Caring as an occupation : content and quality of working life among home helps

CARING AS AN OCCUPATION

Content and quality of working life among home helps

Suzanne E.J. Arts

Arts, S.E.J.

Caring as an occupation.
Content and quality of working life among home helps

Utrecht: Nivel - Nederlands instituut voor onderzoek van de gezondheidszorg
Proefschrift Universiteit Maastricht. - Met lit. opg. - Met samenvatting in het Nederlands.
ISBN 90-6905-545-7

Language consultant	Stafford Wadsworth
Lay-out	Marcelle van der Meulen, Bernadette Kamphuys
Cover Design	Twin Design
Printed by	Twin Design

Caring as an occupation

Content and quality of working life among home helps

Zorgen als beroep

Inhoud en kwaliteit van arbeid van uitvoerenden in de gezinsverzorging

PROEFSCHRIFT

ter verkrijging van de graad van doctor aan
de Universiteit Maastricht,
op gezag van de Rector Magnificus,
Prof. dr. A.C. Nieuwenhuijzen Kruseman
volgens het besluit van het College van Decanen,
in het openbaar te verdedigen
op vrijdag 1 februari 2002 om 14.00 uur

door

Suzanne Emmarentia Johanna Arts

geboren op 22 maart 1969, te Veldhoven

Promotores:

Prof. dr. J. van der Zee
Prof. dr. H. Huijer Abu-Saad

Co-promotor:

Dr. A. Kerkstra (Nivel, Utrecht)

Beoordelingscommissie:

Prof. dr. F.J.N. Nijhuis (voorzitter)
Dr. N.P.G. Boumans
Prof. dr. P.A.H. van Lieshout (Universiteit Utrecht)
Prof. dr. K. Luker (University of Manchester)
Prof. dr. H. Philipsen

The study presented in this thesis was conducted at Nivel (Netherlands institute for health services research), Utrecht, the Netherlands.
Nivel is a participating member of the Netherlands School of Primary Care Research (CaRe), acknowledged in 1995 by the Royal Dutch Academy of Science (KNAW).

The study was funded by the Landelijk Centrum Verpleging & Verzorging (LCVV).

CONTENTS

1	Overview	7
Part I		
2	Caring in home help services, a review of the literature	53
3	The daily practice in home help services in the Netherlands	77
4	A job profile of home helps in the Netherlands	99
Part II		
5	Quality of working life and workload in home help services, a review of the literaturen and proposal for a research model	123
6	Workload, capacity for coping and psychological and physical outcomes amongst home helps in the Netherlands	161
7	Factors related to burnout among Dutch home helps	187
8	Determinants of job satisfaction and absenteeism of home helps in Dutch home care	207
Literature		231
Samenvatting (Summary in Dutch)		249
Dankwoord		261
Curriculum Vitae		267

CONTENTS

1 Overview 7

Part I

2 Caring in home help services: a review of the literature 53

Part II

Overview

Overview

INTRODUCTION

This is a study in 'Caring as an occupation', meaning the care provided by caregivers who are paid and trained to do so. In this thesis, a specific group of paid and trained caregivers was studied, namely home helps working in home care.[1]

Background of the study

In the Netherlands, as in other European countries, there is no systematic research tradition in the area of home help services. There is no detailed data available on the actual care provided, the differences in task profiles among the various categories of home help, workload and psychological and physical outcomes of work. Interest in this area is increasing, though. In the last decade, in addition to studies at local level, some studies at national level have been carried out, focusing on the above mentioned topics (Veerman, 1989; Vulto et al., 1994; Commissie Verzorging, 1995; Gremmen, 1995; Van den Herik et al., 1995). An overview of the work in Dutch home help services cannot be derived from these studies. Therefore, a national study was carried out with the aim of gaining insight into the work of home helps and to shed light on its physical and mental burdens. In other words, the content and quality of working life among home helps in the Netherlands were studied.

Caring as an occupation

Situation at the time of the study (1995-1996) and recent developments

Home help services include help of a domestic and caring nature, occasionally supplemented by personal, psychosocial and supportive services (helping with personal health problems). Home help services are offered to the population of the Netherlands who need a minimum of domestic services because of illness, convalescence, old age, handicap, psychosocial, and personal problems that threaten the maintenance of the household. Its objectives are to support families and individuals in need and enable them to live as independently as possible (Van den Heuvel et al., 1991). In the recent decades, new forms of home care have been developed, known as "tailor-made home care". This includes 24 hour- and weekend services. Recently, a new form of home care has been developed: a

[1] Dutch readers may have noticed that I have adapted the title from Mok's thesis 'Dienen als beroep (Serving as an occupation) (1962), about professionals in the hotel and restaurant sector.

client-centred budget, enabling the chronically sick to purchase their own home care. In the Netherlands, home help services and home nursing are provided at the interface between social services and health services (Hutten et al., 1996).
Since 1997 home help services have been funded within a legal framework of the General Exceptional Medical Expenses Act: AWBZ. The AWBZ is the Dutch, publicly funded, catastrophic illness and long term care insurance. This framework, called the General Home Care Claim, is only applicable for accepted home care organizations, on the condition that they provide the integral package of home care. At the time of the study, the financing of home help services was separately arranged via a subsidy-regulation of the AWBZ.
Under the provisions of the General Exceptional Medical Expenses Act, all inhabitants of the Netherlands are entitled to receive home care and no formal referral is needed. A co-payment of NLG 10.00 (4.5 euro) per hour is required in the costs of home help services. The maximum amount of co-payment per week depends on the client's income and varies between NLG 5.00 (2.3 euro) and NLG 260.00 (118 euro) per week (LVT, 2000).
As no formal referral is needed for home help, potential clients can contact the home help services themselves. Sometimes a GP, family member or other professional caregiver makes the first contact. After the first contact, an assessor, who is not involved in direct care, makes an assessment of needs. Then, a home help manager allocates the care. Finally, home helps provide the actual care. This was the procedure at the time the study was conducted. Nowadays, the assessment procedures go via a Regional Assessment Organization (RIO), which performs assessments for a wide range of care (home nursing, institutional care, and nursing homes) that previously had their own assessment procedure.
In 1995, the total number of people working in home care was 126.670. In 1998 this number increased to 134.402 (Hingstman et al., 2000). In 1995, home care was provided to 466.000 clients (Baars et al., 1998). In 1999 this number increased to 580.000 (LVT 2000).
The client-centred budget, the funding of home help services by the AWBZ, and the new assessment procedure, are recent financial and organizational developments of which the consequences are not known yet.
Another development that might affect the work content and quality of working life among home helps, is the ongoing integration-process of organizations for home nursing and home help services into combined home care organizations, resulting in a substitution of home help services for home nursing. This process, however, had already started at the time of the data collection, and also it was accounted for in the sampling method of the study: both types of organizations (organizations for home help services and combined home care organizations) were included in

the study.

Challenges in Dutch home care

Like in other European countries, challenges have arisen in Dutch health care, and in home care in particular. Firstly, the ageing population: the proportion of people aged 65 or over and people aged 80 or over is increasing (Hutten et al., 1996).

Secondly, in order to save costs and to allow people to remain at home as long as possible, there was the policy of the substitution of home care for institutional care (Walker, 1991; Nijkamp et al., 1991; Hutten et al., 1996). This policy causes a higher demand for home care.

Thirdly, there has been an acute shortage of personnel in home care. With an annual turnover percentage of 11.6% and a yearly decreasing number of new home helps entering caring education, a shortage of staff in home care is becoming an increasing problem in the Netherlands (Van der Windt et al., 1998). This is also a problem in many other countries in Europe (Hutten et al. 1996). The reasons for this shortage are firstly that the occupation is not considered attractive, because it has a low status; secondly it is poorly paid and thirdly the training is considered to be inadequate (Hutten et al., 1996).

Another problem is the percentage of absenteeism due to illness in the Netherlands, which is very high compared to other countries like France, Germany and Great Britain (IDW, 1989). Absenteeism is very high in Dutch health care and especially in home help services with an average of 10% (Calsbeek et al., 2000). In 1999, the average percentage of absenteeism in the Dutch health care and welfare sector was 8.5%, compared with an overall, national percentage of 5,4% (Calsbeek et al., 2000).

Finally, Dutch health care is being confronted with budget cuts. These five factors together result in waiting lists in home help services (Hutten et al., 1996).

Many of these challenges that were important for Dutch home help services at the time of the data collection, still affect Dutch home help services. The results and recommendations of this study are therefore still valid.

Firstly, the policy of the substitution of home care for institutional care, allowing people to remain at home as long as possible. This is still causing a high demand on home care (need for more personnel).

Secondly, the shortage of personnel. In Dutch home care, the amount of vacancies in 1999 was almost three times higher than in 1995 (Hingstman et al., 2000).

Thirdly, the very high percentage of absenteeism among home helps (10%),

which has not decreased yet (Calsbeek et al., 2000).
And finally, the high work pressure. Due to shortage of personnel, the work pressure of home helps increases resulting in a higher absenteeism (Allaart et al., 2000).

Due to the earlier mentioned budget cuts, efficiency in home care had to be increased. Two solutions were tried at national level, in the first half of the nineties. The first one was the integration of organizations for home nursing and home help services into combined home care organizations, resulting in a substitution of home help services for home nursing. Besides cost reduction, the quality of care was assumed to increase (Ministry of Well-being, Health and Culture, 1990). The second solution was called "differentiated practice", a clear distinction in the work among the various categories of home helps. This gave home helps more career opportunities, and thus more personal development. It was intended to improve the image of what is perceived as a rather unattractive occupation with few prospects. Differentiated practice resulted in 1993, in a new, more detailed job categorization. Since then, instead of the existing five categories, six categories of home help have been distinguished: alpha help, 'A' home help, 'B' caring help, 'C' carer, 'D' carer, and specialized 'E' carer. Alpha helps are formally employed by the client, and therefore not employed by the organization. The client pays their salary. They are not entitled to receive training, education or feedback. Alpha helps have no meetings or opportunities for contact with their colleagues, their co-ordinator or the home care organization itself. Furthermore, they have a weak legal position, and they receive only 6 weeks salary during sickness, but not during the first two weeks of sickness.
These various categories of home help also have their own task profiles, based on a job description for caring and home help staff (Working Group SOGW, 1992) (Table 1). Four main categories of activity can be distinguished in these task profiles: household activities, caring, psychosocial activities, and consultation and co-operation (Working Group SOGW, 1992).
A schematic presentation of the task profiles per category of home help is given in Table 1.

Table 1 Formal task profile for each category of home help

Activities Categories of home help	Household activities	Caring	Psychosocial/ Supportive	Co-operation & consultation
Alpha help	X			
'A' home help	X			
'B' caring help	X	•		
'C' carer	•	X		
'D' carer		X	X	•
Specialised 'E' carer	•	•	X	X

X = main tasks
• = secondary tasks

Source: AbvaKabo/Union of Public Sector Workers, 1994

Home helps work content

In a modern society, where the family care for ill family members slowly disappears, professional (home) care plays an important role in filling this gap or to state it more formally to meet the household care deficits. In order to study professional care scientifically, the concept of care needs to be explored. A review of the literature resulted in three main concepts of care and caring in home help services. Firstly, concepts on caring from a feminist point of view (Graham, 1983; Wærness, 1984; Fisher et al., 1990; Simonen, 1990; Ungerson, 1990). Secondly concepts regarding (the relation between) non-professional and professional caring (Hattinga Verschure, 1981; Orem, 1983a; 1983b; 1985; Tadych, 1985; Hanchett, 1988; Taylor, 1989; Hancett, 1990; Kempen, 1990; Orem, 1991; Duijnstee, 1992; Hartweg, 1995). And finally concepts regarding the functioning of a household (Zuidberg, 1978a; De Vos, 1987; STRATEGO, 1991). The concepts are further elaborated in Chapter 2. A conceptual model to describe

the process of caring in home help services was proposed for this study based on these care-concepts and the results of studies found in the search. This model was used as a basis for the registration form on which home helps recorded the activities they carried out during their home visits (Chapter 3).

The process of caring (Figure 2.4, Chapter 2), can be described as follows. In home help services, the household, and not just the client, is regarded as a unit. When a household experiences deficits, which cannot be met by the household itself or by informal caregivers such as family members, friends or neighbours, professional help is needed to neutralize these deficits.
Professional help starts by assessing the client's situation and the nature of the deficit(s): what kind of care is needed? Professional care can be provided by several services, depending on how it is funded. It can either be a private service (a private nurse or a private help), or a service from the public sector like home help services or alpha help. In cases where care is provided by home help services, the next step is to allocate the help needed in order to make a household as self-supporting as possible (again). Allocation of time and help, performed by a home help manager, is based on an assessment. The tasks that home helps carry out can be distinguished in, the earlier mentioned, four main categories. The majority of the tasks (household activities, caring, and some psychosocial tasks) can be carried out at three different levels, which depends on the client's self-care ability. According to the home care organization, the help provided can be either supportive/ educational, partly compensatory (assisting the client with activities) or wholly compensatory (taking activities over from the client). A client can also be in need of all three levels for various tasks.

This mixture of basic household and caring tasks on the one hand and psychosocial and reporting tasks on the other, characterizes home help services. It is also this mixture of tasks that make working in home help services very demanding.

Quality of working life among home helps

Working in home help services is characterized as emotionally demanding, possibly resulting in high levels of stress with little support from supervisors and colleagues, and high potential for burnout and a high percentage of absenteeism (Haemmerlie et al., 1982; Berger et al., 1984; BVG, 1995; De Jonge et al., 1996). These and aspects such as job satisfaction, job involvement, motivation, productivity, health, safety and well-being, all operationalization of psychological and physical outcomes of work, are associated with the concept *quality of working life* (De Jonge, 1993; Hood et al., 1994). *Workload* is an important element of quality of working life (Chapter 5).

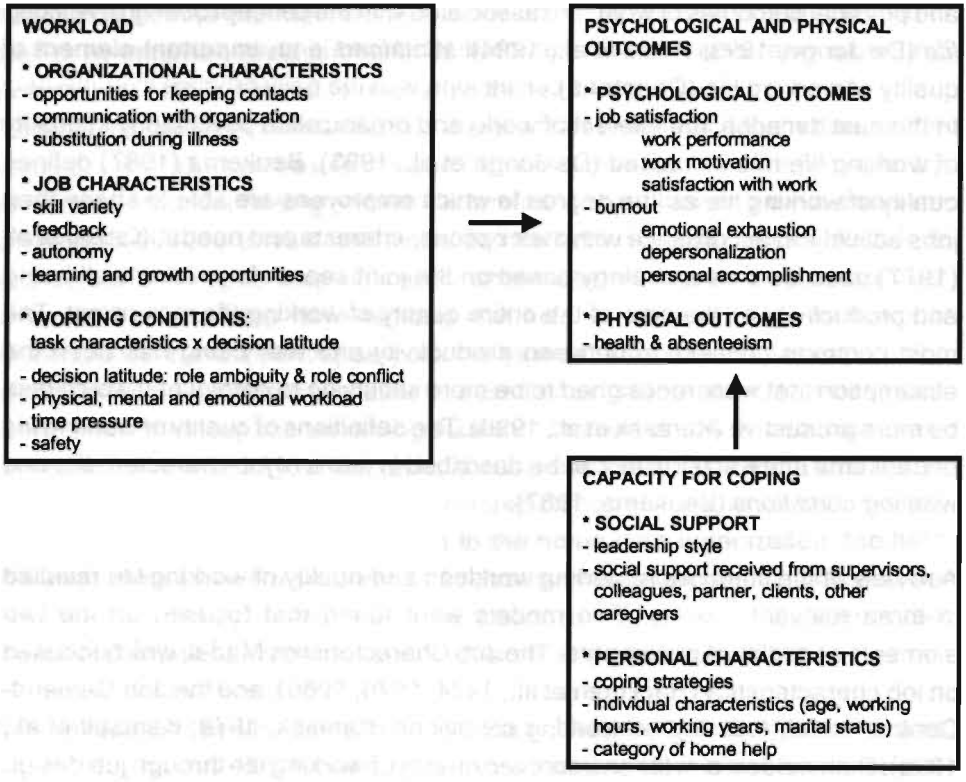
In the past decades, the interest of work- and organization psychology in quality of working life has increased (De Jonge et al., 1993). Beukema (1987) defines quality of working life as 'the degree to which employees are able to shape their jobs actively, in accordance with their options, interests and needs'. Katzell et al. (1977) describe it as a strategy based on the joint search for worker well being and productivity as the core of the entire quality of working life movement. The most common connection between productivity and well being has been the assumption that work redesigned to be more satisfying to employees would also be more productive (Karasek et al., 1990). The definitions of quality of working life of Beukema and Katzell et al. can be described in terms of *job characteristics* and *working conditions* (Beukema, 1987).

A review of the literature regarding workload and quality of working life resulted in three relevant models. Two models were found that focused on the two elements of quality of working life. The Job Characteristics Model, which focused on job characteristics (Hackman et al., 1974; 1976; 1980), and the Job Demand-Control model, focusing on working conditions (Karasek, 1979; Karasek et al., 1990). Both models aim for an improved quality of working life through job design or redesign. Only one model of workload in home help services was found. This model, the Workload/Capacity model, was used by Veerman (1989) in previous research on absenteeism among home helps in the Netherlands (Meijman et al., 1984; Veerman, 1989; Smulders et al., 1990).

The models are further elaborated in Chapter 5. Based on these models and the results of the studies found in the search, a new model on quality of working life among home helps was proposed for this study. The 'workload/capacity-balance model' is used as a basis for the integration of the models and the research results, presented in Figure 1. This model consists of three dimensions: workload (organization characteristics, job characteristics, working conditions), capacity for coping (social support, coping), and psychological and physical outcomes of work

(job satisfaction, burnout, health and absenteeism) which are assumed to be interrelated: workload causes certain psychological and physical outcomes of work, which are influenced by a person's capacity for coping.

Figure 1 An integrated model for assessing the psychological and physical outcomes of working in home help services



Research questions

The aims of this study are to gain insight into the work of home helps and to shed light on its physical and mental burdens. Four research questions guided this study:

Research questions with regard to the content of work:

1. What constitutes daily practice of home helps working in home help services? (Chapter 3)
2. To what degree do formal job descriptions and task profiles of home helps in the Netherlands correspond with the daily practice in home help services? (Chapter 4)

Research questions with regard to the quality of working life:

3. Do the six different categories of home help differ regarding the quality of their working life? (Chapter 6)
4. How are aspects of workload (organization characteristics, job characteristics, working conditions) and capacity for coping (social support, coping) related to the psychological and physical outcomes of working in home help services (job satisfaction, burnout, health and absenteeism)? (Chapters 7 and 8)

In 1995, this study among a representative sample of organizations for home help services and home helps, was conducted in order to answer these research questions.

The study consisted of two parts: a registration of the work of home helps was carried out (research questions 1 and 2; part I); and a questionnaire on quality of working life assessing workload, capacity for coping and psychological and physical outcomes of work (research questions 3 and 4; part II).

METHODS

Sample and response

A two-stage sampling method was used to obtain a representative sample of home helps: first the organizations and then the home helps. Three types of stratification criteria were used to ensure the representative status for the organization: region (north, south, east and west), integration process of the home help organization (integrated with home nursing or not), and catchment area of

the organization (care provided in an area including a city of more than 100,000 inhabitants or less). The stratification procedure yielded 16 cells. Thirty organizations were approached to ensure the participation of 16, one per cell. Fourteen organizations declined. The main reasons for not participating were lack of time due to reorganization or merger (6x) or involvement in other research (8x). Finally, 16 organizations (53%) took part in the study.
Each organization was expected to select 30 home helps, five of each of the six categories of home help, resulting in a total of 510 home helps (one organization participated with two teams of 30 home helps). Not all organizations, however, were able to select these 30 home helps, resulting in a total of 474 home helps (93%). Only 458 home helps participated in part I of the study, 474 home helps participated in part II of the study. Three per cent of the 474 home helps were male and 97% female. The mean age of the 474 home helps was 39 years with a standard deviation of 10, and the average hours worked per week were 20 (standard deviation of 10).

Instruments
Two instruments were developed for the study: a registration form and a questionnaire. Table 2 gives an overview of these instruments.

Design and procedure of data collection
This survey, which was carried out in 1995, had a cross-sectional design.
An instructional meeting was organized in each participating organization, where the purpose of the study was explained to the 474 participating home helps. They were asked to record all the activities that are carried out during the home visits on a registration form, one form for each home visit. For each four-week period following this meeting, the home helps were asked to complete the questionnaire on psychological and physical outcomes of work, and return them at the end of the period. The home helps that withdrew from the program within one week also filled in the questionnaire, which yielded a total of 474 completed questionnaires. Data was collected within a period of eight months, to minimize the influence of seasonal-fluctuation.

Analyses
The analyses used to answer the first research question were mainly descriptive. Furthermore, analysis of variance was used to test for significant differences between the mean number of activities carried out by the six categories of home help.

Table 2 An overview of instruments used in the study

Instrument	Aim and dimensions	Origin	Reliability
Registration form (Chapter 3)	Gain a representative picture of the work of home helps by recording the activities carried out during home visits. The registration form contains 110 activities in the area of household activities, caring, psychosocial/supportive activities.	The self-registration form was based on the conceptual model describing the process of caring in home help services (Chapter 2).	The level of agreement, i.e. the similarity between the frequencies scored by the home helps and the frequencies scored by the observer expressed in percentages, was computed for every item on the form. The reliability scores of the main categories varied between 94 and 98%.
Questionnaire (Chapter 6)	Examine constraining aspects of home helps, taking into consideration three components of working in home help services	The questionnaire was based on the research model for assessing psychological and physical outcomes of working in home help services (Chapter 5) and consisted of existing scales:	The reliability of these scales (Crombach's alpha) was calculated for the total groups of home helps, and the majority of the reliability scores were sufficient, varying between 0.61 and 0.96.
Workload	organizational characteristics, job characteristics and working conditions	Van Veldhoven et al. (1994) (VBBA-experience and assessment of work)	The reliability of two sub-scales was insufficient: internal work motivation (job satisfaction) (α=. 43) and depersonalization (burnout) (α=. 52). Therefore, in this study, these sub-scales were removed from analysis
Psychological and physical outcomes of work	job satisfaction burnout health	Boumans (1990) (job satisfaction) Schaufeli et al. (1994) (MBI-burnout) Knibbe et al. (1994) (health)	
Capacity for coping	social support leadership style coping strategies	Bergers et al., (1986) (VOS-D, Organizational Stress Questionnaire) Boumans (1990) (leadership style) Scheurs (1988); Van Dierendonck et al.(1992) (adapted version of the UCL-coping list)	

Analysis of variance (one-way) was used to test for significant differences between the mean scores of the six categories of home help on the various scales of the questionnaire (the Bonferroni test) (third research question).Multiple stepwise regression analyses (Ordinary Least Square), were carried out to investigate how the aspects of workload and capacity for coping were related to the psychological and physical outcomes of work (fourth research question)[2].

RESULTS AND DISCUSSION

Results

For a period of four weeks, 458 home helps completed and returned 15,921 registration forms. Based on these registration forms, the first research question was answered.

Research question 1:
What constitutes the daily practice of home helps working in the home help services?

In all 15, 921 home visits, the home helps spent on average 38% of the time on household activity, 33% on personal care and 27% on psychosocial activities. Only 2% of the time was spent on activities in the area of co-operation and consultation (reporting activities).
The results show that household activities were the main activity of alpha helps, 'A' home helps and 'B' caring helps. Specialized 'E' carers and 'D' carers also performed some household activities. As expected, 'D' carers, and 'B' and 'C' carers to a lesser degree performed many caring activities. 'C' carers spent their time more or less equally distributed over household, caring, and psychosocial activities. Specialized 'E' carers carried out psychosocial activities mainly. Both 'C' and 'D' carers performed most reporting activities. Specialized 'E' carers reported less during the home visits than the 'C' and 'D' carers, because they spent a lot of time on meetings and consultation outside the home visits.

Based on the assessment of their daily practice in home help services (a combination of activities that were carried out and the time spent on these activities), a new task profile of the six categories of home help was developed

[2] Alpha helps were excluded from these analyses (Chapters 7 and 8).

(DP). Table 3 shows an overview of the formal task profiles (FTP) and the daily practice (DP) of home helps.

Table 3 Formal task profile (FTP) and profile of daily practice (DP) for each category of home help

Activities Categories of home Help	Household activities		Caring		Psychosocial/ Supportive		Co-operation & consultation	
	FTP	DP	FTP	DP	FTP	DP	FTP	DP
Alpha help	X	X				•		
'A' home help	X	X		•		•		
'B' caring help	X	X	•	•		X		•
'C' carer	•	X	X	X		X		•
'D' carer		•	X	X	X	•	•	•
Specialised 'E' carer	•	X	•	•	X	X	X	X

X = main tasks
• = secondary tasks

The new task profiles (DP) were used to answer the second research question.

Research question 2:
To what degree do formal job descriptions and the task profiles of home helps in the Netherlands correspond with the daily practice in home help services?

To examine whether the home helps do the work they are supposed to do, the formal and the new task profiles were compared. Three main differences were found (Table 3). First, the practice findings show that the four lower categories of home help perform more psychosocial tasks than prescribed in their job

description and 'D' carers perform less of these activities. Secondly, in daily practice, the three higher categories of home help carry out more household activities than they are supposed to do. Finally, 'B' and 'C' carers performed more in the area of co-operation and consultation than is described in their formal task profiles.

Three conclusions can be drawn with regard to the new task profile of home helps based on daily practice (Table 3). Firstly, it showed an overlap between the consecutive categories of home help with regard to the content of their work ('A' home helps and 'B' caring helps, 'C' carers and 'D' carers). Consequently, although the work of all six categories of home help showed significant differences, there are no clear boundaries in their work: home helps sometimes carry out activities for which they are not formally qualified (personal caring and psychosocial activities). This may have a negative effect on the quality of care. Finally, the new profiles also show that personal caring and household activities are never carried out separately in home help services, but in combination with psychosocial activities at least.

The questionnaire, completed by all 474 home helps, was based on the three dimensions of the research model for assessing the psychological and physical outcomes of working in home help services, and was used for answering the third research question.

Research question 3:
Do the six different categories of home help differ regarding the quality of their working life?

The differences between the six categories of home helps for all variables of the three dimensions of the research model (Figure 1) are described below: workload (organizational characteristics, job characteristics and working conditions), capacity for coping (social support, coping), and psychological and physical outcomes of work (job satisfaction, burnout, health and absenteeism).

The dimension *workload* consists of three sub-dimensions: organizational characteristics, job characteristics and working conditions.
The results show that two '*organizational characteristics*', opportunities for contact with colleagues and communication with the organization were experienced differently by the various categories of home help. Alpha helps had little opportunity for keeping contact with colleagues and infrequent communication

with the organization. Substitution during illness, as an organizational characteristic, was also examined. For alpha helps and specialized 'E' carers this was an unsatisfactory method.
With regard to *'job characteristics'*, the higher categories of home help experienced greater skill variety in their work, had more learning and growth opportunities, and had more feedback compared with the lower categories of home helps. On the other hand, alpha helps had much more autonomy in their work than 'B' caring helps and 'C' and 'D' carers.
Seven types of *'working conditions'* were measured in the questionnaire. Alpha helps felt safest in their work, had to perform few conflicting tasks but also experienced the highest degree of confusion about their tasks (role ambiguity). 'B', 'C' and 'D' carers experienced stressful physical working conditions, such as high time pressure and a high physical workload. Mental and emotional workloads were increased for higher categories of home help: alpha helps experienced the lowest mental and emotional workload and specialized 'E' carers experienced the highest.

The dimension *capacity for coping* can be distinguished in 'social support' (social support experienced from supervisor, colleagues, and clients; and leadership style) and 'coping strategies'.
With regard to *'social support'*, the results showed that alpha helps, not surprisingly, were significantly less well supported by their supervisors compared with all other categories, but they reported the highest social support from their clients. Specialised 'E' carers, on the contrary, experienced the lowest level of support from their clients, and were only moderately satisfied with the contact with their clients. Finally, the higher categories of home help experienced significantly more social support from their colleagues than the lower categories (alpha helps, 'A' home helps and 'B' caring helps).
All home helps experienced rather a social-emotional leadership style (focused on well being and comfort) than an instrumental leadership style (mainly focused on production) from their supervisors.
Three sub-scales measured *'coping'*: an active approach to problems, seeking social support and a passive approach to problems. 'C' carers and specialized 'E' carers used the active approach significantly more than the other home helps. The levels of passive coping did not differ among the six categories of home help. 'C' and 'D' carers mainly use the coping strategy 'seeking social support'. 'A' home helps hardly ever used this coping strategy.

Four *psychological and physical outcomes of work* were distinguished: 1) job satisfaction, 2) burnout (psychological outcomes); 3) general health and 4) absenteeism (physical outcomes).

With regard to *'job satisfaction'*, the results showed that alpha helps were considerably less satisfied with almost all aspects of work than the other home helps, except for satisfaction with the contact with clients. 'A' home helps were most satisfied with clarity in their task, promotion opportunities, contact with supervisor, and were also highly satisfied with the contact with clients. Specialized 'E' carers were also quite satisfied with opportunities for growth at work, contact with colleagues, and their work performance. 'D' carers experienced the highest fulfilment in their work.

In this study, two of the three dimensions of *'burnout'* were analysed: emotional exhaustion and personal accomplishment[3]. Alpha helps were significantly less emotionally exhausted compared with the four other categories of home help. Feelings of personal accomplishment were not significantly different among the home helps.

The home helps also made an assessment of their health. In general, all home helps felt quite healthy, and this did not differ from one home help to the other. The home helps were also asked about their 'absenteeism' in the past 12 months. Almost two-thirds of the home helps had been absent due to illness in the past 12 months, with an average frequency of 1.2 times and an average duration of 19.3 days. The average absenteeism-percentage of the organizations was 10.3% (varying from 7.1% to 16%). There were significant differences in the frequency and duration of absenteeism between the home helps.

Research question 4:
How are aspects of workload (organization characteristics, job characteristics, working conditions) and capacity for coping (social support, coping) related to the psychological and physical outcomes of working in home help services (job satisfaction, burnout, health and absenteeism)?

With this fourth research question, the research model is tested. Multiple stepwise regression analyses (Ordinary Least Square), were carried out to answer the final research question[4].

---

[3] The reliability of the third dimension of burnout, depersonalization, was insufficient. Therefore, this scale was left out of the analyses.

[4] Alpha helps were excluded from these analyses (Chapters 7 and 8).

In the literature, hardly any determinants for health were found, but strong empirical evidence regarding health as a determinant for absenteeism was found. On the basis of these findings, it was decided to use '*health*' in the analyses regarding absenteeism, not as an independent but as a dependent variable. Therefore, from now on, only three instead of four outcomes of work are distinguished.

Job satisfaction was primarily positively related to opportunities for contact with colleagues, learning and growth opportunities and social support experienced from supervisors and colleagues. Role conflict and physical workload were negatively related to job satisfaction. The percentage explained variance for job satisfaction by all variables is moderately high (37%).

Burnout was negatively related to opportunities for communication with the organization, autonomy and learning and growth opportunities.
Role ambiguity, physical and emotional workload and time pressure were positively related to burnout. Furthermore, a relation was found between burnout and coping strategies: active coping was negatively related to burnout, passive coping was positively related to burnout. Finally, burnout was negatively related to age and positively related to the number of working hours per week.
The percentage of explained variance of burnout was moderate: 20% and 39% respectively for personal accomplishment and emotional exhaustion.

Absenteeism over the past 12 months was measured by three measures: absent or not, frequency of absenteeism and total duration of absenteeism. The results of this study showed that none of the three measures of absenteeism were explained by any of the (expected) workload and capacity for coping variables. Only home helps that are less healthy and younger home helps were more frequently absent.
The percentage explained variance of frequency of absenteeism was 13%.

The results showed that 'emotional exhaustion' (one of the two burnout dimensions) and 'job satisfaction' were better explained by the workload and capacity for coping variables than 'personal accomplishment' (the other burnout dimension) and 'absenteeism'.

DISCUSSION

In this paragraph, the results of this study are compared with results from other relevant studies.

Content of work

One of the main conclusions of the study is that the overlap between the consecutive categories of home help with regard to the content of their work ('A' home helps and 'B' caring helps and 'C' carers and 'D' carers respectively), was more substantial than can be derived from the formal task profiles. Although the work of all six categories of home help showed significant differences, there are no clear boundaries in their work: home helps sometimes carry out activities for which they are not formally qualified (caring and psychosocial activities). This may have a negative effect on the quality of care. This is supported by studies of Van den Herik et al. (1995) and the Commissie Verzorging (Committee for Caring) (1995), the latter being installed to formulate an inventory and analyse problems in the area of job development, education and workload of home helps. Both studies concluded that the boundaries between the content of work of the consecutive categories of home helps, except for the specialised 'E' carers, are blurred, and appealed for a removal of this overlap.

The new task profiles (Table 3) also show that household activities and caring are never carried out alone in home help services, but in combination at least with psychosocial activities. This is also supported by Van den Herik et al. (1995) who showed that carrying out household activities separately is quite exceptional in Dutch home help services. In 2000 a new job profile for helping and caring staff in home care and elderly care was developed (Van de Haterd et al., 2000). In the new profile the combination of household activities, caring and psychosocial activities is also found. Compared with the former job profile, the new job profile distinguishes less categories of caregivers (four instead of six) and more categories of tasks (six instead of four).

The categories of home help are: the assistant help, the home help, the carer, and the carer in individual health care.

The tasks are:

- assessing the need for care
- planning of the care
- performing care tasks (physical care, household care, support clients, signal changes in the need for care, provide information and advice)
- evaluating the care

- occupation-related tasks
- organization-related tasks

The main task of the assistant help (e.g. current alpha help and 'A' home help) is household care. Other tasks are providing support to the client, signalling changes and having social conversations.
The home help (e.g. current 'B' caring help) provides general household and physical care in addition to occasional psychosocial support. She also provides support to the client and signals changes.
Both carer (e.g. 'C', 'D' and specialized 'E' carer) and carer in individual health care (e.g. 'D' and specialized 'E' carer) carry out activities of all six categories. The latter type of caregiver is, based on her education, allowed to perform more nursing technical activities. All caregivers carry out occupation- and organization-related tasks.

Quality of working life

Workload

The findings that alpha helps experience little organizational and job characteristics, but a high level of autonomy, were also found in another Dutch study on home helps by Van den Herik et al. (1995). The results that home helps who predominantly carry out household activities (alpha helps and 'A' home helps) experience less variety in their work, is in line with Veerman's (1989) conclusion that home helps describe household activities as 'little variety between strenuous and less strenuous work'.
The results show that higher categories of home help, who carry out more caring and psychosocial activities, and therefore do more complex work, experience a higher mental and emotional workload than alpha helps and 'A' home helps. Compared to other groups of female health care workers, home helps in general have a lower mental workload and a higher emotional workload (Van Veldhoven et al., 1994).
Higher categories of home help also experienced more role conflict. This corresponds with Veerman's study in which he found that higher categories of home help experienced more role conflict and higher psychosocial workload (Veerman, 1989).
Home helps, and especially the higher categories ('C' and 'D' carers), experienced also more time pressure. Compared with a group of female health care workers, home helps experience greater time pressure (Van Veldhoven et al., 1994). The underlying reason that 'C' and 'D' carers are more exposed to time pressure might be the type of work: carers provide personal care in many different client situations each day, with fixed planning. Veerman (1989) concluded that

working at several addresses each day causes a high workload for home helps (Veerman, 1989).

Capacity for coping

In general the home helps in this study had a high level of social support, with the exception of alpha helps. This is in line with Veerman's conclusions from his study in 1989. On the other hand, alpha helps feel better supported or appreciated by their clients than the other home helps. This makes sense because alpha helps are formally employed by the client and consequently have a different relationship with them from that of other home helps with their clients.

Three coping strategies were measured: an active approach, seeking social support, and a passive approach. Specialized 'E' carers used the active approach significantly more when compared with the five categories. When these results are compared with the scores of Dutch community nurses (Jansen et al. 1996), no differences were found between home helps and community nurses, with the exception of the coping strategy 'seeking social support' which was used less by home helps.

Psychological and physical outcomes of work

Job satisfaction: The study showed that in general, home helps were reasonably satisfied with their work. Van den Herik et al. (1995), who also studied home helps in the Netherlands, found the same results. Home helps' job satisfaction is comparable to job satisfaction among community nurses (Jansen et al., 1996).

In this study, two dimensions of *burnout* were analysed: emotional exhaustion and personal accomplishment. Feelings of emotional exhaustion are highest for the higher categories of home help. A possible explanation for this is that the subordinate categories of home helps work less hours per week and therefore run a smaller chance of emotional or physical overload. Compared with the norm-scores, home helps had average scores on these two burnout dimensions (Schaufeli et al., 1994).

Absenteeism: To get a better understanding of the absenteeism-figures, the figures in this study were compared with the national home help services-figures, and it can be concluded that the absenteeism-figures for home helps and organizations participating in this study are fairly similar to the national figures (Calsbeek et al., 2000).

Factors related to psychological outcomes of work: burnout and job satisfaction
The majority of the results that were found regarding factors related to *burnout* were in line with what was expected and found in other studies (Chapter 7).
However, there were a few surprising results: relations that were expected based on the literature, but that were not found (Table 4).

Only half of the results that were expected regarding factors related to job *satisfaction*, were in line with what was found in this study (Chapter 8) (Table 5).

Factors related to physical outcomes of work: absenteeism
With regard to factors related to *absenteeism*, only for a few of the predicted relations empirical evidence was found (Chapter 8). In contrast to the expected negative relation between socio-emotional leadership style and absenteeism, a positive relation was found in this study. A feasible explanation is that supervisors of home helps who have been more absent are more focused on comfort and well-being. It remains unclear as to why no relation was found between job characteristics or working conditions and any form of absenteeism, although they were expected based on the literature (Table 6).

Methodological reflections

Sample
With regard to the sample of the study, some restrictions should be formulated. The first restriction concerns the *selection of the home helps* who participated in the study. The way the home helps were selected for the study, either voluntary or selected by a supervisor, is a possible bias for the total sample of home helps. Another restriction is that the chronically ill home helps were not included. Due to these restrictions, the results may appear a little less clear cut, and an underestimation of burnout and absenteeism might have occurred. This was probably not the case though, because the results found in this study were in line with other studies on home helps (Veerman, 1989, Van den Herik et al. 1995. Commissie Verzorging, 1995; Calsbeek et al., 2000).

Table 4 Expected and found results of burnout

Independent variables	Expectations	Results	Explanations
Control variables			
Age		–	
Working hours per week		++	
WORKLOAD			
Organizational characteristics			Colleagues are maybe less important due to part-time work
Opportunities for keeping contact with colleagues	–	–	
Communication with organization	–		n.a.
Job characteristics:			
Autonomy	–	–	n.a.
Learning-/growth opportunities	–	–	n.a.
Working conditions:			
Role conflict	++		Possible indirect effect via emotional workload
Role ambiguity	++	++	n.a.
Physical workload	++	++	n.a.
Emotional workload	++	++	n.a.
Time pressure	++	++	n.a
CAPACITY FOR COPING			
Social support:			
From supervisors	–		Co-presence of coping strategies in regression analyses
From colleagues	–		
Coping strategies:			
Active approach	–	–	n.a.
Passive approach	++	++	n.a.

++ = a positive relation was expected/found

– = a negative relation was expected/found

Table 5 Expected and found results of job satisfaction

Independent variables	Expectations	Results	Explanations
Control variables			
Years worked (in months)	++		
WORKLOAD			
Organizational characteristics			
Opportunities for keeping contact with colleagues	++	++	n.a.
Job characteristics:			
Autonomy	++		
Learning-/growth opportunities	++	++	n.a.
Feedback	++		
Skill variety	++		A relatively high correlation between skill variety and learning and growth opportunities
Working conditions:			
Role conflict	–	–	n.a.
Role ambiguity	–		Excluded from analysis
Physical workload	?	–	n.a.
Emotional workload	–		A relatively high correlation between emotional workload and role conflict
	–		
Time pressure			A relatively high correlation between time pressure and physical workload
CAPACITY FOR COPING			
Social support:			
From supervisors	++	++	
From colleagues	++	++	
Leadership style:			
Socio-emotional leadership	++		Excluded from the analyses

++ = a positive relation was expected/found
– = a negative relation was expected/found
? = both a positive and a negative relation was expected

Table 6 Expected and found results of absenteeism

Independent variables	Expectations	Results	Explanations
Control variables			
Category of home help	–		
Age	?	–	Younger home helps have families with young children
Working hours per week	?	–	Less involvement or fewer hours due to absence
Educational level	–		
Years worked	?	++	
Marital status			
WORKLOAD			
Organizational characteristics			
Opportunities for keeping contact with colleagues	?		
Communication with organization	–		
Job characteristics:			
Autonomy	–		
Feedback	–		
Skill variety	?		
Working conditions:			
Role conflict	++		
Role ambiguity	++		Excluded from the analyses
Physical workload	?		
Emotional workload			
Time pressure	++		
CAPACITY FOR COPING			
Social support:			
From supervisors	–		Excluded from the analyses
From colleagues			
Leadership style:			Supervisors focus more on wellbeing and comfort after absenteeism.
Socio-emotional leadership	–	++	
Instrumental leadership	++		
Health	–	–	

++ = a positive relation was expected/found

– = a negative relation was expected/found

? = both a positive and a negative relation was expected

Design

The third restriction of the study concerns the *design of the study*, and is an obvious one. It was a cross-sectional design where the assumptions about causality (between the *'workload'* and *'capacity for coping'* variables on the one hand and the psychological and physical outcomes of work on the other hand) require a longitudinal approach. However, a lot can be argued against longitudinal designs and if the assumed causal relationships were found they would also express themselves in a cross-sectional design. A longitudinal design also involves the collecting of data at more than one point in time, which is in general time-consuming and costly.

On the other hand, earlier research has showed that job characteristics and working conditions were significantly correlated to absence occurring 3 to 6 years later (Rentsch et al., 1998; Smulders et al., 1999). Results regarding burnout found in studies with a cross-sectional design, though, could not be replicated in a study with a longitudinal design (Schaufeli et al., 1998).

Instruments

Two instruments were used for this study: a registration form to gain a representative picture of the work of home helps and a questionnaire to examine the workload, capacity for coping and psychological and physical outcomes of work. The registration form was found to be clear and easy to use. Shortcomings are restricted to the occasional occurrence of an activity not being cited. Consequently, the self-registration form appears to be a reliable and valid instrument for measuring the work of home helps.

The questionnaire on psychological and physical outcomes of work consisted of existing scales for the dimensions of the model: workload, psychological and physical outcomes of work, and capacity for coping. The scales were validated in previous studies and the reliability (expressed in Cronbach alpha's) varied between 0.60 and 0.90 (Bergers et al., 1986; Boumans, 1990; Van Dierendonck et al., 1992; Van Veldhoven et al., 1994; Schaufeli et al., 1994). The reliability of these scales was also calculated in our study and the majority of the scores were sufficient (alpha higher than 0.60), varying between 0.61 and 0.96. The reliability of two subscales was insufficient. One subscale of job satisfaction, internal work motivation had an α of 0.43) and one dimension of burnout, depersonalization, had an α of 0.52. Therefore, these two subscales were left out of the analysis. Other research has also shown a lower internal consistency for the depersonalization-dimension than for the other two subscales: between α=.50 and α=.70 (Schaufeli, 1990; Van Dierendonck et al., 1993; Schaufeli et al., 1993; Schaufeli et al., 1994; Jansen et al., 1996). There are some indications that depersonalization should be treated as a

multidimensional construct that includes various aspects such as distancing, hostility, unconcern, and rejection (Garden, 1987). Thus, the low internal consistency is not only due to the small number of items, but it may also reflect conceptual problems (Garden, 1987; Schaufeli et al., 1998).
A final restriction of this study concerns the subjective measurement of absenteeism. Home helps were asked about their absenteeism in the past 12 months. An objective way to measure absenteeism would be using the absenteeism-figures from the central registration department of the organization.

Procedure of data collection

During an instruction meeting in each participating organization, the purpose of the study was explained to the participating home helps. The home helps were asked to record the activities they carried out during all home visits on separate forms over a four-week-period. Following this instruction, the home helps were asked to complete the questionnaire on psychological and physical outcomes of work, and return them at the end of the instruction. Registration forms, completed by the home helps, were sent back to the researcher at the end of every week.
The response rates for both parts of the study were high. In the first part, 16 out of 474 home helps (3%) did not complete the four-week-period of recording, as a result primarily of illness and holidays. The response rate was 97%. In the second part, all 474 home helps completed the questionnaire on psychological and physical outcomes of work (response rate 100%).

Theoretical reflections

A research model was developed to study the factors related to the 'psychological and physical outcomes of working in home help services' (Figure 1). The model was based on three existing models concerning the quality of working life and workload, and literature about job satisfaction, burnout and absenteeism in home help services. The three models are the following. The Job Characteristics Model, which focused on job characteristics (Hackman et al., 1974; 1976; 1980), the Job Demand-Control model, focusing on working conditions (Karasek, 1979; Karasek et al., 1990), and the Workload/Capacity model, was used by Veerman (1989) in previous research on absenteeism among home helps in the Netherlands, focusing on workload (Meijman et al., 1984; Veerman, 1989; Smulders et al., 1990). The 'workload/capacity-balance model' is used as a basis for the integration of the models and the research results.
The overall conclusion is that on the one hand, this research model is suitable to explain the psychological outcomes of work among home helps, while on the other

hand, the research model is not appropriate to explain the physical outcome of work among home helps.

With regard to *burnout* and *job satisfaction* (the psychological outcomes) the research model was supported by this study. The results show that several workload variables (organizational characteristics, job characteristics, working conditions) and capacity for coping variables (social support, coping strategies) affect burnout and, to a lesser degree job satisfaction. In addition, the results of this study show that feelings of burnout are affected by both a home help's experienced workload and his/her capacity for coping, whereas job satisfaction is more a result of a home help's experienced workload. Subsequently, some comments have to be made.

Regarding 'burnout', nine of the twelve expected relations were found in this study. Younger home helps and home helps who experienced sufficient communication with the organization, high autonomy, sufficient learning and growth opportunities, and home helps who have an active coping approach, were less susceptible for burnout. Home helps who work under stressful conditions (high physical and emotional workload, time pressure and high role ambiguity), and work more hours per week, experience more feelings of burnout.
Three of the twelve expected results were not found. The first regards the social support experienced from supervisors and colleagues. A possible explanation for not finding a significant effect, might be the presence of coping strategies in the regression-model together with social support experienced from supervisor and colleagues. Pearlin (1985), Lindgren (1990) and Schaufeli et al. (1998) reported that social support can be considered as a resource for coping with stress, and is negatively related to feelings of burnout. Also other studies indicated that perceived support has a mediating role in the stress process (Turner, 1983). Some studies take either coping or social support as a possible determinant of burnout (Ceslowitz, 1989; Kandolin, 1993; Spaans, 1995; De Jonge, 1996). Van Dierendonck et al. (1993) and Jansen et al. (1996) studied both coping and social support in relation to burnout. Although Jansen et al. found relations between both variables and burnout, Van Dierendonck et al. found a relation between coping and burnout, and between social support and coping, but not between social support and burnout directly. A possible explanation is that social support in combination with coping strategies plays a moderator role more than a direct role in the relation to burnout. Secondly, it was expected that home helps with fewer opportunities for keeping contact with their colleagues have more feelings of burnout. This relation appeared to be different for this specific group of respondents, because among this group of

home helps, many have part-time jobs. Therefore, colleagues might be less important for them. So, fewer opportunities for keeping contact with their colleagues are not related to feelings of burnout for home helps.
Finally, it was also expected that home helps that had to perform conflicting tasks and/or had to perform their work differently compared to how they want to have more feelings of burnout. In this study, this direct relation was not found, but an indirect relation probably does exist. It is possible that a high degree of role conflict leads to more feelings of burnout, namely via emotional workload. Role conflict has a high correlation with emotional workload (.42). Being in the same regression-model, emotional workload, which is significantly, positively related to burnout, might have taken away the effect of role conflict.

Regarding 'job satisfaction', six of the thirteen expected relations were found. Home helps with social support from supervisors and colleagues and home helps who experience sufficient opportunities for keeping contact with colleagues, and sufficient learning and growth opportunities in their work, are more satisfied with their work. Home helps who work under stressful working conditions, high role conflict and high physical workload, are less satisfied with their work. Two variables were excluded from the analyses (role ambiguity and socio-emotional leadership style) due to a high correlation with feedback and social support from supervisors respectively.
The remaining five relations were not found. The first is the relation between autonomy and job satisfaction. Although many studies did find this positive relationship (Hackman et al., 1974; 1975; 1976; 1980; Boumans, 1990; Spector et al., 1991; Iverson, 1998; Tummers et al., 2000), Jansen et al. (1996) and Berkhout (2000) on the other hand, did not find a relation between autonomy and job satisfaction (indirectly concluded from Berkhout's study). It might be possible that the effect of autonomy on job satisfaction is only shown when interacting with other workload variables like time pressure or working conditions. Dwyer et al. (1991), De Jonge et al. (1992) and Mulder et al. (1997) concluded from their studies that the degree of autonomy determines if high (physical and emotional) workload and time pressure lead to job(dis)satisfaction. High workload and time pressure do not lead to lower job satisfaction, due to a high degree of autonomy. Another explanation for not finding a relation between autonomy and job satisfaction might be the meaning of the concept 'autonomy'. Autonomy is a typical concept from higher professionalized occupations with the meaning 'responsibility', 'professional independence'. For lower educated people 'autonomy' means something is less positive, like' feeling left out in de cold' and 'being on your own'. This is possibly only

valid for the relation with job satisfaction, because the results show that autonomy did have a relation with burnout.
Secondly, it was expected that home helps who experience a high emotional workload, work under high time pressure, and experience less skill variety in their work are less satisfied with their work. In this study, these relations were not found. It might be possible that these three aspects of working in home help services are indirectly related to job satisfaction, namely via another work-related aspect.
1) Home helps that work under a high time pressure experience also a high physical workload (correlation of .44). The results of the regression analyses show that home helps that experience a high physical workload are less satisfied with their work.
2) Home helps that experience a high emotional workload (higher categories of home help), also had to perform conflicting tasks and/or had to perform their work differently compared to how they want to (role conflict) (correlation of .42). The results of the regression analyses show that home helps that had to perform conflicting tasks among others are less satisfied with their work.
3) Home helps that experience the most skill variety in their work are the higher categories of home helps. Higher categories of home help experience more learning- and growth opportunities (correlation of .39). The results of the regression analyses show that home helps that experience sufficient learning and growth opportunities are very satisfied with their work.

Recent figures show that absenteeism, the physical outcome of working in home help services, in Dutch home help services is very high. In the literature regarding absenteeism, a distinction is made between absenteeism as an individual characteristic and absenteeism as an organizational characteristic (Nijhuis, 1984; Smulders, 1984). In this study, in accordance with the model that was considered at individual level, absenteeism was examined as an individual characteristic. Home helps were asked about their absenteeism in the past 12 months (self-reported). Absenteeism was measured by three measures: absent or not, frequency of absenteeism and total duration of absenteeism. The results of this study showed that none of the three measures of absenteeism were affected by any of the (expected) workload and capacity for coping variables. Only home helps that are less healthy and younger home helps were more frequently absent. None of the other workload variables (organizational characteristics, job characteristics, working conditions) or capacity for coping variables (social support, coping strategies) were significantly related to any of the three measures of absenteeism. In other words, the results of testing the research model showed that home helps are absent for two reasons. Firstly because they are ill. Secondly, because younger home helps also have a family and household to take care of, besides their job. The pressure of

having two jobs might contribute to a higher level of absenteeism. There were no indicators describing the role of the occupation itself. This is in line with results from many other researches studying individual absenteeism (Chapter 8).
Individual absenteeism can be measured differently however. For instance by using an objective and thus a more reliable way such as using the absenteeism-figures from the central registration department of the organization. Objective absenteeism measurements may yield in more significant relations between absenteeism and the workload and capacity for coping variables.
Absenteeism was included in the research model, because it was one of the outcome factors in both the job characteristics model by Hackman et al. (1980) and the workload/capacity model by Veerman (1989).
Absenteeism can be addressed differently however, using organizational characteristics such as: the size of the organization, stressful physical working conditions, autonomy in operational management, average age of personnel, degree of repetitive work. Examining variables on organizational level probably explains the differences in absenteeism between organizations. Philipsen (1969), Nijhuis (1984) and Smulders (1984) who studied absenteeism related to organizational characteristics earlier, did already find some interesting and significant results. For example a high percentage of absenteeism appeared in both small and large organizations, in organizations with little repetitive work and a low autonomy in operational management, in organizations with a bad reputation, and in organizations with a high degree of urbanization of the environment.
This is again an illustration of the fact that the organizational approach of absenteeism is more fruitful than the individual approach. Therefore, it is recommended to exclude absenteeism from the current research model, and to measure absenteeism in the future with the organizational approach.

Methodological limitations could have contributed to the present results namely the problems of self-reporting of absenteeism versus central registration as well as bias in selection of home helps. Both limitations might have caused an underestimation of absenteeism.

A final comment is made about the psychological and physical outcomes of working in home help services of the research model. Burnout, job satisfaction and absenteeism have been studied independently. According to the research model, there are no mutual relations between outcomes of work. It also appeared from the study that burnout, job satisfaction and absenteeism are not interrelated.

Recommendations for practice

The study took place at a time of major change in Dutch home care. Many home help organizations were merging or integrating with organizations for home nursing, which cost a lot of time and energy. At the same time, government policy was to introduce a client-centred budget, private for-profit organizations (privatizing) and substitution of care. The aim in home care organizations was therefore to increase efficiency, productivity and flexibility. Budget cuts lead to financial problems in some organizations for home care. And finally, the demand for home help services was still larger than the supply, resulting in large waiting lists at the time of the study (10.000 households).

On the other hand, during the period of the study, more attention was paid to the position of carers and helpers in home care and home help services (Commissie Verzorging, 1995), resulting in recommendations to guarantee or otherwise make home help services more attractive. The conclusions of the study and the resulting recommendations should be seen in the light of these developments and changes.

Daily practice

From the results of the registration survey, the following conclusions were drawn. Firstly, there appears to be an overlap between the consecutive categories of home help with regard to the content of their work ('A' home helps and 'B' caring helps, 'C' carers and 'D' carers). This is demonstrated by the lack of clear boundaries in their work: home helps sometimes carry out activities for which they are not formally qualified. This mainly relates to the performance of psychosocial tasks by the lower categories of home helps.

I *A new categorization of categories of home help is recommended in the occupation of home care worker. This categorization should not only be based on tasks, but also the complexity of the client system should be taken into account. A suggestion is to establish four categories of home help. The first category, category I, mainly carries out household activities and supporting activities (currently carried out by alpha helps and some 'A' home helps). The second category, category II, carries out a combination of household activities and basic personal caring activities with supporting activities (currently carried out by some 'A' home helps, 'B' caring helps, some 'C' carers). The third category, category III, carries out mainly personal care activities and psycho-social activities (currently carried out by some 'C' carers and 'D' carers). Finally, the fourth category, category IV, provides mainly psychosocial guidance for families with multiple-complex problems (currently carried out by specialized 'E' carers). All home helps*

carry out activities in the area of consultation and co-operation (reporting), some more than others.

Finally, the new profiles also show that household and caring activities are never carried out solely in home help services, but in combination at least with psychosocial activities.

II *In allocation of time at least 10% should be assessed to supportive (and psychosocial) activities. It appears that all home helps spend time on supportive activities, although these activities were not assessed or allocated and no time was reserved for it. Daily practice showed that this kind of support is always given to a client.*
Furthermore, explicit attention should be paid to (hidden) psychosocial needs of clients. By taking into account psycho-social support during the assessment of needs as well as during the allocation of help, the extra activities home helps carry out in this area will be limited, both in duration and quantity. This will probably increase the efficiency of the work.

Quality of working life
In this study, the indicators for the quality of working life were job satisfaction, burnout and absenteeism.
On the basis of the results of this study, it can be concluded that home helps in general are reasonably satisfied with their work. Alpha helps are the exception. They are dissatisfied with almost all work aspects, but mainly with learning and growth, promotion opportunities and contact with supervisors and colleagues. This has mainly to do with the fact that alpha helps are not in service of the organization, but the client is formally their employer. Consequently they have hardly any contact with the organization and are not entitled to training and education. From the results it appeared that job satisfaction of the other categories of home help is positively related to learning and growth opportunities of home helps and to the social support they receive from their supervisors. This relation is probably also valid for alpha helps.

I *In order to increase the (low) job satisfaction experienced by alpha helps, home care organizations are recommended to increase alpha helps' involvement in the organization. One can think of formal or informal meetings for discussion or social gatherings respectively, which can improve the contact between the alpha helps with their colleagues and the organization. Furthermore, the organization can show appreciation for the*

alpha help through gestures such as sending a Christmas card, Christmas-present or flowers during sickness.
Since early 2000, discussion at national, political level is going on about the option to offer alpha helps a position in the organization as 'A' home helps. This would take away the 'negative' aspects of an alpha help-occupation such as no contact with organization and colleagues, only 6 weeks salary during sickness, but not during the first two weeks of sickness, and a weak legal position. However, this would probably also take away some of the 'positive' aspects of an alpha help-occupation, like flexible working hours, same clients for a longer period of time, and longer (unpaid) leave. It is therefore important that organizations take these positive aspects into consideration.

In this study, emotional exhaustion and personal accomplishment were indicators of burnout. It can be concluded from the study that home helps that experience a high autonomy, sufficient learning and growth opportunities, and use an active coping strategy were less susceptible for burnout.

II *Home helps should have the opportunity of training and education, suitable for the various categories of home help and their job content. Home care organizations have to make sure that this opportunity is present. For example training and education is the area of psychosocial support. Learning and growth opportunities increase a person's job satisfaction and decrease feelings of burnout.*

Further it can be concluded that negative working conditions like a high physical workload, emotional workload and a high time pressure and the passive coping strategy were positively related to burnout.

III *All home care organizations have to make sure that there is an adequate policy for working conditions in their organization. It appears that negative working conditions are related to a higher risk of burnout and to lower job satisfaction. Examples of such aspects that should be included in this policy are the Arbo-check by the supervisor (checking if the working situation is safe and adequate working material are present in the household) and training in appropriate procedures lifting of clients.*

Although the home helps consider themselves to have a good health, the average absenteeism in the participating organizations is rather high: more than 10% (1995).

From the results it can be concluded that younger home helps and less healthy home helps are more often absent. There is also a positive relation between home helps whose supervisors use a socio-emotional leadership style and the frequency of absenteeism of these home helps.

IV All home care organizations have to appoint someone, a co-ordinator perhaps, to monitor and even counsel absent home helps (separately or in a group). This might reveal work-related problems sooner and increase a home helps involvement with the organization.

Recommendations for future research

The study yielded some interesting results regarding the content of work and the quality of working life of home helps in the Netherlands. Although the majority of the research questions were answered satisfactorily, some questions remained unanswered and some new questions arose. Therefore further research is needed.

Firstly, it is recommended that absenteeism in home help services should be studied more thoroughly in the near future. The high absenteeism figures and the few explanations that were found, make it important to do things differently in future research. One can measure absenteeism in another, possibly more accurate, way like using the absenteeism figures from the department of personnel affairs or making a distinction in short-term and long-term absence. Another recommendation is to focus on absenteeism as an organizational characteristic, and investigate the influence of several variables at the organizational level, like company HRM policy, level of urbanisation, salary, support, absence-control and type and size of organization. This would also imply the use of multi-level analyses. Future research should elaborate on the work of Philipsen (1969), Nijhuis (1984) and Smulders (1984).

Additional research is recommended to study two categories of home helps specifically: the 'extremes' of the six categories of home helps. The results of this study showed that alpha helps and specialized 'E' carers differ in many ways from the other categories of home helps, especially regarding the quality of working life. Compared with the traditional home helps, alpha helps are less satisfied in their work, they have few opportunities for learning and growth at work, little variety in their work and experience little feedback from their supervisor. Compared with the other categories of home helps, specialized 'E' carers work most hours per week, they work under high time pressure and experience high mental and emotional workload in their work. Further they experience the highest role conflict (performing

conflicting tasks), and their supervisors focus more on production than on well being and comfort (instrumental versus socio-emotional leadership style). Specialized 'E' carers experience more feelings of burnout (emotional exhaustion), especially compared with alpha helps and 'A' home helps.
Future research should focus on the possible transition of alpha helps from being a client's employee to become an employee of the home care organization. Furthermore, explicit attention should be paid to the position of specialized 'E' carers, who work under stressful working conditions.

Further insight is required in one of the tasks of home helps: psychosocial and supportive activities. The results from the study showed that these activities are, in general, more often carried out than was assessed by the home help manager. Future research should focus on the necessity and the importance of these activities, carried out by all categories of home helps. Attention should also be paid to the need for training and education in this area.

In addition, the mediator role of 'autonomy' might be worthwhile studying. In this study, autonomy was related negatively to burnout, but no relation was found with job satisfaction, although expected. This might have to do with the fact that home helps are relatively autonomous in their work. It might be interesting to study the effect of the amount of autonomy, someone's preference for autonomy and interaction with other workload variables in relation to the various psychological and physical outcomes of working in home help services (Dwyer et al., 1991; Jansen et al., 1996; Mulder et al., 1997). Furthermore, also the curvilinear relationship between autonomy and the various outcomes of working in home help services should be studied (Warr, 1990; Fletcher et al., 1993; Mulder et al., 1997).

Finally, it is recommended to study the quality of working life of home helps over a longer period of time. It is firstly important to test the research model in a longitudinal design, in order to find cause-effects relations between the independent and dependent variables, and more insight in the mutual relations between the dependent variables. Secondly, a longitudinal design is furthermore interesting, because earlier research has showed that job characteristics and working conditions were significantly correlated to absence occurring 3 to 6 years later (Rentsch et al., 1998; Smulders et al., 1999), although in this study no relations were found between job characteristics, working conditions and present absence.

REFERENCES

Allaart PC, van Essen G, Peters F. Arbeid in zorg en welzijn. [Work in care and well-being]. Tilburg: OSA, 2000

Baars JA, Spaan JM. Jaarboek Thuiszorg 1996. [Yearbook Home Care 1996]. Bunnik/Utrecht: LVT/NZi, 1998

Berger RM, Anderson S. The in-home worker: serving the frail elderly. Soc Work 1984; 29:456-61

Bergers GPA, Marcelissen FHG, de Wolff CH. Vragenlijst Organisatie Stress-D Nijmegen. [Questionnaire Organisation Stress-D Nijmegen]. Nijmegen: Katholieke Universiteit Nijmegen, Vakgroep Arbeids- en Organisatiepsychologie, 1986

Berkhout AJMB. Resident-oriented care in nursing homes: an evaluation study of the model of resident-oriented care, the implementation and the effects. [Thesis]. Maastricht: Universiteit Maastricht, 2000

Beukema L. Kwaliteit van de arbeidstijdverkorting. [Quality of reduction of working hours]. Groningen: Karstapel, 1987

Boumans NPG. Het werk van verpleegkundigen in algemene ziekenhuizen. [The work of nurses in general hospitals]. [Thesis]. Maastricht: Rijksuniversiteit Limburg, 1990

BVG (Dutch Industrial Board for Human Services). BVG-Berichten 1995. [Dutch Industrial Board for Human Services Reports 1995]. Zeist: BVG, 1995

Calsbeek H, Hingstman L, Talma H, van der Windt W. Verpleging en verzorging in kaart gebracht 2000. [Nursing and caring charted 2000]. Maarssen: Elsevier Gezondheidszorg, 2000

Ceslowitz SB. Burnout and coping strategies among hospital staff nurses. J Adv Nurs 1989; 14:553-7

Commissie Verzorging (Caring Committee). Zorg voor Zorg. [Caring for Care]. Utrecht: LCVV, 1995

van Dierendonck D, Groenewegen PP, Sixma H. Opgebrand: een inventariserend onderzoek naar gevoelens van motivatie en demotivatie bij huisartsen. [Burnout: an inventory on feelings of motivation and demotivation among general practitioners]. Utrecht: NIVEL, 1992

van Dierendonck D, Schaufeli WB. Burnout en organisatiebetrokkenheid bij leerlingverpleegkundigen: de rol van billijkheid, sociale steun en probleemhantering. [Burnout and organizational commitment among student-nurses: the role of equity, social support and problem-management]. TSG 1993; 71:339-44

Duijnstee M. De belasting van familieleden van dementerenden. [The workload of family members of people with dementia]. [Thesis]. Nijkerk: Intro, 1992

Dwyer DJ, Ganster DC. The effects of job demands and control on employee attendance and satisfaction. J Organ Behav 1991; 12:595-608

Fisher B, Tronto J. Towards a feminist theory of caring. In: Abel E, Nelson M (eds). Circles of care: work and identity in women's lives. Albany: State University of New York Press, 1990

Fletcher BC, Jones F. A refutation of Karasek's demand-discretion model of occupational stress with a range of dependent measures. J Organ Behav 1993; 14:319-30

Garden AM. Depersonalisation: a valid dimension of burnout? Hum Relat 1987; 40:545-60

Graham H. Caring: a labour of love. In: Finch J, Groves D (eds). A labour of love. London: Routledge & Kegan Paul, 1983

Gremmen I. Ethiek in de gezinsverzorging: gender en de macht van zorg. [Ethics in home help services: gender and the power of care]. [Thesis]. Utrecht: Jan van Arkel, 1995

Hackman JR, Oldham GR. The Job Diagnostic Survey. New Haven: Yale University, 1974

Hackman JR, Oldham GR. Development of the Job Diagnostic Survey. J Appl Psychol 1975; 60: 9-170

Hackman JR, Oldham GR. Motivation through design of work: test of a theory. Organ Behav Hum Perform 1976; 16:250-79

Hackman JR, Oldham GR. Work redesign. Reading: Addison-Wesley, 1980

Haemmerlie FM, Montgomery RM. Role conflict in a homemaker aide program for frail elderly. Psychol Rep 1982; 51:63-9

Hartweg DL. Dorothea Orem: Self-care Deficit Theory. In: McQuiston CM, Webb AA (eds). Foundations of nursing theory: contributions of 12 key theorists. Thousand Oaks: Sage, 1995

van de Haterd J, Liefhebber S, Leistra E, Hens H. Beroepsprofiel van helpenden en verzorgenden. [Job profile for home help and caring staff]. Maarssen: Elsevier gezondheidszorg, 2000

Hattinga Verschure JCM. Algemene zorgkunde voor de zorgverlenende beroepen. [The general art of caring for caregiving professions]. Lochem: De Tijdstroom, 1981

van den Herik C, de Been M, Vulto M. 'Alles draait om de cliënt': de inhoud, het eigene en de kwaliteit van de arbeid van het uitvoerende werk in de gezinszorg. ['Everything revolves around the client': the content, characteristic and quality of work in home help services]. Leiden: Rijksuniversiteit Leiden, Faculteit Sociale Wetenschappen, Vakgroep Vrouwenstudies, 1995

van den Heuvel W, Gerritsen H. Home care services in the Netherlands. In: Jamieson A (ed). Home care for older people in Europe: a comparison of policies and practices. Oxford: Oxford University Press, 1991

Hingstman L, Peters P, van der Windt W, Harmsen J, Allaart PC, de Voogd-Hamelink AM. Rapportage Arbeidsmarkt zorg en welzijn 2000. [Report on labour market of care and well-being 2000]. Tilburg: OSA, 2000

Hood JN, Smith HL. Quality of work life in home care. J Nurs Adm 1994; 24:40-7

Homman M. Terwijl je afstoft kom je heel wat tegen: professionele huishoudelijke zorg: een onmisbare pijler onder een verantwoorde thuiszorg. [You come across a lot while dusting: professional household care: an indispensable pilar for justified home care]. Utrecht: STING, 1994

Hutten JBF, Kerkstra A. Home care in Europe. Aldershot: Arena, 1996

IDW (Institut der Deutschen Wirtschaft). Sozialraum Europa. Köln: IDW 1989

Iverson RD, Olekalns M, Ervin PJ. Affectivity, al stressors and absenteeism. J Vocat Behav 1998; 52:1-23

Jansen PGM, Kerkstra A, Huijer Abu-Saad H, van der Zee J. The effects of job characteristics and individual characteristics on job satisfaction and burnout in community nursing. Int J Nurs Stud 1996; 33:407-21

de Jonge J. Job autonomy, well-being, and health. [Thesis]. Maastricht: Rijksuniversiteit Limburg, 1996

de Jonge J, Landeweerd A. Werkdruk en autonomie. [Quality of working life and autonomy]. TVZ 1992; 12:465-8

de Jonge J , Landeweerd A. Toetsing van de Job Demand-Control benadering bij werknemers in de gezondheidszorg. [Testing the Job Demand-Control approach among employees in health care]. Gedrag en Organisatie 1993; 21:79-92

Kandolin I. Burnout of female and male nurses in shiftwork. Ergonomics 1993; 36:141-7

Karasek RA. Job demands, job decision latitude, and mental strain: implications for job redesign. Adm Sci Q 1979; 24:285-308

Karasek RA, Theorell T. Healthy work: stress, productivity and the reconstruction of working life. New York: Basic Books, 1990

Katzell R, Bienstock P, Faerstein P. A guide to worker productivity experiments in the United States 1971-1975. New York: New York University Press, 1977

Knibbe JJ, Kersten JWET, Friele RD. Rotterdam in de lift: een onderzoek naar de effecten van de introductie van patiëntenliften in de thuiszorg. [Rotterdam elevated: a study about the effects of the introduction of patient-lifts in home care]. Utrecht: NIVEL, 1994

Lindgren CL. Burnout and social support in family caregivers. West J Nurs Res 1990; 12:469-87

LVT (Landelijke Vereniging voor Thuiszorg-National Association for Home Care). Zorg thuis. [Care at home]. Bunnik: LVT, 2000

Meijman TF, O'Hanlon JF. Arbeidsbelasting, een inleidend overzicht van psychologische theorieën en meetmethoden. [Pressure of labour: an introductory overview of psychological theories and measure-methods]. In: Drenth PJD, Thierry H, de Wolff CJ (eds). Handboek Arbeids- en Organisatiepsychologie. [Handbook of Work and Organizational Psychology]. Deventer: Loghum Slaterus, 1984

Mok AL. Dienen als beroep. [Serving as an occupation]. [Thesis]. Leiden: Stenfert Kroese, 1962

Mulder JGP, de Jonge J, Nijhuis FJN. Effecten van werkkenmerken op de gezondheid. [Effects of work characteristics on health]. TSG 1997; 5:235-43.

Nijhuis F, Beoordelingen van organisatiekenmerken: een sociaal gezondheidkundige studie naar organisatiekenmerken en ziekteverzuim. [Assessments of al characteristics: a socio-medical study on al characteristics and absenteeism]. [Thesis]. Maastricht: Rijksuniversiteit Limburg, 1984

Nijkamp P, Pacolet J, Spinnewyn H, Vollering A, Wilderom C, Winters S. Services for the elderly in Europe: a cross-national comparative study. Leuven/Amsterdam: HIV/VU, 1991

Orem DE. Analysis and application of Orem's theory. In: Clements IW, Roberts FB (eds). Family health: a theoretical approach to nursing care. New York: John Wiley, 1983a

Orem DE. The family coping with a medical illness: analysis and application of Orem's theory. In: Clements IW, Roberts FB (eds). Family health: a theoretical approach to nursing care. New York: John Wiley, 1983b

Orem DE. Nursing: concepts of practice (3rd edition). New York: McGraw-Hill, 1985

Orem DE. Nursing: concepts of practice (4th edition). St. Louis: Mosby, 1991

Pearlin LI. Social process and social support. In: Cohen S, Syme L (eds). Social support and health. New York: Academic Press, 1985

Philipsen H. Afwezigheid wegens ziekte. [Absence due to illness]. Den Haag/Groningen: NIPG-TNO/Wolters-Noordhoff, 1969

Rentsch JR, Steel RP. Testing the durability of job characteristics as predictors of absenteeism over a 6-year period. Pers Psych 1998; 51:165-90

Schaufeli WB. Opgebrand: over de achtergronden van werkstress bij contactuele beroepen -het burnout-syndroom. [Burnout: about the jobstress in the human services professions -the burnout-syndrome]. Rotterdam: Ad Donker, 1990a

Schaufeli WB, van Dierendonck D. Burnout, een begrip gemeten: de Nederlandse versie van Maslach Burnout inventory (MBI-NL). [Burnout, a concept measured: the Dutch version of the Maslach Burnout Inventory (MBI-NL)]. Gedrag & Gezondheid 1994; 22:153-71

Schaufeli W, Enzmann D. The burnout companion to study & practice: a critical analysis. London: Taylor & Francis, 1998

Schaufeli WB, Enzman D, Girault N. Measurement of burnout: a review. In: Schaufeli WB, Maslach C, Marek T (eds). Professional burnout: recent developments in theory and research. Washington: Taylor & Francis, 1993

Scheurs PJG, van den Willige G, Tellegen B, Brosschot JF. De Utrechtse Coping Lijst: UCL- handleiding. [The Utrecht Coping List: UCL-Manual]. Lisse: Swets & Zeitlinger, 1988

Simonen L. Caring by the welfare state and women behind it-contradictions and theoretical considerations. Tampere: University of Tampere, Research Institute for Social Sciences, 1990

Smulders PGW. Bedrijfskenmerken en ziekteverzuim in de jaren zestig en tachtig: een vergelijkende studie. [Organizational characteristics and absenteeism in the sixties and eighties: a comparative study]. [Thesis] Den Haag: NIPG/TNO, 1984

Smulders PGW, Veerman TJ. Handboek ziekteverzuim. [Handbook absenteeism due to illness]. Den Haag: Delwel, 1990

Smulders PGW, Nijhuis FJN. The Job Demand-Job Control Model and absence behaviour: results of a 3-year longitudinal study. Work Stress 1999; 13:115-31

Spaans M. Opgebrand in zorg en verpleging. [Burnout in caring and nursing]. Tijdschr Gezondh Polit 1995; 2:5-7

Spector PE, Jex SM. Relations of job characteristics from multiple data sources with employee affect, absence, turnover intentions, and health. J Appl Psychol 1991; 76:46-53

STRATEGO. Aan de slag. [Get busy]. Beverwijk: Stichting Thuishulp IJmond, 1991

Tummers GER, Landeweerd JA, van Merode GG. Organisatieaspecten, ervaren werkkenmerken en werkreacties in de verpleging. [Organisational characteristics, job characteristics and outcomes of working in nursing occupations]. Verpleegkunde 2000; 15:132-41

Turner RJ. Direct, indirect and moderating effects of social support on psychological distress and associated conditions. In: Kaplan HB (ed). Psychological stress. New York: Academic Press, 1983

Ungerson C. The language of care: crossing the boundaries. In: Ungerson C (ed). Gender and caring: work and welfare in Britain and Scandinavia. Hertfordshire: Harvester Wheatsheaf, 1990

Veerman TJ. Ziekteverzuim in de gezinsverzorging. [Absenteeism due to illness in home help services]. Amsterdam/Leiden: NIA, 1989

van Veldhoven M, Meijman T. Het meten van psychosociale arbeidsbelasting. [Measurement of psychosocial workload]. Amsterdam: NIA, 1994

de Vos EL. Aspecten van de huishouding. [An approach of household activities]. In: Goossens RC, de Vos EL (eds). Huishoudvoering met een laag inkomen.[Housekeeping with a low income]. Wageningen: Landbouwuniversiteit, Vakgroep Huishoudkunde, 1987

Vulto M, Morée M, van den Herik C. 'Thuis bij de cliënt sta je er alleen voor': kenmerken en eisen van het beroep helpende en verzorgende in de gezinsverzorging. ['You are on your own at the client's home': characteristics and demands of the home help and home care occupation]. Leiden: Rijksuniversiteit Leiden, Faculteit Sociale Wetenschappen, Vakgroep Vrouwenstudies, 1994

WVC (Ministry of Well-Being, Health & Culture). Heroverwegingsonderzoek 'Van samenwerken naar samengaan': gezinsverzorging en kruiswerk naar een geïntegreerd aanbod in de thuiszorg. [Reconsideration-study 'From working together to going together': home help services and community nursing to an integrated supply in home care]. Rijswijk: WVC, 1990

Walker A. Home care in Europe: current trends and future prospects. Brussels: European Association of Organisations for Home Care and Help at Home, 1991

Warr PB. Decision latitude, job demands and employee well-being. Work Stress 1990; 4:285-94

Wærness K. Caring as women's work in the welfare state. In: Holter H (ed). Patriarchy in a welfare society. Oslo: Universitetsforlaget, 1984

van der Windt W, Calsbeek H, Hingstman L. Feiten over verpleging en verzorging in Nederland 1998. [Facts about nursing and caring in the Netherlands 1998]. Maarssen/ Utrecht: Elsevier/De Tijdstroom/ LCVV, 1998

Working Group. (Werkgroep Werkveld). SOGW. Beroepsprofiel Verzorgende/Helpende. [Job profile home help and caring staff]. Leiden: Spruyt, van Mantgem & de Does, 1992

Zuidberg ACL. Het verzorgingsniveau van huishoudens. [The level of domestic care of households]. 's-Gravenhage: SWOKA, 1978a

PART I

Home helps work content

PART

Home helps work content

2 CARING IN HOME HELP SERVICES
a review of the literature

S.E.J. Arts, A. Kerkstra, J. van der Zee, H. Huljer Abu-Saad
Submitted for publication

ABSTRACT

In this literature review, various care-concepts applicable for studying caring in home help services are presented. The aim is to develop a scientifically based process description of caring in home help services. The concepts described in this review contain relevant aspects like caring from a woman's point of view, professional and informal care, and the functioning of a household. The concepts could also be categorized according to their object (caring as a whole, or a specific part of caring) and according to their subject (caring for an individual or for a household). Integrating the care-concepts and the results of the categorizations, together with the results of studies, a process description of caring can be presented, which will be used as a conceptual model to describe the process of caring in home help services.

Keywords: caring, professional care, home help services, model

2 CARING IN HOME HELP SERVICES
a review of the literature

S.E.L. Arts, A. Kerkstra, J. van der Zee, H. Huijer Abu-Saad

Submitted for publication

ABSTRACT

INTRODUCTION

One of the major trends in modern society is the disappearance of the multi-generation family and the replacement of inter-generational care for feeble or ill family members by privately or publicly delivered professional care. Although this is a world-wide trend, largely determined by economic factors, there are considerable differences in the extent to which this process has developed in countries in roughly the same economic circumstances. In 1988, 65% of the over 65 population of Japan lived with relatives; in Spain 30% of these elderly lived with their children, and in Sweden and Denmark this percentage was 4% (OECD, 1996). North West Europe is the front-runner of this trend of replacing family care by professional care; a process that is not without tension and debate. If something private is replaced by something public and if something natural is replaced by something artificial, debates about the obligations of the family versus the entitlements of the person-in-need and the demarcation of public and private care form sensitive and emotionally charged topics in public opinion and policy making. This study in professional home care deals with the professional answer to care deficits in households and with the reaction of professional care-givers to the framework of task-division imposed by the Dutch home care organizations in the mid-nineties. It is a study about Care, professional Care and Caregivers in particular. This article deals with the scientific base of the care concept. The line of reasoning is the following: if care, care giving and the amount and type of professional care are studied scientifically, the question has to be answered which scientific connotations the practical term "care' has. In order to study 'care' scientifically, the question has to be answered as to whether, to what extent or under which circumstances 'care' is a scientific and theoretical concept. Van Lieshout (1994) observes that a specific theory of care is still lacking, a problem that can only be solved by operationalizing 'Care' using other concepts like power, work and justice.

The 'Care' concept

In mature science, the notion of theory is well defined: a Theory is an integrated set of relationships with a certain level of validity (Willer, 1967). Both concepts and rationale, mechanisms and predictive values are pretty well determined. In emerging sciences, like nursing or caring research, the process of theory formation; the 'empirical cycle' in the terms of the Dutch methodologist De Groot (1961) leaves some room for both concept formation and the establishment of meaningful relationships between concepts. According to Koningsveld (1976) a

'concept' can be considered a theory in miniature; a microcosm of material validity and relationships between concepts. It is evident that nursing or caring research or nursing or caring science are emerging scientific disciplines. So both exploring the main concepts of nursing and caring and the establishment of meaningful, i.e. empirically tested and logically connected, relationships between concepts are in a stage of theoretical formation and empirical testing. This implies that a thorough exploration of the 'care'-concept is a worthwhile exercise in the process of theory formation in care research. In an emerging science emphasis on concepts rather than on theoretical and logical links, is a defensible strategy in theory construction. The concept of 'care' has both a very common sense value as an all pervading sense of reality.

Accordingly, an overview of the ways the Care-concept has been modified, adapted and linked to other concepts in order to fit into a broad range of theories, may form a useful tool for theory construction in nursing and caring sciences.
In this paper we try to relate empirical, common sense concepts in the theory of (home)Care to scientific notions, concepts and mechanisms. Using a search process, we link theory with the empirical operationalization of the concepts.

This article aims to provide the reader with an overview of caring in home help services with regard to theory and research, and come to a scientifically based process description of caring in home help services. To that effect, the following questions have been formulated:

1 What theoretically-based care-concepts, applicable for studying caring in home help services, are there?
2 What are the objects of these care-concepts?

METHODS

In order to gather the available literature, searches were done in four computer data-bases: Medline (1985-1998), Nursing and Allied Health Literature (1983-1998), and the Catalogue of the Netherlands Institute of Primary Health Care) catalogue (up to and including 1998).
The keywords used in these searches were caring theory, home economics theory, caring theory-home health care, informal care-home health care, professional care-home health care, and home health aides-caring theory, home health aides-informal care, home health aides-professional care. A combination

of the keywords with research and theory was also used. A total of 398 references was collected this way. Additional references were found by the snowball-method, which means that references cited in the discipline and research literature were also screened and used.

The following inclusion criteria were used. The articles 1) had to be published in the English, German or Dutch language and 2) had to be published officially in journals, books or PhD-theses. Excluded were studies described in 1) internal reports, 2) one-page reviews or 3) letters and 4) studies in other than the selected languages. Also excluded were many articles and studies in journals that are not available in the Netherlands, unless it was a journal with an 'impact factor'. Finally, 35 references describing concepts and/or research regarding care and caring in home help services met the inclusion criteria.

RESULTS

From the literature search, three main concepts regarding care and caring in home help services can be distinguished: (1) concepts regarding caring from a woman's point of view (feminist concepts) 2) concepts regarding (the relation between) non-professional and professional caring; and (3) concepts regarding the functioning of a household (home economic concepts). Six feminist concepts regarding caring were found, four concepts were found that focused on non-professional care (among others informal care) in relation to professional care, and two concepts were found that focused on the functioning of a household and the tasks that have to be carried out. Finally, two empirical studies were found regarding caring performed in home help services.

Feminist concepts to the caring in home help services

Caring has always been associated with women and the private sphere. Traditionally, women take care of the household, the children, their husbands and sometimes the parents and their in-laws. On the other hand, women also perform care as salaried employees, being home helps is one of them (Simonen, 1990). A short overview of the *various meanings* of care and caring is given (Graham, 1983; Wærness, 1984; Simonen, 1990; Ungerson, 1990). Then, attention is paid to caring as *a profession*: the content of caring and the ethics of caring in home help services (Simonen, 1990; Gremmen, 1995). Finally, the *process* of caring (in general) according to Fisher et al. (1990) is described.

Formal and informal care, private and public care

Ungerson (1990) claims that carers are usually seen as mothers and housewives, working in their own homes and providing services for close kin, also called *informal care*. When this kind of care is performed for similar dependent people, and performed by social services and/or voluntary agencies, at home or at an institution, it is called *formal care*. This distinction also exists with regard to working conditions, which are much better for formal care than for informal care (Ungerson, 1990). For example, formal care is characterised by division of labour, dispersed responsibility, social networks with other workers at the workplace and wages, while informal care is characterised by total responsibility, on call all the time, and no payment (Ungerson, 1990).

On the other hand, Graham (1983) states that this distinction between formal and informal care is not so clear. She argues that love and labour, as two dimensions of caring, are interrelated, and to express this, she describes caring as 'labour of love' (Graham, 1983; Ungerson, 1990; Gremmen, 1995).

Wærness (1984) declares that (more) emphasis on the power relationship between carer and cared for and on the actual work involved dissolves the distinction between private-public. Wærness states that there are three types of care, each corresponding to a different kind of relationship between carer and cared-for (Wærness, 1984; Ungerson, 1990). Firstly, there is *personal services*: an unequal relationship between carer and cared-for, where the latter has a higher social status; secondly there is *care-giving work*: an unequal relationship between carer and cared-for, where the latter is dependent and helpless; and finally, there is *spontaneous care*: impulsive and spontaneous and is not, like care-giving work, of a consistent and reliable nature. All three types of care can be provided both in private and public domain and can be both paid and unpaid work (Wærness, 1984; Ungerson, 1990).

Caring as a profession

Simonen (1990) considers that, in Finland, municipal homemaking, which she sees as *public caring work*, is a form of occupational mothering. In a way, it is an extension of home making. Lately, the Finnish home help occupation and also the caring work have been greatly changed. The main point in social care used to be emotional labour wrapped in manual housekeeping and care work. Nowadays, the mental work has become more important in home help services in order to understand different standpoints and meet varying client needs and be able to help and organize auxiliary help for them (Simonen, 1990). The foundation of the

work lies more in the combination of manual labour, which consists of concrete household activities and caring for people; mental labour, which involves in social care the allocation of time among different work activities; and emotional labour, which consists of involvement in clients' problems and respecting their intentions (Rose, 1983; Simonen, 1990).
Also Gremmen (1995) regards 'professional home care' as women's work: that is, almost all home helps are female, the work requires skills that are considered feminine, and the status is low as illustrated by almost complete absence of formal qualifications. She also states that feminist theory on caring has already changed from caring in the private sphere to caring as an occupation (Gremmen, 1995). Gremmen studied the ethics in professional home care and the relation with gender and power, and distinguishes two types of ethic: *a formal professional ethic* and *an ethic of care*. The formal professional ethic involves guidelines and standards that form the boundaries of the tasks, time-spending, professional secrecy, ways of caring etcetera. The ethic of care emphasises providing care corresponding with the wellbeing of the client in specific situations: meaning the recognition and understanding of the client's dependency on caregivers. Further, it emphasises a way of working where the relation with the client is essential. Although the ethic of care does not have an official status in professional home care, home helps find this ethic more important than the professional ethic. It provides opportunities to justify the home help's specific performance (Gremmen, 1995). Home helps believe that sometimes the professional ethic stands in the way of their 'caring', from an ethic of care point of view. On the other hand, the professional ethic can also support their ethic of care considerations and actions (Gremmen, 1995).

The process of caring

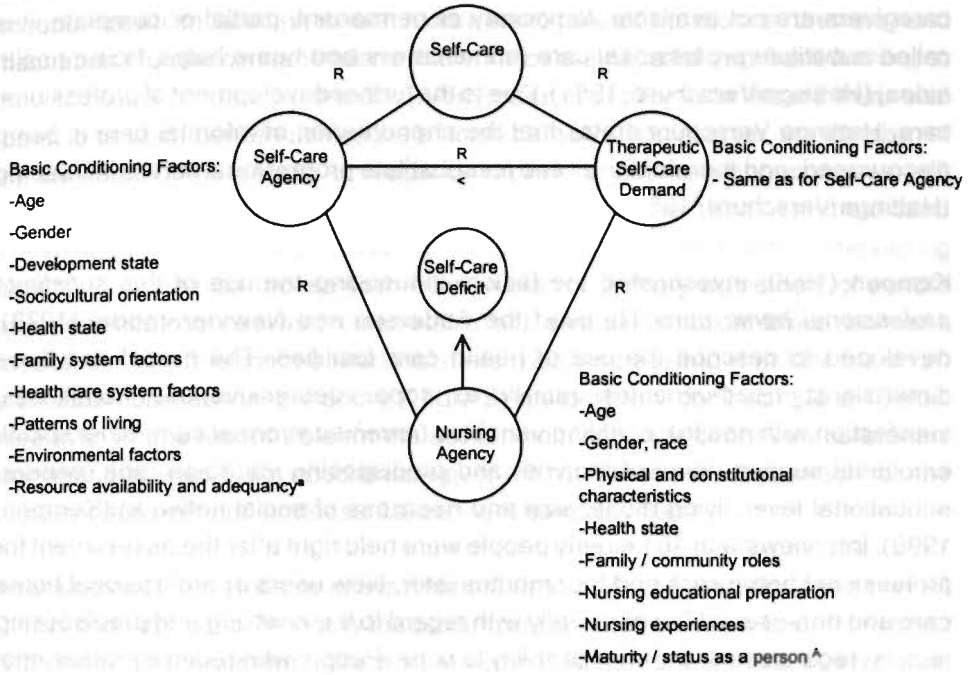
Fisher et al. (1990), do not agree with the emphasis on 'love' in the discussion regarding 'care'. They state that there can be other motivations for caring for others, for example fear, sense of duty, paternalism, pity, or habit (see Miller, 1976; Abel et al., 1990; Fisher et al., 1990; Gremmen, 1995). Further, they distinguished four consecutive phases in practising care. In the first phase, *caring about,* with the emphasis on observing or signalling needs, a relation is assumed between the carer and the person cared for. Responsibility is taken in the second phase for the fulfilment of these needs: *taking care of.* Phase three, *care giving*, involves performing the concrete caring activities necessary to fulfil the need. The content of these activities needs to be specified, depending on the situation. Finally, in the fourth phase, a response of the person cared-for to the care

provided, is given: *care receiving*. What is needed in all four phases, but in every phase in a different combination, are time, means, knowledge and skills. In every phase, carer and cared-for negotiate about the definitions of needs and on responsibilities they take. This also shows the relational aspects of the concept 'caring' (Fisher et al., 1990; Gremmen, 1995).
In order to gain more insight into the actual relationship between carer and cared-for, two concepts relating professional and non-professional care will be described.

Concepts regarding professional and non-professional care

The first concept that describes the relationship between professional care (nursing) and non-professional care (self-care and dependent care) is Orem's Self-Care Deficit Theory of Nursing (S-CDTN). Orem described her work as a 'general theory of nursing' containing three interrelated theories: theory of self-care or dependent-care deficit, theory of self-carer dependent-care, and theory of nursing systems. Central to all three theories is that people function and maintain life, health, and well-being by caring for themselves (Orem, 1985). In order to care for one's self, therapeutic self-care demands have to be achieved. Discrepancies can exist between self-care needs and the capability for self-care, resulting in self-care deficits (actual or potential, complete or partial, permanent or temporary, single or complex). In this case, professional care is legitimate. The goal of professional care is to increase the client's capabilities to meet their self-care needs, or to decrease their demands. Three levels of a professional caregiver's actions can be distinguished: wholly compensatory, partly compensatory and supportive educative. A patient or client may need all three types, but at different times throughout one health condition (Orem, 1987; Hartweg, 1995). Although this theory is developed for nursing and the care for an individual patient, the model can also be used with families (Orem, 1983a; 1983b; Tadych, 1985; Taylor, 1989) and communities (Orem, 1984; Hanchett, 1988; 1990) (Hartweg, 1995), and is therefore applicable in home help services, which provide care for a total household with existing or potential deficits. Figure 2.1 shows a conceptual structure of the S-CDTN.

Figure 2.1 Conceptual structure of the Self-Care deficit theory of nursing



Source: Orem (1987)
Note: R=relationship; < means that a self-care deficit exists when self-care agency is less than the therapeutic self-care demand.
A: From Orem (1991)

The second concept in professional and non-professional care, is by Hattinga Verschure (1981). He introduced, besides self-care, the term '*informal care*'. In his vision, self-care is the basis for all caring. Self-care is directly and accurately tuned to individual needs, possibilities and desired effects, without interference of other people (Hattinga Verschure, 1981). He defines informal care as all caring given by the members of a small social system, based on naturalness and reciprocity. In other words support from informal networks. Self-care and informal care together form the 'caring web' necessary for daily life; they make a couple; they complete and reinforce each other (Hattinga Verschure, 1981). Sometimes professional care is needed. When professional care provides specific and highly specialised tasks, which informal caregivers are not able to provide, it is called

complementary professional care (surgeons, nurses, psychologists, and physicians). When professional care provides informal care, because informal caregivers are not available, temporary or permanent, partial or complete, it is called *substitute professional care* (home carers and home helps, home health aides) (Hattinga Verschure, 1981). Due to the further development of professional care, Hattinga Verschure states that the phenomenon of informal care is being discouraged, and therefore the need for substitute professional care is increasing (Hattinga Verschure, 1981).

Kempen (1990) investigated the factors influencing the use of this *substitute professional home care*. He used the Andersen and Newman-model (1973), developed to describe the use of health care facilities. The model has three dimensions: need-variables (ability to cope, depressiveness, loneliness, satisfaction with health), enabling variables (*received informal care*, other social/ emotional support, level of income) and predisposing variables (age, gender, educational level, living alone, size and nearness of social network) (Kempen, 1990). Interviews with 101 elderly people were held right after the assessment for professional home care and four months later. New users of professional home care and non-users differ especially with regard to the enabling and predisposing factors, regardless of the level of ability to cope. People who receive professional home care are characterised more often by living alone, as being women, receiving less informal care and a generally lower income (all three types of variables). The results showed that people receiving a relatively large amount of professional home care after the assessment, are characterised by many problems relating to the ability to cope, depression, dissatisfaction with their health, receiving a relatively large informal care, a high income, being female, not living alone, relatively few social network-members living closer than 15 minutes and a high educational level. Further analyses show that problems in particular with regard to the ability to cope and the informal care received play a role in the amount of professional home care (Kempen, 1990).

The study of Duijnstee (1992) also focused on the *professional-informal care relation*. She studied the workload of family members of people with dementia, also called informal caregivers or primary caregivers. She compared the workload of these primary caregivers, and concluded that the differences were partly based on the factual differences in caring situations (objective workload) and partly on how the caring situation is experienced (subjective workload). A classification of intervening factors was made, based on two rounds of in-depth interviews with 40

primary caregivers. These factors included management (active forms of adjustment that manage the objective workload, stopping or reducing problems), acceptance (acceptation is what makes people take things the way they are) and motivation (subjective motivations that enforce the capacity and have nothing to do with objective capacity-aspects). A number of background factors were also found to be of influence such as the primary caregiver's character, the duration of the care giving, the degree of reciprocity in the relation between caregiver and care-receiver, help from others, and information about the disease and the care. These factors are versatile and complex, and so is their effect on the intervening factors. Duijnstee concluded that the workload of primary caregivers of people with dementia often shows an unpredictable individual variation. Based on these results, the author recommended that professional caregiving should focus on an individual approach of the primary caregiver's problem, for example a special caregiver who is responsible for the assessment of needs of primary caregivers and their problems. This special caregiver will remain the contact person for the primary caregiver and professional caring (Duijnstee, 1992).

After studying caring from feministic point of view, and study the relations between formal and informal care, finally the content of caring is reviewed. In order to shed further light on the content of the work in home help services, two home economic concepts are described.

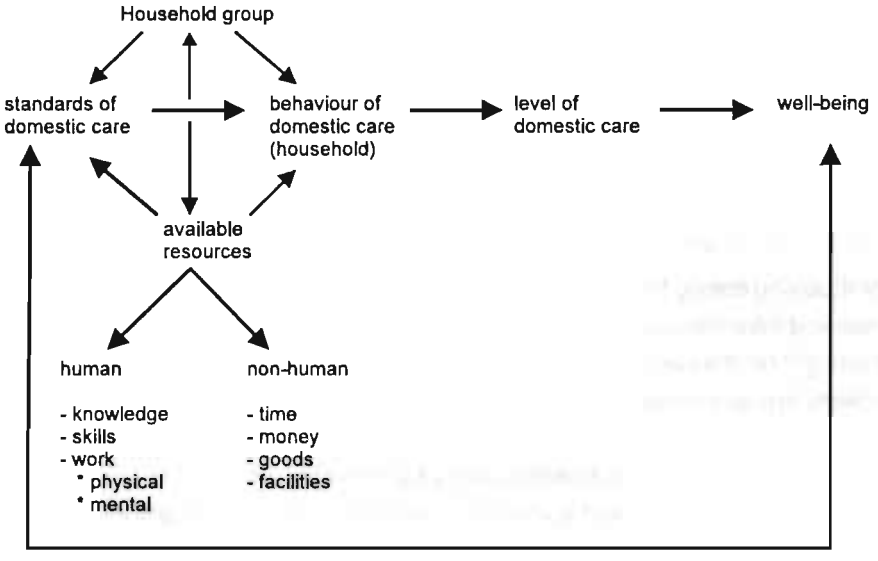
Concepts relating to the functioning of a household

Carrying out household and caring activities in households is among others, the work of home help services. This is studied in home economics. Theories derived from home economics seem therefore suitable to describe caring in home help services. More specifically, home helps work in households and take care of the client's household. Therefore, 'household caring' in a broad sense is a suitable concept for describing the work of home help services. With a scientific basis for the work of home helps, the existence of home help services will be indisputably acknowledged (STRATEGO, 1991). Specifically there are two models which clarify the meaning of the concept 'household', namely the household-analysis-model of Zuidberg (1978a) and the household activities approach of De Vos (1987) (STRATEGO, 1991). The first addresses the functioning of a household group, and the latter explains the specific activities carried out in a household.

Zuidberg's model of domestic care

Zuidberg views the household group as "a system of which the parts are inextricably bound up with each other" (Zuidberg, 1978a; 1978b). A disturbance somewhere in the system directly influences the entire system. Zuidberg uses the following concepts (Figure 2.2).

Figure 2.2 The analysis scheme of the level of domestic care by Zuidberg



Source: Zuidberg, 1978a

The starting point is a *household group*, which means the members of a family or members of a group living in the same house. This household group has certain *standards of domestic care*: beliefs and habits regarding goals and the usage of available resources. In order to fulfil the needs of the household group, certain behaviour is necessary which is called '*behaviour of domestic care*' (or household). This household is defined as a complex of activities on behalf of, and usually also performed by, members of a social unit: the household group, directed towards the fulfilment of material needs and towards the creation of material conditions for the fulfilment of non-material needs. Within the actions of the household, three elements can be distinguished: the definition of goals based

on the needs of the members of the household group, the planning and organizing of household actions, and the performance of these actions (Zuidberg, 1978a; 1978b). Then there are *available resources*, which can be used in the fulfilment of needs. These resources can be distinguished in human (work, knowledge and skills) and non-human resources (time, money, goods and facilities). As a result of the behaviour of domestic care, a *level of domestic care* is reached, performed on behalf of the daily care of the members of the household group. When the standards of domestic care meet the level of domestic care, *well-being* is achieved. Well-being is the recognition of the level of domestic care by members of the household group (Zuidberg, 1978a; 1978b).

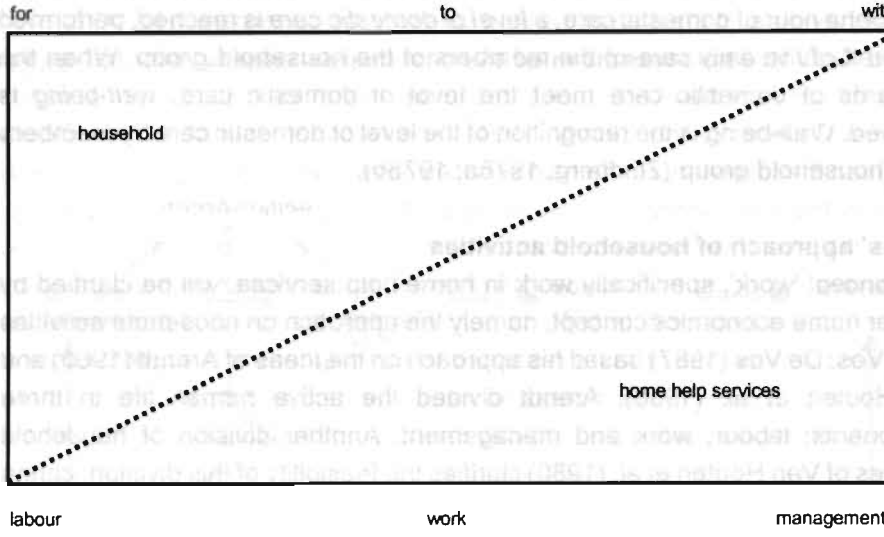
De Vos' approach of household activities

The concept 'work', specifically work in home help services, will be clarified by another home economics concept, namely the approach on household activities by De Vos. De Vos (1987) based his approach on the ideas of Arendt (1960) and Van Houten et al. (1980). Arendt divided the active human life in three components: labour, work and management. Another division of household activities of Van Houten et al. (1980) clarifies the feasibility of this division: caring for, taking care of, and managing. Combining both divisions of household activities, a third division was formed by De Vos (1987). He studied the active human activities regarding the household, what led to a taxonomy of household activities. He distinguished three kinds of activities, each representing an increasing degree of complexity: 1) *household labour* means routine and cyclical activities that need to be done and take relatively a lot of time (cleaning activities, laundry and ironing); 2) *household work* includes caring for the members of the household group. Apart from personal physical care, it includes also support for babies, young children, adults, elderly and the sick people; and 3) *household management* contains psycho-social support/guidance; management and control of the household: managing the activities, controlling the money, organising the household, bringing up children (De Vos, 1987).

The division made by De Vos generally corresponds with the classification of activities used in Netherlands home help services: household activities, personal caring activities and psycho-social/supporting activities. The nature of De Vos' activities varies from simple to complex: from household labour to managing the entire household. Each of these activities goes together with a certain relationship between the home help and the members of the household: when doing household labour, one is *caring for* a person; when doing household work, one is *giving care to* a person; when managing the household, one is *caring with* a

person (STRATEGO, 1991). Figure 2.3 gives an overview of De Vos' taxonomy of household activities with the corresponding relationships.

Figure 2.3 The taxonomy of household activities by De Vos



Source: STRATEGO, 1991

The Figure shows that household activities constitute a continuum. The nature of the activities that have to be carried out becomes more complex from left to right in the Figure; that is where the home help gradually takes over from the household/client. The Figure shows both the activities (labour, work, management) and the corresponding relationships between carer and cared for (caring for, caring to, caring with).

Two empirical studies were found which focused on *job content and job characteristics of caring in home help services*. The aim of one study was to establish data on the tasks of home helps, the profile and requirements of current service recipients, and possible gaps in existing provision in Ireland (National Council for the Elderly, 1994). The results show that the tasks carried out by the Irish home helps can be divided into three categories: personal care (assisting the client to wash and dress); instrumental tasks within the home (day-to-day

cleaning, preparing meals); and instrumental tasks outside the home (shopping, paying bills). Tasks performed inside and outside the house were carried out regularly by the home helps. Personal care tasks were not mentioned very frequently (National Council for the Elderly, 1994). There appeared to be uniformity in performing tasks among two of the three categories: tasks within and outside the home. In the area of the third category, personal care, a lot of variation existed. Only little help was provided by home help services for informal carers. This is indicative of the overall lack of resources to provide help to informal carers (National Council for the Elderly, 1994). The National Council for the Elderly concluded the following. Home help services have been providing help to elderly people in the community, to those living alone in specific. Among these latter people, the level of dependency, both instrumental and physical, is increasing and this trend is expected to continue. This implies that a greater demand on home help services is expected. In order to deal with this, the role and purpose of the home help service needs to be redefined to complement and support informal carers and to cope with the increasing needs for help and care among elderly people living at home without day-to-day care or support (National Council for the Elderly, 1994).

Van den Herik et al. (1994, 1995) studied the professionalization of the work in home help services in the Netherlands (Vulto et al., 1994; Van den Herik et al., 1995). An insight was given in the characteristics of the work of home helps, which were operationalized as 'activities', 'complexity of the client-situation' and 'job characteristics' (Vulto et al., 1994; Van den Herik et al., 1995). Results showed that *activities* can be divided in household activities, caring, supporting activities and specialised guiding activities. Although, the proportion between the activities differs for each category of home help, some overlap in activities exists. The higher categories of home help (home carers) carry out more supporting and caring activities. Secondly, four levels of *complexity* were found: simple, moderately complex, complex and very complex. The home helps show similarities regarding the type of client they have, although the higher categories of home help (home cares) work in more complex situations (e.g clients with dementia and terminally ill clients). Only the specialized 'E' carers have their own type of clients: clients with multi-complex problems in need of specialised guiding care. Thirdly, the essence of *job characteristics* lies in the head- and heart-aspects of the work, the so-called invisible aspects of this occupation. For example, observing: watching clients closely for signs of improvement or regression and report this to their supervisor (Vulto et al., 1994; Van den Herik et al., 1995). The results of the study suggest that a new classification of home helps

is needed to eliminate the overlap between categories of home help to a large extent. Three measures are used for the new classification: the complexity of the client-situation, the proportion between household caring and personal physical caring, and the amount of clients cared for on a morning or afternoon (Vulto et al., 1994; Van den Herik et al., 1995).

So far, we have looked at various theoretically-based care-concepts, applicable for studying caring in home help services, and found three main concepts. The next step in this article is to classify these care-concepts according to their objects. A distinction can be made in the object being care as one whole concept and the object being a part of the care-concept. Scheme 2.1 shows an overview of this classification. The concepts that studied care as one whole concept are studies regarding the mechanisms and/or phases of caring. The concepts where the object is a part of the care-concept can be divided into concepts at the interface of emotional and businesslike aspects of care (informal and formal care) and concepts regarding the content of caring (tasks and activities).

With regard to the care-concepts, a distinction can also be made on the subject of the care-concept in terms of an individual or a household. The majority of the concepts focuses on caring for an individual, like the feminists' concepts (the person cared-for), Orem (self-care), Hattinga Verschure (self-care and informal care), Kempen (client, informal care, social network) and the Irish National Council (little attention paid to informal care). Although many authors also take informal caregivers of the client into consideration, their main subject is 'the individual client'. Only a couple of concepts concentrate on caring for a household: Zuidberg (domestic care), De Vos (household activities). From the descriptions of the concepts themselves, it is not clear whether Gremmen and Van den Herik et al., focus on the care for an individual or for a household. Because both authors study home help services in the Netherlands, which focus on the entire household and not just on the client, they should be categorised under 'caring for a household' (Zuidberg, 1978a; 1978b; Hattinga Verschure, 1981; Orem, 1983a; 1983b; 1985; 1991; De Vos, 1987; Kempen, 1990; Duijnstee, 1992; National Council for the Elderly, 1994; Vulto et al., 1994; Van den Herik et al., 1995).

Scheme 2.1 Categorization of care-concepts regarding its object.

Object of care-concept	**Mechanisms and phases of caring**	**Concepts at the interface of professional (formal) and non-professional (informal) care**	**Concepts focused on the tasks and activities carried out in professional caring**
Care-con-cepts	* Fisher and Tronto's 4 consecutive phases of caring * Orem's Self-care theory * Zuidberg's household scheme	*Ungersson's division in formal and informal care * Graham's 'labour of love' * Hattinga Verschure's relation between informal and professional care * Kempen's model of professional care * Duynstee's relation between informal and professional care	* Wærness' division in personal services, care-giving work and spontaneous care * Simonen's division in manual, mental and emotional labour * De Vos' division in household labour, work and management * Irish Council's division in personal care, tasks inside the home and tasks outside the home * Van den Herik's division in hand, heart and head tasks * Gremmen's division in professional ethic and ethic of care

CONCLUSION AND DISCUSSION

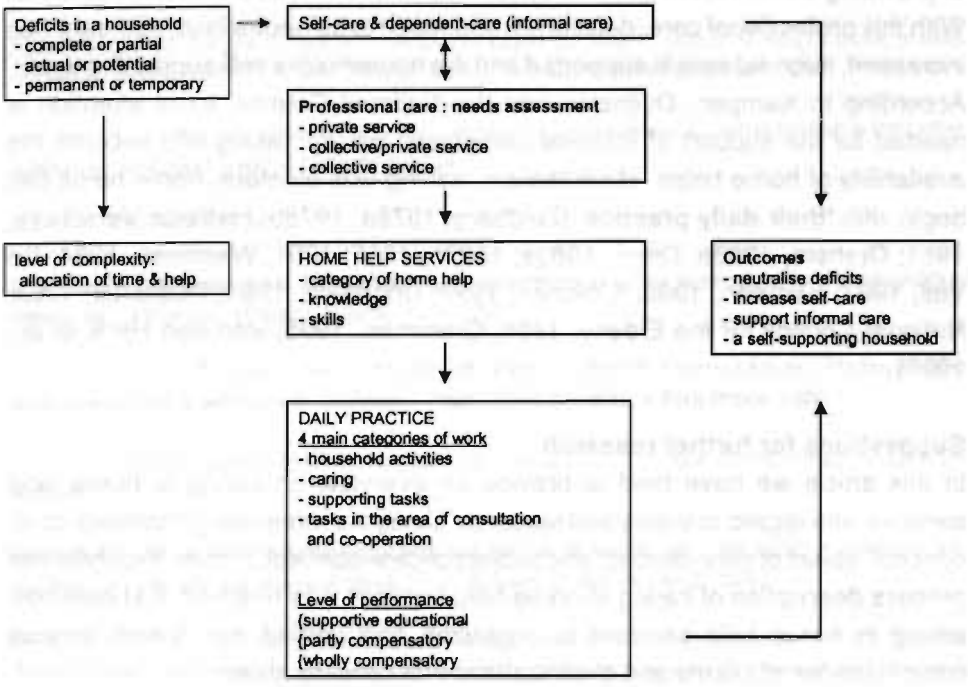
The aim of this article was to provide the reader with an overview on professional care in the Netherlands and it deals with the scientific base of the care-concept. A literature review was carried out to answer the two research questions. With regard to the first question "What theoretically-based care-concepts, applicable to studying caring in home help services, are there?", three care-concepts were found: concepts relating to caring from women's point of view (feminist concepts), concepts regarding (the relation between) non-professional and professional caring; and concepts regarding the functioning of a household.
To answer the second question "What are the objects of these care-concepts?" the care-concepts were classified according to their objects. A distinction can be made in the object being care as one whole concept (the mechanism or phases

of care) and the object being a part of the care-concept (the interface between professional and informal care, tasks performed in professional caring). For completeness, the subject of the care-concept was also considered: caring for an individual or for a household. Only a few care-concepts focused on caring for a household.

Integrating these care-concepts and the results of the categorizations, together with the results of the studies, a process description of caring in home help services can be presented. Figure 2.4, based on the feminist concepts and the concepts of Orem, Hattinga Verschure, Zuidberg, De Vos, and the results of previously-mentioned studies, will be used as a conceptual model to describe caring in home help services: the daily practice of home helps (Zuidberg, 1978a; 1978b; Hattinga Verschure, 1981; Orem, 1983; 1983b; 1985; 1991; De Vos, 1987; Kempen, 1990; Duijnstee, 1992; National Council for the Elderly, 1994; Vulto et al., 1994; Van den Herik et al., 1995).

The starting point of the scheme is the Zuidberg's mechanism of a **household with deficits**, which are defined by Orem: complete or partial, actual or potential, permanent or temporary, simple or complex. According to Orem and Hattinga Verschure, either the household itself (**self-care**) or other family members, friends or neighbours (**informal care**) have to neutralise these deficits, completely or *partly. When self-care and informal care are insufficient*, **professional care** has to help. It is here, at the interface between informal and formal/professional care, where feminists like Ungerson and Graham stand. Based on the client's situation and the nature of the deficit(s), a professional caregiver will make a needs-assessment of the household's situation: what kind of care is needed. Professional care can be provided by several services, depending on how it is funded. It can either be a private service (a private nurse or cleaning service), a collective service like home help services, or a collective service with the client being the employer (alpha help). When professional care is provided by **home help services**, the next step is to allocate the help needed in order to achieve the major aim of caring in home help services, namely to make a household as self-supporting as possible (again). Simonen, Gremmen, Van den Herik et al. and the National Council studied these professional home help services.

Figure 2.4 A process description of caring in home help services



Allocation of time and help, performed by a home help manager, consists of identifying what kind of activities have to be carried out, on what level, for how long and what category of home help is needed. In Dutch home help services, a large variety of **home helps** are employed: alpha helps, 'A' home helps, 'B' caring helps, 'C' and 'D' carers, and specialised 'E' carers. Each category of home help has a different level of education, and therefore different skills and knowledge (Zuidberg). Every category also has a different job profile. The tasks that home helps carry out can be distinguished in **four main categories**, according to De Vos, Van den Herik et al., Simonen, Wærness, and the National Council. These four categories are household activities, caring, and psycho-social/supporting tasks and tasks in the area of consultation and co-operation (a.o. reporting). Household activities, caring, and some psycho-social/ supporting tasks can be carried out at three different levels, which depends on the client's situation, that is his or her self-care ability. The help provided can be either supportive / educational, partly compensatory (assisting the client with activities) or wholly

compensatory (taking activities over from the client), according to Orem's levels of providing care. A client can also be in need of all three levels for various tasks. With this professional care, deficits are supposed to be neutralised, self-care has increased, informal care is supported and the household is self-supporting again. According to Kempen, Duijnstee and the National Council, extra attention is needed for the support of informal caregivers. Finally, taking into account the availability of home helps, absenteeism, waiting lists etcetera, home helps can begin with **'their daily practice'** (Zuidberg, 1978a; 1978b; Hattinga Verschure, 1981; Graham, 1983a; Orem, 1983a; 1983b; 1985; 1991; Wærness, 1984; De Vos, 1987; Kempen, 1990; Simonen, 1990; Ungerson, 1990; Duijnstee, 1992; National Council for the Elderly, 1994; Gremmen, 1995; Van den Herik et al., 1995).

Suggestions for further research

In this article we have tried to provide an overview on caring in home help services with regard to theory and research. Using the three categorizations care-concept, object of care-concept and subject of care-concept, a scientifically based process description of caring in home help services was reached. It shows how caring in home help services is organized and carried out, taking various circumstances of clients and organizations into consideration.

Future research should concentrate on theory-development in the area of professional care and the 'division' of (social) sciences which seems most appropriate and relevant to study this.

Another suggestion for future research is explore the demand-side of professional care more in trying to explain what care (specifically) is needed.

The other side, the supply-side, can be further studied by specifying the job content of home helps, that is the specific activities of each of the four main categories of work. It might also be interesting to look at the consequences for home helps of working in home helps services: what is their workload, how do they experience their workload, what are the effects of a high workload, how do they cope with problems at work, what kind of support do they receive etcetera.

Acknowledgement

This research was carried out at the initiative of the Ministry of Public Health, the Professional Association of Home Helps (STING); the Association of Management of Home Help Organizations (STRATEGO); and the Netherlands institute of primary health care (Nivel). The study was financed by the National Centre of Nursing and Caring (LCVV) in the Netherlands.

REFERENCES

Abel E, Nelson M. Circles of care: an introductory essay. In: Abel E, Nelson M (eds). Circles of care: work and identity in women's lives. Albany: State University of New York Press, 1990

Andersen R, Newman JF. Societal and individual determinants of medical care utilization in the United States. Milbank Mem Fund Q 1973; 51:95-124

Arendt H. Vita Activa, 1960

Duijnstee M. De belasting van familieleden van dementerenden. [The workload of family members of people with dementia]. [Thesis]. Nijkerk: Intro, 1992

Fisher B, Tronto J. Towards a feminist theory of caring. In: Abel E, Nelson M (eds). Circles of care: work and identity in women's lives. Albany: State University of New York Press, 1990

Graham H. Caring: a labour of love. In: Finch J, Groves D (eds). A labour of love. London: Routledge & Kegan Paul, 1983

Gremmen I. Ethiek in de gezinsverzorging: gender en de macht van zorg. [Ethics in home help services: gender and the power of care]. [Thesis]. Utrecht: Jan van Arkel, 1995

de Groot AD. Methodologie: grondslagen van onderzoek en denken in de gedragswetenschappen. [Methodology: foundations of research and thinking behavioural sciences]. 's Gravenhage: Mouton & Co, 1961

Hanchett ES. Community assessment and intervention according to Orem's theory of self-care deficit. In: Hanchett ES (ed). Nursing frameworks and community as client: bridging the gap. Norwalk: Appleton & Lange, 1988

Hanchett ES. Nursing models and community as client. Nurs Sci Q 1990; 3:67-72

Hartweg DL. Dorothea Orem: Self-care Deficit Theory. In: McQuiston CM, Webb AA (eds). Foundations of nursing theory: contributions of 12 key theorists. Thousand Oaks, Sage, 1995

Hattinga Verschure JCM. Algemene zorgkunde voor de zorgverlenende beroepen. [The general art of caring for caregiving professions]. Lochem: De Tijdstroom, 1981

van den Herik C, de Been M, Vulto M. 'Alles draait om de cliënt': de inhoud, het eigene en de kwaliteit van de arbeid van het uitvoerende werk in de gezinszorg. ['Everything revolves around the client': the content, characteristic and quality of work in home help services']. Leiden: Rijksuniversiteit Leiden, Faculteit Sociale Wetenschappen, Vakgroep Vrouwenstudies, 1995

van Houten M, Spaander G. Beroep: huisvrouw: een inventariserende studie van het dagelijks werk van huisvrouwen, hun beleving ervan en hun behoefte aan verandering. [Occupation: housewife: an inventory study about the daily work, their experiences and their need for change]. Wageningen: Uitbuyt, 1980

Kempen GIJM. Thuiszorg voor ouderen. [Home care for the elderly]. Groningen: STYX Publications, 1990

Koningsveld H. Het verschijnsel wetenschap: een inleiding tot de wetenschapsfilosofie. [The science phenomenon: an introduction into the philosophy of science]. Meppel/Amsterdam: Boom, 1976

van Lieshout P. Zorgen en laten zorgen. [Caring and letting care]. [Inaugural Lecture]. Utrecht: Rijksuniversiteit Utrecht, 1994

Miller JB. Toward a new psychology of women. Boston: Beacon press, 1976

National Council for the Elderly. Home help services for elderly people in Ireland. Dublin: National Council for the Elderly, 1994

OECD (Organization for Economic Co-operation and Development). Caring for the frail elderly, policies in evolution. Paris: OECD, 1996

Orem DE. Analysis and application of Orem's theory. In: Clements IW, Roberts FB (eds). Family health: a theoretical approach to nursing care. New York: John Wiley, 1983a

Orem DE. The family coping with a medical illness: analysis and application of Orem's theory. In: Clements IW, Roberts FB (eds). Family health: a theoretical approach to nursing care. New York: John Wiley, 1983b

Orem DE. Orem's conceptual model and community health nursing. In: Asay MK, Ossler CC (eds). Conceptual models of nursing: applications in community health nursing. Proceedings of the Eight Annual Community Health Nursing Conference. Chapel Hill: University of North Carolina, School of Public Health, Department of Public Health Nursing, 1984

Orem DE. Nursing: concepts of practice (3rd edition). New York: McGraw-Hill, 1985

Orem DE. Orem's general theory of nursing. In: Parse RR (ed). Nursing science: major paradigms, theories and critiques. Philadelphia: W.B. Saunders Company, 1987

Orem DE. Nursing: concepts of practice (4th edition). St. Louis: Mosby, 1991

Rose H. Hand, brain and heart: a feminist epistemology of the natural sciences. J Women Cult oc 1983; 9:73-90

Simonen L. Caring by the welfare state and women behind it-contradictions and theoretical considerations. Tampere: University of Tampere, Research Institute for Social Sciences, 1990

STRATEGO. Aan de slag. [Get busy]. Beverwijk: Stichting Thuishulp IJmond, 1991

Tadych R. Nursing in multiperson units: the family. In: Riehl-Sisca J (ed). The science of art and self-care. Norwalk: Appleton-Century-Crofts, 1985

Taylor SG. An interpretation of family within Orem's theory in practice. Nurs Sci Q 1989; 23:131-6

Ungerson C. The language of care: crossing the boundaries. In: Ungerson C (ed). Gender and caring: work and welfare in Britain and Scandinavia. Hertfordshire: Harvester Wheatsheaf, 1990

de Vos EL. Aspecten van de huishouding. [An approach of household activities]. In: Goossens RC, de Vos EL (eds). Huishoudvoering met een laag inkomen. [Housekeeping with a low income]. Wageningen: Landbouwuniversiteit, Vakgroep Huishoudkunde, 1987

Vulto M, Morée M, van den Herik C. 'Thuis bij de cliënt sta je er alleen voor': kenmerken en eisen van het beroep helpende en verzorgende in de gezinsverzorging. ['You are on your own at the client's home': characteristics and demands of the home help and home care occupation]. Leiden: Rijksuniversiteit Leiden, Faculteit Sociale Wetenschappen, Vakgroep Vrouwenstudies, 1994

Wærness K. Caring as women's work in the welfare state. In: Holter H (ed). Patriarchy in a welfare society. Oslo: Universitetsforlaget, 1984

Willer D. Scientific sociology: theory and method. Englewood Cliffs: Prentice-Hall, 1967

Zuidberg ACL. Het verzorgingsniveau van huishoudens. [The level of domestic care in households]. 's-Gravenhage: SWOKA, 1978a

Zuidberg ACL. Inleiding tot de huishoudkunde [Introduction in home economics]. In: Zuidberg ACL (ed). Huishoudkunde in Nederland. [Home economics in the Netherlands]. Wageningen: Landbouw Hogeschool Wageningen, 1978b

3 THE DAILY PRACTICE IN HOME HELP SERVICES IN THE NETHERLANDS
Instrument development

Suzanne Arts, **Hans Kersten**, **Ada Kerkstra**
Health and Social Care in the Community (1996) **4**(5), 280-289

ABSTRACT

Many developments have taken place in home help services which have made their further professionalization necessary. For this reason, a national study has been planned, to obtain a representative picture of the work of home helps and to examine overloading aspects of their workload. Five instruments were developed for this purpose and a pilot study was carried out to establish the reliability and content validity of the main instrument: a registration form to record the activities that home helps perform. Twenty-five home helps participated in the pilot study. An observer monitored them during their home visits for the period of 1 week. Both the observer and the home help recorded the activities that were carried out independently on the registration form. The reliability of the registration form was assessed by inter-rater-reliability. The validity of this instrument was estimated by the content validity. The results show that the registration form is, in general, a reliable instrument. There is a high level of agreement between home helps and observers in the four main categories: 94% for the household and the caring activities, 98% for the psycho-social or supporting activities and 96% for the reporting activities. The content validity of the form is adequate and only a few items will be added to the final version of the form.

Keywords: home help services, instrument development, professionalization, the Netherlands

3 THE DAILY PRACTICE IN HOME HELP SERVICES IN THE NETHERLANDS

Instrument development

INTRODUCTION

In the last decade, important developments and changes have occurred in health care and in particular in home care. These developments have made further professionalization of the home help services necessary. In order to contribute to this professionalization, research in this area has to be carried out. Currently there is no information available on home help services, task differences between the various types of home help, discrepancies between home help care assessed, allocated and provided, and the workload of home helps. A national study on home help services in the Netherlands is planned, to obtain a representative picture of the daily practice of home helps and to examine possible overloading aspects of their work. In Ireland, a similar study was carried out to establish baseline data on the nature and components of home help services, the profile and requirements of current service recipients, the impact of the service on the life of service recipients and possible gaps in existing provision (National Council for the Elderly, 1994). The home helps were asked what they were able to do and a job profile, that tested the specific tasks of home helps, was used. Additionally, a questionnaire was used to ask the home help clients what tasks they could do for themselves and how difficult they found them. If they were not able to carry out these specific tasks, they were asked who did (including the home help).

Before the national representative study started, a pilot study was conducted in order to develop the measurement instruments. In this paper, the results of the pilot are reported. Five measurement instruments were developed: an individual client plan for information about assessed and allocated home help care; an interview scheme for home care organisers about criteria used to assess the need for home help care; a registration form to record the activities that home helps carry out; a weekly report for the non-client based activities and a questionnaire to measure the pressure of working in home help services. The pilot study was meant to establish the reliability and validity of the most important instrument. The main question in the pilot study was whether the reliability and content validity of the instrument was sufficient to warrant its use in the main study. Reliability stands for the degree of consistency or dependability with which an instrument measures the attribute it is designed to measure. Validity is the degree to which an instrument measures what it is intended to measure. Before we report on the methods of the pilot study, a short overview

of the organization of home help services in the Netherlands is given.

Home help services in the Netherlands

Home help services are defined as help of a domestic and caring nature, occasionally supplemented by help of a personal and supporting nature, offered to all inhabitants of the Netherlands who are in need of domestic help because of illness or recovery, old age, handicap, death, psycho-social, and personal problems that threaten the maintenance of the household. The home help service's objectives are to support families and individuals in need and enable them to live as independently as possible (Van den Heuvel et al., 1991). In the Netherlands, home help services are provided either by organizations for home help services (foundations) or by home care organizations (integrated organizations for home help services and home nursing services). In January 1995, 41 home care organizations had already been integrated, and the process of integration is continuing. The remaining 60 home help organizations provide home help services only. Five years earlier, in 1990, the umbrella organizations for home help services and home nursing services had already merged to form the National Association for Home Care (LVT). Home help care can be divided into four main categories: household activities, caring activities, psycho-social or supporting activities and activities in the area of consultation and cooperation (including reporting activities) (Working Group SOGW, 1990). A large variety of workers are employed in home help services: 'A' home helps, who are restricted to household activities; 'B' caring helps, who do the housekeeping and give some personal care; 'C' carers, who are mainly involved in providing personal care and some household activities; 'D' carers, who mostly carry out caring and psycho-social or supporting tasks, and specialized 'E' carers, who support households with multiple complex problems. In addition, there are 'alpha-helps', who were introduced in 1973, as a way of providing cheaper help. The alpha-helps are not employed by the organizations, but in formal terms, the client is the direct employer of the alpha-help. Most organizations operate as intermediary between the client and the alpha-help. In 1993, approximately 45 000 alpha-helps were active in the Netherlands. This is an increase of 50% in 1 year, as the number of alpha-helps in 1992 was estimated at 30 000 (Hornman, 1994). In addition to the alpha-helps, there are about 110 000 home helps and home help organizers working in the Netherlands. However, most of these people are part-time, because there were only 40 500 FTEs (full time equivalents) (see Table 3.1).

Up to June 1993, home help care was provided by alpha-helps, home helps, home carers and specialized home carers. The FTEs in Table 3.1 are based on these former categories (De Lange et al., 1994).
In June 1993, the new job designations based on a job evaluation were introduced: 'A' home help, 'B' caring help, 'C' carer, 'D' carer and specialized 'E' carer (AbvaKabo, 1994).

Table 3.1 Staff of home help services by category in 1993, in full time equivalents

Alpha-helps	4.700
'A' home helps & 'B' caring helps	20.500
'C' & 'D' carers	9.000
Specialized 'E' carers	900
Home help organisers	3.300
Other	2.000
Total FTEs	40.500

Reproduced by kind permission of De Lange et al., 1994

Three-quarters of the home helps (77%) do not have specific qualifications. This means that, of home carers and to a lesser degree home helps, only 23% have received training (Hornman, 1994). Recently, home help organizations have started in-service training for their home helps, mainly for the 'A' home helps and 'B' caring helps.

METHODS

Instrument

Home helps spend the majority of their working time on client-based activities. Therefore, the most important instrument tested in the pilot was the registration form. On this form, home helps collect these activities. For this purpose, a self-registration form was developed based on a theoretical model for the care provided by home help services (Arts et al., 1994). This integrated model is founded on the theories of Orem (self-care), Zuidberg (analysis-scheme of households), De Vos (theory of household activities) and their corresponding

concepts, and will be used as a framework to carry out research on the daily practice of home helps (Zuidberg, 1978a; De Vos, 1987; Orem, 1991). Existing task profiles and classifications and existing assessment forms have been investigated thoroughly for a realistic classification of the activities, as used on the registration form (Working Group SOGW, 1990; AbvaKabo, 1992; Stichting Thuiszorg Hilversum, 's-Graveland & Loosdrecht, 1992; Verheij et al., 1993; AbvaKabo/Union for Public Sector Workers, 1994). The registration form represents virtually all activities that home help services may provide. It also has the option to distinguish between taking activities over from the client and assisting the client with activities. On the registration form this can be scored as '1' or '2' respectively. Furthermore, the home helps recorded both the time spent on the four main categories and the travelling time between clients on the registration form.

Sample

Eight home care organizations were contacted for taking part in this pilot study. Three organizations, who were either very occupied with the integrating process or already involved in a research project, declined to participate. Therefore, five organizations for home help services, from different parts of the country, rural and urban organizations, traditional home help services and integrated with home nursing services, took part in the pilot study. Five different types of home help, based on the former categories, were examined in this pilot study: alpha-help, 'A' home help, 'B' caring help, 'C' carer, and specialized 'E' carer. The participating organizations were asked to select five home helps, one of every type of home help. Consequently, a total of 25 home helps took part in the pilot study, of whom 24 were female. The mean age of the home helps was 41 years, with a range from 22 to 58 years. Their average period of employment in the home help services was 8 years and 8 months, with a range from 7 months to 21 years.

Procedure

During an instruction meeting, the purpose of the study was explained to the 25 participating home helps. For a 1-week period, each home help was monitored by one of the two observers during all her home visits, unless the client, the home help or the organization refused the presence of an observer during the home visit. After every home visit, both the home help and the observer independently recorded the activities that were carried out on sepa-

rate registration forms.
During the registration period, the 25 home helps made 223 home visits. In 29% of the home visits (n=64) the home help was not observed for practical reasons. For example, the client, home help or organization refused the observer's presence in 25 of the non-monitored home visits (39%). In another 39%, the observers had simultaneous duties, like monitoring two home helps with the same working hours and preparing and holding instruction meetings during the registration period. Almost half of the non-monitored 64 home visits (46%) were carried out by specialized 'E' carers, 28% by 'C' carers, and the remaining 26% by 'B' caring helps, 'A' home helps and by alpha helps (17%, 6% and 3% respectively). Therefore, the home helps were monitored during 159 home visits. These registration forms, of the home helps and observers respectively, were used for the analyses.
Chi-square analysis was used to compare the activities recorded by the home helps during the 159 observed home visits and the activities recorded during the 64 non-observed home visits. The results showed that 101 of the 111 activities (91%) were not significantly different. The 10 activities (9%) that were scored significantly different at a nominal 5% level, are presented in Table 3.2; given the number of comparisons made, Chi-square values in excess of 9.55 correspondence to a 10% overall significance level.

The household activities were performed less frequent in the non-observed home visits, while the psycho-social or supporting activities were carried out more frequent in the non-observed home visits. This outcome was somewhat expected, because the specialized 'E' carers, who mainly perform psycho-social and supporting activities and occasionally household activities, made almost half of the non-observed home visits.

Table 3.2 Significant differences in activities recorded during 159 monitored home visits and 64 non-monitored home visits, using Chi-square analysis.

Activities	N=159 %	N=64 %	X^2	P-value
Household activities				
Doing the dishes/putting them away	29%	16%	4.29	0.04
Making the beds	33%	19%	4.69	0.03
Cleaning the kitchen	26%	13%	4.69	0.03
Psycho-social or supporting activities				
Topics of conservation				
Loneliness	8%	20%	7.47	0.00
Parent-child relationship	6%	19%	9.16	0.00
Dealing with problems				
Seek for solution	11%	23%	5.31	0.02
Encourage the client for certain behaviour	11%	33%	15.79	0.00
Observing the client for mental changes	19%	44%	14.68	0.00
Observing the client for social changes	7%	38%	32.25	0.00
Supporting/guiding children	6%	16%	5.81	0.02

Analyses

The reliability of the registration form was assessed by inter-rater-reliability: the respondent and the observer simultaneously and independently recorded the activities carried out (Polit et al., 1987). The level of agreement, i.e. the similarity between the frequencies scored by the home helps and the frequencies scored by the observer expressed in percentages, was computed for every activity, subcategory and main category. When the frequencies are equal, the level of agreement is 100%. Two different agreement percentages were calculated: a percentage based on the frequencies scored without taking into account the distinction between the score 1 and 2 of the registration form (column 3 in Tables 3.3, 3.4, 3.5, 3.6) and a percentage age based on the frequencies, which accounted for the distinction between the scores 1 or 2. The distinction between scores 1 and 2 can not be made for the psycho-social or supporting and reporting activities and this agreement percentage (column

4) is therefore lacking in Tables 3.5 and 3.6.
The validity of the registration form was estimated by the content validity, which means the degree to which the items of the registration form adequately represented the universe of content, i.e. the daily work of home helps (Polit et al., 1987).

RESULTS

Reliability of the registration form
Activities that were recorded in fewer than 5% of the home visits, which were included in the analyses, are not presented in the Tables 3.3, 3.4, 3.5 and 3.6.

Household activities
Household activities were performed in 79% of the home visits. Table 3.3 shows that the level of agreement between home helps and observers concerning this main category is high (94%). The highest level of agreement is achieved for the subcategory "vacuuming" (99%) and the lowest level of agreement for the subcategory "preparing meals/drinks" (87%). "Vacuuming" is most frequently carried out (40%).

Caring activities (Table 3.4)
This main category has also a high level of agreement (94%). In 52% of the home visits, caring activities were carried out. The most common activity according to the home helps, is "putting on/taking off socks and shoes" (26%). According to the observers, on the other hand, the most common activity is "getting the client (un)dressed" (28%). The subcategory "complex personal care" (98%) had a higher level of agreement than the subcategory "simple personal care" (89%), with and without the distinction between the scores 1 and 2.

Psycho-social or supporting activities
The majority of the "psycho-social or supporting activities" (Table 3.5) scored less frequently than activities in the other main categories, but the level of agreement was also high (98%).

Table 3.3 Frequencies of household activities carried out (column 1 and 2) and the level of agreement between the home help and observer regardless of the value 1 or 2 (column 3) and when taking into account the value 1 and 2 (column 4), expressed in percentages (n=159 home visits).

	Frequency home helps (%)	Frequency observers (%)	Overall agreement (%)	Adjusted for amount of support agreement (%)
Household activities	79	79	94	72
Daily household activities	66	66	97	87
Tidying up the room	19	19	89	86
Vacuuming	40	42	99	99
Doing the dishes/putting them away	29	30	91	89
Making the beds	33	26	89	88
Dusting	36	39	92	89
Scrubbing the floors	19	27	89	88
Cleaning bathroom/toilet/kitchen	42	45	95	94
Cleaning the toilet	36	36	95	94
Cleaning the kitchen	26	28	91	90
Cleaning the bathroom	33	33	98	98
Periodical household activities	30	35	90	88
Changing the beds	13	14	97	97
Wiping the windows	16	17	96	96
Changing/taken out garbage can	9	13	93	92
Taking care of linen, clothing and footwear	19	21	94	92
Doing the laundry/hanging it out/taking it in	15	18	94	92
Ironing/folding up/ putting away the laundry	12	13	96	96
Preparing meals/drinks	45	48	87	87
Preparing coffee/tea/other drinks	37	42	82	72
Setting/clearing the table	8	14	92	89
Preparing breakfast/lunch	13	14	97	96
Cooking (freezing)	7	7	97	96
Grocery shopping	13	14	98	96
Daily grocery shopping	11	12	95	94

Social activities, like chatting with the clients and inquiring about their health should be distinguished from 'real' psycho-social or supporting activities, like talking about (emotional) problems and managing these problems. Consequently, the frequency-percentage of this main category (98%) is mostly a result of the frequency of 'social activities' (94%). The frequencies of the remaining subcategories were substantially lower, e.g. "dealing with problems" (51-67%). The other subcategories also yielded lower levels of agreement. The "topics of conversation" subcategory, for example, had an agreement level of 63% between respondent and observer, with considerable differences between the frequencies of the home helps (35%) and the observers (59%). Apparently there was a lack of clarity about the topics.

Table 3.4 Frequencies of caring activities carried out (column 1 and 2) and the level of agreement between the home help and observer regardless of the value 1 or 2 (column 3) and when taking into account the value 1 and 2 (column 4), expressed in percentages (*n*=159 home visits)

	Frequency home helps (%)	Frequency observers (%)	Overall agreement (%)	Adjusted for amount of support agreement (%)
	52	52	94	82
Simple personal care	40	45	89	67
putting on/taking off shoes/socks	26	27	86	81
getting (un)dressed	21	28	93	88
helping in/out bed	11	9	92	
hair/nail care	10	13	96	94
Complex personal care	42	43	98	77
putting on/taking off supported stockings	21	21	98	97
washing/bathing/showering the client	23	23	97	92
skin care/preventing bed sores	12	15	96	94
putting on/taking off incontinence material	6	6	98	97
setting out medicine	6	4	95	95
administering medicine	8	8	96	94

Table 3.5 Frequencies of provided psycho-social *or* supporting activities, scored by home helps (column 1), by observers (column 2), and the level of agreement between the home help and observer regardless of the value 1 or 2 (column 3), expressed in percentages (*n*=159 home visits)

Supporting activities	Frequency home helps (%)	Frequency observers (%)	Overall agreement (%)
	98	100	98
Social activities	94	99	95
Have a chat with the client	93	99	95
Inquire about the client's condition	67	67	74
Inform about what has to be done	25	25	86
Topics of conservation	35	59	63
Provided home (help) care	18	35	68
Acceptation of disease/handicap	8	14	84
Loneliness	8	16	91
Parent-child relationship	6	17	85
Dealing with problems	51	67	74
Listen	47	66	70
Express sympathy	33	33	70
Seek for solution	11	13	86
Give advice	9	9	89
Encourage the client for certain behaviour	11	11	86
Health promotion and education	16	11	86
Inform about education	11	6	91
Inform about nature of disease/illness	8	4	92
Encouraging the client to realise certain goals	13	27	79
Nutrition/diet	8	9	91
Observing the client for...	37	48	71
Physical changes	31	31	75
Mental changes	19	1	79
Social changes	7	16	84
Informal care	13	6	89
Discuss the client's situation	6	4	93
Provide emotional care	6	3	93
Special activities	9	18	80
Making the house cosy	9	18	81
Children	9	10	99
Play with children	8	8	97
Support/guide children	6	6	96
Educate children	5	3	97

Activities regarding reporting

The home helps recorded reporting activities (Table 3.6) in approximately 30% of the home visits. Consistent with the other main categories, this main category had a high level of agreement (96%). The activity with the highest frequency of reporting is use of a communication notebook (26%). This is a notebook, which is used by the client and can also be used by other professional care providers and family members of the client for comments and observations. "Reporting about the client's health problems" was more often scored by the home helps than by the observers (10% and 2% respectively). An explanation for this might be that the home helps reported this, and also scored it, after the home visit and thus out of the sight of the observer.

We have also examined if the levels of agreement are similar for the various types of home help. The overall level of agreement and the level of agreement for the main categories and of the majority of the subcategories were good for all types of home help (85% or higher). Agreement percentages lower than 85% are presented in Table 3.7. Three household subcategories had a moderate level of agreement (82%-84%) recorded by the 'B' caring helps, 'C' carers and specialized 'E' carers. Two psycho-social or supporting subcategories were recorded less reliable by 'B' caring helps and specialized 'E' carers (70%-82% agreement). Five other subcategories of the "psycho-social or supporting activities" had a low level of agreement for almost all the types of home helps (41% to 85%). Apparently, not the different types of home help, but the activities themselves were recorded less reliable.

Table 3.6 Frequencies of provided reporting activities carried out (column 1and 2) and the level of agreement between the home help and observer regardless of the value 1 or 2 (column 3), expressed as percentages (*n*=159 home visits).

Reporting activities	Frequency home helps (%)	Frequency observers (%)	Overall agreement (%)
	30	27	96
Reporting in a communication notebook	26	25	98
To colleagues	24	24	97
To informal care	15	16	97
Reporting about the client's health problem(s)	10	2	90
To colleagues	6	1	92
To informal care	9	1	92

Table 3.7 shows that in general, there are no major differences in the reliability of recording between the types of home help.

Table 3.7 The level of agreement between home help and observer for the five types of home help, expressed as percentages (*n*=159 home visits).

	Total *n*=159	Ah *n*=8	A *n*=27	B *n*=37	C *n*=70	E *n*=17
Household activities						
Cleaning bathroom/toilet/kitchen		100	100	95	96	82
Periodical household activities		100	85	84	96	88
Preparing meals/drinks		88	89	87	84	100
Psycho-social or supporting activities						
Health promotion and education		88	89	73	91	88
Informal care		100	100	70	96	82
Topics of conservation		63	63	65	64	53
Dealing with problems		63	70	73	73	88
Encourage client to realise certain goals		100	85	76	77	71
Observing the client for changes		100	78	65	76	41
Special activities		63	85	89	83	47

Although the majority of the items at the registration form were recorded reliably, there are a few items that are less reliable: 17 items have a difference in frequency between the home help and the observer of 5% or more. This can partly be explained by a low face validity of certain items. "Vacuuming" for example is a more distinct activity than "listening". Two of the 17 activities, "making the beds" and "observing the client for mental changes", were overestimated by the home helps. A probable explanation for the first mentioned activity, is that the home helps actually were asked to change the beds and because they automatically made the beds, they recorded these activities on the registration form. The observers on the other hand, only recorded "changing the beds", because they assumed that this included making the beds. The second activity is an example of an 'invisible' activity. It is very difficult for the observers to see or determine if the home help observed the client for possible mental changes. In these situations, only the home help recorded this activity, which led to an overestimation compared to the obser-

vers. In contrast, "observing the client for social changes" is an activity that is overestimated by the observers (16% to 7% by the home helps). The observers interpreted certain actions, mainly questions enquiring indirectly about the client's social life, wrongly as being "social observations". The remaining 15 activities were underestimated by the home helps. There are two types of underestimation. First, the home help records the same activity at a different item than the observer. This has to do with concept definition. An example of this is "scrubbing the floor". When the kitchen is cleaned, the floor will usually be scrubbed too. The home helps did not score "scrubbing the floor" separately, but only scored "cleaning the kitchen". The observers on the other hand, scored both "cleaning the kitchen" and "scrubbing the floor". This has led to an underestimation by the home helps. The second type is when a certain activity is scored by the observer and not by the home help. This can be illustrated by the activity "set or clear the table". Many clients receive 'meals-on-wheels' (a warm meal delivered by a nearby home for the elderly). When a home help is providing care at that time, he or she usually puts the cutlery and a plate on the table. This is a quick and simple action, which could easily be missed by the home help when filling in the registration form. The observer, recording the activities directly, may not miss it and this can lead to an underestimation by the home helps. There are a number of activities where this could also apply. One is "making the house cosy" for example, which was recorded more frequently by the observers too. A few supporting activities, topics of conversation to be more precise, were also affected by this type of underestimation. For the home helps, talking about the client's loneliness and the client's acceptation of his or her disease is so natural that they do not record it as such. The observers, on the contrary, did record these activities.

In addition to recording the various activities, the time spent on them was recorded by home helps and observers. Medians and lower and upper quartiles were used to describe the distribution of the travelling time between clients, the duration of a home visit and the time spent on the four main categories of work (see Table 3.8). The distribution of these times appeared to be not normal. To test if these distributions are the same for the home helps and the observers, the Wilcoxon signed-ranks test was used. The results confirm the assumption, with levels of significance between 0.11 and 0.88, that the distributions of the travelling time between clients, the duration of a home visit and the time spent on the four main categories are similar for the home helps and the observers.

Table 3.8 Distribution of the travelling time between clients, the duration of a home visit, time spent on the main categories recorded by home helps and observers, in minutes with *P*-values (*n*=159 home visits).

	Home helps (median)			Observers (median)			
	25%	50%	75%	25%	50%	75%	P-value
Travelling time between clients	5	5	10	5	5	10	0.88
Duration of home visits	30	85	180	30	85	180	0.25
Time spent on household activities	5	45	120	5	60	135	0.11
Time spent on caring activities	0	0	15	0	0	15	0.59
Time spent on supporting activities	10	23	45	10	30	45	0.15
Time spent on reporting activities	0	0	5	0	0	2	0.56

At the end of the reliability-study we considered the likelihood of a learning effect having taken place. This can occur when information is collected over a longer period of time and the possibility of the instrument used becoming more reliable over such a period must be examined. In the pilot study, the home helps and observers recorded for 5 consecutive days. Analysis of variance, with the reliability scores of the main categories as dependent variables and the 5 recording days as independent variables, produced no significant differences. There is, therefore, no learning effect when recording for 5 consecutive days. If there had been any significant differences, this would have meant that the results were unequally distributed among home helps with large and small employment contracts.

Content-validity of the registration form

Remarks and comments were made by a few home helps. The content of these remarks were similar and mainly centred around the fact that the registration form was clear and conveniently arranged, but not comprehensive enough. For example, one home help said that it was 'not possible to make a distinction between household activities on the first floor and the same activities on the second floor'. However, when developing the registration form, it was never intended to make this distinction. According to the home helps, the registration form was also lacked a few activities, mainly activities that are

rarely carried out (twice or three times a year). However, such activities could be recorded in the subcategory "miscellaneous". It is intended that activities that were scored more than 10 times during the pilot study, will be added to the new version of the registration form. A few examples are washing the curtains, taking care of pets or plants, taking children to school or picking them up and getting clients ready for day-centre. The other activities can be recorded at "miscellaneous" or are covered by activities already included. Finally, one respondent had difficulties recording the psycho-social or supporting activities.

DISCUSSION

This pilot study was meant to estimate the reliability and validity of the primary instrument in order to achieve the general aim of the main study i.e.: to obtain a representative picture of the daily practice of home help services. The reason for this study is that in the last decade, important developments and changes have occurred in both health care and home care. Home help services are confronted with an increased demand for home care. Firstly because of the ageing of the population, and secondly because of the policy of substitution of home care for hospital care. This increasing demand for home care, together with the savings on the health care budget, caused long waiting lists in home help services. In December 1992 in the Netherlands, almost 1300 households were waiting to be assessed for need for home help services and approximately 12 500 households, which had already been assessed positively, were waiting to receive home help care (Groenewegen et al., 1993). Waiting lists are quite common in many countries of the European Union, for example home help services in Belgium, Portugal and Spain are experiencing the same problem. According to experts in these countries, the waiting lists are caused by financial problems, i.e. budgets are too low while the demand for home help services is increasing. Only in Denmark, Finland, Germany, Luxembourg, Sweden and the United Kingdom are no waiting lists reported. In the United Kingdom, people receive care if the local authority or the individual are prepared to pay for it. Otherwise it is refused until further application (Familiehulp, 1991; Holstein et al., 1991; Hutten et al., 1996). Another problem is the shortage of personnel, which will become an even bigger problem in the near future. In the year 2000 it is expected that there will be a shortage of approximately

7500 home helps in the Netherlands (Van Tits et al., 1991; Van Tits et al., 1992). This will increase the already long waiting lists in home help services. Shortage of personnel is also a problem in many other countries in Europe, e.g. Belgium, Denmark, France, Germany, Greece, Ireland, Italy and Portugal. According to experts, in these countries this type of employment is not considered attractive, because it has a low status, it is poorly paid and the training is considered to be inadequate (Familiehulp, 1991; Hutten et al., 1996). Furthermore, research has shown that absenteeism due to illness among home helps is very high (almost 10% in 1993) (Hornman, 1994). Finally, a development that involves a lot of extra time and work, is the integration, at a regional level, of organizations for home help services and home nursing services. These developments have made further professionalization of the home help services necessary. In order to contribute to this, research in this area is required. Research is planned in the Netherlands because information regarding home help services, workload, task differences between the various types of home help, and discrepancies between assessed, allocated and actual home help care is not available. A pilot study was carried out to establish the reliability and content validity of the registration form used to record the activities that home helps carry out.

The results of the pilot study showed that the registration form is clear and conveniently set out. Shortcomings are restricted to the occasional occurrence of an activity not being cited. Consequently, the self-registration form appears to be a reliable and valid instrument for measuring the work of home helps. Nevertheless, a few activities will be added to the form, like washing the curtains, taking care of pets or plants, taking children to school or picking them up and getting clients ready for day-centre. The new form will also have a better layout. The type of underestimation where home helps do not record certain activities while the observers do, also occurred in a comparable study by Kerkstra et al. (1987) among community nurses and in a study of Sluijs (1988) on patient education by physiotherapists. Sluijs mentioned the most obvious explanation,

> "... that physiotherapists consider educating the patient, as such, a natural part of their work that they do not regard it specifically as patient-education (and therefore also do not record it as such)".

She also refers to forgetting certain activities or considering them unimportant. Similar explanations possibly can be applied to this study too. However, this does not alter the fact that this type of underestimation prevents a reliable and valid representation to a certain extent. For the benefit of the main study, we will try to minimize the effect of this type of underestimation by clustering. An attempt is made by clustering some items in the subcategory "topics of conversation". To keep the other type of underestimation, due to concept definition, as low as possible too, this should be taken into consideration at instruction-meetings. The items that could possibly cause confusion of concept, have to be clarified during the instruction and in the handbook. All above mentioned findings were used to adjust or improve the registration form.

In summary, the main measurement instrument appeared to be reliable and valid for use in the main study, by all types of home help. This main study, involving a representative sample of 16 organizations for home help services and 500 home helps, has started in March 1995 with the adjusted and improved instrument.

Acknowledgements

This research was carried out at the initiative of the Ministry of Public Health, the Professional Association of Home Helps (STING), the Association of Management of Home Help Organizations (STRATEGO) and the Netherlands Institute of Primary Health Care (Nivel). The study was financed by the National Centre of Nursing & Caring (LCVV).

REFERENCES

AbvaKabo (Union of Public Sector Workers). Overzicht van verschillende functies in de Gezinsverzorging. [Review of various functions in home help services]. OAW: stuknummer 9210220y.15.4, 1992

AbvaKabo (Union of Public Sector Workers). Concept CAO-Thuiszorg met salarisregelingen. [Draft Collective Labour Agreement Home Care with salary-regulations]. Utrecht: AbvaKabo, 1994

Arts SEJ, Kersten JWET, Kerkstra A. Werken in de gezinsverzorging: een overzicht van de dagelijkse praktijk. [Working in home help services: an overview of the daily practice]. Utrecht: NIVEL, 1994

Familiehulp. [Family help]. Yearly report family help. Brussel: Familiehulp, 1991

Groenewegen PP, Kerkstra A, Jansen G. Wachtlijsten in de thuiszorg. [Waiting lists in home care]. Utrecht: NIVEL, 1993

van den Heuvel W, Gerritsen H. Home care services in the Netherlands. In: Jamieson, A (ed). Home care for older people in Europe: a comparison of policies and practices. Oxford: Oxford University Press, 1991

Holstein BE, Due P, Almind G, Holst E. The home help services in Danmark. In: Jamieson, A (ed). Home care for older people in Europe: a comparison of policies and practices. Oxford: Oxford University Press, 1991

Hornman M. Terwijl je afstoft kom je heel wat tegen: professionele huishoudelijke zorg: een onmisbare pijler onder een verantwoorde thuiszorg. [While dusting, you see a lot: professional household care: an indispensable pilar for responsible home care]. Utrecht: STING, 1994

Hutten JBF, Kerkstra A. Home care in Europe. Aldershot: Arena, 1996

Kerkstra A, de Wit AMGJ. Het werk van wijkverpleegkundigen en wijkziekenverzorgenden: instrumentontwikkeling. [The work of community nurses and auxiliary community nurses: instrument development]. Utrecht: NIVEL, 1987

de Lange HJ, Spaan JM. Jaarboek Thuiszorg 1993. [Yearbook Home Care 1993]. Bunnik/Utrecht: LVT/NZi, 1994

National Council for the Elderly. Home help services for elderly people in Ireland. Dublin: National Council for the Elderly, 1994

Orem DE. Nursing: concepts of practice (4th edition). St. Louis: Mosby, 1991

Polit DF, Hungler BP. Nursing research: principles and methods. Philadelphia: J.B. Lippincott Company, 1987

Sluijs EM. Patiëntenvoorlichting door fysiotherapeuten: ontwikkeling van het observatie-protocol. [Patienteducation by physical therapists: development of the observation-protocol]. Utrecht: NIVEL, 1988

Stichting Thuiszorg Hilversum, 's-Gravenland & Loosdrecht. [Home care Foundation Hilversum, 's Graveland & Loosdrecht]. Functie schema uitvoerenden [Job schema for home helps]. Hilversum: Organisatie voor Gezinsverzorging, 1992

van Tits M, Groot W. Zorgen om kruiswerk en verzorging. [Caring for community nursing and home help services]. TVZ 1991; 101:56-9

van Tits M, Vermeulen H. Ontwikkelingen op de arbeidsmarkt. [Developments on the labour-market]. TVZ 1992; 102 :104-7

Verheij RA, Caris-Verhallen WMCM, Kerkstra A. Integratie kruiswerk en gezinsverzorging, ervaringen van hulpverleners en cliënten. [Integration community nursing and home help services, experiences of professionals and clients]. Utrecht: NIVEL, 1993

de Vos EL. Aspecten van de huishouding. [An approach of household activities]. In: Goossens RC, de Vos EL (eds). Huishoudvoering met een laag inkomen. [Housekeeping with a low income]. Wageningen: Landbouwuniversiteit, Vakgroep Huishoudkunde, 1987

Working Group (Werkgroep Werkveld) SOGW. Beroepsprofiel Verzorgende/Helpende. [Job profile home help and caring staff]. Leiden: Spruyt, van Mantgem & de Does, 1992

Zuidberg ACL. Het verzorgingsniveau van huishoudens. [The level of domestic care of households]. 's-Gravenhage: SWOKA, 1978a

4 A JOB PROFILE OF HOME HELPS IN THE NETHERLANDS

S.E.J. Arts, A. Kerkstra, H. Huijer Abu-Saad, J. van der Zee
Health and Social Care in the Community (1998) **6**(6), 397-406

ABSTRACT

Owing to many developments and changes in home care in the Netherlands, a national study on home help services was carried out. One of the aims was to examine to the job content of the six new categories of home help, the differences in their work and the correspondence of daily practice with formal job descriptions. Six home help categories were examined: alpha helps; 'A' home helps; 'B' caring helps; 'C' and 'D' carers; and specialised 'E' carers. Self-registration forms and weekly reports were used for data-collection. For a period of 4 weeks, 458 home helps recorded on these forms all the activities they carried out during and outside home visits. The daily work of alpha helps, 'A' home helps and 'B' caring helps mainly involves household and psychosocial/supportive activities whilst 'B' caring helps also carry out some personal care and 'C' carers do some household activities, personal care and psychosocial or supportive activities. The main work of 'D' carers consists of personal care and psychosocial activities. Psychosocial activities are mainly carried out by specialized 'E' carers, who also perform household activities, mostly together with the client. In daily practice, the four subordinate categories of home help carry out more psychosocial and reporting activities, and the three highest categories do more household activities compared with their formal job descriptions. There also appears to be an overlap in the work of 'A' home helps and 'B' caring helps and in the work of 'C' and 'D' carers. An adjustment of formal job descriptions to the daily practice of home helps is required, as well as more time for the extra activities home helps have to carry out. Finally, the overlap between various categories of home help needs to be resolved whereby instead of six categories of home help, four new categories should be created.

Keywords: home help services, home helps, job content, the Netherlands

4 A JOB PROFILE OF HOME HELPS IN THE NETHERLANDS

S.E.J. Arts, A. Kerkstra, H. Huijer Abu-Saad, J. van der Zee
Health and Social Care in the Community (1998) 6(6), 387-409

ABSTRACT

INTRODUCTION

In the Netherlands, home help services and home nursing services are provided in the border area of social services and health services (Hutten et al., 1996). At first, home help services were mainly focused at temporarily help for the housewife and her family, only at a later stage being provided for elderly and chronically ill people (Handboek Gezinsverzorging, 1989; Maessen, 1989; Howe et al., 1990; Jamieson, 1990; OECD, 1996). Today, home help services includes help of a domestic and caring nature, occasionally supplemented by personal and psychosocial or supportive services. Home help services is offered to the population of the Netherlands who need minor domestic services because of illness, convalescence, old age, handicap, death, psychosocial, and personal problems that threaten the maintenance of the household. Its objectives are to support families and individuals in need and enable them to live as independently as possible in their own homes (Van den Heuvel et al., 1991).

As in other European countries, one of the important developments in Dutch health care is the ageing population: the proportions of people aged 65 or over and people aged 80 or over are increasing (OECD,1990; Hutten et al., 1996). At the same time, in order to save costs and to allow people to remain at home as long as possible, there is the policy of substitution of home care for institutional care (Walker, 1991; Nijkamp et al., 1991; Hutten et al., 1996). Further, there are health care budget cuts. These three factors together cause long waiting lists in home help services (Hutten et al., 1996). Consequently, home care organizations have had to work more efficiently. Two solutions were tried for this problem. First, the integration of organizations for home nursing and home help services were integrated as home care organizations, resulting in a substitution of home help services for home nursing. This integration process was assumed to improve the quality of care and to reduce costs of home care (Ministry of Well-being, Health and Culture, 1990). In 1990, the umbrella organizations for home nursing and home help services merged, and in 1992 the first individual organizations started the integration process. Although in the last years, efficiency in home care has improved, partly because of the substitution of tasks of home helps for tasks of home nurses, the quality of care has not improved, and in some cases even become worse (De Bruin et al., 1996). The second solution was differentiated practice, a clear distinction in the work between the various categories of home help. Besides achieving a more efficient way of working, it also gave home helps more varied opportunities,

and thus more personal development. It was thus intended to improve the image of what is perceived as a rather unattractive occupation with few prospects.

A few years ago, the general categorization of home helps was replaced by a more detailed categorization. In 1993, with the new Collective Labour Agreement, new job designations for home helps were introduced. They were based on a job evaluation study in home help services, carried out by the KMPG-consultancy (Welschen et al., 1990), amongst others. Since then, six categories of home help have been distinguished: alpha help, 'A' home help, 'B' caring help, 'C' carer, 'D' carer, and specialized 'E' carer. Each category has its own task profile and (training) qualifications (AbvaKabo/Union of Public Sector Workers, 1994). In framework I below, an overview of the six categories of home help is given.

Framework I **Home helps in the Netherlands** (situation at the time of the research, 1994)

The Working Group SOGW developed a job description for caring and home help staff in 1992. The four main categories of activity are household activities, caring, psychosocial/supportive activity, and consultation and co-operation (Working Group SOGW, 1992). This work is done by a wide variety of workers. New job designations for home helps were introduced with the new Collective Labour Agreement for 1993. Since then, six categories of home help have been distinguished: alpha help, 'A' home help, 'B' caring help, 'C' carer, 'D' carer, and specialized 'E' carer. These various categories of home help also have their own task profiles (AbvaKabo, 1994), based on the above-mentioned job description (Working Group SOGW, 1992). The (training) qualifications are also given for every type of home help (AbvaKabo, 1994).

- *Alpha helps* were introduced in 1973, as a way of providing cheaper help. The alpha helps are not employed by the organizations, but in formal terms, the client is their direct employer. Most organizations operate as an intermediary between the client and the alpha help. The task of an alpha help is to support the client in doing daily or weekly household activities, which the client can either not do or not do alone. Alpha helps have no opportunity of contact with colleagues; and notify their intermediaries in case of major changes or problems. There are no specific qualifications for an alpha help.
- *'A' home helps* mainly carry out household activities, of which nature, content and frequency are stable. They follow an individual care plan. The home help A also has periodical contact with colleagues and supervisor. This job requires some years of domestic science as a school subject and recently an in-service qualification (certificate 'A' home help) has also been required.

- *'B' caring* helps provide some caring activities, limited in time and type in addition to household activities. The nature, content and frequency of the activities are more or less stable. 'B' helps follow an individual care plan and can make minor alterations in this plan. Besides periodical contact with colleagues and supervisor, 'B' helps also have occasional contact with other professional care-givers. 'B' helps need a home help certificate or a 'B' caring help certificate (via in-service education).
- *'C' carers* are mainly involved in caring activities and some household activities, but only limited in time. They carry out these activities partly using their own judgment and change the plans independently. The client situations are often unstable. Like the 'B' caring helps, 'C' carers, apart from the fixed meetings with colleagues and the supervisor, only have infrequent contact with other care-givers. A carer certificate or an auxiliary nurse certificate is required for both the carers-functions ('C' and 'D').
- *'D' carers* are largely concerned with caring and psychosocial issues, the nature, content and frequency of which vary considerably. They plan their work using their own judgment and initiative and are able to deviate from fixed programs. In addition to regular meetings with colleagues and the supervisor, 'D' carers maintain regular contact with other professional care-givers.
- *Specialised 'E' carers* support households with multiple complex problems, related to the client's behavioural change. They also do household and caring activities. The nature, content and frequency of the activities are strongly affected by the instability of the client situation. The specialised 'E' carers plan their work using their own judgments and initiative and are able to deviate from fixed programs. Their activities are systematically adjusted to other professional care-givers, with whom they are in frequent contact. A carer certificate and a specialized 'E' carer certificate are required for this position.

The five categories of traditional home help also observe potential changes in the client situation and report these to their supervisor (AbvaKabo/Union of Public Sector Workers, 1994).

A schematic description of the different job profiles for the six categories of home help is presented in Table 4.1. It shows that alpha helps and 'A' home helps are restricted to household activities; 'B' caring helps do the household activities and give some personal care; 'C' carers are mainly involved in providing personal care and some household activities; 'D' carers mostly carry out personal care and psychosocial or supporting tasks, and specialised 'E' carers support households with multiple complex problem.

Table 4.1 Formal task profile for each category of home help

Activities → / Category of home help ↓	Household	Caring	Psychosocial/ supportive	Cooperation & consultation
Alpha help	X			
'A' home help	X			
'B' caring help	X	o		
'C' carer	o	X		
'D' carer		X	X	o
Specialized 'E' carer	o	o	X	X

X = main tasks
o = secondary tasks

Source: AbvaKabo/Union of Public Sector Workers, 1994

Apart from the work home helps carry out during home visits, they spend time on travelling and other activities such as team meetings, planning, courses, working in day-care, training and education, supervising activities and administrative work (not included in the table).

The problems which Dutch home help services are facing, are not restricted to the Netherlands, but also arise in other countries of the European Union, where there are similar organizations for home help services. In most countries, home help services belong to the social services, are organized by and fall under the responsibility of the local authorities. Belgium, France, Italy and Portugal have a mixture of organizations operated by municipalities and private organizations. Germany and Ireland are the only countries, besides the Netherlands, where home help services is part of the health care system (Hutten et al., 1996).
Direct help to the clients is provided by various categories of home help: home and family helps, homemakers, home carers, social workers, care attendants, and other personnel trained for home helping tasks. In general, home helps have no formal training, but there are a few short courses and 'training on the job'. Only in Belgium, Germany, Italy, Sweden, and for the most part in Finland do home helps receive specific training, varying from 6 months to 3 years. This is also true to a small extend in the Netherlands. In many European countries there is a shortage of home helps. Experts in these countries say that the occupation is considered unattractive, because it has a low status, it is poorly

paid and the training is considered to be inadequate (Hutten et al., 1996). The main tasks of European home helps are household activities, caring, and general support. Sometimes they also provide moral support with psychosocial problems and stimulate informal care (Hutten et al., 1996).
In most European countries there is a distinction in the work of the various categories of home help. With regard to Dutch home help services, it is expected that in daily practice the distinction in the work of the six categories of home help is as evident as it is in theory.
The division of tasks and time over six categories of home help in daily practice in the Netherlands had not been studied before. Therefore, an extensive description of the work of home helps in the Netherlands was the objective of this study. The study addresses the following main question:

> "To what degree do formal job descriptions and job profiles of home helps in the Netherlands correspond with the daily practice in home help services?"

In order to answer the main question, two further questions have to be answered:

1) How do the various categories of home help spend their working time?
2) How are the activities in the four main categories of working in home help services carried out by the six categories of home helps during the home visits and in what way do the activities of the various categories of home help differ?

METHODS

Sample

A two-stage sampling method was used to obtain a representative sample of home helps: first the organizations and then the home helps. For the organizations, three stratification criteria were used: region (the four regions north, south, east and west), integration process of the home help organization (integrated with home nursing or not), and catchment area of the organization (care provided in an area including a city of more than 100 000 thousand inhabitants or not). This resulted a matrix of 16 cells, containing all the 104 organizations for home help services in the Netherlands. From each cell, one organization was randomly selected and asked to participate in the study. If an organization did not want to participate, another organization from the same

cell was asked. In total 30 organizations were asked to participate.
Each organization was to recruit 30 home helps equally divided over the six categories of home help, as described above. There was one inclusion criterion for home helps: they should have been in service for at least 1 month. A total of 510 home helps, one organization participated with two teams, was expected to take part in the study.

Procedure

During an instruction meeting, the purpose of the study was explained to the home helps, and all forms that had to be used were clarified fully. The home helps were asked to record the activities they carried out during all home visits on separate forms over a four week period and to fill in a report at the end of each week, recording all activities additional to the home visits. The recorded periods for the 16 organizations were divided over 8 months for practical reasons and to minimize the effect of possible season-fluctuations.

Instruments

Registration form

Home helps spend most of their time on home visits. In order to gain a representative picture of these activities, home helps recorded their work after every home visit. A self-registration form was developed for this. The form is based on the descriptive model for working in home helps services (Arts et al., 1997). In this model a distinction is made between the four main categories of work in home help services highlighted earlier (Framework I). The form specifies each of the four main categories in subcategories and activities: household with 30 activities, personal caring with 22 activities, psychosocial activities with 40 activities (including 4 social activities) and 18 reporting activities. This categorization is based on existing task profiles and classifications, and existing assessment forms used in home help services (Working Group SOGW, 1992; AbvaKabo/Union of Public Sector, 1992; Stichting Thuiszorg Hilversum, 's Graveland & Loosdrecht, 1992; Verheij et al., 1993; AbvaKabo/Union of Public Sector, 1994). A pilot study was carried out to test the inter-rater-reliability of the form (Arts et al., 1996). The level of agreement, i.e. the similarity between the frequencies scored by the home helps and the frequencies scored by the observer expressed in percentages, was computed for every activity, subcategory and main category. When the frequencies are equal, the level of agreement is 100%. In general, the items on the registration form were scored reliably, and the reliability scores of the main categories varied between 94%

and 98%. A few home helps made remarks regarding the content-validity of the registration form, such as 'the registration form is clearly and conveniently arranged, but not comprehensive enough'. The relevant remarks were taken into account with the final version of the registration form. The results of this study showed that the self-registration form is a reliable and valid instrument in assessing the daily practice in home help services, representing virtually all activities that home help services may provide (Arts et al., 1996). Additionally, the home helps recorded at the registration form both the time spent on the four main categories and the travelling time between clients and between clients and organization.

Weekly report

For all other activities, a so-called weekly report was developed. Activities outside the home visits, like planning and meetings, and the time spent on these activities were recorded on this form. The home helps were also able to note additional activities that had been carried out, like training, administrative work, and absence due to illness or to holidays.

Analyses

Because of the nature of this article, mainly descriptive analyses were used: (frequencies) means, standard deviations, and in some tables confidence intervals (CI). Analysis of variance (ANOVA) was used to test if there were significant differences between the mean number of activities carried out by the six categories of home help for the main categories of work (Norusis, 1992).

RESULTS

Response

Thirty organizations for home help or home care were asked to participate in the study. Fourteen organizations declined to take part. The main reasons for not participating were lack of time due to reorganization or merger (6) or involvement in other research (8). Finally, 16 organizations (53%) took part in the study, one organization participated with two teams.

Each organization was expected to select 30 home helps, five of each of the six categories of home help (510 home helps). Not all organizations though were able to select these 30 home helps, because there were not always five home helps in each category, nor were all six categories of home help present

or available in the organization. At first, 474 home helps (93%) were selected to participate in the study. As a result primarily of illness or holidays, 458 home helps remained (97%) to record their activities for almost 16 000 home visits. Table 4.2 shows the distribution of the home helps over the six categories, the corresponding number of completed registration forms per category and the average number of registration forms completed per home help per category during the registration period.
Almost all (97%) of the home helps were women. The mean age of the home helps was 39 years with a standard deviation of 9.9, and the average hours worked per week were 20 (standard deviation of 10).

Table 4.2 Distribution of home helps over the six categories of home help, the corresponding number of registration forms and the average number of registration forms per category of home help.

Category of home help	Number of home help	Number of registration forms	Average number of registration forms per home help
Alpha help	73	569	7.8
'A' home help	88	1 623	18.4
'B' caring help	87	2 125	24.4
'C' carer	81	3 364	41.5
'D' carer	75	6 845	91.3
Specialized 'E' carer	54	1 393	25.8
Total	458	15 921	34.8

Instead of 1832 weekly reports (i.e. when 458 home helps each return 4 weekly reports), the home helps returned 1784 weekly reports (97%). Thirty-two home helps sent back three instead of four weekly reports, and eight home helps sent back two instead of four. The majority of the non-responses can be explained by a failure to return the weekly reports during holidays or illness. Some bias may therefore, have occurred in the figures for holidays and illness. Sometimes people forgot to send the reports back, particularly at the end of the recording period.

Time spent on the various activities by home helps

The total amount of time comprises the duration of the home visits, the travelling time between clients and between clients and the organization, the time spent on meetings and the time spent on additional activities (training, working in daycare (caring for and looking after elderly, who normally live at home, in a centre during daytime) or administrative work). The time home helps were absent due to illness or holidays was noted, but not included in this overview of actual working time. Table 4.3 shows that the distribution differs for every category of home help: alpha helps spent almost no time outside home visits, 'D' carers travelled the most, due to the relatively short time they spent with the clients and the many clients they visit. The time spent on meetings and additional activities increased with higher categories of home help and therefore the time spent on home visits decreased.

Table 4.3 Distribution of the time spent by the 6 categories of home help: means and standard deviations, in percentages

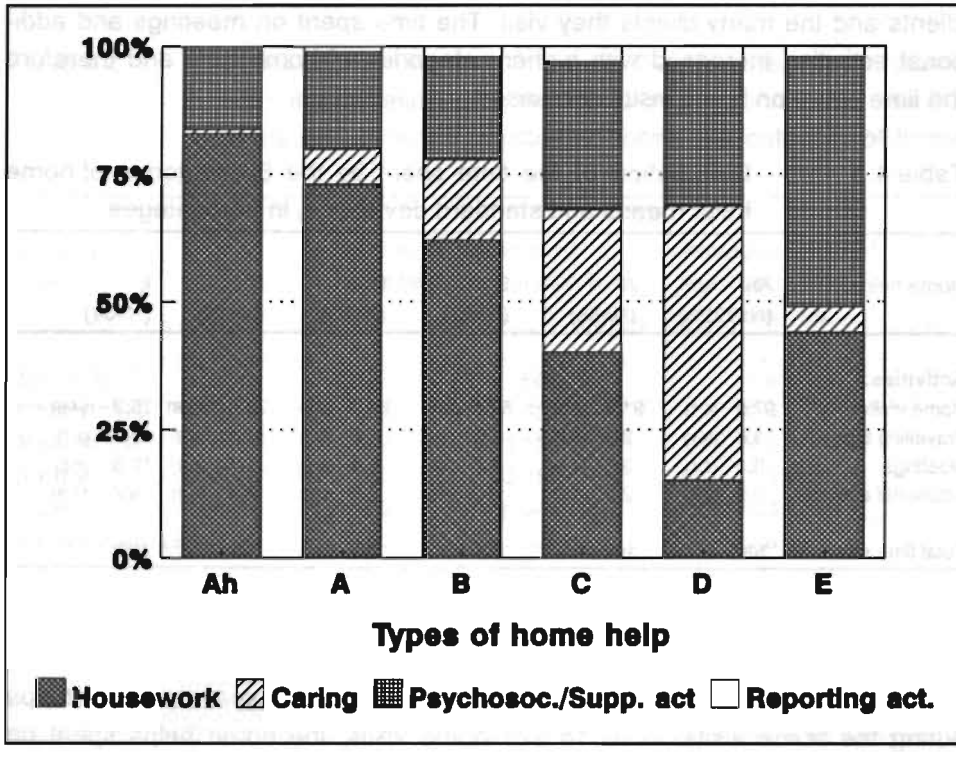
Home helps	Ah (N=73)	A (N=88)	B (N=87)	C (N=81)	D (N=75)	E (N=54)
Activities:						
Home visits	97.5 (4.1)	91.4 (7.8)	89.4 (9.9)	84.3 (2.5)	74.6 (12.8)	76.3 (14.6)
Travelling time	1.6 (3.1)	2.9 (5.1)	2.5 (2.4)	3.8 (3.4)	11.4 (6.3)	4.2 (2.7)
Meetings	0.3 (1.1)	3.6 (4.3)	4.5 (3.6)	6.4 (4.7)	7.7 (6.6)	10.8 (8.8)
Additional activities	0.6 (2.3)	2.1 (5.0)	3.6 (8.2)	5.5 (0.8)	6.3 (8.8)	8.7 (11.9)
Total time spent	100	100	100	100	100	100

The majority of the time in the four main categories is spent by home helps during the home visits. In all 15 921 home visits, the home helps spent on average 38% of the time on household activities, 33% on personal care and 27% on psychosocial activities. Only 2% of the time is spent on reporting.

Figure 4.1 shows the distribution of time during home visits for each of the six categories of home help. Like the alpha helps, 'A' home helps and 'B' caring helps spent the majority of their time on household activities. All three categories spent also some time on psychosocial activities. 'C' carers spent their time more or less equally distributed over household activities, caring and

psychosocial activities. 'D' carers spent half of their time on personal care, and also some time on psychosocial activities. Specialised 'E' carers spent almost half of their time on psychosocial activities, and another large part of the time on household activities, usually carried out together with the client. All home helps spent only a little time on reporting.

Figure 4.1 Time spent on the four main categories of working in home help services (in percentages for each category of home help)



The home helps were asked whether they participated in one or more meetings during the registration period. Three-quarters of the home helps (n=344) indicated that they had participated in one or more meetings during 4 weeks (Table 4.4). The total average time that was spent on meetings was 4 h and 45 min, increasing with higher categories of home help.

Table 4.4 Percentage of home helps participating in meetings during the registration period (4 weeks) (N=344), the average time spent on it, and standard deviations, for each category of home help.

	Number of home helps participating in meetings	Average time spent in h and min		Standard deviation in h and min	
		h	min	h	min
Alpha help	7%	1	43	1	57
'A' home help	75%	2	21	1	28
'B' caring help	82%	3	41	2	17
'C' carer	100%	4	34	2	43
'D' carer	88%	5	54	4	51
Specialized 'E' carer	100%	7	54	4	31
Total	344	4	45	3	49

Almost all meetings were together with colleagues and supervisors. Occasionally other professional care-givers, like GPs or other relevant people, like informal care-givers, were at these meetings. The most commonly discussed subjects during these meetings were the weekly plans, clients, and the functioning of group or team. The majority of the home helps indicated that there was enough time in their planning for these meetings.

Almost half of the home helps (*n*=227) carried out additional activities during one or more weeks of the study period, besides home visits and meetings. The most frequently occurring activities were those for training programs, and planning and co-ordinating activities. Most time-consuming was 'working in day-care centres'. The time spent on additional activities increased with higher categories of home help.

Finally, home helps also indicated on the weekly report if they had been absent due to illness or holidays. About one-fifth of the home helps had been ill during the study period. The duration of their absence varied from one day to four weeks. One-third of the home helps had a holiday during that period, varying from one day to three weeks.

Distribution of the activities over the main categories of working in home help services

Table 4.5 shows, per category of home help, the distribution of all activities performed in 15 921 home visits, over the five categories of work: household activities, caring, social, psychosocial and reporting activities. A distinction is made in social activities like chatting or asking after client's situation or condition, and psychosocial support.

For each home visit, the number of activities for each of the five categories of work carried out was calculated. In the next step, the data were aggregated from home visit level to the level of home help. Table 4.5 shows the mean number of activities carried out during the 15 921 home visits by the six categories of home help.

Table 4.5 Mean number of activities carried out during home visitis per main category by the six categories of home help, standard deviation, and confidence intervals with accompanying F-ratio's and p-values (N=458).

Home helps	Ah(N=73)	A(N=88)	B(N=87)	C(N=81)	D(N=75)	E(N=54)		
Number of home visits →	(569)	(1623)	(2125)	(3364)	(6845)	(1393)	F-ratio	P value
Activities ↓								
Household activities								
mean - s.d.	9.9(3.1)	9.4(4)	8.6(3.2)	6.7(3.5)	1.5(1.7)	4.7(2.2)	78.8	<.001
confidence interval	9.2-10.6	8.5-10.2	7.9-9.2	5.9-7.5	1.1-1.9	4-5.3		
Personal care								
mean - s.d.	0.1(0.2)	0.4(1)	1.1(1.3)	2.2(2)	3.2(1.3)	0.4(0.6)	71.7	<.001
confidence interval	0.02-0.1	0.2-0.6	0.9-1.4	1.8-2.7	2.9-3.5	0.3-0.6		
Social activities								
mean - s.d.	2.3(0.8)	2.2(0.7)	2.2(0.7)	2.1(0.6)	1.7(0.6)	2.3(0.7)	7.9	<.001
confidence interval	2.1-2.5	2-2.3	2-2.3	2-2.2	1.5-1.8	2.1-2.5		
Psychosocial/supportive activities								
mean - s.d.	3.1(3.2)	3.8(3.2)	4.4(2.9)	5.1(3.3)	3(2.4)	8.4(4.3)	23.7	<.001
confidence interval	2.3-3.8	3.1-4.4	3.8-5	4.3-5.8	2.4-3.6	7.2-9.6		
Reporting activities								
mean - s.d.	0.02(0.1)	0.3(0.8)	0.5(0.7)	0.7(0.9)	0.7(0.8)	0.4(0.8)	9.5	<.001
confidence interval	0-.05	0.1-0.4	0.3-0.6	0.5-0.9	0.5-0.9	0.2-0.7		

Table 4.5 shows that household activities was the main activity of alpha helps, 'A' home helps and 'B' caring helps. Specialised 'E' carers also did household activities, but performed these activities often together with the client instead of taking over from the client. As expected, 'D' carers, and 'B' and 'C' carers to a lesser degree performed much personal care. Compared the other home helps, 'D' carers carried out the least social activities. Psychosocial activities were carried out mainly by specialized 'E' carers, and by 'C' carers to a lesser degree. Both 'C' and 'D' carers performed most reporting activities. Specialised 'E' carers reported less during the home visits than the carers, probably because they spent a lot of time on meetings and consultation outside the home visits (see Table 4.4).

At the beginning of the paper, it was assumed that the various categories of home helps had dissimilar task profiles, and therefore did different work. With the results obtained in this study, this assumption was tested with an analysis of variance test. The last two columns in Table 4.5 (F-ratio and significance-level) show that the job content of the six categories of home helps indeed differs significantly ($P < 0.001$). With regard to household activities, 'C', 'D' and 'E' carers did significantly fewer activities compared with alpha helps, A and B helps. On the other hand, 'B', 'C' and 'D' carers performed significantly more personal care. Social activities like informal chats, were carried out significantly less by 'D' carers compared with the other five categories of home help. Psychosocial activities were carried out significantly more by specialised 'E' carers and 'C' carers to a lesser degree. Both 'C' and 'D' carers, and 'B' and 'E' carers to a lesser degree, reported significantly more compared with the subordinate categories of home help.

Based on the assessment of their daily practice in home help services, both the activities carried out and the time spent on it, a new task profile of the six categories of home help was created (Table 4.6).

Correspondence of formal job descriptions and tasks profiles with the daily practice in home help services

To examine whether the home helps do the work they are supposed to do, two task profiles (Tables 4.1 and 4.6) were compared. The two schemes differ for all six categories of home help: the differences are presented in Table 4.6 between brackets. Three main differences were found. First, the practice findings show that the four subordinate categories of home help perform more psychosocial tasks than prescribed in their job description and D carers perform less of these activities. Secondly, in daily practice, the three higher

categories of home help carry out more household activities than they are supposed to do. Finally, 'B' caring helps and 'C' carers performed more in the area of co-operation and consultation than is described in their formal task profiles.

Table 4.6 Task profile for each category of home help, based on daily practice

Activities → Category of home help ↓	Household	Caring	Psychosocial/ supportive	Cooperation & Consultation
Alpha help	X		o (++)	
'A' home help	X	o (++)	o (++)	
'B' caring help	X	o	X (++)	o (++)
'C' carer	X (+)	X	X (++)	o(++)
'D' carer	o (++)	X	o (-)	o
Specialized 'E' carer	X (+)	o	X	X

X = main tasks
o = secondary tasks

++ = done, but not described in formal task profile
+ = done more than described in formal task profile
- = done less than described in formal task profile

DISCUSSION

This study was carried out to gain insight into the work, time and activities, of home helps in Dutch home help services. As a result of recent developments and changes in health care and particularly in home care, which were mentioned in the introduction, home care organizations have had to work more efficiently and improve quality of care at the same time. Other developments like the implementation of personal budgets for special groups of clients and the increasing number of private home care organizations, only emphasize the need for increasing efficiency and quality of care.

Based on the activities home helps carry out and on the time spent on these activities, a new profile set for home helps had to be developed. With regard to the new task profiles, two main conclusions can be drawn. The first is that the new task profiles show rather large differences between formal task profiles

and daily practice, especially for psychosocial activities. For a better adjustment to the daily practice, time has to be reserved during the assessment of needs procedure for psychosocial support (for example by 10%). This kind of support is always given to a client following the home helps professional performance. Secondly, explicit attention should be paid to (hidden) psychosocial needs of clients. By taking into account psychosocial support during the assessment of needs as well as during the allocation of help, the extra activities home helps carry out in this area will be limited, both in duration and quantity. This will probably increase the efficiency of the work. Efficiency can also be increased by providing the home helps more authority on assessment and re-assessment procedures. They should be able to modify minor changes in the care plan based on a changing client situation. Consequently, home helps can work more flexibly and, therefore likely more efficiently (Svensson et al., 1996).

An additional factor is the overlap between the consecutive categories of home help with regard to the content of their work ('A' home helps and 'B' caring helps, and 'C' carers and 'D' carers), which is more substantial than appears from the formal job descriptions. Although the work of all six categories of home help showed significant differences, there are no clear boundaries in their work: home helps sometimes carry out activities for which they are not qualified (personal caring and psychosocial activities). This may have a negative effect on the quality of care. This is supported by studies of Van den Herik et al. (1995) and the Commissie Verzorging (Caring Committee) (1995), the latter being created to formulate an inventory and analyse problems in the area of job development, education and work pressure. They both concluded that the boundaries between the work of the consecutive categories of home helps, except for the specialized 'E' carers, are vague, and appeal for a removal of this overlap.

There is also some overlap in the work of home help services and home nursing services. The boundaries in the work of 'C' and 'D' carers (carers from home help services) and community nurses auxiliaries (home nursing) are not clear either. Both groups are involved in personal care (basic and less complex care), but home help services are aimed at the functioning of the total household whilst home nursing are aimed at the individual health problem of the client (Jansen et al., 1993). Compared with separate organizations for home nursing and home help services, in organizations for home care the overlap between these two groups is less because of substitution of care that took place in the integration process of home nursing and home help services.

The work of specialised 'E' carers and social workers has similarities too: both are involved in clients or families with (multiple) psychosocial problems. The difference here is that the specialized 'E' carer helps clients/families when their problems also have an effect on the household. Re-organization of the household, carried out together with the client, is essential and therefore help is provided at the client's home. The primary tasks of social work, carried out in social services setting, are among others, guidance and treatment, support and providing information and advices (VOG, 1997).

The new profiles also show that household activities and caring are never carried out alone in home help services, but in combination with at least psychosocial activities (see Table 4.6). This is also supported by findings from a study by Van den Herik et al. (1995) that showed performing household activities alone is quite exceptional in Dutch home help services. The research findings show that, besides reporting tasks, there are three main tasks: household activities, caring and psychosocial tasks. Four new categories of home help can be distinguished, based on this division and on the fact that household activities and caring are carried out in combination with at least psychosocial activities. The first category mainly carries out *household activities and supporting activities*, the second category carries out a combination of *household activities and basic personal caring activities with supporting activities*. The third category carries out mainly *personal care activities and psychosocial/supportive* activities, and finally the fourth category with the main task of providing *psychosocial guidance for families with multiple-complex problems*. All home helps carry out activities in the area of consultation and co-operation (reporting), the higher categories maybe more than their subordinate colleagues. This suggestion is being supported by both Van den Herik et al. (1995) and the Commissie Verzorging (Caring Committee) (1995).

Limitations of the study

The study has some restrictions with regard to the sample of home helps participating.

The way the home helps were selected for the study, either volunteering or selected by a supervisor, is a possible bias of the total sample of home helps, that also did not include long-term sick helps. Therefore, the results may be favourable. The number of home helps from each category taking part in the study varied. Of course, the total of home helps is not equally divided over the six categories.

Recommendation

This new classification of categories of home help is based on the tasks Dutch home helps carry out in daily practice. As described previously, these tasks are also carried out by home helps in other countries (Hutten et al., 1996). Therefore, this classification is also suitable for home help services in other countries of the European Union (EU). Together with formal and comparable education and training for all categories of home help in the EU, home help hopefully will become a more attractive occupation in all member states of the EU. Due to an ageing population and the increasing demand for home care in Europe, home help services are a fundamental part of the health care system. Differentiated practice enables home helps to work with each other and with other professional care-givers in various client situations. A further substitution of home care, home helps and especially 'D' carers, will fill the gap between these areas.

In future research more attention should be paid to the quality of care, provided by home helps and perceived by clients. In addition to the differences found in the job content of the six categories of home help, a new issue was raised: the differences between the six categories of home help regarding job satisfaction, burnout, health and absenteeism.

Acknowledgements

This research was carried out at the initiative of the Ministry of Public Health, the Professional Association of Home Helps (STING), the Association of Management of Home Help Organizations (STRATEGO) and the Netherlands Institute of Primary Health Care (Nivel). The study was financed by the National Centre of Nursing & Caring (LCVV).

REFERENCES

AbvaKabo (Union of Public Sector Workers). Overzicht van verschillende functies in de Gezinsverzorging. [Review of various jobs in home help services]. OAW: stuknummer 9210220y.1-5.4, 1992

AbvaKabo (Union of Public Sector Workers). Concept CAO-Thuiszorg met salarisregelingen. [Draft Collective Labour Agreement Home Care with salary-regulations]. Utrecht: AbvaKabo, 1994

Arts SEJ, Kersten H, Kerkstra A. The daily practice in home help services in the Netherlands: instrument development. Health Soc Care Commun 1996; 4:280-9

Arts SEJ, Kersten JWET, Kerkstra A. Werken in de gezinsverzorging. [Working in home help services]. Utrecht: De Tijdstroom/LCVV, 1997

Baars JA, Spaan JM. Jaarboek Thuiszorg 1995. [Yearbook Home Care 1995]. Bunnik/Utrecht: LVT/NZi, 1997

de Bruin A, Ruiter EC, Kerkstra A. Integratie kruiswerk en gezinsverzorging: meningen en ervaringen van hulpverleners en cliënten. [Integration community nursing and home help services: opinions and experiences of care-givers and clients]. Utrecht: NIVEL, 1996

Commissie Verzorging (Caring Committee). Zorg voor Zorg. [Caring for Care]. Utrecht: LCVV, 1995

van den Herik C, de Been M, Vulto M. 'Alles draait om de cliënt': de inhoud, het eigene en de kwaliteit van de arbeid van het uitvoerende werk in de gezinszorg. ['Everything revolves around the client': the content, characteristics and quality of work in home help services']. Leiden: Rijksuniversiteit Leiden, Faculteit Sociale Wetenschappen, Vakgroep Vrouwenstudies, 1995

van den Heuvel W, Gerritsen H. Home care services in the Netherlands. In: Jamieson A (ed). Home care for older people in Europe: a comparison of policies and practices. Oxford: Oxford University Press, 1991

Howe A, Ozanne E, Selby Smith, C (eds). Community care policy and practice: new directions in Australia. Victoria: Clayton, 1990

Hutten JBF, Kerkstra A. Home care in Europe. Aldershot: Arena, 1996

Jamieson A (ed). Home care for older people in Europe: policies and practices. Oxford: Oxford University Press, 1991

Jansen PGM, Kerkstra A. Functiedifferentiatie binnen de thuiszorg: de functies van wijkverpleegkundige, wijkverpleegster en gezinsverzorgende nader omschreven. [Differentiated practice in home care: the jobs of community nurse, community nurse auxiliary, and home help more precisely described]. Utrecht: NIVEL, 1993

Maessen PJJ. Bezuinigingen op de gezinsverzorging. [Budget cuts in home help services]. [Thesis]. Leiden: Rijksuniversiteit Leiden, 1989

Nijkamp P, Pacolet J, Spinnewyn H, Vollering A, Wilderom C, Winters S. Services for the elderly in Europe: a cross-national comperative study. Leuven/Amsterdam: HIV/VU, 1991

Norusis MJ, SPSS. SPSS/PC+ tm Base System User's Guide, version 5.0. Chicago: SPSS, 1992

OECD (Organization for Economic Co-operation and Development). Ageing populations: the social policy implications. Paris: OECD, 1990

OECD (Organization for Economic Co-operation and Development). Caring for the frail elderly, policies in evolution. Paris: OECD, 1996

Stichting Centrale Raad voor Gezinsverzorging. [Central Board for Home help services Foundation]. Handboek gezinsverzorging. [Handbook home help services]. Amsterdam: Vuga, 1989/1990

Stichting Thuiszorg Hilversum, 's Graveland & Loosdrecht. [Home care Foundation Hilversum, 's Graveland & Loosdrecht]. Functie schema uitvoerenden. [Job scheme for home helps]. Hilversum: Organisatie voor Gezinsverzorging, 1992

Svensson JS, Dirks JEM. Indicatiestelling en autonomie: een nieuwe aanpak. [Assessment-procedure and autonomy: a new approach]. Hengelo/Wageningen: Thuiszorg Centraal Twente / Universiteit Twente, 1996

Verheij RA, Caris-Verhallen WMCM, Kerkstra A. Integratie kruiswerk en gezinsverzorging, ervaringen van hulpverleners en cliënten. [Integration community nursing and home help services, experiences of professionals and clients]. Utrecht: NIVEL, 1993

VOG-sectie AMW. [VOG-section Social Work]. Het algemeen maatschappelijk werk in beeld 1995. [An overview of social work 1995]. Utrecht: SWP, 1997

Walker A. Home care in Europe: current trends and future prospects. Brussels: European Association of Organizations for Home Care and Help at Home, 1991

Welschen PTM, Griffioen HP, Manders PJC, Niebuhr TM. Eindrapportage functiewaarderingsonderzoek gezinsverzorging. [Final report of job evaluation study home help services]. Bunnik: LVT, 1990

van der Windt W, Calsbeek H, Hingstman L. Verpleging en verzorging in kaart gebracht. [An overview of nursing and caring]. Utrecht: De Tijdstroom/LCVV, 1997

Working Group (Werkgroep Werkveld) SOGW. Beroepsprofiel Verzorgende/Helpende. [Job profile home help and caring staff]. Leiden: Spruyt, van Mantgem & de Does BV, 1992

WVC (Ministry of Well-Being, Health & Culture). Heroverwegingsonderzoek 'Van Samenwerken naar Samengaan': gezinsverzorging en kruiswerk naar een geïntegreerd aanbod in de thuiszorg. [Reconsideration-study 'From Working Together to Going Together': home help services and community nursing to an integrated supply in home care]. Rapport van de heroverwegings-werkgroep doelmatigheidsonderzoek organisatiestructuur gezinsverzorging en kruiswerk. Rijswijk: WVC, 1990

PART II

Quality of working life
among home helps
working in home help services

5 QUALITY OF WORKING LIFE AND WORKLOAD IN HOME HELP SERVICES
a review of the literature and a proposal for a research model

S.E.J. Arts, A. Kerkstra, J. van der Zee, H.Huijer Abu-Saad
Scandinavian Journal of Caring Sciences (2001) 15:12-24.

ABSTRACT

In this literature review, several models for quality of working life and workload, appropriate for home help services are presented. The aim was to develop a model for assessing the psychological and physical outcomes of working in home help services. Although the models described in this review contain many relevant aspects, such as job characteristics, working conditions, social support, stress, job satisfaction and burnout, they were not fully adequate for the specific situation in home help services. Accordingly, a new research model was developed, based on the models presented and their research results. This integrated model has three main components: workload, psychological and physical outcomes and capacity for coping. Although a relationship between these three components is assumed, its nature needs to be investigated.

Keywords: home care, burnout, job satisfaction, health, absenteeism

5 QUALITY OF WORKING LIFE AND WORKLOAD IN HOME HELP SERVICES

a review of the literature and a proposal for a research model

INTRODUCTION

In the last few years, many studies showing a high workload, lack of autonomy and a high degree of burnout among nursing and caring staff have been published (De Jonge et al., 1996). Extensive research has been done on the work of informal caregivers (Aneshengel et al., 1993; Boaz et al., 1994), carers in nursing homes (De Jonge, 1996; Dobbelaar et al., 1994; Kuremyr et al., 1994), community nurses, nurses in hospitals (including psychiatric) (Jansen et al., 1996; McNeese-Smith, 1995; Melchior, 1996), and health care personnel in general (Van Dierendonck et al., 1992; Lindström, 1992; Olkinuora et al., 1992). Little research, however, has been conducted on the home help services. Furthermore, according to Bartoldus et al. (1989), more studies have been conducted from the perspective of administrators or clients than from the perspective of workers themselves (Trent, 1986; Eustis et al., 1991).

Home helps are continually dealing with emotionally demanding situations that can result in high levels of stress (Bartoldus et al., 1989). Research has shown that besides psychosocial stressors, physical load, time pressure and heavy workload also have negative effects on health care staff (Elovainio et al., 1997). Other indicators include reduced job satisfaction (Norbeck, 1985), diminished job performance and physical and mental health problems (Jennings, 1990). In addition to working with dependent and needy people, most home helps also provide care for their families. Without the support from supervisors, colleagues and the organizations, which is assumed to increase positive outcomes and diminish negative outcomes (De Jonge, 1996; Ylipsää et al., 1996), the potential for burnout is high and turnover is common (Haemmerlie et al., 1982; Berger et al., 1984). Although job-related stress has been examined, little or no research has been done on the way home helps cope with stress.

Absenteeism

The percentage of absenteeism due to illness among health care workers is quite high, particularly in Dutch home help services: 9.5% compared with 6% in other health care settings (BVG, 1995). Whereas the average duration of absenteeism among home helps is higher than in other health care settings, the average frequency is the same. Veerman concluded from his study on absenteeism in home help services in 1989, that the high percentage of absenteeism is caused by its long duration and not by its high frequency (Veerman, 1989). The absenteeism figures indicate that this conclusion remains valid: home helps are absent for longer than other health care workers, but not more often.

Veerman (1989) also found that the main reasons for absenteeism in home help services are problems of the musculoskeletal system (e.g. low back-problems, neck- and shoulder-problems), followed by psychological problems such as reaction to stress, neuroses and being over strained. Also according to Hedin (1997), the most common health problems among health care workers in Sweden are pain in the neck/shoulder and low back areas and symptoms of psychological stress, for example fatigue and finding it difficult to relax after work. When these problems become chronic, sufferers receive disablement insurance benefits (WAO). In 1993, almost twice as many workers in home help services received disablement insurance benefits than other health care workers (BVG, 1994). The turnover of staff is also higher in home help services than in other health care sectors (Van der Windt et al., 1998). High physical workload is one of the reasons that people stop working in home help services (Van der Windt et al., 1998).
In summary, home helps in the Netherlands have a heavy workload and a high percentage and long duration of absenteeism, back problems being the main cause. A high percentage of workers receive disablement insurance benefits and there is a high turnover. Based on the results of their study, De Jonge et al. (1993) concluded that the heavy workload that carers and nurses experience in their work, is one of the main issues needing attention in order to reduce workers' health problems, the resulting absenteeism and staff turnover.

Quality of working life

In recent decades, interest in work and organizational psychology in relation to the quality of working life has increased (De Jonge et al., 1993). This is actually a late result of "the division of labour" by Taylor (1911) and Gilbreth (1911) and the Human Behaviour Movement in the 1960s. *Quality of working life* is not a distinct concept, but can be associated with aspects such as job satisfaction, job involvement, motivation, productivity, health, safety and well being (De Jonge, 1993; Hood et al., 1994). These aspects, along with burnout and stress, are all operationalized psychological and physical outcomes of work. *Workload* is therefore an important element of the quality of working life. Beukema (1987) defines quality of working life as 'the degree to which employees are able to shape their jobs actively, in accordance with their options, interests and needs'. Katzell et al. (1977) describe a strategy based on the joint quest to improve worker well being and productivity as the core of the entire quality of working life movement. The most common connection between productivity and well being has been the assumption that work, which is redesigned to be more satisfying to employees, will also be more productive (Karasek et al., 1990). Both of these

definitions of the quality of working life can be described in terms of *job characteristics* and *working conditions* (Beukema, 1987).

Aims and research questions

The aim of this article was to develop a model to investigate the psychological and physical outcomes of working in the home help services, based on the existing models and research outcomes. Because workload is an important element in the quality of working life, the latter concept is used as a frame of reference for a review of the literature on workload in home help services. The questions that will be answered in this review article are:

1. What models of quality of working life or workload are available that are appropriate to home help services?
2. To what extent does empirical evidence exist for these models in home help services?
3. What aspects should be included in a research model assessing the psychological and physical outcomes of working in home help services?

METHODS

In order to gain insight into the available literature for this review, searches were done in five computer databases: American Psychological Association (1967-mid 1998), Coronel catalogue CARTBOX (1988-1998), Medline (1985-1998), NIVEL-catalogue (up to and including 1998), Nursing & Allied Health Literature (1983-1998), Occupational-Safety & Health data-base (1970-1998), Sociofile (1973-mid 1998).

The searches were performed using the following keywords in alphabetical order: burnout, home care, home aides, home help, home help services, job satisfaction, workload, and stress. The result of the searches with the keywords burnout, job satisfaction, stress and workload, yielded a large number of references. Combining each of these keywords with home care, home help, home help services and/or home health aides however, imposed strong selection criteria on the databases. Additional references were found by the snowball method, which means references cited in the discipline and research literature were also screened and used.

The following inclusion criteria for the studies were used: they had to be officially published in a journal, book or PhD-thesis, and they had to be published in English, German or Dutch. Excluded were studies described in internal reports,

one-page reviews letters and studies in other than the selected languages. Most of the 21 relevant studies found during the search were of Scandinavian and American origin. To a lesser degree, other European studies were included in the results.

RESULTS

The literature search produced a number of existing models, which can be categorized either as models on quality of working life or as models of workload in home help services. Two models were found that focused on the two elements of quality of working life. The job characteristics model, which focused on job characteristics (Hackman et al., 1974; Hackman et al., 1976; Hackman et al., 1980), and the job demand-control model, focusing on working conditions (Karasek 1979; Karasek et al., 1990). Both models aim for an improved quality of working life through job design or redesign. Only one model of workload in home help services was found. This model, the workload/capacity model, was used by Veerman (1989) in previous research on absenteeism among home helps in the Netherlands. The search also yielded many studies on home helps. On the basis of the foci in each, these studies will be categorized under one of three models: the job characteristics model, the job demand-control model or the workload/capacity model. Only the main results of the studies will be presented. More detailed information regarding the studies can be found in Table 5.2. In the various studies, various terms are used to refer the people working in home help services. From now on, they will be referred to as 'home helps'.

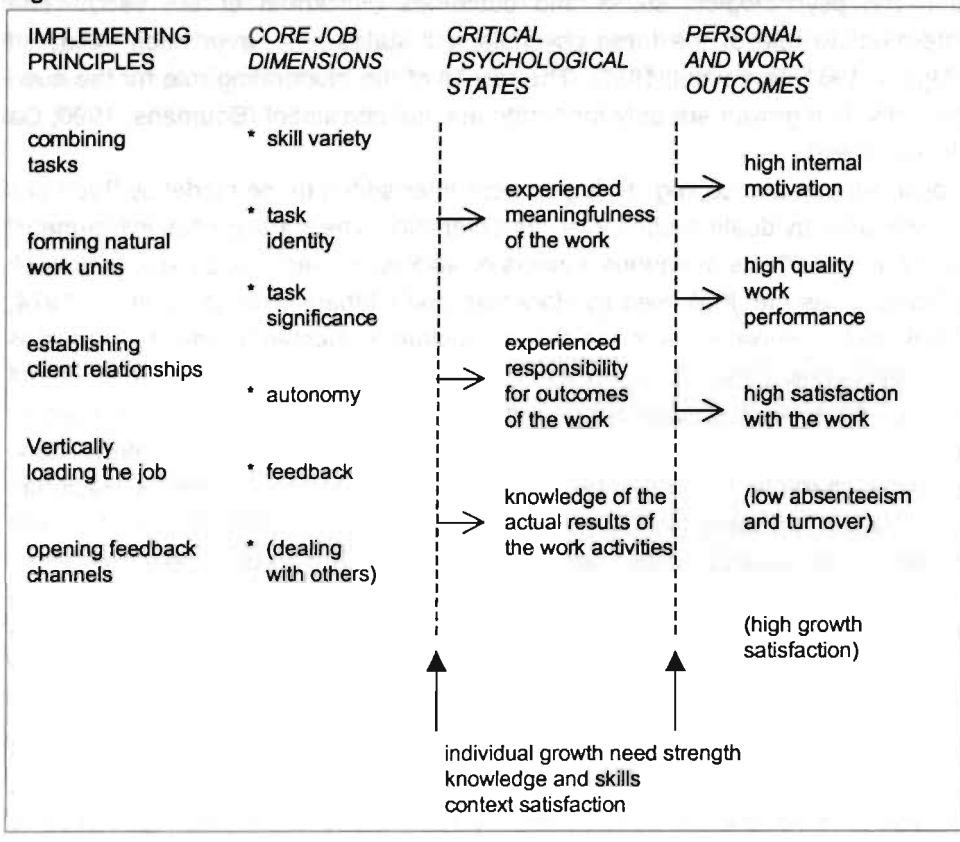
Models of quality of working life and empirical evidence found in home help services

The *job characteristics model (JCM)* specifies the conditions under which individuals become internally motivated to do their jobs effectively. The basic model, presented in Figure 5.1, distinguishes five *core job dimensions* (skill variety, task identity, task significance, autonomy and feedback). These are seen as prompting three *critical psychological states* that must be present for internally motivated work behaviour to develop. These psychological states, in turn, lead to a number of beneficial *personal and work outcomes* (internal work motivation, quality of work performance, job satisfaction, absenteeism and turnover). *The need for individual growth* and *context satisfaction*, for example supervision, moderates the links between job dimensions and psychological states, and

between psychological states and outcomes (Hackman et al., 1980). The intermediate role of the three psychological states has never been validated (Algera, 1981; Boumans, 1990). The results of the moderating role for the need for individual growth are only moderate and not consistent (Boumans, 1990; De Jonge, 1996).
Social support and coping strategies were later added to the model by Boumans (1990), as individual/psychosocial characteristics. The starting point in Boumans' study on the effects of various aspects of work on nurses' response to their work situation, was the JCM used by Hackman and Oldham (Hackman et al., 1974; 1976; 1980). However, in terms of the population selected for the study (nurses in general hospitals), Boumans noted that the model was not complete without taking into account nurses' social support and how they dealt with problems or problematic events, so these variables in the final model (Boumans, 1990). These personal characteristics are therefore not a part of the basic model by Hackman and Oldham, presented in Figure 5.1, but are considered in this review. The final model can be used in the analysis of jobs that are being considered for redesign. In addition, the model can serve as a framework for assessing and interpreting measurements collected to evaluate the effects of changes that have been carried out.

Four studies on home helps were found that focused on the same aspects of quality of working life as the JCM. Hollander Feldman (1993) and Ditson (1994) studied *turnover and work performance* among home helps. Two organizational projects, one to improve working life and one to reduce high turnover rates, resulted in reduced turnover (Hollander Feldman, 1993; Ditson, 1994) and perceived improvements in quality and continuity of care (Hollander Feldman, 1993). Björkhem et al. (1992) studied *quality of work performance*. Work-related aspects, such as relationship with the client and the client's family, background information and training, were needed to provide good care (a high quality of work performance). Finally, Hood et al. (1994) and Smith et al. (1994) carried out a study regarding *supervision*.
From the results of the these studies found in the literature, it can be concluded that empirical evidence was found for the significance of two personal and work outcomes: reduction of turnover rates and high quality of work performance (Björkhem et al., 1992; Hollander Feldman, 1993; Ditson, 1994) and for the positive effect of the intervening variable of the leader's personal concern (leadership style) on job involvement (Hood et al., 1994; Smith et al., 1994).

Figure 5.1 Job characteristics model



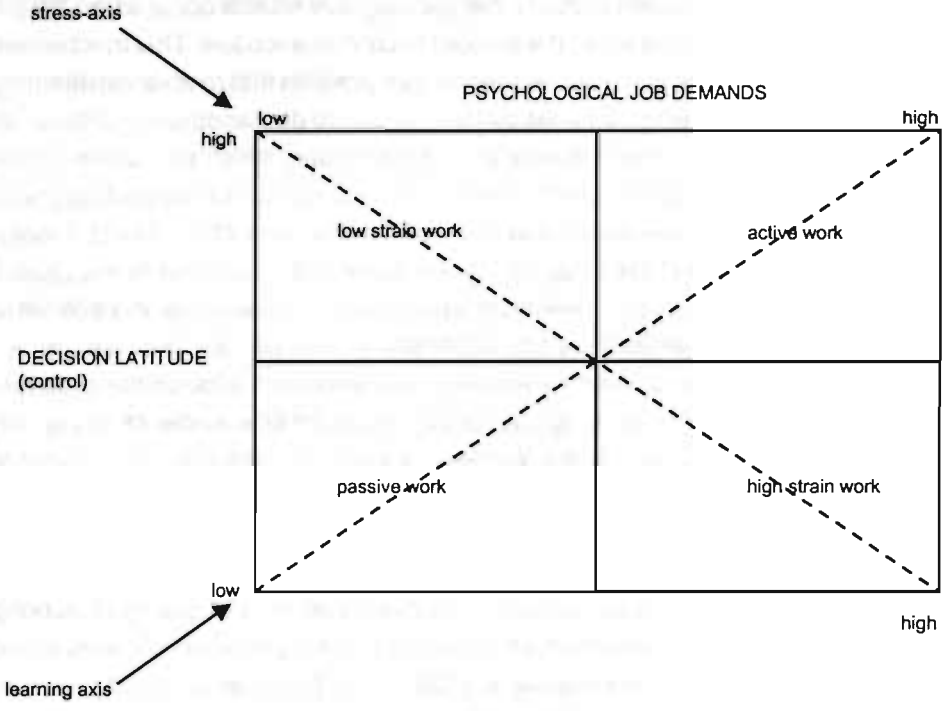
Source: Hackman and Oldham (1980). Reprinted with permission of Addison-Wesley Longman.

The other part of Beukema's definition on the quality of working life, in addition to job content, concerns the working conditions, the circumstances under which the work has to be carried out. Working conditions are central in Karasek's work-stress research and his *job demand-control model (JDCM)* (Karasek, 1979). Like Hackman and Oldham's JCM, Karasek's JDCM aims to improve quality of working life, not only by reducing work stress, but also by creating the right conditions under which motivation and personal growth in work can be achieved. Karasek's JDCM implies that *strain* (all psycho-physiological stress reactions) is caused by a combination of the level of *psychological job demands* and the amount of *decision latitude* (control) one has. Figure 5.2 shows this two-dimensional model,

with four types of work: high strain work, active work, low strain work and passive work (Karasek et al., 1990). In this model there are also two mechanisms presented. One mechanism predicts that the negative effects occur when the job demands are too high and when the amount of control is too low. This mechanism represents the *stress axis*. The other mechanism predicts that motivation, learning and growth can occur when both the psychological job demands and control of an employee are high: the *learning axis*. A third dimension, which was added to the model later, is *social support* which refers to the total amount of 'supportive' social interaction from both colleagues and supervisors (Karasek et al., 1982). Finally, Karasek and Theorell (1990) tried to add *personal characteristics* to the model. Although the influence of personality on work stress is undeniable, it is difficult to determine which characteristics are important in this context (Karasek et al., 1990). De Jonge (1996) studied the empirical evidence for the job demand-control and the job demand-control-support models. He found little evidence to support the assumed interaction of the models, owing for example, to probable confounding effects, indirect conceptualization and operationalization of job control and objective versus subjective assessment of job characteristics.

Eleven studies of home care, focusing on the same aspects of quality of working life as the job demand-control model by Karasek (working conditions), were found in the literature search. Eskelinen et al. (1990) and Tuomi et al. (1991) studied the *consequences of physically demanding work*. Three studies were carried out regarding *working environment and working conditions*: Hayashi et al. (1994), Dutcher et al. (1994) and Ström (1995). Myers et al. (1993) and Ono et al. (1995) studied *musculoskeletal injuries* in home care workers. Finally, Nordhus et al. (1991); Bradley et al (1995); Elovainio et al. (1997) and Hedin (1997) studied *stress and stress symptoms* among home helps.
From the results of these studies, it can be concluded that working and employment conditions in home care are poor (Hayashi et al., 1994). Evidence was also found for the negative effect of physically demanding work on health, especially on on the incidence of musculoskeletal and cardiovascular diseases (Eskelinen et al., 1990; Ono et al., 1995; Elovainio et al., 1997) and on the effect of control/influence on better working conditions (Ström, 1995). One study showed significantly higher levels of clarity and control, lower levels of peer cohesion, job involvement and work pressure among home helps compared with staff nurses (Hayashi et al., 1994). Finally, two studies found conflicts and lack of career prospects (Nordhus et al., 1991) and workload and instrumental role orientation (Bradley et al., 1995) to have a positive relation with job stress.

Figure 5.2 Job demand-control model (JDCM)



Source: Karasek (1979). Reprinted with permission of Administrative Science Quarterly.

Model of workload and empirical evidence found in home help services

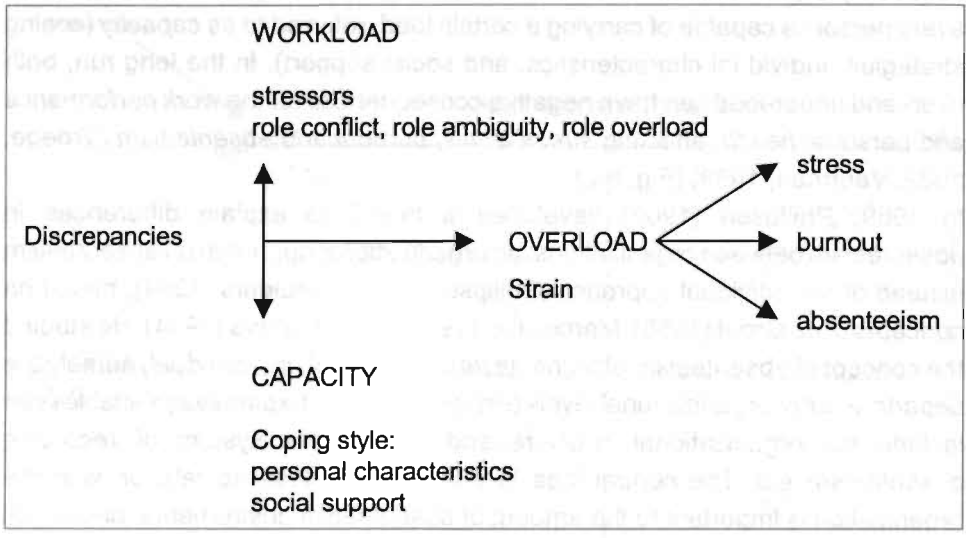
A model frequently used in workload research is the *'workload/capacity-model'* which aims for equilibrium (balance) between workload and capacity (Meijman et al., 1984; Veerman, 1989; Smulders et al., 1990). This model has its origins in industrial medicine (Vroege, 1982). Veerman (1989) used this model in his study of absenteeism among home helps and extended it with additional stress models and parts of the decision model (Smulders et al., 1990). In this model, discrepancies in workload and capacity could lead to *over- or under-load* strains. *Workload* is defined as the tasks someone has to perform under certain conditions (stressors, role conflict, role ambiguity). Veerman distinguishes three

types of workload: physical workload, psychosocial workload and workload caused by organizational characteristics (Veerman, 1989). On the other hand, every person is capable of carrying a certain load, referred to as *capacity* (coping strategies, individual characteristics, and social support). In the long run, both over- and under-load can have negative consequences for the *work performance* and personal *health*, affecting *stress levels, burnout* and *absenteeism* (Vroege, 1982; Veerman, 1989) (Fig. 5.3).

In 1969, Philipsen (1969) developed a theory to explain differences in absenteeism between organizations: an organizational approach on absenteeism instead of an individual approach (Philipsen, 1969; Smulders, 1984), based on concepts of de Groot (1958), March et al. (1958) and Lammers (1964). He studied the concept of absenteeism at higher levels than that of an individual, namely the departmental or organizational levels (Philipsen, 1969). Explanatory variables can include the organizational structure and climate, the system of recording absenteeism etc. The central idea in this theory is that the relation with the organization is important to the amount of absenteeism. Instrumental and social relations were expected to reduce the frequency of absenteeism, more than its duration (Philipsen, 1969; Smulders, 1984). This approach can be very useful for many reasons. Not only does it relate sociological, organization-related variables to absenteeism in organizations, but the organizational approach also checks for both typically medical and individual causes of absenteeism. This approach is useful when the differences among various organizations are either large or small, and also in testing the effect of organizational characteristics on absenteeism. Finally, for statistical reasons, the relationships among variables will also be stronger because at a higher level, absenteeism is not as skewed as it is at an individual level (Smulders, 1984). In reducing the variance of absenteeism by aggregation, the relationships among explanatory variables and absenteeism will be strengthened.

In the literature, six studies were found that investigated aspects of workload as suggested by the extended workload/capacity model of Veerman (1989). Johansson (1993) and Friele et al. (1994) studied effects of physical workload. Koes et al. (1987), Veerman himself (1989), Bartoldus et al. (1989) and Tompkins (1995) studied consequences of work overload, like *stress, burnout and absenteeism* among home helps. Based on these results, it can be concluded that empirical evidence was found for the effect of working solo (no contact with colleagues or supervisors) on higher levels of burnout (Veerman, 1989; Friele et al., 1994) and absenteeism (Veerman, 1989), and also for the effect of social support from supervisors on coping with stress (Bartholdus et al., 1989).

Figure 5.3 The extended "workload/capacity-model"



Source: Smulder and Veerman (1990). Reprinted with permission of the authors.

Evidence was also found for the positive relationships among role conflict, role ambiguity, higher levels of absenteeism (Veerman, 1989) and stress/burnout (Tompkins, 1995).
Finally, evidence was found for the effect of time pressure on higher levels of burnout (Koes et al., 1987), physical workload on higher levels of absenteeism (Koes et al., 1987) and physical workload and psycho social factors on health (musculoskeletal diseases) (Johansson, 1993).

Towards an integrated model for assessing psychological and physical outcomes of working in home help services

All three models include meaningful aspects, which are appropriate for home help services, but none includes all aspects that affect workload in home help services. Integrating the relevant variables and conclusions in one model, appropriate for home help services, is a result recommended in order to assess the psychological and physical outcomes of working in home help services adequately. On the basis of the models reviewed and results of the studies, a list can be made of variables that may influence the quality of working life in home help services. Table 5.1

shows that none of the three models is completely adequate for assessing psychological and physical outcomes of working in home help services.

The final integrated research model will be used to assess the psychological and physical outcomes of work for individual home helps. Due to their nature, some variables are not integrated in the new model, although empirical evidence has been found for them. Turnover, for example, is more of a collective variable and therefore difficult to measure individually. Stress is another variable that will not be integrated in the model. When working with people, and consequently being confronted with problems and problematic situations in respect of clients, work and organization, burnout is a more appropriate concept (Schaufeli, 1990).
Methodologically, every study on workload starts with an analysis of the job content and the conditions under which the work has to be performed (Meijman et al., 1984). As shown in Table 5.1, *job content* is found in the JCM (job characteristics) as well as in the JDCM (psychological job demands). *Working conditions*, circumstances under which work must be carried out, was also found in both the JDCM (decision latitude/control) and the workload/capacity model (workload). Engelen (1983) states that quality of working life is also highly influenced by the way work is organized within the organization, which is also acknowledged by Philipsen (1969); Smulders (1984) and Veerman (1989) (*organizational characteristics*).

The ultimate goal of the JCM and the JDCM is to improve the quality of working life. Both models have different approaches to achieve this. The presence of Hackman and Oldham's core job dimensions has a positive influence on *internal motivation*, *job satisfaction*, *work performance*, *health*, *turnover* and *absenteeism* (Hackman et al., 1974; 1976; 1980). Karasek, on the other hand, states that a certain level of psychological demand should exist alongside a corresponding level of control, in order to avoid *stress* and to stimulate *motivation*, *learning and growth opportunities* (Karasek, 1979; Karasek et al., 1990). Veerman argues that workload and capacity should be in balance in order to avoid overload. Overload can have negative consequences such as stress, burnout and absenteeism for *work performance* and *personal health* (Veerman, 1989; Jennings, 1990; Elovaino et al., 1997).

Table 5.1 Overview of possible influences on quality of working life in home help services, for each of the three models

	Job characteristics model	Job demand control model	Workload-capacity model
Independent variables			
Workload			
Organizational characteristics			X
Substitution during illness			X
Working solo			X
Job characteristics (job demands)	X	X	
Autonomy/control	X	X	
Growth opportunities	X	X	
Learning opportunities		X	
Feedback	X		
Skill variety	X		
Working conditions		X	X
Role ambiguity			X
Role conflict			X
Workload (mental-/physical-)			X
Capacity for coping			
Social support			
Social support from colleagues/supervisor	X	X	X
Supervision/leadership style	X	X	
Personal characteristics			
Coping strategies	X		X
Personal characteristics	X	X	X
Dependent variables			
Job satisfaction	X		
Work performance	X		X
Internal motivation	X	X	
Stress/burnout		X	X
Turnover	X		
Health	X	X	X
Absenteeism	X		X

The relationships between the independent and the dependent variables in both the JCM and the JDCM, is completed with two intervening variables: *social support* and *personal characteristics*. Both variables are also included in the capacity dimension of the workload/capacity model. As part of the social support,

the influence of *supervision* was shown not only by Hackman and Oldham (1980) and Karasek (1979; 1990) (see Table 5.1), but also by Boumans (1990), Hood et al. (1994) and Smith et al. (1994), and Lindström (1994). Personal characteristics such as gender, age, and education also play a part in this. These personal characteristics determine a person's 'capacity for coping', which is the ability to achieve and defy something (Van Dijk et al., 1990). Closely related to the capacity for coping is the concept of *coping* (the ability to deal with stress). Veerman concluded in his study, that coping corresponds with the capacity part from the workload/capacity model (Veerman, 1989). In Hackman and Oldham's JCM (1974;1976;1980), coping strategies were also added as personal characteristics. On the basis of the empirical evidence found in studies on home help and home help services, the main dimensions of the model can be further specified. Table 5.2 gives an overview of the variables influencing quality of working life in home help services. The studies are in alphabetical order, by author.
Only a few studies on home helps were done, with burnout and job satisfaction as specific outcome variables. Other studies among health care personnel however, showed that these are very important work-related reactions, and therefore should be included in the research model measuring psychological and physical outcomes of work among home helps. In the last few years, various studies of these outcome variables have been conducted, including some others in the Netherlands. De Jonge (1996), Jansen et al. (1996), and Melchior (1996) studied the effect of certain work-related aspects, on outcome variables like job satisfaction and burnout, in their research on health care workers from general hospitals and nursing homes, community nurses, and nurses in psychiatric hospitals respectively.

De Jonge (1996) found that high and low levels of job autonomy were related (reversed U-shaped) to relatively low levels of emotional exhaustion and also that high levels of job autonomy were related to high levels of job satisfaction in his study on the role of job autonomy in relation to job characteristics and well being and health. High levels of job demand were related to high levels of emotional exhaustion and low levels of job satisfaction. Finally, high levels of workplace social support were related to low levels of emotional exhaustion and high levels of job satisfaction.

Table 5.2 Overview of variables influencing quality of working life in home help services for which empirical evidence was found

Organizational characteristics		
Source	**Sample**	**Independent variable**
Bartoldus et al. 1989	32 home helps	communication with organization
Ditson 1994	homemakers and home health aides	communication with organization
Dutcher et al. 1994	94 staff nurses, 48 home helps	working solo/no opportunities for keeping contacts
Friele et al. 1994	68 home helps	working solo/no opportunities for keeping contacts
Hollander Feldman 1993	11 home care agencies	communication with organization
Hedin 1997	99 home helps (61 in favourable condition (FC) and 38 in unfavourable condition (UC)	communication with organization
Veerman 1989	594 home helps	working solo/no opportunities for keeping contacts substitution during illness

Characteristics of independent variables	Relationship found with dependent variable
due to weekly supervisory meetings, which were useful	
through a collaborative action research project	reduced turnover rates
home helps did not have as much opportunities for keeping contact as staff nurses	home help were less satisfied with the work environment than staff nurses
	higher levels of burnout
through four working life demonstration projects	reduced turnover rates, increased quality of work performance
UC-home helps reported lower scores on 'clearness of organization' compared with FC-home helps	UC-home helps reported more musculoskeletal and stress symptoms
problems due to working solo, not able to talk to colleagues	higher levels of burnout and of absenteeism
	lower absenteeism

(Table 5.2 continued)

Job characteristics		
Source	**Sample**	**Independent variable**
Björkhem et al. 1992	63 home helps	learning and growth opportunities (clinical supervision)
Bradley et al. 1995	63 social workers and 74 home helps	learning- and growth opportunities (career prospects)
Dutcher et al. 1994	94 staff nurses, 48 home helps	autonomy
		skill variety (variety, new approaches, changes)
Hedin 1997	99 home helps (61 FC and 38 UC)	learning - and growth opportunities
Johansson 1993	305 home helps	control/influence on work
		learning - and growth opportunities & skill variety (stimulus from work)
Ström 1995	home helps of 1 organization	control (in a change project to improve working conditions)
Veerman 1989	594 home helps	skill variety (too much housework)

Characteristics of independent variables	Relationship found with dependent variable
	higher work performance (providing better care)
home helps experienced less career prospects compared with social workers	source of job stress
not significantly different between staff nurses and home helps not significantly different between staff nurses and home helps	higher work performance (home helps are not used to their maximum potential)
UC-home helps had significantly less opportunities for development	UC-home helps reported more musculoskeletal and stress symptoms
home care workers are less satisfied with influence and control on their work and home care workers are less satisfied with stimulus from work compared with reference group of 694 municipal workers	health problems: a high prevalence of musculoskeletal diseases
creation of smaller teams (6-8) groups with no foreman (more autonomous teams)	high quality work performance (better understanding of quality of work)
	physical overload

(Table 5.2 continued)

Working conditions		
Source	**Sample**	**Independent variable**
Bartoldus et al. 1989	32 home helps	time pressure
Björkhem et al. 1992	63 home helps	role ambiguity
Bradley et al. 1995	63 social workers and 74 home helps	conflicts between work and home
Dutcher et al. 1994	94 staff nurses, 48 home helps	control role ambiguity (clarity) physical workload time pressure
Elovainio et al. 1997	204 municipal employees in residential homes, nursing homes and home help organizations	physical load time pressure
Eskelinen et al. 1990	343 home helps	physical workload
Friele et al. 1994	68 home helps	physical workload
Hayashi et al. 1994	1900 home helps	working conditions
Johansson 1993	305 home helps	physical workload
Koes et al. 1987	119 home helps	physical workload time pressure

Characteristics of independent variables	Relationship found with dependent variable
	physical and mental overload (stress)
	higher work performance (providing better care)
home helps experienced more conflicts than social workers	source of job stress
home helps experience a significantly higher level of control than staff nurses idem not significantly different between staff nurses and home helps home helps experience a significantly lower level of work pressure than staff nurses	
	psychological stress symptoms and musculoskeletal symptoms
physically demanding work	health problems: physical stress, cardiorespiratory, musculoskeletal and psychological symptoms
too much physical uncomfort: lifting, pulling	physical overload
harsh	
lifting, repetitive and monotonous movements, unsuitable work postures, trunk flexion, hands above shoulder level workload, extent of feeling tired and exhausted after work, possibility for relaxation/having break, mental strain, stress at work	health problems: a high prevalence of musculoskeletal diseases
	more absenteeism

(Table 5.2 continued)

Working conditions		
Source	**Sample**	**Independent variable**
Myers et al. 1993	incident reports of low back injuries '84-'86 (nursing aides & home helps)	physical workload
Nordhus et al. 1991	322 care giving personnel of which 31% home helps	workload emotional over-involvement
Ono et al. 1995	105,000 home helps	physical workload
Tompkins 1995	117 home helps	role ambiguity
Tuomi et al. 1991	343 home helps	physical workload
Veerman 1989	594 home helps	role ambiguity role conflict mental workload

Characteristics of independent variables	**Relationship found with dependent variable**
lifting, pushing and pulling activities	health problems (low back injuries)
home helps expressed more workload than nurses and nursing assistants regarding occupation and organization	high workload and emotional involvement are indicators for job stress
person/patient-handling task (lifting etc.)	health problems: musculoskeletal diseases and over-exertion accidents
	stress and (higher levels of) burnout
physically demanding work	poor health and poor work ability
due to working solo	more absenteeism (indirectly) more absenteeism higher levels of burnout

(Table 5.2 continued)

Social support		
Source	**Sample**	**Independent variable**
Bartoldus et al. 1989	32 home helps	social support from colleagues social support from supervisor coping strategies
Björkhem et al. 1992	63 helps	social support from supervisor
Dutcher et al. 1994	94 staff nurses, 48 home helps	social support from colleagues (peer cohesion) social support from supervisor
Hedin 1997	99 home helps (61 FC and 38 UC)	social support
Tompkins 1995	117 home helps	social support

Characteristics of independent variables	Relationship found with dependent variable
weekly supervisory meetings are useful	
idem	coping better with stress
identification with the client and altruism were both used among home helps	coping with stress
	higher work performance (providing better care)
home helps experienced significantly lower levels of social support from colleagues than staff nurses	home helps were significantly less satisfied with the work environment than staff nurses
not significantly different between staff nurses and home helps	
UF-home helps had a less positive attitude towards colleagues and experienced the management as less positive	UC-home helps reported more musculoskeletal and stress symptoms
	stress and (higher levels of) burnout

(Table 5.2 continued)

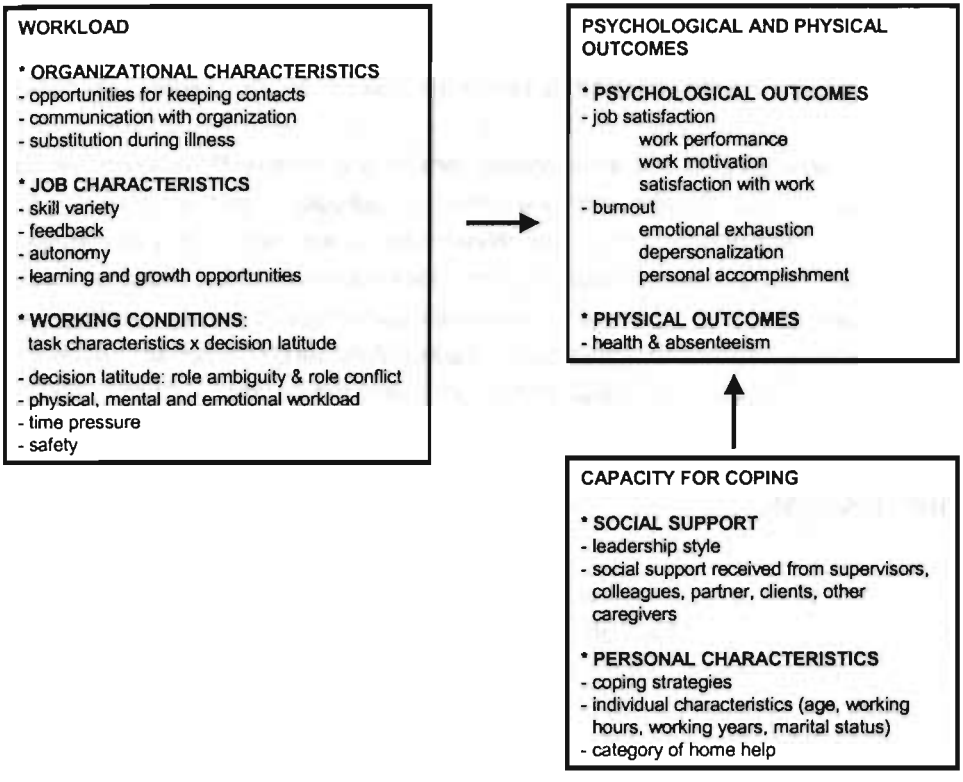
Leadership style		
Source	**Sample**	**Independent variable**
Hood et al. 1994	52 nurses, 94 home helps	leadership
Smith et al. 1994	52 nurses, 94 home helps, 41 support staff	leadership

Characteristics of independent variables	Relationship found with dependent variable
not significantly different between nurses and home helps	personal concern is a significant predictor of job satisfaction
transformational leadership (stimulating and motivating for change)	correlated with higher job satisfaction and job involvement and indirectly related to higher work performance

Jansen et al. (1996) studied the effects of differentiated practice in home care and found relations between the individual characteristics, job characteristics and personal and work outcomes, such as job satisfaction and burnout. Both individual characteristics and job characteristics were found to be related with job satisfaction and burnout: job satisfaction was affected more by job characteristics, and burnout was affected more by individual characteristics. In Melchior's study (1996), the aim was to determine which work-related factors reduced or prevented burnout among psychiatric nurses. He studied the relationship between burnout and a number of work related factors and concluded that a certain work environment is associated with low levels of burnout. This environment is illustrated by good support and feedback, job clarity, autonomy, low levels of complexity in the work, managers with a social leadership style, and realistic expectations about the potential for rehabilitation.

The 'workload/capacity-balance model' (Meijman et al., 1984; Veerman 1989; Smulders et al., 1990) is used as a stepping-stone for the integration of the models and the research results. This research model has three dimensions: workload, psychological and physical outcomes and the capacity for coping, which are assumed to be interrelated. Workload causes certain psychological and physical outcomes that are influenced by a person's capacity for coping (Fig. 5.4).

Figure 5.4 An integrated model for assessing the psychological and physical outcomes of working in home help services



Workload, the activities someone must perform in a certain environment, can be classified in terms of three types of variable: organizational characteristics (Veerman, 1989; Tuomi et al., 1991), job characteristics (Hackman et al., 1974; 1976; 1980) and working conditions (Karasek, 1979; Karasek et al., 1990). Organizational characteristics are operationalized as contact opportunities, communication with organization and substitution during illness; job characteristics are defined as skill variety, autonomy, feedback and learning and growth opportunities; and working conditions are operationalized as role ambiguity, role conflict, physical workload, mental workload, time pressure and safety.

Psychological and physical outcomes are defined as the effects of the workload (Hackman et al. 1974; De Jonge, 1996) and involve psychological and physical effects. In this model, the outcomes are operationalized to include job satisfaction (work performance, work motivation) (Hackman et al., 1980; Karasek, 1990), burnout (Veerman, 1989; Karasek et al., 1990; Smulders et al., 1990) and health/absenteeism (Karasek 1979; Hackman et al., 1980; Smulders et al., 1990).

Capacity for coping is the third component of the model. Psychological and physical outcomes are affected by the mental capacity of home helps and the support they experience. Social support includes the leadership style and support from supervisors, colleagues and partners (Hackman et al., 1980; Veerman, 1989; Karasek et al., 1990). Personal characteristics, in this model, are coping strategies (Hackman et al., 1976; 1980; Veerman, 1989), individual characteristics (Karasek 1979; Hackman et al., 1980; Boumans, 1990) and the category of home help.

DISCUSSION

The aim of this literature review was to achieve a research model for assessing the psychological and physical outcomes of working in home help services. The first research question investigated what models of quality of working life and workload, appropriate for home help services, are available. The literature search yielded three models: Hackman and Oldham's job characteristics model (1974; 1976; 1980), Karasek's job-demand-control model (1979; 1990) and the workload/capacity model (Meijman et al., 1984; Veerman, 1989; Smulders et al., 1990). The first two models aim for an improved quality of working life, while the third model is a balance model, where overload (strain) exists due to discrepancies between a person's workload and his or her capacity. The three models contained many relevant aspects for assessing the psychological and physical outcomes of working in home help services. Examples of these aspects are job characteristics, working conditions, workload, coping style, support, and outcomes of work, eg. work performance, satisfaction, absenteeism and turnover, stress and burnout.

The next step (research question 2) was to investigate whether empirical evidence was found for these models in home help services. The literature search yielded 21 studies carried out among home helps and/or in home help services. The results of these studies validated the relevance of the aspects derived from the three models. Several studies showed that, compared with staff nurses, home

helps experienced higher levels of control (Dutcher et al., 1994) and clarity and lower levels of peer cohesion and work pressure in their work. Evidence was found for the significance of two outcomes: reduction of turnover rates and high quality of work performance (Björkhem et al., 1992; Hollander Feldman, 1993; Ditson, 1994), and for the positive effect of the leader's personal concern (leadership style, social support) on job involvement (Hood et al., 1994; Smith et al., 1994), and on coping (Bartoldus et al., 1989). In the literature, evidence was found for various variables related to absenteeism: working solo, role conflict, role ambiguity (Veerman, 1989), and physical workload (Koes et al., 1987). Furthermore, relations were found among working solo (Veerman, 1989; Friele et al., 1994; Tompkins, 1995), role conflict (Nordhus et al., 1991; Tompkins, 1995), role ambiguity (Tompkins, 1995), lack of career prospects (Nordhus et al., 1991), high levels of workload (Bradley et al., 1995), instrumental role orientation (Bradley et al., 1995), time pressure (Koes et al., 1987) and high levels of stress/burnout. Finally, empirical evidence was found for the negative effect of physical workload and psychosocial factors on health (musculoskeletal and cardiovascular diseases) (Eskelinen et al., 1990; Tuomi et al., 1991; Johansson, 1993; Ono et al., 1995; Elovainio et al., 1997).

The third and final research question was to investigate what aspects of the various models, for which empirical evidence was found, should be included in a 'new' research model assessing the psychological and physical outcomes of working in home help services. We integrated the three models of quality of working life and workload for home help services with the empirical evidence found for the models in home help services. The balance model was used as a stepping stone for the integration of the relevant aspects in one new model. The new research model contains three components: workload, psychological and physical outcomes and capacity for coping. The workload of working in home help services (organizational characteristics, job characteristics and working conditions) is related to certain psychological and physical outcomes (job satisfaction, burnout, health and absenteeism), which have a buffer in the capacity for coping. Whether or not home helps become overloaded by their workload depends on the capacity for coping, meaning the amount of social support experienced and their ability to deal with stress.

CONCLUSION

By comparing the three existing models, and reviewing the outcomes of various studies, it can be concluded that none of these models was completely adequate to investigate the entire concept of quality of working life in home help services. Therefore, a new research model integrating the different aspects of models and outcomes of studies was developed. The new model is a 'balance' model including three components. In this model, relationships between workload and the psychological and physical outcomes of work is assumed. The nature of this relationships in home help services is still unclear and needs further study. Additionally, the relationships between capacity for coping and psychological and physical outcomes, regardless of the workload, needs to be examined. Finally, previous studies have shown that the various aspects of psychological and physical outcomes of work are interrelated. Consequently, research examining these results needs to be conducted in home help services.

Acknowledgements
This project was carried out at the initiative of the Ministry of Public Health, the Professional Association of Home Helps (STING), the Association of Management of Home Help Organizations (STRATEGO) and The Netherlands Institute of Primary Health Care (Nivel). The study was financed by the National Centre of Nursing & Caring (LCVV).

REFERENCES

Algera JA. Kenmerken van werk. [Characteristics of work]. Lisse: Swets & Zeitlinger, 1981

Aneshengel CS, Pearlin LI, Schuler RH. Stress, role captivity, and the cessation of care giving. J Health Soc Beh 1993; 34:54-70

Bartoldus E, Gillery B, Sturges PJ. Job-related stress and coping among home-care workers with elderly people. Health Soc Work 1989; 14:206-10

Berger RM, Anderson S. The in-home worker: serving the frail elderly. Soc Work 1984; 29:456-61

Beukema L. Kwaliteit van de arbeidstijdverkorting. [Quality of reduction of working hours]. Groningen: Karstapel, 1987

Björkhem K, Olsson A, Hallberg IR, Norberg A. Caregivers' experience of providing care for demented persons living at home. Scand J Prim Health Care 1992; 10:53-9

Boaz RF, Muller CF. Predicting the risk of "permanent" nursing home residence: the role of community help as indicated by family helpers and prior living- arrangements. Health Serv Res 1994; 29:391-414

Boumans NPG. Het werk van verpleegkundigen in algemene ziekenhuizen. [The work of nurses in general hospitals]. [Thesis] Maastricht: Rijksuniversiteit Limburg, 1990

Bradley J, Sutherland V. Occupational stress in social services: a comparison of social work and home help staff. Br J Soc Work 1995; 25:313-31

BVG (Dutch Industrial Board for Human Services). BVG-Berichten 1994. [Dutch Industrial Board for Human Services Reports 1994]. Zeist, 1994

BVG (Dutch Industrial Board for Human Services). BVG-Berichten 1995. [Dutch Industrial Board for Human Services Reports 1995]. Zeist, 1995

van Dierendonck D, Groenewegen PP, Sixma H. Opgebrand: een inventariserend onderzoek naar gevoelens van motivatie en demotivatie bij huisartsen. [Burnout: an investigating study on feelings of motivation and demotivation among general practitioners]. Utrecht: NIVEL, 1992

van Dijk FJH, van Dormolen N, Kompier MAJ, Meijman TF. Herwaardering model belasting-belastbaarheid. [Revaluation of the workload/capacity model]. TSG 1990; 68:3-10

Ditson LA. Efforts to reduce homemaker/home health aide turnover in a home care agency. J Health Care Prac 1994; 6:33-44

Dobbelaar T, Bosink J. Verzorgenden onder druk: ziekteverzuim in het verzorgingstehuis. [Caring staff under pressure: absenteeism in homes for the elderly]. Tijdschr Verzorgenden 1994; 9:293-6

Dutcher LA, Adams CE. Work environment perceptions of staff nurses and aides in home health agencies. J Nurs Adm 1994; 24:24-30

Elovainio M, Sinervo T. Psychosocial stressors at work, psychological stress and musculoskeletal symptoms in the care for the elderly. Work Stress 1997; 11:351-61

Engelen CHMG. Arbeidsomstandigheden in de zorgsector. [Working conditions in the health care sector]. Tijdschr Verzorgenden 1993; 7:198-204

Eskelinen L, Toikkanen J, Tuomi K, Mauno I, Nygard C-H, Ilmarinen J. Symptoms of mental and physical stress in different categories of municipal work. Scand J Work Environ Health 1990; 17(suppl 1):82-6

Eustis NN, Fischer LR. Relationship between home care clients and their workers: implications for quality of care. Gerontologist 1991; 31:447-56

Friele R, Beemster F. Positie helpende belangrijker dan deugdelijk huishoudmateriaal. [Position of home help is more important than adequate household material]. Thuiszorg 1994; 2:4-7

Gilbreth FB. Brick laying system. New York: Clark, 1911

de Groot MJW. Veranderingen in verzuimfrequentie in het algemeen en door neurosen in het bijzonder. [Changes in absenteeism frequency in general and due to neuroses in specific]. In: de Groot MJW (ed). Kwalitatieve benadering van het verzuim door neurosen bij Nederlandse fabrieksarbeiders. [Qualitative approach of absenteeism due to neuroses among Dutch factory workers]. Leiden: NIPG-TNO, 1958

Hackman JR, Oldham GR. The Job Diagnostic Survey. New Haven: Yale University, 1974

Hackman JR, Oldham GR. Motivation through design of work: test of a theory. Organ Behav Hum Perform 1976; 16:250-79

Hackman JR, Oldham GR. Work redesign. Reading: Addison-Wesley, 1980

Haemmerlie FM, Montgomery RM. Role conflict in a homemaker aide program for frail elderly. Psychol Rep 1982; 51:63-9

Hayashi R, Gibson JW, Weatherley RA. Working conditions in home care: a survey of Washington State's home care workers. Home Health Care Serv Q 1994; 14:37-48

Hedin AM. From different starting points...: a longitudinal study of work and health among home care workers. Eur J Public Health 1997; 7:272-8

Hollander Feldman P. Work life improvements for home care workers: impact and feasibility. Gerontologist 1993; 33:47-54

Hood JN, Smith HL. Quality of work life in home care. J Nurs Adm 1994; 24:40-7

Jansen PGM, Kerkstra A, Huijer Abu-Saad H, van der Zee J. The effect of job characteristics and individual characteristics on job satisfaction and burnout in community nursing. Int J Nurs Stud 1996; 33:407-21

Jennings BM. Stress, locus of control, social support, and psychological symptoms among head nurses. Res Nurs Health 1990; 13:393-401

Johansson JA. Psychosocial factors, physical load and symptoms from the neck, shoulders and back among home care workers. In: Hagberg M, Hofmann F, Strössel U, Westlander G (eds). Occupational health for health care workers. Landsberg: Ecomed, 1993

de Jonge J. Job autonomy, well-being, and health. [Thesis]. Maastricht: Rijksuniversiteit Limburg, 1996

de Jonge J, Janssen PPM, van Breukelen GJP. Testing the Demand-Control -Support Model among health-care professionals: a structural equation model. Work Stress 1996; 10:209-24

de Jonge J, Landeweerd A. Toetsing van de Job Demand-Control benadering bij werknemers in de gezondheidszorg. [Testing the Job Demand-Control approach among employees in health care]. Gedrag en Organisatie 1993; 21:79-92

Karasek RA. Job demands, job decision latitude, and mental strain: implications for job redesign. Adm Sci Q 1979; 24:285-308

Karasek RA, Triantis KP, Chaudhry SS. Co-worker and supervisor support as moderators of associations between task characteristics and mental strain. J Occup Behav 1982; 3:181-200

Karasek RA, Theorell T. Healthy work: stress, productivity and there construction of working life. New York: Basic Books, 1990

Katzell R, Bienstock P, Faerstein P. A guide to worker productivity experiments in the United States 1971-1975. New York: New York University Press, 1977

Koes B, van de Mheen D. Werkomstandigheden en ziekteverzuim in de gezinsverzorging. [Working conditions and absenteeism due to illness in home help services]. TSG 1987; 65:755

Kuremyr D, Kihlgren M, Norberg A, Åström S, Karlsson I. Emotional experiences, empathy and burnout among staff caring for demented patients at a collective living unit and a nursing home. J Adv Nurs 1994; 19:670-9

Lammers CJ. Uiterlijke samenhang en bindingskracht van de organisatie. [External coherence and the adherence-control of the organization]. [Inaugural Lecture]. Assen: van Gorcum, 1964

Lindström K. Work organization and well-being of Finnish health care personnel. Scand J Work Environ Health 1992; 18 (suppl. 2):90-3

Lindström K. Psychosocial criteria for good work organization. Scand J Work Environ Health 1994; 20:123-33

March JG, Simon HA. Organizations. New York: Wiley, 1958

McNeese-Smith D. Job satisfaction, productivity, and organizational commitment. J Nurs Adm 1995; 25:17-26

Meijman TF, O'Hanlon JF. Arbeidsbelasting, een inleidend overzicht van psychologische theorieën en meetmethoden. [Pressure of labour: an introductory overview of psychological theories and measure-methods]. In: Drenth PJD, Thierry H, de Wolff CJ (eds). Handboek Arbeids- en Organisatiepsychologie. [Handbook of Work and Organizational Psychology]. Deventer: Loghum Slaterus, 1984

Melchior MEW. Burnout and work in long-stay psychiatric nursing. [Thesis]. Maastricht: Universiteit Maastricht, 1996

Myers A, Jensen RC, Nestor D, Rattiner J. Low back injuries among home health aides compared with hospital nursing aides. Home Health Care Serv Q 1993; 14:149-55

Norbeck JS. Perceived job stress, job satisfaction, and psychological symptoms in critical care nursing. Res Nurs Health 1985; 8:253-9

Nordhus IH, Fleime AM. Job stress in two different care-giving contexts: a study of professional and semi-professional health personnel in Norway. Work Stress 1991; 5:229-40

Olkinuora MA, Asp S, Juntunen J, Kauttu K, Strid L, Äärimaa M. Stress symptoms, burnout and suicidal thoughts of Finnish physicians. Scand J Work Environ Health 1992; 18 (suppl. 2): 110-2

Ono Y, Lagerström M, Hagberg M, Linden A, Malker B. Occupational musculoskeletal injuries among home care service workers in Sweden. In: Hagberg M, Hofmann F, Stössel U, Westlander G (eds). Occupational Health for Health Care Workers. Landsberg: Ecomed, 1995

Philipsen H. Afwezigheid wegens ziekte. [Absenteeism due to illness]. [Thesis]. Groningen: Wolters-Noordhoff, 1969

Schaufeli WB. Opgebrand: over de achtergronden van werkstress bij contactuele beroepen -het burnout-syndroom. [Burnout: about the jobstress in the human services professions -the burnout-syndrome]. Rotterdam: Ad Donker, 1990a

Smith HL, Hood JN, Piland NF. Leadership and quality of working life in home health care. Home Health Care Serv Q 1994; 14:3-22

Smulders PGW. Bedrijfskenmerken en ziekteverzuim in de jaren zestig en tachtig: een vergelijkende studie. [Organizational characteristics and absenteeism due to illness in the sixties and eighties: a comparative study]. [Thesis]. Leiden: NIPG-TNO, 1984

Smulders PGW, Veerman TJ. Handboek ziekteverzuim. [Handbook absenteeism due to illness]. Den Haag: Delwel, 1990

Ström P. Reactivity and pro-activity. Staff attitudes in changing the organization of the Swedish home help service. In: Hagberg M, Hofmann F, Stössel U, Westlander G (eds). Occupational Health for Health Care Workers. Landsberg: Ecomed, 1995

Taylor FW. The principles of scientific management. New York: Harper, 1911

Tompkins CJ. The effects of stress, role ambiguity, and social support on burnout among home health aids caring for the frail elderly: toward the prevention of maltreatment. [Thesis] Baltimore: University of Maryland, 1995

Trent CH. Effects of patterns of supervision on home care worker performance. New York: Fordham University, 1986

Tuomi K, Ilmarinen J, Eskelinen L, Järvinen E, Toikkanen J, Klockars M. Prevalence and incidence rates of diseases and work ability in different work categories of municipal occupations. Scand J Work Environ Health 1991; 17(suppl 1):67-74

Veerman TJ. Ziekteverzuim in de gezinsverzorging. [Absenteeism due to illness in home help services]. Amsterdam/Leiden: NIA, 1989

Vroege C. Verkenningen rond het concept belasting-belastbaarheid. [Investigating the concept of workload/capacity]. TSG 1982; 60 793-8

van der Windt W, Calsbeek H, Hingstman L. Feiten over verpleging en verzorging in Nederland 1998. [Facts about nursing and caring in the Netherlands 1998]. Maarsen/Utrecht: Elsevier/De Tijdstroom/ LCVV, 1998

Ylipää V, Arnetz BB, Preber H, Benkö SS. Determinants of work satisfaction among Swedish dental hygienists. Scand J Caring Sci 1996; 10:247-53

6 WORKLOAD, CAPACITY FOR COPING AND PSYCHOLOGICAL AND PHYSICAL OUTCOMES AMONGST HOME HELPS IN THE NETHERLANDS

S.E.J. Arts, A. Kerkstra, J. van der Zee, H. Huijer Abu-Saad
Health and Social Care in the Community (1999)**7**(2), 79-90

ABSTRACT

Owing to many developments and changes in home care in the Netherlands, a national study was carried out. One of the aims was to examine the differences between the six categories of home help in the Netherlands regarding workload, psychological and physical outcomes and capacity for coping. A total of 474 home helps of six categories of home help participated in the study. A structured questionnaire, based on the components of the research model, was used, which consisted of existing scales regarding workload (organizational and job characteristics, working conditions), psychological and physical outcomes (job satisfaction, burnout, health) and capacity for coping (social support, leadership style, coping strategies). Workload, specifically organizational and job characteristics are scored low by alpha helps and, to a lesser degree, by 'A' home helps. The higher categories of home help experienced relatively bad working conditions. Home helps, except for alpha helps, are, on the whole, quite satisfied with their work, which is one of the psychological and physical outcomes. The higher categories of home help ('C', 'D' and 'E' carers) experienced high feelings of emotional exhaustion. Health, absenteeism and back problems did not differ significantly among home helps. When looking at capacity for coping, the traditional home helps ('A' to 'E') received more social support. The subordinate categories of home help dealt less actively with their problems and sought less social support than the other categories. Alpha helps are not employed by the organization and this might cause low organizational and job characteristics, and little social support. Their satisfaction scores suggest that they like to see their low organizational involvement changed.

The higher categories of home help, who carry out many psychosocial tasks, have higher emotional and mental workload and high burnout scores. 'B', 'C' and 'D' carers, who perform personal care and have a strict planning, experience extreme time pressure and a high physical workload.

Keywords: capacity for coping, home help services, psychological and physical outcomes, the Netherlands, workload.

INTRODUCTION

In the last decade, home care organizations in the Netherlands have been confronted with some serious problems, as was shown in a previous article on home help in the Netherlands (Arts et al., 1998). Besides a higher and more complex demand for home care and the existence of waiting lists, home care organizations have been confronted with two other problems. One problem is shortage of personnel, which will become even more serious in the near future: a shortage of 7500 home helps (7% of present number of home helps) in the Netherlands is expected in the year 2000 (Van Tits et al., 1991; Van Tits et al., 1992). A shortage of personnel is also a problem in many countries in Europe, including Austria, Denmark, France, Greece, Ireland, Italy. Luxembourg and Portugal. The reasons for this shortage are that the profession is not considered attractive, because it has a low status; it is poorly paid and the training is considered to be inadequate (Hutten et al., 1996). The second problem is that absenteeism due to illness among these health care workers is very high: 9.5% in 1995 (BVG, 1996). Among the main reasons for absenteeism in home help services are problems of the musculoskeletal system (back-problems) (43%), followed by psychological problems (30%) (Veerman, 1989). When these problems become chronic, the afflicted individual has a good chance of receiving disablement insurance benefits (WAO). In 1993, 2.9% of the employees in Dutch home help services were getting disablement insurance benefits. Among all Dutch health care workers, the average percentage is only 1.6% (BVG, 1994). In the Netherlands, turnover is also very high in home help services. In 1993, 28% of the employees left the sector (Hornman, 1994). An overview of the organization and provision of home help services in the Netherlands was presented in the first article by Arts et al. (1998).

Differentiated practice, a clear distinction in the work between the various categories of home help, was expected to have a positive influence on the regulation of these problems. In 1993, new job designations for home helps were introduced with the new Collective Labour Agreement. Since then, six categories of home help have been distinguished: alpha helps, 'A' home help, 'B' caring help, 'C' carer, 'D' carer, and specialised 'E' carer. Each category has its own task profile, as is shown in Table 6.1 (AbvaKabo-Union of Public Sector

Workers, 1994). The Table shows that alpha helps[1] only carry out housework; 'A' home helps are restricted to household activities; 'B' caring helps carry out household activities and give some personal care; 'C' carers are mainly involved in providing personal care and some household work; 'D' carers mostly carry out personal care and psychosocial or supportive tasks, and finally specialised 'E' carers support households with multiple complex problems.

Table 6.1 Formal task profile for each category of home help

Activities → / Category of home help ↓	Household	Caring	Psychosocial/ supportive	Cooperation & Consultation
Alpha help	X			
'A' home help	X			
'B' caring help	X	o		
'C' carer	o	X		
'D' carer		X	X	o
Specialised 'E' carer	o	o	X	X

X = main tasks
o = secondary tasks

Source: AbvaKabo, 1994

It is hoped that the system of differentiated practice provides home helps more promotion and development opportunities, and thus more career opportunities. This is required to change a rather unattractive occupation as home help with limited prospects into a more attractive one, and hopefully at the same time reducing the high percentages of absenteeism in home help services. This study will show what other changes have to be made to achieve this.

This paper is the second of a series of two on home help services in the Netherlands. In the first paper, the job content of the various categories of Dutch home help was described and compared with formal job descriptions (Arts et al., 1998). Based on the time spent by home helps and the activities they carried out, we concluded that household activities is mainly done by the

1 The alpha helps are not employed by the organizations, formally, the client is the direct employer of the alpha help. Most organizations operate as intermediary between the client and the alpha help.

three subordinate categories of home help (alpha helps, 'A' home helps, 'B' caring helps). Personal care is performed by 'C' and 'D' carers and by 'B' caring helps, and psychosocial activities are done by all categories of home help, but mostly by specialised 'E' carers. Reporting is also done by all home helps, except alpha helps. The second conclusion is that household activities or personal care are not carried out alone, but in combination with other activities. And the third conclusion was that the actual practice in home help services does not correspond with the above-mentioned formal task profiles. In daily practice, the four subordinate categories of home help carry out more psychosocial/supportive activities. Additionally, 'A' home helps, 'B' caring helps and 'C' carers do more in the area of consultation and co-operation (reporting) than is formulated in their formal job description. A further, fourth conclusion was that certain home helps carry out in daily practice more activities than they are supposed to doin their daily practice: 'C', 'D' and 'E' home helps carry out more household activities, and alpha helps, 'A', 'B' and 'C' home helps carried out more psychosocial/ supportive activities. Unfortunately, during assessment no extra time was reserved for the majority of the psychosocial/supportive activities. Finally, a major overlap was found in the content of the work of the consecutive home helps ('A' and 'B' home helps, and 'C' and 'D' carers). A new differentiation, with only four categories of home help, was suggested based on the results of the study (Arts et al., 1998).

In this paper, the effect of this division of tasks on the psychological and physical outcomes of Netherlands home helps is reported. Psychological and physical outcomes is defined as the subjective experience of workload and is operationalized to include job satisfaction, burnout, health and absenteeism. A research model was developed to measure this (Arts et al., 1997). The model is based on various models and theories on quality of working life in combination with the workload/capacity-model (Hackman et al., 1974; 1975; 1976; 1980; Karasek, 1979; Meijman et al., 1984; Veerman, 1989; Karasek et al., 1990; Smulders et al., 1990). The workload/capacity model is used as a stepping-stone to integrate the theories and models on quality of working life. This research model has three dimensions: workload, psychological and physical outcomes and capacity for coping.
The main research question in this paper is: What are the differences between the six categories of home help regarding workload, psychological and physical outcomes and capacity for coping?

On the basis of earlier work (Arts et al., 1998), some expectations for this study were formulated.

- It is expected that alpha helps score low on organizational characteristics and on some job characteristics, because they are not employed by the organization and therefore have no strong relation with the organization, colleagues and intermediaries, consequently receive no feedback, and are not entitled to receive education.

- Home helps are expected to be exposed to time pressure, because they have to carry out extra activities for which, during assessment, no extra time was planned. The time pressure is expected to be higher for home helps who visit more than two or three clients on a day, with many personal care.

- Home helps were expected to have a high emotional and mental workload owing to the extra psychosocial activities they carry out. For the higher categories of home help ('C', 'D' and 'E' carers), who carry out more complex work, this might even be higher. This also implies that these higher categories of home help also score higher on the burnout scales.

- With regard to the various activities home helps undertake, the subordinate categories are expected to view their work as more monotonous than the higher categories of home help.

- The higher categories of home help spend more time on meetings and other activities, and are therefore expected to receive more information about their work (feedback).

METHODS

Sample

A two-stage sampling method was used to obtain a representative sample of home helps. For the organizations, three stratification criteria were used: region (the four regions north, south, east and west), integration process of the home help organization (integrated with home nursing or not), and catchment area of the organization (care provided in an area including a city of more than

thousand inhabitants or not). This resulted a matrix of 16 cells, containing all the 104 organizations for home help services in the Netherlands. From each cell, one organization was randomly selected and asked to participate in the study. If an organization did not want to participate, another organization from the same cell was asked. In total 30 organizations were asked to participate.
Each organization was asked to recruit 30 home helps, equally divided over the six categories of home help. There was one inclusion criterium for home helps: they had been in service for at least 1 month. A total of 510 home helps (one organization participated with two teams), was expected to take part in the study.

Procedure

During an instruction meeting, the purpose of the study was explained to the participating home helps, and all forms that had to be used during the registration period, were explained fully. Following this instruction, the home helps were asked to fill in the questionnaire on quality of working life.

Instrument

Questionnaire on quality of working life

In order to examine possible constraining aspects of home helps, a structured questionnaire was used, based on the research model "Psychological and physical outcomes of working in in home help services" (Arts et al., 1997). The questionnaire consisted of existing scales for the components of the model: workload, psychological and physical outcomes and capacity for coping. The scales were validated in previous studies, with Crombach's alpha's varying between 0.60 and 0.90 (Bergers et al., 1986; Boumans, 1990; Van Veldhoven et al., 1994; Schaufeli et al., 1994).

Workload, the activities that someone has to carry out in a particular environment, can be classified using three types of variable: organizational characteristics (Veerman, 1989; Engelen, 1993), job characteristics (Hackman et al,, 1974; 1975; 1976; 1980) and working conditions (Karasek, 1979; Karasek et al., 1990).
The questionnaire "Experience and Assessment of Work" (VBBA) by Van Veldhoven et al. (1994) was used for scales on organizational characteristics, job characteristics and working conditions. The organizational characteristics were operationalized in three subscales: communication with organization (α=.69), contact opportunities with colleagues (α=.68) and substitution during

illness. Four job characteristics were measured: skill variety (α=.71), feedback (α=.76), autonomy (α=.81) and learning and growth opportunities (α=.81). Finally, working conditions were operationalized in seven subscales: role ambiguity, clarity concerning a specific task or concerning the expectations of a client regarding a specific task (α=.61); role conflict, performing tasks that are conflicting or performing tasks one prefers not doing (α=.61); time pressure (α=.88), physical, emotional and mental workload (α=.82, α=.76, α=.88 respectively) and safety at work.

Psychological and physical outcomes is defined as the subjective experience of the actual workload, which is operationalized in this model to include job satisfaction, work performance and work motivation (Hackman et al., 1974; 1975; 1976; 1980), burnout, health and absenteeism (Karasek, 1979; Veerman, 1989; Karasek et al., 1990).
Based on the study by Boumans (1990), job satisfaction was measured by nine subscales: satisfaction with clarity at work (α=.71), satisfaction with growth at work (α=.75), satisfaction with promotion opportunities (α=.82), satisfaction with contact with colleagues (α=.95), satisfaction with contact with supervisor (α=.87), satisfaction with contact with clients (α=.76), work performance (α=.78), internal work motivation (α=.43) and general work fulfilment (α=.78). The Dutch translation of the Maslach Burnout Inventory (MBI-NL) by Schaufeli et al. (1994) was used to measure 'burnout'. Burnout is operationalized in questions regarding emotional exhaustion (α=.86), depersonalization (α=.52) and personal accomplishment (α=.72). Health was estimated by a self-assessment of the general health state on a five point scale from very bad to very good.

Capacity for coping is the third component of the model. It is hypothesized that psychological and physical outcomes is also affected by the mental capacity (personal circumstances, recognition from others, social position of profession) of the home help and the support experienced by the home help. Social support includes the leadership style and support from supervisors, colleagues, partner, clients and other care-givers (Hackman et al., 1974; 1975; 1980; Karasek, 1979; Veerman, 1989; Boumans, 1990; Karasek et al.; 1990; Hood et al., 1994). Personal characteristics in this model are coping strategies (Hackman et al., 1974; 1975; 1980; Veerman, 1989), biographical characteristics (Hackman et al., 1974; 1975; 1980; Karasek, 1979; Veerman, 1989; Boumans, 1990; Karasek et al., 1990) and category of home help (Jansen et al., 1996).

Social support experienced at work was measured by questions regarding experienced social support from supervisors (α=.72), colleagues (α=.83) and partner (α=.80) from the Organizational Stress Questionnaire (VOS-D) (Bergers et al., 1986). The leadership style scales were constructed by Boumans (1990), based on the Algera questionnaire (Algera, 1981; Algera et al., 1986). Two types of leadership are measured: social-emotional leadership (α=.96) and instrumental leadership (α=.91). To assess ways of dealing with problems, a shortened version by Van Dierendonck et al. (1992) of the Utrecht Coping List (UCL) by Scheurs et al. (1988) was used. Coping strategies were measured on this 25 item questionnaire by three sub- scales: active approach (α=.77), passive approach (α=.76) and seeking social support (α=.79).

As described above, the reliability of these scales was calculated for this group of home helps (N=474), and the majority of the reliability scores was sufficient (higher than α=.60), varying between 0.61 and 0.96 (Table 6.2). The reliability of two subscales was insufficient: internal work motivation (job satisfaction) (α=.43) and depersonalization (burnout) (α=.52). Therefore, for this study, the subscales of burnout and job satisfaction were removed from analysis. Although the reliability of the depersonalization-scale in other burnout-studies (Van Dierendonck et al., 1992; Jansen et al., 1996; Van Dierendonck, 1997) is also the lowest of the three dimensions, in those studies the scores were still acceptable (respectively α=.64, α=.64, α=.71).

Analysis

Analysis of variance (one-way) was used to test if there are significant differences between the mean scores of the six categories of home help on the various scales of the questionnaire on quality of working life. The Bonferroni test (a modified least significant difference test), was used to determined which means were significantly different from each other (Norusis, 1992).

Table 6.2 Reliability scores of the scales used in the questionnaire on quality of working life, with accompanying Crombach's alpha's and the number of items per scale (N=474).

Crombach's	α	items
Organization characteristics		
Communication w. organization	.69	4
Contact with colleagues	.68	4
Job characteristics		
Skill variety	.71	6
Feedback	.76	6
Autonomy	.81	11
Learning- and growth opportunities	.81	9
Working conditions		
Role ambiguity	.61	5
Role conflict	.61	6
Physical workload	.82	7
Mental workload	.88	7
Emotional workload	.76	7
Time pressure	.76	11
Burnout		
Emotional exhaustion	.86	9
Depersonalization	.52	5
Personal accomplishment	.72	8
Job satisfaction		
Clarity	.71	5
Colleagues	.95	6
Supervisor	.87	6
Growth	.75	3
Promotion	.82	4
Clients	.76	4
Work performance	.78	7
General work fulfilment	.78	7
Work motivation	.43	4
Total satisfaction	.95	42
Experienced social support		
Supervisors	.72	5
Colleagues	.83	5
Partner	.80	5
Leadership style		
Socio-emotional	.96	11
Instrumental	.91	9
Coping-strategies		
Active approach	.77	7
Passive approach	.76	12
Seeking social support	.79	6

RESULTS

Response

Thirty organizations for home help or home care were asked to participate in the study. Fourteen organizations declined to take part. The main reasons for not participating were lack of time due to reorganization or merger (6x) or involvement in other research (8x). Finally, 16 organizations (53%) took part in the study.

Each organization was expected to select 30 home helps, five of each of the six categories of home help (510 home helps). Not all organizations though were able to select these 30 home helps, because there were not always five home helps in each category, nor were all six categories of home help present or available in the organization. Finally, 474 home helps (93%) were selected to participate in the study. The way the home helps were selected for the study, either voluntary or selected by a supervisor, is a possible bias of the total sample of home helps. Both the total number of home helps participating from 16 organizations and the number of home helps per category were sufficient for a representative picture of the work of home helps in the Netherlands and for an accurate comparison between the six categories of home help, respectively.

All 474 home helps filled in the questionnaire. Table 6.3 shows the distribution of the number of home helps over the six categories of home help.

Almost all of the (97%) of home helps were women. The mean age of the home helps was 39 years with a standard deviation of 10, and the average hours worked per week were 20 (standard deviation is 10).

Table 6.3 Distribution of home helps over the six categories of home help

Alpha-helps	73
'A' home helps	90
'B' caring helps	94
'C' carers	84
'D' carers	78
Specialized E home carers	55
Total	474

Missing data

Scales were constructed based on the sum of the relevant items. When half or fewer of the items were missing, the scale was constructed based on the valid items. Alpha helps were not able to fill in certain scales regarding contact with colleagues, social support from colleagues and from other care-givers, and regarding leadership styles, because of their working situation. Alpha helps are not employed by the organization but by their client(s). Accordingly they have no direct supervisor and no opportunities to meet other alpha helps. Consequently, certain scores of alpha helps are missing in Tables 6.4 and 6.6.

The mean scores of the six categories of home help on all variables of the questionnaire are presented in Tables 6.4, 6.5 and 6.6. High scores indicate a high presence of the variable. For example, specialised 'E' carers had significantly more skill variety in their work than the other categories of home help (Table 6.4).

Workload

Table 6.4 shows that opportunities for contact with colleagues, and for communication with the organization, two organization characteristics, were different for the various categories of home help. Alpha helps scored low on these scales. The other home helps generally found few opportunities for contact. Substitution during illness was also examined. For alpha helps and specialised 'E' carers this was insufficiently organized.

Job characteristics like a high degree of skill, variety, learning and growth opportunities increased for higher categories of home help. Alpha helps and 'A' home helps have the lowest skill variety, learning and growth opportunities and feedback. On the other hand alpha helps have a much bigger degree of autonomy than 'B' caring helps, and 'C' and 'D' carers.

Seven *types of working conditions* were measured in the questionnaire, varying for all categories of home help. Alpha helps felt safest in their work, experienced the highest role ambiguity lack of clarity about a specific task or about the client's expectations of a hone help), and the lowest role conflict (performing conflicting tasks). Both 'B' caring helps and 'C' and 'D' carers scored very high on the physical working conditions like time pressure and physical workload. The other two types of workload, mental and emotional, increased for higher categories of home help: the lowest degree of mental and emotional workload was experienced by alpha helps and the highest of both by specialised 'E' carers. Both 'D' carers and specialised 'E' carers rated the quality of the household material as lowest.

Table 6.4 Mean scores of all variables of workload for all six categories of home help (N=474), using one-way analysis of variance

Categories of home help Variables	range	Ah (N=73)	A (N=90)	B (N=94)	C (N=84)	D (N=74)	E (N=55)	F- ratio	P value	
Organization characteristics										
Communication	(0-16)	10.3	12.7	12.0	11.7	10.9	10.9	11.0	<.001	ah vs A-B-C; E vs A-B; D vs A
Contact with colleagues	(0-16)		5.9	6.6	7.3	7.8	7	32.1	<.001	A vs C-D-E; B vs D
Substitution during illness	(1-2)	1.3	2	2	2	2	1.7	98.3	<.001	ah vs A-B-C-D-E; E vs A-B-D
Job characteristics										
Skill variety	(0-24)	12.7	14.3	15.2	16.3	17.7	19.4	57.7	<.001	ah vs A-B-C-D-E; A vs C-D-E; B-C vs D-E; D vsE
Learning/growth opportunities	(0-36)	13.2	19.0	20.1	21.0	20.2	20.9	33.2	<.001	ah vs A-B-C-D-E; A vs C
Feedback	(0-24)	12.5	14.7	15.2	15.8	15.0	16.8	13.1	<.001	ah vs A-B-C-D-E; A-D vs E
Autonomy	(0-44)	34.0	33.0	31.5	31.5	28.6	32.8	11.3	<.001	D vs ah-A-B-C-E; B-C vs ah
Working conditions										
Role ambiguity	(0-20)	10.7	9.7	10.0	9.3	9.7	9.9	2.8	<.05	C vs ah
Role conflict	(0-24)	7.0	7.1	8.1	8.0	7.8	8.7	14.4	<.001	ah-A vs B-C-D-E; D vs E
Time pressure	(0-44)	21.1	21.8	23.7	23.7	24.5	22.3	12	<.001	ah-A vs B-C-D; E vs D
Physical workload	(0-28)	13.4	14.4	15.7	14.8	15.0	12.6	8.1	<.001	E vs A-B-C-D; ah vs B-D
Mental workload	(0-28)	14.3	16	17.9	20.0	22.9	23.6	72.6	<.001	ah vs A-B-C-D-E; A vs B-C-D-E;B vs C-D-E;C vs D-E
Emotional workload	(0-28)	10.5	12.1	13.8	14.2	14.7	17.7	91.5	<.001	ah vs A-B-C-D-E; A vs B-C-D-E; B vs D-E; C-D vs E
Safety during work	(0-4)	3	2.7	2.6	2.8	2.8	2.6	2.7	<.05	B-E vs ah
Household material	(1-4)	3.6	3.7	3.6	3.6	3.5	3.3	38.0	<.01	D-E vs ah-A-B-C; D vs A

Table 6.5 Mean scores of all variables of psychological and physical outcomes for all six categories of home help (N=474), using one-way analysis of variance

Categories of home help Variables	range	Ah (N=73)	A (N=90)	B (N=94)	C (N=84)	D (N=74)	E (N=55)	F- ratio	P value	
Satisfaction with										
Clarity about job	(0-25)	18.1	19.6	18.9	19.1	18.8	18.7	4.5	<.01	ah vs A-C
Growth at work	(0-15)	10.0	11.0	10.4	11.1	11.6	11.6	10	<.001	ah vs A-C-D-E; B vs D-E
Promotion	(0-20)	11.1	12.5	12.2	11.8	12.1	11.1	3.5	<.01	ah-E vs A
Contact with colleagues	(0-30)	16.2	21.7	21.5	22.8	22.8	23.3	4.9	<.001	ah vs A-B-C-D-E; B vs E
Contact with supervisor	(0-30)	19.8	23.2	23.2	23.2	22.7	22.8	13.8	<.001	ah vs A-B-C-D-E
Contact with clients	(0-20)	16.4	15.9	15.4	15.4	15.2	14.8	8.1	<.001	B-C-D-E vs ah; E vs A
Work performance	(0-35)	25.9	26.0	25.3	25.7	25.8	27.2	2.9	<.051	B vs E
General work fulfilment	(0-35)	24.9	27.0	26.9	29.1	29.8	28.8	15.7	<.001	ah vs A-B-C-D-E; A-B vs C-D
Overall job satisfaction	(0-210)	121.4	154.5	152.6	157.6	156.5	158.2	37.5	<.001	ah vs A-B-C-D-E
Burnout										
Emotional exhaustion	(0-63)	9.9	12.1	15.2	14.0	14.8	16.6	7.9	<.001	ah vs B-C-D-E; A vs E
Personal accomplishment	(0-48)	32.0	32.4	32.5	33.8	33.2	33.2	1.4	n.s.	
Experienced health										
State of health	(0-5)	4.2	4.2	4	4.1	4.1	4.1	1	n.s.	
Absenteeism										
Average frequency	(0-6)	.4	1.2	1.4	1.2	.9	1.0	7.5	<.001	ah vs A,B,C,E
Total duration	(0-150)	1.9	7.9	13.2	15.0	12.5	13.0	3.4	<.05	ah vs B,C

Table 6.6 Mean scores of all variables of capacity for coping for all six categories of home help (N=474), using one-way analysis of variance

Categories of home help Variables	range	Ah (N=73)	A (N=90)	B (N=94)	C (N=84)	D (N=74)	E (N=55)	F- ratio	P value	
Social support										
Supervisor	(0-20)	16.4	16.9	16.6	16.9	15.9	15.8	4.4	<.001	ah vs A-B-C-D-E
Colleagues	(0-20)		15.1	15.1	15.6	16.0	15.9	4.1	<.001	A-B vs C-D-E
Partner	(0-20)	17.6	17.7	17.0	17.4	17.0	16.3	5.7	<.001	E vs ah, A,C
Clients	(0-4)	3.6	3.3	3.3	3.1	3.1	3	11.3	<.01	C-D-E vs ah E vs ah,A,B
Other care givers	(0-4)		3.0	3.0	3.0	2.9	3	0.3	n.s.	
Opportunities for contact with supervisor	(0-15)	3.4	7.2	7.5	8.5	9.6	9.5	50	<.001	ah vs A-B-C-D-E; A vs C-D-E; B vs D-E
Leadership styles										
Social-emotional	(0-55)		42.9	43.4	44.1	42.0	41.7	2.2	n.s.	
Instrumental	(0-45)		18.6	20.3	21.1	21.1	22.8	7.7	<.001	A vs C-D-E; B vs E
Coping strategies										
Active approach	(0-28)	18.7	18.9	18.9	20.3	19.6	21.4	8.3	<.001	ah-A-B vs C-E; D vs E
Passive approach	(0-48)	21.7	21.4	21.9	20.7	21.4	20.6	1.4	n.s.	
Seeking social support	(0-24)	13	12.3	13.5	13.8	14	13.5	4.0	<.001	A vs C-D
Personal characteristics										
Amount of hours p w	(0-40)	7.3	17.1	22.1	25.5	21.8	28.7	67.3	<0.01	ah vs A-B-C-D-E; A vs B-C-D-E; D vs C-E;BvsE
Age	(19-61)	40.7	39.8	38.9	38.3	40.4	38.4	0.8	n.s.	

Psychological and physical outcomes

Job satisfaction on eight work elements was assessed. Table 6.5 shows that alpha helps were considerably less satisfied with almost all work aspects then were the other home helps, except for contact with clients. 'A' home helps were most satisfied with clarity in their task, with promotion opportunities, contact with supervisor, and scored also high on contact with clients. Specialised 'E' carers were also quite satisfied with growth at work, contact with colleagues, and work performance. 'D' carers had the highest general work fulfilment. Alpha helps also experienced the lowest overall job satisfaction, which was estimated taking into account the various parts of job satisfaction.

In this study, *burnout* is operationalised in questions regarding emotional exhaustion and personal accomplishment. Alpha helps were significantly less emotionally exhausted compared with the four highest categories of home help. Personal accomplishment was not scored significantly differently among the six categories of home help.

The home helps also made an assessment of their *health*. In general, all home helps felt quite healthy, and this state of health did not differ between the home helps. There were significant differences in the *frequency of absenteeism* between the home helps. Alpha helps were least absent due to illness compared with the other categories of home help, except 'D' carers. There were no significant differences in the *average period of illness* between the home helps.

The prevalence of back problems among home helps is relatively low: one-third of the home helps had back problems during the last 12 months. Back problems occurred with equal frequency amongst the six categories of home help (not in the table).

Capacity for coping

Social support in their work from supervisors, colleagues, partners, clients and other care-givers was also measured. Table 6.6 shows that it is obvious that alpha helps scored significantly lower on social support from supervisors compared with all other categories, although they scored highest on social support from their clients. Specialised 'E' carers experienced the lowest level of support from their clients, just as they experienced the lowest level of satisfaction with their clients (Table 6.5). Compared with alpha helps, 'C' carers received most social support from supervisors, and the higher categories of home help received significantly more social support from their colleagues than alpha helps, 'A' home helps and 'B' caring helps. All categories of home help felt, in general, well supported by their partners. Support from other care-givers

increased with higher categories of home help ('B' caring helps, 'C', 'D' and specialised 'E' carers).
All home helps said their supervisor more often used a social-emotional leadership style (focused on well-being and comfort) than an instrumental leadership style (mainly focused on production). 'A' home helps experienced the lowest instrumental leadership style and specialised 'E' carers experienced the highest.
There are three ways of dealing with problems and events (*coping strategies*): actively, passively and seeking social support. 'C' carers and specialised 'E' carers used the active approach significantly more. The scores on the passive coping strategy were not different among the six categories of home help. Seeking social support is a coping strategy less used by 'A' home helps.

CONCLUSION

Workload
As expected, alpha helps have little organizational and job characteristics in their work due to the fact that they are not employed by the organization. The results of another Dutch study on home helps by Van den Herik et al. (1995) confirm these findings. Because alpha helps work more independently, they experience more autonomy. These feelings decrease among the higher categories of home help ('B', 'C' and 'D' home helps).
Home helps who predominantly carry out household activities (alpha helps and 'A' home helps) have less variety in their work, as was expected before based on the results of the previous article. This is in line with Veerman's (1989) conclusion that home helps describe household activities as 'little variety between strenuous and less strenuous work'.
It was also expected that the higher categories of home help would have more feedback, because they were more involved in meetings and therefore receive more information about their work. This turned out to be partly true: only specialised 'E' carers scored significantly higher on this compared with alpha helps, 'A' home helps, and 'D' carers.
As expected, results showed that higher categories of home help, who carry out more personal care and psychosocial care, and thus more complex work, have a higher mental and emotional workload than alpha helps and 'A' home helps. The subordinate categories of home help probably also run a smaller chance of mental or emotional overload, because they work fewer hours per

week. Home helps have a lower mental workload (19,1 versus 22,6) and a higher emotional workload (13,8 versus 11,2) compared with other groups of female health care workers (Van Veldhoven et al., 1994).
Higher categories of home help also had more role conflict. This corresponds with Veerman's study (1989) were he found a relationship between higher categories of home help, role conflict and psychosocial workload.
Home helps were expected to be exposed to time pressure, especially the higher categories of home help, because of the nature of their activities and the extra activities they had to carry out and our results confirm this expectation. Compared with another group of female health care workers, home helps experience a greater time pressure (22,9 versus 11,6; Van Veldhoven et al., 1994). 'B', 'C' and 'D' carers experienced a greater time pressure and a higher physical workload than the other home helps. The type of work is probably the underlying reason: they all give personal care in many different client situations each day, with a fixed planning. Veerman (1989) concluded that working at several addresses each day causes a high workload for home helps (Veerman, 1989).

Psychological and physical outcomes
Home helps were, in general, reasonably satisfied with their work, as were the home helps in the study by Van den Herik's et al. (1995). Alpha helps however, were significantly less satisfied with their work, especially with task clarity, growth and promotion opportunities at work, and with opportunities for contact with supervisors and colleagues. Alpha helps scored low on the presence of these items, except for role ambiguity, and the low satisfaction scores indicate that they would like to see this changed. They would like to have more contact with their organization (supervisors and colleagues) than they have now, receive some training, experience less ambiguity in their work. Alpha helps score also very low on the overall job satisfaction. In order to get a better understanding of these scores, an average overall job satisfaction score was calculated for all home helps (3.55) and compared with an average overall job satisfaction score for community nurses (3.67) (Jansen et al., 1996). The averages are almost similar, and both home helps and community nurses are therefore reasonably satisfied with the various aspects of job satisfaction.
Alpha helps have also no rights under Dutch Health Law for example, they do not receive sick pay. Accordingly, they will first try to reschedule appointments with the clients before they call in sick. This is a feasible explanation for the low level of absenteeism per year for alpha helps.

Back problems among home helps are an important problem. However, compared with other health care workers, the incidence rates are lower: one-third of the home helps experienced back problems in the last 12 months compared with more than half (56%) of nursing and caring staff in nursing homes (Bakker et al., 1995). This figure may be an underestimation, due to the selection procedure of home helps. It is likely that home helps with serious back problems were not asked to participate or could not participated in the study due to their state of health.

As was expected, feelings of emotional exhaustion are highest for the higher categories of home help. A feasible explanation for this is that the subordinate categories of home help (alpha helps, 'A' home helps and 'B' caring helps) work fewer hours per week and therefore run a smaller chance of emotional or physical overload. The averages of these scores were compared with average norm scores from a study by Schaufeli et al. (1994) of 2500 nurses. On a scale from 1 to 6, the average score for emotional exhaustion is 1.9 and home helps score 1.5 (scores between 1.1 and 2.5 are average). The average score for personal accomplishment is 3.9 and home helps score 4.1 (scores between 3.4 and 4.3 are average (Schaufeli et al., 1994). Compared with the norm-scores, home helps had average scores on the two burnout dimensions.

Capacity for coping

As Veerman (1989) concluded, home helps experience in general high social support, with the exception of alpha helps. It was expected that alpha helps would experience less support from supervisors and colleagues, because they have hardly any contact with them. Nevertheless, they feel better supported or appreciated by their clients than the other home helps. This is logical as alpha helps are formally employed by the client and therefore have a different relationship with them from that of other home helps with their clients. This kind of support decreases with higher categories of home help, especially with the specialised 'E' carer. The type of client and the nature of the help provided probably have an influence on the relationship between home help and client.

Higher categories of home help feel more supported by other care-givers, compared with the subordinates categories, probably because they, and especially specialised 'E' carers, have more contact with other professionals and therefore may receive more support or appreciation from them.

Specialised 'E' carers used the active approach significantly more compared with the five categories. For a better idea of these scores, the average scores were compared with the average coping scores of Dutch community nurses

(Jansen et al., 1996). On a scale from 1 to 4, the average score for the active approach to the problems of home helps is 2.81 and for community nurses 2.95. For the passive approach the average score of home helps is 1.77 and of community nurses 1.96, these scores are similar. The average score on seeking social support is 2.22 for home helps and 2.65 for community nurses. This coping strategy was used less by home helps than by community nurses.

DISCUSSION

This study was carried out to gain insight into the effect of division of tasks, differentiated practice, on the psychological and physical outcomes of home helps in the Netherlands.

The system of differentiated practice was expected to provide home helps with more perspectives in their work, and to improve the attractiveness of the occupation. Consequently, the percentage of absenteeism in organizations for home help services was predicted to decrease.

The differences between the six categories of home help with regard to workload, psychological and physical outcomes and capacity for coping were studied. Four profiles can be distinguished: alpha helps, home helps mainly involved in household activities, home helps mainly involved in personal care; and home helps with complex work. These profiles are comparable with the new categorization of home helps, suggested by Arts et al. (1998).

Alpha helps score very low on organizational characteristics, experience lack of clarity concerning a specific task or concerning the expectations of a client regarding a specific task; receive only little social support from supervisors and colleagues. They are, in general, dissatisfied with many aspects of their work and specifically with opportunities for contact and for growth and promotion, and score low on general work fulfilment. Alpha helps experience high autonomy in, and safety during, work and high social support from their clients.

Home helps mainly involved in household activities (alpha helps and 'A' home helps) experience little skill variety, feedback, learning and growth opportunities, but their working conditions are reasonably good; they score low on role conflict, physical, mental and emotional workload. Home helps involved in household activities experience high social support from their clients and are satisfied with this, and have low feelings of emotional exhaustion (burnout).

Carers, home helps involved in personal care ('B', 'C' and 'D' carers), experience high time pressure and high physical workload.

Home helps with complex work (personal care and psychosocial or supportive tasks), thus 'C', 'D' and 'E' carers, score high on several organizational and job characteristics (contact with organization, supervisor and colleagues, skill variety, and feedback). They also experience high social support from supervisors, colleagues and other professional care-givers, and use an active approach to deal with problems. These higher categories of home help are quite satisfied with the contact with supervisors and colleagues and opportunities for growth in their work. However, they have a high mental and emotional workload and experience feelings of emotional exhaustion (burnout). Finally, their supervisors have an instrumental leadership style, meaning that they define and clarify the role of the home help and tell them exactly what they are expected to do, rather than focusing on well-being and comfort.

Limitations of the study

The study has some restrictions with regard to the sample of home helps participating. The way the home helps were selected for the study, either volunteering or being selected by a supervisor, could bias the sample. Home helps who had long-term ill health were not included. Therefore, the results may appear a little clear cut, but they are in line with other studies on home helps (Veerman, 1989; Van den Herik et al., 1995; Commissie Verzorging, 1995). A final restriction is the number of home helps from each category. Although this was required to adequately compare the scores between the six categories of home help, it is not in accordance with reality, because the total number of home helps is not equally divided over the six categories (Arts et al., 1998).

Recommendations

Although differentiated practice has been implemented in Dutch home help services, the situation with regard to workload, psychological and physical outcomes and capacity for coping still has to be further improved: decreasing the workload and the negative outcomes like burnout and absenteeism and increasing the home helps' capacity for coping and their job satisfaction. In order to make home help services more attractive to work in, improvements have to be made for all four profiles.

Although for *alpha helps* major improvements should be made in the area of social support, promotion and growth opportunities and various work aspects, their legal working situation - employed by the client and not by the organization - does not allow for these changes.

Home helps mainly involved in household activities lack satisfactory job characteristics. For these home helps, new tasks have to be created to reduce the monotony of work, and supervisors have to pay more attention to this group of home helps (feedback). Further, the organization should provide them with more training and with more prospects in their job.
An improvement of working conditions is required for the *carers*. During assessment-procedure, the allocation of time needs special attention to prevent time pressure among these home helps. Better material and aides, and training on how to work ergonomically is needed.
Teaching *home helps with complex work* how to deal with stressful working situation, and thus how to decrease high emotional and mental workload and high feelings of emotional exhaustion, is highly recommended.

Further research should focus on the causal relations between workload, psychological and physical outcomes and capacity for coping, and on the significance of the variables psychological and physical outcomes included in the model.

Acknowledgements
This research was carried out at the initiative of the Ministry of Public Health, the Professional Association of Home Helps (STING), the Association of Management of Home Help Organizations (STRATEGO) and the Netherlands Institute of Primary Health Care (Nivel). The study was financed by the National Centre of Nursing & Caring (LCVV).

REFERENCES

AbvaKabo (Union of Public sector Workers). Concept CAO-Thuiszorg met salarisregelingen. [Draft collective labour agreement home care with salary-regulations]. Utrecht: AbvaKabo, 1994

Algera JA. Kenmerken van werk. [Characteristics of work]. Lisse: Swets & Zeitlinger, 1981

Algera JA, van der Flier H, van der Kamp LJT. Causal modelling of quality of work. In: Debus G, Schroif HW. The psychology of work and organization. Amsterdam: Elsevier Science, 1986

Arts SEJ, Kersten JWET, Kerkstra A. Werken in de gezinsverzorging. [Working in home help services]. Utrecht: De Tijdstroom/LCVV, 1997

Arts SEJ, Kerkstra A, Huijer Abu-Saad, H, van der Zee, J. A job profile of home helps in the Netherlands. Health Soc Care Community 1998; 6:397-406

Bakker RHC, Knibbe JJ, te Winkel A, Friele RD. Rugklachten van verzorgend en verplegend personeel van verzorgingshuizen. [Back problems of caring and nursing staff in homes for the elderly]. In: Friele RD (ed). Rugklachten, fysieke belasting en preventie mogelijkheden in verzorgingshuizen. [Back problem,s physical workload and prevention possibilities in homes for the elderly]. Utrecht: NIVEL, 1995

Bergers GPA, Marcelissen FHG, de Wolff CH. Vragenlijst Organisatie Stress-D Nijmegen. [Questionnaire Organization Stress-D Nijmegen]. Nijmegen: Katholieke Universiteit Nijmegen, Vakgroep Arbeids- en Organisatiepsychologie, 1996

Boumans NPG. Het werk van verpleegkundigen in algemene ziekenhuizen. [The work of nurses in general hospitals]. [Thesis]. Maastricht: Rijksuniversiteit Limburg, 1990

BVG (Dutch Industrial Board for Human Services). BVG-Berichten 1994. [Dutch Industrial Board for Human Services Reports]. Zeist: BVG, 1994

BVG (Dutch Industrial Board for Human Services). BVG-Jaarverslag 1995. [Dutch Industrial Board for Human Services Year Report]. Zeist: BVG, 1996

Commissie Verzorging (Caring Committee). Zorg voor Zorg. [Caring for Care]. Utrecht: LCVV, 1995

Engelen CHMG. Arbeidsomstandigheden in de zorgsector. [Working conditions in the care-sector]. Tijdschr Verzorgenden 1993; 7:198-204

Hackman JR, Oldham GR. The Job Diagnostic Survey. New Haven:Yale University, 1974

Hackman JR, Oldham GR. Development of the Job Diagnostic Survey. J Appl Psychol 1975; 60: 9-170

Hackman JR, Oldham GR. Motivation through design of work: test of a theory. Organ Behav Hum Perform 1976; 16:250-79

Hackman JR, Oldham GR. Work redesign. Reading: Addison-Wesley, 1980

van den Herik C, de Been M, Vulto M. 'Alles draait om de cliënt': de inhoud, het eigene en de kwaliteit van de arbeid van het uitvoerende werk in de gezinszorg. ['Everything revolves around the client: the content, characteristic and quality of work in home help services']. Leiden: Rijksuniversiteit Leiden, Faculteit Sociale Wetenschappen, Vakgroep Vrouwenstudies, 1995

Hood JN, Smith, HL. Quality of work life in home care. J Nurs Adm 1994; 24:40-7

Homman M. Terwijl je afstoft kom je heel wat tegen: professionele huishoudelijke zorg: een onmisbare pijler onder een verantwoorde thuiszorg. [You come across a lot while dusting: professional household care: an indispensable pillar for justified home care]. Utrecht: STING, 1994

Hutten JBF, Kerkstra A. Home care in Europe. Aldershot: Arena, 1996

Jansen PGM, Kerkstra A, Huijer Abu-Saad H, van der Zee J. The effects of job characteristics and individual characteristics on job satisfaction and burnout in community nursing. Int J Nurs Stud 1996; 33:407-21

Karasek RA. Job demands, job decision lattitude, and mental strain: implications for job redesign. Adm Sci Q 1979; 24:285-308

Karasek RA, Theorell T. Healthy work: stress, productivity and the reconstruction of working life. New York: Basic Books, 1990

Meijman TF, O'Hanlon JF. Arbeidsbelasting: een inleidend overzicht van psychologische theorieën en meetmethoden. [Pressure of labour: an introductory overview of psychological theories and measure-methods]. In: Drenth PJD, Thierry H, de Wolff CJ (eds). Handboek Arbeids- en Organisatiepsychologie. [Handbook for Work and Organizational Psychology]. Deventer: Van Loghum Slaterus, 1984

Norusis MJ, SPSS. SPSS/PC+ tm Base System User's Guide, version 5.0. Chicago: SPSS, 1992

Schaufeli WB, van Dierendonck D. Burnout, een begrip gemeten: de Nederlandse versie van Maslach Burnout inventory (MBI-NL). [Burnout, a concept measured: the Dutch version of the Maslach Burnout Inventory (MBI-NL). Gedrag & Gezondheid 1994; 22:153-71

Scheurs PJG, van den Willige G, Tellegen B, Brosschot JF. De Utrechtse Coping Lijst: UCL-handleiding. [The Utrecht Coping List: UCL-Manual]. Lisse: Swets & Zeitlinger, 1988

Smulders PGW, Veerman TJ. Handboek ziekteverzuim. [Handbook absenteeism due to illness]. Den Haag: Delwel, 1990

van Tits M, Groot W. Zorgen om kruiswerk en verzorging. [Caring for community nursing and home help services]. TVZ 1991; 101:56-9

van Tits M, Vermeulen H. Ontwikkelingen op de arbeidsmarkt. [Developments on the labour market]. TVZ 1992; 102 :104-7

Veerman TJ. Ziekteverzuim in de gezinsverzorging. [Absenteeism due to illness in home help services]. Amsterdam/Leiden: NIA, 1989

van Veldhoven M, Meijman T. Het meten van psychosociale arbeidsbelasting. [Measuring psychosocial workload]. Amsterdam: NIA, 1994

7 FACTORS RELATED TO BURNOUT AMONG DUTCH HOME HELPS

S.E.J. Arts, A. Kerkstra, H. Huijer Abu-Saad, J. van der Zee
Submitted for publication

ABSTRACT

Burnout is generally viewed as a long-term stress reaction specific to professionals who work with people. Because also in caring professions burnout is considered as a problem, this study among home helps was carried out. The aim of the study was to examine burnout more thoroughly with regard to the factors related to burnout.

401 Dutch home helps working in 16 organizations for home help services were asked to complete a questionnaire on quality of working life. Multiple stepwise regression analysis was performed to show the relation between the independent variables and emotional exhaustion and personal accomplishment.

The results showed that high feelings of emotional exhaustion were foremost related with emotional workload, physical workload, time pressure and passive coping strategies. High feelings of personal accomplishment were mainly related with little role ambiguity and an active coping style. Only a moderate relation was found between job characteristics like autonomy and learning and growth opportunities and feelings of burnout. Remarkable is that no relation was found between burnout and social support experienced from supervisors and colleagues. It can be concluded that the strongest relation appeared between burnout and a passive coping style, emotional workload and time pressure, like was expected.

Keywords: burnout, home help services, the Netherlands

FACTORS RELATED TO BURNOUT AMONG DUTCH HOME HELPS

INTRODUCTION

Burnout is generally viewed as a long-term stress reaction specific to professionals who work with people (Maslach, 1993). Although the psychiatrist Freudenberger first 'discovered' and described burnout, Maslach (1976) became one of the most influential authors and widely published researchers in the field of burnout. According to Maslach et al. (1986), burnout can be defined as '....a syndrome of emotional exhaustion, depersonalization and reduced personal accomplishment'. Emotional exhaustion refers to feelings of being emotionally overextended, with no emotional resources left. Depersonalization refers to a negative, callous, or excessively detached response to other people, who are usually the recipients of one's services or care. Reduced personal accomplishment refers to a decline in one's feelings of competence and successful achievement in one's work (Maslach, 1993). Maslach assumes that burnout is a sequential process that starts with emotional exhaustion resulting from the emotional demands of dealing with recipients. Next, in an inappropriate attempt to cope with exhaustion, depersonalisation develops. Because this is a dysfunctional coping strategy that further deteriorates the relationship with the recipient, more and more failures are experienced so that gradually a sense of diminished personal accomplishment develops (Maslach, 1982a; 1982b). Schaufeli (1990) refers to burnout as 'the draining of energy, that is more energy is lost than replenished'. According to Koeske et al. (1989) and Maslach et al. (1986), emotional exhaustion is considered as the essence of occupational burnout. It is also closest to more traditional strain variables (Shirom, 1989).

Many studies have been carried out studying burnout among professionals working with people in areas such as: health care, teaching, social work, police and justice. In health care, burnout has been studied for instance among nurses (Riordan et al., 1992; Kandolin, 1993; De Jonge, 1995; Jansen et al., 1996), general practitioners (Van Dierendonck et al., 1992; Schaufeli et al., 1994, Van Dierendonck, 1997), mental health care workers (Abbenhuis, 1993; Melchior, 1996), and physical therapists (De Vries et al., 1998). However, home care workers like home helps have not been topic of burnout-research, although also in caring professions burnout is considered as a problem (Van Dierendonck et al., 1993).

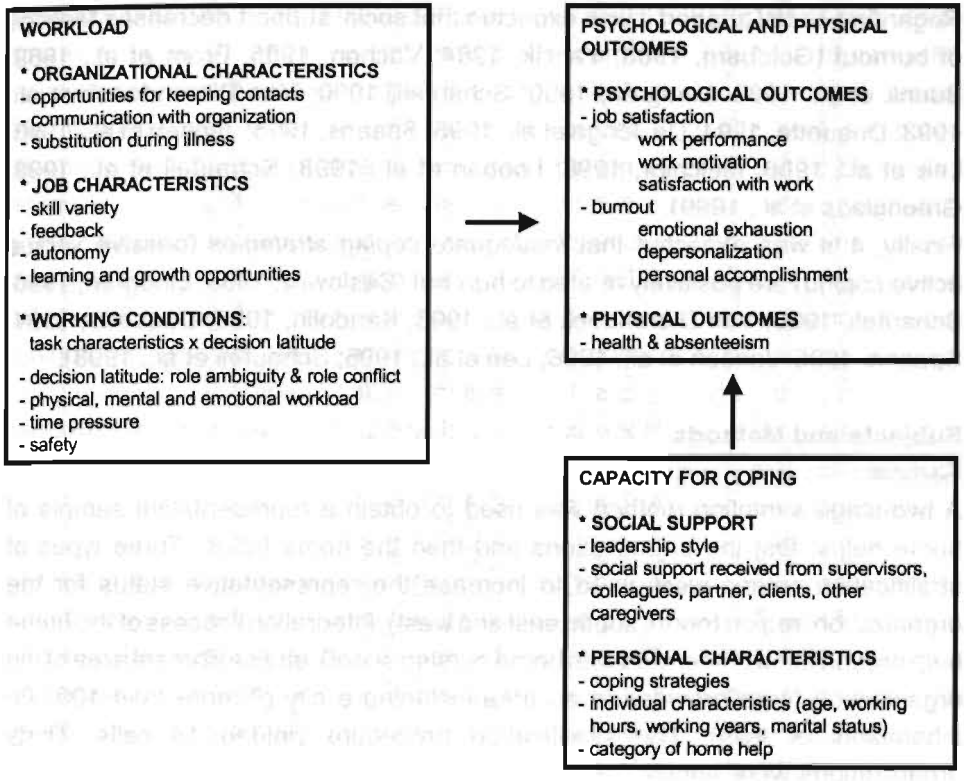
In order to study burnout, and other psychological and physical outcomes of working in home help services, we have developed a research model (Arts et al., 2001) based on existing theoretical models of quality of working life (Hackman et al., 1974; 1975; 1980; Karasek, 1979; Karasek et al., 1990) and workload (Meijman et al., 1984; Veerman, 1989; Smulders et al., 1990). In our research model, Figure 7.1, *psychological* (job satisfaction and burnout) and *physical outcomes* (health and absenteeism) of working in home help services, are influenced by two dimensions: workload and capacity for coping. The *workload*-dimension contains three factors: 1) organisational characteristics (communication with organisation, opportunities for contact with colleagues, substitution during illness), 2) job characteristics (feedback, skill variety, autonomy, learning and growth opportunities) and 3) working conditions (role conflict, role ambiguity, physical and emotional workload, time pressure). The *capacity for coping*-dimension contains two factors: 1) social support (leadership style, social support from colleagues, supervisors, partner and appreciation from client and other professional caregivers) and 2) coping style (active coping, passive coping, seeking social support) (Arts et al., 2001).

In the literature empirical evidence was found for numerous factors related to burnout. Table 7.1 shows an overview of variables from the research model correlating with burnout. The relations between a number of these variables with job satisfaction and absenteeism, are described in different article (Chapter 8). This article focus primarily on burnout. Therefore, the main question that will be answered in this article is:
1) What factors are related to burnout among home helps?

Based on the research model (Arts et al., 2001) and the empirical evidence found in the literature for other professionals (Table 7.1), the following expectations were formulated. The expectations are formulated with regard to factors relating to burnout in general, and not to one of the dimensions of burnout specifically.
Regarding the *organizational characteristics* it was expected that lack of communication opportunities with the organization and opportunities for having contact with colleagues are positively related to burnout (Gray-Toft et al., 1986; Yancik, 1986; Schaufeli, 1990*).

* Results of meta-analysis of empirical research on burnout

Figure 7.1 An integrated model for assessing the psychological and physical outcomes of working in home help services



Based on the results of other studies it was expected that the *job characteristics* autonomy at work, learning- and growth opportunities and receiving feedback are negatively related to feelings of burnout (Roelens, 1986; Landsbergis, 1988; Schaufeli, 1990; Duquette, 1994; De Jonge et al., 1994/95; Spaans, 1995; Jansen et al., 1996; Lee et al., 1996*; Melchior, 1996; Schaufeli et al., 1998*).
Furthermore It was expected that *poor working conditions* with high physical and emotional workload and working under pressure of time are positively related to burnout (Schaufeli, 1990; Kandolin, 1993; Duquette, 1994; Spaans, 1995; Jansen et al., 1996; Lee et al., 1996; Elovainie et al., 1997; Schaufeli et al., 1998). In

* Results of meta-analysis of empirical research on burnout

addition, it was predicted that role ambiguity and role conflict increase feelings of burnout (Kahn et al., 1964; Munley, 1983; Yancik, 1986; Gray-Toft et al., 1986; Schaufeli, 1990; Spaans, 1995; Melchior, 1996; Schaufeli et al., 1998).
Regarding *social support* it was expected that social support decreases feelings of burnout (Goldberg, 1983; Yancik, 1984; Vachon, 1986; Bram et al., 1989; Buunk et al., 1989; Lindgren, 1990; Schaufeli, 1990; Van Dierendonck et al., 1993; Duquette, 1994; De Jonge et al., 1995; Spaans, 1995; Jansen et al., 1996; Lee et al., 1996; Melchior, 1996; Lobban et al., 1998; Schaufeli et al., 1998; Greenglass et al., 1999).
Finally, it is was expected that *inadequate coping strategies* (passive versus active coping) are positively related to burnout (Ceslowitz, 1989; Lindgren, 1990; Schaufeli, 1990; Van Dierendock et al., 1993; Kandolin, 1993; Duquette, 1994; Spaans, 1995; Jansen et al., 1996; Lee et al., 1996; Schaufeli et al., 1998).

Subjects and Methods

Sample

A two-stage sampling method was used to obtain a representative sample of home helps: first the organizations and then the home helps. Three types of stratification criteria were used to increase the representative status for the organization: region (north, south, east and west), integration process of the home help organization (integrated with home nursing or not), and catchment area of the organization (care provided in an area including a city of more than 100,000 inhabitants or less). The stratification procedure yielded 16 cells. Thirty organizations were approached to ensure the participation of 16, one per cell. Fourteen organizations declined. The main reasons for not participating were lack of time due to reorganization or merger (6x) or involvement in other research (8x). Finally, 16 organizations (53%) took part in the study.
Within these 16 organizations, 25 home helps were to be selected: five from each of the five categories of home help. Not all organizations were able to select these 25 home helps, because there were not always five home helps in each category, nor were all five categories of home help present or available in the organizations. Finally 401 home helps (94%) participated in the study (one organization selected two complete groups of home helps in two different regions). These home helps were asked to complete a questionnaire on quality of working life.

Table 7.1 Overview of factors correlating with burnout

Factors correlating with burnout	Feelings of burn out	Reference
Organizational characteristics		
little organizational-involvement	++	Schaufeli, 1990
feelings of isolation	++	Gray-Toft et al., 1986; Yancik, 1986
Job characteristics		
lack of autonomy/low decision latitude	++	Roelens, 1986; Landsbergis, 1988; Schaufeli, 1990; Duquette, 1994; De Jonge et al., 1994/95; Spaans, 1995; Jansen et al., 1996; Lee et al., 1996; Melchior,1996; Schaufeli et al., 1998
sufficient learning and growth opportunities	–	Roelens, 1986; Spaans, 1995; Jansen et al., 1996
lack of feedback	++	Schaufeli et al., 1998
Working conditions		
role conflict	++	Kahn et al., 1964; Schaufeli, 1990; Spaans, 1995; Schaufeli et al., 1998
unrealistic expectations from clients/ role ambiguity	++	Kahn et al., 1964; Munley, 1983; Yancik, 1986; Gray-Toft et al., 1986; Schaufeli, 1990; Spaans, 1995; Melchior, 1996; Schaufeli et al., 1998
time pressure/high workload demands	++	Schaufeli, 1990; Kandolin, 1993; Duquette, 1994; Spaans, 1995; Jansen et al., 1996; Lee et al., 1996; Elovaino et al., 1997; Schaufeli et al. 1998
emotional workload	++	Schaufeli, 1990; Lee et al., 1996; Schaufeli et al., 1998
Social support		
lack of social support from	++	Goldberg, 1983; Yancik, 1984; Vachon, 1986; Bram et al., 1989; Buunk et al., 1989; Lindgren, 1990; Schaufeli, 1990; Van Dierendonck et al., 1993; Duquette, 1994; Spaans, 1995; De Jonge et al., 1995; Jansen et al., 1996; Lee et al., 1996; Melchior, 1996; Lobban et al., 1998; Schaufeli et al., 1998; Greenglass et al., 1999
Coping style		
passive coping	++	Ceslowitz, 1989; Lindgren, 1990; Schaufeli, 1990; Van Dierendock et al, 1993; Kandolin, 1993; Duquette, 1994; Spaans, 1995; Jansen, 1996
active coping	–	Ceslowitz, 1989; Lindgren, 1990; Kandolin, 1993; Spaans, 1995; Jansen et al., 1996; Lee et al, 1996; Schaufeli et al., 1998

++ evident indication for positive relation with dimension of burnout – evident indication for negative relation with dimension of burnout

Procedure

An instruction meeting was held at all participating home care organizations or organizations for home help services, explaining the purpose of the study. At the end of the meeting, all home helps were asked to complete a questionnaire on quality of working life.

Instrument

The questionnaire on quality of working life, based on our research model assessing the psychological and physical outcomes of workload among home helps (Arts et al., 2001), was used for the analyses in this article. Table 6.2 (Chapter 6) provides an overview of the number of items per scale. Only the scales representing variables for which evidence was found in the literature (Table 7.1), were included in the analyses. These scales are described below.

Workload: The questionnaire "Experience and Assessment of Work" (VBBA) by Van Veldhoven et al. (1994) was used for scales on organizational characteristics, job characteristics and working conditions. The organizational characteristics were operationalised in two subscales: communication with organization (α=.69) and contact opportunities with colleagues (α=.62). Two job characteristics were measured: autonomy (α=.79) and learning and growth opportunities (α=.78). And finally, working conditions were operationalised in five subscales, as follows: role ambiguity, inadequate job description or ignorance of the expectations of a client regarding a specific task (α=.59); role conflict, performing tasks that are conflicting or performing tasks one prefers not to do (α=.55); time pressure (α=.75), physical and emotional workload (α=.82 and α=.72 respectively).

Capacity for coping: Social support experienced at work was measured by questions regarding experienced social support from supervisors (α=.63) and colleagues (α=.69) from the Organizational Stress Questionnaire (VOS-D) (Bergers et al., 1986). To assess ways of dealing with problems, a shortened version by Van Dierendonck et al. (1992) of the Utrecht Coping List (UCL) by Scheurs et al. (1988) was used. Coping strategies were measured on this 25 item questionnaire by three subscales, but in this article, only the sub-scales active (α=.73) and passive coping strategies (α=.72) were used.

Burnout: The Dutch translation of the Maslach Burnout Inventory (MBI-NL) by Schaufeli et al. (1994) was used to measure burnout.The MBI-NL consists of 22 items assessing three dimensions: nine items assess emotional exhaustion, depersonalization is assessed in five items, and eight items assess feelings of personal accomplishment. The internal consistency of the subscales is sufficient

for emotional exhaustion (α=.85) and personal accomplishment (α=.70), and low for depersonalization (α=.52). Other research has also shown a lower internal consistency for depersonalization than for the other two subscales, between α=.50 and α=.70 (Schaufeli, 1990; Van Dierendonck et al., 1993; Schaufeli et al., 1993; Schaufeli et al., 1994; Jansen et al., 1996). This low internal consistencie is not only due to the small number of items, but it may also reflect conceptual problems (Schaufeli et al., 1998). Due to the low Cronbach's α of the depersonalization-subscale, only two dimensions of burnout were studied in this article.

Analysis

Firstly, Pearson's correlations were calculated between the two dependent variables and the independent variables. Secondly, analyses were done to exclude multicollinearity, meaning high correlations between the independent variables. Finally, multiple stepwise regression analysis (Ordinary Least Square) was done to show the relations between the independent variables and emotional exhaustion and personal accomplishment.

RESULTS

Pearson's correlations showed that both dimensions of burnout are only correlated moderately (-.31). This implies that the two dimensions contain two different aspects of burnout. Table 7.2 presents the Pearson's correlations between emotional exhaustion and personal accomplishment, and the independent variables, which varied between .01 and .39, and between the independent variables, which varied between .01 and .49.

Multicollinearity-analyses were carried out, by regressing one of the independent variables on the other independent variables. The results showed no high multiple correlation between the independent variables (multiple R <0.8) (Norusis, 1992). Therefore, multicollinearity can be excluded, and therefore a standard multiple regression analyses can be carried out.

In Table 7.3, two phases were used to build the regression model. In the first phase, three control variables were entered. Secondly, the independent variables were entered, according to the stepwise method. This means that the variable with the highest correlation with the dependent variable is added first to the regression model. One by one the variables are added, while counting R^2.

If R^2 does not increase by adding the new variable, this new variable does not add to the prediction, and is excluded from the regression model. At the end, the most important predicting vairables are remained.

Emotional exhaustion

The results show that two control variables affect emotional exhaustion: age and the amount of working hours per week. Younger home helps and home helps who work more hours per week seem to experience more emotional exhaustion. Of the organizational characteristics, opportunities for communication with the organization are negatively related to emotional exhaustion. When opportunities for communication with the organization are low, home helps experience more feelings of emotional exhaustion. Two job characteristics are related to emotional exhaustion: autonomy and learning and growth opportunities. High levels of both autonomy and learning and growth opportunities are likely to diminish feelings of emotional exhaustion. Working conditions are strongly related to feelings of emotional exhaustion. Physical and emotional workload and time pressure have a positive relation to emotional exhaustion. A strong positive relation is also found between dealing passively with problems and feelings of emotional exhaustion: passive coping seems to increase feelings of emotional exhaustion. This is unlike the other coping strategy, active coping, which is negatively related to this dimension of burnout. The percentage explained variance for emotional exhaustion by all variables is moderately high (39%).

Personal accomplishment

Two job characteristics are related to this dimension of burnout: autonomy and learning and growth opportunities. High levels of these job characteristics are likely to increase feelings of personal accomplishment, therefore decrease burnout. Only one of the working conditions, role ambiguity, is negatively associated with personal accomplishment. Home helps who experience unclarity concerning a task or concerning the expectations of a client feel less personal accomplishment. Finally, a strong positive relation is found between dealing actively with problems and personal accomplishment. Passive coping is related negatively with personal accomplishment. The percentage explained variance of the regression model for personal accomplishment is moderately low (20%).

Table 7.2 Pearson's correlations between the independent variables, and between the independent and dependent variables

1: opport. contact w. colleagues														
2: communication w. org.	.07													
3: autonomy	.01	.18												
4: learning-/growth opport.	.18	.11	.18											
5. feedback	.30	.27	.12	.36										
6: role ambiguity	-.21	-.22	-.15	-.18	-.49									
7: role conflict	-.01	-.18	-.10	-.05	.13	.24								
8: physical workload	-.02	-.05	-.03	.00	-.09	.07	.22							
9: emotional workload	.11	-.19	-.03	.16	.18	.01	.42	.21						
10: time pressure	.07	-.09	-.20	.01	-.04	.02	.27	.44	.27					
11: social support supervisors	.06	.22	.23	.25	.33	-.33	-.38	-.09	-.17	-.14				
12: social support colleagues	.28	.15	.01	.19	.29	-.24	-.16	-.09	-.01	-.05	.34			
13: active coping	.05	.05	.08	.19	.18	-.20	.09	-.09	.21	.01	.00	.07		
14: passive coping	-.04	-.01	.03	-.03	-.12	.18	.10	.19	.02	.05	-.04	-.11	-.04	
emotional exhaustion	.01	-.26	-.16	-.09	-.10	.21	.33	.35	.35	.37	-.22	-.10	-.13	.30
personal accomplishment	.01	.11	.14	.20	.14	-.25	-.05	-.08	.00	.01	.13	.10	.39	-.13
	1	2	3	4	5	6	7	8	9	10	11	12	13	14

Correlations between 0.10 and 0.13: $p < 0.05$ Correlations > 0.13: $p < 0.01$

Table 7.3 Results of regression analysis (ß's and adjusted R squares) with workload and capacity for coping as independent variables and emotional exhaustion and personal accomplishment as dependent variables for the total group (N=401)

	Emotional exhaustion	Personal accomplishment
Control variables		
category of home help (C=reference category)		
A		
B		
D		
E		
age	-.09*	
working hours per week	.13**	
WORKLOAD		
Organizational characteristics		
communication with organization	-.13**	
opportunities for keeping contact		
Job characteristics:		
autonomy	-.09*	.10*
learning-/growth opportunities	-.10*	.11*
feedback		
Working conditions:		
role ambiguity		-.12**
role conflict		
physical workload	.14**	
emotional workload	.23***	
time pressure	.21***	
CAPACITY FOR COPING		
Social support:		
from supervisors		
from colleagues		
Coping-strategies:		
active approach	-.14**	.34***
passive approach	.27***	-.11*
Adj. R^2	**.39**	**.20**

* $p \leq 0.05$, ** $p \leq 0.01$, *** $p \leq 0.001$

DISCUSSION

In this article, two dimensions of burnout, emotional exhaustion and personal accomplishment, were studied among 401 Dutch home helps. Based on literature and the research model by Arts et al. (2001), expectations for factors correlating with burnout were formulated. Multicollinearity between the independent variables was excluded and multiple regression analyses were done to show the relations between the independent variables and emotional exhaustion and personal accomplishment.

It was expected that having infrequent communication opportunities with the organization and having few opportunities for contact with colleagues were positively related to burnout. With regard to communication with the organization, the results showed that having infrequent communication opportunities increases feelings of emotional exhaustion, but no relation was found with the other dimension of burnout, personal accomplishment. Apparently, a low level of organizational involvement and feelings of isolation are only associated with feelings of emotional overload, and not with feelings of competence and successful achievement in work.
The moderate relation between high levels of autonomy and learning- and growth opportunities, and lower feelings of burnout is in line with what was expected and found in other studies (Roelens, 1986; Landsbergis, 1988; Spaans, 1995; Jansen et al., 1996; Melchior, 1996; Schaufeli et al., 1998). With regard to the strength of the relation, Jansen et al. (1996) found comparable results when studying burnout among community nurses. They concluded that job characteristics (autonomy and learning and growth opportunities among others) had a relatively small impact on burnout compared with coping strategies
A negative relation was found between role ambiguity and personal accomplishment, like expected and found in international literature (Kahn et al., 1964; Munley, 1983; Gray-Toft et al., 1986; Yancik, 1986; Schaufeli, 1990; Spaans, 1995; Melchior, 1996; Schaufeli et al., 1998). No relation was found between role ambiguity and emotional exhaustion. No relation was found between either dimension of burnout and role conflict. An explanation for this might be that the distribution of the scores on role conflict was skewed towards the lower scores (50% was scored in the lowest 30% of the scale) (Arts et al., 1999).

Demanding working conditions like emotional workload and time pressure, are positively associated with feelings of emotional exhaustion. This is in accordance with the expectations that time pressure and emotional workload would increase feelings of emotional exhaustion. Jansen et al. (1996) also found a positive relationship between time pressure and high feelings of emotional exhaustion among community nurses. Spaans (1995) also found a relation between these variables and burnout in his study. Physical workload, although not found in the literature as a factor of influence, but assumed to be typical of home helps, was related to emotional exhaustion. No such relation was found between these working conditions and personal accomplishment. Emotional workload and time pressure in particular are more likely to affect feelings of being emotionally overextended (emotional exhaustion) than a decline in one's feelings of competence (personal accomplishment).
Furthermore, the results showed a relation between coping and burnout. This is in line with the expectations and shown by Bartoldus et al. (1989), who found an effect of the use of coping strategies in dealing better with stress, and therefore minimizing feelings of burnout. The results showed more specifically that on the one hand active coping decreased burnout, and on the other hand passive coping increased burnout. Jansen et al. (1996) and Van Dierendonck et al. (1993), studying burnout among community nurses and student-nurses respectively, both found a positive relation between dealing actively with problems and feelings of personal accomplishment. In addition, Jansen et al. (1996) and Spaans (1995) found in their study on burnout among community nurses and psychiatric nurses respectively that the passive approach to problems was related positively with feelings of emotional exhaustion.

A remarkable result is that experiencing a lack of feedback, and having few opportunities for keeping contact with colleagues and social support from supervisors and/or colleagues were not related to emotional exhaustion nor to personal accomplishment, although in the literature many studies did find this relation (Goldberg, 1983; Yancik, 1984; Gray-Toft et al., 1986; Vachon, 1986; Bram et al., 1989; Buunk et al., 1989; Lindgren, 1990; Schaufeli, 1990; Van Dierendonck et al., 1993; Duquette, 1994; Spaans, 1995; De Jonge et al., 1995; Jansen et al., 1996; Melchior, 1996; Lobban et al., 1998; Schaufeli et al., 1998; Greenglass et al., 1999). A possible reason for not finding a relation between feedback and burnout is the high correlation between feedback and role ambiguity (.49). Because both variables were included in the regression model,

role ambiguity might have taken way the effect of feedback. A possible reason for not finding a relation between having few opportunities for keeping contact with colleagues and burnout is that the distribution of the scores on this variable was not normal, but skewed to the left (50% of the cases are scored in the lowest 25% of the scale) (Arts et al., 1999). This skewness could make it difficult to find a relation between opportunities for keeping contact with colleagues and feelings of burnout. This explanation could also be valid for the variables social support experienced from supervisors and colleagues. The home helps scored quite high on both scales of social support: 16.5 and 15.5 respectively on a scale from 0-20; and the distribution of both scales was skewed to the right: 50% of the cases are scored in the top 20% of the scales) (Arts et al., 1999). Another explanation might be the presence of coping strategies in the regression-model together with social support experienced from supervisor and colleagues. Pearlin (1985) and Lindgren (1990) reported that social support can be considered as a resource for coping with stress, and is negatively related to feelings of burnout. Also other studies indicated that perceived support has a mediating role in the stress process (Turner, 1983). Many studies were found taking either coping or social support as possible determinators for burnout (Ceslowitz, 1989; Kandolin, 1993; Spaans, 1995; De Jonge, 1996). Van Dierendonck et al. (1993) and Jansen et al. (1996) studied both coping and social support in relation to burnout. Although Jansen et al. (1996) found relations between both variables and burnout, Van Dierendonck et al. found a relation between coping and burnout, and between social support and coping, but not between social support and burnout directly. It can be concluded that social support in combination with coping strategies, plays a moderator role more than a direct role in the relation to burnout.

Limitations of the study

The study has some restrictions with regard to the sample of home helps participating. The way the home helps were selected for the study, either voluntary or selected by a supervisor, is a possible bias for the total sample of home helps. A subsequent restriction is that the long-term ill home helps were not included. Therefore an underestimation of burnout might have occurred.

Recommendations

Firstly, it appears from the results of this study that coping strategies are important determinants of burnout among home helps. Coping is considered as

"a dynamic process used by some one to cope with the demands, experienced as aggravating, required by the relation person-environment" (Lazarus et al., 1984). In other words: stress relates to those transactions where environmental demands are perceived as challenging or taxing the individual's ability to cope, thus threatening well-being and necessitating individual effort to resolve the problem (Dewe et al., 1993). Interventions to deal with problems and stress in an adequate way, are therefore focused on both the individual and the organization (environment), (Schaufeli, 1990). Examples of the interventions to increase self-control, enabling people to deal with burnout are cognitive restructuring methods, stress management, and time management (Schaufeli, 1990; Dewe et al., 1993). Considering the prevention and the developmental process of burnout, it is obvious to develop interventions specifically for the new or re-entering home help (Spaans, 1995). Effective coping strategies to increase the tolerance for threatening events should therefore be included in nursing and caring curricular.

Secondly, although feelings of burnout among home helps are not extremely high, previous research by Arts et al. (1999) showed that home helps score very high on the positively influencing factors physical and emotional workload and time pressure.

It is therefore recommended to monitor the stressful working conditions among home helps. This can, for example, be done during regular meetings or during a performance appraisal.

Acknowledgements

This research was carried out at the initiative of the Ministry of Public Health, the Professional Association of Home Helps (STING), the Association of Management of Home Help Organizations (STRATEGO) and the Netherlands Institute of Primary Health Care (Nivel). The study was financed by the National Centre of Nursing & Caring (LCVV).

REFERENCES

Abbenhuis GM. Burnout bij hulpverleners van probleemgezinnen: een verkennende studie. [Burnout among health care workers with problematic families: an explorative study]. [Thesis]. Utrecht: Rijksuniversiteit Utrecht, 1993

Arts SEJ, Kerkstra A, van der Zee J, Huyer-Abu Saad H. Workload, capacity of coping and psychological and physical outcomes amongst home helps in the Netherlands. Health Soc Care Community 1999; 7:79-90

Arts SEJ, Kerkstra A, van der Zee J, Huyer-Abu Saad H. Quality of working life and pressure of work in home help services. Scand J Caring Sci 2001; 15:12-24

Bartholdus E, Gillery B, Sturges PJ. Job-related stress and coping among home-care workers with elderly people. Health Soc Work 1989; 14:206-10

Bergers GPA, Marcelissen FHG, de Wolff CH. Vragenlijst Organisatie Stress-D. [Questionnaire Organization Stress-D]. Nijmegen: Katholieke Universiteit Nijmegen, Vakgroep Arbeids- en Organisatiepsychologie, 1986

Bram PJ, Katz LF. A study of burnout in nurses working in hospice and hospital oncology settings. Oncol Nurs Forum 1989; 16:555-60

Buunk AP, de Wolff CJ. Sociaal psychologische aspecten van stress op het werk. [Social psychological aspects of occupational stress]. In: Drenth PJD, Thierry H, de Wolff CJ (eds). Nieuw handboek A&O psychologie. [New handbook labour & organizational psychology]. Deventer: Van Loghum Slaterus, 1988

Ceslowitz SB. Burnout and coping strategies among hospital staff nurses. J Adv Nurs 1989; 14:553-7

Dewe P, Cox T, Ferguson E. Individual strategies for coping with stress at work: a review. Work Stress 1993; 7:5-15

van Dierendonck D. Balancing give and take: an equity approach to burnout. [Thesis]. Utrecht: Rijksuniversiteit Utrecht, 1997

van Dierendonck D, Groenewegen PP, Sixma H. Opgebrand: een inventariserend onderzoek naar gevoelens van motivatie en demotivatie bij huisartsen. [Burnout: an inventory on feelings of motivation and demotivation among general practitioners]. Utrecht: NIVEL, 1992

van Dierendonck D, Schaufeli WB. Burnout en organisatiebetrokkenheid bij leerlingverpleegkundigen: de rol van billijkheid, sociale steun en probleemhantering. [Burnout and organizational commitment among student-nurses: the role of equity, social support and problem-management]. TSG 1993; 71:339-44

Duquette A, Sandhu BK, Beaudet L. Factors related to nursing burnout: a review of emperical knowledge. Issues Ment Health Nurs 1994; 15:337-55

Elovainio M, Sinervo T. Psychosocial stressors at work, psychological stress and musculoskeletal symptoms in the care for the elderly. Work Stress 1997; 11:351-61

Gray-Toft P, Anderson J. Sources of stress in nursing terminal patients in a hospice. OMEGA: J Death Dying 1986 17:27-39

Greenglass R, Burke RJ, Konarski R. A study of the consistency of burnout over time. J Health Hum Serv Adm 1999; 21:429-40

Hackman JR, Oldham GR. The Job Diagnostic Survey. New Haven: Yale University, 1974

Hackman JR, Oldham GR. Motivation through design of work: test of a theory. Organ Behav Hum Perfor 1976; 16:250-79

Hackman JR, Oldham GR. Work redesign. Reading: Addison-Wesley, 1980

Jansen PGM, Kerkstra A, Huijer Abu-Saad H, van der Zee J. The effects of job characteristics and individual characteristics on job satisfaction and burnout in community nursing. Int J Nurs Stud 1996; 33:407-21

de Jonge J. Job autonomy, wellbeing, and health. [Thesis]. Maastricht: Rijksuniversiteit Limburg, 1996

de Jonge J, Boumans N, Landeweerd A, Nijhuis F. Werkkenmerken en werkbeleving. [Job characteristics and psychological outcomes]. TVZ 1995; 105:186-9

Kahn RL, Wolfe DM, Quinn RP, Snoek JD, Rosenthal RA. Organizational stress: studies in role conflict and ambiguity. New York: John Wiley, 1964

Kandolin I. Burnout of female and male nurses in shiftwork. Ergonomics 1993; 36:141-7

Karasek RA. Job demands, job decision latitude, and mental strain: implications for job redesign. Adm Sci Q 1979; 24:285-308

Karasek RA, Theorell T. Healthy work: stress, productivity and the construction of working life. New York: Basic Books, 1990

Koeske GF, Koeske RD. Construct validity of the Maslach Burnout Inventory: a critical review and reconceptualization. J Appl Behav Sci 1989; 25:131-44

Lee RT, Ashorth BE. A meta-analytic examination of the correlates of the three dimensions of job burnout. J Appl Psychol 1996; 81:123-33

Landsbergis PA. Occupational stress among health care workers: a test of the job demands-control model. J Org Behav 1988; 9:217-39

Lazarus RS, Folkman S. Stress, appraisal and coping. New York: Springer, 1984

Lindgren CL. Burnout and social support in family caregivers. West J Nurs Res 1990; 12:469-87

Lobban RK, Husted J, Farewell VT. A comparison of the effect of job demand decision latitude, role and supervisory style, on self-reported job satisfaction. Work Stress 1998; 12:337-50

Maslach C. Burnout. Hum Behav 1976; 5:16-22

Maslach C. Burnout: a social psychological analysis. In: Jones, JW (ed). The Burnout Syndrome. Park Ridge: London House, 1982a

Maslach C. Burnout: the cost of caring. Englewood Cliffs: Prentice Hall, 1982b

Maslach C. Burnout: a multidimensional perspective. In: Schaufeli WB, Maslach C, Marek T (eds). Professional burnout: recent developments in theory and research. Washington: Taylor & Francis, 1993

Maslach C, Jackson SE. MBI: Maslach Burnout Inventory: manual research edition. Palo Alto: University of California, Consulting Psychologists Press, 1986

Meijman TF, O'Hanlon JF. Arbeidsbelasting, een inleidend overzicht van psychologische theorieën en meetmethoden. [Pressure of labour: an introductory overview of psychological theories and measure-methods]. In: Drenth PJD, Thierry H, de Wolff CJ (eds). Handboek Arbeids- en Organisatiepsychologie. [Handbook of Work and Organizational Psychology]. Deventer: Loghum Slaterus, 1984

Melchior MEW. Burnout & work in long-stay psychiatric nursing. [Thesis]. Maastricht: Universiteit Maastricht, 1996

Munley A. The hospice alternative. New York: Basic Books, 1983

Pearlin LI. Social process and social supports. In: Cohen S, Syme L (eds). Social Support and Health. New York: Academic Press, 1985

Riordan RJ, Saltzer SK. Burnout prevention among health care providers working with the terminally ill: a literature review. OMEGA: J Death Dying 1992; 25:17-24

Roelens A. Burnout in de verpleging. [Burnout in nursing care]. Acta Hosp 1986; 2:17-26

Schaufeli WB. Opgebrand: over de achtergronden van werkstress bij contactuele beroepen -het burnout-syndroom. [Burnout: about the jobstress in the human services professions -the burnout-syndrome]. Rotterdam: Ad Donker, 1990a

Schaufeli WB. Burnout: een overzicht van empirisch onderzoek. [Burnout: an overview of emperical research]. Gedrag & Gezondheid 1990b; 3:3-31

Schaufeli WB, van Dierendonck D. Burnout, een begrip gemeten: de Nederlandse versie van Maslach Burnout Inventory (MBI-NL). [Burnout, a concept measured: the Dutch version of the Maslach Burnout Inventory (MBI-NL)]. Gedrag & Gezondheid 1994; 22:153-71

Schaufeli W, Enzmann D. The burnout companion to study & practice: a critical analysis. London: Taylor & Francis, 1998

Schaufeli WB, Enzmann D, Girault N. Measurement of burnout: a review. In: Schaufeli WB, Maslach C, Marek T (eds). Professional burnout: recent developments in theory and research. Washington: Taylor & Francis, 1993

Scheurs PJG, van den Willige G, Tellegen B, Brosschot JF. De Utrechtse Coping Lijst UCL-handleiding. [The Utrecht Coping List: UCL-manual]. Lisse: Swets & Zeitlinger, 1988

Shirom A. Burnout in work organizations. In: Cooper CL, Robertson I (eds). International review of industrial and organizational psychology. New York: Wiley, 1989

Smulders PGW, Veerman TJ. Handboek ziekteverzuim. [Handbook absenteeism due to illness]. Den Haag: Delwel, 1990

Spaans M. Opgebrand in zorg en verpleging. [Burnout in caring and nursing]. Tijdschr Gezondh Pol 1995; 2:5-7

Turner RJ. Direct, indirect and moderating effects of social support on psychological distress and associated conditions. In: Kaplan HB (ed). Psychological Stress. New York: Academic Press, 1983

Vachon M. Myths and realities in palliative/hospice care. Hosp J 1986; 2:63-79

Veerman TJ. Ziekteverzuim in de gezinsverzorging. [Absenteeism due to illness in home help services]. Amsterdam, Leiden: NIA, 1989

van Veldhoven M, Meijman T. Het meten van psychosociale arbeidsbelasting. [Measurement of psychosocial workload]. Amsterdam: NIA, 1994

de Vries T, Hoogstraten J. Burnout bij fysiotherapeuten: een psychometrische studie. [Burnout among physical therapists: a psychometric study]. Gedrag & Gezondheid 1998; 26:177-84

Yancik R. Sources of work stress for hospice staff. J Psychosoc Oncol 1984; 2:21-31

8 DETERMINANTS OF JOB SATISFACTION AND ABSENTEEISM AMONG HOME HELPS IN DUTCH HOME CARE

S.E.J. Arts, A. Kerkstra, H. Huyer Abu-Saad, J. van der Zee
To be submitted

ABSTRACT

The percentage of absenteeism is very high in the Netherlands when compared with other European countries. In the health care sector, particularly in home care, absenteeism is high, even for Dutch standards. Dutch home care organizations have also been confronted with other serious problems, like shortage of staff and a high workload.

This study among home helps was carried out because of these problems and their impact on job satisfaction. The aim of the study was to examine job satisfaction and absenteeism more thoroughly in respect of their determinants.

401 Dutch home helps working in 16 home help service organizations were asked to complete a questionnaire on their quality of working life. Multiple stepwise regression analysis was performed to show the relation between the independent variables, job satisfaction and absenteeism.

The results showed that the presence of learning and growth opportunities was most closely related to high job satisfaction.

Age and health were both strongly negative in relation to absenteeism (absence and frequency). The fact that the percentage of the variance in absenteeism explained by all variables is low at < 13% is striking.

Results also show that absenteeism is not related to job satisfaction.

The determinants of absenteeism should be further studied. Absenteeism might be more strongly determined by characteristics of an organization instead of individual characteristics.

Keywords: job satisfaction, absenteeism, home help services, the Netherlands

8 DETERMINANTS OF JOB SATISFACTION AND ABSENTEEISM AMONG HOME HELPS IN DUTCH HOME CARE

S.E.J. Nijs, A. Kerkstra, H. Huyer Abu-Saad, J. van der Zee

To be submitted

ABSTRACT

INTRODUCTION

The Netherlands has a very high percentage of absenteeism compared with other countries. Standardised measures showed the highest absenteeism percentage among Swedish workers (12.7%), followed by the Netherlands (8.5%), and then France, Germany and Great Britain (with 8.2%, 8.1% and 6,7% respectively) in 1988 (IDW, 1989). The percentage of absenteeism in health care is even high by Dutch standards. In 1999, the average percentage of absenteeism in the Dutch health care- and welfare-sector was 8.5%, compared with an overall, national percentage of 5,4% (Calsbeek et al., 2000). Absenteeism is highest in home help services (10%), lowest in hospitals (6%) (Calsbeek et al., 2000). While the duration of absenteeism for home helps is higher than in other health care settings, the frequency is approximately the same (BVG, 1996).
Veerman (1989) showed that the main reasons for absenteeism in home help services are problems of the musculoskeletal system, such as lower backproblems, neck and shoulder problems; followed by psychological problems, such as respons to stress, neuroses and overstrain. Also according to Hedin (1997), the most common health problems among health care workers in Sweden are pain in the neck/shoulder and lower back areas and symptoms of psychological stress such as fatigue and difficulties in relaxing after work.

In the last decade, home care organizations in the Netherlands have been confronted with serious problems, like shortage of staff, high workload, and a high percentage of absenteeism (Van Tits et al., 1991; Van Tits et al., 1992; De Jonge et al., 1995; Van der Windt et al., 1998). With a yearly turnover percentage of 11.6% and a yearly lower number of new community nurses and home helps entering nursing and caring education, a shortage of staff is becoming an increasing problem in Dutch home care every year (Van der Windt et al., 1998). A shortage of home helps is also a problem in many other countries in Europe (Hutten et al., 1996). According to experts the reasons for this shortage are first that the profession is not considered attractive, because it has a low status; secondly it is poorly paid and thirdly the training is considered to be inadequate (Hutten et al., 1996). These factors might also influence the job satisfaction of home helps already working in home care. In the light of these problems, the aim of this paper is to investigate the factors related to absenteeism and job satisfaction of Dutch home helps.

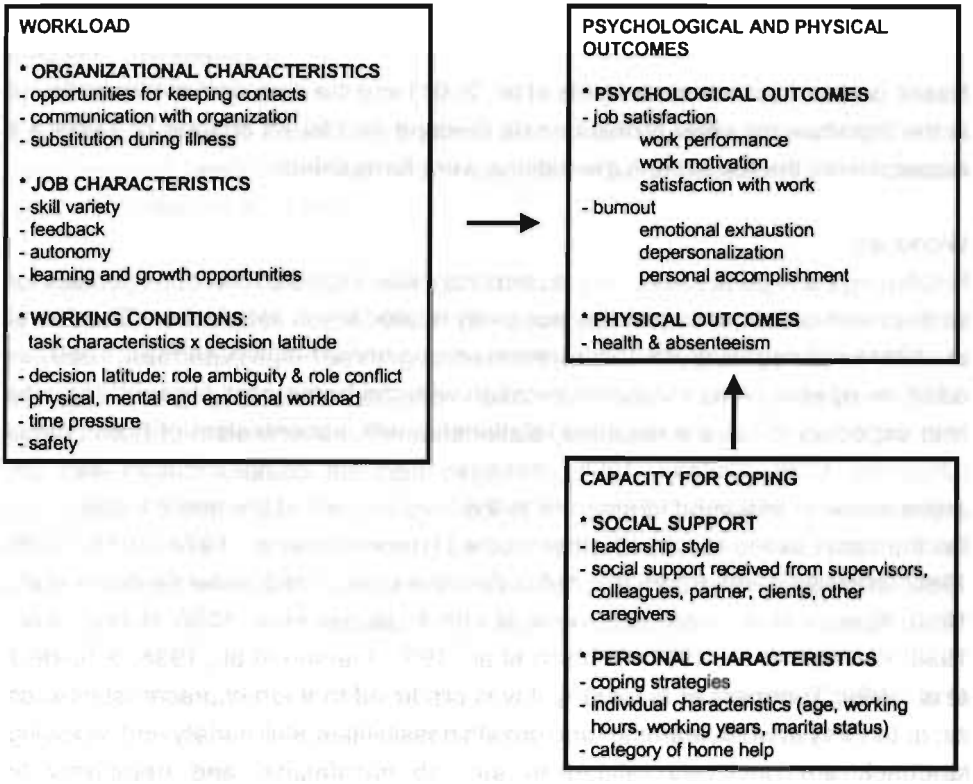
In the literature on absenteeism, a distinction is made between absenteeism as an individual characteristic on the one hand and absenteeism as an organizational characteristic on the other hand (Nijhuis, 1984; Smulders, 1984). Studies of the first variety look for the variables at an individual level, which explain differences in absenteeism between individuals; studies of the second variety examine what variables explain differences at organizational level between organizations (Philipsen, 1969).
The aim of this study is to explain absenteeism solely in relation to individual characteristics; organizational characteristics will therefore not be included.
Later in this article, the term *organizational characteristics* is introduced. This term refers to certain characteristics or aspects of the organization that influence the work of home helps and how home helps carry out this work. Examples are the existence of opportunities for maintaining contact with colleagues, being informed about developments and changes in the organization and if and how substitution is being organized.

In the literature, it is suggested that lack of job satisfaction may contribute to absenteeism (Shelledy et al., 1992; Matrunola, 1996; Larocque, 1996; Borda et al., 1997; Song et al., 1997). Consequently, factors influencing job satisfaction and the relation between job satisfaction and absenteeism are also investigated.

Many studies have been carried out into factors influencing absenteeism and job satisfaction, also in respect of health care professionals (for instance Veerman, 1989; Boumans, 1990; Leigh, 1991; Björkhem et al., 1992; Dutcher et al., 1994; Hood et al., 1994; Houtman, 1994; Smith et al., 1994; Jansen et al., 1996). However, factors relating to the job satisfaction and absenteeism among home helps have scarcely been investigated at all. In order to study these factors, we have developed a research model based on existing theoretical models of quality of working life (Hackman et al., 1974; 1975; 1976; 1980; Karasek, 1979; Karasek et al., 1990) and workload (Meijman et al., 1984; Veerman, 1989; Smulders et al., 1990) (Arts et al., 2001). In our research model, Figure 8.1, *psychological* (job satisfaction and burn-out) and *physical outcomes* (health and absenteeism) of working in home help services, are influenced by two dimensions: workload and capacity for coping. The *workload*-dimension includes three factors: 1) al characteristics (communication with, opportunities for contact with colleagues, substitution during illness), 2) job characteristics (feedback, skill variety, autonomy, learning and growth opportunities) and 3) working conditions (role conflict, role ambiguity, physical and emotional workload, time pressure). The

capacity for coping-dimension takes in two factors: 1) social support (leadership style, social support from colleagues, supervisors, partner and appreciation from client and other professional caregivers) and 2) coping style (active coping, passive coping, seeking social support) (Arts et al., 2001).

Figure 8.1 An integrated model for assessing the psychological and physical outcomes of working in home help services



In the literature empirical evidence was found for the relation between a number of variables specified in our research model and job satisfaction or absenteeism (see Table 8.1 for an overview). The relations between a number of variables presented in the model, has been described elsewhere (Chapter 7). This article focuses primarily on job satisfaction and absenteeism.

The principal questions that will be answered in this article are:

1) To what extent are variables, specified in our research model and found in the literature to be predictors of job satisfaction, also related to job satisfaction of home helps?
2) To what extent are variables, specified in our research model and found in the literature to be predictors of individual absenteeism, also related to individual absenteeism of home helps?
3) To what extent are the job satisfaction and absenteeism among home helps related?

Based on the research model (Arts et al., 2001) and the empirical evidence found in the literature for other professionals (second and fourth column of Table 8.1 respectively), the following expectations were formulated:

Workload

Regarding the *organizational characteristics* it was expected that opportunities for contact with colleagues would be positively related to job satisfaction (Dutcher et al., 1994) and negatively to absenteeism among home helps (Veerman, 1989). In addition, opportunities for communication with the home care organization was also expected to have a negative relationship with absenteeism of home helps (Grosfeld, 1988; Gellalty, 1995), because frequent communication with the organization is assumed to encourage the involvement of the home helps.

On the basis of the results of other studies (Hackman et al., 1974; 1975; 1976; 1980; Grosfeld, 1988; Boumans, 1990; Smulders, 1990; Hollander Feldman et al., 1990; Spector et al., 1991; Dutcher et al., 1994; Jansen et al., 1996; Nijhuis et al., 1996; Kivimäki et al., 1997; Rentsch et al., 1998; Iverson et al., 1998; Smulders et al, 1999; Tummers et al., 2000), it was predicted that *job characteristics* such as: autonomy at work, learning- and growth possibilities, skill variety and receiving feedback are positively related to the job satisfaction and negatively to absenteeism among home helps.

Working conditions such as: role ambiguity, role conflict, physical and emotional workload and time pressure were expected to be negatively related to the job satisfaction (Boumans, 1990; Björkhem et al., 1992; Jansen et al., 1996; Ulleberg et al., 1997; Yousef, 1999; Tummers et al., 2000) and positively to the absenteeism of home helps (Grosfeld, 1988; Veerman, 1989; Smulders, 1990; Leigh, 1991; Houtman et al., 1994; Heaney et al., 1995; Nijhuis et al., 1996; Yousef, 1999; Smulders et al., 1999).

Capacity for coping

As regards the *capacity for coping* dimension it was expected that *social support* from both supervisor and colleagues and *socio-emotional leadership style* would be positively related to job satisfaction, (Hollander Feldman et al., 1990; Boumans, 1990; Björkhem et al., 1992; Dutcher et al., 1994; Hood et al., 1994; Smith et al., 1994; Jansen et al., 1996; Iverson et al., 1998), and negatively to absenteeism among home helps (Grosfeld, 1988; Veerman, 1989); whereas an *instrumental leadership style* was expected to have a positive relationship with absenteeism (Przygodda et al., 1991). *Social support from colleagues* was not expected to be related to absenteeism.

It was expected with regard to relations among the *psychological and physical outcomes* that health would be negatively related to absenteeism among home helps (Smulders et al., 1999).

And finally, the relation between job satisfaction and absenteeism will be investigated. Although in the literature, a negative relation between the two variables was assumed, the results from other studies showed no conclusive relation between job satisfaction and absenteeism. The relation was found to be either unclear or non-existent (Shelledy et al., 1992; Larocque, 1996; Matrunola, 1996; Borda et al., 1997; Song et al., 1997).
It is therefore, difficult to specify beforehand the direction of the relation between job satisfaction and absenteeism. The research model does not indicate that absenteeism is related to job satisfaction nor is the literature conclusive about it. Accordingly, we decided to examine job satisfaction and absenteeism separately.

Table 8.1 shows an overview of the factors related to job satisfaction and absenteeism, based on the literature and the results found in this study.
When a cell in the Table is empty, it means that no relation was predicted or found.

Table 8.1 Overview of factors correlating with job satisfaction and absenteeism

Factors correlating with...	Job satisfaction		Absenteeism	
	Predictions	Results (Table 8.3)	Predictions	Results (Table 8.4)
WORKLOAD				
Organizational characteristics				
Opportunities for contact with colleagues	++ (1)	+ +	++ (28) -- (24)	
Communication with organization			– (18,28)	
Substitution (In-/external				
Job characteristics				
Autonomy	++ (2-6,9,13,17)		– (19,20,21,22,23, 28)	
Learning- /growth opportunities	++ (6-8)	+ +		
Skill variety	++ (2-6,8, 9, 10)		– (20,21,23)	
Feedback	++ (1-5,8, 9)		– (21)	
Working conditions				
Role ambiguity	– (7,11)		++ (11,28)	
Role conflict	– (11)	- -	++ (11,24,28,29)	
Physical workload	– (12,13) ++ (17)	- -	++ (21,22,23,25,27,28)	
Emotional workload	– (13)			
Time pressure	– (6,8,12,13)		++ (21,22,28)	
CAPACITY FOR COPING				
Social support				
From supervisors	++ (7,8,10,17)	+ +	– (24,28)	
From colleagues	++(1,8)	+ +		
Soc-emotional leadership	++ (6,14,15)		– (28)	+ +
Instrumental leadership			++ (26)	
Coping strategies				
Active approach				
Health status			– (21)	- -
Control variables				
Category of home help			– (28)	
Age			– (18), ++(25,27,28)	- -
Working hours per week			++ (28)	- -
Educational level			– (24,28)	
Years worked				+ +
Marital status	++ (16)		– (27,28)	
Children			++ (27)	

++ = a positive relation was expected/found

– = a negative relation was expected/found

+- = both a positive and a negative relation was expected

(1) Dutcher et al., 1994; (2) Hackman et al., 1974; (3) Hackman et al., 1975; (4) Hackman et al., 1976; (5) Hackman et al., 1980; (6) Boumans, 1990; (7) Björkhem et al., 1992; (8) Jansen et al., 1996; (9) Spector et al., 1991; (10) Hollander Feldman et al., 1990; (11) Yousef, 1999; (12) Ulleberg et al., 1997; (13) Tummers et al., 2000; (14) Hood et al., 1994; (15) Smith et al., 1994; (16) Dillard et al., 1991; (17) Iverson et al., 1998; (18) Gellalty, 1995; (19) Kivimäki et al., 1997; (20) Rentsch et al., 1998; (21) Smulders et al., 1999; (22) Smulders, 1990; (23) Nijhuis et al., 1996; (24) Veerman, 1989; (25) Houtman et al., 1994; (26) Przygodda et al., 1991; (27) Leigh, 1991; (28) Grosfeld, 1988; (29) Heaney et al., 1995.

METHODS

Sample

A two-stage sampling method was used. Thirty of the 104 organizations for home help or home care in the Netherlands were asked to participate in the study, using three stratification criteria: region (north, east, south and west of the Netherlands), integration with home nursing or not, and size of catchment area of the organizations. The 16 participating organizations (53%) were equally distributed over the country. Within these 16 organizations, 25 home helps were to be selected: five from each of the five categories of home help. Not all organizations were able to select these 25 home helps, because there were not always five home helps in each category, nor were all five categories of home help present or available in the organizations. Finally 401 home helps (94%) participated in the study (one organization selected two complete groups of home helps in two different regions). These home helps were asked to complete a questionnaire on quality of working life.

Instrument

Questionnaire on quality of working life

The questionnaire on quality of working life, based on a model assessing the psychological and physical outcomes of work among home helps (Arts et al., 2001), was used for the analyses. Table 6.2 (Chapter 6) provides an overview of the number of items per scale. Only the scales for which evidence was found in the literature (Table 8.1), were included in the analyses. These scales are described below.

Workload: The questionnaire headed "Experience and Assessment of Work" (VBBA) by Van Veldhoven et al. (1994) was used for scales on organizational characteristics, job characteristics and working conditions. The organizational characteristics were operationalized in three subscales: communication with (α=.69), contact opportunities with colleagues (α=.62) and substitution during illness. Four job characteristics were measured: skill variety (α=.68), autonomy (α=.79), feedback (α=.72) and learning and growth opportunities (α=.78). And finally, working conditions were operationalized in five subscales: role ambiguity, that is ambiguity relating to the tasks or the client (α=.59); role conflict, that is performing conflicting or unpleasant tasks (α=.55); time pressure (α=.75), and physical and emotional workload (α=.82 and α=.72 respectively).

Capacity for coping: Social support at work was measured by questions regarding social support received from supervisors (α=.63) and colleagues (α=.69) from the Organizational Stress Questionnaire (VOS-D) (Bergers et al., 1986).
To assess ways of dealing with the problems, a shortened version by Van Dierendonck et al.(1992) of the Utrecht Coping List (UCL) by Scheurs et al. (1988) was used. Coping strategies were measured on this 25 item questionnaire by three subscales, of which only one is used in this article: active coping (α=.73).

Psychological and physical outcomes: Using the study by Boumans (1990), job satisfaction was measured on nine subscales: satisfaction with clarity at work (α=.61), satisfaction with growth at work (α=.71), satisfaction with promotion opportunities (α=.81), satisfaction with contact with colleagues (α=.86), satisfaction with contact with supervisor (α=.79), satisfaction with contact with clients (α=.66), work performance (α=.75), internal work motivation (α=.42) and general work fulfilment (α=.76). Due to the low Cronbach's α of the internal motivation sub-scale (0.42), only eight dimensions of job satisfaction were studied in this article. Total job satisfaction was therefore calculated on the basis of the eight reliable subscales. The reliability of the total job satisfaction scale was high: α=. 93.
Health was estimated by a self-assessment of the general health state on a five-point scale from very bad (1) to very good (5). Absenteeism was also self-reported. Home helps were asked about the frequency and the total duration of their absenteeism in the past 12 months and about the prevalence of back problems during the last 12 months.

Analyses

First, Pearson's correlations were calculated to measure the relations between the independent variables, and between the independent and the two dependent variables. Secondly, multiple stepwise regression analyses (Ordinary Least Square) were carried out to show the relations between the independent variables and job satisfaction and absenteeism.
In order to analyse the influence of nominal variables adequately, three variables were changed into dummy-variables. These variables are category of home help ('A' home help, 'B' caring help, 'C' carer, 'D' carer, and specialised 'E' carer), marital status (married without children, married with children, single parent with children, single living with some one, single living alone), and substitution during illness (no substitution, colleagues take over, external substitution.

RESULTS

Table 8.2 shows the Pearson's correlations between the independent variables and job satisfaction and absenteeism. The correlations varied between .01 and .48 for job satisfaction, and between .01 and .23 for absenteeism. Table 8.2 also shows that the independent variables are not or moderately related, except feedback and role ambiguity (-0.49), and social support from supervisors and socio-emotional leadership correlated (0.51). Role ambiguity and socio-emotional leadership had lower bivariate correlations with job satisfaction and were therefore excluded from further analysis regarding job satisfaction. Based on lower bivariate correlations with absenteeism, role ambiguity and social support from supervisors were excluded from further analysis regarding absenteeism.

Factors related to job satisfaction

Table 8.3 shows the results of regression-analyses with job satisfaction as dependent variable. Two steps were used to build the regression model for job satisfaction. In the first step, four control variables were entered. Secondly, the independent variables were entered, according to the step-wise method.

Table 8.3 shows that job satisfaction is principally related to learning and growth opportunities. Sufficient learning and growth opportunities seem to increase a home help's job satisfaction. Opportunities for keeping contact with colleagues, and experienced social support, from both supervisor and colleagues, are also positively related to job satisfaction. On the other hand, performing tasks that are conflicting or performing tasks one prefers not doing (role conflict) and physical workload seem to decrease job satisfaction. None of the control variables was related to job satisfaction.

The percentage explained variance for job satisfaction by all independent variables is moderately high (37%).

Table 8.2 Pearson's correlations between workload variables, capacity for coping variables and psychological and physical outcomes of working in home help services (n=401)

1: opport. contact w. colleagues																			
2: communication w. org.	.07																		
3: no substitution	-.06	-.14																	
4: internal substitution	.10	.11																	
5: autonomy	.01	.18	.05	-.05															
6: learning-/growth opport.	.18	.11	.03	-.04	.18														
7: skill variety	.21	-.12	.18	-.21	.07	.39													
8: feedback	.30	.27	.03	.00	.12	.36	.25												
9: role conflict	-.01	-.17	.13	-.06	-.10	-.05	.13	-.13											
10: role ambiguity	-.21	-.22	-.01	.05	-.15	-.18	-.18	-.49	.24										
11: physical workload	-.02	-.05	-.04	.03	-.03	.00	-.10	-.09	.22	.07									
12: emotional workload	.11	-.19	.29	-.21	-.03	.16	.43	.17	.42	.01	.21								
13: time pressure	.07	-.09	.04	-.08	-.20	.01	.08	-.04	.27	.02	.44	.27							
14: social support supervisors	.06	.23	-.04	.07	.23	.25	.01	.33	-.38	-.33	-.09	-.17	-.14						
15: social support colleagues	.28	.15	-.04	.05	.01	.19	.20	.29	-.17	-.24	-.09	-.01	-.05	.34					
16: active coping	.05	.05	.03	-.05	.08	.19	.25	.18	.09	-.20	-.09	.21	.01	.00	.07				
17: socio-emotional leadership	.21	.25	-.07	.06	.18	.27	.07	.33	-.17	-.28	.01	-.05	-.08	.51	.22	.17			
18: instrumental leadership	.09	.04	.09	-.09	-.14	.15	.16	.10	.22	.05	.05	.17	.11	-.22	.04	.11	-.01		
19: health	.04	.05	-.02	-.01	.11	.03	.08	.01	-.08	-.10	-.23	-.13	-.11	.09	.07	.02	.03	-.11	
20: back problems (12 months)	-.02	-.09	-.01	.04	-.04	-.05	-.05	-.18	.06	.09	.21	.09	.06	-.12	-.07	-.02	-.03	-.07	-.20
Total job satisfaction	.29	.29	-.02	.01	.17	.48	.22	.37	-.23	-.20	-.20	-.03	-.15	.36	.30	.03	.27	.08	.20	-.16
Absent yes/no	-.02	.03	.08	-.08	.03	.03	.04	.06	-.01	-.03	.10	-.01	.05	.12	.09	.06	.13	-.01	-.18	.03
Frequency	.03	.03	.07	-.05	.05	.05	-.04	.03	.02	-.02	.15	.00	.02	.06	.05	.06	.11	-.05	-.23	.11
Total duration	-.02	.02	-.12	.04	.06	.03	.05	-.06	.05	.01	.10	.10	.07	.01	.02	.03	-.05	.02	-.12	.08
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20

Correlations between 0.10 and 0.13 $p < 0.05$ Correlations > 0.13 $p < 0.01$

Table 8.3 Results of regression analysis (ß's and R-squares) with workload and capacity for coping as independent variables and job satisfaction as dependent variable for the total group (N=401)

	Job satisfaction
Control variables	
category of home help (C=reference group)	
A	
B	
D	
E	
age	
working hours per week	
marital status (married without children=reference group)	
married with children	
single parent with children	
single living alone	
single living with others	
WORKLOAD	
Organizational characteristics	
opportunities for keeping contact	.19***
Job characteristics:	
autonomy	
learning-/growth opportunities	.39***
feedback	
skill variety	
Working conditions:	
role conflict	-.09*
physical workload	-.13**
emotional workload	
time pressure	
CAPACITY FOR COPING	
Social support:	
from supervisors	.17***
from colleagues	.09*
Adj. R^2	**37%**

* $p \leq 0.05$, ** $p \leq 0.01$, *** $p \leq 0.001$

Factors related to absenteeism

Table 8.4 shows the results of regression-analyses with absence (no/yes), frequency of absenteeism (0-6 times), and the total duration of absenteeism (1-180 days) as dependent variables. Two steps were made to build the regression models for absenteeism. In the first step six control variables were entered: category of home help, age, number of working hours per week, number of number of years worked (in months), educational level, and marital status. Secondly, the independent workload and capacity for coping variables were entered, in terms of the step-wise method.

Whether or not a home help was *absent due to illness*, was mainly related to age: younger home helps and home helps that worked fewer hours per week called in sick. Furthermore, absence was negatively related to the number of working hours and health. Absence occurred more often among home helps with fewer working hours per week and home helps with a poor health. Absence was positively related with a supervisor's socio-emotional leadership style, meaning that home helps whose supervisor focused on wellbeing and comfort were more absent. The percentage explained variance for absence by all variables is low (8%).

The *frequency of absenteeism* was also foremost related to age. Younger home helps were more often absent. There was also a strong relation between health and the frequency of absenteeism, i.e: less healthy home helps called in sick more often. Finally, there was a positive relation between socio-emotional leadership style and frequency of absenteeism, meaning that home helps whose supervisor focused on wellbeing and comfort were more often absent.
The percentage of explained variance for frequency of absenteeism by all variables is only 13%.

The *total duration of absenteeism* was only related to one variable: the number of working years. Home helps who had been working in home help services for longer, were, once sick, absent for a longer period. The percentage explained variance for the total duration of absenteeism is very low (0,2%).

Table 8.4 Results of regression analysis (ß's and adjusted R squares) with workload and capacity for coping as independent variables and absenteeism as dependent variable for the total group (N=401)

	Absent yes/no (n=401)	Frequency 0-6 times (N=401)	Duration 1-180 days (N=258)
Control variables			
category of home help (C=reference group)			
A			
B			
D			
E			
age	-.27***	-.31***	
working hours per week	-.14*		
educational level (1=low, 4=high)			
years worked (in months)			.18*
marital status (married without children=reference group)			
married with children			
single parent with children			
single living alone			
single living with others			
WORKLOAD			
Organizational characteristics			
opportunities for keeping contact			
communication with organization			
Job characteristics:			
autonomy			
learning-/growth opportunities			
skill variety			
feedback			
Working conditions:			
role conflict			
physical workload			
emotional workload			
time pressure			
CAPACITY FOR COPING			
Social support:			
from colleagues			
Leadership style:			
socio-emotional leadership	.11*	.10*	
instrumental leadership			
Health (1=very bad,5=very good)	-.19***	-.23***	
Adj. R^2	**8%**	**13%**	**0,2%**

$p \leq 0.05$, ** $p \leq 0.01$, *** $p \leq 0.001$

Relation between job satisfaction and absenteeism

Table 8.5 shows the results of Pearson's correlation between job satisfaction (and the eight subscales) and absenteeism (absence, frequency and duration). The Table shows very weak relations between job satisfaction and absenteeism: a weak positive relation between job satisfaction and absence (.03), a weak negative relation between job satisfaction and the frequency of absenteeism (-.06) and finally no relation between job satisfaction and the total duration of absenteeism (.00). Nor did seven of the eight separate (sub) scales of job satisfaction correlate highly with the three types of absenteeism. The correlations varied between .01 and (-) .09.

Only general work satisfaction was moderately correlated with the frequency of absenteeism (-,13).

Table 8.5 Results of correlations between job satisfaction, absence, frequency of absenteeism and duration of absenteeism (N=401/258)

	Absent yes/no (N=401)	Frequency 0-6 times (N=401)	Duration 1-180 days (N=258)
Job satisfaction	.03	-.06	.00
general work satisfaction	.03	-.13*	.03
satisfaction			
with colleagues	.03	-.03	.02
with supervisor	.07	.02	-.05
with growth at work	-.03	-.09	-.05
with promotion	-.05	-.08	.01
with clients	.04	.04	.01

* $p < 0.05$

DISCUSSION

In this article, factors that are related to job satisfaction and absenteeism among Dutch home helps were studied. Based on the literature a research model was developed and expectations were formulated. Table 8.1 shows an overview of these expectations (2nd and 4th column) and the relations found in this study (3rd and 5th column).

Table 8.1 shows that in this study empirical evidence was found for approximately half of the factors that were predicted, on the basis of the literature, to be related to *job satisfaction*. The variance in job satisfaction among the home helps is explained moderately. The variables that are strongest related to job satisfaction are sufficient learning and growth opportunities, sufficient opportunities for keeping contact with colleagues, high social support experienced from supervisors, low role conflict and a low level of physical workload.

Job characteristics that were predicted to be related to job satisfaction, but not found are autonomy, skill variety and feedback. There are several possible explanations for not finding these relations in the regression analysis. One is a weak bivariate correlation between autonomy and job satisfaction. This weak correlation is possibly due to a low variation in the scores on autonomy (50% of the home helps scored their level of autonomy in the top 30% of the scale). Another explanation might be a relatively high correlation between feedback and learning and growth opportunities, and skill variety and learning and growth opportunities (.36 and .39 respectively), the latter taking away the effect of the former.

As regards working conditions, the expected relations between emotional workload and time pressure on the one hand, and job satisfaction on the other were not found either. A relatively high correlation between emotional workload and role conflict (.42) and between time pressure and physical workload (.44) might be an explanation for this. The results showed that both role conflict and physical workload were negatively related to job satisfaction.

No relation was found between two independent variables, role ambiguity and socio-emotional leadership, and job satisfaction, although predicted, because these variables were excluded from the regression analyses, on the basis of multicollinearity with feedback and social support from supervisors respectively. Extra analyses showed that including role ambiguity and socio-emotional leadership in the regression model (and therefore excluding feedback and social support from supervisor) did not result in significant relations between these variables and job satisfaction.
Including feedback and socio-emotional leadership, however, resulted in a significant positive relation between feedback and job satisfaction. But it did not result in a higher percentage explained variance.

Table 8.1 shows that empirical evidence with regard to *absenteeism* was found only for a few of the predicted factors. For example, none of the organizational characteristics, job characteristics or working conditions, including back problems were related to any form of absenteeism, although in the literature many studies did find one of these relations (Houtman, 1984; Grosfeld, 1988; Veerman, 1989; Smulders, 1990; Przygodda et al., 1991; Leigh, 1991; Heaney et al., 1995; Nijhuis et al., 1996; Kivimäki et al., 1997; Rentsch et al., 1998; Smulders et al., 1999).

There are two possible explanations for finding so few results. One is that the absenteeism figures in this study, which are self-reported individual figures over the past 12 months, differ from the absenteeism figures in the other studies. Possible reasons for this are firstly an incorrect idea of absenteeism figures due to the self-reporting. Home helps had to report their absence for the past 12 months. Because of the long period involved, home helps might have overlooked some absence-episodes or have estimated the figures because they did not remember them all. Secondly the individual absenteeism figures were provided by the organization instead of being self-reported. Thirdly in the other studies a difference was made between physician-excused and non-physician-excused absence. Finally, in the other studies a difference was made between short term and long term absenteeism.

Secondly, due to different combinations of independent variables used in the various studies and the circumstances under which the study took place (during a period of economic decline, in a third world country, in work-redesign-situation etc) the results of regression analyses can vary greatly.

The main factors are age, number of years worked in the organization, number of hours worked per week and health. Although it was predicted that age was related to absenteeism, the direction of the relation was not clear. In this study, both age and working hours were negatively related to absence and to the frequency of absenteeism. This is in line with results from studies by Gellalty (1995) and Grosfeld (1988) respectively. An explanation for younger home helps being more often absent could be that these home helps often have families with young children. The pressure of having two jobs might contribute to a higher frequency of absenteeism among these home helps. One plausible explanation of the negative relation between absence and the number of hours worked per week can be that home helps who work fewer hours per week, feel less involved with the organization, and therefore call in sick more easily. The relation could

also be entirely the opposite, i.e.: home helps who have been absent due to (physical or emotional) limitations (in the past), work fewer hours.

Finally, the relation between job satisfaction and absenteeism was also studied. Pearson's correlations showed not only very weak relations between job satisfaction and the various absenteeism variables and between the separate satisfaction-scales and absenteeism, but also an incongruity in the direction of the relations. Matrunola (1996) and Borda et al. (1997) found similar results, studying the relation between job satisfaction and absenteeism.
Although neither the research model nor the literature indicated a relation, we have now also found empirical evidence that absenteeism is not related to job satisfaction. Maybe absenteeism is better explained by various variables on organizational level.

The overall conclusion is that this research model is suitable to explain the psychological outcome of work among home helps studied in this article: job satisfaction. The research model is, however, not appropriate to explain the physical outcome of work, absenteeism, among home helps.

Limitations of the study

The study has some restrictions with regard to the sample of home helps participating. The way the home helps were selected for the study, either voluntarily or selected by a supervisor, is a possible bias of the total sample of home helps. A consequent restriction is that the long-term ill home helps were not included. Therefore an overestimation of job satisfaction and an underestimation of absenteeism might have occurred. With regard to the latter, comparing the absenteeism figures from this study with national absenteeism figures, shows that our figures are only slightly lower, so no extreme underestimation has occurred. The way absenteeism was measured also needs attention. These figures, which were collected via self-report, are possibly not as accurate as figures collected from the organization itself.

Recommendations

Certain job and organizational characteristics (learning and growth opportunities and opportunities for keeping contact with colleagues) appeared to be important for the job satisfaction of home helps. In order to increase the job satisfaction of home helps further, it is suggested that opportunities for learning and growth for home helps be increased, enabling them to seek more contact with their

colleagues. Also the socio-emotional leadership style of supervisors and the physical workload of home helps are issues worth improving.

Due to low percentage explained variance of absenteeism, we should be careful with formulating recommendations to decrease absenteeism in home help services. One recommendation is, because the group of absent home helps is rather large, to appoint someone, a co-ordinator perhaps, to monitor and even counsel absent home helps (separately or in a group).
The high absenteeism figures and the few explanations we found, urge us to do things differently in future research. One can be to measure absenteeism in an another, possibly more accurate, way. Another suggestion is to focus on absenteeism as an organizational characteristic, and investigate the influence of several variables at the organizational level. Some examples are company policy, level of urbanisation, and type of organization.

Acknowledgements
This research was carried out at the initiative of the Ministry of Public Health, the Professional Association of Home Helps (STING), the Association of Management of Home Help Organizations (STRATEGO) and the Netherlands Institute of Primary Health Care (Nivel). The study was funded by the National Centre of Nursing & Caring (LCVV).

REFERENCES

AbvaKabo (Union of Public Sector Workers). Concept CAO-Thuiszorg met salarisregelingen. [Draft Collective Labour Agreement Home Care with Salary-Regulations]. Utrecht: AbvaKabo, 1994

Arts SEJ, Kerkstra A, van der Zee J, Huyer-Abu Saad H. Workload, capacity of coping and psychological and physical outcomes amongst home helps in the Netherlands. Health Soc Care Community 1999; 7:79-90

Arts SEJ, Kerkstra A, van der Zee J, Huyer-Abu Saad H. Quality of working life and pressure of work in home help services. Scand J Caring Sci 2001; 15:12-24

Bergers GPA, Marcelissen FHG, de Wolff CH. Vragenlijst Organisatie Stress-D Nijmegen. [Questionnaire Organization Stress-D Nijmegen]. Nijmegen: Katholieke Universiteit Nijmegen, Vakgroep Arbeids- en Organisatiepsychologie, 1986

Björkhem K, Olsson A, Hallberg IR, Norberg A. Caregivers' experience of providing care for demented persons living at home. Scand J Prim Health Care 1992; 10:53-9

Borda RG, Norman IJ. Factors influencing turnover and absence of nurses: a research overview. Int J Nurs Stud 1997; 34:385-94

Boumans NPG. Het werk van verpleegkundigen in algemene ziekenhuizen. [The work of nurses in general hospitals]. [Thesis]. Maastricht: Rijksuniversiteit Limburg, 1990

BVG (Dutch Industrial Board of Human Services Reports). BVG-Jaarverslag 1995. [Dutch Industrial Board of Human Services Reports Year Report 1995]. Zeist: BVG, 1996

van Dierendonck D, Groenewegen PP, Sixma H. Opgebrand: een inventariserend onderzoek naar gevoelens van motivatie en demotivatie bij huisartsen. [Burnout: an inventory on feelings of motivation and demotivation among general practitioners]. Utrecht: NIVEL, 1992

Dillard BG, Feather BL. The association between attitudes and job satisfaction: a study of in-home care aides. Educ Geront 1991; 17:209-18

Dutcher LA, Adams CE. Work environment perceptions of staff nurses and aides in home health agencies. J Nurs Adm 1994; 24:24-30

Gellatly IR. Individual and group determinants of employee absenteeism: test of a causal model. J Org Behav 1995; 16:469-85

Grosfeld JAM. De voorspelbaarheid van individueel ziekteverzuim. [The predictability of individual absenteeism]. [Thesis]. Nijmegen: Katholieke Universiteit Nijmegen, 1988

Hackman JR, Oldham GR. The Job Diagnostic Survey. New Haven: Yale University, 1974

Hackman JR, Oldham GR. Development of the Job Diagnostic Survey. J Appl Psychol 1975, 60: 9-170

Hackman JR, Oldham GR. Motivation through design of work: test of a theory. Organ Behav Hum Perform 1976; 16:250-79

Hackman JR, Oldham GR. Work redesign. Reading: Addison-Wesley, 1980

Heaney CA, Clemans J. Occupational stress, physician-excused absences, and absence not excused by a physician. Am J Health Promot 1995; 10:117-24

Hedin AM. From different starting points...: a longitudinal study of work and health among home care workers. Eur J Public Health 1997; 7:272-8

van den Heuvel W, Gerritsen H. Home care services in the Netherlands. In: Jamieson A (ed). Home care for older people in Europe: a comparison of policies and practices. Oxford: Oxford University Press, 1991

Hollander Feldman P. Work life improvements for home care workers: impact and feasibility. Gerontologist 1993; 33: 47-54

Hood JN, Smith HL. Quality of work life in home care. J Nurs Adm 1994; 24:40-7

Houtman ILD, Kompier MAJ, Smulders PGW, Bongers PM. Werkstress-risico's en gezondheid. [Work stress risks and health]. TSG 1994; 72:198-203

Hutten JBF, Kerkstra A. Home care in Europe. Aldershot: Arena, 1996

IDW (Institut der Deutschen Wirtschaft). Sozialraum Europa. Köln: IDW, 1989

Iverson RD, Olekalns M, Ervin PJ. Affectivity, organizational stressors and absenteeism. J Vocat Behav 1998; 52:1-23

Jansen PGM, Kerkstra A, Huijer Abu-Saad H, van der Zee J. The effects of job characteristics and individual characteristics on job satisfaction and burnout in community nursing. Int J Nurs Stud 1996; 33:407-21

de Jonge J, Boumans N, Landeweerd A, Nijhuis F. Werkkenmerken en werkbeleving. [Job characteristics and psychological outcomes]. TVZ 1995; 105:186-9

Karasek RA. Job demands, job decision latitude, and mental strain: implications for job redesign. Adm Sci Q 1979; 24:285-308

Karasek RA, Theorell, T. Healthy work: stress, productivity and the reconstruction of working life. New York: Basic Books, 1990

Kivimäki M, Vahtera J, Thomson L, Griffiths A, Cox T. Psychosocial factors predicting employee sickness absence during economic decline. J Appl Psychol 1997; 82:858-72

Larocque D. Absenteeism. Can Nurs 1996; 92:42-6

Leigh JP. Employee and job attributes as predictors of absenteeism in a national sample of workers: the importance of health and dangerous working conditions. Soc Sci Med 1991; 33:127-37

Matrunola P. Is there a relationship between job satisfaction and absenteeism? J Adv Nurs 1996; 23:827-34

Meijman TF, O'Hanlon JF. Arbeidsbelasting, een inleidend overzicht van psychologische theorieën en meetmethoden. [Pressure of labour: an introductory overview of psychological theories and measure-methods]. In: Drenth PJD, Thierry H, de Wolff CJ (eds). Handboek Arbeids- en Organisatiepsychologie. [Handbook of Work and Organizational Psychology]. Deventer: Loghum Slaterus, 1984

Nijhuis F. Beoordelingen van organisatiekenmerken: een sociaal gezondheidkundige studie naar organisatiekenmerken en ziekteverzuim. [Assessments of organizational characteristics: a socio-medical study on organizational characteristics and absenteeism]. [Thesis]. Maastricht: Rijksuniversiteit Limburg, 1984

Nijhuis FJN, Smulders PGW. Die Wirkung von Arbeitsanforderungen und persönliche Kontrollmöglichkeiten auf Gesundheitsbeschwerden und Fehlzeiten. Zeitschrift für Arbeits- und Organizationspsychologie 1996; 40:173-80

Philipsen H. Afwezigheid wegens ziekte. [Absence due to illness]. Den Haag/Groningen: NIPG-TNO/Wolters-Noordhoff, 1969

Prins R. Sickness absence in Belgium, Germany (FR) and the Netherlands: a comparative study. [Thesis] Maastricht: Rijksuniversiteit Limburg, 1990

Przygodda M, Arentz K-P, Quast H-H, Kleinbeck U. Vorgesetztenverhalten und Fehlzeiten in Organizationen: eine Studie mit Rettungssanitätern im kommunalen Rettungsdienst. Zeitschrift für Arbeits- und Organizationspsychologie 1991; 35:179-86

Rentsch JR, Steel RP. Testing the durability of job characteristics as predictors of absenteeism over a 6-year period. Pers Psych 1998; 51:165-90

Scheurs PJG, van den Willige G, Tellegen B, Brosschot JF. De Utrechtse Coping Lijst: UCL-handleiding. [The Utrecht Coping List: UCL-Manual]. Lisse: Swets & Zeitlinger, 1988

Shelledy DC, Mikles SP, May DF, Youtsey JW. Analysis of job satisfaction, burnout, and intent of respiratory care practitioners to leave the field or the job. Respir Care 1992; 37:46-60

Smith HL, Hood JN, Piland NF. Leadership and quality of working life in home health care. Home Health Care Serv Q 1994; 14:3-22

Smulders PGW. Bedrijfskenmerken en ziekteverzuim in de jaren zestig en tachtig: een vergelijkende studie. [Organizational characteristics and absenteeism in the sixties and eighties: a comparable study]. [Thesis]. Den Haag: NIPG/TNO, 1984

Smulders PGW. De arbeidssituatie van twaalf beroepsgroepen in de intramurale gezondheidszorg. [The job situation of twelve professions in the intramural health care]. TSG 1990; 68:247-55

Smulders PGW, Nijhuis FJN. The Job Demand-Job Control Model and absence behaviour: results of a 3-year longitudinal study. Work Stress 1999; 13:115-31

Smulders PGW, Veerman TJ. Handboek ziekteverzuim. [Handbook absenteeism due to illness]. Den Haag: Delwel, 1990

Song R, Daly BJ, Rudy EB, Douglas S, Dyer MA. Nurses' job satisfaction, absenteeism and turnover after implementing a special care unit. Res Nurs Health 1997; 20:442-52

Spector PE, Jex SM. Relations of job characteristics from multiple data sources with employee affect, absence, turnover intentions, and health. J Appl Psychol 1991; 76:46-53

van Tits M, Vermeulen H. Ontwikkelingen op de arbeidsmarkt. [Developments on the Labour market]. TVZ 1992; 102:104-7

van Tits M, Groot W. Zorgen om kruiswerk en verzorging. [Caring for community nursing and home help services]. TVZ 1991; 101:56-9

Tummers GER, Landeweerd JA, van Merode GG. Organisatieaspecten, ervaren werkkenmerken en werkreacties in de verpleging. [Organizational characteristics, job characteristics and outcomes of working in nursing occupations]. Verpleegkunde 2000; 15:132-41

Ulleberg P, Rundmo T. Job stress, social support, job satisfaction and absenteeism among offshore oil personnel. Work Stress 1997; 11:215-28

Veerman TJ. Ziekteverzuim in de gezinsverzorging. [Absenteeism due to illness in home help services]. Amsterdam: NIA, 1989

van Veldhoven M, Meijman T. Het meten van psychosociale arbeidsbelasting. [Measuring psychosocial workload]. Amsterdam: NIA, 1994

van der Windt W, Calsbeek H, Hingstman L. Feiten over verpleging en verzorging in Nederland 1998. [Facts about nursing and caring in the Netherlands 1998]. Maarsen/Utrecht: Elsevier/De Tijdstroom/ LCVV, 1998

van der Windt W, Calsbeek H, Hingstman L. Verpleging en verzorging in kaart gebracht. [An overview of nursing and caring]. Utrecht: De Tijdstroom/LCVV, 1997

Working Group (Werkgroep Werkveld) SOGW. Beroepsprofiel Verzorgende/Helpende. [Job profile caring personnel]. Leiden: Spruyt, van Mantgem & de Does, 1992

Yousef DA. Antecedents and consequences of job stressors: a study in a third world setting. Int J Stress Manage 1999; 6:265-82

Literature

Abbenhuis GM. Burnout bij hulpverleners van probleemgezinnen: een verkennende studie. [Burnout among health care workers with problematic families: an explorative study]. [Thesis]. Utrecht: Rijksuniversiteit Utrecht, 1993

Abel E, Nelson M. Circles of care: an introductory essay. In: Abel E, Nelson M (eds). Circles of care: work and identity in women's lives. Albany: State University of New York Press, 1990

AbvaKabo (Union of Public Sector Workers). Overzicht van verschillende functies in de Gezinsverzorging. [Review of various functions in home help services]. OAW: stuknummer 9210220y.15.4, 1992

AbvaKabo (Union of Public sector Workers). Concept CAO-Thuiszorg met salarisregelingen. [Draft collective labour agreement home care with salary-regulations]. Utrecht: AbvaKabo, 1994

Algera JA. Kenmerken van werk. [Characteristics of work]. Lisse: Swets & Zeitlinger, 1981

Algera JA, van der Flier H, van der Kamp LJT. Causal modelling of quality of work. In: Debus G, Schroif HW. The psychology of work and organization. Amsterdam: Elsevier Science, 1986

Allaart PC, van Essen G, Peters F. Arbeid in zorg en welzijn. [Work in care and well-being]. Tilburg: OSA, 2000

Andersen R, Newman JF. Societal and individual determinants of medical care utilization in the United States. Milbank Mem Fund Q 1973; 51:95-124

Aneshengel CS, Pearlin LI, Schuler RH. Stress, role captivity, and the cessation of care giving. J Health Soc Beh 1993; 34:54-70

Arendt H. Vita Activa, 1960

Arts SEJ, Kersten JWET, Kerkstra A. Werken in de gezinsverzorging: een overzicht van de dagelijkse praktijk. [Working in home help services: an overview of the daily practice]. Utrecht: NIVEL, 1994

Arts SEJ, Kersten H, Kerkstra A. The daily practice in home help services in the Netherlands: instrument development. Health Soc Care Commun 1996; 4:280-9

Arts SEJ, Kersten JWET, Kerkstra A. Werken in de gezinsverzorging. [Working in home help services]. Utrecht: De Tijdstroom/LCVV, 1997

Arts SEJ, Kerkstra A, Huijer Abu-Saad, H, van der Zee, J. A job profile of home helps in the Netherlands. Health Soc Care Community 1998; 6:397-406

Arts SEJ, Kerkstra A, van der Zee J, Huyer-Abu Saad H. Workload, capacity of coping and psychological and physical outcomes amongst home helps in the Netherlands. Health Soc Care Community 1999; 7:79-90

Arts SEJ, Kerkstra A, van der Zee J, Huyer-Abu Saad H. Quality of working life and pressure of work in home help services. Scand J Caring Sci 2001; 15:12-24

Baars JA, Spaan JM. Jaarboek Thuiszorg 1995. [Yearbook Home Care 1995]. Bunnik/Utrecht: LVT/NZi, 1997

Baars JA, Spaan JM. Jaarboek Thuiszorg 1996. [Yearbook Home Care 1996]. Bunnik/Utrecht: LVT/NZi, 1998

Bakker RHC, Knibbe JJ, te Winkel A, Friele RD. Rugklachten van verzorgend en verplegend personeel van verzorgingshuizen. [Back problems of caring and nursing staff in homes for the elderly]. In: Friele RD (ed). Rugklachten, fysieke belasting en preventie mogelijkheden in verzorgingshuizen. [Back problem,s physical workload and prevention possibilities in homes for the elderly]. Utrecht: NIVEL, 1995

Bartholdus E, Gillery B, Sturges PJ. Job-related stress and coping among home-care workers with elderly people. Health Soc Work 1989; 14:206-10

Berger RM, Anderson S. The in-home worker: serving the frail elderly. Soc Work 1984; 29:456-61

Bergers GPA, Marcelissen FHG, de Wolff CH. Vragenlijst Organisatie Stress-D Nijmegen. [Questionnaire Organisation Stress-D Nijmegen]. Nijmegen: Katholieke Universiteit Nijmegen, Vakgroep Arbeids- en Organisatiepsychologie, 1986

Berkhout AJMB. Resident-oriented care in nursing homes: an evaluation study of the model of resident-oriented care, the implementation and the effects. [Thesis]. Maastricht: Universiteit Maastricht, 2000

Beukema L. Kwaliteit van de arbeidstijdverkorting. [Quality of reduction of working hours]. Groningen: Karstapel, 1987

Björkhem K, Olsson A, Hallberg IR, Norberg A. Caregivers' experience of providing care for demented persons living at home. Scand J Prim Health Care 1992; 10:53-9

Boaz RF, Muller CF. Predicting the risk of "permanent" nursing home residence: the role of community help as indicated by family helpers and prior living- arrangements. Health Serv Res 1994; 29:391-414

Borda RG, Norman IJ. Factors influencing turnover and absence of nurses: a research overview. Int J Nurs Stud 1997; 34:385-94

Boumans NPG. Het werk van verpleegkundigen in algemene ziekenhuizen. [The work of nurses in general hospitals]. [Thesis] Maastricht: Rijksuniversiteit Limburg, 1990

Bradley J, Sutherland V. Occupational stress in social services: a comparison of social work and home help staff. Br J Soc Work 1995; 25:313-31

Bram PJ, Katz LF. A study of burnout in nurses working in hospice and hospital oncology settings. Oncol Nurs Forum 1989; 16:555-60

de Bruin A, Ruiter EC, Kerkstra A. Integratie kruiswerk en gezinsverzorging: meningen en ervaringen van hulpverleners en cliënten. [Integration community nursing and home help services: opinions and experiences of care-givers and clients]. Utrecht: NIVEL, 1996

Buunk AP, de Wolff CJ. Sociaal psychologische aspecten van stress op het werk. [Social psychological aspects of occupational stress]. In: Drenth PJD, Thierry H, de Wolff CJ (eds). Nieuw handboek A&O psychologie. [New handbook labour & organizational psychology]. Deventer: Van Loghum Slaterus, 1988

BVG (Dutch Industrial Board for Human Services). BVG-Berichten 1994. [Dutch Industrial Board for Human Services Reports]. Zeist: BVG, 1994

BVG (Dutch Industrial Board for Human Services). BVG-Berichten 1995. [Dutch Industrial Board for Human Services Reports 1995]. Zeist: BVG, 1995

BVG (Dutch Industrial Board for Human Services). BVG-Jaarverslag 1995. [Dutch Industrial Board for Human Services Year Report]. Zeist: BVG, 1996

Calsbeek H, Hingstman L, Talma H, van der Windt W. Verpleging en verzorging in kaart gebracht 2000. [Nursing and caring charted 2000]. Maarssen: Elsevier Gezondheidszorg, 2000

Ceslowitz SB. Burnout and coping strategies among hospital staff nurses. J Adv Nurs 1989; 14:553-7

Commissie Verzorging (Caring Committee). Zorg voor Zorg. [Caring for Care]. Utrecht: LCVV, 1995

Dewe P, Cox T, Ferguson E. Individual strategies for coping with stress at work: a review. Work Stress 1993; 7:5-15

van Dierendonck D. Balancing give and take: an equity approach to burnout. [Thesis]. Utrecht: Rijksuniversiteit Utrecht, 1997

van Dierendonck D, Groenewegen PP, Sixma H. Opgebrand: een inventariserend onderzoek naar gevoelens van motivatie en demotivatie bij huisartsen. [Burnout: an investigating study on feelings of motivation and demotivation among general practitioners]. Utrecht: NIVEL, 1992

van Dierendonck D, Schaufeli WB. Burnout en organisatiebetrokkenheid bij leerlingverpleegkundigen: de rol van billijkheid, sociale steun en probleemhantering. [Burnout and organizational commitment among student-nurses: the role of equity, social support and problem-management]. TSG 1993; 71:339-44

van Dijk FJH, van Dormolen N, Kompier MAJ, Meijman TF. Herwaardering model belasting-belastbaarheid. [Revaluation of the workload/capacity model]. TSG 1990; 68:3-10

Dillard BG, Feather BL. The association between attitudes and job satisfaction: a study of in-home care aides. Educ Geront 1991; 17:209-18

Ditson LA. Efforts to reduce homemaker/home health aide turnover in a home care agency. J Health Care Prac 1994; 6:33-44

Dobbelaar T, Bosink J. Verzorgenden onder druk: ziekteverzuim in het verzorgingstehuis. [Caring staff under pressure: absenteeism in homes for the elderly]. Tijdschr Verzorgenden 1994; 9:293-6

Duijnstee M. De belasting van familieleden van dementerenden. [The workload of family members of people with dementia]. [Thesis]. Nijkerk: Intro, 1992

Duquette A, Sandhu BK, Beaudet L. Factors related to nursing burnout: a review of emperical knowledge. Issues Ment Health Nurs 1994; 15:337-55

Dutcher LA, Adams CE. Work environment perceptions of staff nurses and aides in home health agencies. J Nurs Adm 1994; 24:24-30

Dwyer DJ, Ganster DC. The effects of job demands and control on employee attendance and satisfaction. J Organ Behav 1991; 12:595-608

Elovainio M, Sinervo T. Psychosocial stressors at work, psychological stress and musculoskeletal symptoms in the care for the elderly. Work Stress 1997; 11:351-61

Engelen CHMG. Arbeidsomstandigheden in de zorgsector. [Working conditions in the health care sector]. Tijdschr Verzorgenden 1993; 7:198-204

Eskelinen L, Toikkanen J, Tuomi K, Mauno I, Nygard C-H, Ilmarinen J. Symptoms of mental and physical stress in different categories of municipal work. Scand J Work Environ Health 1990; 17(suppl 1):82-6

Eustis NN, Fischer LR. Relationship between home care clients and their workers: implications for quality of care. Gerontologist 1991; 31:447-56

Familiehulp. [Family help]. Yearly report family help. Brussel: Familiehulp, 1991

Fisher B, Tronto J. Towards a feminist theory of caring. In: Abel E, Nelson M (eds). Circles of care: work and identity in women's lives. Albany: State University of New York Press, 1990

Fletcher BC, Jones F. A refutation of Karasek's demand-discretion model of occupational stress with a range of dependent measures. J Organ Behav 1993; 14:319-30

Friele R, Beemster F. Positie helpende belangrijker dan deugdelijk huishoudmateriaal. [Position of home help is more important than adequate household material]. Thuiszorg 1994; 2:4-7

Garden AM. Depersonalisation: a valid dimension of burnout? Hum Relat 1987; 40:545-60

Gellatly IR. Individual and group determinants of employee absenteeism: test of a causal model. J Org Behav 1995; 16:469-85

Gilbreth FB. Brick laying system. New York: Clark, 1911

Graham H. Caring: a labour of love. In: Finch J, Groves D (eds). A labour of love. London: Routledge & Kegan Paul, 1983

Gray-Toft P, Anderson J. Sources of stress in nursing terminal patients in a hospice. OMEGA: J Death Dying 1986 17:27-39

Greenglass R, Burke RJ, Konarski R. A study of the consistency of burnout over time. J Health Hum Serv Adm 1999; 21:429-40

Gremmen I. Ethiek in de gezinsverzorging: gender en de macht van zorg. [Ethics in home help services: gender and the power of care]. [Thesis]. Utrecht: Jan van Arkel, 1995

Groenewegen PP, Kerkstra A, Jansen G. Wachtlijsten in de thuiszorg. [Waiting lists in home care]. Utrecht: NIVEL, 1993

de Groot AD. Methodologie: grondslagen van onderzoek en denken in de gedragswetenschappen. [Methodology: foundations of research and thinking behavioural sciences]. 's Gravenhage: Mouton & Co, 1961

de Groot MJW. Veranderingen in verzuimfrequentie in het algemeen en door neurosen in het bijzonder. [Changes in absenteeism frequency in general and due to neuroses in specific]. In: de Groot MJW (ed). Kwalitatieve benadering van het verzuim door neurosen bij Nederlandse fabrieksarbeiders. [Qualitative approach of absenteeism due to neuroses among Dutch factory workers]. Leiden: NIPG-TNO, 1958

Grosfeld JAM. De voorspelbaarheid van individueel ziekteverzuim. [The predictability of individual absenteeism]. [Thesis]. Nijmegen: Katholieke Universiteit Nijmegen, 1988

Hackman JR, Oldham GR. The Job Diagnostic Survey. New Haven: Yale University, 1974

Hackman JR, Oldham GR. Development of the Job Diagnostic Survey. J Appl Psychol 1975; 60: 9-170

Hackman JR, Oldham GR. Motivation through design of work: test of a theory. Organ Behav Hum Perfor 1976; 16:250-79

Hackman JR, Oldham GR. Work redesign. Reading: Addison-Wesley, 1980

Haemmerlie FM, Montgomery RM. Role conflict in a homemaker aide program for frail elderly. Psychol Rep 1982; 51:63-9

Hanchett ES. Community assessment and intervention according to Orem's theory of self-care deficit. In: Hanchett ES (ed). Nursing frameworks and community as client: bridging the gap. Norwalk: Appleton & Lange, 1988

Hanchett ES. Nursing models and community as client. Nurs Sci Q 1990; 3:67-72

Hartweg DL. Dorothea Orem: Self-care Deficit Theory. In: McQuiston CM, Webb AA (eds). Foundations of nursing theory: contributions of 12 key theorists. Thousand Oaks, Sage, 1995

van de Haterd J, Liefhebber S, Leistra E, Hens H. Beroepsprofiel van helpenden en verzorgenden. [Job profile for home help and caring staff]. Maarssen: Elsevier gezondheidszorg, 2000

Hattinga Verschure JCM. Algemene zorgkunde voor de zorgverlenende beroepen. [The general art of caring for caregiving professions]. Lochem: De Tijdstroom, 1981

Hayashi R, Gibson JW, Weatherley RA. Working conditions in home care: a survey of Washington State's home care workers. Home Health Care Serv Q 1994; 14:37-48

Heaney CA, Clemans J. Occupational stress, physician-excused absences, and absence not excused by a physician. Am J Health Promot 1995; 10:117-24

Hedin AM. From different starting points...: a longitudinal study of work and health among home care workers. Eur J Public Health 1997; 7:272-8

van den Herik C, de Been M, Vulto M. 'Alles draait om de cliënt': de inhoud, het eigene en de kwaliteit van de arbeid van het uitvoerende werk in de gezinszorg. ['Everything revolves around the client': the content, characteristics and quality of work in home help services']. Leiden: Rijksuniversiteit Leiden, Faculteit Sociale Wetenschappen, Vakgroep Vrouwenstudies, 1995

van den Heuvel W, Gerritsen H. Home care services in the Netherlands. In: Jamieson A (ed). Home care for older people in Europe: a comparison of policies and practices. Oxford: Oxford University Press, 1991

Hingstman L, Peters P, van der Windt W, Harmsen J, Allaart PC, de Voogd-Hamelink AM. Rapportage Arbeidsmarkt zorg en welzijn 2000. [Report on labour market of care and well-being 2000]. Tilburg: OSA, 2000

Hollander Feldman P. Work life improvements for home care workers: impact and feasibility. Gerontologist 1993; 33: 47-54

Holstein BE, Due P, Almind G, Holst E. The home help services in Danmark. In: Jamieson, A (ed). Home care for older people in Europe: a comparison of policies and practices. Oxford: Oxford University Press, 1991

Hood JN, Smith HL. Quality of work life in home care. J Nurs Adm 1994; 24:40-7

Homman M. Terwijl je afstoft kom je heel wat tegen: professionele huishoudelijke zorg: een onmisbare pijler onder een verantwoorde thuiszorg. [You come across a lot while dusting: professional household care: an indispensable pillar for justified home care]. Utrecht: STING, 1994

van Houten M, Spaander G. Beroep: huisvrouw: een inventariserende studie van het dagelijks werk van huisvrouwen, hun beleving ervan en hun behoefte aan verandering. [Occupation: housewife: an inventory study about the daily work, their experiences and their need for change]. Wageningen: Uitbuyt, 1980

Houtman ILD, Kompier MAJ, Smulders PGW, Bongers PM. Werkstress-risico's en gezondheid. [Work stress risks and health]. TSG 1994; 72:198-203

Howe A, Ozanne E, Selby Smith, C (eds). Community care policy and practice: new directions in Australia. Victoria: Clayton, 1990

Hutten JBF, Kerkstra A. Home care in Europe. Aldershot: Arena, 1996

IDW (Institut der Deutschen Wirtschaft). Sozialraum Europa. Köln: IDW, 1989

Iverson RD, Olekalns M, Ervin PJ. Affectivity, organizational stressors and absenteeism. J Vocat Behav 1998; 52:1-23

Jamieson A (ed). Home care for older people in Europe: policies and practices. Oxford: Oxford University Press, 1991

Jansen PGM, Kerkstra A. Functiedifferentiatie binnen de thuiszorg: de functies van *wijkverpleegkundige, wijkverpleegster en gezinsverzorgende* nader omschreven. [Differentiated practice in home care: the jobs of community nurse, community nurse auxiliary, and home help more precisely described]. Utrecht: NIVEL, 1993

Jansen PGM, Kerkstra A, Huijer Abu-Saad H, van der Zee J. The effects of job characteristics and individual characteristics on job satisfaction and burnout in community nursing. Int J Nurs Stud 1996; 33:407-21

Jennings BM. Stress, locus of control, social support, and psychological symptoms among head nurses. Res Nurs Health 1990; 13:393-401

Johansson JA. Psychosocial factors, physical load and symptoms from the neck, shoulders and back among home care workers. In: Hagberg M, Hofmann F, Strössel U, Westlander G (eds). Occupational health for health care workers. Landsberg: Ecomed, 1993

de Jonge J. Job autonomy, well-being, and health. [Thesis]. Maastricht: Rijksuniversiteit Limburg, 1996

de Jonge J, Boumans N, Landeweerd A, Nijhuis F. Werkkenmerken en werkbeleving. [Job characteristics and psychological outcomes]. TVZ 1995; 105:186-9

de Jonge J, Janssen PPM, van Breukelen GJP. Testing the Demand-Control -Support Model among health-care professionals: a structural equation model. Work Stress 1996; 10:209-24

de Jonge J, Landeweerd A. Werkdruk en autonomie. [Quality of working life and autonomy]. TVZ 1992; 12:465-8

de Jonge J , Landeweerd A. Toetsing van de Job Demand-Control benadering bij werknemers in de gezondheidszorg. [Testing the Job Demand-Control approach among employees in health care]. Gedrag en Organisatie 1993; 21:79-92

Kahn RL, Wolfe DM, Quinn RP, Snoek JD, Rosenthal RA. Organizational stress: studies in role conflict and ambiguity. New York: John Wiley, 1964

Kandolin I. Burnout of female and male nurses in shiftwork. Ergonomics 1993; 36:141-7

Karasek RA. Job demands, job decision latitude, and mental strain: implications for job redesign. Adm Sci Q 1979; 24:285-308

Karasek RA, Theorell T. Healthy work: stress, productivity and the reconstruction of working life. New York: Basic Books, 1990

Karasek RA, Triantis KP, Chaudhry SS. Co-worker and supervisor support as moderators of associations between task characteristics and mental strain. J Occup Behav 1982; 3:181-200

Katzell R, Bienstock P, Faerstein P. A guide to worker productivity experiments in the United States 1971-1975. New York: New York University Press, 1977

Kempen GIJM. Thuiszorg voor ouderen. [Home care for the elderly]. Groningen: STYX Publications, 1990

Kerkstra A, de Wit AMGJ. Het werk van wijkverpleegkundigen en wijkziekenverzorgenden: Instrumentontwikkeling. [The work of community nurses and auxiliary community nurses: instrument development]. Utrecht: NIVEL, 1987

Kivimäki M, Vahtera J, Thomson L, Griffiths A, Cox T. Psychosocial factors predicting employee sickness absence during economic decline. J Appl Psychol 1997; 82:858-72

Knibbe JJ, Kersten JWET, Friele RD. Rotterdam in de lift: een onderzoek naar de effecten van de introductie van patiëntenliften in de thuiszorg. [Rotterdam elevated: a study about the effects of the introduction of patient-lifts in home care]. Utrecht: NIVEL, 1994

Koes B, van de Mheen D. Werkomstandigheden en ziekteverzuim in de gezinsverzorging. [Working conditions and absenteeism due to illness in home help services]. TSG 1987; 65:755

Koeske GF, Koeske RD. Construct validity of the Maslach Burnout Inventory: a critical review and reconceptualization. J Appl Behav Sci 1989; 25:131-44

Koningsveld H. Het verschijnsel wetenschap: een inleiding tot de wetenschapsfilosofie. [The science phenomenon: an introduction into the philosophy of science]. Meppel/Amsterdam: Boom, 1976

Kuremyr D, Kihlgren M, Norberg A, Åström S, Karlsson I. Emotional experiences, empathy and burnout among staff caring for demented patients at a collective living unit and a nursing home. J Adv Nurs 1994; 19:670-9

Lammers CJ. Uiterlijke samenhang en bindingskracht van de organisatie. [External coherence and the adherence-control of the organization]. [Inaugural Lecture]. Assen: van Gorcum, 1964

Landsbergis PA. Occupational stress among health care workers: a test of the job demands-control model. J Org Behav 1988; 9:217-39

de Lange HJ, Spaan JM. Jaarboek Thuiszorg 1993. [Yearbook Home Care 1993] Bunnik/Utrecht: LVT/NZi, 1994

Larocque D. Absenteeism. Can Nurs 1996; 92:42-6

Lazarus RS, Folkman S. Stress, appraisal and coping. New York: Springer, 1984

Lee RT, Ashorth BE. A meta-analytic examination of the correlates of the three dimensions of job burnout. J Appl Psychol 1996; 81:123-33

Leigh JP. Employee and job attributes as predictors of absenteeism in a national sample of workers: the importance of health and dangerous working conditions. Soc Sci Med 1991; 33:127-37

van Lieshout P. Zorgen en laten zorgen. [Caring and letting care]. [Inaugural Lecture]. Utrecht: Rijksuniversiteit Utrecht, 1994

Lindgren CL. Burnout and social support in family caregivers. West J Nurs Res 1990; 12:469-87

Lindström K. Work organization and well-being of Finnish health care personnel. Scand J Work Environ Health 1992; 18 (suppl. 2):90-3

Lindström K. Psychosocial criteria for good work organization. Scand J Work Environ Health 1994; 20:123-33

Lobban RK, Husted J, Farewell VT. A comparison of the effect of job demand decision latitude, role and supervisory style, on self-reported job satisfaction. Work Stress 1998; 12:337-50

LVT (Landelijke Vereniging voor Thuiszorg-National Association for Home Care). Zorg thuis. [Care at home]. Bunnik: LVT, 2000

Maessen PJJ. Bezuinigingen op de gezinsverzorging. [Budget cuts in home help services]. [Thesis]. Leiden: Rijksuniversiteit Leiden, 1989

March JG, Simon HA. Organizations. New York: Wiley, 1958

Maslach C. Burnout. Hum Behav 1976; 5:16-22

Maslach C. Burnout: a social psychological analysis. In: Jones, JW (ed). The Burnout Syndrome. Park Ridge: London House, 1982a

Maslach C. Burnout: the cost of caring. Englewood Cliffs: Prentice Hall, 1982b

Maslach C. Burnout: a multidimensional perspective. In: Schaufeli WB, Maslach C, Marek T (eds). Professional burnout: recent developments in theory and research. Washington: Taylor & Francis, 1993

Maslach C, Jackson SE. MBI: Maslach Burnout Inventory: manual research edition. Palo Alto: University of California, Consulting Psychologists Press, 1986

Matrunola P. Is there a relationship between job satisfaction and absenteeism? J Adv Nurs 1996; 23:827-34

McNeese-Smith D. Job satisfaction, productivity, and organizational commitment. J Nurs Adm 1995; 25:17-26

Meijman TF, O'Hanlon JF. Arbeidsbelasting, een inleidend overzicht van psychologische theorieën en meetmethoden. [Pressure of labour: an introductory overview of psychological theories and measure-methods]. In: Drenth PJD, Thierry H, de Wolff CJ (eds). Handboek Arbeids- en Organisatiepsychologie. [Handbook of Work and Organizational Psychology]. Deventer: Loghum Slaterus, 1984

Melchior MEW. Burnout & work in long-stay psychiatric nursing. [Thesis]. Maastricht: Universiteit Maastricht, 1996

Miller JB. Toward a new psychology of women. Boston: Beacon press, 1976

Mok AL. Dienen als beroep. [Serving as an occupation]. [Thesis]. Leiden: Stenfert Kroese, 1962

Mulder JGP, de Jonge J, Nijhuis FJN. Effecten van werkkenmerken op de gezondheid. [Effects of work characteristics on health]. TSG 1997; 5:235-43.

Munley A. The hospice alternative. New York: Basic Books, 1983

Myers A, Jensen RC, Nestor D, Rattiner J. Low back injuries among home health aides compared with hospital nursing aides. Home Health Care Serv Q 1993; 14:149-55

National Council for the Elderly. Home help services for elderly people in Ireland. Dublin: National Council for the Elderly, 1994

Nijhuis F. Beoordelingen van organisatiekenmerken: een sociaal gezondheidkundige studie naar organisatiekenmerken en ziekteverzuim. [Assessments of organizational characteristics: a socio-medical study on organizational characteristics and absenteelsm]. [Thesis]. Maastricht: Rijksuniversiteit Limburg, 1984

Nijhuis FJN, Smulders PGW. Die Wirkung von Arbeitsanforderungen und persönliche Kontrollmöglichkeiten auf Gesundheitsbeschwerden und Fehlzeiten. Zeitschrift für Arbeits- und Organizationspsychologie 1996; 40:173-80

Nijkamp P, Pacolet J, Spinnewyn H, Vollering A, Wilderom C, Winters S. Services for the elderly in Europe: a cross-national comperative study. Leuven/Amsterdam: HIV/VU, 1991

Norbeck JS. Perceived job stress, job satisfaction, and psychological symptoms in critical care nursing. Res Nurs Health 1985; 8:253-9

Nordhus IH, Fleime AM. Job stress in two different care-giving contexts: a study of professional and semi-professional health personnel in Norway. Work Stress 1991; 5:229-40

Norusis MJ, SPSS. SPSS/PC+ tm Base System User's Guide, version 5.0. Chicago: SPSS, 1992

OECD (Organization for Economic Co-operation and Development). Ageing populations: the social policy implications. Paris: OECD, 1990

OECD (Organization for Economic Co-operation and Development). Caring for the frail elderly, policies in evolution. Paris: OECD, 1996

Olkinuora MA, Asp S, Juntunen J, Kauttu K, Strid L, Äärimaa M. Stress symptoms, burnout and suicidal thoughts of Finnish physicians. Scand J Work Environ Health 1992; 18 (suppl. 2): 110-2

Ono Y, Lagerström M, Hagberg M, Linden A, Malker B. Occupational musculoskeletal injuries among home care service workers in Sweden. In: Hagberg M, Hofmann F, Stössel U, Westlander G (eds). Occupational Health for Health Care Workers. Landsberg: Ecomed, 1995

Orem DE. Analysis and application of Orem's theory. In: Clements IW, Roberts FB (eds). Family health: a theoretical approach to nursing care. New York: John Wiley, 1983a

Orem DE. The family coping with a medical illness: analysis and application of Orem's theory. In: Clements IW, Roberts FB (eds). Family health: a theoretical approach to nursing care. New York: John Wiley, 1983b

Orem DE. Orem's conceptual model and community health nursing. In: Asay MK, Ossler CC (eds). Conceptual models of nursing: applications in community health nursing. Proceedings of the Eight Annual Community Health Nursing Conference. Chapel Hill: University of North Carolina, School of Public Health, Department of Public Health Nursing, 1984

Orem DE. Nursing: concepts of practice (3rd edition). New York: McGraw-Hill, 1985

Orem DE. Orem's general theory of nursing. In: Parse RR (ed). Nursing science: major paradigms, theories and critiques. Philadelphia: W.B. Saunders Company, 1987

Orem DE. Nursing: concepts of practice (4th edition). St. Louis: Mosby, 1991

Pearlin LI. Social process and social supports. In: Cohen S, Syme L (eds). Social Support and Health. New York: Academic Press, 1985

Philipsen H. Afwezigheid wegens ziekte. [Absenteeism due to illness]. [Thesis]. Groningen: Wolters-Noordhoff, 1969

Polit DF, Hungler BP. Nursing research: principles and methods. Philadelphia: J.B. Lippincott Company, 1987

Prins R. Sickness absence in Belgium, Germany (FR) and the Netherlands: a comparative study. [Thesis] Maastricht: Rijksuniversiteit Limburg, 1990

Przygodda M, Arentz K-P, Quast H-H, Kleinbeck U. Vorgesetztenverhalten und Fehlzeiten in Organizationen: eine Studie mit Rettungssanitätern im kommunalen Rettungsdienst. Zeitschrift für Arbeits- und Organizationspsychologie 1991; 35:179-86

Rentsch JR, Steel RP. Testing the durability of job characteristics as predictors of absenteeism over a 6-year period. Pers Psych 1998; 51:165-90

Riordan RJ, Saltzer SK. Burnout prevention among health care providers working with the terminally ill: a literature review. OMEGA: J Death Dying 1992; 25:17-24

Roelens A. Burnout in de verpleging. [Burnout in nursing care]. Acta Hosp 1986; 2:17-26

Rose H. Hand, brain and heart: a feminist epistemology of the natural sciences. J Women Cult oc 1983; 9:73-90

Schaufeli WB. Opgebrand: over de achtergronden van werkstress bij contactuele beroepen -het burnout-syndroom. [Burnout: about the jobstress in the human services professions -the burnout-syndrome]. Rotterdam: Ad Donker, 1990a

Schaufeli WB. Burnout: een overzicht van empirisch onderzoek. [Burnout: an overview of emperical research]. Gedrag & Gezondheid 1990b; 3:3-31

Schaufeli WB, van Dierendonck D. Burnout, een begrip gemeten: de Nederlandse versie van Maslach Burnout inventory (MBI-NL). [Burnout, a concept measured: the Dutch version of the Maslach Burnout Inventory (MBI-NL). Gedrag & Gezondheid 1994; 22:153-71

Schaufeli W, Enzmann D. The burnout companion to study & practice: a critical analysis. London: Taylor & Francis, 1998

Schaufeli WB, Enzmann D, Girault N. Measurement of burnout: a review. In: Schaufeli WB, Maslach C, Marek T (eds). Professional burnout: recent developments in theory and research. Washington: Taylor & Francis, 1993

Scheurs PJG, van den Willige G, Tellegen B, Brosschot JF. De Utrechtse Coping Lijst: UCL-handleiding. [The Utrecht Coping List: UCL-Manual]. Lisse: Swets & Zeitlinger, 1988

Shelledy DC, Mikles SP, May DF, Youtsey JW. Analysis of job satisfaction, burnout, and intent of respiratory care practitioners to leave the field or the job. Respir Care 1992; 37:46-60

Shirom A. Burnout in work organizations. In: Cooper CL, Robertson I (eds). International review of industrial and organizational psychology. New York: Wiley, 1989

Simonen L. Caring by the welfare state and women behind it-contradictions and theoretical considerations. Tampere: University of Tampere, Research Instititute for Social Sciences, 1990

Sluijs EM. Patiëntenvoorlichting door fysiotherapeuten: ontwikkeling van het observatie-protocol. [Patienteducation by physical therapists: development of the observation-protocol]. Utrecht: NIVEL, 1988

Smith HL, Hood JN, Piland NF. Leadership and quality of working life in home health care. Home Health Care Serv Q 1994; 14:3-22

Smulders PGW. Bedrijfskenmerken en ziekteverzuim in de jaren zestig en tachtig: een vergelijkende studie. [Company characteristics and absenteeism in the sixties and eighties: a comparative study]. [Thesis] Den Haag: NIPG/TNO, 1984

Smulders PGW. De arbeidssituatie van twaalf beroepsgroepen in de intramurale gezondheidszorg. [The job situation of twelve professions in the intramural health care]. TSG 1990; 68:247-55

Smulders PGW, Nijhuis FJN. The Job Demand-Job Control Model and absence behaviour: results of a 3-year longitudinal study. Work Stress 1999; 13:115-31

Smulders PGW, Veerman TJ. Handboek ziekteverzuim. [Handbook absenteeism due to illness]. Den Haag: Delwel, 1990

Song R, Daly BJ, Rudy EB, Douglas S, Dyer MA. Nurses' job satisfaction, absenteeism and turnover after implementing a special care unit. Res Nurs Health 1997; 20:442-52

Spaans M. Opgebrand in zorg en verpleging. [Burnout in caring and nursing]. Tijdschr Gezondh Polit 1995; 2:5-7

Spector PE, Jex SM. Relations of job characteristics from multiple data sources with employee affect, absence, turnover intentions, and health. J Appl Psychol 1991; 76:46-53

Stichting Centrale Raad voor Gezinsverzorging. [Central Board for Home help services Foundation]. Handboek gezinsverzorging (Handbook home help services). Amsterdam: Vuga, 1989/1990

Stichting Thuiszorg Hilversum, 's Graveland & Loosdrecht. [Home care Foundation Hilversum, 's Graveland & Loosdrecht]. Functie schema uitvoerenden. [Job scheme for home helps]. Hilversum: Organisatie voor Gezinsverzorging, 1992

STRATEGO. Aan de slag. [Get busy]. Beverwijk: Stichting Thuishulp IJmond, 1991

Ström P. Reactivity and pro-activity. Staff attitudes in changing the organization of the Swedish home help service. In: Hagberg M, Hofmann F, Stössel U, Westlander G (eds). Occupational Health for Health Care Workers. Landsberg: Ecomed, 1995

Svensson JS, Dirks JEM. Indicatiestelling en autonomie: een nieuwe aanpak. [Assessment-procedure and autonomy: a new approach]. Hengelo/Wageningen: Thuiszorg Centraal Twente / Universiteit Twente, 1996

Tadych R. Nursing in multiperson units: the family. In: Riehl-Sisca J (ed). The science of art and self-care. Norwalk: Appleton-Century-Crofts, 1985

Taylor FW. The principles of scientific management. New York: Harper, 1911

Taylor SG. An interpretation of family within Orem's theory in practice. Nurs Sci Q 1989; 23:131-6

van Tits M, Groot W. Zorgen om kruiswerk en verzorging. [Caring for community nursing and home help services]. TVZ 1991; 101:56-9

van Tits M, Vermeulen H. Ontwikkelingen op de arbeidsmarkt. [Developments on the labour market]. TVZ 1992; 102 :104-7

Tompkins CJ. The effects of stress, role ambiguity, and social support on burnout among home health aids caring for the frail elderly: toward the prevention of maltreatment. [Thesis]. Baltimore: University of Maryland, 1995

Trent CH. Effects of patterns of supervision on home care worker performance. New York: Fordham University, 1986

Tummers GER, Landeweerd JA, van Merode GG. Organisatieaspecten, ervaren werkkenmerken en werkreacties in de verpleging. [Organizational characteristics, job characteristics and outcomes of working in nursing occupations]. Verpleegkunde 2000; 15:132-41

Tuomi K, Ilmarinen J, Eskelinen L, Järvinen E, Toikkanen J, Klockars M. Prevalence and incidence rates of diseases and work ability in different work categories of municipal occupations. Scand J Work Environ Health 1991; 17(suppl 1):67-74

Turner RJ. Direct, indirect and moderating effects of social support on psychological distress and associated conditions. In: Kaplan HB (ed). Psychological stress. New York: Academic Press, 1983

Ulleberg P, Rundmo T. Job stress, social support, job satisfaction and absenteeism among offshore oil personnel. Work Stress 1997; 11:215-28

Ungerson C. The language of care: crossing the boundaries. In: Ungerson C (ed). Gender and caring: work and welfare in Britain and Scandinavia. Hertfordshire: Harvester Wheatsheaf, 1990

Vachon M. Myths and realities in palliative/hospice care. Hosp J 1986; 2:63-79

Veerman TJ. Ziekteverzuim in de gezinsverzorging. [Absenteeism due to illness in home help services]. Amsterdam/Leiden: NIA, 1989

van Veldhoven M, Meijman T. Het meten van psychosociale arbeidsbelasting. [Measurement of psychosocial workload]. Amsterdam: NIA, 1994

Verheij RA, Caris-Verhallen WMCM, Kerkstra A. Integratie kruiswerk en gezinsverzorging, ervaringen van hulpverleners en cliënten. [Integration community nursing and home help services, experiences of professionals and clients]. Utrecht: NIVEL, 1993

VOG-sectie AMW. [VOG-section Social Work]. Het algemeen maatschappelijk werk in beeld 1995. [An overview of social work 1995]. Utrecht: SWP, 1997

de Vos EL. Aspecten van de huishouding. [An approach of household activities]. In: Goossens RC, de Vos EL (eds). Huishoudvoering met een laag inkomen. [Housekeeping with a low income]. Wageningen: Landbouwuniversiteit, Vakgroep Huishoudkunde, 1987

de Vries T, Hoogstraten J. Burnout bij fysiotherapeuten: een psychometrische studie. [Burnout among physical therapists: a psychometric study]. Gedrag & Gezondheid 1998; 26:177-84

Vroege C. Verkenningen rond het concept belasting-belastbaarheid. [Investigating the concept of workload/capacity]. TSG 1982; 60 793-8

Vulto M, Morée M, van den Herik C. 'Thuis bij de cliënt sta je er alleen voor': kenmerken en eisen van het beroep helpende en verzorgende in de gezinsverzorging. ['You are on your own at the client's home': characteristics and demands of the home help and home care occupation]. Leiden: Rijksuniversiteit Leiden, Faculteit Sociale Wetenschappen, Vakgroep Vrouwenstudies, 1994

Walker A. Home care in Europe: current trends and future prospects. Brussels: European Association of Organisations for Home Care and Help at Home, 1991

Warr PB. Decision latitude, job demands and employee well-being. Work Stress 1990; 4:285-94

Wærness K. Caring as women's work in the welfare state. In: Holter H (ed). Patriarchy in a welfare society. Oslo: Universitetsforlaget, 1984

Welschen PTM, Griffioen HP, Manders PJC, Niebuhr TM. Eindrapportage functiewaarderingsonderzoek gezinsverzorging. [Final report of job evaluation study home help services]. Bunnik: LVT, 1990

Willer D. Scientific sociology: theory and method. Englewood Cliffs: Prentice-Hall, 1967

van der Windt W, Calsbeek H, Hingstman L. Verpleging en verzorging in kaart gebracht. [An overview of nursing and caring]. Utrecht: De Tijdstroom/LCVV, 1997

van der Windt W, Calsbeek H, Hingstman L. Feiten over verpleging en verzorging in Nederland 1998. [Facts about nursing and caring in the Netherlands 1998]. Maarssen/ Utrecht: Elsevier/De Tijdstroom/ LCVV, 1998

Working Group (Werkgroep Werkveld) SOGW. Beroepsprofiel Verzorgende/Helpende. [Job profile home help and caring staff]. Leiden: Spruyt, van Mantgem & de Does BV, 1992

WVC (Ministry of Well-Being, Health & Culture). Heroverwegingsonderzoek 'Van Samenwerken naar Samengaan': gezinsverzorging en kruiswerk naar een geïntegreerd aanbod in de thuiszorg. [Reconsideration-study 'From Working Together to Going Together': home help services and community nursing to an integrated supply in home care]. Rapport van de heroverwegings-werkgroep doelmatigheidsonderzoek organisatiestructuur gezinsverzorging en kruiswerk. Rijswijk: WVC, 1990

Yancik R. Sources of work stress for hospice staff. J Psychosoc Oncol 1984; 2:21-31

Ylipää V, Arnetz BB, Preber H, Benkö SS. Determinants of work satisfaction among Swedish dental hygienists. Scand J Caring Sci 1996; 10:247-53

Yousef DA. Antecedents and consequences of job stressors: a study in a third world setting. Int J Stress Manage 1999; 6:265-82

Zuidberg ACL. Het verzorgingsniveau van huishoudens. [The level of domestic care of households]. 's-Gravenhage: SWOKA, 1978a

Zuidberg ACL. Inleiding tot de huishoudkunde [Introduction in home economics]. In: Zuidberg ACL (ed). Huishoudkunde in Nederland. [Home economics in the Netherlands]. Wageningen: Landbouw Hogeschool Wageningen, 1978b

Samenvatting
(Summary in Dutch)

Het proefschrift is gebaseerd op een onderzoek dat uitgevoerd is binnen de gezinsverzorging in Nederland. Het doel van het onderzoek is tweeledig. Ten eerste het in kaart brengen van de zorgverlening door de verschillende thuiszorgmedewerkers in de dagelijkse praktijk en ten tweede inzicht krijgen in de kwaliteit van arbeid, zoals ervaren door de thuiszorgmedewerkers.
Aanleiding voor het onderzoek is de vele veranderingen en ontwikkelingen die zich in de Nederlandse gezondheidszorg de afgelopen jaren hebben voorgedaan, en de gevolgen daarvan voor de thuiszorg in de zin van wachtlijsten, personeelstekort, het hoge ziekteverzuim in de sector en de hoge werkbelasting van thuiszorgmedewerkers.

In de overview, het eerste hoofdstuk van dit proefschrift, wordt de achtergrond van het onderzoek geschetst. Tevens worden in dit hoofdstuk de gebruikte onderzoeksmethoden, de belangrijkste resultaten en de conclusies aan de hand van de onderzoeksvragen beschreven.

In het proefschrift staan de volgende onderzoeksvragen centraal:

- onderzoeksvragen betreffende de inhoud van het werk:

1. Waaruit bestaat de dagelijkse praktijk van uitvoerenden in de gezinsverzorging?
2. In welke mate komen de formele functieomschrijvingen en taakprofielen van uitvoerenden in de gezinsverzorging in Nederland overeen met de dagelijkse praktijk van de gezinsverzorging?

- onderzoeksvragen betreffende de kwaliteit van arbeid:

3. Wat zijn de verschillen tussen de zes categorieën uitvoerenden in de gezinsverzorging met betrekking tot werklast, werkdrukkenmerken en verwerkingsvermogen?
4. In welke mate zijn aspecten van werklast en verwerkingsvermogen gerelateerd aan de psychologische en fysieke werkdrukkenmerken?

In aansluiting daarop worden de gevonden bevindingen bediscussieerd. Vervolgens wordt een reflectie gegeven op de gebruikte onderzoeksmethoden en het gebruikte onderzoeksmodel. Wat betreft het onderzoeksmodel wordt geconcludeerd dat het geschikt is om de psychologische werkdrukkenmerken arbeidstevredenheid en burnout te verklaren. Aan de andere kant blijkt het niet mogelijk om met behulp van het model het fysieke werkdrukkenmerk, ziekteverzuim, te verklaren.

Tot slot worden aanbevelingen geformuleerd voor de praktijk en voor toekomstig onderzoek.

De belangrijkste aanbevelingen voor de praktijk zijn:

- In het beroep van thuiszorgmedewerker dient een nieuwe differentiatie tussen de functies plaats te vinden. Deze differentiatie dient niet alleen op basis van taken te geschieden, maar tevens dient rekening gehouden te worden met de complexiteit van het cliëntsysteem. Een suggestie is te komen tot vier categoriëen uitvoerenden.
- De thuiszorgmedewerkers dienen de mogelijkheid te hebben om bij- en nascholing te volgen, die geschikt is voor en afgestemd op de diverse functieniveaus en werkzaamheden. De thuiszorgorganisaties dienen er zorg voor te dragen dat deze mogelijkheid geboden wordt.
- De thuiszorgorganisaties dienen er zorg voor te dragen dat er een goed beleid is ten aanzien van de arbeidsomstandigheden.

Toekomstig onderzoek zou zich vooral op de volgende onderwerpen moeten richten:

- Het verklaren van ziekteverzuim, op een andere manier dan in dit onderzoek gedaan is. Bijvoorbeeld door gebruik te maken van verzuimcijfers zoals ze bekend zijn bij de afdeling Personeelszaken/P&O of door een onderscheid te maken tussen kortdurend en langdurend verzuim. Een andere mogelijkheid is om verzuim als een organisatiekenmerk te onderzoeken in plaats van als een persoonskenmerk, wat in dit onderzoek gebeurd is.
- De werkinhoud en de ervaren werkdruk van twee categorieën uitvoerenden, namelijk de alphahelpenden en de gespecialiseerd verzorgenden E. Uit dit onderzoek bleek dat deze thuiszorgmedewerkers een bijzondere positie innemen in de thuizorgorganisaties. De alphahelpenden omdat zij niet in dienst van de instelling zijn; de cliënt is hun werkgever; en de gespecialiseerd verzorgenden E omdat zij werken in gezinnen met multi-complexe problematiek, wat zich uit in het uitvoeren van taken die onderling in strijd zijn, een hoge emotionele en mentale werkbelasting, en meer gevoelens van burnout (emotionele uitputting). Daarnaast ervaren de gespecialiseerd verzorgenden E, vergeleken met hun collega's, het meeste instrumentele leiderschap van hun leidinggevenden, wat gericht is op productie.

- Inzicht in de specifieke psychosociale en begeleidende activiteiten als één van de taken van uitvoerenden, het belang van deze activiteiten en de noodzaak voor scholing op dit gebied.
- De interveniërende rol van autonomie in het werk op de relatie tussen werkbelasting en tijdsdruk enerzijds en arbeidstevredenheid anderzijds.
- Het werken in de gezinsverzorging in een longitudinale opzet onderzoeken, om op deze manier inzicht te krijgen in de oorzaak en gevolg relaties tussen de verschillende werklast- en verwerkingsvermogen variabelen enerzijds en arbeidstevredenheid, burnout en verzuim anderzijds.

In hoofdstuk 2 wordt een overzicht gegeven van de literatuur op het gebied van 'zorgen als beroep' (professionele zorg). Hieruit kan een drietal concepten over 'zorg in de gezinsverzorging' worden gedestilleerd. Het eerste concept betreft de zorg vanuit een feministisch gezichtspunt (Graham, 1983; Wærness, 1984; Fisher et al., 1990; Simonen, 1990; Ungerson, 1990), het tweede handelt over de relatie tussen professionele en niet-professionele zorg en mantelzorg (Hattinga Verschure, 1981; Orem, 1983a, 1983b, 1985; Tadych, 1985; Hanchett, 1988; Taylor, 1989; Hancett, 1990; Kempen, 1990; Orem, 1991; Duijnstee, 1992; Hartweg, 1995), en het laatste concept betreft het functioneren van een huishouden (Zuidberg, 1978a; De Vos, 1987; STRATEGO, 1991). In dit hoofdstuk zijn deze concepten verder uitgewerkt en op basis hiervan en van reeds verricht onderzoek is een conceptueel model opgesteld om het proces van zorgverlening in de gezinsverzorging te beschrijven. Het model is als uitgangspunt gebruikt voor het formulier waarop uitvoerenden hun werkzaamheden registreerden die zij tijdens de huisbezoeken bij de cliënten verrichtten.

In het derde hoofdstuk wordt verslag gedaan van de instrumentontwikkeling voor het in kaart brengen van de dagelijkse praktijk in de gezinsverzorging. In een vooronderzoek is met name de betrouwbaarheid en de inhoudsvaliditeit van het registratieformulier onderzocht. Op dit formulier kunnen de activiteiten die door de uitvoerenden tijdens de huisbezoeken zijn verricht worden geregistreerd.
Vijfentwintig uitvoerenden hebben aan het vooronderzoek deelgenomen. Een waarnemer observeerde hen tijdens de huisbezoeken, gedurende een week. Zowel de uitvoerende als de waarnemer registreerden de verrichtte activiteiten op een registratieformulier, onafhankelijk van elkaar. Op basis van deze gegevens is de inter-beoordelaars-betrouwbaarheid van het registratieformulier vastgesteld. Het registratieformulier bleek, over het algemeen, een betrouwbaar instrument

en de validiteit ervan was voldoende. Verder is het een duidelijk formulier en gemakkelijk te gebruiken.

Vervolgens zijn in hoofdstuk 4 de bevindingen van het hoofdonderzoek naar de inhoud van het werk van uitvoerenden in de gezinsverzorging beschreven. Zes categorieën van uitvoerenden zijn onderzocht: alphahelpende, thuishulp A, verzorgingshulp B, verzorgende C, verzorgende D en gespecialiseerd verzorgende E. Gedurende een periode van 4 weken hebben 458 uitvoerenden (respons 97%) alle activiteiten die zij tijdens de huisbezoeken verrichtten, geregistreerd. Er zijn vier hoofdcategorieën in het werk van uitvoerenden in de gezinsverzorging te onderscheiden: huishoudelijke taken, verzorgende taken, psychosociale en begeleidende taken, en taken op het gebied van overleg en samenwerking (rapportage). Uit de registratie bleek dat alphahelpenden, thuishulpen A en verzorgingshulpen B voornamelijk huishoudelijke taken verrichten, maar ook gespecialiseerd verzorgenden E en verzorgenden D voerden enkele huishoudelijke taken uit. Zoals verwacht verrichtten verzorgenden D, en verzorgenden C en verzorgingshulpen B in mindere mate, veel verzorgenden taken. Vervolgens bleek uit de resultaten dat verzorgenden C hun tijd min of meer gelijk verdeelden tussen huishoudelijke, verzorgende en psychosociale taken. Tot slot kwam uit de registratie naar voren dat gespecialiseerd verzorgenden E voornamelijk psychosociale taken verrichtten. Op basis van deze gegevens over de dagelijkse praktijk zijn nieuwe taakprofielen voor de zes categorieën uitvoerenden opgesteld.
Vervolgens is onderzocht in hoeverre deze nieuwe taakprofielen overeen kwamen met de bestaande functieomschrijvingen en taakprofielen. Drie grote verschillen kwamen hieruit naar voren: 1) in de dagelijkse praktijk verrichten de vier lagere functieniveaus meer psychosociale taken dan in hun formele functieomschrijving staat, en verzorgenden D verrichten deze taken minder; 2) in de dagelijkse praktijk voeren de drie hogere functieniveau meer huishoudelijke taken dan ze zouden moeten op basis van de formele functieomschrijving; 3) in de dagelijkse praktijk rapporteren verzorgingshulpen B en verzorgenden C meer dan in hun formele taakomschrijving staat beschreven. Op basis van deze resultaten wordt een aantal conclusies getrokken. Ten eerste blijkt er in de dagelijkse praktijk een overlap te zijn tussen de elkaar opvolgende categorieën van uitvoerden (tussen thuishulp A en verzorgingshulp B, tussen verzorgende C en verzorgende D). Dit kwam tot uiting in de onduidelijke grenzen wat betreft het werk van deze uitvoerenden. Dit leidde er toe dat uitvoerenden soms taken moesten doen waar zij niet voor zijn gekwalificeerd. Tot slot blijkt uit de nieuwe taakprofielen dat

huishoudelijk en verzorgend werk nooit alleen wordt uitgevoerd, maar altijd in combinatie met in ieder geval psychosociale of begeleidende taken.

In hoofdstuk 5 wordt een tweede literatuuroverzicht gegeven, en wel over de kwaliteit van arbeid en werkdruk. Dit literatuuroverzicht leverde een drietal relevante modellen op. Het 'job characteristics model' van Hackman & Oldham (1974; 1975; 1976; 1980), het 'job demand control model' van Karasek (1979; Karasek et al., 1990), en het model belasting/belastbaarheid (Meijman et al., 1984; Veerman 1989; Smulders et al., 1990). De modellen worden verder in dit hoofdstuk toegelicht. Geen van de modellen bleek echter voldoende geschikt om de kwaliteit van arbeid in de gezinsverzorging te bepalen. Aspecten die voor de gezinsverzorging van belang bleken en in diverse modellen terugkwamen, zijn: organisatiekenmerken, taakkenmerken, arbeidsomstandigheden, sociale ondersteuning, copingstrategieën, arbeidstevredenheid, burnout en ziekteverzuim. Op basis van (delen van) de relevante onderzoeksmodellen en van reeds verricht onderzoek is gekomen tot een nieuw onderzoeksmodel om de kwaliteit van arbeid in de gezinsverzorging te bestuderen. Het model bestaat uit drie dimensies: werklast, psychologische en fysieke werkdrukkenmerken, en verwerkingsvermogen. Er wordt vanuit gegaan dat werklast leidt tot bepaalde psychologische en fysieke werkdrukkenmerken, welke beïnvloed worden door het verwerkingsvermogen van een persoon.

In hoofdstuk 6 worden de verschillen tussen de zes categorieën van uitvoerenden beschreven met betrekking tot de diverse aspecten en variabelen van het onderzoeksmodel: werklast (organisatiekenmerken, taakkenmerken, arbeidsomstandigheden), psychologische en fysieke werkdrukkenmerken (arbeidstevredenheid, burnout en ziekteverzuim) en verwerkingsvermogen (sociale ondersteuning, copingstrategieën). De resultaten van dit deel van het onderzoek zijn gebaseerd op een vragenlijst welke door 474 uitvoerenden is ingevuld. Werklast, met name organisatie- en taakkenmerken, wordt verschillend ervaren door de uitvoerenden. Vooral alphahelpenden en thuishulpen A ervaren minder binding met de organisatie en collega's, minder afwisseling, en minder feedback en leer- en groeimogelijkheden in hun werk. Ook de arbeidsomstandigheden verschillen tussen de uitvoerenden. De hogere functieniveaus ervaren meer stressvolle arbeidsomstandigheden zoals een hoge fysieke en emotionele werkbelasting en het werken onder tijdsdruk.
Er zijn ook verschillen tussen de uitvoerenden wat betreft de psychologische en fysieke gevolgen van werkdruk. Alphahelpenden zijn aanzienlijk minder tevreden

met diverse aspecten van het werk. Thuishulpen A zijn het meest tevreden met de duidelijkheid in hun werk, promotiemogelijkheden, contact met hun leidinggevenden en contact met hun cliënten. Verzorgende D ervaren de meeste werkvoldoening. Gespecialiseerd verzorgenden E zijn het meest tevreden met groei in hun werk, contact met collega's en hun werkprestatie. Wat betreft de algemene arbeidstevredenheid zijn de alphahelpenden aanzienlijk minder tevreden dan hun collega's in andere functieniveaus.
Twee dimensies van burnout zijn geanalyseerd: emotionele uitputting en persoonlijke bekwaamheid. De hogere categorieën van uitvoerenden (verzorgenden C, D en E) vertonen meer gevoelens van emotionele uitputting dan de overige functieniveaus. Gevoelens van persoonlijke bekwaamheid verschillen niet tussen de uitvoerenden. Ook gezondheid en ziekteverzuim verschillen niet significant tussen de uitvoerenden.
De afzonderlijke aspecten van het verwerkingsvermogen van uitvoerenden verschillen ook tussen de diverse functieniveaus. De traditionele uitvoerenden (thuiszorgmedewerker A t/m E) ervaren meer sociale ondersteuning van leidinggevenden en collega's. Daarnaast worden twee typen leiderschapstijlen onderscheiden: sociaal-emotioneel en instrumenteel leiderschap. Alle uitvoerenden, met uitzondering van de alphahelpenden, vinden dat hun leidinggevende in hoge mate een sociaal-emotionele leiderschapstijl hanteert (gericht op welzijn, comfort en arbeidsvoldoening). Daarentegen ervaren zij weinig instrumenteel leiderschap. Vergeleken met de andere functieniveaus ervaren de gespecialiseerd verzorgende E het meeste instrumentele leiderschap van hun leidinggevende (gericht op productie).
Er zijn drie manieren om met problemen en gebeurtenissen om te gaan (copingstrategieën): de actieve benadering, de passieve benadering en het zoeken van sociale steun. De gespecialiseerd verzorgenden E gaan aanzienlijk actiever met problemen om dan de andere functieniveaus. De verzorgenden C gebruiken deze copingstrategie meer dan de alphahelpenden, thuishulpen A en verzorgingshulpen B. De zes functieniveaus verschillen niet van elkaar wat betreft de passieve benadering van problemen. Het zoeken van sociale steun als copingstrategie wordt aanzienlijk minder gedaan door de thuishulpen A.

In hoofdstukken 7 en 8 wordt het onderzoeksmodel getoetst. Nagegaan wordt welke aspecten van werklast en verwerkingsvermogen van invloed zijn op burnout (hoofdstuk 7), arbeidstevredenheid en ziekteverzuim (hoofdstuk 8).

Uit hoofdstuk 7 blijkt dat gevoelens van burnout minder zijn als er sprake is van voldoende communicatie met de organisatie, een hoge mate van autonomie en voldoende leer- en groeimogelijkheden (organisatie- en taakkenmerken). Gevoelens van burnout nemen toe als er sprake is van stressvolle arbeidsomstandigheden: onduidelijkheid over werk (rolonduidelijkheid), hoge fysieke en emotionele werkbelasting en hoge tijdsdruk. Tot slot is een relatie gevonden tussen copingstrategieën en gevoelens van burnout. Een actieve probleembenadering vermindert de kans op burnout, een passieve probleembenadering lijkt daarentegen de kans op burnout te bevorderen.

Uit hoofdstuk 8 kan betreffende arbeidstevredenheid geconcludeerd worden dat vooral taakkenmerken en organisatiekenmerken, en in mindere mate arbeidsomstandigheden en sociale steun van invloed blijken te zijn op arbeidstevredenheid. Zo blijkt arbeidstevredenheid hoger te zijn als er sprake is van voldoende mogelijkheden voor contact met collega's, voldoende leer- en groeimogelijkheden en voldoende sociale steun van leidinggevenden en collega's. De tevredenheid in het werk blijkt lager te zijn als er sprake is van rolconflict en een hoge fysieke werkbelasting.
Betreffende ziekteverzuim kan geconcludeerd worden dat geen van de drie verzuimmaten (afwezigheid, frequentie van verzuim en de totale duur van het verzuim) beïnvloed worden door de afzonderlijke werklast- en verwerkingsvermogenvariabelen. Uit de resultaten komt wel naar voren dat uitvoerenden die zich minder gezond voelden en jongere uitvoerenden vaker verzuimden dan hun collega's.

REFERENTIES

Duijnstee M. De belasting van familieleden van dementerenden. [The workload of family members of people with dementia]. [Thesis]. Nijkerk: Intro, 1992

Fisher B, Tronto J. Towards a feminist theory of caring. In: Abel E, Nelson M (eds). Circles of care: work and identity in women's lives. Albany: State University of New York Press, 1990

Graham H. Caring: a labour of love. In: Finch J, Groves D (eds). A labour of love. London: Routledge & Kegan Paul, 1983

Hackman JR, Oldham GR. The Job Diagnostic Survey. Yale University, 1974

Hackman JR, Oldham GR. Development of the Job Diagnostic Survey. J Appl Psychol 1975; 60:9-170

Hackman JR, Oldham GR. Motivation through design of work: test of a theory. Org Behav Hum Perform 1976; 16:250-79

Hackman JR, Oldham GR. Work redesign. Reading: Addison-Wesley, 1980

Hanchett ES. Community assessment and intervention according to Orem's theory of self-care deficit. In: Hanchett ES (ed). Nursing frameworks and community as client: bridging the gap. Norwalk: Appleton & Lange, 1988

Hanchett ES. Nursing models and community as client. Nurs Sci Q 1990; 3:67-72

Hartweg DL. Dorothea Orem: Self-care Deficit Theory. In: McQuiston CM, Webb AA (eds). Foundations of nursing theory: contributions of 12 key theorists. Thousand Oaks: Sage, 1995

Hattinga Verschure JCM. Algemene zorgkunde voor de zorgverlenende beroepen. [The general art of caring for caregiving professions]. Lochem: De Tijdstroom, 1981

Karasek RA. Job demands, job decision atitude, and mental strain: implications for job redesign. Adm Sci Q 1979; 24:285-308

Karasek RA,Theorell T. Healthy work: stress, productivity and the reconstruction of working life. New York: Basic Books, 1990

Kempen, GIJM. Thuiszorg voor ouderen. [Home care for the elderly]. Groningen: STYX Publications, 1990

Meijman TF, O'Hanlon JF. Arbeidsbelasting, een inleidend overzicht van psychologische theorieën en meetmethoden. [Pressure of labour: an introductory overview of psychological theories and measure-methods]. In: Drenth PJD, Thierry H, de Wolff CJ (eds). Handboek Arbeids- en Organisatiepsychologie. [Handbook for Work and Organizational Psychology]. Deventer: Van Loghum Slaterus, 1984

Orem DE. Analysis and application of Orem's theory. In: Clements IW, Roberts FB (eds). Family health: a theoretical approach to nursing care. New York: John Wiley, 1983a

Orem DE. The family coping with a medical illness: analysis and application of Orem's theory. In: Clements IW, Roberts FB (eds). Family health: a theoretical approach to nursing care. New York: John Wiley, 1983b

Orem DE. Orem's conceptual model and community health nursing. In: Asay MK, Ossler CC (eds). Conceptual models of nursing: applications in community health nursing. Proceedings of the Eight Annual Community Health Nursing Conference. Chapel Hill: University of North Carolina, School of Public Health, Department of Public Health Nursing, 1984

Orem DE. Nursing: concepts of practice (3rd edition). New York: McGraw-Hill, 1985

Orem DE. Orem's general theory of nursing. In: Parse RR (ed). Nursing science: major paradigms, theories and critiques. Philadelphia: W.B. Saunders Company, 1987

Orem DE. Nursing: concepts of practice (4th edition). St. Louis: Mosby, 1991

Simonen L. Caring by the welfare state and women behind it-contradictions and theoretical considerations. Tampere: University of Tampere, Research Institute for Social Sciences, 1990

Smulders PGW, Veerman TJ. Handboek ziekteverzuim. [Handbook absenteeism due to illness]. Den Haag: Delwel, 1990

STRATEGO. Aan de slag. [Get busy]. Beverwijk: Stichting Thuishulp IJmond, 1991

Tadych R. Nursing in multiperson units: the family. In: Riehl-Sisca J (ed). The science of art and self-care. Norwalk: Appleton-Century-Crofts, 1985

Taylor SG. An interpretation of family within Orem's theory in practice. Nurs Sci Q 1989; 2:131-6

Ungerson C. The language of care: crossing the boundaries. In: Ungerson C (ed).Gender and caring: work and welfare in Britain and Scandinavia. Hertfordshire: Harvester Wheatsheaf, 1990

Veerman TJ. Ziekteverzuim in de gezinsverzorging. [Absenteeism due to illness in home help services]. Amsterdam/Leiden: NIA, 1989

de Vos EL. Aspecten van de huishouding. [An approach of household activities]. In: Goossens RC, de Vos EL (eds). Huishoudvoering met een laag inkomen. [Housekeeping with a low income]. Wageningen: Landbouwuniversiteit, Vakgroep Huishoudkunde, 1987

Wærness K. Caring as women's work in the welfare state. In: Holter H (ed). Patriarchy in a welfare society. Oslo: Universitetsforlaget, 1984

Zuidberg ACL. Het verzorgingsniveau van huishoudens. [The level of domestic care of households]. 's-Gravenhage: SWOKA, 1978a

Dankwoord

Het zit erop. Het proefschrift is af. Ik sluit hiermee een leerzame, leuke, maar ook roerige periode in mijn carrière af. In de afgelopen zes jaar heeft het proefschrift stukje bij beetje vorm gekregen. Dat het geworden is zoals het nu is, heb ik aan veel mensen te danken. Een aantal mensen wil ik in het bijzonder bedanken.

Dit proefschrift was inhoudelijk niet geworden zoals het nu is zonder de begeleiding, steun en het geduld van een drietal mensen. Hen ben ik veel dank verschuldigd.
Allereerst Ada Kerkstra. Ada, je hebt eerst als projectleider en later als co-promotor een grote rol gespeeld bij het uitvoeren van het onderzoek en later bij het tot stand komen van mijn proefschrift. Ik kon altijd bij je aankloppen en rekenen op je steun en je wetenschappelijk en inhoudelijke kennis. Ik heb veel van je geleerd. Bedankt voor de fijne en gezellige samenwerking.
Vervolgens mijn promotoren Jouke van der Zee en Huda Huyer Abu-Saad. Jouke en Huda, jullie hebben de afgelopen jaren veel concept artikelen van waardevol commentaar voorzien en mij veel bruikbare adviezen gegeven. Het was een leerzame ervaring. Bedankt voor de fijne samenwerking.

Zonder de enthousiaste medewerking van de uitvoerenden en de thuiszorginstellingen die hebben deelgenomen aan het onderzoek was dit proefschrift niet mogelijk geweest. Daarom wil ik alle uitvoerenden, managers en instellingen die betrokken waren bij het onderzoek hartelijk bedanken voor hun inzet.

Ook bij het uitvoeren van het onderzoek heb ik de veel hulp gehad. Daarvoor wil ik de volgende personen bedanken. Allereerst Hans Kersten, die als assistent-onderzoeker een belangrijke rol heeft gespeeld bij de data-verzameling, observaties en andere onderzoekswerkzaamheden. Ellen Schinkel, Anneke Franke en Ingrid de Gruyter hebben een berenklus geleverd met het invoeren en controleren van alle onderzoeksgegevens. Jan Gravestein heeft de SPSS invoerprogramma's gemaakt. Allen hiervoor hartelijk bedankt.

Marcelle van der Meulen en Bernadette Kamphuys hebben ervoor gezorgd dat het proefschrift er ook qua uiterlijk mag zijn. Bedankt voor jullie ondersteuning gedurende de afgelopen jaren, en jullie inzet en geduld bij de tekstverwerking en lay-out van het proefschrift.

Rinske van den Berg en Linda Schoonmade van de bibliotheek wil ik bedanken voor hun hulp bij het uitzoeken van de literatuurreferenties.

Verder gaat er veel dank uit naar mijn overige oud-Nivel collega's. Gedurende mijn 'Nivel-periode' heb ik veel gezelligheid, collegialiteit, en interesse van jullie mogen ontvangen. Een aantal collega's wil ik in het bijzonder bedanken, en wel Atie van den Brink-Muinen, Jack Hutten, Irma Kruyver en Madelon Kroneman. Als kamer- en ganggenoten kon ik bij jullie voor veel dingen terecht die het schrijven van een proefschrift iets makkelijker maakten: een luisterend oor, advies, steun, opbeurende woorden en veel gezelligheid. Bedankt voor dit alles.

Vervolgens wil ik enkele mensen bedanken die wat verder van het proefschrift zelf, maar dichter bij mij staan. Hiermee bedoel ik mijn familie en vrienden. Ik wil hen bedanken voor hun interesse in mijn proefschrift en hun gezelligheid. Een paar mensen wil ik in het bijzonder bedanken.
Als eerste mijn ouders. Lieve mam en pap, jullie hebben mij altijd gestimuleerd om me verder te ontplooien. Bedankt hiervoor en voor jullie liefde, betrokkenheid en onvoorwaardelijke steun.
Ook mijn overige familie- en schoonfamilieleden wil ik bedanken voor hun interesse en medeleven.

Vervolgens mijn paranimfen Deirdre Giesen en Laurens Arts. Deirdre en Laurens, ik ben blij dat jullie dit met mij samen willen doen en ook jullie wil bedanken voor jullie interesse, steun, en medeleven. Deirdre, we hebben samen veel lief en leed gedeeld. Bedankt voor je vriendschap.

Tot slot, Claudius, Meike en Jasper. Lieve Meike en Jasper, jullie komst heeft de afronding van dit proefschrift weliswaar iets vertraagd, maar het heeft alles ook enorm gerelativeerd.
Lieve Claudius, in de loop van de tijd heb ik ingezien dat het schrijven van een proefschrift inderdaad iets is dat je puur voor jezelf doet, en niet voor anderen. Dit inzicht heeft me op momenten van twijfel goed geholpen. Bedankt voor je liefde, geduld, morele steun, maar ook voor je zorgzaamheid voor Meike tijdens de weekeinden dat ik aan mijn proefschrift bezig was. Het zit er op!

Curriculum Vitae

Suzanne Arts was born March 22, 1969 in Veldhoven. She completed high school (VWO) at the Strabrecht College in Geldrop in 1987.
Subsequently, she started to study Health Sciences with specialization in Nursing Science at the University Maastricht. She carried out the research for her final dissertation at the Prince of Wales Children's Hospital in Sydney, Australia. With this dissertation, 'The management of acute pain in children', she won two awards: the students award of the Stichting Wetenschapsbeoefening and the Catharina Pijlsprijs. She received her Master's degree in 1992.
From 1992 until 1999 she started to work as a researcher. In 1992 she worked with prof. dr. M.E. Sluijter, specialist in chronic pain management at the Boven-IJ Hospital in Amsterdam. In 1993 she was employed by the Research Centre for Primary and Secondary Care at the Vrije Universiteit in Amsterdam. In 1994 she commenced work as a researcher at the Nivel (Netherlands institute for health services research). A part of her research at Nivel is reflected in this thesis. Since January 2000, she runs her own company, SiZoP (Samenwerking In ZOrgProjecten). The company supports health and research institutes in a wide variety of care and well being projects.

Suzanne is geboren op 22 maart 1969 in Veldhoven. Zij heeft het VWO (met Latijn) afgerond aan het Strabrecht College in Geldrop (1981-1987).
In 1987 begon ze haar studie Gezondheidswetenschappen met de specialisatie Verplegingswetenschap aan de Universiteit Maastricht. Het onderzoek voor haar afstudeerscriptie heeft ze uitgevoerd in het Prince of Wales Children's Hospital in Sydney, Australië. Met haar scriptie 'The management of acute pain in children' heeft Suzanne twee prijzen gewonnen: de studentenprijs van de Stichting Wetenschapsbeoefening en de Catharina Pijlsprijs. Ze rondde de opleiding af in 1992.
Van 1992 tot en met 1999 heeft Suzanne als wetenschappelijk onderzoeker gewerkt. In 1992 heeft ze bij prof. dr. M.E. Sluijter, specialist in chronische pijnbestrijding, gewerkt in het Boven-IJ ziekenhuis in Amsterdam. In 1993 was ze in dienst bij het Onderzoekscentrum 1e-2e lijn van de Vrije Universiteit in Amsterdam. Vanaf 1994 was Suzanne werkzaam bij het Nivel in Utrecht. Een deel van haar onderzoekswerkzaamheden bij het Nivel is terug te vinden in dit proefschrift. Sinds januari 2000 leidt Suzanne haar eigen bedrijf, SiZoP (Samenwerking In ZOrgProjecten). Het bedrijf ondersteunt zorg- en onderzoeksinstellingen in een grote variëteit van zorg- en welzijnsprojecten.

nivel