PSA

More Effective Social Services issues paper

Submission to the Productivity Commission

2 December 2014

For a better working life
New Zealand Public Service Association
Te Pūkenga Here Tikanga Mahi

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Introduction

Who we are

The New Zealand Public Service Association *Te Pūkenga Here Tikanga Mahi* (the PSA) is the largest union in New Zealand with over 59,000 members. We are a democratic organisation representing members in the Public Service, and the wider State sector (the district health boards, crown research institutes and other crown entities), state owned enterprises, local government, tertiary education institutions and non-governmental organisations working in the health, social services and community sectors.

Since 1913, most State servants have been members of the PSA and as State services have been contracted PSA coverage has extended to non-governmental organisations and the private sector. People join the PSA to negotiate their terms of employment collectively, to have a voice within their workplace and to have an independent public voice on the quality of public services and how they're delivered.

Who contributed to this submission

In preparing this submission, we have circulated information about the inquiry amongst the PSA membership and invited PSA members to share their views with us through targeted newsletters to particular groups of members and a form on the PSA website. We have included extracts from the comments received as an appendix to this submission.

This submission begins by giving the PSA's views about the issues within the scope of the inquiry and then makes specific comments (from page 13) in response to some of the key questions in the issues paper.

PSA submission

How the PSA sees the issues within the scope of the inquiry

A context of spending constraints

The government has requested the Productivity Commission to undertake this inquiry into social services at a time in which government spending has been subject to extensive constraints over a period of more than 6 years. Our members have been reporting that the delivery of quality services in that time has become harder and harder.

In Budget 2014 the government forecasted a $372 million surplus next year – small, but larger than previous forecasts which put it at under $100 million. The "operating allowance" for new spending has been very small over recent years although it is expected to rise for next year at least. Despite this increase core

Crown expenses are forecast to be 30.3 percent of GDP in the year to June 2015 (down from 35.1 percent in 2011) and to go under 30 percent in 2017 and "remain below that level" from there on[1]. It means that there will be unrelieved pressure on already stressed social services such as social welfare, health and education.

In real terms, after taking account of rising prices and population, this means there will be continuing falls in funding for many public services. Treasury fiscal strategy forecasts[2] show the following:

Forecast increase in funding in real terms for public services (Years to June)					
Public sector	**2014**	**2015**	**2016**	**2017**	**2018**
Health	-0.6%	-2.3%	-3.7%	-3.6%	-3.1%
Education	-2.2%	1.9%	-1.0%	-1.6%	-1.4%
Social Welfare (excluding Super)	-2.7%	-2.9%	-4.9%	-1.3%	-0.9%
Other expenses	2.7%	-3.3%	-2.8%	-4.6%	-2.8%
New Zealand Superannuation	1.2%	0.9%	-0.2%	-0.2%	0.7%

For example, for health, the forecast is for a fall in funding in real terms of $352 million in the year to June 2015, $566 million in 2016, $539 million in 2017 and $473 million in 2018. At the same time the government has consistently pointed out over recent years that health has received greater increases than the rest of the public sector, so we know that the pressures are worse elsewhere. At the Ministry of Justice for example, the original post-election briefing to the Minister identified the pressures that that department was under, before it was changed.

Government agencies have responded by engaging in major restructurings, contributing to a loss in morale, and by contracting services out to non-governmental providers, both for-profit and not-for-profit. These providers are generally characterised by poorer pay and conditions and often by less capacity in important corporate and back-office functions such as finance and HR. In short, they are cheaper.

Under-investment in workforce

The arm's length funding arrangements for contracted social services providers allows the government to distance itself from the real cost of services, but there is also a pattern of under investment in the workforce and not recognising and rewarding women's work. The predominantly female workforce is low paid and that is where the bulk of the savings come from.

Women's work not recognised or rewarded

To demonstrate the gender bias in all of this in 2009 the PSA commissioned a gender-neutral job evaluation exercise, which compared the work of the predominantly female workforce in disability support with therapy assistants in hospitals (also largely female but part of the state sector) and the predominantly male corrections officers in prisons[3]. It concluded that the work was comparable but that the pay gap was as large as 52% in the case of corrections officers. The

[1] As reported in the *CTU Report on Budget 2014* p.4
[2] Ibid p.5
[3] PSA, *Community Support Workers: a job evaluation exercise*, 2008

Terranova case involving Kristine Bartlett is also challenging the assumptions behind the funding model and the nature of the work in the contracted out sector.

Disability services as a case study of community provision

The Productivity Commission is looking at some case studies as part of this inquiry, including services for people with disabilities. This sector constitutes a classic example of the problem we have described, involving both de-institutionalisation and a shift from male dominated to female dominated workforces, and it is well worth exploring. The previously largely male workforce (psychopaedic nurses) had access to an on-site School of Nursing at the Kimberley Centre and there was also a National Training School that ran course for training officers who worked alongside those nurses[4].

The community based providers that succeeded the large institutions replaced that male, qualified workforce with a predominantly untrained female workforce. While much of the training of staff in the institutionalised model reinforced the paternalistic and medical models of care, it was replaced with very little for mainly female staff who worked in the support of people with disabilities from 1990 onwards. Training was substantially left up to the new non-governmental employers whose response to the challenge has been variable. As the PSA said in its submission to the 2008 Social Services Select Committee Inquiry into disability support services:

> *The move to community based services required a higher level of autonomy from support staff and therefore a higher level of expertise and skill but paradoxically the shift has been characterised by reduced access to training, reduced levels of supervision, and reduced access to peer support and expert advice[5].*

In addition to cost, a number of other reasons have been advanced for delivering more services through community and voluntary groups:

- Community and voluntary organisations provide strong connections to clients and communities;[6]
- They enable government to secure services to vulnerable or other populations that have been hard to reach[7]. This is particularly true of Māori and iwi organisations that are seen as having the ability to deliver for Māori by Māori programmes;
- Their advocacy on behalf of consumers and on policy matters is a strength;[8]

[4] Ibid p. 9 The staff at the Kimberley Centre at the point of closure included management and administration staff, registered nurse educators, registered Nurses, enrolled nurses, 'psychopaedic' nurses, psychopaedic assistants, and a range of maintenance staff.

[5] NZ Public Service Association Te Pūkenga Here Tikanga Mahi, (2006) Submission to the Social Services Select Committee Inquiry into the quality and care of service provision for disabled people and how they might be improved p.4

[6] Macmillan, Rob, *The third sector delivering public services: an evidence review*, Third Sector Research Centre, July 2010, p14

[7] O'Brien, Mike, et. al, *The New Zealand Non-profit Sector and Government Policy*, Office for the Community and Voluntary Sector, 2009, p27

[8] ANGOA (the Association of Non-Governmental Organisations of Aotearoa), *Good Intentions: An Assessment of the Statement of Government Intentions for an Improved Community-Government Relationship*, 2009, p17

- Community and voluntary organisations provide useful service information and support to citizens;[9]
- Involving the sector is a means of strengthening democratic engagement;[10]
- Community and voluntary organisations are perceived to be more innovative;[11]
- They are cost-effective.[12]

In practice the performance has been mixed. The State has relied on a contract model to provide accountability for money spent through community and voluntary groups. Public sector contracting was derived from agency theory and is consistent with the public sector reforms that sought to separate service provision from funding and policy making[13].

Effects of the contracting model on provider independence

But the use of contracts has been criticised for compromising the independence of community and voluntary organisations and turning them into "convenient conduits for services to the community."[14]

The New Zealand Council of Christian Social Services also suggests that contracting can emphasise the funded project over the provider organisation and its community[15]. This can contribute to 'mission drift', in which the organisation moves away from its original mission of helping people to meet the requirements of the funder.

This trend can be exacerbated by the compliance requirements of contracting and the scope of some of the programmes. For example, Mission Australia, which was formed out of the Anglican missions from a number of Australian cities and states, now delivers a wide range of public services (e.g. employment services) that have a questionable link with its original mission, and in 2011 it was looking to expand its operations in the UK just as a multinational corporation might. [16]

Vern Hughes of the Centre for Civil Society in Australia has recently characterised the problem thus:

> Many organisations that began life as voluntary associations have become corporatised instruments of government service delivery and no longer need, or even want, volunteers. Managerialism – in public, private and community sectors – is the prevailing ideology of our time. It has trumped entrepreneurship in the private sector, and perverted notions of service in the public sector. But in the non-profit sector it has swept all before it[17].

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[9] Ibid
[10] Davies, Steve, *Third Sector Provision of Local Government and Health Services,* Unison, 2008, p12
[11] Macmillan, Rob, ibid
[12] NZ Council of Voluntary Welfare Organisations, *Counting for More: A report of the Value Added by Voluntary Agencies (VAVA) Project*, 2007, available at http://www.nzfvwo.org.nz/wp-content/uploads/2010/06/VAVA2_Summary-Report.pdf?phpMyAdmin=758c4d2cf2b3t63746902
[13] O'Brien, Mike, et al, ibid, p26
[14] Foreman, Nowland, cited in O'Brien, Mike, et al, ibid, p26
[15] Cited in O'Brien, Mike, et al, ibid, p28
[16] Davies, Steve, *Third Sector Provision of Employment-related Services*, PCS, 2006, p21
[17] Hughes, Vern, 'Non Profits Lose Sight of Volunteer Heritage', *Sydney Morning Herald,* 4 Feb 2011 http://www.angoa.org.nz/pages/show_page.php?&page=news/2011-02-28-Non-profits-volunteer-heritage

This suggests that some organisations have had their independence and ability to advocate for their communities tested by contracting and their relationship with the state. A recent study by Sandra Grey and Charles Sedgewick found that:

> *What is demonstrated in responses from the community and voluntary sector is that it is the very nature of their relationship with the state that has contributed to an environment in which debate is discouraged in some cases and barely tolerated in others. Only 87 of the 595 written responses given in the returned survey affirmed that debate was encouraged by two successive governments – the Labour-led coalitions of 1999-2008 and the National-led coalition of 2008-2009*[18]*.*

They conclude that:

> *This study to a large extent affirms that the trajectory has been to control through contracts, administrative requirements, and efficiency demands… . The consequences (unintended or otherwise) have led to the conclusion that the emancipatory role of community and voluntary sector organisations as "indispensable intermediaries" or, the "voice for marginalised groups", may have been subverted. This role has been transformed into one that is focused almost entirely on the technical and administrative aspects of performance and compliance*[19]*.*

Particular challenges for tangata whenua providers

For tangata whenua organisations, there are particular challenges in the relationship with the state, given the role of the Treaty of Waitangi and their organisations' often strong levels of accountability back to iwi and hapu. They have concerns about how "they are made to fit with the government" and how political sensitivities about Treaty issues can undermine the relationship and the services to Māori.[20]

For all community organisations this control can be implicit (generated by the imbalance of power) or explicit (some contracts carry provisions requiring the providers to maintain the political neutrality of state services). Either way it may not only inhibit advocacy and limit independence, but also induce the same risk-averse behaviour exhibited by the public sector itself.

Effects on innovation

The tight specifications of contracting, together with detailed reporting requirements, can inhibit innovation by promoting uniformity and the goals of the funder over local circumstances and the needs of clients.[21] [22] This is a serious concern, given the sector's supposed advantage in innovation. There is plenty of anecdotal evidence that community and voluntary organisations deliver innovative services, but a UK study suggests that "innovative capacity is not a constant or

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[18] Grey, Sandra and Sedgewick, Charles *Fears, constraints, and contracts: The democratic reality for New Zealand's community and voluntary sector,* A report presented at the Community and Voluntary Sector Forum, Victoria University of Wellington, 26 March 2013 p. 54

[19] Ibid. p.55

[20] ANGOA, ibid, p22

[21] O'Brien, Mike, et al, ibid, pp28-29

[22] Macmillan, Rob, ibid, p23

inherent organisational characteristic, but varies according to the cues and incentives of the public sector policy context".[23]

The experience of provider consolidation

Since the global financial crisis there has been an increasing push for value for money from community providers, as well as from the public sector. Both the current and the previous government have argued that there are too many community organisations and pushed for consolidation. As Trevor McGlinchey, Executive Officer for the New Zealand Council of Christian Social Services has pointed out[24], this has led to some interesting outcomes. For example, ACC's approach to funding disability services has seen a reduction from 86 service providers in communities down to 4 national providers and 2 regional providers. These large providers now act as 'super contractors' and contract smaller community based organisations to actually deliver the service, leaving less funding for direct services.

He also argues that under the current model "the groups that are good at the tender process are winning bids whether they are really the best service provider or not" and that "we are losing not only services, but some of the other value adds community organisations contribute"[25].

The role of the for-profit sector

The discussion thus far has been about community and voluntary sector provision, but we also need to address the role of the for-profit sector in the delivery of social services. They do not have the advantages that community providers have, of closeness to the community and being representative of vulnerable groups, and their contribution is influenced by the need to deliver to shareholders. Their workers are similarly mainly female and poorly paid. Most private commercial providers have to make a return to their shareholders and consequently this leaves even less available to pay fair wages or provide quality services. It also creates a moral hazard in that as commercial providers become more important in service delivery they gain greater influence over policy development in the social services sector.

Good policy processes should be grounded in the experience of the front line, and if the front line consists of for-profit providers there is a real risk that policy will be designed to reinforce good outcomes for those shareholders.

Reforming contracting practices

In the last few years, the Government has attempted to reform contracting practices. It started with the Funding for Outcomes approach in the Ministry of Social Development and has been picked up under the Streamlined Contracting for NGOs programme. The aim is to have longer contracts, and to integrate contracting arrangements across state sector agencies to lessen the compliance burden on providers. This is to be welcomed but it does not address responsible contracting issues such as workforce development and pay and conditions, and our understanding is that it still excludes the DHBs – which represent a significant proportion of the contracts let.

[23] Osbourne et al cited in Macmillan, Rob, ibid, p23

[24] McGlinchy, Trevor 'The State Sector Act 1988: community matters' in *Rethinking the State Sector Act: views from the PSA and New Zealand Fabian Society's 2013 Seminar Series*, February 2014 p. 21

[25] Ibid.

Responsible contracting

Government procurement is a powerful lever to improve practice and this is becoming increasingly important as the social services supply chain lengthens. It is time to strengthen the focus on responsible contracting in policy and departments contracting guidelines. We note that Working Safer, the Government's response to the Health and Safety Taskforce report, recognises the importance of this in relation to health and safety[26].

Such responsible contracting policy should be developed in collaboration with community sector and for-profit sector providers, the relevant unions and the Council of Trade Unions, contracting agencies and service users and their representatives. We propose the following principles, extracted from a 2007 Cabinet paper and based on analysis of contacting regimes with equity objectives, as a starting point:

1. Government contracting policy should be based on fairness, equity, transparency and responsibility
2. contracted services should contribute to the achievement of Government outcomes and objectives
3. Government should only contract with providers in the sector who demonstrate a commitment to pay and employment equity
4. Government should sufficiently fund the provision of services and target funding to enable providers to implement pay and employment equity policy, including 'hidden costs' such as employee training and upskilling
5. Funding levels should recognise the central importance of good quality services
6. Government should provide financial and other assistance to other stakeholders to build capacity and develop improved relationships
7. There should be a strengthened relationship between the concepts of the 'good employer', equal employment opportunities and pay and employment equity
8. Appropriate unions should be notified of the terms of contracts between Government and providers and have a role in enforcing the terms of those contracts
9. Collective bargaining and the role of unions should be promoted.

Workforce is absent

The issues paper is hampered by the fact that it ignores the workforce. The issues paper begins with descriptions of what each of the participants in the social services system want. Social services professionals and other workers are not mentioned as participants in the system. They are not merely agents of the organisations they work for but are actors within the system in their own rights. They engage with the system as individuals and seek to influence it collectively through the professional and industrial bodies to which they belong.

They have views about the effectiveness of the organisations they work for and the policy and delivery settings, and the contracting arrangements, that shape their

[26] Working Safer: A blueprint for health and safety at work, New Zealand Government, August 2013, p34.

work. They are for the most part the face of the system for clients and are trusted by both clients and their families. They are motivated by their desire to make a difference.

We are encouraged that the Commission has sought data about workers' experience and organisational performance from the Victoria University of Wellington and PSA research collaboration Workplace Dynamics. We submit that workforce and workplace have an important role in the overall effectiveness of social services, regardless of who the provider is, and that this should be reflected in the Commission's draft report and recommendations.

The PSA is concerned about two other assumptions behind this project as framed by the issues paper. These are that innovation that improves efficiency and effectiveness only comes through structural change, such as changing the way the government commissions social services, and that innovations in social service delivery only come through contracted services.

In the same way that much education research points to the quality of teaching as being a key factor in how children learn, rather than the administrative structures of the education system, the PSA thinks that it is important to look within organisations and how they work to encourage and support innovation.

Public sector innovation

There is also evidence that there is much innovation within the public sector, but it is often not recognised or well-supported. Together these points suggest that potentially greater value can be achieved at looking at ways in which existing public sector providers work, rather than further contracting out – no matter what model of commissioning is used.

The focus on commissioning in this project takes the attention away from places closer at hand where improvements in efficiency and effectiveness can be achieved without the disruption and fragmentation that is the consequence of outsourcing, no matter what model of commissioning seems attractive at any given time. Too much policy over the last 20-30 years has been based on the assumption that the public sector is inefficient, ineffective and lacks innovation.

A 2008 project looking at collaboration and innovation found numerous examples of both happening in New Zealand's public services, but mostly under the radar. The authors described those engaged in innovative and collaborative activities as public entrepreneurs:

- Someone in the middle, is sometimes within an organisation, sometimes outside, who is focussed on the outcome and who is marvellous at working with others
- Someone who listens first to the client, who works with and not 'over' or for the client, using resources at their disposal to achieve what's needed
- Someone who doesn't regard rules as fixed or as a constraint, someone who invents new ways as they act (but regards themselves as acting normally)
- Someone who has a can-do attitude but also a deeply felt grasp of the public interest in a democratic society and the role of the official [27]

[27] Eppel, E., Gill, D., Lips, M., and Ryan, B., *Better Connected Services for Kiwis,* Institute of Policy Studies, July 2008, p6

The authors went on to describe the public entrepreneur as one of a trio, accompanied by the 'guardian angel' – the manager who enables and protects the public entrepreneur – and the 'fellow-traveller', the like-minded person focussed on common problems and common goals. This trio, often with an active client (an individual or a group or an organisation), created new ways of working that involved all parties. Public sector entrepreneurship needs to be a collaborative process, with different actors working in partnership to achieve common goals, and with leadership that enables, not disables, innovation. While this 'Better Connected Services for Kiwis' project focused principally on the middle manager, rather than on the frontline worker, public entrepreneurship is also embedded in high-performing workplaces – the ones that 'make a difference' to the people with whom they deal.

The contribution of high performance workplaces

The PSA is also committed to high performing workplaces in both the community sector and the public sector with a view to creating a climate and culture where frontline workers, including those who might qualify as public entrepreneurs, can flourish. We have two principal objectives:

- Enabling PSA members to have good jobs, within a workplace culture of meaningful and substantive engagement of workers and their union with the employer on how the work is organised and carried out
- Supporting the delivery of high quality public services that provide value for money and good outcomes for New Zealanders.

A high performing workplace is one where our members can mobilise their knowledge to improve the efficiency and quality of services and embed positive and productive workplace relationships and practices with a view to creating sustainable services, sustainable jobs, and productive workplaces.

The PSA believes that high performance workplaces can be achieved through a culture of engagement and collaboration by direct, meaningful and regular engagement with the workforce on all matters over which the workforce directly influences performance. This is essential for sustained high performance and for achieving the productivity gains that employers (and members) seek in a time of scarce resources. In the highly unionised public sector the union is central to improving productivity and innovation and the PSA wants to be involved.

For example, we have developed Sustainable Work Systems (SWS) as a programme for putting the high performance workplace agenda into practice. SWS sits within our wider agenda, and is an important and effective tool for realising high performance in workplaces where the conditions are right for it. We have a number of projects underway with employers to implement this programme. It has been running with bookers and schedulers at Bay of Plenty DHB since 2009, where the introduction of SWS reduced (and sustained) the time taken for scheduling acute appointments from 5 hours to 1.5 hours, significantly reduced the need to rebook appointments at short notice and allowed patients to choose their appointment times so that they are much more likely to turn up. At Waitakere District Courts in 2011 there were similar improvements, and we have other projects underway at Auckland Council, Manukau District Court, WorkSafe New Zealand and Hutt Valley and Wairarapa DHBs.

These are promising signs which should be encouraged, but public entrepreneurship needs structures that promote it – both the "soft" ones of managerial and workplace cultures, and the "hard" one of legislation. Culture change needs to be normalised, to become the "way we do things round here", so that lessons are systematised and used to innovate and improve outcomes, and failures are examined for ideas on how to improve. The think tank Demos[28] says institutions must learn to 'fail intelligently' as part of an evolutionary approach to frontline innovation.

The barriers created by the State Sector Act

However, the top-down managerialism enshrined in the State Sector Act 1988, with its focus on the powerful role of the public service chief executive as an individual employer, does not help create a culture of high-trust workplaces where all workers contribute to public value and are supported as entrepreneurs. The Better Public Services Advisory Group in its 2011 report identified that "sharply improved state sector performance will require a culture that supports and actively encourages innovation and continuous improvement".[29] But the subsequent Better Public Services Programme and the amendments to the State Sector Act in 2013 indicate a rather limited view of the imperative for change. We do note the establishment of a continuous improvement unit by the central agencies, which we see as a positive development.

So, legislative change is required but we also need a paradigm shift on the part of public managers, which need not wait for legislative change, and this is where the government and the Productivity Commission should focus their attention. We find that public sector employers are finally wanting to address their engagement and relationship deficit with staff, but they are unwilling to take the final but important step of recognising that the union can be a vital part of making an effective change.

Deciding who provides which services

The State services have a significant role in the provision of social services however the productivity of State services organisations are outside of the scope of this review. It is the PSA's view is that a general consensus would be helpful on the principles which guide decisions about who provides which social services. We propose the following:

1. Public services, such as health, social services and education, are by their very nature a public good that the state must fund, co-ordinate and provide within the framework of these principles.
2. Given the coercive powers of the state and the need to maintain accountability for those powers, services requiring the state to exercise the power of coercion should belong with a public agency.
3. Services that require high levels of co-ordination, significant capacity and economy of scale may be best provided by the state.
4. Where the risks arising from provider failure are high, the service should stay with the state.
5. The community and voluntary sector should complement those delivered by the state. Community and voluntary sector provision of services may be advantageous where:

[28] Parker and O'Leary, op cit, p50

[29] Better Public Services Advisory Group Report, November 2011 p.39

a. Organisations that have better links to their communities than can be provided by the state and can deliver information and services in a way that will give people improved access to better services;
b. Maori communities would benefit from a Treaty-based approach;
c. Client groups will benefit from having a range of providers delivering services to them;
d. And the benefits of community provision outweigh any risks arising out of a lessening in accountability to the taxpayer.

6. In those services where a significant role has been given to the community and voluntary sector, it may be important that the state retain the capacity to act as a backstop if required.

New Zealand is already innovative its delivery of services through State services agencies with various relationships to the State and private and community sector procurement. New models must offer genuine advantages to current arrangements. Our concern is that the benefits of models such as social impact bonds and public sector mutuals are as yet unproven and much of the literature available is produced by those advocating for their adoption.

Comments on selected questions

Question 1

Q1. The trends that will change the social services landscape in New Zealand
The past 20 years have seen a rapid increase in workforce participation of women caring for children and workers over the age of 60. This has significantly reduced the capacity for these groups to provide voluntary social care both within families and in community organisations.

This social change has happened in not insignificant part because successive governments have established policy settings to support this as, as Treasury says, increased labour market participation is good for the economy[30]. The women and older people who once provided social care in families and created and drove community care through community organisations are increasingly in paid employment through economic necessity.

The following comments were provided by PSA members in response to this question:

"Health continues to see Tangata Whenua and low socio economic families at the worst end of the spectrum. With increasing unemployment, again Tangata Whenua and low socio economic families are highlighted as being most affected, and so they will least be able to avoid GP visits."

"Within my role immigration with lack of growth in service provision and the aging population are causing a HUGE demand on services. Within my nonprofessional life - the inequality between the rich and poor are my largest concern."

[30] P 3, http://www.treasury.govt.nz/publications/research-policy/conferences-workshops/labourforce/pdfs/lfpw-johnston.pdf

"Growth of Auckland and influx of immigrant populations into Auckland. This will bring pressures onto some of the social infrastructures there. Re-growth of Christchurch."

"Living in Northland 1st home ownership for workers is a pipe dream. Due to the low economy and the lack of full time work in the region. Rural areas hard to get housing at affordable price."

"Lack of suitable social housing and expensive private rentals, the 'working poor' i.e. people working that cannot afford to meet all their living costs, zero hours work contracts, what appear to be higher thresholds for community mental health services accepting referrals for children and adults alike, child poverty and the widening gap between rich and poor."

Question 2

Q2. The importance of volunteers to the provision of social services

Volunteers have an important role in social care however this role complements and should not replace that of paid staff. Service delivery standards are best maintained through a trained and stable workforce with career pathways.

It should not be assumed that volunteering will continue on the same scale as at present. As noted in our response to question 1, the past 20 years have seen a rapid increase in workforce participation of women caring for children and workers over the age of 60. This has significantly reduced the capacity for these groups to provide voluntary social care both within families and in community organisations. The availability of the post-war generation as volunteers is a temporary phenomenon and as this generation continues to age they too will need additional social and economic support.

Question 3

Q3. The role of iwi in the funding and provision of social services

In the emerging post-settlement world, iwi are increasingly taking on a role in the funding and provision of social services. The PSA has membership in a number of Maori providers contracting to iwi.

PSA members have provided the following comments in response to this question:

"For me this is not a matter for Iwi to solve all on its own. Yes, whilst they may include it 25 year plans, there is too much expected of Iwi to solve this government, and future governments', responsibilities in regards to health. The Treaty settlements are compensation for the Iwi, not to prop up the government health, education or housing budgets. On employment they are contributing already."

"Iwi's role in social service provision could include initiatives to teach real world skills for their wellbeing in a modern age whilst including most important aspects of cultural teaching tradition."

Question 4

Q4. The contribution of social enterprise

Social enterprises are not a new phenomenon and will continue to have a role, however private finance will be most attracted to enterprises where there is clear opportunity for profit in the short or medium term. Given that income in social services derives mainly from the State, and funding is often not adequate, it is

perhaps realistic to expect that social enterprise will play at most a niche role in social service delivery.

Questions 5 & 6

Q5, Q6. Opportunities for, or barriers to social-services partnerships between private business, not-for-profit social service providers and government

Given that income from social services is largely from the State, and given that the State can raise finance more cheaply that the private sector, there are limited opportunities for profit that attract private finance to social services. Where there is current significant for-profit provision, profit is largely achieved through a business model based on a low paid and low skilled workforce. This model is, in our view, unsustainable.

Attempts internationally to find ways around this, for example through complicated funding arrangements such as public private partnerships or social bonds, do not seem to have been particularly successful at attracting long term private investment in social services. They are interesting experiments in form but perhaps not worthy of significant focus.

Question 7

Q7. The capabilities and services Māori providers are better able to provide

PSA members have provided the following comment in response to this question:

"In our joint working they help the client to negotiate their way through formalised services and their presence adds security mana and support to the client and advocacy services through the process. In a small area though we find that some of our clients don't want to access their services due to history on a personal level with the staff in the Māori service."

"Services where a Māori cultural connection and/or understanding are required, or where they make things easier. People in the same culture communicate more fully and completely, so can provide comfort and assurance better, but also can provide all services with better communication."

Question 8

Q8. Why private for-profit providers are involved in providing some types of social services and not others

Please see our response to questions 5 and 6.

Page 33 of the issues paper details selected New Zealand initiatives. In terms of the commissioning and purchasing process that led to the contracting of prison services at Mt Eden and Wiri prisons to a private provider, no public sector comparator was allowed to be produced or considered. It appears that this decision was based on a political imperative rather than any real assessment of the effectiveness of the particular options for delivery.

It appears to us that where initiatives are developed in collaboration with funders, providers, service users and the relevant workforce and where they are trialled, evaluated and adjusted in response, they are more likely to be successful.

Question 9

Q9. The success of recent government initiatives in improving commissioning and purchasing of social services

The Streamlining NGO Contracting project would appear to be having some success. However, it is still early days for this project and the project does not attempt to tackle issues around the workforce.

Questions 10 & 11

Q10, Q11. International examples of innovative approaches to social services commissioning and provision and the barriers to implementing these

PSA members provided the following comments in response to these questions:

"Community needs at a community level. People should have the opportunity to have a say as to how their community services are run. However, care should be taken that everyone receives the same standard of care so that those in poor areas are not left out. An example of community services run by central government is the Sure Start programme in England, which was designed to ensure that young mothers could access services for pre-schoolers. These programmes were locally run yet answerable to the government from which they were funded."

"Our leadership team go overseas to do studies. They have brought back ideas and adopted them but fail to remember NZ is a totally different economy and population to those countries. They need to be careful when adopting innovated ideas from Australia or Ireland etc."

"Think of the differences in culture, population size, geography – how this may affect the translation of models from overseas. Also we have Te Tiriti as our founding constitution. Culturally Maori are different to other races."

"Barriers would be costs and time to research and implement changes. Most social workers are working really hard with little time available for additional tasks. As well, change can be scary! Risks can be trying to apply a model that worked well in one community may not mean it works well in Aotearoa/NZ, there are so many factors that go into successfully implementing programmes, models etc, as mentioned above "differences in culture, population size, geography"."

New Zealand is already innovative its delivery of services through State services agencies with various relationships to the State and private and community sector procurement. New models must offer genuine advantages to current arrangements. Our concern is that the benefits of models such as social impact bonds and public sector mutuals are as yet unproven and much of the literature available is produced by those advocating for their adoption.

To further inform the inquiry, we refer the Commission to:

- *Proof of delivery? A review of the role of co-operatives and mutual in local public service provision*, produced in 2011 the UK Association for Public Service Excellence (APSE)[31]
- A UNISON brief from October 2014 summarising UNISON's experience of public sector mutual (attached as appendix 1).
- *Public services, co-operatives and mutuals: Best practice guidance* published jointly in 2013 by the UK Trades Union Congress and Co-operatives UK[32].

[31] Available at http://www.apse.org.uk/apse/index.cfm/research/current-research-programme/proof-of-delivery-a-review-of-the-role-of-co-ops-and-mutuals-in-local-public-service-provision/

[32] Available at: http://www.uk.coop/sites/storage/public/downloads/tuc_co-operatives_uk_guidance_0.pdf

Question 15

Q15. The services best suited to client directed budgets and the merits of this approach

The Enhanced Individualised Funding (IF) of the Ministry of Health's "new model of disability support" and individualised funding packages of "Enabling Good Lives", are a good example of client-directed funding. They are good examples in that they demonstrate both the strengths and weaknesses of the model.

IF encourages people with disabilities to gain a greater measure of personal independence and play a greater role in the communities in which they live. In practical terms IF means that some people with disabilities are able to hire, manage, pay, train and make their own contracts with their support workers or choose to manage aspects of this process. There is a human rights aspect to the use of this kind of model in disability services but there remain not insignificant practical issues which mean that the model has limited scope for application in other areas.

These initiatives are being implemented on a trial basis in parts of New Zealand and it is likely that they will be rolled out to a much wider group of disabled people. The PSA supports the intent of this programme but we are deeply concerned about the approach taken in New Zealand where the person with a disability is the employer of staff. This approach:

a) Diminishes the skills and contributions of the disability support workforce
b) Undermines meaningful workforce planning and development and national standards of service delivery
c) Places considerable responsibility on the person with a disability to manage the obligations of being an employer
d) Will increase insecurity in employment and expose the workers to health and safety risks (we note the exemption being considered under the Health and Safety Reform Bill).

The trend to increasing the choices available for people with disabilities (including IF) is likely to increase the skill levels required of those who support them. As people with disabilities in community living arrangements have greater control, then support workers will require a greater ability to manage alone as well as highly developed sense of judgement about, for example, how to allow those they work with to take the risks necessary to lead their own lives, and knowing when to intervene for the purposes of safety. This will be a particular challenge for those working with people with intellectual disabilities.

> *To be confident supporters of risk taking, people who provide supports must possess skills beyond basic risk identification and developing a risk plan. They must have developed skills in:*
>
> - *Multidisciplinary interactions, including a common understanding of risk and the ability to effectively empower, challenge, and support people.*
> - *Negotiation, including the ability to clearly state positions and goals, identify boundaries (i.e. clear issues of person safety), and be prepared to 'agree to disagree'.*

- *Facilitation, using empowerment strategies in order to encourage people "to have more say over their lives, but also to assume responsibility for their decisions in relation to risk."*[33]

Another issue is thrown up by the work by Anne Junor and others, which suggests that disability support work requires high-level skills are required beyond instrumental or bodily care. Junor looks at the other skills required in what could be called a 'social' model of care:

> *…the skills required by this 'social' model include interactive or emotion management skills, cognitive skills of shaping awareness, skills used to shape long-term support relationships, and co-ordinating skills. These skills appear to be underspecified in qualifications and job descriptions. Firstly they need to be recognised as skills, not as 'natural' attributes, and secondly there is a need to recognise how they develop to higher levels in the workplace, through a progressively deepening capacity for reflective problem-solving in shared activities*[34].

All of these are advanced skills, well beyond the basics of personal care, which require training and career paths for the workforce and which not reflected in the wages currently paid in the sector. Care workers' experience of negotiating this challenging employment environment is well described in Briar, Liddell and Tolich's 2014 research report "Still working for love? Recognising skills and responsibilities of home-based care workers"[35], which is attached as appendix 2.

With increasing demand for IF there is likely to be increasing pressure on wages. People with disabilities who are managing their own arrangements under IF are going to want to employ people with whom they can develop long term supportive relationships, and the findings of an Australian assessment of IF programmes concluded that the level of remuneration affects the availability of qualified support workers[36]. Those who could afford it often paid above award wages while those who were purely dependent on public funding sometimes struggled to pay decent wages.

For IF to be successful, a model is required that includes emphasis on a secure and co-ordinated workforce, able to access appropriate training and structured careers.

PSA members provided the following comments in response to this question:
"Paying only for the time spent with the client does not appreciate the costs of the mobile worker in transport, administration of paper-work, stationery costs or full running costs of providing their own vehicles, plus the company's administration

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[33] Bonardi, p.65

[34] Anne Junor, Ian Hampson, and Kay Robyn Ogle 'Vocabularies of Skills: The Case of Care and Support Workers', in S. Bolton and M. Houlihan (eds) *Work Matters*, Palgrave, London, 2009

[35] Briar, C., Liddell, E. and Tolich, M. (2014) 'Still working for love? Recognising skills and responsibilities of home-based care workers'. Quality in Ageing and Older Adults 15; 3. http://www.emeraldinsight.com/doi/abs/10.1108/QAOA-04-2014-0006?journalCode=qaoa

[36] Karen R. Fisher, Ryan Gleeson, Robyn Edwards, Christiane Purcal, Tomasz Sitek, Brooke Dinning, Carmel Laragy, Lele D'Aegher and Denise Thompson, *Effectiveness of individual funding approaches for disability support,* Department of Families, Housing, Community Services and Indigenous Affairs, 2010 p. 43

and supervision costs. Support workers cannot afford to carry these costs when they are on minimum wage."

"I believe some mental health support services do not lend themselves to client directed budgets, for the reason that some clients do not always have the capabilities to effectively manage their own budgets."

Question 18

Q18. Better including the views of clients and their families in the design and delivery of social services

As service delivery becomes increasingly fragmented and devolved from the State services, involving clients and families in policy and service design becomes more complex but no less necessary.

PSA members provided the following responses to this question:

"Strengthening Families (SF) - As long as the process is open and transparent with goals and ideas shared that are family-centred and easily achieved by the family. Which starts with trust and engagement from a lead person/agency."

"Yes, a consultation process could be of added value as clients' families can sometimes identify problems unique to these service users."

Question 19

Q19. Decision making at the local level

The ability to make decisions at the local level has been identified as one of the key enablers of innovation in public service agencies[37]. It makes sense that services will work better when staff and agencies have the ability to respond to individual and local conditions.

PSA members provided the following examples in response to this question:

"A good example could be the new concept of 'Child Action Teams' being rolled out by Govt under the Green & White Paper umbrella. (I think there is one in Rotorua). They will only succeed if the relevant local community/social agencies are part of decision making from day one. Rather than an idea thought up by central Govt who may not know 'fit' of communities."

"Yes, locally. In older persons health the CREST service introduced to Canterbury after the earthquakes filled a definite need in providing for elderly, vulnerable clients in their own homes when there was an acute shortage of hospital beds. A one size fits all service on a national basis can sometimes be fraught with problems unique to specific areas."

Question 20

Q20. Examples of where government contracts restrict the ability of social service providers to innovate

PSA members provided the following comment in response to this question:

"The quantification and performance indicators limit this work and personal touch and input to the numbers calculated for what reason?"

[37] Eppel, Elizabeth, et al, Better Connected Services for Kiwis, Institute of Policy Studies, Victoria University, 2008

"In our service continuum the loss of funding to residential homes has reduced the speed and safety of discharge from hospital for some of our clients."

"Contracts generally involve short term thinking. The people change, there is no 'memory' when the people doing the work change over frequently. With no memory, mistakes get repeated, things fall between the cracks without being noticed, communications shut down, etc."

"Yes: Home-based care for elderly. Lack of payment to support worker means that only the bare minimum service can be supplied. When health and safety issues are noted by the support worker, there is no time or funds to act proactively."

"It is very sad when a social provider who operates successfully is forced to close down because their funding is cut."

Question 26

Q 26. What factors should determine whether the government provides a service directly or uses non-government providers? What existing services might be better provided by adopting a different approach?

The PSA's view is that it is useful for such decisions to be made on the basis of guiding principles. We propose the following:

7. Public services, such as health, social services and education, are by their very nature a public good that the state must fund, co-ordinate and provide within the framework of these principles.
8. Given the coercive powers of the state and the need to maintain accountability for those powers, services requiring the state to exercise the power of coercion should belong with a public agency.
9. Services that require high levels of co-ordination, significant capacity and economy of scale may be best provided by the state.
10. Where the risks arising from provider failure are high, the service should stay with the state.
11. The community and voluntary sector should complement those delivered by the state. Community and voluntary sector provision of services may be advantageous where:
    a. Organisations that have better links to their communities than can be provided by the state and can deliver information and services in a way that will give people improved access to better services;
    b. Maori communities would benefit from a Treaty-based approach;
    c. Client groups will benefit from having a range of providers delivering services to them;
    d. And the benefits of community provision outweigh any risks arising out of a lessening in accountability to the taxpayer.
12. In those services where a significant role has been given to the community and voluntary sector, it may be important that the state retain the capacity to act as a backstop if required.

PSA members provided the following comments in response to this question:

"In my experience when government decides that an NGO or community organisation should provide a service it is with little or no funding often, as well as a huge amount of administration as well as an enormous amount of time to prepare an application for funding, which may be unsuccessful. The reality is that government providers have access to a lot more resources than NGOs."

"Health and education are best delivered by the Government as many NGO's do not invest enough in training their staff to do the work required of them and they have staff do work at a cheaper rate than a professional would cost. With this change in cost, services are not as good as they should be even if they cost less."

"The government needs to be seen as giving fair and equal services to everybody and that those in poor areas receive what they need. This may mean that for-profit services may not be the most appropriate model to deliver services in poor areas. "

"I don't know for certain but often cost is a major factor without considering whether this is a result of a policy to pay low wages, operate with the bare minimum staff and rely on volunteers for delivery. This is often not really sustainable - it works at the moment as there is a large pool of unemployed who would rather work for nothing than sit at home or who hope it will lead to paid employment."

"Cost factors appear to be the determining factor as to why some government contracts are let to NGO's. DHBS appear too have no conscience about letting contracts to NGOs knowing that such service providers must pay their support workers considerably less wages than what DHBs would pay their own staff to do the same work. - Existing services could be better improved be 'RING FENCING' funds to allow progression in CSWs' wages and training."

"Risk is if we move too fast the new contractors will fail and we lose out and have to pick up the mess again after losing workers who had the experience, due to down-sizing of their case loads."

Question 30

Q 30. Is there evidence that contestability is leading to worse outcomes by working against cooperation?
The Glenn Inquiry reports provide evidence of this in relation to child abuse and domestic violence prevention[38].

Question 34

Q 34. For what services is it most important to provide a relatively seamless transition for clients between providers
This is important to clients, and for effectiveness of outcomes, in all such situations.

A PSA member provided the following comment in response to this question:
"Where there are many providers at once, e.g. with a disabled child, all information needs to be re-provided etc."

Question 35

Q 35. Examples of where the transition to a new provider was not well managed
PSA members directly experienced a poorly managed transition to a new provider when Capital and Coast Health DHB ended a contract with Healthcare of New Zealand and awarded it instead to Access Home Health and Presbyterian Support.

[38] Wilson and Weber, The People's Inquiry into Addressing Child Abuse and Domestic Violence, The Glenn Inquiry, 2014 and The People's Blue Print: Transforming the Way We Deal with Child Abuse and Domestic Violence in New Zealand, The Glenn Inquiry, 2014.

Both clients and workers were impacted badly through this process. Part 6A of the Employment Relations Act is complex and provides inadequate protection for workers in such situations, and the process was badly managed by the DHB.

A PSA organiser directly involved in supporting members in this process has provided the following list of specific issues:

- "The employers concerned were confused as to whether part 6A of the Employment Relations Act applied. We had get a ruling from the Employment Relations Authority to establish this.
- No rationale was provided by the DHB for changing providers. Many of our members were very loyal to the organisation they worked for (Healthcare of New Zealand) and the clients they supported, and were concerned to know what the organisation they worked for had "done wrong".
- The funder (the DHB) refused to meet with us.
- The work was divided between two new providers. People (workers) had to elect to transfer to one of the providers but needed to work for both in order to maintain their hours. Those who did go on to work for both providers were disadvantaged as one of those jobs became a secondary job for which they had to pay secondary tax.
- The provider that lost the contract did not transfer annual leave over to the new providers which resulted in litigation, which caused uncertainty for our members.
- The contract was taken over over-night and so there was no real transition of arrangements."

This organiser also supported PSA members when two community providers (Presbyterian Support Otago and the Disability Resource Centre) lost contracts to a multi-national for-profit provider (Royal District Nursing), Healthcare of New Zealand and Access Home Health. She reports that in this situation, "people (workers) had no choice about which provider they were transferred to and the outcomes (terms and conditions and pay) were very different depending on where they ended up. There was no equity in this."

In response to this question some PSA members mentioned the difficulties caused during transfers between providers of information needing to be transferred between multiple and incompatible computer systems.

Question 37

Q 37. How well do government agencies take account of the decision-making processes of different cultures when working with providers?

A PSA member provided the following comment in response to this question:

"Don't know exactly but I would be fairly sure they don't take into account any cultures other than NZ European, Maori and Pacific Islanders. We now have a large Asian population (this includes Indians) - are there any special considerations there?"

Question 40

Q 40. How well do commissioning processes take account of the Treaty of Waitangi

The PSA commends the excellent guidance on this provided by Te Puni Kokiri[39].

[39]Available from: http://www.tpk.govt.nz/en/a-matou-mohiotanga/crownmaori-relations/measuring-

Question 43

Q 43. What kind of measures work best and what should be included in contracts

The kind of measures needed varies across sectors and social outcomes in particular can be difficult to measure. There is a general view that currently social service outcomes are not well measured.

Almost universally members have said that measuring numbers alone is not enough. The use of qualitative data, while time consuming, is generally seen as the most effective way to ascertain the effectiveness of outcomes. When outcomes are measured by throughput alone it may decrease the quality of delivery of service and work against long term preventative measures being implemented.. If the focus was more on the quality of care rather than throughput we might also see fewer users needing to come back for subsequent treatment. A PSA member provided the following comment in response to this question:

"If there were a service code in the system that specifically asked for the amount of time spent on education, coaxing of patient, discussing treatments etc, management would be able to see that whilst it doesn't look like we have done much treatment-wise, we have put a lot of effort into preventing recurrence by educating patients and parents and also providing good quality treatment as appointments are able to be longer."

"Works best when consistent data is kept over time and project outcomes are tracked – such as the prevention of admissions / re admissions after the introduction of a specific service. In contracting, a balance needs to be struck between flexibility and stability of funding, so that outcomes have time to be reached."

Cultural issues

Members also report that crucial outcomes are not being captured in some sectors because of the focus on capturing clinical data alone, which does not capture the extent of work done in, for instance, a Tangata Whaiora context.

Questions 44 & 46

Q44, Q46. Do we have the right data needed to know whether or not programmes are effective. What are the benefits, costs and risks of using data? Is there sufficient learning within the social services system?

If used correctly, data can be useful for finding out where to best target funding and resources. Problems with data arise when inappropriate data is used, or gathered in a haphazard inaccurate way. Currently the sense is from PSA members that data collection can be inaccurate and biased. A PSA member provided the following comment in response to these questions:

"Unless you observe staff daily for a while, you will not get a true reflection of how much work certain things need. Looking at complex SU's in mental health especially."

Again, the message from members is that quality of service rather than numbers needs to be the measure.

performance-and-effectiveness-for-maori-

"The database used to record clinical data for the dental service doesn't sufficiently record the amount of time spent doing non-clinical tasks (i.e. phoning patients, calling to remind patients of appointments, coaxing patients into treatments, discussing treatment options with parents etc.)."

And again, members have noted cultural issues around what kind of data is collected in relation to Tangata Whenua.

Question 52

Q 52. How important are the organisational culture and leadership of providers, public, community and private, to effectiveness and innovation?
Organisational culture and leadership are key to effectiveness and innovation. They are also key to the kind of high integrity behaviours and outcomes the public has a right to expect from publicly funded organisations.

Low-trust workplaces where employees are not involved in decision making about their jobs and leaders micro-manage rather than respecting employees' professionalism, are less likely to produce the innovation needed in this sector. This is the case whether the organisation is in the community, public or private sector.

Question 54

Q 54. Have recent amendments to the Public Finance Act 1989 made it any easier to coordinate across government agencies?
The PSA will be very interested in the impact of the recent changes to the Public Finance Act and in particular the use made of multi-category appropriations. This would seem to be a useful innovation, however many of the barriers to collaboration created by the accountability structures in the State Sector Act, remain.

Appendix 1

UNISON Brief for Chi Onwurah Labour MP for Newcastle Central &
Shadow Cabinet Office Minister

Meeting 15 October 2014

Aims of meeting:

1. Provide a brief background of UNISONs work in the 'third sector' and joint co-operative work ethos and our Voluntary and Community and Business service groups
2. Discuss the inclusion of reserving public contracts for 'types' of social enterprise in the new public procurement regime and UNISONs concerns set out below in its response to the UK government.
3. Discuss Chi's plans to legislate definition of social enterprise and aims for this sector and find common ground where UNISON can assist

UNISON response to the UK Governments transposition of the public procurement directive in the Consultation Document

UK Transposition of new EU Procurement Directives
Public Contracts Regulations 2015

Cabinet Office

Section14. Reserved contracts for mutual's Article 77

UNISON notes that the draft Regulations transpose Article 77 of the Directive on reserved contracts in full but the UK government has chosen to modify this Article in one important respect by stating that an organisation would qualify where its structures of management or ownership were based on employee ownership or participatory principles "if and when it performs the contract".

Article 77 states (UK modification in bold):

Reserved contracts for certain services
77.

(1) Contracting authorities may reserve the right for organisations to participate in procedures for the award of public contracts exclusively for those health, social and cultural services referred to in regulation 74 which are covered by CPV codes 75121000-0, 75122000-7, 75123000-4, 79622000-0, 79624000-4, 79625000-1, 80110000-8, 80300000-7, 80420000-4, 80430000-7, 80511000-9, 80520000-5, 80590000-6, from 85000000-9 to 85323000-9, 92500000-6, 92600000-7, 98133000-4, 98133110-8.

(2) [An organisation referred to in paragraph (1) shall] fulfil all of the following conditions:—

(a) its objective is the pursuit of a public service mission linked to the delivery of [the] services referred to in paragraph (1);

(b) profits are—
(i) reinvested with a view to achieving the organisation's objective, and

(ii) where profits are distributed [or redistributed], this should be based on participatory considerations;

(c) the structures of management or ownership of the organisation are **[or will be, if and when it performs the contract]** —
(i) based on employee ownership or participatory principles, or

(ii) require the active participation of employees, users or stakeholders; and

(d) the organisation has not been awarded a contract for the services concerned by the contracting authority concerned [pursuant to this regulation] within the [preceding] three years.

(3) The maximum duration of the contract shall not be longer than three years.

(4) The call for competition shall make reference to Article 77 of the Public Contracts Directive.

(5) This regulation does not apply in relation to the procurement of health care services for the purposes of the NHS within the meaning and scope of the National Health Service (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013(a).

14.1 UNISON has been working with partner trade union and social enterprise representatives in Europe since the inception of the new Directive and jointly expressed its concerns regarding the ambiguous wording of the Directive:

The Directive, reflected in the draft regulations, provides reserved contracts of up to three years to organisations:

- that reinvest profits with a view to achieving the organisation's objective
- that, when distributing or re-distributing profits, do so on the basis of "participatory considerations"
- that have structures of management or ownership that are based on employee ownership or "participatory principles" or require the "active participation" of employees, users or other stakeholders

14.2 Far from reserving contracts for tightly defined co-operatives, mutuals or social enterprises, this wording would allow a contracting authority to reserve a contract for a wide variety of hybrid and private sector organisations who could arguably qualify under these definitions.

14.3 Furthermore, the UK government has chosen to modify this Article in one important respect by stating that an organisation would qualify where its structures of management or ownership were based on employee ownership or participatory principles "if and when it performs the contract". This raises further concerns that commercial enterprises could enter the market through this non-competitive means through the use of special purpose vehicles established primarily to meet these criteria.

14.4 UNISON has serious concerns that the under this regulation, those commercial enterprises in question would not even need to meet the minimal requirements set out in Article 77 to engage in the bidding process.

14.5 The Regulations and further guidance should also clarify that Regulation 75 and Regulation 76 also apply to reserved contracts. This means that reserved contracts will be subject to some kind of publicity, at the very least a prior information notice. Most importantly, it would help to clarify that the awarding principles listed in Regulation 76 (quality, continuity, accessibility etc.) also apply in the case of reserved contracts.

14.6 We believe that through additional regulation and guidance, the government should provide more tightly defined criteria that provide greater clarity as to the kinds of organisation that would qualify for reserved contracts under this new regulation. As it currently stands, it is not fit for purpose.

14.7 Transposition of Article 77 must be tightened so as to avoid purely commercial services interfering in the procedure of reserving contracts for certain social services for genuine co-operatives, mutuals or social enterprises who wish to deliver public services with a community and social not for profit ethos. For example Regulation 77(b) could be improved by clarifying that at least the *majority of profits* must be reinvested with a view to achieving the organisation's objective.

14.8 Strengthening the draft Regulations and providing guidance for contracting authorities and eligibility guidelines for economic operators (through improving the legal definition of co-operatives, mutuals and social enterprises) would provide clarity and better understanding for those contracting authorities wishing to reserve contracts.

14.9 An example of the importance of regulations is the extent to which those organisations eligible to apply for reserved contracts will have the freedom to operate in the open market. The current UK regulations appear to have been written to overcome perceived market risks in the public sector by private companies operating a social enterprise arm who don't want to be restricted by the EU public procurement regime or complex liabilities and risks that delivering public services can bring.

14.10 One way of dealing with those risks is setting up the type of hybrid organisations that goes against the principles of Article 77:

"One way of mitigating the risks is to engage a commercial partner. This is the approach adopted by MyCSP and an established model elsewhere. For example, Circle, a private sector health care partnership, uses co-ownership to share accountability and risk. The organisation comprises two elements: the Circle Partnership (49.9% of the company) is owned by its practitioner and consultant partners with shares allocated on the basis of performance and Circle International plc (50.1% of the company) is owned by a group of City financial institutions which receive shares for investment."[40]

14.11 UNISON believes that further Regulation, legal definitions and guidance should be subjected to open and full consultation and trade unions should be included as key stakeholders in that process.

[40] http://www.theguardian.com/public-leaders-network/blog/2011/sep/23/planning-for-mutual-success

14.12 These should also define the eligibility of 'Public service mutuals' or 'mutual/social enterprise spin offs' which the current government has encouraged in the health and social services.

14.13 UNISON notes that the government says *'Public Service Mutual's are defined as organisations which have: spun out from the public sector; which continue to deliver public services; and which have a significant degree of employee engagement and control.'*

14.14 Yet there is no UK legal definition or agreed definition in the mutual community of what a 'public service mutual' is and therefore they could be private for profit companies. UNISON believes that this term has been unfortunately invented by the government to help with its open public services agenda which is an agenda to allow all public services to be run by any other sector – private or mutual.

Ed mayo the Secretary General of Co-operatives UK, the national business association for co-operative and mutual enterprises said of the governments' definition of mutualisation

"There is no vote for staff in this version of mutualisation, so they can perhaps be pressed into something they don't buy into. It is not really a new model but rather good old privatisation .....the government's entry definition of mutual ownership, with a paltry 25% for staff and no rights for service users, gives no guarantees of member control and leaves investors in charge. It is a start, but when public services have been sold in this way before, such as the bus firms in the 1980s, the assets moved as night follows day from being employee-owned into private hands. We respect the right of government to try different models for public services. But with respect, we don't want to be sheep's clothing for someone else's animal, whether predator or prey." [41]

14.15 UNISON believes there is a need for a cautious approach to health and social care mutual and social enterprise spin offs advising that benefits of employee owned mutuals running public services to employees are not sustainable in the long term once these delivery models are subject to competition in the open private market and are no longer entitled to 'incubation' state support.

14.16 The most comprehensive research into the benefits of mutualising public services has been by the Association of Public Service Excellence (APSE). In their study they assert that there is no real evidence in the benefits of mutualisation of public services. The evidence of 1,600 cases studies that that they did find was:

- *A pattern of financial instability and cuts to terms and conditions of the workforce in order to meet the financial deficits;*
- *Difficulties in raising capital were evidenced as was the inability to break away from financial reliance upon the public sector;*
- *In those case studies where the model was found to be successful (just 12 of all case studies explored) a critical success factor was the continuation of a nurturing and supportive public sector; this was an essential factor to success; and*
- *The availability of longer term contracts (at least 10 years) to support financial stability*[42]

[41] http://www.guardian.co.uk/commentisfree/2013/may/03/nudge-unit-mutualisation-but-not-as-we-know-it

[42] http://www.publications.parliament.uk/pa/cm201213/cmselect/cmcomloc/112/112we07.htm

14.17 Without a clear commitment in the UK procurement Regulations to mandate and encourage contracting authorities to consider social criteria in commissioning UNISON believes that the future or public service mutuals or spin offs are not sustainable.

14.18 UNISON provided evidence to the Communities and Local Government Select Committee explaining this:

"Until procurement rules are revised to enable greater consideration of social and environmental factors, UNISON is concerned that the shift towards coops and mutuals will be a short-term one. Our concern is that when the contract for a given service is retendered in the future, the conditions will have been created to allow the private sector to effectively "clean up". Furthermore unless robust governance arrangements are put in place there is a danger that if an alternative model runs into financial difficulties mid-contract it will be ripe for a takeover by a large private company." [43]

14.19 The current UNISON estimate of 10% of Community services becoming social enterprises largely involved straight top-down management buy-outs rather than anything organic from staff.

14.20 UNISON has found no evidence from its health and local government members for an employee led drive to mutualise public services. There have been a handful of enforced top down management drives to create social enterprises in social work, libraries or community care

"Crucially, reports from UNISON branches suggest that the move to more cooperative ways of working is generally instituted by council leaders, with senior officers tasked with implementation, and with little or no involvement of the workforce or those who use services. We believe that attempting to undertake sweeping changes to the way services are designed and delivered without the input of staff and service users is a fatal error, and one that runs contrary to many of the principles of cooperative ways of working. In light of this, employee-led mutuals and not-for-profit "spin outs" begin to appear more as management buy-outs than a spontaneous expression of latent entrepreneurial spirit being unleashed in the public sector."[44]

14.21 UNISON has a strong track record working with co-operatives, mutuals and social enterprises delivering public services. We would like to see future guidance based on the principles that the TUC and Co-operatives Uk have already jointly agreed on in their publication *Public Services, Co-operatives and Mutuals Best practice guidance*[45]

14.22 The guidance calls for the government to establish quality standards in its programme of public service mutualisation and outlines a set of principles agreed between trade unions and representatives of the co-operative and mutual sector. And addresses concerns in five key areas where the two organisations have identified best practice for successful mutualisation:

[43] http://www.publications.parliament.uk/pa/cm201213/cmselect/cmcomloc/112/112we21.htm
[44] http://www.publications.parliament.uk/pa/cm201213/cmselect/cmcomloc/112/112we21.htm
[45] http://www.uk.coop/sites/storage/public/downloads/tuc_co-operatives_uk_guidance_0.pdf

- workforce engagement and consultation in the process
- governance and democracy in the mutual
- commissioning of services
- safeguarding of public assets
- employment standards

14.23 UNISON seeks further clarification that Regulation 77(5):

This regulation does not apply in relation to the procurement of health care services for the purposes of the NHS within the meaning and scope of the National Health Service (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013(a)

will apply to healthcare commissioning in England as a permanent regulation as opposed to be being part of the delay of the implementation of the light touch regime in clinical healthcare services until April 2016 as set out in 49 part 2 of the UK draft consultation document.

14.24 UNISON also notes that Article 77(5) states that *Notwithstanding Article 92, the Commission shall assess the effects of this Article and report to the European Parliament and the Council by 18 April 2019.*

Appendix 2

Briar, C., Liddell, E. and Tolich, M. (2014) 'Still working for love? Recognising skills and responsibilities of home-based care workers'. Quality in Ageing and Older Adults 15; 3.
http://www.emeraldinsight.com/doi/abs/10.1108/QAOA-04-2014-0006?journalCode=qaoa

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

Introduction

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

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

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

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

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

conditions.

The article is organised in the two parts. It begins with a description and analysis of a small in-depth study of domiciliary care work in New Zealand. It details the daily activities of an experienced domiciliary care worker, in her own words. This is followed by a discussion of some of the complex skills required by this worker and others doing the same work. The skills required tend to be tacit and hard to see (Junor, Hampson and Oge 2009; Hampson and Junor, 2005; Guy and Newman 2004: 290; Palmer and Eveline 2012: 271). It then looks at the working conditions of home-base care workers, which differ in some respects from those in residential care work.

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

Methodology: about this project

The research draws on two focus groups: one with eight women, and the other with six. The focus groups were conducted by a professional facilitator. Her notes from the debriefing sessions following the focus groups are included below. Nine of these women subsequently agreed to be interviewed by telephone and the interviews were professionally transcribed. Participants were based in a number of provincial towns across New Zealand[46] and recruitment took place with the support of a service workers union. All of these participants were providing home-based care for clients with disabilities.

Most of the workers were over 50 years old, just one in her late 30's and were female. Most had been involved in this sort of work for over 10 years, some for 15-20 years and one for over 25 years. The names of all the women quoted have been changed and the names used are all pseudonyms.

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

Each focus group discussion and interview was asked open ended questions asking the group or the interviewer to describe how they became a care worker. Supplementary questions had the care workers describe a normal day. The interviews provided rich data and the focus groups allowed participants to raise issues that were elaborated by other participants.

Both authors read the transcripts and manually coded them thematically developing fours broad themes: the workers background, their day to day responsibilities, their working conditions and how they described care work as skilled work. Together these insights form a growing body of evidence about care work, adding to job analysis interview data such as that reported by Junor, Hampson and Ogle (2009), Junor, Hampson and Smith (2009) and Hampson and Junor (2010) and Briar and Junor

[46] Ethics approval 12/285 gained from the Otago University Human Subjects Ethics Committee.

(2011).

Part I: Skills, responsibilities and working conditions

A day in the life of a domiciliary care worker

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

> I don't start till 8.30 am. I shoot down and do a 1) colostomy bag lady and monitor her. Then I go on from her to 2) a shared cared one [with another home based care worker] at 9 am which is the stroke lady and it's two persons' care. She is a large lady who won't use a hoist so it is a bit dodgy and she takes an hour. At 10 o'clock 3) I go up to a cerebral palsy man for 2 hours. Give him a quick spruce up and do his cleaning and his cooking. I've gone to him for over 25 years. I've got the key and I am basically his house carer really. I do his cooking and I also do 7 hot meals a week and pop that into the deep freeze for him. At 12 o'clock [I see] 4) a very frail elderly lady who lives with her family but they work. I just see if she needs a wee toilet trip and make sure she has something to eat. She's a half hour. At 1 o'clock 5) I go to a shared care man, he's got dementia so we do his hoisting and toileting. [She paused] and then where do I go on Monday? Um oh yes then 6) I go to a poor young man who is not 30 and has dystonia. Bright as a button, and I also do his cooking. Then at 4 pm 7) I go to my little boy who has cerebral palsy and he's been in and out of a cast and I shower him and feed him, help with his homework and all the rest. Then at 6 pm 8) I go and do a women's support stockings. She suffers from anxiety. That's 6.30 pm. I'm starting to get a headache [remembering all this]. And then 9) I go and do the shopping for the man I should do on Tuesday, I usually do it on Monday night because I have a got a gap. And then 10) I go back to do the dystonia man because he can't actually self-medicate because he can't get the wee pills out of the wee things, so I go to him. Then I go to – oh yeah at 8 o'clock-ish 11) I go and put the old man I saw at 10am to bed. That's shared care with another caregiver. And then 12) I go back to the dystonia man and give him his second lot of pills and then 13) I go to a women with multiple sclerosis at 9 pm and she's a standing hoist and we just get her into bed and that's it. So that's Monday. Saturday, Sunday, Monday, Tuesday are just insane and then the rest of the week is quite civilised.

Sylvia has a long working day, under constant pressure. She also works unsocial hours – evenings and weekends. She is out working for 13 hours a day, but is only paid for 9 hours. Because of the variety of clients' ages and conditions she needs a wide and detailed practical knowledge base and skill sets. Some of the techniques she uses would also be used in hospitals.

Skills used in home-based care work.

Building a body of knowledge

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

> [You might say to the client], look I'll do your lunch. "No, no you don't have to do my lunch, my daughter is coming". And you think: "I know you don't have a daughter, she died eleven years ago".

Most of the carers who took part in this study had been in their current roles for a many years, and had accumulated knowledge about the clients and their families.

Skills of assessment

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

> After meeting the client for the first time I called the coordinator manager and asked: "now tell me, has this lady got slight dementia?" She looked up the notes and said "yes she has". I said "fine, that's all I needed to know: so now I know why she was repeating herself". But I was not told that.

They need to start by making keen observations. They may then need to sit down with the client and/ or the family and ask a series of follow-up questions. These care workers realised that a new recruit to their occupation would not have the body of knowledge that enabled them to do this as effectively. Janice said:

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

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

Fluently dealing with complex issues

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

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

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

Coordination and time management skills

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

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

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

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

Working safely alone

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

Negotiation, tact and diplomacy

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

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

> When you are in their homes you are stepping into their *marae* [it's their territory] and you have to be so careful. Not just to the client but the whole family dynamic and I've been caught out. You know one daughter will stamp in and say, why are you doing this for mum? She is absolutely capable of doing that. And the next daughter will say poor mum, and she really does need more help.

Participants take responsibility for clients' health and wellbeing, but as Lydia explained, this has to be balanced this with tact and diplomacy to avoid offending some family members:

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

Relationship-building skills

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

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

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

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

Problem-solving skills

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

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

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

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

A strong sense of responsibility

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

Clients are often dependent for their health and safety as well as their wellbeing on the care workers.

Lydia knew the consequences of not caring could be extremely serious or even fatal.

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

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

Maintaining professional standards

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

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

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

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

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

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

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

Working conditions in home-based care work

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

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

> It's variety which I just thrive on. If you were in the rest home it would be "go shower some people".

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

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

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

Feeling valued by clients and their families

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

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

Rita also said that most family members are extremely appreciative:

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

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

Management, supervision and support

For a time the focus group became a forum in which shortcomings in management were discussed and in her debrief the focus group facilitator gave this summary:

> The group were very critical about their organisations. I don't think I heard anything positive. They obviously are very hierarchical and they are at the bottom of the heap, and the coordinators have a very powerful role.

None of the workers interviewed for this project felt that their employer took the time to value and thank them for their commitment. For example Lydia disclosed:

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

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

> Once a year the coordinating nurses come out and assess us. They ask us what we do and how we do it or watch us do it. And yeah, just sort of pass us or fix us up on different things as

> we go ….they would just come to a job where we have a shower and pretty much they stay while you do that shower and yeah, leave and that passes for another year. We get something in the mail saying, I am very confident and have a fabulous rapport with my clients and they are very happy with me.

Vulnerability to false accusations

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

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

Hours of work: no time for love?

The workers who took part in this study were keen to discuss issues surrounding their working hours. Most of the participants worked between 20 and 50 hours a week, but were not paid for all the hours they worked. Some are on 'zero hours' contracts. It was pointed out that clients' needs are variable; one size does not fit all, so half an hour may be enough for one client but not another:

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

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

Travelling between clients

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

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

Health and safety

Risks to care workers included injuries from lifting clients onto and off wheelchairs, beds, showers and toilets. As obesity becomes more common, care staff are meant to use hoists to help avoid injury.

However, Sylvia reported working with 'a large lady who won't use a hoist'. Care staff are also at risk from infections as a result of dealing with bodily fluids.

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

The stress of working under constant pressure, in isolation and feeling undervalued and unsupported can also undermine physical and mental health and wellbeing.

Working in isolation

The home-based care workers who took part in focus groups for this project were delighted to meet other care workers in their locality and in similar circumstances to themselves. They normally work in isolation, so this was a rare opportunity to share and compare experiences. The focus group facilitator said in her debriefs:

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

Some of these women work in the same occupation, for the same service providers in the same region, and yet they did not know one another. At present these employees work alone most of the time[47] except when they work with 'shared care' clients. When staff exchange ideas about clients it can be a valuable source of support, guidance and informal peer supervision which improves the quality of services.

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

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

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

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

[47] Working in isolation is also an issue in the UK, where over half of care workers surveryed (43%) do not see co-workers more than once a week, and nearly a third hardly ever see colleagues (UNISON 2013: 31).

II Discussion

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

Undervaluation of care work: links to emotional labour

Hochschild (1983) developed the notion that many service sector workers are required as part of their job to perform superficial 'emotional labour', using smiles and stock phrases, to keep the customers happy. Many studies have centred on the use of women's emotional labour (Hochschild, 1983; Tibbals, 2007; Valdez, 2011; Wharton, 2009) and particularly on the ways this has been exploited by employers (Colley, 2006:15; Herd and Meyer, 2002: 665). It has also been suggested that emotional labour is the link that produces lower wages for jobs held primarily by women (Guy and Newman, 2004: 296).

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

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

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

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

The term 'emotional labour' may therefore be too broad-brush to capture the complexity of all the professional skills required in care work. Other hidden skills of care workers include: assessment,

awareness of consequences, problem-solving, negotiation, tact and diplomacy, coordination and time management. Some work has been done on a vocabulary for describing these skills and stages for acquiring them over time (Junor et al 2009) and there is scope for developing this further in relation to care workers.

Gender, class, age, power and privilege

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

The pay and value attached to home-based paid care workers suffers from association with work done at home by family members, especially women: work that 'counts for nothing' (Waring, 1988). Even though home-based care workers are dealing with strangers whose needs are too great to be met by family, the skills required and demands are not recognised. It is primarily women who are employed as care workers (Anderson, 2003; Lopez, 2010).

Sylvia pointed out that people who are unable to get better paid, higher status work with better working conditions, typically perform care work:[48]

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

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

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

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

[48] In the UK a high proportion of new recruits to the adult social care workforce are recent imigrants and members of ethnic minority groups.

particular about activities and attributes that come 'naturally' to women.

Contesting the undervaluation of care work

Shortly after this study took place in 2013 the Service and Food Workers Union brought a successful court case under the 1972 Equal Pay Act on behalf of a group of residential aged care workers, on the basis that they are paid less than if they were not a female-dominated group[49]. Many of these workers were paid only the National Minimum Wage, whilst others earned very little more. The previous year Australian Services Union won a similar case in front of a full bench of Fair Work Australia on behalf of community sector care workers[50]. Further steps are needed. Love is not enough.

Conclusion

The care workers who took part in this project are able to judge the impact of their own work, and know what could go wrong if it was not done. They have developed keen observation, awareness of unfolding situations and the ability to quickly assess clients' needs. The challenge now is for politicians, employers and the public to recognise the knowledge and skills of care workers. Making emotional labour more visible is a first step towards making it compensable (Guy and Newman 2004: 296).

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

The care workers who took part in this project do love their jobs. They know they are making a huge difference to the lives of the people they care for. However, they feel exploited, and want to be valued for their experience, complex skills and committed, professional attitude. The focus groups did not agree with the Minister of Senior Citizens statement that 'love' is an adequate substitute for fair pay.[51] When one participant read an early draft of this paper she said its recognition of her story made her weep.

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

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

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

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

[51] A larger-scale by the report by the New Zealand Human Rights Commission (2012: 20) also found that carers feel undervalued

workers that can afford to donate their labour.

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

A caring profession?

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

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

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

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

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

Government funding constraints pose the largest obstacle to recognising, promoting and rewarding care skills, and this is affecting all of health and social care provision to some degree. However, valuing care workers’ skills would not only help protect standards of care. There is also potential for it to be more cost effective. For example, allowing sufficient time for visits, so that clients’ needs are met would reduce hospital admissions and re-admissions. Continuity in care also makes a positive

difference to the quality of clients' lives (UNISON, 2012). It is difficult for clients to maintain their dignity if they receive personal care from a series of strangers. This means it is vital that working conditions encourage staff retention. Employees who feel valued, respected and believe they are being treated fairly are more committed and less likely to leave their jobs. Staff turnover is very high in New Zealand care work, especially amongst the newer recruits, with over half lasting less than a year in the job (Human Rights Commission, 2012).

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

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

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

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