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Does better quality contracting improve pay and HR practices? Evidence from for-profit and voluntary sector providers of adult care services in England

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Abstract

This article investigates the complex interaction between contracting arrangements and quality of human resources (HR) practices. It draws on quantitative and qualitative empirical evidence for the adult social care sector in England where most services are purchased by local authorities and delivered by private for-profit and voluntary sector organisations. The study finds sufficient evidence among surveyed care providers that higher fees and partnership-oriented contracting have positive influences on pay levels and quality of HR practices to suggest that better local authority contracting may be an enabling condition for the improvement of employment standards. However, the relatively weak statistical associations suggest other factors mediate, or distort, the anticipated relationship between quality of contracting and quality of HR practices. The type of provider is identified as a key mediator: private, for-profit providers and those managed by a national chain are least likely to distribute the benefits of better quality contracting fairly through improved employment standards.

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Introduction

While outsourcing and subcontracting in some studies is identified as a significant cause of increasing vulnerabilities in employment (James and Walters, 2011; Zatz, 2008), in others better quality contracting arrangements positively influence the standard of HR practices in subcontractors (Bibby, 2011; Wright and Brown, 2013). By demanding continuous repeat tendering, contractors may impose cost pressures that make it difficult for subcontractors to sustain quality HR practices. Equally contractors may require subcontractors to meet specified employment standards (such as training or job security), as part of a more collaborative, trusting partnership approach involving a shared performance strategy and regular communication. These mixed tendencies suggest that interactions between organisational goals and client–provider contracting arrangements (Rubery et al., 2002; Scarbrough, 2000) have complex influences on organisations' HR practices and workers' experiences. These interactions are further refracted by the specific regulatory, industrial relations and labour market context (Doellgast, 2012; Grimshaw and Miozzo, 2006; Marchington and Vincent, 2004).

To further our knowledge of how contracting influences the quality of pay and HR practices, this article reports evidence from the adult social care sector in England. Most adult social care is organised via local authority (LA) contracts for services delivered by private and voluntary sector organisations. The sector is characterised by variation in contracting arrangements and weak labour market institutions (unions, collective bargaining, working time and employment protection rules), which provide significant scope for employers to shape conditions. The HR outcomes have particular importance for women as the workforce is primarily female. The research collected data on the HR strategies of over 100 private and voluntary sector providers of residential homes and domiciliary care, commissioned to provide services by 14 LAs. A key finding is that there is no simple matching between quality of contract and standards of pay and HR practices; better quality contracting may be an enabling condition but other factors prove significant, especially many employers' unwillingness to upgrade HR practices in response. Client organisations can shape the quality of contracting practices, but as Scarbrough (2000) warned, positive impacts are not guaranteed and the net effects of supply chain relations are contradictory and uncertain. Our evidence, from a sector where trade union and regulatory pressures on organisations are weak, questions the belief that better quality contracting relations will necessarily lead to employment upgrading. Our findings also have implications for understanding the impact of budget cuts to LA social services on the quality of care and prospects for the recruitment and retention of a quality labour force.

The influence of supply chain relations on human resource management

A good deal of empirical evidence and theoretical reasoning has identified the nature and quality of contractual relationships between organisations as a significant factor in shaping HR practices and employment outcomes. The complexities of inter-organisational (client–provider) relationships include features of trust, dominance and modularities (Blois, 2002; Sturgeon, 2002), all of which can be expected to have implications for HR and employment outcomes. Empirical contributions have focused on the outsourcing of in-house activities, dominant-client supply chains, long-term collaborative partnerships, multi-client networks and public–private/public–voluntary partnerships (Cunningham and James, 2009; Flecker and Meil, 2010; Perraudin et al., 2013; Wright, 2011). In drawing out the implications for a study of subcontracted adult social care services, our review focuses on the generic lessons for client–provider relationships and HR outcomes.

While we now know more about contracting relationships, the research to date has suffered from a frequent presumption of a neat relationship between contracting quality and quality of HR practices and employment outcomes. This framework neglects three important issues.

First, all client–provider relationships involve elements of competition and collaboration; common values, partnership and trust matter, but so too do market competition, government policy and threats by one of the contracting parties to terminate the relationship. For example, Scarbrough's (2000) study found that it was not the form of contracting relationship that had most impact on human resource management (HRM) in the subcontractor, but the problems of logistical integration with the client and implementation of just-in-time production techniques. The influence of inter-organisational trust on HR practices may therefore be superceded by other factors such as pressures to adapt new production technologies. Other studies highlight the hierarchical relationship that defines many subcontracting relationships, whatever their character (Perraudin et al., 2013). For example, in portraying new subcontracting relations in an Australian municipality, O'Flynn and Alford (2008: 215) highlight the opportunistic essence of subcontracting; one interviewee claimed subcontractors would devise ways '... to screw the client without the client knowing they are being screwed ... at the same time as keeping the client happy'. Trusting relations can thus overlay unequal power relations. The issue for research is how to disentangle the collaborative attributes of contracting (e.g. partnership activities) from the competitive attributes (e.g. contract fees, or the dependence of a supplier on client business).

A second issue concerns the indeterminacy of distributive outcomes for workers. Trusting client–provider relationships may align with and support strategic managerial interests in both organisations, enabling maximisation of revenue, market share or managerial reward, at the expense of improving HR practices in one or more of the partner organisations (Grimshaw and Rubery, 2005). Employer opportunism is a real risk, especially in organisations where

workers lack collective representation; thus, employers may be able but unwilling to raise employment standards in the absence of push factors. Moreover, managers may be better at aligning contracting practices across organisational boundaries than HR practices. Collaborative subcontracting is frequently associated with a fragmentation of employment terms and conditions; case studies in Marchington et al. (2011) revealed many impediments to the alignment of HR practices with the partnership goals of contracting, especially in public–private partnerships where strategic HR goals differed sharply among client and provider.

Third, contracting relationships do not operate in a vacuum. The external regulatory environment (especially industrial relations, labour market and product market regulations, government policy) shapes both the quality of contracting relations and their influence on HR practices. Bach and Givan's (2010) analysis of a public–private partnership suggests that opportunistic behaviour by the private sector provider was deterred by several factors, including effective workplace union organisation, legal regulations protecting outsourced staff and an innovative collective bargaining agreement. Grimshaw and Miozzo's (2006) UK/Germany comparison of IT outsourcing found IT professionals in Germany benefited from works councils' legal rights to negotiate the form of staff transfer, including establishing a joint venture organisational form that facilitated coordination of HR policy. Doellgast's (2012) study found that telecommunications firms in both Germany and the United States downgraded pay and employment conditions through subcontracting call centre services, although from different starting points reflecting differing union strengths and minimum employment standards. The relationship between contracting and HR practices thus needs contextualising within the country and sector environment.

The characteristics of the adult social care sector in England

Most adult social care services in England are now organised via LA contracts for services delivered by private and voluntary sector organisations – responsible in 2012 for 92% (78% and 14%, respectively) of care home places and 89% of domiciliary care hours.[1] Compared to other privatisation programmes, this massive outsourcing, first residential care in the 1980s followed by domiciliary care in the 1990s/early 2000s, was, as Humphries (2013: 5) notes, 'largely unplanned and unaccompanied by any significant debate about the role of private providers in public services'. The organisations providing adult social care include a mix of large and small organisations, national chains and single units (Care Quality Commission (CQC), 2013).

Private, self-funded social care has been expanding significantly due to both tougher eligibility criteria for LA services and rising property values that remove individuals from means-tested provision. Nevertheless, the LA remains the largest funding source with 55% of care home places LA-funded in 2012–2013 (including 10% with a self-funded top-up) (CQC, 2013: Technical Annex 2).

Social care funding was already under pressure prior to the crisis, but the squeeze intensified from 2010 when the new Conservative-led coalition government decided to target public expenditure cuts on LAs, involving a 27% reduction in LA budgets over four years despite a rising and ageing population. By 2013, LAs had reduced adult social care budgets by 20% by renegotiating provider contracts, reducing the real value of unit fees (often by removing inflation-indexed rises) and, in 9 out of 10 LAs, raising eligibility criteria for adult users, reducing by 10% the number of over 65-year-olds receiving LA-funded domiciliary care (Appleby et al., 2013; Local Government Association (LGA), 2013; United Kingdom Homecare Association Ltd (UKHCA), 2013). By 2013, the CQC, the regulatory body that inspects care providers to determine whether they meet national standards (using a one to three star rating at the time of fieldwork), reported that only 83% of providers met the minimum care and welfare standards, with significant and ongoing problems with 'suitable staffing standards' (2013: 33–34), including HR practices related to training and supervision. The UK Homecare Association, which represents independent domiciliary care providers, lays the blame squarely on the 'dominant purchasing power' of LA commissioning managers who have exerted downwards pressure on unit costs (UKHCA, 2013: 7). However, the roots of the problem lie with central government; the Low Pay Commission (LPC), which investigates compliance with the national minimum wage, has repeatedly recommended government to address 'the mismatch between funding of social care and the obligations, including the national minimum wage, which providers must meet' (LPC, 2014: xvi).

Studies of contractual arrangements between LAs and adult social care providers report that LAs as purchasers of care services prioritise low cost over quality; for example, 75% of domiciliary care providers in UKHCA's 2010–2011 survey (2012: 22) said the LA valued low price over quality. LAs are also moving away from the commissioning of guaranteed block contracts towards spot agreements (i.e. from long-term arrangements with a known pricing structure to flexible, stand-alone contracts) (Bessa et al., 2013). The reported reason is to avoid becoming locked in with powerful national chain providers and to encourage competition among more providers. Furthermore, two-thirds of LAs in England commission visits of less than 30 minutes; such evidence led the UKHCA (2012: 20) to ask whether it amounts to 'institutional abuse' given the risk to users' dignity and safety.

Employment standards in the sector are generally poor, especially in the for-profit sector where care has become commoditised through cost-cutting contracting practices (Bessa et al., 2013; UKHCA, 2012). The LPC found around one in three social care workers earned less than £7 per hour in 2013 when the national minimum wage was £6.19 (LPC, 2014: 37). Non-compliance with the minimum wage is extensive, due to unpaid training or travelling time and incorrect use of apprentice rates (HM Revenue and Customs, 2013). Many care workers also suffer insecurity of working hours. The high use of zero-hours contracts by care providers is associated with multiple unpaid gaps of time in a working day and lost entitlement to tax credits because of irregular working hours (Bessa et al., 2013; LPC, 2014: 136).

Research design

This article draws on a three-year (2007–2010) research project into the recruitment and retention of workers in the adult social care sector funded by the UK's Department of Health. The project's over-arching hypothesis was that recruitment and retention are influenced by the bundle of HR practices implemented by provider organisations, which in turn are influenced by LA contracting practices. This article draws on the second stage of data collection,[2] which applied a mixed-methods approach (Bryman and Bell, 2003) comprising qualitative and quantitative data sources and analysis:

(I) a case survey of 14 LAs (selected from analysis of commissioning practices of 92 LAs surveyed in the project's first stage;
(II) a telephone survey of 115 social care providers; and
(III) interviews with managers at the headquarters of 10 national chains.

The case survey of LAs involved 34 semi-structured interviews with one or more managers responsible for commissioning social care for older adults. Analysis of these interview data, alongside documentary evidence, published data on costs and user satisfaction and generated a three-fold classification of contracting practices described later (for full details of this classification, see Rubery et al., 2013).

The telephone survey of providers was designed to interrogate management practices and experience in six areas: recruitment and retention, pay and working time, performance management, training, relationships with LAs, and attitudes towards care standards and public policy. We selected a sample of providers from the 14 LAs' lists of providers, ranging from 27 to 147 homes and 6 to 80 domiciliary care providers per list. For each LA, we aimed to include three to four domiciliary care providers (primarily preferred providers rather than those only used occasionally by the LA), an in-house domiciliary care provider and three to four care homes. Through contact with 303 providers, we achieved a final sample of 105 independent sector providers (102 used for analysis, with three excluded as more than 10% of the survey questions were incomplete); 10 in-house organisations were also surveyed but are excluded from this analysis. The targeted telephone survey respondent was the owner or manager responsible for the establishment. The interviews were recorded and lasted 45 minutes on average. Some questions requiring statistical information were sent in advance.

Data analysis

The data analysis involved descriptive statistical analysis, multivariate regression and interpretation of interview data.[3] To address our research questions, we developed two analytical constructs. First, the quality of contracting is captured by three independent variables.

1. The LA's standard fee level (per hour for domiciliary care, per week for homes) to the care provider for non-specialist adult social care services is categorised as low (£10.00–£12.00, £300–£390), medium (£12.01–£14.00, £390–£460) and high (>£14.00, > £460) in the descriptive statistics, but entered into the regression analysis as the money amount.
2. The contractual relationship each LA has with its providers is classified as partnership, mixed or cost-minimising according to the approach towards fees, quality policies towards care and human resources and the stated strategy towards partnership (Rubery et al., 2013). Key discriminating factors were use of block versus spot contracts, framework agreements, training targets, selection of quality criteria, guaranteed fee rises, payment for travel time, fee enhancements for quality, strategies to ensure rural cover and use of partnership language in interviews/documentation.
3. For care homes, each is categorised according to the percentage of service users with LA funding to indicate client dependency. (Comparable data for domiciliary providers proved insufficiently varied – see Table 2.)

The second analytical construct concerns the dependent variables. Using telephone survey data, we scored each provider against six HR indicators and calculated a seventh aggregated HR indicator:

- pay level (basic hourly pay, regular pay upgrading, unsocial hours premiums, pay for training);
- pay strategy (pay progression opportunities, career opportunities, pay for upfront costs);
- working time (work schedules fit staff preferences, weekend working, long hours/long weeks, time off for training);
- work organisation (time discretion, task discretion);
- recruitment and retention (formality of recruitment, selection by skill/qualification/experience, role of push factors in staff quits);
- employee development (employee voice practices, employee appraisal);
- aggregate index of HR practice (unweighted average of six indicators).

In the statistical analysis, we distinguished the effects of contracting quality on pay and HR practices by controlling for other variables identified as significant in the extant literature: local area female part-time pay; establishment size; ownership (national chain, local chain, single establishment); and for-profit or voluntary status. Two of the three independent variables for contracting quality – fee levels and partnership orientation – display moderate correlation but well below the advised level of 0.8, beyond which the risk of multicollinearity is a problem (Field, 2013). The classifications of LAs also include many hybrid cases; for example, four of the five LAs displaying a mixed contracting orientation pay low-level fees.

The multivariate analysis is based on several Ordinary Least Squares regressions, which employ the backwards method. This method removes those independent variables that only offer weak explanatory power in predicting the variance of the dependent variable. Stepwise methods are appropriate for exploratory model building. As certain independent variables (quality of contracting) were developed by the research team rather than derived from previous research, this method selects those predictors that establish a better model fit.

Portrait of care providers

Table 1 summarises the characteristics of the surveyed providers. Most homes are small/very small, while domiciliary providers are larger. Nearly half the sampled 102 providers belong to national chains and most were for-profit, with 17% from the voluntary sector. Out of the 1- to 3-star quality ratings by the CQC, most were 2 star, and around three-quarters had operated more than five years.

Table 2 summarises the contracting arrangements. Providers are evenly distributed across the classes of fee levels: residential weekly fees ranged from below £300 to more than £460 and domiciliary care standard hourly fees from around £10.50 to more than £14.00. Providers are somewhat more unevenly distributed across types of commissioning with 41% under partnership contracting. Finally, the importance

Table 1. Organisational characteristics of surveyed providers.

		Homes	Domiciliary	Total	%
	Total sample size	52	50	102	100
Establishment size (staff headcount)	Very small 0–24	15	5	20	19.6
	Small 25–49	23	8	31	30.4
	Medium 50–99	12	25	37	36.3
	Large 100+	2	12	14	13.7
Chain (local or national) or single agency	Local chain	14	10	24	23.5
	National chain	18	29	47	46.1
	Single home/agency	20	11	31	30.4
Private or voluntary sector	Private	41	44	85	83.3
	Voluntary	11	6	17	16.7
CQC star rating	1 star	8	6	14	13.7
	2 star	31	34	65	63.7
	3 star	13	10	23	22.5
Age of business	<2 years	0	3	3	2.9
	2–5 years	8	15	23	22.5
	>5 years	44	32	76	74.5

CQC: Care Quality Commission.

Table 2. Type of contracting practices associated with the providers.

		Homes	Domiciliary	Total	%
	Total sample size	52	50	102	100
LA fee level[a]	Low	23	15	38	37.3
	Medium	10	20	30	29.4
	High	19	15	34	33.3
LA commissioning strategy	Cost-minimising	14	13	27	26.5
	Mixed	18	15	33	32.4
	Partnership	20	22	42	41.2
Proportion of service users LA funded	0%–25%	13	1	14	13.7
	26%–50%	8	3	11	10.8
	More than 50%	31	46	77	75.5

[a]For domiciliary care, we refer to the standard/modal fee since fees sometime varied by geographical area or provider. For care homes, residential fees derive from published 2007–2008 data on 'care price per week for older people' and verified against our interview data. Enhancements of fees are captured in our second qualitative classification of contracting.
LA: Local Authority.

of LAs as funders is particularly clear for domiciliary care providers where 92% relied on LAs for more than half their business.

Figure 1 displays scores for the six indicators of HR practices and the aggregate index. The horizontal bar on the box and whiskers charts identifies the median value, the box covers the lower to upper quartiles and the whiskers the bottom and top deciles. The aggregate index median score is similar for care homes and domiciliary providers (0.66 and 0.65, respectively). Scores for half of both homes and domiciliary providers fall within a narrow range (0.63–0.72 and 0.61–0.71, respectively). The limited range is a forewarning of likely difficulty in identifying statistically significant associations with independent variables. More variation in values is evident for the six HR indicators; the inter-quartile range is especially wide for recruitment and retention (0.50–0.83 homes and 0.50–0.82 domiciliary).

These quantitative indices need to be interpreted by reference to prevailing standards of HR practices. For example, behind the two indicators for pay levels and pay strategies is widespread evidence of very poor pay practices: nearly one in five care homes set normal hourly pay rates at the national minimum wage; most domiciliary care providers did not differentiate between minimum/entry and normal rates of pay, and even among providers offering pay progression, the average pay differential was just 40 pence (homes) and 50 pence (domiciliary); and in more than one-third of domiciliary care providers and one in four homes new recruits must fund upfront costs, such as Criminal Records Bureau[4] checks and uniforms. Similarly, very low standards underpin the index of working time: among domiciliary providers, only 1 in 10 paid for breaks between users and 7 in 10 only offered care workers 'zero-hours contracts' whereby employers do

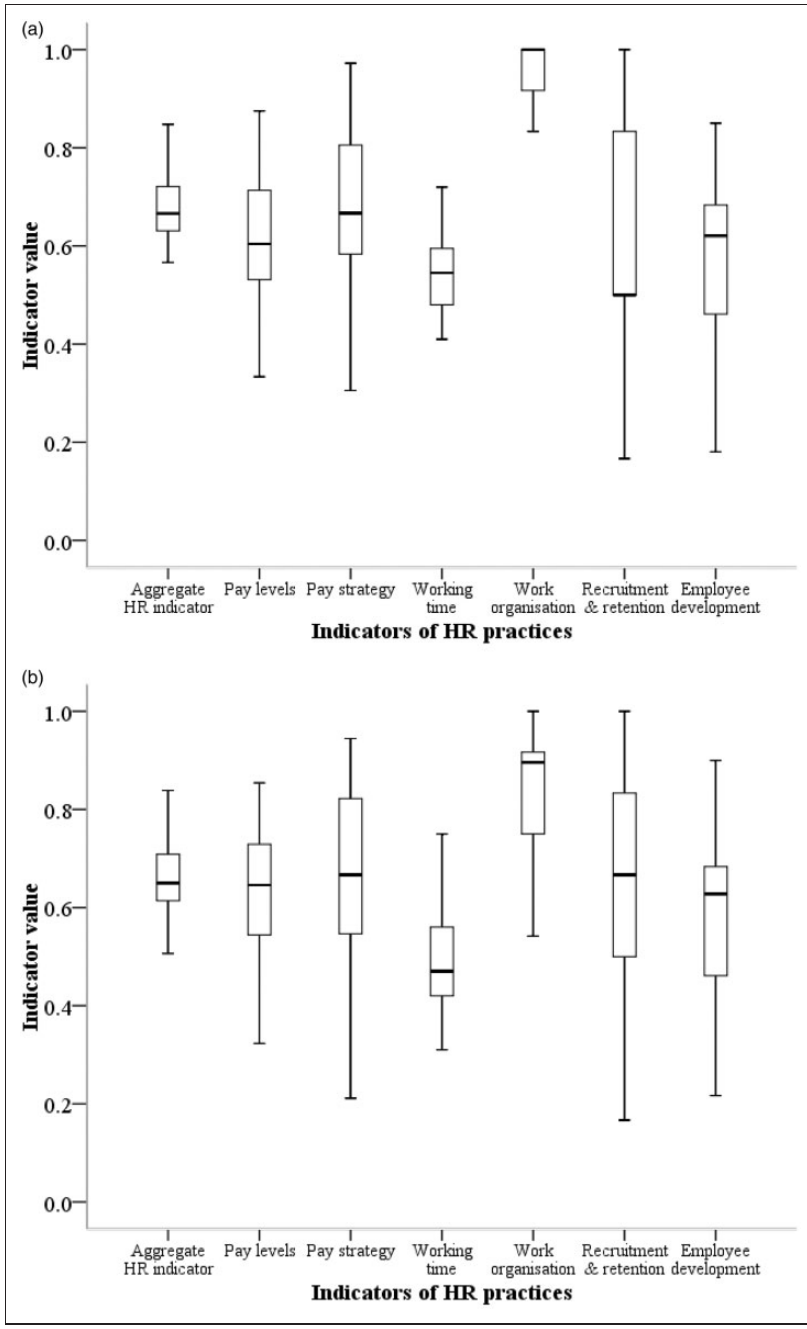

Figure 1. Range of scores for indicators of HR practices for care homes and domiciliary care providers. (a) Care homes and (b) domiciliary care.

Note: A description and the range of scores for each indicator and sub-indicator are detailed in Appendix Table A3 (available online at: http://jir.sagepub.com, also available on request from the author).

not guarantee any hours and workers are not obliged to accept work. Despite these practices, most providers found it easy, or very easy, to find staff willing to work additional hours at two to three days' notice (e.g. 86% of domiciliary care providers).

Other indicators reveal a greater mix of quality of HR practices. Although only 15% of homes and 8% of domiciliary care providers recognised a trade union, opportunities were more frequent to contribute ideas through regular staff meetings with management, typically every one to three months, or in answers to staff surveys (in more than two-thirds of providers). Annual appraisal systems were also widely established among providers. However, despite regulatory requirements during 2005–2009 for providers to train at least half of staff to NVQ (National Vocational Qualifications) Level 2, only two-thirds of domiciliary care providers had met the target; homes performed better, with 9 in 10 achieving the target.

Analysis: Does type of contracting influence pay and HR practices?

Descriptive statistics

Beginning with our first contracting dimension, the fee level, we assess whether or not higher fees are associated with higher pay and better quality HR practices. Regarding normal rates of pay, there is only a weak-to-moderate positive relationship with the fee level (Figure 2). The trend lines suggest for every additional pound in higher fees, hourly pay increases by 14 pence (homes) and 18 pence (domiciliary). Note that for care homes we divide the weekly fee by 40 to derive comparable hourly fee levels. There are many mediating factors. One factor is the different responses of national chain providers to high-level fees compared to other establishments. Among care homes in receipt of high fees (more than £11), 60% of national chains pay below the trend line compared to 75% of other providers. By contrast, domiciliary providers in receipt of high fees (£13 and above), national chains are more likely than other providers to pay below the trend line – 53% of national chains compared to 36% of other establishments.

Descriptive statistics for our sub-indicators of pay practices (pay levels, unsocial hours premiums and pay progression) also show statistically significant differences between providers classified by fee level: for example, domiciliary care providers receiving high fees from LAs score 0.52 for pay progression, significantly higher than the 0.26 score among those receiving low fees (Table 3). However, other HR indicators display mixed results. For example, high-fee care homes are least likely to require weekend working but are more likely to have staff working long hours or over six or seven days per week. Mixed results also hold for discretion at work; workers in low-fee homes are more able to exercise task discretion than in high-fee homes.

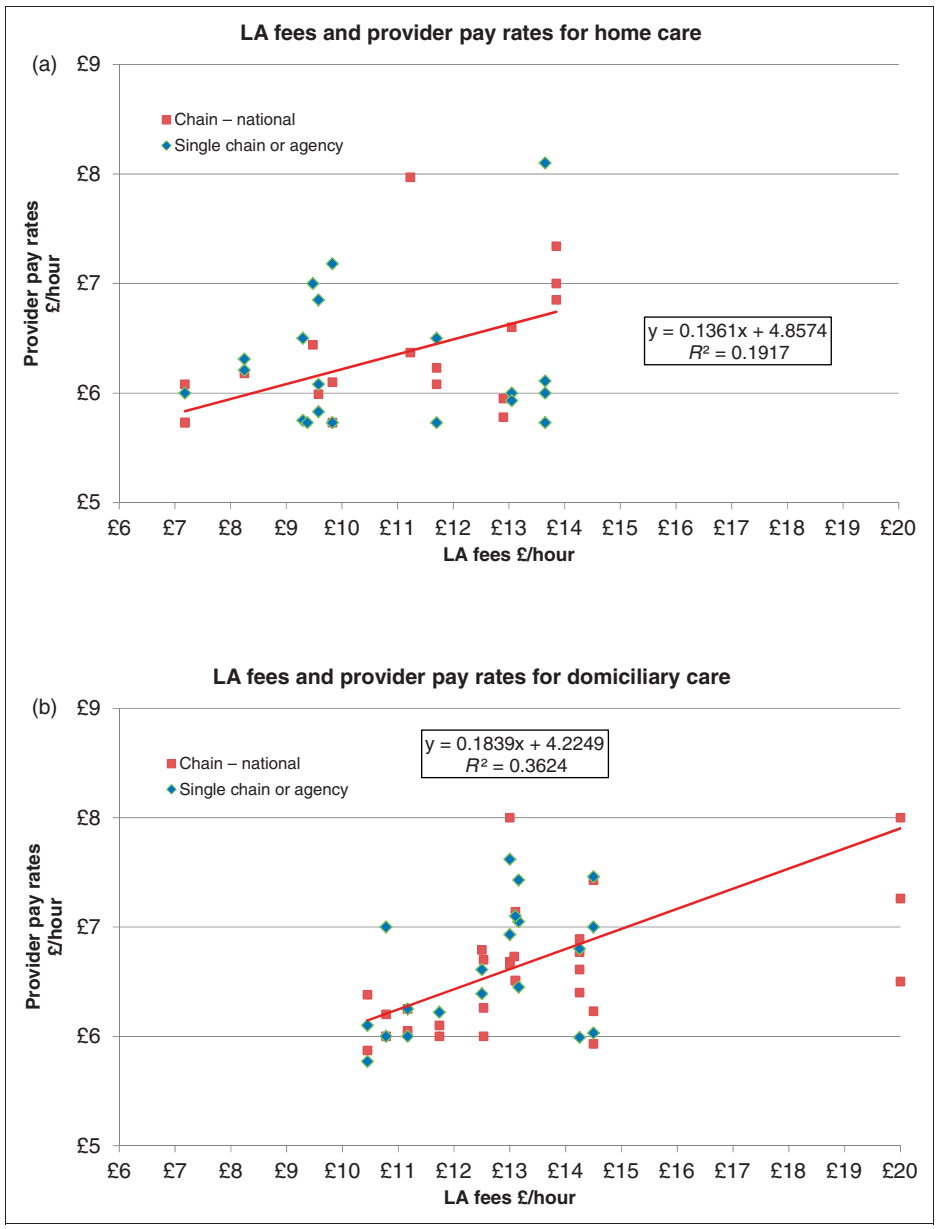

Figure 2. Contractual unit fees and hourly pay by type of provider organisation. (a) Care homes and (b) domiciliary care.

Table 3. Quality measures of providers' HR practices by fee level.

Sub-indicators	Low fee	Medium fee	High fee	All
Care homes				
Pay levels	.20** (H)	.34	.47**(L)	.33
Pay for unsocial hours	.25	.13	.39	.28
Pay progression	.37* (H)	.38	.55*(L)	.44
Weekend working	.17* (H)	.23	.46*(L)	.29
Long hours, long weeks	.84* (H)	.95**(H)	.66*(L)**(M)	.80
Task discretion	.96* (H)	.93	.89*(L)	.93
Aggregate HR indicator	.66	.67	.70	.68
Sample size	23	10	19	52
Domiciliary care providers				
Pay levels	.38**(M) **(H)	.54**(L)	.57**(L)	.50
Pay for unsocial hours	.36*(H)	.40	.58*(L)	.44
Pay progression	.26**(M) **(H)	.57**(L)	.52**(L)	.46
Weekend working	.29	.49	.31	.38
Long hours, long weeks	.63	.66	.62	.64
Task discretion	.82	.81	.91	.84
Aggregate HR indicator	.62*(H)	.66	.70*(L)	.66
Sample size	15	20	15	50

Note: L, M and H refer to significant differences (ANOVA – analysis of variance Gabriel test) with those providers in receipt of low, medium or high contractual fees, respectively.
**$p < .05$; *$p < .01$. Only those sub-indicators are listed with a statistically significant difference between providers classified by fee level. See Appendix Table A3 (available online at: http://jir.sagepub.com, also available on request from the author) for details of components of sub-indicators.

Overall, the aggregate HR indicator increases with fee level for both homes and domiciliary care providers, although the relationship is statistically significant only for the latter. In their open-ended responses to our survey, many managers identified the LA fee level as a major factor in their HR decisions.

> They [the LA] haven't offered enough over the last year, so we have not upgraded staff [pay] for 18 months. Prior to that they got one regularly each year. (LK.D.3 DS)

> I do think care workers should be paid more than what they do get paid, especially because [the LA] don't pay mileage. It's very difficult. And they are needed, you know, care workers are essential. (ON.D.3 BN)

Regarding our second contracting dimension, the type of contractual relationship with the LA, we again find some evidence of influence, albeit far from determinant. Normal pay levels tend to be higher in providers under a partnership relationship (Table 4). Among the top 20 care homes ranked by pay, 13 are under partnerships

Table 4. Normal pay for care workers by type of contractual relationship.

Range of normal pay	Number of providers by type of contractual relationship		
	Cost-minimising	Mixed	Partnership
Care homes			
Top 10 £6.85–£8.12	1	2	7
Top 20 £6.23–£8.12	3	4	13
Bottom 20 £5.73–£6.00	9	7	4
Bottom 10 £5.73–£5.75	5	4	1
All care homes £5.73–£8.12	14	17	20
Domiciliary care providers			
Top 10 £7.14–£10.00	0	3	7
Top 20 £6.73–£7.10	3	4	13
Bottom 20 £5.77–£6.26	8	9	3
Bottom 10 £5.77–£6.00	5	4	1
All domiciliary providers £5.77–£10.00	14	15	22

Note: See Rubery et al. (2013) for derivation of classifications of contractual relationship.

and just three under a cost-minimising contractual relationship. Conversely, among the lowest paying 20 care homes, nine are under a cost-minimising relationship and only four a partnership. The pattern for domiciliary care providers is similar.

Nevertheless, as with fee levels, the effects of contractual relations on HR practices sometimes conflict with expectations. For care homes, partnership relationships with LAs do exhibit the expected positive impact on other aspects of pay practice, particularly pay progression opportunities (Table 5). However, certain working-time practices again conflict: care homes in the mixed category were least likely to have requirements for long-hours working.

Finally, Table 6 reports the influence of our third contracting dimension (applied to care homes), the share of users who were LA funded. As anticipated, care homes with over two-thirds LA-funded residents have a statistically significant lower score for the pay level indicator; indicators for unsocial hours and pay progression are also lower, although not statistically significant. The requirement to work weekends, however, is equally likely in care homes with low and high shares of LA-funded users.

Regression analysis

For all providers, the type of contractual relationship with the LA and the contractual unit fee level offer some, but overall relatively weak, explanatory power in the regression models (Table 7). For domiciliary providers, the fee level is in fact one of only two statistically significant variables that explain variation in the

Table 5. Quality measures of providers' HR practices by type of contractual relationship.

Sub-indicators	Cost-minimising	Mixed	Partnership	All
Care homes				
Pay levels	.24**(P)	.27*(P)	.44**(C) *(M)	.33
Pay for unsocial hours	.31	.15*(P)	.37*(M)	.28
Pay for training	.98	.89	.89	.91
Pay progression	.33*(P)	.41	.54*(C)	.44
Weekend working	.27	.12**(P)	.46**(M)	.29
Long hours, long weeks	.74	.93**(P)	.71**(M)	.80
Time off for training	.93	.75	.93	.87
Aggregate HR indicator	.68	.66	.69	.68
Sample size	14	18	20	52
Domiciliary care providers				
Pay levels	.43*(P)	.45	.58*(C)	.50
Pay for unsocial hours	.37	.38	.53	.44
Pay for training	.77	.83	.76	.79
Pay progression	.38	.38	.56	.46
Weekend working	.48	.29	.37	.38
Long hours, long weeks	.67	.61	.64	.64
Time off for training	.88	.80	.98	.90
Aggregate HR indicator	.62**(P)	.66	.69**(C)	.66
Sample size	13	15	22	50

Note: C, M and P refer to significant differences with those providers experiencing cost-minimising, mixed or partnership relations with their LA.
**$p < .05$, *$p < .01$.

aggregate HR indicator, after controlling for other variables, and has the expected positive direction of association. The type of contractual relationship offers no explanatory value for either homes or domiciliary providers. Among the six HR indicators, fee levels explain differentiation in the indicators for pay levels and recruitment and retention for homes, and for pay strategy and working time for domiciliary providers. In all cases, the relationships are again positive. The statistical significance is especially strong in the models for care homes.

We also now find some explanatory power associated with the type of contractual relationship for the indicators of pay levels and employee development, although it is negative for homes, which conflicts with the descriptive statistics. The share of LA-funded users does not generate any statistically significant results for care homes.

The regression results illuminate the significance of other variables. The most powerful is whether or not the provider operates for a profit. For-profit homes and

Table 6. Quality measures of care homes' HR practices by share of users with LA funding.

Sub-indicators	Low share	Medium share	High share	All
Pay levels	.43**(H)	.45	.25**(L)	.33
Pay for unsocial hours	.40	.19	.23	.28
Pay for training	.92	.86	.92	.91
Pay progression	.51	.44	.40	.44
Weekend working	.25*(M)	.64*(L) **(H)	.23**(M)	.29
Long hours, long weeks	.79	.82	.79	.80
Time off for training	.88	.86	.86	.87
Aggregate HR indicator	.69	.70	.67	.68
Sample size	16	7	29	52

Note: L, M and H refer to significant differences with those providers with low, medium or high shares of users LA funded. Low refers to a 0%–33% share of users, medium 34%–66% and high 67%–100%.
**$p < .05$; *$p < .01$.

domiciliary providers have significantly lower aggregate HR practice index scores than voluntary sector organisations; indeed, this is the single most important variable for domiciliary providers and strongly significant (although note that our sample only includes six voluntary sector domiciliary providers). For-profit care homes score a lower pay level indicator and recruitment and retention indicator than voluntary homes, and for-profit domiciliary providers score lower on the pay strategy and working time indicators. Ownership-type also matters; for example, single-establishment domiciliary care providers score higher on the recruitment/retention indicator than local or national chains. Finally, the local labour market matters, especially for care homes: the two indicators of pay strategy and working time are significantly higher for homes located in areas with high median part-time pay for women (although caution is required given the low adjusted R^2).

Interrogating views from national chain employers

The quantitative results suggest that the nature of contracting can impact positively on pay and the standards of HR practices, yet its influence is weaker than anticipated. Detailed interviews with senior managers at the headquarters of 10 national chain providers (nine for-profit, one voluntary not-for-profit) throw some light on this puzzle.

National chains are interesting for several reasons. They account for the largest share of our surveyed providers (compared to local chains and single-site establishments) and have grown in prominence in the sector. Also, unlike local chains or single establishments, national chains face an interesting strategic choice of whether to adapt pay and HR practices to varying local conditions or to smooth out local differences in contracting and labour demand by implementing a national pay and HR policy.

Table 7. Backward regression results for different dependent variables.

Independent variables	Aggregate HR indicator	Pay levels	Pay strategy	Working time	Work organisation	Recruitment & retention	Employee development
Care homes							
Contractual relationship (1–3)	−.183	−.286*	–	−.133	.207	−.200	−.347*
Contract fees	.293	.502***	–	–	−.250	.432**	.170
Share of users LA funded	–	−.138	–	–	–	.189	.112
Establishment size	−.164	−.309**	−.149	.000	–	−.111	.211
Local chain	–	.189	–	–	−.334**	–	–
Single establishment	–	–	–	–	–	–	.087
For profit	−.269**	−.353***	–	−.079	.202	−.287**	−.089
Local female part-time pay	.172	–	.296**	.438***	–	–	–
R^2	.219	.436	.107	.200	.181	.176	.127
Domiciliary care providers							
Contractual relationship (1–3)	.233	.311**	–	–	.178	–	.169
Contract fees	.240*	–	.237*	.266*	–	–	–
Provider size	–	–	−.298**	–	–	–	–
Local chain	–	.140	.228*	.178	–	–	–
Single	.165	.119	–	.128	–	.247*	–
For profit	−.460***	−.246*	−.388***	−.294**	–	−.211	−.230
Local female part-time pay	–	.157	.242*	.176	−.194	–	−.181
R^2	.379	.188	.382	.200	.060	.085	.117

Note: The values of the table correspond to standardised beta scores. Significance levels of independent variables denoted by * if $p < 0.1$, ** if $p < 0.05$, and *** if $p < 0.01$. See Appendix Table A2 (available online at: http://jir.sagepub.com, also available on request from the author) for means, standard deviations and correlations between variables.

The reference categories for each independent variable are: contractual relationship (partnership = 3, mixed = 2, cost minimiser = 1); contract fees (hourly fee, range £7.18–£20.00); local female part-time pay (median level in local area); establishment size (range 9–320 staff); ownership (local chain dummy = 1, others = 0, single-establishment dummy = 1, others = 0); for profit dummy = 1, not-for-profit = 0.

> One of the challenges that we've got in relation to our terms and conditions at the moment is, do we actually adopt a standard approach in terms of certain things like pay for training, CRB [Criminal Records Bureau], uniform policy? Or do we actually say, just go local and align it to what's happening in your local market? (NatDom2, for-profit)

All but one of the 10 national chains emphasised the difficulties of managing varying relationships with LAs. Managers said differences in LAs' approaches to communication, contractual details and commissioning practices generated waste and duplication. Moreover, some interviewees said that aggressive pricing strategies by some LAs were stretching the viability of funding and placing at risk the company's reputation to meet minimum service standards:

> Local authorities will sometimes fix in the contract what the price should be. So I suspect they haven't necessarily market tested whether you can get care workers at some of those rates. . . . We will walk away from contracts if we think that the local authority is going for cheap and cheerful and basically putting lives at risk. (NatDom4, for-profit)

> Some providers go in at pricing that . . . I just don't know how they can provide a safe service on price. And I think one of the challenges for us as a business is to say, . . . if we want to develop people, if we want to retain them, if we want to give them a career as opposed to a job, then that's going to cost more than £9 an hour. (NatDom2, for-profit)

While such frustrations seem valid, it is surprising that national chains have not responded by levelling out differences in contract margins to establish a decent set of minimum standards across company branches. Only two of the 10 had implemented a national pay scale and national terms and conditions – one was agreed jointly with the trade union, the General, Municipal and Boilermakers' union, GMB (NatHome4, for-profit), and the other is a local-national hybrid arrangement that facilitates local fixing of jobs to pay grades (NatHome3, for-profit). A typical view among the other eight chains was that differing LA contracting arrangements hindered standardisation of employment conditions.

> We don't have any national rates. We have purely local rates and so some parts of the country it's national minimum wage, in other parts it would be significantly higher than that . . . There has got to be a match between money coming in and money going out. (NatHome2, for-profit)

> We can't pay the same rates everywhere because we get paid differently in different places. (NatDom5, for-profit)

However, as we saw earlier, national chains in domiciliary care appear to favour adapting pay downwards rather than upwards, evidenced by the weak elasticity of

pay to higher fee levels. A plausible interpretation of their HR strategy is that in the absence of tight labour markets and/or trade union presence, these employers will take the opportunity to maximise margins by not adjusting pay significantly upwards.

Although not part of the survey design, the telephone survey fortunately included several providers from the same national chains, thereby enabling further interrogation of pay strategy. The survey included seven from the NatDom1 chain and six from NatDom2, both for-profit companies. Both firms have contracts with LAs paying low, medium and high fee levels, and one might therefore anticipate variation pay rates. Instead, NatDom1 consistently set hourly pay within a narrow range of less than £1 (£5.87–£6.51) and NatDom2 a similarly narrow although higher range (£6.00–£6.89), while unit fees for both varied by around £4 (£10.45–£14.25/£14.50). In 12 of the 13 surveyed branches, the rate of pay is below the trend line in Figure 2(b), with an especially large negative penalty at NatDom1.

Indeed, the four NatDom1 providers in receipt of medium or high fee levels had adopted an overwhelmingly standardised low-pay policy consisting of a low normal pay rate (£5.93–£6.51), narrow differentials between entry rates and normal pay (zero to 30 pence) and limited unsocial hours premiums (0%–30% for weekends and nights). This despite senior manager claims that the company 'has adopted the practice of paying people in accordance with the contract that they're working on' (NatDom1). These four NatDom1 providers also applied consistently poor HR practices, offering zero-hours contracts only and providing only unpaid breaks between service visits, again despite medium/high fee levels. Moreover, three of these four had partnership relations with their LAs. These data put manager statements from providers that LA fees are 'key to whether we get a [pay] increase' (NatDom1) into perspective. However, managers' pay does appear to be linked to LA fees: branch managers' salaries ranged from around £20,000 to more than £40,000, with bonus pay used to reward managers for the contributions of their branch to the company. Thus, managers benefitted directly from the strategy of low-cost services in high-fee areas.

Discussion

This article contributes to a more nuanced understanding of the interaction between contracting type and quality of HR practices, adding to a growing body of research on supply chains and the employment relationship (Marchington et al., 2005; Doellgast, 2012; Wright and Brown, 2013). By disaggregating the nature of contracting for the adult social care sector in England into three inter-related dimensions, we derive the following results.

First, the contract fee level paid by an LA has a positive, albeit weakly significant, relationship with pay levels and several other HR practices implemented by care providers. An additional £1 in fees translates, on average, into 18 pence (domiciliary care) and 14 pence (care homes) extra for a care worker's normal rate of hourly pay. Since labour costs constitute the bulk of a provider's total costs, LAs

may not consider this increase good value for money if the aim was to improve pay in the sector. The fee level nevertheless has additional positive influences on payment of premiums for unsocial hours working – very significant in this 24-hour, seven-days a week service. However, working time practices and work organisation were sometimes better in low-fee than high-fee establishments.

Second, our results suggest a broadly positive association between the type of contracting and the quality of pay and HR practices offered by care providers. Pay rates were higher in providers under partnership-type relationships than in those under cost-minimising or mixed relationships. However, the association with other HR practices is less easy to explain, especially for care homes. This may reflect a weaker link between contracting and opportunities for developing HR practices in homes compared to the domiciliary sector, where LA-funded activities accounted for a higher share of revenue and also involved detailed specification of tasks and time allowed for the care work. Our third dimension, the share of care home users reliant on LA funding, displayed the expected association with pay levels (reflecting the lower LA fees compared to private fees), but divergent results with regard to required weekend working.

These findings suggest that the quality of the LA contracting environment may be a necessary condition for the improvement of employment standards, but not a sufficient condition. For example, we only find decent levels of hourly pay (above £7, close to the living wage at the time) among domiciliary care providers where unit fees are £13 and higher, yet payment of these relatively high fees does not guarantee normal rates of pay of £7 and above.

Overall, what is most striking about the data is the limited variation around a low quality of HR practices across all providers. This puts the discussion of better and worse HR practice into context; here, our findings complement those from recent research on other UK services sectors that find limited evidence of a positive association between product market characteristics, skill and pay (Lloyd et al., 2013). The failure to establish a broader set of strongly significant statistical results for contracting in part reflects the role other factors play in social care in mediating, or distorting, the relationship between contracting quality and quality of HR practices.

One key factor relates to the heterogeneity of organisations in the English adult social care sector. Quality of HR practices is shaped by organisational characteristics such as size, ownership and profit-making status (Kepes and Delery, 2007). Therefore, quality supply chains may exert a stronger purchase on approaches to HRM in particular types of organisations. Our analysis highlights two organisational characteristics that distort the potentially positive association between contracting quality and HRM – whether the provider (a) operates for profit and (b) is part of a national chain. The evidence suggests for-profit, national chain providers are least likely to distribute the benefits of better quality contracting by improving employment standards. This may be because they are better positioned to exploit monopsony employer power (Machin and Manning, 2004) or more exposed than voluntary sector providers to pressures of

financialisation, managers' demands for higher pay and the need to maximise shareholder returns (Thompson, 2013).

Thus, while the favoured policy approach towards public services contracting emphasises the innovative capabilities of the for-profit private sector, our findings point to the reality of a hard-nosed HRM approach towards pay and quality of working conditions. Senior managers at national chains told us that they valued the freedom to exercise local discretion to adapt to contracting conditions, as well as local labour market and competitive conditions. However, our analysis suggests that discretion operates mostly to keep standards down and to prevent better commissioning ratcheting up pay and the standard of HR practices in the sector. National chain providers are certainly not acting as lead employers in the sector for better pay and HR practices, and there is evidence to suggest that in fact they are leveraging conditions downwards.

With the growing presence of national chains in the sector, particularly among preferred providers, our evidence suggests that the extent of vulnerable work will increase. The sector is characterised by low pay, fragmented working time, insecurity of hours and weak opportunities for skill development, all problems that are being intensified by budgetary cuts; future analysis of workers' views is therefore needed. The failure of response among employers and government reflects in part discriminatory norms that undervalue caring work because it is 'the quintessentially female identified activity' (England, 2005: 382–383) and because low pay is wrongly assumed to be compensated for by women's preference for caring work (Folbre, 2001). Turning this tide requires at a minimum new regulations for more favourable contracting practices that lock in, or oblige, better quality HR practices. Without new lock-in agreements, employers, especially the national chains, are likely to persist in their unwillingness to distribute the benefits of partnership, high-fee contracting arrangements, to care workers. Thus, although increased LA budgets for commissioning social care are a necessary condition for improved employment conditions, two additional reforms are required. First, union representation coupled with a sector-level collective bargaining agreement is needed to establish, monitor and improve the quality of HR practices and to counteract both monopsony employer power and the undervaluing of care work. Second, evidence of win-win benefits of social clauses in compulsory sustainable sourcing (Schulten et al., 2012; Wright and Brown, 2013) suggests that we need a stronger national regulatory framework for contracting adult social care services under which LAs could require providers to move their HR practices up to a decent standard. These reforms would shift the focus to changing employers' behaviour through direct action rather than assuming that positive responses will follow from improved contracting relationships.

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Notes

1. Data sourced from press releases for market reports on domiciliary homecare (www.laingbuisson.co.uk/MediaCentre/PressReleases/DomiciliaryCare2013PR.aspx).
2. Stage 1 involved a postal survey of 92 LAs; stage 3 involved case studies of 20 care providers.
3. A set of Appendix tables (available online at: http://jir.sagepub.com, also available on request from the author) provides details of surveyed providers and variables used in the regression analysis.
4. Since 2012, known as the Disclosure and Barring Service.

References

Appleby J, Humphries R, Thompson J, et al. (2013) *How is the Health and Social Care System Performing? Quarterly Monitoring Report*. London: The King's Fund.

Bach S and Givan RK (2010) Regulating employment conditions in a hospital network: The case of the private finance initiative. *Human Resource Management Journal* 20(4): 424–439.

Bessa I, Forde C, Moore S, et al. (2013) *The national minimum wage, earnings and hours in the domiciliary care sector*. Research report for the low pay commission. Available at: www.gov.uk/government/publications (accessed 29 May 2014).

Bibby A (2011) *Responsible contracting*. ILO Working paper no. WP282. Geneva: ILO.

Blois K (2002) Business to business exchanges: A rich descriptive apparatus derived from Macneil's and Menger's analyses. *Journal of Management Studies* 39(4): 523–551.

Bryman A and Bell E (2003) *Business Research Methods*. New York: Oxford University Press.

Care Quality Commission (CQC) (2013) *The State of Health Care and Adult Social Care in England*. London: The Stationery Office.

Cunningham I and James P (2009) The outsourcing of social care in Britain: What does it mean for voluntary sector workers? *Work, Employment and Society* 23(2): 363–375.

Doellgast V (2012) *Disintegrating Democracy at Work: Labor Unions and the Future of Good Jobs in the Service Economy*. Cornell: Cornell University Press.

England P (2005) Emerging theories of care work. *Annual Review of Sociology* 31: 381–399.

Field A (2013) *Discovering Statistics using IBM SPSS Statistics*. London: SAGE.

Flecker J and Meil P (2010) Organisational restructuring and emerging service value chains: Implications for work and employment. *Work, Employment and Society* 24(4): 680–698.

Folbre N (2001) *The Invisible Heart: Economics and Family Values*. New York: The New Press.

Grimshaw D and Miozzo M (2006) Institutional effects on the market for IT outsourcing: analyzing clients, suppliers and staff transfer in Germany and the UK. *Organization Studies* 27(9): 1229–1260.

Grimshaw D and Rubery J (2005) Inter-capital relations and the network organization: redefining the issues concerning work and employment. *Cambridge Journal of Economics* 29(6): 1027–1051.

HM Revenue and Customs (2013) *National Minimum Wage Compliance in the Social Care Sector*. London: HMRC.

Humphries R (2013) *Paying for Social Care: Beyond Dilnot*. London: The Kings Fund.

James P and Walters D (2011) Supply chains and the protection of vulnerable workers. In: Sargeant M and Giavannone M (eds) *Vulnerable Workers: Health, Safety, and Well-being*. Surrey: Gower, pp. 57–74.

Kepes S and Delery JE (2007) HRM systems and the problem of internal fit. In: Boxall P, Purcell J and Wright P (eds) *Oxford Handbook of Human Resource Management*. Oxford: Oxford University Press, pp. 385–404.

Lloyd C, Warhurst C and Dutton E (2013) The weakest link? Product market strategies, skill and pay in the hotel industry. *Work, Employment and Society* 27(2): 254–271.

Local Government Association (LGA) (2013) Adult social care spending round submission. Local Government Association. Available at: www.local.gov.uk/c/document_library/get_file?uuid=67059995-adb7-422c-a726-df83f17f47a2&groupId=10180 (accessed 1 April 2015).

Low Pay Commission (LPC) (2014) *The National Minimum Wage: Low Pay Commission Report 2014*. London: The Stationery Office.

Machin S and Manning A (2004) A test of competitive labor market theory: The wage structure among care assistants in the south of England. *Industrial and Labor Relations Review* 57(3): 371–385.

Marchington M, Grimshaw D, Rubery J and Willmott H (eds) (2005) *Fragmenting Work: Blurring Organizational Boundaries and Disordering Hierarchies*. Oxford: OUP.

Marchington M, Rubery J and Grimshaw D (2011) Alignment, integration and consistency in HRM across multi-employer networks. *Human Resource Management* 50(3): 315–341.

Marchington M and Vincent S (2004) Analysing the influence of institutional, organizational and interpersonal forces in shaping inter-organizational relations. *Journal of Management Studies* 41(6): 1029–1056.

O'Flynn J and Alford J (2008) The separation/specification dilemma in contracting: The local government experience in Victoria. *Public Administration* 86(1): 205–224.

Rubery J, Earnshaw J, Marchington M, Cooke FL and Vincent S (2002) Changing organizational forms and the employment relationship. *Journal of Management Studies* 39(5): 645–672.

Rubery J, Grimshaw D and Hebson G (2013) Exploring the limits to local authority social care commissioning: competing pressures, variable practices and unresponsive providers. *Public Administration* 91(2): 419–437.

Perraudin C, Petit H, Thèvenot N, et al. (2013) Inter-firm dependency and employment inequalities: Theoretical hypotheses and empirical tests on French subcontracting relationships. *Review of Radical Political Economics*. Epub ahead of print 9 September 2013. DOI: 0486613413497912.

Scarbrough H (2000) The HR implications of supply chain relationships. *Human Resource Management Journal* 10(1): 5–17.

Schulten T, Alsos K, Burgess P, et al. (2012) *Pay and other social clauses in European public procurement*. Report for EPSU. Brussels: EPSU.

Sturgeon TJ (2002) Modular production networks: A new American model of industrial organization. *Industrial and Corporate Change* 11(3): 451–496.

Thompson P (2013) Financialization and the workplace: Extending and applying the disconnected capitalism thesis. *Work, Employment and Society* 27(3): 472–488.
United Kingdom Homecare Association Ltd (UKHCA) (2012) *Care is not a commodity*. Report of the UKHCA Commissioning Survey 2012. Sutton: UKHCA.
United Kingdom Homecare Association Ltd (UKHCA) (2013) An overview of the UK domiciliary care sector. Available at: www.ukhca.co.uk/pdfs/domiciliarycaresectoroverview.pdf (accessed 29 May 2014).
Wright CF (2011) *Beyond the employment relationship: Collective bargaining and supply chain coordination*. Report for the TUC. London: TUC.
Wright CF and Brown W (2013) The effectiveness of socially sustainable sourcing mechanisms: Assessing the prospects of a new form of joint regulation. *Industrial Relations Journal* 44(1): 20–37.
Zatz N (2008) Working beyond the reach or grasp of employment law. In: Bernhardt A, Boushey H, Dresser L and Tilly C (eds) *The Gloves-Off Economy: Workplace Standards at the Bottom of America's Labor Market*. Champaign, IL: Labor an Employment Relations Association (LERA), pp. 31–64.

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