

Market-Modelled Home Care: Impact on Job Satisfaction and Propensity to Leave

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Face à l'augmentation des coûts des soins de santé, à la nécessité de financer les déficits et au vieillissement de la population, plusieurs pays de l'OCDE explorent de nouveaux modèles de soins de santé économiques. L'Ontario a déjà adopté ce genre de modèle, pour gérer, sur la base des principes de quasi-marché, le système de soins à domicile. Les résultats de cette étude de cas, impliquant 835 travailleurs du domaine des soins à domicile, indiquent que choisir une approche de marché pour restructurer l'organisation des soins de santé peut conduire, chez les travailleurs du domaine des soins à domicile, à une baisse du niveau de satisfaction à l'égard du travail et à une plus grande propension à abandonner leur emploi.

Responding to increasing health-care costs, deficit financing and the aging of the population, many OECD nations are exploring new cost-efficient health-care models. One such model, designed to manage the home-based health-care system through the application of quasi-market principles has been adopted by the province of Ontario. Findings from a case study of 835 Ontario home-care workers indicate that a market-modelled approach to health-care restructuring may be leading to decreased levels of job satisfaction and a greater propensity to leave among workers in the home-care sector.

INTRODUCTION

Research on the impact of restructuring and organizational change in home care has been identified as a high priority by academic researchers (Armstrong 2002; Aronson 1999; Koehoorn *et al.* 2002), the Canadian Association of Retired Persons (CARP 2001), and by the home-care agencies we partnered with in this research project. This paper examines the impact of the implementation of a market-modelled approach to the organization and delivery of home-care services on the retention of home-care workers. Findings from a case study of 835 home-care workers from both for-profit and non-profit agencies provide strong evidence that restructuring may have led, or be leading, to decreased levels of job satisfaction and a greater propensity to leave among workers in the home-care sector.

MARKET-MODELLED CARE: POLICY CONTEXT

Responding to increasing health-care costs, deficit financing, and the aging of the population, many Organisation for Economic Co-operation and Development (OECD) nations are exploring new “cost-efficient” health-care models (Gill and Ingman 1994; Kane and Saltman 1997; Williams 1996). These reforms involve both the hospital and home-based health-care systems, and attempt to shift the locus of care from expensive acute care institutions into community and home-based settings (Lesemann and Martin 1993). Canada has been no exception to this trend. Beginning in 1986, in response to increased pressure to lessen state expenditures and increase deficit financing, the federal government began to reduce its contributions to provincial health budgets (Deber *et al.* 1998). Virtually every province responded to these declines by reducing acute care expenditures and shifting the locus of care to the community in an effort to control costs (Wilkins and Park 1998; Williams *et al.* 1999; Williams *et al.* 2001). At the same time, there was an increased ability to care for people in their own homes due to

technological changes leading to the increased use of day surgery and outpatient treatment for problems that were once addressed only in hospitals. Other forces were also transforming the home-care sector such as health consumers’ preference for care at home, the development of more drugs that control problems much more effectively than in the past and the development of alternatives to nursing home care such as supportive housing and assisted living (Williams *et al.* 2001).

As an integral part of the “continuum of care,” home care is comprised of an array of health and social services including medically based interventions such as home nursing and physiotherapy as well as non-medical services such as housekeeping and personal care (Hollander and Walker 1998). In Canada, home-care expenditures have increased by 204 percent in the decade since 1991 and represent about 3.3 percent of total health-care expenditures (Canadian Home Care Association 2003). Prior to 1997, Ontario delegated the governance and delivery of home-care services to a variety of local coordinating agencies such as the Victorian Order of Nurses (VON), local hospitals or Public Health. There was no single regional authority responsible for community-based care, with 74 different Home Care and Placement Co-ordination Programs receiving funding from various governments. Services were provided by the managing agencies themselves, or referred by them to other service provider agencies (SPOs). Under the New Democratic (NDP) government (1990–95), there was a “not-for-profit” preference, whereby the province purchased care services through the Home Care and Placement Co-ordination Programs from the same non-profit providers every year (Armstrong and Armstrong 2003). Regional Home Care Programs and Placement Services were accountable to the provincial government for spending and providing summaries of services and associated costs, but were given the responsibility to assess need, deliver, and organize care. There were no provincial standards of care and eligibility criteria were established locally. This led

to uneven development and equity issues around the province.

Plagued with problems of fragmentation, accessibility, and inequity (Deber and Williams 1995; Williams 1996), and inspired by other OECD nations that have attempted to restructure their health-care systems through market-based reforms, in October 1997, the newly elected Conservative government in Ontario implemented a series of restructuring initiatives to reform the way home care was organized and delivered, including introducing a quasi-market approach to home care, whereby SPOs compete for contracts to provide a range of services (Baranek, Deber and Williams 2004; Randall and Williams 2006). The existing Home Care and Placement Co-ordination Programs in the province were replaced with 43 Community Care Access Centres (CCACs), whose function is to choose service providers through a process termed “managed competition,” whereby for-profit and non-profit service providers bid for contracts through a Request for Proposals (RFP) process every three to four years (Government of Ontario 1996; Williams *et al.* 1999).¹ One of the goals of the creation of the CCACs was to clearly separate the role of service provider from that of service authorizer because of the potential conflict of interest, as well as to eliminate the wide discrepancies in funding levels, service eligibility, and program implementation across the province. Unlike previous home-care programs, the CCACs have no direct responsibility for providing services themselves. Rather, they are responsible for determining eligibility, planning a program of care and ensuring that services are delivered (Armstrong and Armstrong 2003; Williams *et al.* 1999). Contracts are based on market share rather than service volumes and are to be awarded on the basis of a “fee-for-service” price in relation to the ability of SPOs to provide care to clients within a particular jurisdiction (Baranek, Deber and Williams 2004; Caplan 2005). The government established the parameters of a unit of service as the basis of the fee-for-service remuneration system. For nurses, the

unit of service was a one-hour visit. For home-making, tasks were allocated a standard amount of time and a unit of service was built up by compiling standardized time blocks. In principle, agencies who can provide “quality” care at the lowest cost will win the contracts (Sutherland and Marshall 2001).

With the introduction of managed competition, the CCAC’s and agency’s relationship moved from a system largely organized and run by the non-profit sector, focused on providing quality care to those in need of service, to becoming more business-like, one of purchaser and supplier and one that provided opportunities to both the non-profit and for-profit service providers (Aronson and Neysmith 2006; Baranek, Deber and Williams 2004). Because contracts were awarded based on market share, there were no guarantees of service volumes which were dependent on the CCAC’s annual budget, the way in which they allocated services and their administrative costs. Under this new arrangement, travel time was not compensated at all or paid at a reduced hourly rate. No allowances were made for a renegotiation of contracts if circumstances such as increases or decreases in service volumes occurred during the contract period (Aronson, Denton and Zeytinoglu 2004; Baranek, Deber and Williams 2004). Post-restructuring funding envelopes were based on historical home-care budgets and utilization; and although home-care funding rose by 70.9 percent between 1991 and 1999, these increases were not sufficient to meet the increased demand (Coyte 2000; Coyte and Young 1999), leading the CCACs to run significant operating deficits (Baranek, Deber and Williams 2004).

In response, the government implemented another series of changes in 1999 which introduced standardized eligibility regulations giving priority to the post-discharge or acute care group and provincially set service maxima on care hours that could be provided (Baranek, Deber and Williams 2004). The provincial government did provide “budget enhancements” in 1999; however, these moderate increases in

funding did not stem the tide of escalating costs and increasing deficits. By 2001, the government announced that CCAC budgets would be frozen at 2000/01 levels and operating deficits would no longer be allowed. The most common response on the part of CCACs and participating organizations was to lay off staff, reduce service levels, and enact tighter eligibility requirements (Baranek, Deber and Williams 2004). The budgeting pressure also led to a significant structural change in the composition of the home-care case mix; patients being discharged from hospitals became the priority clients of the CCACs and those clients with ongoing needs for home support were either dropped from the system or had their hours greatly reduced (Baranek, Deber and Williams 2004).

THE IMPLICATIONS OF MARKETIZATION OF HOME CARE IN A MID-SIZED CITY IN ONTARIO AND THE RETENTION OF WORKERS

Prior to the implementation of the managed competition system in 1997, the management of home care in the mid-sized city in our case study was contracted to the VON. Home care, in turn, subcontracted services from their sponsoring agency and three other non-profit agencies. Together they provided 85 percent of services and the remaining were provided by other for-profit and non-profit agencies.² Home care was managed by community-based boards of directors and health-care professionals and was built on their professional knowledge and experience. Home care in our study city was considered well developed and locally integrated and the executive directors of the three non-profit agencies took a collaborative approach to problem-solving (Aronson, Denton and Zeytinoglu 2003). It should be noted that the majority of local home-care programs were operated by local departments of public health, several by hospitals and less than five by VONs, therefore the city in which this study took place was not typical of service delivery in Ontario.

The marketization of home care has had serious implications for the SPOs and home-care workers in our study city. Within the current system, revenues are directly linked to the volume of service that SPOs provide. Fearing loss of contract with the next RFP, agencies submit their proposals based on a low service fee and often they are unable to absorb changes in volume or an increase in client acuity (Aronson, Denton and Zeytinoglu 2004). As a consequence, workloads have increased as SPOs make more client visits per day with fewer resources to clients with greater care needs (Aronson, Denton and Zeytinoglu 2004; Aronson and Neysmith 1997; Woodward *et al.* 2004). Workers have been faced with fewer continuous hours of work and a lack of job security as they were expected to follow their clients (Aronson, Denton and Zeytinoglu 2004). In order to remain competitive, SPOs are not able to guarantee hours to employees or to pay benefits. The concessions won by unions in the non-profit sector just prior to managed competition have largely been lost as non-profit organizations opened up their compensation and benefit packages to compete with the lower wages in the for-profit sector. Communications amongst agencies competing for contracts has been hindered, creating an environment characterized by “distrust and isolation rather than solidarity and connection” (Abelson *et al.* 2004; Aronson and Neysmith 2006, 42). Job insecurity associated with the threat of closure and cutbacks has increased dramatically and to date, agencies have lost many of their employees and some have closed. The future of each agency is uncertain (Aronson, Denton and Zeytinoglu 2004; Aronson and Neysmith 2006; Denton *et al.* 2006a).

The retention of home-care workers has been identified as a major challenge to home-care provider agencies (Ontario Association of Community Care Access Centres, Ontario Community Support Association and Ontario Home Health Care Providers' Association 2000). This may be attributed in part to the fact that work in the home has typically been devalued as low status and characterized by

poor employment conditions across Canada (Armstrong and Armstrong 2003; Aronson, Denton and Zeytinoglu 2004; Aronson and Neysmith 1996). The casualization of labour, work intensification, low wages and benefits, and increases in job insecurity are seen as characteristic outcomes of quasi-market approaches to labour-intensive service work (Aronson and Neysmith 2006; Ladipo and Wilkinson 2002; Light 2001). The impact of the implementation of policy that introduces market principles on the retention of home-care workers, however, is far less clear. Retention of home-care workers in the face of deteriorating conditions and increasing instability may further be complicated by the fact that in addition to being in competition with one another, SPOs compete with institutionally based settings for health-care professionals. It is estimated that workers in hospitals and long-term care facilities earn between 30 to 50 percent more than their counterparts within home care (Home Care Study Corporation 2003*b*; Ontario Home Health Care Providers' Association 1999). Our research has shown that in a five-year period between 1996 and 2001, three non-profit agencies in our case study city lost 52 percent of their employees. Many nurses sought employment in the hospital sector, while some personal support workers (PSWs) sought employment in nursing homes where wages are higher, benefits are better, and there are more and stable hours of work. Nearly one-third are working in a non-health-care field (Denton *et al.* 2006*a*).

METHODS

This study uses a case-study design to explore the impact of introducing a market-modelled approach to home care on levels of job satisfaction and propensity to leave. The study took place in a mid-sized city in Ontario, and as such the results may not be generalized to Ontario as a whole, but they are instructive for understanding the impact of the policy on the way that home care was organized and delivered at a particular site.

Mail-out questionnaires focusing on occupational health and safety, working conditions and perceptions of the impact of home-care reforms were sent to 1,949 home-care workers in 11 participating agencies in our case study city in early 2002. A total of 1,339 home-care workers from the 11 agencies responded to the survey, representing a response rate of 70 percent after follow-up. For details on the study methodology, see Denton, Zeytinoglu and Davies (2003).

THE SAMPLE

The sample is made up of both front-line workers and staff in administrative and management positions who were employed in the home-care sector prior to the implementation of reform in 1997 (N = 835). This group was selected for study as they were able to provide information on how their work has changed with the implementation of a market-modelled approach to in-home care. As is reflected in Table 1, home-support workers made up the greatest proportion of the sample, followed by nurses, administrators, case managers, support staff, and therapists. Respondents were predominantly women (95 percent, N = 790), whose age ranged from 23 to 72 (SD: 8.99) with a mean of 47. The vast majority (76.6 percent, N = 639) had completed some form of postsecondary education or training. On these characteristics — occupation, gender, age, and education — the sample closely resembles the most recent profile of the home-care workforce in Canada (Home Care Study Corporation 2003*b*).

DATA COLLECTION AND ANALYSIS

The 2002 questionnaire was designed in consultation with the 11 partner agencies in order to enhance its clarity and ensure that key issues were covered. Two waves of qualitative data collection were conducted in 2000/01 which later formed the basis of the survey used here. The first wave involved 59 key

TABLE 1
Coding, Means and Standard Deviations of Independent, Dependent and Control Variables

	<i>Mean</i>	<i>SD</i>	<i>N</i>
Restructuring Variables			
Shift to business focus <i>Range 5–25: higher score, greater emphasis on business</i>	17.41	3.93	
Staff shortages <i>Range 3–15: higher score, greater staff shortages</i>	10.27	2.60	
Individual effects of shift to business focus <i>Range 3–15: higher score, greater the individual effects of shift</i>	9.10	2.55	
Work intensification <i>Range 6–30: higher score, greater work intensification</i>	21.35	4.46	
Fewer resources <i>Range 4–20: higher score, fewer resources</i>	17.28	2.35	
Job insecurity <i>Range 10–50: higher score, greater levels of job insecurity</i>	27.19	7.77	
Independent Variables			
Satisfied with level of pay <i>Range 1–5: higher score, greater level of satisfaction</i>	2.76	1.13	
Age measured in years	47.08	8.99	
Pay accounts for % of household income <i>Range 1–5: higher score, greater contribution to household income</i>	2.73	1.03	
Average number of hours worked per week	28.52	10.45	
Type of Agency	<i>non-Profit</i>		519
	<i>for-Profit</i>		316
Occupation	<i>managers/administrators</i>		70
	<i>office support staff</i>		65
	<i>case managers</i>		67
	<i>nurses</i>		155
	<i>therapists</i>		44
	<i>home-support workers</i>		425
Dependent Variables			
Job satisfaction <i>Range 1–5: higher score, greater satisfaction</i>	3.54	0.88	
Propensity to leave <i>Range 3–15: higher score, greater propensity to leave</i>	6.25	2.74	

informant interviews with the chief executive officers, directors, managers, administrators, supervisors, local union presidents or chief stewards, union health and safety representatives and board members of the agencies we partnered with. The interviews used open-ended in-depth questions focusing on the impact of health-care restructuring and working conditions. The key informant interviews were followed up with 29 focus groups (N = 171) made up of nurses, home-support workers, therapists, and supervisors or coordinators from the 11 agencies. This also served to provide us with information on issues related to restructuring and working conditions among front-line and administrative employees.

The variables selected here to measure the potential impact of restructuring initiatives on job satisfaction and propensity to leave were derived from the questionnaire and based on concerns identified by the focus groups and key informant interviews as consequences or outcomes of the process of home-care restructuring. Thematic analysis of the qualitative data revealed that home-care workers attributed organizational change, excessive workload, job insecurity, loss of organizational support, and a loss of peer support to health-care restructuring (Denton, Zeytinoglu and Davies 2003). Moreover, many felt that these factors contributed to increased stress levels and decreased levels of job satisfaction (See Appendix, Tables A1 and A2). To explore these themes quantitatively, variables were created which measured the perceptions of home-care workers in relation to whether there had been a shift to business focus, lack of organizational support (less co-worker/managerial support, less job security), staff shortages, work intensification, fewer resources available and increases in job insecurity since the implementation of a market-modelled system in 1997. All of the “restructuring” variables used are summative scales which were created by combining several measures. The scales have high reliability scores and were created based on a content analysis of the focus groups and a review of the literature on home-care work. Exploratory factor

analysis was conducted to identify items composing each scale. Also included in our analyses were more general measures which, based on existing literature, were hypothesized to be related to a greater propensity to leave, including the percentage that respondents personally contributed to the household income, age, number of weekly hours worked, occupation, and whether the SPO worked for was a non-profit or a for-profit agency. All the variables used in this study, as well as the range, mean, standard deviations or categories used are presented in Table 1.

The first dependent variable, job satisfaction, was based on the question: Overall, how satisfied are you with your job? and was measured by using a five-point scale ranging from “very dissatisfied” to “very satisfied.” The second dependent variable, propensity to leave, was created based on results from exploratory factor analysis. Three questions based on a Likert type scale (If I were completely free to choose, I would prefer to continue working at this agency; I would like to stay at this agency for a long time; and, If I had to quit work for a while, I would be likely to return to this agency), were summed to create a continuous measure. A detailed description of all the scales used, along with measures of reliability are provided in Table A3.

In order to include as many respondents as possible continuous or scale variables were re-coded using SPSS’s replacement of missing values (RMV) function, replacing missing values with their means.³ In order to ensure that the replacement of missing values did not distort or bias the results, the final models were run using, first, the RMV function and then again using listwise deletion. The final results indicated that, although there were some differences in relation to values of coefficients and levels of significance, these differences are minimal and the overall model was made stronger with the missing values replaced. The results presented here reflect the larger sample with the missing values replaced. All independent variables were then regressed on job satisfaction and propensity to leave.

Following this, job satisfaction in addition to other independent variables was regressed on propensity to leave in order to determine whether job satisfaction was a mediating factor in the likelihood of terminating employment with the agency with which workers were employed at the time the questionnaire was completed.

FINDINGS

Job Satisfaction

As shown in Table 2, several variables identified in earlier phases of the research as outcomes of a market-modelled approach to the organization and delivery of home-care services were found to have a significant relationship to lowered levels of job satisfaction. Our findings indicate that those who reported that there was

an emphasis on the “business” of care were more likely to report lower levels of job satisfaction. More significantly, the lack of organizational support and job security were found to be highly significant predictors of less satisfaction on the part of agency workers. In addition, several other variables hypothesized to be associated with recent restructuring initiatives were also associated with levels of job satisfaction. Those who were more satisfied with their pay or who worked more weekly hours reported higher levels of job satisfaction. Age also emerged as a significant indicator of job satisfaction among those in this sample, with findings indicating that those who were older were more satisfied with their work. It is important to consider the relationship between age and job satisfaction in that age itself may not be a predictor of job satisfaction, but may instead be a reflection of higher levels of pay associated with greater seniority.

TABLE 2
OLS Regression, Job Satisfaction

	<i>B</i>	<i>SE</i>
Constant	4.45	0.35***
Shift to business focus	-0.03	0.01*
Staff shortages	0.01	0.01
Lack of organizational support	-0.07	0.01***
Work intensification	-0.01	0.01
Fewer resources	0.02	0.02
Job insecurity	-0.04	0.00***
Satisfied with level of pay	0.10	0.03***
Age	0.01	0.00*
Pay accounts for % of household income	0.02	0.08
Average number of hours worked per week	0.01	0.00*
Type of Agency	0.06	0.07
Managers/administrators	0.34	0.29
Case managers	-0.13	0.30
Nurses	0.39	0.28
Therapists	0.58	0.31
Home-support workers	0.16	0.28

Notes: * $p < .05$; ** $p < .01$; *** $p < .001$.

B = Regression Coefficient.

SE = Standard Error.

Job Satisfaction and Propensity to Leave

Table 3 provides a detailed examination of factors that influence propensity to leave. The first model regressed all independent variables on propensity to leave. Findings indicate that among the restructuring variables, job insecurity was the most highly significant predictor of propensity to leave. Although it would be expected that as workloads increased with no increases in pay, so too would propensity to leave, our findings show that those who reported *lower* rates of work intensification were significantly more likely to leave their agency, although not by a large margin. Fewer resources within the home-care system was also found to be a significant indicator of propensity to leave, as were staff shortages and

lack of organizational and peer support, although their effects were found to be relatively minor. Once again, the average number of hours worked per week, satisfaction with levels of pay and age emerged as important indicators of propensity to leave. Finally, within this model, we found that in some instances occupation was related to propensity to leave. Findings indicate that case managers were among the most likely to leave the home-care sector ($p < 0.001$), whereas therapists were the least ($p < 0.01$).

Consistent with our original hypothesis, when job satisfaction was added and regressed on propensity to leave, it was found to be a highly significant

TABLE 3
OLS Regression, Propensity to Leave

	Model 1		Model 2	
	B	SE	B	SE
Constant	9.62	1.09***	14.17	1.13***
Job satisfaction			-1.02	0.10***
Shift to business focus	0.04	0.03	0.01	0.03
Staff shortages	0.10	0.04*	0.11	0.04**
Lack of organizational support	0.09	0.05*	0.02	0.04
Work intensification	-0.08	0.02***	-0.09	0.02***
Fewer resources	-0.12	0.05**	-0.10	0.04*
Job insecurity	0.07	0.01***	0.03	0.01*
Satisfied with level of pay	-0.37	0.08***	-0.26	0.08***
Age	-0.04	0.01***	-0.03	0.01**
Pay accounts for % of household income	-0.05	0.09	-0.20	0.08
Average number of hours worked per week	-0.04	0.00***	-0.03	0.01**
Type of agency	0.07	0.21	0.23	0.20
Managers/administrators	0.06	0.42	0.07	0.40
Case managers	1.52	0.43***	1.04	0.41*
Nurses	-0.56	0.37	-0.50	0.35
Therapists	-1.61	0.54**	-1.35	0.51**
Home-support workers	-0.19	0.34	-0.35	0.32

Notes: * $p < 0.05$; ** $p < 0.01$; *** $p < 0.001$.

B = Regression Coefficient.

SE = Standard Error.

intervening variable, mediating the effects of organizational and peer support. Although job insecurity and fewer resources in the home-care sector remained significant indicators of propensity to leave in this model, their effects were significantly diminished once job satisfaction was considered, whereas the effects and significance of staff shortages increased. As with the previous model, work intensification remained a highly significant indicator of propensity to leave. Among other variables tested in this model, satisfaction with current levels of pay, the number of hours worked per week, and age were once again found to be highly significant indicators of propensity to leave. Once again, caution should be used when interpreting age, as it may be associated with retirement rather than propensity to leave. When specific occupational and professional groups were considered, we again found that employment as a case manager was related to propensity to leave, although the effects of occupational status in this case were significantly diminished once job satisfaction was considered. Although somewhat diminished once job satisfaction was considered, therapists were the least likely to leave the home-care sector in relation to other occupational groups.

DISCUSSION

Marketization, Job Satisfaction and Propensity to Leave

Although working conditions in home care are typically characterized as being poor across Canada, no matter what model of service organization and delivery employed (Aronson, Denton and Zeytinoglu 2004; Aronson and Neysmith 1996), the introduction of market principles characteristic of a post-industrial economy may further serve to degrade the conditions experienced by home-care workers. Since the implementation of managed competition in 1997, downward pressure has been exerted on wages and benefits, and cost-cutting strategies such as the casualization of work, layoffs, and increased

caseloads have become the dominant strategies employed by agencies attempting to achieve a profit, remain competitive or ensure their survival (Abelson *et al.* 2004; Aronson, Denton and Zeytinoglu 2004; Aronson and Neysmith 2006). The commercialization of home care through the adoption of the managed competition system has led to an increase in instability within this sector (Caplan 2005; Ontario Health Coalition 2005). With each RFP process, agencies are at risk of losing their contracts and workers are faced with the prospect of losing their jobs. Business principles have been applied to caring labour through the managed competition system and fee-for-service payment scheme operating under the assumption that caring labour constitutes measurable units of work amenable to management practices applied in an industrialized market (Rasmussen 2004).

The effects of these developments emerge in our findings. In 2001, our interview and focus group participants identified what they believed to be outcomes associated with the introduction of the managed competition system to the organization and delivery of in-home care in relation to both the ideological underpinnings and daily working conditions within their agencies including: a greater emphasis on the business side of providing care and the effects of this shift, including less peer and organizational support, staff shortages, work intensification, fewer resources, and greater job insecurity. Our findings indicate that, when examined quantitatively, several of the factors associated with the implementation of the managed competition system, including job insecurity, a lack of organizational and peer support and a shift in emphasis to the “business” of care rather than the “provision” of care have negatively impacted upon overall levels of job satisfaction among front-line and administrative employees of both for- and non-profit agencies in our study.

The findings presented here are consistent with prior literature which has found that the provision of peer and organizational support is an important

mechanism in reducing stress and increasing levels of job satisfaction (Denton, Zeytinoglu and Davies 2002; Denton *et al.* 2002). Prior study has also found that home-care workers indicated that the most negative aspect of working within the home-care sector was the lack of job security and consistent hours (Caplan 2005; Home Care Study Corporation 2003*b*). Moreover, although often unrecognized, emotional support or “care work” is often identified by front-line workers as the most valuable and satisfying aspect of their jobs (Aronson and Neysmith 1996; Neysmith and Aronson 1996). In a similar vein, although case managers are not involved in hands-on care, they often develop personal and working relationships with both clients and front-line workers, becoming a critical point of contact and mediator for both (Woodward, Abelson and Hutchison 2001; Woodward *et al.* 2004). Yet caring labour is only possible through regular contact with the same care worker and sufficient time to build relationships. Given increased caseloads, greater client acuity, and dwindling resources, the provision of caring labour may be difficult or impossible. In addition to time and budgetary constraints, the ideological shift in emphasis from the “provision of care” to a business-oriented model may serve to decrease levels of job satisfaction as the caring element of the job of caregiver is eroded.

The importance of decreases in levels of job satisfaction to home-care work is underscored by its impact on propensity to leave the home-care sector. Overall levels of job satisfaction were found to be a highly significant predictor of propensity to leave and mediated or significantly reduced the effects of many of the “restructuring” variables, including fewer resources and a lack of organizational and peer support. This is not to suggest, however, that levels of job satisfaction override working conditions associated with restructuring. The results presented here clearly show that lack of resources and staff shortages and job insecurity remained or increased in significance as indicators of propensity to leave even when job satisfaction was considered. More-

over, one of the consistent findings throughout the analyses was that workers were generally dissatisfied with levels of pay, and this in turn led to both a greater level of dissatisfaction with their jobs and a greater propensity to leave. Age was also consistently found to be an indicator of both satisfaction and propensity to leave. In this case, as age increased, levels of job satisfaction decreased, but older workers were also less likely to leave their current work situation. This is most likely attributed to the precarious labour market position that older workers find themselves in and the high costs associated with retraining at mid-life, persuading workers to remain in the home-care sector despite negative feelings and attitudes about the conditions of their employment.

Interestingly, results indicate that intensification increased and fewer resources were associated with less propensity to leave the organization. At first, these findings would seem counterintuitive as prior literature has suggested that as work intensification increases, levels of job dissatisfaction and propensity to leave would also increase (Denton *et al.* 2006*a*; Ladipo and Wilkinson 2002). One possible explanation is that this variable is actually capturing the changes in the home-care case mix (see Table A3). Prior literature has shown that as agencies attempt to provide more care at the lowest possible cost, personal support workers (PSWs), are increasingly called upon to perform procedures that were once provided by higher paid care workers such as LPNs (Woodward, Abelson and Hutchison 2001; Woodward *et al.* 2004). Similarly, as a greater number of clients enter the home-care system experiencing greater levels of acuity, home-care nurses may be performing tasks that were at one time limited to in-hospital care. Job satisfaction among PSWs has been shown to be significantly related to their ability to use enhanced personal care skills in their daily work (Ontario Home Health Care Providers’ Association 1999), and recent study has found that some home-care workers attributed their decision to leave their employer to the lack of

challenging work and educational opportunities (Denton *et al.* 2006a). These findings would suggest that although work intensification has typically been seen as a negative outcome from both the perspective of workers (Aronson and Neysmith 1997, 1996), and clients receiving care (Abelson *et al.* 2004; Aronson and Sinding 2000), workers may feel some intrinsic reward from being challenged by their work, thereby providing some incentive to remain in the home-care sector.

Our study also pointed to differences in relation to propensity to leave among two occupational groups: case managers, and therapists. As noted earlier, case managers often serve as a crucial link between clients in need of care and workers providing care in the context of dwindling resources and increasingly strict eligibility requirements (Woodward, Abelson and Hutchison 2001; Woodward *et al.* 2004). Low wages, lowered morale, and the increased strain of being “the bearer of bad news” (Abelson *et al.* 2004) may have resulted in an increased propensity to leave among this group. It is also important to consider, however, that at the time the survey was conducted, case managers in our study city had recently been embroiled in a strike situation that may have influenced the results presented here. Among home-care workers, therapists were the least likely to leave their agencies, which may be attributed to the work itself. They have among the greatest levels of prestige, pay, and autonomy and are in the greatest demand within the health-care sector generally (Home Care Study Corporation 2003b; Randall and Williams 2006). Again, this may point to the importance of autonomy, education, consistent working hours, and satisfactory levels of pay in retaining workers in this sector.

Our findings are further supported by several related studies in this city. A longitudinal study of employees from three non-profit agencies holding 85 percent of the market share in home care in 1996 showed that 52 percent of the nurses and personal support workers left their employment between 1997

and 2001. Analysis of the data showed a spike in turnover during periods where contracts were awarded to SPOs (Denton *et al.* 2006b). Further analysis of this data indicated that respondents mentioned dissatisfaction with pay, hours of work, benefits, heavy workload, and lack of managerial/supervisory support (all factors impacted by the marketization of the home-care sector) as reasons for leaving (Denton *et al.* 2006a). A 2003 paper by Aronson, Denton and Zeytinoglu portrays the consequences to visiting homemakers of the closure of their once successful agency under managed competition. Together, these four studies provide convincing evidence that the roll-out of managed competition in Ontario decreased job satisfaction and increased worker turnover or their propensity to leave in our study site. It is not possible to generalize the findings from our case study to other communities in Ontario. The way managed competition was rolled out varied from one community to another. Nevertheless, other research has shown that retention and turnover are serious problems for home-care agencies, and this study suggests that this problem may have been exacerbated by the implementation of a market model of care.

Implications for the Home-Care Sector

The health and home-care sectors have gone through major changes over the last decade in an effort to contain costs. Despite increased interest among many OECD nations in a market-modelled approach as a cost-effective way of organizing and delivering care, there is little evidence of the superiority of this system. Indeed, many critics claim that these new arrangements may compromise stated goals, to improve the quality of care while containing costs (Aronson, Denton and Zeytinoglu 2004; Aronson and Neysmith 2006; Randall and Williams 2006). In the short term, the casualization of the workforce may be viewed as a way to reduce costs through the provision of lower wages and elimination of benefits (Deber 2002; Home Care Study Corporation 2003b). In the long term, however, a destabilized workforce and increased job dissatisfaction among

workers in relation to wages, benefits, and working conditions may increase costs associated with recruitment, training, and turnover.

In addition to the potential financial costs associated with the implementation of managed competition, recent estimates indicate that there will be considerable shortfalls in the number of care workers needed to support the system in the coming years (Caplan 2005; Home Care Study Corporation 2003*b*; Ontario Home Health Care Providers' Association 1999). The findings presented here suggest that the implementation of managed competition has resulted in decreased levels of job satisfaction and a greater propensity to leave among home-care workers. The climate of instability and degrading working conditions within home care may be leading to a greater number of workers opting to leave the sector entirely, particularly when workers are presented with attractive alternatives within institutionally-based settings (Denton *et al.* 2006*a*). The sustainability of the home-care sector itself may be in question should present trends in relation to working conditions and funding levels and devolution continue. As increasing numbers of patients with high levels of acuity are being redirected to home care, there is a question as to whether there will be sufficient numbers of well-trained health professionals to meet their needs (Armstrong and Armstrong 2003; Home Care Study Corporation 2003*a, b*).

Staff shortages, high turnover rates, and under-trained or under-qualified workers also have tangible implications for recipients of care. High-quality continuous care is only possible through sustained contact with a regular care provider. High turnover rates, staff shortages, and increased caseloads may result in a lack of familiarity with the health of individual care clients, and front-line care workers may no longer be able to actively monitor the health status, changes in medications or needs of their clients effectively; thus compromising the quality of care provided (Vogel 2001). Among service users, the lack of continuity amongst service providers was

found to be dehumanizing by older clients who often required help with intimate activities (Aronson 2002; Woodward, Abelson and Hutchison 2001; Woodward *et al.* 2004). The need to re-explain care needs to new service providers who, at times, did not possess the skills to meet their needs or who were unable to carry out their duties because of an unfamiliarity with the organization of the household has also been identified as a source of dissatisfaction and potential barrier to service use (Woodward, Abelson and Hutchison 2001). Further, the delivery of high-quality health care is largely dependent on the quality of the staff delivering the services. It is well-known in the human resources management field that satisfied workers are more productive and efficient, and provide better quality services or goods produced. Since the implantation of restructuring, studies have found that client trust in the ability of workers to provide them with adequate care has been eroded, indicating that providers were often poorly trained and did not provide the care they were supposed to deliver (*ibid.*).

Although some of the issues associated with the implementation of managed competition such as the length of contract and the standardization of the RFP process are being addressed, real issues around pay and benefit levels, hours of work, job insecurity, and lack of organizational support remain. With the increase in demand for their services and competition for health human resources among a greater number of SPOs and other health providers, agencies need to know how to attract employees to the home-care sector and retain their employees. In sectors where the competition for skilled workers is high, employers must use a combination of intrinsic and extrinsic rewards in order to retain their workforce. Ongoing training and educational opportunities, reimbursements, promotions as well as competitive wage and benefit packages, flexible hours, and greater autonomy over work are among the many incentives that may serve to attract or retain workers (Denton *et al.* 2006*a*; Ontario Health Care Providers' Association 1999). In a competitive environment,

however, these initiatives and changes in working conditions are unlikely to occur without government intervention and support. Should increasing numbers of home-care workers choose to leave the sector; the home-care system as it currently exists may no longer be sustainable. Without an adequate supply of qualified and committed workers, clients will not receive the care necessary to remain independently in their homes, once again relocating them to institutional settings or having their care needs go unmet. The investment of additional resources devoted to eliminating or decreasing the imbalance that currently exists between workers in institution- and home-based settings, and the provision of further educational and training opportunities would be both a care- and cost-efficient step in reducing many of the human resource issues faced in the home-care sector today.

NOTES

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¹Although the initial contracts were shorter as managed competition was rolled out.

²It is estimated that for-profit home-care providers delivered about 30 percent of the total home-care service business prior to the implementation of managed competition in Ontario.

³In total, 269 missing values were replaced with their mean.

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APPENDIX

TABLE A1
Key Informant Interview Results: Impact of Health-Care Restructuring on Clients and the Delivery of Services

<i>Item Mentioned in Interviews</i>	<i>No. of Interviews Mentioned</i>	<i>% of Interviews</i>
Client impacts		
Higher client acuity, shorter length of hospital stay, increased complexity of care, higher client satisfaction	49	84
Increased complexity of care, higher client satisfaction	29	50
Service delivery impacts		
Heavier workload or intensification of work	34	59
Reduced length of home-care visits/more client visits per day	25	43
Downloading of work	28	48
Lack of resources (insufficient funding, pressure to discharge from home-care program, delays in obtaining service for clients, less money available for service delivery, lack of long-term care beds, capping services, inadequate funding to support base functions such as education, training, supervision)	46	79
Loss of focus (loss of preventive care function, holistic approach, shift to sub-acute system)	29	50
Loss of continuity of care	31	53
Inconsistencies in the volumes of work	24	41

Note: N=59.

TABLE A2

Focus Group Results: Impact of Home-Care Restructuring and Managed Competition on the Home-Care System, their Jobs and on Clients

<i>Items Mentioned in Focus Groups</i>	<i>Number of Focus Groups Mentioned</i>	<i>% of Focus Groups</i>
Impact on home-care system		
Reduced quality of services	19	66
Lack of resources	26	90
Loss of preventive function/loss of holistic approach	12	41
Impact on their jobs		
Heavier workload/work intensification	20	69
Downloading	16	55
Reduced length of visits or more visits per day	14	48
Difficulties in mastering the RFP process	16	55
Less organizational and peer support	7	24
Changes in support and relationships with other agencies or service providers	16	55
Job insecurity	12	41
Heavier workload	12	41
Unpaid work	8	28
Created a unionized environment	8	28
Impact on clients		
Higher client acuity	25	86
Higher public expectations/awareness/complaints	19	66
Clients falling through the cracks	17	59
Less time to give emotional support	10	35
Less continuity in care	22	76
Impact on work environment in general		
Higher turnover	12	41
Stability issues	14	48
Note: 29 focus groups, N = 171.		

TABLE A3
Scale Items

<i>Effects of Restructuring: Organizational Changes Since 1997</i>		<i>Chronbach's Alpha</i>
Shift to business focus	<i>Home care is more "business like"</i> <i>There is more emphasis on productivity at your agency</i> <i>There is less emphasis on preventive care for clients</i> <i>There is less emphasis on care for the "whole person"</i> <i>There is less cooperation between home-care agencies</i>	0.78
Staff shortages	<i>There are more staff shortages at your agency</i> <i>There is more staff turnover at your agency</i> <i>There are more staff shortages in the home-care field</i>	0.74
Lack of organizational support	<i>I receive less support from my co-workers</i> <i>I receive less support from managers or supervisors</i> <i>I have less job security</i>	0.64
Work intensification	<i>My workload is heavier</i> <i>There is pressure to do more with less time</i> <i>I work more evenings and weekends</i> <i>The amount of unpaid work I do has increased</i> <i>The skills required to do my job have increased</i> <i>My job is more complex</i>	0.77
Fewer resources	<i>There is a shortage of resource (money) in the home-care field</i> <i>Families of clients are expected to provide more care</i> <i>Home-care workers now do tasks that were once nursing tasks</i> <i>Nurses do tasks that were once done in hospitals</i>	0.74
Job insecurity	<i>I am presently safe from dismissal at this agency*</i> <i>I am confident that this agency will remain a steady place of employment for as long as I want to continue working here*</i> <i>My feelings about my future with this agency have a negative influence on my overall attitude toward my job</i> <i>The way my future looks to me now, hard work seems almost worthless</i> <i>I am not getting ahead at this agency</i> <i>I feel uneasy about the security in my present job</i> <i>I feel I am likely to be employed in this job three months from now*</i> <i>I am worried about my future with this agency</i> <i>I am worried about my job security</i>	0.87
Propensity to leave	<i>If I were completely free to choose, I would prefer to continue working at this agency*</i> <i>I would like to stay at this agency for a long time*</i> <i>If I had to quit work for a while, I would be likely to return to this agency*</i>	0.87

Note: *Items were reversed in the scale.

