

**Women's Budget Group Response to
Independence, wellbeing and choice: our vision for the future of social care
for adults in England: Social Care Green Paper**

July 2005

About The Women's Budget Group

The Women's Budget Group (WBG) is an independent organisation bringing together academics and people from non-governmental organisations and trades unions to promote gender equality through appropriate economic policy.

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If you would like more information about the work of the WBG, or to join the group and contribute to our work, please contact the Project Officer, Erin Leigh, or visit our website.

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Introduction

The WBG welcomes the government's commitment to developing a long-term strategy for social care which is more in tune with the needs and wishes of older people and other adults needing care. We wish first to comment on the overall objectives of this strategy and second to focus on issues concerning the social care workforce, which is predominantly female. Our comments reflect our overall commitment to encouraging the development of policies which are informed by sound evidence. The WBG is also concerned that the implications of policy developments for women and for men are understood and made explicit.

Does the vision for adult social care as set out summarise what social care for adults should be trying to achieve in the 21st century?

The title of the Green Paper reflects the emphasis the government places on ensuring that older people and adults needing care achieve 'independence' and are given 'choices' about how best to do this consistent with their own well-being.

Independence

We question both the dichotomy set up in the Green Paper between 'dependence' and 'independence' and the assumption that 'dependence' is a state to be avoided wherever possible. All of us are more or less dependent on others throughout our lives. As infants we are completely dependent on the generation of adults who, when they become old, are going to need our support. When we become adults our concern for the older generation's well-being and our willingness to provide this support, either directly or indirectly, is an expression of the solidarity between the generations upon which *all* societies depend.

Some of us are always going to be very dependent on others because of physical or mental incapacity. Others become dependent as we age because of increasing physical frailty or because of a reduction in our mental capacities. We welcome the recognition in the Green Paper that more sensitive housing and transport policies together with the greater use of technology in the home could help people to fully use their capacities. However, to aim for 'independence' for all is a cruel deceit. Rather what should be possible is what Gilbert in his recent study of the transformation of welfare states calls, 'a life of honourable dependence' (Gilbert, 2002, p.189) in which individuals, irrespective of their capacities, are treated with respect and their dignity and autonomy protected as much as possible. Indeed this is the mark of a good society to which we should all aspire.

A recent JRF funded study of older people in Leeds, *Building a Good Life for Older People in Local Communities* found that they stressed 'inter-dependence' rather than independence. "... formal help was not just to be resorted to in the absence of supportive family and friends: it might indeed be preferable in order

not to be perceived as a 'burden' on them...whilst people identified need for practical help, they also sought to sustain social engagement and valued social activities, even when they experienced restrictions on account of a disability." (Godfrey, Townsend and Denby , 2004 p222).

John Reid, writing in his capacity at the time as Secretary of State for Health, in the Foreward to the Green Paper, acknowledged this. "People do not always want to be entirely dependent on friends and family." In other words formal services are necessary to avoid *unwanted* dependence on family. Conversely family and friends who do care are not always willing or able to care without any formal help. The wish of many carers not to do it all is thus entirely consistent with the wishes of the majority of those for whom they care. The current practice of 'targeting' services on the most incapacitated is inconsistent with the wishes and needs of both carers and care-users.

The WBG believes that fostering and recognising 'interdependence' both between and within the generations, is a more appropriate policy goal than the achievement of 'independence'. Dignified dependence should be well supported and resourced.

Choice

Over the past 25 years the direct provision of residential care and more recently, domiciliary care has moved out of local authority departments and into the private-for profit sector. Today over four-fifths of residential care places and two-thirds of domiciliary care provision is found in the market. It is asserted in the Green Paper in support of the extension of direct payments and the introduction of 'individual budgets' that 'the ability of people to 'buy' elements of their care or support packages will stimulate the social care market to provide the services people actually want, and help shift resources away from services which do not meet needs and expectations.'(p.35)

Where is the evidence for this? It is not to be found in the Green Paper.

There is however, strong evidence that neither residential care nor childcare markets in the UK provide the number of places needed let alone choice. Provision is inadequate overall and is unevenly distributed both within and between regions of the country. These variations do not reflect different needs, wishes or 'choices' but are related, as they must be, to market providers' judgements about capacity to pay fees high enough to sustain a profitable business. Direct payments or 'individual budgets' are unlikely to be high enough to attract and sustain private providers in all areas any more than childcare tax credits have been. As Ed Balls, the Chancellor's former chief economic adviser, told a recent Daycare Trust's conference 'there are real constraints on the ability of market mechanisms alone to deliver for parents the kind of reliable and quality care, at affordable prices that we need.'(Nursery and Childcare Market News, Feb. 2005, p130)

There are also difficulties for the 'consumers' of care because they do not have sufficient or appropriate information to make a 'good' choice. A 'bad' choice may be irreversible and have undesirable and costly consequences both for the individual and for the rest of society. We all have an interest and stake in the provision of good quality social care. What does 'choice' mean for an isolated and confused old person who has outlived the family and friends who might help and speak up for her? Focus groups of able-bodied, younger adults may not give us all the relevant data necessary for appropriate policies. Schwartz in his book *The Paradox of Choice*, cites research that showed that although nearly two thirds of people surveyed said if they had cancer they would want to choose their own treatment, when people actually have cancer only 12% want to do so. "What patients really seem to want from their doctors ... is competence and kindness. Kindness of course includes respect for autonomy, but it does not treat autonomy as an inviolable end in itself" (Schwartz, 2005, p32).

Gordon Brown himself has questioned the desirability of treating health care provision as a commodity to be left to the market, in part because people lack information. 'Not only is the consumer not sovereign but a free market in health care will not produce the most efficient price for its services or a fair deal for the community.'(Cited by Needham, 2003, p30).

Markets are an inadequate mechanism for supplying and distributing good quality care. Care is a personal service which makes it different from a commodity which can be separated from the person making or delivering it. This is recognized in the statement in the Green Paper that "people who use social care services say the service is only as good as the person delivering it" (p14 and p64). Social care is a highly labour intensive industry in which productivity rises resulting from improved training for example, can improve quality but not cut costs. Costs in such industries inevitably have to rise if pay is to keep up with wages in other sectors (if wages do not keep up with other sectors, there will be continuing recruitment and retention problems. This is what we are observing at the moment). This means that any expenditure should be planned to rise at least in line with average earnings, and faster than earnings if the aim is to make improvements.

This is the case whether or not the provider is in the public or private sector. However the private provider is faced with a growing tension between constraining wages and the continuing need to make a profit. In the short run it may be tempting to rely on cheaper but precarious, immigrant labour but this will not lead to improvements in the quality of care or to a well qualified, sustainable work force. This is particularly the case if workers from overseas have less access to benefits than UK citizens and have permits which tie them to a particular employer.

The temptation to lower standards in the private sector can be resisted if there is a healthy public sector to set good standards known to practitioners, the wider public and potential care users. The WBG fears that reliance on the private

sector has now become so great that this mechanism for protecting standards has been weakened. The majority of those needing domiciliary or residential care can no longer choose a public provider who can be held more fully to account and who, under the Human Rights legislation, has a duty of care towards care users that private providers do not have.

The WBG urges that policies for social care should recognise that there are negative consequences both for care workers and care-users if care is treated as a commodity and sold in the market. This has implications both for the organisation, management and regulation of services provided by the private sector. Improvements in the quality and availability of care will require more resources.

Direct Payments

Direct payments have been very slow in developing in the UK, particularly among older people, as the Green Paper acknowledges. There is much however, that policy makers in the UK could learn from the experience of direct payments in other countries where their use has been more widespread. Recent comparative research on direct payments shows that as a mechanism for enhancing choice and empowering adults needing care, their use is more complex than suggested in this Green Paper. In her study of 'cash-for-care' schemes in five European countries including the UK, Ungerson found that

the outcomes of cash-for-care schemes vary considerably largely because of two major variants in the rules and regulatory framework-whether or not it regulates the type of worker employed by the care user and enforces the social rights of care workers, and whether or not the payment of relatives is permitted.'(Ungerson,2004,p210)

As experience in the US shows, little or no regulation may result in the state funded expansion of the 'grey economy' of care and domestic workers with heavy dependence on immigrant workers (See Gilbert, 2002).

The proposed expansion of the direct payment scheme outlined in the Green Paper appears to offer minimal regulation of the employment of personal carers. Responsibility for and the cost of criminal record checks and the payment of minimum wages and national insurance contributions are to be left to the individual receiving the direct payment. Ungerson's study shows how this responsibility can be shared with the state in ways which *reduce* the opportunities for exploitation. Her study also shows how broader geographical, social and economic contexts, including immigration policies, have an impact both on the availability and character of care-givers or workers that care-users employ. We agree with her that 'policy makers should proceed with caution'.

The WBG welcomes the recognition that projects piloting direct payments are needed. Meanwhile more could be learnt from the experience of other countries, in particular those practices which effectively guarantee the social rights of care workers and the protection of both care-users and workers from danger and exploitation.

The capacity of the wider community

“It is family and friends, of course, who still take on most of the caring responsibilities. This support is given willingly but must not be taken for granted.”(Prime Minister, Preface to the Green Paper.) Despite this statement there is disappointingly little discussion of the needs of carers. There is not even a specific question focussed on carers in this consultation and the chapter on the role of the wider community is only 9 paragraphs long. The government does recognise carers more than previously was the case. The Carers (Equal Opportunities) Act 2004 is evidence of this. However in this Green Paper there is only one brief mention of this Act and little discussion of the implications its full implementation could have on formal care services. Overall there is little evidence of joined-up thinking across policy areas that are the responsibility of the Department of Work and Pensions and the Department of Trade and Industry.

Half of all carers in the UK are aged between 45 and 64 years with a further fifth over the age of 65. Currently one in four of men and women in their 50s are carers. The government’s policy, in order to put both state and private pension schemes on a sounder financial footing, is to increase economic activity rates among men and women over 50 years and to raise pension and therefore actual retirement ages. These policies are of particular concern to carers because currently the opportunity costs involved in being a carer while of working age are considerable. These currently in the UK, take the form of lower or no wages followed, particularly in the case of women, by lower or no pension entitlements. They also face poorer training and promotion prospects. The DTI’s proposal to extend to carers the right to ask to work flexibly is a step in the right direction but it is a very small step. Carers who have reduced or interrupted their paid employment need support in either increasing their hours again or returning to employment after a period of heavy care.(Evandrou and Glaser, 2004). Some will need retraining as the 2004 Act recognises. This cannot be done without additional resources. Carers are unlikely to have their own resources to fall back on and in any case have low priority in access to family resources.

The unwillingness to argue for additional resources is short-sighted because the European countries with the highest economic activity rates (over 65%) among women aged 50-64 years are found in Northern European countries, where there is extensive formal childcare and social care provision within the welfare state. The lowest rates (under 30%) are found in Southern Europe where dependence

on the extended family is substantial and welfare state provision is residual (Eurostat, 2004). Meanwhile in the UK, the 'long hours culture' continues to undermine the efforts of parents and carers to reconcile their family and employment responsibilities. It is worrying that one of the groups of workers *most* dissatisfied with their hours of work are now women in their 50s (Taylor, 2002).

The WBG supports 'joined up thinking' across government departments in order that policies are consistent. The WBG urges that more resources are made available for reforming and investing in social care broadly defined. The WBG regrets that the government still supports the individual opt out to the Working Time Directive and would like the UK to come in line with rest of the EU.

Demographic and social changes are affecting the capacity of families to care but these are barely discussed in the Green Paper. The form and extent of care and support between the generations is indeed changing (see Grundy, 1999) but this cannot be attributed simply to increased geographical mobility (Green Paper,p10) In the UK co-residence between older people and one of their adult children has declined but this is partly because as more people, particularly men, are living longer a higher proportion are living with their spouse in old age Rates of marriage of the current generation of newly retired are higher and the incidence of childlessness is lower than either previous or subsequent age cohorts It should not be assumed that extended families are caring less than in the past. Indeed there is evidence that they are providing more rather than less care despite the increased economic activity rates of women. Different minority ethnic groups may have different practices and preferences for care within and by the family. Policies need to be sensitive to these.

Living alone should not be equated with loneliness or lack of support, especially for women. There is little evidence that old people are more lonely than 50 years ago.(Victor *et al*, 2005) A more sophisticated analysis of the changing demand for *and* supply of care, which takes gender differences seriously in the context of restructured welfare states and socio-economic changes, is required. For example, women are much more likely than men to receive help from family members living outside the household because they have invested more in family life at an earlier age. Moreover this investment usually continues beyond marriage or partnership breakdown. For men the picture may be different in future. "The care of men without a spouse may become an increasingly problematic issue, as the willingness of relatives to provide assistance may decrease" (Tomassini, Glaser and Askham,2004,p123).

The WBG recommends that fuller use of the wealth of demographic and sociological data available is made in order to inform the further development of the policy proposals concerning the caring capacity of the community in general and carers in particular.

Do you think the direction proposed for strengthening and developing skills in the workforce is right?

What actions are needed by government and others to assist employers in recruiting, retaining and developing the workforce?

The paid social care workforce is more than twice as large as the childcare workforce. There are three-quarters of a million 'hands-on' care workers in the domiciliary and residential care sectors. (If social workers and some health professionals are included in the figures the total is over one million.) At least 90% are women and, in contrast to the childcare sector, many are older women. About half of domiciliary care workers and 40% of those working in the residential care sector are over the age of 50. About half are employed part-time. Two-thirds of social care workers are now employed in the private-for profit sector. This movement out of the public sector raises a number of issues, some of which can have negative consequences for the workers, the care-users and the policy makers. The WBG believes these issues need to be addressed more actively than indicated in the Green Paper if the skills of the care workforce are to be strengthened and developed.

First, the social care workforce is now inadequately monitored compared with the time when, as public sector employees, they were included in every local authority's annual returns giving the basic characteristics of their workforce. The latest Topps (England) report on the social care workforce reveals an alarming state of ignorance.

There is a great deal that is not known about the social care workforce. The key areas where information is lacking are: the independent sector workforce, levels of training and qualification in the workforce as a whole, day care, employees of partnership bodies, social care staff in the NHS, information about new types of care providers and separating the adult's services from the children's services workforce" (Topps(England) 2004,p10).

Unless policy makers take steps to become better informed, appropriate workforce strategies cannot be either developed or evaluated. Topps (England) have developed a National Minimum Data Set for Social Care to use in collecting standardized employment data from employers throughout England. They suggest that it will 'probably' be collected annually. This is not good enough and the WBG suggest that employers should be *required* to provide basic workforce information, particularly if (as most of them are) they are in receipt of and indeed, heavily dependent on, public money.

This information is also important as the Office for National Statistics is in the process of improving its methods of measuring government output in adult social services. When measuring national output it will measure both direct public provision, and provision which has been commissioned (ONS, 2005). If output is to be captured in full then the independent sector must be required to report on its provision of adult social services. Data on the characteristics of its workforce would make it possible to link increased investment in improving the skills of the social care workforce with changes in the output of these services.

Collection of standardized employment data from the private sector is done in other countries. For example in the USA, private sector companies with 100 or more employees have to provide information to the EEOC about gender and race representation in different job categories. In Canada the Employment Equities Act of 1995 requires public sector organisations, and large private sector companies undertaking federal government contracts, to analyse workforce representation, and to develop employment equity plans that address the hiring, training, promotion and retention of women. More recently in Australia the Equal Opportunity for Women in the Workplace Act (1999) requires private sector companies (as well as public sector and other organisations) with 100 or more people to establish a workplace program to remove barriers to women entering and advancing in their organisation. A workplace profile is required which it is suggested should include information about women and men at different grades, with breakdowns of full-time and part-time, casual workers, and average salary for each category. (Salary information may be excluded from public disclosure of information.)

While the WBG strongly believe that information about gender equality in the workplace should be available to the public as well as to government, the situation in the UK at present requires no disclosure on these issues at all to either the government or the public. We believe this is a major barrier to progress, and one that it is not impossible to address. It is essential if the skill levels and pay of the social care workforce are to be improved so that recruitment and retention problems are reduced.

Second, the social care workforce is underpaid. The current wage levels of social care workers puts them in the bottom decile of the earnings distribution. It is estimated that half of them work part-time. Pay and conditions in the private sector are worse than in the public sector. The Social Services Inspectorate in their final report (before they were replaced by Topps and the CSCI) compared workers in the public and independent sectors concluded :

The in-house home care service was long established usually with a stable workforce in whom there had been investment in training and personal development over a number of years. Private agencies were mostly of more recent origin and were often not funded to provide the

kind of terms and conditions, such as mileage and traveling time which in-house staff enjoyed. (SSI, 2002 p38)

It is of particular concern that Topps found evidence from the UK Home Care Association's 2004 survey that in the independent domiciliary care sector "there is no fixed number of workers needed and the concept of a 'vacancy' is largely meaningless. Providers recruit on a continuous basis to get as many workers as possible. Providers instead drew on a pool of workers who work more or fewer hours as demand dictates."(Topps(England), 2004,p46) This is 'flexible' working of a kind which is not in the interests of either care workers or those needing care. As the Social Services Inspectorate concluded when they came across similar practices among home care agencies, "it was difficult to recruit, retain and train good quality staff on these terms."(SSI, Ibid.)

Poor pay and conditions result in high turnover rates of staff. The evidence that is available suggests that turnover rates in the private sector are double (30%) those found in the public sector. High staff turnover rates lower the quality of care because a caring relationship is based on trust and familiarity. Relationships take time to build and sustain. This means that those needing care do not get to know and trust those caring for them and undertaking personal and intimate tasks. This is not consistent with respecting the care-users' dignity.

Third, only a quarter of the current workforce has a relevant qualification, although many of the older workers have a great deal of relevant *experience*. Moreover many of them have caring responsibilities for children or older relatives themselves. Employers in the UK in general are not as committed to training their workers as those in some other European countries. Social care providers are no exception. As discussed above, the wages bill is the largest component of the cost of providing care so there is resistance in the private sector to increasing it, particularly if the costs cannot be passed on to the user so profits are reduced. The leading consultants in this field, Laing and Buisson, estimated a fair fee level based on care staff wage levels little different from the minimum wage and *three days paid training a year*.

We welcome the additional resources available to employers for training but arrangements for supervision in the workplace and completion and drop rates should be carefully monitored. The consequences of a better trained workforce for the cost of care will need to be addressed. Fewer staff to look after the residents or visit clients in their homes means the standard of care decreases. A further consequence of high turnover rates is that social care workers either do not get or complete the training required to do the more skilled tasks or learn to deal with the more difficult old people. They therefore have the easier clients and the more pleasurable tasks. As a result the job satisfaction of the more experienced staff declines as they become demoralized and exhausted.

A market culture too easily works against good quality staffing and therefore good quality care. As Knijn (2000) found in the Netherlands, the home care sector is in danger of ceasing to be an attractive occupation for working class women without formal qualifications but a wealth of experience relevant to providing good care. Home carers have never been well paid in the UK but they took pride in their work, most enjoyed a good relationship with their clients and knew that what they did for them was needed and valued. Many did far more than they were paid to do. These older care workers who really did try to care for the old people for whom they felt responsible will be very difficult to replace unless social care workers are more highly valued. This cannot be done without increasing the social care budget.

Both the Social Services Inspectorate and Topps concluded that one of the reasons for the poor employment practices and low wages in the private sector was that social service departments, with whom they had contracts to provide domiciliary services, did not pay them enough. Local authorities in turn argue that they are not given adequate budgets and the Association of Directors of Social Services have estimated that currently there is a one and a half billion shortfall for social care funding (Care and Health, 17 July 2005). However, additional resources must be spent on providing better care, not on increased profits. This will require more rigorous and transparent mechanisms for holding the private sector to account for its use of public money than currently exist in England.

Good and safe care is not cheap The social care workforce can only be developed and trained to provide good quality care with additional resources to improve the pay and conditions of care workers. Overall more robust mechanisms for improving the accountability of social care providers, especially in the private sector, are urgently needed.

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