**Pursuing equity to combat fragmentation in the home care sector:**

**A study of using integrated care programs to deliver health and social care**

**to elderly persons living at home**

by

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# Abstract

Integrated care programs (ICPs) deliver care that is coordinated across carers, care sites, and support systems; continuous over time and between visits; tailored to clients' expressed needs and preferences; and based on shared responsibility for optimizing health among clients, carers, and the state. This research asks how ICPs combat issues of fragmentation in a home care sector fundamentally reshaped by neoliberalism. Using a post-positivist epistemological approach, I collect and analyze data from federal and provincial government documents, NGO reports, scholarly literature, and 118 interviews with program administrators, paid care workers, unpaid family carers, and elderly clients in five Canadian ICPs working in the home care sector. These include Aging in Place in Ottawa, Ontario; SMILE in South Eastern Ontario; Carefirst in Scarborough, Ontario; CHOICE in Edmonton, Alberta; and Hope Home Health in Hope, British Columbia. My central argument is that ICPs are most useful as a policy solution to fragmented home care when they use policy techniques that promote equitable processes and outcomes as opposed to focusing on enhancing cost-efficiencies for the state. To understand the interrelations among fragmentation, efficiency, equality, and equity, I use a Feminist Political Economy theoretical framework to assess the gendered, classed and racialized impacts of the policy techniques used by ICPs. By looking at which groups are affected through their involvement in ICPs, in what ways, and under what conditions, I find that policy techniques aimed at achieving cost savings for the state often increase inequality/inequity between, and among, clients and carers. Increasing inequality/inequity increases fragmentation. In contrast, ICPs that use policy techniques that challenge neoliberal ways of working often promote equality/equity as their primary policy goal. These techniques help mitigate fragmentation. Understanding if, how and why ICPs meet the expressed needs of clients and carers in different contexts is essential for

program administrators looking to improve their programs, as well as for the clients and carers involved in the daily relations of home care. Knowing that ICPs are most useful as a policy solution to fragmented home care when they promote equitable processes and outcomes gives a clear direction for future reforms that can benefit clients and carers alike.

## Dedication

For Baby.

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## Acronyms and Abbreviations

ADL _____ Activities of Daily Living
ADP _____ Adult Day Program
AHS _____ Alberta Health Services
AIP _____ Aging in Place - integrated care program (Ottawa, Ontario)
ALC _____ Alternate Level of Care
BC _____ British Columbia
CAP _____ Canada Assistance Plan
Carefirst _____ Carefirst - integrated care program (Scarborough, Ontario)
CASI _____ Community Action for Seniors' Independence (BC)
CC _____ CCAC Care Coordinator (AIP)
CCAC _____ Community Care Access Centre (Ontario)
CCC _____ Client Care Coordinator (SMILE)
CHA _____ *Canada Health Act*
CHATS _____ Community Home Assistance to Seniors agency (Carefirst)
CHC _____ Community Health Council (BC)
CHN _____ Community Health Nurse (HHH)
CHOICE _____ CapitalCare Comprehensive Home Option for Integrated Care for the Elderly - integrated care program (Edmonton, Alberta)
CHSS _____ Community Health Services Societies (BC)
CHST _____ Canada Health and Social Transfer
CHSW _____ Community and Health Support Worker (CHOICE)
CHT _____ Canada Health Transfer
CHW _____ Community Health Worker (HHH)
CIHI _____ Canadian Institute for Health Information
COC _____ OWCS Community Outreach Coordinator (AIP)
CSC _____ Home Care Client Service Coordinator (Carefirst)
CSIL _____ Choice in Supports for Independent Living (HHH)
DOT _____ Delegation of Task (BC)
EAP _____ Employee Assistance Program
FHT _____ Family Health Team
FPE _____ Feminist Political Economy
HCW _____ Home Care Workers
HHH _____ Hope Home Health - integrated care program (Hope, BC)
HMO _____ Health Maintenance Organization
HSW _____ Home Support Worker (AIP)
IADL _____ Instrumental Activities of Daily Living
ICP _____ Integrated care program

IHSP        Integrated Health Services Plan (Ontario)
LHIN        Local Health Integration Network (Ontario)
LPN         Licensed Practical Nurse
LTC         Long-term care
MOHLTC      Ministry of Health and Long-term Care (Ontario)
NP          Nurse Practitioner
NPM         New Public Management
OCH         Ottawa Community Housing (AIP)
OECD        Organisation for Economic Co-operation and Development
OT          Occupational therapy/therapist
OWCS        Ottawa West Community Support (AIP)
PACE        Program of All-inclusive Care for the Elderly
PROCARE     Providing Integrated Health and Social Care for Older Persons research project
PSW         Personal Support Worker (Ontario)
PT          Physiotherapy/therapist
RHA         Regional Health Authority (Alberta, BC)
RHB         Regional Health Board (BC)
RN          Registered Nurse
SMILE       Seniors Managing Independent Living Easily - integrated care program (Ontario's
            South-East LHIN covering Kingston, Trenton and surrounding areas)
VHA         Visiting Homemakers Association Home Healthcare (Carefirst)
VON         Victorian Order of Nurses (SMILE)
WHO         World Health Organization

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# Chapter 1: Introduction

> "Better never means better for everyone.  It always means worse for some" (Atwood 1985).

## Introduction

In Canada, the desire to revamp the health care system to make its parts work better together has occupied the minds of politicians and policy makers for a long time.  Government interest in better "integrating" our care systems goes as far back as 1944 with Premier Douglas' mandated review of Saskatchewan's health system prior to the advent of Medicare (Taylor 2009, 244; Naylor 1986, 138-9).  Talk about integration has come and gone repeatedly since then - from the introduction (and eventual demise) of Canadian Integrated Delivery Systems in western Canada in the 1980s, to the advice of the Federal/Provincial/Territorial Health Disparities Task Group in 2004, to Ontario's *Local Health System Integration Act* (2006), to the Drummond report's recommendations in 2012.

It is not only governments who are interested in the possible advantages of integration. The academic literature is replete with claims about the potential advantages of integrating health care.[1,2]  Yet, there remains considerable uncertainty as to how improvements in integration are to be achieved and who will benefit from them.  Where to begin? What ingredients, processes, systems, and change management are necessary (de Jong & Jackson 2001, 71)?  In contexts such as Canada, where there is "little in the way of planning for health or social goals as compared with economic ones" (Rachlis 2007, 232), many questions remain regarding how to get the parts of the health and social care systems to work better together to help make Canada a healthier place to age and a healthier place to care for the elderly.

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[1] Brickman *et al*. 1998; Campbell *et al*. 1998; Ouwens *et al.*  2005; Low *et al*. 2011; de Stampa *et al*. 2013; Martínez-González *et al*. 2014; Janse *et al*. 2016b.

[2] When a reference contains more than four citations, I will place these in a footnote rather than in-text to ease the flow of reading.

The delivery of health and social care in private residential dwellings, what I refer to in this dissertation as "home care", is an important component of health care in Canada. Home care takes many forms. It can be medical monitoring or intervention, wound care, physiotherapy (PT), occupational therapy (OT), counselling, foot care, diabetes management, or nutrition advice. It can assist with activities of daily living (ADLs), such as feeding, bathing, dressing, toileting, and help with medication (Mitchell *et al.* 2004, 915). It can also involve instrumental activities of daily living (IADLs), such as transportation, shopping, running errands, laundry, household chores, meal preparation, home maintenance, shovelling, yard work, banking and financial management, and organizing appointments with paid service providers (Sims-Gould *et al.* 2008, 69). Finally, home care can provide assistance with system navigation, or involve social interaction and emotional support.[3] Home care is provided by a variety of paid and unpaid carers, including those conventionally defined as professionals, paraprofessionals and unpaid caregivers, such as family members, neighbours or volunteers. Depending on the jurisdiction, paid carers can be full-time, part-time, or casual public sector workers. They can also be employed by not-for-profit, for-profit, or charitable organizations, or self-employed. There is substantial variation in what qualifies as home care, how it is funded, and from whom it is delivered, both across Canada as well as within the various provinces.

A significant amount of money is spent on home care in Canada each year and there are many Canadians who rely on it. In 2012, 2.2 million Canadians 15 years of age and older, received help or care at home because of a long-term health condition, a disability, or problems related to aging (Turcotte 2014, 1). The total spending on home care in 2010 was estimated to range from $7.09 billion to $8.7 billion in Canada (Hermus *et al*. 2012, 12). This represents

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[3] These various care tasks can alternatively be classified as home health, home support, or community care. For my purposes, I consider them all to be components of "home care" broadly defined.

between 3.7 and 4.5 percent of total health spending (ibid).  The total public spending on home health services in Canada ranged from an estimated $2.35 billion to $3.96 billion in 2010, while public home support services spending was estimated at $3.23 billion (ibid, 11).  Private spending on home health was estimated at $25 million, while private out-of-pocket and insurance-provided sources spent an estimated $1.48 billion on home support services in 2010 (ibid, 11).  These numbers underestimate the value of care being delivered to Canadians at home because they do not include unpaid care or services classified as "community care", such as meal preparation, homemaking, home help, errands/shopping, respite care/caregiver support, home visiting, adult day program, falls prevention, transportation, Meals on Wheels, and activation. The economic cost of unpaid care has been estimated at $25 billion per year (Hollander *et al.* 2009).  Meanwhile, estimates for community care services show public and private sources, together, paid between $1.77 billion and $1.82 billion in Canada in 2010 (Hermus *et al.* 2012, 15).

Home care as a means of caring for an aging population is increasingly present on policy agendas in North America and Europe as well as being taken up by international governance institutions (Government of Canada 2016; European Commission 2015b; WHO 2017).  This is, in part, because of misapprehensions that the care requirements of the baby boomer generation will overburden the health care systems of western democracies.  This thinking has contributed to the construction of population aging as a "social crisis" (Gee 2002), which Gee and Gutman (2000) have termed "apocalyptic demography".  Metaphors emerging from this discourse have framed aging seniors as a pressing policy problem requiring an immediate solution by characterizing them a "grey tsunami" (Gordon 2014) or "ticking time bombs" (Friesen 2010), for example.  The accuracy of this crisis discourse is disputed; however, it has been an important

catalyst in getting home care onto the political and policy agendas of the federal and provincial governments in Canada.

In addition to the 461,000 Canadians who reported having "unmet" home care needs in 2012, 331,000 of the individuals who received home care that same year reported being able to access some, but not all, of the help that they needed (Turcotte 2014, 12). To decipher the complexities of using integrated care to design and deliver home care that meets the needs of Canadians, I investigate Integrated Care Programs (ICPs) targeting seniors in five jurisdictions across Alberta, Ontario, and British Columbia. People of all ages receive home care; however, I focus on seniors, especially older seniors, because they are by far the most likely to receive care at home (Turcotte 2014, 2). In 2012, 10 percent of those 65 to 74 years, 21 percent of those aged 75 to 84, and 45 percent of those 85 years and older received care in their home (ibid). Despite the fact that the number of older seniors with unmet or partially met care needs is likely underrepresented,[4] Turcotte (2014, 3) found that nearly 110,000 Canadians 65 and older reported having unmet care needs in 2012. In addition, 6 percent of care recipients 85 and older and 12 percent of those aged 75 to 84 said that they had received some, but not all, of the help they needed during the year (Turcott 2014, 5). Given the number of people affected and their age-related vulnerability, understanding if and how ICPs are meeting seniors' care needs is a particularly timely and worthy area of research and policy attention.

My study seeks to understand women's experiences as a group in relation to men, while also accurately capturing the differences among women. I study women because they account for the majority of those who receive and provide home care (Canadian Home Care Association

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[4] Studies that have shown that seniors 65 and older are less likely than other age cohorts to report that they needed more help or care than they were getting (Kasman & Badley 2004).

2013).  The greater proportion[5] of women home care clients reflects women's longevity, their lower incomes, and the fact that many women had older male partners who passed away first (Armstrong & Armstrong forthcoming).  Women clients also experience disproportionately more unmet care needs than men[6] (Turcotte 2014, 3).  Some of the reasons for these differences are explored later in Chapter 4.  In addition, women's dominance of the home care labour force reflects assumptions about their nature and skills in comparison to those of men and contributes to their being at higher risk of becoming caregivers with unmet needs for help or care.  Turcotte (2014, 4) identifies unpaid carers as an especially vulnerable group based on his findings that, in 2012, 38 percent of persons with unmet needs were providing help or care to others, compared to 29 percent of persons whose care needs were met and 28 percent of persons who did not need help.

Understanding the classed and racialized experiences of women as a basis for differential treatment is at the heart of understanding their unique and subjective realities as providers and recipients of home care.  Not all individuals or groups interact with public policies and programs in the same ways.  For example, lower-income Canadians are substantially sicker than upper-income Canadians and consequently use twice as many health care services (Health Disparities Task Group of the Federal Provincial Territorial Advisory Committee on Population Health and Health Security 2004).  Yet, persons with lower incomes are also more likely to have unmet home care needs (Turcotte 2014, 4).  In 2012, 18 percent of persons with unmet needs for help or care had a household income of less than $20,000, compared with 12 percent of those who received care at home and 4 percent of persons who did not need any care (ibid).  Similarly, Turcotte (2014, 4) found that immigrant status was also associated with the likelihood of having

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[5] 57 percent women versus 43 percent men (Turcotte 2014, 3).
[6] 58 percent women versus 42 percent men (ibid).

unmet home care needs. Immigrants accounted for 30 percent of those with unmet needs for help or care and 20 percent of care recipients in 2012 (ibid). Groups that experience structural inequalities based on the socially constructed categories of class, gender, and race/ethnicity, are more likely to be disadvantaged by government policies and processes made in the interests of those who have historically occupied positions of social, political, and economic power.

In this dissertation, I argue that ICPs that use neoliberal policy techniques to design and deliver home care are well positioned to meet the expressed needs of clients, unpaid carers, or paid care workers[7] in positions of class, race/ethnicity and/or gender privilege. However, these ICPs often increase inequality by contributing to the continued marginalization of less powerful groups. I conclude that ICPs are most useful as a policy solution to fragmented home care when they use policy techniques that promote equitable processes and outcomes as opposed to focusing solely on enhancing efficiency. This is essential information for policy makers, program administrators, and the clients and carers involved in the daily relations of home care. Both the decisions made by policy makers in how to reform home care, and by program administrators as they organize and manage front-line service delivery in their program, shape how clients and carers experience home care delivered though an ICP.

In this chapter, I begin by laying out the context within which home care has crept onto the policy agendas of governments in Canada. I introduce neoliberalism as the dominant political and economic ideology, governance structure, and policy toolkit that has shaped policy-making generally, and home care sector reform in particular, from 1992 to 2013. I then propose feminist political economy (FPE) as my critical theoretical framework. I use FPE to illuminate

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[7] I use the term "clients" throughout this dissertation to refer to research participants who are clients of an ICP, "unpaid carers" to refer to research participants who are family members, friends or neighbours of an ICP client or volunteers with an ICP, and "paid carers" or "paid care workers" to refer to research participants who are employed (either directly or on contract basis) by an ICP.

how neoliberalism has reshaped the conceptualizations of care, equality, and efficiency, influenced the framing of policy problems, and impacted which policy goals are prioritized by policy makers and which are disregarded. After presenting my research question, I describe my use of a post-positivist approach and qualitative research methods focused on the lived experiences of clients and carers as my primary data source. I then outline my argument in detail and present my key findings and recommendations. Finally, I describe the chapters that form the body of this dissertation, leading to my conclusion that focusing on equity as a policy goal is fundamental to ICPs' ability to meet the expressed needs of clients and carers by reducing the impacts of fragmented care.

## Context and Concepts

As policy makers work to come up with innovative solutions to deal with elder care provision, they have done so within a policy-making environment fundamentally shaped by neoliberalism. Neoliberalism intensified in Canada in the early 1990s and was still influencing policy development at this study's data collection end date in 2013. Neoliberalism can be understood as a hegemonic political and economic ideology that promotes the use of business solutions to public policy problems (Steger & Roy 2010; Harvey 2005). Market mechanisms and for-profit management techniques are used to restructure governments and their ways of working to be more cost-efficient. Neoliberal policy makers place high value on individual autonomy. They argue for minimal state involvement in the market. Neoliberalism is also a governance structure that revolves around the idea of governing at a distance (Armstrong 2013). Using the New Public Management (NPM) mode of governance, self-responsibilization, and quantification, neoliberal governments have relocated much of the responsibility for funding, management, and service delivery of home care to lower levels of government, the private

sector, households, and individuals.  Neoliberalism as a set of policy tools emphasizes the use of privatization and de/re-regulation.  Encouraging state partnerships with the private sector, the downloading of care work, the commercialization of service delivery, increased standardization, the delisting of services, and the introduction of user fees, are examples of neoliberal policy tools.  This toolkit is used to reduce the state's share of the costs associated with health and social care provision.

Neoliberal ideology, governance, and policies have influenced the choices of policy makers tasked with restructuring the health care system to better address the care needs of an aging population.  While its application varies by context, there are broad patterns in the policy choices and directions of the Canadian federal government and the provincial governments in Alberta, Ontario, and British Columbia (BC).  An emphasis on individualism and consumer choice has been infused into government policy strategies.  The management and delivery of health services has been decentralized and the responsibility for care relocated to individuals and families.  There has been an increased focus on collecting quantitative evidence to enhance public transparency and accountability.  Finally, we have seen the hollowing out of the welfare state through government withdrawal from funding health and social care and the increasing use of privatization at the federal, provincial, and municipal/regional levels.

Deinstitutionalization is one of the most significant neoliberal directions shaping policy choices in elder care.  Deinstitutionalization has been actively pursued by neoliberal governments.  Operationalized as "aging in place" or "aging at home", keeping clients in their homes longer as they age has been a key objective of federal and provincial health care restructuring initiatives. Relocating the responsibility for elder care from the state to individuals and households fits with neoliberal tendencies to seek privatization, promote state withdrawal,

emphasize individualism, and prioritize consumer choice. According to the Canadian Institute for Health Information (CIHI) (2011), seniors in Canada clearly prefer to age in their private dwellings, given existing alternatives. Yet, this should not disguise the fact that supporting them to do so is much less costly for the state than caring for the elderly in publicly funded institutions, such as hospitals or long-term residential care homes. Shifting the costs of care and the care work onto unpaid carers, usually women, is an important part of why relocating care from the state to households saves governments money. Yet, this is often rendered invisible under a neoliberal policy-making framework.

Women are more likely than men to both live alone in private dwellings and receive formal home care (Turcotte & Schellenberg 2006; Canadian Home Care Association 2013). They are also more likely to have their care needs go unmet because of the challenges and barriers they encounter when trying to access care (Chen & Wilkins 1998). Women make up the majority of paid and unpaid carers in the home care sector (Keefe 2002). Furthermore, many of the women working as paid carers, especially those in less powerful positions on the home care occupational hierarchy, come from minority racial/ethnic communities and/or are in precarious financial situations. Yet, the gendered, classed and racialized nature of home care is obscured when working from a neoliberal perspective. The relationships between the state, the market, and domestic relations, as well as the sexual division of home care labour, are often invisibilized under neoliberalism. To see and understand what is rendered silent under neoliberalism, I use FPE to undertake a gender-, race/ethnicity-, and class-sensitive analysis of home care policy.

FPE theory is rooted in both liberalism and Marxist/socialist feminism. It attends to the historical, economic, political, and social relations that shape hierarchies of gender, race/ethnicity, and class. Questions of "who benefits" and "who pays" are central to FPE. These

questions help to illuminate which groups are affected by home care policies, in what ways, when, and under what conditions. Economics, politics, culture, and ideologies are understood within FPE as integrally related, shaped by unequal forces of power and resistance differently in different historical periods and circumstances (Armstrong & Day 2017, 7). This is important because concepts such as care, efficiency, equality, and equity, are fundamental to understanding the impacts of home care restructuring. Yet, these are often conceptualized differently depending on one's ideological position. FPE helps make sense of what these concepts mean and why some are emphasized within a neoliberal policy-making environment while others are subordinated.

Under neoliberalism, care is defined in market terms as an array of services that are viewed as distinct from each other and can be categorized on a continuum. This conceptualization of care is rooted in the biomedical discourse that draws artificial lines between 'medical' care and 'custodial' care, in part because health care can be more easily counted and tracked than social care. Likewise, "professional" workers have been valued more than "ancillary" care workers.

While seeing care as "services" is consistent with the idea of care as paid work provided by external workers, it obscures unpaid care work. This is especially limiting in a home care setting where a significant amount of care is provided by spouses, children or other unpaid carers. FPE challenges the understanding of care as services by constructing care as both work (Armstrong & Day 2017) and as a relationship, albeit one that involves activities (Day 2013). FPE draws attention to the relational nature of care, the skill and labour of care work, and the time and energy it takes to provide care. It also considers the contributions of carers traditionally thought to provide non-relational services, such as cleaning, meal preparation, or laundry. These

are all aspects of care that are invisible from a neoliberal perspective but that are highlighted when using an FPE lens.

Another significant contribution of FPE is its ability to draw attention to the classed, racialized, invisibilized, and devalued nature of the paid and unpaid care work done by women. FPE makes visible the role of the state in creating policies and processes that reinforce power hierarchies and perpetuate inequalities between, and among, clients and carers in the home care sector. For example, FPE looks at the changing boundaries between public and private as a way of highlighting how neoliberalism perpetuates inequality among women, between women and men, and among the employers and workers involved in home care. In doing so, FPE provides a useful entry point for understanding how the separation of public and private that is typical of capitalist development is more complex under neoliberalism (Armstrong & Armstrong 2005, 169). As the boundaries between public and private have become increasingly blurry, the responsibility for care, costs of care, and care work have been relocated and redistributed (Lyon & Glucksmann 2008, 102). This has increased the vulnerability of women as a group, but even more so for women who experience class and/or race/ethnic-based inequalities (Armstrong & Armstrong 2005, 170).

In this dissertation, I use a critical FPE framework to assess how, directly or indirectly, our governments' choices affect our health. National and provincial policies guide Canadian health and social care systems. For instance, the *Canada Health Act* (CHA) mandates public funding for care provided by physicians or within hospitals. Governments at the federal, provincial, regional, and municipal levels play a role in funding, managing, and/or delivering home care. Home care's positioning outside of the medical mainstream means that there are no national standards for publicly funded home care. The CHA principles of universality,

accessibility, portability, comprehensiveness, and public administration are not applicable to its delivery (Williams *et al.* 2001, 21). As a result, home care is delivered differently across Canada and even within provincial jurisdictions, through complicated networks of programs, organizations, and carers in governments, not-for-profits, for-profits, charitable agencies, communities, and households. The lack of protection under the CHA makes the home care sector especially vulnerable to neoliberal restructuring as governments focus on "doing more for less" (Borins 1995, 123). The neoliberal position is that the state has "no higher purpose than efficiency" (Jorgensen & Andersen 2011). As a result, equality and equity goals are subordinated to efficiency goals under neoliberalism (Newman & Ashworth 2016, 350).

## Equality

In the same way that FPE takes a critical look at how care has been conceptualized under neoliberalism, it likewise brings a more nuanced understanding of equality. This is needed to make sense of the gendered, classed, and racialized impacts of neoliberal home care restructuring. The concept of equality/inequality is fundamentally political. Its meaning has shifted to reflect social, economic, political, and ideological contexts (Newman & Ashworth 2016, 348). Historically, equality has been conceptualized as "administrative justice" - where everyone is subjected to the same rules (Health Canada 2003, 8). For example, Health Canada (ibid) explains that having the government treat people equally means giving women and men the same opportunities, services, and programs.

The conceptualization of equality under neoliberalism is rooted in this idea of equal opportunity but is even narrower in focus. Neoliberal policy makers see the state's job as being to protect the right of each individual to compete in the free market (Braedley & Luxton 2010, 8), as opposed to requiring the state to ensure equal access to public resources for all citizens.

The neoliberal understanding of equality gives rise to individualization and self-responsibilization. Clients are made responsible for choosing their own care and producing their own health outcomes. This is typically achieved by "taking on characteristics of the dominant groups in whose image organizational cultures have been moulded over successive generations" (Newman & Ashworth 2016, 349). The neoliberal definition of equality does not acknowledge the barriers to market participation caused by systemic discrimination. Seeing the market as the most efficient allocator of goods and resources, neoliberals are inclined to accept whatever markets bring (Coburn 2000, 138). They contend that market inequalities are the necessary by-product of a well-functioning economy. Seeing these inequalities as "just" is based on the idea that what one puts into the market, one gets out (ibid, 138-9). By constructing a passive role for the state in redressing historical and institutional inequalities, groups with class, gender or race/ethnicity privilege are able to reproduce their positions of power. Meanwhile, marginalized groups go unheard and remain excluded from centres of power and decision-making.

## Equity

In contrast to the narrow neoliberal definition of equality, "substantive equality" reflects the importance of ensuring not only equality of opportunity but also equality of outcome (Health Canada 2003, 8). For the purposes of this dissertation, equality conceptualized in this manner is referred to as "equity". Equity is the idea that different treatment may be required to achieve fairness when differences between people cause disadvantages and inequality (ibid). Equity recognizes the need to respond to difference rather than ignore it. Its recognition of the relational, intersectional nature of systems of class, gender, and racial/ethnic oppression, and their connection to context, capacity, and power, makes equity a useful tool for understanding a

key silence in the neoliberal view of equality as "sameness" (Young 1998) or "independence" (Armstrong 2010).

## Efficiency

The neoliberal emphasis on marketization as the key to reshaping the welfare state centres on an efficiency discourse (Waked 2014, 652). Neoliberals claim that markets are the most efficient mode of social organization. In market theory, it is assumed that if all the exchanges in a system are efficient, the result will be efficiency at the societal level of "maximum social welfare" (Stone 2002, 69-70). The denotative definition of efficiency under neoliberalism is rooted in microeconomic theory: "maximizing aggregate resources, as represented by the sum of individual cost-benefit calculations in the (presumably free) market" (McCluskey 2003, 786).[8] In health care policy, efficiency is concerned with the relation between resource inputs (costs, in the form of labour, capital, or equipment) and either intermediate outputs (clients treated, waiting times, client satisfaction, etc.) or final health outcomes (lives saved, life years gained, etc.) (Palmer & Torgerson 1999, 1136). Technical efficiency, or productivity, is defined as producing the maximum amount of output from a given amount of input, or alternatively producing a given output with minimal input quantities (Hollingsworth 2008, 1108; Stein 2001, 21-22). Allocative efficiency occurs when the input mix is that which minimizes cost, given input prices, or alternatively when the output mix is that which maximizes revenue, given output prices (Hollingsworth 2008, 1108). Together technical and allocative efficiency help us determine "the allocation of resources in which value is maximized" (Posner 1992, 13).

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[8] This definition of efficiency reflects Kaldor-Hicks efficiency: resource allocations in which aggregate gains outweigh aggregate costs (despite losses for some individuals). In contrast, Pareto optimality is a more ideal version of efficiency that occurs when resource allocations increase aggregate gains without imposing costs on any individual according to that individual's own subjective cost calculation (McCluskey 2003, 786).

Efficiency is about how we should allocate our resources to achieve our goals, not what our goals should be (Wildavsky 1979, 131; Stein 2001, 68; Stone 2002, 61). However, under neoliberalism, efficiency has become an end in itself, a value more important than others (Stein 2001, 3). For example, Health (2001, 7) argues that efficiency is a value because it is a criterion that we use to decide what is good and bad, what to choose. Furthermore, under neoliberalism efficiency language is often used to advance political purposes and agendas (Stein 2001, 7). For example, it is often used connotatively as a code word for an attack on "the sclerotic, unresponsive, and anachronistic state" (ibid), while market mechanisms are heralded as the efficient alternative. The result is that efficiency is often "twisted by political leaders to mean cost-cutting or cost-containment" (Stone 2002, 70-71) of public expenditures. For instance, in federal and provincial governments in Canada, efficiency discussions frequently focus on reducing, or at least better managing, the state's share of the costs associated with the funding, management, and delivery of health and social services. It is no accident that efficiency is often used to mean cost-effectiveness (Stone 2002, 70-71). This relates to the broad neoliberal theme that smaller government makes for a more efficient economy/society, and so cost-cutting is supposed to create efficiency. However, Stone (2002, 70-71) points out that neither cost-cutting nor cost-containment is inherently efficient if the quality or the quantity of the public good governments provide is reduced more than the costs. Yet, this is rarely acknowledged in neoliberal discourse. In this study, I use a connotative definition of efficiency rather than a denotative one in recognition of the varied and ill-defined ways efficiency is used within the neoliberal policy-making context.

## Research Question

There has been interest in integration since the 1940s. However, the creation of ICPs as a policy solution to the policy problem of fragmentation has assumed primary importance in recent decades, in large part due to the neoliberal focus on enhancing efficiency. In this dissertation, I ask the primary research question: how have integrated care programs been used to combat issues of fragmentation in the home care sector?

## Fragmentation

Fragmentation under neoliberalism is seen as a manifestation of an inefficient system (Axelsson & Bihari Axelsson 2006; Clarfield *et al*. 2001; Glendinning 2003). The neoliberal restructuring of the home care sector has aimed to establish more efficient practices that will result in cost savings for the state (Dubuc *et al*. 2013). Fragmentation refers to components of care systems that "function in silos" (Tsasis *et al*. 2012, 8), such as the separation of health and social care, or the distinction between "professional" and nonprofessional care workers. Fragmentation can also mean the lack of coordination between those responsible for care, gaps in or the duplication of services and infrastructure across levels or settings, or care that is provided in an inappropriate location (Montenegro *et al*. 2011, 5).

Fragmented home care can result in a care system that is insufficiently equipped to meet the care needs of older adults.[9] Potential consequences of fragmented care can include: misunderstanding by the client, adverse drug events, impaired treatment participation, and treatment errors (Nolte *et al*. 2012; Vogeli *et al*. 2007). Moreover, fragmentation can lead to worse health outcomes for clients through unnecessary delays in treatment that result in negative

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[9] Boyd & Fortin 2010; Nolte & McKee 2008; OECD 2011; Spoorenberg *et al.* 2015; Vedel *et al.* 2009; Bowles *et al*. 2003; Berglund *et al*. 2015; Spoorenberg *et al*. 2015.

clinical outcomes (Montenegro *et al.* 2011, 13), such as urinary tract infections, pressure sores, dehydration, depression, and reduced quality of life (Gittell *et al.* 2008). Fragmentation can also impact paid workers (Gittell *et al*. 2008, 165) and unpaid carers, particularly with regards to respite care (Janse *et al*. 2014).

Yet, these effects of fragmentation are often subordinated to the fact that fragmentation results in the "irrational and inefficient use of resources, unnecessary increases in production costs, and a low user satisfaction" (WHO 2000, 2007, 2008). In a neoliberal system that strives to "better coordinate services, eliminate duplication and manage costs" (England *et al.* 2007, 191), fragmentation has been equated with "efficiency and quality problems, such as duplications, gaps and discontinuity" (Axelsson & Bihari Axelsson 2006; Clarfield *et al*. 2001; Glendinning 2003). Being linked to a lack of efficiency and profitability has resulted in the construction of fragmentation as a health care crisis requiring immediate intervention in order to avoid a "global health emergency" (WHO 2015).

## Integrated Care

Integration as a tool to redress fragmentation in medical care delivery resurfaced in the 1970s and 1980s with physicians voicing concerns that the then emerging trend of specialization would end up disintegrating professional practice (Kodner & Spreeuwenberg 2002). As NPM proliferated around the same time, "integrated care" as a distinct concept was coined and subsequently appropriated by policy makers as a core component of neoliberal health and social care reform across much of Europe and North America (ibid; Lloyd & Wait 2006).

Several definitions of integrated care have been proposed. This is indicative of scholars' attempts to capture the complexity of the concept. In this study, I conceptualize integrated care

as "patient care that is coordinated across professionals, facilities, and support systems; continuous over time and between visits; tailored to patients' needs and preferences; and based on shared responsibility between patient and caregivers for optimizing health" (Singer *et al.* 2011, 113).[10] I have selected Singer *et al.*'s (2011) definition because of its construction of care as relationship among the client, unpaid carers, and paid care workers, as opposed to seeing it as a unidirectional service provided by a carer to a client. It also acknowledges the blurry line between client preferences and needs. I refer to expressed needs in this study in an attempt to problematize a system where paid workers (usually case managers) assess clients and tell them what their needs are. This devalues the lived experience of clients and their understanding of their unique reality and needs. I recognize that emphasizing the client's role in their own care has been co-opted by neoliberal policy makers who wish to relocate the responsibility for care from the state to the client; this is not my intention. However, I think there is a place for client involvement in integrated care, something this definition attempts to capture.

The academic literature discusses an assortment of integrated care approaches (Kodner & Spreeuwenberg 2002), types (Conrad & Shortell 1996; Leatt 2002; Kodner 2009), forms (Leutz 1999), and levels (Contandriopoulus *et al.* 2003; Edwards & Miller 2003; Banks 2004; Kodner 2009). I narrow in on service delivery integration as a particularly salient component of

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[10] This definition is not perfect, particularly in its terminology. It conforms to the biomedical model with the use of the term "patient". It also uses the problematic term "caregiver" which has connotations of care being given by one person and passively received by another. It lumps all paid care workers into the category of professionals. This invisibilizes the substantial number of care workers on the bottom of the occupational hierarchy that do the majority of the body work and home upkeep (the ADL and IADL work) but whose training and/or credentials exclude them from being classified as "professionals". Lastly, this definition is missing some acknowledgement that integrated care must work to meet the needs of unpaid and paid carers in addition to those of clients. The conditions of work impact the conditions of care. Clients, unpaid carers, and paid carers all experience impacts of fragmentation through their involvement in home care. If integrated care is to be a solution to fragmentation than it must consider the needs of all the people involved in home care by addressing fragmentation in both the home and the workplace.

integrated care in the reshaping of home care. Service delivery integration is conceptualized as working towards continuity, cooperation, and coherence in the process of care delivery at the individual level of care provision (Delnoij *et al.* 2002). Conrad and Shortell (1996) explain it as the coordination of care services across providers, functions, activities, processes, and settings. Service delivery integration is most concerned with communication, teamwork, collaborative care planning, joint training, and providing a holistic basket of services (Hollander 2002; Leatt 2002; Kodner & Spreeuwenberg 2002; Kodner & Kyriacou 2000). In this study, I focus on three key aspects of service delivery integration as it applies to home care ICPs: combining health and social care (Sun *et al.* 2014), taking a team approach to care involving paid and unpaid carers,[11] and balancing seamless care with client-centered care.[12] These align closely with the four areas of unmet care need identified by my research participants: continuity of care, social inclusion, inclusive decision-making, and communication/joint working.

Both academics and policy makers emphasize the potential of ICPs to enhance the efficiency of a fragmented, inefficient home care sector. ICPs promise to "avoid duplication…to ensure quality and efficiency...to stabilize markets, to use excess capacity, to secure profits..." (Brown & McCool 1992, 67). Yet, fragmentation is distinct from a lack of integration. Reflecting the neoliberal tendency to see in dualisms, fragmentation and integrated care are often positioned as a dichotomy in neoliberal discourse. When fragmentation is constructed as a problem of inefficiency, it becomes easy to construct integrated care as its opposite, positioning

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[11] Kodner & Spreeuwenberg 2002; Xyrichis & Ream 2008; Walker *et al.* 2016; Sampalli *et al*. 2012; Johri *et al.* 2003; Wagner *et al.* 1996; Wagner *et al.* 2001; Ouwens *et al.* 2005; Batalden & Mohr 1997; McCormack *et al.* 2008; Hartgerink *et al.* 2014; Leutz 1999; Harris *et al.* 2012; Frossard *et al.* 2004; Pappas *et al.* 2013; Carpenter *et al*. 2000; Atwal & Caldwell 2002.

[12] Wolff *et al.* 2002; Singer *et al.* 2011; Walker *et al*. 2016; Gittell *et al.* 2008; Greenfield *et al.* 2014; Rogers & Sheaff 2000, 53; Coddington *et al.* 2001; Banks 2004; Leutz 1999; Harris *et al.* 2012; Frossard *et al.* 2004; Pappas *et al.* 2013; Carpenter *et al*. 2000; Atwal & Caldwell 2002.

it as an efficiency-enhancing solution. However, this juxtaposition is insufficient to capture the complexities in their meanings.

There is a contradiction in neoliberal policy makers advocating the use of publicly funded ICPs to increase the efficiency of home care delivery, given that it was the efficiency-motivated restructuring of the welfare state that exacerbated disintegration in the home care sector in the first place. However, before ICPs can be dismissed as just another neoliberal policy tool, their inherently contradictory nature gives a hint of something more complex. In a sector where so much of the reform has been about the state distancing itself from service provision, creating ICPs that are state-funded, and in Alberta and BC, also entirely state delivered, is unusual. Furthermore, there is interest at the provincial government level to maintain, if not expand, the ICPs in this study. In a neoliberal context that is fundamentally opposed to increasing state intervention in health and social care delivery, the push to create and expand ICPs is an anomaly and worthy of study. Integrated care and its contradictory nature and outcomes are discussed in greater detail in Chapter 3.

## Research Methodology and Design

To explore the contradictions of using integrated care to combat fragmentation, I study which groups were affected by their involvement in ICPs, in what ways, and under what conditions. I research the lived experiences of program administrators, paid carers, unpaid carers, and clients involved in five ICPs and situate the data I collect in the social, political and economic contexts that shaped their lives. Starting from the position that women are the experts of their own lives with unique and context-dependent experiences, I use a post-positivist epistemological approach to guide my research design.

Post-positivism is a critical research paradigm that challenges the view of researchers as "objective" observers who are able to control their biases and collect "neutral facts" that will lead them to a universal "truth". Instead, it focuses on how social constructs, forces, and relations shape "the ways in which we conceptualize and speak and write about health, [these] are never just about health; they also function as repositories and mirrors of our ideas and beliefs about human nature and the nature of reality" (Robertson 1998, 155). Post-positivism offers an alternative to a positivist way of knowing. Most important to this study, post-positivism challenges the idea that data can be de-contextualized in order to make generalizations. My analysis emphasizes the centrality of gender, race/ethnicity, and class as fundamental forces shaping women's lives, as opposed to treating these as variables to be controlled. In contrast to a positivist research approach that risks obscuring the gendered, racialized, and classed inequalities and inequities that exist in home care, a post-positivist approach makes these visible. For example, a post-positivist approach facilitates looking at both paid labour in the formal economy as well as the unpaid care labour of family members or paid carers working beyond their paid work hours. This creates space within which to ask the questions: why is care work devalued when it occurs informally, and why does paid care work count for less than other types of service sector work? Understanding the classed and racialized experiences of women as a basis for differential treatment, both in comparison to each other and to men, is at the heart of understanding their unique and subjective realities as providers and recipients of home care.

My qualitative research design uses in-person interviews and thematic analysis to capture the rich and complex experiences of the clients and carers seeking to get their expressed needs met through involvement in an ICP. I interpret the lived experiences of my research participants in their social, economic, and policy contexts in order to critically assess whose interests matter,

what policy goals are considered legitimate, and how care is designed and delivered to meet people's expressed needs. My study challenges the sex/gender-, race/ethnicity- and class-blindness of much of the research on integrated care undertaken from the prevailing positivist, biomedical paradigm. I highlight tensions, contradictions, and outliers in my data to avoid presenting a unitary account that invisibilizes the experiences of minority groups. Multiple voices enrich my data and I pay particular attention to incorporating the voices of individuals and groups who are traditionally excluded.

Instead of seeking to produce generalized recommendations in the form of "best practices" that are decontextualized and disembodied from the multiple subjectivities involved in the delivery and receipt of home care, I look for practices that are worth sharing. These "promising practices" (Baines & Armstrong 2016) consider the conditions and contexts that are indispensable to understanding why they work well for a certain group, in a particular location, at a specific time. Different groups have different, and often conflicting, interests. Promising practices acknowledge that policies cannot always work well for everyone, all the time. They allow me to talk about the tensions and contradictions that arise as a result of the neoliberalization of home care without being trapped into proposing the "right" way to organize ICPs.

My data are collected from federal and provincial government documents, including legislation and regulations, strategy documents, action plans, news releases, commissioned reports, and annual or progress reports. I analyze non-governmental organization reports and both commissioned and independent academic reports. My primary data are collected from 118 semi-structured interviews with program administrators, paid care workers, unpaid carers, and clients in five community-based home care programs that identified integrated care as one of

their guiding principles for service delivery.  I also use informational brochures, pamphlets, and/or reports from each ICP.  My research participants are from the Aging in Place (AIP) program in Ottawa, Ontario; the Seniors Managing Independent Living Easily (SMILE) program based in Ontario's South-East Local Health Integration Network (which covers Kingston, Trenton and surrounding areas); the Carefirst program in Scarborough, Ontario; the Comprehensive Home Option for Integrated Care for the Elderly (CHOICE) program in Edmonton, Alberta; and the Home Health (HHH) program in Hope, British Columbia.  I introduce each of these programs in detail below.

Using thematic analysis based on Braun and Clarke's (2006) method, I identify four categories of expressed need from the data: continuity of care, social inclusion, communication/joint working, and inclusive decision-making.  Using FPE to interpret my empirical data, I illuminate the complex interconnections between fragmentation, efficiency, equality, and equity in the delivery of integrated home care under neoliberalism.  My dissertation tells the complicated story of how ICPs work differently for different groups of clients and carers.  Oftentimes ICPs reduce fragmented care for clients and carers in positions of class, gender and race/ethnic privilege, yet they do not bestow similar benefits on individuals belonging to marginalized groups.  To explain this, I analyze the specific policy techniques used by each ICP to design and deliver care.  The extent to which an ICP's policy techniques are influenced by neoliberalism, in particular, whether they seek to enhance efficiency or equality/equity, is fundamental to whether the ICP redresses or perpetuates home care fragmentation.

## Argument

My central argument is that ICPs are most useful as a policy solution to fragmented home care when they use policy techniques that promote equitable processes and outcomes as opposed to focusing solely on enhancing efficiency. ICPs use a variety of policy techniques to design and deliver home care. These include neoliberal techniques with a market orientation, such as service cuts, contracting out, task-shifting, lean staffing levels, work intensification, responsibiliziation of the client, independent contracting agreements, flexible funding arrangements, and prescriptive care plans. They also include techniques that aim to distribute the benefits of integrated care more equally among, and between, clients, unpaid carers, or paid care workers. The specific policy techniques used differed among the five ICPs studied here. Similarly, the mix of neoliberal versus non-neoliberal techniques varied within each ICP under consideration.

My empirical evidence indicates that integrated care has been fundamentally shaped by neoliberalism in ways that have resulted in fragmentation, inefficiency, inequality, and equity being inextricably linked. Although the increasing importance of integration to health and social care delivery systems has not escaped scholarly and policy attention, the significance of using ICPs as a policy solution within a neoliberal context remains understudied. I content that one cannot understand the complexity of using integrated care to redress fragmentation in home care without thinking about the influence of neoliberalism. I see this as a unique contribution to the academic literature.

The main finding from my exploration of the relationships among fragmentation, inefficiency, equality, and equity in ICPs, is that the goal of a policy technique is connected to its impact on fragmentation. Policy techniques that seek to enhance efficiency as their primary

policy goal often perpetuate fragmentation, while policy techniques that focus on promoting equality and/or equity reduce fragmentation. I show that policy techniques aiming to achieve cost savings for the state increase inequality between, and among, ICP clients and carers. ICP policies and processes that increase inequality contribute to increased fragmentation for clients and carers, while those that decrease inequality help reduce it.

This is important because a focus on equity as a policy goal does not align with the typical objectives of neoliberal policy makers. However, my empirical evidence shows a pattern of unsuccessful attempts to redress the inefficiencies of fragmentation by using policy techniques focused primarily on achieving cost savings for the state. I call this the fragmentation-inefficiency paradox: when policy makers prescribe neoliberal policy solutions aimed at enhancing efficiency to redress fragmentation, in many cases they actually perpetuate the fragmentation which they viewed as inefficient. This is an example of one of the "messy actualities" of neoliberalism.

I conclude that despite initially being created as a neoliberal tool to enhance efficiency, ICPs have the ability to disrupt the "common sense understanding in society" (Mitchell *et al*. 2004, 4) that increasing efficiency will reduce fragmentation. ICPs can be a policy solution to fragmented home care when they use policy techniques that promote equitable processes and outcomes, as opposed to focusing on enhancing efficiency. The ICPs I study provide several examples of promising practices that meet the expressed care needs of clients and carers. They demonstrate how to reduce barriers to accessible care, fill care gaps in an equitable manner, and facilitate collaboration and communication. My key recommendation is for ICP program administrators to prioritize the use of policy techniques that distribute the benefits of ICP involvement more equitably between, and among, clients and carers. When ICPs work for the

benefit of everyone, the expressed needs of home care clients and their paid and unpaid care workers alike can be met.

## Chapter Descriptions

This dissertation comprises eight chapters.  It is based on the premise that understanding the complexity of using integrated care to redress fragmentation in a home care sector fundamentally shaped by neoliberalism requires a dialogue between the theoretical and the empirical.  Chapters 1-4 provide the theory, while Chapters 6-7 contain my empirical evidence.  Chapter 5, my methodology and research design, links these together.  In Chapter 1, I present my central argument situated in the concepts and context fundamental to understanding it.  I justify my focus on home care, the elderly, and women.  I also conceptualize key terms including neoliberalism, feminist political economy, equality, equity, efficiency, fragmentation, and integrated care and outline my research methodology and design.

In Chapter 2, I describe the three interrelated components of neoliberalism: neoliberalism as an ideology, a mode of governance, and a policy toolkit.  I use this conceptualization of neoliberalism to show how it has contributed to a narrow understanding of efficiency and equality.   I argue that a neoliberal policy-making environment has encouraged policy development focused on cost-efficiency, sidelining consideration of equality and equity as legitimate policy goals.

In Chapter 3, I investigate how neoliberalism has been used by the federal government and the provincial governments of Alberta, Ontario, and BC to restructure the health care system. I show that despite being customized in each context, neoliberalism has had a substantial influence on how home care is funded, managed, and delivered in each jurisdiction.  I then argue

that neoliberalism is both uneven and inconsistent in its penetration leading to contradictory outcomes. I present two case studies where neoliberal policy solutions have created tensions or contradictions: the use of community care access centres and competitive bidding in Ontario and the use of aging at home strategies to deal with the alternative level of care crisis. Making sense of the "counter-tendencies" (Tickell & Peck 2003, 165) created under neoliberalism is fundamental to understanding why integrated care is a useful tool for combating fragmentation in home care in spite of its neoliberal origins. I argue that it is the complexity of integrated care that enables ICPs to break the cycle of fragmentation and inefficiency by bringing equity considerations into the discussion.

In Chapter 4, I propose using Feminist Political Economy (FPE) as a critical lens to make sense of the contradictions, tensions, and silences that arise under neoliberalism. I contend that using FPE as my theoretical framework better positions me to take a critical look at whether ICPs can offer equitable outcomes for clients, unpaid carers, and paid carers, than working from a neoliberal perspective with its narrow focus on efficiency and insufficient conceptualization of equality. This chapter focuses on two key contributions of FPE to a critical understanding of home care restructuring within a neoliberal context. First, FPE provides a conceptual framework for thinking about care and care work. Second, it guides my understanding of the blurring of the public-private dichotomy. I argue that FPE puts equality and equity "on the table" in a way that is not possible when working from a neoliberal perspective.

This dissertation's methodology and research design are presented in Chapter 5 to link the theoretical to the empirical. I use a post-positivist epistemological approach to connect my FPE theoretical framework to my qualitative research design. Challenging the neoliberal push for quantification, I build knowledge about the realities of women's lives as clients and carers

involved in ICPs using their lived experience as my primary data source. In-person interviews and thematic analysis capture the rich and complex experiences of my research participants. By interpreting these experiences in their social, policy, and economic contexts I diverge from the sex/gender-, race/ethnicity- and class-blindness of much of the research on integrated care undertaken from the prevailing positivist, biomedical paradigm.

Drawing on interview data in four areas of expressed need identified by research participants: continuity of care, social inclusion, collaborative decision-making, communication/joint working, Chapters 6 and 7 use empirical evidence to support my argument that ICPs are most useful as a policy solution to fragmented home care when they use policy techniques that promote equitable processes and outcomes as opposed to focusing solely on enhancing efficiency. In Chapter 6, I demonstrate that ICPs that use policy techniques aligned with neoliberalism to deliver home care, often meet the needs of clients, unpaid carers, or paid care workers in positions of class, race/ethnicity or gender privilege at the expense of addressing the needs of less powerful groups. I highlight the impacts of service cuts, contracting out, task-shifting, lean staffing levels, work intensification, responsibilization of the client, independent contracting agreements, flexible funding arrangements, and prescriptive care plans, as policy techniques that use market-oriented solutions to deal with issues arising from fragmentation. Despite their objective to reduce fragmentation through enhanced efficiency, these policy techniques increase class, race/ethnicity and/or gender inequality. ICPs using these techniques are less able to meet the expressed needs of their clients, unpaid carers and paid workers. This, in turn, perpetuates fragmentation.

In Chapter 7, I show how ICPs use policy techniques, such as providing care without user fees, supporting care workers, making time for social support, and facilitating collective forums

for carers, in the pursuit of equity as a policy goal. By distributing resources more equitably between, and among, clients, unpaid carers, and paid workers, as well as working to reduce power disparities within groups, ICPs are able to reduce fragmented care delivery. For instance, traditionally marginalized groups are less likely to need to look outside their ICP to get their needs met. Carers report more collaborative workplace relationships, with better quality communication. Finally, there is a more seamless provision of services for the benefit of clients, unpaid carers, and paid workers. Policy techniques promoting equitable outcomes help redress fragmentation.

Rooted in the empirical data presented in the previous chapters, Chapter 8 highlights promising practices in using ICPs to deliver home care and recommends ways program administrators could consider moving forward. I share practices that reduce barriers to accessible care, fill care gaps in an equitable manner, and facilitate collaboration and communication between, and among, clients and carers. My primary recommendation is for ICP program administrators to use their positions of power to resist the use of neoliberal "common sense" policy techniques. I call for program administrators to reshape the policies and processes used in their ICP to, where possible, move away from using efficiency-motivated techniques to redress fragmentation – something that this dissertation shows does not work. There is much to be gained by making small changes in how care is delivered at the program level to promote equity as opposed to focusing solely on efficiency.

## Conclusion

Much of the policy work on integrated care has emphasized efficiency goals at the expense of equality and/or equity goals. Folbre (2008, 381) argues that, in many cases, efficiency and equity goals are played against each other, as though invoking one somehow

weakens the other. In the context of ICPs, equity considerations have been subordinated to efficiency goals to such an extent that they are essentially absent from the discussion. It may be possible to reconcile equity with efficiency; however, neoliberal tendencies make it difficult to deliver this type of holistic approach. The benefit of implementing my recommendation for ICPs to pursue equity goals is the creation of conditions under which both inequality and fragmentation are reduced. It may follow that reduced inequality and fragmentation achieve greater efficiency in the longer term.

I argue that for ICPs to be useful as a policy solution to fragmented home care, they must use policy techniques that promote equitable processes and outcomes. When ICPs use neoliberal policy techniques that emphasize efficiency goals, while subordinating equality and equity goals, they perpetuate fragmentation instead of redressing it. It is worth trying something different in hopes of achieving a better result. In order to understand the nuances of how ICPs work to meet the needs of clients and carers and why they often fall short, Chapter 2 provides a foundation for understanding why efficiency is more likely to be "on the table" in neoliberal policy discussions about health and home care system reform than equity.

# Chapter 2: Neoliberalism in Theory

## Introduction

To understand how neoliberalism has shaped the interconnections among efficiency, equality, and equity in the context of integrated home care, I begin by describing neoliberalism in theory. I conceptualize neoliberalism as three interconnected components. First, I discuss how neoliberalism can be understood as a hegemonic political and economic ideology. Neoliberal ideology is visible in the use of market-oriented language in legislation and policy documents, the state's preference for using business solutions to policy problems, and the focus on individualism in government documents and policy initiatives. Second, I discuss neoliberalism as a governance structure rooted in New Public Management (NPM), self-responsibilization, and quantification. The neoliberal mode of governance promotes the idea of governing at a distance which has resulted in the relocation of the responsibility for funding, management, and service delivery to lower levels of government, and from the state to the private sector, households, and individuals. It has also contributed to a push for evidence-based best practices and an increased emphasis on reporting and accountability. Third, I explore neoliberalism as a set of policy tools that emphasizes the use of privatization and de/re-regulation to achieve greater cost-efficiencies for the state. State partnerships with the private sector, the downloading of care work, the commercialization of service delivery, increased standardization, the delisting of services, and the introduction of user fees, have all been encouraged by the state as strategies to reduce its share of the costs associated with health and social care provision.

The following chapter takes the discussion of neoliberalism from theory to practice by showing how neoliberalism, in its various forms, has been used by the federal, Alberta, Ontario,

and BC governments to restructure health and home care. Together, Chapters 2 and 3 demonstrate how a disproportionate emphasis on efficiency is rooted in neoliberal theory, and has fundamentally reshaped health and home care policy in four Canadian contexts.

## Neoliberalism as an Ideology

An ideology is a coherent way of understanding social reality (Armstrong 2013, 188) rooted in specific values and assumptions about the world. The lack of consensus on what social values are fundamental for the creation of a "better world" (Steger & Roy 2010, xi) creates space for the construction of multiple, competing political and economic ideologies. Some political theorists, like Dahl and Lindbloom (1953), have proposed "peace, inclusion, well-being, and stability" as most important to constructing relationships between states, markets, and citizens. Others align more closely with Mill's (1869) philosophy, seeing individual autonomy as paramount. These conflicting values contribute to contrasting views on what constitutes a policy "problem" and what role the state should play in devising and implementing appropriate "solutions".

Neoliberalism originated as an alternative to the Keynesian political and economic ideology in capitalist democracies. Premised on the work of economists such as Hayek (1960) and Friedman (1955), welfare states and public sector workers were redefined as part of the problem of expensive and inefficient governments. Neoliberal ideology sees the state as distorting the market, creating inefficiencies in the provision of public goods. The proposed solution is to use market mechanisms and for-profit management techniques to restructure governments and their ways of working to be more productive and efficient. Neoliberal governments work to reduce the public expenditures used to operate public institutions, run programs, deliver services, or pay public servants. Government cost cutting is based on the

assumption that doing so will motivate public servants and citizens to get more done with less; neoliberals see this push to get the best value for public money as a good thing. Cutting costs also facilitates the creation of a smaller government. This leaves more opportunity for market forces, thereby creating a more competitive and efficient economy and society. Finally, cost-cutting frees up public funds that governments can redirect to paying down the debt/deficit. Debt/deficit elimination is a top political priority for many neoliberal governments. When neoliberalism became the new form of capitalism, this ideology achieved hegemonic status becoming a matter of "common-sense consensus" in policy circles on both the left and right (Armstrong 2013, 189).

Neoliberalism as a political economic ideology proposes that "human well-being can best be advanced by liberating individual entrepreneurial freedoms and skills within an institutional framework characterized by strong private property rights, free markets, and free trade" (Harvey 2005, 2). The assumption that free markets and liberalized trade can guarantee individual freedoms is central to neoliberal thinking (ibid, 7). Neoliberal ideology emphasizes the intensification and expansion of the exchange of material goods and services (Steger & Roy 2010; Ward & England 2007a; Larner *et al.* 2007) by prioritizing profit-making, striving for market efficiency, and maximizing competition (Brodie 2007; Braedley & Luxton 2010; Steger & Roy 2010). It assumes that because of competition, the for-profit sector is necessarily efficient and effective (Christie 1996). Through the pursuit of self-interest, each firm and individual stimulates the economy, eliminates waste, and expands choice. The role of the state under neoliberalism is to create and preserve an institutional framework appropriate to market-based practices (Harvey 2005, 2).

Neoliberal ideology conceptualizes health as a consumer commodity and health care as a business with the potential to yield profit. Neoliberals invoke business-like, bottom-line, and value-added language (Armstrong 2001a, 72) when talking about health. They refer to health care as services, health care facilities as one-stop-shops, and citizens as clients or consumers. The neoliberal emphasis on consumer preferences prioritizes giving "choice" to informed service users who can, and want to, make decisions about their care. However, a service user's choices are still limited to options that conform to market requirements (Armstrong 2013, 191) - services must be available to purchase.

Unlike Keynesian theory, which assumes shared risks and the right to collectively provided supports, neoliberal policy makers focus on freeing individuals and businesses from state interference in the economy (Armstrong 2001b; Hackworth & Moriah 2006; Woolford & Curran 2011). Equality under neoliberalism is to provide equal opportunity for each individual to compete in the free market (Braedley & Luxton 2010, 8) and face the same market conditions (Armstrong 2001b). The state's role is to put policies in place that "empower" clients to "choose" the care they need from what is available in the market (Braedley & Luxton 2010, 8). The focus on ensuring equal access to the market does not require the neoliberal state to consider how individuals and groups interact with the market differently or how public goods are distributed among citizens.

Neoliberalism expects a certain kind of equality, but separates the goal of efficiency and the goal of social equity. Equity and efficiency are framed under neoliberalism as being in a zero-sum relationship: the more we have of one, the less we have of the other (Stone 2002, 80). This artificial trade-off between efficiency and equity means that we are told that we must choose between greater efficiency as an end and greater equity as an end (ibid, 72). McCluskey

(2003, 786) characterizes the separation of efficiency and equity under neoliberalism as a "fundamentally flawed division" because it "enables neoliberals to turn social citizenship from a public benefit to a public threat". If the free market is, by definition, the system that maximizes overall societal well-being, then equitable redistribution - which by definition diverges from that market - inherently risks detracting from overall societal well-being (ibid).

With market mechanisms being stressed as the way to enhance efficiency and cost-effectiveness, inequitable outcomes are perceived as "inevitable" under neoliberalism (Braedley & Luxton 2010, 8). Neoliberalism gives more power to people who control money and property than to people who do not (Stone 2002, 79). Harvey (2005, 19) argues that it is precisely this unequal distribution of power and material benefits that has enabled neoliberalism to remain entrenched as the dominant political economic ideology. He explains that neoliberalism "has succeeded remarkably well in restoring, or in some instances creating, the power of an economic elite" (ibid). This elite class has the political and economic control to project its own way of seeing the world so that those who are subordinated by it accept it as "common sense" (Ward & England 2007a, 11). Braedley and Luxton (2010, 18-20) argue that neoliberalism fundamentally deepens class divisions for two reasons. First, the existence of the elite class depends on the continued exploitation of a global working class population. Second, those benefiting from the neoliberal system have a deeply vested interest in containing any efforts on the part of working class people to reduce class inequalities. Neoliberalism deepens the already existing class-based alliances that exist under capitalism, incentivising elite actors and institutions to maintain their position as the dominant group by reinforcing the inequalities upon which their power is based.

These inequalities are class-based as Harvey argues, but they are also rooted in gender and race/ethnicity hierarchies. Bannerji (1995) describes class as "always constituted and

mediated by gender and race/ethnicity". In the same way that class, gender and race-based struggles are built into the capitalist mode of production (Vosko 2002, 77), these social relations remain fundamental to the neoliberal form of capitalism. While neither sex nor gender is considered an inevitable block to competing in the market, the prevailing sex/gender division of labour in most countries has resulted in a decline in women's positions and material well-being under neoliberalism (Braedley & Luxton 2010, 13). Similarly, neoliberalism arises out of, and advances, earlier capitalist systems rooted in imperialist and colonial domination (Connell 2010). Racial discrimination in which non-whites are marginalized remains entrenched in the neoliberal project (Braedley & Luxton 2010, 16).

Neoliberal ideology prioritizes efficient labour markets which depend on differentiated labour power. At the top of occupational hierarchies there are workers with the education, skills, and knowledge appropriate to the demands of "professional" or "skilled" jobs. Lower down are other workers who take the precarious, low-paid, "unskilled" jobs. At the very bottom are the "reserve armies" of casual or on-call workers who are ready to work when jobs become available often for low pay rates (Luxton 2015, 168). Those higher up on the occupational hierarchy often occupy positions of class, race/ethnicity, and/or gender privilege. Meanwhile, those at the bottom are more likely to be from historically marginalized groups, with the labour of women of colour being the most exploited for profit (Teeple Hopkins 2015, 137). The maintenance of class, race/ethnic and gender hierarchies yield distributional advantages for influential groups who benefit from the continuation of the neoliberal system. Meanwhile, the voices of those who bear the costs of the inequalities perpetuated under neoliberalism remain in the background.

Recognizing that "increasing social inequality has in fact been such a persistent feature of neoliberalization as to be regarded as structural to the whole project" (Harvey 2005, 16) is

important to a critical analysis of neoliberal health care restructuring. If those in power under neoliberalism have a vested interest in maintaining class, race/ethnicity, and gender hierarchies, it is a clear disincentive for them to create or support redistributive policies that redress inequity. Yet, Wilkinson and Pickett (2010) persuasively argue that increasing income inequality is correlated to worse health outcomes for *everyone* both between, and within, countries. When those in positions of power use neoliberal ideology to "produce and circulate a coherent program of ideas and images about the world, its problems and how these are best solved" (Ward & England 2007a, 11), it makes it difficult to identify inequality and inequity as legitimate policy problems and put them at the top of political or policy agendas. This, in turn, reinforces the neoliberal view of equality as equal opportunity to participate in the market while ignoring how increasing inequity based on class, gender and race/ethnic disparities makes everyone worse off. As the implementation of equitable policies and processes is taken "off the table", it facilitates a narrow focus on enhancing efficiency as the only legitimate goal of reform when, in fact, Stone (2002, 79) argues that "the best way to achieve efficiency is to provide a democratic governing structure that allows for these contests [about what constitutes social welfare] to be expressed and addressed in a fair way".

## Neoliberalism as a Mode of Governance

In addition to its influence as an ideology, neoliberalism has also shaped ideas about the proper scope and nature of government activity. Governance under neoliberalism revolves around the desire for "leaner and smaller government that sheds service delivery while governing from a distance through the greater reach of the rule of market-based law" (Armstrong 2013, 190). The turn to New Public Management (NPM) and the focus on accountability,

operationalized through self-responsibilization and quantification, are trademarks of the neoliberal governance structure.

Fiscal pressures were a major concern in many industrialized countries, including Canada, during the post-welfare state period (Armstrong 2001b). While the causes of debt and deficits remain contested, inefficient state bureaucracies (Ruggie 1996) and the demands of a large public service under the traditional public administration governance structure were seen by neoliberal policy makers as exacerbating state financial problems (OECD 1995, 19; Lynn 2001). During earlier periods of strong economic growth, the bureaucracies of most liberal democratic countries were large, hierarchical structures. Public servants were tasked with guiding expensive public sectors based on the values of "ministerial responsibility, prudence, stability, ethics, probity, fairness, transparency" (Charih & Rouillard 1997, 31).

The rise of neoliberalism, with Margaret Thatcher in Britain (1979) and Ronald Reagan in the United States (1980), stimulated a shift in ideas about governance and public management. This shift moved away from a communitarian conception of public administration to focus instead on the individual consumer (Charih & Rouillard 1997, 31). Proponents of neoliberalism rejected the hierarchical architecture of most government bureaucracies. They saw these bureaucracies as costly, lumbering organizations that were driven by rules rather than results (Pal 2014, 70). Neoliberals argued that traditional public administration stifled creativity, discouraged problem solving in favour of following routine, and devoted significant resources to managing people within the system, rather than achieving policy goals (ibid).

Neoliberal governance was framed as an alternative to the traditional public administration paradigm. NPM was supposed to "reinvent government" (Osborne & Gaebler

1993) based on values of competitiveness, self-interest, "entrepreneurship, freedom for managers, flexibility, creativity, enthusiasm, and risk taking" (Charih & Rouillard 1997, 31). This new governance structure promised to "get the debt problem under control" by both "doing more for less" (increasing efficiency) and "doing less with less" (welfare state retrenchment) (Borins 1995, 123).

NPM introduced private sector management techniques into the public sector based on the assumption that governments should try to be as efficient and responsive as possible (Pal 2014, 204). This was to be accomplished by making the public sector work more like the private sector (ibid, 202; Common 1998). Goals of smaller government, balanced budgets, and reduced public debt rose to prominence under NPM. Meanwhile, concerns such as social justice and redistribution fell out of favour (Pal 2014, 70). Neoliberals argued there is no legitimate role for government in the quest for egalitarianism and social justice, as this would undermine individual liberties and generate excessive public expenditure (Charih & Rouillard 1997). NPM transformed the relationship between the state and its citizens into a relationship between a producer of services and consumers (ibid).

NPM is grounded in the assumption that government is necessary but that it does not necessarily have to act like government. Osborne and Gaebler (1993, 19-20) outline ten principles of using NPM to create market-oriented governments that "steer, not row":

> Most entrepreneurial governments promote competition between service providers. They empower citizens by pushing control out of the bureaucracy, into the community. They measure the performance of their agencies, focusing not on inputs but on outcomes. They are driven by their goals - their missions - not by their rules and regulations. They redefine their clients as customers and offer them choices...They prevent problems before they emerge rather than simply offering services afterward. They put their energies into earning money, not simply spending it. They decentralize authority, embracing participatory management. They prefer market mechanisms to bureaucratic mechanisms. And they focus not simply on providing public services, but on catalyzing all sectors - public, private, and voluntary - into action to solve their community's problems.

NPM's entrepreneurial values of competitiveness, self-interest, individual empowerment, and decentralization are neoliberalism repackaged for the public sector.

Neoliberalism's emphasis on enhancing efficiency as its primary goal of reform has also been carried over into NPM. NPM responds to perceived bureaucratic and system inefficiencies by restructuring the public sector to be more entrepreneurial. Public servants are urged to privilege efficiency at the level of their individual agencies and also in the sector in which they are operating (Hood 1995; Aucoin 1995). For example, creating markets where none existed before (such as in the home care sector in Ontario) as a means of harnessing the power of the private sector is an important legacy of NPM (Manning & Lau 2016, 41).

In addition to operationalizing neoliberalism through NPM, self-responsibilization and quantification are also key components of governance under neoliberalism. Part of being accountable in neoliberal terms is to be responsibilized (Burchell 1993; Clarke 2005; Ren 2005). Neoliberals see a connection between the choices an individual makes and the outcome of their lives (Luxton 2010 164, 173). The idea that individuals should be accountable for their own health is part of the lifestyle/behaviour discourse about health. Self-responsibilization is used by the neoliberal state to justify downloading the responsibility for good health to individuals and households through policy initiatives, such as promoting healthy eating, smoking cessation, and encouraging physical activity. Neoliberal policy makers are wary of creating dependency by "overspending" on social services that they believe will undermine individuals' incentive to participate in the paid workforce (Armstrong 2001b, 19). Instead, the state seeks to construct autonomous, entrepreneurial, self-responsibilized neoliberal subjects (Rose 1996; Larner 2003). This shifts attention away from the communitarian conception of public administration (Charih & Rouillard 1997) and onto the individual, family, or household as the responsible agents for

social welfare. Compelling clients to rely on their own earnings to purchase services from the private sector, seek support from friends, families, and voluntary organizations, or to go without care before turning to the state for help (Luxton 2010, 167), reduces the government's portion of the costs of care provision. As the responsibility for care is relocated from the state to individuals and families, neoliberal policy makers can justify further cuts in state expenditures and the use of means-testing to limit access to state subsidized services to those they designate as "needy".

Quantification is another aspect of accountability under neoliberalism. Accountability at the organizational level often focuses on measurement and monitoring. Organizations seek quantitative data as evidence of their "competent administration of predefined tasks" (Woolford & Curran 2011, 595). Based on the idea that everything that is important can be counted and counted accurately, managerial practices under NPM assume "if you can't measure it, you can't manage it" (Newcomer 1994, 19). This pushes policy makers and program administrators to measure things that can be easily tracked, such as tasks completed, clients served, and client satisfaction. What are counted as data, how they are counted, how the data are processed, and what is done with what is found are value laden choices (Stone 2002). Yet, the political nature of quantification frequently remains "hidden" (Tesh 1988).

In health care, accountability formulas that prioritize quantification often result in a loss of control for care workers. For example, paid carers' decision-making power can be undermined through prescriptive job descriptions. Checking items off a care plan to provide statistics showing that specific program objectives have been met is not the same as responding to the expressed needs of a client. Privileging quantitative data as evidence of accountability risks these data being used to control and limit care given the context of state retrenchment rather

than to improve the quality of the care being provided. Furthermore, quantification encourages service providers to view clients through a universalizing lens that may not be representative of individual needs; thus, failing to take women's interests into account (Woolford & Curran 2011, 597). Not accounting for women's unique needs and interests, as both clients and paid and unpaid carers, is a critique that is similarly applicable to the push for self-responsibilization as well as the use of the NPM governance structure. In their attempts to govern from a distance, neoliberal governments invisibilize the gendered (as well as classed and racialized) impacts of policies aimed at enhancing cost-efficiency by failing to consider the disparities in health outcomes that arise as a result of their reforms.

## Neoliberalism as a Policy Toolkit

Government restructuring focused on finding new ways to create a more efficient system (Ward & England 2007a, 12) has used policy tools to promote both roll-back and roll-out neoliberalism (Peck & Tickell 2002). "Roll-back" policy tools are those that promote the hollowing out of the welfare state through privatization, deregulation, and the reduction of social services and welfare programs (ibid). "Roll-out" neoliberalism involves active state-building in terms of new regulatory reforms, policies or programs that support marketization (ibid). Home care in Canada has been reshaped by both of these policy tools with the privatization of public assets and institutions and the de/re-regulation of the economy being of particular significance.

The neoliberal policy toolkit has been used to promote the penetration of markets into fields in which public goods, including health care, were prominent under Keynesianism (Armstrong 2013, 189). This reflects the neoliberal assumption that private sector organizations are more efficient and effective at delivering publicly funded services than the public sector (Armstrong 2010, 191). The view of private goods or services as something of value, while what

is public is denigrated, is rooted in individualism (Coburn 2000, 141) – a value fundamental to neoliberal ideology.  Armstrong (2010, 192) strongly refutes the link between the privatization of public goods and services and enhanced cost-effectiveness.  However, neoliberals continue to seek individualistic market-based "solutions" to the policy problem of inefficiency in health care. For example, governments have turned to managed care, contracting out, user-fees for public services, and partnerships with the various levels of government, not-for-profit, volunteer, and for-profit organizations (Charih & Rouillard 1997) as ways of offloading services formerly provided by the state to the private sector and households.  These alternative ways of organizing and delivering care shift the balance of power to the partner with more resources, which in the context of a business paradigm, is more likely to be a for-profit organization (Armstrong 2001b). This has resulted in public agencies, not-for-profits, and voluntary organizations adopting management techniques and practices developed in the for-profit sector (Rekart 1993) to compete in the market.

In other cases, complete state withdrawal from care delivery (for example, delisting a service) or the failure of the state to provide care in an emerging area has led to private, and often for-profit, organizations moving in to fill the gap (Armstrong 2001b, 26). The cost of care in this form of privatization is borne either by private insurance, the individual, or the household.  These shifts towards privatization can benefit some, specifically clients in positions of economic privilege or private sector organizations.  However, the state's preoccupation with achieving cost-efficiencies at the expense of providing equitable care increases class, gender and race/ethnic disparities in the health outcomes of clients and carers.

The neoliberal policy toolkit also involves using a combination of deregulation and reregulation of economic activity and labour markets to pursue efficiency outcomes.  As Martin

(1993, 48) points out, it is "not whether or not the state intervenes in the economy that has changed [under neoliberalism] but how, and to whose benefit". Rooted in the assumption that private choice is better than public regulation as a mechanism for allocating resources and ordering social affairs (Phillipps 2002), the neoliberal state has moved to deregulate economic activity while regulating more labour and personal activities (Armstrong 2001b). Reducing state regulation of the economy is a neoliberal tool allegedly used to stimulate competition and expand service options for consumers at improved rates (Steger & Roy 2010, 62). Deregulation reinforces the emphasis on self-responsibilization discussed earlier. For instance, neoliberal policy makers have encouraged retaining non-unionized workplaces where the regulation of employment standards can be determined more directly by market forces (Thomas 2010, 77). Among the many repercussions, this has helped increase employers' control over workers' time and job status. For example, the use of individualized disputes resolution processes has made workers, particularly vulnerable ones, more susceptible to the unequal power relationships that characterize many employer-employee relationships (ibid).

Deregulation has also assisted organizations in maintaining leaner staffing levels by allowing them to supplement with a temporary, casual workforce. Consider, for instance, the practice of misclassifying employees as "independent contractors" (Workers' Action Centre 2007). When employers characterize paid care workers as "self-employed", even though their job retains all of the key characteristics of an employment relationship, workers are placed in an unnecessarily precarious position. Not only are they exempt from protections contained in employment standards legislation, but they are often denied access to benefits, such as paid leave, staff training, supplemental health insurance programs, or Employee Assistance Programs, that would be available if they were employed directly by the organization.

The re-regulation of the labour market often occurs in parallel with deregulation efforts. Under neoliberalism, having competitive advantage is seen as vital to competing in the global marketplace. The idea that a workforce must strive to be responsive to shifting market conditions is based on the notion that well-trained and highly skilled workers will be easily employable. Meanwhile, workers with limited or outdated skills will find themselves left behind. This will allegedly "motivate" workers to upgrade or be more flexible in order increase their employability (Steger & Roy 2010, 43). However, inherent in these assumptions is a neoliberal contradiction.

As discussed earlier, neoliberalism prioritizes efficient labour markets which depend on differentiated labour power. Regardless of one's motivation or work ethic, neoliberalism does not allow for all workers to move to the top of the occupational hierarchy. In practice, neoliberal re-regulation of the labour market has produced a growing workforce of part-time, casual, and contract labour at the bottom of organizations. Connell (2010, 26) characterizes this as the creation of a class of precarious workers. The neoliberal project perpetuates inequality by reinforcing the "irregular but insistent rollback of entitlements and security" of workers at the bottom of the labour force. Thomas (2010, 86) agrees, arguing that state policies redesigned to promote the employer-oriented labour "flexibility" required for competitiveness, have "deepened class divisions and facilitated labour exploitation through the production, maintenance and intensification of a low wage racialized labour force". As neoliberal policy makers push for new ways to de/re-regulate and privatize, they remain mostly silent on the ways their policy tools and choices perpetuate class, gender, and race/ethnic inequality.

## The Neoliberal Push for Health Care System Efficiency

Neoliberalism, as an ideology, mode of governance, and set of policy tools, looks to separate markets and market logics from the social and political processes that constraint them (Harvey 2005, 11). The neoliberal view of "welfare policy [as being] at the heart of economic inefficiency" (Steger & Roy 2010, 43) has contributed to an understanding of state involvement in the areas of health and social welfare as being inappropriate (Braedley 2010, 149). The claims that individuals and their families should take more responsibility for their own care, that government provision of services is inefficient and costly, and that reliance on state services weakens individual initiative (Luxton 2010, 163) have been used to justify bringing private sector management techniques into government through NPM, introducing competition into public sector service provision, and promoting the privatization of public services (Common 1998).

Although health care delivery models and programs vary across Canada, they share a common goal: "to integrate services across an ever expanding continuum of care to better serve patients (including those in rural and remote regions) and drive efficiencies" (Health Council of Canada 2011, 24). The neoliberal restructuring of the health care system has been constructed by the state as a way to make health care delivery more cost-efficient (England *et al*. 2007, 172). Since the late 1960s, there have been concerns about the escalating costs of health care. Evans *et al*. (1991) point out that prior to 1970, "meeting needs" and expanding the flow of resources into health care were policy makers' principal concerns. After 1970, "cost containment" became an increasingly important part of the policy agenda (ibid). With the advent of neoliberalism, policy makers became even more preoccupied with cost cutting in the public sector and whether health care dollars were being spent wisely (McDaniel & Chappell 1999; Evans 2000).

Neoliberal policy makers view public spending on health and social services as wasteful (Steger & Roy 2010, 43).  They, likewise, reject the idea that problems with health systems stem from funding shortages, attributing them instead to "bureaucratic inefficiencies" (ibid, 44).  Yet, both the 1964 Hall Commission on Health Services (Hall 1964) and the 2002 Romanow Commission (Romanow 2002) found that a universal public scheme for health care provision would be more efficient than a fragmented private one.  Despite these conclusions, neoliberals continue to argue that turning to market-based practices is the most economically efficient way of organizing the delivery of health and social services (Armstrong 2010, 192).  As a result, national and provincial governments have tried to limit their direct involvement in health and social service provision by pursuing privatization, promoting self-responsibilization, and experimenting with decentralization.

The inefficiency of the health care system has been framed by neoliberal policy makers as a particularly pressing problem in light of the ongoing demographic shift towards an aging population.  The "grey tsunami" rhetoric has been challenged by scholars (Gee 2002).  Yet, the anticipated increase in service demand by a growing number of seniors has been used by neoliberal governments to justify health system restructuring to enhance efficiency.  As Johri *et al.* (2003, 223) explain, care of the frail elderly, with their complex health and social needs, mix of acute and chronic medical problems, and functional disabilities, "poses a central challenge to current health care systems".  In addition, they argue that the social support networks of frail seniors are frequently overextended, or at risk of breaking down (ibid).  These factors contribute to increased, and as Bergman *et al.* (1997) argue, sometimes inappropriate, use of medical and social services.  This puts publicly financed and regulated health care systems under increasing

pressure to operate within economically and politically acceptable budgetary limits (Glendinning 2003, 141).

Under neoliberalism, home care has been increasingly regarded as a way to maximize the efficiency, and ensure the effective functioning, of the Canadian health care system (Hollander *et al*. 2009; Canadian Home Care Association 2015). Alberta's *Aging in the Right Place* strategy proposes to "provide assistance for individuals to transition from facility care back to home or community living" (Alberta Health Services 2016). The objective of Ontario's *Aging at Home* strategy is to "decrease the number of alternate level of care patients in Ontario hospitals" (Ontario Ministry of Health and Long-Term Care 2010b). Finally, BC's *Better at Home* strategy aims to "help seniors remain independent at home and stay connected with their community" (British Columbia Ministry of Health Services 2016). While stated explicitly or not, aging in place strategies like those cited above offer the prospect of considerable cost savings for the state and have become a preferred tool of neoliberal policy makers seeking economic efficiencies (Johri *et al*. 2003, 222).

Aging in place initiatives reinforce deinstitutionalization and community-based care for the elderly. As many of the costs of providing for seniors' health needs are relocated from public institutions to communities and households, it is anticipated that most seniors can be offered minimal levels of publicly funded support enabling them to continue living in a private residential dwelling. Combined with shifting more responsibility onto unpaid carers, the expectation is that this will reduce the need for seniors to access more costly health care interventions, such as emergency room visits, long hospital stays, or admission to long-term care homes. By substituting less expensive community-based services and unpaid care for more costly institutional care, policy makers assume that the state will save money and be able to

operate more efficiently.  However, as I will show in the next chapter, neoliberal theory does not always hold in practice, but instead leads to all sorts of contradictions and tensions.

## Conclusion

Neoliberal ideology, governance structures, and policy tools shape policy makers' choice to put efficiency goals "on the table" while keeping the pursuit of equitable processes and outcomes off.  Doing so creates and reinforces class, gender, and race/ethnicity disparities that perpetuate structural inequalities.  The consequences of policy-making focused on enhancing health care efficiencies are especially significant in the context of the neoliberal restructuring of the home care sector.  I provide evidence of this in the next chapter by showing how neoliberalism has been applied to home care reform in four different contexts - at the federal government level and by the provincial governments in Alberta, Ontario, and BC.  Seeing how equality and equity are subordinated to efficiency in theory and practice, provides the foundation for my argument that policies and processes that seek primarily to enhance cost-efficiency for the state are an inappropriate solution to the issue of fragmentation in home care because they increase inequality, which in turn perpetuates fragmentation.

# Chapter 3: Neoliberalism in Practice

## Introduction

Neoliberalism has impacted the health and home care reforms introduced by the federal government and the provincial governments in Alberta, Ontario, and British Columbia. However, there is evidence of incomplete and uneven penetration of neoliberalism within, and among, the jurisdictions studied. Moreover, many of the neoliberal policy solutions adopted by the governments under consideration have produced contradictory outcomes. In this chapter, I focus on one of these contradictions: the fragmentation-inefficiency paradox. This paradox is one in which neoliberal policy makers have prescribed neoliberal policy solutions aimed at enhancing efficiency to redress fragmentation, but that, in many cases, have actually perpetuated the fragmentation which they viewed as inefficient. ICPs are a neoliberal policy tool with the ability to solve this paradox. ICPs embody the uneven messiness of neoliberalism; they use policy techniques focused on efficiency goals alongside policy techniques that pursue equality and/or equity goals. It is precisely this complexity that enables them to break the cycle of fragmentation and inefficiency by bringing equity considerations into the discussion.

## Neoliberalism at the Federal and Provincial Levels

Although the application of neoliberalism across Canada has varied by context, there are broad patterns in the policy directions of the federal government and the provincial governments in Alberta, Ontario, and BC. In all four of these contexts, the neoliberal assumption that competition is necessarily good and results in both greater choice and efficiency, has permeated government plans and programs. Of the three provinces, Ontario's government maintained the strongest and most consistent focus on efficiency in its policy documents and reforms from

1992-2013. Alberta remained focused on efficiency until Redford's election in 2011 when equality and equity were included in some government policy documents and strategies. The BC government made the most obvious attempt to balance efficiency with equality/equity goals throughout the time period assessed. For instance, it introduced reforms to labour regulations that enabled collective bargaining for care workers, outlined provincial health goals that prioritized equity and stressed the need for collective efforts of government, and produced reports on women's health undertaken using an equity and gender lens in both 1995 and 2008. While efficiency generally overshadowed equality and equity in the policy choices of the federal, Alberta, Ontario, and BC governments throughout the neoliberal restructuring of 1992-2013, the extent to which this pattern applied varied by context and was uneven even within each jurisdiction.

## The Federal Context

Neoliberalism has contributed to a disproportionate focus on efficiency at the expense of equality and/or equity at the federal government level. Throughout the 1990s, Canada was faced with a large and growing public debt alongside increasing health care costs (Swimmer 1996, 1). These financial concerns, coupled with an "astounding increase in the number of persons living beyond 65 years of age" (Struthers 1997, 174), contributed to a persistent discourse about the unsustainability of Canada's publicly funded health care system. The apocalyptic demography discourse has been perpetuated by both neoliberal policy makers and the media (see Ontario Ministry of Finance 2012; Morgan 2015 for examples). While many have challenged this rhetoric (Gee 2002; Gee & Gutman 2000), these concerns were an important catalyst in, and continue to be used as a justification for, home care sector reform focused on enhancing cost-efficiencies for the neoliberal state.

The focus on efficiency and the corresponding absence of equality/equity as a policy goal is evident in federal government strategies and documents that often use market language and focus on enhancing efficiency, individualism, and accountability. NPM techniques, such as decentralization and privatization, have been used to facilitate state withdrawal from the funding and delivery of social and health services. Lastly, the search for efficiency has also influenced the government's choice of policy tools for implementing reforms.

The policy directions of the 1980s[13] set the stage for the intensification of neoliberal reforms at the federal level in the 1990s (Pierson 2001; McKeen & Porter 2003). Many of the Mulroney Conservative government's policy priorities were maintained by Jean Chretien's Liberal government when it took power in 1993. For example, both governments prioritized debt and deficit reduction, the devolution of responsibility for welfare programs and social service delivery, and the remixing of the responsibility for social welfare among the state, families and households, the third sector, and the for-profit sector.

The Chretien government pursued public sector reform with explicit links to a neoliberal-inspired deficit reduction strategy. The Program Review, launched in 1994 and ended in 1999, required all federal government departments to review their programs in order to "bring about the most effective and cost-efficient way of delivering programs and services that are appropriate to the federal government's role in the Canadian federation" (Department of Finance 1995, 33).

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[13] Savoie (1994, 231) points to the Thatcher government's reforms in the United Kingdom during the late 1970s and early 1980s as being a key inspiration for the Canadian federal government's shift away from a universal welfare state beginning with the Mulroney-era changes to the federal public service in the mid-1980s. In Canada, the Progressive Conservatives were elected to the federal government for terms in 1984 and 1988. Key elements of their political agenda were broadly neoliberal in orientation. The federal government under Brian Mulroney participated in the downsizing of health care through cuts to federal funding transfers to the provinces for the delivery of health and social care. The reductions in federal financial contributions to health care that occurred in 1977 under Pierre Trudeau were exacerbated by additional cuts in 1986, 1989, 1990 (Bill C-69), and 1991 (Bill C-70). Bills C-69 and C-70 froze transfer payments from the federal government to the provinces for five years (Scott *et al.* 2001).

The federal government adopted a range of measures to reduce the deficit as a result of this review, notably the elimination of public service jobs, the reduction of program spending, and the transfer of programs in whole, and in part, from the public to the private sector (Charih & Rouillard 1997; Paquet & Shepherd 1996).

In the 1995-96 fiscal year, the federal government froze Canada Assistance Plan (CAP) funding for social assistance and social services at 1994-95 levels for all provinces. Previously, the government had allocated enough funding to CAP each year to cover 50 percent of the costs of eligible social assistance and social service spending in each province. As provincial social welfare expenditures increased, so did federal government funding. In the 1995 federal budget, CAP was merged with the Established Program Financing into one block fund called the Canada Health and Social Transfer (CHST) (Wilson 1995). Previously, the Established Program Financing had comprised cost-sharing programs for health services and post-secondary education and had been indexed to Gross National Product. The CHST, instead, rolled federal support for health care, post-secondary education, social assistance, and social services together. Under the CHST, transfers to the provinces were allocated on a per capita basis. This meant that the federal government was no longer committed to subsidizing a percentage of the actual costs of service provision as it had been under CAP. The shift to block funding dramatically reduced the overall funding transfer from the federal government to the provinces. For instance, the CHST was set at $26.9 billion for 1996-7 and then reduced to $25.1 billion in 1997-8 (Hallstrom 2016).

The introduction of the CHST reflected the push to cut costs but it was also indicative of the federal government's adoption of NPM principles encouraging decentralization. The CHST gave provincial governments greater decision-making authority over how their transfer dollars could be allocated (Armstrong & Armstrong 2001). While the provincial governments

welcomed more autonomy, they argued that the federal government was devolving the responsibility for the management and delivery of health and welfare to them without adequate cost-sharing. The federal government's effort to decentralize in order to reduce costs also had unintended consequences on accountability. As the federal government retreated from health and social service funding it became more difficult for them to enforce the principles of the CHA. With the CHST's block funding formula, it was no longer possible to determine exactly how much the federal government contributed to health specifically (ibid). The provinces and territories could say that they spent a certain amount of money on health care, but the federal government could not guarantee that federal funding allocations were being spent by the provinces in a manner that conformed to the CHA's principles or federal government priority areas (ibid). Moreover, the CHST made it more difficult to know how much the federal government could threaten to withhold from a province for CHA violations. The CHST saved the federal government money but at the cost of accountability.

In 1997, the federal government laid out its NPM-inspired approach to governance in the *Getting Government Right* strategy (Treasury Board of Canada Secretariat 1997). With its themes of modernizing program delivery, alternative service delivery, and partnering with other levels of government and the private sector, this strategy emphasized key neoliberal principles of state withdrawal and privatization. The strategy aimed to create a more "affordable" government by involving clients in decision-making to give them more choice, using "modern" service delivery tools and strategies, reducing the deficit, and enhancing efficiency (ibid).

The focus on individualism, choice, and efficiency continued in the Treasury Board's *Results for Canadians* report (Treasury Board of Canada Secretariat 2000). This report aimed to build a "citizen focus" into all of the federal government's activities and service delivery, and

promote "discipline, due diligence and value for money in the use of public funds" (ibid, 1). Driven by the NPM belief that institutions perform as well as they are managed (Drucker 1974), the federal government promised to manage efficiently and ethically by establishing partnerships with the private sector, reporting on results, and spending responsibly (Treasury Board of Canada Secretariat 2000).

By 2003, the federal government was working with a leaner, more partnered, and more decentralized institutional framework (Pal 2014, 79). Their policies and programs increasingly emphasized more efficient performance, reporting results, and more client-centered service. For example, the 2000 and 2003 agreements between the federal and provincial/territorial governments to strengthen and renew Canada's publicly funded health care system emphasized "improved accountability and reporting" as an important part of the increasingly decentralized federal-provincial government relationship (Department of Finance 2014).

Federal-provincial negotiations on health care renewal culminated in September 2004 with the First Ministers signing the *10-Year Plan to Strengthen Health Care* (Government of Canada 2004). This agreement stipulated that the CHST would be restructured into two new transfers - the Canada Health Transfer (CHT) and the Canada Social Transfer "to improve transparency and accountability" (ibid). Reflecting provincial spending patterns, 62 percent of the CHST was allocated towards health with the remainder earmarked for post-secondary education, social programs, and social assistance. The federal government committed to increasing the CHT through a base adjustment and an annual six percent escalator. In addition, in the 2003 federal budget, the federal government allocated $16 billion over five years through a new Health Reform Transfer targeted to primary health care, home care, and catastrophic drug coverage. This was to be incorporated into the CHT effective April 2005.

In February 2006, the Conservative Party of Canada was elected to government. In accordance with Stephen Harper's election commitment to restore fiscal balance in Canada, the 2007 federal budget pre-set all funding transfers to the provinces up to 2013-14 (Department of Finance 2014). Canada Social Transfer levels were set to grow by three percent annually, effective 2009-10, while the CHT would get an annual six percent increase (ibid). In 2011, the federal government announced that instead of continuing with a pre-set escalator, starting in 2017-18 CHT increases would be determined by economic growth.[14] Under this new formula, it is likely that the proportion of federal funds allocated to cover health costs will diminish.

In addition to fiscal retrenchment, neoliberal policy directions under the Harper government continued to focus on enhancing accountability. The Liberal government's 2005 launch of the Canadian Institute for Health Information's Home Care Reporting System (CIHI 2010b) paved the way for new policy initiatives focused on collecting quantitative evidence to enhance accountability and efficiency. In 2012, CIHI worked on developing a model to measure the efficiency of the health system in Canada (CIHI 2012). Similarly, the Canadian Institutes of Health Research released a *Strategy for Patient-Oriented Research Network in Primary and Integrated Health Care Innovations* in 2013 to "support evidence-based transformation, integration, and cost-effective health care delivery in community-based primary health care" (Canadian Institutes of Health Research 2013).

Federal government initiatives, such as the Family Caregivers' Tax Credit (2011), reflect policy choices and directions influenced by neoliberalism. This tax credit, announced in the 2011 federal budget, reinforced the responsibilization of families as the caregivers of their

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[14] There was a guaranteed minimum increase of at least three percent per year. Additional increases were based on a three-year moving average of nominal Gross Domestic Product growth which typically varies between 0.2 and 0.6 percent (Department of Finance 2014).

dependent relatives (Government of Canada 2012). In 2013, the federal budget continued in this direction by expanding health-related tax relief for homemaker services to include personal care services, such as bathing and feeding (Government of Canada 2013). These types of policy initiatives entrench the relocation of the responsibility to care from the state to the household. Furthermore, by using market tools, such as tax credits, to encourage care work to be done in the home, the federal government reinforces the primacy of market mechanisms while avoiding direct state involvement in the provision of care.

Regardless of the political party in power, the federal government's policy choices around health and home care from 1992-2013 remained largely congruent with neoliberalism. Through its emphasis on individualism, governing from a distance, welfare state retrenchment, downloading responsibility to families, and quantification as a means of accountability, governments at the federal level have sought to enhance efficiency and accountability, paying little attention to equality or equity as policy goals.

## The Provincial Contexts

From 1992-2013, provincial governments across Canada found themselves in the difficult position of needing to cope with the impacts of neoliberal reforms at the federal level while simultaneously pursuing neoliberal restructuring of their own. Lindquist and Murray (1994) argue that provincial governments in the 1990s engaged in downsizing, delayering, and focusing on service quality. However, the Conservative governments of Alberta under Ralph Klein and Ontario under Mike Harris attracted the most attention. These governments paved the way for later neoliberal reforms in British Columbia under both the New Democratic Party and Gordon Campbell's Liberal government (Pal 2014, 77). In each of Alberta, Ontario, and BC there was a disproportionate focus on efficiency at the expense of equality and/or equity in both government

strategies and documents and the choice of policy techniques and reforms implemented by the state. Yet, the neoliberalization of the health system was neither uniform nor complete in any of the provinces. Contradictions exist in each context. While the policy changes in each province are broad and diverse, I provide an overview of key choices and developments in each context, in roughly chronological order, to give a sense of how neoliberalism influenced health and home care reform over the period of 1992 to 2013.

## Alberta

The "Klein Revolution" was considered the "poster child" of neoliberalism (Albo 2002; Clark 2002) and a role model for other provincial governments (Lindquist & Vakil 2016). The Alberta government maintained a consistent focus on enhancing the cost-efficiency of the state as its key policy objective throughout much of the period under review. The government's policies and strategic plans cut health and social care spending and services, promoted privatization, encouraged self-responsibilization for health, decentralized the management of health through regionalization, prioritized measurement and reporting to enhance accountability, and emphasized individualism and client choice. However, starting in 2011, cost-efficiency began to occupy a less prominent position in government policy documents about health care reform. Some policy discussions, while still broadly neoliberal in orientation, began to touch on equality and/or equity as desirable policy outcomes.

Historically, the approach to health care reform in Alberta has been driven by strong preferences for the adoption of market solutions and limited government involvement in the lives of individuals (Taylor 2009; Scott *et al.* 2001). The values of individualism, self-reliance, and choice have had a place in debates about health and social care reform in Alberta since the 1960s. These views intensified in the early 1990s under Klein's Progressive Conservative

government to bring about a political agenda focused on fiscal restraint (Church & Smith 2013, 39, 43). In 1992, the provincial government passed a *Deficit Elimination Act* that committed it to spending cuts and welfare state restructuring (Bruce *et al*. 1997). From 1992 to 1996, public sector spending was reduced by 20 percent, public servants' wages were decreased by 5 percent, and public service jobs were cut by 6,500 (Charih & Rouillard 1997).

Alberta's policy documents from the early 1990s focused heavily on achieving cost savings for the state using the justification that government costs were "spiralling out of control" (Alberta Health 1997, 13). One of the first documents to outline the Klein government's neoliberal approach to health care reform was *Starting Points: Recommendations for Creating a More Accountable and Affordable Health System* (Alberta Health Planning Secretariat 1993). This report offered recommendations couched in the market-oriented language of one-stop-shops, consumer choice, and self-responsibilization. The strategy recommended the creation of a "new system [that] adopts a service-oriented attitude that places the needs of the consumer as the highest priority" (ibid, 13). It also advocated for increased privatization in the form of cost-shifting from the state to clients and households. Of special importance, *Starting Points* advised that going forward not all services would be covered by Alberta Health Care, "consumers will...need to pay for services considered non-essential under a newly created definition of basic health services" (ibid). The provincial government's adoption of a narrower definition of "basic health services" restricted the number of publicly funded services, transferring the responsibility of paying for services that fell outside of this new definition to the client or his/her family. It justified privatizing previously publicly funded services by arguing that it was simply respecting "the consumer's right to a maximum choice of non-essential services" (ibid, 15).

In 1993, the Alberta government also released the *Health Goals for Alberta: Progress Report* (Alberta Health 1993). This report recommended that the state support clients to deal with their health issues at home through establishing partnerships with groups outside the traditional health system. It argued that this would facilitate more cost-efficient and cost-effective service delivery. This report was followed up in 1994 with *A Better Way I: A Plan for Securing Alberta's Future* (Alberta Health 1994). Again, individual and community responsibility, a consumer focus, providing only evidence-based services, and reducing the cost of health care provision for the state, were identified as key aspects of health care reform. Disguised in rhetoric reaffirming the provincial government's commitment to public funding, this document outlined strategies to reduce the state's share of the costs of health and social care provision. For instance, it recommended shifting an increasing proportion of health care costs to individuals by increasing health care premiums by 20 percent for everyone, including seniors, who had previously been exempt (ibid, 7).[15] In addition, it suggested cost-efficiencies could be attained through shortening acute care stays. This was to be accomplished by shifting pre- and post-operative care and long-term palliative care into the community. The report cited the added benefit that by doing so, home care services would become more "consumer focused" because service providers would be required to address the more complex or long-term health needs of clients discharged directly from hospitals (ibid). Offering respite and education for family carers were also acknowledged in this report. These were positioned as ways that the state could encourage deinstitutionalization and sustain the relocation of care to the household.

Despite earlier indications that regionalization was not favoured in Alberta, in 1993 the province's Health Planning Secretariat recommended that "a regional structure be created for

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[15] Health care premiums in Alberta were eliminated in 2008 and then reintroduced again in 2015 for Albertans earning more than $50,000 annually.

local decision-making" (Alberta Health Planning Secretariat 1993, 17). As a result, the *Regional Health Authorities Act* (Government of Alberta 1994) legislated the formation of 17 Regional Health Authorities (RHAs) and their links with two existing boards - the Mental Health Board and the Alberta Cancer Board (Church & Smith 2008, 224). Two hundred local hospital boards, public health boards, and continuing care boards were replaced by RHAs. In particular, RHAs were tasked with:

> the promotion and protection of the health of the population in the health region and working towards the prevention of disease and injury; assessing on an ongoing basis, the health needs of the health region; determining priorities in the provision of health services in the health region and allocating health resources accordingly; ensuring that reasonable access to quality health services is provided in, and through, the health region; and promoting the provision of health services in a manner that is responsive to individuals and communities and supports the integration of services and facilities in the health region (Government of Alberta 1994).

This legislation shifted the responsibility for the management and delivery of a wide range of health services, including home care, to RHAs. It also mandated that RHAs work within consolidated regional global budgets. Financial considerations related to the government`s desire to enhance efficiency were the main impetus for regionalization in Alberta (Scott *et al.* 2001). However, pushes for more local control, deinstitutionalization, and putting the consumer at the centre of decision-making were also factors in this policy decision (Alberta Health Planning Secretariat 1993; Alberta Health 1991; Premier's Commission on Future Health Care for Albertans 1989).

The Alberta government's business plan for 1995/96-1997/98 was outlined in *A Better Way II: Blueprint for Building Alberta's Future* (Alberta Health 1995). This document laid the groundwork for the reduction of $749 million from acute care and subsequent reinvestment of $110 million in home care over three years (Morris *et al.* 1999). This hospital downsizing removed approximately one half of all inpatient acute care beds in the province (Wilson 2000). Meanwhile, the proportion of health system funds allocated to home care and community health

remained relatively constant over the same time period (4.7 percent in 1996-97, 4.9 percent in 1997-98, 5.1 percent in 1998-99) (ibid). The relocation of caregiving from hospitals to households created savings for the state by transferring the costs of care to families. In particular, it was the women within families who shouldered the increase in caregiving work.

*A Better Way II* also reported on the provincial government's move to "de-insure medically unnecessary services" as part of an omnibus agreement reached with the Alberta Medical Association (Alberta Health 1995). This document reaffirmed a continued role for "not-for-profit organizations, volunteers, volunteer organizations and private for-profit operators [to] continue to make significant contributions to the health system" (ibid, 15) by providing services that the government no longer would. Scott *et al.* (2001, 258) argue that these policy choices are the Alberta government's response to the continued reductions in federal health and social funding transfers. The use of these particular policy tools, namely partnerships with the private sector and downloading care work to households, are also evidence of neoliberal influence in shaping which options are on the table for provincial policy makers and which are not.

The Alberta government's use of cost-shifting to individuals as a preferred mechanism for dealing with resource constraints contributed to conflict with the federal government over CHA violations. In late 1995, these tensions culminated with the federal government reducing transfer payments to penalize Alberta for allowing private clinics to charge facility fees to people receiving publicly insured services (Scott *et al.* 2001, 277). To resolve this, the federal and Alberta health ministers developed a set of principles that clarified the rules around the private purchase and provision of health services in the province (Alberta Health and Wellness 2000).

In the early 1990s, the fiscal crisis provided an easy justification for neoliberal reforms to Alberta's health care system. However, Harrison (2005, 10) argues that the Klein government's neoliberal revolution "lost its momentum" once the deficit was eliminated in 1996. In response to increasing public pressure and resentment about government withdrawal from the welfare state (Gazso & Krahn 2008; Harrison 2005), the Klein government's second term reforms consisted of targeted reinvestment in health and social services. By 2000/01, funding for health services had returned to 1992/93 levels (Sonpal-Valias *et al.* 2016, 79). Consistent with assumptions rooted in the biomedical model about social care being less valuable than health care, the same could not be said for social services until 2010.

Prior to regionalization, Alberta had multiple funding formulas and processes for home care programs and services. Regionalization entailed a move to a population-based funding model. In 1997-98, a block funding amount based on per capita allocations adjusted for age, gender, Indigenous status, low income status, and residency in remote or northern communities, was allocated to each RHA. This was an attempt to redistribute funding among RHAs to account for different measures of client "need" (McIntosh *et al.* 2010; Smith & Church 2008). It was intended to correct for the increased inequality among regions that resulted from decentralization. However, increasing provincial funding to RHAs that served higher needs populations did not guarantee that the most vulnerable individuals within these RHAs saw a corresponding improvement in care. Likewise, it was unable to correct the fact that regionalization resulted in care services being downsized in rural areas, centralized in urban centres, and relocated from public facilities to private homes (Hanlon & Halseth 2005; Hanlon *et al.* 2007).

Population-based funding had other adverse impacts as well. For instance, it required RHAs whose residents received care outside of their boundaries to reimburse the RHA that provided the care for the cost of the treatments. The provincial government claimed that this made local communities more responsible and accountable for managing their health resources. Provincial policy makers argued that putting the onus on each RHA to deliver services that reflected the needs and priorities of their local population would increase consumer choice (Church & Smith 2008). This, in turn, would reduce the incentive for clients to seek out care from neighbouring RHAs. Wilson (2000) challenges the validity of these assumptions, suggesting that these policies created unstable funding to RHAs which required state funded and delivered home care programs to be scaled back. This was particularly problematic in rural RHAs where staff layoffs were used to achieve short-term savings in periods of funding instability (ibid). Care workers who were required to move from public to private sector employment often saw their autonomy and decision-making power diminished. As the majority of care workers are women, many from low income and/or racial/ethnic communities, this move to more precarious employment had gendered, classed, and racialized impacts.

In addition to the privatization of home care delivery being a consequence of population-based funding under regionalization, RHAs were actively encouraged by the provincial government to solicit direct payments from care recipients as an alternative source of funding (Alberta Health Planning Secretariat 1993). Home care falls outside of the CHA's protection of essential services. This makes it particularly susceptible to the application of client co-payments or user fees for care services that had previously been completely subsidized by the state. Likewise, government withdrawal from direct service provision contributed to tighter boundaries between health and social services resulting in professional health care services becoming

increasingly segregated from homemaking and personal care services. In Alberta, social care services were more likely to be contracted out to private for-profit agencies as part of neoliberal restructuring. Meanwhile, health care services continued to be provided directly by the government. Not only did these reforms normalize the contracting out of social care further reinforcing the devaluation of social care in comparison to health care, but in doing so they disproportionately disadvantaged the care workers who were already in the most vulnerable positions in the occupational hierarchy.

Regionalization, in combination with welfare state retrenchment, also contributed to the "hollowing out" of the bureaucracy (Gow 2004, 11; McArthur 2007, 247-248) in the Alberta Ministry of Health. Under regionalization, the cohort of policy makers at the Ministry of Health was downsized and reclassified as "support" for RHAs (Church & Smith 2006). By the time the provincial government began to "reinvest" in health care in 1996, the previous devolution of responsibility for management and service provision to RHAs had cemented provincial policy makers in a minor role (Aucoin 2002). Both a lack of capacity and the previous framing as "supporters" rather than "stewards", made it difficult for provincial policy makers regain the control over decision-making required to "steer" home care as envisioned under an NPM governance structure.

Evidence of NPM's influence can be seen in the Alberta government's implementation of new business-oriented and accountability processes, such as its three-year business plans and performance measures. The business plans, particularly those from 1999-2003, focused on creating "partnerships" between the government and private sector health services providers (Alberta Treasury 1999; 2000). These partnerships were framed as "better approaches" to care

provision that could yield "benefits in excess" of those available under the existing CHA provisions (Alberta Treasury 1999).

Passing the *Health Care Protection Act* (2000) (Province of Alberta 2000) further reinforced the provincial government's commitment to partnerships with the private sector.  This Act, which permitted surgical facilities to operate using both public and private financing, had indirect implications for the home care sector.  Inherent in the Act was the assumption that, following privately financed surgery, clients would take responsibility for choosing and paying for their follow up care or else rely on the unpaid care of family members.  This was in contrast to relying on the state to provide post-surgical care, as would be the case with publicly financed surgery.  Scott *et al.* (2001) argue that relocating the responsibility for care in this way opens the door for the state to de-list even more publicly funded services, instead offering them as uninsured user-pay procedures for clients who can afford them.

The use of these types of market-based "innovative solutions" to solve what was increasingly being framed as an unsustainable public health care system (Horne 2005) was supported by both the Mazankowski (Premier's Advisory Council on Health for Alberta 2001) and Graydon (M.L.A. Task Force on Health Care Funding and Revenue Generation 2002) reports.  Working within a neoliberal framework, these documents called for increasing user fees, expanding private payment options, and more for-profit delivery of selected medical procedures (Sonpal-Valias *et al.* 2016, 80).

By 2005, the provincial debt in Alberta had been eliminated (Government of Alberta 2005).  Yet, the government's focus on enhancing efficiency and cost savings continued to influence its policy choices about health and home care reform.  In 2006, the government

released a *Health Policy Framework* that emphasized the need to create "a sustainable and affordable health care system" (Government of Alberta 2006, 2-3). This document suggested a variety of neoliberal policy directions, including self-responsibilization, more "flexibility" both in workers' scopes of practice and funding options, "paying for choice and access", deinstitutionalization, incentivizing quality care using alternative compensation structures, more efficient service provision, better interprofessional collaboration, and the elimination of public funding for services that are "not of proven benefit" (ibid).

In December 2006, amid declining popularity and pressure from the Progressive Conservative Party membership, Ralph Klein was replaced by Ed Stelmach.[16] With forecasted deficits looming, Stelmach's government took a position in opposition to Klein's anti-debt philosophy (Terry 2009). Yet, the government's policy positions on public sector and health care reform under Stelmach's leadership continued to reflect neoliberal priorities. In particular, there was a clear emphasis on using NPM to "identify efficiencies" (Government of Alberta 2007, 14). Program Reviews, similar to the kind implemented at the federal level under Chretien, led to public sector hiring and management salary freezes, reductions in discretionary spending, and the "streamlining" of administrative and other "non-core" functions (Government of Alberta 2010b).

Despite the reinvestment of some of these cost savings in health and social programs (Sonpal-Valias *et al.* 2016, 81), keeping the costs of health and home care delivery under control remained a top priority of the provincial government. The *Service Optimization Review* (Alberta Health and Wellness 2008b, 1), for example, sought to "identify opportunities to increase the quality and improve the efficiency and effectiveness of health care service delivery in Alberta".

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[16] Premier of Alberta from December 2006 to September 2011.

Couched in market-oriented language, this report looked at how to "actively manage the factors that can reduce demand for the costliest and least-efficient health care services, ensure that health care supply matches the quality, timeliness, and cost-effectiveness that Albertans require, and create a delivery mechanism that facilitates equilibrium between supply and demand" (ibid, 5). Its key recommendations involved deinstitutionalizing care from hospitals and LTC homes to communities and households; increasing health professional productivity and collaboration through changes to benefits structure, salary guidelines, and/or reimbursement schemes; and increasing workforce efficiency by, for example, "re-focusing staff on those activities through which they provide the most value" (ibid, 36).

Also in 2008, the Alberta government released the *Continuing Care Strategy: Aging in the Right Place* (Alberta Health and Wellness 2008a). This document encouraged the continuation of efforts aimed at deinstitutionalizing seniors and persons with disabilities. Like policy documents before, this strategy used consumer-focused language to encourage the relocation of care from the state to the client and family, citing clients' preference to age at home. Advocating for "a more client-focused continuing care system that puts health and personal care needs first and promotes increased choice of where to receive these services" (ibid, 3), this strategy highlighted a "new funding model" that would allow clients to "shop" for their own health providers and make "choices" about where they receive services (ibid, 4, 16). The need for more respite programs for family carers was also emphasized.

In April 2009, the Alberta government reversed its direction on regionalization by consolidating the nine geographically-based health authorities, the Alcohol and Drug Abuse Commission, the Mental Health Board, the Cancer Board, and ground ambulance services into one provincial governance board and health authority, called Alberta Health Services (AHS)

(Government of Alberta 2009). Centralizing decision-making authority in this case, while contradicting the tenets of governing from a distance, was yet another attempt by the provincial government to enhance cost-efficiency. The administrative costs associated with regionalization were seen as being excessive. It was argued that regionalization resulted in "a fragmented system, with considerable duplication of health care issues" that added to the cost of managing health care planning and delivery of health services (Wilson 2000, 13). Provincial policy makers argued that taking back control over staffing and funding allocations would result in cost savings associated with economies of scale and sector-wide integration (ibid).

The influence of neoliberalism remained apparent in the Minister's Advisory Committee on Health's *Becoming the Best: Alberta's 5-Year Health Action Plan* (Government of Alberta 2010a), released in 2010. This document focused on meeting consumer demand for care. The plan proposed expanding home care hours to facilitate easier access to care for at least 3,000 more people (ibid, 13). It also suggested standardizing policies and services to ensure consistency in home care services across the province.

In October 2011, Alison Redford was appointed premier of Alberta.[17] Her 2012 election promises included balanced budgets with no new taxes or service cuts, increasing funding to contracted service providers to help them maintain a sustainable workforce, and implementing a ten-year poverty reduction plan as part of a new social policy framework for the province (Progressive Conservative Party of Alberta 2012). In 2013, the provincial government's *Social Policy Framework* was released (Government of Alberta 2013a). It articulated four overarching goals: to protect the vulnerable, reduce inequality, create a person-centered system of high-quality services, and enable collaboration and partnerships (ibid). Concerns about cost-

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[17] Premier of Alberta from October 2011 to March 2014.

efficiency were incorporated into the discussion of system "sustainability" but occupied a much less prominent position in this framework in comparison to previous policy strategies and documents. The push for privatization was still present but it was couched in language about "partnerships". The framework's clear focus on equality and equity as legitimate policy goals is noteworthy as an indication of a potential shift in the provincial government's views regarding the value of efficiency, equality, and equity.

Collaboration continued as a key theme in other policy documents produced in 2013. *Working Together to Build a High Performance Health System: Report of the Health Governance Review Task Force* (2013) emphasized the importance of partnerships to the improvement of health outcomes (Government of Alberta 2013b). This report argued that collaboration between the Government of Alberta and AHS must be improved. Suggesting that the provincial government had been "overly involved" in the operations of AHS, this report proposed returning to a more decentralized approach (ibid, 10). For instance, applauding the creation of "zones" within the AHS as "progress", it called for even broader delegation of authority to move decision-making "closer to the client" (ibid, 11). The report also recommended a more transparent and accountable relationship between the provincial government and AHS. This report aligned closely with the NPM mode of governance, prioritizing governing from a distance through decentralization, self-responsibilization, and increased accountability as preferred policy directions.

*Alberta's Strategic Approach to Wellness 2013-14* (Government of Alberta 2014) also outlined the roles of individuals, families, communities, non-governmental organizations, businesses, and governments in contributing to outcomes related to health and wellness in Alberta. However, this document contained an emphasis on social justice and equity that was

absent from the *Report of the Health Governance Review Task Force* discussed above. Arguing that everyone should have the opportunity to "attain their full health potential" (ibid, 15), this document emphasized the need to create equal opportunities for good health by reducing avoidable and unfair differences in health among Albertans (ibid). The strategy's rhetoric advocated moving beyond equality to focus on equity as a legitimate policy goal. Yet, the method by which the provincial government planned to move from policies aiming to treat everyone the same to those that prioritize equity remained vague. Moreover, the strategy proposed using primarily neoliberal tools to achieve better health outcomes. Self-responsibilization for health was repeatedly emphasized (ibid, 17). Likewise, governing from a distance and sharing the responsibility for health among the Ministry of Health and "business leaders and employers, workplaces and schools, local governments and provincial ministries" was proposed as the means of achieving the "greatest impact" (ibid, 19). The document suggested that "broader structures and institutions affect our lives" (ibid, 17). However, acknowledgement of the gendered, classed, and racialized hierarchies embedded within these structures and institutions and the need to address systemic inequality and discrimination remained absent. While neither efficiency nor sustainability was mentioned as a goal of reform in this document - a clear departure from policy documents of the past - the strategies with which equitable outcomes could be achieved lacked clarity.

In sum, neoliberalism significantly shaped the policy documents and reforms of the Alberta government from 1992-2013. Its influence was most significant under the Klein administration but was also visible under both Stelmach's and Redford's leadership. The Alberta government consistently used market-oriented language and tools in its policy documents. It focused on individualism, self-responsibilization, and choice when framing its policy choices.

Lastly, it facilitated state withdrawal in the management, funding, delivery, and monitoring of health and home care. Enhancing efficiency was a key policy goal of health and home care reform in Alberta. Efficiency overshadowed equality and equity from 1992 until Redford's election in 2011. In 2013, discussion of equality and equity as goals of health care restructuring was increasingly visible in the government's policy frameworks and strategic directions but even then, specifics about how these policy goals would be achieved remained in short supply.

## Ontario

Neoliberal ideology, governance structures, and policy tools influenced the Ontario government's choices regarding health care reform in ways that parallel the Alberta context. Like Alberta, Ontario's policy choices were frequently efficiency-motivated; for example, the individualization and self-responsibilization of care, regionalization, and a push for increased reporting and accountability. However, the impacts of the neoliberalization of the home care sector, in particular, were more obvious in Ontario than in Alberta or BC. The structure and functioning of the home care management and delivery system in Ontario changed dramatically as a result of neoliberal restructuring. The Ontario government's commercialization of the home care sector using the managed competition model fundamentally reshaped home care service delivery along business lines. This has had significant and lasting consequences for service provider organizations, clients, and carers in the province.

Prior to the 1995 election of a Conservative government in Ontario, the previous Liberal and New Democratic governments had begun delisting and contracting out some health care services (Armstrong & Armstrong 2001). However, Mike Harris' election platform in Ontario mirrored the neoliberal configuration of Klein's in Alberta (Ibbitson 1997). As a result, both the pace and extent of efficiency-motivated policy change increased substantially with the Harris

government.  Harris' Common Sense Revolution promised to provide the people of Ontario with "better for less" (Ontario Conservative Party 1993).  The Ontario Conservative Party proposed to achieve savings by cutting overhead, bringing in management techniques from the private sector, and rooting out waste, abuse, health card fraud, mismanagement, and duplication (ibid).  Upon election, the Harris government announced plans to cut welfare services by 22 percent, eliminate a $10.6 billion deficit in five years, and remove 10,600 employees from the government payroll within two years (Charih & Rouillard 1997).

Privatization was used by the Ontario government to restructure home care along neoliberal lines.  In 1996, the responsibility for long-term and community care was transferred from 36 Placement Coordination Services and 38 Home Care Programs located in municipal public health departments, to 43 not-for-profit, regionally-based corporations called Community Care Access Centres (CCACs) (England *et al*. 2007, 180).  CCACs did not directly provide services except for case management.  They were responsible for providing information on publicly funded services and programs, conducting assessments, determining eligibility, planning programs of care, and ensuring services were delivered (Armstrong & Armstrong 2001; Williams *et al.* 1999).  CCACs purchased home support and professional services from care providers in the community on the behalf of clients, in accordance with the guidelines set out in Ontario's *Home Care and Community Services Act* (1994) and within the capped budget set by the provincial government.  In addition to organizing home care delivery, CCACs were also responsible for admissions to long-term care facilities and referring clients to support services, including Meals on Wheels, transportation, home maintenance and repair, friendly visits, and security checks.  They redirected clients to other service providers if the care they needed was

outside of what a CCAC offered (e.g., physician visits, blood work) or if the client's needs exceeded the limit for publicly subsidized hours.

NPM informed how the provincial government structured CCACs. CCACs were mandated to provide a simplified single point of access for the management and coordination of care services in their local area (England *et al.* 2007, 182). They employed case managers to assess client eligibility for services. These case managers were given the authority to decide whether or not to authorize a service plan for a client based on the CCAC's eligibility criteria. They also monitored and adjusted clients' care plans. CCACs were required by the province to develop business plans (ibid, 170) that would set out how the CCAC would operate cost-effectively, remaining within their allocated budget. The business plans were subject to detailed accountability requirements which permitted little or no flexibility in program delivery or funding (Eakin 2001, i).

The most significant neoliberal reform to the home care sector in Ontario came in 1996-97 when the provincial government introduced managed competition for bidding on CCAC contracts, creating an internal market for provincially funded home care. This policy decision enshrined competition and commercialization into the province's home care delivery system. Looking to rectify the home care sector's "lack of some of the basic features of a 'free' market" (Christie 1996, 14), the provincial government wanted to "create incentives for improving efficiency, and possibly also effectiveness and quality, depending on the competence and expertise of the purchaser" (ibid). Under the managed competition model, home care contracts were paid for with public funds and subject to some government regulation, but the allocation of the contracts was done through market mechanisms (Jerome-Forget & Forget 1998, 12).

As part of managed competition, the provincial government mandated that CCACs use a request for proposals process for contracting out home care services. This was intended to encourage competition between for-profit and not-for-profit organizations for home care market share. Everyone was to be given equal opportunity to bid on service contracts. Prior to this change, almost all publicly subsidized home care services had been provided by not-for-profit agencies. Managed competition was promoted as a way to drive down costs, resulting in increased efficiency for the state and more choice for clients (OECD 1992, 10). The move to a managed competition model is evidence of the significant influence of neoliberalism in reshaping the operation of the home care sector in Ontario. Home care was "transformed into commodified forms [that could be] regulated according to market principles" (Rose & Miller 1992, 198).

CCAC boards were responsible for executing the competitive bidding process within the overall budget established by the provincial government. Despite the requirement for CCACs to submit their budgets and business plans for annual approval by the Ministry of Health and Long-term Care (MOHLTC), in 1997-98 CCACs reported a $34 million deficit (Ontario Ministry of Health 1998b). Low CCAC budget allocations, in combination with the competitive bidding process, incentivized CCACs to prioritize cost-efficiency. Community-centered care, personalized service, and other similar policy outcomes were constructed as extraneous and even "hostile" to the logic of this market-based mechanism (Scott 2003, 31). As a result, service contracts under the managed competition model were often awarded to the lowest bidder (Evans *et al.* 2005, 81).

Commodifying home care fundamentally changed the mix of service provider organizations involved in home care provision in Ontario. Managed competition intentionally

facilitated the transfer of care work from not-for-profit to for-profit agencies based on the assumption that more competition is necessarily good and results in both greater choice and efficiency[18] (Ontario Ministry of Health 1998a, 2). Armstrong (2007) notes that an increasing number of the for-profit organizations involved in home care provision as a result of managed competition were large, foreign-owned corporations. This contributed to a shift in the decision-making power about the working conditions in home care from public and not-for-profit organizations to for-profit agencies. For-profits were generally less likely to have unionized workforces and typically offered lower wages and fewer benefits to workers in comparison to not-for-profits (Williams *et al.* 2001, 19). This put for-profit agencies in a better position to compete in an open market for care contracts because they were able to bid lower than not-for-profits.

The criteria used by CCACs to select service providers were supposed to balance cost against more difficult to quantify considerations, such as innovation, provider diversity, and service quality. However, putting not-for-profits in competition with for-profits incentivized both organizations to reduce their expenditures on employee training, wages, and/or benefits in the attempt to win contracts (Williams *et al.* 1999). This had adverse consequences on the conditions of care work as well as the quality of care. Furthermore, some of the for-profit agencies were better able to survive a low bid than not-for-profits because once they gained access to the home they could recommend that clients pay out of pocket for the agency to provide extra services (Older Women's Network & Registered Nurses Association of Ontario n.d., 2). For-profits used this additional revenue to offset losses sustained by bidding artificially

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[18] Many scholars contest this assumption, arguing persuasively that competition is actually more expensive than government provision (Himmelstein & Woolhandler 1994; Deber *et al.* 1998; Armstrong 2010).

low on CCAC contracts.  In order to compete, not-for-profits began acting more like for-profit agencies and soliciting clients to privately supplement their publicly funded care.  This, in turn, was used by the provincial government to justify reductions in the number of publicly funded care hours available per client and push for agencies to adopt "flexible" funding schemes (discussed in Chapter 6) based on the assumption that clients are equally able, and should be willing, to pay privately for some of their care.

The creation of CCACs and implementation of managed competition are examples of the Ontario government's desire to distance itself from the administration of home care.  This is part of a broader trend, consistent with a NPM governance strategy, of state withdrawal from health and social service funding, administration, and delivery.  Bill 152, the *Services Improvement Act* (1997) offers a good example of this trend (Government of Ontario 1997).  This bill relocated the responsibility to fund public health, ambulance services, social housing, and a greater proportion of social assistance, from the provincial level to municipal governments.  The Ontario Minister of Community and Social Services at the time explained that this legislation reflected the "stewardship" role of the provincial government (Ontario Ministry of Community and Social Services 1997).  As Osborne and Gaebler (1993) explain, the neoliberal governance structure encourages governments to "steer, not row".

The provincial government's efforts to distance itself from the responsibility for home care continued after the election of Dalton McGuinty as Liberal Premier in October 2003.  In line with the other provinces, the Ontario government turned to regionalization as a means of improving the cost-efficiency of the health care system.  It hoped to save money by shifting the management of care service delivery to local level funding and oversight organizations called Local Health Integration Networks (LHINs) (Bhasin & Williams 2007, 2).  In March 2006, as

part of the Liberal government's plan to "transform" the health care system (Government of Ontario 2004), Bill 36, the *Local Health System Integration Act* (Government of Ontario 2006), legislated the creation of LHINs in 14 geographical regions across Ontario.  This Act aimed:

> to provide for an integrated health system to improve the health of Ontarians through better access to health services, coordinated health care in local health systems and across the province and effective and efficient management of the health system at the local level by Local Health Integration Networks (ibid, c. 4, s. 1 [1]).

Unlike the RHAs in Alberta, LHINs were not direct service providers. Instead, they were delegated the responsibility of planning, funding, and monitoring hospitals, CCACs, community support services, community mental health and addictions services, and LTC homes.  CCACs were re-aligned to match LHIN boundaries, with the 42 CCACs being amalgamated into 14 CCACs.  The LHINs created service accountability agreements with local service provider organizations to deliver publicly subsidized care in accordance with the LHIN's expectations. The relationship between the MOHLTC and each LHIN was likewise governed by an accountability agreement.  This was a memorandum of understanding that detailed the funding, services, and standards to be maintained by the LHIN, a business plan for keeping spending within the budget determined by the MOHLTC, and the health service and system outcomes the LHIN was expected to achieve (Bhasin & Williams 2007).

In line with an NPM approach to governance, the creation of the LHINs permitted the provincial government to spend more of its time acting as the "steward" of Ontario's health system.  The government retained control of strategic policy-making and standard-setting.   It also continued to deliver some province-wide programs and services.  As part of its "steering" duties, the provincial government guided LHINs in the development of mandatory Integrated Health Services Plans (IHSPs) (Government of Ontario 2006, c.4, s.15(2) [1]).  The MOHLTC

provided LHINs with five strategic directions as a guide, but left the work of drafting a plan up to each LHIN (Bhasin & Williams 2007). The IHSP strategic directions reflected neoliberal-inspired goals as evidenced by sub-headings, such as building partnerships, enabling Ontarians to age in the most appropriate place, placing the consumer at the center, increasing efficiency of service delivery, basing planning and decision-making on evidence, and ensuring the financial stability of the health care system (ibid).

Despite evidence of neoliberal influence, the IHSPs were significant because they were one of the first instances where goals of equality and/or equity were mentioned in a MOHLTC policy document. In addition to the objectives outlined above, the MOHLTC's strategic directions also included improving the health of all Ontarians especially groups with the poorest health status, ensuring equitable access to health care for all Ontarians no matter where they live, eliminating barriers to access, and providing equitable allocation of health resources according to the health needs of the population (ibid). Moving beyond an exclusive focus on enhancing cost-efficiency was a departure from Ontario's strategy documents and government action plans of the past. The MOHLTC, however, offered the LHINs little guidance on how to balance efficiency with equality and equity as they drafted their IHSPs. The focus on efficiency versus equity in the IHSPs was varied and uneven across the LHINs.

Following the creation of the LHINs, the provincial government in Ontario renewed its focus on enhancing the efficiency of the health care system. In 2007, a four year, $1.1 billion *Aging at Home Strategy* was announced (Local Health Integration Network 2006). This strategy's objective was to prevent the decline in seniors' health in order to reduce institutionalization rates in long-term residential care homes (ibid). The *Emergency Room/Alternate Level of Care Strategy* (2008) continued this "shift in thinking" by focusing on

"discharging elderly patients home after an acute episode in hospital instead of assuming that a long-term-care home is the only option" (Ontario Ministry of Health and Long-term Care 2008a). The government dubbed this the "Home First" philosophy. It was intended to improve emergency room performance and reduce wait times by avoiding unnecessary emergency room visits and hospital admissions and supporting timely discharge (ibid).

Both of these government strategies, as well as the Home First philosophy generally, were the provincial government's attempts to deal with the inefficiencies caused by increasing numbers of Alternate Level of Care (ALC) "bed blockers". Bed blockers are individuals who no longer require acute care but cannot be discharged because there is no place available in a LTC facility and/or there is a lack of community supports available to permit them to go home (Peckham *et al.* 2014; CIHI 2010a). The expense of keeping ALC clients in the hospital was a strong motivation for the provincial government to find ways to move these clients into the community. The costs of care for the state are less when seniors are cared for in a private home or a LTC facility, as opposed to in a hospital. In fact, the cost to the state may be eliminated almost entirely if a client's care can be shifted onto his/her family. In 2009/10, the government invested an additional $272 million in the *Aging at Home Strategy* and related community care initiatives designed to deal with the ALC "crisis". This included $22 million for Ontario's 14 LHINs to invest in local solutions that would address ALC pressures in their areas (Ontario Ministry of Health and Long-term Care 2010a; 2010b).

Based on its 2008 *Excellent Care for All Strategy* (Ontario Ministry of Health and Long-term Care 2008b), in June 2010 the Ontario government passed the *Excellent Care for All Act* (Government of Ontario 2010 c. 14, s. 8 (1)). This was part of a quality improvement strategy intended to "make better use of public funds" in health care delivery (ibid). One of the

cornerstones of this legislation was that every fiscal year, every publicly funded health care organization[19] would be required to develop a quality improvement plan that would be made publicly available (ibid). This Act focused on establishing, justifying, and meeting annual performance improvement targets. This was an attempt to improve the "quality" of the health care system using the neoliberal tools of quantitative measurement and increased reporting to enhance accountability. Though the Act defined quality as "accessible, appropriate, effective, efficient, equitable, integrated, patient centered, population health focused, and safe" (ibid, c. 14, preamble), there was a much stronger emphasis on efficiency over equity in the content of the legislation.

The discussion on "reforming the health care system to make it operate more efficiently and give us greater value for money" was once again initiated in February 2012 with the release of the *Ontario Public Service: Commission on the Reform of Ontario's Public Services* (Ontario Ministry of Finance 2012), also known as the Drummond Report. This report emphasized the interconnected nature of quality of care and efficiency. It argued that "better care delivered smoothly and briskly across a range of needs will benefit patients and providers alike; it will also save money in the long run" (ibid, 144). Of its many recommendations, a significant number revolved around enhancing cost-efficiency through cost-cutting, downloading, and privatization (ibid, 175-6). The report suggested diverting patients from hospitals and into "more appropriate", and "less expensive", forms of care (ibid). It proposed facilitating the provision of care in the community by encouraging delivery by private, for-profit entities that operate within the public payer system. It recommended increasing the use of home-based care, where appropriate, to reduce costs. Finally, it advocated spending restraint by moving the health care

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[19] As of 2013, this legislation had only been applied to publicly funded hospitals.

system towards a more efficient overall design and finding efficiency gains within its constituent parts (ibid). Equity as a component of quality care was conspicuously absent from the report.

Later in 2012, the provincial government released *Ontario's Action Plan for Health Care: Better patient care through better value from our health care dollars* (Government of Ontario 2012). This plan laid out the same reasons the government should pursue efficiency-motivated health care reform that the Harris government used in the 1990s. Citing the "current state of our provincial deficit and Ontario's aging population" (ibid, 14) as pressing policy issues, this action plan constructed the policy problem as one of cost inefficiency caused by inappropriate emergency room use, hospital re-admittances within 30 days of discharge, and consistently high numbers of ALC clients (ibid, 4-5). With regards to home care, much of the report focused on deinstitutionalization with some mention of standardizing policies and services.

Encapsulated within *Ontario's Action Plan for Health Care* was a Seniors Strategy with "an intense focus on supporting seniors to stay healthy and stay at home longer, reducing strain on hospitals and long-term care homes" (Government of Ontario 2012, 12). The Seniors Strategy proposed the further decentralization of decision-making by "empowering LHINs with greater flexibility to shift resources" (ibid, 13). It also encouraged privatization through the "shifting [of] more procedures out of hospital and into non-profit community-based clinics" (ibid). These policy techniques are consistent with a neoliberal approach to enhancing cost-efficiencies for the state. The Seniors Strategy also called for more state investment in home care in the form of funding for three million more Personal Support Worker (PSW) hours, more Care Co-ordinator oversight for seniors recovering after hospital stays, and increased state resources to expand house calls for frail seniors. The Seniors Strategy illustrates how

inconsistencies can arise when operationalizing neoliberalism in the home care sector. While the strategy's aim was to relocate care from state institutions to homes, the policy techniques recommended to do so were mixed in their alignment with the neoliberal toolkit. Some prioritized efficiency as a policy goal while others focused on equality or equity. We see something similar with the operationalization of integrated care in home care programs.

In the same way that neoliberalism shaped the policy documents and reforms of the Alberta government from 1992-2013, it had a similar impact in Ontario. The influence of neoliberalism on health and home care reform was most significant under the Harris administration but continued throughout McGuinty's time in office. The provincial government in Ontario focused consistently on cost-efficiency in its strategies, reports and action plans. It facilitated state withdrawal through funding cuts and freezes, the decentralization of home care funding and management through LHINs, and the administration of service delivery through CCACs. The provincial government promoted privatization by encouraging partnerships with the private sector, though less emphasis was placed on this in comparison to Alberta. It also relocated care from the state to seniors and their families. Most significantly, the Ontario government commercialized the home care sector through the introduction of managed competition. Later policy initiatives paid slightly more attention to equality and equity, though to a lesser extent in Ontario than in Alberta. The Ontario government's focus on efficiency as a key policy goal of health and home care reform consistently overshadowed the pursuit of equality and equity.

## British Columbia

The influence of neoliberalism on health care reform in BC from 1992-2013 was moderate in comparison to Alberta and Ontario (Harrison & Weber 2015, 15). Even so, in line

with Ontario and Alberta, the BC government focused on enhancing cost-efficiency at the expense of equality and equity as policy goals. This was particularly true when the province's neoliberal orientation intensified under Gordon Campbell's leadership starting in 2001. BC used regionalization and deinstitutionalization to reduce the costs of health care management and service delivery to the provincial government. It also implemented funding and service cuts and freezes, introduced user fees for services not protected by the CHA, and sought partnerships with the private sector. There are some differences in how neoliberal home care reform took shape in BC compared to the other provinces. The BC government focused more on using standardization to enhance accountability. It also strongly emphasized self-responsibilization through self-management of lifestyle and behaviour. Labour reforms played a more significant role in shaping home care service delivery in BC than elsewhere. Finally, there is more evidence in BC that provincial policy makers sought to balance efficiency with equality and equity as policy outcomes than in either Alberta or Ontario. While BC government reports, strategies, and policy plans frequently emphasized efficiency, several documents also considered equality and/or equity as legitimate goals of health care reform.

Health care reform in BC in the early 1990s was influenced by the Seaton Commission's report *Closer to Home: The Report of the British Columbia Royal Commission on Health Care and Costs* (Seaton 1991). This report looked at how to improve the health status of individuals and control health care costs. Acknowledging the growing disparities in health across BC's population and the persistence of inequities in access to health services in the province, this report called for an "overhaul" of BC's health care system (Health Information Management Coordinating Council 1996).

In response to the *Closer to Home* report, the British Columbia Ministry of Health initiated a review and public consultation that fed into the 1993 *New Directions for a Healthy British Columbia* strategy (British Columbia Ministry of Health & Ministry Responsible for Seniors 1993). This strategy document argued for greater public participation in and responsibility for health outcomes, bringing health closer to home, respecting the caregiver, and effective management of the health system (ibid). It suggested improvement in these areas would allow for more health care services to be delivered outside the acute care sector in a more efficient manner (Fuller 2001, 287). There is evidence of neoliberal influence in these early documents. They focused on cost-efficiency, individualization, self-responsibilization, and relocation of care to households. Yet, they also touched on health inequalities in a way that the documents produced by the Alberta or Ontario governments around the same time did not. This likely set the stage for the consideration of equality and equity alongside efficiency in the BC government's approach to health care reform in the years to come.

In 1995, BC's Provincial Health Officer released an overview of the health status of women in the province. It was called the *Feature Report: Women's Health* (Government of BC 1995). In discussing women's health as distinct from men's health, the government implicitly acknowledged health equity as worthy of consideration. This report responded to some of the policy priorities identified in the government's *New Directions Strategy* (1993). For example, it recommended strengthening support for the mostly female unpaid carers (Government of BC 1995). Improving respite services was framed as the government's preferred policy direction (ibid). The gendered nature of caregiving was identified in the *Feature Report* and the negative impacts of caregiving women and their health were noted. Yet, the report's proposed response to the problem of increasing caregiver burden was contradictory. By advocating improved respite

care, it did not seek to rectify the gender-based inequality associated with caregiving work. Instead, the focus on respite care illuminates its support for the continued relocation of the responsibility for care from the state to households (Fuller 2001). Respite care helps women cope with caregiver burden but it does not address the fundamental issues of state withdrawal from the responsibility for elder care provision and the increasing relocation of care work onto women and families. In fact, from 1993 to 1996, the BC provincial government intensified the push to move care out of hospitals and into the community. Hospital workforces were reduced and new hospital bed construction was restricted, despite increases in the population aged 75 and older (Fuller 2001; Cohen *et al*. 2005).

Health care reform in BC in the mid-1990s also entailed a move to regionalization as a means of using decentralization and downloading to "bring decision-making and planning 'closer to home'" (Frankish *et al*. 2002). In 1993, the BC government established 102 Regional Health Boards (RHBs) and Community Health Councils (CHCs). RHBs were made responsible for the direct management and delivery of health care services. CHCs were given responsibility for acute care and continuing care residential services at the community level. Regionalization was framed as being better for responding to individual clients' demands. It was also promoted as a way to enhance cost-efficiency through the creation of a smaller provincial government (ibid). In April 1997, the government redesigned the regional governance structure again. This time, the authority to deliver health care was transferred to 11 RHBs in major urban centres, 34 CHCs in rural and geographically isolated areas, and seven newly established Community Health Services Societies (CHSS). CHSS were given responsibility over public health, mental health, and some continuing care at the community level (Fuller 2001).

Regionalization required devolving control over decision-making and resource allocation to the local level. As we saw in Alberta, this resulted in increased inequality among regional jurisdictions. The provincial government's *Health Goals for British Columbia* (1997) (British Columbia Ministry of Health & Ministry Responsible for Seniors 1997) was an attempt to moderate the health disparities among various groups across the province that arose, in part, as a result of regionalization. The provincial government's health goals were rooted in the social determinants of health. They touched on cost-efficiency and equality, but focused quite significantly on equity. For example, the fourth health goal was to create an effective and efficient health service system that provides equitable access to appropriate services (ibid, 23-4). Another health goal addressed the need for positive and supportive living and working conditions in all communities (ibid, 14). Yet another, suggested creating opportunities for all individuals to develop and maintain the capacities and skills needed to thrive and meet life's challenges and to make choices that enhance health (ibid, 20). These were broad statements of intent and aspiration. While some were linked to measurable indicators, many of the health goals challenged typical neoliberal values and ways of working. For instance, these strategic directions focused on the importance of "collective efforts". Instead of this meaning the establishment of "partnerships" with the private sector as we saw in Alberta and Ontario, these goals strongly emphasized the role of the provincial government in improving the health and wellbeing of BC's citizens and communities. This emphasis on the state's responsibility for health is in opposition to what one would expect from a government influenced by a neoliberal ideology and governance structure.

Reforms to labour legislation in BC also ran somewhat contrary to neoliberalism. More home care workers (HCWs), especially those providing social care, remained directly employed

by the provincial government in BC, in comparison to Ontario and Alberta where these jobs were relocated to the private sector to a greater extent. One consequence of this was that labour reforms in BC had a more significant impact on home care service delivery than in other provinces. BC labour unions pushed for better employment conditions for public sector workers with notable success. Bill 28, the *Health Authorities Amendment Act* (1997) (Government of BC 1997), for example, established bargaining associations for paramedical professionals, health services/support staff, and registered and psychiatric nurses in the community and hospital sectors. Unionization assisted public sector care workers to push for increases in wages and benefits above the minimum set in employment standards legislation (Fuller 2001). As evidence of this, BC home support workers waged a strong campaign during the 1998 round of bargaining. They won improvements in working conditions for casual public sector employees, enabling them to convert their hours into regular positions (Hospital Employees' Union 1998). Similarly, in April 2001, legislation was passed integrating the bargaining units of facility- and community-based health services workers. This gave community workers more power to advocate for pay and benefits equivalent to their hospital-sector counterparts.

While there were areas where the influence of neoliberalism remained marginal during the late 1990s and early 2000s, this was not a government-wide phenomenon. The BC government still proceeded with the implementation of many neoliberal-inspired policies and reforms. In February 2000, for example, the BC Treasury Board required all government ministries to develop business plans (British Columbia Treasury Board 2000). These plans had to specify goals, performance measures, and expected results for the next fiscal year in an effort to make the state more cost-efficient and accountable to the government's strategic objectives (ibid). Around the same time, the BC government undertook a reduction in both hospital beds

and home care services, despite a growing elderly population (Cohen *et al*. 2005). This intensification of government withdrawal from hospital and home care was consistent with the NPM tenet of state retrenchment from health and social services. These cuts to care funding and provision resulted in a 29 percent reduction in home support hours for clients aged 75 and over, and a 40 percent reduction in clients, between 1997/98 and 2002/03 (ibid, Table 11).

The trends of the adoption of business practices in the public sector and state withdrawal from health and social care funding and provision continued in BC as governing power transitioned from the New Democratic Party to the Liberal Party in June 2001. In fact, MacPhail and Bowles (2008, 545) argue that the provincial government's neoliberal orientation intensified under Gordon Campbell's leadership. Citing a fiscal reality of declining provincial tax revenues, rising health care costs, and a campaign promise to cut income tax, Campbell's government sought more cost-efficient ways to deliver services (Lindquist & Vakil 2016, 28).

In 2001, the BC government initiated a NPM-oriented Core Services Review inspired by previous federal, Alberta, and Ontario government initiatives. The Review required ministers and government ministries to review the mandate, affordability, public interest, and efficiency of all of their programs, activities, and business units, as well as those of their agencies, boards, and commissions (ibid). Seeking to eliminate "nonessential" programs and units, and remove duplication and overlap among government departments, the Campbell government "aggressively pursued" ministry downsizing and outsourcing (ibid, 29). In November 2001, the government announced a three-year plan to reduce the BC public service by one-third (Dobell 2002).

Neoliberalism, as operationalized by the Campbell government, had both direct and indirect impacts on home care delivery in BC. From 2001 to 2004, the BC government made significant strides in deinstitutionalizing seniors' care (British Columbia Ministry of Health Planning 2002) through the closure of 26 residential care facilities (2,529 residential care beds) (Cohen *et al*. 2005, Appendix 8, Table 6). Moreover, in April 2002, the government introduced its *Continuing Care Renewal* plan (British Columbia Ministry of Health 2002). This plan laid out new access criteria for residential care facilities which were intended to limit LTC home admission to people with the most complex care needs. Cohen *et al.* (2005) argue that these policy choices reinforced the relocation of the costs of care from government onto individuals and communities. The government's plan did not redirect the savings from closing residential care beds back into home care. Likewise, it did not consider whether the clients who were determined ineligible for residential care had access to suitable housing options in the community. Nor did it assess whether ineligible clients had access to, or the ability to pay for, the supports they needed to age in their home.

The push for deinstitutionalization occurred concurrently with government withdrawal from the funding and provision of housekeeping services to home care recipients. In 2001, the BC government terminated housekeeping as a component of state funded home health care. Clients receiving these services were responsibilized to seek out this care from the private sector or unpaid carers. This policy decision had unique repercussions for clients who could not afford to pay for care and for those who lived in rural or remote areas, where often a private market for housekeepers did not exist. These clients were expected to resume housekeeping for themselves, seek help from unpaid carers, or go without this assistance. The paid care workers that had been providing housekeeping services were re-tasked. Their job descriptions were adjusted to have

them perform increasingly medicalized tasks downloaded from nurses through the delegation of tasks (DOTs).

The government's efforts to increase the efficiency and cost savings of the state resulted in more care work being downloaded to clients, unpaid carers, and lower skilled paid care workers (England *et al*. 2007, 189; MacPhail & Bowles 2008, 546). While care downloading occurred in Alberta and Ontario, it was most obvious in BC because of the focus on using DOTs to standardize the process of transferring care work from registered nurses to community health workers. DOTs were based on the assumption that costs would be reduced if less skilled workers could be assigned small, specific tasks requiring minimal supervision (Evans *et al.* 2005, 89). In practice; however, the anticipated cost savings often did not materialize (ibid). England *et al.* (2007, 189) explain this contradiction as an example of the "messiness of neoliberalism". The attempt to reduce labour costs using DOTs actually resulted in more government intervention in the form of administration and management.

In addition to justifying the use of DOTs to task-shift, the government's push for standardization contributed to its reversal on the issue of regionalization. Similar to Alberta's experience, the BC government began to question the cost-efficiency of its decentralized approach to the management of health service delivery in the province. Motivated by a desire to reduce fragmentation, streamline services, reduce duplication, and regain efficiencies, in 2003, the BC government consolidated the 52 regional and community health structures into five Regional Health Authorities (RHAs) and one provincial health authority (Axelsson *et al.* 2007, 154).

The desire for more centralized control over home care occurred in parallel with a push for enhanced accountability. This was pursued through an increase in monitoring and reporting on state funded service delivery. For example, in 2004, data collection regarding home care services was intensified with the province-wide implementation of the standardized InterRAI Home Care Assessment System in BC (Canadian Home Care Association 2013). Both Alberta Health Services and the CCACs in Ontario were using this data collection tool. Furthermore, the adoption of the InterRAI system was encouraged by the federal government (Alberta Health Services n.d.; CIHI 2016). Measuring service delivery by collecting increasing amounts of quantitative data was framed by neoliberal policy makers as a way of proving efficiency and quality. Yet, the quantification of home care placed a burden on home care service providers who needed to demonstrate specific "results", typically aligned with government priorities, as a condition of funding renewal. Home care administrators were required to deal with increasing, and sometimes overwhelming, amounts of paperwork. Finally, front-line care workers saw their autonomy and control increasingly limited as their tasks and work organization were dictated by the requirement for data collection as opposed to the provision of quality care.

The provincial government's desire to quantify not only home care delivery but also the health status and outcomes of the BC population was evident in the *Provincial Health Officer's 2002 Annual Report: The Health and Wellbeing of People in BC* (British Columbia Ministry of Health Planning & Office of the Provincial Health Officer 2002). This report used 91 indicators to show trends related to the achievement of BC's six health goals. The report's ten action items focused on encouraging healthy lifestyles as the key to achieving better health outcomes for individuals and families. The push for quantification, individualization, and self-responsibilization aligns with neoliberal values. However, this report juxtaposed the rhetoric of

the lifestyle/behaviour health discourse with the acknowledgement that inequity has produced health disparities within the province. For example, the report stated "not everyone has the same abilities, opportunities, or life circumstances to enable them to make healthy choices" (ibid, xii). In addition, it identified women and Indigenous persons as needing supportive policies and programs to overcome systemic disadvantage.

The report echoed language from the 1997 *Health Goals* document, calling on governments and citizens to take "collective responsibility" for health (ibid). The provincial government's role was framed as being to "provide equitable access to appropriate services and programs to help improve the health of citizens" (ibid). Despite naming equity as a policy goal, many of the policy techniques proposed in the report reflected a neoliberal ideological orientation. For example, the report suggested that governments focus on creating a healthy, diverse economy; continue to build an evidence-based culture focused on appropriate health care services; support and expand programs that help citizens become wiser health consumers; and be committed to health research, analysis of trends, and evaluation of programs (ibid, xiii). The report's discussion of the role of equity in creating healthy citizens was novel compared to the documents being produced by the Alberta, Ontario, and federal governments around the same time. Yet, policy techniques pursuing equality and equity received less emphasis than recommendations aligned with the neoliberal priorities of marketization, self-responsibilization, and accountability.

Self-responsibilization was a cornerstone of the BC government's policy strategy for improving the health of seniors throughout the 2000s. This was conceptualized as getting individuals to adopt healthier lifestyles. In October 2004, the Ministry of Health facilitated a conference on health and aging. From this, *From Dialogue to Action Summary Report of the*

*Working Group and Framework for Change* (British Columbia Ministry of Health 2005a) was produced. The government subsequently released a *Healthy Aging through Healthy Living* framework (British Columbia Ministry of Health Services 2005). The BC government's strategic plan for healthy aging focused on healthy eating, injury prevention, physical activity, tobacco cessation, and social connectedness (ibid, 3-4). Along the same lines as the *Provincial Health Officer's 2002 Annual Report*, these initiatives sought to achieve cost-efficiencies for the state while also taking equity concerns into account. The government was clear in its view that adopting healthy lifestyles could prevent, minimize, or even reverse frailty and poor health in older age. It argued that this would, in turn, reduce the demand for health care services, resulting in savings to the health care system. Yet, this policy framework simultaneously acknowledged links between health and the determinants of health (British Columbia Ministry of Health 2005a). It suggested that income, gender, housing, and personal health practices influenced a person's capacity to engage in a healthy lifestyle.

Many of the BC government's policy documents indicated an understanding of the interrelated nature of efficiency and equity in health. Yet, how the provincial government framed its role in the redesign of the health care system to achieve these objectives evolved over time. As discussed previously, the earlier reports emphasized the collective nature of responsibility for health. These reports positioned the provincial government as a provider of health care, albeit one that shared this responsibility with others. In later documents, the role of the provincial government was reframed to be more in line with a NPM approach to governance. In the *Healthy Aging through Healthy Living* (2005) framework, for instance, the Ministry of Health's role was to set the overall strategic direction for system restructuring (British Columbia Ministry of Health Services 2005). The government saw itself in a "stewardship role", providing

leadership and support to health system partners, but avoiding direct administration or service provision whenever possible (ibid, 22).

Collaboration and partnerships, while a component of early policy documents, were reconceptualised in later ones. In the *Healthy Aging through Healthy Living* (2005) framework, for example, partnership was defined from a neoliberal perspective, similar to how it had been used in Alberta and Ontario. The "partnership approach" used by the provincial government involved the delegation of policy initiatives to health authorities, government ministries, or seniors' organizations. Downloading ownership over health policy initiatives was justified by the provincial government as a way to "bring a sense of responsibility and accountability to the owner of each initiative" (ibid, 23). Having removed itself from most of the administration and delivery of home care, the provincial government focused on facilitating best practice development, monitoring the health of the population, and evaluating health system performance (British Columbia Ministry of Health Services 2005; British Columbia Ministry of Health 2005b).

In 2008, the provincial government again focused on establishing partnerships with the private sector in its *Seniors in British Columbia: A Healthy Living Framework* (British Columbia Ministry of Healthy Living and Sport 2008). This framework advocated the creation of age-friendly communities, the mobilization of volunteerism, the promotion of healthy behaviours, and the need to support older workers to remain in the workforce (ibid, 5). While avoiding mention of the provincial government's previous decision to delist home support services, this framework returned to the idea that "we know that help with simple tasks, such as housekeeping and yard work, can make an enormous difference in helping older people remain in their own homes and communities" (ibid). As part of creating age-friendly communities, the government

promised to "explore innovative models" of providing non-medical home support services (ibid). The assumption; however, was that "innovation" would come from partnerships with private sector organizations or volunteer groups. The option to re-incorporate housekeeping services back into the basket of eligible state delivered care was never put on the table. This is evidence of the continued neoliberal influence on the government's policy choices.

In 2009, the provincial government partnered with the United Way of the Lower Mainland to develop and pilot the Community Action for Seniors' Independence (CASI) project (Government of BC n.d.). CASI gave seniors in five BC communities access to a range of non-medical home support services, such as transportation, housekeeping, home repair, yard maintenance, friendly visiting, and information and referral services. The services available through CASI were partially funded by the provincial government and partially by charitable organizations. The care was delivered by private sector organizations. This setup meant that, while home support care became more available to a particular subset of seniors, it was not universally accessible in the way housekeeping services had been when provided directly by the state prior to 2001.

The provincial government's *Innovation and Change Agenda* (2010) was an attempt to connect its focus on self-management to its health service delivery reform agenda (Government of BC & ThinkHealthBC 2010). In contrast to previous policy documents that incorporated both cost-efficiency and equity as policy goals, the search for cost-efficiencies occupied a disproportionately prominent place in this policy agenda. "Improved innovation, productivity and efficiency in the delivery of health services" was placed at the centre of its strategy map (ibid). In contrast, equity was only implicitly referenced through a mention of the special needs of some frail and vulnerable citizens. Along with the emphasis on efficiency came a renewed

focus on market-oriented strategies as the government's preferred policy tools. For instance, the agenda indicated that the government would pursue "assertive expenditure management through the use of innovative strategies to increase productivity and improve efficiencies" (ibid). Moreover, it proposed the use of "lean process improvements to reduce waste, consolidation of back-office functions, and implementing shared purchasing across health authorities" as suitable policy techniques (ibid, 18-9). This was much more in line with NPM than the previous policy agendas released by this government.

The *Innovation and Change Agenda* was the precursor to the provincial government's $68.7 million investment in the *Healthy Families BC Strategy* (Office of the Premier 2011) in May 2011. The *Healthy Families Strategy* was promoted as a way for the government to help its citizens, including seniors, "make the healthier choice the easier choice" (ibid).

Following the appointment of Christy Clark as Premier in March 2011, the BC government finally released the 2008 report entitled *Health and Wellbeing of Women in British Columbia* (British Columbia Ministry of Health & Office of the Provincial Health Officer 2008). This was intended as an update to the 1995 *Provincial Health Officer's Report on Women*. The 2008 report broke with the *Innovation and Change Agenda*'s focus on efficiency, returning to the use of a gender and equity lens.[20] The report's findings indicated that both overall life expectancy and life expectancy in good health had increased for women in BC since 1995. However, these increases occurred at a slower rate than in the past (ibid, xix). Furthermore, the gains in life expectancy for BC women had been less than those of men. They had also been less

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[20] Perhaps this can be explained by the substantial delay in its release. It is possible that the 2008 report had been prepared prior to the drafting of the 2010 *Innovation and Change Agenda*.

favourable for BC women than for women in other Organisation for Economic Co-operation and Development (OECD) countries (ibid).

The 2008 *Health and Wellbeing of Women in British Columbia* report also noted increasing inequality among women in different RHAs.  This was attributed, in part, to unequal access to health care services across BC.  The report also suggested the possibility that some women faced disproportionate barriers to care even when care services were available in their jurisdiction (ibid, xxii).  It provided disability, language, and unfamiliarity with the health care system as examples of these barriers.  The report found that health delivery focused on process equality contributed to increased negative health outcomes for women of lower socioeconomic status.

The report's key recommendations were to develop a comprehensive women's health and wellness strategy, increase capacity for sex- and gender-based analyses of programs and services, and improve the monitoring and surveillance of women's health status.  It also recommended the development of a "made in BC" multi-sectoral anti-poverty strategy.  Finally, it proposed to increase health care system accessibility, particularly for women with disabilities or from cultural minority groups (ibid, 237-244).

The 2008 report offered the clearest focus on equity as a policy goal of health care reform of any government document from any province during the time period under consideration.  It brought the issue of women's systemic marginalization to the forefront of the discussion. Moreover, it touched on how gender intersects with class- and race/ethnicity-based discrimination.  Its recommendations were high level, limiting their usefulness in guiding specific equity-focused policy reforms; however, the idea of developing a women's health and

wellness strategy was not something that was even being discussed in the other provinces at this time.

Sadly, this strong emphasis on equity was not consistently applied to future government documents. In response to the February 2012 Ombudsperson's Public Report 47, *The Best of Care: Getting it Right for Seniors in British Columbia (Part 2)* (British Columbia Ombudsperson 2012), the provincial government released *Improving Care for BC Seniors: An Action Plan* (2012) (Government of BC 2012). This action plan identified increasing access to information about publicly funded services for clients and families, ensuring consistent and fair delivery of care, and protecting vulnerable seniors from abuse, as its key objectives (ibid, 1). Despite referencing equitable care delivery as a policy priority, the neoliberal policy tools described in the plan were better positioned to enhance cost-efficiency than to promote equity. First, the plan emphasized the need to implement standards and best practices that could be easily measured in order to enhance transparency and accountability. Next, it proposed to establish clinical guidelines for treating frail seniors in emergency rooms and hospitals, as well as for follow up care and home support upon discharge. No reference was made to the need to ensure equitable approaches to care for different clients in different contexts. Finally, the plan advocated creating partnerships with the private sector to make services more "flexible". This was based on the assumption that increased flexibility would contribute to increased access to care. Expanding the CASI project partnership with the United Way was proposed as a preferred way to provide clients and their families with greater choice and flexibility in obtaining non-medical home support services (ibid, 7). Despite the provincial government's attempt to use this action plan to communicate its intent to pursue equity, by adhering to the neoliberal policy toolkit, it instead positioned itself to enhance cost-efficiency.

Similar to Alberta and Ontario, the BC government's policy choices regarding health and home care reform between 1992-2013 show evidence of being shaped by neoliberal ideology, governance structures, and policy tools. Yet, neoliberalism was more unevenly applied in the BC context than in either Alberta or Ontario. This led to policy choices that in some ways challenged neoliberal policy goals, policy initiatives that contradicted each other, and internal inconsistencies within policy agendas whereby the stated policy goal was in tension with the tools proposed to achieve it. The BC government made more of an effort to balance efficiency with equality and equity than in either Alberta or Ontario. However, the specifics detailing how equitable processes would be implemented and health outcomes achieved, remained consistently lacking. Meanwhile, the use of market-oriented policy solutions that prioritized efficiency goals and cost savings for the state remained ever present.

## The Messiness of Neoliberalism

As the above analysis illustrates, there are definite patterns in how neoliberalism has influenced health and home care sector reform in various Canadian contexts. There is also evidence of neoliberalism at work in each of the five ICPs under consideration in this study. However, neoliberalism is not an "encompassing, unitary, coherent apparatus" (England *et al.* 2007, 170). A peculiar feature of neoliberalism is its messiness, as evidenced by its incomplete and uneven penetration and its tendency to produce tensions and contradictions. As Larner (2003, 511) points out, neoliberalism "arrives in different places in different ways, articulates with other political projects, takes multiple material forms". Likewise, Harvey (2005, 13) explains that, "the uneven geographical development of neoliberalism, its frequent partial and lop-sided application from one state and social formation to another, testifies to the tentativeness of neoliberal solutions".

There is evidence of incomplete and uneven penetration of neoliberalism within the jurisdictions and ICPs studied here. For example, after periods of significant state funding cuts and freezes, each of the provincial governments of Alberta, Ontario, and BC subsequently reinvested in health and social care funding despite still adhering to a broadly neoliberal policy orientation. Similarly, after all three provinces implemented some form of regionalization to decentralize the responsibility for managing and delivering health care, each reversed course by partially consolidating the regional decision-making bodies into a more centralized structure. Lastly, while each of the federal or provincial governments emphasized the search for cost-efficiencies for the state as an important policy goal, this focus was uneven and incomplete in each context.

The uneven messiness of neoliberalism is apparent at the program level too, particularly in the inconsistent use of the term efficiency in ICP documents and by those involved in the programs. In Carefirst, for instance, efficiency was frequently cited but never defined. Carefirst's 2010/11 Annual Report discussed efficiency as a goal of program reform: organizational restructuring was presented as a way to "improve efficiency and streamline the agency's operations" (Carefirst Seniors and Community Services Association 2010-11, 8), establishing new partnerships as means of "enhancing the organization's capacity and efficiency in service delivery" (ibid, 11), and developing an entrepreneurial culture as a means of "focusing on operation cost efficiency" (ibid). In contrast, research participants with Carefirst understood efficiency in relation to service provision. They most often framed it in terms of saving time, which is implicitly related to cost savings. For instance, one paid care worker referenced the program's use of "volunteers to finish their job efficiently and timely…" (I: May 10, 2013). Meanwhile, another explained that Carefirst is "very efficient" because "if you want something

done, you ask for it and you get it within the same day or the next day" (I: May 8, 2013). Interestingly, none of the research participants or program documents in any ICP explicitly linked efficiency with the idea of allocating resources in ways that maximize value, despite this being the denotative definition of efficiency under neoliberalism.

The messiness of neoliberal policy solutions can contribute to what Larner (2003, 511) calls "unexpected outcomes" in the form of tensions and contradictions. Bonoli (2005, 435), Rubery (2011, 659), and Jenson (2015, 541) suggest that a policy community's diagnosis of problems and identification of appropriate interventions can either reduce the social issue or increase it. I argue that using policy techniques focused on enhancing efficiency and cost savings to deal with fragmentation in the design and delivery of home care often increases it. This paradox is one in which neoliberal policy makers have prescribed neoliberal policy solutions aimed at enhancing efficiency to redress fragmentation, but that in many cases have actually perpetuated the fragmentation which they viewed as inefficient. Below I provide two examples of this fragmentation-inefficiency paradox.

## Case 1: CCACs and Competitive Bidding

The Ontario government's creation of CCACs and the use of competitive bidding to allocate home care contracts provide an illustration of the fragmentation-inefficiency paradox. As discussed earlier, the Harris government mandated the creation of CCACs in 1994. Neoliberal policy makers argued that CCACs operating at the local level were better positioned to respond to individual citizens' demands because of their proximity to them. Likewise, a smaller, decentralized government is "better" from a neoliberal perspective in terms of market efficiency and economic effectiveness (Steger & Roy 2010, 30). CCACs employed case managers who arranged access to care by contracting services from not-for-profit and for-profit

agencies using competitive bidding via a request for proposals.  The managed competition model was introduced through CCACs in 1996 to further systematize the fragmented "patchwork quilt" of home care services, programs, providers, eligibility requirements, funding mechanisms, and quality standards (England *et al.* 2007, 191).

While CCACs and the managed competition model were intended to enhance the efficiency of the home care system, they were subject to the "messy actualities" (Larner 2000, 14) of so many neoliberal policy interventions.  As a result, they produced mixed results in terms of fragmentation.  CCACs provided a simplified "single point of access" for home care services making system navigation for clients and unpaid carers easier.  They also attempted to rectify the historical disconnect between health and social care by linking these together.  Both of these strategies were intended to reduce fragmentation.  However, in some ways these strategies simultaneously created and reinforced fragmentation.  For example, in this new system clients could access IADL care only if they were eligible for ADL care.  If a CCAC case manager determined a senior did not need help with tasks categorized as ADLs, that senior was not eligible to receive state-funded help with IADLs, even if they needed it.  The senior was instead required to seek IADL care from the private sector, unpaid carers, or to go without.

The introduction of competitive bidding into the home care sector boosted competition.  By opening up care contracts for bids, it was anticipated that the price the state paid for care delivery would go down and efficiency would be increased increased.  Instead, in some cases the costs of home care increased because of the costs of operating the CCACs and administering the bidding process.  Similarly, increasing competition simultaneously increased inefficiency by encouraging unnecessary duplication.  Competitive bidding requires many service providers who do the same thing to bid on contracts.  This means that there are extra services available that

could be provided by the agencies that do not win the bid. More competition also often means a lack of continuity. The competitive bidding process can result in fluctuations in both the supply of services and in the providers of services. Fragmentation is increased as contacts are won by many different agencies or as contracts are subcontracted out to other agencies. This has resulted in multiple agencies serving the same client.

The increased competition among home care service providers, in conjunction with reduced government funding, has also meant that cooperation among agencies has eroded (England *et al.* 2007, 185) and working conditions have deteriorated (Steger & Roy 2010, 33). As agencies are required to submit lower bids to win care contracts, they pass these costs on to workers. This has resulted in high attrition rates as workers leave the home care sector for higher wages and more stable jobs in hospitals or long-term care homes. Clients and unpaid carers also pay the price of the state's increase in efficiency. With the high worker turnover, clients experience less continuity of care and unpaid carers are often expected to fill the gaps in the increasingly fragmented care (Roberts 2004).

## Case 2: Aging at Home as a Solution to the ALC Crisis

The state's attempt to use aging at home initiatives to deal with the Alternate Level of Care (ALC) crisis is a second example of the fragmentation-inefficiency paradox. Aging at home programs are intended to enhance efficiency, promote cost savings for the state, and reduce fragmentation by managing seniors' health needs at home instead of in publicly funded institutions. By offering seniors minimal levels of lower cost in-home support, the hope is that this should enable them to maintain a level of functionality required to continue living in their home. As a result, the number of costly emergency room visits as well as admissions to hospitals and long-term care homes should decline. Similarly, aging at home programs should

permit the state to shorten the lengths of hospital stays by allowing seniors to be discharged back into their homes as quickly as possible. In both scenarios, neoliberal policy makers hope to cut costs by substituting less expensive community-based care for more costly hospital care. Keeping seniors out of hospitals and in their homes should also reduce fragmentation. When seniors bounce between home and hospital it results in fragmented care that is both disruptive for the client and their unpaid carers and costly for the health care system.

However, in a context where public funding for home care is tightly controlled and increasingly rationed (Roberts 2004), there is significant pressure for administrators to provide evidence that their program reduces the institutionalization of seniors. In 2009, provincial policy makers renewed Aging at Home funding only for programs that were able to demonstrate that they had contributed to a reduction in the number of hospital ALC beds occupied by "bed blockers" (LHIN 2006; Central East LHIN 2010; CIHI 2010). The perception of SMILE program administrators was that this redesign in funding eligibility was an attempt by the provincial government to "push" the LHIN into collecting statistics related to efficiency (I: April 2, 2013). They explained that the government wanted aging at home programs not simply to "reduce barriers to care for seniors who are especially vulnerable to institutionalization" (SMILE Program n.d.; SMILE Program 2010) but to be able to show a correlation between public funding and value, defined as a reduction in ALC beds.

Targeting public funding at programs that help address the "ALC challenge" (Canadian Home Care Association 2015) should, in theory, enhance efficiency by helping to minimize the length of ALC clients' hospital stays (Madigan 2007). This would allow hospitals to treat more clients at roughly the same costs. But this efficiency comes at a price. The improvement in the efficiency of hospitals has come from the capacity to discharge clients back into the community

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"quicker and sicker" (Armstrong *et al.,* 2008). As a result, costs are shifted to other parts of the health care system and outside of the health care system to families and individuals. As Stein (2001, 178) argues, greater efficiency in the acute care system leads to the "passive privatization of the health care system".

Using aging at home programs to deal with the ALC crisis, while intended to enhance efficiency and cut costs in an environment of resource scarcity, in practice has restricted access to publicly subsidized home care for some seniors. For instance, as a result of the 2009 funding redesign, the SMILE program increased its threshold for program eligibility to target very high needs seniors who were already making trips to the hospital. Only seniors who had been hospitalized, visited the emergency room, or had an unscheduled physician visit in the 90 days prior to application, would be admitted or waitlisted for the SMILE program. By withholding services until clients entered the acute care system, program administrators they were able to capture the quantitative data they needed to prove to provincial policy makers that their interventions were indeed addressing the ALC crisis.

Unfortunately, the push to prioritize ALC seniors for access to aging at home programs such as SMILE amplified the risk of missing the opportunity to prevent frail seniors from getting frailer. When seniors who need preventative support services are put on a waitlist or deemed ineligible for publicly subsidized care, their ability to function independently can be compromised as their care needs increase. This puts them at increased, and arguably unnecessary, risk of having their health decline until they reach a crisis point. Focusing on home care as a means of reducing ALC bed occupancies has succeeded in enhancing acute care system efficiency; however, it has also created an inefficient system whereby to get access to home care one must go through the acute care system. Once seniors visit to the doctor or emergency room,

they meet the SMILE program's eligibility criteria. As a result, seniors are experiencing expensive encounters with doctors and bouncing around between hospital and home when their care needs could have been met at home had they been able to access the SMILE ICP earlier, before they reached a crisis point requiring acute care intervention.

## The Complexity of Integrated Care

Integrated care is a neoliberal policy intervention typically used to enhance efficiency in an effort to redress fragmentation. However, like CCACs' use of managed competition and the Ontario government's attempts to use aging at home programs to deal with the ALC crisis, ICPs can have mixed results with regards to their impacts on fragmentation. The academic literature on integrated care focuses disproportionately on its potential to fix fragmentation and reduce inefficiency but says little about the complex messiness of ICPs and their tendency to produce unexpected outcomes.

The quantity of literature calling for policy makers to use integrated care to deal with fragmentation in health and home care is overwhelming.[21] Scholars refrain from stating a causal link between integrating care and reducing fragmentation, admitting that "this assumption has been difficult to prove empirically" (Glendinning 2003, 141). Instead, they make tentative assertions about the supposed relationship between integrated care and fragmentation. For example, "It is, therefore, widely assumed that integrating services can reduce fragmentation and discontinuities" (Rummery & Glendinning 2000), "integrated care models might offer a solution to the fragmentation in the healthcare system" (Spoorenberg et al. 2015, 2), or "decision-makers

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[21] Boeckxstaens & de Graaf 2011; Looman *et al.* 2016; Hudson & Henwood 2002; Schwab *et al*. 2003; Billings 2005; Gittell *et al*. 2008; de Jong & Jackson 2001; Allen *et al.* 2009; Clark 2003; Dubuc *et al.* 2013; Tsasis *et al.* 2012; Kodner & Spreeuwenberg 2002.

at the regional level identified improved system integration as a response to problems of access and continuity" (Alberta Health and Wellness 1999; Regional Health Authority 2000).

The potential of integrated care as a policy tool to combat fragmentation has motivated substantial policy work on integration from global to local levels. For example, in 2007, the World Health Organization (WHO) Director-General stressed the "need [for] a comprehensive, integrated approach to service delivery" as a way to "fight fragmentation" (Chan 2007, 1). In 2015, the WHO undertook public consultations on their global strategy on integrated people-centered health services for 2016-2026. Their policy documents framed integrated care as a solution to "the fragmented nature of today's health systems", citing the focus on "hospital-based, disease-based and self-contained 'silo' curative care models" as a key contributor global health emergencies, such as the Ebola crisis in West Africa (WHO 2015).

In addition to framing integrated care as a fix for fragmentation, the literature simultaneously positions integrated care as a solution to health system inefficiencies.[22] Care integration is constructed as a means of containing the costs borne by the state, particularly those associated with demographic change (Hofmarcher *et al*. 2007; Calciolari & Ilinca 2011) and the ALC crisis (Sutherland & Crump 2013). Even the Canadian Home Care Association has adopted the view of integrated models of care "as critical to improving health outcomes and quality of life, and for producing efficiencies within the system" (Canadian Home Care Association 2015, 6).

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[22] Kodner 2009; Allen *et al.* 2009; Jackson *et al.* 2016; Dubuc *et al.* 2013; Bergman *et al.* 1997; Johri *et al.* 2003; Montenegro *et al.* 2011; Janse *et al.* 2016a; Tollen 2008; Singer *et al.* 2011; Brown & McCool 1992; Leutz 1999; Kodner & Spreeuwenberg 2002; Hubbard & Themessl-Huber 2005; Mur-Veeman *et al.* 2003; Glendinning 2003; Leutz 1999; Harris *et al.* 2012; Frossard *et al.* 2004.

Calciolari and Ilinca (2011, 4) explain that integrated care has an intrinsic political appeal and moral desirability. It directly addresses problems of disconnection and fragmentation that are relevant for growing target populations. Health care policy makers see integrated care as a win-win situation. It is a way for the state to fulfill the wishes of citizens to grow old in their own homes and communities. Meanwhile, it is also a potential solution to the looming economic consequences of increasing numbers of older persons with complex care needs (Wise 2014; Oliver *et al.* 2014; Poot *et al.* 2016).

Over the past two decades, the European Commission (2015a) has engaged in substantial policy work regarding integrated care in the European Union. Much of their research through the Care Management of Services for Older People in Europe Network has focused on improving service system efficiency (Banks 2004) and maximising older people's quality of life, independence, and control (Nies 2004). The United States has also pioneered the use of integrated care, in the form of "managed care", to combat care fragmentation and system inefficiencies. Health Maintenance Organizations (HMOs)[23] and the OnLok Lifeways Program

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[23] Cost-efficiency is the dominant driver of managed care under HMOs; purchasers demand HMOs control the costs of care. In theory, the managed care model has the capacity to "change fundamentally the fragmented delivery system in the USA" (Sekhri 2000, 832-833). Its focus is on monitoring and coordinating care through the entire range of services (primary care through tertiary services), emphasizing prevention and health education, encouraging the provision of care in the most appropriate setting and by the most appropriate provider, and promoting the cost-effective use of services through aligning incentives (e.g., by capitation of providers and cost-sharing by consumers) (ibid). Most health plans in the USA have implemented this vision only partially. However, the epitome of managed care is embodied by HMOs, such as Kaiser Permanente or the Harvard Community Health Plan. Kaiser Permanente, the largest not-for-profit integrated health care system in the United States, is often seen as a "prime example of integrated care" (Pines *et al.* 2015, 1). Its aligned structure and underlying contractual relationship between organizations, institutions, and service providers enables it to address clients' acute care needs while simultaneously offering low cost care and maximizing health outcomes (ibid).

of All-inclusive Care for the Elderly (PACE) model[24] have both contributed significantly to the literature on integrated care.

Despite the majority of the literature on integrated care focusing on its potential to redress problems of fragmentation and inefficiency, in practice using integrated care to restructure the home care sector is a complex process that often yields contradictory outcomes. There is a smaller body of research detailing the other impacts of integrated care. For care recipients, there is some research showing that integrating care can improve health outcomes (Coleman *et al.* 2009; Homer *et al.* 2008). Scholars have reported positive effects of integrating care on older persons' satisfaction with care (Berglund *et al.* 2013; Hébert *et al.* 2010; Morales-Asencio *et al.* 2008). Studies have also linked integrated care with increases in access to care (Gröne & Garcia-Barbero 2001, 7) and the provision of more equitable services (Barcelo *et al.*, 2012, 9). Finally, integrated care has been shown to fulfill clients' care needs (Dubuc *et al.* 2011; You *et al.* 2012) and contribute to improvements in their quality of life (Lin *et al.* 2009; Phillips *et al.* 2004; Preen *et al.* 2005).

Most of the academic work has focused on the implications of integrated care for care recipients. However, some scholars have studied what participating in integrated care means for

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[24] The OnLok Lifeways PACE model of care for seniors has been influential in shaping some Canadian ICPs. Elements of the PACE model have been incorporated in ICPs in Alberta (in CHOICE), Ontario (in Carefirst), and Quebec (in PRISMA). The OnLok ICP in San Francisco, California, uses full integration to provide acute and long-term care services which are coordinated by, and largely organized around, adult day health centres (Eng *et al.* 1997). Similar to CHOICE and Carefirst, OnLok uses the PACE service delivery model to offer in-home support services, primary care services, and case management of acute and chronic health services to clients. An interdisciplinary team of physicians, nurses, PTs, OTs, social workers, dietitians, PSWs, and drivers provide medical and social care. The OnLok ICP emphasizes its use of a client-centered approach (ibid). Clients participate as active partners in the creation of individualized care plans. They have access to one-stop-shops where they can obtain medical care, participate in social activities, exercise and get meals. OnLok stresses that they do not have a "standard" daily routine (ibid). Instead, each client's care revolves around his/her needs and interests. The OnLok ICP uses a form of risk-based capitation whereby in exchange for fixed monthly payments from Medicare and Medicaid for each enrollee, the program bears full financial risk for their care (ibid).

unpaid carers. There is some research showing that integrated care arrangements targeting the client-unpaid carer relationship may reduce caregiving burden and improve the overall quality of life and health of unpaid carers (McAdam 2008; Hallberg & Kristensson 2004; Eklund & Wilhelmson 2009; Janse *et al.* 2014). Scholars have also suggested that integrated care can enable more timely recognition of the unmet needs of unpaid carers (Fabbricotti *et al.* 2013). In addition, participating in ICPs can provide unpaid carers with information, improve their access to support services, and increase their competence in coping with their care responsibilities as a means of safeguarding against overburdening and deteriorating health (McAdam 2008; Wimo *et al.* 2002).

A very limited amount of scholarship has looked at the impacts of integrated care on paid workers. Research in this area has focused on how common integration mechanisms, such as multidisciplinary meetings or shared information systems, impact coordination among professionals (Leutz 1999; Harris *et al*. 2012) or affect the daily activities (Leutz 1999; Campbell *et al.* 2006) and routines[25] of workers.

The value of integrated care, aside from as a means to enhance efficiency, is vastly underrepresented in the literature. Likewise, the possibility of contradictory outcomes arising from the use of integrated care policies has gone virtually unacknowledged. Only a few scholars have studied how integration mechanisms can result in duplication and inefficiency, making coordination more difficult (Leutz 1999; Harris *et al.* 2012; Janse *et al.* 2016a). Billings' (2005, 18) work juxtaposing the "aspirational perceptions [of integrated care] with the organizational, environmental and professional actualities of trying to make it work" was particularly influential

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[25] Singer *et al.* 2011; Hubbard & Themessl-Huber 2005; Janse *et al.* 2016a; Liedtka & Whitten 1998; Axelsson & Bihari Axelsson 2006; Hall 2005; Campbell *et al.* 2006.

in shaping my study. She noted that "the consequences of these tensions and barriers seemed, paradoxically, to create a shortfall in the quality of care provided and perhaps experienced" (ibid).

The contradictory nature of integrated care is tied to its neoliberal roots. The ICPs in this study used the same components of service delivery integration in their attempts to reduce fragmentation: they all offered some combination of health and social care, took a team-based approach to care delivery, and tried to balance seamless care with client-centered care. However, their methods of implementation differed. For the purposes of this study, I call these methods "policy techniques". Different ICPs used different policy techniques to accomplish similar objectives revolving around the reduction of fragmentation. Like the ideology within which they were created, I find that ICPs are "contingent, contradictory and partial" (Ward & England 2007b, 168). They are truly "hybrid assemblages of diverse practices" (ibid). In fact, ICPs mirror Connell's (2010, 32) description of neoliberalism; they too are a "sprawling family of related policies [or policy techniques] that get proposed and implemented in different sequences". Like neoliberalism, ICPs are also "geographically uneven" (Ward & England 2007a, 15) and "extremely adaptable to specific social contexts" (Steger & Roy 2010, 131).

It is, thus, not unexpected that integrated care has been operationalized differently across the various jurisdictions under consideration in this study. Nor that neoliberalism has unevenly and inconsistently penetrated each ICP's ways of working. This has resulted in ICPs that use a mix of policy techniques. Some of their policy techniques align with the neoliberal ideology, mode of governance, and policy toolkit, particularly in their focus on enhancing efficiency as their primary aim. However, ICPs also use policy techniques that challenge neoliberal market-oriented approaches. These policy techniques typically seek to enhance equality and/or equity as

their primarily policy goals of home care delivery. The contradictory nature of ICPs is evidence of their complexity and it is precisely this complexity that enables them to break the cycle of fragmentation and inefficiency. In a neoliberal context that frames efficiency and equity as being in a zero-sum relationship and fundamentally opposes increasing state intervention in health and social care delivery, the fact that publicly-funded ICPs have put equity considerations "on the table" and are still considered by provincial governments to be important tools in redressing fragmentation, is of the utmost importance.

## Conclusion

In this chapter, I investigate the implications of the neoliberal restructuring of the health care system, focusing on home care. I begin with an analysis of the influence of neoliberalism on federal and provincial government policies aimed at health or home care system reform from 1992-2013. I then focus on the contradictions associated with neoliberal attempts to use efficiency-motivated policy tools to resolve issues of fragmentation in the home care sector. I show that neoliberalism in practice is messy and cite the contradictory nature and outcomes of ICPs, as a neoliberal tool, as evidence of this. I argue that ICPs are complex and complicated, though this aspect of them is underrepresented in the literature. ICPs use policy techniques that challenge neoliberalism at the same time as using policy techniques that reinforce it. I conclude that it is precisely this contradictory nature of ICPs that enables them to break the cycle of fragmentation and inefficiency.

# Chapter 4: A Feminist Political Economy Framework

"There isn't a single answer to the problems of gender and justice. I think that for me feminism is always contextual. And also, I think I've become much more aware of how the solution has to be a conversation, an action plan, a change, but whatever it is it has to involve men and women" (Ngozi Adichie 2017).

## Introduction

The analysis of integrated care programs (ICPs) in this dissertation is guided by a feminist political economy (FPE) theoretical framework. FPE has roots in both liberalism and Marxism, especially Marxist/socialist feminism. It builds on, and challenges, critical political economy's focus on the production and distribution of goods and services in relation to the distribution of costs and benefits for people (Day 2013, 11). FPE takes into account the relationship between market and domestic relations and the sexual division of labour (ibid). Economics, politics, culture, and ideologies are understood within FPE as integrally related. These are shaped by unequal forces of power and resistance in different historical periods and circumstances (Armstrong & Day 2017, 7). Class, gender, and race/ethnicity – among other intersecting social relations of inequality – are critical to FPE. They make visible which groups are affected, in what ways, when, and under what conditions. The relationship between the state and capital underlies this theoretical framework.

FPE as a theoretical framework helps me assess the impacts of using ICPs to design and deliver home care by guiding *where* I look. My analysis of home care focuses on the lived experiences of clients, unpaid carers, and paid carers. These groups are made up mostly of women, many from racialized communities and in positions of economic vulnerability. I use FPE to explore how intersecting class, gender, and race/ethnicity inequalities impact if, and how, the expressed needs of clients and carers are met. This is central to understanding why the benefits of ICP policies are unevenly distributed among groups. I study the specific contexts

within which home care restructuring took place in Alberta, Ontario, and BC from 1992-2013 with the aim of connecting the personal lived experiences of those involved in ICPs to the broader social contexts that shaped their lives.

FPE also influences *how* I look. I focus on two key contributions of FPE to a critical understanding of home care restructuring within a neoliberal context. First, I use FPE to develop a conceptual framework for thinking about care and care work. Second, I use it to guide my understanding of the blurring of public-private under neoliberalism. I use these theoretical tools to make the argument that the structural conditions of paid and unpaid care work, as well as the gendered, racialized, and classed relations that exist under neoliberalism, have shaped the provision and receipt of home care through ICPs in ways that benefit those in positions of power and privilege while marginalizing others.

Efficiency/inefficiency dominates the discourse on home care reform under neoliberalism. Fragmentation has been framed as a key policy problem arising from the inefficiency of the home care system. Yet, in many cases neoliberal reforms aimed at enhancing efficiency have had the perverse outcome of increasing fragmentation. My goal in this dissertation is to explain the role of integrated care in resolving this contradiction. I use FPE to bring equality and equity into a policy discussion that is disproportionately focused on efficiency. I contend that using an FPE framework better positions me to take a critical look at whether ICPs can offer equitable outcomes for clients, unpaid carers, and paid carers. In doing so, it creates space for me to explore the impacts of ICP policy techniques that promote equality and equity as policy goals in comparison to those that prioritize efficiency.

## Where to Look

Home care is on our governments' political and policy agendas (Government of Alberta 2017; Government of BC 2017; Government of Canada 2017a; Government of Ontario 2017). Aging in place strategies remain an important component of federal and provincial government health policy.  As a result, greater numbers of older and increasingly vulnerable seniors, the majority of whom are women, are remaining longer in their private residential dwellings. Despite the fact that the provision of supportive health and social care is essential for seniors to age at home, there is a pattern of low value being attached to seniors who are no longer working (Armstrong & Armstrong 2005) and to the work and skills of the carers who help keep these seniors at home (Armstrong 2013).  Home care is still considered women's work.  Private homes are the workplaces of thousands of women as paid and unpaid carers, many from racialized communities and/or in economically vulnerable situations.  Yet, the care delivered by women in private homes remains largely hidden from public view.  This too often renders invisible the experiences of those who receive and deliver home care.  I use FPE to make visible the labour and relationships of the clients and carers involved in home care.  By explicating the links among the social relations of inequality, the dominance of the market, and paid and unpaid work, FPE contributes to an understanding of why home care is devalued within a neoliberal system.  In doing so, it illuminates possible avenues through which to challenge the hegemony of neoliberalism, for the benefit of clients and carers alike.

FPE gives me the tools to explore how clients' and carers' gendered lives intersect with relations of race/ethnicity and class in ways that result in women experiencing home care differently than men, but also differently than each other.  My analysis uses "lumping and slicing" (Armstrong & Armstrong 2004) to look at what is experienced in common, and what is

not.   The individuals and groups involved in home care often have different, and sometimes conflicting, interests.   They also occupy different positions of power and privilege based on gender, class, and race/ethnicity.   Looking at how the processes and policies used by ICPs benefit certain groups over others, I use FPE to illuminate the tensions and contradictions inherent in the provision and receipt of home care under neoliberalism.   For example, what works for clients might not work for carers, what works for those in the middle class might not work for those in positions of economic vulnerability, or what works for men might not work for women.   Taking these differences seriously, looking for patterns in who benefits versus who pays through participation in ICPs and why, and recognizing that tensions are often complex and cannot always be resolved, are fundamental components of this project.

In this dissertation, I study ICPs in three Canadian provinces that have undergone significant neoliberal restructuring of their home care sectors.   By analyzing both policy documents and the lived experiences of ICP participants, I assess how home care sector reforms in these three contexts have influenced, and been influenced by, historical, political, economic, and social factors.   This allows for meaningful comparisons between contexts while also demonstrating that similar arrangements in different contexts can have different outcomes (Day 2013, 11).  FPE highlights the ways clients and carers participate in the public and private sectors of the formal economy, as well as in the informal economy of the household or community. Considering both the overlap and separation of these sectors draws attention to the complex ways that care work moves among governments, individuals, families, not-for-profits, for-profits, and charitable agencies.

The feminist tenet that the "personal is political" (Smith 1989) is central to my analysis. Linking historical, social, economic, and political shifts at the level of policy-making to the

experiences of those involved in care relationships, contributes to my understanding of how people's lives are shaped and reshaped by neoliberalism. What work women do, how they do that work, how they experience the work, and the consequences not only for them but also for their households matters (Armstrong & Day 2017, 9). The conditions of care work are inextricably linked to the conditions of care. A client or carer's position in the classed, gendered, and racialized hierarchies of power influences how their conditions of work or care are impacted by changes in the funding, design, and delivery of home care. In addition to the fact that different groups are impacted differently by policy decisions, the interests of program administrators, paid workers, family carers, and clients can, and do, come into conflict. Oftentimes these tensions are not resolved equitably. Instead, the interests of groups in positions of power can be prioritized over those from historically disadvantaged groups. Drawing on the experiences of both clients and those who do the care work, I use FPE to situate the tensions and contradictions among, and within, groups in the broader social, economic, and political context of neoliberal restructuring. This makes visible patterns in who benefits and who pays when home care is redesigned and reformed by neoliberal ideology, governance structures, and policy tools.

## How to Look

FPE shapes how I assess the influences of neoliberalism on home care by creating an awareness of its limitations regarding issues of equality/inequality and equity/inequity. FPE guides my critique of the neoliberalization of home care in two ways. First, I use it to develop a conceptual framework for thinking about care and care work. I challenge a market-based understanding of care as a service. Instead, I use the concept of relational care to understand care as labour rooted in a relationship between a client and a carer. In doing so, I challenge the

invisibility and devaluation of women's care work typical of neoliberal ideology. Second, I use FPE to highlight the complexity of defining what is public versus what is private in home care. I argue that the neoliberalization of home care has redefined and blurred the boundaries between public and private in ways that have reinforced and perpetuated gender, race/ethnicity, and class disparities to the detriment of paid and unpaid carers and clients. I use FPE to bring equality and equity to the forefront of my analysis in order to challenge the disproportionate focus on efficiency typical of the neoliberal discourse on home care.

## Conceptualizing Care

Under neoliberalism, care is defined in market terms as an array of services that are viewed as distinct from each other and can be categorized on a continuum. Home care policies in BC, Alberta, and Ontario are explicit in their construction of care as "services". For example, BC's Home and Community Care Policy Manual states that service providers must "ensure clients identified as having the greatest need and urgency receive priority access to the relevant service(s)" (British Columbia Ministry of Health Services 2016). Alberta's Care Aides Competency Profile outlines the job of a Health Care Aide as to "provide personal support and basic health services directly to clients of the health system in Alberta" (Alberta Health and Wellness 2001). Ontario's CCAC Client Services Policy Manual "describes the community services available to CCAC clients, including professional, personal support and homemaking services" (Ontario Ministry of Health 2007).

Defining care as services is rooted in the biomedical discourse that draws artificial lines between medical/health care and custodial/social care. In the context of home care, these separations are often arbitrary as care workers undertake multiple care activities concurrently. For instance, consider the carer who changes the dressing on a client's wound while discussing

the news, or one who does the laundry while helping a client bathe and sharing strategies with the client's spouse on how to prevent falls in the bathtub. When care is conceptualized as services, the connectivity of care is broken down as it is redefined as small, distinct interventions (England & Folbre 1999). This makes it easier to attribute significance to relatively arbitrary juxtapositions, such as separating ADLs from IADLs, or distinguishing personal hygiene activities (e.g. bathing, dressing, grooming) from routine personal activities of living (e.g. assistance with eating, toileting, turning), for example. Likewise, it encourages a view of professional services as fundamentally different from personal support or homemaking services. The neoliberal view of care as distinct services facilitates the quantification and measurement of certain types of care. This promotes the distribution of care on a hierarchy of importance where some kinds of care are deemed more valuable than others without a legitimate reason. This has contributed to health care, which can be more easily counted and tracked, being prioritized at the expense of social care. The quantification and valuation of care have reinforced the neoliberal push to treat care as a product to be bought and sold in the market.

The neoliberal conceptualization of care is particularly limiting in the context of home care where a significant amount of care is provided by unpaid carers. Seeing care as services is consistent with the view of care as a product provided by paid workers. However, it obscures the vast amount of unpaid care work done by spouses, children, siblings, extended family members, neighbours, volunteers, and carers working beyond their paid hours. Given the central and demanding role of carers doing unpaid care work over extended periods of time (Peckham *et al.* 2014, 132), conceptualizing care in a way that invisibilizes this misses an important part of the picture.

Commodifying care fits it into a market-based model which feminist political economists challenge on a fundamental level (Duffy 2011, 13). An FPE view of care cannot be reduced to merely money or services, but fundamentally, is about relationships. Care is both "labour" and a "labour of love" (Armstrong & Kits 2003). Care work involves supporting ADLs and IADLs, providing clinical care, fostering social relationships, providing emotional and social support, and navigating and managing care services (Rosenthal & Martin-Mathews 1999). FPE draws attention to the ways care work is different from other forms of labour (Armstrong & Day 2017, 10). An FPE understanding of care merges the skill and labour of care work (Armstrong 2013) with the relational nature of care (to care about) and caring activities (to care for) (Folbre & Nelson 2000, 129; Graham 1983). It also acknowledges the time and energy it takes to provide care (Duffy 2011, 140; Armstrong 2013, 274; Mahon & Robinson 2011, 15). As Palmer and Eveline (2012, 257-8) explain, "caring straddles deep cultural schisms between home and work, emotion and rationality, feeling and activity, affection and skill". Relational care offers a complex understanding of care rooted in the social relations between client and carer.

Relational care also provides a foundation upon which to explore the gendered, classed and racialized nature of care. It makes visible the ways in which care work and relationships are shaped and constrained by the relations of power created and maintained under a neoliberal system. Care is allocated mainly to women (Lyon & Glucksmann 2008, 113). This can lead to gendered assumptions about the feminine sphere of domesticity and women's role as natural caregivers (Duffy 2011, 11-12). Acknowledging the existence and reinforcement of power hierarchies that sustain, and magnify, the social inequalities among care workers is another important part of understanding care. Occupational hierarchies are present in many home care workplaces. The higher-paid, professional workers at the top of the occupational hierarchy more

often occupy positions of class, gender, and race/ethnic privilege. Meanwhile, the lower-paid, less skilled workers are more likely to come from historically disadvantaged communities and remain stuck at the bottom of the hierarchy in positions of less autonomy and control.

Relational care challenges the neoliberal tendency to separate and rank care work and care workers. It resists dichotomizing explicitly relational care (e.g. bathing, social engagement, nursing, medical intervention) from care that allegedly requires less direct face-to-face connection between clients and carers (e.g. housecleaning, meal preparation, laundry, gardening). In the context of home care this juxtaposition is artificial as the majority of paid carers engage in face-to-face relationships with their clients. As a housekeeper in the study explained, "I work but I can still talk. Even when I'm washing I can talk (laughs)!" (I: March 5, 2013). In this study, all of the carers I interviewed reported providing relational care regardless of the specific activities or tasks they undertook.

In sum, FPE contributes to the conceptualization of care by offering an alternative to the neoliberal understanding of care. FPE acknowledges the relational nature of care, the skill and labour of care work, and the time and energy it takes to provide care. It also permits the consideration of the contributions of all carers while seeking to illuminate how the relationships among carers, and between clients and carers, are shaped and constrained by the power dynamics created and maintained under a neoliberal system.

## Paid and Unpaid Care Work

With the objective of individualizing care, neoliberal discourses often stress "client-centered" or "citizen-centered" service delivery (Treasury Board of Canada 2000a; 2000b). This relocation of the responsibility for care from the state to the individual has manifested in home

care policies that place a disproportionate focus on clients over carers. The push to provide client-centered home care is evident in numerous government documents. There are policy documents that emphasize "patient-centered health care" (British Columbia Ministry of Health Services 2001) or "self-directed care options" (British Columbia Ministry of Health Services 2016). There are provincial websites advertising the creation of "a customized home care plan that meets your specific needs" (Ontario 2014). Finally, there are local home care programs that advocate "developing comprehensive and client-centered services to meet client's needs" (Carefirst Seniors and Community Services Association n.d.).

Quantifying client perceptions of care and reporting on client satisfaction (Health Quality Ontario 2015) occupy a disproportionate amount of space in the policy discourse on home care evaluation. Meanwhile, policy work looking at the experiences of HCWs in areas such as care coordination or communication is relatively sparse. FPE takes care labour seriously (Armstrong *et al.* 2008) by challenging the neoliberal tendency to focus on the care recipient. The repercussions of neoliberal home care restructuring on the working conditions of paid and unpaid carers shape the conditions of care experienced by clients.

FPE focuses on both paid and unpaid care work as a means of drawing attention to the gendered, racialized and classed nature of care work and the impacts of this work on the lives of women. Teeple Hopkins (2015, 139) argues that with the intensification of neoliberalism women's work has increased, both within and beyond the home, contributing to their increased marginalization. Drawing attention to the ways that women, and the care work that they do, are invisibilized and devalued under the neoliberal form of capitalism highlights the role of the state in reinforcing power hierarchies that create and maintain inequality.

Traditional Marxian analysis treats paid work in the formal economy as the exclusive site of class struggle under capitalism. Women's care work in the home is located at the margins, rendering much of their lives "invisible from the standpoint of the relations of ruling" (Smith 1989, 7). Feminist scholarship building on and critiquing Marxist traditions have named women's unpaid domestic labour as "work". Women's unpaid care work is seen an important part of the economic and social structure (Duffy 2011, 11; Teeple Hopkins 2015, 135). FPE provides the key insight that capitalism depends on the labour of workers outside the formal economy (Vosko 2002; James 2012; Federici 2012; Teeple Hopkins 2015). Much of this unpaid labour is done by women and racial minorities (Mitchell *et al.* 2004, 6). FPE makes visible the sex/gender division of labour by drawing attention to women's unpaid domestic work. It also highlights the racialized division of labour, specifically in care work (Vosko 2002, 77). FPE draws attention to the ways class, gender and race/ethnicity-based struggles are built into the capitalist mode of production (ibid, 77; Luxton 2015, 168) by placing "women's work" (James 2012, 51) at the center of the political economic analysis (Armstrong & Connelly 1989).

Gendered assumptions about caregiving as an intrinsic feminine capacity (Palmer & Eveline 2012) based on beliefs that women are genetically oriented to nurture (Braedley & Martell 2015, 60) continue to shape the nature of care work. This intersects with, and is reinforced by, racialized assumptions about women from some ethnic groups being more "naturally" suited to care work (Bourgeault *et al.* 2010). Redefining the unpaid care that occurs in domestic settings as "work" is an attempt by feminists to problematize these types of naturalized assumptions regarding women and caregiving (Mahon & Robinson 2011, 4; Duffy 2011, 11) in order to redefine care as learned, skilled labour both inside and outside the home (Palmer & Eveline 2012). However, unpaid care labour in the domestic sphere continues to be

subject to an unequal gendered division of labour that assigns care and housework primarily to women (Braedley & Martell 2015, 60). Furthermore, societal expectations and preferences for care from women persist. These entrench the conditions that make the redistribution of unpaid care work difficult (ibid, 77). Feminist political economists highlight this reinforcement of inequitable domestic labour relationships in private households as perpetuating inequality between men and women (ibid), as well as among women.

As employment for women in the formal economy has expanded, more women are performing care work outside the home in return for a wage (Armstrong & Armstrong 2005, 177). Paid care work in the home care sector is shaped by intersecting classed, gendered, and racialized relations with almost all HCWs being women but a disproportionate number of them also identifying as immigrants and racialized minorities (Colombo *et al.* 2011). Care work pays less than other occupations after controlling for individual, occupation, and industry characteristics (England & Folbre 1999; England *et al.* 2002; Meagher & Healy 2006). Furthermore, the growing demand for elder care has not produced higher wages (Palmer & Eveline 2012, 256). Historical assumptions about women's natural capacity to care have contributed to the view of care work as unskilled and subsequently low paid. Palmer and Eveline (2012, 256, 271) explain that by labelling the social and organizational skills necessary to provide care as "soft skills" that require little formal training, care work has been constructed as "appropriately" poorly remunerated.

Under neoliberalism, the ability to choose work and to be paid what that work is found to be worth in free market competition is the "basis for all freedom" (Braedley & Luxton 2010, 9). Despite the neoliberal rhetoric that "everyone has an equal opportunity to get ahead" (Luxton 2015, 216), the day-to-day experiences of women who do care work indicate that their positions

and material well-being have declined under neoliberalism (Braedley & Luxton 2010, 13). When paid care work is influenced by the "romanticized" notion that care is done by women for reasons of altruism rather than a wage (Palmer & Eveline 2012, 254; Nelson 1999, 44), women carers are simultaneously valorized for their self-sacrifice and penalized for their good will through low pay (Harrington-Meyer 2000, 6).

This gendered rhetoric has contributed to assumptions by neoliberal policy makers that women would prefer "family-friendly work arrangements" rather than well-paying jobs (Palmer & Eveline 2012, 266). Policies, such as promoting part-time or "flexible" work arrangements or providing wage supplements for low-paid work (Jenson 2015, 542), are positioned by neoliberal governments as legitimate solutions to the challenges of women "struggling with the double day" (Luxton 2015, 218). Defining women primarily through their activities as carers encourages the creation of policies that have differential outcomes for men and women. These sideline relevant and necessary discussions about the impacts of structural inequalities on women's lives. The prevailing sex/gender division of labour that characterizes the care sector in Canada, in combination with neoliberal restructuring that works primarily in the interests of men, serve to reproduce and perpetuate the marginalization of the low-paid care workers who are disproportionately women and racialized minorities (Ward & England 2007a, 20).

The redesign of social and economic environments under neoliberalism has resulted in working conditions that "normalize the restrictions, abuse, and exploitation" faced by racialized female care workers (Arat-Koc 2012, 7). The result is the creation and perpetuation of workplaces in which power relations favour employers and workers at the top of the occupational hierarchy (Thomas 2010, 85). Meanwhile, precarious work is distributed among workers at the bottom of the workplace pyramid in line with systemic class, gender, and

race/ethnicity hierarchies (Bakan & Stasiulis 1997; Vosko 2006; Vosko *et al.* 2009; Zeytinoglu & Muteshi 2000). Vosko (2011, 194) defines precarious work as "work for remuneration characterized by uncertainty, low income, and limited social benefits and statutory entitlements". Arat-Koc (2012, 7) points to the working conditions of migrant carers in Canada as a particularly striking example of how gender and race/ethnicity inequalities are constructed, condoned, and reproduced by the neoliberal state. Not only is precarious work associated with adverse effects on the health of paid care workers (Quinlan *et al.* 2001), it also contributes to poorer conditions of care for clients and creates instability and stress for unpaid carers. As paid carers leave the home care sector for higher wages and more stable jobs in hospitals and long-term care homes, home care agencies experience high worker turnover. This often results in a lack of continuity of care for clients and greater pressure on unpaid carers to fill the care gaps. Bringing paid and unpaid carers into the analysis facilitates looking at how neoliberal reforms targeting paid carers have residual impacts on unpaid carers and clients. This contributes to a more complete understanding of how the conditions of work are the conditions of care.

FPE facilitates my analysis of both paid and unpaid carers by drawing attention to the gendered, racialized, and classed nature of care work. This guides my discussion of the inequalities rooted in systemic power hierarchies and their impacts on the lives of the often racialized, low-income women working in the home care sector.

## Invisible and Devalued Care Work and Care Workers

FPE makes the experiences of women carers visible by drawing attention to the ways that their knowledge is systematically devalued and their voices silenced when home care is restructured under neoliberalism. As discussed in Chapter 2, NPM reforms to promote efficiency through standardization often result in tighter regulation of work organization. With

fewer opportunities for paid carers to apply their problem-solving skills or make decisions based on their experience, workers' autonomy, discretion, and control over their daily interactions with clients are compromised. Likewise, under neoliberal restructuring there are fewer opportunities or processes to integrate workers' knowledge into decision-making at organizational and policy levels (Banerjee *et al.* 2015, 33). For example, collective spaces, such as all-staff meetings, agency-community forums, peer supervision, and staff educational sessions, are often reduced or removed to "curb waste" as part of neoliberal restructuring (Baines 2006). This leaves workers feeling like they have "lost their voice" in agency issues (Baines 2010). Paid carers report feeling that their work is less meaningful (ibid). They feel less connected to the larger plan or mission of their organization (Baines & Daly 2015, 151). When organizations are reshaped by neoliberalism, Banerjee *et al.* (2015, 33) note the recurring trend of reduced dialogue among staff, and between workers and management. They argue that structural conditions, such as the elimination of overlapping shifts or insufficient staffing levels, create barriers to communication (ibid). This contributes to a perception of invisibility among workers and the feeling that management is disconnected from the day-to-day conditions of work and care (ibid). Improved team communication, joint working, and worker engagement are cited as advantages of designing and delivering home care using ICPs. Chapter 7 discusses the experiences of paid workers in these areas and the impacts of creating collective forums for team-based collaboration.

Organizational practices that reduce or eliminate opportunities for communication also limit workers' abilities to participate in relational care. Neoliberalism's alignment with the dominant medical model, and the gendered assumptions embedded within it, emphasize "care's instrumental aspects [but] fail to acknowledge the emotional labour critical to good care"

(Palmer & Eveline 2012, 258). Under neoliberal home care restructuring, the social, spiritual and emotional aspects of care are particularly undervalued (Braedley & Martell 2015, 77). As discussed earlier, neoliberal reforms have intensified the focus on care as visible tasks that can be measured. The pressure to quantify care neglects to account for the nature of care required by seniors aging in private residential homes. It is more difficult to measure both the relational aspects of care and the benefits that come from encouraging workers to take the time to have conversations with their clients (ibid, 69).

As front-line care workers increasingly report to managers trained in business rather than, or in addition to, nursing or medicine (Armstrong & Armstrong 2005, 181), the relational aspects of care are more likely to be viewed as separable from other "more essential" aspects of care. In response to pressure by administrators to eliminate the relational aspects of care during paid work time, care workers continue to work for clients outside of their paid hours (Banerjee *et al.* 2015, 33). For instance, there are many reports of paid carers staying late or coming in on their days off. Drawing attention to the unpaid care work done by paid carers demonstrates how care that is hidden under neoliberalism becomes visible when looking through an FPE lens. It is interesting to note that some ICPs were designed in ways that challenge the neoliberal push to eliminate time to talk. The policy techniques these programs used to encourage their paid carers to engage in relational care with their clients are discussed later in Chapter 7.

In addition to silencing the voices of many of the women workers providing care to seniors in their homes, neoliberalism has also contributed to the devaluation of care by relocating it from the public sector into the private realm of the home. The withdrawal of the neoliberal state from care provision has created conditions of increased dependency on privatized care. In cases where public sector workers no longer provide care, some of the care work has shifted to

paid care workers from for-profit or not-for-profit agencies.  However, much of the care has been relocated to unpaid carers in families or the voluntary sector.  When care moves from a paid to an unpaid worker, it is no longer "financially recognized" (Palmer & Eveline 2012, 258).  In a neoliberal system that assumes that wages reflect the value of the work performed (Braedley & Luxton 2010, 14), this care is seen as less valuable.

Many women engage in unpaid care for long periods of time.  In doing so, they are unable to compete equally in the paid labour market with those unencumbered by these responsibilities or who have access to support (ibid).  On one hand, neoliberal policies assume that families should be the main providers of care.  On the other hand, they require that family members work out their own solutions to the problems of combining paid employment and unpaid care work (Luxton & Corman 2001).  Devaluing unpaid care work, while individualizing the responsibility to provide it in a system characterized by a sex/gender division of labour, places a disproportionate burden on women who are the primary unpaid carers.  Furthermore, a neoliberal economy requires that workers be traditionally "men-like" in terms of their working hours and commitment to paid work (Arat-Koc 2012, 7).  This expectation compels women workers to conceal their unpaid caregiving responsibilities from their employers and co-workers. The negative impacts of the stress of unpaid caregiving on women's health and well-being are well documented (Cohen & Pulkingham 2009; Luxton 2010).

Neoliberalism also incentivizes the creation of a racialized workforce of migrant care workers.  These women are constructed as the "ideal workers in this new economy" (Arat-Koc 2012, 7) based on the assumption that they do not have to juggle their unpaid care commitments with paid work since they have left their families in their countries of origin.  Yet, these carers are often marginalized regardless of whether they are "live-in" carers in a private home or new

immigrants working for a home care provider. Neoliberalism perpetuates the racial/ethnic discrimination of migrant or newly immigrated care workers in both visible and invisible ways. On one hand, it reinforces a system whereby racialized carers are hidden in the private homes of (often) white Canadian-born women, doing invisible domestic work to enable those women to participate in paid employment outside of the home. On the other hand, newly immigrated workers often encounter visible discrimination when working in the formal care economy. It is common for the experience and qualifications they acquired in their countries of origin not to be recognized in Canada (Barken *et al.* 2015, 305-6). These workers may also experience linguistic, racial, and/or cultural discrimination (Bourgeault *et al.* 2010) in ways that obscure their capacity to provide good care. FPE creates the space to acknowledge how gender, class, and race/ethnic inequalities are constructed and reproduced by neoliberal structures, policies, and practices that put the needs of care workers in conflict with each other, as well as in conflict with clients and program administrators. FPE helps draw attention to the ways that the interests of groups in positions of power are systematically prioritized while other groups experience gender, class, or race/ethnic marginalization.

Personal, emotional, and home support work can be more difficult to count than the "professional" work of doctors, nurses, or therapists. Care work that is difficult to quantify is more susceptible to being judged as "unskilled" (Palmer & Eveline 2012, 264). The neoliberal system values measurement and subscribes to the biomedical model that esteems professionalization. Hence, the work of carers who do not possess a professional certification is often devalued in health systems that have undergone neoliberal restructuring. At the same time; however, there is a financial incentive for the care industry to deny the need for professional

skills in caring for the elderly (ibid). This helps keep care labour cheap. It is also used to justify task-shifting or deskilling (Armstrong 2013; Sibbald *et al.* 2004).

The downward substitution of care work is supported by neoliberal governments and employers as a means of enhancing the efficiency of home care delivery. Not only is management's control over workers increased, but the costs of care are minimized as some of the responsibilities of health care professionals are divided up into simpler tasks and downloaded to unregulated, lower paid, and "low skilled" HCWs (Barken *et al.* 2015, 290). Task-shifting facilitates the replacement of workers trained through formal education with cheaper, less formally skilled HCWs (Palmer & Eveline 2012, 263). This often results in pitting "professional" and "non-professional" women against each in terms of scope of practice and control with a workplace already characterized by a rigid occupational hierarchy. Many of the HCWs being assigned delegated tasks are new immigrants. Task-shifting reinforces power hierarchies linked to racialization and immigration status as well as to class (Armstrong & Armstrong 2005, 178, 182). The impacts of policy techniques that perpetuate or redress these power inequalities in the workplace are discussed in Chapter 6.

In conjunction with deskilling, many home care employers simultaneously participate in up-skilling. Up-skilling occurs when workers at the bottom of the occupational hierarchy are provided with in-house training modules to improve their skill set. This training is less tangible, less measurable, and hence less valued than formal education or a professional designation (ibid, 265). However, it creates better skilled workers who can take on more difficult care tasks from regulated workers but does not mandate a concurrent increase in pay. Palmer and Eveline (2012) explain that up-skilling often sets up a paternalistic employment relationship. This is based on the employer's assumption that unskilled care workers, often new immigrants, will express their

gratitude for the opportunities that the employer affords them by providing, in turn, quality, cheap, and compliant labour (ibid, 266). Skills enhancement programs for HCWs were widespread in ICPs.

Employers and governments often assume that women will "pick up the slack" and "fill the gaps" even when their voices and work are systematically undervalued (Aronson & Neysmith 1996; Baines 2011; Roberts 2004). This continues to be true under neoliberalism. As workloads, expectations, and pressure on paid and unpaid carers increase (Aronson & Neysmith 1997; Abbott 1998; Armstrong & Armstrong 2003), so too do the negative work-related health outcomes for women carers (Braedley & Martell 2015, 69). Despite their struggles, much of the care work done by women remains invisible (Grant *et al.* 2004). Meanwhile, class, race/ethnicity, and gender hierarchies in home care workplaces persist, reinforcing inequalities among the women, as well as between the women and men, responsible for designing and delivering home care.

In sum, FPE as a theoretical framework makes the experiences of women carers visible by drawing attention to the systemic ways that their knowledge and voices are undervalued or silenced when home care is restructured by neoliberalism.

## The Blurred Boundaries between Public and Private

Building on the concept of relational care, the importance of considering both paid and unpaid care work, and the invisible and devalued nature of care and care workers, FPE draws attention to the impacts of neoliberalism on the changing boundaries between public and private. In the context of home care, the state or public sector, the not-for-profit and voluntary sector, the for-profit sector, and households are in some ways treated as distinct from each other and in

other ways viewed as intersecting (Lyon & Glucksmann 2008, 102). Feminist political economists argue that households and formal economies interpenetrate each other (Armstrong & Armstrong 2005, 169). FPE is a useful entry point for understanding how neoliberalism contributes to shifting public-private boundaries that shape and reshape care labour and its distribution (Lyon & Glucksmann 2008, 102) in ways that increase women's precariousness (Armstrong & Armstrong 2005, 170).

From a neoliberal perspective, the formal economy is framed as distinct from the informal economy. "Formal" care is seen as comprising government provided care as well as the care work done by workers employed by for-profit and not-for-profit organizations. This is juxtaposed with "informal" care that comprises the unpaid care that occurs within private households, volunteer work, or paid care work that takes place outside of traditional working arrangements. Similarly, neoliberal policy makers often position the private sector in opposition to the public sector. Typically, "public" means the government and public service. Meanwhile, "private" can mean the market if we are thinking in terms of the components of the formal economy. Otherwise, it can be used to refer to all non-state actors; for instance, the for-profit sector, and the not-for-profit sector and voluntary sector, and households (Armstrong & Armstrong 2005, 169-70).

As neoliberal governments have retreated from the responsibility for care, care funding, and care delivery, the boundaries between public and private have become increasingly blurry. Armstrong and Armstrong (2005, 175, 180) argue that the marketization of the state has reduced differences between the public and private sectors of the formal economy. This has occurred both directly through privatization and indirectly through the application of NPM to the public institutions that remain. State retreat from social service provision in combination with the

neoliberal push to widen existing markets and create new ones (Connell 2010, 23), has resulted in the increased privatization of public services. Care needs that were previously met by public sector workers are now met by not-for-profit or for-profit agencies that have taken over government care contracts. Clients' care needs are also being increasingly met by unpaid carers or volunteers. The state's preference under neoliberalism is to step in only as a provider of last resort.

The move to privatization is often framed as a reduction of state involvement in care provision. Through neoliberal restructuring, governments have "engaged in massive health care reforms that shift...the process outside of the 'rules' of universal entitlements of Medicare" (Williams *et al.* 2001, 10). When care is not provided by physicians or in hospitals, the government is not legislatively required to fund or manage it. Governments focused on containing public costs have turned to bed reductions, facility closures, and mergers to shrink the hospital sector (Abelson *et al.* 2004; Aronson & Neysmith 1997). Pressure to enhance efficiency, supported by technological and treatment advances, has also manifested in shifts to day surgery and shorter hospital stays. These health sector reforms have relocated elder care from the visible publicly-funded realm of hospitals into a variety of other settings. Seniors requiring assistance with health or social care tasks have moved into retirement residences, long-term residential care facilities, assisted living accommodations, and private households. As governments have devolved the responsibility of providing elder care by encouraging deinstitutionalization, older people and paid and unpaid carers have been expected to pick up the slack.

Care is simultaneously commodified and de-commodified under neoliberalism (Armstrong & Armstrong 2005, 186). In response to the neoliberal critique that differences in

the relations and conditions of work between the public and for-profit sectors are a primary problem with government, governments have reshaped themselves to act more like the private sector. Based on the neoliberal assumption that for-profit methods enhance efficiency (ibid, 180), governments (and not-for-profit agencies) have increasingly adopted private sector techniques for care provision. Consumer choice in the public sector has replaced collective rights as a policy objective (ibid). As a result, the view that governments and citizens should take "collective responsibility" for health has been increasingly penetrated by private sector concerns (Armstrong 2010, 198). For example, new public investments in care, such as those seen in Alberta, Ontario and BC following the extreme cuts to public spending and services that characterized early neoliberal reforms, might initially seem to contradict neoliberal approaches. However, Armstrong (2010, 190) argues that these are not about a renewed interest in the welfare state but about creating employment in the private, for-profit sector. This sheds light on the state's potential motivation for creating and publicly financing ICPs. While some ICPs deliver care directly, many contract out the care work to a mix of for-profit and not-for-profit agencies or independent contractors. Increasing private sector involvement in care provision as a means of enhancing client choice is contradictory. The blurring of the public and private has made it exceedingly difficult for clients and unpaid carers to tell public from private in the provision of their home care. Instead of giving clients and their families more choice, the numerous service providers involved in the home care system under neoliberalism has resulted in client confusion and their increased dependence on case managers to assist with system comprehension and navigation.

As the public sector increasingly relies on partnerships with the private sector to deliver care (Armstrong & Armstrong 2005, 175), the costs of the government's efficiency-seeking

reforms are not eliminated but downloaded onto care workers (Aronson & Neysmith 1997). Blurring of the public and private through practices such as contracting out has facilitated the expansion of precarious care work. As part-time, casual, and on-call positions have proliferated in the home care sector, paid care workers find themselves juggling many positions at different agencies or supplementing their wage with informal paid work, in order to make a living wage. This is particularly significant for workers low on the occupational hierarchy (Aronson & Neysmith 1997), many of whom are ethnic minority women from countries in the global South (Coyle 2005, 74).

As a result of the efficiency-motivated reforms typical of neoliberal restructuring, paid care workers are increasingly expected to put in unpaid overtime or provide supplemental paid care informally outside of their regular working hours. For example, Baines and Daly (2015, 148) note that in long-term care, "managers seemed to accept unpaid overtime and extra initiative as part of the regular workday and did not always regard worker's extra efforts as extraordinary". The unpaid or supplemental paid care done by paid workers straddles the boundary between formal and informal care and is particularly "invisible" (Daly & Armstrong 2016, 475). It occurs in a space somewhere in between the public, market, and household spheres and is hidden in the often isolated setting of a private home (ibid, 476). Relying on paid workers to provide supplemental paid or unpaid care extends the limits of both publicly funded and familial care. Yet, this is often at the expense of the client and the care worker. Workers in this blurry space are frequently asked to perform tasks without the training or credentials that would be required if they were working in the formal economy. They also work with no agency oversight or labour protection, which puts both the client and the worker at greater risk. Paid carers providing paid or unpaid supplemental care fill care gaps and meet clients' needs. Yet,

their precarious position between the family and the market puts them at higher risk of exploitation.

As the work of those providing home care becomes more precarious under neoliberalism (Armstrong & Armstrong 2005, 170-1, 181), HCWs experience a significant amount of pressure to negotiate multiple management styles, deal with dozens of clients, and drive between many different homes often late into the night. When public care is contracted out, HCWs may need to move from public sector employment into the private sector where wages are typically lower and the protections afforded by unionization less prevalent (Williams *et al.* 2001, 19). HCWs at for-profit agencies can also find themselves working alongside the carers who remained in the public sector (Armstrong & Armstrong 2005, 181). This further blurs the lines between public and private. Moreover, it can create and exacerbate inequalities among women who do similar work, often for the same client, but whose wages and working conditions differ based on their employer (ibid, 186-7). Women lose significantly under the neoliberal redefinition of public and private. Neoliberal practices make women's paid work lives unstable, with serious consequences for their capacity to function in other parts of their lives (Leach & Joseph 2011) or in the case of illness or lost employment (Armstrong 2010, 196).

Armstrong (2010, 188) argues that privatization also represents a shift in the responsibility for care from the public to the private. As neoliberal governments redirect seniors away from publicly funded and/or delivered services, clients are compelled to take responsibility for their own care needs at an increased cost to themselves and/or their families. Household costs increase when clients are cared for at home (ibid). For example, an elderly person living in a private residential dwelling must pay privately for drugs, supplies, and other necessities. These

would be covered by public money if the senior was receiving care in a public institution (ibid, 196).

The costs and benefits of care commodification and relocation are unevenly distributed among clients in ways that reinforce gender, class, and race/ethnicity-based inequalities. As more care is available for purchase, neoliberal policy makers argue that clients are empowered through choice. However, market-based systems base choice on the ability to pay. This means that access to care is increased for clients and families in positions of class privilege who have the resources to pay out of pocket for care or supplies, or have access to employment-based supplemental health insurance plans that can cover these costs. Meanwhile, access to care is decreased for those without the means to purchase it. Furthermore, the implications of privatizing care reach beyond class. Women and racialized groups have less capacity to pay for care because they have disproportionately less access to secure, well-remunerated employment. Women also take more time away from paid employment to provide unpaid care. In these ways, classed, gendered, and race/ethnicity-based hierarchies shape who has access to the resources to pay for care that is delivered outside of public institutions or using market mechanisms (Armstrong 2010, 196-97). Clients' care needs do not disappear when access to public care is constrained despite neoliberal policy efforts to promote individual responsibility (Braedley 2010, 143) and marketization. Yet, they are increasingly hidden from public view when care is shifted into private lives and homes (Aronson & Neysmith 1997).

As the state retreats from public service provision, it relocates the responsibility to care to individuals and families (Brassolotto & Daly 2016, 520). If clients cannot use personal funds to purchase services from the private sector, they are compelled to rely on support from friends, family, or volunteers, or else go without care (Luxton 2010). The self-responsibilization of care

is based on the assumption that each client has a network of family and friends who are willing and able to provide care at home (Aronson & Neysmith 1997; England *et al*., 2007; England & Dyck, 2011). While neoliberal policy makers frame unpaid care work as a choice, there are many instances where family members are not in a position to decline or secure care from another source and are thus obligated to provide unpaid care themselves (Guberman 2004). Unpaid carers are disproportionately women (Cranswick & Dosman 2008; Sinha 2012) and so, family care often equates to "female care" (Sherif-Trask 2010, 139). Armstrong (2007) suggests that relocating the responsibility to care from the state to the household can result in women feeling "conscripted" into unpaid care. Gendered, classed, and racialized divisions of labour spread the burden of unpaid care work unevenly among the population. For example, women are more likely than their male counterparts to spend more hours per week on unpaid caregiving tasks (Sinha 2012). Women are also more likely than men to have their unpaid caregiving responsibilities negatively impact their paid employment (Lero & Joseph 2007; Sinha 2012), health outcomes (Braedley & Martell 2015), and personal well-being (Hinojosa *et al.* 2014; Neri *et al.* 2012; Takai *et al.* 2009). The care burdens of unpaid carers have intensified as a result of neoliberal reforms to the health and home care sectors. The relocation of care under neoliberalism may be framed as a move to "family" care (Armstrong 2007) but the physical, emotional, and psychological costs of this shift are borne disproportionately by economically vulnerable and/or racialized women.

In sum, FPE gives me the tools I need to understand how the neoliberal restructuring of home care has contributed to shifting boundaries between public and private, what impact this blurring has on women's care work, and how it creates and exacerbates inequalities between women and men, among women, between employers and employees, and among care workers.

## Conclusion

An FPE theoretical framework draws attention to the ways that gender, class, and race/ethnicity shape the paid and unpaid care work of women under neoliberal capitalism. It also offers insight into the impacts of the increasingly blurry boundaries between public and private on home care clients, unpaid carers, and paid carers. Understanding how the neoliberal restructuring of home care has contributed to the devaluation of both home care work and workers guides both where I look and how I look in my quest to make sense of the interconnections among integrated care, fragmentation, efficiency, equality, and equity. Using an FPE framework positions me to take a critical look at "who benefits" and "who pays" when ICPs use policy techniques focused on enhancing efficiency versus promoting equality or equity.

# Chapter 5: Methodology and Research Design

## Introduction

In this dissertation, I use a post-positivist epistemological approach drawing on both interpretivist and critical social science traditions to connect my FPE theoretical framework to my qualitative research design.  I use a post-positivist perspective to acknowledge the role of subjectivity in research and the importance of placing lived experience in a social context.  In doing so, I build knowledge about the realities of women's involvement in the design, delivery, and/or receipt of home care as part of an ICP.  My research design combines document review, in-person interviews, and thematic analysis.  I attempt to capture the rich and complex experiences of clients, paid carers, unpaid carers, and program administrators.  In line with an FPE perspective, I pay particular attention to incorporating the experiences of groups who are traditionally excluded.  I also interpret the lived experiences of my research participants in their social, policy, and economic contexts.  This positions me to critically assess how neoliberalism shapes whose interests matter and what policy goals are considered legitimate.  I use this analysis to share promising practices in home care design and delivery that meet the expressed needs of clients and carers alike.  This methodological approach and research design addresses the sex/gender-, race/ethnicity- and class-blindness of much of the research on integrated care undertaken from the prevailing positivist, biomedical paradigm.  My research enhances and challenges current understandings of integrated as a solution to fragmentation in home care by keeping women, and the conditions under which they live and work, at the centre of the analysis.

## A Post-positivist Epistemological Approach

My objective is to understand the impacts of using ICPs to design and deliver home care in a system that has been fundamentally reshaped by neoliberal restructuring. To accomplish this, I use a methodology based on a post-positivist epistemology influenced by interpretivist and critical social science views. Post-positivism understands social reality as a unique experience of individuals or groups. It seeks to theorize the sociocultural contexts, and structural conditions, that shape these realities (Neysmith 1995, 101; Braun & Clarke 2006, 85). Feminist research is rooted in post-positivist views of what knowledge is, how we recognize it, who are seen as the experts in our society, by what means someone acquires this status, and by what means competing knowledge claims are adjudicated so that some are legitimated while others are dismissed (Stanley & Wise 1993, 188).

Post-positivism is a critical research paradigm challenging the epistemological assumptions of positivism. Post-positivism problematizes the idea that social phenomena exist "out there" in the world, simply awaiting the right methodological tools in order to be "discovered" (Robertson 1998, 158). Instead, it focuses on how social constructs shape "the ways in which we conceptualize and speak and write about health, [these] are never just about health; they also function as repositories and mirrors of our ideas and beliefs about human nature and the nature of reality" (ibid, 155). This understanding of knowledge as socially constructed fits with the FPE view of concepts and discourses as attached to interests and agendas. For example, FPE researchers are particularly conscious of dualisms (Neysmith 1995, 110). In this research study, I draw attention to a variety of dichotomies, including formal and informal economies, public and private spheres, political and personal worlds, health and social care, professional and ancillary workers, and relational and non-relational care. All of these terms

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assume simple, distinct divisions.  However, in practice the separations between them are increasingly blurry.  Challenging dualisms is important because when social phenomena are categorized in this way, it often leads to their being placed on a hierarchy of power or importance based on pre-existing power structures (ibid, 105).  Unless the underlying assumptions upon which certain terms are conceptualized can be identified and deconstructed, challenging neoliberal "common sense" is nearly impossible.

A post-positivist perspective also makes a useful contribution to this project through its recognition of the researcher as an active presence in the research process and thus in the construction of data and findings.  Positivists view themselves as "objective" observers who are able to control their biases and collect "neutral facts" that will lead them to the "truth".  In contrast, post-positivists work from the premise that, as researchers, we do not occupy a privileged position outside of the social reality we study.  Rather, our beliefs and values about the world, and who we are in it, influence our inquiries about the world.  This determines what we can say about the world and ourselves (Robertson 1998, 160).  Post-positivists emphasize that what "counts" as data depends on what the researcher thinks exists "out there" to be discovered and what he\she judges to be important enough to notice and measure (ibid, 158).  Furthermore, the particular tools a researcher uses to gather and analyze his/her data, in this case policy documents, in-person interviews, and thematic analysis, carry ontological and epistemological assumptions.

Its acknowledgement of subjectivity makes post-positivism a useful methodological approach for this study.  In the quest to understand the experiences of traditionally marginalized groups, researcher reflexivity is paramount.  Post-positivist researchers are aware of the tendency for only certain aspects of participants' lives to get picked up through their research.  Fine (2002,

218) argues that a post-positivist "giving voice" approach to research "involves carving out unacknowledged pieces of narrative evidence that we select, edit, and deploy to bolster our arguments". Post-positivist researchers must make their assumptions explicit and acknowledge that their methodological decisions impact what knowledge is produced. They must also be aware of the active role they play in identifying patterns and themes from their data (Holloway & Todres 2003). Post-positivists challenge the view that themes "emerge" through a passive process of analysis. Instead, they argue that themes of interest are purposely selected by researchers and reported to readers. When undertaking policy research from a post-positivist perspective, researchers must be especially careful to resist interpreting their data in terms of professional and organizational mandates (Fraser 1989). Otherwise, data can be used to support particular programmatic directions that do not fit with participants' lives or expressed needs. Researchers are seen as having substantial power in post-positivist research approaches. Only a "conscious tending" to this can permit others to assess how the researcher's social location and assumptions influenced the project and thus evaluate the validity of their findings (Neysmith 1995, 106).

The post-positivist epistemological approach used in this dissertation emphasizes the lived experience of research participants and the need to situate it in the social, policy, and economic contexts that shape their lives. Park (1993) draws attention to "lay knowledge" as derived from lived experience, focusing on the meanings and interpretations individuals provide to events. In contrast, "critical knowledge" is reflective knowledge. It is concerned with the role that societal structures and power relations play in promoting inequalities. I agree with Park's argument regarding the need to increase the focus on both lay and critical knowledge. Both kinds of knowledge yield information about health, health status, and health determinants that is

necessary for understanding and improving health. This project "tries something different" by using the lived experiences of those most affected by ICPs to examine how these are shaped by the geographical, social, economic, and policy contexts in which the research participants live their lives. I see this as a valuable contribution to the integrated care literature.

By legitimizing the lived experiences of clients and carers as fundamental to understanding if, and how, ICPs meet the expressed needs of research participants, post-positivism offers an alternative to a positivist approach focused on the isolation and measurement of variables. This dissertation follows in the tradition of comparative work on integrated care (Amann 1980; Van Raak *et al.* 2003; Billings *et al.* 2003; Kodner 2006). However, it does so differently by emphasizing the centrality of gender, race/ethnicity, and class in the lives of women as opposed to treating these as variables to be controlled. A post-positivist approach views gender, race, ethnicity, and class as social constructs. These affect the meaning of research questions and the content of responses. This research recognizes that women's experiences are worthy of recognition without reference to those of men, because "although men and women may co-exist, they do not live in the same world" (Neysmith 1995, 112). Valuing the lived experience of women is in line with feminist research methodologies that understand persons who live the effects of belonging to particular groups in our society are experts in what they experience (ibid, 108). In feminist research, the experience of interest is that which is related to belonging to one gender within a society where gender is a basis for differential treatment. The same approach can be used by scholars studying racism, classism, or intersectionality. While this study does not take an explicitly intersectional approach, I focus on the classed and racialized experiences of women as a basis for differential treatment both in relation to each other and to men. Positivist research approaches can obscure gendered,

racialized, and classed inequalities and inequities in home care. In contrast, a post-positivist FPE approach makes these visible by looking beyond paid labour in the formal economy to see the invisibility and devaluation of the care labour and care workers located in the increasingly blurry spaces between public and private created by neoliberalism.

There are two methods for dealing with context in the integrated care literature. The first is to decontextualize data in line with a positivist methodology (Hollander & Prince 2002; Banks 2004; Kodner 2006; Johri *et al*. 2003). In these studies, quantitative data is aggregated into statistics to produce generalizable results. This is an effort to develop best practices, broadly applicable frameworks, or successful models of integrated care. Post-positivists challenge this approach (Nord 1989) arguing that when data are treated as independent variables, the individual is removed from the context of their concrete daily lives (Robertson 1998, 159). Instead, FPE scholars argue that to understand the realities of women with unique social locations, one must take into account the historical, social, political, and economic conditions that impact their descriptions and interpretations of their experiences.

The second method calls for context-specific analysis into the causes of health services fragmentation and the proposal of context-specific solutions to this fragmentation (Carpenter *et al*. 2003; King & Ross 2003; Vanhaecht *et al*. 2007; Montenegro *et al*. 2011). By taking into account how the "structural factors, pressures and constraints operating at the macro and meso levels can profoundly influence and circumscribe the degree of integration in the services received by individual older people" (Glendinning 2003, 140), this approach is more aligned with a post-positivist perspective.

My analysis goes beyond an acknowledgement of these structural factors, pressures, and constraints to provide a critical analysis of neoliberalism as a dominant ideology, mode of governance, and policy toolkit. In contrast to studies that advocate creating policies and programs that are "politically feasible and adapted to the reality of each country/local setting" (Montenegro *et al*. 2011, 10), I aim to create space for alternative voices to be heard. I seek to challenge "common sense" understandings of how home care should be designed and delivered under a neoliberal system. In doing so, I make visible how the interests of certain groups are ignored while others in positions of class, race/ethnicity, and gender privilege use their power to make their own voices heard instead. I show the ways neoliberalism has been taken up or resisted in the policy techniques used by ICPs and then connect this to people's experiences of receiving or providing care within a specific context and under the constraints of their everyday lives. As best I can, I emphasize the voices of the clients and carers who experience marginalization since otherwise they remain invisible as their expressed needs are often overlooked in policy and program design and implementation processes. My overarching goal is to improve the lives of the women involved in home care. My research methods and design challenge the current system of gender, class, and race/ethnicity based inequality. This enables me to identify and share practices that move towards a more equal and equitable home care system for clients and carers given their different positions of power, privilege, and vulnerability.

## Research Design

I selected five Canadian home care programs to study. My inclusion criteria required programs to be focused primarily on the delivery of home care in private residential dwellings, and to target vulnerable elderly persons. In each program's literature, "integration" or "integrated care" was identified as one of their guiding principles of service delivery. The

programs also highlighted their use of an interdisciplinary team to deliver care, and purported to provide some combination of health and social care. Home care can be delivered through a variety of service providers: public sector providers, private for-profit or not-for-profit agencies, voluntary organizations, or in households. Rooted in my view that the state should play some role in designing and delivering home care as a publicly funded, universally accessible citizenship right, each of the programs I selected was at least partially state funded, though they used a variety of delivery mechanisms.

There are many variants of integrated care and thus, a variety of programs that can be broadly classified as ICPs. ICPs can work at a systems level by integrating social and health services, acute and long-term care, and community-based and institutional care (Beland 2012). They can also work at a local level by focusing on agencies and workers delivering care within one sector only. There is much that can be learned from ICPs operating in either scope. In this study, I focus on ICPs that target the home care sector specifically, as opposed to broader programs working at a systems level. While Canada is not replete with ICPs, I found five programs that met the required criteria:

- the CapitalCare Comprehensive Home Option for Integrated Care for the Elderly program in Edmonton, Alberta;
- the Aging in Place program in Ottawa, Ontario;
- the Seniors Managing Independent Living Easily program in South-Eastern Ontario;
- the Carefirst program in Scarborough, Ontario; and
- the Fraser Health Authority's Home Health program in as implemented in Hope, British Columbia.

Each of these programs is described in detail at the end of this chapter.

## Sampling

The strength of my study is in its empirical contribution to the literature. Primary data was collected through 118 interviews. Data was collected between February 20th and May 31st, 2013.[26] My research participants were composed of four key informant groups: ICP administrators, paid care workers, unpaid family carers (spouses, siblings, or children), and clients.[27] Lists of potential interviewees within each category were compiled with the help of a program administrator at each ICP site. The program administrator initially approached potential research participants to explain the study and asked for their permission to provide me with their contact information. Despite being a necessary safeguard to protect client confidentiality, this initial recruitment strategy introduced bias into the sample as program administrators used convenience sampling to recruit participants at this stage. To mitigate this bias, I stressed to each administrator the importance of having access to a wide variety of perspectives. I emphasized that this could only be accomplished by speaking to a diverse group of people. My study included a larger sample size than is standard practice for qualitative research in hopes increasing the validity of my data. My interviews solicited both positive and negative experiences from research participants which supports my assumption that program administrators were unbiased in their recruitment.

To maintain the confidentiality of research participants, each administrator provided me with a list of ten willing participants in each key informant category. From each list, I used

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[26] Prior to data collection, this project was approved by Carleton University's Research Ethics Board that adheres to the Tri-Council Policy Statement on Ethical Conduct for Research Involving Humans. Additional ethics approvals were obtained from CapitalCare's Research Facilitation Committee and the Fraser Health Research Ethics Board prior to data collection. Informed consent was collected from each research participant. Research participants were advised of the voluntary nature of their participation in the study, the risk and benefits of participation, and confidentiality safeguards regarding data recording, access, storage, and destruction.
[27] See Appendix 5 for a more detailed description of my sample.

simple random sampling to choose five participants to contact for an interview by pulling names from a hat.  In three instances, I was unsuccessful at arranging an interview with a participant selected in the first round due to scheduling conflicts.  In these cases, I randomly selected a replacement name from the hat.  After five client interviews and five unpaid carer interviews I reached the point of saturation and ceased interviewing members of these groups at each site.  Despite planning to interview five paid workers and five administrators in each program, this sample size was not realistic given the rich diversity of workers on some of the teams.  As a result, I interviewed at least one paid carer of each job description.  When there was more than one worker in each role I interviewed until the point of saturation.  For instance, at Carefirst I interviewed seven different types of program administrators and eleven paid carers across nine job categories.  In ICPs, such as AIP or SMILE, where there were only two program administrators, both were interviewed.  As a result, the final number of paid workers and administrators interviewed differed by program.

The study's sample included many more women than men, in line with the expected demographics of home care clients and carers.  There was also limited racial diversity in the sample.  The majority of the clients and carers I interviewed were white, with the exception of those from Carefirst.[28]  The lack of race/ethnic diversity among client interviewees mirrored the demographic distribution I observed in the programs with on-site ADPs where I was able to observe the demographic makeup of a larger subset of the program's clientele.  There was more racial diversity among paid care workers than among clients or unpaid carers, though this was still limited.

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[28] As expected given its positioning as a program for Chinese Canadians.

## Qualitative Methods

In line with Jenson & Sineau's (2001, 6) research, my study involves paying attention to the details as they affect citizens' everyday lives. This is based on the premise that it is only by analyzing the particular traits of program spending and delivery that we can understand the ways in which new patterns of rights, access, and belonging are being created (ibid). A methodology rooted in post-positivism, in combination with the use of qualitative research methods, grounds my study in the lived experiences of the women providing and receiving care within a complex web of social relations. I put the voices of my research participants and their experiences of unequal gender, class, and race/ethnicity relations at the centre of my analysis to allow women and other marginalized groups to be heard (Armstrong & Messing 2014, 9). My decision to use qualitative methods challenges the "hierarchy in evidence" (ibid, 8) whereby quantitative data is seen as most legitimate. While the use of quantitative methods dominates the existing literature on integrated care,[29] it does not leave room to explore the contradictions and unevenness that comes from using neoliberal tools to reshape home care. By collecting rich, in-depth data about the experiences of various groups of women, my study addresses this gap.

My research participants and I co-constructed the data collected in this study by developing a relationship across different social locations so that knowledge could be shared (Neysmith 1995, 107). This involved acknowledging the power inherent in my position as the researcher and my privilege associated with being a white, financially secure, well-educated woman with Canadian citizenship. My social location shapes how I see the world and influenced my question formulation, interactions with research participants, and data analysis. Similarly, my research participants were unique in their social and geographical locations and positions in

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[29] See Boorsma *et al.* 2011 or Sunde 2014, though there are many examples.

the political and economic hierarchies. All of these intersecting identities shaped their worldviews, experiences, and interactions with me. The power of the co-construction of the research relationships in this project was particularly noticeable in the sense of camaraderie that developed in my interviews with carers. The fact that I was near the end of pregnancy while conducting interviews made my identity as a caregiver immediately visible to my research participants. I expect this likely enhanced the quality and specificity of the data I collected as carers may have felt especially comfortable sharing details about their caregiving experiences with me given this shared aspect of our identities.

I made an effort to balance researcher "distance and reliability with the validity that comes from recognising the voices of subjects" (Armstrong & Messing 2014, 10). I used semi-structured interviews guided by the interview schedules used in the Providing Integrated Health and Social Care for Older Persons (PROCARE) research study (Billings & Leichsenring 2005, 277-90).[30] Using interview guides ensured that I touched on the same areas in all my interviews. They also permitted flexibility in the order of questions enabling me to maintain an easy and natural flow during the interview. A semi-structured interview technique empowered respondents in the research relationship by giving them the opportunity to introduce new topics and give emphasis to the topics they thought were important. In line with the flexibility permitted when using a post-positivist approach, I modified my interview guides after the second interview to include questions about emotional labour. This had been noted by my first research participants as being absent from my original interview guides.

My interviews lasted between 23 minutes and 1 hour 55 minutes, with an average length of one hour. All but one of the research participants agreed to the digital recording of their

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[30] Interview guides can be found in Appendices 1-4.

interview, which enabled full data capture. These excellent records made the tone, pace, and atmosphere of each interview easy to recall for transcription purposes. I took written notes during the interviews to supplement the recordings. These included jots about body language and relevant contextual information as well as my reflexive memos. Throughout the interview process I kept a reflexive journal to record my thoughts and emotions before and after interviews as well as my preliminary suggestions for promising practices and cross-cutting themes. The journal also served in a therapeutic function, especially after emotionally intense interviews. I also used member-checking[31] during the interview process to empower research participants as well as increase the trustworthiness of my data. Participants were invited to provide feedback on the interview data for clarification or modification and further discussion.

I also collected and analyzed secondary data in the form of documents, reports, websites and brochures. Documents collected from ICPs offered the organizational perspective on each program's mission and objectives. These documents both supplemented and sometimes contradicted data from interviews. In the same way that subjectivity played a role in data collection using interviews, I used this secondary data with caution to avoid treating government, academic, or organizational information as more credible than interview data (Becker 1967). Collecting multiple sources of data ensured the gathering of rich, varied information from the perspectives of many stakeholders. This enhanced the data's trustworthiness by enabling triangulation.

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[31] Member-checking is a method of placing the researcher and research participant on the same critical plane by factoring in, and making visible, the researcher's influence on the data (Neysmith 1995, 106).

## Transcription

Rooted in the understanding that transcription is "a key phase of data analysis within interpretative qualitative methodology" (Bird 2005, 227), I transcribed all of my interviews by hand. While this was incredibly time consuming, it allowed me to develop a thorough familiarity with, and deep understanding of, my data (Riessman 1993). Transcription convention should be practically suited to the purpose of analysis (Edwards & Lampert 1993). In line with Halcomb and Davidson's (2006) argument that the use of thematic analysis techniques seeking to identify common ideas and patterns from the data does not necessarily require complete verbatim transcripts, I used partial transcription to convert the digital recordings into written text. All information relevant to the research study I transcribed verbatim with pauses, sighs and gestures noted in the transcripts. The portions of the interviews that were unrelated to the research were not transcribed. Using Wengraf's (2001) method, I added reflexive memos to the transcripts during the process of listening to the recordings as a way of capturing my thoughts and interpretations.

## Thematic Analysis

Thematic analysis offered me an accessible and theoretically flexible approach to analyzing my qualitative data (Braun & Clarke 2006, 77). It was also an appropriate choice given my use of an FPE theoretical framework and post-positivist epistemological position. I used thematic analysis as a method of organizing and describing my data set in rich detail. It also enabled me to identify, analyze, and report patterns in my data. Finally, it helped me to interpret these themes using FPE to examine the ways they connected to the dominant neoliberal discourse that shapes policy-making and health care reform in Canada (Boyatzis 1998; Braun & Clarke 2006, 79-81). This project's analysis covers the period between December 14th, 1992

and May 31st, 2013, starting with the election of the Klein government in Alberta and ending with my final research interview.

To begin, I organized my data from interview transcripts, reflexive journaling, interview notes, memos, and secondary source documents into two categories: 1) expressed needs, and 2) practices and policy techniques that addressed expressed needs.  Data on similar needs or practices were grouped together first *within* programs and then *across* programs.  Once all my data were coded and collated, I analyzed my codes and considered how different codes could be combined to form overarching themes (Braun & Clarke 2006, 89) that captured something important about if and how ICPs meet clients' and carers' expressed needs.  I identified four key themes associated with expressed needs and the policies that had been created to meet them: social inclusion, continuity of care, participatory decision-making, and communication/joint working.

Using the FPE tools outlined in Chapter 4, I examined the underlying ideas, assumptions, and conceptualizations that shaped the experiences of clients and carers in each thematic area given the social, economic, and policy context within which each ICP was operating.  This interpretive analysis illuminated the complex interconnections between my empirical data on integrated care, fragmentation, inefficiency, inequality, and inequity.  In my search for practices worth sharing, I grappled with the tensions and contradictions that arose as a result of neoliberal home care restructuring.  My thematic analysis tells the complicated story of my data and explains how the broader context shaped by neoliberalism has impacted if, and how, ICPs meet the expressed needs of clients and carers.  I conclude that more neoliberal policy techniques increase inequality and fragmentation through their quest for enhanced efficiency.  In contrast, policy techniques that challenge neoliberalism reduce fragmentation by more equitably

distributing access to care and/or reducing power inequalities between, and among, clients and carers.

## Methodological and Design Limitations

Designing my study using the post-positivist research paradigm and a qualitative methodological approach, shaped by an FPE theoretical framework, has advantages but also limitations. The fact that my findings are not generalizable across locations, nor directly translatable between ICPs without consideration of the conditions that support them, could be seen as a limitation. I see the effort to contextualize my findings as a strength of my study. However, policy makers working within the positivist paradigm might see this as more burdensome than their typical approach to knowledge transfer.

Seeing promising practices as context-specific justifies my selection of ICPs that operate in the home care sector specifically. This choice excluded at least one ICP at a more complete stage of integration.[32] However, based on the view that context matters in understanding why policies work for some groups, in specific places, at certain times, it made sense to look at home care ICPs instead of ICPs operating at a broader systems level. I used a similar justification for my decision to look at ICPs targeting seniors living in private residential dwellings, instead of those receiving home care services in other settings, such as seniors' residences, retirement homes, or assisted living facilities. My hope is to capture implications of using ICPs that may be unique to providing care in the context of private, often isolated, residential homes. Lastly, focusing on ICPs within the home care sector means that I did not look at how ICPs can impact the transitions between hospital and home, or home and assisted living. Despite these transition

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[32] For a description of the SIPA model in Quebec see Beland 2012.

periods being flagged by multiple research participants as areas requiring further study, they were outside my scope of inquiry in this project.

Part of using an FPE approach to shape my research design meant giving saliency and centrality to certain social relations of inequality, in particular gender, race/ethnicity, and class. In doing so, this rendered other experiences invisible (Dei 2010, 13). I concur with Dei that "we cannot adequately explore all experiences with the same vigour and intensity" (ibid). Yet, my decision to select gender, race/ethnicity, and class inequality as my main points of entry created blind spots in my analysis. To address this limitation I attempted to capture as much data as possible from the points where gender intersects race/ethnicity and class, though other inequalities, disability and sexual orientation, for example, remain for the most part outside of my analytical scope. Likewise, focusing on seniors as my target client population meant excluding younger people with disabilities who also experience marginalization in home care. While this should not be seen as an attempt to privilege one group's experiences over another, drawing attention to one group necessarily relegates others to the margins.

There were also limitations in using narrative interviews as my primary data collection tool. As mentioned above, I was only able to interview people who agreed to speak with me after being contacted by program administrators. This may have introduced bias in my sample as the clients and unpaid carers who agreed to be interviewed may have been those with either very positive or very negative experiences with their ICP. There were a few instances, particularly with clients, where they emphasized that everything with the program was perfect and could offer no suggested areas of improvement. Despite reiterating that the interviews were confidential and data would not be shared directly with program staff, clients may have been worried that they were at risk of losing services if they spoke ill of the program. Negativity

biases and memory biases are also inherent limitations to collecting data via interviews. To address these, my interview guides included questions intended to solicit both positive and negative experiences. I also asked participants to provide concrete examples to illustrate their views whenever possible. For Carefirst interviews with participants who did not speak English or felt their language skills were insufficient to participate in an English interview, I relied on a volunteer interpreter who could speak both Mandarin and Cantonese to translate. I used the same translator for all of my interviews and I reviewed the purpose of the study, interview guides, and technical terminology with her prior to commencing interviews.

Program administrators introduced me to paid care workers on my first day at each program site. In line with my ethics protocol, I was clear that participation in my study was entirely voluntary. However, as none of the paid workers I approached for an interview declined, it is possible that they may have felt that program administrators expected them to participate. Likewise, program administrator involvement in recruitment meant that I was only granted access to the paid workers that the administration classified as being part of the ICP. I did not interview workers from external agencies in ICPs where care work was contracted out. For example, I did not get access to paid workers providing CCAC-funded care in AIP or the PSWs providing in-home personal care in CHOICE. Despite these workers providing a substantial amount of necessary and important care to ICP clients and likely experiencing precarious working conditions, my research design rendered their work invisible.

As discussed above, subjectivity plays a role in the co-construction of all research relationships. However, during interviews with paid workers in the least powerful positions I was aware of our unequal power relations. It is certainly possible that racialized, newly immigrated or English-as-a-second-language workers did not feel comfortable sharing the extent

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of their experiences of racial/ethnic or linguistic discrimination in the workplace given my positioning as a white researcher introduced to them by their manager. If this was the case, the impacts of race/ethnicity-based marginalization may be under-reported or under-emphasized in my data.

Finally, I interviewed only key informants with day-to-day experience with the ICPs under investigation. Given my aim of understanding the ways race/ethnicity, class, and gender influence clients' and carers' experiences in ICPs, I chose to focus on the lives and experiences of clients and carers. I did not interview policy makers or politicians in order to gain their perspectives on how state institutions have reshaped home care through neoliberalism and the subsequent implications for ICPs. However, as a result of this methodological decision, aside from interviewing program administrators, I did not explicitly call on those with the power to reshape socio-political contexts at a structural level. Despite my findings that more neoliberal policy techniques increase inequalities and exacerbate fragmentation, I did not ask provincial government officials to account for their continued use of policies that seek to enhance efficiency over equality or equity. Instead, I have identified program administrators as being well positioned to affect change at the level of the ICPs themselves. Program administrators can influence a program's culture, resources, and design. They are also close enough to the day-to-day workings of ICPs to see the impacts of different policy techniques on the lives of clients and workers. I hope that program administrators will disseminate my findings to clients, unpaid carers, and paid care workers motivating a shared call to action for ICPs to focus on implementing policy techniques that promote equality and equity in order to better meet the expressed needs of clients and carers alike.

## Program Descriptions

A brief overview of the five ICPs I study is provided below.

### CHOICE (Comprehensive Home Option for Integrated Care for the Elderly)

In Alberta, the CHOICE program operates in the city of Edmonton, population 812,000 (Statistics Canada 2011). CHOICE was established in 1996 and has been implemented in five centres across Edmonton as well as through an outreach program. In this study, I focus on the CHOICE program housed within the CapitalCare Dickinsfield long-term residential care facility in a middle class, suburban area of Edmonton. In 2012, the Dickinsfield program served close to 600 clients, mostly seniors.

The goal of CapitalCare's CHOICE program is to "reduce the need for inpatient and emergency room services" (Alberta Health Services 2009, 3). This is done by "coordinating home and day centre services with round-the-clock support for people living in their own homes" (CapitalCare Edmonton Area n.d.). CHOICE serves frail seniors who are at high risk for further decline in the absence of intervention, require continued medical supervision, and frequently visit the ER. CHOICE clients have to meet the majority of the following eligibility criteria to be considered for admission to the program. Clients must be at least 60 years old, functionally frail, physically disabled or cognitively impaired, and have a history of increased utilization of the health care system for complex, chronic medical conditions. They must be at moderate-to-high risk of not managing to remain in the community and require comprehensive services to meet their needs, but also be able to be safely cared for at home. Both the client and his/her unpaid carers must want the client to remain at home, the family carers must be willing to partner with the program and continue to support the client in their unpaid carer role. The client must be willing to attend the CHOICE ADP on a regular basis and a client's health issues must not be a

barrier to program participation. Finally, a client's potential length of stay in the program must be no less than three months.

CHOICE promotes a "comprehensive, multidisciplinary, managed care approach" to providing care coordination services, an ADP, OT and PT rehabilitation, social work and pastoral care, after hours on-call support, medical, nursing and pharmacy services, home support, transportation, and in-facility treatment/respite care beds (Alberta Health Services 2004). The program is government funded but requires means-tested client co-payments. It is operated by the CapitalCare Group, a wholly owned subsidiary of Alberta Health Services. Most of the care provided by CHOICE is delivered by workers employed directly by CapitalCare. However, the program's transportation services and in-home personal care are contracted out to the private sector.

Paid workers in the CHOICE program are organized on a rigid occupational hierarchy, the implications of which are discussed further in Chapters 6 and 7. CHOICE's Site Manager/Clinic Supervisor is responsible for hiring, training, supervising, and evaluating Community and Health Support Workers (CHSWs). She also coordinates the intake process for the on-site care and treatment beds and has a clinical role as an RN. The program has two family physicians who share a full-time position and a clinic clerk for administrative support. A pharmacist works at the program three days per week in collaboration with licensed practical nurses (LPNs) to organize and dispense medications. A Lead LPN processes doctor's orders, faxes medication delegations to external agencies, communicates with families, and tracks clients' external appointments. The program's staff also includes a social worker, OT, PT, PT Attendant and a part-time Recreational Therapist. CHSWs deliver a combination of medical care, ADL and IADL care, and recreational activities during the ADP. As mentioned above, the

in-home personal care and transportation to and from the ADP are contracted out. Workers from the external agencies are not part of CHOICE despite their daily interaction with clients. Lastly, two front office workers provide administrative support and redirect incoming communication from family carers to the correct care worker. My observations at the program site showed CHOICE clients to be mostly white, with only a few visible racial/ethnic minorities. The racial/ethnic profile of CHOICE staff was divided, with most of the CHSWs being from visible racial/ethnic minority backgrounds while the remainder of the staff was largely white. Clients were a relatively even mix of men and women. In contrast, all of the care workers were women, except the physicians and one of the therapists.

In contrast to the other ICPs I study, there is no case manager position in the CHOICE program. Instead, clients are strategically assigned to have one of the Social Worker, OT, PT, RN, or Lead LPN as their case manager. This is determined by matching a client's most pressing needs with the specialities of the staff members. For example, a client experiencing mobility issues would get assigned to have the PT as their case manager.

Unpaid family carers are supported, but also in some ways managed, in the CHOICE program. The program provides access to in-facility respite by operating ten care beds at the program site. CHOICE offers unpaid carers emotional support provided by the OT and one-on-one teaching related to medical care, such as how to dispense medications, catheter and peri care, wheelchair use, and insulin administration. In contrast to the other ICPs; however, CHOICE moves beyond providing unpaid carer "support", to an explicit expectation of an active "partnership" between the paid workers, clients, and unpaid carers (Capital Care CHOICE and Community Programs 2012, 2). Paid care workers see a broad conception of the care team as key to the program's success, "It's the medical piece along with the social piece along with the

client themselves, and their family, all working together" (I: March 20, 2013).[33]   Case conferences are used to promote joint working between paid care workers, clients, and unpaid carers.  These conferences occur six weeks after a client joins the program, and on an annual basis thereafter, or sooner if needed.  Standard operating procedure in all CapitalCare programs is for case conferences to include family carers.  Managers, paid carers, and unpaid carers saw case conferences as an important collaborative tool; however, the expectation for unpaid carers to participate in them is evidence of the blurred line between unpaid carer inclusion and management.

## AIP (Aging in Place)

Within Ontario, I study three ICPs in different parts of the province.  The AIP operates in the city of Ottawa, population 883,000 (Statistics Canada 2011).  This program was established in 2007 as a collaborative effort of Ottawa Community Housing (OCH), the Champlain Community Care Access Centre (CCAC) and the not-for-profit, charitable Ottawa West Community Support (OWCS) agency.  Its target population in 2013 was the 2,800 tenants living in the low-income housing units in several apartment buildings throughout Ottawa.   The apartments are private residential dwellings rented by clients.  Participation in the program is optional for OCH residents.  However, to be eligible, clients have to be 60 years or older and live in one of the buildings in which the program is offered.  In 2011/12, AIP served 2,055 clients. 2,002 clients received only social care services, 612 clients received only health care services, and 559 clients received both health and social care services (Aging in Place 2012).   The programs' clientele is racially/ethnically heterogeneous, comprising white seniors but also a large number of visible minorities.  Like CHOICE, the racial/ethnic profile of AIP staff is

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[33] Data from interviews will be cited using "I:" and the date of the interview.

divided. Many of the Home Support Workers (HSWs) are from racial/ethnic minorities. Meanwhile the management, care/outreach coordinators, and nurses are largely white. The majority of the care workers are women, though not exclusively. Some of the drivers running the social excursions are men and I encountered men in HSW and outreach coordinator positions.

The aim of AIP is to provide "an integrated mix of services" (Aging in Place n.d.) to at-risk seniors living in low-income apartment complexes. When AIP started, the initial five OCH buildings were chosen because their residents were the highest users of emergency rooms and had the most hospital admissions (I: February 20, 2013). Achieving cost savings for the state through reduced emergency room visits and hospitalizations is explicit as a goal of the program. AIP clients are provided with outreach and interventions aimed at reducing institutionalization, including efforts to reduce barriers to accessing CCAC services, direct provision of certain health and social care services, and linking residents to community resources and services (Aging in Place n.d.).

The daily operation of the AIP at each site is jointly managed by a CCAC Care Coordinator (CC) and an OWCS Community Outreach Coordinator (COC). These workers share a store-front office in each apartment building. CCs are CCAC employees. COCs are employed by the not-for-profit OWCS agency. All care offered through AIP is government funded. The CCAC and OWCS each have their own portion of the budget for which they are responsible. Funding for the social side of the program comes from the Champlain LHIN though the Aging at Home Initiative. Funding for health side of the program is part of CCAC base funding. There are no user fees for any of the care provided by AIP.

The responsibilities of CCs, COCs, and the two public health nurses affiliated with the program are divided along the health and social care lines dictated by organizational affiliation. An occupational hierarchy structures the relationships of the workers. The CCAC employees and public health nurses receive better pay, access to benefits, and more job security than their not-for-profit colleagues. This contributes to perceived power inequalities among the workers as they see themselves doing very similar work but for different pay/benefits.

CCs coordinate all CCAC-funded "professional" services, including nursing care, OT, PT, social work, speech-language pathology, and dietician care. They also arrange personal support services and homemaking for CCAC clients receiving at least one professional service. These services are entirely subsidized through the CCAC. Ottawa Public Health nurses provide other health related services to clients "for free". These include flu clinics, dental hygiene clinics, screening clinics for fall prevention, blood pressure check-ups, nutrition education, and equipment fairs. Lastly, COCs coordinate all of the social services. These are still free to clients but are paid for by the AIP program directly as opposed to being subsidized through the CCAC or the public health unit. COCs arrange for short-term homemaking services for non-CCAC clients, access to Meals on Wheels, transportation for health related activities and social excursions, taxi fare for emergency medical appointments, and foot care.

In addition to the complexities associated with the source of the care funding, the lines between public and private are blurry in the AIP. The CCs use Ontario's managed competition model to allocate the care contracts for the CCAC funded services to for-profit and not-for-profit agencies. The workers that provide this outsourced care work with AIP clients, often alongside AIP employees, but are not considered part of the program. A Nurse Practitioner (NP) is employed directly by the CCAC but assigned to AIP. She works exclusively with AIP clients

and is responsible for screening and treating clients without a family physician until they are placed with one.  The NP also intervenes for AIP clients in acute situations.

All care not managed by CCACs is delegated by COCs to AIP workers.  These paid carers are either employed directly by the AIP or hired on a contract basis.  There are directly employed AIP drivers who are responsible for running day excursions.  There are also directly employed HSWs who provide house cleaning and grocery shopping on a short-term basis.  Foot care nurses are hired by the AIP on a contract basis to offer fully subsidized foot care services to clients.  The HSWs and foot care nurses sometimes work alongside the for-profit and not-for-profit agency workers with CCAC contracts.  These workers report being present in either clients' apartments or the building's communal areas (e.g., the laundry room) concurrently, but that there is no communication or collaboration among them.

AIP's "client-centered" focus was emphasized in interviews and the program literature. For example, program administrators emphasized that the "client is the main person and everything is happening around them" (I: February 20, 2013).  While this may be the intent, the extent to which client-centeredness has been achieved in practice is less clear.  In contrast, unpaid carers remain firmly at the periphery of the program.  Despite unpaid carers' reports of performing a significant amount of care work for clients, family involvement in client care was often seen by paid workers and administrators to be "minimal and relatively uncommon" (I: February 20, 2013).  Paid workers cited clients' mental health and addiction issues as well as the requirement in Ontario's *Freedom of Information & Protection of Privacy Act* for clients to provide consent before their information could be shared with family members as reasons for the (perceived) low participation of unpaid carers in the program (I: February 28, 2013).  AIP did not have policies or processes specifically designed to incorporate unpaid carers into the program.

## SMILE (Seniors Managing Independent Living Easily)

South-east of Ottawa, the SMILE program serves the rural and suburban population in the geographic area bordered by Brighton, Prescott, Cardinal, Perth, Smith Falls, and Bancroft. SMILE was established in 2008 as a state funded Aging at Home Initiative through the South East Local Health Integration Network (LHIN). The program is administered by the not-for-profit, charitable Victorian Order of Nurses (VON) Canada. The program served approximately 1,700 clients in 2012-13 and had over 900 seniors on their waitlist. SMILE typically serves middle to low income seniors, the vast majority of whom are white. Similarly, there is very little racial/ethnic diversity among SMILE's care workers. Both those directly employed by the program as well as the independent contractors are typically white. In SMILE, the gendered division of work is particularly apparent. Women carers provide homemaking services while men do the outdoor maintenance work. Many of the women carers hired as contracted homemakers self-identified as low-income.

SMILE's overarching goal is to "reduce barriers to accessing services" (SMILE Program n.d.) for seniors "most at risk of progressive frailty, premature dependency and institutionalization" (SMILE Program 2010). Reducing high risk seniors' use of publicly funded institutions as a cost saving measure is a key objective of this program. Only seniors who have been hospitalized, visited the emergency room, or have had an unscheduled physician visit in the 90 days prior to application, are eligible for admission to SMILE. Additional eligibility criteria include the need for assistance with four or more IADLs due to either a functional or cognitive impairment, at least 75 years of age or living with a disease of aging, living alone or with a caregiver unable to consistently assist with IADLs, and risk of hospital or long-term care home admission within the next year unless additional support is provided.

The SMILE program has two key components: the provision of care coordination and funding, and community entrepreneurship. Client Care Coordinators (CCCs) provide referral services to all eligible seniors. For those admitted to the program, clients are offered both case coordination and the funds to hire a care worker to provide pre-approved services. These can include meal preparation, housekeeping, shopping, laundry, running errands, transportation for health care appointments, seasonal outdoor chores, respite, and foot care. Like AIP, SMILE was promoted by program managers as being "very, very client-centered" (I: April 2, 2013). There is a clear emphasis on client choice with the program advertising that "seniors choose what services they need, when they need them and who will provide those services" (SMILE Program n.d.). This choice, however, is constrained by the funding and service boundaries set by the program and the availability of care workers in the market. CCCs make the final decision about each client's needs and eligibility for care. SMILE clients do not pay for any of the program's services unless they chose to receive services in excess of the funding limit set by the CCC. Client choice is also constrained by the need to find a carer who is willing to provide a specific kind of care, in a specific geographic location, for the price that SMILE is willing to pay.

The SMILE program has a secondary aim of supporting "community entrepreneurship". Program managers explained this as using government funding to hire workers from for-profit and not-for-profit agencies in the community as well as "non-traditional" independent contractors (I: April 2, 2013). The wages of paid carers are paid by SMILE directly or by the client who is then reimbursed by SMILE. The boundaries between public and private as well as formal and informal care are blurred by the program's use of public funds to create employment in the private, and often for-profit, sector. The neoliberal technique of classifying paid carers as independent contractors is used extensively by the SMILE program. Hiring carers as

contractors, as opposed to employees, is used to reduce the costs of labour. As a result, the SMILE program did not set a standard rate of pay for equal work, require that workers be paid for sick days or statutory holidays, grant workers vacation leave, give workers access to a benefits plan or professional development opportunities, or guarantee workers a minimum number of working hours or number of clients. SMILE's use of independent contracting arrangements benefits the program through reduced workforce costs but results in precarious working conditions for the contractors, many of whom are women in economically vulnerable situations. Moreover, the relationship between SMILE managers/CCCs and the independent contractors is one of very unequal power relations. The repercussions of this are discussed in Chapter 6.

In contrast to the independently contracted homemakers, CCCs at SMILE are directly employed by the program. They work in both full-time and part-time positions as case managers. They are responsible for the assessment, admission, care plan creation, and monitoring of clients. One third of SMILE's CCCs are distributed across the South-East LHIN. These CCCs receive referrals and provide case management for clients in their geographic area who are not connected to a CCAC. The remainder of the CCCs work out of the program's head office in Trenton where they manage clients referred by CCACs.

Program administrators explained that SMILE "looked for gaps" and so will not reimburse unpaid carers for any care they are already providing (I: April 2, 2013). SMILE, likewise, will not replace care that is being provided by a CCAC-funded worker or a privately paid carer, unless paying for services is putting the client at financial risk. The relationships between CCCs and unpaid carers are very uneven. Some unpaid carers described their interactions with their family member's CCC very positively. Meanwhile, other unpaid carers

lamented that they were not even given access to the CCC's direct phone line. They were required to use mail or call the switchboard each time they wanted to get in touch. SMILE did not have specific policies or processes intended to engage unpaid carers with the program.

## Carefirst

Further south, the Carefirst program operates in suburban Scarborough, Ontario, population 625,000 (Statistics Canada 2011). The Carefirst ICP is a partnership between the Carefirst Family Health Team (FHT) and Carefirst Seniors. The FHT was established in 2007 as a primary health care clinic funded by the Ontario government. The FHT offers access to physician and allied health professional services, an on-site specialist clinic, chronic disease and chronic obstructive pulmonary disease education and counselling, a cardiac rehabilitation program, a weight management program, and preventative health promotion activities. Carefirst Seniors is a not-for-profit, charitable agency established 1976.

In 2011, Carefirst Seniors provided care to over 6,500 elderly or physically disabled clients, 1,800 of whom were "homebound" and frail (Carefirst Seniors and Community Services Association 2011). Carefirst's target population is seniors who have immigrated to Canada from China or Hong Kong. The majority of both Carefirst's clients and paid carers have English as their second language or do not speak English at all. Carefirst clients typically belong to the upper middle-class and are more likely than seniors in any other ICP to live with and be financially supported by their children. Clients and carers in Carefirst explained this as part of Chinese culture. Most of the unpaid carers, both family members and volunteers, are also first or second generation immigrants. These unpaid carers are more likely than clients to be bilingual, with English and either Cantonese or Mandarin. Carefirst's paid care workers are generally racially homogenous; most are of Chinese descent. The vast majority of Carefirst's paid workers

are women.  However, like SMILE, there is a gendered division of care work.  Men are involved in providing transportation, while women undertake the personal care and homemaking tasks.

Carefirst's goal is "ensuring that Chinese seniors and, where appropriate, others in need of services…live a quality and enriched life in the community" (Carefirst Seniors and Community Services Association 2009).  The Carefirst agency emphasizes the promotion and enhancement of "personal wellness through a range of social, health care and supportive services [that are] planned and delivered on a holistic basis" (ibid). It offers "culturally relevant" care (ibid).  Carefirst Seniors serves the Greater Toronto Area, including York Region and Mississauga.  It is funded by both public and private sources, including the Central and Central East LHINs, the Ontario Ministry of Health and Long-term Care, the City of Toronto, the United Way, private donations, and client co-payments.

Carefirst as a service provider operates in both the public and private spheres.  The FHT provides government-funded care as per the CHA.  The method through which services are provided through Carefirst Seniors is more complex.  Carefirst Seniors provides a range of CCAC funded services.  Yet, the agency does not compete directly in Ontario's managed competition system for these contracts.  Instead, it has developed a reputation as "the Chinese arm [of home care providers] to service the [Chinese] community" (I: May 10, 2013).  Carefirst Seniors secures work by sub-contracting to service providers, such as Visiting Homemakers Association Home Healthcare (VHA) and the Community Home Assistance to Seniors (CHATS), which hold CCAC contracts.

Carefirst allows clients to privately purchase the kinds of care offered by a CCAC.  This typically occurs when clients wish to supplement, or do not qualify for, CCAC funded care.  For

instance, a client might need personal care or housekeeping services but not health care services making him/her ineligible for CCAC funded care. In this case, the client could buy personal care or housekeeping services directly from Carefirst Seniors.

Carefirst also offers care that is not available through a CCAC. It provides an ADP, information and referral services, supportive counselling, Chinese bereavement services, elder abuse prevention and education, a Chinese elder abuse hotline, Meals on Wheels, friendly visiting, telephone reassurance and security checks, hospice visiting, transportation, interpretation and escort services, wellness education, social and recreational activities, and community outreach programs. Many of these types of care are completely subsidized by Carefirst and so are "free" to clients. Some care is partially subsidized by Carefirst and requires clients to co-pay through a user fee.

Carefirst directly employs its workers and structures them in a large and complex occupational hierarchy. Home Care Team Leaders are responsible for the daily operations of Carefirst Senior's Home Care Department. They supervise Client Service Coordinators (CSCs) and PSWs in addition to providing case management services to clients. CSCs match PSWs to clients needing care and schedule daily PSW home visits. They also complete at-home assessments, create care plans, collaborate with VHA, CHATS and the CCAC, make referrals to outside community agencies, respond to client and unpaid carer feedback, supervise PSWs, and manage a client caseload. A Team Scheduler is responsible for arranging "relief" PSWs to cover multiple day PSW sick leave and vacation leave. Team Assistants provide administrative support to the Home Care Department. A Homemaking CSC organizes all aspects of Carefirst's housekeeper service. Drivers and escort staff transport clients to and from ADPs, medical appointments, grocery shopping, and following discharge from the hospital. Carefirst's

Community Support Services Department coordinates Cantonese and Mandarin information, telephone assessment, and referral services; supportive counselling; bereavement services; interpretation and escort services; telephone reassurance and security checks; unpaid carer support and education programs; and the volunteers. Carefirst's two ADPs have a manager, a casual Registered Nurse (RN), a recreational therapist, activation staff, and a home helper to do the meal preparation and cleaning. The ADPs also hire PTs, foot care nurses, and a reflexologist on a contract basis for individual therapy sessions with clients. The FHT includes seven physicians, a dietitian, a social worker, several RNs, medical receptionists, and administrative staff. In addition, Carefirst employs close to 400 HCWs. These PSWs and housekeepers are typically hired on a part-time, casual or on-call basis.

Carefirst directs substantial resources to integrating volunteers into their agency. It is the only ICP to significantly rely on the unpaid care work of volunteers. In 2013, Carefirst had a contingent of 800 people volunteering time with the organization annually. 400 of these were regular volunteers who worked 2-4 hours each week. Paid workers manage volunteer recruitment, training, evaluation, retention, and recognition. The roles and responsibilities of volunteers are laid out in a volunteer handbook (Carefirst Seniors and Community Services Association 2011) and all volunteers undergo four levels of mandatory job specific training before beginning their work. Volunteers are also granted access to professional development, education, emotional support, and peer networking opportunities organized by the agency. Carefirst formally recognizes the contributions of their volunteers in the form of appreciation certificates, awards and gatherings. Volunteers with greater than 100 hours are invited to the staff Christmas party, and Carefirst routinely nominates volunteers for provincial service awards.

Carefirst does not invest in family carers to the same extent as their volunteer workforce, though the ICP advertises that it aims to "draw the family members in" (I: May 10, 2013). Carefirst is the only ICP to offer formal counselling, support groups, and education programs for family carers. It also offers help with system navigation in either Cantonese or Mandarin to family carers from Chinese backgrounds. In addition, paid workers with Carefirst give family carers informal support. For example, paid carers engage in impromptu one-to-one teaching with family members to share information and skills. Some paid carers act as "informal counsellors" for family members by sharing coping strategies for the emotional labour of providing elder care. This informal support occurs frequently enough to have been discussed by several paid and unpaid carers in their interviews. Family carers were generally seen by the paid workers in this ICP as being part of the care team. Some workers proposed additional efforts be made to include family carers, such as inviting them to participate in case conferences as part of the interdisciplinary team of care providers.

### HHH (Hope Home Health)

In British Columbia, the HHH program is operated by the Fraser Health Authority in the town of Hope, population 5,969 (Statistics Canada 2011). Unlike the other ICPs, HHH does not specifically target seniors. As a government program, it is subject to the province's general eligibility criteria to receive home and community care services. To be eligible for HHH, a client has to be older than 19 years of age, a Canadian citizen, and a BC resident for at least three months (British Columbia 2016). Unsurprisingly, elderly persons comprise the majority of HHH's clientele. In 2013, HHH served 93 clients. A portion of these clients were living in their private residence while others had moved into an assisted living facility.

Both HHH and SMILE serve "rural" populations. Rural in HHH means that clients live in small private dwellings nestled close together. Hope is isolated from neighbouring towns in a mountainous stretch along the Trans-Canada Highway. In contrast, many of the clients served by SMILE live in old homesteads scattered throughout the Ontario countryside. Many of these farms are farther than walking distance from their closest neighbour, leaving SMILE clients physically isolated unless they can drive.

In HHH, the clients, unpaid carers, and paid carers are typically white. I encountered a few clients and unpaid carers with Indigenous heritage. Both clients and program administrators in HHH emphasized that poverty is a pressing issue in Hope and most clients self-identified as economically vulnerable. Like many of the other ICPs, the majority of the care workers are women, with the exceptions of some of the physicians, the ADP Coordinator, and one of the therapists.

HHH aims to "help seniors stay at home by setting them up with the support they need to be independent for as long as possible" (Fraser Health n.d.). This is accomplished by assisting "clients and families [to] work toward caring for themselves and their loved ones [using]...a team of professionals to provide clients and families with the necessary education to meet this goal" (Fraser Health 2011). HHH is funded through the Regional Health Authority's (RHA) global budget in combination with means-tested client co-payments for services not covered by the CHA (e.g., long-term personal support services, the ADP, and transportation). The HHH program works in collaboration with the publicly funded Home Support department in neighbouring Chilliwack. Home Support is responsible for traveling to Hope to deliver personal care services to HHH clients. HHH targets clients needing either short-term support because of a recent discharge from hospital or long-term support to age in place.

HHH, in collaboration with the Home Support department, provides care coordination, personal care, medication management, nursing care, in-home respite care, an ADP, transportation, and short-term OT and PT services. It also makes community referrals to Meals on Wheels, Lifeline emergency response system, private housekeeping services, and Hope community dining. Prior to 2001, HHH had also offered IADL care, such as housekeeping, meal preparation, and grocery shopping. These services were eliminated as part of neoliberal restructuring. Views of IADL care as "not health related services" and "not really required" persist among program administrators (I: April 18, 2013).

Paid workers with HHH are public sector employees. A team leader supervises the HHH staff in addition to doing a substantial amount of administrative work. Community Health Nurses (CHNs) are responsible for wound care, palliative care, catheter changes, IV changes, and blood work. They also delegate select nursing tasks to the Community Health Workers (CHWs) who provide the ADL care in clients' homes. CHWs are directly employed through the Home Support department, though often on a part-time or casual basis. Many work split shifts. A Case Manager is responsible for assessing, monitoring, and transitioning clients from home to assisted living or long-term residential care. Two OTs, a PT, and a dietician provide part-time care to HHH clients in their homes. These carers work concurrently in acute, outpatient, and residential long-term care settings in Hope. An ADP Coordinator performs a wide range of activities. This carer drives the ADP bus, prepares meals for clients attending the ADP, runs recreational activities, bathes clients at the ADP site, completes health assessments, and changes catheters. Two part-time Rehabilitation Assistants do daily exercises with ADP clients. A supporting ADP worker assists the ADP Coordinator with recreational programming and personal care. There is also a part-time clerical worker to assist with administrative tasks.

In contrast to the client-centered focus of the AIP and SMILE, both clients and families are referenced in the HHH mission statement.  HHH offers respite for family carers through daytime in-home supervision, admitting the client to the ADP, or providing access to a bed in the community's long-term care home if overnight care is required.  Respite care is one option for meeting the expressed needs of family carers.[34]  However, respite care reinforces the expectation that family members should and will continue to provide unpaid care.  The option to pay family carers for the care they provide is discouraged by policy makers in BC.  For example, HHH workers discussed a program closely affiliated with HHH called the Choice in Supports for Independent Living (CSIL) program.  CSIL was created to support elderly and disabled clients living in difficult to access (remote) locations.  The CSIL program stipulates that only in "exceptional circumstances" could a family member be paid to provide care (British Columbia Ministry of Health Services 2016).  Furthermore, "immediate family members" (defined in the program guidelines as a parent, child, or spouse) are never permitted to be paid unless a special exception is granted by the RHA (ibid).  This mirrors the design of SMILE where family members are excluded from being hired by clients as their paid carers.

## Conclusion

Using a post-positivist epistemological approach I connect my FPE theoretical framework to my qualitative research design.  Focusing on locating lived experiences in a social context, I use this project to I build knowledge about the realities of women's involvement in

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[34] Alternative policy options exist in other jurisdictions that could also support unpaid carers.  For example, in Europe, caregivers' allowances - whereby the state remunerates unpaid carers for their caregiving work - are more common (see United Kingdom Government 2008).  The option for family carers to be directly paid for their care work has been actively taken "off the table" in HHH and SMILE.  Furthermore, it has not been "put on the table" by clients or unpaid carers, except in one case where a SMILE client expressed the desire to pay his niece for delivering groceries to him.  I suggest that this reflects how we have internalized neoliberal values of individualism and self-responsibility as well as how we reinforce the devaluation of the care work done by family members.

ICPs.  I assess the influence of neoliberalism in creating and reinforcing gender, class, and race/ethnicity-based inequalities between, and among, clients, carers, and program administrators.  I also use this methodology and research design to identify promising practices in home care design and delivery that meet the expressed needs of clients and carers.  My research enhances and challenges positivist methods of undertaking research on integrated care. I am thus able to reveal the nuances of using ICPs as a solution to fragmentation in a neoliberal context while keeping women and the classed and racialized conditions under which they live and work at the centre of my analysis.

# Chapter 6: Increasing Inequality Reinforces Fragmentation

## Introduction

ICPs that use neoliberal policy techniques to design and deliver home care are well positioned to meet the expressed needs of clients, unpaid carers, or paid care workers in positions of class, race/ethnicity and/or gender privilege. However, they often increase inequality by contributing to the continued marginalization of less powerful groups. Throughout this chapter, I identify policy techniques used by ICPs that align with neoliberal ideology, its mode of governance, or its policy toolkit. I draw on my interview data to show the impacts of policy techniques in the four key areas of expressed need identified by respondents: continuity of care, social inclusion, communication, and involvement in decision-making. First, I investigate the CHOICE program's elimination of funding for social excursions. I show that, when coupled with contracting out and task-shifting, this reduction of services increased class-based inequality among clients and reinforced race-based power inequalities among paid workers. Second, I analyze the impacts of the HHH policy of giving on-site baths to ADP clients on the staff's ability to offer day excursions. In a context characterized by low staffing levels and intense workloads for existing carers caused by an increase in demand by high acuity clients for on-site bathing assistance, I show that restricting access to day trips to those who do not need bathing assistance has created unequal access to social inclusion care among clients. Third, I evaluate the SMILE program's policy of responsibilizing their clients to hire their own paid care workers. Probing the blurry line between client empowerment and responsibilization, I show that this policy benefits clients with higher education, management experience, larger social networks, or unpaid carer support. However, it does not work as well for more vulnerable clients, unpaid carers or paid care workers. Fourth, I discuss the implications of the "flexible" funding schemes

used by Carefirst and SMILE.  These schemes encourage clients and unpaid carers to privately supplement publicly funded care, resulting in increased class-based inequalities among clients.  I also show that these schemes put pressure on unpaid carers, and foster inequality among carers through the creation of an invisible and precarious subset of the paid workforce.  Lastly, I assess the "collaborative" care planning process used in SMILE, AIP and CHOICE.  I show that this process can result in the creation of prescriptive care plans that facilitate client inclusion in decision-making while simultaneously presenting dilemmas for client empowerment.  I also highlight the costs of this policy, particularly the exclusion of paid carers from the care planning process.  I use these five examples to prove that despite their objective of reducing fragmentation through enhanced efficiency, ICPs that use neoliberal policy techniques often increase inequality between, and among, their clients, unpaid carers and paid workers.  This leaves them less able to meet the expressed needs of clients and carers, which, in turn, perpetuates fragmentation.

## Service Elimination, Contracting Out, and Task-shifting

In interviews, paid and unpaid carers at the CHOICE program were clear in their support for social inclusion care for home care clients.  Similarly, the ICP's documentation emphasized "structured recreation and social activities" as a key component of their basket of services (Alberta Health Services 2010, 1).  The CHOICE program initially offered an ADP at their program site as well as access to day excursions into the community.  Later; however, paid workers explained that government funding for day excursions was eliminated.  A staff member described this change as the "worst thing" about the ICP, "...they [clients] always used to go on out trips.  They went to the museum, the botanical garden, the conservatory...all these things. They took the bus and they went.  And [now] we don't go on out trips as all...So to me, that's discouraging" (I: March 19, 2013).  I argue that the CHOICE program's elimination of social

excursions, when coupled with the neoliberal policy techniques of contracting out and task-shifting, increased class-based inequality among clients and reinforced race-based power inequalities among paid workers.

Cost cutting in social care provision is connected to the neoliberal view of state involvement in the areas of health and social welfare as often "inappropriate" (Braedley 2010, 149). It is justified as a way to reduce wasteful government spending so that public money can be redirected to more valuable endeavours, such as paying down the debt or deficit. The elimination of day trips increased reduced clients' options for formal ICP-provided social inclusion care to ADP attendance. The ADP no longer provided a gateway into the community for homebound seniors. As a result, ADP clients no longer had access to the opportunities for social engagement that these trips used to provide. As clients remained full-time at the ADP, the responsibility for meeting their needs for social engagement was shifted to the CHSWs who were delegated the activation component of the ADP. Taking a client out into the community was relocated to unpaid carers, who were expected to take over the responsibility of making sure clients remained connected to their community.

Around the same time that funding for day trips was eliminated, CHOICE's in-home personal support services were contracted out to the private sector. Private sector delivery of certain social care services, such as transportation, homemaking or in-home personal support, was a policy technique used in both CHOICE and SMILE, often as an attempt to cut costs and enhance efficiency. Workers at CHOICE reported that the ICP had experienced difficulties hiring workers to provide in-home personal support because of the shortage of qualified HCWs (I: March 20, 2013). They also identified clients' fluctuating needs as a challenge to providing in-home personal support in house (ibid). The private sector was seen by CHOICE staff as being

a more "flexible" employer (ibid). CHOICE workers explained that contracting out in-home care to private sector agencies would allow clients to receive better continuity of care[35] (ibid). Additionally, they felt that this reform would alleviate the ICP from the burden of dealing with the difficulties associated with recruiting, scheduling, and retaining CHSWs (ibid).

Armstrong *et al.* (1997) challenge the notion that for-profit techniques are necessarily more efficient or that they are applicable to the care sector. Competition and the transfer of services to private providers may reduce short-term costs; however, there is no reason to believe that contracting out will lead to savings in the long run (Armstrong 2001b). Contracting out provides little long-term gain in terms of cost benefits for the state or increased quality of care for clients (Glazer 1993; Deber *et al.* 1998). Meanwhile, transferring the responsibility to provide social care from the public to the private sector reinforces the devaluation of social care in comparison to health care. In doing so, it undermines the working conditions of the paid workers providing social care in both sectors.

Contracting out can also result in both job re-definition and job loss for public sector care workers. This often has negative implications for HCWs, both those who leave the public sector and those who stay. HCWs who must leave the public sector when their work is contracted out, report receiving lower wages, fewer benefits, and less stable working hours upon relocation to the private sector (Williams *et al.* 2001, 19). For-profits also typically offer care workers less training than public sector employers. When some paid carers remain directly employed in the public sector while the work of others is contracted out, the workers who remain are often framed as "lucky" to have avoided the move to the private sector. This weakens their position to apply pressure to improve their working conditions and lessen the precariousness of the

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[35] A claim that clients and unpaid carers with CHOICE contested.

remaining part-time or contract public sectors workers. Even the implicit threat that their work could be contracted out at a future date reinforces power inequalities between workers and management, making vulnerable workers even less able to resist management's demands.

As discussed above, prior to contracting out, in-home services for CHOICE clients had been provided by directly-employed CHSWs. Following the decision to contract this work out to the private sector, the job description of the CHSWs who remained at CHOICE was rewritten by management. In light of the increased strain on the ADP following the elimination of day trips, some of the tasks regarding social engagement (previously the responsibility of the recreational therapist and OT) were redistributed to the CHSWs. While retaining responsibility for all on-site personal care work for ADP clients, the responsibility to "run all these [social] programs and make the calendar and play all these games" with ADP clients (I: March 19, 2013) was relocated to CHSWs.

Transferring work from regulated health care professionals to HCWs is another neoliberal policy technique used to cut costs. Task-shifting, a form of downward substitution (Armstrong 2013; Sibbald *et al.* 2004), increases managerial control over work organization. It also minimizes costs as the responsibilities of "professional" workers are divided into simpler tasks and transferred to lower paid, "low skilled" workers (Barken *et al*. 2015, 289-90). Task-shifting is often framed as a way to enhance efficiency – the same tasks get done but cost less to do. The trend of task-shifting to HCWs is not new. The consequences of the deskilling of nursing are well documented (Guberman *et al*. 2005; Duffy 2011). Because of the unequal power relations that often exist among workers and different value associated with care work done by different workers, task-shifting involves a re-characterization of the work, not just a redistribution of tasks (Duffy 2011, 91).

Task-shifting may have promised enhanced efficiency at the program level but its use perpetuated inequality among paid workers. A program manager with CHOICE explained that requiring CHSWs to run social activities "didn't go well at first. No, there was a real struggle" (I: March 25, 2013). In addition to assigning workers tasks for which they had no specific training, the social location of most CHSWs as new immigrants from non-European, non-English speaking countries, shaped how they experienced this policy choice. One CHSW reportedly quit over the reassignment, while the others were forced to adapt to the new combination of personal care, meal preparation, and recreational activities. Several CHSWs shared their feelings of powerlessness, insecurity, and anxiety as a result of the task redefinition. One CHSW explained, "When I started the Tea Group I didn't know [if] I could do it. I just tried it and I thought 'Whatever. You assigned me to this job so maybe I can do this'" (I: March 21, 2013).

In their new role, racialized CHSWs were expected to run Eurocentric games according to a schedule created by a white recreational therapist. CHSWs reported being initially unfamiliar with many of the games and activities they were being asked to run. Additionally, they felt that their difficulties went unacknowledged by their white co-workers. As one CHSW explained, "The games...because when I came here – zero – I didn't know nothing. I didn't know *nothing* [emphasis]! So [clients], not the staff, these guys taught me how to play all the games" (I: March 18, 2013). During an informal discussion with several CHSWs, they explained that it was easier for them to accept their new job descriptions once they were invited by a program administrator to participate in the creation of new recreational schedules: "Because sometimes when you're involved in it, then you do it with pride, right? Because you're the one, you're part of the one that made the calendar and planned the activities so you have some input" (I: March 21, 2013).

The CHOICE ICP was a hierarchical work environment in the form of a "power pyramid" (Banerjee *et al.* 2015, 32). Similar to what Banerjee *et al.* (2015, 32) describe in their study of residential care, this power pyramid allocated the most prestige to physicians. CHSWs occupied the least powerful positions at the bottom of the occupational hierarchy. Hierarchies among the various workers seemed quite rigidly enforced with those on the top given substantial autonomy over their work organization. Meanwhile, the work of CHSWs was organized as a series of tasks which were determined by management and scheduled in advance.

The reassignment of recreation tasks to CHSWs was not well received by some of the "professional" workers on the CHOICE team. Therapists in several of the ICPs studied, CHOICE included, viewed shifting work associated with activation and recreation to HCWs as a "trivialization" (Guberman *et al*. 2005) of recreational therapy. These workers saw the tasks of a recreational, occupational, or physical therapist as requiring specific skills and training. They resented managers' assumptions that this work could be easily done by unskilled workers with minimal instruction from a trained therapist, and it seemed directed this resentment at the CHSWs.

These tensions between therapists and HCWs directed by management to provide activation and recreation care were not isolated to CHOICE; I also saw them at Carefirst. A therapist at Carefirst suggested the problem could be solved by having "more training be provided to ADP workers who have no activation training background because most of these workers are PSWs and they may not know how to run a program in the best way" (I: May 8, 2013). In Carefirst, the therapist and the PSWs belonged to minority race/ethnic groups. In this context, "the best way" had class-based implications. The therapist meant that the HCWs should provide the same quality of recreational care that she, or someone with comparable training and

credentials, would.  In the context of the CHOICE program; however, the racialized workers who ran activities were constructed as being less capable than their white, Canadian-born colleagues.  In CHOICE, the "best way" meant the "white" way.

Program administrators at CHOICE were aware that some white care workers felt that the racialized CHSWs "weren't working well with the [white] staff assigned to do recreation" (I: March 25, 2013).  They also suggested that the CHSWs interpreted the issue differently than their white colleagues.  From management's perspective, CHSWs characterized the problem as one of task-shifting without a corresponding transfer of autonomy.  The CHSWs "felt those [white] staff sort of delegated their work to them [the CHSWs] and didn't recognize that they might have a role in it" (I: March 25, 2013).  A program administrator from a racialized background suggested that a change in organizational culture might be necessary to redress the racialized inequalities in power relations among ICP workers.  This manager proposed that instead of focusing on teaching CHSWs to run "Canadian" activities, white therapists might consider embracing the "really cool ideas...that people that come from different countries that have brought in games and stuff that we might not have ever seen...in Canada and sort of approach it with lots of enthusiasm, bring things in to try out" (I: March 25, 2013).  Despite this proposed intervention, the power inequalities arising from race/ethnic disparities among CHOICE workers went largely unaddressed by management.

The neoliberal policy techniques used by the CHOICE program, specifically the combination of funding cuts for social inclusion care, contracting out, and task-shifting, increased inequality.  Class-based inequalities among clients were exacerbated with the elimination of day trips and consequently fragmentation in home care was increased for the most vulnerable.  As publicly funded options for social engagement were reduced, clients were

required to look outside of the ICP for alternate ways to maintain their connection to others and to their community. Clients who could afford to hire private help could still get out into the community to experience things like museums, the botanical garden, and the conservatory. Meanwhile, clients without financial means or family support had to accept the ADP as their primary (and perhaps only) form of social inclusion. This disproportionately impacted low-income clients and those without family support networks as they would have had more difficulty organizing and paying for social care from the private sector.

Like clients, paid carers also experienced increased fragmentation as a result of this increase in inequality. Inequalities between paid workers were reinforced by the ICP's contracting out and task-shifting policies. These policy techniques intensified unequal power relations among workers positioned differently in the occupational hierarchy. Occupational hierarchies that value workers with more education and professional certification over those who do the "dirty" work can create adversarial workplace relations (England *et al.* 2007, 185) that make team work and information sharing among workers more difficult. Barriers to communication, collaboration, and joint decision-making increase the risk of duplicated or fragmented care. When inequitable working conditions prevent paid carers from doing their best work, the conditions of client care are also compromised.

## Lean Staffing Levels and Work Intensification

Health system restructuring under neoliberalism, in particular attempts to shorten the time ALC seniors spend in hospital, has contributed to ICPs serving a higher needs population than they have in the past. In a context of perpetual resource scarcity and government cost-reduction initiatives, there is evidence that the workloads of paid and unpaid carers are increasing (Aronson & Neysmith, 1997; Abbott 1998; Armstrong & Armstrong 2003). Neoliberal reforms

help employers maintain leaner staffing levels. Meanwhile, deskilling and the speedup of work have left many workers overwhelmed and overworked (England *et al.* 2007). Insufficient time and inadequate staffing have been noted as the most significant barriers to care (Banerjee *et al*. 2012). Likewise, heavy workloads and inadequate funding have been identified as significant barriers to quality care (Harrington *et al*. 2012; McGregor & Ronald 2011). In this subsection, I analyze the impacts of the HHH policy of giving on-site baths to ADP clients on the staff's ability to offer day excursions. In a context characterized by low staffing levels, intense workloads for existing carers, and an increasing proportion of high needs clients, I show that restricting access to day trips to those who do not need bathing assistance has created unequal access to social inclusion care among clients.

In a context of lean staffing levels and increasing client acuity, the HHH's ADP required ADP workers to shoulder an intense workload. The Coordinator of the HHH ADP was responsible for the operational details of running the ADP, including driving the bus to pick up clients from their homes, preparing lunch and snacks, and running recreational activities. This worker also performed quarterly and annual health assessments on clients, transported clients to on the on-site lab or X-ray department, did wound care, changed catheters, monitored blood pressure, and gave baths. On one hand, the ADP Coordinator's job description can be seen as fostering holistic and continuous care - a return to a time before specialization when a single worker could meet many (if not all) of a client's care needs. On the other hand, it is evidence of the intensification of workers' duties motivated by the neoliberal push to enhance cost-efficiencies.

Like the CHOICE program, HHH is facing challenges retaining day trips as part of their ADP's basket of services. However, workers attributed this less to direct funding cuts and more

to work intensification and lean staffing levels given the increasing number of high needs clients enrolled in their ICP. From the perspective of paid workers, the HHH ICP lacked the human resources necessary to accommodate a greater number of clients with higher personal care needs while still making day excursions possible. As an ADP worker explained, "we don't have the staff to leave anyone behind so it's either we all go [or no one goes]" (I: April 15, 2013). Workers identified the increased demand for on-site baths, without a concurrent increase in staffing, as particularly problematic. The ADP's policy of offering clients an assisted bath during their time at the ADP was intended to reduce or eliminate the need for a care worker to travel to a client's home to assist them with bathing. On-site baths also offered clients choice about where to receive their care. Finally, on-site baths offered more seamless care by enabling clients to receive their bath from the same workers who ran their ADP. Despite these benefits, ADP workers felt that the expectation for them to provide a greater number of baths, in addition to their other duties, was compromising their ability to offer day trips as part of the ADP. As one worker explained, "we used to do [day trips] a fair bit in the past. Last summer was really challenging...because of the number of baths" (I: April 15, 2013).

To deal with the need to provide more baths as well as still offer day trips, ADP staff at HHH used needs-based targeting of clients from within their roster of ADP participants. "We pick a day where [we have] the clients [who] do like to go, can go, so the ones who don't like to [or can't] aren't here that day" (I: April 15, 2013). By scheduling clients with similar personal care needs to attend the ADP on the same day, HHH workers were able to offer day trips to a subset of their clientele, those who did not need on-site baths. It is possible that a client might have attended the ADP more than once a week and so could have had a bath one day and participated in a day trip later. Yet, in cases where a client wanted/needed both types of care but

only attended the ADP once per week, on-site baths were systematically prioritized over participation in day trips.

Strategically scheduling clients enabled HHH workers to avoid eliminating day trips entirely. However, it had the adverse impact of increasing inequality among the HHH clientele. By making day trips available to some clients but not others, barriers to social inclusion care were created for high acuity clients. Clients needing on-site baths were then left to compensate for their ineligibility to participate in the social excursions offered by the ICP by looking outside the ICP for help, either from the private sector or from unpaid carers. This represents a move to increasingly fragmented care for a subset of HHH clients, those with the highest needs. Furthermore, clients' abilities to supplement publicly funded care with privately purchased care are subject to class, race/ethnicity, and gender disparities. Clients in positions of privilege are better positioned to arrange and/or pay for supplemental care than clients from marginalized groups. This left economically vulnerable clients with the possibility that they may not be able to access assistance getting out into their communities at all. It also affected clients without family support networks; for example, new immigrants or clients from rural areas, who did not have unpaid carers to turn to in the event that the ICP was unable to meet their needs for social inclusion.

## Responsibilization of the Client and Independent Contracting Arrangements

Maximizing client choice and empowerment were significant components of SMILE's mandate:

> You really have to be committed to a client's right to choose and know what's best for them… you want to enable people to the best of their abilities...with the SMILE program they are very empowered because it's their care plan, their budget and they've chosen who's going to come in (I: April 2, 2013, Program administrator).

The SMILE program provided clients with public funding to hire a paid care worker of their choice, with the caveat that they could not select a family member or relative. Clients were very receptive to SMILE's emphasis on "choice". Several clients stressed that this was the "best part" of the program. In this subsection, I argue that the SMILE program's policy of requiring their clients to hire and manage their own paid care workers worked well for ICP administrators and for clients with higher education, management experience, larger social networks, or unpaid carer support. However, the costs of this policy choice were borne by SMILE's more vulnerable clients and their unpaid carers who were asked to take on responsibilities they did not feel equipped to handle. There was also a substantial cost to the paid care workers who were subjected to precarious working conditions and unsupportive relationships with program administrators through SMILE's independent contracting design.

SMILE's approach of responsibiliziation of the client aligns with the neoliberal governance strategy of devolving more "choice" to a seemingly ever more autonomous and empowered individual. This strategy alleges increased productivity and profits for the employer while reducing the responsibility of both the employer and the state in managing and sustaining the reproduction of labour power (Mitchell *et al*. 2004, 3-4). However, inherent in this policy technique is a tension between client empowerment and client responsibilization. Neoliberalism constructs autonomous, self-responsibilized, neoliberal subjects (Rose 1996). Yet, as Mitchell *et al.* (2004, 4) point out, the kind of "autonomy" on offer under neoliberalism has a distinctly economic flavour. Through "privatization and personalization, neoliberal govern[mentality] aims at transforming recipients of [social] welfare [services]…..into entrepreneurial subjects, who may be motivated to become responsible for themselves" (Ren 2005, np). The expectation for clients to take responsibility for their care by selecting their own paid worker was

fundamental to the SMILE program.  It was repeatedly emphasized by SMILE administrators as well as reflected in the program's documentation.

A subset of clients benefitted from being given funds to hire a care worker of their choice.  Higher income, typically male, clients who were educated and/or had experience with hiring though management positions during their careers, were much better positioned to benefit from being given the choice of whom to hire.  Likewise, clients who had engaged and knowledgeable family carers to help them were able to benefit from the opportunity to choose their care workers.  These clients explained that SMILE's design enabled them to prioritize client-paid carer compatibility when hiring a carer.  This helped them pre-empt language, age, or personality-based compatibility issues that could cause friction between clients and paid workers and perhaps lead to the dissolution of the care relationship.  Some SMILE clients reported very good continuity of care – one client had been with the same SMILE worker for five years!

SMILE administrators constructed autonomy as empowerment.  However, during an interview they implicitly acknowledged that requiring clients to choose their own paid carer is not always sufficient to ensure meaningful client empowerment, "They [clients] love it...*while most of them choose not to* [my emphasis], they love it that they can choose their worker..." (I: April 23, 2013).  Larner (2003) argues that when we discuss the rise of the entrepreneurial, self-responsible individual under neoliberalism, we often imply that the state somehow "forces" people to act in these ways.  The fact that SMILE asked clients to choose their worker, but that most of them did not actually make this decision, is evidence of the complexity of concepts, such as autonomy, empowerment, and choice.  This supports Larner's proposition that clients cannot be forced to be autonomous but suggests, instead, that in order to get clients to take responsibility for their own care, they may need more than financial support.

Many clients shifted the responsibility to choose their care worker onto an unpaid carer or back to SMILE administrators by asking them to choose for them. In some instances, clients relied on acquaintances to find them a paid carer. As one client explains, "No, no. [My driver's] daughter knew her. (Laughs) I never met her but I said 'Okay'" (I: April 3, 2013). In other cases, clients requested that their CCC select a suitable worker on their behalf. Even then, CCCs were expected to shift the responsibility back to these clients a second time. CCCs were directed by management to provide clients with a "randomly generated list" of potential workers to choose from. Yet, this directive was inconsistently applied by CCCs. Clients reported that some CCCs did send a list, while others recommended a specific worker that they thought would be a good fit.

Program administrators strongly emphasized that if a CCC did provide the client or unpaid carer with a list of candidates, it was to be understood that these workers were not vetted by the program. It was the client's responsibility to obtain a police check on a potential worker and check their references prior to offering them a position (I: April 2, 2013). Very few clients took these precautions. Most indicated that they "trusted" the CCC's judgment, "...I got such a comfort in [the CCC] with her conversation on the phone, that I felt comfortable in who she was sending to us..." (I: April 4, 2013). There is a tension here between the program's design, intended to empower clients by offering them the economic autonomy to take responsibility for their care, and the resistance of clients and unpaid carers to accept this relocation of responsibility. In theory, clients liked the feeling of being given choice. However, in practice, many clients and unpaid carers indicated that they did not feel equipped to take on such a responsibility. They felt that they did not have the education or expertise in recruiting or interviewing to select (and then manage) a suitable care worker.

Clients bore the costs of SMILE's policy of self-responsibilization. When required to hire a paid worker, many clients had the tendency to make uninformed or misinformed choices about whom to hire or to make choices based on convenience. This was problematic for two reasons. First, because selecting the most available worker, as opposed to the most qualified or experienced, presents challenges for the delivery of high quality, continuous care. Second, because clients often internalized the responsibility for the outcomes of their "choices". One very elderly client admitted to hiring the acquaintances of an acquaintance as her care workers without interviews or police checks. This client did not know the paid workers when she hired them but in order to meet SMILE's expectation for her to choose her own worker, she relied on her informal network to locate individuals willing to provide care for the amount of money SMILE was willing to give her. However, she also explained that, "Because I've chosen the two people [with funding from SMILE] then if something is wrong it's my fault for choosing the wrong people, isn't it? You know you can't blame anyone [else] for that" (I: April 3, 2013). For this client to feel personally accountable for this decision given what little guidance she had in the hiring process is troubling, especially if it contributes to her hesitation to report or terminate a dysfunctional care relationship.

SMILE's push for self-responsibilization also adversely impacted paid and unpaid carers. Unpaid carers were often called on by clients to assist in finding a paid worker. They frequently undertook the work of interviewing and requesting police checks for potential hires. Family carers also reported approaching program administrators to ask for help in the hiring process because many explained that they did not feel equipped to take on this responsibility.

A significant consequence of SMILE's emphasis on client responsibiliziation was that most of the paid care workers who were hired by SMILE clients entered into non-standard

employment agreements.  Some paid workers were employed by small for-profit home care agencies where they were assigned by their agency to a SMILE funded client.  However, the vast majority of paid workers involved with SMILE were what the ICP called "independent contractors".  They were viewed as contract workers hired by the client, not SMILE employees. These workers' wages were paid by the SMILE program, either directly or by the client who was then reimbursed by the ICP.

The practice of misclassifying employees as "independent contractors", despite the fact that their job retains all of the key characteristics of the employment relationship, is commonly used under neoliberalism (Workers' Action Centre 2007).  Using this policy technique allowed the SMILE ICP to relocate the costs and time involved in care worker recruitment, interviewing, and background checks to the client/unpaid carer.  It also limited the ICP's responsibility for the conditions of work.  By characterizing the HCWs as technically self-employed, the ICP was exempt from employment standards legislation.  In addition, the ICP did not have to offer a standard rate of pay – they provided with client with a pre-determined funding allocation and left it up to the client to negotiate with the carer how many hours they could get for that sum of money.  It also enabled the SMILE ICP to distance itself from costs associated with providing contractors with access to employment benefits like paid sick days, vacation leave, health insurance or Employee Assistance Program access, professional development opportunities or training.  The SMILE program did not have to provide independent contractors with a steady roster of SMILE clients, a guaranteed number of working hours, or job security.  Program administrators were also saved the costs of managing paid carers or evaluating them, dealing with performance issues, coordinating replacements for absent workers, worker appreciation, or any of the other expenses associated with maintaining and sustaining a labour force.  The

independent contractor design relocated all of these costs and responsibilities from the ICP to the client or unpaid carer.

Independent contracting arrangements placed SMILE workers in positions of very little power and autonomy, contributing to vastly unequal power relations between program administrators and paid carers. Many of the HCWs that were paid through SMILE were women in economically vulnerable positions. These HCWs reported being required to expend significant unpaid time trying to secure employment contracts with SMILE clients with no assistance or support from management (I: April 4, 2013), even if they had held several previous contracts with other SMILE clients. As SMILE administrators explained, "[The service providers] are told [by the program] 'You're a small business – if you want more business, [then] advertise.' It is not our responsibility. We want to stay very clean that way" (I: April 2, 2013). The independent contractors were not assigned clients through SMILE, they were not supposed to be recommended to clients by CCCs, nor were they able to advertise their services through the program (ibid). Not surprisingly, workers reported difficulty finding new SMILE clients. This was significant because many also reported experiencing a reduction in their working hours as their existing clients' SMILE funded hours were reduced. One worker explained that "seven hours are now five, five hours are now three and two hour [allocations, while her overall number of] clients has remained the same" (I: April 1, 2013). Moreover, SMILE did not facilitate training or peer networks among the independent contractors associated with the ICP. Workers believed that access to these types of networking could have helped them find new clients or replace each other to facilitate time off (ibid). Lastly, paid workers reported poor communication with program administrators, feelings of exclusion, and a lack of connection to other workers also caring for their clients (I: April 1, 2013; I: April 4, 2013).

SMILE's focus on client empowerment/responsibiliziation through the requirement for clients to hire their own care worker, in combination with its use of independent contracting arrangements, produced positive outcomes in terms of continuity of care for a subset of their clients, typically those who felt empowered to take on the responsibility for recruiting and managing care workers or who had an unpaid carer who was able to do this for them. In addition, these policy techniques saved the ICP time and money, contributing to enhanced efficiency at the program level. However, these policy techniques came at a cost to the subset of clients and unpaid carers who did not feel equipped to hire and manage their own care worker. Research participants in positions of vulnerability frequently reported making uninformed or convenient choices or else attempting to shift the responsibility for hiring back to program administrators. Furthermore, the use of independent contracting arrangements reinforced unequal power relationships between program administrators and contracted carers. This contributed to feelings of marginalization, powerlessness, and exclusion among paid carers, and very precarious working conditions. This is another example of how neoliberal policy techniques can contribute to inequality among clients and between clients and program administrators, resulting in more fragmented care and care work for a subset of the ICP's population.

## "Flexible" Funding Arrangements

Carefirst and SMILE offered clients "flexible" funding options. These schemes were promoted as enabling clients to receive continuous care from "the same person" (I: May 21, 2013) paid for by multiple funding streams. For example, a paid carer's wages could be paid in part through a CCAC, in part through a not-for-profit agency, and, in part, privately by a client or their family. Flexible funding arrangements were promoted by SMILE and Carefirst as ways to

increase choice and continuity of care for clients.  They also offered a competitive advantage to

the ICP by making it more desirable than similar programs that did not offer such flexibility.

However, in parallel with neoliberal rhetoric about creating a flexible workforce,[36] these funding

arrangements promoted the privatization of care.  I argue that "flexible" funding schemes

encouraged clients and unpaid carers to privately supplement publicly funded care, resulting in

increased class-based inequalities among clients.  These schemes also put pressure on unpaid

carers, and fostered inequality among paid care workers through the creation of an invisible and

precarious subset of the paid workforce.

Flexible funding schemes benefited the clients and unpaid carers who were willing and

able to pay privately for continuity of care.  For example, one client's family reported using

Carefirst's flexible funding arrangement to increase the number of days per week a client

attended the program's ADP.  ADPs are offered by a variety of community organizations.

However, some ADPs will only enroll CCAC-funded clients, others will only take private pay

clients, and only a few will accept clients whose care is funded by a combination of sources.

Carefirst allows clients to pay the fees associated with ADP enrollment partially through CCAC

funding and partially via private pay.  The family carers explained that the dependability of

having the client attend the same ADP each day was important to them (I: May 6, 2013).  It

offered the client a consistent routine that reduced her stress and also reduced both the physical

and emotional care burden on them as unpaid family carers.  Knowing that the client was unable

to remain at home unsupervised, the family carers also paid privately to extend the client's time

at the ADP beyond their CCAC allocated funding.  They thought of this as "after care", similar

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[36] The need for a more "flexible" workforce in order to remain competitive is often used to justify shifting work from the public to the private sector (as we saw in CHOICE's contracting out of in-home personal care) and from full-time to contract and on-call positions.

to the care offered to children before and after school (ibid).  This extra care enabled the client's family to work regular shifts at their paid jobs.  Despite acknowledging the financial burden of paying for supplemental care, these unpaid carers could afford it and felt Carefirst's flexible funding scheme eased their feelings of guilt about not taking care of the client themselves (ibid). Moreover, they felt like the client was happy in a consistent routine that involved spending her days at the ICP's ADP.

Program administrators at Carefirst and SMILE explained that their program's flexible funding arrangements were used by clients and unpaid carers to augment clients' hours with their regular care provider.  Both programs encouraged clients and families to "top up" publicly funded care services.  Making it easier for clients and family carers to privately supplement publicly funded care is part of the neoliberal discourse that sees competitive advantage as dependent on "flexibility" (Steger & Roy 2010, 43).  The family carers discussed above chose Carefirst's ADP over other similar ADPs because it permitted them the flexibility to privately supplement publicly funded care.  In a market where ADPs compete for clients, this policy technique gave Carefirst an advantage.

Encouraging a reliance on private subsidies to meet a portion of a client's needs comes at a cost to both current, and future, clients.  Flexible funding schemes allow the state to limit its responsibility to collectively bear the costs of home care.  This facilitates state retrenchment in social service provision through reductions in either publicly funded services or the number of publicly funded hours made available to each client.  This results in the normalization of the assumption that clients can and will pay privately to supplement their care.

Relocating the costs of care from the state to households perpetuates inequality between clients who can afford to pay privately for care and those who cannot. It also risks creating an expectation among paid workers that clients should pay privately to supplement their publicly funded care. For example, a paid worker at Carefirst reported "tell[ing] the family 'I can't finish' and they didn't pay [privately] so what can [I] do?" (I: May 7, 2013). This means that clients who do not privately supplement their publicly funded are more likely to have their care needs go unmet or be only partially met, than those who do. There is demand by some clients and families for the option to privately subsidize care because flexible funding schemes allow families with economic means to fill a care gap. This policy technique benefits groups with economic power but it simultaneously undermines the public funding of home care by removing pressure for the government to meet all of a client's care needs.

Flexible funding schemes set a dangerous precedent in home care provision as not all clients or their unpaid carers are willing or able to pay privately for extra care. When more care is available for purchase, it means more choice for those who can afford it but less choice for those who cannot. Funding flexibility benefits middle- and upper-income clients and unpaid carers who have extra disposable income but does not address the financial realities of the many seniors relying on modest retirement incomes. The right to buy care is limited to one's economic resources which are increasingly related to class, gender, and race/ethnicity (Armstrong 2010). This policy technique allows clients in positions of privilege to purchase continuity of care while those who cannot must be satisfied with care provided by different (paid and/or unpaid) workers or else have some of their care needs remain unmet.

Program administers at Carefirst recognized that their flexible funding scheme created more choice but only for those who could afford it. Their response was to try to use the market

to redress the inequity that resulted from this policy technique. Specifically, they sought to generate profit through a private pay homemaking service which could then be used to subsidize the costs of supplemental care for seniors who could not afford to purchase extra homemaking care:

> The homemaking service is more like a private pay entrepreneurial [endeavor] – something like a productive enterprise…[we] promote it to whatever households can take advantage of this homemaking service, even including cleaning service[s], so that we will be able to bring in more resources, generate more revenue, reinvest into the program so that needy seniors who cannot really pay the full fee [for homemaker provided home care] will be able to benefit from a subsidized rate… (I: May 10, 2013).

A critique of social enterprise endeavours of this type is outside the scope of this analysis but it is worth noting that Carefirst administrators recognized that their flexible funding arrangements benefited some clients more than others and were hoping to rectify this.[37]

Encouraging private funding for supplemental care also puts additional pressure on already stressed unpaid carers. As clients experienced both a reduction in their publicly funded home care hours and an elimination of services that had been previously available, unpaid carers reported that it was often left up to them to fill gaps in care. Unpaid carers explained that when the option to pay out of pocket for care was available, they felt more pressure to hire a client's care worker to work extra hours and perform tasks outside of those offered by the ICP. For example, a family carer of a SMILE client with advanced dementia paid privately for a paid carer to work both beyond her publicly funded hours and outside her scope of practice to avoid dealing with multiple publicly subsidized workers. She explained:

> Because of the stage of [the client's] dementia, we didn't want to have a caregiver from CCAC in as well [as the ICP worker] to do personal care... [The clients] have good pensions so they were able to pay privately. If they weren't able to pay privately we would probably have more fragmented service because we would have got the CCAC in here way sooner to help with the personal care because the SMILE person doesn't do that [on SMILE's time], that's not part of their [job description] (I: May 21, 2013).

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[37] This is another example supporting the importance of this study's aim of sharing promising practices. Program administrators often recognize the limitations of their current policy techniques and are looking for ways to improve their delivery of home care.

Flexible funding streams also impacted the paid workers who were asked by clients and unpaid carers to perform extra work. Carefirst required clients to book supplemental care with their worker through the worker's agency. Conversely, in SMILE, supplemental care was a private agreement between the client and the paid worker; these private work arrangements were made without any organizational oversight. As a result, when SMILE carers worked extra hours for a client it fell outside of any formal framework for accountability if things went wrong. SMILE carers were still considered independent contractors when they were doing work funded by the ICP but, in this case, clients (and paid carers but to a lesser degree) could approach a CCC for assistance if they needed help navigating the client-carer relationship. This option to involve the CCC did not exist when the client was paying the carer out of pocket.

In the same way that informal paid companion care in long-term care homes studied by Daly and Armstrong (2016, 486) overlapped with informal unpaid care and formal paid care, privately funded, supplemental home care is performed in the spaces between formal and informal care. This care work exists outside of standard labour arrangements and is done without labour protections. The neoliberal push for flexible labour makes paid carers, particularly vulnerable ones, highly susceptible to unequal power relations in their employer-employee relationships. It facilitates labour exploitation through the production, maintenance, and intensification of an invisible, low wage, racialized labour force that disproportionately impacts economically vulnerable workers who need the extra hours. The neoliberal assumption that there is not a power imbalance in the workplace and that workers are free agents, is inconsistent with employment relationships defined by economic insecurity (Thomas 2010).

Privately funded care makes workers especially vulnerable to requests to go beyond the tasks offered by an ICP or CCAC during the time they are paid privately by the client. The

neoliberal emphasis on self-reliance as an enforcement mechanism places the burden on the individual employee to refuse to work outside their scope of practice, beyond their training, or outside their comfort level.   In practice, this often does not happen.   Workers, already in precarious positions, explained that they needed the work and feared reprisal if they refused to do what the client or family asked of them.  In one interview, a client's family member explained that the housekeeper from the ICP helped the client shower.  She acknowledged that she was asking the worker to perform a task that she was not trained to do.  Despite this, the family carer felt that this was a good solution for the client because it meant that she had a consistent worker that could meet all of her care needs.  It also benefited herself as the unpaid carer because it minimized her workload.  There were other cases where workers were paid privately to perform tasks outside their ICP job description.  These frequently included homemakers assisting with personal care, yard work, transportation, or social engagement care, such as taking a client out to eat, out for coffee, or to a community meeting.  In one case, a homemaker even helped a client maintain his bee hives.  Having a carer work outside their job description in an ICP is not always bad, but it can put both the paid worker and the client at greater risk.

In sum, flexible funding arrangements have encouraged the private supplementation of publicly funded care.  This has reinforced inequalities among clients and perpetuated unequal power relations between employers and workers.  This policy technique gives clients in positions of privilege more choice about their care while those in less privileged positions are left with less robust publicly funded services, reduced per client funding, and the need to rely on unpaid labour to fill the gaps.  It has also resulted in workplaces in which paid workers in economically vulnerable positions are expected to provide care in areas outside of their training and expertise. The increased inequality experienced by clients perpetuates fragmentation in a context of state

retrenchment whereby the diversity and quantity of publicly funded services available to clients have been reduced leaving them to seek assistance from the private sector. In some ways, flexible funding schemes have resulted in more continuity for paid workers as they work more hours for the same client. Yet, these schemes have simultaneously created more fragmented working conditions as paid carers work for both agencies and clients/families, often with minimal continuity between employers, management styles, and job descriptions.

## The "Collaborative" Creation of Prescriptive Care Plans

Neoliberal pressures for self-responsibilization and cost-efficiency have encouraged employers to seek ways to increase their control over workers' time. This is done using techniques to increase accountability, such as best practice, audit, contracts, performance indicators, and benchmarks (Larner 2003). In ICPs this has manifested as a focus on creating care plans, justified as an effort to enhance client-centered care. This is especially relevant in ICPs like SMILE where the care work is contracted out. Despite program administrators' emphasis that "we don't have a relationship per se…They [paid carers] are NOT our staff!" (I: April 2, 2013), SMILE CCCs used care plans to control the work organization of supposedly "independent" contractors. In this subsection, I argue that the "collaborative" care planning process used in SMILE, AIP and CHOICE resulted in the creation of prescriptive care plans that, despite facilitating client inclusion in decision-making, simultaneously presented dilemmas for client empowerment. This policy technique also excluded paid carers from the care planning process. This led to tensions between care workers and clients when paid carers were asked to deviate from the care plan. Paid workers also faced consequences from program administrators if they were caught working outside their scope of practice. These unequal power relations

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between clients, paid carers, and program administrators contributed to fragmented care as care relationships broke down when conflicts over care plans could not be resolved.

The creation of care plans as a neoliberal policy technique is entrenched in a narrowly defined understanding of accountability based on adhering to prescriptive rules. Paid workers are increasingly monitored and held accountable to rigid sets of guidelines, which they typically had no part in creating. In the SMILE, AIP, and CHOICE programs, clients collaborated with their case managers to develop care plans that fit within the constraints of program limits on available services and funding. Family carers were sometimes included in these discussions with the client's consent and a written document was produced, placed in the client's home, and used to direct the tasks done by paid workers.

Being included in the care planning process benefitted both clients and unpaid carers. It made them feel invested and empowered in directing care. Likewise, making care plans transparent and easily accessible to clients and unpaid carers by keeping them in the home (as opposed to locked away in a care worker's office) inspired feelings of inclusion and client buy-in. An unpaid carer explained how being included in the care planning process made getting access to a copy of the finished care plan (something that had been difficult to do in the past) into a non-issue:

> Coming here [to CHOICE] – not a problem, here's your copy. Things like that, that seem miniscule but in the bigger scheme of things when you're constantly having to fight for things for your family that you need to help assist them, it gets frustrating. With CHOICE we don't have that (I: March 20, 2013).

Unfortunately, these benefits of collaboration on care plans in improving communication and collaboration between clients and case managers were often at the expense of the front-line HCWs. HCWs were directly impacted by the care planning process but typically excluded from participating in it. In a neoliberal context, care that can be quantified is highly valued. It was, thus, in the interest of case managers to detail HCWs' tasks on a care plan with as much

specificity as possible. It is easier to measure if HCWs are doing their job if their duties have been laid out in minute detail so workers can record which duties they have completed. Stone (2000) describes this dynamic as the "routinization" of the work of HCWs.

Despite these advantages, program administrators in SMILE also acknowledged that using a prescriptive care planning approach to work organization created certain difficulties for them. After receiving numerous calls from paid workers each day requesting whether they could do certain tasks for clients, program administrators felt that perhaps their care plans were "a little too prescriptive….[if] a client said, "Can you take my garbage out?" the worker wouldn't do it without first phoning us and asking us. We were like, "Okay, that's crazy – just take it out if you are willing to do it" (I: April 23, 2013). This is evidence of a tension between managerial control and worker autonomy. Under neoliberalism, managers want control over workers. Yet, this can sometimes be more inefficient for managers who are then required to spend increasing amounts of time on administration. When paid workers are given more autonomy to make decisions based on their experience and common sense, it can be more efficient for both the worker and the manager.

Collaborative care planning also produced mixed results for clients. On one hand, an AIP client felt that having a document that clearly outlined what duties she could expect a paid worker to provide gave her the authority she felt she needed to keep workers on task:

> There was one day, one girl, woman, came and she was reading me the Bible (so I think she thought I needed it – I don't know), but anyway, I said to her, you have to vacuum. "Oh, no, no, no – I don't do vacuuming, no!" So I said, "Well here's the paper" and once she saw the paper [she said] "All right, for you I'll do it" (I: May 16, 2013).

On the other hand, some clients found that the lack of flexibility in their care plan tied them and their paid carer to a contract that did not meet their changing care needs. For example, paid

workers in all ICPs reported that clients frequently asked them to sit down for a cup of tea and a chat. In ICPs where social support was not explicitly listed on an otherwise detailed care plan, paid carers felt more conflicted about taking the time to provide this care in spite of clients asking for it. Furthermore, when paid carers did take the time to talk, prescriptive care plans made this type of relational care "literally invisible" (Duffy 2011, 88). Diamond (1992) argues that work schedules that neither leave time for, nor acknowledge, the relational elements of care cause the quality of care to suffer.

Unpaid carers reported they were left to fill the gaps when care plans with very strict rules deviated from the reality of everyday life. For example, a daughter with the HHH program explained a common situation in her household whereby her mother's care plan stated that for meal preparation a CHW is only allowed to reheat a meal in the microwave (I: April 17, 2013). The daughter emphasized that this was not practical as she often had difficulty keeping the fridge stocked with pre-made meals in addition to completing her other unpaid care tasks. The rigidity of this care plan put the paid worker in the position of having to "break the rules" in order to feed the client (ibid). The daughter knew that the CHW could be reprimanded by management for cooking up eggs and toast on the stove, for example - but she nonetheless appreciated when paid workers deviated from the care plan to meet the client's needs:

> I do find that some of the girls are very inventive and do their own thinking…There are some that are logical and if there isn't something to feed them, they will take the initiative and do it. And I would never ever say who it was and what they did (ibid).

Finally, many of the costs associated with the creation and use of prescriptive care plans fell on paid workers. Paid workers were placed in disadvantaged positions by being excluded from the care planning process in spite of its significance in shaping their relationships with clients and their conditions of work. In addition, the neoliberal push to develop care plans with

strict rules conflicted with workers' desire to have autonomy over their work organization. This left paid workers feeling that their expertise and experience were being devalued. Many reported being asked by clients and unpaid carers to deviate from the care plan and then finding themselves engaged in spontaneous negotiations with clients and unpaid carers about the types and timing of the tasks they would perform. Paid carers explained that clients were often preoccupied with obtaining assistance with what they felt were their most pressing needs at the time, regardless of what tasks were outlined on their care plan and without sufficient consideration of the possible repercussions for the worker of deviating from the approved plan.

Paid workers were put in especially difficult positions when clients asked them to deviate from the care plan in ICPs where different categories of care workers were responsible for providing ADL and IADL care. Paid carers reported being reprimanded from program administrators for providing services not approved in the care plan despite the client asking for (and in the paid carer's opinion - needing) the help. A paid carer with the SMILE program shared her experience:

> [The program administrator] says [the client] needs mostly vacuuming done or something and then you get there [to the client's home] and these people [the client and unpaid carer] want other things done so you have to be [careful]. I did get into trouble when I first started (laughs) because I had a gentleman, he came home from the hospital, and he hadn't had a bath or anything, no wash, no nothing. He couldn't wash his back - so being me, I put gloves on and I washed his back with a washcloth. He wanted cream on it because he was so itchy... and they had no idea when a PSW would be there. So in turn, he told them [the program] so I got into trouble (I: April 1, 2013).

Most paid workers reported knowing when they were being asked to provide "unsanctioned" care because the tasks they were being asked to do fell outside of their scope of practice. Yet, many workers reported "covertly" performing these duties anyway. This was typically out of concern that if they did not do them, then the client's needs would go unmet, as opposed to being worried about overstepping into another worker's scope of practice. In a few cases, there was obvious confusion among paid workers about what tasks were permitted by the ICP and which

were not. These workers were constantly worried about "getting in trouble" if they performed the "wrong" tasks and management found out.

In some ways, prescriptive care plans perversely incentivized paid carers to deviate from them. Paid carers who provided help with tasks outside of those listed on the client's care plan reported being met with gratitude by both clients and unpaid carers. However, in a few cases this ironically incited clients' frustration over a lack of standardization in workers' willingness to "break the rules". A paid carer explained that she had a client who would request that HCWs help her with a task she knew was not listed on her care plan. Some HCWs would apply ointment to her body when asked while others would decline. The client was annoyed by the "inconsistency" in workers' propensity to bend the rules, repeatedly asking one of her paid workers, "Why will some workers do it and others won't?" (I: May 7, 2013).

The policy technique of "collaborative" care planning has resulted in prescriptive care plans that give rise to concerns about liability and client and paid worker safety. Moreover, when care is provided outside of a worker's scope of practice, it can reinforce unequal power relations between case managers, clients, and paid workers. By structuring care as a contract developed between case managers and clients, paid workers were excluded. This created tensions between clients and paid workers that made it more difficult for them to jointly navigate the ever changing realities of day-to-day care. Care plans that did not give clients and paid workers the tools needed to navigate relational care often resulted in paid workers "giving up" (I: April 12, 2013) when they were unable to resolve conflicts with clients. Workers reported either acquiescing to clients' care priorities despite their own judgements, or terminating the client-carer relationship – both at a cost to the paid worker and the client. When clients and paid workers were unable to find common ground because of constraints imposed by inflexible care

plans it contributed to increased fragmentation for both parties as the client lost their worker and the worker lost their employment.

## Conclusion

In this chapter, I have focused on policy techniques used by ICPs to address collaborative decision-making, continuity of care, social inclusion, and communication as the areas of expressed need identified by research participants.  I have shown that using policy techniques focused on enhancing efficiency can distribute the costs and benefits of integrated care unevenly between, and among, clients, unpaid carers, paid carers, and program administrators.  Neoliberal policy techniques often increase inequality along class, gender, and/or race/ethnicity lines by meeting the needs of groups in positions of power and privilege over those belonging to marginalized groups.  In doing so, these policy techniques have maintained or increased fragmentation instead of reducing it.

# Chapter 7: Promoting Equality and/or Equity Reduces Fragmentation

## Introduction

When ICPs use policy techniques that focus on equality and/or equity as their goal, they are better positioned to meet the expressed needs of clients, unpaid carers, and paid care workers in the areas of collaborative decision-making, continuity of care, social inclusion, and communication. I begin this chapter by analyzing the AIP's provision of day trips and transportation without fees for clients. I use this example to demonstrate that providing care without user fees increases class-based equality among clients to the benefit of the clients and their unpaid carers alike. Second, I discuss Carefirst and CHOICE's techniques of supporting their paid and unpaid carers. I focus on how these ICPs arrange for paid carers to take time off, provide them access to support for emotional labour, and formally acknowledge their contributions to care. Showing carers that their work is valued reduces inequality among carers by ensuring that, regardless of their position in the power hierarchy, they feel supported and appreciated. Drawing on policy techniques used in SMILE, HHH, CHOICE, and Carefirst, my third point argues that supporting the social engagement of clients and carers is beneficial to all parties. Inequality among clients is reduced when barriers to their social inclusion are eliminated. Moreover, facilitating social connections reduces the caregiving burden on unpaid carers and contributes to a positive working environment for paid carers. Lastly, looking at CHOICE's use of collective forums for team-based collaboration, I show that whole team meetings and family conferences have substantial benefits for clients, unpaid carers, and the paid workers who are included in them. I also point out how CHOICE's manner of operationalizing these collective forums presents a dilemma for the mostly racialized paid workers who are excluded from them. I propose a more inclusive approach, one that increases equality among

paid workers regardless of their position in the occupational hierarchy. I use these four examples to highlight the connection between policy techniques that challenge neoliberal ways of working and a more equal and fair distribution of the costs and benefits of integrated care between, and among, clients, unpaid carers, and paid workers. Policy techniques that promote equality and/or equity also reduce power disparities among, and within, these groups helping to eliminate the need for marginalized groups to look outside an ICP to get their needs met. As a result, workplace relations are more collaborative, care services are provided more seamlessly, and communication between, and among clients, unpaid carers and paid workers is improved.

## Care without Fees

AIP was the only program in this study to make day trips available to all of their clients free of charge. Clients in each AIP apartment building were offered the opportunity to participate in a day trip organized by the ICP once every two weeks. AIP drivers would take up to nine seniors at a time on a variety of excursions into the community; for example, day trips could involve going to a shopping mall, for a drive to a neighbouring town, fishing in a provincial park, to a sugar bush, to see Christmas lights, or to the movies. An AIP driver explained that for his clients, it is not about where they go but about creating an opportunity for social inclusion for homebound seniors, "…they [clients] are just happy to get the hell out...because for a lot of them...they don't drive anymore..." (I: February 26, 2013).

At the inception of the AIP program, clients wishing to participate in the day trips were charged a user fee of four dollars per person per excursion. Program staff noticed, however, that participation in these day trips was "very poor" (I: February 26, 2013). Workers explained that some clients "would like to go [on an outing] but they can't because their financial situation won't allow it...a lot of them [clients] won't ask for help because it is a matter of pride and stuff

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like that…" (I: February 26, 2013).  AIP eliminated the user fees early in the program and instead fully subsidized the costs of day trips for any client who wants to participate.  When the user fees disappeared, the day trips became more accessible and client participation increased.

While the CHA limits service providers' ability to charge user fees for physician and hospital care, care services outside of these can be subjected to client co-payments.  Cost recovery is a neoliberal policy technique used to offset the government's share of the costs associated with delivering health and social services.  The total costs of care remain unchanged or increase but a portion of them are shifted from public to private pockets.  Neoliberal policy makers advocate means-testing, that is, having clients pay for public services based on their income (Steger & Roy 2010, 43).  They argue that fully subsidized care should be reserved for those the state classifies as "truly needy" (ibid).  This is based on the assumption that the more care services are universally available, the less chance there is for private enterprise to make profits in those areas (Braedley & Luxton 2010, 15).  Charging clients to access services, while waiving fees for the poor, is supposed to allow neoliberal governments to both save money and more tightly control how public money is spent.  Neoliberals allege that clients place greater value on services, and will use them more wisely, if they have to pay a portion of their cost though co-insurance, cost-sharing, or a deductible.

Despite the suggestions that user fees for care reduce client "abuse" while bringing more money into the health care system, studies have demonstrated that neither is true (Barer *et al.* 1994).  There is no reliable evidence to suggest that user fees achieve the stated aim of reducing or controlling health care costs (ibid, 19).  For instance, user fees themselves are inefficient for the state.  The administration required to collect fees as well as the task of separating eligible from ineligible clients, in order to charge fees to some but not others, imposes administration

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costs on the state.  Furthermore, charging clients user fees does not lead to more appropriate use of health services because the clients deterred from seeking care cannot distinguish necessary from unnecessary care (ibid, 6).  Instead, user charges discourage people from seeking care, not because they do not need it, but because they cannot (or think they cannot) afford it.  Moreover, in cases where clients do not have a choice about whether to seek care, clients from vulnerable groups are more likely to be disadvantaged if there is a need to co-pay.

ICPs with cost recovery policies negatively impacted the abilities of some economically vulnerable clients to access certain types of social care.  Several clients in the AIP, CHOICE, and HHH programs self-identified as low-income and reported feeling that their retirement incomes limited their ability to pay for participation in "extras", such as day excursions or ADPs.  This occurred even if the social care services in question were highly, but not completely, subsidized by the ICP.  This view of social care as an "extra" echoes the enduring, and problematic, perception of social care as peripheral to healthy aging.  When combined with the requirement to co-pay on a limited income, this contributed to some clients' hesitancy to access certain types of care regardless of their potential health benefits.

In contrast, clients and their unpaid carers that self-identified as middle-class, reported that the fees they were required to pay in order to participate in their ADP were "a minimal amount" (I: March 19, 2013, Client, CHOICE), "fair" (I: March 20, 2013, Unpaid carer, Carefirst), "not expensive at all" (I: March 19, 2013, Client, CHOICE), "quite cheap", or "reasonable" (I: May 10, 2013, Unpaid carer, Carefirst).  Carefirst, HHH, and CHOICE charged user fees for ADP access but HHH and CHOICE waived these for individuals who fell below a pre-set income threshold.  Several HHH and CHOICE clients noted that they would be unable to continue attending their ADP if they were required to co-pay.  I also heard from some clients in

HHH and CHOICE who found it a struggle to pay the program fees associated with attending the ADP despite falling above the low-income threshold set by the program. In HHH, 80 percent of clients were exempt from user fees (I: April 12, 2013). Likewise, 65 percent of CHOICE clients had some or all of their user fees waived (I: March 25, 2013). With a minority of clients actually paying user fees to attend the ADP, the usefulness of this tool as a means of creating cost-efficiencies is questionable.

Charging user fees for social care services like ADPs or day trips exacerbated class-based inequalities among clients. When care services entailed a private pay component, some clients were able to pay easily, while others were not. User fees created barriers to care for seniors who had too much income to qualify for a subsidy, but not enough to be able to afford the full premium amount. This exacerbated gender-based inequality as high-income earners, more likely to be men, spent a lower proportion of their overall income on premiums than lower income earners who were above the threshold cut-offs. Requiring user fees for care, while waiving fees for low-income individuals, reduced access to care for clients who were deemed able to afford to pay but who experienced financial hardship as a result. Similarly, user fees sometimes created animosity among clients by drawing attention to existing class disparities. A CHOICE client explained that she had to co-pay for the ADP and while she did not feel that the program fees were necessarily too expensive, she did resent those who got their care for "free" (I: March 19, 2013). This client saw it as "unfair" that some clients paid more than others for the ADP, especially when participation in the CHOICE ADP was mandatory for admission to the ICP.

Charging user fees for access to care also put a strain on family carers as some of the care work was shifted into the community to be taken up by family carers, most of whom were women. User charges for homemaking and meal services created financial barriers for some

families making them more hesitant to take advantage of the care being offered and instead opting to do the care work themselves. An unpaid carer with HHH explained,

> Well, they offered...for them to come to get him up and put him to bed at night....you have to pay a certain amount too, it's on your income too and I said, to me, it's just a waste of money because I can give him a hand to get up in the morning and it's not that he actually really needed [the help] (I: April 17, 2013).

In contrast to the unpaid carer's statement that the client did not "actually really need the help", it was clear from meeting the client that he was unable to ambulate. Transitioning into, and out of, bed from his wheelchair unassisted would have been impossible. What the family carer actually meant was that, given their limited income as a couple, it was more fiscally prudent to shoulder the cost of care now and provide it unpaid. The unpaid carer explained that their shared income was going to be required to pay for her future care needs too, given the assumption that she would outlive her elderly husband and would not have a spouse to provide unpaid care for her. To her, it made sense to do the unpaid work for her husband now while she was able, in order to save money to pay for her own care at a later date. If the care had been fully subsidized by the state, the client and his unpaid carer wealthy, or the unpaid carer a man, this might have been a different discussion.

User fees, even when they are on a sliding scale based on income and number of dependents, shift costs from the state onto unpaid carers. Family carers must make trade-offs between the user fees for care and the present and future costs of other living expenses and associated with other dependents. The above example illustrates how the requirement for private payment disproportionately impacts the choices of unpaid carers in economically vulnerable positions. Clients and families in positions of economic privilege do not have to be concerned with saving money now in order to purchase care later. The costs imposed by user fees also

disproportionately impact women as the primary unpaid carers and as the majority of home care clients living alone after the passing of their elderly husbands.

The elimination of user fees runs contrary to neoliberal ways of working that see them as a way to enhance the cost-efficiency of the state. However, eliminating user fees for care is complicated, particularly in light of another neoliberal policy technique frequently adopted by ICPs – standardization. Standardization is a key issue for professional care workers (Choiniere 2011). As discussed in Chapter 3, the push for increased standardization of health and social care was especially prevalent in the neoliberalization of the home care sector in BC. At the time of interviewing, HHH administrators explained they had been given a mandate by the provincial government to standardize home care services across the Fraser Health Authority. Part of this restructuring involved a proposed elimination of the variation in ADP user fees across the RHA. The HHH ADP charged clients the lowest fees in the RHA at $6 per day. Provincial government regulations permitted a maximum charge of $10 per day. HHH administrators expressed support for increasing their ADP rate as a means of increasing revenue. However, they simultaneously acknowledged that "poverty is a huge issue here in Hope. I think we're the worst local health area in Fraser Health for sure and I think it's one of the worst even in the province [BC]. So our per capita income is really low" (I: April 10, 2013).

This contradiction highlights the complexity of promoting fairer access to social inclusion care for clients. Not only are ICPs under pressure to charge user fees for ADPs and day trips but, as in the example of HHH, they are being asked by the state to increase these user fees so that all clients in a particular jurisdiction pay the same fee. This would result in more "equality" among clients but it would not make things more "equitable". Increasing user fees for the HHH ADP would disadvantage the economically vulnerable women who rely on this

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program. As a result, their access to social inclusion would be comprised and their care more fragmented as they are required to look for alternative, perhaps more affordable, options to get their needs met. This is another example of the fragmentation-inefficiency paradox discussed in Chapter 3. Standardization is intended to enhance efficiency, but it actually increases the fragmentation of care for vulnerable clients, fragmentation that neoliberal policy makers view as inefficient. A better option for reducing fragmentation is to make access to social inclusion care more equitable by eliminating user fees altogether, like in the case of the AIP ICP. By eliminating financial barriers to care, ICPs are able to meet the needs of all of their clients regardless of class, gender, or race/ethnicity. Increasing equity can result in more seamless and inclusive care.

## Supporting Paid and Unpaid Carers

Ward and England (2007a, 20) argue that in the process of neoliberal restructuring people with more power and resources "matter" most. Drawing its social power from the political and economic elites whose interests it restores and maintains (Harvey 2005, 19), neoliberalism works better for corporate managers, policy makers, and politicians than it does for the workers who "bring this political project to life" (Ward & England 2007a, 20). Even among workers, those at the top of the occupational hierarchy "matter" more than those at the bottom who are disproportionately women, often from lower-income and/or racial/ethnic minority groups.

As neoliberal policy makers push for service providers to be more responsive to the market, responsibilities associated with employment are shifted from the state to the individual and from the employer to the worker (Steger & Roy 2010, 43). In the resource-scarce context of the home care sector, requiring care workers to absorb more of the costs of employment often

results in HCWs who are overworked, overwhelmed, and find themselves unable to cope with the demands of their paid and unpaid caregiving responsibilities.

Precarious working conditions have significant consequences for continuity of care. There was consensus among clients in all ICPs that "I would like to have the same girl all the time…because then the person knows exactly how to wash me, how to dry me, how to help me. This is what I like" (I: May 6, 2013, Carefirst client). Yet, the issue of high HCW turnover, contributing to a lack of continuity of care, was cited as a persistent problem, especially by clients and unpaid carers in HHH and CHOICE. A HHH client described what was, for herself and others, a common occurrence, "...last week I had a different person every night...*every* night I had a different person! And some of them I'd never seen before in my life. I didn't know them" (I: April 17, 2013).

Many paid care workers providing ADL and IADL care in all ICPs, except SMILE, reported having very little control over which clients they saw. For example, an AIP worker explained that he does not control the timing or the duration of his visits, nor the length of time he remains with a specific client - this is all done by a coordinator (I: May 7, 2013). Yet, even the program coordinators tasked with scheduling care workers reported struggling with how to prioritize continuity of care given the many competing factors impacting their scheduling decisions. Despite most ICPs noting continuity of care as an organizational priority, high employee turnover, worker scarcity, and increasing numbers of high acuity clients with intense care needs, often resulted in ICP clients experiencing fragmented care.

The ICPs that challenged the devaluation of workers from marginalized groups were better positioned to address the lack of continuity in home care delivery. They used various

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techniques to show that the work of paid and unpaid carers, particularly those in the most vulnerable positions, made an important contribution to the organization. These involved ensuring workers could take time off, providing access to support for emotional labour, and having supervisors formally acknowledge the contributions of workers.

## Time Off

Both paid and unpaid carers frequently reported feeling unable to take any time off from their care work. The fact that contracted workers would have lost pay if they had taken sick leave or time off for holidays was not mentioned. Instead, contracted workers focused on how they felt guilty missing work for any reason because they were worried that their clients would go without care. This was noted as a particularly pressing issue in the SMILE program where independent contractors were used to deliver care to clients. As one of these SMILE carers explained, "a really big problem with this job - you can't take holidays...we all need time off or we're going to get burned out" (I: April 4, 2013). ICPs that directly employed their workers were better positioned to build processes into the organization to enable replacement workers to be sent to assist a client in the event that his/her usual worker was absent. For example, the Carefirst ICP had a Team Scheduler who organized coverage for clients when their care workers were away. Allowing paid workers to take time off knowing that their clients will continue to receive care benefits paid carers and clients alike.

A few family carers shared the responsibilities associated with caregiving with their partners. However, most unpaid carers were women who reported being solely responsible for providing their relatives' unpaid care. Caring for a family member is an intense time commitment which impacts women and their households. For example, when not living in the same residence, daughters reported visiting their elderly mothers daily or even twice daily.

Many women simultaneously cared for their children and spouses, in addition to their elderly relations. They were also responsible for the other domestic work required to maintain a home. Moreover, in many cases women concurrently participated in the paid economy. Many unpaid carers experienced difficultly trying to balance all of these responsibilities. They expressed feeling like they were caregiving "24/7", "trapped in their home", "giving up one's life", and wanting to "escape".[38]

Unpaid carers benefited from a break from care work through access to respite care. Family carers expressed a need for both short stay respite options in an institutional setting, like a long-term residential care home, as well as in-home respite care. The client's comfort was one of the primary considerations in whether an unpaid carer would use respite services. Unpaid carers sought respite beds "similar to an ADP where there are people who know the language, who can comfort her, and understand her, so it is more feeling like home…" (I: May 6, 2013). The CHOICE ICP provided precisely this type of respite care.

CHOICE operated ten care beds at their program site which was housed in a wing of a long-term residential care facility. ICP clients could occupy these care beds for a short-term respite stay at a subsidized cost of $40 per day/night. The program also used the care beds to assist clients in making the transition from hospital to home after an encounter with the acute care system. Access to care beds was free to clients in this case. The CHOICE program offered respite in a familiar setting. The fact that the care beds were located at the site where all clients came for their medical and social care appointments and attended the ADP at least once a week invoked feelings of comfort for both clients and family carers. This setup was possible because clients in respite beds were cared for by ICP staff during the day and nursing home staff

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[38] I: April 4, 2013; I: April 10, 2013; I: April 15, 2013; I: April 17, 2013.

overnight. Offering respite care in a familiar environment, where clients would be surrounded by their usual paid carers, was beneficial to both clients' and unpaid carers' peace of mind.

## Coping with Emotional Labour

In addition to enabling paid carers to take time away from their care responsibilities, ICPs also supported care workers by helping them cope with the emotional labour of their care work. It is well documented that care work is emotionally difficult,[39] often resulting in burnout for front-line care workers. Paid care workers were supported in their emotional labour by ICPs that ensured that all workers, regardless of employment status, had access to an Employee Assistance Program (EAP). In the HHH, Carefirst, and SMILE programs, EAP access was tied to permanent job status. Meanwhile, in AIP it was dependent on being a public sector, as opposed to a not-for-profit, employee. In contrast, the CHOICE ICP granted EAP access to all its care workers regardless of their job status.[40] Eliminating barriers to accessing emotional support based on one's position in the occupational hierarchy promoted equality among ICP staff. Class, race/ethnicity, and gender disparities are closely associated with power hierarchies in the workplace, as discussed in the previous chapter. Improving the conditions of work for paid carers in marginalized positions by granting universal access to EAPs also contributed to better, more seamless conditions of care for clients though less employee turnover and caregiver burnout.

The creation of peer support groups was another technique used by ICPs to support their carers. As part of a volunteer retention strategy, Carefirst facilitated four activity-based sharing

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[39] Graham 1983; Finch & Groves 1983; Ory *et al*. 1999; Aronson 2002; Grant *et al*. 2004; Gray *et al*. 2010; Arber & Venn 2011; England & Dyck 2011; Ryan *et al.* 2013; Power 2016.
[40] The care workers from the external agencies with contracts to provide in-home personal support or transportation services were not considered CHOICE employees and so were not included.

groups for its volunteers. Volunteers could meet to socialize and share their interests in calligraphy, dance, photography, or badminton. Carefirst also organized a Mandarin-speaking volunteer support group four times per year. These groups created peer networking opportunities and acted as a means of informal support for volunteers who could discuss both their challenges and what they feel they had achieved through their unpaid work. Program administrators also asked these groups to provide input on how Carefirst could be improved.

Carefirst also facilitated opportunities for paid workers to support each other. For example, all Carefirst employees involved in transportation gathered together for "drivers' meetings" every 2-3 months. At these meetings drivers, escort staff, and the transportation coordinator would discuss their daily work, submit equipment requests, and share any difficulties they might be having. A driver explained that he found these meetings "helpful" as they were the "only chance you [get where you] can talk before everyone" (I: May 9, 2013). Similarly, Carefirst held small monthly gatherings for home care PSWs where they could "share the[ir] feeling[s], to [get to] know each other…" (I: May 7, 2013). Workers lower on the occupational hierarchy especially appreciated these formally scheduled opportunities for peer support. As one worker explained,

> I make friends in this company…we can share the experience[s] and we can share the feeling[s], you know? Sometimes, me or my workmates, they will feel some bad things like maybe the client go away, pass away, something like this. We are the human beings, we still have the feelings, we still need people to talk [to] – yeah, sometimes they don't want to talk with the[ir] family, right? They want to share with their workmates to deal [with] these feelings…(I: May 7, 2013).

Some PSWs reported that "everyone wants to share, so [the] time [each person] has for sharing her stories is limited" (I: May 7, 2013). However, paid workers agreed that having their agency create these opportunities to network, share information, and support each other made them feel important and valued.

## Acknowledging Carers' Contributions

Care workers also felt supported when their supervisors directly acknowledged the value of their care work.  Workers suggested that the best appreciation strategies were the "soft approaches" (I: May 10, 2013); they appreciated when their direct supervisor made an effort to develop a relationship with them.  Paid carers described times when their supervisor wrote them a short appreciation letter or thank you card, or gave them a small token of appreciation: a Tim Horton's gift card, McDonald's gift card, or movie tickets.  Workers appreciated when managers acknowledged their contributions in front of other staff members at an annual retreat or in a group email to the entire team.  They also liked when managers shared that they had received a complimentary letter or card from a family or client praising their care.  Finally, workers appreciated when managers verbally acknowledged their suggestions for improvement.  Workers were not looking for recognition strategies that were elaborate or expensive.  They connected with managers who could empathize with the challenges of providing care in a resource-constrained environment.  They wanted their supervisors to occasionally give them a "pat on the back" for a difficult job well done.  When managers took the time to acknowledge the contributions of individual workers to the care team, workers felt important, appreciated and valued.

When ICPs were proactive in supporting the paid and unpaid carers who worked with their clients, it benefited carers and clients alike.  Better conditions of work contribute to better conditions of care.  Supporting carers reduced power inequalities among them by ensuring that regardless of their position carers felt that their contribution to the care team was visible and valued.  Some policy techniques, such as making EAPs universally accessible to paid carers, organizing peer support groups, or offering no cost respite services for unpaid carers could pose

an upfront cost to ICPs.  However, it is likely that these costs would be offset downstream in the form of less fragmented care through fewer sick days, less worker turnover, and less caregiver burnout.  This is another example where reducing inequality/inequity can contribute to reduced fragmentation.

## Making the Time to Talk

The reorganization of front-line care work to enhance efficiency is one consequence of increased competition among for-profit and not-for-profit agencies for home care contracts. Through prescriptive care plans, program administrators have attempted to exert control over work organization by directing paid workers to perform a series of visible, measurable tasks. This has contributed to an intensification of work where workers are expected to provide the same, or more, care in less time.  Paid carers described feeling increasingly stressed as they cared for clients who had been allocated fewer publicly funded hours but whose care needs had not similarly declined, "Ten years ago we had two hours for [a] shower but now governments [have] no more funding.  They cut, cut, cut [to] one hour service...Now [they] gives for a shower of a senior only a half hour – too rushed!  Too rushed!" (I: May 7, 2013).  The intensification of work has posed increased safety risks to both clients and paid carers.  A paid carer explained, "...they jam pack cleaning, meal prep. And all this into one hour...It's actually a hazard because the PSWs are rushing and they're rushing the client and then that's where accidents happen and that's where the risks are higher" (I: May 6, 2013).  The neoliberal restructuring of front-line care work has also compromised workers' abilities to develop and maintain the social relationships with clients that are the basis of good care (Banerjee *et al.* 2015, 32).

In neoliberal contexts, employers play a critical role in defining what it means to work efficiently and effectively (Armstrong 2013, 268).  As the public sector increasingly adopts

private sector management practices, there has been a push to measure care work by setting quantitative targets and using accountability systems to closely monitor outcomes and track cost-efficiency (Armstrong 2013; Armstrong *et al*. 2008). As policy makers and administrators of publicly funded home care programs become increasingly measurement focused, care tasks with visible outputs, such as those associated with transferring a client from a bed to a chair or inserting a catheter, for example, are prioritized (Barken *et al.* 2015, 292). Developing and maintaining interpersonal care relationships, by contrast, cannot easily be captured by quantitative means. This complicates efforts to demonstrate quality or accountability using measurable indicators (Mykhalovskiy *et al*. 2008).

As neoliberal restructuring continues, workers are becoming increasingly aware of, and resistant to, their experience that the quality and content of care is being "leaned out" (Baines 2010; Baines & Daly 2015). Relational care requires both time and invisible skills to do it well. This has contributed to a view of relational care as less valuable than other types of measurable care, and hence inefficient (Barken *et al.* 2015, 291-92). To enhance efficiency, tasks related to relationship building and maintenance are removed from workers' repertoires and replaced by those that are easier to track and document. Carers are directed to focus on specific, measurable tasks and are under increasing pressure to provide care in shorter amounts of time. The result is that less, if any, time is allocated for clients' social connection and support.

Paid workers in the SMILE, AIP, and HHH programs emphasized that one of the "best things" about working for their respective ICP was that they did *not* feel rushed while providing care. Many workers reported past experiences with other home care providers where they did not have sufficient time to deliver care. However, in their current positions, they reported feeling like they had enough time to engage with their clients socially. As a paid carer with AIP

explained, "they give you time, a chance to build a good relationship – if all the time you rush you can't do anything...but here you can work and talk" (I: March 7, 2013).

To position social interaction as a legitimate type of care, the ICPs listed it alongside other more visible types of care; for example, showers, meal preparation, or housekeeping, on clients' care plans. In doing so, management gave paid workers a mandate to spend time providing social support to their clients. A paid worker with SMILE described that after signing a contract with a client with no family support, the SMILE CCC assigned her to spend five hours per week with the client, "Just [to] give him your support" (I: April 1, 2013). While the worker also did laundry and dishes, she emphasized that her job with this client was "talking more than anything" (ibid). Under management's direction, paid carers were supported in dedicating a portion of their time at each visit to relationship building with clients in recognition that establishing trust and providing emotional support are important components of good care. "...We understand that there's a client need to develop those relationships. The clients need to, as well as they want to. They love the relationships." (I: April 10, 2013, Program administrator, HHH).

ICPs that valued "time to talk" benefited paid carers and clients alike. For paid workers, it led to a safer, more enjoyable work environment. In line with Banerjee *et al.*'s (2015, 32) findings, the relational dimensions of care were reported to be among the most rewarding for workers, and presumably for clients as well. It was clear when interviewing paid carers that many considered their personal interactions with clients to be the best part of their day. Workers ascribed significant value to their relationships with clients saying that this part of the job makes them "happy" (I: May 6, 2013) and "makes it feel like it's worth doing the job for" (I: April 12, 2013). Validating social support as legitimate care is good for clients too. It facilitates the

building of trusting relationships with their paid carers, gives them access to emotional support, offers a sense of security, and provides them with opportunities for social inclusion.

Paid workers consistently note that quality care should involve relational care and when they are unable to provide it, it is a source of great distress (Banerjee *et al*. 2015, 32). This view of the inherent value of relational care was supported by the explicit comparisons of the paid carer-client relationship to a family-like relationship. The fact that some paid carers reported that their relational obligations sometimes compelled them to offer social support to clients outside their paid working hours is further evidence of the importance workers placed on maintaining relationships with their clients.

Yet, some paid carers struggled with how to reconcile a neoliberal system that devalues relational care with their lived experience that social connection is an important component of good care. When discussing their ability to take the time to talk to clients, some paid carers did not position social support as inherently valuable to clients but instead constructed it as a means to a measurable end. For example, several workers suggested that they use talking with clients as a means of monitoring their health status. For instance, a paid carer with the HHH program felt he often needed to justify his social interaction with clients.

> I like to just sit and talk with them [clients] and sometimes people might think that 'Oh, he's just there playing a game with that guy'…But I actually use it as an assessment tool too…so it helps you know more about their mental status too, where they're at (I: April 15, 2013).

It is certainly possible that taking the time to talk to clients can accomplish multiple goals. Yet, I argue that this struggle experienced by some paid carers shows how they have internalized the neoliberal rhetoric about quantification. Workers know from experience that having time to talk to clients is important to meeting their care needs. They also know that developing a relationship with clients makes their work as carers more enjoyable and fulfilling. Yet, they subconsciously

participated in constructing social support as valuable, not for the above reasons, but because of its usefulness in achieving measurable outcomes in health status.

ICPs that clearly identified the provision of social support as part of a paid worker's duties helped alleviate workers' concerns about needing to justify spending time socializing with clients or having to choose between providing more measurable types of care over offering social support. It also reduced the risk that the cost of providing companionship would be relocated from the paid to the unpaid realm, especially as publicly-funded care hours are reduced. Enabling paid workers to provide multiple types of care, including social support, helped redress the tendency to prioritize health care over social care. This contributed to more responsive, less fragmented, and more fulfilling care that better met the expressed needs of clients and carers.

Making time for the social engagement of clients is important given the frequency with which both clients and carers shared their personal experiences of social exclusion and loneliness, or those of their clients. While many seniors required only minimal physical support to continue living in a private residential dwelling, they frequently reported feeling confined to their house because of physical and/or mental limitations. Some were even restricted to one floor of their home because they were no longer able to navigate stairs safely. This eliminated the possibility of going for walks in their neighbourhood, spending time in their yard, or visiting with neighbours. Seniors lamented the loss of the social networks they once maintained. They missed participating in their church groups, coffee clubs, and doing volunteer work. They often felt "very unhappy at home" explaining that "by myself at home, I don't like. It is too quiet" (I: May 8, 2013). The experience of a male client in the HHH program was a common one shared by many women clients as well,

> I've become indrawn. I don't go out and about anymore. I used to go for coffee in the mornings but I haven't done that for 6 weeks now. I just can't be bothered. It bothers me that I don't go because I've been drinking coffee with the same guys for 23 years but...every once in a while I say I'm going to go tomorrow and then something happens and I don't make it. I used to belong to [the] Rotary Club but I don't belong to that anymore either...my own doctor says she thinks I'm getting depressed ... (I: April 12, 2013).

Many clients reported relying on the paid care workers coming into their home as their primary, and in several cases their only, form of social engagement.

Extra effort is required for home care to meet the social inclusion needs of vulnerable groups, such as new immigrants, non-English speaking clients, and clients with disabilities. Many paid workers reported that the development of social relationships among clients, and between clients and themselves, were constrained by language barriers and mobility or cognitive limitations. A worker at the CHOICE program explained that language barriers in their ADP are "a huge challenge for [clients as] they sit and they don't participate. I can't imagine sitting all day not knowing what's going on" (I: March 18, 2013). AIP workers reported experiencing similar challenges, "You get people who just moved in from somewhere else...they don't know the language. There are a lot of language barriers – like there's Polish, Russian...so they'll stick to themselves, they don't come out as much. Same with the Asians – there's a language barrier…" (I: February 26, 2013). Some workers, such as a nurse with AIP, described her challenges communicating with non-English speakers as her "least favourite part [of the job] because...I am not able to do my work. I am not able to serve them [clients]" (I: March 7, 2013). Putting social engagement on care plans is a necessary step towards equality. However, it is also important to work towards equity by making sure that policies aimed at enhancing clients' social inclusion do not privilege those who speak the same language as their care worker or those who can most easily participate in outings or activities. An AIP worker pointed out that this placed clients who do not speak the dominant language at a significant disadvantage, "...for people who speak [a language] other than English [and] who cannot communicate with other people in their

building. They cannot even understand the notice[s]..." (I: March 5, 2013). ICPs that sought a fairer distribution of social engagement care adopted practices aimed at reducing barriers to social inclusion by making extra efforts to include marginalized groups.

To address language or cultural barriers to social engagement, CHOICE and the AIP programs strategically scheduled clients to attend their ADP or participate in social excursions with other clients who spoke the same language. In the CHOICE ADP, efforts to "pair [clients] who speak the same language" resulted in having "two Chinese people now who can talk to each other in the same dialect. It is really nice" (I: March 22, 2013). Similarly, a driver who organized day trips at AIP explained that he made an effort to offer excursions that he knows appeal to clients in different cultural groups. For example, he described an outing he organized for non-English speaking Chinese men, "The Asian crowd likes to go fishing, so we'll go to Fitzroy Harbour Provincial Park...there are carp and catfish...That's very popular..." (I: February 26, 2013). Despite the driver not speaking the same language as his clients, he was able to develop a relationship with them. He noted that the clients were very appreciative of the opportunity to socialize with others who spoke their native language and he, the worker, found these excursions enjoyable too, "A good, good day? Fishing with the Asians. They all bow to me after which means thank you in Mandarin or Cantonese..." (ibid).

In addition to creating opportunities for verbal communication, some programs used practices for overcoming language-based communication barriers using written prompts. In the CHOICE program, paid workers collaborated with clients' families to make cue cards with English on one side and a client's native language on the other. These facilitated communication and relationship building between non-English speaking clients and both their paid carers and English speaking peers.

Paid workers with Carefirst's ADP strategically scheduled clients for day trip participation in an effort to include typically excluded clients. For instance, they offered excursions specifically suited to clients with special needs, such as limited mobility or cognitive impairments. This was highly valued by clients and their unpaid carers:

> Carefirst was the only place that told me they may plan an outing to the supermarket, let's say. Just for them [the clients] to walk around in and still get the feel of shopping, you know? That's a big (emphasis) deal for her [the client]. That's a really huge thing. Whereas the other two places [community ADPs], for sure they won't go out like that (I: May 6, 2013).

Clients who self-identified as having significant mobility issues explained that having the program organize opportunities for companionship among clients with similar needs promoted inclusivity in the program. Clients were clear in their appreciation of being invited to participate in wheelchair accessible outings, such as feeding the ducks or eating lunch in an accessible dim sum restaurant.

Clients and carers benefited when program administrators organized initiatives to match clients with others who had similar interests or language abilities and facilitated communication between those who speak different languages. These types of initiatives increased clients' access to opportunities for daily social engagement. They also benefited unpaid carers by alleviating part of the burden for them to translate for their family member. These types of initiatives reduced, though did not eliminate, the need for "three-way communication" (whereby the client communicates to the unpaid carer who passes the information along to the paid workers) to communicate across language barriers. Family carers of clients from traditionally marginalized groups reported feeling worried that if they did not take responsibility for keeping their family member up-to-date about the activities available to them, then their family member would be at greater risk of becoming socially isolated. These types of initiatives aimed at overcoming communication barriers helped alleviate some of this worry by involving the client directly

instead of relying on the family carer to process information for them.  These types of program initiatives also supported paid carers in their efforts to understand and address the needs of vulnerable clients that they would otherwise have difficulty meeting.  They encouraged paid carers to put extra time and effort into communicating with clients from traditionally marginalized groups.  In addition to improving the relationships between clients and paid carers, this also fostered the creation of social networks among clients that offered them opportunities for social engagement outside of the ones provided through the ICP.

Reorganizing front-line care work to include social interaction as a legitimate aspect of good care supports and encourages paid carers to take the time to talk to their clients.  In addition, making extra effort to overcome the language and communication barriers experienced by clients from marginalized groups helps ensure a more equitable distribution of the benefits associated with social inclusion and support among all seniors involved in ICPs.

## Collective Forums for Team-Based Collaboration

The importance of good communication between the members of an integrated care team is well documented (Challis *et al.* 1995; Atwal & Caldwell 2002; Pappas *et al.* 2013).  The physical working arrangements within which a team's discussion and dialogue take place also matter (Billings 2005, 16).  A communal space, a small staff size, and mandatory attendance were cited by paid carers at CHOICE as promoting team collaboration and communication.  As one paid worker explained, "Hearing it first hand, all together – not passed down the chain...You can't care for people well when you are forever leaving notes..." (I: March 20, 2013).

When paid workers were excluded from decision-making they felt like they had no voice in agency issues and little sense of how their work contributed to the organization's mission.  In

SMILE, paid workers explained that a lack of interest from management contributed to feelings of disillusionment about being involved in decision-making:

> I would love more of everything - meetings, training - even if it was on our own time - I would do it, unpaid - I would do it. I would love any of that and I know the other women would too but there has to be interest [from management]. And we're suspicious of who is heading this [the SMILE program] because it seems like we're only told something when we absolutely have to know and we have no decision-making...I kind of feel like we're in the dark most of the time. Have you ever heard of the analogy - they treat us like mushrooms? 'They keep us in the dark and feed us shit' (I: April 4, 2013).

CHSWs at CHOICE were aware that the organization had strategic goals but felt that these were not communicated to them as the "lowest" workers, "Here we feel we are on the bottom side of the organization. Maybe we don't know what is happening there so it's not been communicated to us" (I: March 21, 2013). Like the SMILE workers, Carefirst workers wanted to contribute to decision-making but being excluded from discussions about program goals made them feel devalued:

> [I] only work in the PSW level. So [I] don't know what the management team is doing. Also, in China, if there is a big project - the whole company will know. But in Carefirst...[I am] not involved…I think if you have one group, one company – even if you are low level – you should know (I: May 7, 2013).

Many HCWs relayed experiences of marginalization in the workplace as a result of their position on the occupational hierarchy. For instance, this PSW's feelings of being dismissed and unimportant were shared by many HCWs,

> One time, I meet them [upper management]. The coordinator, they have a group, they have a meeting. I just go to that room, they just turned (makes a dismissing wave with her hands) [and said,] 'Don't come. Don't come to me'" (I: May 7, 2013, Carefirst).

This created real barriers to HCWs' participation in decision-making and team-based collaboration.

Promoting team-based dialogue and collaboration through the creation of shared spaces is contrary to neoliberal managerialism. The neoliberal restructuring of the home care sector has involved rationalizing costs, introducing efficiencies, and shifting the performance and personal

ideologies of care workers to a more private-sector style of working (Baines & Daly 2015, 137). Baines (2006) argues that governance strategies based on NPM reduce or remove collective spaces, such as all-staff meetings, agency-community forums, peer supervision, and staff educational sessions. This is an effort to move away from work practices that are difficult to quantify and focus on ones that are easier to track, document, and thus thought to contribute to cost-efficiencies (Aronson & Neysmith 1996; Baines 2010; McDonald 2006).

Challenging the neoliberal push to eliminate collective spaces, the CHOICE program relied on in-person meetings to facilitate team communication and collaboration. Hour-long "whole team meetings" were held each weekday morning at 8:00AM in the on-site boardroom. Paid workers strongly supported the use of daily team meetings, explaining that this is "how the team works together.... because there are so many staff members from different disciplines" (I: March 18, 2013). Attendance at these morning meetings was mandatory for most paid workers, including the site manager/clinic supervisor, physician(s), social worker, PT, OT, pharmacist, recreation therapist, the lead LPN, and the lead CHSW.

Using collective forums to facilitate team-based collaboration benefited the paid workers who participated in them. In-person team meetings were praised by workers as a time when "everyone shares how they see the patient and we'll be learning from the other people around the table. You all learn from each other on this" (I: March 18, 2013). This made navigating joint working easier, particularly given that the ICP team was composed of workers' whose scopes of practice and job descriptions sometimes overlapped. Bronstein (2003) explains that when autonomy is valued, practitioners are empowered to utilize their specialized expertise. Yet, too much autonomy can be detrimental to a team (Hurst *et al.* 2002; San Martin-Rodriguez *et al.* 2005) by promoting hierarchy and fragmentation (Raak *et al.* 1999; Smith-Carrier & Neysmith

2014). These meetings helped team members from a variety of disciplinary backgrounds understand how their work contributed to the team's objectives and outcomes, while recognizing the complementarity skills that members bring to the group. They also helped resolve potential conflicts when a worker felt that others were "stepping on her toes" by overstepping their disciplinary boundaries. CHOICE workers were clear that the benefits of their participation in these meetings outweighed the costs of an increased workload as they were still expected to complete all of their regular duties in addition to attending these meetings.

In addition to facilitating collaboration among paid carers, there was the need to consider how to share information among paid carers, clients, and unpaid carers in a collaborative fashion. Despite all of the ICPs advertising the delivery of "client-centred care", many clients and unpaid carers described a unidirectional information transfer from paid worker to the client. This positioned paid workers as the "experts" and left clients feeling peripheral to the care planning process. For instance, when asked if he felt "involved in the decision about what kind of care" he received, a HHH client summarized the typical experience of home care clients, "No (adamantly)...not at all. They decide what they're going to do and I do, kind of, as I'm told..." (I: April 17, 2013). Clients did not see themselves as passive recipients of care and requested practices that focused on information "exchange" among those involved in their care team.

Like clients, unpaid carers often reported feeling peripheral to the decision-making process about a client's home care. Many reported frustration navigating the system. They often had difficulty understanding what choices were available – a necessary precursor to making decisions about care. Some unpaid carers reported having difficulties getting in touch with their family member's case manager or getting information from them because of confidentiality regulations. Others were unable to provide input on, or get access to, the client's care plan.

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Unpaid carers often challenged the normative assumption that they are willing, able, and appropriately resourced to continue providing unpaid care to their family member. By virtue of the fact that the provision of unpaid care was rarely positioned as a choice, family carers were denied the option to opt out. Moreover, as home care hours and eligibility are increasingly restricted, unpaid carers are expected to take on even more of the care work. Finally, unpaid carers noted a lack of collaborative decision-making about their own expressed needs. Many requested more support to help them deal with the stress of unpaid caregiving. They also asked for access to more frequent and affordable respite care, as well as respite options that were better suited to their needs as unpaid carers as well as the client's needs (I: April 17, 2013; I: May 6, 2013).

A promising practice used to overcome some of these barriers was CHOICE's use of "family conferences" to facilitate collaboration among the paid workers, clients, and unpaid carers involved in the ICP. Family conferences were held for each CHOICE client six weeks after joining the ICP and then on an annual basis thereafter. They occurred in the on-site boardroom and included the client, the client's regular unpaid carers (often family members or close friends), and the paid carers involved with the client at the ICP, except for the CHSWs. Family conferences were held for all clients at regularly scheduled intervals, not just for high risk ones. This was an important means of ensuring equality among clients and emphasizing the value placed on prevention and health promotion at the program level.

Unpaid carers and clients felt that CHOICE's family conferences were collaborative undertakings, as opposed to a strategy designed to shift the responsibility for care from paid workers to the client or family. Family conferences provided a forum within which "clients are involved in the decision-making about their care when possible" (I: March 20, 2013). Unpaid

carers felt welcomed as valued members of the care team. Huang and Cummings (2011) argue that the arrangement of knowledge-sharing relationships within a team is related to team performance. More specifically, decentralized teams that are able to share critical knowledge equally rather than hierarchically lead to better outcomes (ibid). Unpaid carers noted that family conferences moved beyond information transfer from "expert" paid workers to clients and their families to information sharing among all those involved in the meeting.

Paid workers described making specific efforts to neutralize perceived power inequalities between themselves and the client or family carers. They referenced the symbolism of having all participants sit at the same level around a large circular table. They described how each participant is directly invited to contribute. Family carers described feeling that power was shared equitably during these conferences saying, "They [the paid carers] say who they are and different issues and we [the family can] say our issues and [the client] can say his issues. It's just ordinary. They don't feel head and shoulders above you" (I: March 21, 2013). In some instances, clients or family members were unable or unwilling to fully participate in family conferences; for example, clients with advanced dementia. However, staff explained that this was not typical. In these cases the clients would still attend the conference and participate as much or as little as they were able or willing to.

Daily team meetings and family conferences are examples of collective forums for team-based collaboration that benefited those included. However, these policy techniques as operationalized within the CHOICE ICP also excluded a subset of the paid workers in the ICP; namely, the workers on the bottom of the occupational hierarchy. The in-person nature of the team meetings and the logistics of holding them in the on-site boardroom meant that each morning the "professional" workers collaborated together in the boardroom participating in the

"whole team meeting". Meanwhile, the "others" - the CHSWs, LPNs, clinic clerk, and administrative staff - were left on the outside, separated but clearly visible through the boardroom's large windows.

This setup was a physical manifestation of othering, reflecting the racialized, classed, and gendered power dynamics at play in CHOICE's rigid occupational hierarchy. At CHOICE the "professional" workers were mainly white. They were middle to high income earners. All of the men on a mostly female staff fit into the "professional" category. Finally, they had all had their education and credentials recognized in Canada and held professional designations. In contrast, the CHSWs who occupied the bottom of the occupational hierarchy were all female, low-income, and mostly racialized. Many were new immigrants. Some were highly educated but with their degrees undertaken outside of Canada, they were unable to get their credentials recognized.

The paid workers on both ends of the occupational hierarchy recognized the contradiction that CHOICE's "collective" forums were, in fact, exclusionary in that they reinforced tensions arising from status difference between social and health care workers. As a therapist explained, "Here, because we're all one team, the only separation at all here is *between* [emphasis] the team in that room [the boardroom where the morning team meeting is held] and the home support" (I: March 18, 2013). Despite challenging the principles of neoliberal governance by creating forums to facilitate communication and collaboration, these forums reinforced a rigid occupational hierarchy by separating "skilled" from "unskilled" care workers. Team meetings and family conferences, as operationalized at CHOICE, simultaneously decreased and increased inequality among paid workers. Power relations were equalized among paid workers already in

positions of relative power. However, this occurred at the expense of exacerbating power imbalances in the workplace created through processes of sexism, classism, and racism.

This contradiction speaks to existing research on the difficulties of structuring teams for successful integration (Challis *et al.* 2010; Irvine *et al.* 2002). Teams that work well together are more effective and innovative, experience increased satisfaction (Kilpatrick *et al*. 2011), and exhibit lower levels of stress (D'Amour *et al.* 2005). Furthermore, collaborative practice is even more vital when client needs are complex and require a range of services, as is often the case for the chronically ill, frail, elderly population (Mukamel *et al*. 2006). Yet, Smith-Carrier and Neysmith (2014) and many others have shown that care teams are often rife with conflict (Atwal & Caldwell 2006; Mitchell *et al*. 2011), low morale, and poor performance (Farrell *et al.* 2001). They are beset by issues of power and control, a lack of understanding of team roles, and failed expectations surrounding fairness (Goldsmith *et al*. 2010).

CHOICE's collective forums did not create the power inequalities that existed among the ICP team but they did reinforce the subordination of an already marginalized subset of their staff. In CHOICE's context there were clear benefits of participation in CHOICE's collective forums. These forums did a good job of sharing power and decision-making among those engaged in them. Keeping in mind that what works for some teams, and within some contexts, does not necessarily work well in others (Buljac-Samardzic *et al*. 2010), a possible way forward in the CHOICE ICP may be to include the CHSWs and LPNs in these collective forums. Making the meetings more inclusive would help validate the experiences of CHSWs as the paid workers who do the most hands-on care with clients. It could also help workers see the perspective of others positioned differently on the occupational hierarchy. This might encourage empathy and garner respect for care work that requires different skills or has been constructed as being of a "lower"

status.  This could be a step towards redressing the race/ethnicity, gender, and class-based power inequalities that characterize the CHOICE workplace.  Restructuring these team meetings and family conferences would require some logistical creativity.  Furthermore, changing the attendance would likely be insufficient to rectify the power imbalances associated with CHOICE's occupational hierarchy.  However, it may reduce the othering of the CHSWs that has led to them feel marginalized and devalued within the care team.  This, in turn, could have positive implications for working conditions broadly, as well as for the team's ability to collaborate and communicate for the benefit of client care.

## Conclusion

In Chapter 7, I have demonstrated that when ICPs use policy techniques that challenge neoliberal ways of working, they are better positioned to distribute the costs and benefits of ICP participation more fairly among clients and carers.  Promoting equality and equity through the provision of care with no user fees, supporting paid and unpaid care workers, legitimizing and encouraging social support as part of good care, and supporting inclusive collective forums for team-based collaboration, have enabled more clients, unpaid carers, and paid care workers to get their needs met by their ICP.  This, in turn, has reduced fragmentation through better collaboration and communication, more accessible care, and a more seamless provision of services.

# Chapter 8: Conclusions, Recommendations, and Future Directions

## Introduction

Policy makers must make choices about who gets what from the state, when, and how. While these choices must keep fiscal pressures in mind, not all of the answers to challenges on the horizon are going to found within the neoliberal array of policy options. In this dissertation, I argue that pursuing equal and equitable outcomes is at least as, if not more, important than seeking to enhance efficiency as a primary policy goal. In the quest to find a solution to problems of fragmentation in home care delivery, the pursuit of efficiency has been overemphasized, creating a vicious cycle of inefficiency and fragmentation. To break this cycle, policy makers and program administrators must shift course. In light of this study's findings, rather than continue to try to solve fragmentation using the market-oriented solutions typical of the neoliberal perspective, we need to re-think our approach. ICPs can help redress fragmented home care. However, in order to do so, the public sector must be willing to deliver services in a way that is open to meeting equality and equity goals. We must move away from a care system that increasingly relies on more service provision by the private sector and continues to relocate the costs and responsibility of elder care onto unpaid carers, typically women. The state can improve public sector performance, not by "doing better for less", but by doing better for everyone - clients and carers alike.

## Recap: Findings and Recommendations

To understand if, how, and why ICPs meet the expressed needs of clients, unpaid carers, and paid care workers in the context of neoliberal restructuring, I investigated the interconnections among fragmentation, integrated care, inefficiency, inequality, and equity. I

found that the policy techniques used by ICPs to design and deliver care impact clients, unpaid carers, and paid care workers differently along class, gender and race/ethnicity lines.

Policy techniques focused on enhancing efficiency promoted an unequal and inequitable distribution of power and benefits among clients, unpaid carers, and paid care workers. The empirical evidence showed that more neoliberal policy techniques, such as the push for privatization, service reductions, contracting out, task-shifting, maintaining lean staffing levels, work intensification, the push for self-responsibilization, and an increased focus on monitoring and accountability, contributed to an increase in inequality and inequity within, and among, the groups involved in ICPs. By reinforcing class, gender, and race/ethnic disparities among clients, unpaid carers, and paid care workers, neoliberal policy techniques perpetuated fragmentation through poorer communication and collaboration, reduced coordination among carers, and the creation of gaps in available services and continuity of care.

In contrast, policy techniques that challenged neoliberal ways of working were more likely to promote equality and equity among clients, unpaid carers, and paid care workers. Such policy techniques included the elimination of user fees, enabling carers to take time off, supporting carers in coping with emotional labour, the acknowledgment of carers' contributions to the team, prioritizing social interaction between clients and paid carers, facilitating social engagement among clients, and prioritizing inclusive team meetings and family conferences. These reduced barriers to care for all groups while also providing extra support for those in marginalized positions. Policy techniques that contributed to increased equality and equity among clients, unpaid carers, and paid care workers, were more likely to be associated with a reduction in fragmentation.

Neoliberal policy makers have been largely unsuccessful at reducing fragmentation in home care using policy techniques focused on efficiency, in many cases actually perpetuating the fragmentation they view as inefficient. Yet, understanding the complex connections among fragmentation, inefficiency, equality, equity, and integrated care within the context of the neoliberal restructuring of home care offers the possibility of disrupting the vicious cycle created by the fragmentation-inefficiency paradox. This study has shown that ICPs, despite existing within a neoliberal context, can implement policy techniques that enhance equality and equity. By doing so, ICPs are better positioned to reduce fragmentation in home care.

The crux of using integrated care to redress fragmentation in the home care sector is to focus on increasing equity as the desired policy outcome. Policy techniques that promote a fairer distribution of costs and benefits between, and among, clients, unpaid carers, and paid care workers even though they occupy different positions of power, privilege, or vulnerability, enable more ICP participants to get their expressed needs met.

## Promising Practices

"Now that we have shown that reducing inequality leads to a very much better society, the main sticking point is whether people believe greater equality is attainable" (Wilkinson & Pickett 2010, 195).

A dilemma in doing research from post-positivist and FPE approaches is how to reconcile the push for knowledge transfer and exchange based on "best" practices (Armstrong & Messing 2014, 6-7) or "model ways of working" (Billings & Leichsenring 2005, 14) with my empirical evidence that policies often work well for some but not as well for others. To reconcile this, I follow the lead of Baines and Armstrong (2016) in seeking out "promising practices" in my study. My promising practices are policy techniques that are worth sharing because they help meet expressed needs by reducing fragmentation. However, they come with the caveat that

considering the conditions and contexts that support them is indispensable to understanding why they work well for a certain population, in a particular location, at a specific time. The vast amount of empirical data collected in this study has facilitated the identification of promising practices that are worth sharing because they advance equality and/or equity and reduce fragmentation in the ICP in which they have been used. The practices outlined here better meet the needs of clients, unpaid carers, and paid care workers in three key ways: by reducing barriers to accessible care, filling care gaps in an equitable manner, and facilitating collaboration and communication between, and among, clients and carers.

An advantage of service delivery integration is its ability to offer clients a seamless overlap of multiple services by removing common barriers to accessible and equitable care. The removal of financial barriers to care, through the provision of services through an ICP at no cost to clients, is a promising practice. This is particularly important for services classified as "social" care. The historical devaluation of social care under the biomedical model and its omission from the CHA has made it susceptible to neoliberal restructuring requiring client co-payments. The AIP's provision of day trips with no user fees illustrates how an ICP has reduced class-based barriers to access in order to meet clients' expressed needs for social inclusion.

ICPs are also able to remove logistical barriers to care by offering transportation in conjunction with ICP services that are provided outside of a client's home. AIP, CHOICE, Carefirst, and HHH demonstrate the promising practice of providing clients with door-to-door service. Clients are brought from their home to an ADP, day trip, medical or therapy appointment, or bath provided at the program facility and then returned back to their home. Many of the clients who participate in ICPs no longer drive or cannot afford a car which, in addition to increasing their risk of social isolation, has made it more difficult for them to access

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care provided outside their home.  Having easy access to transportation organized by their ICP simplifies the process of getting to the program facility or participating in excursions into the community.  As a paid carer with the AIP explained, "[Of the seniors] that could get to the community centre... then there's the fee of a taxi or trying to get a ride – all the detail that goes along with it ends up costing…" (I: May 15, 2013).  AIP's strategy of coupling free transportation to their day trips helped overcome both logistical and financial barriers to care accessibility.  Expanding opportunities for transportation beyond movement between ICP services would be welcomed by clients and unpaid carers.  Clients wished that their ICP drivers could bring them to the grocery store, bank, pharmacy, library, and specialist appointments, for example.

Adjusting ICP services to accommodate clients who are at risk of experiencing language, culture, or ability-related barriers to care is a third promising practice promoting equity.  In CHOICE, care workers created bilingual cue cards for non-English speaking clients.  In Carefirst, paid carers organized accessible day trips for ADP clients with limited mobility.  In addition, paid workers in both CHOICE and AIP created opportunities for companionship between clients who spoke the same language, had similar ethnic backgrounds, or came from the same city or country of origin.  These extra efforts to make care more inclusive, particularly for groups who otherwise remained at the margins, enables a fairer distribution of the benefits of participating in an ICP by making the social inclusion of all clients a priority.

ICP practices that address care gaps for clients while minimizing class, gender, and/or race/ethnicity disparities among workers are also promising.  For example, clients expressed a need for continuity of care.  Carefirst's strategies of meeting this need through the creation of a Team Scheduler position and implementation of an organizational process through which paid

care workers could arrange for a replacement worker to cover their shift, are practices worth sharing. By enabling all paid care workers to take time off when needed without the guilt of having their client go without care in their absence reduced power disparities among paid workers at different positions in the occupational hierarchy. Giving HCWs more control over their work schedules, and some flexibility to meet commitments outside of work without compromising their employment status or client care, is something that "professional" workers often take for granted. The ability to take time off is important to all workers, but especially for the women who make up the bulk of the PSW workforce. Many HCWs were balancing paid employment with unpaid caregiving responsibilities that sometimes required their attention during their typical work hours. Offering all paid care workers access to paid sick leave and vacation time would further empower those lower on the occupational hierarchy. This could be considered by ICPs as a way to move forward towards even more equitable power relations in the workplace.

Increasing the accessibility of respite care is another practice that fills a gap in care identified by unpaid carers. Family carers requested short stay respite options in an institutional setting, such as a long-term residential care home. They also expressed a need for in-home overnight respite care. CHOICE's operation of ten care beds at their program site where clients could receive respite care in a familiar environment, surrounded by the client's usual care providers, is a promising practice in the provision of institutional respite care. Family carers in other jurisdictions cited long-wait lists for care and might have benefited from access to CHOICE-style respite care in their ICP. Family carers also cited a lack of culturally appropriate care for non-English speaking clients. This and the absence of in-home overnight respite care

are two areas where ICPs could improve access to respite care to better meet clients' and family carers' expressed needs.

In addition, for a subset of family carers, the user fees applied to respite care and limits on its use can be prohibitive. Unpaid carers noted that having to co-pay for respite care reduced accessibility for economically vulnerable families, "…My doctor recommended [respite care] too and [the client] herself knows [that caregivers need a break] and then we decided no. We didn't have enough money then..." (I: April 16, 2013). Family members, particularly those of clients who could not be left alone in the home, also questioned the value of rules limiting institutional respite use. As one daughter explained, "...You're only entitled to 30 days per year of respite….Like if you have grandchildren, I have some [who live out of town], that I have not been able to see very often since [the client has] come [to live] with me" (I: April 17, 2013). I recommend increasing the availability of respite beds, offering more culturally-sensitive respite options, eliminating user fees to increase the accessibility of respite care, and adding in-home overnight respite options for clients and unpaid carers who see this as being a more appropriate option for them.

CHOICE's practice of offering all paid care workers access to an EAP, regardless of their employment status, is a promising practice worth sharing. Eliminating class-based barriers to accessing emotional support promoted equality among paid workers while meeting their expressed need for support associated with the emotional labour of front-line caregiving. This was especially important for workers lower on the occupational hierarchy who, despite performing the most intimate care tasks and developing the closest relationships with clients, were the mostly likely to be deemed ineligible for EAP access. This was often justified on the basis of their casual or contract status or due to their employment with a not-for-profit agency as

opposed to the public sector. In addition to supporting paid workers in their emotional labour by facilitating EAP access for all care workers, program administrators must play a more direct role in employee support by acknowledging their contributions through thank you cards, gift certificates, and/or praise. Making the effort to give paid workers a "pat on the back" is a promising practice that created better working conditions within the Carefirst ICP with workers at all levels feeling more important, appreciated and valued as a result.

Carefirst's program-led peer support groups are a similarly promising practice for supporting volunteers in coping with the emotional labour of their unpaid care work. Paid staff at Carefirst organized support groups for volunteers, targeting carers involved in providing bereavement, hospice or friendly visiting care, in particular. Creating these groups as part of the agency's mandate helped overcome logistical barriers to unpaid carers self-organizing. It also sent a strong message about the value that the Carefirst organization placed on volunteer work and demonstrated the agency's willingness to take an active role in supporting their volunteers.

Similar support mechanisms were not in place within ICPs for unpaid family carers, despite their expressed need for formal emotional support. Some ICPs referred family carers to external support groups in the community. However, most family members reported not having access to an EAP through paid employment. In the absence of access to counselling for family carers at the organizational level in any of the programs studied (with the exception of Carefirst who had volunteers that could offer family members bereavement counselling), family carers reported relying heavily on ICP paid care workers for informal emotional support. Unpaid family carers suggested that they would benefit from the creation of program-facilitated peer support groups or networks where they could share their experiences with each other - similar to those created by Carefirst for their volunteers. Family carers saw these groups as a coping

strategy that would help them deal with feelings of social exclusion while allowing them to challenge the perception that they should keep their experiences a secret. I recommend that ICPs take a lead in coordinating support groups for the family caregivers of the clients enrolled in their programs. This would both address the existing gap of emotional support for the family members participating in unpaid care work as well as alleviate the burden on the paid care workers who are currently acting as the primary source of emotional support for family carers.

SMILE and HHH's strategy of adding time to talk to care plans is a promising practice. This positions social interaction as an important type of care and, in doing so, legitimizes paid care workers in taking the time to build relationships with their clients. In a context characterized by work intensification, enshrining relational care in the care plan is significant as a means of improving communication, providing more seamless care, and meeting clients' expressed need for social engagement. It also contributes to a safer, more enjoyable work environment for paid workers who reported deriving happiness and a sense of meaning from interactions with clients that were not rushed.

In addition to encouraging communication between clients and paid carers, promoting daily face-to-face interaction among paid workers is a promising practice supporting team collaboration. In programs where faxes, emails, voicemails, or computer systems were the primary means of communication among team members, workers noted an overall lack of interaction, communication delays, feelings of disconnection, and isolation. Paid carers reported that physically seeing their colleagues was important for feeling like part of a team. Similarly, paid workers felt that communication among team members was much easier if they shared a physical area and had overlapping work hours. Paid carers suggested that when they "see each other all the time" it facilitated a sense of "cohesiveness" and enabled "really good

collaboration" among team members (I: April 15, 2013; I: April 12, 2013; I: April 10, 2013). CHOICE's strategy of holding mandatory, in-person team meetings each morning is one practice worth sharing. Likewise, CHOICE and HHH's set up where paid workers shared office space and were constantly coming and going from the same facility encouraged the face-to-face interactions that provided workers with a sense of camaraderie and a collegial working environment.

Regularly scheduled, in-person meetings between paid workers, clients, and unpaid carers is also a promising practice facilitating information sharing and collaboration among all those involved in a client's care. CHOICE's purposeful inclusion of clients and unpaid carers in their family conferences was unique among the programs studied and was especially promising as a means of promoting equality/equity and inclusiveness. In addition, CHOICE's decision to schedule regular case conferences for all clients supported client participation in decision-making from the time that they joined the program (when typically their capacity to participate actively in their care was the greatest) all the way through to their discharge. Family conferences empowered clients to participate in shaping their care according to their preferences. They also allowed them to share their perceptions of their most significant needs with their care team before their declining health limited their capacity to participate as fully. Finally, these conferences promoted equality/equity among clients by making sure that all clients, not just those classified as the highest risk or those with the most vocal family carers, had an opportunity to be heard.

My final recommendations involve the need to take additional steps to address the substantial inequalities in power among paid workers - a reality in all of the ICPs I studied. Based on my empirical evidence, there is a need for program administrators to encourage a

broader conception of the "team" in their respective programs. Instead of the current system where care workers at the bottom of the occupational hierarchy are systematically excluded from team collaboration and communications, workers, such as homemakers/HSWs, PSWs/CHSWs/CHWs/HCWs, and LPNs, should be viewed as equally valuable members of the care team. In parallel with this, ensuring equal access to information for all team members involved with a client is essential. This has the potential to reduce power inequalities among paid workers and reduce risk to front-line care workers who, under current ways of working, frequently find themselves missing vital information about a client's background and health conditions.

When subsets of workers are systematically excluded from a team-based approach to care, communication gaps arise. These compromise workers' abilities to provide appropriate, seamless, good quality care to clients. My interview data indicated that there remains significant resistance among "professional" ICP workers to the inclusion of workers lower on the occupational hierarchy in decision-making processes. This contradicts this study's findings that integrated care is most likely to reduce fragmentation through the promotion of equality and/or equity. In response to some workers' suggestions that collaboration among workers is in tension with the imperative of maintaining client confidentiality, I recommend implementing an organizational policy along the lines of Carefirst's consent requirement. As a condition of enrollment, clients in Carefirst must agree that their information can be shared among all workers under the ICP's umbrella. In combination with a shift in team culture towards a more inclusive conception of the care team, this is a possible way forward that could facilitate the flow of information among all paid workers involved in a client's care. In turn, this would make it

easier for them to collaborate by creating a more equal, inclusive, and cooperative work environment.

Lastly, encouraging input from, and (even better) the collaboration of, paid workers at all levels in developing and revising program policies and organization priorities is my concluding recommendation for promoting equality/equity within ICPs. Paid workers at all levels of the occupational hierarchy reported feeling devalued or "replaceable" (I: April 16, 2013; I: April 4, 2013) when they did not feel included in working towards a shared organizational objective. Workers requested better communication with management, to be better informed of organizational initiatives, and to have the opportunity to feel more like part of the ICP team. Adopting a strategy similar to the "participatory collaboration" approach used by the program administrators at CHOICE, whereby CHSWs were included in the development of work organization guidelines is a proposed way forward. At CHOICE, managers asked each CHSW to "tell me what you do on your shift" (I: March 25, 2013). Program administrators then worked with each CHSW shift separately to come up with detailed documents that "really fit" with both the tasks prioritized by the workers and the needs of the administration. This approach was an attempt to move towards a more inclusive team by bringing workers on the lower levels of the occupational hierarchy into the decision-making process about their work organization. Showing workers that their input is valued by the administration has the potential to shift how the contributions of certain groups of workers are viewed, both by themselves and others on the team. This is a step towards bringing about a needed culture change whereby ICPs adopt a more inclusive definition of the care team and more equitable power relations across the occupational hierarchy.

## Research Limitations

In this study, I use an explicitly social explanation of health as opposed to a biomedical one. Kuhn (1970, 59) observed that "the decision to employ a particular piece of apparatus and to use it in a particular way carries an assumption that only certain sorts of circumstances will arise". In agreement with this, I acknowledge that selecting an FPE framework and narrative interviews as my theoretical and methodological tools have biased my data collection and interpretation in line with a post-positivist epistemology. In doing so, I have prioritized a theory-directed choice of questions and methods to generate empirical data on how the lived experiences of the clients and carers involved in ICPs have been shaped by the classed, racialized, and gendered relations that permeate their social, policy, and economic contexts.

In addition to recognizing my data as theory-laden, I also see my findings as necessarily contextualized. The idea that aspects of a person's life not only can be, but should be, decontextualized and still have any meaning is problematic (Nord 1989). This means that despite a large sample size of 118 participants, I do not generate statistics, make generalizations, nor identify best practices easily amenable to knowledge transfer. I have, instead, focused on understanding the lived experiences of ICP clients, unpaid carers, and paid care workers and figuring out what these tell me about if, how, and why integrated home care programs meet the expressed needs of those involved in them. Studying actual clients and carers in the context of their concrete daily lives legitimizes them as being as important to understanding health (Robertson 1998, 159). It also makes room for the voices of the individuals and marginalized groups who are often silenced when data on health is aggregated into statistics (Labonte *et al.* 2005, 9). This study intentionally presents promising practices as a means of problematizing the neoliberal tendency to import "High Impact Practices...[to] facilitate the transfer of knowledge,

expertise, and experience" (Canadian Home Care Association 2015, 26). I support sharing practices across jurisdictions, but suggest that this must be done in a way that simultaneously provides an understanding of the conditions under which specific practices work well and for whom.

My research has focused on key informants from the "front lines" of home care delivery and receipt. I interviewed program administrators to gain an organizational perspective. However, my priority was to understand the needs of the clients, unpaid carers, and paid care workers involved in the daily work of home care and whether their needs were being met by ICPs. I acknowledge the important role of policy makers in shaping the social, political, and economic contexts that, in turn, shape the lives of my participants. Yet, policy makers were neither the focus of my data collection nor the target audience for my analysis and discussion of promising practices.

To avoid "being immobilized by the difficulties involved in articulating resistance to neoliberalism on a grand scale" (Baines & Daly 2015, 142), my dissertation focuses on the local level to explore opportunities for resistance in the ICPs I studied. I present my promising practices and recommendations to program administrators. I call on them to push for small changes in their own ICP. It is precisely the details of services, the eligibility rules, the forms of delivery, and their potential consequences for fostering equality/equity or entrenching inequalities/inequities that matter (Jenson & Sineau 2001, 5).

Implicit in my analysis is the belief that equity-oriented policy change is unlikely to occur without an informed civil society capable of exercising pressure to overcome opposition by economic and political class-based elites. As such, I also target family carers and clients as the

people who must hold program administrators accountable for the policy techniques they use to design and deliver home care at the program level.  In line with Zawilski's (2010, 1) view that "as individuals, as members of a group, and as citizens of a state, we can contest acts of social injustice against vulnerable populations…", I encourage families and clients to resist ICP practices that prioritize efficiency over equality/equity and to challenge their program administrators to more fairly distribute the benefits of ICP involvement where they can.

While I was successful in answering the questions that I set out to answer, I was not able to explore many other important issues related to the use of integrated care to deliver care in private residential dwellings, or in the transitional periods between home, seniors' residences, assisted living facilities, nursing homes, and hospitals.  My dissertation also does not discuss home care reforms that have occurred since May 2013.  For instance, I do not touch on the elimination of both regionalization in Alberta and the CCACs in Ontario.  My analysis studies only the impacts of the neoliberal restructuring of home care during the period beginning with the election of Klein in 1992 up until the conclusion of my interviews in May 2013.

## Directions for Future Research

In the same way that integrated care can occur at different levels - the macro level where policy makers establish the general statutory framework, the meso level where organizations establish cooperative relations, and the micro level where professionals or groups take autonomous initiatives (Delnoij *et al*. 2002) - there are opportunities for further research at all three levels as well.

Future work is needed to establish specific policy recommendations regarding home care restructuring at the provincial and federal levels that are better positioned to navigate the

"divide" between equity and efficiency outcomes. As Jenson (2015, 540) argues, "there can be excellent analyses of the patterns of gendered inequalities without any solid prescription for equality". With the Trudeau government's promise of $1 billion for home care infrastructure over four years, starting in 2018–19 (Government of Canada 2017b), it is important to change this. There is a pressing need to tackle structural conditions, such as public funding levels and for-profit service provision, that shape how home care programs, including ICPs, are designed and implemented. It is important to close the gap between academics, policy makers, program administrators, paid care workers, family and other unpaid carers, and clients by creating spaces for dialogue. We must convert our understandings of how inequality/inequity is generated and socially reproduced into concrete policy recommendations that can at least reduce inequality and inequity, even if we cannot eradicate them entirely.

This study has shown that using neoliberal policy techniques focused on improving efficiency, does not offer a successful path forward for tackling the fragmentation in home care delivery. Yet, the range of options that policy makers might deem "legitimate" will be constrained by their pre-existing assumptions about the overall shape of political, social and economic conditions under neoliberalism. However, the status quo is not an option. We must articulate clear policy options for governments rooted in a critical analysis of the current system. We can outline how existing and/or additional public resources might be better spent to spread the responsibility of aging across society rather than concentrating it on clients, within families, and on precariously employed care workers.

Through my doctoral work at the micro level, two topics at the meso level have stood out as warranting further research. In light of the push to contract care out of the public sector to not-for-profit and for-profit agencies, there is a need to explore possibilities for better integration

and collaboration across sectors.  My research indicated a virtual absence in communication and collaboration among paid workers in for-profit agencies and those in public or not-for-profit organizations despite working for the same client, in the same home, often at the same time. This has implications for care continuity, effective communication, information-sharing, team work, etc., and warrants further consideration.

Second, there is a need for more research around the possibility of better integrating care in the transitional phases of a client's journey along the health care continuum - between home, private seniors' residences, assisted living facilities, long-term residential care homes, and hospitals.  These transitions are often times of significant disruption for clients and family carers as the client's care needs, place of residence, and paid care workers change.  We need to better understand what kinds of arrangements can help support clients and unpaid carers through these transitional periods to minimize their stress and uncertainty and maximize their health outcomes and wellbeing.

Finally, more work is needed to understand how we can move away from a "home is best for everyone" philosophy and an ALC-focused home care strategy that perpetuates a crisis model of care.  A better system would be one where homes, assisted living facilities, and long-term residential care homes are all taken seriously as good places to age with dignity.  Research at the local level is required to look, for example, at the possibility of using seniors' communities that include private residences, assisted living facilities, retirement residences, low-income housing units, long-term residential care homes, and palliative care beds, to ease the transitions points along the care continuum.  Case studies worthy of consideration include Finlandia Village in Sudbury and Georgian Village in Simcoe County.  Both are seniors' communities that include a range of housing and assistance options designed to prioritize a smooth transition as seniors age.

How the state could support these types of set ups and the potential classed, gendered, and racialized implications for clients and carers are worthy of serious consideration.

## Conclusion

This dissertation has revealed how ICPs are embedded in the wider social, economic, and political relations of power resulting in gendered, classed, and racialized experiences of home care. Neoliberalism has fundamentally transformed home care through the reworking of relationships among those involved in ICPs. ICPs that use neoliberal policy techniques to design and deliver care reinforce inequality and inequity between, and among, clients, unpaid carers, and paid care workers. In this dissertation, I have shown that neoliberal policy techniques often meet the expressed needs of clients and carers in positions of power and privilege, while further marginalizing those from vulnerable groups. This perpetuates fragmentation as clients are required to seek care from the private sector, and carers must navigate workplaces characterized by strict power hierarchies. The result is increased inefficiency for the state as paid worker turnover increases, unpaid carers burn out, and more clients end up in hospitals, doctors' offices, and nursing homes when their unmet care needs reach a tipping point. In contrast, ICPs that use policy techniques that challenge neoliberalism are better positioned to reduce fragmentation. These policy techniques more evenly and fairly distribute both care and power between, and among, clients and carers. The pursuit of equality and equity is fundamental to the reduction of fragmentation in home care because of its ability to break the vicious cycle of fragmentation and inefficiency created by neoliberal policy reforms. My conclusion is that ICPs that use policy techniques in opposition to neoliberalism can better meet the expressed needs of clients, unpaid carers, and paid care workers regardless of differences in positions of power, privilege, and vulnerability.

Understanding that neoliberalism is produced in, and through, human actions, opens up possibilities for resistance (Ward & England 2007a, 19). This study of ICPs disrupts the "common sense understandings in society" (Mitchell *et al*. 2004, 4) that increasing efficiency reduces fragmentation. ICPs have the ability to make positive change in the home care system by implementing policy techniques that challenge neoliberal ways of working and, in doing so, combat fragmentation. In fact, many already are through promising practices such as providing care without fees, supporting care workers, giving carers time to talk to their clients, and implementing collective forums for collaborative teamwork. It is difficult to work towards more equity in an inequitable world as any approach is likely to hold different consequences for differently situated clients and carers (Braedley & Martell 2015, 76). Yet, in this dissertation, I call for ICP program administrators to prioritize the use of policy techniques that aim to more evenly and fairly distribute the costs and benefits of ICP involvement. Providing more equitable, accessible, and good quality home care within a neoliberal context is certainly challenging, but as ICP policy techniques are redefined to ensure that public money is employed for the public good, these goals become more attainable. It is my hope that by drawing attention to how ICPs can be used to redress the fragmentation that has arisen in a home care system reshaped by neoliberalism that I create momentum for program administrators, unpaid carers, paid care workers, and clients to pursue equity as their primary policy goal. When ICPs work for the benefit of everyone - clients and carers, the privileged and the powerless - the expressed needs of home care clients and their paid and unpaid carers can be met.

# Appendices

## Appendix 1: Interview Guide for Clients

This interview will take approximately 90 minutes.  The following lists of topics will be discussed in the interview. This is a semi-structured interview schedule therefore the topics will vary slightly based on the answers to questions.

A. Services Received
1. What services do you receive from this program?
2. How long have you been receiving these services?
3. How often do you receive these services? (e.g. how many times per day or week)
4. Do you go to a day center or medical center for additional services?
    a. How long have you been attending this center?
    b. How often do you go?
    c. What sorts of services do you get here?
    d. Who schedules these services?
    e. How do you get there (i.e. transportation)?

B. Initial Contact
Describe how you contacted (or were put in touch with) this program.
1. What were the events leading up to this?
2. Was it a self-referral or did a professional or family carer make the referral?
3. Were you in the hospital or at home at the time of referral?
4. Why did you select this particular program?
5. Who was your initial contact with?
6. How did you feel about the initial contact?
7. What (if any) were your expectations of this program?
8. Did you feel you needed the services offered by this program?
9. Was joining the program the right thing to do?

C. Needs Assessment
1. When you first joined the program, were you asked questions about your health and social care needs?  If so, can you describe this experience to me?  Who asked you these questions?
2. Were you aware of any assessment (of your needs or your home) taking place?
3. If so, was there one assessment or more than one?
4. Were you provided with a written care plan?  If so, where is this document kept?  Do you know why it was written?
5. Was there a waiting list to receive any of the services offered by the program?
6. Do you get the care you need from this program when you need it?
7. Are there services missing from your current care plan that you feel you need?  Why are you not getting these services?

D. Evidence of Person-centred Care
1. Do you feel that you were involved in any decisions made about your care? Did you have a say in what happened? (Give examples)
2. Do you get care you want?
3. Do you feel you are treated with respect? If so, can you give me an example? If not, can you give me an example?
4. Did a family carer (or spouse) arrange for you to join this program? If so, did you feel confident that this person understood what you needed?
5. What sort of information was provided by the service? Was this the right information for you? Was it presented in a way you could understand?

E. Evidence of Integrated Care
1. Do the program staff keep you informed about your case?
2. If so, how do they keep you up to date on your progress?
3. How many different services do you receive?
4. How many paid carers are involved with your care?
5. Are there enough paid care providers?
6. How many people help you out regularly who are not paid? What types of things do they do for you? How often?
7. Do you need more help than you are getting?

If more than one formal carer, ask:
8. Do the care providers change frequently or do you see the same people regularly?
9. Do the different paid carers know what they are each doing for you?
10. Are the different paid carers aware of how you are doing?
11. Do you know which paid carer is in charge of your case?
12. Who would you get in touch with if you have any questions of concerns about your case?
13. Is there a way that you can make a complaint? Does anything happen as a result?
14. If there are any changes to your condition, do you think that the paid carers would be aware of this? If so, how?
15. If you were hiring your care providers, what would you look for?

F. Experience in Program
Based on questions in Section E above, try to discover the service users' experience of each program's integrated services.
1. Can you describe your experience receiving care from your carers?
2. Would you say the program meets your needs?
3. Can you describe how this program has changed things for you?
4. Have you been able to receive services or attend clinics, day centers at a time that suited you (and whomever takes you to these appointments/clinics, if relevant)?
5. Do you feel safe? What helps you feel secure?

G. Experience of Personal Care
1. What was your experience with the personal care given to you by formal (paid) carers?
2. What kinds of services do you receive?
3. Was enough time allocated to you?

4. Are there services you feel you need that are not being offered?  How do you get these services now?  Does the program help you make appointments for these services?
5. Can you request a carer with whom you felt most comfortable?
6. Can you ask for carers to come at a time convenient to you?
7. Have the services provided by the program been reliable? (i.e. Do carers show up when expected?  Do you know which carer was coming, and why they are coming?  Are you told about a carer's holidays in advance, and does another carer come in their place?  What happens if a carer is sick?)
8. If a new carer is coming, do they know about your needs and how to care for you?
9. Is privacy important to you and, if so, can you have privacy when you want it?
10. How do your carers manage sensitive issues, such as dignity, privacy or confidentiality?
11. Can you talk about your worries or feelings with your formal carers?

H. Experience of Health Care
1. What was your experience with the health care given to you by formal (paid) carers?
2. What kinds of services do you receive?
3. Is enough time allocated to you?
4. Are there services you feel you need that are not being offered?  How do you get these services now?  Does the program help you make appointments for these services?  Is transportation provided?
5. How much do you see your family doctor?  Are they aware of your participation in the program?  How involved are they in it?
6. Can you request a carer with whom you feel most comfortable?
7. Can you ask for carers to come at a time convenient to you?
8. Have the services provided by the program been reliable? (i.e. Do carers show up when expected?  Do you know which carer was coming, and why they are coming?)
9. If a new carer is coming, do they know about your needs and how to care for you?
10. How have your carers managed sensitive issues, such as dignity, privacy or confidentiality?
11. Can you talk about your worries or feelings with your carer?

I. Financial Considerations
1. How do you pay for your care?
2. Do you pay for extra services or extra care? If not, would you like to do so?
3. Do you have any comments about the cost of this program?
4. Do you get financial help?  Is it enough to allow you to cover the costs of the program?

J. Overall Experience with Program
1. Can you describe your overall experience with this program?
   a. What, if anything, can be done to improve this program?
   b. What was the best thing about this program?
   c. What was the worst thing about this program?

K. Is there anything else you would like to tell me?

*Thank you for your participation.*

# Appendix 2: Interview Guide for Paid Carers

This interview will take approximately 90 minutes. The following lists of topics will be discussed in the interview. This is a semi-structured interview schedule therefore the topics will vary slightly based on the answers to questions.

A. Formal Carer's Individual Role
1. How long have you worked with this program?
2. How long have you worked in long-term care?
3. How long do you plan to work here?
4. Why did you decide to work for this program?
5. In your view, what should be the main purpose this program?
6. Do you work full-time, part-time, casual? Would you prefer other hours and, if so, why?
7. Can you describe your day, starting with when you come to work?
8. What are your favourite and least favourite parts of your working day?
9. On a good day, what is best about your job? What makes a bad day?
10. What sorts of things do you do?
11. Do you enjoy your work?
12. If you could change one thing about your workplace, what would it be?
13. What are the values that you think are most significant in the day- to-day work in this program? What is acknowledged by your colleagues as most important?

B. Training, Pay, Hours, Conditions, Job Security, Job Satisfaction
1. Do you enjoy your job?
2. Are you satisfied with your working conditions? (e.g. hours worked, breaks, environment)
3. Do you think that you are paid well enough for the job that you do?
4. Do you get paid holidays?
5. Do you get increased pay for off hours? (nights, weekends, evenings)
6. Do you feel that your job is secure?  Can you tell me why? (or why not)
7. What formal education do you have?
8. When did you last attend training updates of any kind and for what?  How often are training or education opportunities available to you?
9. Are you ever asked to do things that you don't feel trained (or ready) to do?
10. What kind of education do you think workers should have?
11. How are your hours (or duties) organized?
12. Do you have any say in how your work is organized?
13. Do you feel valued? (by your organization, managers, team, clients)
14. Do you feel supported? (by your manager, team, informal carer)
15. Do you have a say in whom you look after?
16. Do you have a say in what you do?
17. Do you have a say about when and for how long you do tasks?
18. Is there a way you can make a complaint and does anything happen as a result?
19. Is your workplace safe? If not, how could it be made safer?
20. How do you deal with the emotional aspects of your work?

21. What kind of reporting do you do? How much time does it take and what is your assessment of the impact on your work and on care?

C. Evidence of Integrated Care
1. Does your job involve 'integrated' working between health and social care?
2. Can you tell me what 'integrated care' means to you?
3. Would you say that all the paid carers involved in the service user's care are able to collaborate and work together for the user?
4. Do you know others carers who are involved with your service user?
5. How many different care providers (both health and social) do you work with during the day? Does this work for you or do you have ideas about how it could be better organized?
6. How do you communicate with other carers involved in your service user's case? Are you able to contact these other carers if the need arises to discuss a case?
7. Can you plan any changes to care alongside other professionals?
8. How does working with a program that uses an integrated care approach affect your working practice on a day-to-day level?
9. Are there enough care providers? If not, what would be the most effective number and kind of workers?
10. Is a case manager or lead carer identified? (between health and social care) Could you describe how the lead carer is chosen and how this is communicated to the service user?
11. What advantages/disadvantages exist for you as a member of an integrated care program?
12. Compare your role now with other jobs that haven't been about providing integrated care. What do you do differently now?
13. Does your organization support you in integrating care?
14. Have you experienced conflict with other professional groups? Are you able to provide examples of this?
15. Have you experienced collaboration with other professional groups? Are you able to provide examples of this?
16. Have you experienced conflict with informal carers? Are you able to provide examples of this?
17. Have you experienced collaboration with informal carers? Are you able to provide examples of this?
18. If there has been conflict, does your organization help you to find solutions to these problems?
19. So you have time to coordinate meetings with others people who provide care/assistance to your service user? Are you able to share data about service users?
20. Do you see the same users regularly? If so, is this appropriate? If not, is that appropriate?
21. If you were hiring care providers, what would you look for?
22. If you were organizing the work, what would be your priorities?

D. Access to Service
1. Does your job involve helping service users access this program?
2. If so, describe how service users access the program.
3. Can individuals self-refer, or do they need to contact you through another professional or organization? (e.g. family doctor, community care access center, regional health authority)

4. Do you think that potential service users are able to access this program if they need it?
5. Do you gather information about individuals who may contact your service but do not gain access to the program for any reason? (e.g. users who decline to receive services, or who do not fit all the admission criteria to the program)

E. Needs Assessment
1. Does your job involve assessing whether or not a service user needs the program?
2. If so, can you describe the process of assessing a user's needs within this program?
    a. Is there usually one assessment or do several professionals make their own assessments?
    b. What actually conducts the assessment?
    c. Where are the assessments done? (outside or inside the home)
    d. How do you communicate the outcome of any assessment to the service user and their informal carer?
    e. Is there a written care plan for each user?  If so, is this shared with other agencies involved?  How is the care plan reviewed or evaluated?
    f. Is this program able to provide care and support to all users who fit the program criteria?  (i.e. are there times when assessed needs cannot be met due to lack of resources)
    g. Is there a waiting list for any part of this program?  If so, how long would a potential user need to wait (on average) before receiving assessment or services?

F. Purchasing Care
1. Is your service user charged for the service you provide?
2. If so, describe how the program organizes and supplies care for users.
3. In your view, are the services provided to the user through this program reliable?
4. Are users able to afford this program?
5. Can you describe how being part of this program has changed things for your servicer user or their informal carers?
6. Can service users (or their informal carers) arrange to attend appointments or have services delivered to them at home at a time that suits them?
7. Is cost control an issue in this program and does it have an impact on your work?
8. Do service users' finances make a difference in the kind of care you can provide?

G. Person-centred Care
1. How do you see 'person-centred' care?
2. How do you involve users and their informal carers in decisions about their cases in this program?
3. Are you able to discuss each case with the service user involved?
4. To what extent are informal carers involved in decisions?
5. Does the service users have a say in the outcome of his/her case?
6. Are there any arrangements in place to get feedback and comments from service users about the program?  If so, how is this information used with the program?

H. Discharge Issues
(Optional – only use if the program has a documented discharge process and the carer being interviewed plays a role in this process)
1. Does your job involve planning discharge from the program?
2. If so, describe how discharge is planned within this program.
3. How do you assess whether a service users is ready for discharge?  What are the discharge criteria?
4. Are all the other health and social carers involved with the user informed of an impending discharge?
5. Is there any follow up of users after they have left the program?
6. Can users or their informal carers self-refer if they require the program again?

I. Overall Experience of the Program
1. Can you describe how you see this program?
2. What, if anything, can be done to improve this program?
3. Are you able to compare this program with other similar programs or services that you have been involved with?
4. What do you think is the best thing about your service?
5. What do you think is the worst thing about your service?

J. Is there anything else you would like to tell me?

***Thank you for your participation.***

## Appendix 3: Interview Guide for Unpaid Carers

This interview will take approximately 90 minutes. The following lists of topics will be discussed in the interview. This is a semi-structured interview schedule therefore the topics will vary slightly based on the answers to questions.

A. Services Received
5. What services does your relative/friend receive from this program?
6. How long have they been receiving these services?
7. How often do they receive these services? (e.g. how many times per day or week)
8. Do they go to a day center or medical center for additional services?
   a. How long have they been attending this center?
   b. How often do they go?
   c. What sorts of services do they get here?
   d. Who schedules these services?
   e. How do they get there (i.e. transportation)?

B. Initial Contact
1. How did you/your relative come to be in contact with this program?
2. Why did you contact this program?
3. What were the events leading up to this?
4. Were you providing care to your relative before the program became involved?
5. If so, can you describe what sort of care you were providing?
6. How often do you see your relative now that they are part of this program? How does this compare to how often you saw them before?
7. Are you still providing care to your relative? How has this changed since your relative's entry into the program?
8. Did you make the referral, or did a professional make the referral?
9. Was your relative in the hospital or at home at the time of referral?
10. Who was the initial contact with?
11. How did you feel about the initial contact?
12. What (if any) were your expectations of this program?
13. Did you feel you/your relative needed this program?
14. Was it the right thing to do?

C. Needs Assessment
1. Were you asked questions about your relative's health and social care needs? If so, can you describe this experience to me?
2. Were you aware of any assessment (of your relative's needs or home) taking place?
3. If so, was there just one assessment, or more than one?
4. Were you (or your relative) provided with a written care plan? If so, where is this document kept? Do you know why it was written?
5. Was there a waiting list to receive any services offered by the program?
6. Does your relative get the care they need from this program when they need it?

D. Evidence of Person-centred Care
1. Do you feel that you are involved in any decisions made about your relative's situation? Do you have a say in what happens? (Provide examples).
2. Are you getting what you want from this program?
3. Is your relative getting what they want from this program?
4. Do you feel like you are treated with respect? If so, can you give me an example? If not, can you give me an example?
5. Do you feel your relative is treated with respect? If so, can you give me an example? If not, can you give me an example?
6. Do you feel confident that you understand what your relative needs?
7. Do you feel confident that the program staff understands what your relative needs?
8. What sort of information is provided to you by the service? Is it the right sort of information for you? Was it presented in a way that you can understand?

E. Evidence of Integrated Care
1. Does the staff keep you informed about your relative's case?
2. If so, how do they keep you up to date on their progress?
3. How many different services does your relative receive?
4. How many formal carers are involved with your relative's care?
5. Are there enough paid care providers?
6. Do the care providers respond to your relative's needs? Can you identify factors that make this possible or would make this possible?
7. How many people care for your relative regularly who are not paid? What types of things do they do? How often?

If more than one formal carer, ask:
16. Do the care providers change frequently or do you see the same people regularly?
17. Do the different paid carers know what they are each doing for your relative?
18. Are the different paid carers aware of how your relative is doing?
19. Do you know which paid carer is in charge of your relative's case?
20. Who would you get in touch with if you have any questions of concerns about your relative's case?
21. Is there a way that you can make a complaint? Does anything happen as a result?
22. If there are any changes to your relative's condition, do you think that the paid carers would be aware of this? If so, how?
23. If you were hiring your relative's care providers, what would you look for?
24. If you were organizing the work of the paid carers, what would be your priorities?

F. Experience in Program
Based on questions in Section E above, try to discover the unpaid carer's experience of each program's integrated services.
6. Can you describe your relative's experience receiving care from their carers?
7. Would you say the program meets their needs?
8. Can you describe how this program has changed things for your relative?
9. Have you been able to arrange for your relative to receive services or attend clinics, appointments, or day centers at a time that suited you (if you need to be present)?

10. Do you feel that your relative is safe?
11. Does the program offer any services for you as an informal carer?
12. If so, what has been your experience with these?
13. Are there services or supports that the program could offer but does not currently that you want or need?
14. How do you deal with the emotional aspects of your unpaid care work?
15. Are you ever in the situation where you are required provide care to your relative that you don't feel trained (or ready) to offer? (Provide examples)
16. Have you experienced conflict with the formal carers?  Are you able to provide examples of this?
17. Have you experienced collaboration with the formal carers?  Are you able to provide examples of this?
18. If there has been conflict, does the program administration help you to find solutions to these problems?

G. Experience of Personal Care
12. What was your experience with the personal care given to your relative by formal (paid) carers?
13. What kinds of services does your relative receive?
14. Was enough time allocated to your relative?
15. Are there services you feel your relative needs that are not being offered?  How do they get these services now?  Does the program help you/your relative make appointments for these services?
16. Can you request a carer with whom you and your relative feel most at ease?
17. Do you have a say in what care providers do for your relative?
18. Do you have a say about when care providers come to look after your relative?
19. Have the services provided by the program been reliable? (i.e. Do carers show up when expected?  Do you know which carer was coming, and why they are coming?  Are you told about a carer's holidays in advance, and does another carer come in their place? What happens if a carer is sick?)
20. If a new carer is coming, do they know about your relative's needs and how to care for them?
21. Do you think privacy is important and, if so, is there enough privacy?
22. How do your relative's carers manage sensitive issues, such as dignity, privacy or confidentiality?
23. Can you talk about your worries or feelings (about your relative) with their formal carers?

H. Experience of Health Care
12. What was you experience with the health care given to your relative by formal (paid) carers?
13. What kinds of services does your relative receive?
14. Is enough time allocated to your relative?
15. Are there services you feel your relative needs that are not being offered?  How do they get these services now?  Does the program help you/your relative make appointments for these services?  Is transportation provided?

16. How much does your relative see their family doctor?  Are they aware of your relative's participation in the program?  How involved are they in it?
17. Can you request a carer with whom you and your relative feel most at ease?
18. Do you have a say in what care providers do for your relative?
19. Do you have a say about when care providers come to look after your relative?
20. Have the services provided by the program been reliable? (i.e. Do carers show up when expected?  Do you know which carer was coming, and why they are coming?)
21. If a new carer is coming, do they know about your relative's needs and how to care for them?
22. How have your relative's carers managed sensitive issues, such as dignity, privacy or confidentiality?
23. Can you talk about your worries or feelings (about your relative) with your carer?

I. Financial Considerations
5. How does your relative pay for their care?
6. Do they pay for extra services or extra care? If not, would they like to do so?
7. Do you paid for any of your relative's care?
8. Do you have any comments about the cost of this program?
9. Do your relative get financial help?  Is it enough to allow them to cover the costs of the program?

J. Overall Experience with Program
2. Can you describe your overall experience with this program?
3. Can you describe your relative's overall experience with this program?
4. What, if anything, can be done to improve this program?
5. What was the best thing about this program?
6. What was the worst thing about this program?
7. Is there anything else the program could do, or offer, that would help you in your role as an informal carer?

K. Is there anything else you would like to tell me?

*Thank you for your participation.*

## Appendix 4: Interview Guide for Program Administrators

This interview will take approximately 90 minutes. The following lists of topics will be discussed in the interview. This is a semi-structured interview schedule therefore the topics will vary slightly based on the answers to questions.

A. General Descriptive

1. What is your role and responsibilities within this program?
2. How long have you worked with this program?
3. How long have you worked in long-term care?
4. What is your understanding of your organization's role in providing long-term care (policy, funding, service provision, brokerage, advocacy)? Has this changed?
5. How is the program funded? Has this changed, and if so, how?
6. How does funding influence staffing and other aspects of access, quality and accountability in the program?

B. Program Organization
1. Who works in your program? (professional, paraprofessional)
2. How is staffing arranged? By whom and on what basis?
3. Are employees organized in any way, such as a collective bargaining unit or other mechanism?
4. How is work organized? (i.e. job categories, hours of work, staffing levels, work intensity, tasks)
5. Who decides how work is organized on what basis?
6. What are some of the toughest challenges in organizing work? What would help you address these challenges?
7. What policies or practices do you consider to be particularly positive for staff in your program?
8. Are there guidelines, requirements or options for staff to obtain credentials? How is this organized?
9. Are there mechanisms for accountability that you feel ensure a) quality care, b) respect for users, carers and family, and c) accurate, appropriate and timely information to funders in your program?

C. Integrated Care
1. What is your understanding of 'integrated care' between health and social care?
2. Does your program focus more on one type of care?
3. Which formal carers do you regularly (at least weekly) have contact with?
4. How many informal carers do you regularly (at least weekly) have contact with?
5. To what extent are you able to work together with other administrators, paid and unpaid carers?
6. What arrangements exist to help the program administration staff communicate with the carers involved in your cases?
7. How does 'integrated care' affect your working practice on a day-to-day level?
8. Compare your role now with other jobs that haven't been about integrated care.

a. What do you do differently now?
b. Is there clarity about where professional roles begin and end?
c. How does this program fit in alongside other services for the same targeted service user group?
d. Are policies and protocols clear? (i.e. are these written down, easy to find, and often used by carers)

9. Are there areas of your program that could be better integrated? Where do you see these gaps in integration?

D. Process

1. Describe how users access the services your program provides.
   a. Do you think that potential users are able to access this program if they need it?
   b. Can individuals self-refer or do they need to contact you through another professional or organization? (e.g. doctor, community care access center, regional health authority)
   c. Are clients assessed before entry to the program to see whether they are suitable?
   d. Would you consider this program to be 'demand-led' (i.e. services are supplied to all users that meet the criteria) or 'supply-led' (services are in short supply and thus are targeted at the high risk, vulnerable users)?
   e. Can the program help everyone who fits the criteria? Is there ever a shortfall between supply and demand?
   f. Is there a waiting list for any part of the program?
   g. Do you gather information about individuals who may contact your program but do not gain access to it for any reason? (e.g. users who decline to receive services, or who do not fit all the admission criteria to the program)

2. Can you explain how service users' needs are identified within your program?
   a. Is a holistic needs assessment conducted? (i.e. single assessment)
   b. Is there usually one assessment, or do several professionals make their own assessments?
   c. Which of the following areas would the assessment(s) cover?
      i. Physical health/well-being
      ii. Functional health/well-being (i.e. ability to do ADLs/IADLs)
      iii. Mental health (e.g. emotions, safety, support, isolation)
      iv. Cognitive health (e.g. independence, decision-making, presents of cognitive impairment)
      v. Current family and informal support
      vi. Housing issues (e.g. appropriate housing for dependency, availability of aids in house)
      vii. Financial issues (e.g. ability to pay, savings, insurance)
   d. Is a written care plan drawn up to document assessment, needs and care? Is so, is this given to users? Is it accessible to all carers who are involved with the user?

3. Is it your experience that the program can provide person-centred care?
   a. How are users and their informal carers involved in decisions about their individual cases within this program?
   b. What steps are taken to involve users and informal carers in the audit of this program? Are their user feedback groups with this program structure?
   c. What do you think your service users get from your program? Are you able to give examples?

4. How is discharge from this program organized?
   (Optional – use only if the program has a documented discharge process)

   a. How are other carers involved in a user's care included in discharge planning?
   b. What sorts of criteria exist for deciding to discharge a user?
   c. How are users and informal carers involved in the discharge planning process?
   d. How sort of follow up arrangements exist?
   e. How do users access the service if their needs change again after discharge?

E. Overall Perspectives of Integrated Care within this Program

1. What can be done to improve this program?
2. What are the best examples of improvements in integrated care that this program offers? (ask for details/examples)
3. What are the main continuing problems with integrated care experienced by this program? (ask for details/examples)
4. Is this program under any sort of threat? (e.g. funding, competition)
5. Is this program likely to be expanded or adopted in other part of your province/country?
6. What would you do differently after experiencing integrated care or what might you do differently to promote more integration between health and social care? Different care providers?

F. Is there anything else you would like to tell me?

***Thank you for your participation***

# Appendix 5: Sample Description

| Program | Participant Category | Number of Participants | Carer Roles | Gender Breakdown | Visible Minority Breakdown |
|---|---|---|---|---|---|
| CHOICE | Administrator | 2 | | Women: 2 Men: 0 | Visible minority: 1 |
| | Paid carer | 10 | CHSW OT Physician LPN Recreation therapist Clinic clerk PT Pharmacist Social worker | Women: 8 Men: 2 | Visible minority: 3 |
| | Unpaid carer | 5 | Spouse Sibling Child | Women: 4 Men: 1 | Visible minority: 0 |
| | Client | 5 | | Women: 3 Men: 2 | Visible minority: 0 |
| AIP | Administrator | 2 | | Women: 2 Men: 0 | Visible minority: 0 |
| | Paid carer | 11 | HSW Public health nurse Foot care nurse CCAC case coordinator Nurse practitioner Driver COC | Women: 8 Men: 3 | Visible minority: 3 |
| | Unpaid carer | 5 | Sibling Child | Women: 5 Men: 1 | Visible minority: 0 |
| | Client | 6 | | Women: 4 Men: 2 | Visible minority: 0 |
| SMILE | Administrator | 3 | | Women: 3 Men: 0 | Visible minority: 0 |
| | Paid carer | 7 | Homemaker Manager of a homemaker agency CCC Driver Outdoor maintenance | Women: 6 Men: 1 | Visible minority: 0 |
| | Unpaid carer | 5 | Spouse Child | Women: 5 Men: 0 | Visible minority: 0 |
| | Client | 6 | | Women: 4 Men: 2 | Visible Minority: 0 |

| Program | Participant Category | Number of Participants | Carer Roles | Gender Breakdown | Visible Minority Breakdown |
|---|---|---|---|---|---|
| Carefirst | Administrator | 8 | | Women: 7 Men: 1 | Visible minority: 8 |
| | Paid carer | 11 | PSW CSC Recreation therapist Homemaker Social worker Driver | Women: 10 Men: 1 | Visible minority: 11 |
| | Unpaid carer | 5 | Spouse Child | Women: 4 Men: 1 | Visible minority: 5 |
| | Client | 5 | | Women: 3 Men: 2 | Visible minority: 4 |
| HHH | Administrator | 3 | | Women: 3 Men: 0 | Visible minority: 0 |
| | Paid carer | 7 | CHW Case manager Community health nurse OT ADP coordinator Team leader/RN | Women: 5 Men: 2 | Visible minority: 0 |
| | Unpaid carer | 5 | Spouse Sibling Child | Women: 5 Men: 1 | Visible minority: 1 |
| | Client | 7 | | Women: 4 Men: 3 | Visible minority: 0 |

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