lots of laughter) Even on a Monday coz I finish Saturday morning and I go back Monday night and it's like even on a Monday I won't go anywhere because it's like I've got work tonight so I'm staying home...

P8 also expressed this need to keep her time off sacrosanct, needing uninterrupted down time to cope with her work demands:

P8: Other people might not think that me spending - what my sister calls hibernating - my days off, she says "I haven't heard from you for two days" and I say, "I've just been hibernating". My days off I do sometimes spend the entire day just in bed on Facebook or whatever, just hanging out, stay in my pyjamas all day. That's what's right for me.

Walking the line between time for self and social isolation was generally best managed with family support. **P8's** mother for example instituted a weekly meal to ensure family connection was maintained. **P8** recognised the benefit of this even if at the time she did not feel like attending.

P8: Mum's very much the driving force in the family. She instituted weekly family dinners so that me, my brother and sister and their partners and their family, we

all have dinners together on a Friday night because she was going two weeks without seeing me...Mum brought that in. It's brilliant because it means I see my brother and my sister and we can all catch up on all the family gossip and ... what everyone's doing. It forces me to leave the house I guess... Some weeks, I do feel like, "Ah, do I really have to go? I don't feel like spending ... I just don't want to be around people," but it works out okay because I just go and I sit in the corner and have my dinner and it's fine...If I want to be sullen and sit in a chair and not talk to people, then I can, but usually that's not what happens. I force myself to go and then within five minutes, it's fine. It's just the getting there that's the ...

The promise of more money allowed **P4** to think about the possibility of having a family holiday, something which until the pay rise had been completely out of the question.

P4: Now, it means I can save money. I can actually save money, and we'll all be able to go on holiday ... see, the big sacrifice I think we've made is holidays. I mean, maybe a couple of days here and there, but that was the first holiday we went on as a family and for that length of time. We went for a week. Yeah, so now I can see that in the future we will be able to have more holidays."

Interviewer: "That sounds like a relief".

P4: Yeah, it is. It's great. I feel like everyone else might feel, you know... like what being on a reasonable income might feel like. Like two people income, whatever.

...being a migrant

One young woman in this study spoke of a different struggle, one that arose from her being a migrant HCA in NZ. Her story is a singular one but I believe it represents themes common to the larger migrant workforce²⁰ currently employed in RAC in New Zealand. Her situation also speaks of the vulnerability shared by the many migrants who work for low wages in aged care in this country.

For some considerable time **P6** had been experiencing difficulties with the renewal of her visa. The uncertainty and stress of dealing with this precipitated a serious health crisis. Feeling unable to seek medical treatment due to the cost involved she battled on as best she could, showing a brave face to the world. A strong sense of shame proved to be an additional barrier to her seeking timely help and so the depth of her struggle remained

²⁰ This is currently estimated at slightly more than 30% of the workforce and growing.

largely hidden. She became depressed and withdrew and it was only when her health issues became critical that she sought assistance from a friend who was able to support her getting medical treatment.

While this is a single case it has a number of themes that would resonate with other migrant HCAs. In relation to the current study it is clear that having to pay the full cost of health care while living on low income is a significant determining factor in migrant HCA's health-related decision making.

Conclusion

The women in this study each revealed their own brand of resilience and resourcefulness as they spoke of their daily challenges. Most strikingly perhaps, to the interviewer, was the hiddenness of their struggle. Daily they determined to turn a brave face to the world keeping the extent of their struggles, on the whole, to themselves. But what was also very evident, was that their challenges were most successfully met when they made known their needs to family and friends and support was forthcoming.

CHAPTER FIVE: Findings 2

Values

It's good to work & it's good work!

Introduction

As shown in Table 3.2, two main themes were identified relating to participants' experiences of managing their own health concerns while working in RAC on a low income. The first of these themes referred to the struggle the women faced in making decisions that supported their own health and wellbeing. This was shown in Chapter 4 where it became evident that the primary challenge was having to decide the best course of action in the context of numerous competing demands, both internal and external. Participants were constantly reasoning and negotiating within themselves to find ways of meeting as many of these demands as possible generally with limited resource available, be it time, money or energy.

Throughout their conversation though, it was clear that each participant held a set of values that deeply influenced their self-assessment of the situation and the choices they made. These values constituted the second major theme found in this study which I have articulated in the phrase 'It's good to work & its good work'. This theme speaks to why the women choose and behave in the way they do in regards their work and their health and wellbeing. In this chapter I show how these core values operate as key compass points in guiding the women's work and health-related decision-making.

Values to Health and Wellbeing

The notion of values represents a set of deeply held beliefs and principles about what it means to be human and as such, they are powerful influencers of human choice and behaviour. Being able to live in accord with one's values enhances health and wellbeing, just as not being able to do so undermines it.

Having some understanding of a person's values helps to shed light on why people act as they do. In this study a small number of values emerged from the interviews as being very influential in the women's lives. These were good relationships/caring, work /self-reliance, and their own health and wellbeing (Table 3.2). In the following I examine how

these values influence participants' health-related decision-making and thereby contribute to their health capability.

Good Relationships

The value of good relationships and social connection was one of the most central values in the women's lives. Attending to relationships, nurturing and maintaining them, clearly took up a lot of their time and energy and it was a central motivator and influencer in their decision-making. Having good social connections, at work and outside work, strengthened the women and contributed to their health capability. This value was expressed via three pathways: sense of mutuality and teamwork in collegial relations; psychological and emotional rewards from residents; and mutual support in non-work relationships.

Collegial relationships

Mutuality refers to the sense of shared feeling or experience that occurred when participants felt they were part of a team working well together to complete the day's tasks.

P8: We're working with people who you care about. You don't have to get on with everybody, but often you really care about the other person you are working with. You have to become close with them and become...You have to become close with them because you are going through the same things together...You grieve for the residents together. You're invested in the residents' lives, but in each other's lives as well.

When colleagues helped and supported each other and shared the load HCAs described it as energising and one of the main contributors to job satisfaction.

This promoted health and wellbeing just as its absence undermined it.

However, in this study the lack of team support was most frequently spoken of, and it was often directly connected to poor mental health. Bullying, back biting and not helping each other, was reported by all the women and they in turn responded as best they could on the day. On a good day for example, **P8** was able to focus on her priorities and ignore the rest.

P8: I prioritize my health, "Are my residents happy?", and then what the owner says. Because if the residents are happy on a day-to-day basis, I feel like I'm doing

my job. My job is to look after them and to keep them happy and to make them feel safe in their home. If that means not necessarily following what the owner wants, then I can reconcile that with myself, that is, in myself-

But on a bad day **P8** would spiral down into intense feelings of guilt and anxiety.

P8: There are days where I am at work and I...it would get too much and I'd turn into a blubbing mess. I'd sit down and like, "It's too much. I just need five minutes out." I'd just go and have a sit in a corner and cry.

At the time we spoke in her interview **P8** was learning to cope by switching off, and if necessary, leave work undone when her shift finished.

P8: A lot of time I would...I was staying late and trying to get everything done for them, but now I've realised that nobody else does it. They wouldn't do it for me so now, as much as possible I leave at the time I'm finished. I can't feel bad about it...

This strategy while good in theory, remained a source of stress due to residual feelings of guilt that would stubbornly persist: "No I still...it is still a problem for me. I feel bad leaving them if things aren't finished" **P8**.

As a migrant caregiver **P6** had a different experience of team, distinguishing between the Kiwi and non-Kiwi carers. Her expressed concern was that Kiwi's often did not care enough about their colleagues, would call in sick too readily, or try to evade caring for the hardest/heaviest people.

P6 What happens is that some people will call sick frequently and everybody else is under pressure because of that. And they may have sick leave or holiday leave and they will get paid...but they are not bothered about the staff or the residents but we feel really bad about it because we have that strong dedication and commitment to the residents (moreso) but also the staff... so I never did that.

All caregivers acknowledged that migrant HCAs were generally better at working in a team and tended to be more supportive of colleagues, and all valued the opportunity to work in this supportive atmosphere. Words like *team*, *loyal*, *support* and *happy*, peppered the conversation when they spoke of this kind of work environment. It was very clear in all the interviews that the value of mutual support in the workplace could not be overstated.

Relationships with residents

Participants' relationships with residents were also important and regarded as a strong source of motivation for the women in their work. While caring for the elderly, was considered by the women to be 'hard' work, it was generally affirmed to be worthy and rewarding also. All the women in this study expressed dedication to making their resident's lives better. They all prided themselves on giving 100% in their caring and they highly valued their relationships with the residents in their care.

The rewards they experienced from these relationships included personal satisfaction knowing that residents' lives were made that bit easier through their efforts, and seeing joy in their faces when they approached a resident. **P3** described the 'buzz' she got when one of her residents 'lit up' when she entered the room, "seeing her recognise me and being really happy to see me". A number of the HCAs spoke of doing a bit extra for the residents, something a little special that they knew would be appreciated.

Non-work relationships and support

What was very evident in this study was the variety and value of the support the women received via their good relationships. Most commonly, this came from family and friends and included monetary loans, the giving or lending of needed goods, as well as moral and emotional support. The material support especially was sometimes of critical importance in relation to the women's health and wellbeing. The presence of family support ensured the women did not become isolated which seemed a distinct possibility given the variable work hours, the resulting tiredness and the general lack of funds.

Importantly, the support of GPs and other health professionals was frequently mentioned and highly valued by the women and in many cases would be the first port of call if there was a problem. Perceived accessibility to this kind of support was a central element in the women's health decision-making.

Another important source of support for some the women were non-governmental, church or charity organisations. One participant for example valued the support she received from ABLE Southern Family Support, the Brain Injury Association and the Dunedin Budget Advisory Service. **P6** was very grateful for the material, emotional and

spiritual support she received from her church community and a number of the women mentioned the value of the *OP Shops*²¹ and their associated services.

Caring

It was evident that the value of good relationship was enhanced by the value of caring. The statement “*I am a caring person; that’s what I do*” was heard in a number of guises indicating it was an important feature of the women’s identity.

P8: ... It always is part of my personality. It's always been more than a job. It's not a job you do for the money, that's for sure. By the nature of what it is, you can't just do it as a job. You can't. It's not just a job. You've got to actually care about the people you're looking after and want to ... You can't just turn up, go through the motions and expect the paycheque at the end.

As **P8** reiterates this wasn’t a job you would do for the money.

P8: I find that those people ... If you're there just for the paycheque, you're not doing what you're supposed to be doing there. We have really great staff, who are just part time and students, but the ones that are really good are the ones that actually care about what they're doing and are doing it because they like to help the residents, not just for the paycheque. You could be making more money very easily at the supermarket or at McDonald's.

The fact that being an HCA was *caring work* clearly elevated it above other possible employment.

The importance of caring to the women was also evident when they discussed their family involvements. The mothers in the group particularly spoke of feeling torn between caring for family members or nurturing family relationships and caring for themselves, often struggling to find an appropriate balance. Negotiating such ‘trade-offs’ took a lot of energy and created a lot of extra stress for the women. **P4** for example, found it very hard not to be able to attend as fully to family need as she would wish. Although in this instance it was largely due to financial hardship, it is still revealing to hear of the strong pull exerted by caring for family.

P4: And my kids couldn't go to see her. My kids couldn't go because I couldn't afford to take them to visit her, or to the funeral. I think that's been quite hard for

²¹ Charity stores supplying second hand clothes and household goods.

them, and that, yeah. Yeah. I mean we Skyped her a couple of weeks before she died, so that was quite good for them, but I think out of the last two years, I think that's the hardest choice I've had to make is not taking them for financial reasons.

Work and family

The nexus of family life and caring was also evident in the workplace where it was generally considered by both the employer and the employee, to be more desirable than not, for the caregiver to develop pseudo-family type bonds with the residents.

P5: Its definitely, definitely I mean we look at these people as we try and treat these people like we would want our parents to be treated and um of course like you know you look after your parents so we kind of do that in the workforce and like when Dad was dying I was trying to look after him as well as work...he died four years ago in December...um so yeah as I said well I personally look at them as parents, grandparents...

For **P2** the relationship between family and work held a promise of her receiving support that she was lacking in her non-work life.

P2: It's like someone said the other day at work. Like I said that I don't have anyone here...and it was to do with the manager in ICU because she doesn't have family here and I said I know how she feels. And they called me back into the nurse's station and asked "What do you mean by that?" and I said "What do you mean?" They said about you know how she feels and I said that I don't have family here and they said well we're your family. That made me feel really good.

Self-Reliance

The value that was perhaps most commonly referred to, or alluded to, by the women was that of self-reliance. To varying degrees, the majority of the women first called upon their own powers and resources when it came to facing life's challenges. They freely discussed their personal strategies for achieving things and expressed some pride in their own resourcefulness. **P4** expressed this value most articulately.

P4: Because when I was young, I was a computer operator before I had kids and earned loads of money in Australia and New Zealand. So I know what it's like to earn a good wage. But I don't know, I think the challenge of having to compromise is quite a lot more satisfying for me than just having loads of money. I mean

because the more you have, the more you spend. So I find it just much more satisfying.

P4: And to me, there's more satisfaction. I don't know. It just gives me a feeling of independence that I'm able to survive on my own. I mean, my boys have one father, and my girl has ... and I don't get any financial assistance, never have from them. So I'm used to having to manage on my own.

Self-reliance was perhaps most evident when the women discussed how they managed their money.

P4: And also, there's bus fares. I mean, (and) uniforms. I just have to put money away every week. I mean, I do everything, like money goes into their school accounts every fortnight, and I have to have money, just little bits that go into an account every fortnight so that ... I do that with my Christmas club account, so that by the time Christmas comes, I don't have to think about buying, you know...

P2: I said there's things that I do have. I said its things that I've saved for, you know I just put a little bit here and there. As I said to someone just the other day. Look I've actually already gone and got all my son's Christmas presents. I started in January this year and I just layby them and put so much on each week... I just put what I can...

P2: At the moment I am actually in credit with half of my bills. Thank God. Because I've just been paying them trying to get them so where I don't want to be in debt with anything and what's left over I buy groceries and then what's left over that I put petrol in the car. So that's just how I do it (chuckles lightly) and I've just got to do it that way.

Coupled with this relative success, but as a negative motivator for self-reliance, was an intention to avoid future feelings of humiliation. This was an especially powerful motivator for **P2** whose recent relationship breakdown had resulted in a sudden and dramatic loss of income and living standards. Feeling rebuffed when she approached a non-governmental organisation (NGO) for assistance she made it a rule never to approach them again.

P2: Never again will I go in there. They made me feel like I was about this big (holding fingers about two centimetres apart). It was just before Christmas. I had

no money (starts crying), I had no food, no presents for my son and I walked in and I asked them for help and they turned around and told me to get lost. They said oh we've got our quota. We can't help you. Go away. And I remember them saying that and I thought don't ever come knocking on my door coz I won't give you nothing.

When queried about approaching other organisations **P2** showed some reluctance to continue that conversation which suggested to me that she had to some extent generalised her rule to all similar organisations.

This avoidance of humiliation was evident in other women's narratives also. **P3** and **P8**, for example both spoke of deferring health care because of an inability to pay for it. For **P3** this was despite knowing her physiotherapist and doctor were both open to payment arrangements.

P3: Yes... like even my physio...she kind of knows...cause I've kind of talked to her about it and she says "if you ever short that week you can kind of just build up and pay it off as you go" which is good but I don't like having to ask people... and be like saying "Oh I don't have any money this week can I pay like in the next...like I just don't want to have that on me... like it would be humiliating, to have to say like "I haven't got any money" and you know if you knew something was coming up and you've got no money...

Another negative motivator for self-reliance was the prospect of having to deal with WINZ. Recourse to welfare assistance was generally seen as a last resort to be avoided if at all possible.

P8: I was on a benefit and unemployed for ten days. Ten days was as long as I could manage being ... Because I found being answerable to WINZ more stressful than being, than aged care. I found it more stressful than that. I felt guilty for being there.

P4: I was still on the DPB, partly, so then I could get off the DPB and go on to family assistance... So it's been ... I mean, for me, being independent is hugely important.

Self-reliance emerged as a very important value once a threshold of having 'enough' money was reached. For three of the women particularly the pay rise seemed to shift

them from a state of being deeply embedded in the struggle to survive to a position of greater personal security and choice.

P8: It's enough in that I can get by on that. Since the pay rise has come in, it is easier to get by because I'm on my own. It's just me. I have no one else to support. It's just me. I was doing five days a week so I was doing 25 hours. That was good. That meant I could ... It was good, but I was finding that the five days was too stressful for me personally with my anxiety and things like that. What the pay rise has meant for me is that I can afford to drop back to the four days in order to I guess to keep myself sane.

P1: I was living on \$28 dollars a week, I think. This week it was \$130, and do you know what, I got up to the counter and I started to fret, but I'd forgot that I hadn't transferred any money, I'd transferred only \$100, because I thought I'll buy 100, and it was 130, and I thought, oh no, now I have to tell them to put all this back.

Then I opened my eyes, and I went, "Oh excuse me just for a minute, I'll just go into my phone". "Oh well then all right", he goes, I said "I'll just transfer it through the bank...bank app", and that's what happened. It was such a relief. Because, no honestly before I would have had to ... Yeah. I had a lot of times that it had to be put back.

The other side of this particular coin however was that self-reliance sometimes created a barrier to the women asking for the help that would have expedited a matter of concern.

P4: I've always tried to work things out for myself which can be good, and can be not so good because, yeah, if you be stubborn about it then things take longer to get through. But ... yeah, it's okay. I mean, I've got kids to deal with. You can't... You can't...You've got to move on.

Work

Very much akin to self-reliance were the associated values around work and a sense of independence. For **P2** especially these values promised much better times ahead.

P2: It (the pay rise) has made a big difference because (the clinical manager) wants me to do the ACE programme once I've been there three months and that will bring my pay up more – bring me up to like \$23 an hour.... Someone's actually

given me a break. That's what it feels like...at last...and like I said it feels like I'm starting to get somewhere...

Fortunately, her employer fostered this through its willingness to accommodate and support employees as much as possible to be able work given the limitations of their respective situations.

P2: (Her employer asks...) Can you be here at 7 and I say I can't be there at 7. I can be there at 8 and they are fine with that as long as someone shows up. It gives me enough time to get ready, drop the boy at school on my way down

...they even said to me, I remember both (managers) saying to me "if you do not have a babysitter and you're working that day, bring the boy in".

This particular employer has also offered its employees life insurance and health plans along with shares in the business. This acknowledgement of staff went a long way to them feeling more independent and committed to their work.

P4: And we're getting free health insurance through work. They just introduced that...So that's another thing that's going to help hugely...So they're doing that, and we're getting, after five years, we get an extra week's holiday long service leave...and they started a uniform allowance last year. I'm assuming it's due this month, so, yeah, they want to keep, you know, people.... Yeah. And we have shares. We got last year, was it 700 and, anyway, whatever it was, 700-odd shares last year they gave us like you buy them for a dollar, and they gave us more this year. And then after three years, you get to keep those shares. So yeah.

The sense of empowerment experienced by the two women employed by this organisation was particularly evident when compared to the remaining women in the group, all of whom worked elsewhere and did not experience the same support.

[One's Own Health and Wellbeing](#)

Valuing one's own health and wellbeing was understandably a key theme in the interviews (given the stated purpose of the study). This was most frequently expressed through concern about not being able to sufficiently attend to a perceived health need. Virtually all of the women had serious health concerns and were attempting to find ways to attend to them and continue working at the same time. Some of these concerns were acute, for example **P2** with a potentially cancerous lump in her neck or **P6** with her

swollen abdomen and excessive menstrual bleeding, and some were of a more chronic nature, for example sprains, strains and pain. The latter were more likely to be passed off as 'just' being part of the job, or 'just' something they had to deal with, and which they had little chance and few options to remedy. A number of the health conditions needed immediate medical attention but that was quite often being deferred because of insufficient funds. While they all spoke of doing this (i.e. not seeking medical attention) on occasions, they again almost universally, stated that their GP was a main source of personal support.

The women's valuing of their own health and wellbeing, seemed to exist on a sliding scale moving in and out of focus in relation to other perhaps more highly valued experiences; for example, family. Perceived responsibilities, duties, and desires for good family relationships meant that the mothers especially put their own health and wellbeing second behind their family's need. Similar trade-offs occurred in relation to work with its perceived obligations to residents and colleagues. The women frequently reported working to the point of exhaustion, of not being able to attend adequately to an injury or illness, of not doing what they 'know' they 'should' do (for themselves) because of the inconvenience to others. For example, their bosses who would have to find work cover; their colleagues who would sustain the extra work load; their friends and family who need support or even just want to spend some time with them. The occurrence of these conflicting values led to significant stress for participants as they struggled to meet everyone's needs.

In contrast, face-to-face time with friends was frequently deferred in favour of rest, 'time-out', or "hanging out on Facebook".

P8: ...but a lot of the time I don't feel like being outgoing. I don't feel like leaving my couch and I don't feel like even doing social activities and things like that....If I don't have my alone time in the afternoon, I feel like I'm really busy and have no time for myself.

While on the one hand this would seem to be honouring their own need it could also be seen to be contributing to social isolation and thereby undermining their wellbeing.

Conclusion

It was important for the women's health and wellbeing that they could honour and live in accord with their values, and to a significant extent their work as HCAs enabled this. What

was clear from this analysis was that each individual operated with an internal hierarchy of values and that the way they negotiated the demands of these values was central in their health-related decision-making. Values tend to be set pieces in a person's nature and any self-assessment of health or wellbeing is largely dependent on the congruence (or lack thereof) between them and daily experience.

Values are also important because of the way they inform an individual's beliefs about health and their ability to achieve good health. In the next chapter I examine some of the important health-related beliefs evident in this study group.

CHAPTER SIX: Findings 3

Health Beliefs

Introduction

In chapter five I examined how participants' values influenced their health-related decision making. What was clear from this was that this relationship between values and behaviour was being mediated by the beliefs the women held about what was possible for them. Essentially beliefs describe the assumptions a person holds to be true about life and are commonly based on past experience. They are used to make decisions about how to be and do in the world and to varying degrees can be considered resourceful (when they increase possibility or capability) or conversely, they can be limiting by diminishing the same. In relation to this study it is important to understand something of participants' health-related beliefs if we are to have understanding of their health choices and behaviours.

In the thematic analysis the following sets of beliefs were commonly expressed as being influential in the HCAs health-related decision making. These are grouped in the following categories: a) expectancy beliefs, b) responsibility beliefs c) self-efficacy beliefs and finally locus of control beliefs. Two further categories of belief are also briefly considered as they too impacted the HCAs health-related decision-making processes. These are normative beliefs and beliefs about time.

Expectancy beliefs

Expectancy beliefs are in play when an individual determines the likelihood that a given health outcome will occur, if a particular behaviour is engaged in (or not) and whether a certain behaviour will lead to a particular outcome. These assumptions about the likelihood of a health-outcome occurring are based on past experience, the experience of others, or on verbal (or written) information (Glanz et al. 2008).

In this study health-related expectancy beliefs were most evident in relation to the HCAs work. While the women desired a state of good health their expectations about what this might mean seemed to be largely defined by their desire to work without (undue) pain, discomfort or tiredness. This was clearly more a wish than a reality, for all of the women I spoke to were daily occupied with finding ways to manage often painful health challenges.

P8: With me, most weeks I'm pushing through some part of my mental illness, but as far as having a cold or something, I feel obligated to come in a lot of the time. I have had ... A couple of times, I've had sprained ankles and I've made do, worked through it. Maybe a wee bit slower than usual, but you get there. *People do that*²².

Often their energy was taken up with managing the current state rather than envisioning a more positive outcome.

P4: It's (yoga) keeping me able to work because again it helps my mental health as well. When I'm not in as much pain, then my brain can focus. With shoulder and neck problems, it goes right up into your head and gives you headache and goes right into your back and everything. I do a lot of ... I try to do as much relaxing as I can when I'm not at work.

When asked directly about their health the women spoke of the injuries and illnesses they carried, and these how affected them at work. They appeared to have little expectation that things could be different. They looked around themselves at other caregivers and observed similar health concerns, reinforcing the belief that this was their lot in life if they stayed caregiving.

P8: ...it worries me a little bit that I'm having those sorts of problems (sore back, shoulders, joints) now when generally, in the general population, you wouldn't expect to be having joint problems until you were maybe in your late 40s. I'm having that at 26, 27, 28, 29,30. Also looking at my older colleagues...who have been doing caregiving since they were 20 odd. I see the problems that they are having now and it worries me for the future...

P6: Aside from the obvious injuries, it's really ... I find I get back problems, back pain. I have shoulder pain. I have shoulder problems. My ankles get really sore mostly from the fact that they've both been sprained a couple of times, but it's just the constant walking, bending down. *You've just got to deal with it.*²³

Lack of money impacted the HCAs expectancy beliefs generally through things like believing they couldn't afford sufficient treatment for injuries (or prevention thereof) for example, regular massage, or physiotherapy, or taking time of work to manage health. **P8**

²² Emphasis added

²³ Emphasis added

spoke of the undermining effect tiredness had on her expectations around what health behaviours were possible or likely to happen.

P8:...I don't eat very well and I don't do as much exercise as I should although I feel like a lot of the time...the physical aspects of my job...it's definitely a work out...I probably do far more exercise (with work tasks) than I need to, but because of the rubbish food I eat, I should probably do a bit more. I'm too tired to do much more because I have worn myself out at work...and sleeping enough and doing all the things you are supposed to do. It becomes you do what you can when you can...I know that if I force myself to do something...If I'm not enjoying it, then I am not going to want to do it and it becomes too much hard work.

In contrast to diet and exercise the perceived need for rest was more pressing and still more difficult for participants, to achieve. Against the need to work to survive the expectation that they could sufficiently attend to their own rest and recuperation needs was seriously diminished.

Responsibility beliefs

As has been evident throughout this study responsibility beliefs strongly influence participants' expectancy beliefs. Most of them had a highly developed sense of personal responsibility that was evident across multiple dimensions including work and family life. They repeatedly chose, sometimes to their own detriment, to direct their efforts to meeting the perceived needs of others. At work this was expressed in behaviours like working while sick or injured, staying after clock-off time (generally unpaid) to complete tasks, sacrificing days off to cover staff absences, not taking tea and lunch breaks because of unfinished tasks. **P4** states she often goes without breaks in order to "get things done" finding it difficult even to drink enough water.

P4: The hardest part is keeping hydrated. Because I find, I mean – I get a lunch break, but its short. I find having breaks...just because you don't want not to do things, get things done in a day...I often don't feel able to take a break.

P5: Another problem I have is feeling guilty about ringing up if I'm sick because no one wants to do it and so you kind of think well ok I'll work the night but I'll just sleep all day and then...get through...

In regard to family, participants' responsibility beliefs led most frequently to actions such as the women giving away their own scarce resources to 'help' family members, sacrificing much needed 'alone' time to be available to family, or, especially in the case of mothers, ensuring that family needs were met, for example for adequate nutrition, while accepting constraints on the gratification of their own dietary needs.

P2 felt she had to put off her own needed health care in order to be available to care for her son when he had his own surgery (not knowing when this was going happen she was not able to plan for it). A perceived lack of support left her isolated in dealing with this burden.

P2: I could ask his father to look after him but then its like..."Oh but I've got to work" or "I've got...college and I thought...said to him...I have got to put a lot of things that I would like to have done on the back burner...I said you can't just think of yourself – you've got to think of him too.

Personal qualities also informed participants' health behaviours and added another layer of complexity to health expectancy beliefs, for example, attributes such as love, loyalty and reciprocity; love that the women felt both in and for their families and the residents in their care, loyalty most frequently spoken of in relation to supporting valued colleagues and helping each other with the work, and reciprocity, the belief in fairness, that they will receive just reward for their caring efforts. Reciprocity was interesting in that it was the belief most readily eroded by negative work experiences including being underpaid or not feeling supported by an employer. The majority of the women stated that they started out in the work prepared to 'go the extra mile' and make a few personal sacrifices for the good of the residents, but eventually realising they got no thanks for it, started following a more 'work to rule' approach. Although my impression was this was voiced more commonly than enacted and to varying degrees, they continued to sacrifice their own health and wellbeing for the employer/colleagues/residents.

Expanded outcome beliefs

Most of the beliefs expressed in the interviews were around the presence and influence of constraint. However, there were two notable occurrences where expectancy health-beliefs were expanded rather than contracted. Firstly, receiving material and social support of family and friends enhanced possibility for the women enabling an increase or expansion of expectancy beliefs.

Also, the experience of having a supportive employer was shown to have a positive impact on the HCA's view of what was possible for them health-wise. For example, **P4's** employer provided a pathway for her to provide for family, manage her own health concerns and meet family commitments.

P4: I've got a different shift based on the fact that I've had surgery, *that's a shift they created for me*²⁴ ... I have a child who's got learning difficulties at home, the 16-year-old. So, I just do day shift and I do 7:00 'til 3:00, five days a week;

P4 is facing the prospect of needing further surgery and expects to cope in the same way she had previously with the help of her employer and colleagues, as well as her friends. As mothers of dependent children **P4** and **P2** had prioritised life insurance and fortunately both of these women worked for the same employer who supported them with health insurance and other material support.

P2: I will admit, like I budget this out. I have life insurance. I did this for my son because I knew I had it (diabetes) and like I know....if I died tomorrow he's got money for him and its only a couple of dollars a week I put away...people think I'm stupid but because of that I've got my funeral costs covered. I've got two lots of funeral costs now because (employer) has given me one...

This employer's support had contributed significantly to a shift in **P4's** and **P2's** sense of possibility around managing work and family.

In contrast to this, **P5**, who was worrying about the effects of physical exhaustion, was left with no option when her employer told her 'she couldn't handle a day-shift'. They could only offer her what she had, that is, continuing to work the night shift full time. She was just coping but not in a way that promoted her health.

P5: There's mental health. There's the mental side of it... it's the mental stress of it and the tiredness...like I'm meant to get up at 10 o'clock because the taxi is ordered for 10.30, but I'm noticing that my alarm is slowly going to about 10 past...which means I'm flying out the door – it's maybe a quick cup of tea and a chocolate bar instead of a piece of fruit or a sandwich.

²⁴ Emphasis added

When she attempted to adjust her health belief to a more resourceful one, that is, the possibility of not working night shift she found it too hard:

P5: I think getting into that pattern and being in my own bed and sleeping at night which is what normal people do...but then I would still have to...I could probably walk to work because it would still be daylight but I would still probably have to get a taxi home...and then though there's still the eating pattern. I would be at work at three and finish at 11 so do I have my tea when I get home or do I have it at midday...um I probably haven't thought it over as much...it's just I want to get off night shift.

Self-Efficacy Beliefs

Self-efficacy consists of an individual's "*beliefs* about (her/his) capabilities and behaviour-outcome links" (Strecher et al. 1986). They are situation specific and do not necessarily reflect reality. Rather, self-efficacy refers to the individual's *perception* of his/her capability to meet the demands of a particular health situation or event. It is a subtle, individual awareness/belief that by and large will determine effective health-related decision-making and behaviour.

In this study self-efficacy was explored directly using the following question.

The health-efficacy question

Interviewees were asked to rate themselves on a scale from 0-10 in regards their current health, with 0 being extremely poor and 10 being excellent (Column two, Table 6.1). They were then asked: "If you were to lift that rating one point on the scale what would need to happen"? (Column three, Table 6.1) Lastly they were asked to rate their perceived ability to undertake this action (Column four, Table 6.1).

Participants' responses to these questions is presented in Table 6.1.

Table 6.1: Self-Assessment of Health-Efficacy Beliefs

Caregiver	Current Health Rated (rated out of 10)	Possible action to raise rating by one point	Ability to perform health action (i.e. Self-efficacy) (rated out of 10)
P1	4	"I'd need a brand new body"	4
P2	3-4	"...I need to get this (lump on neck) seen to..."	4
P3	4	"I'd take some more time off work so my shoulder could heal properly"	4
P4	7-8	"Stop eating cakes at work...sugar is my worst enemy..."	7-8
P5	4	"...just that damn sleeping pattern...If I could just get enough sleep..."	4
P6	5-6	"...I'd need to get a job (as an RN) and get my work visa..."	6-7
P7	9	"I'd take more holidays"	10
P8	6	"I think its probably the exercise...I don't eat very well and I don't do as much exercise as I should...but I'm tired"	4

P4, **P6**, and **P7** stood out in the group as having a comparatively high sense of self-efficacy in relation to health. For **P4** this was consistent with the self-belief, independence and personal resilience that she evidenced throughout her interview but it was surprising also given that with three dependent children she was the one who appeared to have the greatest care obligations. At the time of the interview however **P4** was newly experiencing her very significant pay rise and this understandably enhanced her sense of self-efficacy.

P6 on the other hand had experienced a recent surge in her sense of self-efficacy once the immediate risk of deportation had been averted. For this, she thanked God and her church community who had supported her. Her faith reaffirmed, she felt sure that all would be well. **P6** also differed from the rest of the group in that as a registered nurse her current status could be viewed as a temporary one. This was likely to have buoyed her overall sense of self-efficacy although she had suffered through a period of significant pecuniary and health disadvantage.

P7 was also a registered nurse but not practising as such. She returned to NZ two years prior and was planning to leave again. She exhibited a lot of anger and disappointment at the current state of the NZ health system and aged-care in particular. **P7** was intensely self-reliant and to a degree, defiant, when it came to being in control of her own health.

The remaining study members rated their health and self-efficacy relatively low at around four out of ten. Interestingly their efficacy rating closely resembled their initial health rating which suggests that they see little prospect of significant change on their horizon. They fundamentally seemed to feel more or less powerless to take proactive steps to improving their health.

It was clearly evident throughout the study that tiredness tended to diminish the women's sense of self-efficacy across multiple domains. This then segued into a concern for mental health. A general sense of powerlessness was evident in relation to perceived mental health need because of very real work/life demands but also because mental/psycho-spiritual concerns were often seemed to be a less valid basis for making health-related choices. To varying degrees, the women found it difficult, if not impossible, to attend sufficiently to things like general life stress, grief issues, workplace bullying, and feelings of having few, if any, options.

Locus of Control Beliefs

Not surprisingly the majority of the women in this study considered themselves to be vulnerable to influences originating outside of themselves. As has previously been shown their lives were to a large extent directed by meeting the needs of others and in endeavouring to meet these needs they often exhausted themselves and their material resources. Interestingly though, the women did not generally sink into a fog of powerlessness but instead took what control they had and used it resourcefully to meet their own need, albeit often in small hidden ways. These 'small' health and wellbeing choices were extremely important, highly valued and intensely protected.

P7 and **P4** were notable exceptions to this. **P7** was vehemently protective of her personal power when managing her health and was offended by the question as to whether there were situations she might not feel 'in control'. **P4** was highly motivated to achieve the best outcome possible for herself and her children and she had worked hard to expand the possibilities. She was grateful for the support she had received from 'the health

system' and by and large it seemed to serve her well. **P4** was a pragmatist and focussed on the things she had some power over and not those she couldn't change.

Normative beliefs

This set of beliefs basically describe the perceived behavioural expectations that arise from social/community/family norms. They are pervasive and often non-verbal, evidenced only in decisions and behaviours affecting health. In this study the power of normative beliefs was most strongly evidenced in relation to caring for others, for family and for self. Normative beliefs also exert considerable influence around work and other obligations and what an individual feels it's legitimate to "ask for". This group of beliefs constitutes the warp and weft of HCAs health decision-making.

Time-related beliefs

Beliefs about time seemed to shift after the pay rise. Prior to it, the women were most likely to be found micromanaging their way through the days and weeks focussing on immediate needs and concerns. They seldom felt able to consider the future; whether it was in relation to potential health benefits of certain food choices, or how to manage their bodily aches and pains so they could continue working, or whether caregiving was actually a viable employment option for them in the long term. It was clear that they worried about these things, but feeling powerless to address them put them in the too hard basket and carried on.

P8: I haven't been to the dentist in probably three years I think at least. Obviously, going for your checkup, each six monthly checkup, it's important, but I went, "Okay, no, they're fine. They're fine." Put that aside, but there is probably ... I probably should have been to the dentist at least once in that time because I had a filling in this tooth that I chipped about two years ago and it's just sitting there. It's okay now. It's actually surprisingly okay. That probably means that my tooth's dead or something, but it doesn't cause me any pain. It doesn't cause me any issue so I haven't done anything about it. The extraneous things other than just going to the GP have become a luxury.

P8: Also looking at my older colleagues...who have been doing caregiving since they were 20 odd. I see the problems that they are having now. It worries me for

the future of..., but then I also look at it and think, "It's been 10 years already. I've probably already done enough damage now that it doesn't really make a difference if I stay or not."

The most palpable consequence of the pay rise was a perceived increase in possibility. This was still fresh for them and thinking of it brought joy to the conversation.

P4: Yeah, so now I can see that in the future we will be able to have more holidays...Yeah, it is. It's great. I feel like everyone else might feel, you know, (it's) on a reasonable income might feel like...like two people income...

P2: Like to have that little bit extra sometimes like when I get an unexpected bill I've got that little bit extra money. I know I can put it aside and at the end of the month treat me and my son a little bit. Like my son enjoys watching movies. So maybe at the end of the month treat him to the movies.

P5: Now I can actually save some money. I can now put \$50 aside for savings...for what you call a rainy day

Time-related beliefs were also being formed in the women through their working in an RAC environment.

P8: it does sort of encourage me, it leads me to consider that maybe signing up for some sort of health insurance would be a good idea now in order to ...that I'm covered for future things. It also makes me look at the fact that maybe I should not be doing caregiving and go and do something that's not going to...Stop doing it now before all the damage is done...But then I look and think, "It's been 10 years already. I've probably already done enough damage now that it doesn't really make a difference if I stay or not..."

P4 also look around and sees what others are dealing with and thinks:

P4: Absolutely. Yep, I mean I see people that, you know, all levels of care. Diabetes, dementia, heart problems, brain injuries... I'm 54 now, and every little bit of - You think about how is that going to come out long term? And I suppose that's why I had surgery now because long term, it would probably be worse. Another ten

years, probably wouldn't be an ideal time to do it. I'm better off doing it when I'm younger and healthier and fitter.

Conclusion

This chapter has shown how key health beliefs are operating to influence the HCAs health-related decision making. It has also shown how, in a kind of feedback loop, values and beliefs mediate and modify the HCAs daily experience, which in turn works to enhance or diminish the women's personal sense of overall health capability.

In chapter seven (following) I discuss the main findings of this study concluding with a brief consideration about what the Health Capability Model might contribute to the conversation about the situation of low-paid women working in caregiving and support roles in relation to health.

CHAPTER SEVEN:

Discussion, Conclusion and Recommendations

Introduction

The aim of this study was to understand something of how HCAs working in RAC made decisions regarding their own and their family's health, given the demanding job they were doing and the very low income they were receiving at the time. The research questions guiding this study were:

- How do participants respond to their own health needs vis-à-vis the needs of others, especially those who depend upon them?
- How does financial constraint impact this process?
- How does a 'caring ethic' manifest/influence and/or complicate health-related decision-making for this group of women?
- What supports are available for the women when they experience diminished health capability due to financial constraints and which do they utilise?
- What compromises do they make in relation to perceived health needs?

These questions are addressed in the early part of this chapter which examines the first of the study's main themes, that is, "It's a struggle". The implications and challenges of gender and low-income in this 'struggle' are discussed alongside the values and beliefs that are mediating health decision-making in the midst of the struggle. This 'process' is then reflected upon in the context of the Health Capability Model (Ruger, 2010). To conclude the chapter a brief discussion of the study's strengths and shortcomings is presented, followed by recommendations for both the RAC sector and future research.

It's a struggle!

A number of studies have highlighted how earlier health choices, experiences, exposures, and economic resources are associated with health outcomes later in life. (Benzeval & Judge, 2001; Corna, 2013; Guneskara et al., 2013; Lynch et al., 1997).

Multiple studies have shown, for example, that patterns of diet and physical activity are contingent on peoples' feasible opportunities to pursue healthy behaviours (Ferrer, et al., 2014; Lynch et al., 1997; Zenk et al., 2011)

All participants in this study acknowledged that living on low income made dealing with their health concerns much harder and that they had to make some difficult decisions regarding the best use of their scarce resources. Some of these decisions were likely to have far reaching effects on their health through their life-course. This was something the HCAs were generally aware of but felt little able to avoid.

Being Poor Women

Having little or no money was a key element in participants' struggle to work, live and be healthy. It was an underlying preoccupation that filtered their 'possibilities' and constrained most, if not all, of their choices. At the most basic level having less money reduced buying power which inevitably, at some point, began to erode participants' capacity to obtain the goods and services they needed for healthy living. As mentioned in the literature review this reflects the widely held neo-materialist position which emphasises the distribution of economic resources as the key determinant in health outcomes (Gunasekara et al., 2013; Jones & Wildman, 2008; Lynch et al., 2000). For the mothers of dependent children in this study this was a daily reality. Children got fed first, Mum second. Meat became a luxury, pasta a staple. Even for the other women though, bills were paid first and what was left was eked out for food. The direct material impact of low income on health and wellbeing is widely recognised as a constraint on practical opportunities for healthy choices and behaviours (Carr et al., 2016; Ferrer et al., 2014; Guneskara et al., 2013; Lynch et al., 2000).

Poverty also constrained the women's choices around seeking health care and support as is also noted in work by Stephens et al., 2014. This choice was often framed by the question "Do I really need it in order to be able to work (usually in the short-term)? If it could be deferred without too much of an impact on work ability, then in all likelihood it was. While the women were generally aware of long-term implications of certain choices, they often felt unable to take this view into account.

Low income reduced other opportunities also, for example, the opportunity to make preparations for future need. This was particularly concerning given the work-related injury burden the women were already carrying. They clearly worried about how they would a) be able to get the care they needed when they needed it and b) their ability to continue working to pay the bills. Another concern repeatedly expressed was how to prepare for retirement. This concern was understandably more common among the

older women in the group and it was intensified by a public discourse that problematises aging, retirement and income. This left some of the women feeling powerless and resigned to a fate of disability and welfare dependence.

The impact of low income on participant wellbeing however, was more nuanced than this analysis suggests. For example, *P4* in this study, said that her life was more 'satisfying' on low income than it was when she was earning more money. This was because with few resources she had greater need to call on her own resourcefulness, resilience and creativity in the managing of her household. These were personal qualities she valued very highly and she appreciated the opportunity to express them. This finding has been supported in 'Capability' studies that found even within '*unfreedoms*' there exist '*functionings*' that are in themselves highly valued (George, 2015). This is an important awareness which perhaps explains something of why negatively valued situations can be so intractable to shift.

Another important pathway to poorer health, identified in the literature review was via the psychosocial stress that resulted from feeling less worthy (Marmot & Bell, 2012; Pickett & Wilkinson, 2015). In this study this aspect was less evident than may have been expected largely because of the positive influence associated with the work the women were doing. In general, they loved the work and expressed a desire to keep doing it. They felt their efforts were valued by the residents and they responded to them with love. As Elwar (2010) found in her study of Swedish caregivers, the centrality of love in their work made it count for something and by association the women's lives also counted.

Another important influence affecting participants' health-related decision-making stems from gendered forces that operate at all levels of human life, from the individual through to society at large. To varying degrees, these forces constrain individual decision making, for example, the women's expectations around what the role of caregiver entails and what it is worth monetarily. Ravenswood and Harris (2016) highlighted this in their examination of how the "doing (of) gender and class" in RAC perpetuates inequality in aged care. As Bird and Rieker (2008) assert in their Constrained Choices theory, gender expectations lie at the core in determining how an individual's daily struggle is played out in terms health behaviour. Chan acknowledges this tension concluding that in relation to choosing health individual responsibility has to be balanced against such social and structural determinants (Chan, 2010).

Structural stressors

Structural stressors are those which originate outside of the women's control. They include organisational pressures, work-related demands, and society's expectations and significantly impact the HCAs capability for health. Historically the role of the HCA in RAC has been constructed as women-dominated work (Dodson & Zincaavage, 2007; Elwer, 2010), physically and emotionally demanding (Kaine & Ravenswood, 2013; Karantzas et al., 2012; King, 2012), very poorly paid (Callister et al., 2014, Ravenswood & Douglas, 2016), of low status (Banks, 2018; Ron, 2008) and with low levels of control (Dodson & Zincaavage, 2007; Ravenswood & Harris, 2016). In this environment amid these structural pressures, it is a constant struggle to decide in favour of one's own health and wellbeing.

Elwer et al. (2010) named the 'struggle' aspect of HCAs work experience as 'working against the odds'. They identified structural stressors as predominant in HCA's experience with them outweighing relationship stressors in terms of their negative impact on HCAs' health, a finding which has been corroborated in earlier studies (Ron, 2008; Schaefer & Moos, 1996). In the current study these factors appeared so inextricably linked that it was difficult to consider them separately. The women placed such a high value on good relationships which was health protective, but these were inevitably being undermined by the ever-present structural stressors that resulted in increased pressure and anxiety. Multiple studies have shown that when stressors outweigh the benefits of the work a decline in job satisfaction occurs along with reduced commitment and a general decline in wellbeing (Karantzas et al.,2012; Morgan et al., 2013; Ravenswood & Douglas, 2017).

Negotiating care and wage relationships

A palpable sense of frustration was apparent in this study when the women spoke of their low pay and being undervalued. They worked in an environment that demanded such a lot of them, physically and emotionally, and the growing awareness that their effort was under-acknowledged, under-rewarded and expected of them, undermined their willingness and commitment. This finding accords with other studies which have examined the adverse health effects of working in high-effort/low-reward conditions (Kuper et al., 2002; Siegrist, 1996) and Karantzas et al. (2012) highlighted the implications of this for the workforce after finding an associated increase in intention to quit among caregivers.

For the women in this study, there came a point, usually after exhausting themselves or sustaining injury, when they realised their limitations and eventually found ways, more or less effective, of saying no to requests for extra work or effort. Having to say no in this way however often created inner conflict for the women who still felt quite deeply that they 'should' do as asked. Carrying this internal conflict and managing it, contributed significantly to the women's sense of struggle.

King (2012) highlights the difficulty faced by many care-workers who have to simultaneously negotiate care and wage relationships. The prevalence of familial caring models in aged-care continues to render carers, and HCAs in particular, more vulnerable to exploitation. This concern was raised by Dodson & Zincaavage (2007) who called for an ethic of reciprocity and equal valuing of all involved in RAC irrespective of status, class, gender or race.

That the organisation (of RAC) impacts men and women's lives differently is evident in its structure and management. Clearly care-work continues to be seen as an extension of the domestic realm, where tasks are performed primarily by women for love and not money, and therefore are regarded as being of less value. Previous authors have highlighted that this situation is untenable and should not be allowed to continue (Palmer & Eveline, 2012; Ravenswood & Harris, 2016) proposing instead that HCAs be regarded and treated as professional carers.

Health concerns

Difficulty dealing with daily health concerns

Most study participants were dealing with their own health concerns including injuries, acute and chronic physical illness, and mental health issues. Attending to injury was extra difficult because of the nature of the work; the need to work for sufficient income to live; the cost of physiotherapy; and the ACC approach to financially supporting injured workers, especially the more mature workers²⁵. This last aspect is particularly concerning, when injury statistics show that HCAs are one of the most vulnerable groups across direct care occupations for sustaining musculoskeletal injuries (Alamgir et al., 2007; Chang et al., 2013) and that the HCA workforce is aging, with the majority now in the over 45 age group (Callista et al., 2014; Ravenswood & Douglas, 2017). Feeling

²⁵ The widely held perception among the women (often based on past experience) was that ACC was very reluctant to compensate older workers for injuries, especially sprains and strains, on the basis that the injury was fundamentally a problem of aging rather than injury.

unable to take sufficient time off work to attend to health issues was a prevalent concern as was working while ill and in pain. When an HCA was caught in this position their capacity for recovery to good health was seriously diminished. The likely consequences of this for their future health were generally understood by the women, but they often felt unable to deal with them. Mental health and tiredness were the issues causing greatest concern and the ones they felt least able to manage.

Deferring health care

It was clear that participants sometimes deferred important medical care and assistance because a) they couldn't afford it; b) they couldn't take time off work; c) they felt there was no point – the damage was done; or e) a family member's need was considered more pressing. As previously noted, constrained choices such as these are gendered and ultimately defined participants opportunities to pursue health (Bird & Rieker, 2008; Bird & Lang, 2014).

Managing relationships

The amount of time and energy the women put into managing relationships was significant and the support they received from others was invaluable to their health and wellbeing. Studies have shown that the majority of HCAs' health resources are of a relational character (de Jonge et al., 2008; Elwer et al., 2010; George, 2017). Positive relationships with colleagues and residents are key health resources which increase job satisfaction, general wellbeing and sense of purpose (de Jong et.al, 2008; Häggström et al., 2010) and one of the most frequently cited sources of stress in this study was negativity in relationships, particularly those at work. Demanding work, systemic understaffing, heavy workloads, shift work, staff absenteeism, and workplace bullying, were all commonplace and took a great toll on the women's capability for good relationship.

The benefits of teamwork for promoting health and wellbeing in the RAC workforce have been highlighted in the literature (Elwer et al., 2010; Eriksen et al., 2006). The work is made much harder when the environment is characterised by poor teamwork, workplace bullying and backbiting. All participants spoke of how they struggled with these negativities and all expressed relief, even joy, when the opposite occurred and the HCAs worked together to complete tasks and give good care to residents.

Reduced non-work social engagement

Having few resources limited participants' opportunities for meaningful social engagement outside of work. They frequently reported feeling tired and depleted with reduced motivation for activities other than the basics. This contributed to actions that exacerbated current health problems, for example deferring preventive health behaviours, such as maintaining healthy diet and exercise. This of course increased the risk of new health issues occurring which in turn threatened to drain economic resources further. That this struggle was protracted, occurring over a number of years, also made choosing health difficult. Going without something that supports health might well have no apparent detrimental effect on an individual's overall health and wellbeing in the short term. However, as many studies have shown an extended period of going without something like certain foods, sufficient heating, or timely healthcare will eventually undermine a person's overall health (Benzeval & Judge, 2001; Gunasekara et al., 2013; Lynch et al., 1997)

Benefits of social support

The findings in this study support the view that social support and coping are the two principal mediators of stress (Kristenson, 2006; Pearlin et al., 1990). For participants the value of family and friends' support could hardly be overstated as the women endeavoured to choose health while meeting the demands of daily life with insufficient resources. Support was often financial, for example helping with unexpected bills or events, but generally the women were very debt averse. If a loan was the only way to meet an important health need, they then made every attempt to repay it as quickly as possible, sometimes to the extent of building a credit balance (for a rainy day), even if it put them under significant mental and financial stress to do so. Having sufficient support from family and friends very often determined whether the women were able to receive needed health care or not.

Family support was also essential for countering the social isolation arising from low income and physical exhaustion. When family were physically close by the women were freely offered involvement in family gatherings, meals, cups of tea, and helping each other out. When they were not, they had to be more self-sufficient and resilient especially if friends were few. The potential for work relationships to compensate for this lack of social support was considerable and worthy of attention particularly in the case of low paid workers.

Social media did offer an easier way to socialise that could be managed when tired and with little expense (as long as one had access to a suitable phone or computer) but it did not substitute for the mutual bonding that is built on being with and helping each other out.

Being a Migrant Woman

The situation of migrant women in RAC is complex and beyond the scope of this study, however issues of diminished health capability were clearly front and centre for the one woman in this study who was born outside of New Zealand. Callister et al. (2014) found that a growing proportion of the HCA workforce were born outside of New Zealand with an increasing number staying, sometimes for quite long periods, on temporary or student visas. For this group, without the rights afforded permanent residents or citizens, health care becomes very expensive and this is a significant barrier to them seeking timely health care and support. This can then lead to an invisible burden of suffering and ill health in the migrant community that will inevitably flow through to impact their families, colleagues and residents in the workplace. The uncertainty of living on temporary visas is very stressful for the women especially when they have families to care for and it also undermines the stability of the workforce, so important to RAC as it prepares for to meet an increased demand for its services. Also, in recent years a significant number of HCAs have arrived from countries such as India and the Philippines where working conditions are very different to NZ. Being unfamiliar with things like employee's rights the women are vulnerable to exploitation by employers which inevitably reduces their capability for health.

The presence of migrant HCAs in RAC may also be enhancing the health capability of the HCA workforce as a whole through the practice of working cooperatively. All of the women in this study spoke of the positive benefits of working together as a team and the negative consequences when this did not occur, and virtually all commented that this was more common practice among the migrant workers. This loyalty to the team however also led some HCAs to put their own health concerns aside because of not wanting to let the team down, or create more work for them. Clearly the task is to balance the needs of the team and selfcare.

It's good to work and it's good work

Good relationships/Caring

Much has already been said about the important and esteemed value of 'caring' in the lives of HCAs (see chapter five). Research confirms this finding (Häggröm et al., 2010; Rakovski & Price-Glynn, 2010) linking it to job satisfaction, commitment and ultimately to quality care (Karantzas et al., 2012). That caring has largely been gendered and constructed as an extension of family, is sometimes seen as problematic and has been challenged on the basis of the vulnerable position it potentially places HCAs in (Dodson & Zinbarg, 2007; Ravenswood & Harris 2016); however, when it is also a congruent and positive expression of HCAs' sense of identity and supports self-esteem and self-worth, it becomes a protective factor.

Research has shown that having good social resources, represented by good social networks, offers crucial support to people managing high levels of demand in their lives (Kristenson, 2006; Pearlin, 1990). In relation to HCAs, Elwer et al. (2010) identified 'strength from the work group', 'satisfaction of caring' and individual responsibility', as key health resources that promote a sense of health agency and wellbeing. They also suggest that these 'relational resources' metaphorically "build up the organisation's social immune system' (Elwer, 2010). This study concurs with these findings. Participants spoke of a sense of mutuality that occurs in a 'good team' working together to give good care to residents. The resulting bond between colleagues has been found to energise individuals and build commitment both to the job and to each other (Toles & Anderson, 2011). In this environment personal health-decisions and challenges are often shared and sometimes collectively attended to. Individuals, while subject to environmental factors, also contribute to the creation of a supportive (or otherwise) environment (Bishop et al., 2008). As George (2016) states in RAC everyone, including management and residents, seems to benefit if the team is nurtured.

The current study also considered the women's non-work lives and found that the influence of social resources extended beyond the workplace, again positively influencing the women's capacity for healthy decision-making. Good relationships with family and friends as well as colleagues and residents, enhanced job satisfaction, commitment and ultimately care.

Work & Self-Reliance

For the women in this study simply being employed, irrespective of the 'goodness' of the work, was a boon because of the increased sense of independence and self-reliance that it engendered. The sense of having some degree of control over their lives and environments was very important to all the women in the study and enhanced their sense of health-agency. However, the constraints they experienced around finances and work were significant and often seriously undermined this sense of agency. Kabeer (2005) points out there are important distinctions to be made between: "'passive' forms of agency (action taken when there is little choice), and 'active' agency (purposeful behaviour)", and also between: "'effectiveness' of agency, and agency that is 'transformative'" (Kabeer, 2005, page. 14). 'Effective agency' refers to the ability to carry out given roles and responsibilities, but the latter refers to their ability to act on the constraints imposed by these roles and responsibilities to challenge and change them if required (Kabeer, 2005). The majority of the women in this study seemed constrained to operate in the realm of 'effective agency' and had little scope for transformative action in their lives.

Kabeer also highlights the importance of understanding how meaning, purpose, values, beliefs and decision-making; influence the individual's sense of (health)agency.

Because of the significance of beliefs and values in legitimating inequality, a process of empowerment often begins from within. It encompasses not only 'decision making' and other forms of observable action but also the meaning, motivation, and purpose that individuals bring to their actions; that is, their *sense* of agency. (Kabeer, 2005, page 14-15.)

This study has revealed something of this phenomenon by examining deeper issues around meaning and motivation that lie behind the women's health-related decision making. It was clear in the interviews that the women were trying to honour their own health and wellbeing needs as best they could, given the circumstances. But it was equally clear that when faced with health-related dilemmas and trade-offs they were consistently prioritising their perceived obligations to others over and against their own. The intensity of the internal conflict that resulted from this was a source of significant distress for them.

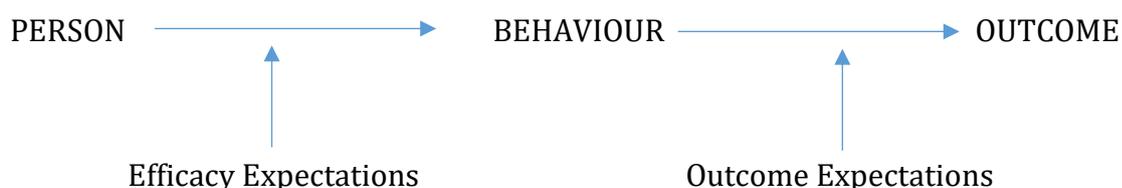
Health Beliefs

The central role of beliefs in the HCA's health-related decision making was clearly manifest in this study. The belief categories that were most commonly expressed were expectancy beliefs, responsibility beliefs, and efficacy beliefs. Together these belief sets had a defining influence on participants' overall health capability.

It is helpful to consider health beliefs in relation to the notion of constrained choices (Bird and Rieker, 2008) because of the way beliefs largely defined what the women considered possible in relation to their health.

Arguably the most influential category of beliefs in relation to health are the expectancy beliefs. Virtually all of the individually-focussed models reviewed, that is, the 'Theory of Planned Behaviour' (Ajzen, 1991); the 'Theory of Reasoned Action' (Fishbein, 2007); the 'Health Belief Model (Strecher and Rosenstock, 1997) and Social Cognitive Theory (Bandura, 2001); identified the centrality of expectancy beliefs in determining health-efficacy and behaviour. In Figure 7.1 Strecher and Rozenstock, (1997) show the role of expectation beliefs in the paradigm where a person engages a (health) behaviour to achieve a (health) outcome. This diagram shows clearly the primacy of expectancy beliefs, particularly self-efficacy expectations in this process. Clearly a degree of self-efficacy in relation to health is essential for health.

Figure 7.1: The Role of Self-Efficacy



(Strecher et al., 1986)

Moving beyond the social determinant and individual agency dichotomy

Much of the research into the relationship between low socioeconomic position and poorer health outcomes has focused on either the impact social factors, such as education or income levels, have on individual and community health; or alternatively, on the role of individual agency and choice in relation to health behaviours. This study took both of these positions as a starting point and moved beyond them to explore the

heterogenous effects on participants of the multiple factors interacting in each of their lives. These factors originated from within themselves, their work, family, community and social policy.

What was most evident was that health and wellbeing exist at the intersection of a number of systems including individual biology, family, work, community, economic, health-care and political systems. This construction of health 'at the intersection' is supported in both the Constrained Choices literature (Bird & Rieker, 2008) and in the Health Capability Model (Ruger, 2010).

Springer et al. (2012) defined intersectionality as an approach

...that explores simultaneous intersections between aspects of social difference and identity (e.g., as related to meanings of race/ethnicity, Indigeneity, gender, class, sexuality, geography, age, disability/ability, migration status, religion) and forms of systemic oppression (e.g. racism, classism, sexism, ageism, homophobia) (Springer et al., 2012).

An intersectionality-informed view of health does not see health as a stand-alone variable but that it's meaning exists in relation to other categories such as occupation, community, and family (Springer et al., 2012). Throughout this study the women spoke of the numerous considerations wrapped around each of their decisions and through this they qualified their readiness or reluctance to adopt positive and negative health behaviours. An awareness of intersectionality allowed for a more individually nuanced view of health and wellbeing that incorporated the question of what was important to the women themselves (George, 2015). Acknowledging the importance of values in health decision-making processes was a key element of this study.

Recognising the pervasive influence of gender in these considerations is also an important development as it shifts the focus from individual responsibility for health problems and solutions to a more structural one (Elwer et al., 2012). Paying attention to how gender plays out in the structure and function of RAC could potentially yield transformative change in the health and wellbeing of its employees and improve the sustainability of the workforce in the long term.

Health Capability

The Health Capability Model (HCM) is founded on two fundamental realities. These are that people not only desire good health but they also desire the means to achieve it (Ruger, 2010). By integrating these two assumptions the HCM recognises the impact socio-economic systems have on individuals' health and wellbeing without losing sight of individual agency in regards to the same (Ruger,2010). This bringing together of individual and socio-economic influences reflects the 'intersectionality' of health capability.

An important precursor to the HCM is the Capability Approach (CA) (Sen, 1993); in which health and wellbeing describe the consequence of having the capability to live a life that one values. Capabilities are what individuals are able to do and be in their lives and as such express the freedom people have to pursue lives they have reason to value (i.e. health and wellbeing) (Ruger, 2004). An individual has certain 'capability sets' for such things as being able to work, to have good relationships and to be healthy.

In this study the women valued lives that included being able to work; being in good relationship with family, friends, colleagues and elderly RAC residents; having a sufficient amount of control over one's life and being able to attend to one's own physical and mental health and wellbeing needs. Being able to fulfil these capabilities constituted health for the women in this study.

It was clearly evident that the degree to which the women felt unable to live lives that honoured their values reflected the degree to which they experienced diminished health capability (HC). This was expressed through constricted health expectancy beliefs and diminished self-efficacy in relation to health. The women also perceived greater influence of external factors and chance on their health and wellbeing and this left them in a state of *passive efficacy*.

The experience of reduced HC meant the women in this study were generally operating with '*effective efficacy*', that is, just managing to get done what had to be done; rather '*transformative efficacy*' which would enable them to challenge the constraints they experience. The exception to this though was in the area of relationships, most particularly relationships with elderly RAC residents. In this realm the women experienced the health enhancing energy of *transformative efficacy* as they perceived they were helping make residents' lives happier and more comfortable through their

efforts. Dissonance was experienced when the power to transform lives was diminished through over-work, exhaustion, pain, and poor collegial relationships. These factors negatively impacted the women's HC ultimately reducing their capability for living lives that they value. Having low-income exacerbated this diminishment primarily because the women felt unable to seek the health care and rest time that would have been sufficient for them to continue to work and live well.

Conclusion and Recommendations

Key findings

This study explored how women HCAs who work in RAC, and who live in low-income households, thought about and made their own personal health-related decisions. Two main themes were identified as predominant in the HCA' experience of health decision-making. These were: a) 'that it's a struggle' and b) that 'it's good to work and it's good work'. The influence of the latter theme both ameliorated and exacerbated the experience of the former. Variations of these 'dual' themes have been found in previous studies (Elwer, et al., 2010; George et al., 2016; King, 2012; Rakovski & Price-Glynn, 2010). Virtually all of the participants in this study had significant health concerns at the time of interview and were contemplating how to manage them. The degree to which they were able to do this satisfactorily largely depended on the availability of support from friends and family.

In the main participants stated they loved their job and exhibited a strong commitment to the elderly residents in their care (Häggström et al., 2010; King, 2010). Surprisingly, low-income did not feature as the major source of stress in the women's lives. Instead structural stressors in the workplace figured most prominently in their health and wellbeing (Elwer et al., 2010; George et al., 2016).

Money was clearly not the main motivation for the HCAs. Instead they spoke of their love of caring, their love of the residents; and the satisfaction of knowing they made the residents' day that bit better, or more comfortable. Lack of money, did impact their health choices however, for example, many spoke of working while ill or injured or of not seeking timely health care.

One of the most frequent concerns expressed by the women was how tired they felt and how this affected their daily choices especially around diet and exercise. Lack of money, mental stress, and extreme tiredness led them to seek rest and solitude when not working; an outcome that effectively diminished their non-work social participation. This was problematic to the extent that some of the women felt unsupported, with no one to turn to in times of trouble. It was clearly evident in this study that having the material,

physical and emotional support from others often determined whether one could access health care or take needed time off work.

A distinctive feature of this study was its attention to the role of values and beliefs in health decision-making. These aspects, which are often overlooked, were found to be strongly influential in the women's choices. For example, it was clear that the high value the HCAs placed on good relationships and caring, provided a main source of motivation and purpose for them, albeit sometimes to their own detriment health wise. Realising this shed light on the HCAs frequently reported experience of internal conflict and mental stress when they felt unable to provide the care they would wish for residents. This was often expressed in relation to feeling extremely tired and/or rushed at work.

The examination of how beliefs mediated values through to 'real-world' choices and actions was another point of distinction in this study. Interestingly, the degree to which the women felt unable to live life in accord with their values corresponded to a diminishment or constriction of health expectancy and efficacy beliefs, alongside feeling increasingly vulnerable to external influences and/or chance. These beliefs inevitably impacted their daily health choices.

Study Strengths

The particular strength of this study was its bringing together multiple theoretical perspectives to create a more holistic lens through which to reflect on the challenges facing lowly paid caregivers in RAC as they sought to achieve good health and wellbeing in their lives.

An important strength was its extension beyond the workplace to incorporate participants' non-work lives in the analysis. This distinguished it from previous research and enabled an exploration of the intersection between the two *life-worlds*. It also fostered an appreciation of the global effects of individuals' health-related decision-making.

The use of a qualitative methodology allowed the women's strengths and values to emerge as both precious and powerful.

Study Limitations

The geographical focus of the research and the relatively small number of interviews conducted limit the generalisability of the findings. However, the final study group included representatives of different age-groups from young women in their 20s to

women nearing retirement who worked across a number of different facilities from different areas of the city. Thus, a variety of experiences were canvassed. One participant was born outside NZ and brought to the study experience particularly relevant to migrant HCAs.

As the women in this study were generally dealing with their own health concerns, they were conceivably more likely to respond to my recruitment requests than their 'healthy' counterparts. This undoubtedly weighted the sample toward the infirm which could be considered a study limitation. However, it also allowed an in-depth exploration of different individuals' coping under stress and this in itself was a strength.

I initially indicated that there would be a shorter follow-up interview, to occur at a later date, with a view to checking the veracity of my data. Time pressures on both the participants and myself prevented this occurring. However, each interview concluded with a summary of what had been discussed and any changes or amendments they offered were noted and included in the analyses.

Recommendations

The main recommendations to emerge from this research are:

1. That mechanisms be adopted to support HCAs constructing themselves as professional carers rather than pseudo-family members through

- developing a sense of partnership between RNs and HCAs. For example, partnering an HCA with an RN with them working together as a team to provide care for designated residents.
- the RN delegating tasks, clinical and non-clinical, to the carer appropriate to their level of competence and capabilities.

2. That adequate staffing levels are maintained to protect the health and wellbeing of HCAs by

- maintaining appropriate numbers and proportion of RNs and HCAs.
- linking staff ratios to quality indicators

3. That a cohesive team culture be fostered in the workplace that includes all staff by:

- requiring a universal high standard of respectful and supportive interpersonal communication among all staff, including management.

- extending this mode of communication to all residents and their significant others
- providing the necessary training and support to ensure these objectives are attained
- incorporating group supervision as a staff management practice which would provide an open forum for airing concerns

4. Offer appropriate and targeted support for migrant workers by:

- advocating for more straightforward pathways for migrant workers to attain residency and citizenship status
- ensuring community advocacy and support services are accessible to the migrant RAC workforce

5. Adopt a health capability framework to inform policy and practice in RAC by:

- utilising shift structures that support HCAs ability to attend to their health and wellbeing needs
- adopting family friendly practices e.g. the provision of childcare
- offer appropriate insurance packages providing health and welfare benefits to lower paid workers
- targetting training and support for staff with the goal of enhancing their health capability.

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Appendix 1: Newspaper Advertisement

Are you a Caregiver in Residential Aged Care?

I am seeking participants for a study examining how caregivers in aged-care maintain their health when living on a tight budget.

If you are a female caregiver in residential aged care and have lived in a low-income household for the past 12 months or more please consider taking part in my research.

You will be asked to take part in an interview which will take about an hour, with a shorter follow-up interview occurring at a later date. A \$30 voucher will be given for reimbursement.

For more information, contact:

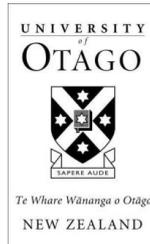
Judith McHugh
claju350@student.otago.ac.nz
027 549 0200



This project has been reviewed and approved by the University of Otago Human Ethics Committee, Ref: 17/043

U003885

Appendix 2: Letter to RAC facility manager



[Date]

[Address]

Dear

I am currently studying for a Masters of Public Health at the University of Otago. As part of my study I am researching how female Health Care Assistants (HCA) who have been living on low income make health decisions for themselves and their families. This question occurred to me during my own employment in the sector when I became aware of some of the particular challenges my colleagues were facing in their own health-related decisions. These often seemed to be directly income or finance related and given the relatively low pay rates for this workforce in New Zealand I began to wonder about the longer term public health consequences of this situation.

The recent government announcement of a significant pay rise for the HCA workforce has presented me with an opportunity to study the impact an increased income has on health related choices made by HCAs in their family life.

As part of my research I am wanting to interview a small number of female HCAs (between 3 and 5) from your facility. In this interview, I want to explore with the women how they each manage the health issues they are faced with in their personal lives. I am also interested in understanding how being involved in care work might influence these choices.

In order to do this I seek your permission to make a short presentation to a staff meeting to inform your HCAs of the research and to request their participation. I would also like to be able to advertise the research project on a staff bulletin board with my contact details attached so that I can be contacted confidentially.

My goal for this research is to benefit both the workplace and the women involved in the study. Having a better understanding of the particular challenges HCAs face in maintaining their own and their families' health should assist government, employers, health and social services to offer more appropriate and timely support to low income workers and their families. A copy of the results will also be made available.

I would appreciate the opportunity to discuss this proposal with you in person. I will phone you within the next couple of days and hopefully we can make a time to meet and discuss this.

Kind Regards

Judy McHugh

Email:

Cellphone:

Appendix 3: Article for staff newsletter

My Research Needs YOU!

It's difficult making healthy choices when you've not got much money. In this study I am asking the question: "How do you do it? "

Caregivers have not been paid much for the work they do and yet they still need to take care of their own health and their families' health. Having worked in aged care myself I know this is not easy. Healthy choices are often costly.

If you are a female caregiver living in a low-income household (less than \$750 per week after tax), please consider taking part in my research. It will involve you having an informal conversation with me about how you make health-related decisions. Whatever you say will be kept confidential and you will be reimbursed for your time.

For more information about the study please contact me by phone or email.

Thank you

Judy McHugh

Email: claju350@otago.ac.nz

Cell: 0275490200

Appendix 5: Ethics approval



17/043

Academic Services
Manager, Academic Committees, Mr Gary Witte

21 April 2017

Dr R Egan
Department of Preventive and Social Medicine
Dunedin School of Medicine
University of Otago Medical School

Dear Dr Egan,

I am writing to let you know that, at its recent meeting, the Ethics Committee considered your proposal entitled “**A study of health-related decision making in a group of female health care assistants who live in low income households**”.

As a result of that consideration, the current status of your proposal is:- **Approved**

For your future reference, the Ethics Committee’s reference code for this project is:- **17/043**.

The comments and views expressed by the Ethics Committee concerning your proposal are as follows:-

While approving the application, the Committee would be grateful if you would respond to the following:

Participants:

The Committee asks whether there is a methodological reason for excluding male participants and suggests that you could remove the gender selection and include any male workers that you may potentially encounter.

Please provide the Committee with copies of the updated documents, if changes have been necessary.

Approval is for up to three years from the date of this letter. If this project has not been completed within three years from the date of this letter, re-approval must be requested. If the nature, consent, location, procedures or personnel of your approved application change, please advise me in writing.

The Human Ethics Committee asks for a Final Report to be provided upon completion of the study. The Final Report template can be found on the Human Ethics Web Page
<http://www.otago.ac.nz/council/committees/committees/HumanEthicsCommittees.html>

Yours sincerely,

Handwritten signature of Gary Witte in black ink.

Mr Gary Witte
Manager, Academic Committees

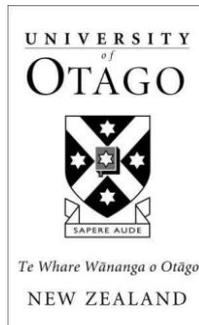
Tel: 479 8256

Email:

[gary.witte@otago](mailto:gary.witte@otago.ac.nz)
.ac.nz

c.c. Department of Preventive and Social Medicine

Appendix 6: Study Information Sheet



UNDERSTANDING HOW FEMALE HEALTH CARE ASSISTANTS MAKE THEIR OWN HEALTH CHOICES

Information Sheet

What the study is about

In this study, I want to find out more about how women who work in aged-care who have been living on low income weigh up their options when taking care of their own health and the health of those who depend on them. As a health care assistant, it may sometimes seem to be more difficult because of the kind of work you do and my goal is to better understand how you personally manage these tensions in your own life. This project is being done as part of a Masters of Public Health at the University of Otago.

To be part of this study

- you have to be female and working as a health care assistant in residential aged-care in Dunedin **AND**
- you need to be living in a household where the total household income is less than \$34,100 per annum. (before tax).

What will be asked of you?

1. To take part in an interview with the researcher.

This will be a relaxed and informal conversation about how you manage your own health concerns when there is little money to spare. The interview will be done at a time and place convenient for you and it is expected to take up to about an hour. You can have a support person with you if you wish.

Although the interview questions are not pre-determined the researcher will have a small number of questions to use as a guide, such as how you think about health and how you weigh up health choices for yourself and your family.

It is important to remember that in the event that the interview develops in a way that makes you hesitant or uncomfortable, you have the right to decline to answer particular questions or to withdraw from the project at any stage without any disadvantage of any kind. In the days following the interview the researcher will give you a written summary of

the conversation. This gives you a chance to check it for accuracy and to clarify further if you think it is needed.

2. To take part in a follow-up interview.

This involves a shorter, second interview done either individually or as part of a small group. It is expected that this will take between 20-45 minutes. The follow-up interview gives you a chance to discuss the research findings with the interviewer. It is an important step in making sure the research analysis is appropriate and accurate.

Do I have to take part?

No, you don't. If you decide not to take part, there will be no disadvantage to yourself of any kind. If you are happy to continue and be part of this study, I thank you. I appreciate your interest and your time and to thank you for this you will be given a \$30 petrol/store voucher once the interviews are complete. At the conclusion of the project I will provide you with a final copy of the research summary.

What will we do with your information?

The interviews in this study will be audio recorded and transcribed by the researcher. All the information you give me will be kept confidential and used only for this research. Recordings, transcriptions and field notes will be stored in a locked cabinet at all times, only accessible to the researcher and her study supervisors. Information stored on computer will be password protected. Care will be taken to make sure you cannot be identified in any of the reports from this study. Upon completion of this study the records will be stored for at least five years in a secure location at the University of Otago.

Questions?

If you have any questions about this project, either now or in the future, please feel free to contact one of my research supervisors below. They both work in the Department of Preventive and Social Medicine at the University of Otago.

Dr Richard Egan
Ph 479 7206
Email: richard.egan@otago.ac.nz

Dr Trudy Sullivan
Ph: 479 8087
Email: trudy.sullivan@otago.ac.nz

Thank you for considering this study. If you are interested in being part of the research please contact me either in person when I visit your workplace, or by phone or email.

This study has been approved by the University of Otago Human Ethics Committee. If you have any concerns about the ethical conduct of the research you may contact the Committee through the Human Ethics Committee Administrator (ph +643 479 8256 or gary.witte@otago.ac.nz). Any issues you raise will be treated in confidence and investigated and you will be informed of the outcome."

Judy McHugh
Ph: 0275490200
Email: claju350@student.otago.ac.nz

Reference Number: 17/043

Appendix 7: Study Consent Form

[Date]



A study of health-related decision making in a group of female health care assistants who live in low income households

I have read the Information Sheet concerning this project and understand what it is about. All my questions have been answered to my satisfaction. I understand that I am free to request further information at any stage.

I know that:-

1. My participation in the project is entirely voluntary;
2. I am free to withdraw from the project at any time without any disadvantage;
3. Personal identifying information [i.e. contact details, audio recordings and transcripts] may be destroyed at the conclusion of the project but any raw data on which the results of the project depend will be retained in secure storage for at least five years;
4. This project involves an open-questioning technique. The general line of questioning will include how I think about health and how I weigh up health choices for myself and my family. The precise nature of the questions which will be asked has not been determined in advance, but will depend on the way in which the interview develops. In the event that the line of questioning develops in such a way that I feel hesitant or uncomfortable I may decline to answer any particular question(s) and/or may withdraw from the project without any disadvantage of any kind.
5. I will receive a \$30 petrol/store voucher as a token of appreciation for my time, once the interviews are complete.
6. The results of the project may be published and will be available in the University of Otago Library (Dunedin, New Zealand). Every attempt will be made to preserve my anonymity.

8. I agree to take part in this project.

.....
(Signature of participant)

.....
(Date)

.....
(Printed Name)

.....
Name of person taking consent

This study has been approved by the University of Otago Human Ethics Committee. If I have any concerns about the ethical conduct of the research you may contact the Committee through the Human Ethics Committee Administrator (ph +643 479 8256 or email gary.witte@otago.ac.nz). Any issues I raise will be treated in confidence and investigated and I will be informed of the outcome.

Appendix 8: Interview Guide

“Up until now caregivers in residential aged-care have been lowly paid and many have been managing in households where the total household income, even with other sources, is still very low. In this interview, I am wanting to understand how living on low income affects your freedom and ability to make healthy choices for yourself and your family.

I am also interested to know how you feel about your work and how that might influence your own health choices.”

Opening

Firstly, can you tell me about a time when you’ve had to make a difficult health-related decision for yourself or your family?

Possible prompts: When was that and what was it about? What was happening at the time? Why was it difficult? How did you weigh up your options? What supports were available and which were utilised? How did you respond to the issue in the end? And now looking back how do you feel about the choice you made? Are there any ongoing issues?

Say you had to make an important health decision for yourself, your child (or other family member) within the next week or so what sorts of things would you be faced with as you tried to decide?

What would lead you to feel that you need to choose an undesirable/less desirable option?

What does being in this situation tell you about yourself/your family? What message or meaning do you take from this?

Capability

If you were to rate your self on a scale from 0-10 in regards to your health, with 0 being extremely poor and 10 being excellent, where you place yourself today?

If you were to lift that rating one notch on the scale what would need to happen?

Possible prompts: How would that improve things for you? Are you able to make this change? What sorts of things make doing this difficult in your life as it is right now? Given this, does it feel like something that you could do, or would want to do? What are the downsides (if any) to achieving this? How might you cope with this side of it? What sorts of support do you have available to help you this? How likely are you to call on support for this?

Caring

Can you tell me what it’s like caring for others, at home and at work, while at the same time trying to take care of yourself and your own wellbeing?

Possible prompts: Can you think of an actual instance when it was difficult for you to choose whose care needs to put first?

Future health

Is there anything health related on the horizon or out there in the future that you are thinking you might have to deal with or prepare for?

Possible prompts: How are you thinking about this at this point in time?

Finally, is there anything else you would like to say or comment on regarding these health and financial issues?