

### ***I. Summary: Reimagining Long-term Residential Care; International Study of Promising Practices***

“A society that treats its most vulnerable members with compassion is a more just and caring society for all” (WHO 2002:5). Long-term residential care is where many of our most vulnerable members live and, in spite of moves towards aging in place, where many will continue to live in the future. It is also a workplace for thousands of paid and unpaid providers, most of whom are women and many of whom are from racialized communities. It is a barometer of values and practices; a signal of economic, cultural and social perspectives. It raises issues well beyond specific services and practices; issues such as human and social rights, the role of the state, responsibilities of individuals and families, work organization and skills; and notions of care. Yet too often it is characterized as failure; failure of the family to care, failure of the health care system to cure and failure of the individual to live independently, perhaps explaining why it has received so little research and policy attention.

Instead of focusing mainly on failures, this project identifies promising practices for conceptualizing and organizing long-term care, learning from and with other countries. What approaches to care, to work organization, to accountability, to financing and ownership offer the most promising practices when the goal is to treat both providers and residents with dignity and respect, to understand care as a relationship and to take differences and equity into account? What contexts and conditions support these practices, allowing residents and providers to flourish? These are questions for the social sciences and humanities, as well as for those who deliver, those who organize and those who need care. Our international, interdisciplinary team is uniquely placed to do so. Our academics are among the few who have done theoretical, empirical, comparative and policy work on residential care, using interdisciplinary, gender and diversity perspectives. Our collaborators are experienced administrators; our partners represent seniors, providers and employers. To insure cross-fertilization, we plan a ‘multi-logue’ among countries, among disciplines and among academics, employers, unions and our seniors partners. We employ innovative multi-method approaches, with site-switching, rapid ethnography used for primary data collection.

Our organizational structure is integrally related to our methodology. Under the entire team’s guidance, members in the four theme areas (approaches to care, work organization, accountability, financing and ownership) begin with mapping residential care in each jurisdiction, providing both a portrait and analysis. Each theme includes an international member, a partner and two leaders from different disciplines. A system for sharing and organizing all documents ensures cross-theme integration. While mapping is ongoing throughout, this first layer provides the basis for key informant interviews and team development of protocols for site selection and primary data collection in layer II. At this stage, half the theme members move to another theme, ensuring both cross-pollination and continuity. In layer III, a Canadian-led team, involving at least one local researcher, conducts rapid ethnographies of foreign facilities. Similarly, a foreign researcher accompanied by a local one leads sites visits in Canada, again with protocols and web-based systems ensuring data sharing across the team in a timely, rigorous manner. Although analysis is ongoing, layer IV focuses mainly on an iterative analysis of our theory and data and a reflexive analysis of our method.

Both our organizational structures and methods are intended to build in interdisciplinary perspectives, along with those of our partners experienced in daily practices, and to stimulate innovative thinking by constantly bringing fresh eyes, balancing the need for comparison and rigour with openness to new insights and diverse contexts. The project allows academics and partners to think through the practical implications of theory and the theoretical implications of practices and processes. It will create conditions for breakthroughs in theory, empirical results, processes of collaboration, policy and practices not only about conceptualization of care and their implications but also about ways of doing and sharing research, filling major gaps in knowledge about long-term care.

Throughout the project we will engage in knowledge translation at conferences, in journals and in books. We will also produce plain language documents as well as technical reports and presentations for the media, for community groups, for employers, for policy-makers and for unions.

## **II. Detailed Description**

### ***Re-imagining Long-Term Residential Care: An International Study of Promising Practices***

#### **Objectives**

Given the goal is to treat both providers and residents with dignity and respect, to understand care as a relationship and to take differences and equity into account, we seek to:

- a. identify approaches to care, to work organization, to accountability, and to financing and ownership in long-term residential care that offer the most promising practices.
- b. identify the contexts, regulations, funding and conditions that allow residents and providers to flourish.

#### **Research Questions**

Our research is organized around four overlapping, interacting and integrating themes that are central to social science and humanities as well as to long-term residential care: namely, approaches to care, work organization, accountability and financing and ownership. These lead to four overarching, related questions.

1. What approaches to and what models of care support long-term care as a viable, desirable and equitable option for individuals, families and caregivers, in the process promoting and supporting a more inclusive notion of citizenship?
2. What kinds of work organization and care models best meet the needs and balance the rights of residents, providers, managers, families and communities?
3. What are the promising practices in approaches to accountability that nurture care and inspire quality workplace relations in long-term residential facilities?
4. What innovative financing and ownership models are promising in terms of ensuring equitable access to quality long-term residential care while reducing the offloading of both material and other costs onto workers, employers, families or individuals?

More specific questions can be found within the sections discussing each of the themes and will be developed within the teams organized around themes.

#### **Issues**

Very little research in Canada or abroad focuses on residential care. The research that has been published tends to document problems, such as resident abuse, low staffing levels and infection rates (McGregor et al. 2005; McGregor 2006). Less attention has been paid to policies for providing quality care, or for integrating analyses that recognize the importance of gender, of population or provider diversity, and of increasingly complex needs. Virtually none has been done on the relationship between conditions of work and conditions of care, even though research on hospitals has established this link (Aiken et al. 2002). As the OECD (2005:5) concludes, “long-term care still lags behind acute health care when it comes to measurement and quality improvement strategies”. The WHO (2002:5) points out that “strategies for providing long-term care have been low on government agendas everywhere”. Similarly, on the basis of Canadian data, Berta et al. (2006:176) argue that “policy around nature (sic) and quality of long-term care (LTC) for the future is virtually absent from the political agenda”. Armstrong & Banerjee (2009) explain in their article exploring the basis of this negligence that it reflects the North American characterization of such care as failure: failure of medicine to cure, of the family to care, and of the individual to be independent (see also Chivers 2003:57-58). It also reflects, as Struthers (1998) shows, the long shadow of hospitals in shaping the care. Residential care, as Guberman (2004) puts it, remains the last and least attractive option, one we seek to avoid rather than to positively develop.

Yet the demand for long-term residential care in Canada and abroad will not decline in the near future. Indeed, it is likely to grow as well as change. Hospital care is increasingly focused on short-term acute

care and outpatient services while many psychiatric, chronic care and rehabilitation hospitals have closed, increasing the intensive care needs outside hospital just as families have become smaller and more dispersed (Armstrong & Armstrong 2002). At the same time, the number of elderly will double in Canada in less than two decades, and similar patterns are evident throughout other high-income countries. This “demographic tsunami” presents what the WHO (2002:vii) calls an “urgent challenge” for long-term care. The current emphasis on aging in place and independent living, focusing on care in individual private homes, can address some of the problems for those without extensive physical, social, mental, medical or housing needs. But this leaves many who will need more collective, residential care. This is particularly the case for those with complex, intensive care needs; for those who are alone, without relatives, friends or family who are willing and able to provide support (Guberman et al. 2006); for those who do not have homes or homes that are safe; and for those who are poor. And it is particularly the case for both women (who account for the vast majority of those currently in such care because women live longer than men, are more likely to be poor and more likely to be without care providers in their old age) and for those who immigrate alone.

While women are likely to remain the majority of those in residential care, more men are entering these facilities as hospital services and men’s care options, along with their needs, change. As is the case today, the elderly will also continue to account for most of those in long-term care (Statistics Canada 2007), but more young people without access to hospitals are altering the residential care population. All are likely to have complex problems requiring a range of provider skills. At the same time, changes in Canada’s post-World War Two immigration policies are beginning to be reflected in the residential population. The increased diversity in needs and cultural practices, and in the resulting preferences, significantly challenges many of the existing approaches to residential care in Canada. Challenges will come as well from the boomer population accustomed to resisting authority and to voicing their concerns.

In short, the need for residential care will undoubtedly continue but the population served and the care providers will change significantly in ways that require new strategies. Indeed, long-term residential care is an integral component of the continuum of care, broadly defined. It is intimately tied to the quality of life for many elderly Canadians as well as for many with severe disabilities, and this will continue to be the case, in spite of efforts to avoid and ignore it. The overwhelming majority of those in long-term care facilities are elderly people who can no longer make the kinds of contribution that are most valued in our culture, but who have done so in the past and who can continue to do so in new ways, if given the opportunity (HCIC 2008). How we treat this vulnerable population and those who provide their care is a critical indicator of our approach to equity and social justice, as well as to care. As the WHO (2002: 5) puts it, “A society that treats its most vulnerable members with compassion is a more just and caring society for all”. Long-term residential care is a barometer of values and practices; a signal of economic, cultural and social perspectives. It thus raises issues that go well beyond specific services and practices; issues such as fundamental human and social rights; the role of the state; responsibilities of individuals, families and governments; work organization and skills; and approaches to care.

Equally important, long-term residential care is a workplace for over 200,000 Canadians who put in more than 414 million hours of paid work in 2004-05 (Statistics Canada 2007:10). And these figures leave out the unpaid overtime and the volunteer labour that support the existing system. Most of these paid and unpaid care providers are women, many are from immigrant and/or racialized communities and this, too, is likely to remain the case with implications for both how work is valued and how it is organized. However, like the population in long-term care, the workforce has become increasingly diverse in ways that also raise issues about how work is valued and organized, as well as about relations among workers and with residents. Combined with changes in the residential population, these developments prompt questions about the division of labour and the skills required for residential care.

The proposed MCRI takes up the WHO challenge as an opportunity for the social sciences, the humanities and the design professions to re-think long-term residential care as an essential, viable and desirable option within the broader context of long-term care in general, and to do so in ways that raise

larger economic, social, cultural and theoretical questions about rights, responsibilities, work organization, gender, diversity and approaches to care. Instead of focusing primarily on failures, this project seeks to identify promising practices for financing, organizing, delivering, regulating and monitoring long-term residential care where the goal is the effective and efficient means of treating both residents and employees with dignity and respect. We prefer ‘promising practices’ to the more common ‘best practices’ because we begin with the assumptions that the issues are complex, that care involves relationships, and that context and social locations as well as individual needs and preferences matter, making it neither possible nor desirable to find a single, right way. Our inquiry is both issue- and theory-driven, focusing on four themes identified in the literature as requiring urgent attention, and which we view as overlapping and interacting: approaches to care, work organization, accountability and financing and ownership. By comparing practices in multiple jurisdictions (Canada, UK, US, Norway, Sweden and Germany) that have adopted different models of care, of work organization, of accountability, of financing and ownership, we purpose is to bring new ways of seeing to the care provided in each of them while identifying promising practices that can be applied at the institutional level.

### **Conceptual approach**

The conceptual approach is both interdisciplinary and multi-scalar, drawing on a range of theoretical perspectives to capture the complexity of issues at various levels of theory and practice. We seek to make a major contribution by extending the line of inquiry established by Burawoy and colleagues (1991; 2000), which strives to make visible the impact of global political and economic forces on the local. Given the increasing pressure of global corporations and private equity firms to transform elder care into a site for capital accumulation combined with the growth in the elderly population, understanding how these global forces are shaping the terrain of long-term care is crucial. By ‘grounding globalization’ as Burawoy (2000) terms it, we will make both a significant theoretical and practical contribution in showing how macro-level decisions affect on the ground practices. At the same time, our exploration of promising practices will allow us to reflect back on models of care, work organization, accountability, financing and ownership, contributing to theory building in the process.

To do this, we have created spaces for new theory as well as for new empirical data. All research, as Thompson (1978) put it, is a dialogue between theory and evidence. Like Harvey (2006:79), we understand theory “as an evolving structure of argument sensitive to encounters with the complex ways in which social processes are materially embedded in the web of life”. Thus, our conceptual approach will develop through this kind of dialogue, enriched by the exchanges among investigators, collaborators and partners bringing diverse perspectives and coming from diverse locations. Our choice of investigators, collaborators, partners, and research sites has been made with an eye towards fostering creative exchanges among different and at times opposing disciplinary perspectives (e.g., physicians, architects, sociologists, philosophers, economists), with representatives of competing interests (e.g., employer and union partners), and empirical sites in countries with vastly different notions of what constitutes a just society (e.g., Sweden and the US). The tensions involved, and indeed sought, will ensure a vibrant and exciting process, encourage committed participation, and enable the sorts of original thinking and intellectual breakthrough that are so urgently needed in long-term residential care. Equally important, our four interrelated themes (approaches to care, work organization, accountability, financing and ownership) will inform each other in ways that advance theory. We have created a structure for our research strategy that will ensure cross-fertilization not only through site-switching but also through thematic switching among participants.

We do however begin with some initial theoretical assumptions. We assume that long-term facility care is shaped by multiple factors; by global and specific historical developments, by political commitments and ethical considerations, by economic necessities and managerial assumptions, by approaches to care and cultural realities, as well as by ideas about gender and other social locations. We therefore draw heavily on the traditions of feminist political economy to capture the complexity of long-term residential

care. Combined with our comparative methodology, feminist political economy will enable us to develop an understanding of the development of this care as the product of social and historical forces and of ideas and practices on multiple scales (Armstrong et al. 2001; Leduc Browne 2003). It will enable us to interrogate and compare the way long-term care is conceived *vis-à-vis* the State, private owners, families and individuals in the participating jurisdictions, linking these to practices at the local, regional and national levels. For example, at a high level of abstraction, what models of care, of citizenship, of ownership, of accountability and of responsibility have shaped and now shape how care is funded, organized, structured and governed? On another scale, what branches of the State or the private sectors are responsible for long-term care and how, as well as to what extent, are these conceptions realized in actual buildings, in staffing levels, eligible funding and other practices? To take another example, what counts as accountability, to whom, with what measures? What values do they reflect not only about governance and power but also about care, gender, racialized communities and work? In taking up these questions, feminist political economy draws attention to the historically and geographically variable meanings of terms we often take for granted when thinking about long-term care, terms such as ‘home,’ ‘place,’ ‘access,’ ‘family,’ ‘responsibility,’ ‘care,’ ‘citizen,’ ‘well-being,’ ‘choice,’ and ‘accountability.’ At the same time, feminist political economy recognizes tensions and contradictions, helping us see the things we can and cannot easily change as well as those that need to be balanced. Unpacking these concepts and showing their effects on both policy and practice will be a central theoretical contribution of this project.

The determinants of health approach can be seen as an outgrowth of critical political economy, which understands health and human well-being as socially produced, linked to the ways in which a society organizes, governs and distributes economic and social resources (Raphael 2004, Wilkenson, 1996). Drawing on the social and economic determinants of health perspective, we seek to contribute to theory by extending the notion to apply within facilities as well as outside them. Such an approach allows us to move long-term care out of the shadows of the hospital and beyond the medical model (Struthers 2003; 2005), broadening the determinants focus to long-term care where theory development is urgently required (Martikainen et al., 2009) and where attention to inequalities in resource distribution, power, and control is especially relevant. It also helps us think about how to theorize and put into practice mechanisms for accountability that make dignity and respect for residents and providers the central concern without forgetting about the need for cost control. This means thinking of care in more expansive terms and of traditional women’s work as not only a skilled but also an essential aspect of care, and as including all paid and unpaid providers (Armstrong, Armstrong & Scott-Dixon 2008). The determinants tradition also focuses our attention on care as women’s work and on the ways conditions of work shape the conditions of care through work organization strategies.

In addition, we turn to a broad range of feminist theory in order to understand the gendered aspects of care work and its devaluation (Williams 2001; 2003). Complemented by an intersectional analysis that takes other social locations into account (Hankivsky 2004; Morrow et al 2007), this approach allows us to theorize care in a manner that attends to inequalities and is faithful to the tensions inherent in caring well. Feminist theories of care have thus far usually been employed to interrogate critically how policy-making construes citizenship and justice in ways which privilege individual autonomy and neglect the inevitable interdependencies that characterize much of human life (Sevenhuijsen 1998; Williams 2003; Knijn 2006). A feminist perspective that is critical of the notion of dependency (Fraser and Gordon 1994) understands interdependency as central to the human condition and provides a useful lens to analyze current policy thinking around elder care (Waerness 1990). Yet little of this theoretical work has explored long-term care and even less has gone beyond this level of abstraction to consider daily practices at the facility level. As Kittay et al. (2005:446) note, there is an “urgent need to formulate a globally pertinent ethics of long-term care”.

We seek to contribute by addressing this urgent need, applying feminist perspectives to the examination of care models and their relationship to the organization, governance, financing and

delivery of long-term care. On one scale, while the instrumental organization of labour is recognized as a pressing problem (CHA 2009) and is clearly grounded in task-based models of care, this approach also draws broader connections, grounding the problem of instrumental labour in the historical development of long-term care under the shadow of hospitals, the effects of public funding for medical care but not social care, the institutional design of facilities, workplace hierarchies, scope of practice guidelines, and quantitative accountability measures that require standardization. On another scale, this means among other things inquiring into the way long-term care policy takes into consideration the needs of the care worker, whether paid or unpaid, and the impact on care quality. Feminist theories are notable for taking caring labour seriously (Armstrong, Armstrong et. al 2008). This perspective counter-balances the current tendency to focus solely on the recipient of care. It will enable us to draw attention to ways in which the needs of the care worker are met (or ignored), and on what this means for residents. It will also enable us to make visible the places where the needs of care workers *conflict* with those of residents, or where the needs of the residents conflict with those of the workers or employers. Highlighting such tensions is a particularly important contribution, given that the current movement to humanize long-term care (often considered as ‘culture change’, (Weiner & Ronch 2003), lacks the critical perspective that interrogates the effects of power, inequality, ageism, and sexism (Estes 2001). Combined with labour process theory from political economy (Smith and Thompson, 1998), this approach will help us develop theory that examines relations of work as integrally linked to relations of care and to ownership and financing as well as to models of care. For instance, drawing attention to all forms of labour, including the unpaid labour provided largely by women, allows us to understand the costs of long-term care differently. This raises different questions of access, pushing us to think beyond the physical or cognitive criteria that currently determine who gains entry and who is refused. This approach will also help us think through the kinds of skills, education and credentialing required in facilities following non-medical models, as well as the kinds of physical spaces that work for care.

In the process, we will extend feminist theory beyond policy analysis to the level of institutional organization and every day/night practices. Feminist theories of care, including the rich literature on the ethics of care, have drawn attention to the complexities of care giving, and are beginning to identify the skills, capacities, forms of knowledge, emotional labour, and ethical judgements that good care requires. These observations have practical implications, pointing to forms of institutional organization and practices that facilitate quality care (e.g., the importance of horizontal communication) and quality workplaces or that impede them (e.g., centralization of power). However, as Lloyd (2004:252) observes, feminist theorizations of care require “continuity of analysis and refinement”. By empirically engaging feminist theory in the context of long-term care and employing it along with other approaches to think about financing, ownership, accountability and work organization, we will contribute towards extending and refining feminist theorizations of care. Long-term care thus serves both as a site of practical intervention where the conceptual frameworks offered by feminist theories of care can help identify practices that work – and clarify for whom they work – as well as it serves as an empirical site to test out and extend feminist theories of care and care models. Together they can help us develop promising theories along with promising practices.

This conceptual approach, along with our collective knowledge based on research in long-term care, has led us to identify four overarching but overlapping themes around which to organize our theoretical and empirical work. It has also led us to create a structure to ensure that the themes inform each other, building to new, more integrated theory, method and data.

## Themes

### i. *Approaches to care* (Lexchin & Struthers, team leaders):

**What approaches to and models of care support long-term care as a viable, desirable and equitable option for individuals, families and caregivers, in the process promoting and supporting a more inclusive notion of citizenship?**

Answering such a question requires a multi-scalar examination of policy regimes, national programs, organizations and institutional applications in long-term care. It also requires, as the WHO (2002:xi) explains, “an assessment of the cultural values that underlie existing systems” and an exploration of ethical issues related to the “ongoing efforts to fashion a coherent and appealing general theory of justice”. The context for care is set at the global, national, regional, and local levels, all shaped by notions of rights and responsibilities as well as by specific models of care and the role of medicine within them (Kittay et al. 2005). Different approaches to care and models of care (medical, social, market) reflect and guide the contexts in which services are structured and shape the practices, locations, built spaces and discourses of care as well as the social relations between care providers and receivers (Adams, 1996). Approaches to care reflect not only ideas about what constitutes necessary, appropriate, effective and efficient care but also ideas about gender, individual and family responsibility, citizenship, dependency, and the sense of self (Lister 2002; Williams 2003; Knijn 2006; Fraser & Gordon 1994; Peace et al. 1997). “Tradition, deeply embedded notions of woman’s social worth and the value of her work, and the distribution of power within a society all explain, in part, why caregiving tasks have fallen disproportionately on women” (WHO 2002:viii). Models of care represent how such ideas are operationalized and embedded at multiple levels of policy and practice. While some scholarship has explored different models of care (Béland et al. 2006; Kodner 2006; Stephenson & Sawyer 2002; Struthers 2008), these models have not been located within larger national and global contexts that shape their approaches to care, as we intend to do in this project. Any project of ‘re-imagining’ long-term care must start by recognizing key institutional, fiscal, and cultural structures which have informed the history of policy-making in this field. For example, in Canada two formative institutions – the poorhouse and the hospital – have profoundly influenced the development of long-term care for the aged in the postwar era (Adams, 2000). The stigmas of poverty and dependency associated with pre-war institutions for the aged continue to act as powerful deterrents to the acceptance of new models and structures of caring for the frail elderly. “We have to concede that, with some few exceptions, residential/nursing provision is still seen as the option of last resort.” (Peace et al. 1997) Hospitals have also shaped the highly medicalized approach to long-term care in many jurisdictions to be studied here. Concern that the chronically ill elderly were ‘blocking’ access to expensive, insured beds influenced much of decision-making around the design and programming of long-term care facilities (Benjamin 1993; Means & Smith 1998; Struthers 1998; 2003). Decisions driven by the needs of hospitals too often created new built spaces for the elderly which took on a form similar to hospitals (Armstrong et al. 2009). Shortages in the supply of both care options for the aged have also been shaped by gendered assumptions which ‘naturalize’ eldercare as the responsibility of women within families. In Canada and the US, in particular, lack of alternatives to institutionalization has sparked caregiving crises, avoidable injuries, and the onset of illnesses which generate premature needs for residential care (Adams 1996; Armstrong et al. 2009; Benjamin 1993; Keefe 2002; Daly 2007; Sims-Gould & Martin-Matthews 2007). In most of the jurisdictions under review in our project, the history of decision-making in both the home and residential care sectors has been deeply inscribed by policy-makers’ fears and biases regarding actions that might undermine the ‘normal’ obligations of family members, mostly women, to provide unpaid care (Means & Smith 1998; Keating *et al.* 1994; Struthers 2003; Peace *et al.* 1997). Through multi-disciplinary and multi-scalar comparative study we intend to integrate theory with practice to interrogate:

- a. Why have different jurisdictions followed different policy paths in their approaches to long-term care?
- b. What notions of citizenship contribute to inclusion on equitable terms for residents, for providers and for their families?
- c. What models of care provide the most promising practices, in what contexts, for whom?

**ii. Work organization** (Baines & Daly, team leaders):

**What kinds of work organization and what care models best meet the needs and balance the rights of residents, providers, managers, families and communities?**

In theoretical and practical terms, care work is a highly gendered and increasingly racialized and ethnicized terrain in which the predominantly female workforce is expected to provide care under any conditions, including conditions of significant violence and exploitation (Banerjee, Daly et al. 2008; Baines 2006; Lanoix 2009). Working conditions such as violence and poor pay exist within particular contexts, sets of relations and models of workplace organization, warranting further study. For example, research on hospitals has convincingly shown that the way work is organized has a profound impact on both workers and patients (Aiken et al. 1999; 2002). High rates of illness and injury among health care workers have been associated with “work overload, pressure at work, lack of participation in decision-making, poor social support, unsupportive leadership, lack of communication/feedback, staff shortages or unpredictable staffing, scheduling or long work hours and conflict between work and family demands” (Yassi & Hancock 2005:32). Patient safety, and thus outcomes and employer costs, suffer as a result. Research on long-term residential care, although not nearly as extensive, also indicates that how work is organized has significant consequences not only for workers but also for residents and employers. For example, international research has shown that the substitution of materials for labour leads to higher rates of morbidity and mortality (Cawley et al. 2006) and has demonstrated a strong link between workload and staff turnover, with cost implications for employers (Castle 2006), while Canadian research suggests a relationship between violence towards workers and low levels of both autonomy and staffing (Armstrong et al. 2009). The same study found, for example, that facility design was an active partner in the organization of work, facilitating or hinder caring labour. Workers spoke of bathrooms so small the safety policy of two workers per lift was impossible to implement, jeopardizing not only worker safety but the wellbeing of residents. In other cases, facilities with dining rooms available on each floor required an organization of meal preparation and delivery vastly different than those with single, large cafeterias; they also afforded very different dining experiences for the residents.

But large areas of work organization, especially in connection to quality of care, remain unexamined. So, for example, while patient safety has become a major issue in hospitals, it has been largely ignored in long-term care (Castle et al. 2007). Even less of the research has explored the implications of work organization for quality care or worker health in relation to gender or other social locations. When Berta et al. (2006) examined staffing, they failed to mention that women account for four out of five workers and a significant proportion of the managers, and that both these groups are increasingly drawn from racialized populations. Berta et al. also commented on the importance of “volunteer care” without considering the very gendered and cultured nature of unpaid care work, and they said nothing about the gender or other social locations of residents. Yet research by Baines (2004a), for instance, has shown that women are more likely than men to put in unpaid overtime in order to compensate for the care deficits. Women are also much more likely than men to provide unpaid care to family and friends who live in facilities (Grant et al. 2004).

Male and female residents may define quality differently, and this may be the case for people from different cultural backgrounds as well. Food and drugs both shape and reflect how care is understood and delivered, altering the consequences for providers and residents (Davies, 2003; Lexchin, 2001). The same can be said about what are often described as social activities. But these are not simply health care issues. The specific example of long-term residential care can lay the foundation for developing our theoretical understanding of managerial issues in the public sector, a sector that requires, as managerial expert Mintzberg (CBC 1999) makes clear, quite different practices from those that may be effective in the for-profit sector. It also leads to critical issues about ownership and power in the public sector.



Equally important, it leads to questions about the consequences for unpaid care, most of which is still done by women.

While a growing body of literature exposes the gendered and racialized inequities that are reinforced by certain types of work organization (Baines 2004b; Prokop et al. 2004; George 2001), little is known about labour processes that generate a positive and constructive experience for workers, residents, their families and communities. With the goal of filling this gap, this theme will draw together theory from four related traditions, seeking to develop a new synthesis relevant to understanding all forms of care as social relationships shaping and being shaped by the labour process and organization of work. First, feminist political economy contributes to the focus on the gendered nature of work (Armstrong et al. 2001), on intersectionality (Stasiulis & Bakan 2003), on the invisible and informal nature of caring skills (Armstrong et al. 2008), and on the importance of linking paid and unpaid work in and outside the formal economy. Second, the care work literature adds significantly to our understanding of care quality in terms of working conditions and social relations (Neysmith 2001; Baines et al. 1998). Third, sociological and industrial relations theorizing on worker participation, union contributions and contradictions (Seago & Ash 2002) helps us understand decision-making structures, rights-based discourses, dignity and forms of organizing (Baines 2007). Analyzing the distribution and relations of control within workplaces, labour process theory in particular will be central to our explorations of how work is organized to reflect, reinforce or challenge the relative power of employers and providers in different jurisdictions or workplaces and their consequences for care (Berberoglu 1993; Braverman 1974). In addition to paid workers and employers, care work involves players such as residents, families and governments, players who establish many of the conditions for work and care through funding, regulation, and reaction to daily practices. Labour process theory helps to tease out the ways power is distributed and negotiated between and among them. Fourth, theories on *models of care, accountability and finances and ownership* explored in other themes can be expected to shed light on work organization and contribute to breakthroughs in this complex field of theory. The following questions will guide our practical and theoretical investigations of these issues.

- a. What are the points of tension, conflict and contradiction in addressing care as a relationship and in taking into account the perspectives and needs of workers, managers, residents and their families and friends?
- b. Taking into account gender, race, and other social locations and their intersections, what kinds of innovative work practices and funding policies lay the foundation for quality care by providing workers with safe, respectful, and rewarding working conditions while simultaneously meeting the needs and respecting the rights of residents and their families and communities?
- c. What design models for physical spaces promote quality conditions for workers and residents, in what contexts?

### iii. *Accountability* (H. Armstrong & Choiniere, team leaders):

#### **What are the promising practices in approaches to accountability that nurture care and inspire quality workplace relations in long-term residential facilities?**

Especially with significant and growing amounts of funding invested in long-term residential care, accountability has become a major issue. Most frequently, the focus is on value for money. Accountability is especially important where public funds and vulnerable populations are involved (Choiniere 2008). However, the tendency is to ignore aspects of accountability other than value for money, and to rely exclusively on the kinds of quantitative measures feminist political economists have convincingly critiqued for their assumptions of objectivity (Armstrong 2001; Smith 1990; Stone 1988). This orientation promotes standardization, rather than standards, with an emphasis on measurable outcomes and performance-based indicators intended to hold providers accountable. A manifestation of this accountability approach is the nursing home resident assessment instrument, a universally adopted, computerized outcome measurement technology in the US (Mor et al. 2003). Meanwhile, Ontario is

introducing a Compliance Transformation Project, the cornerstone of which is the universal application of the Resident Assessment Instrument – Minimum Data Set (MOHLTC 2009). Yet research suggests that there are critical problems with the oversight, enforcement and evaluation of standardized assessment tools (Harrington & Carrillo 1999; Harrington et al. 2004). When accountability is narrowly conceived and practiced, and not understood in broader contexts, its measures “are often impoverished and abstracted from the processes involved in care delivery and the environment in which they occur” (Coughlan & Ward 2007:48). The voices of residents and providers are silenced and their perspectives on quality ignored. Instead, complicated, elaborate measures are imposed, taking up valuable care time without producing visible, positive results (Armstrong et al. 2009; Bowen & Kreindler 2008). As the OECD (2005) points out, little attention has been paid to developing effective, appropriate means of assessing and ensuring quality for LTC residents and providers.

Quality is of course a complex concept, embracing features that range from the maintenance of health status and the prevention of injury, abuse and violence to the establishment of rewarding social relations and a sense of accomplishment and joy. The central concern of the approaches to care theme, quality will be addressed in accountability terms along the avenues of its broader contexts, training and certification mechanisms for providers, and the impacts of organizational and governance structures on democratic accountability. Because “one cannot overlook the quality of care providers’ work lives when attempting to improve the quality of life for LTC residents” (Casper & O’Rourke 2008:S264), and because the quality of work life for providers is itself important, training and certification mechanisms are understood to be significant aspects of accountability, and related to staffing levels (Isola et al. 2008), ongoing education opportunities (Stolee et al. 2005) and provider empowerment (Casper & O’Rourke). At the same time, we take seriously the feminist critiques of the gendered ways skills are recognized, assessed, certified and rewarded (Armstrong & Armstrong 2008).

Finally, the democratic aspect of accountability is seldom addressed in research on LTC facilities, to the particular detriment of the less powerful within them (Newdick 2008). Accountability is typically understood as a one-way process, with provider organizations accountable to funders, but not funders to provider organizations, and those in lower positions in hierarchical structures accountable to those above them, but not vice versa. Linking accountability to *models of care, work organization, and finances and ownership*, we will broaden the scope of accountability to address such questions of standardization, regulation, training and certification, ownership, quality of life for providers and residents, and democratic impacts. With all these issues, our core concern is for the dignity and respect accorded residents and providers. Specific research questions within the accountability theme include:

- a. What are the contributions and limitations of strictly quantified measures of accountability?
- b. How does a focus on accountability, broadly conceived, overlap and interact with the foci on care, work organization, and finances and ownership?
- c. What promising accountability practices can be identified and adapted to promote quality care, the ongoing involvement of residents and providers, the training and certification of providers in ever-changing circumstances, and the democratization of care?

#### **iv. *Financing and ownership*** (MacDonald & Leduc Browne, team leaders).

**What innovative financing and ownership models are promising in terms of ensuring equitable access to quality long-term residential care while reducing the offloading of both material and other costs onto workers, employers, families or individuals?**

Ownership has become a major issue, especially as many governments have turned to the private sector for financing and models of practice. In this theme we consider ownership alternatives (i.e., public, private not-for-profit, private for-profit, public/private partnerships) and financing/payment structures as they influence access to, and the quality of, care as well as the quality of work. At a time when the demand on government health and social care spending is increasing, it is important to examine the relationship between financing, ownership and quality of care, taking into account the displacement of

costs when poor long-term care is provided. As Bowes (2007:455) concludes, “there is further work to be done on understanding the cost implications of different models of care” and, we would add, of ownership.

Although governments in OECD countries have been increasingly turning to the for-profit sector to deliver services paid for by the state, there is a growing body of research suggesting that both quality and access decline with this move. The trend towards private for-profit ownership and an increasing role for the market in long-term residential care parallels the increase in the commercialization of home care in Canada (Daly 2007). As private for-profit facilities strive to maximize profits, proprietors make decisions about the organization, location, and eligibility criteria based on the market rather than on resident and/or worker needs (Player & Pollock 2001). Research in North America shows that private for-profit do worse than not-for-profit residential facilities on measures such as the use of restraints and psychoactive pharmaceuticals, pressure ulcers, rates of hospitalization, staff turnover, nursing time, quality of nursing and food service, and measures related to patient dignity and choice (Harrington 2001; Hillmer et al. 2005; Castle & Engberg 2006; Shapiro & Tate, 1995). McGregor (2006) and McGregor et al. (2005) document how lower staffing levels in for-profit facilities are related to poorer health outcomes for residents in BC. Moreover, for-profit facilities in Ontario provide fewer hours of care compared to non-profit ones (Berta et al. 2005). Research in BC (McGrail et al. 2007) also suggests that the relationship between quality and ownership is complex, influenced by factors such as connection to acute care hospitals. McGrail et al. (2007) suggest that the advantage of integration with a broader network of health care facilities may result from economies of scale.

There are also important questions about who pays for care, on what basis, and with what impacts. Funding dimensions include intergovernmental relationships which structure the financing, delivery and control over residential care, as well as the design of the payment structure and physical space. Some funding models, regardless of ownership, result in offloading responsibility onto individual workers who must try to do more with fewer resources, creating poor working conditions (Armstrong & Armstrong 2002; Armstrong et al. 2003). Research suggests that user fees can be an obstacle to accessing long-term care, making funding models that rely on fees inequitable (Fine & Chalmers 2000). For example, Hancock et al. (2007) show that funding regimes can have a profound impact on access for the rich and poor in the UK, and Jenkins (2009) reveals how in the US race, income, and gender intersect to make nursing home care more accessible for some than others. There is much more work to be done on funding issues related to gender and other social locations, especially in terms of access. Unable to access residential care in a timely manner, individuals are expected to rely more on family members to provide care, often under precarious conditions, in the community. This downloading of monetary and non-monetary costs is again disproportionately placed on women and others who are marginalized (Armstrong & Armstrong 2002; Armstrong & Banerjee 2009; 2004a); on those who make up the majority of residents and unpaid providers. Here, access will be conceptualized on multiple scales, broadening from a narrow focus on admission to include access to services and care providers within a facility, to physical accessibility within the built space. Access will also be conceptualized from the perspective of workers as access to job security, safe working environments, and fair wages. Conceptualizing access on multiple levels opens up innovative lines of inquiry at the levels of practice and theory that emphasize the implications of particular funding models.

To date, there is an absence of empirical research that examines promising funding models for residential long-term care in ways that consider the relationship between ownership and access together with the needs of residents and unpaid as well as paid providers. Moreover, much of the research on funding and long-term care has conceptualized care largely in terms of individual physical and behavioural measures. Although physical health is an important factor in assessing quality and equitable care, the social or relational aspects of care are equally important. Indeed, residents report that quality of life based on relationships is a more valid measure of overall well-being than conventional quantitative quality of care measures (Bowers et al. 2001; Coughlin & Ward 2007). The specific funding framework

that determines which services are publicly funded and which are not reflects implicit assumptions of how care is conceptualized. For example, Daly (2007) describes how recent changes to funding of home care services in Ontario reflect a shift from a social care to a health care model. Here we expand the definitions of costs and payments to include both monetary and non-monetary forms, thereby thinking about *funding models* in broader terms and linking them to *care models* as well as to *work organization*. The specific case of long-term residential care thus has implications for theory and practices well beyond these kinds of services, raising important questions about the role of financial systems and profit in access, in the structure of workplaces and in the nature of care.

- a. How do ownership type and scale shape access to care, quality of care and conditions of work?
- b. How do funding models shape access to care, quality of care, and conditions of work and how might we re-imagine funding long-term residential care, if we assume both that care is a social citizenship right and that funding should be transparent and accountable?
- c. What are the spatial/geographic issues to consider around access, such as availability in rural areas, in inner city areas, integration with the ‘community’, layout within the facility, and how are these related not only to ownership and funding but also to work organization and models of care?

### **Methods and methodology**

This international, collaborative, comparative project seeks to identify promising practices through a lens that takes the specifics of each country into account and that recognizes differences as well as similarities at levels ranging from the conceptual to the national and the individual. Our overarching analytic approach is one of lumping and slicing (Armstrong & Armstrong 2004b), in other words one of looking for both commonalities and differences. This project offers innovation in both design and methodology. It is also a unique blend of thinking through the practical implications of theory and the theoretical implications of practices and methods -- for both research practices and on-the-ground practices in long-term care. We expect by the end of this project to make substantial contributions to the intellectual and practical developments in method and collaborative research.

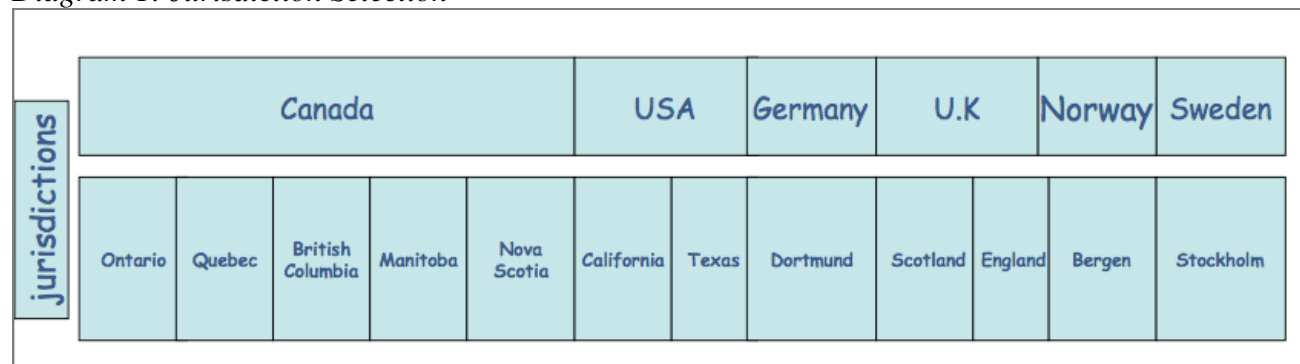
**Design:** We will use a *comparative, multi-level, multiple case* study design of long-term care in 6 countries, at the level of regional government (states, provinces, county councils), referred to as jurisdictions, with long-term care facilities (sites) as the embedded sub-units (Yin 1994). This project will make visible not only the similarities in patterns that make such comparisons a rich source of promising practices but also the complexity of the issues and the difficulty of comparing across countries.

**Jurisdiction Selection:** For the purposes of international comparisons we included the US, because of our cultural similarities, the reliance on a medical model and the increasing similarities in our ownership structures; the UK because of their ownership and organizational reforms in a universal system; two Nordic countries because they exemplify social democratic welfare regimes that offer a broad range of supports and a social care approach; and Germany because it offers an example of an alternative social insurance model and mixed approaches to care (Glendinning, 2007). These six countries (*Diagram 1*) fit neatly into Esping-Andersen’s (1990) welfare regime typology: liberal (Canada, US and increasingly UK), corporatist-conservative (Germany), and social democratic (Norway, Sweden). As do other critiques of his typology, our framework foregrounds gender (O’Connor et al. 1999; Bamba et al. 2009) and the political economy context (Coburn 2004). We have at least one co-applicant located in each jurisdiction. As a multi-scalar investigation that draws on Burawoy and colleagues (2000), our ethnographic study aims to link micro-practices and macro-structures.

**Site Selection:** Within each country, we have identified one or more jurisdictions where two to three facilities (sites) will be chosen prior to entering the field (yr. 4). Specific sites will be the entry point for our multi-scalar explorations, locating and comparing contexts as well as particular policies and practices. We will employ purposive sampling drawing on the outcomes of layer I research (below) and local consultation with partners, using a ‘predictable contrasts’ approach (Schwandt 1997). We expect

to consider selection criteria such as ‘award winning’, ‘best reputation’ or specific promising practices related to our stated goal of treating both residents and providers with dignity and respect, of understanding care as a relationship, and of taking differences into account.

*Diagram 1: Jurisdiction Selection*



**Project Flow:** a detailed overview of the project’s activities, timelines, and outcomes is provided in Table 1. The entire project team will meet each year to facilitate integration among the themes, allowing time to work through issues face-to-face; and for on-going project findings to be presented. Team meetings will be about theory, findings and analysis, with administrative work done by e-mail and webcam. The first project meeting held in year 1 will launch the project, enable the themes to strategize, generate ideas, and to finalize and implement research plans. The team will also host two symposia in years 3 and 7, inviting team members along with researchers, governments, employers and workers to share progress and to obtain feedback, and allowing us to build on their insights. Throughout, team members will share materials with partner organizations and their members. Additional costs for these symposia will be covered by funds solicited from granting agencies and our respective universities.

**Research and Analysis:** As mentioned previously, the research is aligned along four overlapping, interacting and integrating themes. Unlike some large projects that are a series of smaller projects, ours is a single project with a multiple-case study design using mixed methods of data collection and analysis. We refer to each of the phases of the research as layers to denote how they build on work in the previous stage while continuing the work begun earlier. In addition, we have designed an innovative ‘pinwheel’ structure (*Diagram 2*) to manage the complexity of the research, analysis and theory work while ensuring cross-fertilization. The research will proceed in four layers that will occur in a permeable and interacting fashion and with overlapping timeframes (Table 1).

**Layer I: Mapping Long-term Care** (yrs 1- 3) Our international comparisons begin by locating specific practices within broader historical, social, economic, and political contexts to establish similarities and differences among compared jurisdictions (Armstrong et al. 2001). In addition to i) *bibliographies* and annotated *literature reviews* of the academic and grey literatures that set the context for analysis, our mapping will be textured by other secondary data analysis: ii) *a discourse analysis* of advertising and media content; iii) *statistical and financial analysis of administrative data* (each jurisdiction’s system level characteristics, e.g., staffing, financing, ownership, outcomes); and iv) analysis of *national/international statistical data*. This includes analyses of databases housed by Statistics Canada; the U.K. National Statistics; The Centre for Disease Control (e.g. the U.S. National Nursing Home Survey); the Official Statistics of Sweden; Statistics Norway; Germany Federal Statistics Office; as well as administrative data housed at regional levels by local Ministries, Health Authorities or County Councils. These quantitative approaches will be informed by and inform our more qualitative work. Decisions about databases and comparable data elements will be discussed and planned by the team at the year one meeting. Level one will involve the development of methods for continuous information sharing.

**Layer II: Design Phase** (yrs 2-3) We will use the layer I findings to create the i) *research protocols* for the field-work and interviews and submit a new ethics protocol; ii) conduct *semi-structured key*

*informant interviews* with policy makers, facility directors, managers and union representatives, and a collectively-created site visit toolkit; and iii) *pilot the field work* with a Canadian and international site switch.

**Layer III: Field Work** (yrs 3 -6) We will conduct a ‘rapid ethnography’ at each site involving an innovative *site-switching methodology*. Informed by the lessons drawn from our pilot site switch, the international team will study Canadian jurisdictions and the Canadian team will study the international ones. Given that the team already includes experts on long-term care in their respective jurisdictions, this method uses the notion of ‘a fresh set of eyes’. Teams will exchange sites in order to identify and challenge both assumptions and promising ways of organizing care, promoting new ways of thinking. At each of the sites this *rapid ethnography* method -- so called because of the short duration but very intensive observation -- will focus on specific questions from the four themes from the layer I mapping. Clear protocols developed collectively will guide data collection, which will be coordinated across themes, acknowledging that the themes are overlapping and permeable. We will use an observation team, a series of interactive observational techniques and collaborative analysis (see for example Millen 2000; Beebe 1995). The observation team will be comprised of a minimum of 3 to a maximum of 6 team members, including at least two faculty (local and international) and one local student. Partners will also be invited. The team will reflect a mix of skills, interests, expertise and availability. The ethnography will involve the following interactive and observational techniques: i) verbatim transcribed *semi-structured key informant interviews* with policy-makers, managers, workers, residents and their families using a snowball technique to identify additional sources and ceasing following saturation; ii) “*shadowing*” workers to capture as Dyck et al. (2005) note “how care ‘works’ through the micro-politics of care negotiation”; iii) a *modified time-use analysis* of resident and care worker routines in relation to care worker and resident needs; iv) an *analysis of the physical environment* in relation to care worker and resident needs; and finally v) observations and reflections will be recorded using *field notes* and a *field-work debrief* will follow each site visit resulting in a report documenting field-note reflections particularly focusing on how themes overlap and the specific issues raised. Reports will be housed on the password-protected part of our web-site shared by the entire team. Field-work will commence in Canada and the US (yr. 3), the Sweden and Norway (yr. 4), and Germany and the UK (yr. 5).

**Layer IV: Analysis of Data and Method** (yrs 4-7) While we expect to contribute substantively through conventional scholarly publications, we also expect this project to lead to major intellectual and practical developments in method as well as to more popular forms of publications. Within this layer we will engage in i) iterative analyses using our conceptual framework to interrogate the data and reflect on theory and ii) a *reflexive analysis of our method*. With all team members as active participants in the research, we will require a reflexive awareness in our analysis of the data and in our evaluation of the data collection method, the site switching methodology and the project ‘pinwheel’ structure (*Diagram 2*).

In our qualitative research, we will achieve rigour using the following measures. Partners will be actively engaged throughout the research process in ensuring *face validity*, observed through working with respondents and partners to verify the accuracy of descriptions, analyses and conclusions. As well, the research is data-driven, aiming for *construct validity* involving the researchers in a “ceaseless confrontation with the experiences of people in their daily lives in order to stymie the tendency to theoretical imposition” (Lather 1986: 67). The project’s ultimate goal will be to achieve *catalytic validity* (Lather, 1986; Baines, 2007), which as Lather (1986: 67) argues is “the degree to which the research process re-orient, focuses, and energizes participants in...knowing reality in order to better transform it”. We will use ‘between method’ *triangulation* (Jick 2008) to confront inconsistencies through the use of multiple data sources, theoretical models and methods. While the project will engage in on-going knowledge transfer, activities will intensify during this final phase, when we expect to translate our findings using the traditional academic outlets of conferences, journals and books. Throughout, we will produce multiple plain language documents as well as technical reports and presentations for the media, for community groups, for employers, for policy-makers and for unions.

Table 1: Coordination; Research & Knowledge Mobilization Activities, Timelines, & Outcomes		Years							All Themes*	Staff	Coordinating Committee	Outcomes KEY: (✓) = task (* ) = main responsibility for task (*) Themes include researchers, partners and students
		1	2	3	4	5	6	7				
<b>Main Project Coordination</b>												
	Apply to Ethics at universities / facilities								✓	✓	*	Ethics approval
Staff	Project Manager (1.0 FTE)								✓	*		Overall project coordination: developing team & external relationships; mobilizing research; executive meetings
	Project Administrator (0.5 FTE)								✓	*		Financial management and contracts
	Info Systems & Tech Support Coord (0.25FTE)								✓	*		Coordinate project website, 2 policy symposia, community reports, 2 special edition journals
	Research Site Coordinator (0.5 FTE)								✓	*		Arrange all aspects of the field-work
	Knowledge Translation Coordinator (0.25 FTE)								✓	*		Coordinate policy symposia, edit "plain language documents" and academic papers
	Train M.A. students	1	2	2	3	3	3	3	✓		✓	Train up to as many as 17 different students for 34 terms of MA student training
	Train Ph.D. students	2	3	3	7	7	3	3	✓		✓	Train up to as many as 20 different CAD and 6 international students for 52 terms of Ph.D. student training
	Mentor Post Doctoral Fellow		1	1					✓		✓	Mentor a post-doctoral fellow
	Plan, Organize and Hold 7 Integrating Team Mtgs.								✓	*	✓	Strategic and working meeting for each theme, present on-going findings; and integrative meeting for whole team
	Creation of Field-work Tool-kit and Site Switching Training								*		✓	Post-pilot training and to prepare researchers for field work
	Plan, Organize and Hold 2 Policy Symposia								✓	*	✓	2 Symposia attended by team, media, policy, and community members. Graduate students & researchers present papers.
<b>Research Layer I: Mapping Long-term Care</b>												
	Prepare Bibliographies & Annotated Literature Reviews								✓		*	Produce freely avail. web-based bibliographies & team annotated lit reviews for 4 themes (incl. acad & grey literatures)
	Discourse Analysis								✓		*	Archival and current-day analysis of promotional material / media in each jurisdiction
	Analyse International and National Secondary Statistical Data								✓		*	Descriptive statistics on population trends (social determinants of health – e.g. housing) -- and facilities-based data
	Secondary analysis of Built Spaces								✓		*	Archival and current-day analysis of architectural drawings; photos; regulations
	Analyse Administrative Data								✓		*	Gather and analyse administrative data for each jurisdiction
	Analyse Policy Documents								✓		*	Analyse each jurisdictions current /historical legislation, pub/priv sector policy briefs
<b>Research Layer II: Design &amp; Pilot Phase</b>												
	Design Protocol: Interview / Observation Guides								*	✓		Design Guides based on Layer I Activities. Submit guides to Ethics (see main project coordination above)
	Conduct preliminary Key Informant Interviews								*	✓		Verbatim transcribed Interviews with policy makers, directors, managers and union representatives
	Pilot a site-switch								✓	✓	*	Choose a Canadian and non-Canadian site to pilot the ethnographic field-work
<b>Research Layer III: Site Switching &amp; Rapid Ethnography</b>												
Switching Sites	Canada & United States								✓	✓	*	Produce ethnographic data: key informant interviews; observations; time-use; & physical configuration of homes
	Sweden & Norway								✓	✓	*	
	United Kingdom & Germany								✓	✓	*	
	Semi-structured Key Informant Interviews								*			Verbatim transcribed semi-structured key informant interviews (policy makers, directors, managers, union representatives)
	Participant observation: Shadow Workers								*			Record worker's care interactions, administrative duties, technologies' use; & machinery available but unused.
	Participant observation: modified Time Use Analysis								*			Capture care relationship in terms of provider and resident routines in relation to provider and resident needs
	Participant observation: Physical Environment Analysis								*			Record and analyse facilities' physical configuration (layout; "homelike" or "institutional" atmosphere)
	Field-work De-brief								*			Provide field-note report to themes addressing site visit insights, theme overlaps and site specific issues
<b>Research Layer IV: Iterative Analysis Phase</b>												
	Iterative Analysis of Data								✓	✓		Use of conceptual framework to reflect on theory and data
	Reflexive Analysis of Methods								✓	✓		Evaluate data collection method; site-switching methodology and project "pinwheel" structure
<b>Knowledge Dissemination &amp; Translation Activities</b>												
	Draft Mid-term and Final SSHRC Reports								✓	✓	*	Financial and research progress reports
	Publish 2 integrated community reports								✓	✓	✓	Community reports in accessible English, Swedish and German detailing Layer I and Layer II findings
	Present papers at project's 2 Policy Symposia								*	✓	✓	Team members will be invited to submit abstracts & present papers
	Publish approx. 10 project papers								✓	✓	*	Prepare peer-reviewed journal articles
	Prepare 2 Edited Books								✓	✓	*	Publish 1 edited and 1 integrated analysis
	Host project & public website & Publicize Research								*			Use listservs, partner newsletters and conferences, media releases; and public access part of website
	Present at 22 Conferences (half for students) **								✓	✓		Present papers at International and National conferences (Researchers at **11 & students at **11)

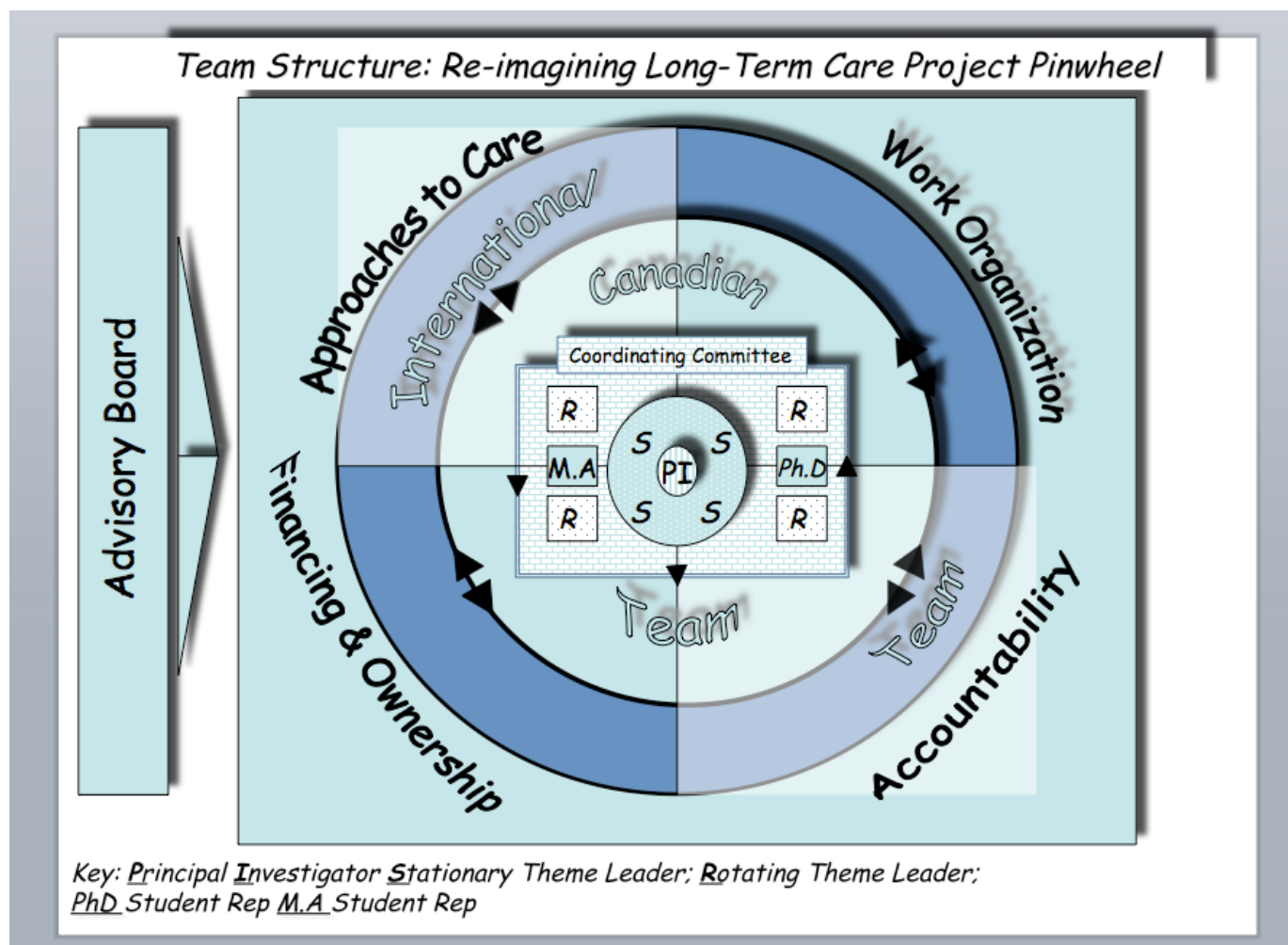
**Team Structure & Governance:** We will employ a multi-perspective, interdisciplinary, collaborative approach. Students, postdoctoral fellows, and faculty at different career stages will all be centrally involved. Collaborating with partners representing seniors' interests, workers, and employers to develop and analyze the research, we will bring together a unique combination of international actors. This goes well beyond traditional interdisciplinary work to engage organizations representing workers, employers, seniors and families in setting out research questions, responding to data, participating in at least one of our four themes, and even engaging in data collection. It will involve regular meetings of the entire project as well as smaller meetings around specific country comparisons and themes to stimulate, clarify, debate and resolve issues.

The project pinwheel (*Diagram 2*) depicts the team's structure. At the centre of the pinwheel, the project's overall intellectual direction will be set out by the Coordinating Committee, comprised of the applicant, the 8 theme leaders (4 stationary and 4 rotating) and doctoral and masters student representatives. Usually, the committee will meet at least three times per year (once per semester) via conference/video call and once in person per year (where possible, these meetings will coincide with project meetings & policy conferences). This number may be increased or decreased as necessary. The Coordinating Committee will resolve all issues that may arise within or among the research themes and will identify areas for collaboration and partnership. The Coordinating Committee will also be responsible for the large yearly project meetings and the policy symposia (Years 3 & 7). For the duration of the project, a *Project Manager* (1.0 FTE) will be responsible for developing relationships with partner organizations, mobilizing research findings and the overall coordination of the research; and a *Project Administrator* (0.5 FTE) will be responsible for financial and contract management, and on-going posting to the project's website. For the first 2 years of the project, an *Information Systems and Technical Support Coordinator* (0.25 FTE), likely with combined library science and technical backgrounds, will be responsible for setting up the knowledge sharing repositories. In years 2.5 - 6 a *Research Site Coordinator* (0.5 FTE) will be hired to arrange all aspects of the field-work; and a *Knowledge Translation Coordinator* (0.25 FTE) with editorial and 'plain-language' skills will be hired part-time for years 3 – 7 to assist with the policy symposia, community reports, and pre-editing articles for special edition journals.

Our collaborative model also allows the stationary (S) and rotating (R) theme leaders to direct the development of each of the four themes through regular theme meetings as well as electronic communications. Our project will be both integrated and challenged by bringing together the whole team to present findings on a yearly basis and by our site-switching studies. In addition to discussing substantive research and knowledge mobilization issues, themes will address procedural and methods issues with respect to their research. In order to facilitate creative interactions, all Canadian team members with the exception of the stationary team leader will rotate between the four themes in years 4 - 6 corresponding with the site-switching. All members will return to their original groups for the final project year (yr. 7). The applicant will be a member of all four themes. In addition to the faculty theme leaders, at least one international researcher and one student will be a member of each theme at all times, along with, where possible, one community partner,. We expect creative tensions will arise not only among disciplines and countries but also among and with our partners. Our exchanges will necessarily be about theory and evidence, about values and interests, and about specifics, as well as about larger conceptual questions, linking our thematic and methodological concerns. An agreed-upon protocol will be established that includes guidelines for the relationships among faculty and community researchers, students, and organizational partners. It will set out the responsibilities of all team members, identify guidelines for interviews and student hiring, and determine how publication authorship will be handled.



Diagram 2



### The Team

The team brings together not only academic researchers from a variety of social science and humanities disciplines and universities but also researchers with considerable policy experience and health professionals who not only do research but also provide care, with organizations representing workers, employers, seniors and families. Sociologist **Pat Armstrong**, the project director, has extensive experience as a mentor and as a manager of people and of interdisciplinary research, with particular expertise in health care, gender, theory and diversity. A former Chair of York's Sociology Department, and former Director of Carleton's School of Canadian Studies, she was selected by an international panel as one of 12 CHSRF/CIHR Chairs in Health Services Research with ten years of funding for capacity building in health services. She has served as interim Director of a centre of excellence and has managed ten years of Health Canada funding for research and policy work as chair of Women and Health Reform. A co-investigator on an MCRI, an INE and a CURA, and a partner with unions and Health Canada on various research projects, she has recently completed a CIHR-funded international comparison of working conditions in long-term care and organized a CIHR-funded international workshop on establishing a research agenda in long-term care. This proposal is a product of those teams. **Anmarie Adams**, from the School of Architecture at McGill University, is an expert on the history of domestic architecture, hospital design, and gendered space. With experience in comparative research, she draws our attention to the material and cultural, and brings the physical environment into the study of social relations. **Hugh Armstrong**, a Professor of Political Economy and Social Work at Carleton, brings expertise on work organization and experience in

partnerships and communities from serving on the Hospital Restructuring Committee of Metro Toronto's District Health Council, as Vice-Chair of the Ottawa-Carleton CCAC, as Chair of the Health Issues Committee of the Council on Aging of Ottawa, and as a research coordinator with the Ontario Federation of Labour. Accountability was his central concern on the Steering Committee establishing a Local Health Integration Network. **Donna Baines**, an Associate Professor of Social Work and Labour Studies at McMaster University, is an expert on the theories and practices of work organization in health and social care, with special expertise in issues of social location and intersectionality. She also is one of the pioneers in site switching methodology. **Sally Chivers**, an Associate Professor and Chair of Canadian Studies at Trent University, brings a cultural studies perspective to her gender-based analysis of disability and of aging, adding a broad humanities approach to this research project. Like Struthers, Daly and P. Armstrong, she has previously collaborated on an MCRI. **Jacqueline Choiniere**, a Registered Nurse and now Assistant Professor at York's School of Nursing, served as the Director of Policy and Research for the Registered Nurses Association of Ontario where she led two health ministry-funded initiatives, involving physician and nursing organizations exploring promising practices, addressing key challenges and enhancing collaboration between nurse practitioners and family physicians. Her sociology doctorate on accountability was based on her continuing work with the Armstrong team. **Tamara Daly**, Assistant Professor in York's School of Health Policy and Management, brings experience from years working in the private sector for Ernst & Young, and significant qualitative skills to her research with the Armstrong team on work organization in long-term care. She has also done major theoretical work on care models. **Megan Davies**, an historian and Associate Professor at York University, brings expertise in the regional aspects of long-term care and deinstitutionalization. In addition, she has explored the implications of food, a particularly critical issue in long-term residential care. **Malcolm Doupe** is an Assistant Professor in the Department of Community Health Sciences, Faculty of Medicine, and a Senior Research Scientist at the University of Manitoba. His current research on growing dependency among residents, as well as his expertise in quantitative analysis and on residential care, relates to several themes in the project. **Bob James**, a physician, a faculty member and the medical director of a long-term care facility, will be particularly important in bringing a management perspective and experiences with daily practices. He will also provide access to worksites. **Monique Lanoix**, although currently in the Department of Philosophy and Religion at Appalachian State University, is a Canadian philosopher who has expertise in disability studies and ethics that are directly relevant to our concern with care models. **Paul Leduc Browne**, a political scientist at the Université du Québec en Outaouais, brings expertise on the ownership of health services, along with experience in working with unions and other community partners while a researcher at the Canadian Centre for Policy Alternatives. He has also published on models of care. **Joel Lexchin**, a Professor in York's School of Health Policy and Management and a practicing physician, has expertise not only in health policy but also in the specific area of drugs, a central issue in models of care. **Martha MacDonald**, Professor of Economics at St. Mary's University adds expertise on women's work and on economic theory, as well as experience with both qualitative and quantitative international comparative research. **Margaret McGregor** is a family physician, Clinical Associate Professor with the Department of Family Practice at UBC and a researcher who has published critical articles on ownership and quality issues in long-term care. **Kathryn McPherson**, an Associate Professor of History and Women's Studies at York, has expertise in gender, care models and health services. She too has explored work organization, particularly in health services. **James Struthers**, an historian and Professor of Canadian Studies at Trent University, is an expert on both the history of long-term care in Ontario and on models of care.

This Canadian team is complemented by several foreign-based researchers. From the US, **Charlene Harrington**, Professor of Sociology and Nursing at the University of California and an international expert on quality, ownership and regulation of long-term care, is recognized through her participation on various government-appointed commissions, while **Pauline Vaillancourt Rosenau**, Professor in Management, Policy, and Community Health at the University of Texas in Houston, has particular expertise on comparing public, private non-profit and private for-profit facilities, and on the relative performance of

long-term care approaches in the US and the Netherlands. From the UK, we are joined by **Liz Lloyd**, Senior Lecturer in Social Gerontology, School for Policy Studies, University of Bristol, who has both research and policy expertise in models of long-term care; and by **Allyson Pollock**, a physician who is Professor and Head of the Centre for International Public Health Policy at the University of Edinburgh. She is a leading authority on the privatization of public services. In addition to writing widely on privatization and on the connections between social and medical care, she has given evidence to the Health, Transport and Treasury select committees of the UK House of Commons, and has given invited lectures in a dozen or more countries. The co-investigators in the Nordic countries are **Marta Szebehely**, Professor in the Department of Social Work, University of Stockholm, who currently leads a major international study on eldercare, has served on multiple government advisory committees and has partnered with the Armstrong team on a previous comparative project; and **Frode F. Jacobsen**, a social anthropologist and Associate Professor in the Department of Public Health and Primary Health Care, University of Bergen, specializing in eldercare. **Monika Goldmann**, our German co-applicant, is Director of the Sozialforschungsstelle in Dortmund, a major research centre for social sciences in Germany. Her expertise on gender and in comparative employment and social policy theories, along with her experience giving advice on organizational and personnel work, will be particularly valuable to the organization theme. In sum, members of our international team are leaders in our theme areas, with a proven record of successful collaboration in international comparative research on long-term care.

Our collaborator **Nasreen Khatri** is a clinical psychologist at Baycrest, an academic centre affiliated with the University of Toronto that focuses on conditions of aging. Her research on women and depression as well as on unpaid caregivers fits into several of our themes. The team also includes **Susan Braedley**, a social worker, sociologist and postdoctoral fellow with Pat Armstrong's CHSRF/CIHR Chair in Health Services and Nursing Research at York University. She offers expertise in changing approaches to care and their gendered implications, particularly as demonstrated in publicly-funded services.

These academics will be joined by a range of partners in Canada, including the **Ontario Association of Non-Profit Homes and Services for Seniors**, a provincial membership-based organization that represents not-for-profit providers of long term care, services and housing for seniors; the **Council on Aging of Ottawa** is a bilingual, non-profit, charitable, voluntary organization dedicated to enhancing the quality of life of all seniors in Ottawa; the **Swedish Association of Local Authorities and Regions**, which represents the governmental, professional and employer-related interests of all municipalities, county councils and regions in Sweden; and five unions that represent workers in long-term care: the **Canadian Federation of Nurses Unions**; the **Canadian Auto Workers, Hospital Employees Union -- Canadian Union of Public Employees**, the **National Union of Public and General Employees** and the **Service Employees International Union**. The extent of partner participation will vary, but they will be encouraged to participate fully in the annual meetings, facilitate in accessing sites, participate in the development of site switching, analysis and dissemination. Their contribution will thus mainly be in-kind, through the participation of their staff. Our MCRI budget will support the participation of some partners and team members in the site-switching research work and of all partners and members in the annual meetings of the full project team.

As required by SSHRC, we have also invited a number of senior scholars to serve as an advisory board. They include **Paul Lovejoy** from York University who has previously held an MCRI; **Leah Vosko**, also from York, has held a CURA and is an expert on gender and the labour process; **Nancy Guberman**, from McGill University, has written extensively on long-term care; and **Patricia Evans** from Carleton University, a widely published author on the ethics of care.

## Training

Including students in this rich theoretical, empirical, policy and practice environment will further enhance the synergy of this interdisciplinary, international and inter-sectoral group, and nurture careers in an area urgently requiring research attention. Indeed, students and post-doctoral fellows have already played a central role in developing this proposal and in the workshops that stimulated it, participation made possible

by our earlier funding and by Pat Armstrong's CHSRF/CIHR Chair. A primary focus of the Chair is mentoring, and the approach has been to make students full and equal participants in the research process, while ensuring they enjoy continual opportunities to learn new skills and ways of approaching research through practice, including through internships for research and policy. Our practice is to include students at every stage of project development, from conceptualization, to data collection, to data analysis, to publication and other methods of dissemination, which means we require funding for student stipends throughout this project. Our practice is also to have faculty involved in the actual data collection alongside students in a manner that creates conditions for continual, shared learning. The project will bring together all the co-applicants, students, post-doctoral fellows and partners at least once a year to develop the methods, conduct research in teams, develop and assess analysis and write up as well disseminate results, with theme-focused groups meeting at least four times a year. Through this close collaboration with a wide range of international scholars and our partners, the estimated 29 graduate students and the doctoral fellow will have the opportunity not only to develop the full range of research, analysis and writing skills but also to work across academic, policy and practice boundaries, developing additional skills in communication and knowledge translation. For this reason, much of our budget that is not going to student stipends will go to travel for students and other team members. At least half of the funding for conference presentations will go to students. The more local theme meetings as well as the full team meetings will provide students with unique opportunities to participate in a process that is at once academic and applied, a place where experts with different perspectives and from various high-income countries bring their knowledge and skills to the particular issue of long-term residential care, with their analysis tempered by the concerns of those with care needs, workers and employers. Our recent CIHR-funded research has already resulted in multiple academic and non-academic presentations by students at national and international conferences and in publications that also cover the full range from technical reports released through press conferences and covered widely in the media to refereed journal articles to books and book chapters, demonstrating the skills they have learned and the contacts they have made. In addition, we will pursue internship opportunities through ACCELERATE Ontario to provide funding for graduate students to work on research projects with our partners. It should also be noted that two of the current tenure-stream faculty members on the team began working with Pat Armstrong as students, demonstrating mentoring at work and bringing their own rich insights on the process.

### **Dissemination**

Dissemination is built into the organization and methods employed here, providing integrated and outcome-based, knowledge sharing strategies. The analytic mapping is intended to produce academic journal articles at an early stage in the project, with the site-switching, rapid ethnographies leading to at least one integrated and one edited book at the end. Results will be ongoing, published and shared. The systems for sharing knowledge as it is created ensures that unions, advocacy organizations, government and agency administrators, and employers can access knowledge throughout the project while contributing to shaping that knowledge creation in ways that ensure it is relevant to a wide variety of users. The meetings themselves will involve knowledge creation and dissemination, as participants work out together what can be compared and what should be further explored as promising practices. This is why we are budgeting to ensure participation is supported. In addition, the partners and collaborators will provide ongoing advice on how to tailor our materials to various audiences, suggest appropriate means of doing so and facilitate access to these audiences. They, along with the *York Knowledge Mobilization unit*, will work together to create space with policy makers and communities for public forums.

This team has long been involved in what is often called knowledge translation based on collaborative, interdisciplinary work and, in addition to traditional academic outlets of conferences, journals and books, has produced multiple and widely-used plain language documents as well as technical reports and presentations for the media, for community groups, for employers, for policy-makers and for unions. A central aspect of Pat Armstrong's CHSRF/CIHR Chair is dissemination, often organized with her decision-

making partners. For example, she was centrally involved in organizing, with her Health Canada partner, a knowledge creation and policy-focused workshop on imagining long-term care with women in mind that brought together policy-makers, researchers and practitioners, as well as some current team members. She recently led an international team of researchers, including several from the proposed team, to examine working conditions in long-term care. Done in partnership with five unions, the project led to more than a dozen academic conference presentations and at least an equal number of presentations at union and community forums. The initial report on violence, written in plain language and made available on the web, was released at a press conference that garnered more press coverage than any other such release at York University. The report is now being submitted to a journal, with a student as main author, and the findings were integrated into a book published earlier this year.

All these dissemination methods will be employed here. More specifically, the project will produce at least two books; one an edited collection based on individual case studies and the other an integrated analysis of promising practices, with an emphasis on theoretical insights as well as applications. In addition, at least two integrated community reports will be produced and distributed through team partners to their members, to governments and to the media, as well as in community events for local audiences. Two policy forums will be organized around research results, with several articles prepared for submission to academic journals. Additional presentations will be made to members of our partner organizations. We have budgeted for a minimum of 20 conference presentations, with at least half involving graduate students. In short, while we definitely intend to employ traditional means to disseminate our theoretical, empirical and methodological insights, given that we are also interested in making a difference in delivery, organization and practices in long-term care, as well as in the assumptions on which they are based, we seek to ensure knowledge sharing is built into the methodology in ways that are relevant and useful to a wide variety of actors, creating “catalytic validity” (Baines 2007).

### **Contributions**

The project will contribute to:

1. new integrated theory development on care, on work organization, on accountability, and on financing and ownership that allows providers and residents to be treated with dignity and respect, that understands care as a relationship and that takes differences and equity into account.
2. not only linking theory to promising practices in approaches to care, work organization, accountability, and financing and ownership but also simultaneously relating the four themes to each other.
3. the development of a rich international portrait of long-term care that identifies contexts, regulations, funding and conditions that allow residents and providers to flourish.
4. advancing research methods that i) use an international interdisciplinary and comparative site-switching approach and ii) develop a model for collaborative research across disciplinary and geographic boundaries and that operate with students, faculty, representative associations, employers, and communities as equal participants.
5. not only the sharing of knowledge across geographic boundaries and social boundaries but also engages in actively promoting new practices at multiple scales.

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