Home care service providers in Brussels: time adjustments during COVID-19 and the consequences for frontline home care workers

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Home care service providers have been considerably affected by the COVID-19 crisis. Since the beginning of the pandemic, their internal organisation has undergone important changes, including in terms of time schedules, to adapt to the needs of the older population and those of workers. In most cases, they had to reduce the provision of services, either because care workers – the majority of whom are women – were no longer available to cover the shifts, or because families had cancelled the services. In other cases, they had to meet increased demand. The most dramatic consequences were borne by female care workers, who had to combine working time adjustments with family obligations. Drawing from the material collected before and after the impact of the pandemic in Belgium, which includes interviews with public and private home care providers, this article explores the consequences that time adjustments had on frontline care workers and on the organisations themselves.

Key words COVID-19 • older care • time adjustments • care workers

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Introduction

The question of working time and the consequences that an increased or decreased number of working hours have on workers has become the centre of renewed attention in Europe and the US (Golden and Figart, 2000; Messenger, 2007). At the heart of the debate is the observation of two contradicting trends. On the one hand, starting from the 1980s, there has been a generalised and sharp reduction of collectively bargained working times in all Western countries, and especially in Europe. On the other hand, evidence shows an increase in the actual working times of individuals in certain sectors of the labour force (Bluestone and Rose, 2000; Lehndorff, 2000).

First, the reduction of working time only affects workers whose contract is covered by standard collective bargaining, leaving all other workers ‘free’ to choose the number of hours worked. A study conducted in Belgium found that the more flexibility workers have in relation to determining their working time, the longer they choose...
to work (Meulders and O’Dorchai, 2009). Second, the reduction of working time may be involuntary. For instance, although part-time work is commonly seen as an instrument for reconciling family and work, it may result in considerable wage loss and can be an involuntary arrangement for many workers (Lehndorff, 2000).

Among the factors that push workers to increase (or wish to increase) their working hours, individual preferences are not the only forces. The proliferation of flexible work, of unstable contracts and of wage inequalities seems to encourage workers to work more: the less protection offered by the job, the more hours will be worked (Bell, 2000; Meulders and O’Dorchai, 2009; McCann, 2004). As highlighted by Bluestone and Rose (2000), workers in jobs characterised by instability may choose to work more hours and engage in overtime whenever the work is ‘available’ in order to compensate for the loss of potential periods of unemployment. The preference for working longer hours may thus be typically triggered by ‘unstructured flexibility’ (Purcell et al, 1999), as a result of which workers have little control over the working schedule or the number of hours.

However, what happens when changes in work schedules and in the volume of hours are due to exogenous factors, over which neither the employees nor the employers have any control? The COVID-19 pandemic represents a striking example in this respect. The lockdown measures imposed to prevent the spread of the virus, coupled with the health emergency that particularly affected older people and people with disabilities, triggered important modifications in the schedules and working times of many workers, especially during the first and second waves of COVID-19. The consequences for workers closely depended upon their professional situation: while for some workers, this meant a shift to working from home, for other workers, it meant either a loss of working hours (and sometimes of the job), or an increase in working hours, such as with medical staff and people involved in the care of the most vulnerable in the population.

In this article, I focus on the home care sector in Belgium and analyse the impact that changes in time arrangements had on home care providers and on frontline care workers during the COVID-19 pandemic. The home care sector represents an interesting case in many respects. Due to the essential nature of the services they provide, and because they are specifically involved with some of the groups most affected by COVID-19, care providers had to ensure the continuity of their services while, at the same time, dealing with considerable internal changes (for example, the cancellation of services and adaptation of services in line with health measures). Contrary to other workers, frontline care workers could not be reassigned to other tasks or shift to remote working. Indeed, they had to ensure their availability while, at the same time, adapting to changes in working time and shifts. This demanded a great deal of effort in terms of reconciliation of their professional and personal lives. Moreover, due to the nature of care jobs – often characterised by poor working conditions, low wages and atypical shift times – working time reductions and reschedules may have had specific effects.

The objective of this article is to explore the impact of time adjustments on home care providers and on frontline care workers. The focus on temporality pertains to different aspects. First, I examine the changes that occurred during the first and subsequent waves of the pandemic in terms of the organisation of services, with a focus on time arrangements, and I analyse the consequences that these changes had on the organisations themselves and on frontline workers. Second, I discuss whether such
changes are to be considered temporary or if they are likely to become permanent work features.

Given the different effect that the reduction or the increase in working hours has on workers with different employment statuses in normal times (Bluestone and Rose, 2000; Ingelsrud, 2021), I make a distinction between the public and the private home care sector, in which care workers are subject to considerably different conditions (Giordano, 2021). This allows for exploration of whether these workers experienced different outcomes, depending upon whether they were employed by a public or private organisation. Moreover, this distinction also allows for investigation of whether private and public organisations were subject to different constraints depending upon whether they have a public agreement and subsidisation. This article contributes to: (1) the debate on working time, on workers’ preferences regarding time arrangements and on the effect of involuntary reductions in the number of working hours; (2) the discussion relating to the specific working conditions of home care workers, with a focus on the differences triggered by different employment statuses; and (3) the discussion on the future of home care services in the light of the changes that took place during the pandemic.

The first part of the article provides a brief insight into the Belgian home care sector for older people and the different types of care providers operating in the Brussels region. The information provided in this section is useful to better understand the changes that occurred during the first and second waves of the pandemic. This section is followed by an outline of the methodology used in the study. The second part presents the main findings, which are organised as follows. First, I present a brief description of the situation in Belgium during the first and second waves of the COVID-19 pandemic, and the official government response. In this part, I discuss the main impact of the crisis on home care providers in Brussels. Second, I focus on the time adjustments operated by home care providers, including the reduction in the volume of hours and specific changes at the level of working schedules. Finally, I discuss the impact of these changes on organisations and subsequently on frontline care workers.

Home care service providers in Belgium

In Belgium, the social care sector includes residential structures (such as care and nursing homes, and day-care centres for older people or people with disabilities) and home care services to older people, people with disabilities and families in need. Since the development of its modern welfare state and at least until the 1980s, state intervention in the provision of care services was predominantly directed towards the provision of residential services, while home care was implicitly left to families (Gilain and Nyssens, 2001; Willemé, 2010; Degavre and Nyssens, 2012). As in other Western European countries, starting from the 1990s, the Belgian social care sector was subject to a process of modernisation, leading to the improvement of home care services and its increased privatisation.

In Belgium, home care provision is based on a system of public subsidisation, which remains exclusively open to non-profit organisations. Although the distinction between public and private home care providers is not straightforward due to the complex system of subsidisation, here, I consider ‘public care providers’ as the non-profit organisations that have a public accreditation (and public subsidisation) and
'private care providers' as all the non-profit or for-profit organisations that do not have agreements with public bodies and do not receive public funding. The organisations that have a public accreditation have to comply with the regulations relating to the field of home care, which include a precise definition of the entitlements of, the type of services provided to and the price for care recipients, based on institutional ladders, as well as the profile of care workers and their employment conditions (De Donder et al, 2012). The state regulation also applies to the definition of working times and time shifts (Giordano, 2020).

Concerning public care providers, the entitlement of the care recipient is based on a medical assessment, which defines not only the type of care service, but also the approximate number of hours to which they are entitled. Not only are the number of hours per beneficiary limited to a few hours per day and are dependent on their needs assessment, but services are only available in the daytime, excluding nights and weekends (Giordano, 2020). Concerning frontline care workers, their job description and employment conditions are fixed by institutional regulations. Frontline care workers include nurses, aides-soignantes ('health assistants'), aides familiales ('family assistants') and aide-ménagères ('housework attendants') (Godard and Sammiez, 2007; De Donder et al, 2012). Regardless of their professional profile, frontline care workers employed by public care providers work under an employee status and are entitled to paid vacations and sick leave, weekly meetings, and training programmes. Joint industrial committees regulate their working conditions, including wages.

Private care providers vary greatly in terms of the type of services provided, as well as the employment status and working conditions of care workers. Contrary to public providers, services are not limited in terms of time (workers can cover long shifts, up to 24 hours) or with regard to the type of activities authorised. Private care providers are not tied to specific regulations stipulating their qualifications or defining their employment conditions. This is reflected in the heterogeneity of the employment status of care workers in the private sector, which can take different forms, including self-employment. As most care workers in the private sector do not have an employee status, this means that they are not entitled to paid sick leave or paid holidays, and their wages are considerably lower than those in the public sector (Giordano, 2020).

**Methodology**

In this article, I use part of the material collected in a research project on the care of older people in Belgium. This research, which started in 2018, includes a specific section on formal home care providers in the Brussels region, with fieldwork conducted before and after the beginning of the pandemic. The first part of the fieldwork, whose objective was to realise a mapping of existing home care service providers in Belgium and to explore their functioning, was carried out between October 2018 and May 2019. In this part, I conducted formal and informal interviews with several key experts in the field of home care, coming from different political orientations and different sectors of society (trade unions, not-for-profit organisations and institutional bodies), as well as nine semi-structured in-depth interviews with the directors/persons in charge of nine care service providers – five public and four private providers. These nine interviews constitute the first part of the material that I use in this article.
The second part of the fieldwork was realised between January and March 2021. The objective of the second phase was to explore the impact of the COVID-19 crisis on home care providers, including the main challenges that they had to face, the consequences for both families and frontline care workers, and the changes that occurred from the beginning of the pandemic. To this end, the nine care service providers that had participated in the first phase of the research were invited to participate in the second phase. Six home care providers agreed to participate in the follow-up phase: four public care providers, two of whom are active in the 19 municipalities of Brussels (the Brussels region) and two only at the local level (one municipality); and two private providers offering care services for older people and working with a pool of self-employed workers. These six interviews constitute the second part of the material that I use in this article.

Given the restrictions imposed by the government, which largely limited the possibility to meet in person, data in the second phase of fieldwork were collected via mixed methods. First, a written interview guide was prepared. This guide included a short introduction explaining the research context and objectives, as well as four open questions. As the main obstacle to carrying out fieldwork during the pandemic was the limited time and resources that the organisations could make available, interviews had to be as rapid and as efficient as possible. In order not to put additional pressure on home care providers and to accommodate different needs, participants were given different options for answering the questions, namely, the possibility to answer in writing or orally, depending on their time schedules and their individual preferences. Those who preferred to answer orally could choose a meeting in person, via videoconference or by phone. Two participants responded in writing, three by phone and one by videoconference. With the verbal consent of the participants, the phone and videoconference interviews were recorded and transcribed.

The sampling method

The material used in this article includes the nine interviews with the directors/persons in charge of the nine care service providers who participated in the first phase and the six interviews with the same directors/persons in charge who accepted to participate in the second phase. The advantage of follow-up interviews with participants from the first phase was that it facilitated a comparison between the situation before and after the outbreak of the pandemic while, at the same time, taking advantage of the information that I already had on each care provider. For instance, during the first phase, I extensively explored such issues as the internal organisation, the types and costs of the services, the characteristics of both the carers and the beneficiaries and families (education, origin and socio-economic status), their preferences, their family situation, the main problems encountered in their daily work, and their ‘vision’ of home care work. All this information constitutes background information that informs the analysis. If new participants had been added to the sample, full in-depth interviews covering the aforementioned issues would have been necessary. Since the directors of home care providers were already lamenting difficulties in terms of freeing up time to participate in the second phase, this option would not have been realistic and would have been too time-consuming. This was confirmed by the participants themselves, who reported having agreed to be interviewed in the second phase because: (1) they...
knew it was a shorter interview; (2) they already knew the researcher and the study; and (3) they felt that it was part of their initial commitment.

Although there is no ideal way to achieve saturation (Guest et al, 2006; Morse, 2015; Hennink et al, 2017), in this case, saturation was achieved by coupling the material from the first round of interviews with the material from the second phase. Concerning the first round, in line with the methodological guidelines provided by Guest et al (2006), thematic saturation was reached by identifying the number and the meaning of recurrent themes and codes in the interviews. The aforementioned themes (for example, types of services, internal organisation and socio-demographic characteristics) were exhaustively covered in all the interviews. At the same time, the sample included diversified participants to cover all the theoretical categories that I intended to explore, based on a previous mapping of existing care providers in the region. The main theoretical categories that I aimed to cover were care providers with and without a public accreditation – which correspond to public and private care service providers – whose difference is salient in terms of the different types of services that they offer.

Concerning the second phase, the number of participants was limited to the pool of participants from the first round but was sufficient to extract meaningful information in relation to the themes that had to be covered. As the second phase was focused entirely on the effects of the pandemic, and because I had already collected in-depth information relating to these care providers, the number of themes was smaller and could be covered more easily. Although the limited number of participants in absolute terms clearly generates limitations in terms of generalisation, this methodology, which had to be adapted to the given circumstances linked to the pandemic, nevertheless facilitated the compilation of rich qualitative findings.

Results

The impact of the COVID-19 pandemic on home care providers

The spread of COVID-19 across the national territory was officially confirmed by the Belgian authorities at the beginning of March 2020. As in other European countries, the first lockdown measures, announced in Belgium on 13 March, resulted in the closure of schools and all economic, cultural and social activities that were not recognised as ‘essential’. There was a restriction of movement across borders and within the national territory, the imposition of a teleworking system for all professions that could be performed remotely, and the limitation of social contacts with people living under the same roof (Jamart et al, 2020).

From the beginning of the crisis, the federal government had to deal with specific problems, mainly linked to: the capacity of the healthcare system, and of hospitals in particular; the lack of personal protective equipment (PPE) for frontline workers; and the lack of coordination between institutions, hospitals and medical doctors. In this context, hospitals were made a priority, leaving aside other residential facilities, including care homes for older people and residential centres for people with disabilities (Jamart et al, 2020). This had dramatic consequences for care homes, which quickly became the epicentres of COVID-19-related infections and deaths (Bergfeld, 2021). It was only during the later phases of the crisis and in reaction to the dramatic increase in death rates in care homes that greater attention was paid to residential care.
Despite their close contact with vulnerable groups (mainly older people), home care service providers received little or no attention, to the point that home care workers were highlighted as ‘the forgotten workers’ of the pandemic in Belgium (Degavre et al, 2020). Due to the characteristics of their work, home care providers and frontline workers faced not only some of the challenges faced in residential facilities, but also their own specific problems.

Similar to circumstances in the residential sector, home care providers were confronted with problems relating to resources, such as a lack of equipment and material, as well as issues of coordination. The lack of PPE was highlighted by all the participants as a major problem, which put both carers and care receivers at risk of infection. Most participants, regardless of their internal organisation or whether they had a public agreement, reported that in the first wave of the pandemic, they had to resort to solidarity groups or to ‘do-it-yourself’ expedients, such as improvising sewing workshops involving workers and their families to produce face masks.

Although they did not experience the same infection and death rates as in residential facilities, home care providers had to face specific problems. First of all, the ‘domestic’ nature of their services made them particularly invisible. This contributed not only to the lack of visibility at the policy level, but also to problems relating to coordination. According to the participants, at the beginning of the crisis, no coordination effort was made to clearly define which services had to be maintained under which conditions. As stressed by all the participants, the coordination of the services and the setting of priorities (in the form of lists of beneficiaries to whom services had to be maintained) were left entirely to them, with little guidance from the authorities: “We kept ourselves well up to date on the government’s measures in order to inform our beneficiaries about what was authorised and what was not. Basically, we were providing the information for our beneficiaries, saying, ‘This is what that means for you’” (private provider). As stressed by this private provider, it was the management (or the persons in charge) who had to interpret the official advice and evolving lockdown measures announced by the government in relation to each specific context. From the point of view of their internal organisation, one of the main difficulties was to match official recommendations and restrictions to both the organisation’s needs and the needs of care receivers and carers. This was perceived as particularly problematic with respect to care receivers, who had problems in understanding and adapting to the changing context due to their cognitive and/or physical situation, or the lack of family support. The participants reported that, in many cases, frontline care workers had to assume an additional workload in terms of psychological support and care.

When asked about the main impact at the organisational level, most participants expressed having experienced a feeling of uncertainty, especially at the beginning of the crisis. The main challenges were described as being forced to improvise and to prioritise work on the basis of urgency, without being able to plan ahead and reschedule services based on the needs of workers and beneficiaries.

**Time adjustments**

This section discusses the main time adjustments that occurred during the first wave of the COVID-19, namely, the reduction in the number of hours of services provided and changes in working schedules, as well as their implications at the organisation and individual levels. Time adjustments were stressed by all home care providers as
the change that mostly affected their work and the lives of both care workers and care receivers, especially during the first lockdown. However, the consequences that time adjustments had in the public and in the private sectors were extremely different. This factor, in turn, had a different impact on frontline care workers, depending on the type of employer.

Changes in the number of hours

The first change in terms of time, which became immediately visible after the announcement of the first lockdown on 13 March and lasted until the end of the first lockdown, was the dramatic reduction in the number of hours of services provided. This change affected all home care providers.

The reasons for this important reduction in the number of hours were multiple. The main factor contributing to such a reduction was a decrease in the demand from older people and families. According to the participants, cancellations were mainly for three reasons. First, the fear of infection and the generalised anxiety that accompanied the first lockdown caused both older people and families to cancel services. While this situation gradually improved with the arrival of PPE and in the following phases of the crisis, participants reported that this fear is still evident among certain care receivers and families. According to both public and private providers, one year after the outbreak of the pandemic, the demand was still fluctuating and new cancellations systematically followed every official announcement regarding the spread of the virus. Second, during the first lockdown, part of the demand was reduced by the fact that families were often more available to take care of their older relatives, either because of remote working or because of unemployment. Finally, in certain cases, services had to be cancelled because of confirmed cases of infection, hospital transfers or the death of the care receiver.

However, while for private home care providers, the reduction of hours was entirely due to a drop in demand, for public care providers, it was also due to decreased supply. First, as stressed by the public sector participants, services were also cancelled by care workers because of confirmed cases of sickness or suspicious COVID-19-related symptoms, and because of family obligations, mainly due to the closure of schools and limitations on day-care options. Concerning sickness and COVID-19-related symptoms, public care providers registered a dramatic increase in the number of sick notes from workers. Rather than being perceived as the ‘fault’ of workers, the high absenteeism was due to the fact that care workers were asked to immediately inform their employer and to cancel services should they experience the slightest symptom of infection. According to the participants, this was crucial in terms of the prevention of further infections and the protection of both carers and care receivers:

‘We have to tell them [carers] – and from the perspective of prevention, it is a lot better – that as soon as there is the slightest symptom, they cannot come to work. Previously, if they had a headache, they would come to work. I mean, we seldom had workers saying: “I’m not coming to work because I have a headache.” But now we want them to inform us of the slightest symptom, we ask them not to come to work and to get in contact with the doctor. So, this was complicated because we also cancelled a lot of hours in this way.’ (Public provider)
Second, contrary to private providers, whose key strategy was to maintain as many hours as possible in order to limit profit losses, public home care providers voluntarily reduced their services to limit the spread of the virus and to protect carers and care receivers. As highlighted by the participants, such providers maintained only the services that were considered essential, following a priority list based on the health condition and family situation of care receivers. It is important to mention that the reduction in the number of hours only had an impact on care receivers whose well-being would not be affected by the temporary interruption of services. On the contrary, services were maintained (and, in some cases, improved) for older people in high-dependency situations and/or without family support. In these cases, the provision of services was vital and could not be discontinued.

Changes in time schedules

Another important change that occurred in terms of time was that work schedules had to be adapted to the evolving situation. These changes affected both the number of hours provided to each care receiver and the modalities of the provision.

With respect to the first point, as previously mentioned, services either had to be reduced or improved, depending upon the needs of care receivers and their personal and family situation, as well as the availability of carers. While several hours were cancelled by the care receivers and their families, in other cases, the care needs of the beneficiaries increased because of the unavailability of other care options or because of the health condition of the care receiver. Moreover, due to the saturation of hospitals, especially during the first phase of the pandemic, many infected patients, including older people, had to stay at home and resort to home care services. This also modified the demand, with an increase in demand for services during the evening and at weekends. Given the regulations governing public home care providers, which limited the time schedules to daytime and weekdays, only private providers could meet these new requirements and adjust their schedules accordingly.

Concerning the second point, a specific adjustment in terms of schedules had to be made by all home care providers. In order to limit the risk of infection and following institutional measures, both public and private home care providers had to reduce the number of carers for each care receiver. While the very nature of the work remained unchanged, the number of contacts had to be limited so as to create ‘closed bubbles’ of carers and care receivers. This meant that each care worker had to spend, on average, more time, if not all their working hours, with the same care receiver. This change had extremely different consequences for public and private providers due to the profound differences in their internal organisation and their vision of care work. Indeed, in normal times, public providers tend to work on a system of rotation of care workers. This was meant to protect care workers from the risks associated with working with the same care receiver (emotional ties, isolation and so on). On the contrary, private providers tend to offer customer-tailored services, including in terms of continuity, and thus tend to assign one care worker to each care receiver (Giordano, 2020). This is facilitated by the fact that they do not have to comply with institutional rules.

This change was therefore more problematic for public home care providers, who had to transform their internal organisation considerably:
Before the crisis, our care workers – there were more or less ten of them – used to do the *grande tournante* [‘large rotation’]. This means that they could visit all our beneficiaries on one week and then return five weeks later because, in the meantime, other colleagues would visit. We call this ‘*la grande tournante*’. It means that everybody visits everybody. Now, we have changed this system in order to send a maximum of three people to each beneficiary to avoid the spread of the virus as far as possible.’ (Public provider)

While in normal times, the care of older people (or other dependent people) was ensured by a rotating team of carers, this system was no longer suited to the health emergency, and the rotation had to be interrupted.

A final change that had to be put in place in terms of time arrangements concerned staff meetings. As in other sectors of the economy, a system of videoconferences, email exchanges and other online tools were put in place to replace face-to-face meetings. This will be developed in the next section and had a more significant impact on public care providers.

**Consequences for home care providers**

The reduction in the volume of hours put a strain on public and private care providers alike, both in terms of financial costs and in terms of the planning of resources and activities. From a financial point of view, in the context of a reduction of activities, private providers whose activities were not covered by public subsidisations were in a situation of potential financial loss. As reported by the participants, they managed to survive and avoid major financial losses thanks to two circumstances. First, they compensated for the reduction in demand with a reduction in costs linked to workers’ salaries, as their frontline carers are self-employed and only paid for the hours actually worked:

> “In our organisation, carers are all self-employed, so for some of them, it was not a problem, and they wanted to keep working, and others decided to stop… So, actually, for us, there was no financial impact at all. I mean, we continued to work, without any problem” (private provider).

Second, as stressed by the two private sector participants, the reduction in the number of hours was only temporary and was completely reabsorbed after the end of the first lockdown, when the demand started to increase exponentially.

Despite the public subsidisation, a reduction in the number of hours worked was also potentially negative for public providers. Since they receive state subsidisation in the form of a fixed number of hours per year, they need to ensure they work the number of hours to which they have committed, rather than risk losing the subsidy. As reported by the participants from the public sector, they only managed to survive in the context of the pandemic thanks to the intervention of grant institutions (the state), which covered the financial loss of the organisations:

> ‘At the beginning, it [cancellations] was non-stop because people were scared that the virus might enter their house. And for this, we also have to thank the grant institutions because they helped us and they supported us financially. Because otherwise … because in our organisation, our staff are employed, so we have to pay them at the end of the month, but we need to work.’ (Public provider)
From the point of view of the planning of resources and activities, the reduction in the number of hours was certainly the main challenge that both public and private care providers had to face. The cancellations, regardless of whether they came from families or workers, led to considerable work in terms of the management of human and economic resources:

‘The management staff were inundated with work because we needed to manage all the workers who were sick, on the one hand, and the cancellations from patients, on the other hand, and try to find solutions…. I mean, there were times when we had only three or four carers still at work and then people in quarantine, beneficiaries who were sick … there really was total chaos, and we didn’t know what to do.’ (Public provider)

Concerning the temporality of these changes, the reduction in demand was limited to the period of the first lockdown. Starting from the lifting of restrictions after the first lockdown (around May 2020), the demand for home care services started to increase again and, in many cases, even exceeded previous levels. According to certain participants, this was mainly a reaction to the ‘infection scandals’ that occurred in care homes during the first wave. The fear of clustered infections, coupled with the restriction of family visits to care homes, prompted many families to opt for home care, rather than residential care:

‘Afterwards, when the “deconfinement” [lifting of the lockdown measures] occurred, conversely, we had a great deal of demand for home care at that time because I think that many people were scared to go to care homes. So, now, we have a lot more clients than previously.’ (Private provider)

‘Many didn’t want to go to care homes or to the hospital because if they were in the care home, they were not allowed visitors and people were confined to their rooms. There were also people at the end of their life, but they wouldn’t go to hospitals, the families wouldn’t let them go to die all alone at the hospital. Because at the hospital, they couldn’t have any visitors, so they preferred to stay at home.’ (Private provider)

According to both public and private providers, this increase in the demand for home care could last over time as a result of the supposedly damaged reputation of care homes. However, a drastic increase in the demand for home services is more likely to affect private organisations, rather than public organisations, where the number of hours is limited by the quota set at the institutional level. In this sense, after the initial difficulties, the COVID-19 crisis may ultimately give private providers a competitive advantage and may contribute to the development of private initiatives.

With respect to changes in time schedules – the limitation in the number of carers per care receiver, new demands for long hours (including evenings and weekends) and the interruption of staff meetings – the consequences were more evident in relation to public home care providers, compared to private providers. Since private providers had already worked on a similar system before the pandemic, the measures imposing a limitation on the number of carers per beneficiary simply consolidated this trend, which is likely to become a permanent feature of their work. On the contrary, public
care providers experienced this adjustment as a negative effect of the crisis and are likely to resume the ‘normal’ order whenever the situation allows. This confirms the different vision of care work in the private and public sectors, with public providers being more inclined to adopt a system of rotation of workers as a form of protection for both carers and care receivers (Giordano, 2020).

Similarly, the shift to virtual staff meetings also had a different meaning for private and public care providers. As expressed by the following participant, in the case of private providers, the shift to online and digital exchanges between workers was very positive and is likely to be maintained in the future:

‘Remote working really brought about new procedures. For example, we always wanted to have staff meetings, but we had problems organising them because we could never find the right time to meet. And therefore, we said, “Great, we can do them by videoconference”, and so we put this in place, and it works perfectly… And then everybody has her/his own schedule, and there are also people living far away, so it is a lot easier. We could do it and we did it, and it is certainly a positive point… And also, with regard to recruiting staff, you can interview people by videoconference, at least the first time, and you really save time.’ (Private provider)

According to this private provider, saving money and time outweighs the inconvenience of the lack of exchanges between colleagues and not being able to meet the workers in person.

On the contrary, the participants from public providers tend to have a mixed view on this subject. While other internal changes, such as partial remote working for administrative staff and new forms of digital communication (online agendas and so on) are seen as innovations with the potential of becoming permanent, continuing to hold meetings online is not sustainable: “This [weekly meeting] is fundamental, really, in order for us to have the information and for workers to give the information. Communicating by email, yes, it works, it’s better than nothing, but it is not the same as being able to freely express yourself” (public provider). This view, which is shared by all the participants from public organisations, expresses the idea that staff meetings in person remain crucial, not only for the correct exchange of information and thus the quality of work, but also for the well-being of workers.

**Consequences for frontline care workers**

While both public and private home care providers managed to survive despite the great reduction in the demand for services, the consequences for carers strongly depended on their employment status, which, in turn, depended upon whether their employer had a public agreement. Since the care workers employed by the participants in the private sector are self-employed and are thus dependent upon working more hours to make a living wage, the reduction in the number of working hours translated into a reduction in their wages. Moreover, the fact of not being entitled to paid sick leave was a factor that considerably influenced their working strategies: “There was a beneficiary who was [COVID-19] positive and it was a stressful situation because there was no protective equipment…. But in our organisation, carers are all self-employed, so for some of them, it was not a problem, and they wanted to
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keep working” (private provider). The situation reported by this participant shows the dilemma that self-employed care workers had to face. Given the precariousness of their employment status, they were entirely left with the decision of whether or not to work. As their wages depend on the number of hours worked, they had to ensure the continuity of their work and tended not to cancel services, even when the beneficiary was infected. Moreover, compared to public care service providers, which registered high levels of absenteeism because of suspicious COVID-19-related symptoms or sickness, private providers did not. On the contrary, most self-employed care workers further increased their availability, including accepting antisocial working hours. This may have contributed to increasing infection risks for both carers and care receivers, as was the case in other sectors of the economy, where workers with unstable employment had no other choice but to continue working, even if showing symptoms of COVID-19 (Bergfeld, 2021).

On the contrary, care workers employed in the public sector were able to enjoy the benefits linked to their employment status, such as paid sick leave. The reduction in the demand for services did not affect their salary or their working conditions because – mainly thanks to state intervention – public home care providers managed to protect workers from unemployment and guarantee full wages: “Nobody in our organisation was out of work, no. It was a clear management strategy: not to put workers on temporary unemployment, so that everyone could maintain his/her level of wages. This was really very important” (public provider). Even when a reduction in the amount of work was necessary, because no administrative or remote work was possible, public home care providers managed to maintain salary levels:

‘During the first wave, as well as the second, we could not work full-time – meaning five days per week – but with a reduced working time – meaning that in week A, some people worked for three days, and the following week, two days. This system was put in place for frontline workers. Because they could not work remotely, we put this in place…. The days when we didn’t work, we were put on an “exemption”, but our salary was maintained.’ (Public provider)

This also allowed care workers employed by public care providers to adjust their working times according to their personal and family situation. Again, a significant difference is visible between the private and the public sector. While time constraints, such as the closure of schools, increased family obligations and/or health reasons partly limited the availability of care workers in the public sector, according to the participants in the private sector, this did not occur at all. When asked whether workers, especially women with children, had expressed any form of distress or difficulty in combining work and family obligations during the first lockdown, the participants stated that their workers did not encounter such problems, or at least they had not expressed experiencing these difficulties:

‘No, here, we didn’t really have anything like that. No, nothing has changed at that level. You know, there are many self-employed people here, but they work in essential services, so they had to go to work and that’s it…. They are very resourceful.’ (Private provider)
‘We always worked in respect of the rules, of course. And these people [carers] put themselves forward and they know what commitments they are making.’ (Private provider)

On the contrary, public providers report having adapted shifts and schedules according to specific requests from care workers, who were encountering difficulties, especially due to the closure of schools during the first lockdown. Without exception, all the participants from the public sector explained that the organisation tried as far as possible to accommodate the requests of care workers, without their wages being affected:

‘We know that every time there was a problem with the school, or that the school had to close early, or that there was a COVID infection in the class, then the class was sent home. We had a lot of demands like this from carers: “Look, I need to go to pick up my son”, etc…. But at the organisational level, we always – of course, we needed a certificate or something saying that the school was closed – we always match the exemptions with the relevant individuals. This was necessary if we didn’t want them to lose any holidays. So, each time they had to leave early, or on Wednesdays, we granted exemptions.’ (Public provider).

Indeed, family obligations seem to have played a role solely in the case of care workers in the public sector but did not present as a concern for private providers. This is again the result of the different employment status and entitlements of care workers in the private and public sectors, as well as the rights and benefits associated with these.

Finally, concerning the changes in time schedules (limitation of the rotation of workers supporting multiple care receivers and interruption of staff meetings), the consequences were more apparent for care workers employed by public providers. This change significantly modified the work of carers in the public sector, as well as the services for the care receiver. Concerning the carers, for the first time, they had to commit to longer hours supporting the same older person, with its associated risks, such as feelings of isolation, lack of contact and exchange with colleagues, and emotional attachment to the care receiver. Concerning the care receiver, this system increased the risk of cancellation of services given that carers could not be replaced by other staff members.

Conclusions

In this article, I have discussed some of the consequences that the COVID-19 crisis had on home care providers and on frontline care workers in Brussels, with a particular focus on the need for time adjustments. The question of time proves to be crucial for both public and private home care providers, at different levels, and had important consequences for both home care providers and frontline care workers.

Concerning home care providers, the crisis brought about important changes in terms of time. These changes mainly concerned the reduction of services during the first lockdown, which, in turn, put a strain on their internal organisation, both financially and in terms of the management of resources. Other time adjustments, which happened to have a more significant impact on public providers, included
the interruption of the rotation of workers per care beneficiary and the loss of staff interaction and support through the cancelling of internal meetings.

Concerning frontline workers, the different impact that time arrangements had on their professional and family situation was directly linked to their employment status, which depended upon whether they were employed by public or private organisations. Although the work of carers employed by public care providers was significantly affected by time adjustments, thanks to their employee status, they could retain their full salary and were able to enjoy the benefits associated with their status, such as paid leave for sickness and/or for family reasons. Moreover, thanks to the flexibility of their employer, they managed to accommodate personal/family issues and were able to reschedule shifts when necessary.

On the contrary, care workers in the private sector did not have any of these entitlements. As self-employed workers, their employment is more precarious, as they do not benefit from paid sick leave or paid holidays, and their salary depends on the actual hours worked. Contrary to workers in the public sector, who were asked to abstain from work should they exhibit any COVID-19-related symptoms, care workers employed by private providers tended to go to work regardless of their health condition, mainly to overcome the risks associated with the reduction in the number of hours worked and to maintain their wages. This is likely to have had serious consequences for both the carers and care receivers. On the one hand, it increased their employment vulnerability, as well as their health risks; on the other hand, this may have increased the care receivers’ exposure risk to the virus.

In conclusion, the analysis of the impact of time adjustments in the context of the pandemic raises a number of important reflections. The results highlight the interconnection of the impact of the pandemic on a specific segment of workers and the importance of the employment status in defining such impact. On the one hand, the results confirm COVID-19 as an unprecedented event, which forced all segments of the population and all sectors of the economy to make important readjustments. As expected, in this context, the sector of older care services was crucial. However, while we could expect that the impact of time adjustments would hit all frontline care workers equally hard – because of their generally poor working conditions and because of their position as frontline workers – the results show that what really made a difference was the level of protection of workers in the labour market. As highlighted by the literature, contract deregulation and involuntary flexibility influence workers’ choices in terms of working hours. Interestingly, even in an unprecedented health-emergency context, only workers with good labour and social protection were able to protect themselves, both from the risk of infection and from any economic or psychological problems related to the pandemic. In this sense, the pandemic seems to have exacerbated inequalities between workers, even in a labour sector generally characterised by poor working conditions.

Notes
1 Older adults are defined here using the statistical definition applied by the Belgian Statistical Institute (Statbel), which defines older people as people aged 65 or more. While this definition is relevant for older people to access certain services (such as specific medical services, transportation, cash-for-care allowances and so on), this category is less relevant in terms of gaining access to home care services, which are available to all ages based on the degree of dependency.
The public subsidisation of both residential and domiciliary care services is managed by the French, the Flemish and the Common Community Commissions (COCOF, VGC and COCOM, respectively).

Even though, for the empirical part of the article, I specifically refer to the in-depth interviews collected with the home care providers (nine interviews in the first phase and six in the second phase), it is important to stress that all the material collected in the first phase – which includes desk research, as well as formal and informal interviews with several experts in the field of home care – was used as background information throughout the analysis.

Although the participants in the second round of interviews do not capture the diversity of employment statuses of carers in the private sector, one common feature of private care providers is that they do not offer employee contracts, but rather other – less stable – types of contracts, the wages of which are often based on the actual working time.

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**Conflict of interest**

The author declares that there is no conflict of interest.

**References**


