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The Occupational Health and Safety of Homecare Contract Workers in Adelaide and the Barossa Region

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1. Executive Summary

This exploratory study of homecare contract workers was undertaken for the Office of Employee Ombudsman of South Australia to better understand key occupational health and safety (OHS) issues encountered by workers in this growing sector of the Australian labour market.

Interviews were conducted with 19 homecare contract workers in Adelaide and the Barossa Region. The respondents were engaged in three broad categories of homecare work: personal aged care, disability care and emergency care for troubled youths.

Many of the respondents experienced similar OHS problems, although there was disagreement between respondents about some of the issues raised. Issues on which there was agreement (convergence) in Adelaide included failures by agencies to carry out risk assessments prior to placement, failures to inform workers of hazards, absent or inadequate OHS policies and procedures, absent or inadequate OHS training and uncertainty about entitlements. In the Barossa Region, there was agreement between respondents regarding a lack of employment benefits, the inadequacy of OHS training and poor implementation of OHS policies.

In both locations, there was disagreement (divergence) regarding problems with working hours, agency responses to reported OHS problems, and demands of particular types of work. There were also some contradictory findings between the locations. Further research is required to determine whether these differences are representative and, if so, whether they are symptomatic of regional labour markets, the type of work undertaken or the practices of particular employment agencies.

Overall, this study provides preliminary evidence of potentially serious OHS issues that require further investigation to guide policy development in the future.

Our major recommendations are:

- A further more detailed and systematic study of the OHS experiences of homecare workers should be undertaken.
- The proposed study should include a survey of homecare workers in three separate locations in South Australia and investigate four distinct categories of homecare work, so the OHS implications of employment in this growing sector can be better understood.
- To broaden its perspective, the study should also include interviews with agency representatives, relevant government officials and other stakeholders.

2. INTRODUCTION

The Growth of Homecare

Over the past thirty years, there has been a significant shift in overall employment towards the service sector in most developed countries. This employment shift has been fuelled by a growth in services themselves, including information technology services, banking and finance, media, tourism and travel, health and personal services. One significant, but often overlooked, area of growth is the provision of services into the home – what is commonly referred to as homecare. Homecare services include healthcare, aged care, home help, disability support and troubled or at-risk youth support. The development of homecare can be attributed to several factors: demographic changes, particularly population ageing; changes in family structures, consumption and lifestyle; and changes in business practices and government service provision resulting from privatisation, de-institutionalisation and outsourcing. Elements of homecare work have evolved from the voluntary sector and there has been recognition that family members or charitable organisations were the traditional providers of these services. Homecare is also affected by developments in labour market practices, including the increased use of temporary and self-employed workers, both through direct hire and via temporary employment agencies. Indeed, the growth in homecare has in part reflected the contemporary shift towards neoliberal policies and labour market 'flexibility'.

It is difficult to determine the extent of homecare and other forms of home-based work because statistical agencies collect limited data in this area. However, available data suggest that practices such as homecare are contributing to changes in the location of work for a minority of the workforce (Felstead *et al.* 2005). The most recent Australian data on the location of work indicate that 24% of the total workforce (10.1 million) spent some time in 2008 working at home in their main or second job (Australian Bureau of Statistics 2009). For most, their home was an adjunct work location and the main reason they worked at home was to *'catch up on work'* (ABS 2009: 5). Furthermore, home-based work was most pronounced amongst those holding a second job. However, for 32% of those undertaking some home-based work (783,800 or 7.6% of all employed people), home was the main or only location of work. Of this group, most were over 35 years of age (83%) and the majority were women (55%). Approximately 38% worked in their own home, while around 10% worked in their employer's or a client's home. It is not possible to determine how many of these workers were engaged in homecare. However, the data suggest that homecare is a significant category of home-based work.

Research Evidence

The differences between working in a home and working in a formal and larger workplace are well recognised. Indeed, this contrast was noted more than a century ago in the renowned medical journal, *The Lancet* (21 April 1888: 792-794). More recently, government inquiries in Australia and elsewhere have investigated home-based work, acknowledging the greater occupational health and safety (OHS) problems that can arise due to lower rewards, disorganisation and the lack of regulatory oversight (Mayhew and Quinlan 1999; Quinlan *et al.* 2001b). Moreover, recent international research has found an association between the kinds of flexible work arrangements that typify homecare work, such as temporary work and subcontracting, and poor OHS outcomes including injury rates, mental health, physical health, and compliance with regulations (for reviews, see Quinlan *et al.* 2001a; Virtanen *et al.* 2005; Benach *et al.* 2007; Quinlan and Bohle 2008). However, relatively limited research has been undertaken regarding OHS in homecare, and no detailed Australian study has been conducted. Further, much of the extant research is confined to healthcare services, which are only a small part of the homecare sector.

In 2008, a systematic review was undertaken of scientific research on the OHS effects of subcontracting, home-based work and homecare (Quinlan and Bohle 2008). Of 25 studies, it identified nine that investigated home-based or homecare work. These studies used a range of research methods (secondary

data analysis, quantitative and qualitative primary data) and OHS measures (injury, subjective health, objective, risk, knowledge and compliance). Of the nine studies, eight found negative results and one found mixed results. This limited research indicates that homecare workers experience worse OHS outcomes to those undertaking the same work in institutional settings. Indeed, the studies on OHS in homecare identified problems including competitive tendering for contracts, high levels of mental and emotional stress, musculoskeletal disorders, work intensity, job insecurity, low rewards, poor job satisfaction, service quality, and labour turnover and retention (Zeytinoglu and Denton 2005). Homecare workers can also be exposed to hazardous materials including infectious agents and blood-borne pathogens, with a recent US study finding blood exposure was not confined to personal care providers engaged in healthcare services (Zanoni *et al.* 2007).

Related research on downsizing and outsourcing in healthcare has identified increases in the incidence of injuries, psychological distress, burnout and occupational violence (Ostry and Spiegel 2004; Snyder 1994; Woodward *et al.* 1999; Trinkoff *et al.* 2005). It also highlights an escalation in attitudinal and behavioural changes amongst healthcare staff, including reduced job satisfaction, increased labour turnover and recruitment difficulties, which can have long-term effects on the quality of healthcare (Burke and Greenglass 2000; Allen 1998; McKenna 1998). The adverse health effects on patients and healthcare workers have repercussions for workers' families, particularly with regard to the potential for costly litigation when, for example, infectious diseases are contracted in hospitals or homecare providers are placed at risk (Miller 2004; Beltrami *et al.* 2000). Several studies also point to other quality effects of the contracting-out process in healthcare (Allen 2002; Kwon and Yoon 2003; Randall and Williams 2006).

Research Gaps

It is apparent that the volume of research on home-based work is diminishing, rather than increasing (Quinlan and Bohle 2008). This trend is significant as there are major gaps in the existing body of research that warrant attention. Several of the related issues have potentially critical policy implications.

Gender Among the evident gaps in the research, the lack of evidence about gender effects is significant. In general, studies on outsourcing and subcontracting focus on male dominated occupations and industries. This may reflect a parallel bifurcation in the labour market, as outsourcing and subcontracting are typically male-dominated work arrangements. However, the growth of outsourcing, especially in the service sector, has meant that more women are working under such arrangements, particularly within the home. The gender effects of both subcontracting and home-based work require more careful attention, especially in the context of other studies pointing to gender differences in the impact of precarious employment, the vulnerable position of women in some forms of home-based work, and the proportionately greater impact of labour market changes on women (Siefert and Messing 2006; Menendez *et al.* 2007).

OHS Indices and Post-Injury Outcomes Studies of home-based work have used OHS indices, including injury, disease, hazard exposure, occupational violence, psychological well-being, and knowledge of, and compliance with, employer policies and OHS laws. However, because of the small number of studies, it is not possible to compare results across different indices. Neither is it possible to draw more general conclusions, such as whether homecare workers are more at risk of occupational violence and sexual harassment (Barling *et al.* 2001). Research on post-injury outcomes for homecare workers is similarly limited. However, wider research indicates that other contingent workers experience poor return-to-work outcomes and treatment under workers' compensation regimes (Quinlan and Mayhew 1999; Quinlan 2004). One study addressing rehabilitation examined Swedish homecare workers with disability pensions due to musculoskeletal disorders (Dellve *et al.* 2002). It indicated that while most attributed their disorder to work, only one third received occupational rehabilitation. It is not clear if any of the sampled workers were self-employed. This is significant because access to workers' compensation for self-employed workers in Australia and other countries can be problematic (Quinlan and Mayhew 1999; Quinlan 2002, 2004). Indeed, the self-employed status of many homecare workers may, in itself, have significance for policy-

makers in terms of both prevention and post-injury treatment.

Types of Homecare, Employment Status and Business Size A further consequence of the small number of studies on homecare is a limited capacity to generalise regarding the effects of types of homecare, employment status and business size. It is not known whether the identified OHS risks apply to all types of homecare work, such as healthcare, aged care, household help and troubled youth support. It is quite possible, however, that there are variations in the nature and extent of risks across different types. Similarly, it is difficult to explore the effects of different employment statuses and business sizes on OHS. While some studies of homecare refer to different categories of employment, it is largely ignored when assessing OHS effects. There is a small body of research on the effect of self-employment on OHS (e.g. Jamal 2007; Mirabelli *et al.* 2007) and the effect of small business size on OHS (e.g. Kines and Lyngby Mikkelsen 2003; Fabiano *et al.* 2004). However, this research seldom takes into account the fact that self-employed workers and micro-businesses are often located in the lower reaches of a subcontracting chain, and are heavily dependent on the principal contractor (for exceptions, see Costabile *et al.* 1989; Salminen *et al.* 1993).

Employer Practices, Working Hours and Payment Systems Further exploration is required to evaluate the OHS effects of different employer practices in homecare, such as the use of labour hire firms or temporary employment agencies. For example, there is some evidence to suggest that workers under labour hire arrangements are at greater risk of injury, have poorer prospects of returning to work when injured, and present a serious challenge to regulatory agencies (e.g. Quinlan 2002; Johnstone and Quinlan 2006; Underhill 2008). Moreover, research is required to determine whether the relocation of work to a home, where the worker remains engaged to the primary employer rather than becoming subcontracted, is a risk factor. Working hours and payment systems are related issues. There is a common failure to consider working hours, even though it is known that the self-employed tend to work longer hours than employees (Louie *et al.* 2006). Piecework payment systems are common amongst self-employed workers, particularly construction workers and truck drivers, and are linked to adverse OHS outcomes (Lacey *et al.* 2007).

Work Arrangements While separating different work arrangements to examine the OHS effects of precarious employment has value, it must be recognised that interactions between different employer practices and work arrangements are common. For example, privatisation of public sector agencies can lead to both downsizing and outsourcing, while outsourcing of some activities by a government agency commonly entails privatisation (for a recent review of research on the OHS effects of privatisation, see Egan *et al.* 2007). Siefert and Messing (2006) found changes in the ergonomic load on hotel cleaners flowed from a combination of the use of temporary workers and outsourcing. It has also been noted that any research on the OHS of self-employed workers or micro-businesses must consider whether location in a subcontracting network affects a capacity to safeguard OHS. Finally, external influences must be recognised. Downsizing and transferring healthcare tasks to the home may adversely affect the reporting of critical incidents involving patients and staff, and require new and logistically demanding surveillance systems (Jones and Arana 1996; NIOSH 2003; Manangan *et al.* 2002).

In many respects, the research gaps identified above reflect pioneering efforts to better comprehend the OHS effects of changing work arrangements (Benach and Muntaneer 2007). However, the problem is possibly more acute with regard to homecare because there is only a slow accretion in published research. Furthermore, many of the studies are too small or isolated to enable more integrated analysis. More fundamentally, the impact of different categories of precarious employment can only be understood when attention is given to the business practices and forms of work organisation that give rise to them. Policies of outsourcing, competitive tendering, privatisation and de-institutionalisation have promoted subcontracting arrangements that, in turn, engage distinct and often smaller units of workers, including self-employed and employee homecare workers.

Overall, the research above indicates that homecare and home-based work may have significant adverse effects on OHS. However, there are major gaps in knowledge and more research is required before several

outstanding questions can be answered. Nonetheless, the consistency that does exist in the literature is more compelling in view of the diverse range of contexts (in terms of both countries and industries), research methods and OHS indices represented in the studies. Furthermore, it suggests that existing regulation strategies have been bypassed, or that they only moderate impacts. Indeed, new types of legislation, policy interventions and employer protocols may be required to address these problems.

OHS Regulation, Legislation, Interventions and Protocols

Emerging evidence suggests that home-based work and other forms of subcontracting undermine existing regulatory regimes designed to safeguard workers and provide compensation and rehabilitation for the injured (Haines 1996; Johnstone *et al.* 2001, 2005; Quinlan 2004; Waehrer *et al.* 2007). Furthermore, recent research indicates that subcontracting, especially home-based work, poses major challenges to OHS inspectors (Quinlan *et al.* 2009). In most countries, OHS legislation and enforcement programs have been designed for relatively secure workers in large workplaces directly employed by a single employer. Subcontracting, leased labour and home-based work can create complex chains of command that make it difficult to implement and enforce these laws. For employers, these work arrangements can create contradictory incentives and confusion about regulatory requirements, especially regarding particular duties and legal obligations. This can also be the case for small businesses with a limited capacity for, or commitment to, compliance (Haines 1993, 1996). Confusion may also arise for workers regarding their employment status and legal rights and obligations regarding OHS and workers' compensation (Bernstein *et al.* 2001; Lippel 2005).

In an Australian study of regulatory responses to changing work arrangements undertaken in 2002, inspectors identified home-care as particularly problematic (Quinlan 2002). Issues identified included the failure to undertake pre-visit risk assessments, inability to manage injury risks and occupational violence, understaffing, long hours, poor design, and the practice of *'locking in'* individual staff to half-way houses. The difficulty of developing guidance material was also noted, due to the diversity of home-based work activities (from manufacturing to various services), and the workers involved (from recent immigrants to public sector employees and self-employed professionals). Finally, the study recognised the difficulty of monitoring and enforcing standards because of the diversity of work settings, even in cases where home-based workers were employed by a large government agency.

Government OHS agencies are well aware of these issues. For example, a report prepared by the UK Health and Safety Commission (2001: 2) noted that while OHS legislation appeared to cover a range of *'atypical'* work arrangements, implementation of standards was an issue:

> *The issue seems largely one of communication, i.e. the need to clarify and promulgate to all stakeholders the current legal position regarding health and safety responsibilities for atypical workers. We know, for example, that many of the problems arise, not because there is a lack of protection, but because stakeholders fail to recognise their responsibilities (deliberately or otherwise); and because the employment status of individual workers is often incorrectly determined. This has a knock-on effect as far as issues like health surveillance, accident reporting, and provision of information, training and Personal Protective Equipment (PPE) are concerned. This presents problems in all sectors where agency workers and mobile workers are concerned, and is also an issue for homeworkers.*

In response to regulation challenges, government OHS agencies have produced guidance material and interventions for home-based work, and some large employers have developed homecare protocols (Quinlan 2002). Interventions target hazards - such as ergonomics, injury risk, occupational violence and working - in isolation. Homecare protocols typically include pre-entry risk assessment, training, policies of visiting prohibition, and practices of having additional staff in *'high risk'* situations. However, these measures focus on *'managing risk'* rather than reconsidering the balance between institutional and home-based service provision. Furthermore, they focus on immediate hazards rather than addressing the

conditions that elevate risks of hazard exposure. Finally, such measures can be difficult to monitor and regulate, leading to serious compliance issues. With some important exceptions, OHS issues for home-based workers are largely unaddressed. In the prevailing policy climate, governments have failed to give regulatory agencies either the resources or explicit mandate to meaningfully pursue these problems.

Unfortunately, the organisational intervention literature on OHS largely ignores homecare and home-based work. It mainly focuses on larger organisations or treats smaller firms as self-standing entities rather than as dependent subcontractors, which they are in many cases (Nytro *et al.* 2000; Saksvik *et al.* 2007). In any case, such small firms usually lack the time, resources or capacity to implement practices such as stress management. Further, as large organisations downsize and outsource, their capacity and eagerness to employ OHS professionals also declines, which has probably contributed to the declining numbers of practising OHS professionals (Davezies 1999; LaDou 2002). The contemporary development of self-employment and home-based work and the growth of subcontracting networks are not conducive to worker input into OHS, either through unions or through mechanisms in OHS legislation (Johnstone *et al.* 2005). This constraint highlights the dissonance between proposals for ever more sophisticated OHS interventions, on one hand, and on the other a more fractured labour market, increasingly characterised by complex subcontracting networks and atomized work locations, where even retaining past OHS standards is difficult.

Overall, governments have taken limited account of evidence of the adverse OHS effects of subcontracting, home-based work, and broader spillover effects and externalities associated with these work arrangements. This can be attributed, in part, to the dominance of neoliberal ideas in both national and global policy agendas. It can also be seen as a consequence of the weakening of organised labour and collective social movements. The transfer of work back into the home gives rise to OHS problems that are reminiscent of those encountered a century ago, even where those affected are professional workers, such as healthcare providers (Quinlan *et al.* 2001b). Homecare work is symptomatic of emerging workspaces that are invisible and often unregulated in terms of basic OHS standards. It can also be understood as part of a shift to a more fractured and atomistic labour market where OHS management systems and regulatory protections have little meaning.

3. Research Methods

Participants

In-depth interviews were conducted with 19 homecare contract workers to explore the key occupational health and safety issues they encountered. To capture some of the diversity between homecare workers in different regions of South Australia, two locations were chosen – Adelaide and the Barossa Region. A representative from the South Australian Office of the Employee Ombudsman recruited participants from three homecare agencies operating in two regions.

In Adelaide, nine contractors were interviewed across three broad categories of homecare work: emergency care for troubled youth (3), disability care, including autism (2), and personal aged care (4). Five females aged from 32 to 53 years and four males aged from 29 to 55 years were interviewed. The average age of the participants was 46 years. One participant declined to have the interview recorded. Consequently, the verbatim quotations reported from Adelaide were drawn from the eight respondents who permitted their interviews to be recorded.

In the Barossa Region, 10 contractors were interviewed across two categories of homecare work: personal aged care, including showering, cleaning, shopping and healthcare duties (6); and a combination of personal aged and disability care, including clients with Alzheimer's and dementia (3). One contractor's work consisted solely of domestic duties and no personal care. Eight females aged between 25 and 66

years and two males aged between 57 and 58 were interviewed. The average age of the participants in the Barossa Region was 53 years.

Interview Procedure

Separate convergent interview processes were conducted in Adelaide and the Barossa Region. Convergent interviewing is a structured process by which detailed, non-directive interviews are conducted and interpreted (Dick 1990). The process involves systematic interpretation of findings after each interview to enable the interviewers to refine research questions and interpretations across successive rounds of interviews. After initial planning, interviewers separately interview one respondent each and summarise and interpret responses. The interviewers then meet to compare notes, test and refine interpretations, and develop probe questions for later interviews. Initial interviews are almost completely non-directive, starting with broad questions imposing minimal constraints on responses. Later interviews begin with the same broad questions but become more focused when probes are used to explore and clarify issues identified in previous interviews.

Tentative interpretations from early interviews converge toward firmer interpretations during successive cycles of interviews. Convergence is achieved by discarding idiosyncratic material mentioned by a single interviewee and exploring issues raised by multiple interviewees. The final product is a list of issues on which there is substantial agreement (convergence) or disagreement (divergence) within the respondent group. Convergent interviewing is particularly suitable for exploratory research (Williams and Lewis 2005). The initial interview questions used in the present study are presented in Appendix 1.

4. FINDINGS

4.1 ADELAIDE

CONVERGENT THEMES

4.1.1 Risk assessments

Among homecare workers interviewed in Adelaide, a majority raised concerns about risk assessment. Many commented that their agencies did not undertake risk assessments prior to the commencement of a contract. Others reported that assessments were taking place but that agencies were failing to inform contractors of the results. The remaining respondents believed that assessments were their responsibility, rather than their agency's.

In general, despite the requirements of OHS regulations and legislation, the respondents reported that homecare agencies rarely carried out objective evaluations of OHS risks, or assessments of the probability of harm for contractors. Consequently, carers reported they were often exposed to volatile and dangerous work environments. As one respondent explained:

> *You can pick up the kid at any given time when they phone you… and they'll fail to give you some information which could be, you know – the child has sexualised behaviours, the child needs medication, the child this and that… And there's no risk assessment. It's, pick the ball up and run with it and hopefully you don't fall over.* (Adelaide, male #3)

In other cases, respondents considered themselves ill informed about the potential dangers posed by particular clients or the hazards involved in specific contracts, despite a risk assessment having been undertaken. Some respondents considered this to be a deliberate strategy on the part of the agency, ensuring the client received care but risking the safety of the carer:

Even if the child's really bad, they make sure they don't tell you. And then you go in there, they don't try to warn you at all. Because otherwise, in the end there's a few kids that they couldn't get workers to get in there. So they try to not let you know that sort of stuff. (Adelaide, female #1)

The other day I was rung from the agency around the corner for two jobs... and I knew that client because fifteen years ago he put me on WorkCover for three months and there was not even one word that that person had challenging behaviours, which I think is unfair. (Adelaide, male #1)

Finally, several respondents reported that the responsibility for performing risk assessments was often left to the contractor, particularly concerning assessments of OHS risks and hazards in the work environment. One respondent, who had been managing a halfway house, stated, *'I did risk assessments. Not Company X, me'* (Adelaide, female #4). Another respondent explained the usual procedure: *'What happens is we get handed the form. So we're not trained to assess risk we're just given the form… There's no on-hand contact by our agency'* (Adelaide, male #4). This respondent further suggested that such assessment was often irrelevant and self-defeating, as accurate evaluations could result in the loss of their contract and the termination of care provision for the client:

So they'll ring an agency, who will ring the worker, who goes in there. When they go in there, they're provided with a form to fill out to assess occupational health and safety… If you filled the form in effectively, you wouldn't get to go back there. They wouldn't let anybody in. (Adelaide, male #4)

4.1.2 Safety policies and procedures

Another area of OHS concern raised by many respondents concerned the agencies' safety policies and procedures. Some were concerned about a lack of policies and procedures. One homecare worker stated, *'That was my big thing when I was there, there's no policies or anything in place'* (Adelaide, female #4). Similarly, another revealed, *'There's not even procedures… How many of those houses have a cupboard that is locked that all sharp knives can be put in? Maybe two or three'* (Adelaide, male #3).

Most respondents, however, were aware of safety policies and procedures, but reported concern about their practicality. Many referred to various situations where agency policies were impractical, irrelevant or ineffective. One respondent explained that while *'all the policies look lovely and great and wonderful… basically most agencies don't give much… when it gets down to grassroots, to the actual hands on, do the job'* (Adelaide, male #1). Another respondent stated that her agency's policies *'didn't even really relate'* (Adelaide, female #2). Other respondents confirmed this view:

Well, their policy is – 'Don't make any decisions about anything. If you come across something that you don't understand, ring us and we'll tell you what to do.' I did that a couple of times and the answer to that – 'Well just don't, and get out of there.' But if I find something that's dangerous to me, it remains dangerous for the people who are living there. So from my point of view something needs to be done about it. (Adelaide, male #4)

They will actually tell you stuff that there's no way you can do it… Now they say to us we're not allowed to give the child our mobile phone number. Yet we're supposed to pick the kids up from everywhere. So in the end we give them our mobile phone numbers. There's so many things that they say... there's no way it would possibly work. It can't work. (Adelaide, female #1)

When you apply for the job, obviously they give you some guidelines… but what do they count for, given any heated situation? They don't count for a lot. You can try to continue negotiating with the child, which they want you to do, but if the kid is past negotiation? They say that you can remove yourself, you can go stand outside the hotel while the child destroys the hotel. (Adelaide, male #3)

4.1.3 OHS training

Convergence emerged regarding the adequacy, facilitation and quality of OHS training. Some respondents were concerned about a complete lack of training. Others objected to the expectation that OHS training must be organised by contractors themselves and undertaken at their own expense and in their own time. Finally, other respondents deemed the available training to be inadequate and irrelevant and objected to the fact that it was obligatory.

Several respondents raised concerns about the lack of OHS training. In some cases, contractors lacked the most basic training. As one respondent revealed, *'There are people that are working as a contractor that don't even have a basic First Aid Certificate'* (Adelaide, male #1). Considering the often precarious nature of homecare work, many respondents reported feelings of vulnerability due to their lack of training and being *'virtually just chucked… straight into the wild'* (Adelaide, male #2). The same contractor who works with autistic clients stated:

> *…like I said there was no training. Like I said my first job, I took the job and I just – I didn't know, that was a big shock to me when I'm driving, the first day I had him and I ran off road and he started screaming and spitting, and the steering while and I'm off the side of the road.* (Adelaide, male #2)

Other respondents who worked with troubled children told of similar precarious experiences, in which they felt unprepared due to a lack of training:

> *Some of these children, their needs are so high. They're the highest need kids in the state. Why are they in emergency care? Why aren't they in community residential care where there's qualified youth workers and qualified supervisors, and they have a much more structured therapeutic approach? Why are we looking after the high needs kids and how can we look after them? What training are we given? Do you have a clean police clearance check? A mandated notification course? A senior first aid? We'll give you one of these high, high needs kids with ADHD, ADD. What training do we have on that? None.* (Adelaide, male #3)

> *I found in ways we were put at risk… our safety was at risk as in we would be put in motel rooms with violent children that couldn't be placed in foster care and we had no training… Basically, they gave us no formal training.* (Adelaide, female #2)

Where training was made available to contractors, respondents reported dissatisfaction with having to complete the training in their own time and at their own expense. As one respondent stated, *'as an independent contractor you are responsible to do your own training'* (Adelaide, female #4). Another respondent explained this disincentive:

> *The thing is, they want you to do all this stuff. They want you to go out of your own time. You don't get paid for any of it… you only do the minimum because you've got to put yourself out, you've got to do it in your own time. You know, you've got to miss a day's work or you've got to do it on your day off. So it doesn't really make you want to do it does it?* (Adelaide, female #1)

Finally, several respondents questioned the quality of mandatory OHS training. One respondent suggested that agencies enforce only enough training *'to cover their liability'* (Adelaide, male #4). Another respondent revealed, *'They're starting to have a little bit more training... and most workers are supposed to do them. I don't know if that really helps. I did find I didn't learn anything when I went… it wasn't anything new'* (Adelaide, female #1). Objecting to this obligatory yet unhelpful training, most respondents affirmed that they gained knowledge and skills through doing the work:

> *When I was new at the job, and sort of not knowing quite what do you do and what not to do, and you've had all this training and you've got all these rules and regulations and acts and policies and procedures running through your head. And then you get out to the house and you think, 'Oh God, this is nothing what I've been taught.' Then I think you just learn to adapt.* (Adelaide, female #3)

I just learnt on the job… When it comes to the practical side of things I can do it, but when it comes to doing courses, I just can't relate to it. I mean, I just don't know how. What it says there just means nothing to me. So I didn't want to do it. But I'm the old way, you learn on the job, that's the way I do it. But the governments bringing these new laws in, well I just can't go ahead with it. (Adelaide, male #2)

4.1.4 Reporting to agencies

Most respondents affirmed that they would not hesitate to report OHS problems to their agency. For some contractors, such reporting was an integrated aspect of their work arrangement:

Well basically, we had to document everything that was done on the shifts with the child. So there were lots of things that were always, you know, everything was always documented, and then the social worker would come and you would show them the book. (Adelaide, female #2)

Another respondent explained that her motivation for reporting OHS problems was to ensure her own personal safety:

I'm very honest now. I think something is an issue I say, 'Well I'm not happy to use that' …I mean, I don't really care if I offend because I think that I have a right to feel safe when I go in to somebody else's home. (Adelaide, female #3)

In contrast, however, another respondent indicated that reporting OHS problems can have negative consequences for clients, including the termination of care service provision:

There's also a compulsion to do the work as opposed to report back to somebody that it's not safe to go there, because that would entail a whole extra range of things which would initially mean lack of service to the people that needed the service. There were two or three places that I were in which wouldn't have passed occupational health and safety requirements, but for the fact of somebody going in there and tidying them up to make them safe, which is more what I saw my role as being, rather than – I don't want to do this, I'll just report it to somebody else so I can give it the flick. (Adelaide, male #4)

4.1.5 Debriefing

Many respondents mentioned the importance of being able to talk to professionals within their agency about the more confronting aspects of their work. More importantly, many criticised the lack of provision for such debriefing by agencies. The significance of this lack of debriefing emerged as a clear convergent theme among respondents, irrespective of the type of homecare in which they worked.

Homecare work can involve exposure to stressful, threatening or traumatic incidents. Moreover, carers may experience difficulty coping with the emotional impact of such exposure, thus creating a need for debriefing. As one respondent relayed:

Recently, one of our employees walked in on a gentleman who had fallen asleep with a cigarette butt and his skin had literally melted to his mattress. Now that is something that someone needs to debrief about… I then had a contractor who walked in on a mental health client who had tried to gas herself… we debriefed with each other but there are no systems put in place. (Adelaide, female #4)

According to many respondents, one of the most challenging aspects of homecare work is managing work-related stress. However, it was apparent that many respondents felt isolated and emotionally unsupported by their agencies:

It's very, very hard to manage your stress in this work because of the nature of the work. Where's the support within your own company? The company never invites you to come in and sit down and discuss how it's affecting you personally. (Adelaide, male #3)

You work autonomously, which can be quite difficult because there is no support structure. (Adelaide, male #3)

One respondent explained that most contractors are disconnected from their agency: *'As a contractor, there would be many of them that have never been to the office, …they only fax those invoices in or post them… so they would have no contact'* (Adelaide, male #1). Another explained his failed attempt to build a working relationship with his agency to ensure opportunities for debriefing: *'Over the course of time I just stopped doing that because those people are too busy to do it and therefore not really very interested in doing it… I got short shrift from that from the agency that I was working for at the time'* (Adelaide, male #4). This respondent also mentioned his agency's rebuttal of his suggestion to appoint a supervisor who would be trained and available for debriefing purposes. A further respondent reinforced this sense of dismissal: *'We also didn't have anyone to debrief with… if you had a problem it was kind of like well, you believed you didn't really have anybody to talk to… Every time you rang up, the main person was very abrupt'* (Adelaide, female #2).

According to respondents, contractors have few options but to rely on themselves to cope with work-related stress:

I mean everybody has got to manage their own stress. I like to do some swimming. At times, I did like to go to the gym as well, talk to my wife, debrief. (Adelaide, male #3)

I debrief in really weird ways, but that's me and that's what gets me through it. (Adelaide, female #4)

I have other friends who work in this industry who we debrief – you have to, you have to find a way. (Adelaide, female #4)

4.1.6 Workers' compensation

Elements of both convergence and divergence emerged regarding respondents' awareness of their workers' compensation cover. The inconsistency related to differences in employment status. Half the respondents were dually employed as both employees and contractors by a single agency, while the other half were exclusively self-employed. Among the dual employment group, there was unanimous agreement that they only had workers' compensation while working as employees. However, a high degree of uncertainty about cover emerged among the exclusively self-employed. Each group was internally convergent, but divergent in relation to each other. What is significant in these findings is the apparent lack of workers' compensation cover for self-employed contractors, and the high degree of uncertainty regarding this lack among workers of this employment status.

All four respondents who had dual employment status reported, correctly, that they were *only* covered by workers' compensation as employees. As one explained, *'Undoubtedly, I was [covered] when I was an employee, but not when I was a contractor'* (Adelaide, male #4). Another respondent confirmed:

No workers' compensation whatsoever. If you hurt yourself, it's your responsibility. You need to have income insurance as a self-employed contractor, otherwise you get nothing… As an employee, there's workers comp. (Adelaide, female #4)

In contrast, uncertainty was reported among the majority of the four self-employed respondents. One was aware that self-employed contractors must provide their own workers' compensation. However, the remaining three respondents were unsure about whether they were covered by workers' compensation or not:

Well, I am assuming – actually that's a good point. I'm assuming that if I get injured at work that I should just ring my agency and that something would be done about it. So they must have some sort of insurance for us, some sort of Work Cover for us. (Adelaide, female #3)

Our insurance was covered and I'm just going to assume that was of a public liability nature. But I actually can't answer the - I'm not sure about the worker's compensation. (Adelaide, male #3)

I think I was. I think. I would have to check my contract. I'm not sure. (Adelaide, female #2)

DIVERGENT THEMES

4.1.7 Agency response to reports

When questioned about the quality of their agencies' response to reported OHS problems, respondents expressed divergent views that ranged from quite positive to extremely critical. Some respondents commended their agencies' capacity to resolve OHS issues. One respondent explained the process:

I think the agency must pass any complaints or any written reports or anything on to the case managers, then it goes from there. Quite often they will call you for a bit more feedback, and then they'll obviously talk to the families concerned, and hopefully something will change. Sometimes big changes, sometimes little changes… I'd say ninety-nine per cent of the time that there is a change for positive, you know, in the positive. (Adelaide, female #3)

In contrast, many respondents perceived agencies as disassociated from the concrete realities of homecare work and condemned their responses as bureaucratic and ineffectual. One respondent was so frustrated by this that he was reluctant to make reports in the first place:

I wouldn't even tell them… All that would do is ensure that I didn't get to go back there, while the system opened up. And it will go to somebody who would pass it to somebody else, who would pass it to somebody else, who would pass it to somebody else, who by the time somebody decided to do anything about it, which might be months, wouldn't understand enough of the story to get an answer from the situation in itself. And so that would be completely pointless to do that in my belief. (Adelaide, male #4)

Homecare agencies were also criticised for being *'huge money-making machines'* (Adelaide, male #3) that *'don't really seem to be interested in supporting their workers other than to meet the agencies requirement'* (Adelaide, male #4). The same contractor also suggested that the agencies were more concerned with their legal liability and possible insurance claims than the safety of their workers or the provision of care to their clients (Adelaide male #4). Another respondent discussed his agency's disregard for his complaints about fellow carers whose actions were endangering their clients' health and safety. He was highly critical of the agency's lack of response and attributed it to high profit margins associated with emergency care:

I know of carers that have taken older boys to buy marijuana and smoked it with the kids... have left children in the hotel and then gone to the pub… There was never anything done about it. There was never any action taken when workers should have been sacked - they were never sacked. The reason they were never sacked is because if the company sweeps it under the table. Then the contract stays with the company, the money stays with the company, and so on… (Adelaide, male #3)

Another respondent made similar criticisms of her agency, which ignored requests made on behalf of young female clients to receive care from female carers only. It was her opinion that the agency was more concerned with covering the shifts than attending to the needs of the clients:

If there were young girls, the social workers would request in their files no male carers. Company X... just wanted their shifts filled, and a lot of the times they would put men in when it was specified by the social worker not to have men in there. (Adelaide, female #2)

Finally, other respondents claimed that agencies made no response whatsoever to reported problems. As one respondent stated, *'They don't really do anything at all. Nothing, not one thing'* (Adelaide, female #1), and another concurred, *'You report it, you hope they've recorded it. Does it go any further? No'* (Adelaide, female #4)

4.1.8 Geographic placement

Divergent views emerged concerning satisfaction with methods employed by agencies to distribute contracts to carers. Apparently, agencies can match a carer to a contract according to a contractor's skills and qualifications as well as their geographic location. Respondents indicated a preference for contracts located near their place of residence.

Some respondents reported satisfaction that their agencies matched contracts with carers according to geographic location. As one respondent explained, *'ninety per cent of it is done through the area'* (Adelaide, female #4). Another concurred:

> *The agency tries to fit you in your area. So that if you live in the northeastern suburbs, they try to give you work that's in that area so that you're not travelling too far out of your way for work… So you're in the area that you know. (Adelaide, female #3)*

In contrast, other respondents criticised the inefficiency of their agency, which resulted in inconvenient work locations:

> *They were just so unorganised, as in they would give you clients over the other side of the city when you had a client that was right in your suburb, do you know what I mean? So you were travelling just to get the work.* (Adelaide, female #2)

Furthermore, methods of matching carers to clients were deemed impersonal and inept:

> *They're just matching a name to a name… Say, like, if they want somebody that knows autism and things like that, so people who have autism [skills]. But they don't know who those people are.* (Adelaide, male #2)

4.1.9 Regular working hours

Most respondents claimed to work regular hours within each of their contracts. However, it was apparent that circumstances could often result in the extension or reduction of working hours. Among the diverse situations that can increase the irregularity of working hours, respondents referred to the impact of seasonality, overtime time due to emotional bonds with clients, the illness of a client and organisational policies.

Referring to the seasonal nature of the work, one respondent explained, *'So if the nature of this industry goes up or down, my hours and everything goes up too'* (Adelaide, male #1). Another respondent discussed the impact of seasonality on the regularity of working hours:

> *You might not have work for two or three months. So you think, I might as well just do this because then there won't be much work. It sort of goes off and on… There's what they call 'the quiet times' and that's usually around like Christmas, January. And then it sort of starts picking up.* (Adelaide, female #1)

Several respondents mentioned the high frequency of unpaid overtime due to the emotional bonds that develop with clients and their need for extra support. According to these respondents, homecare workers often work *'outside the boundaries of the contract'* (Adelaide, female #3), performing duties that are not in their contract or spending extra time with certain clients who need extra care:

> *You don't always get in to a place at nine o'clock and walk out the door at 10:30 on an hour and a half job for instance. Because you potentially need to meet other needs than just what's written on*

the sheet in terms of what you're doing as a support work… You have to attend to the person's emotional needs as well… You quickly develop a bond and you might sit around talking for half an hour, which is to give the person time to express themselves, to help with the development of the relationship, to bleed off any strain and stress that they're feeling. But then you're still left to do the same job within a reduced time, and it's not always that that you don't get enough time to do it. (Adelaide, male #4)

...because the familiarity, the bond that grows. I mean, I like the clients that I work with too, otherwise I wouldn't work with them. Because there's no point going to work and not liking or enjoying the people that you're working with or for. But it does get difficult when you get asked to do things that possibly overstep the contractual arrangements and probably step outside of the boundaries of what would be expected in your job description from the office, and that happens a lot. (Adelaide, female #3)

One respondent, whose primary homecare work was *'social inclusion'* with autistic clients (taking clients on outings), explained that his hours can be reduced if his client is not well enough to go out. This respondent considered that he had regular working hours because he had regular clients, but he revealed that such instances result in a loss of income and thus add to irregularity:

And sometimes when you go there, you might get told that you can't have him today because he's sick. And I ring the company up and I only get an hour's pay... Yeah, so I feel, I don't know if it's right, but I feel if you've got a contract that says you're working five hours on a Monday or on a Friday and you get there and they say, 'Oh no, he's sick', I should be paid for that really. And they say, 'No, no, no - you only get paid just the one hour'. (Adelaide, male #2)

Finally, organisational policies can influence work regularity. One respondent commented on the impact of the non-negotiable management style of shift rosters:

But then a roster could get put in place where you're the weekend person and you do a forty-eight hour shift over the weekend whether you like it or not. And you cannot get hours during the week because if there is none, they will not give them to you. And they will not negotiate a shift, roster it, so that everybody does a few of the weekend and a few during the week. (Adelaide, male #3)

4.1.10 Control of working hours

Respondents were divided on the question of whether they had control over their work hours. In general, contractors who worked in emergency care with troubled youth reported perceptions of very little control over their working hours. In contrast, those who worked in aged care and disability care reported higher levels of control.

Many contractors who worked with troubled youth noted the importance of being viewed favourably by the children in their care to avoid complaints that could result in the loss of a contract. This precarious aspect of the work contributed to their perceptions of having little control over their working hours:

The children who are in the ward of the state can make that request... You're somebody keeping them from their family and telling them what to do. And depending on the age of the child – and these are pretty savvy, pretty street wise kids – they might just be of the opinion – 'I don't want this person telling me what to do'. [They] go back to the case worker and exaggerate or embellish and you're off the roster. (Adelaide, male #3)

Other aspects of youth work that diminished perceptions of control over working hours included the requirement to remain on-shift until the arrival of the subsequent care worker. As one respondent explained, *'If the next person doesn't turn up, you're there, bad luck. And it could be twenty hours, it can be longer. You can't leave. We're not allowed to leave until the next worker comes'* (Adelaide, female #1).

Respondents who claimed to have control over their working hours were predominantly working with elderly or disabled clients. Many related their perceptions of control to a lack of pressure to accept work opportunities:

> *No, there's no repercussions if you turn work back. I mean, you still get offered work. But then, I think the more work you take the more work you're likely to get.* (Adelaide, female #3)

> *They ring and offer you the hours. They don't say you have to do this. That's been my experience.... I haven't found that I've been harassed to take on work or that I've got so much work that I've got to knock it back.* (Adelaide, male #4)

4.1.11 Continuity in the industry

A final issue upon which respondents diverged was the question of whether they would continue working in the industry. Some respondents were adamant that they would stay in the industry: *'Yes, I'm working in the industry still'* (Adelaide, female #4). However, others were less certain about how much longer they planned to remain in the industry. As one respondent stated, *'I would like to [remain working in the industry]. I cannot say yes or cannot say no'* (Adelaide, male #1). Another explained that she would like to remain in the industry *'for some time, but I do plan to move on'* (Adelaide, female #2).

Conversely, several respondents resolutely stated that they were *not* planning to remain in the industry. One respondent cited health issues as the main reason for wanting to change occupations:

> *Well, as it happens now, I am on sick leave because of deteriorating health, which is peripheral neuropathy. A degenerative disease. I don't know whether or not my work has contributed to that. But if there were a couple of things in it that might have contributed it would be the exhaust from vacuum cleaners, which you're constantly exposed to, and cleaning products, primarily bleach… I am very unlikely to be going back in to the industry.* (Adelaide, male #4)

Another respondent had recently quit his job as a youth care worker, citing emotional exhaustion. However, he did mention that the rewards of having a positive influence upon the lives of children he had cared could provide motivation to continue in the industry:

> *Over the four years I can probably name six or seven kids that I know I've helped and that I've stayed in contact with and they've gone on to foster care or community residential care where they're still able to contact me… and ringing me up wanting me to go to their football games and stuff like that. That sort of thing would motivate you to continue in the work… [But] I can say to you after four years, even though having those experiences, I've recently quit working for the companies I've been working for because I've got no more to give in that capacity and that line of work.* (Adelaide, male #3)

4.2 Barossa Region

Convergent Themes

4.2.1 Emotional and mental stress

The majority of homecare workers interviewed in the Barossa Region reported experiencing high levels of emotional and mental stress. One female respondent stated, *'emotional distress is one of the most severe aspects'* of homecare work (Barossa Region, female #6) and another reflected that homecare work can be *'more mentally wearing than anything'* (Barossa Region, female #5).

Emotional and mental stress can be experienced in three main ways: in response to a client's situation, as *'emotional distress'* (Barossa Region, female #6); in response to a client's demands, as an *'emotional*

overload' (Barossa Region, female #1) or as *'mentally draining'* (Barossa Region, female #5); and as a result of the bond between carer and client, as *'emotional attachment'* (Barossa Region, female #1).

A client's situation can have an emotionally draining effect on the carer. The majority of homecare workers in the Barossa Region were working in aged care and many mentioned their client's helplessness, isolation and suffering:

> *I have often walked out with just tears streaming down my face because of the situation that some of these people are in: loneliness, sitting there listening to the clock tick, their pain, the amount of pain they have got. Yeah, all that does affect me for sure… I go away pretty heavily burdened some days.* (Barossa Region, female #1)

Clients' demands can also create an emotionally stressful and mentally draining work environment. One respondent described this aspect of homecare work: *'You are trying to clean a house and you have the client there talking to you, so you are trying to do two things at once. It is just not on'* (Barossa Region, female #5). Another explained that as a homecare worker, *'you are basically on call 24/7,'* a situation that can *'affect your stress level and be draining a bit mentally'* (Barossa Region, female #5).

The most significant cause of emotional stress for homecare workers is the bond that often develops between the carer and client. Many respondents commented on their close connection to their client, and sometimes also to their client's family. As one respondent explained, *'You become a part of their lives. I know we're not supposed to, but you can't help that'* (Barossa Region, female #8). Because of the inevitable familiarity created within such situations, bonds between carer and client can have implications for working hours and earnings:

> *You work longer hours, some of which you get paid for and some of which you don't, because you want to help out a bit. There's a fair bit of that goes on. I think that's one of the issues with contracting and getting clients that you've become friends with over the years – you probably get paid for three quarters of the hours that you actually work. The rest of it you just put in because they need it and you can provide it.* (Barossa Region, male #2)

More poignant implications of the carer-client bond can emerge when a client passes away:

> *It can be a bit of an emotional roller coaster ride for the carer. You can get attached to your clients, particularly those that are on their own and haven't got family and haven't got the family support. It takes a long time then to turn off. And they die.* (Barossa Region, female #7)

> *I think the biggest effect on me is emotional distress. You can become very close to your clients and a lot of them you'll deal with for years at a time and when they suddenly pass away, it's quite difficult. There's a lot of grieving to do and in my case last year, I lost seven clients in the one winter, which was quite heartbreaking.* (Barossa Region, female #6).

4.2.2 Bathroom design and safety

The design and safety of bathrooms emerged as a significant convergent theme. Many respondents commented on the poor design of bathrooms and the consequent safety implications for both themselves and their clients. As one respondent stated, *'I can honestly say that I have never seen a bathroom designed properly for anybody'* (Barossa Region, male #1).

Respondents mentioned a variety of safety hazards encountered in bathrooms. The danger of slippery surfaces was frequently reported:

> *Yourself and the client have got to fit in that bathroom and there's got to be room to manhandle them safely in and out the showers. You know, floors are a big issue… slippery floors.* (Barossa Region, female #6)

Other common complaints were the positioning of the hot and cold water taps, a lack of hand rails, poor

drainage and small sized bathrooms unable to accommodate wheelchairs and walkers. Below are a few selected quotations illustrating the OHS risks that can be attributed to poorly designed bathrooms:

> *Probably the most risky place to work in people's homes is usually the bathroom: slippery floors, dealing with unsteady clients, dealing with taps that aren't set up for people or shower heads that aren't set up for people with a disability.* (Barossa Region, female #3)

> *They have shower recesses, you know, with glass around them or curtains which is really, really silly if you're working with somebody with a disability or if you're working with someone in aged care. They really need to have an open – you know, where you can take them in a chair.* (Barossa Region, male #1)

> *The last bathroom I worked in actually needed another rail. It wasn't suitable the way the rail was.* (Barossa Region, female #2)

Even when improvements were made to a bathroom, not all hazards could be resolved:

> *…In the end they decided to put another floor in and some shower screens. While that was a good idea, there is still not a proper drainage system with the floor and the floor is still slippery, the only difference is the water is not going right out to the bathroom sink.* (Barossa Region, female #5)

4.2.3 Lack of benefits

One of the most significant issues raised was the lack of benefits within contract work arrangements. As one respondent claimed, *'As far as conditions go, there are no conditions. We have no holiday pay. We have no sick pay. We have no superannuation. We have no insurance. All those things we have to provide ourselves'* (Barossa Region, female #6). The agencies that coordinate homecare work deem the carers to be self-employed. As such, it is considered to be the responsibility of the individual carer to include holiday pay, sick pay, superannuation, insurance and tax within their proposed contract fee, and to then extract these amounts from their earnings. As one respondent stated, *'When holidays come in and you ask for holiday pay and things like that, they say, "No, you have to put that in your rate of pay when you state how much your contract will be" '*(Barossa Region, female #8). However, according to many respondents, the rate of pay and the way in which a contract rate is determined can create disenfranchisement and undermine the financial and employment situations of contract workers.

Firstly, many respondents reported dissatisfaction with their rate of pay. As one respondent stated, *'If you take all of our expenses out of our hourly rate, which is all it is, it sure ain't no contractors rate. We are working very, very cheaply… I just think a contractor should be getting a contractor's rate not an hourly rate'* (Barossa Region, female #1). Such a situation left many respondents in dire financial situations:

> *We need to be employed instead of, you know, left flapping in the wind to our own sort of designs. What happens to us when we reach retirement age? I'll have no super. I can't afford to pay super out of the wages I'm getting. I mean, I work six days a week now. So you know, how can I earn a living and pay all these things that we have to pay with what we're getting an hour? It's impossible. So we do without things like income protection insurance or health insurance or superannuation. We do without those things.* (Barossa Region, female #6)

Furthermore, what is truly vexing for these contractors is that they are seemingly in no position to address this apparent imbalance in their wages because of the agencies' control over contract rate negotiations based upon threats of job loss:

> *I do get told, 'You put your rate up too much, you won't get any work…'* (Barossa Region, female #1)

> *You can nominate any rate you want but if it's anything above what they're willing to pay, you won't get the contract. So as far as I can see, they're capping our wages.* (Barossa Region, female #6)

We can put our own rates in. I can say I want thirty dollars an hour. But that just means I'll do myself out of work because they're not going to pay that… So if you nominate a rate, they're more than likely to knock it back and make you take their preferred rate. (Barossa Region, male #1)

So they actually control your wages, even though you're the contractor. (Barossa Region, female #8)

Respondents reported that these limitations on earnings had further negative implications. Firstly, many contract workers could not afford to contribute into a superannuation scheme. Consequently, many will retire with no superannuation, a situation that has further social and economic consequences. Secondly, because there is no provision of sick pay, many carers work while unwell, thereby potentially exposing elderly clients to illness. These issues are highlighted in the following response:

The biggest issues I've got are insurance, tax, holiday pay, superannuation, all of those things, which as a contractor you have to look after yourself, and I'm sure a lot of contractors get in strife over it because they don't. So a lot won't have superannuation; a lot are taking unpaid leave when they have leave. There's a chance that if you're sick you still roll up to work because you need the money, which is crazy, particularly when you're dealing with a lot of people that are low down on the health scale. You know, they're not healthy people in general, but if you've got a bit of a cold and you're not getting paid, the chances are you'll turn up for work. So it's those sort of issues, there's no cover, there's no advice on it. It's all left up to you and good luck. I just find it to be really difficult. That sort of stuff is the hardest part of all. (Barossa Region, male #2)

4.2.4 OHS training

Concerns about the facilitation of OHS training emerged as a significant convergent theme. It was apparent that the homecare agencies had strict requirements regarding training and the updating of qualifications. As one respondent explained, *'If we don't go to training, we lose clients. We do have to keep up with that. It's a bit of a "have to" '* (Barossa Region, female #1). Despite this requirement, many respondents revealed that their agencies provide a limited amount of OHS training:

I've done an external course on manual handling myself but it's just something you have to find in the community. Sometimes there's agencies that come up and they'll do a St John course or they'll do a manual handling course but they're far and few between. (Barossa Region, female #6)

Probably the two major ones that I work with don't, because they don't provide any training at all, because you're a contractor. The training isn't a necessary part of their payment to you. (Barossa Region, male #2)

We have to provide our own training. We have to find our own… They give us the information, of course, which is in their policies but apart from that I believe that we're expected to find our own training. (Barossa Region, male #1)

They have manual handling once a year… and first aid but it is our responsibility to contact the training organisation. (Barossa Region, female #5)

Most respondents reported dissatisfaction with the agencies' requirement for updated qualifications and the lack of training provision. Specifically, respondents objected to the lack of funding for their training and the need to complete it in their own time, thereby forgoing opportunities to earn income:

Unfortunately, a lot of those things are in our working time, so we have to toss up what we do – go without the money that we could be earning now and go to the OH&S or do we just not do the OH&S? …At times, I have missed them purely because I thought I just can't have half a day or a day away from my clients. (Barossa Region, female #1)

And any training or anything that we have to do is all taken up in our own costs… You've got to find the time to go along. (Barossa Region, female #6)

Many respondents commented that, despite the lack of training provided by agencies, they had gained adequate OHS knowledge through their studies at TAFE, including manual handling, first aid and medication: *'We're all supposed to have done Certificate III which is a TAFE course, aged care, and that brings in occupational health and safety'* (Barossa Region, female #7). Consequently, some respondents felt the necessary updates of qualifications to be superfluous:

> *I did all of that with my Certificate III. Upgradings, I find it a bit odd to try and upgrade the skills that you're using every day, you know. If you're using your skills everyday, why would you have to go and do a course to see if you're using your skills, if you know what I mean? It seems a bit sort of around the mulberry bush to me… why do I have to leave my work to go and do a course on what I'm doing already? (Barossa Region, female #7)*

4.2.5 Safety policies and provision of agency guidelines

Most respondents were aware of the existence of their agencies' safety guidelines and policies:

> *I mean we're given their policies and procedures at the start.* (Barossa Region, female #3)

> *They give you an information pack and let you know what the hazards are and if there's any problems.* (Barossa Region, female #6)

> *We get a folder when we first start. We get a folder with a lot of that in.* (Barossa Region, female #7)

However, there did not appear to be much emphasis placed on these guidelines by the agencies. As one respondent commented, *'They have not really been made available, or I have not really had it, say, pushed in my face'* (Barossa Region, female #5). Another concurred, *'They've never been made clear to me what they are, whether there are any standards or anything'* (Barossa Region, male #2).

4.2.6 Transport costs

The issue of transport costs was a source of frustration for the majority of respondents. The principal objection was to the lack of reimbursement for fuel expenses, despite the need to travel lengthy distances to service clients. Many respondents recognised the benefit of being able to claim a portion of their travel expenditures as a tax deduction. However, it was also recognised that while tradesman and service providers are compensated per kilometre, compensation for homecare providers is capped at five thousand kilometres per year:

> *We can claim five thousand kilometres per vehicle per year… I travel at least fifteen to sixteen thousand kilometres a year and I logbook my mileage… That's it. The other ten thousand kilometres I'm paying for. It's costing me money to go to work… I can't understand why we can't be reimbursed for every kilometre that we do. If I was a tradesman and I was working in the country… or a delivery van, they're able to claim every mile they do. Why can't we? I just find that astounding. Why can't we claim for the mileage that we do?* (Barossa Region, female #6)

Several respondents reported travelling more than five thousand kilometres a year. For example, one respondent claimed, *'I did thirty-seven thousand kilometres last year and I did something like forty-six thousand the year before'* (Barossa Region, male #1). Furthermore, several reported that they should be reimbursed for car maintenance and upkeep:

> *Well, wear and tear on the car, I suppose. Tyres, registration, everything that goes with it, insurance. Everything that goes with a motor vehicle I would cover myself.* (Barossa Region, male #1)

> *And of course you're using your car to transport clients – you must make sure your car is serviced. Mine's probably the most well serviced car on the road in Adelaide… and you have to take time off*

to do that so it doesn't happen for you overnight, you know. Yeah, there's a lot. (Barossa Region, female #8)

The devaluation of your car – I mean, you're carrying groceries and putting wheelchairs in the back and walkers. You're chipping paint, you're denting this, you know, your cars get wrecked within, I don't know, twelve months of working and that's an extra added cost. (Barossa Region, female #6)

4.2.7 Hospitalisation of clients

The majority of respondents were carers for elderly clients and the hospitalisation of clients was a common occurrence. Many commented on the range of problems that can arise when clients are hospitalised, including a loss of income, a disruption of regular hours, and the difficulties of taking on new contracts during the hospitalisation or respite period.

Many respondents reported the precariousness of their income due to the constant possibility of clients being hospitalised:

Our biggest problem is, I believe, when you have a client that falls ill or needs to be put in respite or is hospitalised or anything like that, you immediately have lost your income. (Barossa Region, female #6)

If you have one or two clients go to hospital or go to respite, they just drop dramatically, so there goes your income as well. (Barossa Region, female #1)

And of course, if your client goes off into hospital, well, you've lost that client so, yeah. There's nothing – you know, you work, you get paid for the work that you do and that's it. (Barossa Region, female #7)

The unanticipated hospitalisation of clients could also result in disruption of regular hours with a negative impact on a contract worker's income: *'You may have planned doing Mrs Green, Mrs Black and she's not there, so you've got an hour and a half to two hours to kill… and there's no compensation whatsoever'* (Barossa Region, female #8).

Finally, the precariousness of income and irregularity of hours due to the possibility of hospitalisation is compounded by the insecurity of the contracts themselves.

Your contract can be terminated at any time for whatever reason... Quite often you're dealing with people with health issues, that they're going to be in and out of hospital and the expectation of the carer is that you will keep providing that service when they return from hospital, not matter how long they've been in hospital. (Barossa Region, female #3)

According to some respondents, agencies can be supportive and proactive in terms of finding additional contracts during the period of hospitalisation. As one respondent claimed, *'I must say, Company X are very good and if they thought that [the hospitalisation period] was going to go on, they do try and give you some smaller contracts'* (Barossa Region, female #3). However, another respondent maintained that taking on more contracts during this time was not always practical, as a contractor must return to their original clients once they have recovered:

There's no way of replacing [a client] until a case manager will give you another contract. If your client has gone into hospital for say two weeks, you can't fill that spot because you're still contracted to that contract and you have to wait until either the person passes away or gets better and comes home or whatever. (Barossa Region, female #6)

Moreover, as another respondent observed, these situations are determined by funding arrangements between agencies and government departments, which further determine the possibility of the supplementation of lost income:

You see, they have to wait for the packages to come up. They've got to wait for the government to release the money to fulfil more packages. When a client goes into hospital, I think they stay on the package but there is a time limit. Like, that package is held open; I don't know whether it's six weeks or something like that. The package is held open for a certain amount of time before, I guess, it's all got to be reviewed. (Barossa Region, female #7)

It seems evident that the contractor needs to have a flexible working relationship with the agency if they are to meet these challenges successfully.

DIVERGENT THEMES

4.2.8 Control of working hours

Respondents revealed divergent opinions on the issue of control of working hours. Several reported perceptions of complete control over their hours of work and their capacity to choose their contracts:

I work the hours that I please, the hours that I want. Sometimes I might do an eighty hour week and sometimes I might only do a twenty-five hour week. But no, I don't do anything to put my own safety or health at risk there… I can request more hours, whether I get them or not is another thing, but I can control the hours I do. (Barossa Region, male #1)

We don't have to accept a contract. They'll ring and say, you know, I've got a client coming up that needs X, Y and Z on certain days, do you want it. No, I don't want that one, thank you. But then, you might get another one that looks okay and suits you and you think… I'll give that one a try. (Barossa Region, female #7)

In contrast, other respondents felt they had no control over their working hours. The main reason for this perceived lack of control was a prevalence of split-shift work. Many contractors were working short shifts throughout the day with long unpaid travel times between each shift:

I might have two or three clients in the morning and there won't be anything until maybe late afternoon. So you're hanging around until you can get to your next lot of work and then you've got your evening work. So you're doing splits shifts all the time… And for me, it works for me because I live in close proximity of where I work. But if I was not living in the town, those breaks in between clients, what do you do? Where do you go, you know? There's no worksite to go to, to, you know, do other work or fill in those hours. A lot of people are sitting on the side of the road waiting to go to the next client. (Barossa Region, female #6)

In addition to the high incidence of unpaid hours of travel and waiting times between contracts, a further negative consequence of split-shifts was an increase in driving hours and night driving:

We've got a couple of girls at the moment are travelling ten to fifteen kilometres at ten o'clock at night on dirt roads in the country to put clients to bed… Where else in the world, or where else in Australia, are you employed for one hour or half an hour? The hours are scattered over a twenty-four hour period and it can take – if I'm starting work at eight o'clock in the morning and I'm not finishing until half past seven, eight o'clock at night, I may still only have five hours of work during that day. But it's taken me all day to do it. (Barossa Region, female #6)

4.2.9 Contact with other carers

Respondents gave varying responses to the question regarding opportunities for debriefing when they were experiencing difficulties in their work. Three respondents claimed that they had the option of debriefing with other carers that were working for the same agency. One agency facilitated contact between carers, indicating a recognition that carers need an opportunity to talk about their work: *'One agency actually offered to put me in contact with some other carers if I was interested to talk to. So that*

was good' (Barossa Region, female #4). Another respondent discussed a telephone network of carers: *'I know the girls and I know I can ring them and they know they can ring me'* (Barossa Region, female #7). Finally, another agency actively encouraged contractors to maintain a support network of carers to help alleviate stress created in the workplace:

> *Yeah, they're fine with it. They even suggested that... we actually get together and form some sort of a, what would you call it, a carers alliance or a support workers alliance, you know, so that we get together and support each other and talk about issues.* (Barossa Region, male #1)

However, such activity was not always encouraged by the agencies. One respondent claimed that the agency actively discouraged contact between carers; this respondent was concerned about the lack of opportunity for debriefing:

> *And they don't really want anyone to talk to anybody, but you can't control people's speech, but that's what they try to do. Because we're not supposed to talk to another carer about the same client that we both look after.* (Barossa Region, female #2)

Similarly, another respondent stated, *'I wouldn't want to be seen talking to another carer while I'm shopping… we almost hide behind the Corn Flakes if you want to talk'* (Barossa Region, female #1). According to this respondent, confidentiality and privacy laws inhibit contractors from discussing clients; contractors are instructed not to *'discuss one of our clients with another carer, even one that shares the care of that client'* (Barossa Region, female #1). This situation was frustrating for the respondent, who expressed her need for debriefing opportunities: *'I would love to go to a fellow carer and say to them I'm finding this, this, this, this and this about Mrs so and so. How are you managing?'* (Barossa Region, female #1). A final respondent reported reluctance towards expressing their need for debriefing for fear of being labelled *'incompetent'* and thereby risking job loss:

> *I would like someone to debrief with but I am a bit scared to go to an agency and debrief, as they might think, 'Oh this lady cannot cope'. I do not know if they would or not – 'Oh this lady cannot cope. I will take her away from that client' or whatever. I do not want to be out of a job.* (Barossa Region, female #5)

4.2.10 Regular working hours

Two categories of working hours were identified: respondents worked either regular hours, or *mostly* regular hours with occasional extra work. Regular hours are advantageous for contractors because they know when and for how long they will be working. The clients of these contractors also benefit, as they know exactly how often and when to expect their carer:

> *I do have regular hours. I do have – particularly for personal care – you're providing a regular consistent service for your clients. That's important. It's important for them to know that they're going to be able to do their shopping or get their medication for their partner or whatever. So that's important to be able to provide that.* (Barossa Region, female #3)

> *Set hours, so the client knows every week. That's the way I work. I don't know how other carers work, but I have set times with my clients that suit them each week.* (Barossa Region, female #4)

> *Most weeks I'm doing the same. So I regularly work on a Monday, Wednesday, Friday, alternative Saturdays and Sundays are sort of set. I work those. I know they're coming.* (Barossa Region, male #2)

Respondents in the second category expected to work regular hours, but often experienced variations in their hours. As previously mentioned, the hospitalisation of clients increases the likelihood of irregular work hours. For example, one respondent stated that hours should be regular, *'but they're not, because for a start you will get somebody who is either going into respite or going into hospital'* (Barossa Region, female #8). Another variation that affects regular work hours is working the occasional weekend shift:

It's more likely that [my hours will] be very similar week to week. But occasionally I might do a whole weekend or a part of a weekend or stay overnight somewhere for a few nights. (Barossa Region, male #1)

And I do a lot of fill-ins and whatever… It changes all over the place. (Barossa Region, female #5)

Finally, one respondent made the distinction between having regular working days and having to perform the work during hours that were not necessarily ideal:

Though we can choose when we work and when we don't work, the hours of work aren't to our choosing, if that makes any sense. You've got to go where the work is. (Barossa Region, female #6)

4.2.11 Reporting to agencies and their response

A divergence of opinions emerged regarding the propensity for carers to report OHS concerns to their agency and the quality of agencies' responses to such reports. Most respondents claimed that they would not hesitate to report OHS concerns to their agency, and many commended their agency's responses to such reports. However, other respondents revealed reluctance to report OHS concerns and some criticised the quality of their agency's response.

The majority of respondents indicated that they would not hesitate to report OHS concerns to their agency:

If I have any issues with anything that I don't think is safe or the client would be in danger, I've got no problems of reporting it to the office... As far as I'm concerned, that's part of my job... If you have any concerns, I believe it's up to you to go and let them know because if you don't let them know, they're not going to know. I'm a big believer in letting people know. (Barossa Region, female #6)

If an issue like that came up, yes, I would go straight to the agency and speak to them. (Barossa Region, female #1)

Further, many respondents commented positively about their agency's response to their reports. For example, one stated, *'They're very thorough on the, I suppose, client safety and contractor's safety as well. If it's a serious matter [the agency will respond] almost straight away. Yes, I think they're pretty good on that, the company I work for'* (Barossa Region, female #6).

In contrast, some respondents revealed reluctance to report problems or concerns to their agency. In some cases, this reluctance was due to a fear of job loss:

Sometimes they're a bit harsh, not always easy to talk to and you sometimes feel like if you make a complaint, well, they won't give you any contracts. (Barossa Region, female #8)

I think a lot of women won't broach the subject for fear of losing contract or you know, rocking the boat. (Barossa Region, female #6)

In other cases, it was implied that reporting OHS concerns to agencies only creates difficulties for clients, which can ultimately result in a loss of care. As such, carers are disinclined to report problems and agencies are disinclined to respond:

They're pretty low key about it I must say… They'd back you okay, but I don't think they'd be coming in to interfere too much... If they did, they'd have to strip the house of everything that's in it... So if they moved in and tried to change that to suit the contractor, [the client would] either drop out of the service or go and find somebody else. So it's all pretty low key… Yes, they were turning a blind eye basically. It's better off for them not to carry it too far, because, again, you end up making value judgments on lifestyles. Is that your role? Really, people are screaming out just to get a bit of respite. (Barossa Region, male #2)

Respondents who were critical of agency responses to OHS concerns mentioned several issues, including ignoring reports and being too far removed from the situation of care to know how to respond properly:

> *Often you will make complaint but nothing will be done about it.* (Barossa Region, female #8)
>
> *Well I think they'd sweep it under the carpet.* (Barossa Region, female #2)
>
> *You see, they're in the office and they're not there. That I think is a big problem. The people in the office are the people who are making all the decisions and choices for our elderly but they're not there. They don't see how it is. They don't know what it's really like. When they come in to do an interview, the client is dressed and ready and waiting and on their best behaviour. We see them at their worst behaviour…* (Barossa Region, female #5)

4.2.12 Physical strain

Among respondents who mentioned a negative impact of physical strain on their health, the majority complained of back and shoulder pain. Many respondents reported that activities such as cleaning, manoeuvring walkers in and out of cars and in small confined spaces placed strain on their backs and shoulders:

> *Yes, your shoulders. You notice it definitely in your shoulders. Stretching and the way you have to move yourself around. Not everybody's bathroom is compatible to walkers and wheelchairs and you just have to be very careful.* (Barossa Region, female #7)
>
> *Backs are a big problem. It's just the general wear and tear of your body of constantly getting in and out the car. I think there was one day I counted forty-eight times I got in and out the car, and that can be a real strain on your lower back.* (Barossa Region, female #6)
>
> *But I find that if I do the domestic work for all three of them, it can affect my back. It is quite a strenuous to clean all three in one day.* (Barossa Region, female #4)

Other respondents did not consider their work to be physically demanding. For example, one stated, *'So I guess from the physical safety it is not too bad, except for being on the go all day. I suppose physically it is just more being on the go all day'* (Barossa Region, female #5). Upon considering the impact of homecare work on his health, another respondent stated, *'Physically, no, not physically demanding at all'* (Barossa Region, male #1). Finally, another respondent observed that homecare work is more tiring than physically straining: *'I guess I am now at the end of my - being sixty-two… I find that the handling of the clients is just getting a bit too much'* (Barossa Region, female #1).

4.2.13 Risk assessment

The majority of respondents believed that risk assessments were undertaken by agencies prior to the commencement or their contract. However, it was apparent that in some cases the information from the assessments was not made available to contractors: *'Well, the case manager might have done the risk assessment or any hazard alerts, but as a contractor, I never got to see that'* (Barossa Region, female #4). In other cases, it was apparent that the risk assessment focussed on the clients care needs rather than OHS risks: *'Not so much the occupational health and safety side of things, just the meeting and knowing the expectation of what they want done and how they want things done'* (Barossa Region, female #3). According to one respondent, a contractor can sometimes be responsible for the risk assessment:

> *With one [agency] that I worked for, they would send me forms every month and I would have to check every bit of equipment that that client was using and then assess myself whether there was anything that needed to be fixed on it.* (Barossa Region, female #1)

Another contractor considered that agencies often avoided risk assessments, as they were loath to create difficulties for the client, which could result in a loss of care for that client and a loss of the contract for the agency:

I think they get the idea that if they did it would cause too many problems, so they just turn a blind eye to it to let it go… the family would just get so upset with it. If you came in and said, look, you have to clean this house out and you have to provide a bedroom for the contractor that comes here and it has to be of this standard and you have to do this, that and the other, it'd be too hard. The family would just say no, we'll get on without it, thanks. So they don't. (Barossa Region, male #2)

5. Conclusions

Several convergent issues from our interviews raise significant concerns regarding OHS management and policy. Convergences identified in the Adelaide interviews include reports of failure by agencies to carry out risk assessment prior to placement, failures to inform homecare workers of hazards, absent or inadequate OHS policies and procedures, absent or inadequate OHS training, and uncertainty about workers' compensation entitlements. In the Barossa Region, convergence emerged regarding concerns about the lack of employment benefits (such as holiday pay and sick leave), inadequacy and poor provision of OHS training, and the poor implementation of OHS policies.

Failings with regard to risk assessment, hazard identification and the implementation of policy and procedures to manage risk are not unusual. Various reviews of OHS management in Australia affirm this view (Quinlan *et al.* 2010). Consequently, there is no reason to doubt the information provided by our respondents in this regard (although further research is required to clarify the extent and nature of these problems before they can be addressed). Indeed, the responses of homecare workers give serious cause for concern on several grounds.

First, failure to undertake adequate risk assessment and hazard identification, and to implement effective policies and procedures, would constitute a clear breach of OHS legislation in South Australia (under the general duty provisions and associated regulations) or any other Australian jurisdiction. As Johnstone and Quinlan (2008) have observed, recent court decisions make it clear that employers are required to take a proactive and systematic approach to managing hazards in their workplaces whether they are homes, factories or shops.

Second, there are grounds for treating any failings in procedures with regard to homecare as particularly important because these workers are sent to locations that lack the oversight and direct supervision of the employer or principal contractor, and they work in isolation in a location that is not a purpose-built workplace. In these circumstances, risk assessment, the development and implementation of risk management protocols, and other OHS procedures are the primary means of safeguarding the health and wellbeing of these workers.

Third, where homecare workers are engaged via an employment agency, OHS management and the assumption of legislative responsibilities are more complex, as there are now two duty-holders in addition to the worker, and they are potentially attenuated. As research and the experience of regulators demonstrate (Johnstone and Quinlan 2006; Quinlan *et al.* 2009), OHS management and the enforcement of laws is often more problematic in labour-hire situations.

Finally, where homecare workers are self-employed, they lack access to industrial conditions that may assist in managing their health and wellbeing, such as sick leave and workers' compensation, or a union to represent their interests. The specific issue of workers' compensation emerged as convergent in the Adelaide interviews, and the broader factor of the lack of benefits was a point of convergence in the Barossa interviews.

In sum, several convergences in the interviews raise important policy and practical issues for government, those outsourcing homecare services, the agencies contracting for the provision of these services, and the workers actually providing the services.

Beyond broad areas of convergence, there were also areas of divergence regarding working hours, agency responses to the reporting of OHS problems, and the demands of particular types of work (in terms of emotional stress, isolation and the risk of experiencing occupational violence). Interviews revealed differences in the background, training and qualifications of homecare workers. There were also differences in the responses of the Adelaide and Barossa respondents. It is not clear to what extent these differences reflect regional labour market or social variations; other differences, such as variation in the types of tasks undertaken; or differences in the practices of particular employment agencies or outsourcing organisations. Nonetheless, the interviews still identified something of the diversity of homecare tasks and the different approaches of employment agencies and outsourcing organisations. As noted in our review of previous research (Quinlan and Bohle 2008), studies of homecare have been generally limited to a few activities, particularly healthcare. There is an urgent need to better understand regional, task-related and organisational differences so that policy and interventions can be devised and targeted effectively.

Without ignoring areas of divergence, worker responses in this study are mainly consistent with the findings of international research into homecare work, as discussed in the first section of this report. They are also consistent with earlier government reports in Australia and recent research in the activities of OHS inspectorates. For example, in 2001 WorkCover NSW commissioned a report into the challenges posed by changed work arrangements (including homecare) that was based on analysis of documents, statistics and interviews with regulatory officials in every state of Australia, including South Australia (Quinlan 2002). The report was a response to concerns amongst regulators about the problems posed by subcontracting, labour hire, temporary work and home-based work, including homecare. It identified significant deficiencies in legislative, inspectorate and workers' compensation responses to changing work arrangements. Consistent with our findings, the WorkCover NSW report found that risk assessment and hazard management in homecare was often poor (including a failure to implement workplace entry protocols), and that effective access to workers' compensation was especially problematic in the case of self-employed workers (even where they were formally covered by statutory provisions). The report identified serious policy issues and suggested ways of addressing these. Amongst other things (and most relevant to homecare), the report recommended:

- Systematic research on the OHS and regulation of homecare (NB. In Canada, federal government reports have been prepared on home-based work and women).
- That government OHS agencies should develop both generic and sector specific codes of practice and guidance material for agencies and homecare workers.
- That government OHS and workers' compensation agencies should undertake compliance audits and targeted enforcement campaigns in relation to the homecare industry.
- That the resourcing of government OHS agencies be considered, to ensure it is adequate to undertake these tasks without compromising other activities.
- That relevant government agencies should incorporate recognition of homecare into media campaigns, or should undertake a specific media campaign on homecare.
- Measures should be undertaken to ensure that accredited OHS trainers have knowledge in the area of homecare.
- Workers' compensation authorities should re-examine coverage and deeming provisions with a view to expanding and clarifying cover with regard to 'disguised' employees.
- Workers' compensation authorities should examine ways to compel those engaging homecare workers to provide workers' compensation entitlements.

- Worker's compensation authorities or the Employee Ombudsman Office should research claims behaviour and injury reporting to identify and target information to vulnerable groups, such as itinerant home-based workers.
- Workers' compensation authorities should increase compliance audits and penalties in conjunction with current data mining to detect evasion or understatement of insurance premiums.
- A study should be undertaken on return-to-work and appropriate supports for injured homecare workers. As inducements are unlikely to be enough, given the competitive nature of the industry and small operators, consideration should be given to mandatory obligations for the host to provide employment while labour hire firms pay the costs.

In more recent research undertaken with four Australian OHS inspectorates, significant problems in relation to both agency work and homecare have been identified (Quinlan *et al.* 2009). The inspectorates' responses often mirrored problems identified by homecare workers interviewed in this study. For example, a Victorian inspector responsible for the health industry noted that the onus for induction was often placed on the labour hire workers themselves:

> *I'm having problems to do with the labour hire people sometimes in the health industry. A lot of them employ their own community agency workers, who I mean even before labour hire they had their own thing… They've got pretty full inductions and they've got other training that they've got to do, and if they don't do it within a month, they don't get any work. They don't get paid and they won't get any work. So there's an incentive there to do whatever training they've got to do beyond the basic induction so this might deal with occupational violence, it might deal with lifting and manual handling issues.*

Poor induction and risk assessment was raised by other inspectors, including a regional inspector in Western Australia who pointed to poor levels of compliance with the legislation. Inspectors pointed to efforts to address labour hire within their industry team as well as actions being taken at legislative level. For example, an inspector covering the service sector stated:

> *In the service team, we've done a fair bit of work in labour hire in raising awareness of their obligations to train people, follow up and inspect the workplace where they're going and require those people they'll be working for to induct them and that sort of thing. It's probably an expanding area. There's more and more of it out there, as well as a workforce and a lot of the people that get injured are labour-hire people. What we're doing about it, when we do have a labour-hire person injured in a workplace, the service team is following up on labour-hire issues so we've now got regulations that require due reporting sort of thing. They're pretty new. We've got new regs that came in in January and another lot in March, I think, putting in a lot more duties of care towards labour hire, shared fishing and those sorts of areas.*

Another inspector identified a problem regarding local government bodies managing their contractors and volunteers, including those providing homecare. This inspector referred to a specific case of a country-based council: *'They've been really, really good in their inductions and things. The only area that they seem to neglect is volunteers or contractors'*. The same inspector referred to more general problems with homecare, including the outsourcing of these activities to private providers, but noted the value of the inspectorate's neighbourhood visit strategy in this regard, and how he had worked through the problem with some success:

> *The only thing that I've seen and really identified is working in homecare, because you've got the risk of occupational violence, but there are other issues from time to time with referral services… And the neighbourhood visits that we're doing is picking up things that the city council [has been amazed at]. So they didn't have a procedure for dealing with violence in the workplace. They wanted to put a [report] in place for contacting, they were going to contact the family of the person*

involved with this report. And they said, 'Well we need a bit of advice,' and I said, 'Well yes, do the report, contact the family, but you also need to contact the individuals in the referring agency with a copy of the report and you've got to commence to say what the [short-term] is.' Because they get the same work benefits as if they're sick… The thing is it will take a little bit more organising with the other employees that are longer-term. But again, it's got to be very reasonable for the agency to be aware because they're the person who is at risk if they don't comply with the law.

6. Recommendations

The following recommendations stem from the above review of the relevant research literature on homecare and agency work plus the findings of the research conducted for this report:

1. Homecare is a growing area of employment. However, its OHS implications are poorly understood and the interviews undertaken for this report identified many OHS issues warranting deeper investigation. In this study, there was convergence on some issues and divergence on others. Unfortunately, even for those issues on which there was strong convergence, the size of this study means that the results may not necessarily be representative and important issues may have been missed. More research is required to validate the present findings and to explore issues further. It is recommended that a larger and more systematic study of homecare work in South Australia should be undertaken.

2. Based on the findings of this report, the recommended follow-up research should systematically identify and investigate the relevant OHS issues, as follows:

   - Selected interviews should be conducted with the management of employment agencies providing homecare workers, and with government regulators responsible for homecare (SafeWork SA, WorkCover SA and industrial relations). These interviews would explore management and policy issues and solutions, and identify issues for further investigation in the survey study to follow.
   - Based on the findings of this report and the selected interviews above, a representative survey should be conducted to investigate the OHS experiences of at least 600 homecare workers, stratified by gender and employment status (employees, self-employed). It should have the following design elements:
     - Sampling for at least three different types of homecare activity (e.g. aged care, troubled youth, disability services).
     - Sampling across three regions of South Australia to take account of regional influences (for example, greater Adelaide, the Barossa and the Clare Valley, and McLaren Vale and Victor Harbour).
     - Sampling from multiple, and representative, employment agencies.
     - Inclusion, if possible, of a comparison group of homecare workers engaged directly rather than via an agency.
     - Two rounds of data collection over two years to measure the consistency of effects and the impact of changes in employment.
     - Follow up interviews with selected homecare workers who participated in the survey and agree to interviews. These interviews would be used to further explore issues not resolved from the survey data.

3. The attractiveness of seeking Australian Research Council Linkage Grant funding for this new research program should be considered. The Linkage scheme has several advantages. If funded, it ensures that

the research meets high international standards of rigor; it encourages the engagement of eminent researchers; it ensures that the majority of the research costs will be met by the ARC and participating universities; and it provides an opportunity for active input from regulators, other government and statutory bodies, employers and employer associations, workers and trade unions.

4. As noted in the report and previous published research, homecare work presents a significant challenge to policy makers and regulators. The research described above would make a significant contribution to better informed and more effective interventions. At the same time, there is scope for research on policy development in this area. For example, do the more generic *'outworker'* provisions in South Australia (Rawling 2007) provide a mechanism for dealing with those homecare arrangements deemed to be particularly problematic on the basis of research carried out under Recommendations 1) and 2).

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8. APPENDICES

APPENDIX I: INTERVIEW SCHEDULE

1. Please briefly describe the work you do in homecare?
2. How does your homecare work affect your health?
3. How does your homecare work affect your safety?

    Probe: Please describe any hazards you experience.

4. Do you think your working hours affect your health and safety?

    Probe1: Do your hours vary from week to week?

    Probe 2: How much control do you have over your hours?

5. How does the homecare agency deal with health and safety issues?

    Probe 1: Does the agency provide sufficient OHS training?

    Probe 2: Does the agency do a risk assessment (assess hazards) before you start work in each home?

    Probe 3: Does the agency have guidelines or rules about dealing with hazards in homes?

6. Have you done the same type of work outside of homecare? If 'yes', were there any differences in terms of health and safety?
7. Have you done the same type of work but not through an agency? If 'yes', were there any differences in terms of health and safety?
8. Is there something important to you that we haven't spoken about that you would like covered?
9. Do you mind if I ask your date of birth? ___________________________
10. Do you mind if I ask if you have children, and if so, how many? _________________
11. Are you currently self-employed or an employee?

    (Interviewer should tick [✓] one box only)

    self-employed ☐ employee ☐

12. How are you paid?

    wage ☐ contract rate ☐ service fee ☐ other ☐ __________________specify

13. Are you covered by workers' compensation?

    Yes ☐ Who provides it? _______________________________

    No ☐

14. The interviewer will note the gender of the respondent: Female_______ Male________

APPENDIX 2: ADELAIDE INTERVIEW PROBES

1. Are you aware of the health and safety inspector for your industry?
2. Would you go to the inspector if you had a problem?
3. Do you report problems or OHS incidents to the agency?
4. Does the agency report on OHS incidents to the relevant government department?
5. Do you have an opportunity to debrief or discuss work with a colleague or anyone else?
6. Do you have concerns about the health and safety of those in your care?
7. Do you plan to stay in the industry?
8. Does your agency match carers to clients in terms of geographic location?

APPENDIX 3: BAROSSA REGION INTERVIEW PROBES

1. How does your work affect you emotionally?
2. How physically demanding is your job?
3. How important is the design of the bathroom?
4. How important is it to have benefits?
5. Who covers your travel expenses?
6. How do pets affect your health and safety?
7. How does your agency view you having contact with other carers?
8. How approachable is your agency?