The caring self within a context of increasing rationalisation: The enduring importance of clients for home care aides

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The Enduring Importance of Clients for Home Care Aides

Abstract

The current political economy imposes cost-saving rationalisation within home care work. In this context, a key question is whether home care aides act with indifference to clients or whether home care aides continue to espouse and act out of the caring self, which centres on the desire to give meaningful care to clients. This paper assesses the thesis of the caring self within a context of rationalisation in relation to home care aides in three organisations. The paper brings qualitative and quantitative research to bear on this question. It finds that despite the processes of rationalisation occurring in home care work, home care aides' overall satisfaction with client relations, and their ability to satisfy clients continue to have significant links to their job satisfaction, and discretionary effort. This offers support for the thesis of the caring self within the context of rationalisation.

Key words: Care; clients; discretionary effort; home care; home care aides; rationalisation

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This paper focuses on an increasingly important topic within the sociology of work – the triadic relations between workers, clients and employers (Lopez, 2010). It examines triadic relations in home care work, which is defined as care and support work undertaken in clients' houses outside of that undertaken by medically trained staff The paper asks whether home care aides (HCAs) in a context of heightened rationalisation act with indifference to clients or whether they espouse and act out of a 'caring self', in which there is a desire to give meaningful care to clients. We bring qualitative and quantitative data from research in three organisations to bear upon the research question.

Triadic Relations: Home Care Work, Rationalisation, and the Caring Self

A key focus within the development of the sociology of work is upon the triadic relations between workers, service-recipients (henceforward, clients) and employers (Lopez, 2010). The initial terms of engagement for sociology of work involved an assumption that the social relations of work were primarily patterned by the dyadic relations between workers and employers. However, since Hochschild's (1983) path-breaking work on emotional labour, it is clear that a richer and more nuanced picture of the social relations of client-facing work necessitates an understanding of the relations between workers, clients and employers. We update one of the great dyadic-centred debates within the sociology of work by embedding it within the triad of relations.

One of the great theses in the social sciences concerns the effect of processes of rationalisation. The most famous thesis is that of Weber who wrote that those who inhabit iron cages of rationality come to lose something of their humanity; they come to be

'specialists without spirit, sensualists without heart' (Weber, 1958: 182). This idea was a central driving idea in Bauman's (1989) argument that the de-humanising element of rationalisation was a necessary part of the processes of the Holocaust. Transferring this idea across to contemporary health care, a key issue becomes whether those in occupations most subject to rationalisation come to act with indifference to clients.

The extent and impact of rationalisation are central issues of concern for scholars studying the social organisation of both the general context of client-facing service work and the specific context of health care work. Regarding service work, one strand of literature argues that the organisation of work is becoming highly rationalised. Most notable here is Ritzer's (1993) McDonalidization thesis which posits that the rationalising principles inherent in the organisation of work at McDonald's (Leidner, 1993) are being applied across the service sector. Another strand of literature, however, points to some significant factors which can limit the rationalisation of client-facing service jobs. The concept of the customer-oriented bureaucracy (Korczynski, 2002) argues that the organisation of service jobs are underpinned not only by the logic of rationalisation but also by a logic of customer-orientation, in which the attempt to offer an enchanting myth of sovereignty to customers limits rationalisation.

Regarding health care, Cohen (2011), echoing Ritzer, points to processes of rationalisation affecting the organisation of client-facing occupations. We can point to two major sources of rationalisation in the current political economy. First, there is rationalisation relating to cost-cutting pressures further to the introduction and/or heightening of market pressures. Increased rationalisation in this context relates to the imperative to deliver equivalent care with fewer resources. The introduction of compulsory competitive tendering is a key policy here (Christensen and Laegreid, 2001). This refers to the process whereby the government

mandates that the delivery of a particular service traditionally undertaken by a public sector organisation is put out to a bidding process in which both private sector providers and the existing public sector provider compete to win the contract. Provided by the local government sector, home care services have been one of the key areas where the reforms of compulsory competitive tendering have been implemented (Ungerson, 2000; Milligan, 2009). As such, this form of rationalisation related to market-driven pressures for increased efficiency is likely to be at is most intense for HCAs, compared to other health care occupations.

The second major source of rationalisation in health care relates to standardisation. Timmermans and Berg (2003) point to the standardization of work processes through the development of clinical practice guidelines, and note that such guidelines have 'boomed' in the UK (2003: 7). They conclude that the increased use of clinical guidelines does not simply lead to standardized labour processes for health care professions. The key form of standardization applied to HCAs is not that related to clinical practice guidelines because HCAs are outside of this remit. Rather, the key form of standardization relates to the development of the increasingly detailed care plan document which specifies the form of care work that is to be delivered to each individual client. Bolton and Wibberley's recent research (2014) suggests that the care plan outlining exact actions and processes to be undertaken for each client by HCAs has become central to the organisation of home care work. Sinclair et al.'s (2000:2) research found that 'tasks are timed and specified very tightly'. Further, it may be that without the status, expertise or autonomy of health care professionals higher up in the occupational tier, HCAs are an occupation with the least resources to be able to withstand the standardization of the labour process. In terms of the dual meanings of care (Fine, 2007), the work of HCAs may be moving from caring *about* to functional caring *for*. Notably, previous

research on care-home work has shown how sizeable sections of the workforce can come to act with indifference to patients if the logic of rationalisation comes to dominate the workplace (Foner, 1995).

If the increasing rationalisation applied to home care work is one side of the debate – suggesting potential indifference from HCAs to clients - the other side of the debate is provided by Stacey's (2011) concept of the 'caring self' of HCAs. Previous research has indicated that HCAs have acted out of an ethic of care, sometimes spending extra time with clients and have even paid out of pocket for client expenses (Aronson and Neysmith, 2006; Cranford and Miller, 2013). Ungerson's (2000) analysis adds a twist here. She acknowledges the rationalising pressures impacting the organisation of home care work, but she suggests that this is partly mitigated by the way in which management de facto informally promote the delivery of extra client-oriented care by home care workers, with home care workers effectively positioned to work 'beyond contract' (p.630). If Brown et al. (2013) are correct to talk of a 'crisis of care' (p.69) in the UK, Ungerson is suggesting that HCAs are positioned to cover up the cracks of this crisis. Stacey has developed this pattern of client-oriented care into the idea of the caring self. Stacey's ethnographic research of home care work in the USA showed that HCAs tend to define themselves in terms of the 'caring self'. Here, caring means emotional caring for a client as an embodied person. By creating the sense of the caring self, aides are able to find dignity and meaning in their work. Stacey's thesis clearly suggests that HCAs will potentially give both care about and care for clients, potentially going beyond the formal structures of the work, engaging in the sort of 'pro-social rule breaking' (Morrison, 2006, Karlsson, 2011) that has been noted in other health care occupations. Stacey's thesis also rests well with Lopez's (2006) outline of a form of

‘organised emotional care' which is not dominated by rationalisation. Below we derive related hypotheses further to our development of Stacey’s thesis.

The Caring Self within a Context of Rationalisation: Related Hypotheses

As well as giving qualitative data into rationalisation and the caring self among HCAs, we also test out hypotheses that are logically linked to the caring self thesis. We focus upon the effect of two independent variables – workers’ overall satisfaction with client relations, and workers’ ability to satisfy clients. Workers’ satisfaction with client relations allows us to access the ‘big picture’ of the impact of the texture of worker-client relations upon outcomes. Assessing the impact of workers’ ability to satisfy clients upon outcomes allows us an insight into whether it matters to HCAs whether their work is able to help clients appropriately.

The study examines the effect of these two independent variables upon three important outcomes – job satisfaction, organisational commitment and discretionary effort. Job satisfaction is a key outcome for workers; organizational commitment is an important outcome for management; and discretionary effort is an important outcome for clients in that it pertains to the degree to which the worker will undertake tasks for the client beyond the minimum necessary effort. Further, the variable of discretionary effort is important for it highlights that because of the itinerant and dispersed nature of HCAs’ labour, there may still be important spaces remaining for some discretion from the HCAs within their labour process – not least because cost pressures mean that supervision levels tend to be low (England and Dyck, 2011) .

We develop Stacey's caring self thesis in two ways. First, it is notable that Stacey's data, relating as they do to 'identity talk' among HCAs, exist at the level of the espoused. Our focus is not only on whether HCAs espouse the caring self; we also seek data to assess whether this informs work behavior. These aims inform our combination of qualitative and quantitative methods, as discussed below. Second, we develop the caring self thesis by proposing a thesis of *the caring self in the context of rationalisation.* This thesis acknowledges the strong rationalising forces structuring the HCAs' labour, and argues that despite these forces, the ethic of the caring self will continue to play a key role within their labour. This approach can also be connected to a wider body of theorizing about the nature of resistance. Hodson (1995) has argued that a given form of control tends to give rise to a distinctive form of resistance as a reaction. So, for instance, the form of resistance that tends to emerge in response to rationalised control tends to be centered on workers defending their autonomy. Developing this idea within a triad of relations, we suggest that health care workers faced by increasingly rationalised forms of control, enact a *client-oriented defense of autonomy*. Here, bureaucratic control is met not simply by a general defence of autonomy but by a specifically client-oriented defence of autonomy. This may mean that workers defy management's rationalised prescription by working harder, so that clients receive meaningful care.

We hypothesize the following set of relationships between satisfaction with client relations, and the 3 dependent variables. If the thesis of the caring self within a context of rationalisation pertains, HCAs' job satisfaction will be influenced by the texture of client relations. Further, it may be that HCAs may attribute some of the credit for positive client relations to their employing organization, and thus it may be that satisfaction with client relations influences organizational commitment. Finally, the thesis suggests that HCAs'

propensity to deliver discretionary effort, for the benefit of clients, is likely to be positively influenced by the texture of client relations.

H1a *Satisfaction with client relations is positively associated with job satisfaction.*

H1b *Satisfaction with client relations is positively associated with organisational commitment.*

H1c *Satisfaction with client relations is positively associated with discretionary effort.*

For the second independent variable, ability to satisfy clients, we hypothesize the following relationships. From the thesis of the caring self we can derive the implication that HCAs' job satisfaction is influenced by their ability to satisfy clients. With regard to organizational commitment, we hypothesize that HCAs give credit to organisations that help them to satisfy clients. In other words, HCAs' ability to satisfy clients should affect organizational commitment. The final hypothesis, hypothesis H2c, involves the postulation of an inverse relationship between variables: that the ability to satisfy clients has a *negative* association with discretionary effort. The reasoning here is that HCAs will extend extra effort when they perceive that clients are not being satisfied.

H2a *Ability to satisfy clients is positively associated with job satisfaction.*

H2b *Ability to satisfy clients is positively associated with organisational commitment.*

H2c *Ability to satisfy clients is positively associated with discretionary effort.*

Research Methods

Quantitative research was complemented by qualitative case study research to give triangulation and complementarity (Bryman, 2008). Regarding our aim of seeking data beyond the level of espousal: interview methods are well-suited to accessing data at the level of the espoused, while quantitative methods can assess whether the espoused goes beyond the level of rhetoric, as they examine relationships between variables without the respondents being aware that the caring self thesis is being assessed. It was not possible to negotiate access to clients. We acknowledge this as a limitation of the research. Our focus on worker-client relations relies, therefore, upon our (quantitative and qualitative) questions to workers about their relations with clients.

Research Sites and HCAs

Research was undertaken in three Local Government Social Services Home Care departments in the UK. The organisations were chosen because they were seen as leading players in the process of the rationalisation of home care services because each had recently adopted a form of monitoring and scheduling technology. The tracking was provided in Organisations A and B by a company hosting voice and data services that track care workers' activities and performance in real time and then feed the data into the scheduling and monitoring system. Organisation C was piloting a handheld personal digital organizer/mobile telephony device. In practice, for the home care workers, this technology meant that their delivery of care to clients was tightly scheduled into activities to be carried out in 15-minute segments or less. The order in which they visited their clients was prescribed as was the actual route to be taken between clients, and this determined the traveling time allowed for in the overall

schedule. Home care workers had to follow this schedule and use telecommunications to report that they had commenced their shift, that they were traveling to/had arrived at a client's address, and when they departed. A specific focus on this technology is given in Brown and Korczynski (2010). Each organisation faced the key environmental context of the central government targets for local governments that the 'in house' care services provided should match or be lower than the unit cost obtained by competitive tender from the private sector.

Organisation A was a department within a large local government council in North England serving an industrial city and several industrial/ mining and ex-mining towns employing 600 internal Home Care staff. Organisation B was a department within a medium sized local government council based in South East England serving several market towns and rural communities employing approximately 300 internal home care staff. Organisation C was a department within a medium sized local government council based in the North of England serving several industrial/mining and ex-mining towns and employed approximately 300 internal home care staff.

Quantitative Methods and HCA Profile

A self-administered questionnaire was distributed to 520 employees out of a population of 922 across three organizations. In the case of Organisation A and B a random sample was taken. At Organisation C, the survey was limited to a team involved in piloting the monitoring technology, which, while only small (22), was drawn from a wide number of teams and locations which management claimed represented a randomly selected, representative group of employees. 266 usable questionnaires were finally returned, giving a response rate of 51 per cent. The response rate at Organisation A was 57%, at Organisation

B, it was 40%, and at Organisation C it was 68%. Checks were made to assess the demographic profile of the respondents against the population profile provided by the three organizations. The respondents were overwhelmingly female (99 per cent), middle-aged (72 per cent were aged 40-59), and with few educational qualifications (75 per cent of respondents had school qualifications to the level of a16 year-old or less). 95 per cent of respondents were on part-time, permanent contracts. The majority (79%) of respondents worked between 15 and 30 hours a week. The mean number of hours worked was 22.2. The majority (55%) of respondents had been working for their present employer for more than 10 years, and only 16% of respondents had worked for their present employer for less than 2 years, indicating a stable workforce reluctant or unable to change careers. Table 1 gives more detail on the length of service across the organisations.

TABLE 1 HERE

Job satisfaction was measured with a single-item question derived from Camman et al. (1983). Organizational commitment was measured with a 3-item question, derived from Cully et al. (1998): 'Do you agree or disagree with the following: I share many of the values of my organisation; I feel loyal to my organisation' I am proud to tell people whom I work for'. Cronbach's Alpha, an internal reliability statistic, was 0.78. Discretionary effort was assessed through a 3-item measure derived from Bailey (1993). Cronbach's Alpha was 0.75. The two key independent variables used in the analysis were ability to satisfy customers and satisfaction with customer relations. Ability to satisfy clients was assessed with a 3-item measure derived from Frenkel et al. (1999): 'How often do you feel that: you can satisfy clients' requirements; you are confident about your ability to satisfy clients; you are making clients happy'. Cronbach's Alpha was 0.77. Satisfaction with client relations was measured

using the single-item question: 'how satisfied are you with relations with clients'. In addition, the following control variables were included in the regression analysis: satisfaction with job influence, satisfaction with pay, full/part time status, age, educational qualifications, gender, time in service, and variables for organisations. All measures of substantive variables used a 5 point Likert scale.

Qualitative Methods

Semi-structured interviews were conducted with 18 manageres/supervisors and 30 HCAs. Details are given in table 2.

TABLE 2 HERE

All managers and supervisors were interviewed individually. Due to time and resource constraints within the organisations, it was necessary however to conduct some group or paired interviews for home care workers as follows: Organisation A - of the 12 HCAs interviewed, 8 were interviewed in a group, 2 as a pair, and 2 individually; Organisation B - of the 6 HCAs interviewed, 2 were interviewed as a pair and 4 individually; Organisation C – all 12 HCAs interviewed were interviewed as pairs. The use of a group of 8 HCAs in Organisation A came about for practical access reasons. For a range of reasons, group interviews can deliver different data, compared to individual interviews. Therefore, we compared the pattern of findings between the two types of interview. We found no clear differences in the data. In addition, some qualitative data was derived from two open survey questions/spaces in which respondents were given the opportunity to write in their own answers/comments.

Qualitative Findings

The data presented in this section are organised as follows. First, we outline qualitative data showing that management were under intense pressure to increase efficiency. Then we present data showing first that HCAs experienced a growing sense of frustration that this increasing rationalisation marginalised the caring-about aspect of their work - and then that HCAs continued to espouse a sense of the caring self despite these forces.

The interview data from both managers and HCAs indicate that there were strong pressures to increase the efficiency of home care services in response to the market pressures related to competitive tendering. Management at Organisation A were aware that the tendering process would lead to a considerable fall in the amount of in-house services provided by the council:

> - You've got to understand market forces; and there's a huge pressure…We have a duty to, where we contract, we get the best price for care. …The next 3 years we've built in some factors on what we're actually going to be purchasing in our care from the independent sector (A – M1 [this indicates organisation A, and manager 1]).

The organisation, therefore, was actively seeking to develop 'more efficient way of working'. For instance, the prime aim of the development of the new home care monitoring technology was to 'help us to reduce the cost.' The efficiency drives had already included a process of some staff having to re-apply for their own jobs. Another manager put it starkly that, 'this is a make or break situation for the in-house service' (A – M2). A manager at Organisation A outlined the imperative of focussing on lowering the unit cost of their service delivery:

- I mean 2 years ago the in-house Home Care service had about 90% to 95% of the Home Care market within the district. Now we have 50% and that obviously brings quite right comparisons between us and other organisations, and for various reasons we have a higher unit cost. (A- M3)

This meant that 'we're trying to get more juice from our lemon'. A manager at Organisation C (C- M1) echoed this approach: 'it's about being more efficient and effective at what we're doing and how we are doing it.'

This drive for greater efficiency further to market pressures was being experienced in a negative way by many HCAs. The following comment from a HCA was typical of this strong theme within the qualitative data:

- I love my job but really feel that the time limitations are reflecting on the more important aspect of caring. (B – HCA5)

Many HCAs believed that rationalising for cost-savings was directly impinging their ability to offer meaningful care:

- Money is more important than people. (A – HCA10)
- The onus nowadays is on profit and not providing good care. (A – HCA12)

One HCA gave an indication of what increased time pressures meant in practice:

- You have 15 minutes for a client and you still have to do that client and your paperwork, and then ring out. Sometimes, you have to rush through in that timescale. (B – HCA2)

Fifteen minute visits to clients had been a recent introduction – previously, visits lasted thirty minutes. Another consequence of the greater emphasis on efficiency was that it was less common for an HCA to have a roster that allowed a continued relationship to develop with a client. One HCA (C – HCA5) noted that this 'makes it more impersonal… Clients need to

keep to carers they are used to… they won't feel comfortable with people they don't know'. The newly introduced monitoring technology (discussed in more detail in Brown and Korczynski [2010]) was being used by management to increase efficiency in time-use of HCAs, and it was perceived by many HCAs as creating a barrier to care:

> - Often clients will want to tell you things but you are tied to time and you can't sit and listen. It's frustrating – that machine (monitor), you watch the timer and you are saying, come on, I want to get on. (C – HCA9)

HCAs expressed a declining morale as their work was subject to cost-cutting changes which worked against them being able to deliver satisfying care to clients:

> - I have always enjoyed my job, until the last year or so. Now we are seeing many changes and I don't feel our clients are being considered. It's all about cost cutting. (A – HCA9)
>
> - All governments are bothered about is making a profit and not giving enough care for the elderly… the elderly always draw the short straw. (A – HCA8)

Another HCA stated with regret that, 'it's more like a business now' (C – HCA9).

That it was management and the organisation that was being blamed for problems in workers' ability to satisfy client was supported in descriptive statistics from a survey question. As a follow-on to the questions which examined workers' ability to satisfy clients, respondents were asked to respond to a series of options of what lay behind the inability to satisfy clients. By far the most popular option was the one that attributed blame to 'the way the work is organized (e.g. shorter duration of care etc.)'. This option was chosen by 84 percent of respondents.

The other major source of rationalisation discussed in the literature, the development of the formalised care plan document and the related national care standards tended not to be singled out as a significant element by HCAs. Only one HCA noted national care standards as a significant factor:

- We think it's getting less and less a caring job, some of the clients you knew very well and now you just get less attached to them. Just different things they keep altering. More rules and regulation because of national care standards. (C – HCA5)

However, some HCAs did allude to the restrictions and conflicts they perceived that segmented care plans together with monitoring technology placed on them with regard to the time spent in the client's home:

- Don't you trust us being at the client's house and being there a certain length of time? Then they want to know where you were every minute of the day. Big Brother watching you. (B – HCA2)

This pattern in the data may be explained by the relatively lax approach by some managers and supervisors who did not seek to impose a tight reading (and monitoring) of the care plan document upon HCAs. Here we are differentiating the monitoring of the time and place of the HCAs via the new technology - which was seen as having element of 'Big Brother' as noted in the previous quote – and the monitory of the HCAs undertaking detailed aspects of the care plan - which was experienced as less stringent. A manager at Organisation C spoke in detail about this:

- We have some managers who go out and they do service plans for each service user … But if we were to put it down to tasks I think then you're taking away that empowerment from the carer. You're more making things

more rigid as well. You will go in and you will put the kettle on and you will make her breakfast in this ten minutes. Then get her washed and dressed. Well we can't do that because it's all down to what the service user wants at the end of the day… everybody is different….. It's all down to the knowledge and experience of the carer. (C – M2)

There had been a greater formalisation of care standards and plans in the organisation, as another manager noted:

- We have published a staff handbook for the first time around care standards, which actually takes them through their responsibilities. It shows you how the process works end to end. (C – M3)

However, this was not taken down towards a form of Taylorized timing and monitoring at the task level:

- We have specifically chosen not to go down to task level… If you're saying you've got another five minutes to get to another house, then you know five minutes to make the breakfast and five minutes to do you know, so at ten past eight you've got them out of bed and dressed them by quarter past and they get breakfast. It just don't happen like that.

A senior manager at Organisation C, however, showed that there were differences within management on this issue:

- My view is that there needs to be a considerable amount of management control, at the end of the day we are offering a service to people who are vulnerable and need that care and first class we need to ensure that that happens and…, we need to ensure that discipline and control. (C – M4)

Broadly, the differences within management related to the seniority of their position, with the more senior managers tending to have a vision of tighter control than that held by managers at lower levels.

The qualitative data showed that a strong majority of HCAs continued to espouse a sense of the caring self. One HCA expressed this in striking terms:

> - We do get terminal patients as well who have come to pass away at home, which is a really nice part of the job, as much as that sounds awful - giving them their last wish to be at home really does make the job worthwhile. We stay with them until they die which might be 2 weeks or 10 weeks. (C – HCA11)

This is a clear statement that what makes the job worthwhile is the relationship that can be formed with clients, even where the clients are close to death. The majority of respondents noted that it was common for HCAs to perform duties for clients which were beyond the formal prescribed duties contained in clients' care-plan. One HCA (B – HCA6) noted that formally this could lead to an official reprimand: 'we do little extras for the client and we do it but we could get told off for that now.' Another (C – HCA7) noted that 'there is a lot of home carers who do more than they put down for' – in other words, they performed tasks beyond those documented. HCAs were more likely to perform discretionary effort for clients when they were able to carve meaningful, caring relationships with them. One HCA put it thus: 'you think – "why should I bother?" - but you do because you care'(C – HCA8). This same HCA articulated that caring was at the heart of her understanding of the job: 'you are told not to get involved, it's a job; but it's not like that, it's caring'. Another HCA (9) from Organisation C laid out a key motivation for the caring self. She argued it was crucial to be able to know 'what it's like to be 84 years old and have no one or that need just a little help that gives them quality of life'. For her, central to the caring self is the ability to empathise

with those in positions of vulnerability and to be able to consider how the quality of their lives can be improved.

While this was the dominant pattern in the findings, it was not the universal pattern. In a quote given above, we heard an HCS state that 'you get less attached to them [the clients]'. A small minority of HCAs indicated that they preferred to keep to the formal policies rather than give 'extra' care. One HCA stated that: 'in general, we stick for the instructions and then if anything goes wrong and we have stuck to the book then there is no blame on us whatsoever' (B – HCA5). Here the bureaucratic logic has become dominant, manifest in the emphasis on formal policies and the bureaucratic protection that adhering to such policies can create.

The idea of most HCAs enacting a client-oriented defense of autonomy found some support within the qualitative research. One HCA directly connected the desire for autonomous decision-making and giving meaningful care to the clients:

- Part of our job is to support the client and talk. I know my clients and I know what they need. (B – HCA3)

Here is a clear statement of autonomous decision-making – the emphasis is that is the HCA, and not a manager, who knows the clients and what they need, and it is also statement that caring for clients - 'to support the client' – is central to the job. This relationship was manifest in how workers reacted to processes of rationalisation which they perceived as hindering client satisfaction, by continuing the delivery of meaningful care, even if this meant increasing their effort. This came out in a number of the interviews from across the organizations:

- I would not rush someone for the sake of 10 minutes if I think something takes longer I will take it. (B – HCA6)

This same HCA noted that although there were formal policies limiting the ability to care, the practical enforcement of these policies were not always strict because the people in the key position of enforcement – the supervisors – often also shared an understanding of the caring self:

- Yes, I guess we have got quite a bit of power… because of our supervisors have been carers. (B – HCA6)

Some managers also recognized that HCAs' commitment to meaningful care for clients meant that they gave effort above that which was required. A manager stated that:

- They deliver [care] despite management. They deliver it in the very informal basis due to the good will of the actual staff on the front line you know and it just happens. (C – M1)

Quantitative Findings

To assess the hypotheses, three sets of regression analysis were run, first with job satisfaction, second with organizational commitment, and third, with discretionary effort as the dependent variable. Table 3 gives the findings of these regression analyses.

TABLE 3 HERE

With regard to the hypotheses 1a-c, the findings show that the workers' satisfaction with client relations had a significant positive relationship with job satisfaction, no significant relationship with organisational commitment and a significant positive relationship with

discretionary effort. Therefore, there was support for hypotheses 1a and 1c, but no support for hypothesis 1b.

With regard to hypotheses 2a-c, the findings show that workers' perceptions of their ability to satisfy customers had a significant positive relationship with job satisfaction, a significant positive relationship with organisational commitment, and a significant negative rleationship with discretionary effort. Therefore, there was suport for hypotheses, 2a, 2b, and 2c.

Of the control variables, satisfaction with job influence was positively and significantly related to job satisfaction and to organisational commitment; satisfaction with pay was positively and significantly related to job satisfaction; and the variable for site 2 was negatively and significantly related to discretionary effort. There were no other significant relationship between the control variables and the three dependent variables. Note that the lack of any statistical significance for the length of tenure variable indicates no support for the idea that the caring self is influenced by an existence of different stages of socialisation into the job, such as would exist within cadres of HCAs as 'idealistic novices' and 'disillusioned veterans'.

Overall, these findings give strong support for hypotheses related to the thesis of the caring self within the context of rationalisation. Despite the processes of rationalisation to which their work roles had been subject, as outlined in the qualitative data, client relations and the ability to satisfy clients still mattered to HCAs. These elements influenced their job satisfaction, their organisational commitment, and their discretionary effort. The only hypothesis which was not supported, hypothesis 1b, was that concerning the relationship between satisfaction with client relations and organisational commitment. HCAs did not give

credit or discredit to the organisation for the quality of client relations. Arguably, this hypothesis is the one that is most distant from the central caring self thesis. Support for hypotheses 1c and 2c, in which discretionary effort is the dependent variable, is particularly notable. The regression analysis showed that although neither satisfaction with pay, nor satisfaction with job influence had a significant relationship with discretionary effort, both satisfaction with client relations and workers' perceived ability to satisfy clients had strong signficant relationships. Further, support for hypothesis 2c is noteworthy as this shows that as HCAs find it more difficult to satisfy clients, then they are more inclined to undertake discretionary effort, i.e. undertake tasks beyond those stipulated in the documented care plan.

Discussion

The combined qualitative and quantitative findings give support for the thesis of the caring self within the context of increasing rationalisation. The qualitative findings outlined that the policy of competitive tendering was feeding directly into a management emphasis on increasing the efficiency in the delivery of home care services. Although care plans were becoming more formalized, management did not use them to try to standardize the labour process at the level of the task. HCAs experienced the drive for efficiency in an overwhelmingly negative way, primarily because they sensed that it was pushing out the time for caring about. In the interviews, most stated that they continued to act out of a sense of a caring self, by delivering meaningful care to clients even if this went against what management wanted them to do. The quantitative findings showed that their relations with clients and their ability to satisfy clients mattered to HCAs. Both of these variables had a significant effect on the job satisfaction of HCAs, and their delivery of discretionary effort.

In addition, the ability to satisfy clients had a significant relationship with organizational commitment. The qualitative and quantitative findings offered support for the idea of home care workers enacting a client-oriented defense of autonomy in response to increasing rationalisation imposed by management. The qualitative data showed that management was rationalising by acting to increase efficiency, and that HCAs contined to try to deliver more meaningful care to clients than was stipulated by management. The quantitative findings showed that the harder it was for HCAs to satisfy clients, the more they delivered discretionary effort to clients.

The qualitative data triangulated the findings from the quantitative data in that the pattern of the quantitative findings tended to be replicated within the qualitative findings. The qualitative data offered complementarity by pointing to the contextual processes underpinning the observed relationships within the quantitative data. Specifically, the qualitative data highlighted the tension at the heart of the HCAs' labour process – a tension between an ethic of care, linked to the caring self, and the increasing rationalisation of the organisation of their labour to increasingly define care as functional, bureaucratic task to be undertaken with the maximum efficiency and minimum cost.

Our development of Stacey's thesis positioned the HCA as a caring agent within the rationalising logic imposed by the structures of the current political economy. The literature discussion pointed to two main sources of rationalisation – market-driven policies to increase efficiency, and increased standardization of tasks. Our interviews with both management and HCAs showed that competitive tendering of home care services was having a strong and direct effect. There was weaker data, however, to suggest that rationalisation was occurring to the same degree in the sense of standardized tasks related to increasingly formalized care

plan documents. The data, therefore, did not offer support for Ritzer's argument that rationalisation acts as the key dominant and quasi-totalising logic in the organization of service work. Among the sectors to which Ritzer applies his argument are education, food service, retail and, most notably for our purposes, health care. Core rationalising pressures are present, but the full letter of the bureaucratic policies tends not to be applied in practice – largely because HCAs enact a client-oriented defense of their autonomy, and, in turn, supervisors and some managers allow these practices to occur as a form of indulgency pattern (Gouldner, 1954). This suggests a novel way in which a customer-oriented bureaucratic pattern is played out in practice within home care. The original statement of the customer-oriented bureaucracy argument suggested that both rationalising and customer-oriented logics were propounded by management. In this case, however, it is the rationalising logic that is emphasized by management, and it is client-oriented logic that is championed by workers (with management de facto tending not to block it). This is exactly the route to the informal playing out of the customer-oriented bureaucracy implicitly suggested by Ungerson's (2000) argument that home care work is increasingly being structured in a *de facto* way that informally promotes home care workers working beyond their contract, in delivering extra care to clients.

Conclusion

This paper has examined whether within a political economy driving forms of rationalisation, HCAs act out of caring self or out of indifference to clients. The paper has focused on HCAs, an occupation at the bottom of the tier of health care occupations. Although this is a populous occupation, it is a relatively under-researched occupation. We found support, from

a combination of qualitative and quantitative findings across three organizations, for the thesis of HCAs acting out of a sense of the caring self in the context of rationalisation. Stacey's development of the concept of the caring self has made a rich contribution to the understanding of HCAs. In this paper, we have sought to build on Stacey's ideas by bringing in a sharper focus on the structures of rationalisation which face HCAs, and by seeking to access data beyond statements of espousal made in interviews.

An important arising question is how far HCAs can continue to generate a caring self approach to their work. It will take further waves of research to find out how far the findings from the current paper represent a point of transition before HCAs come to accommodate themselves to the prescribed role of front line bureaucrats, or whether HCAs can continue to enact forms of client-oriented defenses of autonomy, with supervisors' and managers' tacit approval. Here, it must be borne in mind that it is HCAs themselves who bear much of the costs of continuing to care beyond the documented care plan. It is they who volunteer discretionary effort when they feel that their clients are not receiving adequate care. They receive no rewards for such discretionary effort beyond the words and looks of recognition and gratitude from clients. How long can the generation of the caring self survive in such circumstances? This is the moot question which derives from this research.

Finally, it is appropriate to consider limitations of this study. An important limitation in a focus upon the triadic relations of work has been the absence of the voice of the clients. Further, it is a limitation that our way to get beyond data at the level of the espoused still relied ultimately upon a self-report instrument. Addressing this limitation, however, is no easy matter. Traditionally, ethnographic research, particularly that of participant-observation, has been a way for researchers to access data at the level of enactment. Such an approach has

important difficulties in the context of home care work, however. These limitations relate to multiple different locations of home care work serving to work against the ethnographic research becoming an accepted and usual part of the work context. For each client, the presence of the researcher is likely to take longer to merge in the background. Similarly, because the work of HCAs is highly individualized the texture of ethnographic research in this sector has the texture of individualized observation, which may make the process of observing normal enactment more problematic. Overall, we have sought to move the assessment of the thesis of the caring self within the context of rationalisation beyond the level of the espoused in interviews. There remain limitations within our approach, but there are likely to be some important limitations within any chosen research approach.

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Table 1 Length of service – Percent of respondents by number of years spent working for present employer

	Org A	Org B	Org C	All
Less than 2 yrs	13	23	0	16
2 to less than 5 yrs	11	23	27	11
5 to less than 10 yrs	16	21	20	18
10 yrs or more	60	46	53	55

Table 2 Interviewees at the 3 sites

Organisation	Senior Managers	Managers/Supervisors	Home Care Aides
A	3	6	12
B	3	2	6
C	3	1	12
Total	9	9	30

Table 3 Regression Analyses with Job Satisfaction, Organisational Commitment and Discretionary Effort as Dependent Variables

	Job Satisfaction		Organisational Commitment		Discretionary Effort	
	B	SE	B	SE	B	SE
Satisfaction with client relations	.440**	.083	.115	.064	.311**	.088
Ability to satisfy clients	.142*	.062	.132**	.048	-.162**	.066
Satisfaction with pay	.133**	.046	..055	.035	-.070	.049
Satisfaction with job influence	.405**	.053	.222**	.041	-.103	.056
Tenure (1-2 yrs)	.002	.273	-.026	.212	.055	.287
Tenure (2-5 yrs)	.356	.274	.249	.211	.011	.288
Tenure (5-10 yrs)	.138	.261	.130	.202	.284	.276
Tenure (>10 yrs)	.288	.260	.186	.201	.152	.273
Full/part-time	.365	.242	.448*	.187	.200	.255
Age: 40-59	.104	.141	-.032	.109	.207	.148
Age 60+	.148	.234	-.024	.181	.033	.246
Qualification: GCSE (D-G)	.262	.156	.221	.121	.029	.165
Qualification: GCSE (A-C) or O level	.086	.142	.123	.111	-.187	.150
Qualification:A level and above	.102	.130	-.061	.101	-.044	.140
Gender	.433	.375	.050	.289	-.005	.450
Site 2	-.188	.112	.045	.087	-.305**	.119
Site 3	-.001	.237	-.154	.183	.385	.250
Constant	-1.161	.424	.223	.328	2.466	.450
Adjusted R Square	.417		.249	.549	.119	.746
N	263		257		253	

*p≤ .05, **≤ .01, (2 tailed test)