Homecare workers:

A case study of a female occupation

A research report commissioned by the
Ministry of Women's Affairs

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Foreword

In August 1997 women's average hourly earnings were 81.2 percent of men's. This relativity has remained almost unchanged over the last decade. Overseas studies suggest that the factors underlying this 'gender earnings gap' fall into three broad categories:

Human capital differences that arise from differences in work experience, educational qualifications and access to on-the-job training. These may either limit or assist progress in paid employment.

Occupational segregation, where women work in different occupations and are concentrated in a narrower range of occupations than men. The pay rates in traditionally 'male' jobs are higher than those in traditionally 'female' jobs, and women are less likely to have access to discretionary payments and other opportunities. In addition, women tend to be segregated into lower-level jobs within occupations.

Discrimination, which can be:

- *direct*, where personal characteristics that have no relevance to the job are brought into an employment decision
- *indirect*, where policies or practices appear to be fair but favour a particular group, or
- *systemic*, where an entire network of rules and practices disadvantages one group while advantaging another.

It is difficult to quantify the effects of these factors because of the paucity of data.

Over 1997 and 1998 the Ministry of Women's Affairs has commissioned four research projects relating to the gender earnings gap, as part of its continuing work on women's labour market participation and lifetime earnings. The aim of this research is to improve understanding of how the factors underlying the 'gender earnings gap' operate in the New Zealand context and how they might be addressed. The research projects explore:

- projections of the gender earnings gap over the next five years, given current industry trends (published January and September 1997)
- changes in occupational segregation by sex between 1981 and 1996
- the factors that affect the pay and conditions of work for employees in a female dominated industry
- the extent to which a particular and increasingly common remuneration system might discriminate against women or provide opportunities to improve remuneration outcomes for women relative to men.

This, the third report, is a case study of homecare workers. Homecare workers are a largely female group of employees who work for service provider agencies. Research has commonly found that employees in this industry are likely to receive low wages and have poor conditions of work. The study draws on the experience of a small selection of homecare service providers, homecare workers and other key informants. It identifies the features that lead to undervaluing of this work and resulting low rates of remuneration and how they in turn are linked with quality issues in service provision.

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The Ministry of Women's Affairs gender earnings gap research reports can be obtained from:

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Executive Summary

This New Zealand research supports the international literature findings that homecare work is predominantly carried out by women, is low paid, and requires skills which are not formally recognised and not valued or recompensed. As such, homecare work almost certainly contributes to the gender earnings gap.

The six agencies included in the study paid hourly rates for both household management and personal care within the range $8.40 to $10.77 an hour, with lower rates (some below the minimum wage) for overnight stays. None of the agencies in the study offered secure hours, leaving workers vulnerable to fluctuations in their hours. Only one of the agencies in the study encouraged workers to accept work from other agencies; the remaining five actively discouraged this. None of the agencies paid for time taken to travel between clients, and three of the six agencies in the study paid no travel costs at all. Time spent negotiating arrangements for new or existing clients with coordinators, discussing time sheets and performance appraisals, and the extra time needed to complete tasks on the care plan, was all mostly unpaid. In addition, all workers at some time do extra work and/or stay longer to talk with their clients. When these unpaid costs and time are taken into account, the effective hourly rates of pay are considerably lower than the nominal rates.

Factors affecting wages and conditions

Four factors affect the wages and conditions of homecare workers: labour market segmentation; the role of the government as funder; contract definition; and the value ascribed to homecare work.

Labour market segmentation

Homecare work fits within the group of industries which has low barriers of entry and competition, and where the costs of turnover are generally lower than the costs of recruitment and training. Workers who have few job options become concentrated in these low paid jobs. The study found that, as in other countries, homecare work is a job option for women (even for those who have formal skills and training) who are looking for employment which fits in with family responsibilities, who are re-entering the labour market, or who want to supplement a benefit or other family income.

The role of government as funder

United States literature suggests that the large role of government in paying for and regulating homecare services may be a more important factor in maintaining low wages and conditions than labour market segmentation. In New Zealand, the Health Funding Authority (HFA) and the Accident Rehabilitation and Compensation Insurance Corporation (ACC) fund most homecare, and service provider agencies are dependent on contracts with these funders for their survival. These funders are able to effectively set prices which in turn have an impact on the pay and conditions of homecare workers.

The impact of contracts

The contracts with funders shape the employment practices in the industry, both in terms of positive effects such as health and safety procedures, and performance

appraisals — and negative effects such as no requirement to pay for travel time between clients, or reimburse for travel costs.

Studies in other western countries show that the trend to move from direct employment of workers to competitive contracting in the service sector tends to have a negative impact on jobs, remuneration and conditions, with women being more adversely affected than men. The New Zealand study was too small to be conclusive about the impact of competition of wages in the homecare environment. Even so, results were consistent with the literature findings that competition tends to depress remuneration overall. There was some evidence that competition may also be counterproductive in terms of achieving quality care and efficient distribution of resources.

The way homecare work is valued

Two documented factors combine to give a low value to homecare work: failing to describe the true nature of the work, and the impact of gender on homecare as an occupation.

The emotional contribution of homecare workers and the personalised, day-to-day needs assessments they undertake tend to be minimised, and the extent and importance of the social contact for clients are not fully ascribed. All research involving interviews with homecare workers about their job suggests that these tasks are almost always part of the caring role, and sometimes done outside the hours for which they are contracted. The same result was found in this study.

The literature suggests that the sex of the worker performing the job is a stronger predictor of the compensation for that job than education, experience or unionisation. Both the women who do the actual work, as well as other women and men, often hold the opinion that work predominantly performed by women is of low value, especially if it is also done unpaid within the home. Because of women's 'caring' role within families, homecare workers have a sense of obligation and 'no choice' over meeting the needs of others who are vulnerable. Moreover, nurturing and caring are seen as an integral part of women's identity, roles which women find meaningful and fulfilling.

Other literature suggests that skills are identified on a gender-linked basis which leads to a lack of recognition of women's skills. In the case of homecare, it is argued that emotional care, in particular, has been discounted because caring and nurturing are not valued by men. Hence the focus in job descriptions is on concrete tasks, rendering invisible such skills as emotional support, communication, personal care skills and companionship. The ability to separate the emotional and practical components of homecare is strongly contested.

Clients in this study, while wanting to have their practical needs met (and to their own personal standards) also highly value — and even expected — a positive, caring relationship with their worker, and preferred not to have visits from multiple caregivers.

Quality issues

From the worker perspective, the literature identifies access to training and supervision, and not being required to do additional tasks, as important to the quality of care. Other factors identified in the literature were the importance of workers having information about clients, contact with peers and clear accountability.

Most providers in the study do not have difficulty recruiting homecare workers with appropriate skills and experience, and some organisations reported waiting lists of people wanting the work. Turnover is high in some agencies, and for some women, homecare is a stepping stone to higher paid work.

The resources devoted to training and the quality of training delivered are variable. In most of the agencies in the study, training was unpaid, and only half the workers interviewed had taken part in any training sessions. There are no industry training standards or external review procedures. The main barrier to offering comprehensive training to all workers is cost.

Most agencies in the study had high ratios of carer to care manager, which meant that homecare workers had very little personal contact with a supervisor and only limited contact with their peers.

Issues for Mäori

In this small study there was no discernible difference between the wages of Mäori and non-Mäori. There were differences, however, in some conditions experienced by Mäori homecare workers. They experienced a more relaxed employment environment within a Mäori agency, where tasks were less prescribed, so that emotional and spiritual care could be included as an integral part of the service.

For Mäori, the best person to care for them may often be a member of their whanau. The two Mäori providers in the study were set up to enable immediate whanau to be paid as care workers, a practice which was uncommon (or not allowed) in the other agencies. For Mäori clients the homecare worker in most instances becomes part of the whanau, and therefore expectations of the work of the care worker are somewhat different from those of non-Mäori.

All but one of the Mäori homecare workers in the Mäori agencies in this study said they would prefer to have a service run by Mäori for Mäori, and the Mäori clients in the study agreed. This has implications for the way in which services are structured and, more importantly, for the way services are funded.

None of the non-Mäori service providers interviewed had policies that explicitly recognised tikanga Mäori. One HFA assessment agency was carrying out a needs survey of Mäori clients, and anticipates that the findings of its survey will flow through to providers offering services to Mäori.

Among the non-Mäori providers there was little evidence of direct training or instruction in cultural sensitivity. This study found that racism from clients had been experienced at some time by most of the small number of Mäori and Pacific Island

workers in the non-Mäori agencies. In such situations, agency management appeared willing to move workers to other clients as a solution.

Policy issues

The research identified the following policy issues:

- The need for comprehensive data on the homecare industry. This would enable a better understanding of the links between wages and conditions, job valuing and quality. The data would also provide a basis for monitoring changes within the sector.

- The importance of accurately describing homecare work to allow evaluation and benchmarking relative to other comparable work, and to acknowledge the value of its ‘caring’ component.

- The need to improve employment contracts for workers. Central government agencies and the funders of homecare services need to be explicit about what is meant by the ‘good employer’ requirements of existing statutes and contracts. Homecare agencies, unions and other bargaining agents have a role in developing an appropriate minimum employment code for the industry, addressing, in particular, payment for currently unpaid travel time and training, health and safety, core hour clauses, pay, and insurance coverage.

- Policies which establish realistic pricing for contracts in the industry.

- The importance of introducing standards for training.

- Strategies to enhance the quality and effectiveness of homecare services. These may include contracting the provider agencies to make professional judgements about changes to the quantity and type of care provided; and ensuring that all homecare workers get adequate training, support and performance appraisal to enable them to carry out the client monitoring role effectively, a role that is currently not formally acknowledged.

- The need to review some of the existing policies and structures in order to promote efficiency.

- The need to adapt the assessment process so that it takes full account of the emotional, spiritual and cultural needs of clients.

- The desire of Mäori for a review of assessment and provision of services.

- The particular desire of Mäori to enable the employment of family members to provide care.

- Attention to the gap between men’s and women’s real earnings, as well as nominal earnings.

Introduction

Purpose of the study

The Ministry of Women's Affairs commissioned this study as part of its programme of work on the gender earnings gap. The aims of the research were to:

- Investigate the factors which affect the wages and conditions of homecare workers, in particular:
  - how homecare work is described and valued from the perspective of funders, assessors, homecare service agencies, clients and homecare workers
  - any mechanisms or structural factors, both formal and informal, which result in, or reinforce, the undervaluing of homecare work
  - the impact of employment practices and contracting homecare services on job security, wages, conditions of employment, training, and health and safety.
- Draw out any findings on how pay and conditions affect the quality of homecare.
- Identify Mäori perspectives on the homecare tasks and their value, and if and how Mäori homecare workers fare differently from non-Mäori homecare workers.
- Make recommendations concerning policy implications of the research findings and possible future research and identify best practice initiatives.

Defining homecare and homecare workers

'Homecare' is generally categorised into two kinds of work. 'Personal care' includes showering, bathing, drying, dressing, shaving, hair-washing, feeding, and toileting. 'Household management' includes vacuuming, dusting, washing floors, washing and drying clothes, cleaning, preparing meals and shopping.

The focus of this study is on homecare workers who are formally employed by agencies and paid to undertake personal and hygiene care and household management within the homes of clients needing support owing to frailty, disability, illness or accident. It does not include unpaid family members (who are estimated to undertake approximately 75 percent of all care), family members paid on a one-off basis to provide care, or those providing care on a voluntary or substantially voluntary basis, such as Meals on Wheels volunteers. It also excludes those who contract on their own account directly with clients, and district health nurses and other allied health professionals employed by public hospitals.

Methodology

Data for this small national study carried out between April and May 1998 were gathered from several sources:

Secondary data

A national and international review of the literature on homecare work was carried out, with particular regard to employment practices, contracting, job security, wages, conditions of employment, training, and health and safety.

Primary data

The primary research was designed to gather information from homecare workers, their employers and their clients. A summary of the research and the question schedules for the interviews is available as a separate technical report from the Ministry of Women's Affairs.

The research approach was to take a vertical slice of the homecare industry in order to explore the relationships between the two main government funders, the Health Funding Authority (HFA) and the Accident Rehabilitation and Compensation Insurance Corporation (ACC); the assessors who decide on the need for care services; the agencies contracted to provide services; the workers employed by the agencies; and clients of the agencies.

Those involved in the study included:

Homecare service providers

Six agencies were selected from a list of those contracted or subcontracted for homecare services by two of the four regional operations of the HFA: the HFA, North Office (two agencies) and the HFA, Central Office (four agencies). The researchers made a purposeful selection which was representative of larger national agencies, small agencies, and regional and Mäori agencies. Of the six service providers, two employed approximately 700 workers, one employed 400 workers, another employed 150, and the two Mäori agencies both employed fewer than 35 workers.

Homecare Workers

Twenty-eight homecare workers were interviewed. The selection process involved a random selection of up to 100 workers from each provider (depending on the size of the agency) who were given the opportunity by their employer to opt out of the research. The list of workers was supplied to the researchers, who randomly selected five workers per agency. The researchers then telephoned those selected to invite them to take part in the study. An interview time was arranged and the worker was sent information about the study and a consent form. In one very small Mäori agency it was possible to interview only three workers. Ten of the 28 workers interviewed were Mäori.

Clients

Up to 20 clients were randomly selected by each provider and invited to participate directly in the research by returning a signed form to the researchers. It had been intended to interview 18 clients (three from each provider) but the final number was 15, of whom 12 were receiving household management service and three were receiving

personal care. It appeared that clients receiving personal care were less inclined to be part of the study.

Other key informants

The field research was supported by interviews with key informants within the homecare industry, who included:

- Ministry of Health staff responsible for the home care policy and standards
- ACC staff responsible for homecare policy and standards
- managers from three funding agencies: two HFA regional divisions (North Office and Central Office, who were selected to take account of different funding regimes and geographic location), and the Otahuhu Branch of the ACC (selected because it was within the HFA, North Office region)
- assessors from three agencies responsible for assessing client need: Facilitated Access to Coordinated Services (FACS) in the HFA, Central Office area; a hospital-based service in the HFA, North Office providing assessment of clients over 65 years old; and an independent contractor to the ACC
- Service Workers Union and Nurses Association representatives
- representatives from the Home Support Association and a small selection of hospital-based homecare, rest home, and private hospital service providers.

The research boundaries were developed through discussions with a number of key informants, researchers, and other individuals knowledgeable about the industry.

Limitations

Although the field research design aimed to provide reasonable coverage of the different funding and contractual arrangements for homecare work, and to maximise findings for Mäori, it involved only a very small number of providers, care workers and clients. The results, therefore, cannot be generalised to homecare arrangements throughout New Zealand.

The size of the study also means that the results cannot be used to make a meaningful comparison of the remuneration practices of non-profit and for-profit agencies, nor of Mäori and non-Mäori agencies. Because of the size of the study, no attempt was made to identify any differences for Pacific Island or other ethnic groups.

Steering group

A steering group was established by the Ministry of Women's Affairs to assist in the framing and management of the project. The members were:

Claire Dominick	Ministry of Health
Luci Highfield	Service Workers Union
Prue Hyman	Victoria University of Wellington

Heather McDonald	Ministry of Women's Affairs
Jean Mitaera	Policy Consultant
Anne Riley	Ministry of Women's Affairs
Pania Te Whaiti	Victoria University of Wellington.

Homecare Services in New Zealand

Accessing homecare

Individuals who need homecare gain access to services in different ways, depending on their type of need. Using a publicly provided service involves:

- the individual client undergoing a needs assessment
- an individual or agency being contracted to provide the specific homecare service
- payment for the service by the funding agency.

The funding of homecare services to disability, acute, and accident clients, and the policies underpinning their provision, differ:

- *Disability*: Access to services is through the needs assessment process for Disability Support Services (DSS). DSS services are intended to complement the role of family, friends, and local community services and are generally fully subsidised for people who have an income-tested Community Services Card. People who do not qualify for the subsidy can choose to organise their own homecare.
- The four regional divisions of the Health Funding Authority (HFA) contract providers to supply DSS homecare services. There are differences between the regions in the processes used, the extent of choice for clients, and competition between providers, which are discussed further below.
- *Acute:* People requiring homecare owing to post-operative and acute conditions are assessed for short-term service needs by public hospitals. Homecare is provided if no family care is available. It is generally not income-tested, but if clients need continuing care they will be transferred to the DSS needs assessment process. Some hospitals employ homecare workers directly, while others contract services from external providers. The HFA, Southern Offices regional division has integrated its contracts for acute and homecare services.
- *Accident-related:* People requiring homecare services as a result of an accident have their needs assessed by the ACC, typically by an independent assessor. In most cases individuals then directly contract their own homecare worker; otherwise the ACC contracts an agency to provide services to them. As an insurance-based scheme, ACC homecare is fully funded, and aims to compensate for individual incapacity, rather than to complement family care.

Informal and other associated care services

The provision of income maintenance benefits to clients and, in limited circumstances, to their family carers, helps partners and other family members to undertake care on a full-time basis. Relief care for full-time family carers is a key interface between formal and informal care systems. The government also contracts with and provides grants to

voluntary organisations, and provides assistance with housing costs, to help meet particular needs. Lottery grants and private charity are further sources of funding assistance for individuals and non-profit services.

Services to Mäori

Mäori have access to services through these same structures. Funders, assessors and service providers differ in their strategies to address the needs of Mäori clients in an equitable way.

Mechanisms for funding, assessment, and service provision

Most formal homecare in New Zealand is funded by a third party, usually the HFA or the ACC. Independent needs assessment and service co-ordination have been progressively introduced since 1993. The separation of the assessment process, the funding decisions, and the provision of homecare services are part of a general move to improve efficiency. In most cases this has also involved competitive tendering for contracts for homecare services. In this discussion we refer to assessment for homecare services only, not the broader needs assessment process. The specific roles within the health and accident-related sectors are described below.

DSS homecare services funded by the HFA

The Ministry of Health sets national guidelines for funding DSS services, including homecare, and allocates funds to the HFA according to a population-based formula. Access to full subsidies for those with a Community Services Card is also a national policy. The assessment process is largely determined by the conditions imposed by the HFA. Each of the four regional HFA divisions has different approaches to funding homecare and the location of budget management. As part of the research, the approaches of the HFA, Central Office and the HFA, North Office were examined.

HFA, Central Office

The HFA, Central Office has contracts with 26 agencies, which it accredits as homecare providers, and pays on a fee-for-service basis. The contracts are generally for two years and involve the payment of a specified fee, negotiated separately with each agency, for household management and personal care. Agencies are not guaranteed any particular quantity of work, and compete for clients. The HFA, Central Office aims to ensure that there is a choice of at least two agencies for clients in most areas and regards client choice as an important driver of quality.

The HFA, Central Office has established Facilitated Access to Coordinated Services (FACS) groups in each public hospital area to which it delegates population-based funding. FACS assessors identify client needs, including needs for homecare and relief care, and determine the nature of the homecare service to be provided and the hours that will be allocated. Any change in the level or type of care to be provided is decided by FACS and then communicated to the provider agency. Each FACS has a Mäori disability service and is required to provide service coordinators who are Mäori. Service coordinators carry out assessments using the support needs assessment system also used in two other HFA regions, Midland Office and Southern Offices.

The HFA, Central Office indicated it does not have a formula to determine the share of the DSS budget to be devoted to homecare services. It experienced a 68 percent increase in expenditure on homecare and carer relief in 1996/97, which put pressure on its overall budget, and in 1997/98 budgeted for a significant decrease.

HFA, North Office

HFA, North Office has 27 homecare providers which are all non-profit, and are contracted to provide a specified amount of homecare services within a specified budget.

Contracts generally run for three years, although three providers were placed on one-year contracts until concerns about services were addressed. The HFA, North Office has contracts with a broad range of agencies, including Mäori and Pacific Island providers, to ensure an appropriate range of services, and aims to work in partnership with providers to maintain and improve quality. It pays carer relief for full-time family carers directly to the family, who organise their own substitute care.

The HFA, North Office uses a consensus approach to determine the size of the homecare budget. It stated it struggles with the issue of equity between different needs, and that it had a waiting list of 400 for homecare services at the time the research was being carried out.

Assessors determine the level of need and the broad categories of services required, such as routine domestic work, personal care, shopping or social support. The assessment goes to the provider chosen by the client, and it is the provider who then decides how the needs will be met and the hours that will be allocated.

ACC

The ACC has recently moved from strictly regulated provisions governing the quantity of homecare that could be provided, to a system which enables discretion over the quantity of care and an emphasis on achieving rehabilitation goals. It contracts independent assessors, who tender for the work and may be registered with the ACC only for specific services. Assessors make recommendations about the service required. Clients, who can generally request a particular assessor, have the right to appeal and can then be seen by another assessor.

Clients usually find their own providers of homecare, who can be family members, and the ACC is only now moving into contracts with providers and assessors, with some branches looking at setting up a competitive model for homecare provision. Branches currently pay a higher fee-for-service rate to agencies, and a lower rate to family members.

The homecare industry

No comprehensive analysis of the New Zealand homecare industry has been undertaken. The industry is dominated by DSS contracts for homecare services, and payments from HFA budgets estimated to total approximately $100 million nationwide a year. No robust statistics are available on the number of people working in the industry.

A wide range of agencies provides homecare services, including hospitals, private businesses and non-profit organisations. Policy changes over the last ten to fifteen years have increased the diversity of provision, with fewer homecare services now being provided directly by the public health system. Diversity among providers has also been stimulated by the goal of providing culturally appropriate DSS homecare services and giving clients a choice of provider.

Self-employment, employment and minimum conditions

Self-employment in the industry is not easy to estimate. Until recently, it was not uncommon for homecare workers to be 'self-employed' contractors to the service provider agencies, which in turn had contracts with the then independent regional health authorities (RHAs).

However, a 1997 Court of Appeal case (*Cashman & Ors* v *Central Regional Health Authority* [1996] 2 ERNZ 159) ruled that the homecare workers (who brought the case) fell within the definition of 'homeworkers' under the Employment Contracts Act 1991 and were therefore entitled to the benefit of the minimum code of rights granted to employees. This means workers are covered by grievance and other procedures contained in the Employment Contracts Act 1991, the minimum wage provision of $7.00 an hour for a worker over 20, and the Holidays Act 1981. The homeworker provision in the Employment Contracts Act was carried over from the Labour Relations Act in recognition of the fact that these workers are not in the position of having bargaining power which would allow them to contract beneficial working conditions as genuinely independent contractors.

Employees in the industry have low levels of unionisation, and their wages and conditions, skills, gender, ethnicity, job security and duration have not so far been analysed in any comprehensive way.

Regardless of the *Cashman* decision, there is still some blurring of the distinction between voluntary work, paid employment and self-employment in the industry. In particular, there are issues around the employment conditions for relief care workers (who relieve for full-time family carers, typically stay overnight and are paid on half- and full-day rates) and the employment and payment levels of family members. The extent of informal private arrangements, and the range of payment involved, are also unknown.

Growth

The homecare industry is growing in all developed countries, and New Zealand is no exception. This growth has been spurred on by a number of overlapping factors, including:

- increased numbers of elderly
- technological change which makes it possible to provide treatments at home that previously had to take place in hospital
- earlier discharge of patients from hospital

- substitution of homecare for institutional care for people with disabilities or a degenerative condition
- substitution of nursing care with care by skilled and semi-skilled workers (for example, the move of district nurses out of direct provision of care in private homes and into the management of home-based services)
- greater emphasis on the values of individualisation, dignity, privacy, autonomy and normalisation, which follows through into a desire for more consumer choice
- reduced supply of family carers available to carry out care unpaid, and the increased assertiveness of family carers about their own needs and rights.

Less certainty over boundaries

A further trend is the blurring of the definitions of 'homecare' and 'institutional care', as assisted and group living situations develop, along with the need to offer a greater range of assistance to clients (Kane, 1995). Ungerson (1997) argues that the boundaries between paid and unpaid work are also overlapping, with trends towards more marketised systems of care. These are designed to tap into voluntary and private providers, and an increase in token payments as a cost-effective way to mobilise and reinforce household and family networks and voluntary care. Evers (1994), in his assessment of changes to care of the elderly, notes the greater tendency to negotiate mixes of formal and informal care.

In New Zealand, individual needs for services are — in all cases apart from those funded by the ACC — determined as supplements to the care that is available within the family. Studies of family care have, however, noted the importance of formal homecare services in maintaining the quality of family care (Belgrave and Brown, 1997).

Wages and Conditions in the Homecare Industry

The literature identifies the vulnerability of homecare workers to low wages and poor conditions and relates this to isolation, difficulty in organising workers, financial hardship, the imprecisely defined nature of the employment relationship, and inequalities in the bargaining powers between the parties.

In the United States, research indicates the homecare workforce is poorly paid and transient, with agencies reporting high turnover rates as well as shortages of workers in some areas. Homecare wages lag behind those for similar jobs in nursing homes and hospitals and for other unskilled, non-supervisory jobs in the local economy. Homecare workers also face unpredictable hours and have few fringe benefits (Brodkin Sacks, 1990; MacAdam, 1993).

Wages and conditions of homecare workers in New Zealand

The *Cashman* court case referred to in the previous section cited evidence of the isolation of homecare workers, and poor conditions such as little job security, no holiday or sick pay, and lack of training. The present research confirmed this, and the general findings in the literature that homecare workers are low paid. The table below summarises wages and conditions in the six agencies in the study.

Pay And Conditions in the Six Homecare Agencies

Issue	**Research Findings**
Standard provisions	• All contracts contained the minimum leave provisions are mandated in the Employment Contracts Act and the Holidays Act; that is, entitlement to three weeks' holiday pay after 12 months, days-in-lieu for working statutory holidays, and five days' special leave after six months, on a pro rata basis. • One agency had no formal contract.
Hours of work	• No agency offered secure hours — all workers had varied hours. • The Range in the research group was 2–35+ hours a week. Workers providing services to clients with high need are particularly vulnerable to fluctuating hours when clients go into hospital.
Hourly pay	• \$8.40–\$10.77 for household management • \$9.00–\$10.77 for personal care. Few workers earned more than \$10.50. Some wages were higher owing to historical factors. One agency had a scale to reflect experience and performance. • Rates for overnight stays were lower.
Skills/other requirements for job	• Agencies required, or could require, a police check. • Previous experience is required for personal care work. • Communication skills. • Caring, reliable, compassionate. • Car in working order and phone (required by most agencies).

Pay And Conditions in the Six Homecare Agencies	
Issue	**Research Findings**
Transport costs	• Three agencies paid nothing. • Others varied from 30c/km for mileage over 10 km a day between clients to 40c/km for all mileage between clients.
Costs/risks of taking client shopping	• Two agencies had formal agreements that clients paid mileage for shopping. • Workers could ask clients for money in other agencies. • No agency ensures workers are covered by insurance while transporting clients.
Equipment costs	• Most agencies provided equipment, although some workers provided their own gloves. • Additional washing of own clothes as a result of work was done by the worker.
Training	• Five agencies provided training – three provided in-house training free of charge. • One agency paid for two hours' training and meetings per month. • One agency paid for two initial hours, and required a further six sessions per year. • Three agencies provided all training on an unpaid basis. • No agencies are linked to NZ Qualifications Authority framework as yet.
Unpaid work (non-optional)	• Travel time between clients (all agencies). • Negotiating arrangements for new or existing clients with coordinators. • Discussing time sheets and performance appraisals. • Assisting with organising relief care (some agencies). • Extra time to complete tasks on care plan.
Other unpaid work	• Many workers reported doing extra tasks for clients, and/or staying longer to chat.
Freedom to take on other employment	• One agency had a restraint of trade clause in its contract. • Two agencies required workers to seek permission to take on other work. • One agency discouraged other work. • One agency accepted, and another encouraged, other work.
Redundancy	• Two agencies had redundancy provisions in contract in lieu of notice (two weeks and four weeks).

Comparison of wages and conditions with others providing care

The ordinary hourly pay rates paid by a selection of employers to homecare workers in personal health, and aids and assistants providing personal care in rest homes and private hospitals, ranged between $7.50 and $11.19 an hour. This compares with a range of $8.40 to $10.77 an hour in the six agencies in the study, and average female ordinary time hourly earnings of $14.98 hour (QES, February 1998).

The lowest remuneration was for the provision of overnight care, which three of the agencies in the research provided. One agency paid $7.50 an hour; another paid $70.00 per nine-hour night with additional payments if the worker had to assist the client during the night; and the third paid $52 for 4.00 pm–9.00 am, or $38 for 9.00 pm–7.00 am. Some of the agencies in the study indicated they were not prepared to employ workers on rates that were below the minimum hourly wage ($7.00 an hour for those aged 20 or over).

The conditions offered to homecare workers in institutional settings, including personal homecare providers based in a hospital, were superior to those available to workers in the agencies studied. These comparisons are based on confidential telephone interviews with a small selection of rest homes, private hospitals, hospital-based homecare providers and employee representatives:

- None of the agencies in the survey provided any security of hours, and homecare workers are effectively casualised. In contrast, most workers providing care in institutions, or homecare from a hospital base, had guaranteed hours, typically part-time, with optional additional hours on occasion. Agencies were aware of the impact such insecurity could have on workers. As one manager said, 'the ideal person for homecare work is not a breadwinner; it is a person with a husband or wife who supports them.'

- Workers in the six agencies personally carry a number of the direct costs of their employment. Most notably, travel time is not paid, and they bear all or part of the costs of using their own transport to travel from client to client, and sometimes to provide a shopping service for the client. In addition, most of those we interviewed spent extra time with some clients, and/or did extra jobs for them.

- Shifts for workers in the institutions and hospital-based homecare were at least three hours, and usually four or five hours. Assignments for workers in the agencies were as short as half an hour, and rarely more than two hours.

- Hospital-based homecare workers were paid travel allowances between 57 cents and 72 cents a kilometre. Three of the agencies in the survey paid no travel allowance, and the other three paid between 30 cents and 40 cents a kilometre for some or all daily travel.

- All the agencies in the study employed workers on the statutory minimum requirements, and none paid overtime or penal rates. Several of the institutions and hospitals had more generous conditions. Workers in this study also had difficulty taking leave, a factor not raised by workers in rest homes or hospitals.

The effective hourly pay rates of homecare workers in the study

When travel costs, including unpaid time, are taken into account, the actual remuneration of agency workers for time spent in client contact or travelling between clients is considerably less than the hourly rate paid for 'eligible' hours.

Using the Inland Revenue allowable travel expense of 62c/km for self-employed people as a benchmark for full travel cost compensation, and cases developed from the study, some examples of effective gross hourly pay rates are:

- *Worker A:* seven clients, 15 hours' client work over four days; hourly pay rate $10.00; 40 kilometres travelled between clients (1.5 hours a week); no travel allowance. Her effective hourly rate is $7.59. With an extra 0.5 hours a week of unpaid activities, that rate falls to $7.36.

- *Worker B:* 12 clients, 28 hours' client work over five days; hourly pay rate $9.38; 100 kilometres travelled between clients (3.0 hours a week); travel allowance of 40 cents a kilometre. Her effective hourly rate is $7.76. With an extra 0.5 hours a week of unpaid activities, that rate falls to $7.63.

- *Worker C:* two clients, four hours' client work over two days; hourly pay rate $9.00; 15 kilometres travelled between clients (0.5 hours a week); no travel allowance. Her effective hourly rate is $5.93. With an extra 0.5 hours a week of unpaid activities, that rate falls to $5.34.

- *Worker D:* ten clients, 20 hours' client work over five days; hourly pay rate $8.90; 80 kilometres travelled between clients (2.5 hours a week); travel allowance of 30 cents a kilometre for travel over 10 kilometres a day. Her effective hourly rate is $6.11. With an extra 0.5 hours a week of unpaid activities, that rate falls to $5.97.

The Impact of Employment Practices on Pay, Conditions, and Quality

This section describes the links between pay, conditions and quality and discusses the influences of market conditions and institutional arrangements on employment practices, and how they affect job security, wages, conditions of employment and health and safety. In particular, we explore how employment practices are affected by contracts between the funders and service providers (the homecare agencies), the funders and the assessors, and the providers and the workers. Underpinning these visible arrangements and practices are the beliefs about the nature of the industry and the nature of the job. These issues, and how undervaluing particular kinds of work depresses remuneration, are discussed in the next section of the report.

Links between pay, conditions and quality

The existence of synergies between positive working conditions, improved productivity, and quality services is supported by a growing body of evidence, including the results of strategies aiming at providing equal employment opportunities. In New Zealand and elsewhere, firms are finding that fair treatment of workers can improve public relations, morale and staff commitment, lower absenteeism and turnover, and improve understanding of client needs. Firms that contract for services can also sell the relationship between quality staff and quality service as a tendering advantage (Burns, 1997).

The links between homecare workers' satisfaction with the job and conditions and the quality of their work does not appear to have been addressed comprehensively in the literature, although homecare managers generally believe that this link exists (Feldman, Sapienz and Kane, 1990).

A major United States study concluded that providing additional benefits and improved conditions for homecare workers has a positive effect on key indicators such as staff turnover, and the length of time clients and carers stay happily matched (Feldman, Sapienz and Kane, 1990). The case studies were carried out in five urban settings, with the additional costs underwritten by an outside agency. The study found training can mitigate loneliness, a factor in job turnover, and that job satisfaction can be improved through supervisor support and task variety, in addition to increased payment. The authors concluded that the financial weakness of the industry, and the risks for agencies of not getting a guaranteed return on any investment in improving conditions and training, made it unlikely that they would make these investments from their own pockets, even though they generally understood the benefits. Some policies, such as guaranteeing hours, were also difficult because of their contracting arrangements.

What determines employment practices?

Homecare work is low paid, even though research suggests that the work is not unskilled. There are several interrelated theories as to why this is so — exploring why workers stay in the homecare industry despite the pay and conditions, and why they do extra tasks and sometimes unpaid hours. Other factors are labour market segmentation,

the role of the government as funder, and contract definition, which are discussed below.

Labour market segmentation

The price and conditions for any job are influenced by market conditions. One view on low wages is that certain industries tend to be 'poor payers' because of pressure to keep costs down as a result of the low barriers of entry and the level of competition, and the costs of turnover being generally lower than the costs of recruitment and training. As a consequence, those industries are unable to provide stable employment and higher wages. The homecare industry in New Zealand appears to fit this description.

Workers who have few job options because of discrimination and/or personal circumstances become concentrated in these industries, taking on these jobs from lack of choice. Women and migrants form the bulk of homecare workers in the United States, and the homecare market has been an important source of first jobs for women who were on welfare (Aronson and Neysmith, 1996).

In the agencies in the sample, most workers shared the characteristics of a secondary or peripheral labour force that has a particularly limited range of jobs open to it. Most of the workers in all agencies were women. Because two of the six agencies in the sample were Mäori service providers, it is not possible to draw valid conclusions on the overall proportion of workers in the industry who are Mäori, or from Pacific Island or other ethnic groups. Of those interviewed, several had taken a significant break from the paid workforce because of family responsibilities or unemployment, and were keen to re-establish their work history. Many of the workers in the research had formal skills and training. Over one-third wanted to earn some income in hours that fitted in with their responsibilities for children and/or family businesses, and another significant group were older women, generally on their own. Most of the women interviewed had access to some other income or resources apart from their homecare earning — either the resources of a partner, or a social welfare benefit.

The role of government as funder

Regardless of the weighting of factors that maintain a supply of homecare workers at low pay rates, funding formulas have a key impact on remuneration arrangements and levels. Burbridge (1993) considers that in the United States, the large role of the government in paying for and regulating homecare may be a more important factor in maintaining low wages and conditions than labour market segmentation. MacAdam (1993) reinforced this view in her study of why the market does not clear, and reduce, labour shortages through more competitive remuneration. Likely reasons she noted were the financial fragility of provider organisations, contracts which did not compensate adequately for high-need cases, and costs of meeting regulations that were too high. The cost-containment motivation for reducing institutional care also sits uncomfortably with the greater costs associated with providing the same intensity of care through home-based services.

The dominant position of the HFA and ACC

The dominant position of the HFA and ACC as funders and the importance of their business to the survival of the service providers, accentuated by inter-agency competition, means they are effectively able to set prices and develop contracts in a way that limits the ability of agencies to provide secure employment.

The HFA contracts were the dominant source of funds for the service providers interviewed. For four agencies they provided as much as 90 percent, and in all cases at least 50 percent, of the agency's total income. This dominance, in tandem with the actual or potential competition in the marketplace, means that funders can effectively dictate prices. ACC branches tended to fix rates for their area, but the HFA, North Office and the HFA, Central Office negotiate rates, based to some extent on historical factors, through benchmarking local homecare wage rates. The HFA, North Office separates its payment into an hourly fee for service and a management fee, the latter calculated from client numbers. The HFA, Central Office pays a higher hourly fee for service for personal care than household management.

The agencies in the research cited difficulties in affording more competitive remuneration for higher skilled workers, or to improve their retention rates, when this was an issue, and felt they had little, if any, ability to alter those rates. One service provider reported that the HFA had told it that unless it put up a tender at the minimum fee level suggested, it would be unlikely to get the contract again. Another experienced a drop in its contract price, and then discovered that other agencies operating in the same area were being paid more.

In the same way that homecare workers are effectively 'price takers' and in a limited bargaining position when seeking employment, the providers in the survey also appeared to be virtually 'price takers' in the contract negotiation process. Few of the agencies were willing to disclose the rates they were receiving from the HFA, but our impression was that, overall, contract prices resulted in very narrow margins above labour costs.

The fixed fee paid by ACC branches are commonly lower than the rates paid by the HFA in the same region. Two of the agencies that provided services to the ACC commented that some of their ACC contracts were not paying their way, but that they took them on in order to diversify their funding base.

The providers varied in how they approached remuneration of their employees and whether, for example, they provided a pay scale for advancement, or paid training or travelling allowances. One provided all of these, but several provided none. The researchers were not able, however, to ascertain how much average compensation varied between agencies, or the differences in their margins.

Contract definition

The contracts with funders shape the employment practices in the industry. The providers interviewed, with one exception, had in place employment practices which responded directly to the requirements of the contracts for DSS services to provide training. Similarly, they all had health and safety procedures and most had, or were developing, performance appraisal systems. On the other hand, none of the funders required the payment of travel time, and no employees in the study received any payment to cover the costs of time spent travelling.

The impact of contracting arrangements on employment practices

Comparing a budget approach with specified service levels

A budget that can be used flexibly for care has the scope to tailor the job and the time it takes directly to the client's needs. This funding approach has also been criticised for expanding the areas of home-based care that are turned into a commodity or paid for. When such budgets are tightly controlled, under-provision can result. This approach can also be unattractive to providers in terms of their exposure to risk, and in the United States, it is argued to be a factor in some major homecare providers selling out of the industry (Snow, 1997b).

Another approach is to fund on a fee-for-service basis, that is, linked to specified service levels. Unconstrained, this exposes funders to budget risk, opening the door to pressure from service providers and clients for increased service provision, since measuring need and functional disability is not an exact process. When budgets are too tightly controlled, it may also make it difficult for providers to plan services, meet expected standards and provide continuous employment.

The HFA, Central Office and the ACC both contract agencies on a fee-for-service basis, to provide clients with the specific number of hours of care determined in the assessment process. The HFA, North Office has a mixed system: it allocates a budget to agencies as a generalised payment for a specified total quantity of care, but leaves decisions on the mix of care to meet the assessed needs of individual clients up to those agencies.

HFA, North Office approach

The flexibility for service providers in the HFA, North Office appears to have a number of benefits for maximising staff skills, encouraging innovation and efficient use of resources and, at least potentially, providing homecare workers with a greater sense of control, and ability to negotiate, over their work.

Agencies that have contracts with the HFA, North Office are able to make independent decisions about:

- *Changing the number of hours of care a client receives:* One care manager commented that this meant the clients did not feel they 'owned' the hours. It also means the process of care workers negotiating extra time with certain clients is easier because the decision can be made within the agency, without a referral back to the assessor.

- *What service to provide:* For one provider this has meant instituting a 'tuck-in' service where pairs of workers spend a very short time with clients each evening to deliver personal care such as showering and ensure they were safe for the night.

This approach also enabled the agencies to be more responsive to clients and allowed them to be more flexible in how they use workers, for example 'buddying' workers at the beginning of a new assignment when some extra jobs may need to be done.

Specified service levels

Specified service levels, on the other hand, may make it easier for service providers to manage limited resources because they are at arm's length from allocation decisions. There is also the possibility, however, that service providers and clients will work together to advocate for increased services, since other options for improving or altering services are not open to them. Moreover, because measuring need and functional disability is not an exact process, the specification of hours during the assessment process is more likely to lead to an undersupply or oversupply of service to clients, with consequent pressures on workers when clients have had insufficient amounts of care allocated.

The managers of agencies with specified service level contracts also reported high compliance costs. For the HFA, Central Office contracts, the delegation of budget responsibility to its FACS groups introduced more complexity, with providers needing to supply the HFA office with data to match the FACS information before receiving payments.

Competitive contracting

Investigations in Northern Ireland, England and Australia show that the trend to move from direct employment of workers to competitive contracting in the service sector tends to have a negative impact on jobs, remuneration and conditions, with women being more adversely affected than men. The main efficiency gains from contracting out tend to derive from improved labour productivity, which is driven by greater flexibility in work practices (Mulgan, 1997). Female-intensive jobs have been more directly affected, so women tend to experience proportionately more job loss than men, and proportionately greater reduction in full-time jobs, hours of work, and wages. The general experience of workers after contracting out was greater physical and/or mental pressure on the job. Pressure came from monitoring systems, as well as from reduced numbers of workers.

A study of the impact of contracting out the New South Wales Government Cleaning Service on women workers with a non-English speaking background, found that reductions in conditions, entitlements and job security affected all workers, but that workers with a non-English speaking background also often experienced increased harassment (Fraser, 1997). Worker representatives can find it more difficult to negotiate in a contracting environment, as the service agencies do not have as much flexibility about employment terms, because of their lack of budget control.

An Equal Opportunities Commission for Northern Ireland study (1996) revealed that contracting out led to variable responses on training, both increases and decreases. Trade union officials observed different treatment of male-dominated and female-dominated jobs, with men's jobs being more likely to be professionally sized and described for contracting purposes. Women's jobs, on the other hand, often had vague job descriptions, which left them more vulnerable to management demands.

Behind the contracting trend is the pressure to increase productivity. A report by the Office of the Status of Women in Australia suggests that responses to pressures to improve productivity have tended to vary. Male-dominated industries approach the challenge through 'functional flexibility', in broadbanding, multi-skilling and increased training. In female-dominated industries, on the other hand, the approach has been one of 'numerical flexibility', that is, increasing the proportion of those working part-time and casually (Hall, cited in Freytag, 1997).

The impact of contracting in the study

The present study was too small to be conclusive about the impact of competition on wages in the homecare environment. Results were consistent, however, with the literature findings that competition tends to depress remuneration overall.

Workers providing homecare for personal health clients from a public hospital base (a non-competitive environment) had hourly wages similar to those or other workers, but better overall remuneration. The ACC, the funder which arguably operates the most competitive model for homecare provision, generally pays service providers, whether self-employed workers or agencies, a lower overall fee for services than the HFA does. The most common hourly rates paid to workers were $8.50 to $9.50 an hour for household management and $9.50 to $10.50 an hour for personal care. These rates applied in all regions of the study. Lower contract prices for agencies appeared to reduce conditions overall and not simply by changes to ordinary-time hourly wage rates.

One argument in favour of competition — that it can increase productivity — was not evident as a goal in the funding arrangements. All the contracts were paid on hours worked rather than 'products delivered', although the difficulty and costs of measuring homecare quality for diverse clients may well preclude this as a serious option. There was no evidence that the FACS role in budget-holding in the HFA, Central Office favoured 'faster' providers. A common perception among managers and care coordinators was that the FACS assessment process was cutting the time available for particular tasks such as showering. One agency in the HFA, Central Office area argued that the tendering process, by diverting resources, actually reduced productivity. Other problems that emerged were the failure of contract prices to deal adequately with costs such as servicing rural areas. Some agencies also cited difficulties with set-up and technology costs.

The casualised nature of the homecare worker contracts confirms the Australian picture of a female-dominated industry improving productivity through 'numerical flexibility', that is, increasing the proportion of employees working part-time and casually, thereby improving the ratio of hours worked to hours paid for. Most agencies felt they had little or no ability to pay for hours that were not spent with clients. One expressed a particular grievance that the FACS was unwilling to reimburse the agency for a worker's time when the worker had failed to notify the agency that the client was no longer receiving care.

Even so, providers were generally keen to improve quality in ways that would also be more beneficial for the homecare workers — through multi-skilling and increased training. Three of them commented that they were looking at ways to provide some security of hours and including paid travel time for a core of higher skilled workers in order to improve their responsiveness. Several said it was preferable for service quality

to have one worker performing both household management and personal care services, but they did not have enough personal care workers to enable this to happen.

Competitive tendering compared with a contestable contracting model

From this small study, the researchers gained the impression that there were no obvious benefits, and some inefficiencies, resulting from the directly competitive model within the HFA, Central Office compared with the contestable contracting model employed by the HFA, North Office.

In both cases, large providers dominated in some geographical areas. The audit process in the HFA, North Office, the limited term contracts, and the contracting of more than one provider in most areas provided a quality and efficiency lever. The directly competitive model, on the other hand, introduced an element of stress for providers in that they could offer even less security to their workers. Those providers were also more likely to raise problems related to investment in infrastructure, and longer-term approaches to training.

Competition may actually be counter-productive. One provider, not included in this research, raised concerns about price dominating over quality in contract negotiations, with larger providers forcing down contract prices across the board. A manager of hospital-based homecare workers noted that being able to guarantee hours meant workers were likely to report that a client needed less care.

Both Mäori service providers commented that is was unhelpful to be 'battling' other Mäori providers rather than working together, and that the competition meant service provision was uncoordinated. As small providers, they also saw particular problems arising from the costs of technology in a competitive environment — the IT programme for one area cost $9,000. In order to gain a homecare contract, the agency subcontracted its administration to another homecare organisation, which has led to risks to confidentiality when clients switch from one provider to the other.

A further issue raised by one provider was the cost of providing rural services.

The impact of funding on client behaviour

Clients using DSS-subsidised homecare services through the health sector rarely regarded the service as an entitlement, and often presented themselves as being powerless to influence decisions on services, but grateful for what they got and 'not being one to complain'. On the other hand, the one service provider who had significant numbers of ACC clients noted that those clients were conscious of their 'entitlements' and that a broader range of services was expected than under DSS provisions. Some saw this as being appropriate, owing to the greater trauma and disruption experienced in the case of accidents, although others thought there was over-provision of DSS services.

The agencies interviewed had very few privately paying clients. Most agencies were of the view that people with homecare needs who were not eligible for a DSS subsidy either did not use homecare, or the homecare was being provided by individuals working privately, often 'under the table'. Concerns raised about these informal arrangements included training, safety for clients and workers, and consequences for tax revenue and benefit expenditure.

Quality issues

Recruitment and turnover

The six agencies in the study had quite different experiences in ease of recruitment and staff turnover. Most did not have difficulty recruiting homecare workers with appropriate skills and experience, although several were cautious about not ‘wasting’ workers with personal care skills on housework. According to one service provider, this is the reverse of the situation two to three years ago, when the demand for homecare was increasing sharply and ‘we couldn’t afford to be fussy’. Some organisations had waiting lists of people wanting the work.

Turnover of workers varied widely, from approximately 50 percent to ‘very minimal’. Managers from the organisations with high turnover suggested that they were employing people, some of whom are new migrants, with very few skills, and helping them to up-skill, thereby giving them the confidence and background to move into higher paying work. This was usually thought to be in a rest home, where there are guaranteed hours, equal or higher hourly rates, and workers do not have to provide their own transport. Homecare work is seen to be a stepping stone for many people. Some managers also noted that the lack of full-time work, the pay rates, and no recognition of travel time contribute to turnover. Another factor in turnover was the proportion of workers chosen by clients, as many of them do not carry on with homecare work once their client’s allocation comes to an end.

Training

The literature is not definitive on the impact of contracting services on training. The researchers’ assessment is that, although training is part of providers’ contracts with the HFA, the resources devoted to training, and undoubtedly the quality of training delivered, are variable. There are no industry training standards or external review procedures.

Five of the agencies offered some form of training to homecare workers. Three of the agencies provided this training in-house, and sometimes paid outside people to assist. Another agency was working with the New Zealand Employment Service to offer a training course, and the fifth had contracted an outside agency to do the training but, because of cost, offered this only to selected workers.

Several agencies were interested in investigating links with a national framework. Various initiatives to link in with one of the two existing Industry Training Organisations (ITOs) which provide related training, or to set up an new ITO for the homecare industry, have begun within the sector. One agency commented that it would not be able to afford ITO fees and the cost of workplace assessors. One provider also expressed doubts as to whether the training would be the most effective way to meet its particular needs.

The main barrier to offering comprehensive training to all workers is cost. With the exception of the one agency which trained selected individuals in small groups, the bulk of training provided was generic, with all workers together in a lecture setting. Several providers had orientation training, which workers were supposed to attend before they started work, but this was not always possible. All six had written orientation material,

and some oriented new workers on a one-to-one basis. Most training was unpaid, although one agency paid for all training, and required workers to attend at least half the training sessions. Not being paid for training was a barrier to attendance for some workers, and thus a quality risk. Only half the homecare workers in the study had attended a training course but, of those who had, most thought the training was valuable.

Only one of the agencies in the study provided regular training sessions for its homecare managers. Most of the homecare managers or coordinators interviewed felt confident of their technical skills such as assessment and quality control, but one group said that they felt that they should be given management training to improve the skills and knowledge needed for interviewing, the legal aspects of contracted employment, budgeting, and adult education.

Health and safety of homecare workers and clients

Most homecare managers indicated that they felt the biggest risks in homecare assignments were to the safety of their homecare workers — rather than the client. Risks they identified included those associated with poor hygiene (including fleas and rats), violent clients, and sexual harassment. The health and safety checks on the first visit to the client was the main vehicle to protect against such dangers. Advice to workers on health and safety issues was evident in the orientation brochures and training materials of most agencies. The contracts rely on high level guidelines rather than developed industry standards.

Although homecare managers commented that they would negotiate an assignment with the assessing agency if there was a safety issue, the research also suggested that certain workers were allocated more difficult clients. There appeared to be some variability in the willingness of agencies to turn down work, and it appeared some might transfer a difficult client to a more assertive or skilled worker rather than drop that client. Thus there was an implicit reliance on workers with extra skills doing more difficult tasks, but not usually for more pay.

Injury was raised more frequently as an issue by workers, and a few commented that their back or occupational overuse (OOS) injuries had not been accepted by either their agency or the ACC. A particular problem facing this group of workers is the difficulty they have in demonstrating work as the place of the accident, owing to the fact that they undertake similar tasks at home. Although training in lifting was fairly common, several workers commented that they or others had not received adequate training in this area, and that client-specific training was also needed. At least two agencies screen applicants so that they do not employ workers with pre-existing back or OOS injury.

Racism from clients had been experienced at some time by most of the small number of Mäori and Pacific Island workers in the study. Agency management did not focus on this as an issue, but generally appeared willing to move workers in this situation.

Management and supervision

Most of the agencies in the study had high ratios of homecare workers to homecare managers. The experience of nearly all the workers is that they have very little personal contact with the homecare manager or coordinator — and in some cases workers had more than one. The general view was that the homecare managers or coordinators 'have

too much on their plate'. This could mean that they were not available to the workers when they telephoned for advice or information, but in some agencies it also meant that regular quality supervision of performance assessment is practically impossible.

How Homecare Work is Described and Valued, and How this Affects the Quality of Care

This section discusses the key factors affecting the valuing of homecare work — explicit and implicit — by funders of homecare services, the service provider agencies in the study, the assessors, the homecare workers, and the clients.

Factors affecting the valuing of homecare work

The literature suggests two influences that combine to give a low value to homecare work: failing to ascribe the full value of the work, and the impact of gender on homecare as an occupation.

Society's response to professions that involve a caring component is complex. Homecare work is an excellent example of work performed predominantly by women. It is work that involves the use of practical knowledge, skills and tools often used in the home for no payment and in which the aspects of the job that require the use of communication and caring skills are understated or ignored.

A failure to ascribe the full value

The valuing of homecare work is influenced by the extent to which the work is seen to include skills other than the practical tasks of cleaning a house or bathing and showering a client. The skills and knowledge used in homecare work are often also carried out in non-paid situations in the home. This domestic application is regarded as outside the 'real' labour market and therefore less complex and less important, a belief which almost certainly influences attitudes to homecare work.

Studies indicate that the emotional input and personalised need assessment undertaken by homecare workers tends to be minimised, and that skills and competence in homecare services do not receive formal recognition or compensation. There is, however, some evidence that providers recognise the contribution of nursing skills in the provision of personal care (Carpinter, 1995).

All research involving interviews with homecare workers about their job suggests that, whether or not social contact is defined as part of the duties, it is almost always part of the caring role, and sometimes done outside the hours for which they are contracted. New Zealand studies concur with this finding (Munford, 1992; Scott, 1997).

The literature suggests that a common pattern is for workers to tailor activity to client need rather than routinely undertake practical tasks. It also stresses the importance of a worker being familiar with, and listening to, the client. Homecare workers not infrequently extend themselves beyond the formal boundaries of their paid jobs into more informal ties and activities — including sharing meals, and contacting clients when not on the job. Workers carry an emotional as well as a physical load. As one worker in this study said, 'You can't forget about it at the end of the day'.

There is a mix of motives for this high level of involvement, ranging from moral obligation, or kindness, to a pragmatic response to insecure work conditions. In Aronson

and Neysmith's study, workers reported being tired and anxious when the time allotted to clients was reduced, but that they felt committed to doing the same amount of work as before. Increased client numbers also made relationship-building more difficult.

Baer and Gordon (1996) see the undervaluing of the care component of nursing as a factor in the replacement of nurses by untrained care assistants. In the case of para-professional workers in institutional settings in the United States, Brodkin Sacks (1990) argues that the failure of unions to take on the issue of unrecognised skills in the 1970s led to cutbacks affecting these workers most in the 1980s.

In a study of quality assurance in homecare, Eustis, Kane and Fischer (1993) concluded that homecare jobs would be more rewarding, and enable higher quality care, if workers had more contact with supervisors and peers, more information about client and care plans, more authority and clearer accountability.

The impact of gender

Labour market patterns of occupation, gender segregation and associated salary differences are well documented. Renwick (1984) maintains that the sex of the worker performing the job is a stronger predictor of the compensation for that job than education, experience or unionisation. The opinion that the work predominantly performed by women is of low value is often held not only by the women who do the actual work, but also by other women, as well as men.

One literature stream links back to the gender-based expectation of care within families, which leads to a sense of obligation and essentially 'no choice' for women when it comes to meeting the needs of other people who are vulnerable. Thus the same pressures that lead to women undertaking a disproportionate share of unpaid caring work within families also leads them to do more than they are paid for in 'caring' occupations. In Aronson and Neysmith's study, the isolation of homecare work reinforces this pressure, particularly as supervisors get larger caseloads. One supervisor acknowledged that the fact that homecare workers could be pressured into responding and 'being used' enabled the supervisor to carry out her own tasks. Similarly, another example cited shows that the client's own family members also try to exact personalised labour from the workers. Race and class divisions reinforce workers' poor negotiating position with families. Munford's study (1990) noted the operation of rewards and sanctions that reinforced these internalised obligations for both paid and unpaid carers.

Other literature stresses nurturing and caring as an integral part of women's identity, and that women undertake these roles, not simply because they have been assigned to them, but because they are meaningful and fulfilling. For some, knowledge that they make a difference compensates for poor wages and lack of autonomy. In contrast, the characteristics which are ascribed to men as 'natural' or innate are also used in a variety of occupations dominated by men. However, work that involves the use of strength or large muscle coordination, such as labouring, building and lifting, usually attracts a higher level of remuneration than work that requires dexterity or small muscle movements, such as typing, sewing, assembly line packing, or drying fragile skin.

Another trend identified in the literature relates the valuing of the job to the general thesis that skills are determined on a gender basis and that this leads to a lack of recognition of women's skills. In the case of homecare, emotional care in particular has

been discounted because caring and nurturing are not sufficiently valued by men. Hence the focus in job descriptions is on concrete tasks, while skills such as emotional support, communication skills, personal care skills and companionship are rendered invisible.

The assumption that emotional care can be separated from personal care is strongly contested. Several writers have identified components of care within work and family settings, drawing out the contribution of 'knowing the patient' to rehabilitation or illness management (Tanner et al, 1996), including qualities such as acting in the best interests of others, sensitivity, and having sufficient time allocated to meet needs effectively (Tarlow, 1996). Poole and Issacs (1997) argue that the gender-based division of labour has resulted in a division of emotion which perpetuates notions of masculine and feminine, and may explain why, even in the same workplace, women and men gain validation for their worth in different ways, which often leads to gender-based inequalities of power and status.

Judgements made about the degree of complexity and difficulty associated with the use of different equipment used in occupations dominated by women and men also contribute to the assessment of value. Although all the employees may be responsible for the operation and simple maintenance of such machines, there is often an assumption that the machines men use are more complex and difficult to operate. This is particularly true if the machines being used by woman are those also used in the home, such as vacuum cleaners and floor polishers.

The following discussion explores the ways in which homecare work is described and valued from the perspective of funders, assessors, homecare service provider agencies, clients and homecare workers.

Funders

The description and value of homecare work from the perspective of the funder can be deduced in two ways: first, from the place of homecare work in health care policy and the quality standards set for that care, and second, from the actual funding allocated.

Policy and standards

The Ministry of Health standards for home-based services (June 1995) state: 'Home based health and disability support services allow people to remain in their own home, where they often feel the most comfortable and in control. It is important, therefore, that personal care and domestic services provided in the home meet both the client's needs and appropriate quality standards.'

Of particular relevance to this study are the requirements that:

- "The clients' knowledge and experience of disability must be respected, and their background, age, beliefs and values must be taken into account.

- Clients have the right to choose and change their caregiver.

- Providers have criteria for selection, assessment and review of workers, an equal opportunities policy, and fair employment conditions and practices.

- Providers have training and career development programmes and supervision, support and stress management.

- The interests, personality and culture, as well as needs and skills of the client are taken into account when ‘matching’ careworkers with clients.

- The client is actively empowered to take responsibility for themselves, including making decisions about daily routines and lifestyle.

- Care workers accept the advice from the client, for example, on the preferred way of transferring from bed to chair, and are considerate of the client’s feelings when performing intimate personal tasks.

- The client’s wish to carry out certain tasks him/herself is respected and encouraged.

- Processes used to develop care plans and develop home-based services are culturally safe; that is, they recognise and are compatible with the client’s cultural values, beliefs and needs.

- Policies and procedures reflect the importance of cultural sensitivity in delivering home-based care services to Mäori, to Pacific Island people, and people from other ethnic groups.

- Careworkers are aware of the impact of their own culture upon people from other cultures, particularly Mäori.”

Both the documentation from and interviews with the three funders (the HFA, North Office; the HFA, Central Office; and the ACC) confirm the key place of homecare work in supporting a health policy which aims to maintain people with a disability in the community and in their own home. Although a key goal of the ACC is rehabilitation, all three agencies seek to maximise the independent functioning of the person with a disability.

The policy is supported by some clear messages about the quality of the homecare being funded, and the roles and responsibilities of both clients and the homecare workers. The contractual requirements on providers by the HFA, North Office reflect the Ministry of Health standards for home-based services and include details of the nature of the care to be provided, or not to be provided, and the quality of the employment conditions of the homecare workers. The explicit message is that there is a link between quality workers and quality care.

The documentation also implies that the work being provided is based on care as much as tasks. It also requires attention to the cultural needs or wishes of clients, the need to treat them with respect and dignity, the need to involve the family or whanau in care decisions, the right of clients to have the service delivered in the way they prefer, and that the personal safety of clients and homecare workers will be protected. There is an explicit requirement that clients have the right to be matched with a person of their own ethnic group if this is what they prefer.

Although the level of detail differs between the HFA, North Office and the HFA, Central Office contracts, there are obligations on the service provider to be a good employer. This refers to section 56 of the State Sector Act 1988 and requires a 'personnel policy containing provisions generally accepted as necessary for the fair and proper treatment of employees in all aspects of their employment ...'. The contract requires the provision of training, supervision and performance appraisal, but does not specify any good employer requirements in relation to the remuneration of homecare work. Overall, there does appear to be an expectation that people 'off the street' without maturity or experience would not be employed to provide this service. The ACC has not yet developed formal contracts at this level of detail with homecare providers, but anticipates the Ministry of Health standards will be a starting point for it also.

The dollar 'value' ascribed to the work, however, seems to be somewhat at variance with the written 'value' ascribed to homecare by the funders themselves, as described below.

Contract prices

No standardised set hourly rate is allocated to service providers for homecare work. The tender process and the subsequent negotiation appear to have created a situation where some providers are able to argue for a higher hourly rate than others. The hourly rate is supposed to cover personnel functions associated with the employment of staff such as leave, training and supervision but, as discussed in the previous section, this does not always happen. Only one agency paid for all training, and homecare workers are not paid for time travelling between clients. None of the 'non-client contact' time, such as telephoning to report on the condition of a client, an activity which can affect the quality of care the client receives, is in paid time. Moreover, if there are financial disincentives for care workers to up-skill themselves, or to spend time reporting to the homecare manager or coordinator, the funding allocated may also directly affect client safety. The care dimension of homecare work required by the funder is not reflected in the contract price.

The assessment process

The ACC uses a common assessment tool for everyone. There is a slight variation in the assessment tools used under the HFA systems, depending on whether a person is over 65 years or in some other disability category.

The quality standards for the assessment process and the assessors are client-centred and emphasise a needs based (rather than a clinical or diagnostic) approach to assessment. The Ministry of Health *Standards for Needs Assessment for People with Disabilities* (June 1994) sets out clients' rights and responsibilities, including the following statements:

- You have the right to be treated with dignity and respect.
- Your knowledge and experience of disability must be respected.
- Your cultural background, beliefs and values must be taken into account during your needs assessment.

- You may decide who will or will not be present at your needs assessment.
- You must be informed about your rights and responsibilities in the needs assessment process before you agree to take part.

Each of the three assessment processes examined is carried out using standardised forms. The ACC assessment form does not specifically mention mental or emotional needs, but the assessment forms of the two other funders do have a section on mental function. This includes items such as memory, motivation, mood problems, anxiety and insight. Both forms have a section in which spiritual or cultural needs can be noted, although there are no prompts in these sections. The physical needs of the clients are extensively documented. Apart from clients who have specific mental health problems, the care plans that link the assessment to the service to be delivered are exclusively task-orientated, for example, washing floors, ironing, dressing or bed sponging. This is also true when the care plan is developed by the provider. This description minimises the actual complexity of the care being provided.

The literature from Northern Ireland suggests that, in contracting out, there is a tendency to provide minimal descriptions of work done predominantly by women, in contrast to the work done by men, which was observed to be described more fully and to be professionally ‘sized’ (Equal Opportunities Commission for Northern Ireland, 1996). The care plan descriptions resulting from the assessment process support this observation. All assessors know that the needs they identify may not be able to be provided for by a formal service. This may be because funding limitations mean that priority has to be given to meeting other needs; it may be because of a policy decision to encourage a volunteer approach to ‘lower level’ needs; or it may be because there are no appropriate service providers in the area, for example, to provide care for someone with a very specific disability. Within the HFA, Central Office, any policy decision by the FACS not to fund needs at a particular level has a direct effect on both the client and the income of the homecare worker.

There appear to be few mechanisms by which assessors would know the extent to which the services have been provided or the quality of what is provided. They have no direct relationship with the providers and may not see the client again for another year, unless, in the HFA, Central Office, there is a request from the provider for a reassessment of the hours. Agencies contracted to the HFA, Central Office commented that such a request is sometimes treated as being a bid for more business, and getting reassessments can be difficult.

Aspects of the assessment process seem to place value on providing the service according to quality standards. It would also seem, however, that the ‘quality’ aspects of the assessment process have little relationship to an actual quality outcome for clients — particularly in terms of having their emotional or spiritual needs met in the way that service is provided.

The service providers

The service providers professed belief about the value and nature of the work, especially personal care, is that it is worth more than the pay it receives and is generally underestimated.

Ways in which 'value' is demonstrated

Although a provider's ability to fully deliver on its contract in terms of being a good employer appears limited, the fact that most of the providers interviewed believe that there should be appropriate induction, training and support for the worker indicates a belief in the worth of the employee to the organisation. In practice, five agencies provide training, the majority of it unpaid, and vary in the quality of their induction and support processes. There are some ideological differences between the providers in terms of the way they value the training. For example, one provider said that if workers valued the training, they should pay for it themselves, as the opportunity to 'graduate' from housework to personal care is of positive benefit to workers — since it is a move which will attract a higher hourly rate.

There is demonstrated concern (articulated in some homecare workers' handbooks and in the behaviour of the coordinators or case managers) that the workers should not be exploited by clients' demands that they extend the 'care' into unpaid time or into inappropriate activities. Although this is partly driven by a need to protect the client from 'care' outside of the expertise of the homecare worker, it is also an acknowledgement that the worker is vulnerable to this sort of demand. This confirms the literature which illustrates that clients and their family members may try to exact personalised care from the workers. The present research shows that the efforts of the providers are only partially successful, in that a high incidence of extra work is being performed, sometimes in the homecare worker's own time.

Literature on clients' experiences highlights the value they attach to workers with whom they have a stable and personalised relationship. Providers, and homecare managers in particular, are fully aware that what makes a difference is that workers are able to interact with the clients, and that clients feel that the worker personally cares about them. Therefore the 'added value' to the client is a dimension which is not part of the funding contract. The task plans tend not to take account of the time it can take for homecare workers to maintain the client's independence as much as possible. This requirement is described in some of the homecare worker handbooks, and in one worker's job description, but homecare workers generally recognised it as part of their role. Two homecare workers described situations where the care plan stipulated that they take the clients shopping, but the clients' conditions (Alzheimers and a mental health problem) meant the shopping took much more time than was allocated. Providers are aware that providing a quality service to clients can involve 'extra' time, effort or tasks for homecare workers.

Providers contracted to the HFA, North Office believe they can exercise a little more control over the quality of the service outcomes because they have control of the allocation of service hours. This allows them to 'juggle' the hours of homecare workers between clients. Providers contracted to the HFA, Central Office are much more dependent on the policy and budget decisions of the FACS intermediary.

Homecare service providers interviewed generally believe that the fee-for-service rate allocated by the funder is inadequate to meet the demands of providing good pay and employment conditions for workers, quality services to clients, or an ability to develop the business in ways which might support a more efficient service, for example, through technological developments. They are all aware, at least in theory, of the link

between these issues in that competent, trained and well-supported staff are more likely to meet the specific and varied needs of the clients.

Providers generally regard the hourly rate being paid to the workers as low, and most believe that the pay rates do not reflect the nature of the work that the workers actually do and their important role in monitoring the well-being of the clients. One employer suggested most homecare workers did not seek employment in the sector for money because the pay is so poor — 'the place really runs on heart'. Managers were also clear about the value of nursing skills to the job and were keen to have more staff with nursing and similar backgrounds.

Another issue is that, although there is a small difference between the hourly rates for housework and personal care (sometimes as little as a dollar an hour), and both roles involve some 'emotional work', there is a significant skill difference between the two roles which is not adequately recognised.

Some providers try to compensate for the low wages and poor conditions by trying to ensure that workers have sufficient hours of work (not always easy to guarantee) and that they provide work in the same geographical area to reduce unpaid travel time. Employing fewer workers for more hours would be of benefit to most workers in terms of their weekly income, and would also benefit employers by reducing administration costs.

Other employer initiatives designed to enhance the quality of the job include the provision of social occasions to facilitate the workers getting together, and developing support systems such as training programmes and structured processes to provide feedback to workers on their performance.

Care managers

The role of the homecare managers or coordinators is pivotal in terms of assuring that the service needs of clients are met and workers are supported. Three of the providers interviewed employ 400 to 700 workers and provide services to 900 to 2000 clients, and the scale of these operations emphasises the need for training and quality supervision. As this research has highlighted, however, the high ratio of homecare workers to homecare managers means that regular quality supervision or performance assessment is not always a reality.

Homecare managers recruit, induct, train, support, deal with grievances and organise replacement workers. Depending on whether they are in the HFA, Central Office or the HFA, North Office area, they either develop or implement the care plan, regularly review the clients' needs, and are the first port of call if there are any problems.

Although the research indicates that homecare managers understand what is involved in homecare work, including the emotional demands on workers, some feel unable to provide the level of support they consider is required, and attribute this to the constraints of funding. As care managers are in between the employer and the workers, they are therefore caught between their own judgement of the needs of both the homecare workers and the clients, seeing both the possibilities for development and the constraints of time and resources.

Several homecare managers are aware that homecare workers can be 'put upon' or emotionally blackmailed into doing extra work for clients, and see their role as empowering workers to say 'no' to clients. Some managers mentioned the fact that they actively discourage workers from giving their home phone numbers to clients but, in practice, a majority of the homecare workers spoken to do so. They say they do this because it is more efficient for clients or their families to notify the worker directly about any changes (if, for example, the client will be away for the day or is going into hospital), rather than go through the care manager. As one homecare manager noted, however, it may also be because many women have difficulty in refusing someone who is vulnerable and in need.

Homecare managers in all agencies surveyed were female and many have a nursing or social service background. Their pay rates vary considerably from agency to agency and, not surprisingly, they had mixed views on the adequacy of their pay. Unlike the workers, homecare managers are employed on fixed-hour contracts and get paid for their travelling and training time. They identified that their work is increasing in complexity because clients tend now to have a higher level of need, and there are fewer other community resources or supports to help them manage to stay in their own homes.

Even though many homecare workers expressed frustration at not being able to get hold of their managers when they needed them, many also expressed appreciation for some of the personal support they had received after the death of a family member, or the death or suicide of a client. One organisation provided access to counselling for workers who experienced trauma.

The homecare workers

The researchers were struck by the contrast between the overt value of the work as expressed through the actual remuneration, the nature of the work actually delivered for that amount, and the positive attitude held by the workers about their service to clients.

Research suggests that the majority of homecare workers under-describe or undervalue the work they perform — both household management work and personal care. They are well able to describe the extent and depth of their role, including the emotional and communication skills required, and they know it is 'not just housework', but are likely to say that it is 'just common sense' or 'something that all women know how to do'. The majority of workers also referred to women's stereotypical attributes, such as an ability to show empathy, gentleness, good communication, tolerance, caring, patience — as well as the virtues of good humour, respect, honesty, trustworthiness, dedication and punctuality. Their perceptions of the work they do are described below.

Household management skills

Some homecare workers identified a range of other skills they regularly applied in household management. These skills included:

- using initiative, for example, in an emergency, or encouraging a client to see a doctor; or moving objects to make the environment safer for the client

- being observant of the health status of the client, such as noticing bed sores, deterioration in eating, mobility problems, or changing mental health

- problem-solving with the client, for example, working out which accounts have to be paid next, and how to budget money
- being flexible so they can meet client needs, and being quick to pick up instructions
- facilitating communication between clients and family members
- time management, so the care plan is adhered to within the allotted time
- basic nursing or first aid skills, as most of the clients are very frail.

Three of those interviewed said that, even for household management, homecare workers should be given some basic nursing training and first aid, 'even if it is just putting the person in the recovery position'. One homecare worker, who is a registered nurse, thinks that it is essential that all workers are at least able to read signs and symptoms of problems regularly affecting the elderly or those confined to bed. These include, for example, skin problems, risks of infection in diabetics (knowing, for instance, not to cut toe-nails in case of a cut which becomes infected), low blood pressure, diabetic coma and poor eating. She believes that all homecare workers need to have some knowledge of how infirmity and disability affect people's lives — whether through old age or sudden disability.

Although household management work does not imply any responsibility for the client's medical condition, often the homecare worker is the only person to visit the client that day, or even that week, and workers are aware of this implicit responsibility.

Personal care skills

Some workers also minimised the skills and knowledge required for personal care. They may have looked after elderly relatives, and during the interviews they brushed aside the skills needed to do this work. Others named some of the skills and knowledge needed, which included:

- lifting skills
- practical and physical skills involved in showering and bathing physically weak or disabled people
- communication skills, persuasion, and sensitivity required to help people overcome embarrassment and accept help with bathing or showering
- skills involved in maintaining a high standard of hygiene; washing people; dealing with people with bowel and bladder incontinence and regularly cleaning up after them as well as bathing them.

One homecare worker, who is a nurse, said that she feels strongly that homecare workers should be involved in the reassessment of personal care clients as the worker has the most intimate knowledge of the client's changing needs. She is concerned that the current system, in which workers have minimal contact with the homecare manager or coordinator, 'puts the worker at the bottom of the heap' and does not acknowledge

the role that they play in maintaining safe, appropriate, and quality community health services.

Homecare workers who provide personal care had often worked as nurses or rest home workers, and many were older women returning to the workforce. They are acutely aware of the low pay and realise that the employer relies on their previous experience to deliver the service. The recruitment of these women relies on the fact that the women 'value' the work they do and may find it difficult to obtain other work.

Other skills and issues

The services provided by homecare workers may be delivered in situations which many people would find difficult to deal with, but homecare workers see as just part of the job. The researchers personally witnessed workers dealing with one client who was extremely rude, difficult and offensive, and another who had significant memory loss and was slightly disorientated.

A majority of homecare workers spoken with were concerned to provide quality care, and all see themselves as performing a valuable service to the community. They know that it is hard for many of the clients to have to accept such intimate help. The workers interviewed frequently talked of 'putting themselves in the client's shoes' and of treating them as they would like to be treated themselves. This involves providing 'proper, dignified care', and they provide this as if the client were family. The research showed that they have no doubt that their work is appreciated by clients and their whanau or family.

One of the ways in which homecare workers directly contribute to their clients' well-being is in monitoring a client's condition and reporting it to the homecare managers, as they may be the only person regularly visiting that person. The majority of homecare workers interviewed recognised that this is a responsible role but do not always think that their employer adequately prepares them for it. One worker said, 'We are as important in the community as nurses'.

The workers considered they were underpaid for the work they perform — especially those who perform personal care — and most considered the unreliability of the hours and the unpaid time was unacceptable. For those who are fully dependent on homecare work as their primary source of income the situation can be critical. Some of those interviewed pondered on why society does not value the care they are providing to the elderly and disabled. It is interesting that none of the homecare workers interviewed blamed the agencies for the low wages, and those who raised this issue believed it was to do with the amount the government was prepared to pay for the service.

To some degree, all the workers echoed the view that 'the place is run on heart'. Their reasons for doing the work nearly always focused on the pleasure they derive from helping people or 'making a difference to people's lives'. Many of the workers would identify with one woman's explanation: 'It warms my heart to know that an average person like myself can at least help make someone's life a bit easier or less stressful.' There were also practical reasons for taking on the work, which included having flexibility around the needs of young children, or trying to get back into the paid workforce. Approximately a third of workers included in the study are women who are receiving some form of income assistance through social welfare benefits.

Half the workers interviewed had received some training, and the majority had found it useful. The unpaid nature of the training had proved a barrier for some. The training had included practical subjects as well as information about issues such as elder abuse and mental health. Many of the workers commented that it would be useful to have some practical information about particular illnesses (such as Alzheimers or cerebral palsy) as this would help them do their job better in that they would have a clearer understanding of the client's needs. Systematically providing such information would be an acknowledgement of the responsibility they have and feel towards their clients.

Doing extra tasks unpaid

This research supports the literature in that all the homecare workers interviewed provide some services to clients for which they are not paid. Sometimes this extra work is in direct response to being allocated insufficient time for a particular activity, but at other times it involves activities not detailed in the care plan. It may involve things like sitting down for a chat in their own time, posting a letter, or picking up some milk on the way to the client's house, but in some cases it involved considerably more. Examples were given of homecare workers cooking and delivering meals, dropping in on their days off, doing the client's personal washing when the client's family was away, and inviting the client to spend time with their own family. One homecare worker said, 'I take my client to the marae if there is something on there — better than her staying at home all day. I know that is not on my list of things to do but she really loves to go there.'

The researcher working with the Mäori homecare workers noted that the client was not just the person with the disability or illness — it was the whanau. This meant that workers were more likely to be involved in work other than the prescribed tasks.

All the homecare workers minimised or underestimated this effort and it was not uncommon for a interviewee to say that she did not do extra work, but then to go on to describe situations where she clearly had done extra. The motivation for doing the extra tasks is a concern for the client and an awareness that there may be no one else who can provide the help or companionship. Most of the homecare workers insisted that they 'don't mind doing it', and one said that she always thinks, 'if this was my grandfather...'.

The clients

Access to care

Available evidence suggests that Mäori and Pacific Island peoples probably use formal services, both hospital and homecare, proportionately less than the overall population. Loomis and Kasanji (1992) noted that Mäori and Pacific Islands communities are more likely to use the care networks of their extended family or marae, rather than voluntary or church groups. These communities indicated that they would like their members trained and provided with resources to enable them to provide services to their elderly. Geriatricians in this study noted that they had not had any Mäori or Pacific Island clients requiring home help, and interviews with Mäori and Pacific Island communities revealed a lack of information about or access to existing benefits and services.

This finding on lack of information has been reinforced in the recent analysis of Mäori claimant and service provider perspectives on ACC services by Te Puni Kokiri (1998), a later study which also stressed the importance of having flexibility to use family as paid carers. Scott (1997) identified that Homecare 2000 did not provide information in any language other than English and, although management said it would arrange interpreters, it usually preferred families to organise their own.

The experience of care

Literature on clients' experiences highlights the value they attach to service providers with whom they have stable and personalised relationships. Other factors important to clients are commitment (such as being available long-term, and turning up for work) and flexibility about what needs to be done. Coordination and minimising the numbers of providers also work for clients. The Bladock and Ungerson study (1993) of homecare managers in Britain noted that care recipients reported considerable insecurity about what seemed unpredictable services from an array of different providers.

The clients interviewed for this study have no doubt what it is that they value from the homecare work. Although they want to have their practical needs met, they value being respected and cared for, and the discussions with clients support the homecare worker's view that the job is 'more than housework'. For Mäori and non-Mäori clients the way in which the service is delivered is important, and essential ingredients of this are described by clients as respect, thoughtfulness, kindness, friendliness and honesty. For Mäori clients this involves a strong sense of the worker as whanau.

Some clients provided examples from their past experience of homecare workers by whom they had not felt cared for, or had actively been taken advantage of. In one case, the homecare worker in question had done the actual housework required, but she had been listening to her Walkman at the same time. For the client, this meant the worker was not doing her job well because there was little interaction and she seemed not to 'care'. As one client said, 'A good worker wants to do the job and likes doing it. It helps if you get on and have a laugh. She sometimes stays for a chat and I like that.'

Empathy and understanding are also important for the clients: '... she can see how frustrated I am in that I can't do it for myself. If I am really sick — if I have to lie down — it wouldn't be a hassle for me to ask her to make me some food. Anyway, she would probably ask if she could.'

Some of the ways in which clients wish to be valued, and the way workers believe the service should be provided, blur the lines between care that is generally provided by someone close to the client, and paid work. There are differences between Mäori and non-Mäori on this issue. For Mäori, the answer is to have a family member paid to do the work. Research confirms, however, that the more similar a job is to that done for no pay by women within families, the less likely it is to be well recompensed.

One of the most valued skills was workers being able to meet clients' own personal standards of care. This might mean that they liked the bathroom cleaned in a particular way, or preferred a certain routine when being showered. All the workers interviewed try to meet their clients' needs and reported taking time to find out what is needed because they recognise that everyone likes things done differently. Although among non-Mäori providers there was little evidence of direct training or instruction in cultural

sensitivity, the workers felt that this approach to their clients worked, no matter what their ethnic background.

Some clients resented the fact that they needed the service at all, and it had become a symbol of their diminishing independence. They also found it hard to imagine that someone who is performing extremely intimate services for them could be doing it just for the money; they must also care too. Most of the clients interviewed either knew, or slightly overestimated, what the homecare worker was paid and the fact that they were not paid for travelling between jobs.

This research supports the literature, which noted that Mäori communities are more likely to use, or to want to use, carers who are whanau. The research highlighted clear differences in what Mäori value about homecare compared with non-Mäori, and Mäori providers tended to be more flexible around this. This is discussed further in the next section of the report.

Issues for Mäori

This section summarises the literature on a culturally appropriate philosophy for disability support services for Mäori and describes Mäori perspectives on homecare tasks and their value. Because the study was small, and most of the Mäori workers and clients were from Mäori providers, it is not possible to generalise the findings for Mäori as a group. For a more in-depth and more representative understanding of Mäori perspectives of homecare and homecare workers, a much wider research project needs to be carried out.

Philosophy for disability support

A New Zealand report on a culturally appropriate philosophy for disability support services for Mäori identified the importance of the following cornerstones:

- *Te Ha o te Tangata:* respect for clients. This includes client, caregiver and whanau contribution to decision-making; and services that are least intrusive and encourage mainstream participation, and develop abilities as much as possible to compensate for disabilities.

- *Te Herenga Tangata:* a community-focused approach. This includes raising awareness in Mäori communities to support client participation, opportunities for whanau participation in services, and developing and maintaining links with Mäori institutions.

- *Whakapakari Mäori:* workforce profiles. This includes workers who are qualified and competent, both professionally and culturally, and an understanding of Mäori perspectives being evident in all aspects of the daily processes of the services.

Key principles that underpin culturally appropriate services were identified as (Ratima et al, 1995):

- *whakapiki:* enablement
- *whai wahi:* participation
- *whakaruruhau:* safety
- *totika:* effectiveness
- *putanga:* accessibility
- *whakawhanaugatanga:* integration.

Wages and conditions

Of the 28 homecare workers interviewed in our research, ten were Mäori and of these seven were working for a Mäori provider. One of the Mäori providers was a rural agency, and both Mäori agencies offered other services to Mäori within their tribal rohe. That is, homecare was not the only service provided.

In this small study there was no discernible difference between the wages of Mäori and non-Mäori, but there were differences in some conditions experienced by Mäori

homecare workers, both those employed by Mäori agencies and those employed by non-Mäori agencies. The Mäori homecare workers who were changing from working for a Mäori agency to working for a non-Mäori agency best described this difference.

Mäori homecare workers experienced a more relaxed employment environment within a Mäori agency. Several Mäori workers found that switching to a non-Mäori provider meant changes such as having to wear name-tags while working with clients (some of whom they have worked with for over three years, and some of whom are also whanau), not using the client's car to go shopping, and not being able take clients on outings to their local marae.

For Mäori clients the homecare worker in most instances becomes part of the whanau. If working for elderly clients, the homecare worker becomes like a daughter and is asked to perform tasks outside the prescribed tasks and agreed hours. If a worker is aware that a client does not have a whanau available to assist, it is difficult for the worker not to respond to the request as part of a collective responsibility that some Mäori feel towards their elders. Non-Mäori clients do not place these expectations on their workers.

According to both the Mäori homecare workers and the Mäori clients of the Mäori homecare agencies, client wishes were better respected and less prescribed when provided by Mäori homecare workers working for a Mäori agency.

For Mäori the best person to care for them may be a member of their whanau. Only the two Mäori providers, however, were willing to allow immediate whanau as paid homecare workers. This restriction on paying family members for homecare may contribute to Mäori and Pacific Island people's low level of use to formal homecare services. There is evidence that these groups use formal services, both hospital and homecare, proportionately less than the overall population. Koroua, kuia and some other Mäori with long-term disabilities often prefer to remain at home even when they do not have facilities for effective homecare.

Assessment

Most of the Mäori service providers, homecare workers and clients who were interviewed for this study were unhappy with the existing assessment processes for Mäori. The way the services were defined and prescribed was felt to limit the ability of the agencies to manage the work in the way Mäori feel is appropriate.

Examples of inappropriateness include having someone not previously connected with the person coming to the home to ask very personal questions. In many cases the assessors are non-Mäori, and most Mäori clients have concerns about their needs being understood. In all cases an assessor visits only once a year or, in the experience of one of the Mäori agencies, a telephone call is made on an annual basis. In a culture that values communication which is kanohi ki kanohi (face to face) and also values building relationships with people, this is neither adequate nor desirable.

Both Mäori clients and workers in our study emphasised the importance of the homecare worker building relationships with the household, not just the client. As one Mäori homecare worker stated: 'It's the whole house. It's the person looking after the client

and anyone else in the house. They all need help with the situation.' Currently, assessments view only the person with the disability or illness as the client.

Service provision

In this study all but one of the Mäori homecare workers and clients interviewed said they would prefer to have a service run by Mäori for Mäori. This has implications for the way in which services are structured and, more importantly, for the way services are funded. At present, Mäori clients use services through the same structures as non-Mäori, and funders, assessors and service providers differ in their strategies to address the needs of Mäori clients in an equitable way.

One of the Mäori agencies felt that there needs to be a more coordinated approach to service provision to Mäori in its area, and that this would lessen the effect of Mäori providers competing with each other, and maximise the impact of the funding. Another agency suggested that if quality and culturally appropriate care is to be provided to Mäori, funding needs to be provided by a Mäori funding agency to Mäori homecare providers which employ Mäori (and possibly non-Mäori) under kaupapa Mäori. As long as service funding and assessments are not in Mäori hands it is unlikely that the service provision will meet the needs of a significant number of Mäori clients.

Health and safety

Some Mäori homecare workers working for non-Mäori clients experienced racism. This took the form of questioning the values and work ethics of the Mäori worker. This ranged from accusation of theft, leaving money around to test the honesty of the worker or treating the care worker as a mokai (servant).

None of the non-Mäori agencies interviewed had policies that explicitly recognised tikanga Mäori. One FACS group was carrying out a needs survey of Mäori clients, and it anticipates that the findings of its survey will flow through to providers servicing Mäori clients.

Among the non-Mäori providers, there was little evidence of direct training or instruction in cultural sensitivity. The non-Mäori homecare workers felt that the most valued skill was the worker being able to meet the client's personal standards of care. Because of this the workers felt that this approach to their clients worked, no matter what their ethnic background.

Conclusion

This research has confirmed that homecare in New Zealand is a textbook example of a low paid, female-dominated industry in which many of the skills needed to perform the work, and many of the complexities of the job, are not formally recognised and not valued or recompensed. As such, it almost certainly contributes to the gender earnings gap.

Wages are low and conditions are poor. In some cases, effective wage rates are below the minimum hourly wage.

The factors contributing to wages and conditions

Key factors identified by the study that contribute to the undervaluing of the job and the low pay and poor conditions were:

- The Health Funding Authority approach to setting the range for contract prices on the basis of historical costs —– with the agencies appearing not to be able to raise wages above these levels.

- The lack of any industry standards for minimum conditions such as payment for travel time.

- The separation of decisions on the hours required to undertake an assignment from the actual provision of the service. This can result in workers having too little time to complete assignments or, in some cases, a too generous allocation.

- The undervaluing of ‘women’s work’ and the assumption that emotional care can be separated from personal care.

- Apparent failure on the part of the funders to recognise the full value of the job. In theory, funders and assessors expect the work to be tailored to the client’s specific needs and tastes, and to promote client rehabilitation. The care plans are task-focused, however, and make no allowance for extra time to develop the worker’s relationship with the client. The research showed that homecare workers tended to put in more effort and time to make sure their client gets a quality service.

The state of the homecare industry

The impression of the researchers was that the New Zealand homecare industry is fragile, with a sense of desperateness, transition and powerlessness common at all levels. Despite the efforts of some organisations and worker and quality advocates, the general picture is of low levels of collaboration between different layers in the industry and across the country. The most collaboration seemed to occur in the HFA, North Office area and be a direct result of the way homecare programmes developed in the 1980s.

There is no single industry voice and no apparent plan for the industry's future. Although some agencies work with each other, and some have sold or promoted their systems and training to other agencies, there appears to be little 'bottom-up' development of codes of practice, training, or standards that apply nationwide.

These findings have implications for the delivery of quality health services. The demand for home-based health services will continue to grow with the ageing population. As budgets become constrained, at the same time as there is an increasing need to get value and quality for money, there may be less involvement of professional health workers, and greater numbers of high-need clients at home. The wages and conditions of homecare workers is not just an issue of fair treatment; it is also an issue of quality and risk management.

Policy issues

Data collection

The demand for homecare services is increasing. At present, very little is known about this sector, and to better understand the links between wages, conditions and quality there is a need for comprehensive data on the homecare industry.

Valuing the job

This study found that descriptions of homecare work omit some of the key components of the work as described and practised by workers and valued by clients. These are the aspects of work that demand emotional effort and the skills associated with caring and nurturing work. If homecare work were more accurately described, this would allow an evaluation and benchmarking of that work relative to other comparable work, and the appropriateness of the remuneration could then be empirically judged and evaluated.

To inform accurate descriptions of homecare work, agencies may find that monitoring workers with extra skills who are performing the more difficult tasks, but not usually for more pay, will provide them with a more accurate skill profile. When skills are explicit and the full range of the homecare worker's role is visible, workers will have a much higher degree of transferability of skills. This should enhance their ability to move from homecare work to higher paying work, and would also put some pressure on the wages and conditions in the homecare industry.

Assessment

The assessment process needs to take full account of the emotional, spiritual and cultural needs of clients. At present, these needs are not recognised, although most workers try to meet such needs in some way, often at their own expense. The holistic service required by Mäori is good practice for all clients.

Homecare workers' contracts

The research has identified a number of 'holes' in the minimum provisions for employees such as homecare workers. It is unlikely that either the good employer requirements of the Ministry of Health, or the *Cashman* judgement of 1996 (which found that these workers should be subject to the Employment Contracts Act), envisaged that homecare workers could receive effective hourly wage rates below the

statutory minimum. In effect, homecare workers have neither the advantages of being employed, nor those of being self-employed.

Three agencies indicated that they were working towards providing some security of hours for at least a core of workers. This was seen as having advantages not just for workers, but also for efficient delivery of services if the agency has flexibility about how much time it provides to clients. With secure hours, workers have no incentive to ‘hold onto’ clients. Providing some security of hours may have an element of budgetary risk for agencies, especially for those without contracts that guarantee a specified quantity of work. There are also risks of even worse conditions for the casual staff left on the periphery. A further issue raised by two agencies was the need for insurance cover for workers when they transported clients in their own cars.

Improved employment contracts for workers needs to be addressed at several levels:

- Central government agencies and the government funders of homecare services need to be explicit about what is meant by the ‘good employer’ requirements of existing statutes and contracts.

- Homecare agencies, unions and other bargaining agents have a role in developing an appropriate minimum employment code for the industry, addressing, in particular, payment for travel time and training, health and safety, core hours clauses, pay, and insurance coverage.

Training for quality services

The research showed that training, although recognised as critical to the quality of the job, lacked any external benchmarking or quality checks. The problems of developing standards in this area are complex; currently there is no recognised national training in this area, and employers may find it too expensive to become involved. Workers are unlikely to see off-the-job training as a good investment unless wages reflect those qualifications. The training of homecare workers has also tended to be overlooked when considering the future needs of the health workforce. However, the Ministry and Health Funding Authority’s recently released joint Disability Support Services Strategic Work Programme for the next three to five years acknowledges the general need for workforce development in the DSS area.

Delivering quality services efficiently, effectively, and fairly

Both the study and the literature suggest that exercising skilled judgements within the homecare setting is a critical element of quality care. This means:

- It may be preferable to contract provider agencies to make professional judgements involving changes to the quantity and type of care provided — that is, valuing their role in a professional sense, and giving them some flexibility within budgets.

- Homecare workers need adequate training, support and performance appraisal to enable them to carry out the monitoring role effectively, a role which is currently not formally acknowledged.

The research has also raised a number of questions about whether some of the policies and structures designed to promote efficiency are achieving their goals, and in particular the use of:

- Assessment processes which specify the hours and type of care required at the same time as a one-off assessment — as opposed to funding flexibly within a budget. This is an even bigger issue for Mäori, because no assessment refers in any detail to cultural context, and when Mäori favour services being better linked with whanau care. Flexible funding would enable providers to change the mix of formal services in order to work in with the changing needs of clients and the wishes and skills of unpaid family carers.

- Competitive tendering for contracts, compared with maintaining and building long-term sustainable relationships with providers within a contestable environment and with regular performance audits.

Fair contract prices

Both the literature and this study suggest that funders can virtually set the price they will pay for homecare, at least to the point where businesses are only just viable. When small contract margins flow into cost shifting onto workers, through not paying travel time and not, or only partially, reimbursing the costs of using their own car, the effective wages of workers are also lowered.

Cutting corners can create risks for service quality. The heavy case and worker loads of homecare coordinators, and the apparent tolerance of good workers not attending training in some agencies were symptomatic of this risk factor and will ultimately have a negative impact on quality. It is in the interests of quality services to have providers with a core of well-trained, stable staff who have some certainty about their own future in the industry, provided they perform. This study suggests a need to revisit realistic pricing for contracts in the industry, and pricing specific issues, such as servicing rural areas, and the set-up costs of new providers that are contracted to provide a diversity of services.

Services for Mäori

The experience of Mäori providers in the study suggests that the current contracting approach and assessment model do not cater well for the more holistic approach that Mäori providers, homecare workers and clients need. Both Mäori clients and Mäori workers in the study emphasised the importance of the homecare worker building relationships with the household, not just the client. None of the general agencies interviewed had policies that explicitly recognised tikanga Mäori.

Even though the sample is small, the study again reinforces what other reports on disability services for Mäori have said, namely that Mäori want to determine their own health needs.

Care by family members

There are clients who want family members to care for them and this is particularly so for Mäori families. Family care, voluntary and unpaid, has always been a cornerstone of home-based care. Quasi-voluntary models, such as the lower rates paid to family

members providing ACC homecare and relief care, have also provided an inducement to 'employ' family members.

From an agency point of view, family members may not have the practical skills, and in some cases it is not cost-effective to train them to be able to provide care. The ACC, for example, is becoming less willing to pay family members because of its concerns about quality. On the other hand, some Mäori agencies were set up to enable family members to care for each other. Some of the other agencies also formally employed family members provided they meet their skills requirements, but varied in their willingness to do so.

As discussed above, it is probably desirable, particularly for Mäori, to have systems which are able to take account of the availability of family care. Even so, flexibility in relation to the unpaid role of families would need to be carefully monitored to ensure agencies did not place an unfair burden on those families. The development of industry protocols on the rights of unpaid family carers, and the formal employment of family members, could assist more satisfactory results for clients in this area.

Best practice ideas

During the course of the study, researchers found a range of solutions to service or employment issues. Although not all of the ideas would work for all providers, they are listed below.

For homecare workers

- increasing their safety (and efficiency) by working in pairs in the night teams
- providing training in paid time to ensure that they get trained
- providing structured performance assessment
- providing workers with the opportunity to upgrade household management skills to personal care through training
- providing opportunities for homecare workers to get together to reduce the isolation of the role and increase 'attachment' to the organisation, and forums for workers to discuss their work and how they approach issues and problems
- establishing computer databases to assist their matching with clients to provide work close to the worker's home
- providing uniforms, which was appreciated by workers in non-Mäori agencies, but not appreciated by workers in the Mäori agencies
- having the right to refuse to service a particular client
- managers being responsible for claiming mileage costs for shopping expenses.

For Mäori homecare workers and clients

- Mäori assessors carrying out needs analysis on the needs of Mäori clients
- allowing whanau to work as paid homecare workers
- allowing homecare workers to help meet clients' spiritual or emotional needs, such as making visits to marae.

For clients

- developing tailored services to meet needs such as a night 'tuck in' service
- establishing computer databases to help match their needs and preferences to an appropriate care worker
- ensuring their wish for a relative to care for them is provided safely, by being prepared to interview the relative and, if the relative meets the agency's standards, provide standard employment conditions and supervision
- monitoring of the client to be formally made part of the homecare worker's role.

New research

This small study identified several avenues for future research. They include:

- A methodology for measuring the gap between the nominal hourly pay rates for homecare workers and the effective pay rates. It has been known for some time that fringe benefits at the top end of the market are likely to raise the remuneration of highly paid men more than highly paid women. This study suggests that, at the bottom end of the market, there is a need to understand whether the failure to reimburse workers for core aspects of their job also has a gender-based pattern. Do poorly paid men and women have similar experiences?
- More in-depth study to capture the perspectives and experiences of Mäori.
- A study to provide a profile of the industry and the trends within it — including Mäori and Pacific Island workers and clients.
- An investigation of the strengths and weaknesses of different approaches to (and location of) assessment processes, in terms of how they contribute to the quality of the work, the accuracy of the time allowed for assignments, and the well-being of the worker.

The purpose of this study was to increase understanding of how and why there is a gender earnings gap. This research demonstrates the extent to which the pay and conditions of homecare workers are associated with both gender and labour market practices which tend to disadvantage women. By explaining the factors that reinforce low pay and poor conditions for homecare workers, and identifying the links between he way homecare work is valued, pay and conditions and the quality of care, these findings are an important start to better understanding the growing homecare industry.

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