Homecare work in the Antipodes:
Time autonomy & time to care

Sara Charlesworth & Wendy Taylor

Centre for People, Organisation & Work

RMIT University

Global Carework Summit
University of Toronto 9-11 June, 2019

Overview

Focus →Publicly-funded home care work in Australia & New Zealand

- How do the different Australian & NZ LTC systems & providers shape home care workers time autonomy & time to care?
  - *'time autonomy' = control workers have over their own time (hours worked & scheduling of those hours) & over time allocated to clients*

1. Compared to Australia, NZ HC system provides conditions for greater worker autonomy & time to care inc thru:
   - Devolved state
   - Empowered agencies
   - Less developed 'individualisation'

2. HC services have a crucial role in enabling (and protecting workers from some system constraints on) time autonomy & time to care

Key Framings

- Political economy (Aronson & Neysmith 2006; Vosko 2010) & regime mapping (Williams 2012):
  - Economic & political institutions shape & interact with gender, care & employment regimes
  - Importance of national context in shaping and interaction
- Labour process theory in care work (see Baines & Van Beek 2017):
  - Workers’ time autonomy shaped not only by employer, service user and worker but also by funding body
  - Time autonomy constrained thru ‘fragmented time practices’ (Rubery et al 2015) & enhanced by enabling workers to have secure time to do work of care (Rubery & Urwin 2011)

Methods

- Regulatory mapping of Australian & NZ Home Care regimes
  - Aged care/home care policy, ‘architecture’ & funding models
  - Industry structure
  - Employment regulation
  - Stakeholder interviews
    - Unions
    - Associations/peak bodies
    - Government agencies
- Home care case studies: rapid ethnographic approach
  - New Zealand – August 2018 – Case studies 1 & 2
  - Australia – February 2018 – Case study 3

Home care case studies: Australia & NZ

	Total formal interviews	Home care workers interviewed	No workers shadowed/ Clients visits
Case study 1 (NZ) Large, home care & day program, generalist service, mixed area	11	4	2 workers shadowed 1 worker observed 8 clients visited
Case study 2 (NZ) Mid-sized, ethno-specific, home care & day programs, disadvantaged area	17	5	4 field co-ordinators shadowed 8 workers observed 9 clients visited
Case study 3 (Aust) Large, multi-service generalist, multicultural clients, poorer outer suburbs	15	7	2 workers shadowed 5 clients visited
TOTAL	**43**	**16**	

Australia & New Zealand - 'At home' Long Term Care

COUNTRY	TOTAL LTC	AT HOME LONG TERM CARE (LTC)					
	LTC spend as % GDP 2011 ⬇	% of *total pop* 65+ using *at home LTC* 2016	% of *total female* pop 65+ using *at home LTC* 2016	% of total pop 80+ using *at home LTC* 2016	% of *total female* pop 80+ using *at home LTC* 2016	*Total* formal care workers at home per 100 pop of 65+	Formal *personal care workers* at home per 100 pop of 65+
Australia	0.8%	5.7%	6.6%	13.9%	19.7%	2.2 (2016)	2.0 (2016)
New Zealand	1.3%	9.5%	12.5%	26.4%	32.1%	3.2 (2011)	3.1% (2011)
OECD 2011	1.6%						

Source: OECD *Health at a Glance* 2013, 2017, OECD *LTC Resources & Utilisation*

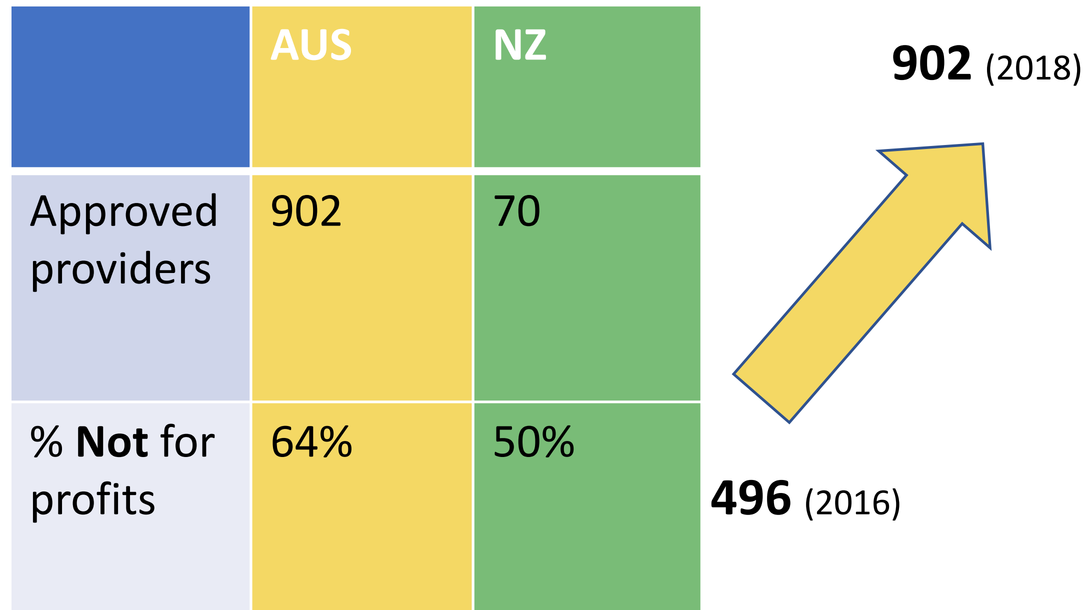
Home Care in Australia & New Zealand

AREA	AUSTRALIA	NEW ZEALAND
Responsibility	National – Department of Health	National - Ministry of Health
Funding administration	Centralised	Devolved to 20 District Health Boards
Funding	Individualised Funding – Consumer-Directed Care ‘packages’ follow clients	Block funding to providers – Tender processes in some DHBs
Philosophy/priorities	Competition, ‘choice and control’	Collaboration, partnerships, ‘Alliancing’
Cost – Personal care	$10.54 pd + means-tested fee (eg $15.15 pd on $40k annual income)	Free
Cost - Household support		Free to community service card holders
Access/waiting list	<2 yrs waiting list for Level 4 packages (highest)	Varies between DHBs – none in CS 1 & 2
Other		Treaty of Waitangi

Sources: Department of Health 2019, myagedcare.gov.au; Director-General’s Reference Group for In-Between Travel, 2015,

Australia & NZ: Marketisation of Home Care

Home care providers



	AUS	NZ
Approved providers	902	70
% **Not** for profits	64%	50%

Aged Care Royal Commission - concerns

… the approval process may not be properly vetting applications to become an approved provider, creating an expectation in a new provider that they are equipped to take on work that they are not ready for.

Dr McEvoy QC, Adelaide 22 March 2019

(Source: 22.3.19R1 p-1103-4)

ACFA, 2018, Dept of Health, 2019, Directors-General's Reference Group for In-between travel, 2015,

System-driven competition / collaboration

Australia: A Competition Model

Now pre-open market, we have people queued, and because the social good of the system is still working where providers and discharge planners and social workers and all the people that used to make up a social network in the area, we were communicating with each other… We pulled everyone through really quickly.

Well on the 27th of February midnight, that stopped, suddenly we're all in competition with each other…

[it became] "I'm not going to share…, because I actually want to grab whoever's next on the list and, so that networking stopped…

It is very difficult to plan in the new market

Senior manager – CS 3

New Zealand: An Alliance Model

It was a huge change… giving away the DHB's control over the allocation of hours and money, giving that to providers, giving the provider the assessment role… And then the concept of getting everybody to sit around the table. [The model of alliance] … has in it a shared risk approach…

over the course of the first two years we made quite a lot of progress and now we are really open… All client volume information is shared. There's some really robust conversations …

The way the referrals are managed are essentially it goes one, one, one, one. Unless there is a client asking for a particular provider… it's reasonably shared.

Senior manager – CS 1

Working time: Org policies & protective practices

CS 1 (NZ) General

- Paid monthly meetings for support worker teams
- Responsive and localised support for workers out in field
- Worker flexibility to respond to client's preferences/advocate for clients

CS 2 (NZ) Ethno-specific

- FT jobs to 'professionalise' the workforce + reliever pool to reduce schedule changes
- Strong external relationships with DHB assessors/regular client reviews, also initiated by HCWs
- Field co-ordinators support workers manage time and care issues with clients

CS 3 (Aust) General

- Org 'work arounds' of CDC – e.g senior care worker role enables HCWs to be involved in clients' care plans
- Managers offer clients 'choice': same worker <u>or</u> regular time to stabilise worker rosters
- Client demand (due to location) provides opportunity to offer FT work

CS 1: Time autonomy & time to care

My overwhelming impression … was that there's enough time factored into these visits… it's a good system that allows both enough time [and] also allows workers like Butri to advocate on behalf of clients when they think that they need more care. Butri told me that at one stage they thought Sandra didn't really need anyone. And Butri insisted she did … Butri now comes on Fridays to take Sandra shopping and she said that she had to advocate for this… because she discovered that while Sandra gets meals-on-wheels five days a week, on the weekends she doesn't have any food in the fridge.'

Researcher observation of shadowing home care worker across 6 clients

CS 1: Balancing scheduling & ‘guaranteed’ hours

Val : *…they have been rotating me. The majority of my clients is like low level dementia I deal with, and they really get close to me. Once they start getting close to me I get changed from that…*

Interviewer: Is that because their service changes, or because they want different hours and you’re not on?

Val: *No, I think when that person would, like Rhonda needs hours, it’s been shifted to her, and then so they try and rotate so that we get our hours.*

Val: *The guaranteed time?*

Val: *Yeah, the guaranteed time.*

Support worker, 10 years

CS 2: Time to chat

Julie says the clients really want the time to chat… "it's part of our work, it's not just to go in there and do showers and cares, but to connect with the client and to build the trust"

Researcher observation of worker she is shadowing

CS 2: FT workers still required to be 'flexible'

Talia *Yeah. She (daughter) is in after school care for "just in cases", so we've covered all our bases*.

Interviewer: All your bases? And so if you were to be offered relieving work, or say somebody, a regular support worker is away or something like that, you then might fill in?

Talia - *Yup. That's why we have all these things in place, just in case if I have to work later or I have a day that is really busy and then I pick her up later on.*

Interviewer: So that means you work at least one day of the weekend, if you work six ...

Talia: *I work Sundays. Saturdays I do not work.*

Home care reliever working 35 hours 'base' but up to 6 days pw

CS 3:Task-based time but giving workers (some) control

They [office] tell you all the time, "If you can't get it done, just do what you can." But if the client would prefer to sit and talk, they come first. So if the cleaning doesn't get done, the cleaning doesn't get done. I'm presuming that maybe the family's not overly impressed with that… but then we can also go back to the [office] … and explain…

Home care worker, case study 3

Sometimes we go into people's homes and we talk to the son or the daughter and …they're advocating for their mum, "I don't want you in here doing all that social nonsense, I don't want you having cups of tea with my mother, I just want the shirts ironed and if I say, I want 30 minutes visits …you'll do 30 minute visits". Now when we talked to the mum, the mum actually really likes the fact that the care workers come into her home, they get to know her, they do things together and it's not just task-based.

Manager, case study 3

CS 3: Time Autonomy – ‘Being available’ rather than ‘on-call’

Scheduler: *‘So let’s say, a care worker from north team calls in sick, we go on north team, we see the whole team roster, we have to take that care worker off and then cover the visits…*

Interviewer: …‘ So you’ve had this person call in sick, you’ve moved them from their five clients?

Scheduler: *…Yeah so on the roster they become red and all their visits become a green colour which just means unassigned. You then go one by one so obviously starting with the priority at 7 o’clock…*

So we look across the team … and see what care worker has green or availability, so they don’t start work till 8 maybe, but they’re available from 7. Let’s say they are available from 7 and it can easily move on… So we call them on their personal phone, if we have to, say, “sorry there’s been a sick call, I’ve put a visit on you for 7 o’clock it’s with Nancy…

Scheduler, case study 3

Marketisation + CDC & volatility = squeeze on workers' time

..the biggest issue for us too with the new market, we can't plan for growth…now our rosters are bursting at the seams.

Yes, we're recruiting, but they [workers] are busy…we try our best,…but they won't have as much allowance in their travel time at the moment. For example. …[if travel usually takes 30 mins] we'll give them 45 minutes…but at the moment they've [only] got that half hour because we're trying to squeeze more onto the rosters as new clients come on …

Manager, Case study 3

CONCLUSION

- Spatial arrangement of home care regime crucial
  - NZ: devolved system = proximity and responsiveness to providers
    - Devolved autonomy from MoH to DHB to agency to worker
  - Australia: distance from providers + DoH lack of responsiveness
    - Encourages CS 3 ‘work arounds’ + location in fast growing outer suburbs = (some) inflexibilities of CDC on rostering modified
- Degree of individualisation of home care regime shapes time autonomy
  - NZ: block funding; personal care not means tested; more outcomes focused
    - Location of assessment staff in agency facilitated involvement of workers in responding to changing client needs for care
  - Australia: CDC task-based, itemised & time limited - set within the confines of ‘a package’– CDC system doesn’t ‘count’ work to support the work of HC, pushing cost onto agencies, workers & clients
    - Care plans inflexible tho CS 3 modifications allow workers to be involved in care plan review
- Role of organisation in buffering or shifting risk is critical but not sufficient
  - Time inflexibilities/rigidities and risks of home care service delivery still shifted to home care workers