Seminars in Ageing

NARI NATIONAL AGEING RESEARCH INSTITUTE

The Royal Melbourne Hospital

THE UNIVERSITY OF MELBOURNE

Weekly Tuesday Seminars
12.00 - 1.00pm

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Homecare work:
Time autonomy & time to care

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NARI Seminars in Ageing

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Decent Work Good Care:

International approaches to aged care*

Investigates how **national policy, funding & employment regulation,** operationalised through **organisational practices & work design**, shapes **decent work & quality care**

***ARC DP170100022**

RMIT UNIVERSITY | THE UNIVERSITY OF SYDNEY | Flinders UNIVERSITY | University of Strathclyde Glasgow | YORK UNIVERSITÉ UNIVERSITY

How do Aus & NZ LTC systems & providers shape homecare workers time autonomy & time to care?

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

2. HC services can:
   - Enable time autonomy & time to care/protect workers from system constraints
   - Shift system/service risks onto workers

Key Framings

- Political economy & regime mapping (Williams 2012):
  - Economic/political institutions shape/interact with gender, care & employment regimes
  - Importance of national context

- Labour process perspectives:
  - Workers' time autonomy shaped by employers (Rubery & Urwin 2011), service users and workers within regime context (Baines & Van Beek 2017)
  - Time autonomy constrained thru 'fragmented time practices' (Rubery et al 2015) & enhanced by providing *secure* time to care

Methods

- Regulatory mapping of Australian & NZ Home Care regimes
  - Aged care/home care: policy, ‘architecture’ & funding models
  - Industry structure
  - Employment regulation

- Home care case studies
  - ‘Rapid ethnographic’ approach
  - New Zealand (August 2018) – Case studies NZ1 & NZ2
  - Australia – (February 2018) – Case study Aus1

Home care case studies: Australia & NZ

Case Study sites
NZ 1 Part of larger multi-service provider. Generalist home care service provides home care & dementia day program, mixed socio-demographic pop
NZ 2 Stand alone mid-sized, ethno-specific home care service, also provides day programs for ethno-specific aged in community, disadvantaged area
Aus 1 Part of large Australia-wide multi-site aged care provider. Generalist home care service also providing services to multicultural clients across wide geographical area in poorer outer suburbs

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

COUNTRY	AT HOME LONG TERM CARE (LTC)					
	% of *total pop* 65+ using *at home LTC* 2016	% of *total female* pop 65+ using *at home LTC* 2016				
Australia Pop: 24m *65+=15%* *HC clients = 50% of LTC users*	5.7%	*6.6%*				
New Zealand Pop: 5m *65+=15%* *HC clients = 72% of LTC users*	9.5%	*12.5%*				

Sources: *OECD Long-Term Care Resources and Utilisation* data for 2016 to enable comparisons

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

COUNTRY	AT HOME LONG TERM CARE (LTC)					
	% 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		
Australia Pop: 24m *65+=15%* *HC clients = 50% of LTC users*	5.7%	*6.6%*	13.9%	*19.7%*		
New Zealand Pop: 5m *65+=15%* *HC clients = 72% of LTC users*	9.5%	*12.5%*	26.4%	*32.1%*		

Sources: *OECD Long-Term Care Resources and Utilisation* data for 2016 to enable comparisons

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

COUNTRY	AT HOME LONG TERM CARE (LTC)					
	% 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+	*Personal care workers* at home per 100 pop of 65+
Australia Pop: 24m *65+=15%* *HC clients = 50% of LTC users*	5.7%	*6.6%*	13.9%	*19.7%*	2.2* (2016) *1.1 FTE (2016)* 2.7* (2012) *1.6 FTE (2012)*	2.0* (2016) 2.4 * (2012)
New Zealand Pop: 5m *65+=15%* *HC clients = 72% of LTC users*	9.5%	*12.5%*	26.4%	*32.1%*	3.7* (2018) *2.6 FTE (2018)* 3.2* (2011) *1.4 FTE (2011)*	3.6* (2018) 3.1* (2011)

Sources: *OECD Long-Term Care Resources and Utilisation* available data for 2011, 2012, 2016 & 2018

*Head count only

Home Care in Australia & New Zealand

SYSTEM	AUSTRALIA
Responsibility	National – Department of Health
Funding administration	Centralised
Funding	Individualised Funding – Consumer-Directed Care 'packages' (Levels 1-4) follow clients
Philosophy/priorities	Competition, 'choice and control'
Cost – Personal care	$10.54 pd + means-tested fee (eg $15.15 pd on $40k annual income)
Cost - Household support	
Access/waiting list	up to 2 yrs waiting list for Level 4 packages (highest)

Home Care in Australia & New Zealand

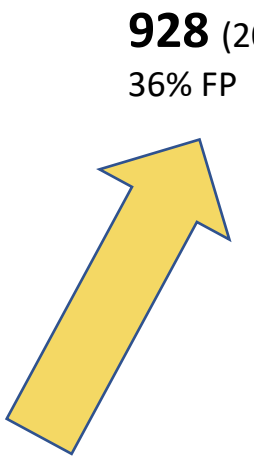
SYSTEM	AUSTRALIA	NEW ZEALAND
Responsibility	National – Department of Health	National - Ministry of Health
Funding administration	Centralised	Devolved to 20 District Health Boards
CDC Funding	Individualised Funding – Consumer-Directed Care 'packages' (Levels 1-4) follow clients	Block funding to providers, based on assessed needs of clients – 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	up to 2 yrs waiting list for Level 4 packages (highest level)	Varies between DHBs – none in CS 1 & 2

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	928	70
% For profits	36%	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)

Sources: ACFA 2019; 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 – Aus 1

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 – NZ 1

Working time: Org policies & protective practices

NZ 1 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

NZ 2 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

Aus 1 General

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

NZ 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 [name] to advocate on behalf of clients when they think that they need more care. [Worker] told me that at one stage they thought [client] didn't really need anyone. And [worker] insisted she did … [Worker] now comes on Fridays to take [client] shopping and she said that she had to advocate for this… because she discovered that while [client] 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

NZ 1: Balancing scheduling & ‘guaranteed’ hours

Worker*: …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 [them]…*

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

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

Interviewer: The guaranteed time?

Worker: *Yeah, the guaranteed time.*

Support worker

NZ 2: Time to chat

[Worker] 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

NZ 2: FT workers still required to be ‘flexible’

Worker *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?

Worker - *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 ...

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

Support worker: 35 hours ‘base’ as reliever, but works 6 days every week

Aus 1: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

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.

General manager – home care

Aus 1: Time Autonomy – 'Being available'

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…

Home Care Scheduler

Aus 1: 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 ….

Area home care manager

CONCLUSION

- Spatial arrangement of home care regime crucial
  - NZ: devolved system = proximity & responsiveness to providers
    - Devolved autonomy from MoH to DHB to agency to worker
  - Australia: distance from providers + DoH lack of responsiveness
    - Aus 1 'work arounds' of (some) CDC inflexibilities enabled by increased demand

- Degree of individualisation of home care regime shapes time to care
  - NZ: block funding + personal care not means tested; more outcomes focused
    - Location of assessment staff in agency involves workers in responding to client needs for time to care
  - Aus: CDC task-based, itemised & time limited - set within the confines of 'a package'
    - Doesn't 'count' work to do the work of HC, pushing cost onto agencies, workers & clients
    - Care plans inflexible tho Aus 1 allow workers some involvement in review

- Services can buffer (some) system constraints on time autonomy. But…
  - Inadequate funding, time inflexibilities & risks of HC service delivery still shifted onto workers