

DREAMING OF HOME: LONG-TERM RESIDENTIAL CARE AND (IN)EQUITIES BY DESIGN

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Abstract

An ideal of “home” as the best site for living and dying in old age has become embedded in residential care policies and practices in many countries, often in tandem with neoliberal restructuring. This article compares the ways that two Canadian jurisdictions have approached this ideal, and identifies contradictions in the effects this policy direction has had for direct care workers and residents. The investigation reveals challenges and possibilities for gender equity.

In the context of rapidly increasing populations over the age of 85 that include a significant proportion with dementia and/or multiple chronic conditions, governments in Canada and many other industrialized countries have been aggressively restructuring old age care, including residential care.¹ Historically, old age residential care in Canadian provinces was provided in large institutions that based the care work on a medical model. This model offered a combination of cost efficiencies and quality, and was defined by what was medically necessary. However, the institutional model has been justifiably criticized for its significant shortcomings for residents. A convergence of gerontological research, popular opinion, and neoliberal restructuring imperatives has shifted residential care policies to a “home-like” model for both physical environments and approaches to care.² This “home-like” model has reshaped both residential care buildings and work organization.

Old age care remains highly feminized work, and it is important to evaluate the gendered consequences of this policy shift.³ Old age care is one area in which states have taken on a share of care, relieving unpaid family

members, mostly women, of some of the more strenuous care and housework demands. These demands are associated with the unequal gendered division of labour that assigns domestic labour and familial and community caring to women. Furthermore, state involvement has created employment for women in this sector, shaping the possibility that both housework and care work are recognized as skilled labour. A third dimension is that state involvement has meant more care security for frail, older persons, and the more “home-like” models for residential facilities emphasize that these people, mostly women, are permanent householders there, thus according residents a certain kind of recognition and respect. These aspects are positive for gender equity.

Feminist political economists have argued convincingly that neoliberal restructuring of welfare state services are reversing women’s gains towards gender equity.⁴ One of the more compelling aspects of this argument is that neoliberal governments, by withdrawing from direct welfare services provision, are redrawing the boundaries between the public sphere and the domestic, or private, sphere, to reprivatize responsibilities for care. In this case, however, residential services have been reorganized and somewhat expanded; they remain partially publicly funded; they have a mostly unionized labour force; and are highly regulated. In this case, restructuring does not seem negative for gender equity.

At the same time, the implementation of a domestic metaphor raises some concern. Feminist political economists have argued that the unequal gendered division of labour that assigns care and housework to women as unpaid work in the domestic sphere is central to women’s oppression. This division is based upon an assumption that these kinds of work are expressions of women’s biologically based instincts to nurture, thus devaluing this necessary work and those who perform it. Feminist political economists locate women’s oppression in the relationship between the household and the reproduction of capital, as a historically specific relation that ensures the generational and daily reproduction of an exploitable labour force, supported by state mechanisms.⁵ It seems possible that “home-like” models of residential care reproduce and reinforce ideologies of domesticity that support women’s oppression and undermine equity⁶ because they replicate

the social relations and built environment of private homes. The “home-like” model could also be perceived as a policy move that deploys a logic that shapes familialization and the feminization of care through policy and practices.⁷

In this paper, we argue that “home” is a problematic reference point for residential care. It promises much, but without any guarantee that it will produce respectful, dignified, and equitable conditions for residents and workers. We advance this argument based on research on the process and effects of integrating this ideal of home into the long-term residential care policies of two Canadian provinces: Ontario and Nova Scotia. While resonant with the public and popular with gerontologists, the more “home-like” models have a tendency to further naturalize the gendered inequities of domestic care arrangements under capitalism as the best of all possible care situations. These effects are created not only through ideological associations and divisions of labour, but through the organization of space, which, as some feminist political economists have noted, is a key constituent of social relations.⁸ These shifts in residential care provision have been implemented through typically neoliberal restructuring strategies, including incentives and subsidies to for-profit providers, which reinterpret and reinforce private care arrangements and involve inherent insecurity for residents and workers. As this comparison shows, however, the working conditions of direct care workers appear to have improved somewhat in the jurisdictions where the domestic model has been adopted most closely. This contradiction is worthy of close examination because it raises questions about gender equity advocacy strategies in the context of old age care and neoliberal restructuring.

We begin by briefly reviewing the arguments in favour of home-like residential care in order to lay out the premises and promises of this approach. Next, the two provincial case studies are presented, including an evaluation of the policy goals and processes that led to the incorporation of “home” into policy. We highlight in particular the relationship between divisions of labour and spatial arrangements. Drawing on an analysis of provincial design and program regulations, 14 site visits, 21 key informant interviews, more than 300 photographs taken from 27 sites, and materials provided by 43

additional residences, we briefly describe the conditions of living and working shaped by this policy direction, paying particular attention to their gendered effects. The conclusion compares how care labour is positioned by these policies, and suggests that while revaluing domestic work is positive for gender equity, replicating domesticity is problematic.

Dreams of Home Calls for more home-like facilities for the frail elderly have long accompanied a critique of institutional care as dehumanizing, neglectful, and even abusive.⁹ Indeed, the ideal of “home” has been posed as an antidote to the much maligned “institution.” Violence, abuse, and neglect in residential care, which is demonstrably structural and contingent on context,¹⁰ is often used as an argument for more care in private households, but without examining the violence, abuse, and neglect that occurs in private households and affects both older people and the largely female unpaid workforce who care for them.¹¹ Despite these issues, it was and is still argued that older people prefer to remain in their own homes for as long as possible¹² and that familial care was and is the most loving and caring. Advocates have argued that care residences should be reorganized to more closely resemble private homes.

Starting in the 1970s, researchers reinforced these popular views that proposed that quality of life in residential care facilities was contingent on a sense of residency, interpreted as feeling “at home.”¹³ Some made this recommendation based upon research demonstrating that smaller, cozier environments produce less agitation and a higher quality of life for residents, particularly for those with dementia. Others used the term as a reminder that a long-term care institution is “home” for residents, or to signal a need for respectful, dignified care. Some of these insights were incorporated into experiments in residential care design that have produced a wide range of environments and corresponding care models with a common reference point. In the United States, “home”-inspired models, including Adards, the Eden Alternative,TM and the Greenhouse model, have been influential,¹⁴ but similar experiments were adopted in Sweden and the Netherlands.¹⁵ Policymakers in many jurisdictions have drawn upon these models in order to respond to public pressure to improve service delivery. This shift in service

provision has been associated with significant financial investment in new construction and renovation of existing facilities. However, in the debates and developments in policy and practice that surrounded this shift, there has not been any assessment of their implications for gender equity.

Ontario and Nova Scotia offer telling case studies in the different ways that the ideal of home has been incorporated into old age residential care policy, with different effects for gender equity. To help situate the comparison, it is important to note that these provinces' programs are organized to serve regions of very different scales, in both population and land mass. Nova Scotia's population is 16 percent that of Ontario's, and has a slightly higher percentage of seniors. At last count, Ontario had 640 long-term care residences and 76,616 beds,¹⁶ while Nova Scotia had 90 long-term care homes and 6,902 beds.¹⁷ In both provinces, residences are owned and operated by a mix of providers, with the majority owned by private, for-profit companies, but also substantial ownership from charitable and non-profit owners and public owner/operators, usually municipalities. Whether for-profit, public, or non-profit, all of these residences—distinct from assisted living or retirement residences—receive public funding for the care. Typically, long-term residential care residents' daily care needs (including 24-hour nursing and personal care, programming, some food, and administration) are publicly funded, while rent, housekeeping, laundry, and similar "room and board" services are paid for by residents. In Ontario, residents with standard rooms pay approximately \$74 per day,¹⁸ while Nova Scotians pay \$102.50 per day. The provincial share of spending per resident per day in Ontario is also lower, \$155.47,¹⁹ compared to \$178.10 in Nova Scotia.²⁰ Not surprisingly considering the relative expenditures, total staff hours per resident per day are higher in Nova Scotia at 5.9 hours, compared to 4 hours in Ontario.²¹

The Ontario Case Study: "Hospit-able" Care In Ontario, the ideal of home is integrated into regulations that, although deploying the discursive power of the concept, do not change the care culture so much as they invoke a break with a disreputable past. The policy path towards "home-like" residences was an uneven and reactive one. When the Harris Conservatives

came into power in 1995, they made a series of changes that affected residential care dramatically. In 1996, they removed regulations that set minimum staffing levels and other quality standards, such as the “one bath a week per resident” rule. In the period from 1995 to 2000, they cut about 9,000 hospital beds and downgraded some chronic care facilities to long-term care residences. They also established a long-term care bed distribution and needs study that, together with the recommendations from a Health Services Restructuring Commission discussion paper,²² led to an announcement that 20,000 new residential beds would be constructed or renovated by 2004. However, the uptake for the renewal program from both nonprofit and for-profit providers was poor, likely because of inadequate funding levels.²³ This failure to increase the number of beds, combined with cuts to community care that restricted home care services, resulted in huge waiting lists for residential care. By the time the Liberals were elected in 2002, the situation was acute and contentious, fuelled by a scathing report from the Provincial Auditor.²⁴ The newly elected government quickly organized a consultation to address the situation.

A brief but intensive consultation and research process led to a 2004 report called “Commitment to Care: A Plan for Long-Term Care in Ontario.” It recommended that “we need to re-introduce ‘the concepts of ‘home’ and care’ into daily life for... residents.”²⁵ In a brief section called “Creating a home environment,” the report encourages residences to allow residents to bring in their own belongings, to respect residents’ personal routines, to have pets and plants, and to encourage family visiting. It also recommended a reworking of the 1998 design standards to “provide smaller homelike settings as size is sometimes a barrier to home-like life.” These recommendations did not establish a clear vision for residential care provision nor a clearly defined role for residential care as part of a system of care for older people.

The Liberals acted on many recommendations. But the policy climate remained heated, due, in part, to a 2005 inquest into the deaths of two residents of the Casa Verde long-term care home in Toronto. New long-term care homes legislation was introduced in 2007.²⁶ At the same time, further consultation on quality of care and staffing was held as a response

to the Casa Verde inquest recommendations, resulting in the “Sharkey” report.²⁷ This report focused on the very low staffing ratios and lack of staffing standards in Ontario’s facilities, but did not suggest changes to qualifications or the organization of tasks.

More than a decade after the 1998 announcement of the bed expansion, and drawing upon the consultation reports and inquest recommendations, the new “Long-Term Care Design Manual” was released, along with a new policy to fund construction costs, and to facilitate both a bed expansion and a change to more “home-like” environments for care.²⁸ Eligible operators were offered a one-time grant to cover design and planning and a construction/renovation per diem for each new or renovated “bed” that met the new home-like design standards—to be paid out over a 25-year period.²⁹ These policies aimed to redevelop 35,000 beds across the province in areas of highest need. The new *Long-Term Care Homes Act*, approved in 2007 and enforced as of 1 July 2010, provided program standards to accompany the built environment renewal. It sets out as its fundamental principle “that a long-term care home is primarily the home of its residents and is to be operated so that it is a place where they may live with dignity and in security, safety and comfort and have their social, spiritual and cultural needs adequately met.”³⁰ No minimum staffing ratios for nurses or personal support workers are included in this legislation, but the Act provides extremely detailed regulation of most facets of care, including a new compliance and enforcement system. While producing a highly regulated environment, this regulation structures daily life within residences through the required reports, resident assessments, and medically oriented programs, rather than by specifying a particular organization or process of work, a model for care, or other means. “Home” is the stated overriding principle, but the details, reporting, recording, and benchmarks emphasize medical care and risk avoidance.

Since 1998, more than two thirds of all new and renovated beds have been in for-profit facilities—dominated by chain, for-profit ownership—despite their poor record on quality of care.³¹ For nonprofit organizations and municipalities, building or renovating to these standards with the available level of funding remains a problem.³² Uptake issues have influenced policy developments, and in 2013 an additional funding program was added to

cover extra costs for facility upgrades and new builds to meet the new standards.³³ But even while these policies were creating a particular environment for residents, a 2011 report on alternative levels of care³⁴ recommended that a permanent bed for most frail elderly seniors might not be the best solution to care. The report foreshadowed the 2012 Sinha Report, which outlined a system-wide vision for long-term care in which “long-term” would be written out of residential care for the most part, in favour of a system where frail, elderly people will be moved back and forth between a private “home” and the places that offer appropriate levels of care. Funding for short-term convalescent beds in long-term care residences was being streamed prior to the Sinha report’s release.

As has been demonstrated, Ontario’s “home-like” model developed within a highly reactive and dynamic policy environment in which policymakers vacillated on the role for residential care facilities in the health care system. Care shifted incrementally towards familial care, while at the same time drawing upon the language of “home” to reshape residential care. The model has been instituted primarily by using public funds to finance for-profit care provision, thus producing a system where care security depends on profitability. The model itself is also remarkably incomplete. The design manual makes some gestures towards instituting more personalized and smaller-scale physical environments, but the regulations in the Act seldom reflect the goal of more “home-like” care. Furthermore, there are no standards for staffing ratios, which produces the conditions for lean staffing.

The inquests and complaints about quality of care, combined with pressures to provide more “beds” and to contain costs, did not lead to a new vision for residential care, but led instead to renovation and redecoration of the old system. New and renovated care residences were built around a “resident home area (RHA) concept” of “smaller, self-contained units” that allow residents “more intimate and familiar living spaces.” With 32 to 40 residents living in each unit, the scale departs considerably from that of a private household.³⁵ These environments, while often pleasant in their décor and features, favour efficiency over familiarity, and have many distinctly hospital-like features. Each unit must operate as a distinct and enclosed living space on no more than two adjacent floors of a building. They must

contain a dining area, at least one “lounge” area, and a program/activity space. A standard resident room and bathroom are shared by two people, usually strangers. While private bedrooms that share a bath or a private bedroom and bath are available, these variations have higher costs for residents, with choice going to those who can afford it. All residences must offer at least 40 percent “standard” accommodations, and there are financial incentives to create up to 60 percent standard beds, thus encouraging a norm of shared personal spaces.³⁶ While displays of personal belongings and even some personal furniture are common, the standards result in environments that are more like hospitals than households.

According to the design manual, dining areas in each RHA are expected to “include design features that promote a ‘home-like’ feel” and that “reinforce familiar eating patterns associated with smaller social gatherings,” but are also to include a “dietary service space” that supports “the delivery of a bulk food system.” “Lounges,” the more public living areas designated in the design manual, are required to be comfortable for conversation, reading and social activities. Kitchens, laundries, and staff rooms are not required as part of the RHA, and might not even be located in the residence at all. Colocation and/or sharing “building service areas” with a hospital, retirement home, or similar facility are accommodated throughout the regulations. Concerns for safety, contingency, and efficiency dominate the standards.

In site visits to eight new or renovated Ontario facilities, we found that dining rooms most often resembled small cafeterias with tables for four that were used only at designated meal times. Residents formed a line of walkers and wheelchairs in the corridor as meal hours approached, although some residents ate in their rooms. None of the residences offer flexible meal times to meet residents’ preferences, and the limited existing kitchen facilities in the units make a more flexible schedule next to impossible. Interviews revealed that families and residents seldom used the serving spaces for preparing meals and snacks. Lounges varied dramatically in their comfort levels and their usage by residents and visitors, but televisions were frequently left on all day. Attractive hospital-like nursing stations were common, and many of the residents spent a good part of their day seated just outside these

stations, in close proximity to the workers who also spent much of their time there. Other residents spent most of their days and nights in their rooms. Nurses spent some of their time in the enclosed spaces of medication rooms, designated treatment spaces, and offices, where they were mostly inaccessible to residents. In hallways, the presence of large medical carts, industrial equipment, and technologies required in the standards, as well as large stands to hold garbage and laundry, added hospital-like touches.

Work organization was congruent with spatial design. The RHAs were staffed by a number of different kinds of care workers. The majority were direct care workers, responsible for residents' bodily care, dressing, toileting, and comfort. These workers are called "personal support workers" (PSW) in Ontario if they have specific training, but sometimes they are called personal care attendants (PCA) in residential settings. In Ontario, the PSW scope of practice is not defined, nor is it overseen by a government department. A PSW registry was established in 2012, but at this time of writing, registration is not required. These workers, as well as the nursing staff, spend a proportion of their days completing the detailed required health information for each resident, answering the telephone, and conferring with colleagues, usually at a nursing station. A registered nurse (RN), who provides medical assessment and some treatment as well as supervisory responsibilities, often responded to residents in two RHAs and worked out of an office. The more plentiful registered practical nurses (RPN) performed medication rounds, maintained medical records, and provided medical treatments, working mostly at a nursing station, desk, treatment room, or resident room. In some facilities, care aides without formal qualifications did some feeding, transporting, nighttime coverage, and some personal care. Care home managers oversaw all aspects of care in these residences, and in those we visited, all managers had backgrounds in health care administration and/or nursing. Hierarchies among the various workers seemed quite rigidly enforced.

We look after our patients. We have a nurse around the clock to oversee everything, the RPNs...[for] the routine care and meds and the PCAs to do the bedside care. There are lots of volunteers here and the recreation director, so they provide most of the activities. We have OT [occupational therapists]

come in too, for those who need it. We think we do a good job. Our rate of falls is way down and our skin care is excellent.” - Director of Care

In all of the site visits, direct care workers, RPNs, and RNs worked in RHA-based teams, most often with some rotation among the RHAs. Most residences hired significant numbers of relief, part-time, or temporary workers to deal with scheduling and coverage issues. Some front-line care workers and RPNs considered rotations and working with relief staff inefficient and uncomfortable, while others enjoyed the change and didn't want the pressure to have to “be friendly” or “stuck” working with difficult residents or coworkers.

Direct care workers appeared to have the most physically arduous and time-pressured work, which involved responding to the bodily needs of residents when and where needed, while also performing required and more routinized assigned tasks. In interviews, most workers told us that they suffered from repetitive strain injuries and complained about having little time for conversation with residents, who, in their opinion, were lonely and needed more time and attention.

There just aren't enough hands, legs, and eyes for the work that is here now. So we just keep the mouths and ears closed sometimes, just to get through it. And it's hard to do things the way we're told to because it takes longer to use a lift, and residents don't like it, usually. So you just do it the old-fashioned way and end up aching. - PSW

On the other hand, direct care workers indicated that working with a staff team helped them to manage their workload because they could cooperate with coworkers, trade off some duties for others, and help each other with heavy work. The high resident-to-staff ratios were mitigated somewhat by the large size of the RHAs, which meant that there were always a minimum of two workers on each shift in each RHA, so workers had some possibilities for co-operation. This seemed to occur most often in residences that seldom rotated workers among shifts and RHAs.

The housekeeping aspects required in these facilities were not combined with care work, but rather were done by designated workers who often had

little to no contact with residents or care workers. Janitorial workers were both women and men, and these workers often talked with residents as they worked in the RHAs. Those who did cooking and laundry, however, worked elsewhere in the building or offsite. Each of these tasks was accomplished by specifically designated workers who often worked for subcontracted companies, sometimes in locations distant from the sites of care. When on site, worker safety was a dominant consideration in spatial design.

“Home,” as it has unfolded in Ontario regulations, is a gesture towards hospitality and personal touches, defining a break from a harsher institutional past, but failing to remove deeply embedded structures of hospital-like care. It is the flowery plaque with “home” written on it, hung above a nurses’ station littered with disposable gloves and files (as observed in one setting). Workers and residents form relationships in spite of the design and work organization, rather than being supported by them. Residents were not engaged in the rounds of tasks associated with domestic life, such as laundry, cooking, and cleaning, because of the configurations of space, work organization, and the medicalized approach to care. Spatial arrangements supported rigid divisions of labour among staff, with clear boundaries between medical care, bodily care, and not care, and between maintenance, cooking, and laundry. Design, therefore, has not shaped any replication of a domestic division of labour that combines cleaning, cooking, and care, as might be anticipated in a more “home-like” residential setting; in fact, the built environment prevents it.

So far, this kind of organization is positive for gender equity in that it acknowledges the labour involved in household tasks typically assigned to women, and it breaks apart the tasks typically clustered together in women’s domestic labour. Moves towards privatization and cost containment, rather than the hospital-like model, appear to be responsible for the low staffing ratios that have resulted, supported by the lack of staffing standards. However, care work involving residents’ bodily and social needs tends to be perceived as being of low value in an environment that privileges medical expertise—which in and of itself privileges masculinity—leaving these direct care workers and their gendered work at the bottom of the skills hierarchy in ways that affect their dignity, respect, and conditions of work.³⁷ Furthermore,

hierarchies based on racialization and immigration status were apparent in many urban facilities—newer immigrant workers, many of whom had nursing qualifications from their countries of origin, worked in the most demanding, lower-paid RPN jobs, while white, Canadian-born workers dominated management positions. A significant majority of the residents in all facilities were white. In Ontario's long-term care system, inequities of gender, race, class, and immigration status are built into the care arrangements, shaping exploitation.

The Nova Scotia Case Study: Embedding “Home” In Nova Scotia, the concept of “home” entered residential care policy as a dramatic policy shift and a central component of the 2006 Conservative government's Continuing Care Strategy—an innovative 10-year plan to meet the care needs of an aging population.³⁸ Prior to this plan, Nova Scotia's long-term care system consisted of a piecemeal assortment of limited services provided inconsistently across a province where care for the frail elderly was largely the responsibility of the family. Residential care was provided in an assortment of charitable nonprofit and municipal facilities, most of which had been constructed much like hospitals, with long corridors, little privacy or opportunity to bring in personal possessions, prominent nursing stations, and centralized dining facilities. Care work was provided by an assortment of nurses and aides. Unlike other provinces, where most care expenses were publicly funded and individuals paid only the costs related to room and board, care in Nova Scotia was funded primarily by individuals and families, with social assistance for those unable to pay. Thus Nova Scotia's residential care services were used primarily by poor older people, and retained some of the stigma of the poor houses from which they evolved.

Between 1991 and 1999, many hospitals in Nova Scotia were closed and the number of hospital beds was reduced by 37 percent. Compounding these reductions in care, in 1993 the province introduced a four-year moratorium on new Homes for Special Care (HFSC) licences, which included nursing homes and other care residences. As an alternative, Home Care Nova Scotia was introduced in 1995 as a supplement to family care, to stem the number of referrals to residential care and to bring Nova Scotia's health

care sector in line with that of other provinces. But residential care waiting lists continued to grow, and hospital beds, in shorter supply, began to fill up with frail seniors awaiting nursing home placement.³⁹

Although Nova Scotia's policymakers asserted that home care could address seniors' needs—noting that Nova Scotians, like other Canadians, prefer to age-in-place⁴⁰—this claim was undermined by the growing number of seniors occupying hospital beds with nowhere else to go. In addition, labour unrest increased among nursing home staff members across the province. They cited unequal/unfair wages and a lack of standardized protections,⁴¹ while public outcry about individual costs for residential care escalated. It was this atmosphere of restructuring, labour unrest, and public controversy that stimulated the government to charge a committee of providers and policymakers with making recommendations about capital investment in long-term care. This committee's recommendations, based largely and explicitly on Ontario policy developments, led to a single-entry access point for long-term care services in 2000; a "level playing field" for providers that has resulted in the dramatic expansion of for-profit chain provision; and a 2005 policy change that brought resident fee structure in line with that of other provinces.⁴² The committee also recommended a large-scale public consultation and visioning process for residential care services as the basis for a comprehensive residential care policy framework.

These public consultations began in 2005, and by 2009 a new vision (consistent with what was clearly a widely held dream for care that mimicked familial care at home) was initiated for what are called "nursing homes" in Nova Scotia. The policy package consisted of facility requirements,⁴³ together with complimentary program requirements and funding for construction based on a competitive process. The bulk of successful bids came from regional for-profit chains.⁴⁴ Between 2009 and 2013, Nova Scotia's build program funded the construction of 987 beds, many located in underserved communities.

The redesign of care came with a training and registration program for front-line care workers overseen by the Department of Health and Wellness.⁴⁵ This program lays out a "full scope of practice" for those designated as continuing care assistants (CCA), with training modules that include nutrition and meal preparation, household management, communication skills

and social care, as well as a range of modules related to bodily care and health.⁴⁶ Direct care work in Nova Scotia nursing homes remains unregulated, but this registration program overseen by government has had the effect of providing a designated set of skills expected from direct care workers that includes a full range of domestic work, including cooking, cleaning, and social care as well as bodily care.

In early 2013, a number of promised new long-term beds were set aside for short-term respite care because of new demand related to a 2009 program that pays low-income familial caregivers \$400 each month to keep frail seniors at home. This represents another aspect of the commitment to “home,” and a clear move towards familialization of care in Nova Scotia’s policy. This policy introduced new kinds of relationships and work for direct care workers and familial carers, and it provided challenges to the model of care that has been recently established.

As confirmed by site visits to six newly built residences and photographic evidence from 25 others, the 2009 design regulations introduced facilities that, in many ways, imitate a private household in size, style, and the organization of space. Each facility is composed of small “household” units with a maximum of 11 residents per household. Each household must include a living room with a central fireplace, a kitchen, and a dining room. All residents have private bedrooms and bathrooms. The standards cite anecdotal evidence that this arrangement leads to sounder sleep and fewer problems with infection spread. Facilities are required to use a “residential scale and detail.” For example, the light bulb colour and illumination and residential-style bathtubs are specified for resident bathing rooms. Household kitchens are designed to imitate those in private homes, for use by staff, residents, and families. Every two households must have a residential-scale laundry room for residents’ clothing, separate from central laundries where more institutional standards prevail. Facility requirements specify details for a welcoming entrance and outdoor areas, including landscaping so that a residential neighbourhood quality is maintained. The architecture and scale of new Nova Scotia residences draws upon the vernacular of the single-family, middle-class house, with a notable absence of obvious medical facilities, such as typical nurses’ stations. Resident rooms usually contain a

hospital-type bed and some personal furniture and possessions. Hallways are short. Living and dining areas uniformly feature inviting arrangements of residential-type furniture, draperies, televisions, computers, and even fresh flowers and photographs. At some residences, the bathing room features the specified residential bathtub and an institutional tub with lift, side by side, suggesting that institutional enhancements to the residential “feel” are sometimes necessary for care. Access to adjoining “households” was constrained via access codes, keys, heavy doors, or other barriers. Observations made in the morning, mid-day, and evenings confirmed that living spaces appeared to be well used by residents, volunteers, visitors, and staff who used the living spaces with the residents.

Consistent with these spatial arrangements, direct care work is organized to replicate the daily round typical of unpaid domestic labour in private households, supported by program regulations.⁴⁷ For example, residents have some choice in when and how they take their meals, go to bed, or bathe, but this is negotiated with care aides, who have some control over their work schedule in order to allow for this flexibility and who co-operate with coworkers, including nurses, to ensure work is accomplished. Although two slightly different staffing models were observed in these residences, the direct care workers combined some housekeeping, meal preparation, and resident laundry work with care duties, which included assisting residents with bathing, dressing, toileting, feeding, and including residents in activities of daily living, as well as assisting nurses with medically necessary care. The care work included developing a relationship with residents, so that the residents’ needs and wishes are understood and respected. During site visits, we noted that care aides were usually assigned to consistent staff teams working in specific households in order to support these care relationships. Observations confirmed that the workers were engaged almost continuously with residents. Along with their care aides, residents with dementia folded clothes and washed mugs. One aide pointed out that because most residents have kept house much of their lives, these chores gave them an involvement that was “like home.” In other interviews, workers commented that care relationships are very similar to family relationships:

We try to keep things going like a family would, you know, with the CCAs kind of like 'mother' or 'daughter,' depending on how you look at it.
– Director of Care

Referring to one resident, a care aide told us that:

She's a go-er, we have to keep up with her and she wants us constantly, so we switch. She is a little confused. She calls me by her daughter's name, and when (her daughter) comes to visit, it isn't appreciated - Care Aide

No doubt this simulation of family is aided by the homogeneity of race, ethnicity, and place of origin among residents and workers at most Nova Scotia homes. While visible minority and immigrant workers and residents were noted in one residence located in an urban area, there were few workers or residents from visible minorities at the others, and in three homes most workers and residents had been born in the immediate area.

While seven of the nine managers and workers interviewed celebrated this model as "home-like," there were consistent reports of problems. Some care aides felt stuck working in a household with a disproportionate number of challenging residents, and they longed for rotation to lighter tasks. Back-up staff appeared to be in short supply in many smaller communities. This was the case, for example, in the fall of 2012 during a flu epidemic that brought residence staff levels to the brink of crisis in Cape Breton facilities. Directors of care, most of whom were nurses, told me that although the household design prevented disease spread, it made staff shortages more difficult. Workers are isolated from one another and constrained from cooperating because of the physical design. At one site visit, residents in one household were left unattended for at least half an hour when a care aide, working on her own, went to help a care aide in another household.

Nova Scotia's nursing home model is not only a break from the sector's institutional past, but it is a new model for residential care based upon domesticity. It is also inherently contradictory for gender equity. On one hand, it involves a form of collective caring that respects residents' autonomy, choices, and right to a comfortable, familiar environment, while also offering opportunities for residents to participate in "homemaking." The care aide

“full scope of practice” regulations and care aide registry potentially offer a reevaluation of women’s work in social reproduction by acknowledging cleaning, cooking, and caring as skilled, visible work deserving of a living wage. Care work is usually considered unskilled and of low value, so these regulations confer respect onto the predominantly female workforce and their necessary work. On the other hand, this model replicates many of the problems associated with domestic labour in private households, including an overall maintenance of a traditional gendered division of labour, as well as some of the isolation, monotony, and uneven distributions of care burden. By replicating them, this model also fails to disrupt intergenerational familial care arrangements in which wives, mothers, and daughters are expected to care. Given the comments made by care workers, this includes the replication of unequal relationships between women, where both carer (daughters) and cared-for (mothers) feel frustrated and exploited.⁴⁸ More broadly, this model reinforces an ideology that caring belongs “at home,” organized according to inequitable gendered scripts.

Gender Equity and Care: Dilemmas and Possibilities This comparison demonstrates many of the challenges to gender equity presented by two configurations of care arrangements in a period of neoliberal restructuring. Old age residential care continues to be modelled on social structures that rely on gender inequities, such as the household and the hospital, and these inequities are structured into discourse, configurations of space, work organization, and approaches to care. They draw upon and reinforce neoliberal tendencies towards familialization by relying on domesticity as a metaphor and model for publicly funded services, at the same time that households are pressured to provide services formerly provided by governments.

Ideally, old age residential care should provide conditions of dignity and respect for both residents and workers. Gender equity is central to this configuration, always in relation to equities of age, race, class, sexuality, and disability. But it is less clear how best to work towards more gender equity in an inequitable world. Any approach is likely to hold different consequences for differently situated residents and workers.

At first glance, the Nova Scotia model of home-like care produces more gender equity in that it recognizes and revalues the work associated with

domestic labour as skilled and waged work. It also produces built environments and relationships that facilitate residents' and their guests' involvement in, and choices about, daily life, thus according respect and dignity to the mostly women who live there. But at the same time, the model replicates intergenerational familial and household relations that expect care from women and produce conditions that make collaboration and sharing more difficult. Through its reference points and metaphors, it constructs collective care on an inscription of, and preference for, familial feminized caring, with all of its incumbent inequities and possibilities for exploitation and neglect in private households. It reproduces and reinforces inequitable domestic labour relationships in private households, while at the same time building a limited form of collective caring.

Clearly, Ontario's more hospital-like approach prevents the replication of domestic labour in paid employment, but given the gendered inequities embedded in the medical model of care—and the limited professional recognition of workers—direct care work remains undervalued in this environment. Hierarchies of labour based on racialization and immigration status are well developed within this feminized work. Nurses do better, not because of gender equity initiatives, but because of the moderating effects of a medically related scope of practice and hard-won labour victories. In Ontario facilities, residents tend to be characterized, and to behave as, “patients.” Their daily lives are structured by the work routines of others—routines that both exclude them from and relieve them of many tasks of daily living, while limiting their access to meaningful activity in ways that diminish their agency and oppress them as social throwaways.

The Ontario model, with its dorm- or ward-like units, seems to have the potential to offer collective caring at a scale that may be affordable and efficient, while at the same time reducing isolation for workers and offering residents a style of living that, although not like a household, could be quite like a community. Its built environments limit this possibility because regulation does not require amenities and spaces for residents, visitors, and staff to participate together in daily life, and the results limit their choices. While there is promise here, this medically based model fails to disrupt the devaluation and invisibility of care work and of frail, elderly people, or to challenge

gendered, racialized divisions of labour beyond separating housework from caring. It also reinforces class divisions, allowing privacy only to those who can afford it.

To imagine long-term care residences as equitable places to live and work, those concerned with these issues must reconsider the romance of the idea of “home,” rejecting institutional caring and privileging medical models. All of these models undervalue caring labour and those for whom care is provided, while creating a dichotomous tension between public caring as being bad and private caring as being good. This tension closes off consideration of more collective possibilities. Dreams of collective caring could focus on making the care relationship central, and could place dignity and respect for workers and residents as the starting point, with long-term care residences as central to community life, like community centres. This kind of dreaming is not part of the regulatory landscape in these jurisdictions, but remains a powerful possibility in light of increased pressures by a new generation of those who are reaching late life.

Notes

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1. See P. Armstrong, H. Armstrong, and T. Daly, “The Thin Blue Line: Long-Term Care as an Indicator of Equity in Welfare States,” *Canadian Women's Studies* 29/3 (2012), pp. 49–60. I use the term “old age care” for clarity, although it is usually called “long-term care” in Canadian jurisdictions (even though it is increasingly not “long-term” and includes care not only for old, frail, and demented individuals, but also for others who require complex continuing care). Furthermore, residential care facilities go by various names: “long-term care homes” in Ontario and “nursing homes” in Nova Scotia.
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3. See S. Braedley, “A Gender Politics of Long-Term Care: Towards an Analysis,” in *Troubling Care: Critical Perspectives on Research and Practices*, P. Armstrong and S. Braedley, (eds.), (Toronto: Canadian Scholars Press, 2013), pp. 59–70.

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