



# THE VALUE OF CARE

UNDERSTANDING THE IMPACT OF THE 2017 PAY EQUITY SETTLEMENT ON THE RESIDENTIAL AGED CARE, HOME AND COMMUNITY CARE AND DISABILITY SUPPORT SECTORS



**NEW ZEALAND  
WORK RESEARCH INSTITUTE**



**The Value of Care: Understanding the impact of the 2017 Pay Equity Settlement on the residential aged care, home and community care and disability support sectors.**

Julie Douglas and Katherine Ravenswood

New Zealand Work Research Institute, Auckland, New Zealand

ISBN: 978-1-927184-53-0

Online copy: 978-1-927184-54-7

---

**Acknowledgements**

First and foremost, we would like to thank all the care and support workers and managers who took part in this research. We would also like to thank those among the *Caring Counts Coalition* member organisations who provided feedback during the design of the research, helped send out focus group notices and spread the word. This research would not have been possible without all of you.

We would like to acknowledge the support of Careerforce, the New Zealand Work Research Institute and the Human Rights Commission.

We would also like to thank Yolina Blanc, Livvy Mitchell, Tamara Tesolin and Tanya Ewertowska for their assistance throughout this project.

# Content

<b>Foreword</b> .....	<b>4</b>
<b>Executive Summary</b> .....	<b>5</b>
<b>1. Introduction</b> .....	<b>6</b>
<b>2. Background to the 2017 Pay Equity Settlement</b> .....	<b>7</b>
<b>3. Research Approach</b> .....	<b>14</b>
<b>4. Residential Aged Care</b> .....	<b>16</b>
4.1 Managers	16
4.2 Care and support workers	23
4.3 Residential Aged Care Conclusions	27
<b>5. Home and Community Care</b> .....	<b>29</b>
5.1 Managers	29
5.2 Care and support workers	35
5.3 Home and Community Care Conclusions	43
<b>6. The Disability Support Sector</b> .....	<b>45</b>
6.1 Managers	45
6.2 Care and support workers	51
6.3. Disability Support Sector Conclusions	53
<b>7. Overall Conclusions</b> .....	<b>55</b>
<b>8. Recommendations</b> .....	<b>58</b>
<b>References</b> .....	<b>60</b>
<b>Appendix 1. Agreed Hourly Rates 2017 to 2022</b> .....	<b>62</b>

# Foreword

The 2017 Pay Equity Settlement for carers was a vital step in valuing the role they have in our society. The work of carers in residential aged care, home and community care and the disability sectors are of critical importance to support the quality of life of our older population as they age.

The pay settlement was a significant first step for Aotearoa New Zealand in re-valuing low paid female dominated occupations that are and have traditionally been viewed as “women’s work”.

New Zealand’s population is ageing rapidly. It is estimated that by 2036 over 1.2 million New Zealanders will be over 65 years old. Ensuring that carers are able to be recruited and retained in residential aged care, home and community care and the disability sectors is becoming more important in light of population growth in this age group.

The impetus for the pay equity settlement for carers came from the Human Rights Commission’s “Caring Counts” Inquiry led by Dr Judy McGregor in 2011 and 2012. Two of the recommendations of the Inquiry related to pay. The findings inspired the E Tū Union to file a pay equity claim for aged care workers led by Kristine Bartlett against Terranova Homes and Care Ltd. The litigation ultimately led to the government

agreeing to a two billion dollar pay equity settlement for carers in the residential aged care, home and community care and the disability sectors, which came into effect in July 2017.

This research examines the impact of this pay equity settlement on the quality of life of the workers, and managers in these sectors. It is world-leading and has implications well beyond Aotearoa New Zealand. It is the first time there has been research into the effect of moving from minimum wage to a living wage for a female dominated workforce.

The findings provide insight into the improvement to the quality of life for workers, unintended consequences of the settlement on different roles and service delivery, and important lessons for implementation of pay equity settlements in the future. The findings also shed light on wider implications for the resourcing of care and support for older and disabled people.

This report will be of use to care provider organisations, the care workforce, policy developers, researchers, decision makers, advocates, and importantly to our elderly and their families.

la manuia, best regards and blessings upon all!



**SAUNOAMAALI'I KARANINA SUMEO,**  
EQUAL EMPLOYMENT OPPORTUNITIES COMMISSIONER

# Executive Summary

The Care and Support Workers (Pay Equity Settlement) Act 2017 was introduced in order to implement changes to funding, wages, and training for care and support workers in residential aged care, home and community care, and disability support. The Act introduced unprecedented changes to New Zealand aimed at addressing historical gender discrimination in these sectors that had resulted in low wages and conditions for care and support workers in a traditionally female dominated workforce.

This research is the first phase of a project that aims to explore the impact of the Settlement and how these changes impacted on managers and care and support workers in the residential aged care, home and community care, and disability support sectors. The full project incorporates three phases.

Focus groups and interviews were conducted with 69 participants nationwide. Participants came from the residential aged care, home and community care, and disability support sectors.

## **Key findings were:**

- Increased wages for care and support workers were supported by both managers and care and support workers.
- The way in which the funding was implemented led to unintended negative consequences for both providers and care and support workers.
- Smaller providers in residential aged care struggled to remain in operation under the current funding model.
- Home and community care managers had mostly reduced the hours available to Level 3 and Level 4 care and support workers in order to reduce costs.

- There was a disconnection between the NZQA Certificate in Health and Wellbeing expectations and graduate outcomes, especially when considering equivalent qualifications, and the skills and knowledge expected by managers and care and support workers.
- There is evidence that care and support workers' workloads and duties have increased since the introduction of the Act.
- Quality of care was negatively impacted in some cases.
- The legislation and funding changes have not been clearly communicated, with a lack of support and clear information for managers and care and support workers.

## **Policy recommendations include:**

- Creating a culture of value.
- Reviewing qualifications and graduate outcomes.
- Focus on strategies to improve literacy and decrease barriers to success for some care and support workers.
- Development of generic, agreed sector wide job descriptions.
- Develop more transparent and consistent funding models across all three sectors.
- Continue to develop readily accessible 'FAQs' for both managers and care and support workers that clarify their rights and obligations under the Act.

# 1

## Introduction

The Care and Support Workers (Pay Equity Settlement) Act 2017 was introduced in order to implement changes to funding, wages, and training for care and support workers in residential aged care, home and community care, and disability support. The Act introduced unprecedented changes to New Zealand aimed at addressing historical gender discrimination in these sectors that had resulted in low wages and conditions for care and support workers.

Although government Ministries and agencies are monitoring changes in these sectors in relation to issues such as funding, qualifications of the workforce and numbers in the workforce, there is little or no research aimed at understanding the impact the Settlement has had on managers and workers in these sectors. Consequently, the *Caring Counts Coalition* agreed a more in-depth understanding was needed of how these legislative changes affected both managers and care and support workers in these three sectors. This report, therefore, presents findings from Phase 1 of a three-phase project exploring the intended and unintended consequences of the Care and Support Workers (Pay Equity Settlement) Act 2017. The next two phases will be conducted in 2020 and 2022 – covering the period of the implementation of the Act.

Focus groups and interviews were held with 1) managers and 2) care and support workers across three sectors: residential aged care, home and community care, and disability support. The research was conducted between September and December 2018, approximately one year after the Act was introduced. Focus group and interview participants came from a range of locations across New Zealand, including large cities, towns and more rural settings. These participants also came from a range of organisations including small providers with one or two facilities or locations, national chains and for profit and not-for-profit organisations.

The report begins with an overview of the background and key aspects of the Care and Support Workers (Pay Equity Settlement) Act 2017. The findings from each sector are then presented separately – differentiated by managers and care and support workers. Concluding comments are provided for each sector separately. Final conclusions comment on the impact overall across all three sectors, as indicated by the findings from the focus groups and interviews. The report concludes with recommendation (drawn from the findings and conclusions) for policy issues that need revision in order to ensure fair and equitable implementation of pay equity in these sectors.

# 2

## Background to the 2017 Pay Equity Settlement

This section provides a brief overview of The Care and Support Workers (Pay Equity Settlement) Act 2017. In addition, it provides some information on the New Zealand Qualification Authority (NZQA) Certificates that are applicable to residential aged care, home and community care and disability support. Finally, it summarises the additional changes to funding, employee payment and scheduling that have been implemented in home and community care since 2016.

The Care and Support Workers (Pay Equity Settlement) Act 2017 was introduced in order to enact changes to funding, wages, and training for care and support workers in residential aged care, home and community care, and disability support. It implements the 2017 Care and Support Workers (Pay Equity) Settlement (Settlement Agreement) between the Crown (as funder of District Health Boards and employers), Accident Compensation Corporation and District Health Boards (as funders of employers) and E Tū Incorporated, New Zealand Public Service Association Te Pūkenga Here Tikanga Mahi Incorporated and the New Zealand Nurses Organisation Incorporated. The New Zealand Council of Trade Unions Te Kauae Kaimahi Incorporated was an interested party to the agreement.

The Settlement Agreement was the result of negotiations between the above parties that commenced after the New Zealand Cabinet sought approval in 2015 to resolve a legal case between Terranova Homes and Care Ltd and Kristine Bartlett (a care worker) under the Equal Pay Act 1972. The case had been filed in 2012 and the Employment Court and then Court of Appeal had found that her claim could be pursued under the Equal Pay Act 1972 (Treasury, 2017). Significantly, this finding meant that claims of unequal pay due to gender discrimination could be determined on an industry basis, rather than through a comparison of two individuals, man and woman, in the same or similar occupation. In December 2014 Terranova Homes and Care Ltd

sought leave to appeal to the Supreme Court which was then dismissed (Care and Support Workers Settlement Agreement, 2017).

Cabinet agreed to appoint a Crown negotiator to “better manage the process and achieve a better outcome than a court decision” (Treasury, 2017, p. 2). Cabinet agreed to these principles to guide the negotiations:

- A stay in proceedings in the Employment Court and possible removal of litigation on the matter of pay equity for care and support workers.
- A fair pay outcome that represents value for money, and supports a sustainable workforce in the future as demand for care services continues to increase.
- Minimum cost e.g. keeping pay increases to the minimum necessary to achieve objectives, avoiding back pay and introducing a phased approach to allow new pay rates to be transitioned into the sector at a fiscally responsible rate.

In November 2016, as part of updating the negotiating parameters, a maximum cost of \$507.25 million per annum from 2021/2022 was introduced (Treasury, 2017).

While the case had been taken with the argument that wages in the sector were low due to historic gender discrimination, the Crown’s focus in beginning negotiations was on minimising cost to the Crown, and contributing to a sustainable future workforce (Treasury, 2017).

### Care and Support Workers (Pay Equity) Settlement

The signatories to this agreement do not include providers. However the New Zealand Aged Care Association, the Home and Community Health Association and the Disability Support Network were represented during the negotiations for the Settlement. Settlement negotiations continued for almost two years. The purpose of the Settlement agreement was to:



- Address historical pay equity issues.
- Record the outcome of settlement negotiations: applying pay equity principles, determining agreed pay rates, and conditions for recognition of experience and qualifications.
- Extinguish the Court proceedings and the right for employees to make any further claims within a five-year period.
- Provide certainty of employer obligations, employee rights and “lawful” funding.

The Settlement prescribes hourly pay rates over four levels, depending on length of service with an employer or qualifications attained (see Appendix 1). The wage rates for tenure/service were intended as a transition to the new arrangements for existing employees at the time of the Settlement. At the end of the five-year funding period, movement through the pay levels will be based on attainment of qualifications only, not through tenure or service.

At Level 4, the hourly rates differentiate between a Level 4 employee via service and a Level 4 employee via qualifications. Employees’ service is assessed based on their continuous service with their current provider. The stated goal is “to have an industry wide workforce which is trained to meet current and future service needs” (Settlement Agreement, 2017, p. 17). Funding for employers was agreed to be equivalent to two days’ training per employee per year, to be funded through an ‘on costs’ payment.

Employers are expected to do everything reasonable to ensure that their employees move through the levels within a total of six years:

- Level 2 NZQA Health and Wellbeing Certificate within 12 months
- Level 3 NZQA Health and Wellbeing Certificate within 3 years
- Level 4 NZQA Health and Wellbeing Certificate within 6 years

The Settlement allows for any weekend or penal rates (for example, ‘time and a half’) to be calculated based on the employees’ hourly wage immediately prior to the implementation date of 1 July 2017. Penal rates are not calculated based on the prescribed Settlement hourly rates.

Employers were paid a one-off amount of \$25 per employee who attended the meetings to ratify the Settlement agreement.

### **The Care and Support Workers (Pay Equity Settlement) Act 2017 and Policy**

This Act is administered by the Ministry of Health, except for employment related disputes which are dealt with under the Employment Relations Act 2000. The Act sets out the hourly wage rates from 2017 to 2022 for the service and qualification paths. It stipulates that workers must be paid the greater of either the wages in the Act or the wage that they were on immediately before the Act. The Act obligates the employer to take every reasonably practicable step to ensure that their employee completes training within the timeframes above. There is nothing to prevent an employee and their employer agreeing to more favourable terms and conditions than are outlined in this Act.

This Act does not change the Sleepover Wages (Settlement Act) 2011 or Home and Community Support (Payment for Travel Between Clients) Settlement Act 2016. Consequently, travel between clients and sleepover wages must be paid at the minimum wage or above. Penal rates are calculated based on the employee’s hourly wage immediately prior to 1 July 2017. The Ministry of Health (2017d) states that the different rates are to be itemised on employees’ payslips. This could include if they are employed in different positions on different rates.

The Care and Support Workers (Pay Equity Settlement) Act 2017 states that the four pay ‘levels’ relate to levels of the New Zealand Certificate in Health and Wellbeing issued by the New Zealand



Qualifications Authority (NZQA) or a qualification that is recognised as equivalent by the relevant industry training organisation (ITO).

Careerforce is the ITO authorised by the Tertiary Education Commission to assess other qualifications to determine if they are equivalent to the New Zealand Certificate in Health and Wellbeing levels awarded by NZQA accredited training providers (Ministry of Health, 2017d).

New Zealand registered and enrolled nurses working as care and support workers have been assessed at Level 4. Overseas qualified registered nurses working as care and support workers prior to the Settlement (such as from the Philippines, Australia, South Africa and the United Kingdom) are to be paid on the level associated with their length of service with their current employer in New Zealand. This is revised when they have achieved two “culturally focussed unit standards” (The Care and Support Workers (Pay Equity Settlement) Act 2017, s. 18). After completing those, they are then deemed to have equivalency to Level 4 of the NZQA New Zealand Certificate in Health and Wellbeing levels (Ministry of Health, 2017d).

The Act addresses funding to providers (Section 18). The funder must fund any amounts “over and above the amounts required by the funding agreement towards offsetting the additional costs faced by the

employer as a result of the Act”. However, the funder assesses what reasonable costs are and the funder has the final determination on this matter.

Ministry of Health operational policies provide for Aged Residential Care costs related to the Act to be funded via a variation to the price included in the current Aged Residential Care Agreement for funding (Ministry of Health, 2017a). This is 1.8% increase to the contract price, plus an extra payment “per each client bed day” (Ministry of Health, 2017e, p.3) (see Table 1 below). In addition, an on-cost payment of 21.7% was made to cover associated costs. These were specified, for all sectors, as (Ministry of Health, 2017e):

- 20 days annual leave
- 11 days statutory holidays
- 5.5 days (time and a half for time worked on statutory holidays)
- 5 days sick leave
- 0.8 percent contribution to training
- 3 percent KiwiSaver employer contribution
- 2 percent for ACC levies.
- Ministry of Health operational policy for Home and Community Support Services and Community

**Table 1. Extra payment for Aged Residential Care**

Service Type	Additional payment (re Pay Equity rate increase)
Rest Home	\$9.41
Hospital	\$13.92
Dementia	\$14.21
Psycho Geriatric	\$16.18

Source: Ministry of Health, 2017a

Residential Living (Ministry of Health, 2017b; 2017c) stipulate that the actual wage costs associated with the Act will be paid through advance payments from funders to providers.

- The period between the Settlement Agreement and implementation was short with Ministry of Health timelines for providers indicating (Ministry of Health, 2017e):
- 1 May 2017 – read draft operational policy
- 8 May 2017 – attend Ministry roadshows
- End May 2017 – report employee data to the Ministry
- End June 2017 – make any payroll adjustments
- 1 July 2017 – full implemented

### **New Zealand Certificate in Health and Wellbeing**

The New Zealand Certificate in Health and Wellbeing is the standard qualification referred to in The Care and Support Workers (Pay Equity Settlement) Act 2017 for residential aged care, home and community care, and disability support, care and support workers. There are three ‘levels’ of qualification, Level 2 through to Level 4. The Level 3 certificate includes several strands specific to different healthcare settings: health assistance; newborn hearing screening; orderly services; support work; vision hearing screening; and whānau, kin and foster care. The Level 4 Certificate is differentiated by the inclusion of ‘Advanced Support’ in its title. There is also a Level 4 Certificate in Health and Wellbeing (Social and Community Services). These levels, referred to in the Act, correspond to the hourly wage rate levels.

The work experience expectations and graduate profiles for each level are outlined in Figure 1 below. Level 2 is considered an entry-level certificate “to provide a training pathway...in the health and wellbeing sectors”. Level 4 is aimed at those who will provide ‘advanced person-centred support to a person with complex needs, and their family/ whānau’ (Careerforce, 2019).

The criteria for the qualification have not changed since prior to the Settlement. Therefore, the graduate profile of care and support workers who hold

these Certificates, and their knowledge, skill and competency have not changed from what they were before the Settlement.

### **Between travel and guaranteed hours in home and community care**

Although the specific focus of this current research is on the implementation of The Care and Support Workers (Pay Equity Settlement) Act 2017, there were additional changes in the home and community care sector around the same period. The changes include the Home and Community Support (Payment for Travel Between Clients) Settlement Act 2016 and the Guaranteed Hours Funding Framework introduced by the Ministry of Health in 2017. The catalyst for these changes was a claim lodged with the Employment Relations Authority in 2013, arguing that the time spent travelling between clients for home-based care and support should be remunerated at a minimum of the minimum wage (Ministry of Health, 2017f). Cabinet stepped in to halt the legal process and authorised the Ministry of Health to begin negotiations with the unions involved, providers of home-based and community-based care and support services, and District Health Boards. The purpose of these negotiations was to reach “an enduring, affordable, and sustainable funding solution for paying workers...for the time and costs of travelling between each client” (Home and Community Support (Payment for Travel Between Clients) Settlement Act 2016, s.2). The 2016 Act implemented the agreement reached in August 2016.

The Act stipulates the minimum costs to be paid according to the kilometres travelled between clients and payment for the *time* as it is time worked. It was agreed that, from 1 July 2015, care and support workers would be paid a minimum of the minimum hourly wage for ‘fair approximation’ of time and compensated for a *proportion* of the costs, not being less than 50 cents per km associated with travel. The Act excludes services ‘for the purpose of preparing an intellectually disabled client to live independently in the community’ and those care and support workers working for clients under ‘individualised funding’. Superior conditions may be agreed to in employment agreements. The Act stipulated that no care and support worker should be financially disadvantaged by the implementation of the Act.

**Figure 1. Graduate Profile of each Level of the New Zealand Certificate in Health and Wellbeing**

<b>Level 2 (40 credits)</b>
Minimum of 80 hours of work experience
<p>Graduates will be able to:</p> <ul style="list-style-type: none"> <li>• Work within the responsibilities and boundaries of their role.</li> <li>• Perform entry level person-centred tasks and functions in a health or wellbeing setting.</li> <li>• Recognise and report risks and/or changes in a person and/or family/whānau.</li> <li>• Communicate to support a person’s health or wellbeing.</li> </ul>
<b>Level 3 (50-70 credits)</b>
Recommended 100 hours minimum work experience
<p>Graduates will be able to:</p> <ul style="list-style-type: none"> <li>• Recognise and respond to signs of vulnerability and abuse in a health or wellbeing setting.</li> <li>• Demonstrate ethical and professional behaviour in a health or wellbeing setting.</li> </ul>
<p><i>Healthcare Assistance Strand.</i> Graduates will be able to:</p> <ul style="list-style-type: none"> <li>• Provide person centred care under the direction and delegation of a health professional.</li> <li>• Recognise and respond to change.</li> </ul>
<p><i>Support Work Strand.</i> Graduates will be able to:</p> <ul style="list-style-type: none"> <li>• Provide person centred support to maximise independence.</li> <li>• Recognise and respond to change.</li> </ul>
<b>Level 4 Advanced Support (70 credits)</b>
Recommended minimum of 200 hours work experience
<p>Graduates will be able to:</p> <ul style="list-style-type: none"> <li>• Work collaboratively to support the health and wellbeing of a person with complex needs.</li> <li>• Implement person centred approaches to support a person with complex needs.</li> <li>• Take a leadership role in a health or wellbeing setting.</li> </ul>
<b>Level 4 Social and Community Services (120 credits)</b>
Minimum of 200 hours work experience
<p>Graduates will be able to:</p> <ul style="list-style-type: none"> <li>• engage and communicate with people, family and/or whānau accessing social and community services in a manner which respects their socio-cultural identity, experiences and self-knowledge</li> <li>• relate the history of Māori as tangata whenua and knowledge of person-whānau interconnectedness to own role in a health and wellbeing setting–display self-awareness, reflective practice and personal leadership in a health and wellbeing setting</li> <li>• actively contribute to a culture of professionalism, safety and quality in a health and wellbeing organisation–relate the purpose and impact of own role to the aims of the wider health and wellbeing sector.</li> </ul>
<p><i>Community Facilitation strand.</i> Graduates will be able to:</p> <ul style="list-style-type: none"> <li>• Work alongside people, family and/or whānau in a community facilitation setting to support autonomy by using tools and strategies to identify goals, address barriers and achieve aspirations.</li> </ul>
<p><i>Community Health Work strand.</i> Graduates will be able to:</p> <ul style="list-style-type: none"> <li>• Work alongside people, family and/or whānau in a community health setting to support autonomy by using tools and strategies to promote self-management of health and wellbeing.</li> </ul>

Source: New Zealand Qualifications Authority, 2014a, 2014b, 2015a, 2015b

Part B of the Settlement Agreement for 'between travel' refers to an overall review of the home and community care sector, including the regularisation of the workforce. This review is still underway. The Ministry of Health states that there are four components to the regularisation of the workforce (Ministry of Health, 2017f, p. 4):

1. Majority of workers employed on guaranteed hours;
2. Training to enable level three NZQA Certificate qualifications within two years of commencing work, consistent with the services needs of the population;
3. Wages paid on the basis of the required levels of training of the worker;
4. A case mix/caseload mechanism to ensure the fair and safe allocation of client to home care workers at a safe staffing level.

'Guaranteed hours' was implemented from April 2017. Guaranteed hours categorises care and support workers into either 'casual' or 'permanent'. Those who are permanent are offered agreed guaranteed hours each week. At the time of the implementation, this was calculated on the basis of 80% of the

average of their hours worked over three months to a maximum of 40 hours or the regular client hours as agreed by the employee (E Tū & PSA, 2017a). Workers are not required to agree to guaranteed hours, in which case they are considered a casual employee. It was anticipated that those who were casual employees 'may slowly lose hours as the work will be given to those on guaranteed hours first' (E Tū & PSA, 2017b). Employers are required under the funding framework to "take all reasonable action to find other work for employees before proposing a reduction in an employee's guaranteed hours" (Ministry of Health, 2017f, p. 5). The framework outlines the expectation that providers aim to minimise the numbers of employees who have their guaranteed hours reduced. In order to mitigate the cost to providers, and provide income certainty to workers, the Ministry of Health continues to fund any 'lost hours' for a period up to three weeks. This is to counter the fluctuation in client hours due to such factors as clients in hospital, moving out of home care or client death (Ministry of Health, 2017f).





# 3 Research Approach

This research has its genesis in discussions within the Caring Counts Coalition. Throughout the development of the research project stakeholders in the aged care and disability support sectors were consulted regarding the research design. In addition, the researchers met with representatives from the Home and Community Health Association, the New Zealand Disability Support Network, Care Association of New Zealand, Human Rights Commission, Public Service Association, E Tū, New Zealand Nurses Organisation and Careerforce. These discussions contributed to:

- a solid understanding by the researchers of the particular sectors and interests;
- the choice of qualitative research (i.e. focus groups, interviews), based on the experiences of managers and care and support workers;
- the development and refinement of research questions;
- an opportunity for the stakeholders to have all questions and concerns addressed;
- identifying contacts within each sector to disseminate the invitation to participate;
- the geographical spread of focus groups and interviews.

The project was supported financially by Careerforce, the Human Rights Commission, and the AUT New Zealand Work Research Institute. The project was granted ethics approval by the AUT Ethics Committee in July 2018.

Data was collected via small focus groups and interviews. These methods were chosen in order to gain more in-depth information about the impact of the Settlement on managers and on care and support workers. Individual interviews were also held with participants who could not attend the scheduled group sessions. Focus groups and interviews were held in five geographical regions across New

Zealand: Northland, Auckland, Waikato, Nelson, and Canterbury. These regions included metropolitan and regional settings. Focus groups were held for each of the following stakeholders:

- Home and Community Care Managers
- Home and Community Care, Care and Support Workers
- Residential Aged Care Managers
- Residential Aged Care, Care and Support Workers
- Disability Support Managers
- Disability Support Workers

Potential participants were sent an invitation to take part in the research. This was distributed through a combination of:

- direct contact with individual care facilities and services;
- peak bodies' dissemination of the invitation and project information;
- social media advertising;
- 'snowballing' (referral) sampling

Each focus group had participants from a range of care providers. These providers represented large national for-profit and not-for-profit organisations, small regionally-based organisations, and stand-alone operators. Participants' identities remain confidential and where names are used in this report, they are pseudonyms – not the participant's actual name.

Participants were asked to answer demographic questions prior to the focus group or interview taking place. This was not compulsory and not intended to provide exact data. Nevertheless, the majority of respondents completed it (58 out of 69 participants). The demographics below (Figure 2) provide an illustrative example of the participants only. Amongst those who indicated that they



**Table 1. Extra payment for Aged Residential Care**

Sector	Occupation	# focus groups, #interviews	Total participants
Residential Aged Care	Managers	4 focus groups, 5 interviews	17
Residential Aged Care	Workers	4 focus groups	14
Home and Community Care	Managers	3 focus groups, 1 interview	7
Home and Community Care	Workers	5 focus groups, 2 interviews	15
Disability support	Managers	4 focus groups	10
Disability support	Workers	3 focus groups	6
Total		23 focus groups, 8 interviews	69

were born in a country other than New Zealand, participants identified that they came from the United Kingdom, South Africa, Fiji, the Philippines and Europe. Ethnicities identified included Indian, Samoan and Tongan.

The majority of the focus groups were facilitated by both researchers together. This ensured consistency in the research approach across all focus groups and interviews. The focus groups and interviews generally lasted for a maximum of 60 minutes. They were digitally recorded and then

professionally transcribed. The data was analysed by both researchers in two main phases. Firstly, each researcher individually analysed the data in each sector for key themes arising across all focus groups and interviews. Secondly, the researchers compared and discussed any differences in their individual analysis, cross checking key themes back to the transcriptions to ensure that the identified themes in this report arose from the issues mentioned by the participants.

**Figure 2. Participant Demographics**





# 4 Residential Aged Care

## 4.1 MANAGERS

The residential aged care managers who participated came from a range of provider organisations including single site facilities, national providers, for profit and not-for-profit. Participants were from a variety of facility types including rest home care, dementia care, hospital level care and retirement villages. Participants came from city, town and regional areas. Six interviews (combination of in-person and telephone) and three focus groups were held with a total of 17 participants.

Key themes that arose across all participants were:

- The pay increases for care and support workers were welcomed.
- The funding associated with the Settlement did not adequately cover the associated costs.
- There had been little change in the number and quality of applicants for care and support worker positions, with the exception, in some geographical areas, of an increase in migrant workers seeking work.
- The effect of qualification equivalency to Level 4, versus practical experience, was a concern; alongside a lack of managerial control over the distribution of Level 1 through to Level 4 care and support workers in their facility.
- In some facilities, the increased wages for care and support workers caused some tension with other occupations such as kitchen and cleaning staff, and registered and enrolled nurses, who did not receive comparable pay increases.

“ I don't know a single person that regrets the idea that these ladies deserve every bloody cent they get from the Equal Pay Settlement, I think it is a wonderful historic moment but boy oh boy, they shouldn't be knocking businesses that sideways”

### Wages to reflect the work

Most managers, if not all, recognised that the increase in hourly rates for care and support workers in residential aged care was long overdue. Most also recognised that the pay increase was because of the value of the work conducted by care and support workers, with some stating that the pay was now close to where it should be:

“the very good things are that staff that have been working in this field for decades – I am speaking purely about where I am – that they are actually paid closer to what they are worth for the tasks that they do, which are huge” (ARM1, speaker 1).

One manager noted that it was 'questionable' why they hadn't been paid more before:

“I think most of us do believe the caregivers needed to get more money. Right? Why we as individuals didn't pay them more before is questionable, let's put that to bed” (ARM3, speaker 1).

Another manager noted not only the positive financial impact for their care and support workers, but also the positive impact on their sense of pride and recognition:

“The good things. First, I think it's a good form of recognition for the type of work that people do, and I think it probably had been undervalued, and it's good to see people get it. There has been an area of, I don't know what you call it, satisfaction or something, by our employees or caregivers that they are now more adequately compensated and recognised for their trade, so to speak. And I don't think anybody in the industry begrudges the fact that they deserve it” (ARM9, speaker 1).

However, nearly without exception, the negative impact on business (which will be covered in more depth below) detracted from the positives:

“I don’t know a single person that regrets the idea that these ladies deserve every bloody cent they get from the Equal Pay Settlement, I think it is a wonderful historic moment but boy oh boy, they shouldn’t be knocking businesses that sideways” (ARM7, speaker 1).

### **Recruiting and retaining workers**

Although it was expected that the increased pay rates would make working in residential aged care more attractive to new recruits, few if any managers had found this:

“Somebody actually asked me about this the other day, ‘you must be having people running in the door’, I’m like, ‘which door?’ Because they’re not. It has made absolutely no material difference whatsoever to our recruitment, none whatsoever... Well, it is still a hard job that people don’t necessarily like to do” (ARM7, speaker 1).

Those who had been involved in recruiting since the Settlement generally reported aiming to recruit at lower levels:

“So if we looked at replacing someone we would never look at Level 4, it just wouldn’t be an option now because if they don’t perform then we would need to go through that process. It is Level 1s but some of our Level 1s are just as good as our Level 4s” (ARM7, speaker 2).

Several (in different parts of the country) noted that although the increased wages appeared to have had little effect on New Zealand recruits, they had had an increase in the number of newer migrants looking for work in residential aged care:

“But we get huge numbers coming in literally coming in with their CV in their hand and about a month or so after the pay equity things went through in July last year, it was just a flood, a lot of those were people looking to, the first question I asked them was, ‘are you a resident?’ If they are not then truly we can’t afford them, it takes so long, you spend such a long time orientating and that is an expensive exercise because you are double shifting them and then if they are good staff that’s fine” (ARM2, speaker 1).

As indicated, not all providers are willing or can afford the process involved to employ someone who does not have New Zealand residency. A further consideration for smaller providers – who may have little administrative support – was the time and effort involved in getting visas for migrant workers, who may not stay in their employment. This was compounded by managers’ doubts over whether applicants with overseas health qualification equivalency would have the necessary practical skills and knowledge. This manager hints at parity issues that arose from the process of Level 3 and 4 equivalencies of overseas qualifications:

“Well it has caused problems, definitely, for me with my senior care givers because they now have people who are getting Level 4 who are very new to the business simply because they jumped immediately to Level 3 as an overseas RN and then jumped into Level 4 but they have maybe a year’s experience as an RN and no experience as a care giver. The senior care givers have a lot more experience, they know what they are doing but they haven’t done their training, they haven’t done their levels, they have only done Level 1 and 2” (ARM2, speaker 2).

### **Experience, training, qualifications**

Providers did note that it was much easier to keep their care and support workers now, and that generally turnover had reduced. Some of that was because of those care and support workers who were on Level 3 or Level 4 based on their length of service with their current employer. This meant they could not change employers without a reduction in hourly rates:

“We always had very high staff retention anyway and this has certainly cemented staff retention in that respect. I suppose the flow on effect of that is that we do have a far more stable staff than we have had previously, in many respects. What we call the churn which is the group underneath our stable cohort is extremely small compared to what it was before simply because the staff who potentially would look to move somewhere else simply are not moving because it would devalue their position in a new organisation – because it is experience based not qualification based they automatically drop” (ARM 7, speaker 1).

However, there was a negative side to this retention, specifically for those who were on Level 4 because of their tenure of service to the provider. This particular route to Level 4 created several tensions: managers reported that not all of the care and support workers who had attained Level 4 through service and experience had the skills and aptitude assumed of Level 4 competencies, creating issues of performance management for managers. Those care workers who were performing at Level 4 would lose that pay level and rating if they left their current provider. Some managers pointed out that this worked against the intention, they thought, of the Settlement:

“We were told the reason for pay parity was to financially recognise a group of women working in rest homes for many years, just above minimum wage. Everyone agreed they deserve more. However, these women have not been recognised for their own work and their own experience. Any increase they’ve been awarded, they only get to keep it if they stay with their original employer. If one of these women who has amazing skills but may not be qualified, leave, they go down to the lowest level with their next employer. They’re tied to that original employer. That means they do not have freedom of economic movement and that’s not fair.” (ARM8, speaker 1).

Having more junior (in skill) care and support workers who, literally overnight, were on a level with existing senior care and support workers posed challenges for managers. Managers noted that now those care and support workers would need to be more closely performance managed as there were some not capable of Level 4 work. Previously, when they were paid lower wages, and perhaps had less complex tasks, managers tended to not review their performance as closely. As one manager pointed out this was an unfortunate and unintended consequence for those workers, as many may now be managed out of the sector:

“The hardest thing for us is accepting that our hands are tied and that there is a possibility that certain caregivers who have been here long-term but are still not Level 3 or 4 material, may be performance-managed out of their jobs. That’s definitely the hardest thing” (ARM5, speaker 1).

However, participants noted that this did not describe all their Level 4 care and support workers:

“To be fair to our staff, most of them who do it would be keen on doing a more senior role if we could give them one and we are looking at that, getting them to do some things. But then, of course, it all takes time” (ARM3, speaker 3).

Managers felt that they had less control to plan employee training under the Settlement requirements, and consequently the composition, by level, of their staff. Managers reported that care and support workers did fund and seek qualifications themselves, without first discussing it with their managers. The consequence was that they would present their training certificate at Level 3 or 4 and the manager would be required to increase their pay – without prior warning. This meant that managers could not plan rosters and teams around their client needs, or plan to balance skill and experience across a team. It also gave them less control to be able to plan and budget for future staff:

“We have a cleaner with us who went away and did a 13 week course came back with supposedly (we thought she was wanting to be a caregiver, we thought she was going to come in at Level 2), she ends up saying, ‘Oh I’m at Level 3’, and went into our nurse manager saying, ‘please sign off this work’, and that ‘I am capable of doing this’. And it’s like, ‘well, no, because you haven’t done half of that’. But now she has turned up with a certificate saying, ‘I’ve got a Level 3’ and we are still sitting there going, ‘we wouldn’t sign off the practical work, so who has?’” (ARM3, speaker 1).

Further, as mentioned above, managers were not convinced of the quality or relevance of online training that did not include practical skill assessment, or consideration of the skills required in the facility itself. This meant that some managers would be reluctant to employ new employees with Level 3 qualifications from training providers that managers were not familiar with:

“I do feel sorry for people that go off and train at some of these places that train you because these are just young people that are trying to get a career and they pay money for it and then they come to us employers who aren’t that keen

to employ them because they haven't got the practical experience. So it's pretty tough for them as well" (ARM 3, speaker 3).

The issue of 'equivalencies' where a non aged-care qualification was assessed as equivalent to Level 3 or Level 4 was problematic for managers. Some managers reported care and support workers bringing Level 4 equivalency to their attention without any prior notice or discussion. This caused issues for planning, rostering and budgeting. Further, most managers agreed that from their perspective, Level 4 equivalency focused more on leadership and knowledge than Levels 2 and 3 which had more practical components. This meant that someone may have knowledge at Level 4 that is not supported by the practical skill, experience and knowledge acquired over Levels 2 and 3.

"We had an ex-registered nurse working for us as a caregiver. She's actually lost her registration and was really not the most competent caregiver. But because she'd done that level of training she automatically got a Level 4, and yeah, education doesn't equate to competence...I think that was a whole element of it that was completely missed" (ARM5, speaker 1).

Several managers mentioned their suspicions of online only training:

"We're not great online advocates. Because again, it's about the deeper understanding of what that knowledge is going to translate into in your job" (ARM4, Speaker 1).

However, others reported a shift, post-Settlement, towards online training at their organisation as it was more cost efficient. Some providers had reduced their overall training offerings (including in-house training), and some were not paying care and support workers for the time taken to attend in-house training, and not allowing as many care and support workers as previously to attend refresher and other in-house training sessions:

"We have dramatically reduced the amount of in-house training. We now have it once a month and it is mainly, we have manual handling every month so that every new employee that comes in that month never waits more than 3 weeks before they are assessed by a physio for their transferring and so on" (ARM2, speaker 2).

Several organisations had not reduced or changed their training, and while it was a cost, those managers viewed in-person training as essential to their business and quality of care:

"Look, we've always been quite proactive with access to assistance with training, so we've had to just increase the amount of hours from our education team to be able to meet our obligations under the Act" (ARM4, speaker 1).

### **Rostering and allocation of tasks to jobs**

As indicated above, the tenure and qualification associated with each level and pay rate had caused managers to consider how they allocate tasks to different care and support workers and teams. Some providers had previously used a 'senior caregiver' role that translated well to Level 4 work. In some cases, providers had added more administrative or managerial tasks to those senior roles since the Settlement. It was generally felt that because Level 4 was a significant pay increase, therefore care and support workers should either do *more*, or that they should have greater responsibilities – taking on tasks once carried out by enrolled or registered nurses:

"So everyone who becomes a Level 4 then gets trained to be a senior care giver and be medication competent, wound management competent and take on supervisory tasks of other care givers and they haven't liked it. But every time that I have happily accepted their diplomas and put their pay rate up, I hand over a new contract with a job description" (ARM2, speaker 2).

This change in expectations of a Level 4 care and support worker role meant that the traditional divide between registered nurse and senior care and support worker was narrowing:

"How you could differentiate an RN [registered nurse] before from a care giver that differentiation is closing, that gap is closing quite dramatically. We are expecting the care giver to do much more of what you would call traditional RN tasks – blood pressures, like I said there is some wound management, definitely pills, medication management and so on and so forth. They are absolutely capable of it but the system before didn't allow that because there was just too much stratification" (ARM7, speaker 1).

Managers spoke of how they now took into account the level of their care and support workers when devising the staff roster. They took into consideration how to best allocate the skills and experience of Level 4 care and support workers, and also how to make the most cost-efficient use of these care and support workers; spreading them across shifts:

“I think more the impact with us is that now there is a very strict four, three, two, one. And so now you’re selective about the number of 4s that are actually on shift, the number of 3s and the number of 2s, in that whole team that you make up... So rather than having all Level 4s who have been there for yonks and know exactly what’s happening, you may well have a more graded system and so we are very clear at looking at that when putting the roster together” (ARM3, speaker 6).

Managers had also been forced to consider what tasks were included in care and support worker roles – especially where care and support workers had done some cleaning or kitchen work (these jobs were not included in the 2017 Settlement parameters). Some managers were moving such tasks out of care and support worker roles:

“Next year [we will] look more specifically at the [non-care] roles and so there are more things that a [non-care] worker can do that an HCA does at the moment. So it is like making the beds, little things like that. So I guess then we will have more of those and the HCAs will be doing more of just care. So I know we are going to look at that but we haven’t yet” (ARM7, speaker 2).

Others had built flexibility into their payroll and rostering system. One example was where a care and support worker agreed at short notice to work in the kitchen to cover an absence. They could be paid a lower rate for that kitchen shift. However, some managers decided to reward their willingness to help out and would pay them at whichever level they were on as a care and support worker. Most managers were no longer putting kitchen staff in to a care and support worker role as it would cost more, and be more administratively complex. However, some chose to reward loyal and hard-working staff if they filled in for a care worker:

“Only for the domestic who, if she is caring, then we’ll pay her a higher rate, because she has been here also 11 years so she definitely deserves her higher rate for the caring. Yeah, we pay her another rate. And if one of the caregivers works in the kitchen, we still pay the higher rate. They do us a favour to fill in that position, yeah, so we can’t just punish them on top of the favour, and that brings a cost with it of course. So yes, to keep the books balanced it will be interesting” (ARM4, speaker 1).

### Parity with other occupations in the sector

As mentioned above, some managers found the implementation of the Settlement challenging; incorporating the different levels, training opportunities, and requirements into the management of their facilities. In some cases, managers had to pay more than they thought an individual’s competencies were worth. There was a misconception among some managers that they could not pay more than the prescribed rate at each level. Among those who thought this, it was contentious because, to them, it removed their managerial discretion to award and motivate their better employees with higher wages. An added frustration, and another loss of managerial discretion was when they had good care and support workers who did not want to do the qualifications, but were performing at Level 3 or 4 – and the manager thought they could not offer higher wages. Managers thought of the prescribed hourly wages not as minima, but the only possible rate:

“So I had 3 senior care givers come to me and they said, ‘I am no longer doing the senior care giver role unless you pay me more than the caregivers [this one, that one, that one]’. And I said, ‘well, unfortunately with Pay Equity it dictates what I can and cannot pay you and this is the level you are at. We used to have extra incentive money that we could pay people. That is no longer part of it’” (ARM2, speaker 2).

Other issues of parity arose in residential care because several occupations work alongside each other. In particular, kitchen staff and cleaners often felt that the significant pay increase for care and support workers was unfair, as reported by managers:





“There’s division amongst staff. Cleaners and cooks felt and were left out, and managers have no money, have no money to pay them extra” (ARM8, speaker 1).

“It’s harder to retain staff in other areas of the business, e.g. kitchen, because the staff have asked and then they see the better money... So we do have staffing issues as a result of that. But I don’t think it’s just that, it’s also pretty full employment these days, so that’s also impacting upon it as well” (ARM9, speaker 1).

Several managers spoke of how they had discussed the changes with all their staff, so that any issues of parity would be minimised. Their approach was to explain it was a gender equity issue, but also to distance managers and the provider from responsibility for any perceived unfairness. This meant that kitchen and cleaning staff had a better understanding of the sudden pay increase for care and support workers, but also could not really lay ‘blame’ on the manager or organisation:

“Well, it was extremely important, because it’s a sensitive subject. It was never going to be easy for some people to swallow what happened, because first of all it was so quick... So for them, it was presenting it in a way that our staff understood that this was not anything personal to the organisation, that this was a difficult decision that the government had made because of pay equity issues... And I guess it was also just giving other

staff the options of – if you would like to pursue this career now it’s more attractive and you can, and we’ll help you to do that. We kind of placed them in a position where they really couldn’t question us as an organisation, ‘cos we were very, very clear that this decision was nothing to do with us, or really, the role. It was something bigger, if that makes sense” (ARM5, speaker 1).

Issues of parity between Level 4 care and support workers and enrolled and registered nurses were more acute. Several managers mentioned that at Level 4 a care and support worker role *may* have tasks very similar to that an enrolled nurse used to do, and that the Settlement was blurring the boundaries between the roles:

“We now expect Level 4 staff to perform at \$24.15 level, you’ve got them perhaps doing maybe some things that you may not have expected of them in the past. We’ve trained them to be able to do that role, PEG [percutaneous endoscopic gastrostomy] feeds, bowel evacs, some of those types of things that we’ve actually trained them to do and they’re very competent to do. But we’ve actually in some ways perhaps tried to take some of the more day to day, mundane stuff away from Registered Nurses” (ARM3, speaker 6).

Some thought that the small difference in pay between a Level 4 care and support worker and enrolled and registered nurses was not fair for the nurses, and had caused disruption:

"I think it's a good thing for the health care assistants, it really has made a difference to their salary structure. The bad thing about it is that we are not being funded by the government to cover that pay increase and it brings the Level 4 rates very close to the entry level RNs and that is causing a lot of disquiet" (ARM3, speaker 2).

Some pointed out that despite small differences in pay, in some cases, enrolled and registered nurses had a legal responsibility and liability for the care of clients, whereas care and support workers did not:

"Both RNs [registered nurses] and ENs [enrolled nurse] are hugely penalized, but you've got the EN with the professional responsibility, the registration and everything that goes with that being paid maybe 25, 50 cents an hour more [than Level 4 caregivers] because that is all you can afford to pay them. As the funding related directly to the 2017 Pay Equity Settlement for caregivers, managers were not funded to increase the wages of other occupations" (ARM3, speaker 2).

Others who had paid their registered nurses at the high end of industry benchmarks before the Settlement did not experience these same issues:

"At the moment our RNs have no trouble because their hourly rate is set at the highest" (ARM4, speaker 1).

## Challenges

Funding was a crucial challenge for most managers. Most, if not all, agreed that the funding was inadequate to cover the costs associated with the Settlement. As one manager commented:

"We were told that the government would fund pay equity 100%, they have not. And then they realised there were so many people going under that we were asked to prove our negativity. And of course that's me, and you had to pay an accountant to work it out" (ARM8, speaker 1).

One manager pointed out the difficulty of maintaining quality of care (as others agreed) with much tighter margins than prior to the Settlement:

"The negative aspects is that it was already a difficult industry to give quality of care and run a business that makes a profit, it is now

exponentially more difficult because we still try to give that top level of care with only a small amount of increase in money but with a much larger increase in expenses in staff wages" (ARM2, speaker 2).

This was reiterated by another manager who stated that the funding had shifted focus from care to money:

"Unfortunately this Equal Pay Settlement has put us all, every single organisation that I know of, it has put every single one of us in a position where money is going to be more important than care because it is killing us" (ARM7, speaker 1).

Those in smaller facilities struggled to stay in operation. This was both in city and small-town areas. Some smaller operators who had more than one facility had chosen to change the services that they offered, such as moving more to dementia care because the funding was higher. Some providers who provided rest home care with 'swing' hospital beds had reduced the availability of hospital care beds because it was more cost efficient.

Some small providers had cut the hours of their staff, (often those in managerial or administrative positions), rather than lose staff because of budgetary constraints. More than one manager spoke openly about the budget with their care and support workers, and in at least one case, care and support workers volunteered to temporarily reduce their hours to keep the facility in operation:

"During the time we had only the [usual core staff] we did, through communication with our team over several weeks suggest to them that financially this was too difficult to keep going and could we look at, as a team, doing some part time hours and so we had people who volunteered taking some hours off, obviously on the condition that when things improved that they would get their hours reinstated which is what we did" (ARM1, speaker 1).

Some smaller providers were barely remaining operational from one week to the other with costs such as GST bills, fire safety checks, fresh (instead of frozen) food becoming impossible to meet. Some were concerned about whether they would be able to stay in operation in the short and medium future. It



was suggested that the Settlement was more difficult for smaller providers to implement because they could not consolidate costs (such as administrative costs) in the same way as larger providers:

“The larger flow on effect from a smaller business perspective is that the larger businesses are able to cut an awful lot of their costs and spread costs across their administrative areas... I have got one facility and one accountant, so obviously spreading that cost is a significant change” (ARM7, speaker 1).

Larger providers and retirement villages did not appear to have the same financial challenges. One manager mentioned that they could make a loss, at least in the short term, in their rest home – because it would be offset by other facilities and units in their organisation. However, another manager disputed the idea that retirement villages were better off because they could subsidise the rest homes, as each business unit needed to be able to operate within its own budget and funding.

Some participants thought that the industry averages the funding model was based on favoured larger providers over smaller ones. Although no single reason explained why this might occur, it was apparent that larger providers did not face quite the same financial difficulties under the Settlement as smaller providers.

One manager summarised their divided feelings on the Settlement:

“I think down the track this will prove to have been a good step because there is no way probably for another 5 years or so anybody can complain that they are underpaid – we will be underfunded for 5 years I imagine – and so in that respect I think, I hope, that will prove to be really positive for the companies, the people who survive. My concern is that there will be more facilities who don’t survive because I know of quite a few that are struggling again now. I think people hoped and prayed that this last budget was going to maybe be something along that 5% line to bring us up to something but it wasn’t, it was 2% or 2.5%” (ARM2, speaker 1).

One suggestion for how the funding could be improved was:

“I think that if I could have had it my way there would have been a lump payment for length of service pre-July 17, but then everybody needed to have worked to the same principles. To move up these levels you need to complete this qualification, we will assist you to do that, but in return we need to talk to you about the consequences that come along with this, and how our expectations of you will increase so that you can be completely sure that this is what you want to do” (ARM5, speaker 1).

## 4.2 CARE AND SUPPORT WORKERS

Four focus groups were held with care workers in the residential aged care sector. A total of 14 participants took part, and they came from a wide range of regions across New Zealand. The participants came from a variety of providers including for-profit, not-for-profit, and large and small facilities.

The major themes that came through in the focus groups were:

- A dramatic increase in quality of life due to the pay improvements.
- A shift in rostering practices and a change in hours offered to workers.
- Tension across occupations due to the relativity of pay rates.
- The Settlement has increased the recognition of the work but has not increased appreciation of the workers.

### Financial impact for care and support workers

For many of the care and support workers who participated in this research the increase in pay had a profound impact on their quality of life. For some, holidays away were now affordable, but for others, more basic choices were now within reach:

“I went to the dentist after not having been to the dentist for about 6 years. My husband has just retired and I was able to buy him for his 65th birthday, a pair of spectacles because we haven’t had glasses for about 15 years” (ARW4, speaker 4).

While the increase in pay was appreciated by workers, some did express concern at the concomitant increase in tax, as many moved to a higher tax bracket. Several care workers saw this as a disincentive to work the number of hours they had prior to the Settlement, and had reduced their work commitment.

Aside from the tax issue, the increased pay also meant care workers were able to make decisions about how many hours they needed or wanted to work. Prior to the Settlement, many workers commented that they needed to work as many hours as they could get, due to the low rate, as one participant noted, “before I had to work 15 more hours to catch up” (ARW3, speaker 2).

Some were now choosing to not work weekends or not to take on extra shifts or overtime, and instead were choosing to spend time with family and participate in other activities. One woman commented that she had not been around for much of her children’s growing-up years, during her career in the sector, but at least now she had time to spend with her grandchildren. Similarly, some participants saw a benefit of not working the long hours they used to as “it has released the stress that we have been through because we had extra money” (ARW4, speaker 2), and that the reduction in hours for some meant they “are less tired so can give better care” (ARW4, speaker 1).

### Changes to the role of care worker

While all the care and support workers expressed a positive response to the increased pay rates for their work, they were also clear that the Settlement had created a range of negative consequences relating to their role. Many of the participants reported a significant increase in workload expectations, since the introduction of the Settlement. Care workers also reported that there appeared to be an increase in the breadth of tasks required of some care workers. This included lower level duties such as cleaning, as well as some tasks traditionally carried out by enrolled and registered nurses. Those expectations came from other workers in the facilities and from management:

“Before I left to go away on holiday our kitchen staff were just dropping things in a big fat bowl and sending it down to us and expecting us to dish it out ourselves, so these are the sort of things that were coming out of it. But then we got told that one of the nurses wants to drop the nurses doing medications and they are wanting the senior care givers to do it. So our role wasn’t based on the equal pay case, it was, ‘you’re getting the good money, you deserve to do all the work’” (ARW1, speaker 2).

There was a general perception that they were now expected to “go harder and faster” (ARW3, speaker 2). As another participant commented:

“ I went to the dentist after not having been to the dentist for about 6 years. My husband has just retired and I was able to buy him for his 65th birthday, a pair of spectacles because we haven’t had glasses for about 15 years”

“The other thing that is noticeable is the baseline things that used to go with care giving like making the beds, tidying up beds, has become more of a ‘if you can get it done’” (ARW1, speaker 2).

Several participants agreed that the increased expectations had somewhat neutralised the positive outcomes for care and

support workers, and some anger surfaced about management’s attitude towards them:

“It comes at a cost. I was asked if I felt more appreciated with the pay rise and I said, ‘I do not feel that management appreciates me anymore, it is not management that has given me the pay rise, it has been the Government that has given me the pay rise, the boss has been forced to give me the pay rise, they don’t appreciate it’. The bosses fought the case, they don’t want to give it to us, they don’t appreciate us, they fought, they spent money to fight the case! So they don’t show that they appreciate us, they couldn’t put that money to better use paying the staff” (ARW4, speaker 4).

Some participants were concerned about whether residents’ quality of care would be compromised if care workers were now performing nurses’ tasks, because nurses were the ones with specialised training:

“Like doing medication, like taking the residents to doctors, things like that, taking them to the podiatrist in the facility, but doing a lot of things

like doing the weights, doing the regular creams and things like that that nurses should be doing so that they are checking their skin at the same time. So a lot of things like that, that nurses should be doing. The nurses are there to do the medication" (ARW4, speaker 3).

One participant also questioned whether the delegation of such tasks to care and support workers was part of a management strategy to save money:

"Now they are trying to train care givers to do medication because they are trying to reduce the nurses" (ARW2, speaker 2).

### Changes to rostering and hours of work

Participants reported negative impacts on the rostering of their hours and workloads since the Settlement – such as a reduction in their rostered hours:

"It's like the hours have dropped so people were used to working a 40 hour week because that was the law then but now it is slowly dropping down to 20 hours or maybe 25 hours which again, we have people thinking what is the point of the equal pay deal because you are screening hours" (ARW4, speaker 1).

Some reported that rostered hours had been cut, effectively making little change in their overall income from prior to the Settlement. This resulted in some care workers expressing their intention to leave.

In some facilities there had been a reduction in the number of nurses, and care and support workers generally:

"Our management have openly said that it is because of the Equal Pay Settlement. They had a meeting the day before the Settlement came in and said that people won't be replaced" (ARW4, speaker 3).

The reduction in staffing at some facilities resulted in changes to staff/resident ratios, sometimes leaving gaps, such as on night shifts:

"We noticed in our place that they don't replace, so on a night shift, I work the night shift and if you leave or if you are off for the night they don't replace that shift" (ARW4, speaker 4).

Overall, the issue of staffing ratios was raised as a concern in general:

"Now that is a guideline, that ratio, but they look upon it as this is scripture, this is our bible, this is what we say is going to be, so their ratio now is 7:1. This is in the continuous care wing, I am not talking about the rest home. This is hospital level care. So they are expecting you to be able to do these people who are stroke victims, people who have Parkinson's and all that, people who are very heavy, a lot more work, you have got to do it yourself. I work on my own, the only time I have someone actually working beside me is when I am hoisting because of health and safety" (ARW1, speaker 1).

Several participants thought that management did not understand the nature of care and support workers' work, and the time needed to carry out their tasks well:

"So they don't staff to acuity, they don't understand the workload and they are putting more and more of the nurses' workload on the care givers" (ARW4, speaker 3).

Participants perceived that the quality of care had lowered with the reduction in hours and numbers of staff:

"Hours cut by the owner or the company that is meaning that it is cutting the care of these people" (ARW4, speaker 2).

The increase in pressure to get work done with fewer staff meant that some participants felt that they had to make choices about the priority of tasks, to ensure good quality of care. If they did not complete all the tasks within their shift then they risked being reprimanded.

A reduction in staffing also led to concerns among some participants regarding health and safety in the workplace:

"On the weekend or when there is a shortage of staff there are always people that need to be hoisted. We have got 13 or 14 that need to be sling hoisted, so that takes 2 caregivers, so if you are already down to 5 or 6, you are struggling. So what people do is they just use the hoist and one person" (ARW4, speaker 3).

“...we have had so many people with accidents at work because they are just rushing and rushing” (ARW4, speaker 1).

Aside from the increased workload expectations for care and support workers – that appears to have occurred for many after the Settlement – relativity issues were also voiced. These include tensions with other workers, and also the division of tasks and responsibilities in the sector. As one participant related:

“And the worse part is that my feeling is that is coming from the nurses, the nurses are saying, ‘why should we work if you are going to get a better pay rate than us? We’ve got nurses who aren’t on much more than us as caregivers and they’re sitting there saying, ‘well you guys get paid the good rate, so you guys can do it’, and we are sitting there going, ‘hey, hey, hey, you are the qualified one’” (ARW1, speaker 2).

“I mean, our manager said to us, ‘if you are Level 4 you have to be leading the shift. And I’m like, ‘no we’re not, what does the RN do? If we are going to lead the shift what is the point of having an RN?’” (ARW4, speaker 1).

### **Pay rates, progression, training and qualifications**

There appeared to be confusion amongst a number of the participants regarding their entitlements and pay progression within the Settlement. One participant expressed their frustration over who receives the increases in pay, in relation to qualifications, at their facility:

“According to our manager, if you get the certificate, even if you start it or you are going up to a Level 1, to a Level 2, you get the qualification for Level 1, Level 2, Level 3 and something like that, you don’t get anything for it because you are already included in the pay rise. There is no extra money, you don’t get any extra money for it because you are already in the pay rise from last year” (ARW3, speaker 3).

This was especially common for those who had moved up levels due to their continuous service with their current provider at the time of the Settlement. A number of participants expressed some dissatisfaction with colleagues who had not

worked towards gaining qualifications over the years, yet who were now receiving significant pay rises because of their experience:

“Yes, but being here for such a long time, in that time when the courses were going you should have at least taken some kind of qualification, actually the whole Level 4, 5 or 6, they should at least have done something to get up top. Just because equal pay came in it is just bang! Straight to the top! I find that is not right” (ARW3, speaker 1).

These concerns reflected a general feeling of unfairness that those who had gained their qualifications were now expected to pick up some tasks previously done by enrolled and registered nurses, with an increased workload, while others on the same level due to tenure, but without the qualifications, had a lower workload – yet were paid the same.

Participants noticed a change in how training was offered after the Settlement. Some reported that their employers offered training towards qualifications, and paid for the course costs, but expected care and support workers to complete the study in their own time. One participant observed that:

“They are not providing training or paying us to train” (ARW4, speaker 2).

This indicates that care and support workers (and possibly their managers) were not aware of their rights and obligations under the Act. As another participant commented:

“I noticed that a lot of the girls are saying stuff which is quite concerning, that the training aspect, being told they cannot and will not go to Level 4, that’s just that” (ARW1, speaker 2)

### **Overall impact of the Settlement**

One unforeseen impact of the Settlement was an increased perception of antagonism towards unions by managers in some organisations. Some of the care and support workers commented on the role of unions, and attitudes towards unions in their organisation. One participant argued that the Settlement has made it easier for unions to recruit new members. However, other participants indicated that an anti-union sentiment prevailed in their organisations – to the point where some workers

were reluctant to participate in the focus group for fear of management reprisal:

"I know, but the thing was we had no union before, we have only just, people are too scared. So like when I got the email about this meeting I asked a few people who belong to the union and I said, 'are you going to go along'. 'We don't want to talk about that', I said, 'didn't you get the email'? 'Yes, we don't want to talk about it'. It is all shush because they might not get treated good, you know? Because there is so much bullying going on" (ARW1, speaker 1).

Overall the participants saw the Settlement as making a positive impact insofar as recognising their work:

"I think it has empowered...you notice that there is something that people can do, that is what I am telling them, if you fight for your rights it is not automatically if you say something now it will happen" (ARW2, speaker 1).

"For my impact, it is my qualification that I have actually got and getting the right pay for it. I could have done with that 10 years ago, and that my qualification has been seen" (ARW3, speaker 1).

However, for many, it also has come at a cost through reduced hours, extended duties and increased workloads. A common theme that came through in the focus groups and interviews, as indicated earlier, was that although care and support workers' work has been recognised through the increase in pay, they were still not appreciated by their managers:

"There's more down than up really but we all, yes we were recognised and that's what we wanted, we wanted to be recognised for what we do but then again, we just don't get appreciated. The pay's good, we don't have to work these long hours and we are able to go on leave and go on holidays and things but then, you know, is it really worth it because mentally, physically and emotionally we are drained" (ARW4, speaker 3).

"They expect us to do more, we are expected to do more and we are not really, I don't think we are appreciated. We never have been appreciated" (ARW4, speaker 4)

## 4.3 RESIDENTIAL AGED CARE CONCLUSIONS

Both managers and care and support workers pointed to the positive impact that increased wages had had. Most of the managers agreed that these workers deserved a pay increase. Care and support workers saw improvements in their personal lives – when their hours were not cut – making it easier to work hours that support work-life balance, to better afford medical care, and for some to take holidays away from home. However, care and support workers felt that although their increased pay recognised the worth of their work, their managers (and other occupations) still did not really appreciate them. This was also reflected in reports that registered and enrolled nurses, and kitchen and cleaning staff, were often resentful of the pay increases for care and support workers, because they did not benefit from comparative pay increases. Some care and support workers were scared to speak up about their work conditions.

Both managers and care and support workers reported a change in care and support worker tasks. Sometimes this was a requirement of Level 4 care and support workers to undertake more complex care tasks than previously, including some tasks that were carried out by registered and enrolled nurses prior to the Settlement. In other cases, Level 4 care and support workers were given additional tasks (allocated from other roles) because they now earned more money and should therefore, in the managers' view, do more work.

The implementation of the Settlement had proved challenging for managers. Some of this was centred upon a reported under-funding of the Settlement costs, which led to needing to manage within very tight budgetary constraints. The link between tenure or qualifications with pay rates had proved most challenging. In some cases, managers had care and support workers who would advise them, without prior discussion, that they had gained a qualification equivalency or particular level of training. This removed managers' ability to plan rosters and budget for the increased costs in those cases.

Service versus experience was an issue raised by both managers and care and support workers. In some cases, it was perceived that with qualification equivalency a care and support worker might be on Level 4 wages, but have much less practical

experience than a care and support worker at Level 2 or 3. Some participants reported that there were care and support workers who were on Level 4 because of their service with their current provider, but that they did not have the skill or aptitude for Level 4 care work, and had not shown previous inclination to complete their qualifications. Another aspect of the service requirements that was perceived to be unfair was that if an excellent care and support worker was on Level 4 through their service, they could not change employers and take that wage rate with them. Related to the issue of experience, qualification and tenure was an issue raised by some managers: that those care and support workers who were on Level 4 because of their length of service, but were not up to a Level 4 job, could be a cohort that would end up without jobs – they might be performance managed out of the sector.

Managers' roles had also become more complex and were often larger than prior to the Settlement. In addition to reporting requirements, they had to look at how they rostered different levels of staff, to ensure adequate coverage across shifts. Performance management of care and support workers had

become more important. These were factors that had sometimes been overlooked when managing low wage workers. Now that there was a greater cost involved, through wages, some managers had to change their practices to adapt to the new environment.

Both managers, and care and support workers, expressed concern that the Settlement, and its associated underfunding, had put more of a focus on money than on quality of care. Some care and support workers reported a reduction in the staff/client ratio, which posed challenges to safe lifting and care of clients. The funding model placed considerable stress on smaller providers, who perceived the model to be more favourable to larger providers who could, for example, spread administrative costs across several facilities. Some smaller providers were uncertain about whether they could continue to operate in the future.



# 5

## Home and Community Care

### 5.1 MANAGERS

Three focus groups and one interview were held with Home and Community Care managers, for a total of seven individual participants. The managers came from a range of providers across the country covering both national and small local organisations.

The key themes that arose across all participants were:

- The pay increase was generally welcomed for the care and support workers.
- The funding delivered through the Settlement did not adequately cover the cost of implementation.
- Rostering care and support workers to meet client need, guaranteed hours and between travel requirements was complex.
- Qualification equivalencies to the New Zealand Certificate in Health and Wellbeing have not met industry needs.
- There was a lack of information for managers regarding the Settlement requirements and expectations.

#### Increased wages with negative consequences

Generally, home and community care managers acknowledged that the pay equity Settlement was important to recognise the work and contribution that their care and support workers made to their organisations and clients. As one commented:

“I guess, the good thing is it’s a recognition of the support workers and the care that they do provide. It is an incredibly important role in society and that does really need to be recognised” (ACM3, speaker 1).

However, although the recognition of care and support workers was appreciated, the Settlement

had created negative consequences for those managing the terms of the Settlement. In particular, all managers commented that the Settlement had increased their workload, and that the increased administrative workload was not reflected in the funding model:

“it’s a full-time job managing the legislation, both financially and operationally, and for us we don’t get any funding for that. So our contracts are literally just to provide the client services, and that’s a real issue for us, particularly as a charitable trust” (ACM2, speaker 1)

Most of the managers perceived that this lack of recognition for the full cost of administration associated with the Settlement was in part because managers and their perspectives were excluded from the Settlement process:

“from the employer perspective, given we weren’t party to that Settlement and to that agreement, the practicalities and the logistics and the flow on consequential effects outside of this group

has been monumental. The decisions were made at a high level from the Government and a support worker perspective without any concern for the employer party in that relationship” (ACM3, speaker 2).

#### Recruiting and retaining care and support workers

The increased hourly wages had not made a significant impact on these managers’ ability to recruit new care and support workers. While several managers did report a higher quality of applicant, they also noted that not all applicants had a good understanding of the work, and that they were motivated by the pay more than a desire to do home and community care:

“ I guess, the good thing is it’s a recognition of the support workers and the care that they do provide. It is an incredibly important role in society and that does really need to be recognised”



“We just also have more higher calibre people coming in the door and interested because they see that it is more sustainable at that level of pay. And I think that what you [other focus group member] said is right, you really need to gently let them know that the hourly rate is great but we can’t really guarantee standard, regular 40 hours a week of work. And some of the reasons for that is that everybody needs help at the same time, so then there is a big gap between for of 10.30 to 12 where there is no work, and then everybody needs it at 12 and dinner here. So we don’t have the work to give them, so I always try to let them know that if they really need a regular number of hours of work they need to think about whether this is the right kind of industry” (ACM4, speaker 1).

The Settlement and costs associated with paying wages for those on Level 3 and Level 4 had driven a change to recruitment strategies, so that managers aimed recruitment at applicants with no qualifications or Level 2. This was in part due to their changed rostering around client need, and level of their care and support worker – as is discussed later:

“So we have had to start taking on people who have no experience and training them up because we could bring on Level 3s or 4s but we wouldn’t have the work for them, so it is not fair on them either” (ACM3, speaker 1).

Another manager commented on how they had become more ‘selective’ in their recruitment:

“We also have changed our recruitment strategy and we are seeking what we see as potentially higher, or more credible, I don’t know how to say that, more literate type of person because then you don’t have to spend lots and lots of time explaining what is a work ethic? And what are your performance boundaries? And, you still failed that test for the fifth time, so we now have to help you for another 3 hours! So, we are looking for people that don’t need as much hands on support from us, no need to spoon feed them” (ACM4, speaker 1).

There were also cost implications for providers in retaining Level 3 and Level 4 care and support workers. If providers were to allocate their care and support workers based on client need and funding,

they would need more workers with no or Level 2 qualifications than Level 3 and 4. Therefore, while retaining good workers was generally viewed as a positive factor, some managers could see the negative cost implications for them and their workers. There would be fewer hours available for those on Level 3 and 4, perhaps leading to them exiting the sector. If this occurred, it could also act as a disincentive to attain higher qualifications, for those workers without qualifications or on Level 2:

“Well that’s right, if you can’t afford to keep them anyway...I mean it is a concern that they will actually have to start moving out of home care and looking for other work and then support workers at a lower level are going to be put off from enrolling and completing those higher level certificates because they know what is happening and they know, they are starting to learn that. So where is that going to leave us in terms of qualified support workers? We are just going to have a lot of Level 2 support workers” (ACM3, speaker 1).

Generally, recruiting enough workers into the sector was still difficult since the Settlement:

“We thought both of these pieces of legislation [The Home and Community Support (Payment for Travel Between Clients) Settlement Act] would have increased our pool but right now we are all struggling across the board” (ACM3, speaker 2).

### **Parity with other occupations in the sector**

Participants highlighted the issue of perceived unfairness that some care and support workers were on Level 3 and Level 4 because of their experience or service, rather than qualifications. This was more obvious to managers when they compared those unqualified care and support workers with coordinators and office staff:

“Our coordinators who do a hugely stressful job with rostering they are not even paid as much as an unqualified support worker” (ACM1, speaker 1).

Several managers highlighted the relatively close level of pay between Level 4 care and support workers, and enrolled and registered nurses, and the problems that generated:

“I think that the difference between a Level 4 or greater than 10 years tenure or 12 years tenure (I can't remember now off the top of my head) but they are earning just about as much as my nursing staff and so there is some tensions” (ACM1, speaker 1).

### Experience, training and qualifications

The link between qualifications and the pay rates under the Settlement brought a sharp focus on those qualifications. While the managers understood the requirement to offer training and support workers in their training, concerns were raised as to the motivations behind workers' training requests. A number of managers believed that some care and support workers were solely motivated by money to gain qualifications, rather than to upskill:

“Now it has become...and for the support workers a lot of the time it is about the money. It is not necessarily about the skilling it is just about the amount of money. I found that they have become quite belligerent, quite empowered and quite demanding” (ACM4, speaker 2).

Increased training requests also placed more pressure on managers to manage costs associated with training. One manager spoke of their strategies to upskill workers without seeking formal qualifications. The manager saw this as important, as care and support workers with higher level qualifications may ultimately end up with fewer hours of work, because of the provider's desire to match the level of support worker with the client need being funded:

“We have more advice available to people who are wanting to do the levels but we also have a lot of other options for them as well. We have a lot of special interest courses for them and a lot of them opt to do that instead and up-skill because that is what they really wanted to do and don't want to end up with less work” (ACM3, speaker 1).

An additional cost of training was the cost of accessing Careerforce training opportunities for their care and support workers. The cost was not just in paying for their care and support workers to undertake the qualification, but in having to provide training for someone at their organisation to assess

the practical application of the care and support worker's learning. This also increasing that assessor's workload. Generally, the participants struggled with the complexity of the Careerforce requirements, particularly around the role of assessors. The requirement to complete Careerforce modules to become an assessor seemed burdensome for individuals who were often already registered nurses or had other tertiary education backgrounds:

“So the option through Careerforce is quite expensive for people in terms of what they have to pay. And then they kind of looked internally to the organisation to see whether the organisation can support them to do that education, which is kind of a tricky one, 'cos of course if you could you would and would want to support them, but financially it's not always possible” (ACM2, speaker 1).

The cost and logistical challenges of using Careerforce training was heightened for smaller providers and for those who were in remote rural areas. Careerforce was perceived by most to be good quality training, and preferable to other online courses, which were not seen as engaging or effective as face-to-face settings.

One key concern around qualifications was the value of a qualification versus practical competency, with competency not always reflected by the level of qualification.

“I am a Careerforce assessor and we always say that you can have the qualification, but it is not a qual until you are competent, so it is not competency based. What you are saying, basically, is that you are going to get the money regardless of whether you are doing a good job or not” (ACM1).

Qualification equivalency to the NZQA Health and Wellbeing Certificate was a significant issue for these managers. This was apparent in the participants' perceptions of the qualifications that were assessed as equivalent to Level 4. A participant spoke of qualification equivalencies they had come across that did not make practical sense to them:

“When you have got aromatherapy or social work or some really random things that makes no sense to me at all. You have got no skill set, nothing



in relation to being able to do this job and you are being qualified more highly than someone who has done this [NZQA Health and Wellbeing] qualification... So these people are just on these higher salaries and these higher levels but they don't have the skill set to be providing the care at that level. So that's a huge competency issue for us that I feel is so massive and it was overlooked. It's huge" (ACM3, speaker 2).

Concerns were also raised with regards to fairness to those who might have experience, but no qualifications, being paid less than someone who may be assessed at Level 4 equivalency while holding little practical experience. Equivalencies meant that a qualification was favoured over practical skill gained through experience:

"You end up with these higher qualified people and they are at Level 3 or 4 of the pay equity, sometimes they'll be at Level 4. And you will have an overseas RN who is earning the same as a Level 3 for pay equity who has more of at least personal care experience however advanced it is. There is quite a discrepancy with that" (ACM3, speaker 1).

Another participant was concerned that the equivalencies of some qualifications was unfair to those that had undertaken focused units in the NZQA Health and Wellbeing Certificate:

"So there is all sorts of weird equivalency qualifications that have been acknowledged that need to be on the different pay scales but they are not relevant to our industry and that is just not fair on somebody who has actually gone through and done a Level 3 or a Level 4 with the right community strand of units and gained that qualification, they should be proud of that, they can actually put it into practice. Whereas the other person that has got an equivalent one, not relevant to our industry, can't put it into practice but they are getting paid the same rate. There is some real unevenness there" (ACM4, speaker 1).

Several managers felt that there was little communication between Careerforce and home and community care providers around the NZQA Health and Wellbeing Certificate and accepted equivalent qualifications. Consequently, managers felt that there could have been more consultation and agreement within the sector over relevant equivalencies.

#### **Rostering and allocation of tasks to jobs**

The implementation of the Settlement, along with the between travel legislation and guaranteed hours, impacted managers due to the increased complexity of rostering involved in managing the client-skill match for care and support workers. All the managers saw this as having a significant and negative impact on their services. This was

compounded by the fluctuating nature of the demand for services and concomitant funding levels.

Participants had made significant changes in how they considered rosters. One cause was some care and support workers choosing to reduce their hours, and availability for extra shifts, as a result of the increase in pay:

“We have seen our workforce from my perspective become more demanding, yes they have actually dropped off on the hours that they do, they don’t have to do as many hours so that’s actually great because they are getting better rest periods and things like that, but in a sense they are a lot more unreliable a lot of them, you know, they flip around a lot, ‘oh I’ll work this week, next week I don’t have to work as much’. They just don’t have to work as much, they get paid really well, they are not actually going to struggle financial and stuff” (ACM4, speaker 1).

All managers were cognisant of the qualification level of their care and support workers, the care required by clients and the funding attached to that, and the actual cost of hourly wages. As described by one manager:

“There is an imbalance now where they are getting paid so much and we are funded according to the level of care that we are providing, not according to the level of the support worker that we are providing for that care. Which means that if the majority of the care that you are providing is at a lower level, you are getting funded at a lower level and you are not really funded enough to be providing a Level 3 or 4 support worker for that care that you’re providing” (ACM3, speaker 1).

There were two broad approaches amongst the participants to resolving this funding and wage-cost imbalance. First, those that rostered care and support workers who were available, such as this:

“We don’t differentiate who we send because we don’t have the opportunity to do that with the sheer number and volume that we are trying to meet everyday. We can’t be as prescriptive I guess now about sending a Level 2 out to do housework. So, yeah, the Level 3s are doing the housework and we are trying now to create it as being a whole holistic approach” (ACM1, speaker 1).

The other group aimed to reduce their wage costs by closely matching Level 3 and 4 care and support workers with high-needs clients. The strategy of more closely matching care and support worker level with client need was linked to a deliberate shift to exclusively hiring lower qualified workers, and reducing the hours offered to Level 4 care and support workers:

“It is a process for them and they are beginning to understand that there is less work for them but obviously previous to this they were being encouraged to do their Levels 3 and 4 but now they say, ‘well, what’s going on? You want me to do it and now you don’t have work for me?’ And this has been within quite a short time frame, so they’re still catching on to the fact that there is less work available for them” (ACM3, speaker 1).

That approach had also impacted the choices that care and support workers made around taking up training opportunities, as reported by one manager:

“Ones who have that experience and have that passion and just want to actually do that qualification to up-skill, to learn, their main motivation is not that pay increase it really is just to up-skill and they will often decide not to because they want to hold on to having enough clients” (ACM3, speaker 1).

The managers also faced further challenges to rostering, due to the guaranteed hours and between travel requirements. Significant stress was felt by management and co-ordinators due to rostering (particularly in rural areas) to maximise the efficiency of distance travelled between clients, the matching of care and support worker to client needs and meeting the guarantee of minimum hours. Some providers deliberately put care and support workers on lower guaranteed hours, so that they could more readily adapt to changes in clients – it was easier to add extra hours than to maintain a higher number of guaranteed hours:

“When it comes to guaranteed hours it is really tricky. So because of the movement of clients as well, and I know in our contracts there’s room to change the guaranteed hours based on whether the clients change, but there’s a lag process there and once again, it’s kind of an onerous process to

go through if you're a small organisation. So what we tend to do is put people on lower guaranteed hours so that we're not constantly changing the contract, but we're giving them more than, generally, what they have most fortnights" (ACM2, speaker 1).

Another manager described how the requirements have forced them to reduce the hours of some care and support workers, to meet the guaranteed hours of another:

"We had a worker who the coordinator just came to me and said – We don't have enough hours for them for their guaranteed hours, and I said – Well, we need to look at everyone's guaranteed hours and see who's working more than their guaranteed hours, because most of them will be, then we'll need to reduce their hours and give some of those hours to this person in order to get them up to their guaranteed hours" (ACM1, speaker 1).

Several managers also expressed a change in their expectations of their care work staff, as a result of paying higher wages:

"We have got all these people on all these great pay rates now, we have aided a lot of them to get qualifications as well which has helped them go up through those scales, but our expectation has grown with that as well that's an ongoing effect really, and it goes up the chain. Our funders too now have an expectation on providers to provide better and more because we have got support workers that are getting paid better and more. So we are seeing that come right the way through" (ACM4, speaker 1).

One manager predicted that there could be an increased need in the future for Level 3 and Level 4 care and support workers, as individuals choose to remain in their homes for longer:

"There is a market that we have where the need for Level 4 that is growing but it is still very small, so I don't envision that it is going to rapidly

change really quickly in the immediate future. So that is still going to take time and we still have enough, currently enough on our books but the requirement to keep pushing them through will potentially get to a point where, yes, staff will be forced to leave" (ACM3, speaker 2).

Further to the guaranteed hours requirement, the between travel payments posed considerable challenges to rostering and payroll administration. In addition, the national trend of increased petrol costs was not recognised in the government funding for travel between clients, and therefore not paid to workers. The impact of this in rural areas in particular was frustrating, as one manager indicated:

"So, if you travel more than 15km from your home to your first client you get paid at 50c a kilometre. Most of our clients live 14.8km from the support worker's last job! Oh my God! How many hours do we spend wasted on that, where support workers just will not go and that is getting more and more and more and more, they just will not, the more the petrol price goes up the more they are refusing to go." (ACM1, speaker 1).

““ It's a full-time job managing the legislation, both financially and operationally, and for us we don't get any funding for that”

#### **Overall impact of the Settlement**

Overall, the managers saw the Settlement as good for workers, but as providers of home and community care they struggled with not being well supported by the Ministry of Health around the implementation process. As one manager said:

"There is so much that is still unknown and there's no guidance for the employer now. So, if you go to the Ministry they say it is up to you how you choose to run this because we have given you the guidelines and now you do what you want. So, it feels like we are left out to dry in terms of the decisions that we make now and that those decisions have been challenged by the Unions. Again, decisions are made at that high level but the consequences we are still dealing with almost every day because something come in" (ACM3, speaker 2).



The sense of being excluded from decision-making processes and information was extended to the funding model for the Settlement:

“It’s almost impossible to understand the funding. I’ve got a picture that came out a few months ago around the bespoke funding calculation. Now, I’ve tried to understand it, I’ve tried to get people to explain it to me, I’ve asked the Ministry of Health for an explanation. It’s so complicated that I can’t make sense of it, so to some extent, it’s hard to know what you are getting funded for, apart from the salaries and the hourly rate. It absolutely doesn’t... I constantly look at it and try and understand it. It certainly doesn’t say anywhere on it that there is anything around management costs or quality” (ACM2, speaker 1).

The issue of the costs covered was significant; in order to implement the legislative requirements, additional administrative and co-ordinating staff sometimes had to be employed. Such extra administrative resources were not covered in the funding:

“So our contracts are literally just to provide the client services, and that’s a real issue for us, particularly as a charitable trust” (ACM2, speaker 1).

There was a strong perception amongst participants of the unions having had too much input into the Settlement process, and that high-level government officials were not well placed to understand the impact of the Settlement at the coalface:

“It (the Settlement creation process) was just hideous and the Ministry didn’t have a clue what they were talking about. The Union were driven on money and rights and where was the client in all of that? I don’t even know if they were represented to be honest” (ACM1, speaker 1).

The above quote mentions the lack of client perspective in the Settlement process. Several managers also commented on the Settlement’s impact on the quality of care, as indicated in this discussion in one focus group:

“It didn’t necessarily change the quality” (ACM4, speaker 2).

“No, it didn’t change the quality which I think is a real misconception” (ACM4, speaker 1).

“It didn’t change the quality it just changed their concept of their own worth, but not actually the quality or change of that provision that they are providing” (ACM4, speaker 2).

As one participant noted the Settlement has significantly changed the way that they do business:

“Pay Equity has definitely flipped around our focus as a service provider, our focus was always on our clients and ensuring that we are actually putting all the supports into the client that are allocated as flexibly as possible, and now it has gone the other way where the focus is totally, because of all the requirements put upon us, the focus is totally on our supporter workers; are they getting enough work? Are we filling up their guaranteed hours?” (ACM4, speaker 1).

## 5.2 CARE AND SUPPORT WORKERS

Three interviews and four focus groups were held with home and community care and support workers. These included both in-person focus groups/interviews, internet-based focus groups, and phone interviews. A total of 15 participants took part. Participants worked for a range of organisations including national providers, for-profit and not-for profit providers, and single location providers.

The major themes that arose across all focus groups and interviews were:

- Increased hourly wages were positive and appreciated.
- The 2017 Pay Equity Settlement appeared to signify a change in providers’ practice of rostering, leading to reduced hours for many.
- The majority of participants were financially worse off.
- Changes to rostering had made a negative impact on quality of care.
- The regulation changes had led to increased stress on co-ordinators and administrators, and a culture of bullying and abuse in the sector.

## Impact of the 2017 Pay Equity Settlement

Participants appreciated the increased hourly wages which made a big difference to their income:

“Don’t get me wrong, I really like the pay equity, I really like the fact that I went from minimum wage now to what is it \$24 something an hour from doing exactly the same work for 15 bucks, hey, you can’t really complain about that!” (ACW5, speaker 1).

While the increased hourly rate was appreciated, some participants noted that their tax level had increased. For some participants, who had to work more than one job to bring their hours up to a liveable income, there was the burden of a higher secondary tax rate. Several participants also noted that the increased price of petrol had reduced the overall positive impact of the Settlement. This had a big impact in home and community care because of the reliance on the care/support worker using their own car and petrol:

“I think the straw that has broken the camel’s back is the price of fuel, at the moment, that is just, ‘oh my goodness, how can we afford to do this’?! I know that I struggle with that, I find it really hard” (ACW4, speaker 2).

Some participants noted that the mileage rate paid differed from other industries, highlighting that it did not really cover actual costs:

“I don’t understand why we’re not like every other organisation and just claim 70 cents per kilometre for every kilometre we do” (ACW1, speaker 1).

Participants felt a sense of pride and appreciation that their work and skill was better recognised through the Settlement:

“I think that the pay increase has really helped us because for someone like myself and [Kath] who have been doing this job for many, many years and always been on really low rates so to be recognised and to be put up to a decent wage has been really good” (ACW6, speaker 2).

There was also a sense of achievement amongst some participants over the success of the Settlement, and its impact on women in New Zealand:

“The Pay Equity was a wonderful campaign, it was really hard work. It follows on with New Zealand’s

history of being pretty proactive in trying to create an equal workplace but it has still got a long way to go” (ACW4, speaker 2).

However, this sense of recognition was undermined for the majority of the participants by the way in which the Care and Support Workers (Pay Equity Settlement) Act 2017, the Home and Community Support (Payment for Travel Between Clients) Settlement Act 2016 and the Guaranteed Hours Funding Framework combined had been implemented in their organisations. As explained later, this had an overall negative impact on participants’ morale, work conditions and finances. Many felt strongly that they were worse off after the Settlement:

“That’s why I say it is a waste of time. The only thing that came good out of that was the amount, the hourly rate, because we were all right down on low money to my mind” (ACW2, speaker 1).

## Changes to rostering and the availability of guaranteed hours

Participants noted that there had been significant changes in home and community care, with guaranteed hours and travel regulations preceding the Settlement. Many of the participants noticed changes to the rostering and availability of hours after the Pay Equity Settlement. They perceived that this was because of the complexity of managing under the regulations, with the Pay Equity Settlement adding an extra burden to their managers and providers:

“I totally appreciate that it is really hard and providers have struggled haven’t they? They have had...for us they have had in between travel and that and guaranteed hours, and the equal pay. It is boom, boom, boom, and in between that they have tried to change their systems to try and incorporate it too, so there has been a lot of change for the providers” (ACW4, speaker 2).

Most participants reported that their regular hours had reduced considerably since the 2017 Settlement. Often, when a permanent client was lost the hours were not replaced.

Some participants felt under pressure to sign revised agreements with lower guaranteed hours, sometimes



on a regular basis – multiple times per year. In some cases, they were advised that if they did not sign the revised agreement then they would be placed on a casual agreement, and therefore would lose any entitlement to guaranteed hours:

“They did it to me once trying to change my contract and I said, ‘no, no, this is what it is and I am not signing another contract’, ‘oh, but then you will go on the casual thing” (ACW1, speaker 1).

Another way in which guaranteed hours was implemented was the way that ‘relief’ (when a care and support worker provides care to cover another worker on leave, or a temporary client) clients were notified to participants. Several participants reported that they would be contacted at times when they were scheduled to be travelling between clients and, therefore, could not answer their phone safely or legally while driving; or that they would receive a phone call or text from their co-ordinator during scheduled care for a client. This would place them in the difficult position of not wanting to compromise client care, but potentially missing the call:

“So all the support workers would get these calls, ‘can you do so and so?’ ‘When do they need it?’ ‘Within half an hour’, I think one of them it was 5 minutes time that you are meant to be somewhere. This sort of thing and it puts pressure on us. We are getting thrown things while we are with other clients or in the car or while we are still in bed asleep, things like this, out of our hours” (ACW4, speaker 2).

“I was over at a job this morning and I got six calls while I was there and that is a job I can’t just stop...they just ring and ring and ring to see if you can...and then, like you are saying, if you haven’t acknowledged that you will take the next job then you’ve potentially turned down the work so then you lose your hours because you have to be available for the work. It never used to be like this did it?” (ACW6, speaker 1).

Some were contacted and offered relief hours that clashed with their current permanent clients:

“When you have got a client away and then like I went down there the other week and I said, ‘this client’s gone into a home’, then they start texting you with ridiculous times, ‘can you go to

this client at that time?’ And you say, you can’t because you are already booked in here. So they are covering themselves by saying, ‘we’ve been offering you work but you are not accepting it’, but they offer it to you at a time when you can’t be there” (ACW2, speaker 1).

The implications of these practices were understandably significant for participants. Firstly, there were drops in income after the 2017 Settlement:

“That’s a pretty big impact! Ever since Pay Equity came in I’ve got no work with the company that I was with. If I had been with them 5 years I might be working my butt off, but because I’ve been there 12 years at the time of the Pay Equity and I went straight up to one of those higher figures, bang, within months my hours just went down and down and down... I am making less now than I was before when I was on \$15 an hour. Crazy!” (ACW2, speaker 2).

The situation also created considerable stress in dealing with unpredictable rosters. This participant describes how it feels like there is constant hourly change; being unable to predict whether a last-minute client will be assigned. She couldn’t refuse such changes because she relied upon relief work after her guaranteed hours had been dropped:

“You will get a call last minute ‘can you go somewhere quickly and do this job?’ For people who want to work and sort of know where you are going for a whole day instead of just always being ‘can you go here now? Can you go there now?’ every hour it is quite stressful working like that when you have always had a permanent roster and you know where you are going all day and these are your clients. And now with the guaranteed hours, once they’re cut you will only get relief work. It is very, very rarely you get offered another permanent client” (ACW6, speaker 2).

“You know it is another of those problems that’s come up but I get very frustrated every time the phone rings, it’s like, ‘oh God, what’s this?’ And you are in the middle of showering somebody” (ACW3, speaker 4).

Participants noted that the irregular hours and clients made it very difficult to track their hours on

payslips, and that often payslips were not accurate. Some noted an increased amount of (unpaid) time spent following up administrative details like these with their co-ordinators and managers:

“I find I get kind of fobbed off quite a lot. Things like we have been guaranteed paid for breaks and we haven't got any breaks, we haven't got guaranteed anything for breaks. We have to do so many things outside of our guaranteed hours like ringing up and finding out stuff. We have to follow up on every pay, every week because our pay is wrong every week so we have to ring up and send emails and try and chase up things that we weren't paid for and figure out where it was” (ACW3, speaker 3).

Aside from a reduction in hours, many participants had rosters that were physically and emotionally demanding. Several participants reported that their clients were scheduled in a way that did not acknowledge the need to get from one to the other, or give time to contact their co-ordinator if needed. No one reported having a roster that included time for them to take breaks (other than those whose hours were spread across 12-hour days). Some reported very long days, with their hours spread over what could end up being a 13-hour day, for example:

“So you might work for 8 hours or 9 hours a day but it is spread over about 13 hours...It's really hard, so it is quite tiring and some of the people that do just work for one provider and work quite big shifts, they do quite a big morning one, might have a bit of a break, and then go back for early evening, into the evening. They get very, very tired. Some of them might actually do an afternoon where they do housework and that kind of thing too, so some of them get really, really tired” (ACW4, speaker 2).

Furthermore, several participants worked for providers who had reduced or eliminated the number of staff meetings throughout the year; Or had ceased paying their workers to attend meetings. This had the effect of compounding the isolated

nature of working in home and community care, especially for those working in rural areas:

“The companies, I actually just don't think they care to be honest. It's actions isn't it? I mean if they really care about how the place is run and if the workers have got any problems or anything like that you would think you'd have monthly meetings, or 6-monthly meetings. They just refuse to have meetings, it just doesn't happen, they don't want them” (ACW6, speaker 1).

However, even non-rural Auckland participants commented that the job was very isolated, and that the distances travelled and time it took with Auckland traffic meant that they seldom saw other people who worked for their provider – sometimes not meeting a co-worker for the first time until they were scheduled to work together with a client.

Consequently, the impact of the Settlement implementation by providers led several participants to consider whether they would stay in the sector. One participant found the stress of worrying about their hours was affecting her home life:

“It tells on you when you come home of a night, you know, when you are stressing about how you are going to get money to pay this and do that and of course he cops it because I'm in a bad mood because I have only had like 4 hours work or something like that” (ACW2, speaker 2).

Another spoke of how she thought – when some clients of 10 years or more were lost – that she might leave home and community care for residential aged care:

“I have started to think about maybe it would be good to just go to a rest home. I have had 12 years rest home experience so, do a shift, get your money, know I have worked an 8 hour shift and 8 hours paid” (ACW6, speaker 2).

One participant, who is a migrant, spoke of the difficulty in changing employers depending on the visa that you held. She was stuck with her employer:

“The pay equity was a wonderful campaign, it was really hard work. It follows on with New Zealand's history of being pretty proactive in trying to create an equal workplace but it has still got a long way to go”

“Because I am on a work visa so I have to stay with this company because my visa says, that is why. If it was under skills we could move but now we have to stick with one company” (ACW6, speaker 3).

Another participant, whose hours had significantly dropped, would not recommend the job to anyone else:

“So, I have gone from bad to worse financially. Would I encourage anybody to take on this career? No, absolutely not, absolutely not, in fact I would be willing to speak to their parents!!” (ACW7, speaker 2).

### **Priority given to lower level care and support workers in rostering**

The participants observed that one of the reasons for their reduced hours was that more hours were being rostered for care and support workers who were on Levels 1 and 2. Those who, through service or qualification, were on Level 3 or 4 often had to struggle to get, or maintain, their hours:

“Everyone that I was talking to at the thing the other day, all the ones that had been there for 12 years or more and some of the other girls like Jennifer and a few of the others out in the field now, they have all been exactly the same as me. They have been peeled back and peeled back and their hours are just going down and down and down. But they still get relief work here and there but it is at ridiculous times” (ACW1, speaker 2).

One worker had needed to find a second job to make ends meet:

“I have actually had to go and get another job, so I am working for 2 different care providers and the reason being is because I have been with them over 12 years and that automatically put me up to that \$24 bracket. So all the ones that are on a lesser pay rate get lots more hours than me. I never get rung excepting for when it is a high needs client... Then they're ringing me and ringing me and ringing me. I thought, 'no, bugger you'. I did, I thought, 'bugger you now, why should I bother?'” (ACW2, speaker 2).

### **Impact on other stakeholders**

Participants, despite feeling disadvantaged by the Settlement implementation, acknowledged not only the negative impact it had on both their co-ordinators and providers, but also on their clients.

Participants noted that the burden of several quick succession regulation changes appeared to have created high workloads and very tense workplaces. Some did not go to their administrative offices anymore because they had become unpleasant places to be:

“Our coordinators looked haunted, they are stressed to the max, people won't go into the office now just simply because of the atmosphere in there so what is it like for them?” (ACW7, speaker 2).

The stressed environments of co-ordinating teams had a flow-on effect for participants, who had inflexible, rushed and irritable co-ordinators assigning clients to workers:

“I don't take it personally, I don't think that the coordinators and that are reacting to us, I just think the amount of pressure that they are on to meet the clients, if the only requirement is to get you there, if you say yes, then that's it, tick. On to the next one, tick, onto the next one. I don't think there is anything personal – they are under an awful lot of pressure, the coordinators are” (ACW3, speaker 4).

Tied in with this culture, and the changes to rostering of hours, several participants reported that workers were afraid to speak up because they feared retaliation through bullying or not being given available hours:

“There are also people that are scared of losing their jobs by speaking up... Oh yes, oh they have tried everything with me. Everything. Being a bully, being patronising, you name it they have done it” (ACW7, speaker 1).

One reported that their colleagues who they knew to be union members were afraid to participate in this research because of the consequences if their managers knew they had taken part. This was also part of a decline in workplace culture in the sector

that had led to increased bullying and a perceived lack of care and consideration for care and support workers:

“But then the pay equity from that point of view has made them be less responsible for us. I mean no support, no care and they don’t, and it doesn’t matter now because they think, well we have bought you with money” (ACW3, speaker 5).

This is linked to a sense of a lack of trust from providers in their care and support workers on several points, including their ability to make decisions around their jobs. One participant commented on managers’ attitude to their work as care and support workers:

“I just think that they think you are a bunch of peasants really to be honest. I think they think it is just a....I did my nursing training years ago, there are plenty of people that have done all sorts of training and they have got people who are really qualified people and they are just...that is what they think...one of the people, what did they say? They said it is like working in a shop. It’s disgusting, but it’s the way they think” (ACW6, speaker 1).

Another participant commented that the Settlement had been implemented without policy makers speaking to the people who did the work. That participant felt that they were undervalued as workers, which was echoed in other comments about care and support workers being ‘numbers’ to get work done:

“I think part of the problem is that nobody has ever consulted or communicated with the support workers. Nobody: Company, Government, anything, DHB, ACC... None of them have, or do even on an individual client basis, speak to the support workers and I think that is perhaps one of the big problems in making this industry work... We are working with very vulnerable people, we are not delivering parcels. We are working in often very stressful environments and dealing with people who are also very highly stressed and sometimes chronically stressed because of what is going on in their lives. We are never consulted about what a client needs, we are argued with, we are ignored” (ACW7, speaker 2).

Another impact noted by participants was a decline in the quality of care. This manifested in several ways. Firstly, the way in which rosters were organised meant that some clients did not know until the last minute who their carer would be. This was perceived to be a significant imposition on vulnerable clients, who allow care and support workers into their personal home:

“Their ordinary carer goes on holiday. The poor people, they are 80 or 90 in the shade and they are worried sick about who is going to turn up, what time they are going to turn up, if they are turning up. It is so stressful on these people and that is what the whole thing is about, the care of these people out in the community, that is the whole point of it” (ACW6, speaker 1).

There were also instances where a replacement worker had not been scheduled, or a client would not accept a change in time, and so they would miss their care for a given week:

“So all the support workers would get these calls, ‘can you do so and so?’ ‘When do they need it?’ ‘Within half an hour’, I think one of them it was 5 minutes time that you are meant to be somewhere. This sort of thing and it puts pressure on us. We are getting thrown things while we are with other clients or in the car or while we are still in bed asleep, things like this, out of our hours...it is not fair on the clients, really not fair, because sometimes some clients wouldn’t even get covered because they couldn’t find relief and that’s dangerous” (ACW4, speaker 2).

Sometimes new, less experienced workers were scheduled to a two-person client. This made the job tougher for existing carers, as the less experienced person may not have had training or experience in a two-person lift, and carers were often left caring for a client together with a colleague they had never met or worked with:

“Yes because Level 3 and 4 is more palliative care and complex care and what they do is that if you go to a place and there is meant to be 2 people, they will put somebody in there that is Level 3 or 4 and they will top it up if the other partner is away, with a 1 or 2. It all comes down to money” (ACW6, speaker 1).

## Training and qualifications

There was a range of work experiences amongst the participants. A majority of them had significant experience in their jobs, and were paid at Level 3 or 4 due to their length of service with their current provider. Most had been offered training, although some had not been proactively offered training in a similar way to their colleagues. In those instances, participants perceived that because of their age (late 50s, early 60s) they were not seen to be worth investing in. One of these participants commented that she appeared to be left off lists for training even though she undertook, and enjoyed, more complex work.

Some other participants did not want further training because they were not interested in the more complex work:

*"I'm on Level 3 and I've been offered Level 4, but that's more into the high care needs, it's almost into nursing things, like doing stoma bags and*

*things like that, and I'm not a nurse in any sense of fashion. So I've declined that"* (ACW5, speaker 1).

Another wryly commented on whether it would be worth gaining Level 4, because it would most likely lead to a drop in rostered hours:

*"Then on the other hand I hear that some of the girls we work with say that it is pointless doing Level 4 because you'll never get any work because of the higher pay rate again, you see"* (ACW6, speaker 1).

One participant noted that she had discussions with her employer over the types of jobs she would do as her tenure meant that she was on a more senior level. Her provider expected her to take more personal care clients rather than the majority of housework assistance. She did not want that, but was unable to decline the increase in pay:

*"Because I've got 17 years of service I go to the top level. So my boss tries to tell me that because I was on the top pay rate I should be doing the hardest work... And I said – Well, I'm not actually on that pay rate because of my level, I'm on that pay rate because I've worked with you for so long. So I went to see her and they reassured me that what I was telling them was fine, and they couldn't*

*enforce, you know, they couldn't expect me to do more of the personal care"* (ACW1, speaker 1).

Several participants appreciated the more challenging, and rewarding work having Level 4 qualifications allowed. This included working in palliative care, and with complex clients. This was important to their enjoyment of the work, and their sense of value as workers. Another spoke of how the Settlement had been motivation to gain her qualifications:

*"Yes, it has got a big influence on me, I mean, I have been in this industry nearly 30 years and I am flying mostly on experience. It is only in the last seven years that I have actually got down and got the qualifications and I have just complete the Level 4 certificate in health and well-being, so it has been a big motivator for me"* (ACW3, speaker 3).

Several participants noted issues with qualification equivalencies, which overlook relevant practical experience:

*"I find it hard that someone who has a Social Work Diploma can come in and get the Level 4 qualification. I actually think it's wrong that it is cross credited because they are not as capable as someone who is a Level 2 or 3 who has been here for years with [our provider] working. It's wrong. Do you know what I mean?"* (ACW3, speaker 6).

Furthermore, several reported a shift to online training that had no practical exercises built in. They perceived this choice to be made due to the lower costs of the training:

*"One thing I had noticed is that... a lot of our training has now become online training rather than face-to-face training"* (ACW3, speaker 2).

Those who had noticed this shift questioned the utility of online learning for practical application, especially if there wasn't on the job skill assessment or training:

*"And apart from the guaranteed hours it is the whole thing of training as well, so they are training people up but it is all done in modules on the computer isn't it? I don't know if they are physically go and learn how to lift or you watch a video"* (ACW6, speaker 1).





In some cases, the support to undertake training had also changed with a shift to online training modules:

“I guess the main difference is with the face to face training you got paid for it. The organisation I worked for paid you for it whereas the online training you don’t have time to do it during work so you do it in your own time” (ACW3, speaker 2).

Finally, while expressing frustration and disappointment with how the Settlement had been implemented, participants also expressed how they thought the system could be improved. Firstly, several noted that policy makers were too distant from the work itself, and had not sufficiently taken into account the knowledge and views of those who actually work in the sector. Secondly, several noted that care provision and funding in the sector was too complex, and felt that it needed to be given more priority and centralised. This may allow service to be provided in a similar way District Health nurses are organised by District Health Boards as:

“In the past I think it used to be a way of earning a bit of extra money, but these days it should be considered a career. And I really believe that it should come under the DHB and be like District Nurses where we have work vehicles and not have all these different organisations doing all that they do... it’s kind of outgrown having contracts, the organisation’s contract to get the work, and really it’s become... it really needs to be managed by the DHB” (ACW1, speaker 1).

“ In the past I think it used to be a way of earning a bit of extra money, but these days it should be considered to be a career”

### 5.3 HOME AND COMMUNITY CARE CONCLUSIONS

It was clear from both managers and care and support workers that the combination of the Home and Community Support (Payment for Travel Between Clients) Settlement Act 2016, Guaranteed Hours Funding Framework, and the Settlement had placed significant pressure on managers and co-ordinators. This was to the extent that care and support workers reported unpleasant workplaces and

a high level of bullying within the sector. Several care and support workers avoided needing to visit the administrative offices because the work environment there made them very uncomfortable. Care and support workers felt that most of their colleagues were afraid of speaking up – that speaking up would result in reduced available hours, reduced training opportunities. This, combined with management’s reduction of staff meetings and opportunities to meet other care and support workers in their organisation, meant that many of the participants experienced a strong sense of isolation.

The requirements of these combined legislative changes were complex and unwieldy for both managers and care and support workers. Managers reported struggling to meet guaranteed hours requirements while working within funding shortfalls to roster an appropriate and cost effective level of care and support worker to each client. Between travel payments were a disincentive to both care and support workers, with some care and support workers refusing clients because of the client’s location. Both managers and care and support workers noted that, with increasing petrol prices, the travel payments did not cover petrol costs. Care and support workers found it difficult to keep track of

whether they had been paid correctly, which sometimes was not the case, because of payslips that differentiated each different pay rate.

In response to tight budgets, managers were working to closely match client need (funding) with the level, and wage cost, of their care and

support workers. They reported that there were fewer hours available for those care and support workers who were Level 3 and Level 4. They also aimed to recruit those on Level 2 or with no qualification because this matched the majority of their clients’ needs, and was more cost effective. Some managers discussed training opportunities with their care and support workers, explaining that as they increased in level there would be fewer available hours. Managers’ experiences concurred with care and support workers’ reported experiences.

The majority of care and support workers reported that since the Settlement their hours had been reduced. They had felt pressured to agree to reductions in their guaranteed hours. For many of the participants, the reduction in hours meant that they were financially worse off after the Settlement.

Care and support workers noted that managers' changes to rostering meant that sometimes clients could miss care, or have new carers at short notice, and sometimes inexperienced carers – all of which had a negative impact on the quality of care for clients.

Managers felt that many equivalent qualifications were not well suited to home and community care, which meant that they could have workers on Level 4 who did not really have the skills and competencies required for the job. Some care and support workers, who were on Level 4 because of the length of their service, were reluctant to take on care for complex clients (deemed to be appropriate for Level 4).

Both managers and care and support workers expressed that in their opinions the Settlement and its process had been decided by policy makers at a high level – managers pointed the blame towards Unions as much as the Ministry of Health – who had little or no knowledge of the actual work and how it was conducted day to day.





# The Disability Support Sector

## 6.1 MANAGERS

Four focus groups were conducted with managers in the disability support sector. These were held across New Zealand and represented day services, community services and residential living. A total of 10 managers took part.

The key themes that arose across all participants were:

- Equivalencies of qualifications and their relevance to the sector.
- Concerns and uncertainty around training expectations for workers.
- Increased expectations of support workers' workloads.
- Poor implementation support from government agencies.

### **The pay increase was well deserved and needed**

Overall, the managers were supportive of the Settlement, and the recognition it gave to their support workers. As several commented:

"I totally believe in the fairness of the Settlement and the purpose behind it" (DM1, speaker 2).

"It really lifted that and gave recognition to an incredibly demanding job and rewarding job at the same time" (DM2, speaker 1).

"There is an emerging value around training amongst our staff"(DM2, speaker 2).

The positives for the sector were: attracting better qualified staff, increased interest in training and progression by many staff, and an increase in responsibility from those staff who are at higher qualified levels. However, participants also identified concerns related to funding of the Settlement's pay and training requirements.

### **Experience, training and qualifications**

The majority of the participants expressed concerns over the tension between qualifications and experience, and the pay rates at each level. As one manager mentioned:

"Experience does not always equal competence" (DM1, speaker 2).

Another manager also highlighted this tension:

"Someone at Level 4 who gained that Level 4 but they are not really good carers, they are not good carers because they don't have a basic understanding of how to care for people" (DM3, speaker 2).

These concerns stemmed, in part, from a general distrust of external non-Careerforce training programmes, which were perceived to provide less rigorous training. This created a perception of unfairness on current staff, who were more skilled but may not yet have their qualification. It also posed questions for the quality of care:

"Level 4 is a whole different can of worms but I am seeing people turning up on our doorstep looking for work and, as I said, the pool is pretty small to start with, and so they are fronting up with a Level 3 Certificate in Health and Wellbeing that they have gained by attending training with an external training provider and we have to pay that person Level 3 pay rate, or if it is Level 4, Level 4 pay rate without having any input into what it is that they have learned, what their habits are or anything like that. This has two side effects: One is that the existing workforce who may have been with the organisation longer but haven't been there long enough are getting paid less and the other is that the standard of training that they are getting at those external providers is, I would say in some cases, almost negligible" (DM2, speaker 2).

One manager expressed a concern that the qualifications and associated training did not necessarily have any correlation with what a care and support worker role required, and how many support workers were needed at each level:

“There is a wording in the Settlement about the need to provide opportunity to do Level 4, that doesn’t mean that we have to put all positions or roles under Level 4. I think we need to be very smart about what roles, based on their competencies, need what level” (DM1, speaker 2).

The connection between skill and qualification was also raised with regards to the Settlement’s transitional arrangements for workers with no qualifications to be paid according to their length of service with their current provider. Some care and support workers with long service were now paid at Level 4 but were not able to work at the expected level. Some raised the concern that care and support workers who may have previously entered the job due to its perceived low skill and qualification may now be excluded from the sector:

“A lovely lady who is illiterate... she can’t do personal cares because she can’t read the care plans. She is now on the top rate and our ability to give her work is really difficult and so people like that who have slogged away for years and years in the system are actually going to be squeezed out and the population of people who you may employ who has been in this group are not necessarily as attractive as perhaps they once were” (DM3, speaker 1).

“There is now a barrier to people who may have found caring work in the sector because they had issues like ESOL, dyslexia etc. Now they will be excluded potentially” (DM4, speaker 1).

Some managers found the training requirements difficult to afford and implement, and there had been changes to the training offerings in their organisations. Most of the managers commented that they are now offering fewer opportunities to staff:

“We are not encouraging people to progress” (DM4, speaker 1).

Training offerings were reduced despite their care and support workers’ increased interest in training:

“There has been a bigger uptake of wanting to do Level 4. The minute Pay Equity came in it was, ‘when can we do our Level 4s?’ Never shown any interest before but hello!” (DM1, speaker 3).

For one manager, the induction process for new staff became unpaid, as a result of the Settlement. Nevertheless, that same manager reported an increased uptake of further optional training:

“Induction has changed. The expectation is that people will do unpaid training now whereas before we paid for all our training that was one of our flagships. But that has not stopped the uptake of the optional training which is quite interesting. So people are...induction now encompasses your Level 2. So once you have been verified at the end, you’re done, you are at Level 2 immediately. The Level 3 is quite weighty in our sector, there’s a lot of papers to get through and you need to be pitching everything quite high but people are powering through it. Whereas before people were disengaged and just bums on seats, yes I attended so therefore...There is a shift.” (DM4, speaker 1).

An issue with respect to casual staff and training was also raised; whether providers’ obligations were the same as for their permanent care and support workers. The lack of clarity for some managers was compounded by the difficulty in gaining good advice. Providing training to casual workers also presented a practical challenge:

“I emailed the Ministry and said, ‘what do we do about casuals?’ They said, ‘oh, they don’t count’. Then at a provider meeting recently, I think it was NZDSN [New Zealand Disability Support Network] said, ‘yes they do!’ So who is right? What do you do about part timers? How are you supposed to put somebody through Level 2 within the first 12 months of their employment if they are only at your facility 6 hours a week? How is that meant to happen? You can’t expect them, if they have got another job, to drop everything. It is just a whole lot of stuff and when we have talked about it before, we talked about it at Ministry meetings, we have talked about with the Union and they love this phrase ‘unintended consequences’” (DM2, speaker 2).



The funding of training was also raised as problematic, with fear of consequences if the requirements were not met. Several managers expressed concern over not fully understanding the requirements, and the difficulties of gaining the correct information:

“Some of the other things that you haven’t touched on yet is the complete disagreement between the signing parties, being the Union and Ministry of Health around the actual dollar value of funding per worker to provide their training. I haven’t yet managed to talk to anyone who can down to an operational level say, ‘OK, this is this person and this is what they did in the last year, this is what they worked, how much money do I get for that person to train them?’ It is an unanswerable question” (DM3, speaker 3).

Another manager commented on training funding:

“It has just developed back to a gross percentage figure and they said, ‘here is this spreadsheet’, and I’m too dumb to work it out so was all their finance people and our HR and we are all too stupid to work that out unfortunately, down to an operational level, and you are just sitting there scared as anything that you are going to be the company that gets taken to court and made an example of and that is what you absolutely don’t want, what you live in fear of” (DM3, speaker 1).

### **Recruiting and retaining workers**

For several managers, recruitment has not significantly improved since the Settlement:

“One of the things that we were sold was that this was going to professionalise your workforce, you are going to get a whole lot more well trained, professional people, you are going to have all these people rocking up at your doorstep with these qualifications and they are going to be really super dooper and you are going to have a much more qualified pool of people to choose from. None of this eventuated at all, in fact, I think it is harder now to recruit decent staff than it ever was” (DM2, speaker 2).

In contrast, several other managers had noticed improvements in recruiting:

“Our last intake, the quality was really high and we had half of them were men, were males, they were young, they were really high calibre” (DM1, speaker 1).

“There is that push to get good quality staff with good qualifications in and build that potential to have longevity in the actual sector is there and that pay equity has allowed us to do that” (DM1, speaker 3).

One manager reported an initial spike in interest after the Settlement, but that for many applicants the reality of shift work was a deterrent. Overall, many managers were still struggling to attract the right candidates for the roles needed. The staff mix that was required drove some recruitment approaches:

“You are never going to put out there that we will choose a Level 0 over a Level 4 to replace a Level 4 but you have got to think about it because now we are legislated to pay people up to Level 4” (DM3, speaker 1).

Turnover, however, had dropped amongst support workers, according to most of the participants. This was explained by care and support workers losing their higher pay rates (due to length of service) if they changed providers. However, several managers did report significant changes to staffing levels (in non-support workers) since the Settlement:

“We’ve lost a lot of senior management, a whole tier disappeared, and that was a direct result, we have lost an arm of our services and we were told that was as a result of pay equity” (DM4, speaker 1).

A number of managers did raise the issue of possible restructuring, and the increased or potentially increased use of performance management measures because of the wage rises through the Settlement:

“Restructures end up having to be done because people are in the wrong jobs doing the wrong things” (DM1, speaker 2).

“Yes, and as a manager I loathe to restructure for the sake of getting rid of people and I don’t do it for that reason but actually unfortunately think that eventually that is what some organisations will end up doing because it will be based on the need of the role and sometimes people don’t fit that anymore and the sector is changing” (DM1, speaker 3).

### Rostering and allocation of tasks to jobs

Rostering had been challenging prior to the Settlement, with funding per client varying depending on who the funder was (e.g. ACC, District Health Boards, the Ministry for Social Development). Tight budgets post-Settlement meant that managers were looking more closely at their rosters and the hours available for care and support workers. One manager discussed how their organisation was essentially subsidising the shortfall in funding:

“Actually Ministry contracts are only 6 hours per client and we pay staff 8. So the 2 hour extra is paid by the organisation not by the contract, so why do we need them for the extra 2 hours? So you really do have to start looking at the actual need of what staffing you need to match what the client wants. If the client is only paying you for 8 hours service, then actually you only need to match that person with someone that will work with them. So we do a lot of client matching now, so we recruit to the need of the client which is a really good method to use because that is where it should be, it should be choice and control of the client but it is tough for us” (DM1, speaker 2).

Another manager noted that they now used more part time staff and casual staff:

“But our services like our supported independent living, they are all casuals and again that is because they are recruited to the person as required, so they are recruited to need” (DM1, speaker 3).

Innovative approaches to managing resources also surfaced, with some organisations working together to ensure they had the care and support workers they needed, and so that good workers also had sufficient hours, albeit across several jobs:

“To the point where we do that between organisations now, particularly with part time staff. So I have no qualms about ringing up partners ... and saying, ‘look, we have got eight hours that we need to deliver and this person wants three on a Saturday and two on a thing, do you have any of your part time staff that want to pick up more hours?’ So I think collaboration and partnership, if you are willing to do it, it is still a siloed sector, people are still quite...” (DM1, speaker 2)

All the managers had heightened expectations of their workforce as a result of the increased wage levels. This was particularly evident with respect to those on Level 4. Since the Settlement, managers had an explicit expectation of leadership in their Level 4 roles:

“Nobody is wanting to do the team leader role. Because they are quite happy with less responsibility, getting paid more at Level 4 and then the middle management is again affected because the pay difference between a team leader and a middle manager is not huge” (DM3, speaker 2).

Another manager commented that expectations were higher, and the tasks were broader for Level 4 staff:

“We do expect them to work harder, especially our team leaders and we are asking for a lot more accountability from our team leaders. We are asking them to be managers which they haven’t been really and we are asking them to do a lot more of the stuff around performance management of

their staff and for them to take more responsibility around the budget for the home that they manage and so on” (DM2, speaker 2).

“ There is that push to get good quality staff with good qualifications in and build that potential to have longevity in the actual sector. Pay equity has allowed us to do that”



### Parity

The impact of significant increases in wages for support workers in the sector had created issues in respect to parity with other workers in the sector. This meant that individuals in roles, such as team leaders and service managers, as well as administrative roles could perceive the pay raises to be unfair. If an organisation chose to provide comparable wage increases in these roles, it would be an additional cost burden:

“Because in the Settlement there was no pay parity between management and the support worker we haven’t, as an organisation, been able to look at, or actually at our detriment we have had to pay our team leaders and service managers and those doing different roles to support work at a different rate. So financially it has been a bit of a burden on the organisation” (DM2, speaker 1).

When looking at other roles in the provision of care to clients, one manager expressed concerns over the application of the pay equity to a narrow group of just support workers:

“For me it would be getting the people that don’t have the title support worker on their contract paid at a rate that actually truly represents the job they do. So we have got different levels that work at different points along our stream and I can’t pay them any more than what the support workers are getting paid yet these are the people that are doing top level stuff but I am stuck with

this Pay Equity that goes boomph because they haven’t got support worker on their contract, I have to go back to [Amanda] and we have got to find money in our system somewhere to put them up to a level that actually truly reflects the job they are doing because there was no money put in the original Pay Equity Settlement for those people” (DM1, speaker 3).

### Challenges

The managers in the focus groups named several other significant challenges for their sector as a result of the Settlement. A significant challenge was that there was insufficient consultation with the sector, and that clear, readily accessible information was not available due to the speed with which the Settlement was implemented. Several managers commented that the implementation process should have been slowed down. One manager expressed disappointment over the focus of the Settlement:

“It was payroll orientated and wasn’t outputs orientated...lack of faith that the sector could actually deliver the Settlement levels to individuals as per a high trust environment” (DM3, speaker 4).

Another also thought that the Act and its implementation did not take into account how different the disability support sector is to the aged care sector which was the focus of the Settlement and Act:

“The disability sector just tagged on to aged care, yet the aged care sector is relatively stable service delivery, disability is going through a fundamental shift in delivery of care model” (DM3, speaker 2).

However, it was seen as a positive change by one manager, who saw that the Settlement could have positive long term effects:

“I have hope for Pay Equity in 10 years’ time, you look at the future, you will have different focus of the staff that are coming through because our younger staff that are coming through are social work, psychology degrees because the start rate is potentially the same as their peers starting as behavioural psychologists or social workers so we are getting a better calibre. It doesn’t mean that the work, yet, is there, because there is this shift in the focus of how we deliver but we are definitely seeing a change” (DM1, speaker 2).

Participants noted that the Ministry of Health’s support and information was insufficient and this raised concerns for the ongoing implementation of the Settlement:

“The appalling lack of support from the Ministry around how we go about setting this up and putting it in place or anything like that. I have seen no one, I have heard of no one, I have been flying by the seat of my pants and we are a moderately sized small provider. I don’t know how people that are really small providers, that may have like 20 staff or less, have managed” (DM2, speaker 2).

The feelings of disengagement and isolation were summed up by one manager’s comment:

“When Ministry came to do the first feedback show, in August I think it was, it was very poorly advertised, I was surprised when I got into the meeting and basically 50% of the people were there that I expected and when Ministry presenter came and said, ‘this is like walking into an air plane and where’s the pilot?’ That was the sort of feeling and it describes it actually quite well. There are many, many, many gaps. Those gaps can become very big, very quickly” (DM2, speaker 1).

One manager was concerned about possibly ongoing negative impacts of the Settlement because of its

origins in a Legal case, which meant the focus of policy makers was reactionary rather than one of strategic planning:

“I am not sure the ripple effect...it wasn’t planned. It came from a court case so this has not been planned through and we are reacting and responding now and doing the best we can but a lot of things are falling over. I would like somebody with an overarching vision to say, OK, this is where we are now and how are we actually going to make this work moving into 2020” (DM4, speaker 1).

A final challenge, noted by the majority of the managers, related to the administrative cost of the additional staff and resources required to implement the Settlement. This was compounded by the multiple contracts in the sector:

“So MoH [Ministry of Health] did it, MSD [Ministry for Social Development] did it and the ACC [Accident Compensation Corporation] did it in good faith and none of them worked together: we had different spreadsheets from Ministry of Health and different from MSD and then ACC just added it to the figure, so there was no...They didn’t want to know because, I mean, ACC’s contract are high trust faith contracts and MSD and MoH tend to be accountability based so the spreadsheets were up the wazoo with what you had to deal with and it took a lot of work and time and effort to get all those sorted. So I think if they had have just worked together a bit better” (DM1, speaker 2).

### **Role of the unions**

Managers had a mixed response to the role of the union in their sector. Several commented that they had low unionised workplaces, but that this had increased slightly since the Settlement. One manager saw the value and necessity of the union in the campaign for pay equity:

“So, although it originated from a gender inequality way that is probably because that was the only way that this could have been got this huge political backup because if they came up with carer rate inequality I don’t think it would have got this traction” (DM3, speaker 2).

However, another manager saw the union involvement as the unions wielding too much power in the workplace. Nevertheless, this manager still felt they had a good relationship with the union on site:

“The attitude of the union during this has changed, the power aspect of it, because obviously they are on the news with the balloons and they are, ‘way hay we are all wonderful!’ That was noticeable for us and we have a great relationship with the union and we told them about the changes to our contracts and our job descriptions because we wanted if one of our staff says, ‘I’m going to go to the union’, we go, ‘fair enough’, knowing that there are no secrets so I think that is a great position to be in and it works well” (DM3, speaker 4).

## 6.2 CARE AND SUPPORT WORKERS

Six participants took part across three different focus groups. Participants came from cities and towns in the North and South Island (although not from Auckland); and from day support services, residential, and community support providers.

The key themes that arose amongst the participants were:

- The pay equity Settlement had improved their personal finances.
- They now felt more appreciated.
- They would now be more likely to stay working in the disability support sector because it felt increasingly like a career.

### Positive impact of the Settlement

Overall, participants strongly felt that the Settlement had made a positive impact. It had been positive for their personal finances, making it easier to get by financially:

“The increase in wage makes it comfortable to actually live and for me it has just made the job more secure kind of thing, because it is more of a wage and you are not struggling too bad” (DW1, speaker 2).

The same participant observed that it must have made it easier for those working on casual contracts in the sector:

“I know a couple of people that are casual on the lower wage end, that made it hard for them because yes, the casuals here do get quite a few hours but if you are not working that full 40 hours that is not really enough to live on. So even if you are working three days a week or whatever that is still not enough but with that extra few dollars an hour that is making it more liveable to still be a casual and have that little bit of freedom if they don’t need the full time every week, which I have noticed” (DW1, speaker 2).

Another participant in community disability support noted that the increased pay rate meant she could have more choice in the hours she worked:

“I think that’s one of the big drivers being able to work less hours if you want to or you can still chase those hours if you want to. It is having that option, which is good” (ACW3, speaker 2).

There was a sense of achievement amongst some participants, and participants felt that they were appreciated and valued more after the Settlement:

“Pay Equity, winning that battle after so many years was really welcome, we were all celebrating it. It was a long battle and of course it didn’t come easy because we battled everybody all the way through it, it was taken to court, and went right through to the Supreme Court” (ACW4, speaker 1).

### Pay rates

For one participant, who held a more senior support worker role, the Settlement had not been beneficial because she continued with the same responsibilities, but with less differential between her and other support workers. This was a contrast to one other participant, who also held team leader responsibilities, but was paid an additional allowance for her responsibilities.



Some participants reported that managers were now reluctant to consider pay increases after the Settlement, including for items that were not part of the Settlement pay increases, such as a uniform allowance. It had also negatively impacted on the participants' ability to negotiate weekend rates, where those existed:

"They kind of think that the pay increase that you get in July through Equal Pay is enough so even getting allowances like clothing allowance increased, a weekend allowance increased, has been hard" (ACW4, speaker 1).

On the other hand, the Settlement pay rates, and feeling appreciated, meant that most of participants now felt that they were happier to remain in disability support work:

"Like a lot of people I would look for something else that was better paid. I think it has been undervalued for a long time. It is certainly a step in the right direction to reward people for the hard work that they do, I don't think it is recognised" (DW1, speaker 3).

### **Training opportunities**

The participants all had opportunities for training, with most agreeing that training was readily offered in their sector prior to the Settlement. One participant noted that not so many people used to take up the training opportunities:

"It was always [available], when I started four years ago, it was when it was offered at the job, obviously not many people used to take it on but it was there" (ACW4, speaker 1).

A different participant highlighted the usefulness of having specific training and qualifications, in addition to their other qualifications that had put them on Level 4 equivalency:

"Our organisation has always paid for the Careerforce training and Level 3, I had a degree before I started so I chose to do the Level 3 because I hadn't had worked in the disability industry before. So for me, that was quite useful for me to actually get a different view and to work through, I think with colleagues as well" (DW1, speaker 3).

Another participant felt that the training was now more worth it both for the participant and also their organisation:

"In terms of training, I feel like for me personally it probably has brought more training opportunities because it has made it more comfortable to stay in this job long term... and because of that pay people are here longer so they are more likely to invest because it is not like you are going to invest into someone's training and then the pay is so low, two months down the track they are gone. I feel like the organisation gets more back from the training because of the pay increase" (DW1, speaker 2).

A participant from a residential facility commented that at their facility, training needs to be done at a high level, and perhaps in-house, because of the needs of their clients – some of whom are non-verbal. The same participant observed that, at her facility, there were a number of support workers who had not taken up any training, and she felt that they should – or exit the sector:

"I kind of look at some of the staff that are around in places and I think they have been there far too long to be giving benefit to the people, it is just the pay cheque. So the people are missing out and they're the people that have been there for many, many years without doing any of the qualifications that are available" (ACW4, speaker 1).

That participant felt that training was crucial in order to maintain and improve quality of care. However, the contrast between younger (or newer) support workers who completed their Careerforce qualifications with those who had been with the organisation for 12 or more years, and earned more but had not studied for any of the qualifications, was a little galling for this participant. She spoke of a lack of parity between these workers:

"So the younger people that are working and doing Careerforce are thinking, 'well these people are sitting on their backsides now getting more than I what I am getting but doing less work'. And it is hard to point out that they had to have a base line of something for time spent in the work place. So it caused a lot of disharmony in a lot of people that work at [our place] for that simple reason; 'these people sit on their bums all day and don't do much, I am working and getting less pay'" (ACW4, speaker 1).

### Rosters, hours and job descriptions

The participants in this study mostly had sufficient and steady hours, although in one residential care facility, there had been a change in how extra hours were offered. This was perceived to be done in order to reduce costs. That participant spoke of how people used to be able to pick up extra hours, sometimes on a sleepover after a day shift; up to a total of 120 hours per fortnight. However, these additional hours had been harder to come by after the Settlement, with part-timers and a 'casual pool' being offered additional hours before full time staff.

Some participants noted a small change in how much work they were expected to do after the Settlement, but it was more that managers asked them to do small extra, often administrative tasks. Where the manager had previously – prior to the Settlement – been a little apologetic for adding these to the support workers' tasks, they now were not.

### Attracting new people to the industry

All the participants agreed that more people were attracted to working in the disability support sector since the Settlement. Generally, they perceived that people joined the sector because they felt passionate about the work, but that the low pay rates had been a barrier:

“I think it has been a disadvantage in the past because people do get into this work because of the way they care about other people. And I think that had been used quite a lot because there will always be people here that will do it because they love doing it and supporting people. I think now it recognises that, but also it may bring more people into the industry that will actually stay longer now rather than going, 'this is a stepping stone for me to something else'” (DW1, speaker 3).

Another participant agreed, adding that it would bring people not just with the passion, but with the right skills as well. The Settlement had given the acknowledgement needed:

“This actually requires skills, it requires a lot of work and it requires the right people to be in the industry and I have definitely seen that you are getting more, kind of a trickle of those of people coming

in who are doing it for those reasons. I mean I think that will definitely be something that is really, really cool” (DW1, speaker 1).

Another participant spoke of how they thought that the Settlement had already changed the way people viewed the sector:

“Rather than being, just, 'I'll do it right out of High School in between jobs', it is actually to me, I look at it as a career path... but actually now my

career, for me, is to be a support worker and that feels really nice for me to say that and people really acknowledge it” (DW1, speaker 4).

“ This actually requires skills, it requires a lot of work and it requires the right people to be in the industry and I have definitely seen that you are getting more, kind of a trickle of those of people coming in who are doing it for those reasons. I mean I think that will definitely be something that is really, really cool”

## 6.3. DISABILITY SUPPORT SECTOR CONCLUSIONS

Both managers and care and support workers agreed that the Settlement brought a well-deserved pay rise that recognised the work done by care and support workers in the disability support sector. The Settlement had had made a positive impact on care and support workers who not only felt more appreciated, but also now viewed this as a sustainable job. Prior to the Settlement, although they enjoyed their work and thought it was important, the wages were not sufficient to sustain over a career. Managers perceived that, although it was not significantly easier to recruit new care and support workers after the Settlement, they were generally able to attract a different calibre of applicant.

Although having well-skilled and knowledgeable workers was important, several managers reported having changed how they offer training in their organisations, since the Settlement. This included ceasing to pay their care and support workers for time spent in training, as well as offering fewer opportunities to staff. This was, in part, because of the increased costs associated with more people wanting training. Managers were also reluctant to provide training to care and support workers who previously may not have shown any interest in it at all.

The managers were concerned about the relevance of some qualifications to the disability support sector, particularly where equivalency or qualifications from lesser-known providers were concerned. Some managers reported that they did not feel that there was a good connection between the experience someone had, their qualification level and the corresponding pay rate. One example given was of someone who may have extensive length of service, but not a high competency level. These concerns were exacerbated by uncertainty around their

obligations as an employer with respect to training their care and support workers. Some managers had been unable to get clear and direct information about how training is funded.

Both managers and care and support workers noted that, since the Settlement, care and support workers had often been given additional tasks to complete because they were now paid more. In some providers, changes to rosters had been made, reducing the availability of hours to care and support workers – in comparison to the hours that had been available prior to the Settlement.

# 7 Overall Conclusions

Overall, the increase in wages for care and support workers was welcomed in all three sectors by both managers and care and support workers. However, the way in which the Settlement was funded and implemented led to several negative consequences for both providers and care and support workers. The following points identify some of the major themes that arose across all three sectors.

## **Changes to hours and rostering**

In residential aged care, smaller providers struggled to survive in the current funding model. They had changed their service provision and often had made cuts to staff numbers or hours available to care and support workers: some care and support workers in residential aged care experienced a reduction in their hours. Managers in home and community care highlighted the complexity of managing the introduction of three separate pieces of regulation within a short timeframe, while attempting to match the qualification level of care and support worker to client need in an effort to minimise cost. Home and community care managers said that the majority of their clients did not need the level of care associated with Levels 3 and 4 care and support workers.

Managers in home and community care had mostly responded to these regulatory changes in a way that reduced the hours available for their Level 3 and 4 care and support workers, to the extent that several participants reported that their hours had halved since the Settlement. This, as well as active discouragement from managers, dissuaded care and support workers in home and community care from wanting to complete their Level 3 and Level 4 qualifications.

It appeared that some managers used practices that attempted to meet the bare minimum of the guaranteed hours framework, but were perhaps somewhat disingenuous, such as contacting their workers when they were scheduled to be with a client. This was done in order to cut costs,

and reduce the hours of high-cost employees. It appeared that the burden of implementing the regulation had escalated tensions and bullying in the sector, which had not been as apparent prior to the Settlement. These issues were reported by most managers and care and support workers across several providers, and are a significant negative consequence of the way in which the Settlement was implemented.

## **Expectations of 'Level 3' and 'Level 4' workers**

Both managers and care and support workers across all three sectors expressed a disconnection between a qualification attained and the competency of a care and support worker to carry out their tasks. This was most apparent for those who were on Level 3 or Level 4 under the transitional arrangements that recognised their length of service with their current employer. Some of these care and support workers provided skilled, high quality care, and their managers and colleagues thought the higher wages well deserved. However, there was a cohort that were perceived to be either less willing to perform at a higher level, or less able to. There was some dissatisfaction that this cohort, being on Level 3 or 4, could be paid a higher rate than someone who had attained a Level 2 qualification and provided an excellent quality of care.

The other issue that arose was that of qualification equivalency. Most of the participants did not see the pertinence of some qualifications that were assessed as equivalent to the Level 4 Certificate in Health and Wellbeing. There was concern that this equivalency did not include assessment of the care and support worker's skill and competency. The scope of equivalency assessment is based on meeting graduate outcome requirements. The Level 4 Certificates include an expectation of 200 hours' work experience "which contributes to the achievement of the qualification's outcomes" and therefore equivalency includes this requirement. However, the findings suggest that a review of Level

4 and its connection to the previous levels may be useful to ensure that the knowledge and skills acquired are well understood by all stakeholders and that graduate outcomes remain relevant within these sectors. The researchers understand that a review of these qualifications is underway at the time of this report.

In some cases, managers' interpretation of what was expected at Level 4 had increased since the Settlement, despite the qualifications themselves not changing. Across all three sectors, there was evidence of an increased workload for Level 3 and 4 care and support workers. Both managers and care and support workers (in residential aged care and home and community care) reported more complex care tasks being given to Level 4 care and support workers – some of which were delegated from enrolled or registered nurses. This was in part due to the smaller gap between the hourly wages, and perceived issues of parity between these occupations, after the Settlement.

### **Quality of Care**

Quality of care had potentially declined in both residential aged care and home and community care, and to some extent in the disability support sector. In residential aged care, this was due to lower staff ratios, which meant those rostered on would have higher workloads, and that clients requiring two carers for lifts might wait longer for attention, for example. In home and community care, issues with scheduling relief carers for clients meant that some clients would not know who would visit them in advance. This also meant that a care and support worker might not be familiar with the client's specific needs. In some cases, a client might miss a day's scheduled care because of issues with rostering. Several managers in residential aged care pointed to the inadequate funding creating a focus on money, not care. One manager in home and community care thought that the complexity of guaranteed hours, between travel, and the pay equity Settlement meant that they focused more on their care and support workers than on their clients.

### **A valued career?**

One of the intents of the Settlement agreement and Act was to create an environment that would attract new people into the care and support workforce, as it would have higher hourly wage rates in addition to guaranteed opportunity for development and career growth. One year after its implementation, there was little evidence of this happening, with most managers reporting no change in the number or quality of applicants for care and support worker positions. There was some evidence that this was different in the disability support sector, with a small increase in higher calibre applicants to new positions. Some participants in the disability support sector felt that the increased wages made the job a sustainable career for those who enjoyed the work and did it for its contribution to society. This was not as evident in the other two sectors. Although no clear reason was given for this difference between sectors, the funding models and aims in the disability support sector are clearly around (as new frameworks allude to) a more encompassing model of care that extends beyond physical cares to supporting people to take part in communities and live fuller lives.

It is likely that with some positive messaging around care and support work, it will gain more value and respect within society, thus attracting a wider range of people to the work. It may also take time for the increased wages and training requirements to be understood in the wider community. This would be supported by a consensus amongst managers on the value of the role – recognising that its skill and worth had been devalued by historic gender discrimination. Comments made around managerial, enrolled and registered nurses, and kitchen and cleaning staff's perception of the increased wages indicate that not everyone has accepted the higher value and recognition of care and support work when once gender discrimination is removed as a factor.

### **Lack of information from the Ministry of Health**

Both managers and care and support workers, across all three sectors, felt that there was a lack of support and information available from the Ministry of Health. They thought that there had been very little,



if any, consultation with the people who actually manage and do care and support work on a daily basis. The lack of attention to what it takes to provide care and support work was perceived to be behind flaws in the funding model. This lack of consultation was exacerbated by the rapid introduction of the Act and short timeframe within which providers had to prepare for and respond to the changes. Managers and care and support workers felt isolated and unsure of their rights and obligations. Managers largely agreed that the funding was inadequate and did not cover the costs associated with the Settlement.

### **Looking forward**

This research was conducted in the latter part of 2018, one year after the introduction of The Care and Support Workers (Pay Equity) Settlement Act 2017. Some of the issues raised (e.g. perceptions of care and support work as a career; the impact on the number and quality of applicants for care and support worker positions; length of service, actual competency; the increased need for management to conduct close performance management; and understanding of the levels of qualification and expectations of the work to be done by

workers at each level) are likely to resolve over the implementation period as both managers and care and support workers adapt and become more familiar with the requirements of the Act.

However, the consequences for two cohorts of care and support workers must be addressed. Firstly, there is a cohort who are now expected to carry out more complex tasks and do not want to, or cannot. Without change to the current system, a cohort of care and support workers who do not complete the qualifications and perhaps do not have the competency required at Level 3 and 4 may find themselves without work. This includes care and support workers who may face literacy or other learning issues that create barriers to their success in this career. Secondly, there appears to be a large cohort whose hours have reduced: they are now financially worse off because of the reduction in their regular hours. Funding models and policy advice must be reviewed with these cohorts in mind – or significant numbers of women will be disadvantaged by the implementation of legislation that was meant to eradicate gender discrimination in wages and conditions for the care and support workforce in New Zealand.

# 8 Recommendations

These recommendations are based on the issues identified by managers and care and support workers in this study. The recommendations are primarily aimed at sector-wide policy initiatives, but could be the responsibility of a range of stakeholders – including government bodies, provider representatives and unions. These recommendations are suggested in order to recognise the intention of the Settlement: to create a skilled, flexible workforce that can work across these three sectors, and to value the work without gender discrimination.

## Creating a culture of value

- Consider an industry wide ‘public service’ campaign that highlights the value of care and support workers to our communities and society (examples have come from past union campaigns highlighting the importance of this work).
- Value the ‘clients’ – highlight the difference that care and support workers make to the lives of older people and people with disabilities. This emphasises care over profit, and encourages a broader approach to care to support all clients to enjoy full lives, participating in society.

## Training and Qualifications

- Review the NZQA requirements for Level 4 qualification equivalency so that it connects to the graduate outcomes of Levels 2, 3 and 4 of the NZQA Certificate in Health and Wellbeing.
- Review the graduate outcomes of Levels 2 to 4 of the NZQA Certificate in Health and Wellbeing to ensure consistency in expectations amongst all stakeholders of how the qualifications relate to the skills and knowledge required across these sectors; emphasising that successive levels build on the previous ones.
- Revise funding models with regard to the actual cost of training.

- Ensure accessibility of quality training to small providers, and those in rural areas.

## Workforce Development

- Focus on literacy initiatives and other appropriate strategies to better support passionate and skilled workers who may face barriers to attaining the New Zealand Certificate in Health and Wellbeing.
- Improve affordable professional development opportunities for managers, to assist in their skill and confidence to manage in a more complex environment.

## Role expectations

- Support the development of agreed sector-wide, generic job descriptions, with examples of tasks required by level in each of the sectors.

## Funding

- Develop clearer and more consistent funding models that are attached to the cost of employing care and support workers (across the levels), rather than attached to bed or client types.
- Develop funding models that recognise the importance of having a range of providers available to communities in New Zealand. Specifically, ensure that funding models are appropriate for small providers.

## Communicating the Settlement

- Continue to develop readily accessible ‘FAQs’ for both managers and care and support workers that clarify their rights and obligations. This should be designed to be accessible to those with literacy challenges, and in languages that reflect key cohorts in this workforce.



# References

- Care and Support Workers (Pay Equity) Settlement Agreement. Retrieved from <https://www.health.govt.nz/system/files/documents/pages/care-support-workers-pay-equity-Settlement-agreement-signed-8may17.pdf>
- Careerforce (2019). *Qualifications*. Retrieved from <https://www.careerforce.org.nz/qualifications/>
- E Tū and PSA (2017a). *Guaranteed Hours – Calculation Method*. Retrieved from <https://www.psa.org.nz/assets/Uploads/Guaranteed-hours-calculation-E-tu-and-PSA-4.pdf>
- E Tū and PSA (2017b). *Guaranteed Hours – Frequently asked questions*. Retrieved from <https://www.psa.org.nz/assets/Uploads/FAQ-E-tu-and-PSA-final.pdf>
- Ministry of Health (2017a). Care and Support Workers (Pay Equity) Settlement Operational Policy Document. For Aged Residential Aged Care. Retrieved from [https://www.health.govt.nz/system/files/documents/pages/arc\\_pay\\_equity\\_operational\\_policy\\_updated\\_16\\_june.pdf](https://www.health.govt.nz/system/files/documents/pages/arc_pay_equity_operational_policy_updated_16_june.pdf)
- Ministry of Health (2017b). Care and Support Workers (Pay Equity) Settlement Operational Policy Document. For Community and Residential Living. Retrieved from <https://www.health.govt.nz/system/files/documents/pages/crl-pay-equity-operational-policy-document-16-june.pdf>
- Ministry of Health (2017c). Care and Support Workers (Pay Equity) Settlement Operational Policy Document. For Home and Community Support Services Providers. Retrieved from <https://www.health.govt.nz/system/files/documents/pages/hcss-pay-equity-operational-policy-16-june.pdf>
- Ministry of Health (2017d). Care and Support Workers (Pay Equity) Settlement. Payroll Processing Guidelines. Retrieved from [https://www.health.govt.nz/system/files/documents/pages/payroll\\_guidance.pdf](https://www.health.govt.nz/system/files/documents/pages/payroll_guidance.pdf)
- Ministry of Health (2017e). Employer Factsheet. Care and Support Workers (Pay Equity) Settlement Agreement. Retrieved from [https://www.health.govt.nz/system/files/documents/pages/employer\\_factsheet-dec2017\\_0.pdf](https://www.health.govt.nz/system/files/documents/pages/employer_factsheet-dec2017_0.pdf)
- Ministry of Health (2017f). Guaranteed Hours Funding Framework (Transitional Arrangements for the period 1 April 2017 to 30 June 2018). Retrieved from <https://www.health.govt.nz/new-zealand-health-system/claims-provider-payments-and-entitlements/between-travel-Settlement/between-travel-guaranteed-hours>
- New Zealand Qualifications Authority (2014a). Qualification Details: New Zealand Certificate in Health and Wellbeing (Level 2). Retrieved from <https://www.nzqa.govt.nz/nqfdocs/quals/pdf/2469.pdf>
- New Zealand Qualifications Authority (2014b). Qualification Details: New Zealand Certificate in Health and Wellbeing (Level 3). Retrieved from <https://www.nzqa.govt.nz/nqfdocs/quals/pdf/2470.pdf>

New Zealand Qualifications Authority (2015a). Qualification Details: New Zealand Certificate in Health and Wellbeing (Advanced Support) (Level 4). Retrieved from <https://www.nzqa.govt.nz/nqfdocs/quals/pdf/2779.pdf>

New Zealand Qualifications Authority (2015b). Qualification Details: New Zealand Certificate in Health and Wellbeing (Social and Community Services) (Level 4). Retrieved from <https://www.nzqa.govt.nz/nqfdocs/quals/pdf/2992.pdf>

Treasury (2017). Budget 2017 Information Release. Release Document July 2017. Retrieved from <https://treasury.govt.nz/sites/default/files/2017-11/b17-3704875.pdf>

---

#### **Legislation referred to**

Home and Community Support (Payment for Travel Between Clients) Settlement Act 2016

The Care and Support Workers (Pay Equity Settlement) Act 2017



# Appendix 1. Agreed Hourly Rates 2017 to 2022

## Hourly Wage rates for workers employed on or after 1 July 2017

Qualification	1 July 2017	1 July 2018	1 July 2019	1 July 2021
No relevant qualification	\$19.00	\$19.80	\$20.50	\$21.50
Level 2	\$20.00	\$21.00	\$21.50	\$23.00
Level 3	\$21.00	\$22.50	\$23.00	\$25.00
Level 4	\$23.50	\$24.50	\$25.50	\$27.00

## Hourly wage rates for workers employed before 1 July 2017, based on service

Length of Service	1 July 2017 Year 1	1 July 2018 Year 2	1 July 2019 Year 3 & 4	1 July 2021 Year 5
< 3 years OR	\$19.00	\$19.80	\$20.50	\$21.50
3 to 8 Years	\$20.00	\$21.00	\$21.50	\$23.00
8 to 12 years	\$21.00	\$22.50	\$23.00	\$25.00
12+ years*	\$22.50	\$23.50	\$24.50	\$26.00
12+ Years	\$23.50	\$24.50	\$25.50	\$27.00

\*This rate is applicable if the worker commenced employment with the employer on or after 1 July 2005; and had not attained a Level 4 qualification; and the employer provided the support necessary for the worker to attain Level 4.





**NEW ZEALAND  
WORK RESEARCH INSTITUTE**

[www.workresearch.aut.ac.nz](http://www.workresearch.aut.ac.nz)

[work.research@aut.ac.nz](mailto:work.research@aut.ac.nz)

 [facebook.com/workresearch](https://facebook.com/workresearch)

 [@NZWorkResearch](https://twitter.com/NZWorkResearch)

 [NZ Work Research Institute](https://www.linkedin.com/company/nz-work-research-institute)

**AUT**