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Prescriptive or Interpretive Regulation at the Frontlines of Care Work in the "Three Worlds" of Canada, Germany and Norway

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See table of contents

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ARTICLE

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Tamara Daly, Jim Struthers, Beatrice Müller, Deanne Taylor, Monika Goldmann, Malcolm Doupe, and Frode F. Jacobsen

Introduction

A wall is more or less white than another wall we can see or imagine. So, our subjectivity, with the wealth of comparisons it implants in us, transforms us into tourists of ourselves, visitors of the odd sights of everyday life. It removes the dull sense that anything at all is obvious.
Arlie Russell Hochschild[1]

Long-term care (LTC) nursing and personal care homes provide specialized medical and social care to society's most vulnerable, including younger but mostly older adults with multiple health ailments and disabilities. These are complex organizations,[2] providing ever more highly acute medical and social care, owned by for-profit, non-profit, and public entities and governed by intersecting regulations that structure tableside and bedside work.

1. Arlie Russell Hochschild, *The Commercialization of Intimate Life: Notes from Home and Work* (London: University of California Press, 2003), 6.

2. Shalom Glouberman and Brenda Zimmerman, Commission on the Future of Health Care in Canada, *Complicated and Complex Systems: What Would Successful Reform Of Medicare Look Like?* Discussion paper No. 8 (July 2002), http://publications.gc.ca/collections/Collection/CP32-79-8-2002E.pdf.

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The sector's complexity drives debate about its regulation; as Kieran Walshe argues, "[n]ursing home regulation remains the constant subject of policy attention…."[3]

In the context of this complexity, how states should regulate to best guarantee good living conditions and care for residents while maintaining good working conditions for staff are important considerations and the focus of this paper. Who does what work, how it is organized, and how many people are available to do it are arguably the most important factors affecting residents' receipt of quality social and health care, so it is particularly important to have the right staffing regulations.[4]

Interestingly, despite the similarity of residents' needs and of LTC work tasks, staffing is regulated and organized quite differently depending on country, regional, and organizational contexts. This variety in the face of similarity invites us to explore the regulatory structures in LTC by investigating the nature and form of macro level staffing regulations – which can be either highly prescriptive or more interpretive – in connection with frontline work organization. We define prescriptive regulation as a tendency to identify which staff should do what work *and* when and how they should do it. Interpretative regulation reflects a tendency to broadly define care but not which staff should do it, nor when and how they should do it. The variety also allows us to explore how frontline care workers react, resist, and respond to the tensions between the regulatory context and the needs of the situation that they encounter in their everyday work. Drawing on the conceptual framework afforded by Gøsta Esping-Andersen's three worlds of welfare capitalism, we examine care work regulation and frontline work organization with examples of music activities, medication dispersal, and dining in liberal, conservative and social democratic regimes, in Canada, Germany, and Norway respectively.[5]

This paper seeks to answer three questions. Where do each jurisdiction's staffing regulations fall on the prescription – interpretation continuum? What are frontline care workers' strategies for accomplishing everyday social, health and dining care tasks? Furthermore, in what ways does a policy-level prescriptive or interpretive regulatory approach affect the potential for promising

3. Kieran Walshe, "Regulating US Nursing Homes," *Health Affairs* 20, 6 (Nov/Dec 2001): 129.

4. Stirling Bryan, Janice M. Murphy, Mary M. Doyle-Waters, et al., "A Systematic Review of Research Evidence on: (a) 24-hour Registered Nurse Availability in Long-term Care, and (b) the Relationship between Nurse Staffing and Quality in Long-term Care," (July 2010), https://open.library.ubc.ca/collections/26566/items/1.0048546, 1–176; Charlene Harrington, Jacqueline Choiniere, et al., "Nursing Home Staffing Standards and Staffing Levels in Six Countries," *Journal of Nursing Scholarship* 44, 1 (February 2012): 88–98; Margaret J. McGregor, Robert B. Tate, Lisa A. Ronald, et al., "Trends In Long-Term Care Staffing By Facility Ownership In British Columbia, 1996 to 2006," (Ottawa: Statistics Canada, 2010), http://www.statcan.gc.ca/pub/82-003-x/2010004/article/11390-eng.htm.

5. Gøsta Esping-Andersen, "Comparative Welfare Regimes Re-Examined," in *Social Foundations of Postindustrial Economies* (1999; Oxford: Oxford University Press, 2003), 73–94.

practices to emerge on the frontlines of care work? Following the literature review in section II, section III outlines the study's methods. In section IV, we first describe the LTC regulatory context in each of Ontario, Manitoba, and British Columbia, Canada; Oslo and Bergen, Norway; and North-Rhine Westphalia, Germany, and then present findings from the sites of our empirical data collection. We use the examples of social (music activities), health (medications dispersal), and dining (health and social care) to highlight how regulatory structures effect how frontline workers' respond to regulation – in reactive, resistive, and responsive ways – in order to best care for residents. The final section analyses each region's regulatory framework along a prescriptive-interpretive axis and discusses the implications of these contexts for policy-makers and frontline work organization.

Literature Review

Like Peter Jacobson, we use regulation as a term inclusive of government-level legislative and administrative oversight.[6] Specific to the LTC sector, regulation has been described as interrelated policy approaches that control quality and guard against abuses; standards to make care practices consistent and to match outcomes to targets; and market-based incentive schemes like performance-based measurement and internal competition.[7] Both definitions of the term focus on government roles but ignore social relations. Our notion is more expansive, draws on feminist political economy[8] and includes the range of norms, values, and ethics that structure and frame who does what work, under what conditions, and with what consequences. As a result, we define care work regulation as the range of laws, rules, norms, ethics, values, and systems that structure care work and workers' actions and activities. Given our broader definition, we draw on several literatures focused on institutional health and social care work at multiple levels of analysis. We consider overarching gender norms and debates about ownership and profit in care; conceptual frameworks addressing forms of government LTC regulation; and additional layers of regulation emanating from professional ethics, self-regulation, and accreditation.

6. Peter D. Jacobson, "Regulating Health Care: From Self-Regulation to Self-Regulation?" *Journal of Health Politics, Policy and Law* 26, 5 (October 2001): 1165–1177.

7. Yuki Murakami and Francesca Colombo, "Regulation To Improve Quality In Long-Term Care," in The Organization for Economic Co-Operation and Development (hereafter OECD) / European Commission, *A Good Life in Old Age?: Monitoring and Improving Quality in Long-term Care* (Paris: OECD Publishing, 2013), 143–176, doi: 10.1787/9789264194564-en.

8. Pat Armstrong, Hugh Armstrong, and David Coburn, "The Political Economy of Health and Care," in Pat Armstrong, Hugh Armstrong, and David Coburn, eds., *Unhealthy Times: Political Economy Perspectives on Health and Care in Canada* (Don Mills: Oxford University Press, 2001), vii–x.

Gender Norms

LTC houses a mostly female clientele in need of intimate social, emotional, and medical care; and employs a mostly female workforce (approximately 90 per cent) of healthcare professionals (e.g. nurses, therapists, and social workers) and non-professionals (e.g. care aides, administrators, and workers in areas like housekeeping, laundry, food services, and social care). The ratio of professionals differs jurisdictionally. In the literature, care work is understood as complex but in practice it is treated as less skilled and less highly paid work compared with other sectors. Early feminist scholars were vocal about the gendered nature of care,[9] its status as skilled work in both its paid and unpaid forms[10] and its position within formal production and informal reproduction systems.[11] There is little debate that this workspace is structured by overarching gender norms and expectations about women's capacities and sense of duty to care. With its feminized labour force there is the expectation that labour will be "endlessly stretchable" and fill care gaps to address residents' needs in the face of austere systems and familial care.[12] LTC is thus a highly gendered home space and workplace regulated by overarching gendered norms and expectations of women that are shared across places but with obligations to provide familial care that are place specific.

"Private" in ltc Regulation

In the context of the LTC regulation, "private" involves delivery (i.e. facility ownership), payment (e.g. user fees), quality (e.g. accreditation), and standards (e.g. licensing, professional ethics and self-regulation). There are different levels of for-profit, non-profit, and public sector delivery based on a jurisdiction's historical context and social welfare approaches.[13] Even so, there remains considerable debate about the impact of ownership on the quality of residents' care. At an aggregate level, studies have shown that commercial provision of care can have negative quality implications, on balance showing higher quality in non-profit and public facilities on important quality measures for residents'

9. Hilary Graham, "Caring: A Labour Of Love," in Janet Finch and Dulcie Groves, eds., *A Labour of Love: Women, Work and Caring* (London: Routledge, 1983), 13–30; Clare Ungerson, "Why Do Women Care?" in Finch and Groves, eds., *A Labour of Love*, 31–49; Deborah Thein and Holly Dolan, "Emplacing Care: Understanding Care Work Across Social And Spatial Contexts," in Cecilia Benoit and Hallgrimsdóttir, eds., *Valuing Care Work: Comparative Perspectives,* (Toronto: University of Toronto Press, 2011), 23–44.

10. Shahra Razavi and Silke Staab, "Underpaid and Over Worked: A Cross-National Perspective On Care Workers," *International Labour Review* 149, 4 (February 2010): 407–422.

11. Dawn Lyon and Miriam Glucksmann, "Comparative Configurations of Care Work across Europe," *Sociology* 42, 1 (February 2008): 101–118.

12. Hochschild, *The Commercialization of Intimate Life*; Donna Baines, "Staying With People Who Slap Us Around: Gender, Juggling Responsibilities In Paid (And Unpaid) Care Work," *Gender, Work and Organization* 13, 2 (February 2006): 129–151.

13. Lyon and Glucksmann, "Comparative Configurations," 101–118.

clinical outcomes.[14] There remains a knowledge gap about the impact of ownership on the quality of LTC working conditions. In contrast, there is little current policy debate about user fees, because governments in all countries differentiate between accommodations and care costs. User fees can be dependent on the person's income level, which is a general feature of institutional care.

Jacobson draws our attention to another aspect of the LTC sector's regulatory complexity: a continuum exists between regulations that "facilitate market forces" – such as private accreditation and professional self-regulation – and ones that "displace" or "substitute for the market" as with government regulation.[15] Private regulation can provide overarching regulatory frameworks. For instance, studies have shown how the quality of LTC is associated with higher numbers of professionals providing it,[16] although any relationship between the nature of regulation (prescriptive / interpretive) and the ratio of professionals to non-professionals on the frontlines is under-explored. Private accreditation conducted by for-profit and non-profit organizations sets standards for quality, skills and qualifications, and adds another regulatory layer. While some studies have looked at the link between accreditation and resident outcomes,[17] the role accreditation plays in structuring frontline LTC work is under-explored.

Government Regulation, Organization Responses, and Frontline Care Work

Policy-makers enact LTC sector regulations to set principles and roles; to guard against abuse, neglect, and risks to residents and workers; to control who does what work; and to delineate who pays for what especially as this concerns allocations of public funds and out-of-pocket user payments. According to Walshe, governments can choose three regulatory paradigms: compliance,

14. Mark A. Davis, "On Nursing Home Quality: A Review and Analysis," *Medical Care Research and Review* 48 (Summer 1991): 129–168; Michael P. Hillmer, Walter P. Wodchis, Sudeep S. Gill, Geoffrey M. Anderson, and Paula A. Rochon, "Nursing Home Profit Status and Quality of Care: Is There Any Evidence of an Association?" *Medical Care Research and Review* 62, 2 (April 2005): 139–166, doi: 10.1177/1077558704273769; Pat Armstrong and Hugh Armstrong, "Public and Private: Implications for Care Work," *Sociological Review* 53, 2 (December 2005):167–187; Margaret J. McGregor, Robert B. Tate, Kimberlyn McGrail, Lisa A. Ronald, Anne-Marie Broemeling, and Marcy Cohen, "Care Outcomes in Long-Term Care Facilities in British Columbia, Canada: Does Ownership Matter?" *Medical Care* 44, 10 (October 2006): 929–935; Vikram R. Comondore, P. J. Devereaux, Qi Zhou, et al., "Quality of Care in For-profit and Not-for-profit Nursing Homes: Systematic Review and Meta-analysis," *British Medical Journal* 339 (August 2009): b2732–b2732, doi:10.1136/bmj.b2732; Lyon and Glucksmann, "Comparative Configurations," 101–118.

15. Jacobson, "Regulating Health Care," 1166.

16. Harrington, et al., "Nursing Home Staffing Standards," 88–98.

17. Shawna M. McDonald, Laura M. Wagner, and Andrea Gruneir, "Accreditation and Resident Safety in Ontario Long-Term Care Homes," *Healthcare Quarterly* 18, 1 (April 2015): 54–59.

deterrence, and responsive regulation, with new public management most closely resembling the deterrence paradigm.[18] However, Walshe's singular focus on governmental rules and organizational responses renders frontline workers' agency invisible. Furthermore, the focus on rule compliance assumes that care is a straightforward, linear process devoid of complex social relations, an assumption categorically challenged in feminist critiques. As Karen Davies argues, care work takes time and requires flexibility;[19] thus, attending to the needs of the situation may require non-compliance with some rules in order to provide good care. This is a point underscored by the application of complex adaptive systems theory to healthcare environments.[20]

Even considering the intersecting layers of regulation such as gender norms, governments, professional ethics and accreditation shows how the tension between rule making and rule following is mired in obfuscation. Confronting this tension, Steven Lopez highlights frontline work with his participant observations in a non-profit nursing home in the United States, by noting that workers, managers and clients engage in "mock routinization" and "institutionalized rule-breaking" because of a "mismatch between time and tasks, the development of new (informal) skills, with the institutionalization of rule-breaking, negative effects on quality, the collaboration of shop-level supervision, and workers' experience of managerial irrationality."[21] His study reveals how complex and tension-prone is the space between regulations and frontline work and further challenges us to better understand how this space functions in different jurisdictional and ownership arrangements. Following presentation of the method, we document several government regulatory approaches vis-à-vis frontline LTC work.

Method

There are limits to using cross-national and even cross-regional statistical staffing data because of the way data are collected and defined, and because the data do not adequately make frontline work and its constraints visible. These limits require us to gather primary data that address how staffing is regulated, how regulations are interpreted, and how work is managed. Data are drawn from an international and comparative Social Sciences and Humanities Research Council funded study of "promising practices" and a Canadian Institutes of Health Research funded study of "healthy active aging"

18. Kieran Walshe, "Regulating US Nursing Homes," 129.

19. Karen Davies, "The Tensions between Process Time and Clock Time in Care-Work: The Example of Day Nurseries," *Time and Society* 3, 3 (October 1994): 277–303.

20. Paul E. Plsek and Trisha Greenhalgh, "The Challenge of Complexity in Health Care," *British Medical Journal* 323 (2001): 625–628.

21. Steven H. Lopez, "Efficiency and the Fix Revisited: Informal Relations and Mock Routinization in a Nonprofit Nursing Home," *Qualitative Sociology* 30, 3 (April 2007): 225.

in LTC led by Dr. Pat Armstrong. The project involves a team of 25 academic researchers and double that number of graduate students. The authors of this study are part of the "work organization" theme led by Tamara Daly and Jim Struthers.[22] Ethics for the project were reviewed and granted by the Office of Research Ethics at York University. The data for this paper are drawn from content analyses of a cross-national mapping of regulations, rules and funding arrangements specifically related to staffing, as well as from observations recorded in field notes during week-long rapid ethnographies[23] and key informant interviews (n=291) conducted in 12 LTC facilities located in Bergen and Oslo in Norway; Toronto, Ontario, Vancouver, British Columbia and Winnipeg, Manitoba in Canada; and North-Rhine-Westphalia in Germany between December 2012 and December 2014. The larger programme of research includes 6 countries, 467 interviews, 21 different sites and over 1,000 hours of work observations with complementary field notes. Exemplary case sites[24] with "promising practices" in the provision of residential long-term care were selected in each jurisdiction following key informant interviews with policy-makers and others knowledgeable about the sector. We conducted observations on open and "locked" LTC units and public spaces starting at 7 am and until midnight and later.

Long-term Residential Care in Context: Canada, Germany and Norway

A BROAD OVERVIEW OF EACH jurisdiction's long-term care legislation, ownership composition, and payment schemes is presented below.

Canada

LTC is an extended health service under the *Canada Health Act*, 1984 giving provinces considerable latitude to decide the terms of its public funding and legislation, with some opting for capped budgets and others including it as an insured service. Admittance to a facility is provincially assessed on the basis of need and space availability. There is a co-pay model, with residents responsible for a varying payment depending on the province/territory. For-profit providers dominate in some provinces, though they own at least one quarter of the homes in most provinces. Many facilities are accredited voluntarily by either the Commission on Accreditation of Rehabilitation Facilities International or Accreditation Canada, of which both are non-profit organizations.

22. See the project website at reltc.apps01.yorku.ca for a full list of investigators.

23. Donna Baines and Ian Cunningham, "Using comparative perspective rapid ethnography in international case studies: strengths and considerations," *Qualitative Social Work* 12, 1 (September 2011): 73–88.

24. Robert Yin, *Case Study Research Design and Methods*, 5th ed. (Thousand Oaks: SAGE Publications, 2014).

Additionally, health professional licensing is handled by each of the provinces. There are provincial similarities in scope of practice, but dissimilar or no staffing ratio standards.

In Ontario, the *Long-Term Care Homes Act*, 2007 merged municipal (public) homes, charitable (non-profit) homes and (private commercial and non-profit) nursing homes into the same regulatory framework. [25] Beds at near full (97 per cent) occupancy are remunerated at full capacity and receive per diem activity-based subsidies from the provincial government using a case mix formula derived from the Minimum Data Set Resident 2.0 (MDS-RAI) assessments.[26] Currently, there are about 78,000 LTC licensed beds located across 643 homes,[27] with more than 60 per cent owned or managed by commercial chain conglomerates.[28] Ontario's local health integration networks – regional health authorities – sign accountability agreements with individual homes. Ontario has basic and preferred monthly accommodation fees (from $1,731.62 for basic to $2,438.81 for private rooms in new facilities) paid by the residents.

Standards for Manitoba's provincially funded "personal care homes" are set out in the *Personal Care Homes Standards Regulation*, 2005.[29] Of the 125 homes most are located in the urban regions, and nearly 4 in 10 (37.9 per cent) are provincially run; over one third (34.9 per cent) are private non-profits; and just under one third are for-profits (27.2 per cent). Like Ontario, Manitoba's regional health authorities hold responsibility for LTC. The MDS-RAI assessment is used in the Winnipeg region, but only for planning purposes and across Manitoba staffing levels are determined on a flat-payment system. There are four levels of care, with the fourth being the highest. To supplement the provincial government funding, residents pay between $34 and $79 per day, depending on a person's marital status and after tax income.[30] Staffing levels in Manitoba are standardized so that all residents receive 3.6 paid hours

25. Ministry of Health and Long-Term Care, Ontario Regulation 79/10, Long-Term Care Homes Act, 2007, *The Ontario Gazette*, 17 April 2010.

26. Pat Armstrong, Hugh Armstrong, and Tamara Daly, "The Thin Blue Line: Long Term Care as an Indicator of Equity in Welfare States," *Canadian Woman Studies* 29, 3 (Spring/Summer 2014): 49–60; the Canadian version of RAI–MDS 2.0 is copyright Canadian Institute for Health Information, 2002.

27. Statistics Canada, *Table 107-5501 – Residential care facilities, by ownership, principal characteristic of predominant group of residents and size of facility, Canada, provinces and territories, annual (number)*, accessed 15 March 2015, http://www5.statcan.gc.ca/cansim/a26.

28. Tamara Daly, "Dancing the Two-Step in Ontario's Long-term Care Sector: More Deterrence-oriented Regulation = Ownership and Management Consolidation" *Studies in Political Economy* 95 (June 2015): 29–58.

29. Manitoba, *Personal Care Homes Designation Regulation 108/2000, Registered 11 August 2000, Health Services Insurance Act* (C.C.S.M. c. H35).

30. Manitoba, *Questions and Answers about Personal Care Services and Charges*, accessed 3 March 2015, http://www.gov.mb.ca/health/pcs/qanda.html.

of direct care from nurses and care aides combined, regardless of the level of care required by the resident. This amount excludes care provided by those who perform laundry, cleaning, and dining care.

The *Community Care and Assisted Living Act Residential Care Regulation* (2009) governs the 281 nursing homes in British Columbia.[31] Nearly one quarter of the homes (24.5 per cent) are in the public sector, one third are controlled by non-profit religious or lay organizations, and the remaining 40 per cent are proprietary.[32] There is a co-payment dependent on peoples' after-tax income with a minimum user fee of less than $325 CAD and a maximum of $2,932; fees cannot exceed 80 per cent of a person's net income.[33]

Germany

As the fifth "pillar" of the social security system, there is a universal, national, and mandatory system of "Soziale Pflegeversicherung" or social long-term care insurance (LTCI) in Germany.[34] Nearly the entire population of Germany has coverage with the public health insurance and the long-term care insurance system. Benefits also cover home-based services and cash payments to family providing care. Persons insured by private health care insurances are obliged to purchase equivalent coverage from private care insurance funds (10.6 per cent in 2007).[35] Facilities are funded from the LTCI[36] and residents' private co-payment.[37] Women "choose" residential care more often than men, often after outliving a partner, while men more often "choose" cash payments while being cared for by partners, often wives. Before the current system was introduced in 1995/96, long-term care provision responsibility resided mainly with the family.[38] Arguably, the system is still built on the foundation of family support. Reliance on informal family care and market-based formal care help with the state's cost containment imperative. While the system provides universal access for a defined set of care services, the goal of the LTCI is to control

31. Statistics Canada, *Table 107-5501 – Residential care facilities.*

32. Statistics Canada, *Table 107-5501 – Residential care facilities.*

33. British Columbia, *B.C. Reg. 330/97 O.C. 1106/97 Continuing Care Act Continuing Care Fees Regulation*, accessed 3 March 2015, http://www.bclaws.ca/EPLibraries/bclaws_new/document/ID/freeside/330_97.

34. Erika Schultz, *The Long-Term Care System for the Elderly in Germany, ENEPRI Research Report* 78 (June 2010), accessed 5 February 2015, http://www.ancien-longtermcare.eu/node/27.

35. Erika Schultz, *The Long-Term Care System.*

36. Germany, *Social Code (SGB) - Eleventh Book (XI) - Social insurance* (Article 1 of the Law of 26 May 1994, I, p 1014), accessed 15 February 2015, http://www.gesetze-im-internet.de/sgb_11/.

37. After a means test the private co-payment might be paid by social assistance.

38. Hildegard Theobald, "Long-term Care Insurance in Germany Assessments, Benefits, Care Arrangements and Funding," *Institute for Futures Studies: Arbetsrapport* 13 (2011), accessed 2 March 2015, http://EconPapers.repec.org/RePEc:hhs:ifswps:2011_013.

rising costs for individuals, and to enable people to age in place with family supports. This insurance was accomplished by the state's creation of a "new type of social rights," establishment of specific funding, maintenance of a family care requirement, and bolstering market-based options for purchasing care.[39] Most homes are run by non-profits (welfare organizations/54 per cent) and for-profits (41 per cent) with the remaining 618 homes run by the public, and mainly by municipalities (5 per cent).[40]

There are three care levels in Germany – I, II, III plus an additional recognition on hardship cases. Level I is reflecting the lowest need and the smallest benefit reimbursement (1064 Euros) as well as hardship cases reflecting the highest need and receiving the highest benefit amounts (1995 Euros).[41]An individual needs to have basic body care needs exceeding 45 minutes for level I; 120 minutes for level II and more than 240 minutes for level III.

The German system is heavily reliant on professional standards to guide structure, process, and outcome quality. For instance, the system uses "national expert standards in nursing" developed by the German Network for Quality Development in Nursing working with the German Nursing Council.[42] The standards define the quality level of professional care that users of both health and LTC services can expect when being cared for by nurses and elder carers. In addition, Germany accredits nursing homes.[43] In the past, quality assurance has been a role played by "provider bodies" such as the länder (state) level Medical Advisory Service (MAS) of the statutory Health Insurance Funds *Medizinische Dienste der Krankenversicherung* (MDK). The MDK-MAS conducts needs assessments for care requirements as well as for quality assurance and publishes all audit results. The Health Insurance Funds contract with LTC homes provided service, funding, and personnel criterion are met. Each German länder (region) holds responsibility for surveilling and monitoring LTC homes' compliance. In terms of workforce accreditation and certification, LTC providers are required to uphold provisions of a quality management system such as e-Qalin.

39. Erika Schultz, *The Long-Term Care System*; BMG (2015): Pflegeleistungen ab, accessed 1 January 2015, http://www.bmg.bund.de/fileadmin/dateien/Downloads/P/Pflegestaerkungs.

40. Pflegestatistik 2011 Pflege im Rahmen der Pflegeversicherung Deutschlandergebnisse," *Statistisches Bundesamt*, accessed 3 March 2015, www.destatis.de.

41. Erika Schultz, "Long-Term Care System," accessed 28 March 2015, gesetze/Tabellen_Plegeleistungen_BRat_071114.pdf [letzter Zugriff am 28.2.2015].

42. Andreas Büscher, "Public Reporting, Expert Standards and Indicators: Different Routes to Improve the Quality of German Long-term Care," *Eurohealth* 16, 2 (2010): 4–7.

43. Murakami and Colombo, OECD/European Comission, "Germany: Highlights from *A Good Life in Old Age? Monitoring and Improving Quality in Long Term Care*," accessed 3 March 2015, http://www.oecd.org/els/health-systems/Germany-OECD-EC-Good-Time-in-Old-Age.pdf.

In 2013, just under one third (29 per cent) of LTCI beneficiaries were in residential services).[44] Furthermore, those with the most wealth opt for services in the home or institutions, while those with less financial means opt for cash payments and are cared for by relatives. Like Norway, there is "free choice" for users about location of care provision (home, facility) and providers (non-profit, public, and for-profit).[45] Gender, socio-economic position and immigrant status all affect the role of family care, levels of professional care, and additional paid care services. The system has been criticized for its bias favouring functional impairment over dementia and privileging Germans over migrants.[46]

Norway

Starting in 1988 with the passage of the municipal health care law, local authorities (municipalities) gained responsibility for long-term care along with primary health care and various types of housing and care services.[47] This "multi-level government model" is centred on local autonomy with integration between the central and local government levels – a "typical" Nordic pattern.[48] Following the act's passage, spaces in LTC were increasingly reserved for older adults with extensive needs, and the average stay of residents decreased,[49] all while home care, including 24 hour in-home nursing, was expanded. By 2010, most (78 per cent) of people residing in the 997 nursing homes were aged 67 or older with extensive care needs;[50] about 41,000 people resided in nursing homes, representing about 16 per cent of those receiving long-term care services.[51] As in other countries, the vast majority (85 per cent) of health

44. Federal Statistical Office (2015a): Pflegestatistik 2013. Pflege im Rahmen der Pflegeversicherung. Deutschlandergebnisse. Wiesbaden, accessed 23 March 2015, https://www.destatis.de/DE/Publikationen/Thematisch/Gesundheit/Pflege/PflegeDeutschlandergebnisse.html.

45. Erika Schultz, *The Long-Term Care System.*

46. Hildegard Theobald, "Long-term Care Insurance in Germany."

47. Anders Næss, Anders Kvale Havig and Mia Vabø, "Contested Spaces – the Perpetual Quest for Change in Norwegian Nursing Homes," in Annell Hujala, Sari Rissanen and Susann Vihma, eds., *Designing Wellbeing in Elderly Care Homes – Reframing Care: Discourses and Context* (Espoo: Aalto University Publication Series, *Crossover* 2, 2013), 68; Norway, Ministry of Health, *Law On Municipal Health Care*, accessed 4 March 2015, https://lovdata.no/dokument/NL/lov/2011-06-24-30.

48. Næss, Kvale Havig and Vabø, "Contested Spaces," 69.

49. Svein Olav Daatland, "Social Protection for the Elderly in Norway," in *Norsk institutt for forskning om oppvekst, velferd og aldring (*hereafter NOVA*)* (Oslo, 1997).

50. Statistisk sentralbyrå (Statistics Norway), *Residential Care Services,* accessed 28 February 2015, http://www.ssb.no/pleie/tab-2011-07-08-01.html; Næss, Kvale Havig and Vabø, "Contested Spaces," 63.

51. Karen Christensen, "Towards a Mixed Economy of Long-Term Care in Norway," *Critical*

and care staff is female. Assessments for long-term care are conducted by the municipalities for placement into both public and private non-profit and for-profit providers. These providers compete because Norwegians have what is understood as "free choice" to determine whether to go into a public or private facility, reflecting a move within the country towards consumerism even for state funded services.[52] There is debate, however, with some arguing that the threshold for getting into LTC is "too high."[53] Of those living in institutions, 10.8 per cent live in a privately owned non-profit or commercial facilities.[54] There are more privately owned facilities in the major cities, with nearly half in both Oslo (21 of 50 facilities = 42 per cent) and Bergen (17 of 40 facilities = 42 per cent).[55] Six main commercial chain firms provide services.[56] Municipalities have become incorporated, mimicking for-profit organizations. National and local taxation funds LTC and co-payments are set by the municipalities: 75 per cent of income over NOK 6 600 up to a maximum basic amount of NOK 75 641 plus any income that exceeds this up to the full cost of the place, with the amount varying by municipality. The government does not take property and capital assets into consideration.[57] The family provides as much help as does the state when care occurs in private homes, but less so when someone is in residential care. As Daatland and Veestra note "[o]f parents with Activities of Daily Living needs (for personal care) about two out of three are institutionalized."[58] The Norwegian Center for External Quality Assurance in Primary Health Care accredits nursing homes as well as primary care physician offices and other health care institutions.

In summary, Ontario is the most privatized jurisdiction, while Norway is the least. Private co-payments are required in all of the places examined, although the algorithms and actual amounts vary. In all instances, co-payment calculations are subject to some income dependent modifications. The reliance and obligations of informal care providers also varies jurisdictionally.

Social Policy 32, 4 (November 2012): 577–596, doi: 10.1177/0261018311435028.

52. Christensen, "Towards A Mixed Economy of Long-Term Care in Norway," 577–596; Mia Vabø, "Caring for People or Caring for Proxy Consumers?" *European Societies* 8, 3 (2006): 403–422.

53. Næss, Kvale Havig and Vabø, "Contested Spaces" 78.

54. Statistisk sentralbyrå (Statistics Norway), *Residential Care Services.*

55. Christensen, "Towards A Mixed Economy of Long-Term Care in Norway," 584.

56. Christensen, "Towards A Mixed Economy of Long-Term Care in Norway," 584.

57. OECD, *Norway: Long-term Care, Help Wanted? Providing and Paying for Long-Term Care*, (Paris: OECD, 2011), accessed 3 March 2015, www.oecd.org/norway/47877969.pdf.

58. Sven Olav Daatland and Marijke Veenstra, *English Summary: Health, family and care across the life-course NOVA Report 4/09*, accessed 23 February 2015, http://www.hioa.no/eng/About-HiOA/Centre-for-Welfare-and-Labour-Research/NOVA/Publikasjonar/Rapporter/2009/Health-family-and-care-across-the-life-course.

German legislation is the most explicit about the primacy of family responsibility, while Norway is the least reliant on informal family care. Norway's system seems most explicit about LTC being a right of citizenship, though the German system is based on social rights founded on the principles of pooled risk and shared responsibility in its codified LTCI scheme. Manitoba retains the insurance model, but Ontario and British Columbia have created separate, capped funding envelopes. Finally, all of the systems are regionalized, however, this also translates into jurisdictional differences. In Ontario, Manitoba, and British Columbia, the legislation is provincial and funding disbursement is to a regional health authority. In Germany the legislation is national but managed at the level of the German *länder*. In Norway, the legislation places onus and responsibility on the municipal level. Finally, all of the jurisdictions have non-compulsory private (non-profit) accreditation.

Findings

THIS SECTION PRESENTS FINDINGS of our jurisdictional care work regulation review and provides examples of frontline care work drawn from our ethnographic field studies in Canada, Germany, and Norway in the areas of social care (music as activity), health care (medications dispersal), and food (meals).

Care Work Regulation

We focus on five regulatory areas. First, staff qualification regulations stipulate the certifications that are required to complete different care functions. Table I compares the study's jurisdictions.

Norwegian care aides receive the most training (Table I) with one to three years of secondary and post-secondary qualifications, while Canadian and German care aide training varies, but generally a six-month course of instruction is completed at a public community college or a private "career" college. In Germany, dementia care aids have been recently introduced; they require much less training to practice. Practical nurses in Canada are college trained like Norwegian and German counterparts, while Canadian Registered Nurses (RNS) have university degrees like their Norwegian counterparts. The highest trained German occupation in nursing homes is the qualified care worker, who requires three years of on-the-job training.

Table II presents comparative "staff mix" regulations. Like the OECD, we found varying requirements for the ratio of professional to non-professional staff.[59]

While minimum nursing staff numbers were required in Norway and Canada, in Germany an impressive half of the staff must be qualified care workers (either elderly care providers or nurses with three year on-the job training). Compared

59. OECD, *Help Wanted? Providing and Paying for Long-Term Care* (Paris: OECD, 2011), 182, http://www.oecd.org/els/health-systems/help-wanted.htm.

Table I: Care Staff Training / Qualifications

	Registered Nurses	Practical Nurses	Care Aides
Ontario	**Registered Nurses** require a Bachelor of Nursing (BN or BScN). Self-regulated health care professionals.[1] The scope of practice is determined by individual competence; requirements and policies of the employer; needs of the client; and the practice setting.[2] The College of Nurses of Ontario is the governing body.	**Registered Practical Nurses** requires an approved Ontario college diploma in practical nursing. The College of Nurses of Ontario is the governing body.	**Personal Support Worker** can study at 3 separate program standards used (public colleges in Ontario; private colleges in Ontario; and district school boards in Ontario. MIN: 324 hrs classroom + 290 clinical/ practicum.[3,4] Average program length = 725 hrs. Workers are not self-regulated but are registered with the PSW Registry Ontario.[5]
Manitoba	**Registered Nurses** require a Bachelor of Nursing (BN or BScN). Self-regulated health care professionals.[6] The scope of practice is determined by individual competence; requirements and policies of the employer; needs of the client; and the practice setting.[7]	**Licensed Practical Nurses** require a college diploma governed by the College of Licensed Practical Nurses of Manitoba.[8]	**Health Care Aides** do not have any province wide curriculum but public colleges use similar learning outcomes. The average program length = 700 hrs. Workers are not self-regulated or registered.

1 Ontario, *Ontario Regulated Health Professions Act, 1991 S.O. 1991, Chapter 18,* accessed 23 March 2015, http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_91r18_e.htm.

2 Canadian Nurses Association (hereafter CNA), *Framework for the Practice of Registered Nurses in Canada* (Ottawa: Canadian Nurs*es Association, August 2007), 13, accessed 9 March 2015,* https://www.cna-aiic.ca/~/media/cna/page-content/pdf-en/framework-for-the-pracice-of-registered-nurses-in-canada.pdf?la=en.

3 OECD, "Help Wanted?: Providing and Paying for Long-Term Care," 182, accessed 15 February 2015, http://www.oecd.org/els/health-systems/help-wanted.htm.

4 The Association of Canadian Community Colleges (hereafter ACCC) / Canadian Association of Continuing Care Educators (hereafter CACCE), *Canadian Educational Standards for Personal Care Providers (ACCC / CACCE*, June 2012), 12–13, accessed 9 March 2015, http://www.collegesinstitutes.ca/wp-content/uploads/2014/05/Reference-Guide_Canadian-Educational-Standards-for-Personal-Care-Providers_ACCC.pdf.

5 PSW Registry Ontario, *Ontario psw Registry*, accesse*d 26 February 2015,* http://www.pswregistry.org/Pages/en/Default.aspx.

6 Manitoba, *S.M. 2009, c. 15 Bill 18, 3rd Session, 39th Legislature, The Regulated Health Professions Act (Assented to June 11, 2009), accessed 23 March 2015,* http://web2.gov.mb.ca/laws/statutes/2009/c01509e.php.

7 CNA, Framewo*rk for the Practice of Registered Nurses in Canada, 13.*

8 Manitoba, *C.C.S.M. c. L125 The Licensed Practical Nurses Act (Assented to July 14, 1999), accessed 23 March 2015,* http://web2.gov.mb.ca/laws/statutes/ccsm/l125e.php.

Table I (continued)

	Registered Nurses	Practical Nurses	Care Aides
British Columbia	**Registered Nurses** require a Bachelor of Nursing (BN or BScN). Self-regulated health care professionals.[9] The scope of practice is determined by individual competence; requirements and policies of the employer; needs of the client; and the practice setting.[10]	**Licensed Practical Nurses** are governed by the College of Licensed Practical Nurses of BC. Self-regulated health care professionals.[11] The programs are stipulated through the Practical Nursing Program Provincial Curriculum (July 2011) The Health Professions Act Nurses (Licensed Practical) Regulation.[12]	**Health Care Assistants** can study at all public colleges and most private institutions follow the BC Ministry of Advanced Education and Labour Market Development curricula (2014) of MIN: 475 hrs classroom; 270 hrs clinical /practicum. The average program length = 775 hrs. Workers are not self-regulated but are registered with the BC Care Aide & Community Health Worker Registry.[13]
North Rhine / Westphalia	**Qualified Care Workers (Schwesternhelfer/in – Elder Carer / Geriatric Care Nurses)** have 3 yrs. nursing school + job training + work experience (about 2100 hours of theoretical training and 2500 hours of practical training, dependent on the state regulations.)[14]	**Assistant Care Workers (Elder Care Assistants/ Nurse Assistants)** / 1 yr. nursing school + work experience with between 700 and 750 hours of theoretical training and 850 to 900 hours of practical training.)	**Care Aides (Altenpflegehelfer/-helferinn)** work under the supervision of qualified care workers Dementia Carer (Betreuunskräfte § 87b SGB XI) involves a five day orientation internship + 3 modules of at least 160 hrs. + 2 week internships.[15]

9. British Columbia, *Health Professions Act [RSBC 1996] Chapter 183*, accessed 3 March 2015, http://www.bclaws.ca/civix/document/id/complete/statreg/96183_01.

10. CNA, *Framework for the Practice of Registered Nurses in Canada, 13.*

11. British Columbia, *Health Professions Act, Chapter 183.*

12. British Columbia, *B.C. Reg 283/2008 M243/2008 Oct 17, 2008, Health Professions Act Nurses (Licensed Practical),* accessed 3 March 2015, http://www.bclaws.ca/EPLibraries/bclaws_new/document/ID/freeside/283_2008.

13. British Columbia, *BC Care Aide & Community Health Worker Registry*, accessed 26 February 2015, http://www.cachwr.bc.ca/Home.aspx.

14. Charlene Harrington, Jacqueline Choiniere, Monika Goldmann, et al., "Nursing Home Staffing Standards and Staffing Levels in Six Countries," *Nursing Scholarship* 44, 1 (2012): 94.

15. OECD, "Help Wanted?," 165.

Table I (continued)

	Registered Nurses	Practical Nurses	Care Aides
Oslo & Bergen	**Registered Nurses** have 3 yrs. of education from university colleges.	**Auxiliary Nurses** with 3 yrs. of upper secondary school-based education.[16]	**Skilled Care Workers** are under the Health and Social Care Training Programme, which involves completing lower secondary education for 2–3 yrs. and it involves at least 50 per cent theory.[17]

16. Harrington, et al, "Nursing Home Staffing Standards and Staffing Levels in Six Countries," 93.

17. OECD, "Help Wanted?," 165.

with Canada there are higher numbers of Norwegian nurses on the floor. In both European countries, we found more qualified or professional staff in the homes. The reverse is true in Canadian settings; care aides, with less formal training, far outnumber nurses and provide the bulk of care work.

As shown in Table III, staffing intensity ratios calculate the minimum staffing allotment overall, usually measured in hours per resident per day inclusive of direct care staff.

Germany has regionally determined minimums tied to its care levels; overall staffing levels are higher with more professional staff than in Canada. According to the most recent representative survey in 2010 the resident-staff ratio was 100 residents to 44.9 care workers.[60] The Norwegian informal levels also far exceed levels practiced by Canadian provinces. Manitoba also has a minimum number of paid hours, though these are shared by professionals and non-professionals.

Table IV shows jurisdictional approaches to funding the LTC sector. As Sutherland and colleagues argue, funding patterns can be population-based, global, activity-based, pay-for-performance, or bundled.[61] Population-based formulas – calculated with age, sex, socio-economic and other health-related characteristics – are used to allocate funds from central to regional governments. A variety of other models are used to directly fund organizations.

The pattern of funding, whether global, directed or activity-based, can determine an organization's flexibility with respect to their staffing complement. Directed funding can challenge frontline staff if there are time lags

60. Bundesministeriums für Gesundheit. Abschlussbericht zur Studie, "Wirkungen des Pflege-Weiterentwicklungsgesetzes, " Bericht zu den Repräsentativerhebungen. TNS Infratest Sozialforschung, München (2011), accessed 1 December 2015, http://www.tns-infratest.com/SoFo/_pdf/2011_Abschlussbericht_Wirkungen_des_Pflege-Weiterentwicklungsgesetzes.pdf.

61. Jason M. Sutherland, Nadya Repin, and R. Trafford Crump, *Reviewing the Potential Roles of Financial Incentives for Funding Healthcare in Canada* (Ottawa: Canadian Foundation for Healthcare Improvement, 2012), accessed 1 March 2015, http://www.cfhi-fcass.ca/sf-docs/default-source/reports/Reviewing-Financial-Incentives-Sutherland-E.pdf?sfvrsn=0.

Table II: Staffing Mix Regulations

	Canada			Germany	Norway
	Ontario[1]	Manitoba[2]	British Columbia[3]	North Rhine / Westphalia[4]	Oslo & Bergen[5]
Professional Staff Minimums	**Director of Nursing** (RN) from 4 hours for 19 or fewer beds ranging to 35 hours for 65 or more beds RN 24 hours per day.	**Director of Nursing** (Nurse in charge of care): RN or Registered Psychiatric Nurse full-time with 60 or more beds; with additional responsibilities with fewer than 60 beds. Registered Nurses in charge of nursing services. Registered Dietician available for consultation as necessary. Sufficient to meet the needs of residents.	**Director of Nursing** is not required. The legislation stipulates that: "[e]mployees on duty are sufficient in numbers, training and experience" Food services manager must be in facilities >50.	**Nurses (Elder Carer / Nurse):** must be 50% of all care staff + 24 hr nurse staffing with minimum of 1 nurse on night shift.[6]	**Director of Nursing** (RN) and Charge Nurse is informally required per home irrespective of size. Registered Nurse at ward level per 8 to 10 residents.
Non-professional Staff Minimums	**Personal Support Workers**: No minimum number **Food Service Workers**: % occupancy of the home x 0.45 = # food service workers.	**Health Care Aides**: No minimum number.	**Health Care Assistants**: No minimum number.	**Care Aides (Schwestern-helfer/in)**: No minimum number.	**Skilled Care Workers**: No formal staffing standards, though some municipalities have unofficial standards.

1. Ontario, *Ontario Regulation 79/10 Long-Term Care Homes Act (2007, S.O. 2007, c. 8)*, accessed 22 February 2015, http://www.e-laws.gov.on.ca/html/source/regs/english/2010/elaws_src_regs_r10079_e.htm#BK37.

2. Manitoba, *Personal Care Homes Standards Regulation, Man Reg 30/2005*, accessed 7 March 2015, http://canlii.ca/t/k8q4.

3. British Columbia, *Community Care and Assisted Living Act (2009, Reg 96/2009 O.C 225/2009) Residential Care Regulation*, accessed 22 February 2015, http://www.bclaws.ca/Recon/document/ID/freeside/96_2009#division_d2e2506.

4. Germany, *Social Code (SGB) – Eleventh Book (XI) – Social Insurance (Article 1 of the Law Of 26 May 1994, I, P 1014). Section 11. Rights And Duties Of Care Facilities*, accessed 2 February 2015, http://www.gesetze-im-internet.de/sgb_11/__11.html.

5. Norway, Ministry of Health, *Law on Municipal Health Care*, accessed 4 March 2015, https://lovdata.no/dokument/NL/lov/2011-06-24-30.

6. Harrington, et al, "Nursing Home Staffing Standards and Staffing Levels in Six Countries," 93.

Table III: Staffing Intensity Regulations

		Canada			Germany	Norway
		Ontario[1]	**Manitoba**[2]	**British Columbia**[3]	**North Rhine / Westphalia**[4]	**Oslo & Bergen**[5]
Ratios /or/ hours per resident per day (hprd)	Standards	**No minimum**. Based on Case Mix Index (CMI). Non-profits and public institutions may supplement	**No minimum**, but a target: 3.6 paid hours per resident per day (funded)[6]	**No minimum** (in general) but newly constructed facilities: 2.8 hprd. "The act stipulates that: the employees on duty are sufficient in numbers, training and experience, and organized in an appropriate staffing pattern"	**Minimum** of 3.0 hprd. 1 FTE for 4 residents (level I); 1 FTE for 2.5 residents (Level II); 1 FTE for 1.8 residents (Level III)[7]	**No minimum** but Bergen ratio is 0.95 FTE direct (RNs, licensed vocational nurses, and nursing assistants) and indirect care workers (managers, and housekeeping staff) per resident. Informally, there is a 4.2 to 5.1 hprd[8]

1. Ontario, *Long-Term Care Homes Act.*
2. Manitoba, *Personal Care Homes Standards Regulation.*
3. British Columbia, *Community Care and Assisted Living Act.*
4. Germany, *Social Code (SGB) – Eleventh Book (XI).*
5. Norway, Ministry of Health, *Law on Municipal Health Care.*
6. Office of the Auditor General of Manitoba, Report to the Legislative Assembly – Audits of Government Operations (November 2009), 51, accessed 1 April 2015, www.oag.mb/ca.
7. Harrington, et al, "Nursing Home Staffing Standards and Staffing Levels in Six Countries," 93.
8. Harrington, et al, "Nursing Home Staffing Standards and Staffing Levels in Six Countries," 93.

between when funding flows and when workloads have already increased based on residents' increased needs, while global funding better allows a facility to internally shift in response to changes in need. As table IV shows, Ontario's activity-based funding, which is an even more stringent form of directed funding, allows the narrowest degree of freedom around staffing flexibility.

Regulations governing the division of labour determine who can do what work, and whether work performed is more task-oriented (e.g. finish each task according to a defined schedule) or relational (flexible in response to what the resident needs at that time); and separated (e.g. health care; social care; dietary care) or integrated (full scope of care). Table V summarizes the potential for work integration between care aides, nurses, and dietary workers in each site.

In care work, a task-oriented focus – for example being focused on getting certain tasks like bathing completed to meet a pre-determined schedule is in contrast with one that is relational – which more flexibly adapts the order, frequency and duration of care to meet the resident's needs.

Table IV: Funding Regulations Directly Affecting Staffing Levels

	Canada		
	Ontario[1]	British Columbia[2,3]	**Manitoba**[4, 5]
Flow of State LTC Funding National Sub-national	**Sub-national**: province to health regions to facilities.	**Sub-national**: province to health regions to facilities.	**Sub-national**: province to health regions to facilities.
Regional / Municipal Funding Capped envelope; Insurance; Block grant	**Capped** in an envelope held outside of the provincial insurance scheme and then transferred to Local Health Integration Networks.	**Block grants** transferred yearly to regional health authorities and then dispersed to facilities.	**Insurance** with funds transferred to Regional Health Authorities using a population-based model.
Facilities' Funding Activity-based; Global	**Activity-based funding** + legislated income-dependent fees from resident per diems. Public funding is based on facilities' CMI, a composite of their assessment scores measured against other facilities. Funding is *relative* to CMI of all facilities. It is at least 1 year for assessment changes to catch up to funding. Based on resource utilization groups care dependencies tied to MDS-RAI™ Assessments but unclear in terms of $$ amounts + legislated, means tested income from resident per diems.	**Global**: provincial funding + legislated income-dependent fees from resident per diems.	**Global funding** with facilities' budget determined yearly by budget officer who recommends budget to Minister, though facilities can appeal +legislated income-dependent fees from resident per diems.

1. Ontario, *Long-Term Care Homes Act.*

2. British Columbia, *Community Care and Assisted Living Act.*

3. British Columbia, *Health Authorities Act, RSBC 1996 Chapter 180*, Queen's Printer, accessed 11 March 2015, http://www.bclaws.ca/civix/document/id/complete/statreg/96180_01#section10.

4. Manitoba, *Personal Care Homes Standards Regulation.*

5. Manitoba, *The Health Services Insurance Act, (C.C.S.M. c. H35) Personal Care Services Insurance and Administration Regulation 52/93 Registered March 19, 1993.*

Table IV (continued)

Germany	Norway
North Rhine / Westphalia[6]	**Oslo & Bergen**[7]
National: Central government to länder to facilities.	**National**: central to municipal governments to facilities.
Insurance with facilities budgets determined by nationally set rates by care levels. It takes 5 weeks for care level changes. Assessments are in the process of being changed.[8]	**Block grants** to municipalities for health & social care with facilities budgets set by municipalities.
Directed: Based on care dependencies (Care I, II, III, IV) + legislated fees from resident per diems.	**Global**: local and national taxation + legislated income-dependent fees from resident per diems.

6. Germany, *Social Code (SGB) - Eleventh Book (XI)*.

7. Norway, Ministry of Health, *Law on Municipal Health Care*.

8. NBA (Neues Begutachtungsassessment zur Feststellung der Pflegebedürftigkeit) is a new assessment tool to assess eligibility and "dependency on nursing care." It has not yet been implemented. According to Büscher and colleagues, assessments are conducted by the Medical Board of the health care insurance – MDK Medizinischer Dienst der Krankenversicherung – the official, independent consultancy that employs doctors and nurses, is jointly financed by the national level health care insurance, but is organized at the Länder (state) level. It assesses individuals' eligibility for insurance benefits for long-term care and controls and evaluates professional services quality. Andreas Büscher, Klaus Wingenfeld, and Doris Schaeffer, "Determining Eligibility for Long-term Care – Lessons from Germany," *International Journal of Integrated Care*, 11 (May 2011): 1–9, accessed 27 March 2015, http://www.ijic.org/index.php/ijic/article/view/584/1252.

Care Work Organization on the frontline

Below, we have drawn from our field notes and key informant interviews to illustrate the ways in which social care activities (music); medication dispersal (health care); and dining care (meals) demonstrate a reactive, resistive, or responsive model of work organization and the division of labour in different settings.

In Canada, nurses (RNs) and assistant nurses (RPNs / LPNs) were responsible for supervision, documentation and regulated acts (e.g. injections and drug dispensing), while care aides were responsible for a range of body and care tasks differing depending on the province. In general, most care aides engaged in washing, feeding, toileting, and, when time permitted, listening, chatting, and comforting residents. In the Canadian context, the work was more constrained and divided such that care aides did body work and cleaning of some of the space, including tables and beds. Sometimes they used computers to document, but often they used paper and pen. Sometimes they put away laundry. Recreation therapists were responsible for social care and their time was usually shared with sixty or more residents. There were also dietary workers who cooked and served meals, and cleaned kitchens, serveries, and dishes. Canada tended to have hierarchical and task-oriented workplaces.[62]

Outside of Canada, care aides' roles were much more expansive. For instance, in Germany and Norway care aides had more decision latitude and more varied work. They did the body work, cleared tables and beds and put away laundry like their Canadian counterparts, however, they also cooked, planned, baked, cleaned, took residents outside for walks, and bought items at local stores for parties. Mostly this is related to the approach *Hausgemeinschaft* and not a general pattern in Germany. In Germany, assistive personnel also ensured residents consumed medicines.

Social Care: Activities

Following the generally strict and hierarchical division of labour in Ontario[63] specially qualified recreation therapists – with at least college education – performed social care in scheduled increments. Ontario workers complained that their work emphasized more counting than caring. The work was highly prescribed, documented, standardized, and audited. As one recreation therapist noted:

> That's what the Ministry looks to when they come in when we're audited. We write down what programs [residents] attend; what needs we meet socially, emotionally, spiritually, physically, and then …we do … a care plan for them.… We do tick off the boxes on the

62. Tamara Daly and Marta Szebehely, "Unheard Voices, Unmapped Terrain: Comparing Care Work in Long-Term Residential Care for Older People in Canada and Sweden," *International Journal of Social Welfare* 21, 2 (April 2012): 139–148, doi: 10.1111/j.1468-2397.2011.00806.x.

63. Daly and Szebehely, "Unheard Voices, Unmapped Terrain," 139–148.

Table V: Work Organization Observed at Sites in "Promising Practices" Study

	Canada	Germany	Norway		
	Ontario	**British Columbia**	**Manitoba**	**North Rhine / Westphalia**	**Oslo & Bergen**
Task Oriented / Relational	Highly **task oriented** & strict division of labour.	**Task oriented** & strict division of labour.	**Task oriented** with relational elements.	**Relational** and team oriented care.	**Relational** and team oriented care.
Health, Social and Dietary Care: Separated Mixed Integrated	**Separated**: minimum number of dietary staff is mandated. Work generally involves delivering food to unit, setting tables, doling food onto plates and washing dishes after the meal is complete. Separate activities with little or no time for care aides to perform this work.	**Separated**: food service employees perform food delivery and provision duties. Separate activities coordinator, with care aides having little or no time for social care.	**Mixed**: workers perform a variety of duties that don't conform to strict categories but there are still divisions of labour between professional and non-professional staff.	**Integrated**: Unit level care workers plan, organize and cook the meals and assist residents with eating, and perform social care during the day in addition to scheduled activities.	**Integrated**: Unit level care workers plan, organize and cook the meals and assist residents with eating and perform social care during the day in addition to scheduled activities.

computer screen … with respect to what programs they attend … and there's a psychosocial box that we have to fill in and an activity section … we have to fill in.[64]

In addition, because the "task" of social care was the purview of the recreation therapists, and the schedule of social care may interfere with tasks other workers needed to perform, this led to staff conflicts. One worker's experience highlights this conflict:

There are times when I'm doing an activity and I really get upset with staff because if somebody is sitting there listening to music, they'll come and just take them out to give them their bath or toilet them or whatever. You take them out and there's that feeling of loss and confusion so they come back and they're not the same. Some of them are agitated … and I know if they were with the doctor they wouldn't come in and take them from the doctor's presence to toilet them or whatever, right?[65]

64. All interviews have been anonymized and the names of the facilities have been changed. Recreation staff, interview by site visit team member, Ontario B site, May 2013.

65. Recreation staff member, interview by site visit team member, Ontario A site, December 2012.

Furthermore, this worker's experience illustrates how, though social care may be counted, it "does not count" in terms of the hierarchy of tasks, with body work and medical work coming first and little appreciation for how the social is an integral part of the care. In this instance described above, workers appeared to be reacting to the pressures to complete their own "tasks," with little attention to residents' relational care needs.

Our observations and interviews in a very large Norwegian long-term care facility revealed a different pattern of integration between health and social care and a different level of staff empowerment for responding to residents' needs for relational care. There, in a 32-resident secure unit within the larger facility, music therapy informed almost every aspect of care delivered to cognitively impaired residents over the past five years. Staff members worked together as a team, in sharp contrast to the Ontario sites both in terms of the teamwork and the integration of the social and medical care. To implement the program, the Director of Music Therapy and her assistant trained staff in how music programs that were individually tailored to each resident could be successful in eliminating the need for psychotropic or sedating medications to manage agitation, depression, and aggression among residents with moderate to severe forms of dementia. As she explained:

> … the easiest way of telling it is that in the music in daily activities as you call it, you use music as a stimulant in the patient for getting them calmed down … But as a music therapist [you are] working out ways of communicating with … the patient with music so you are sort of reflecting with the person.… [I]t's sort of psychological processing and your goal is not to stimulate that person with the music to get them to do what you want. It's more like what is their meaning and you try to make meaning out of things speaking together through music. So it's a different way of thinking.… So when I meet somebody we *do* music together as a verb. We don't *use* music as an object.… One of the main theories in music therapy is that everybody is born with a basis to communicate. As a child … you already start to communicate. And this is a musical way of communicating. So we all are really musical. But it's not a musical way of being able to play scales or sing perfect. That you have to learn. But what lies underneath [is] the music everybody knows … and that's why everybody gets moved by music. So I use this small thing to communicate with the patient.[66]

All staff working with residents in this secure unit received training about how to integrate singing, dancing, touch, and rhythm into all phases of their daily interactions with them. The success of music therapy on this floor has led to a dramatic reduction in the use of mood-altering medications and has contributed greatly to staff being satisfied about their work. These positive results have also led to the gradual introduction of music therapy on other units. A nursing social worker described its transformative impact on her job in this way:

> I have been working a lot with music here and we see that makes [residents] more relaxed. Maybe they can tell about their past. Maybe they speak more. People that don't have any language anymore they can suddenly sing a whole song from the memory and then they suddenly started speaking more because of the music … Before, maybe five, six years ago I didn't sing at all. Never. Never sang because I don't like my voice. But we started this project

66. Music therapist, interview by Norwegian site visit team member, Norway site C, May 2014.

and I started singing and I just thought that it doesn't matter if I have a bad voice. It's not for me, it's for the patient. Now I sing all day long. I dance and sing with my patients and if they're maybe … if they have problems brushing their teeth I can start singing a song I know they like and some manage. It's just moments that make things easier for them just by using music, just by singing. It's really, really interesting.[67]

In the German sites, half of the staff need to be qualified care workers (elder carers or nurses). There are also care aides (dementia carers) separately funded by the LTCI. One organization actively resisted state funding level limitations; it increased the staffing complement by adding large numbers of student apprentices. The costs of the training of the apprentices (wages) are refunded not carried by the facility. They also included a sizable number of "1-Euro Jobbers" – who were remunerated at 1 € per hour and additionally funded through a labour market program aimed at job re-training. As a result, we observed a much higher level of social interaction in this facility.[68] Apprentices performed bodywork and social care under the direction of the nursing staff, which then enabled the nursing staff to work in a more direct way with residents. In our observations, we noted that the large numbers of staff, apprentices and 1-Euro Jobbers available to provide care was the precondition for the comprehensive social care that was provided on the units. In this site, the facility resisted lower staffing allotments in favour of a model that ensured there were plenty of people available to provide care, even if they were precariously employed, by actively resisting the funding constraints imposed by the legislation. As a result, the facility had enough people available to provide care and did not lock its doors, even on units with highly mobile people living with dementia. We also found that there was plenty of smiles and every-day activities for residents to be engaged in (meal preparation, cooking, cleaning, reading newspapers, singing, sitting together, hand holding) that supplemented the "formal" activity schedule (cafés, games). One researcher's field notes recorded the interactions as follows:

When we arrive we see two apprentices sitting with one resident and talking to each other but also to the resident. Other residents are sitting around the table. The atmosphere feels calm and relaxed. All residents are dressed nicely. One woman in a wheelchair makes sounds (she did this as well on the other days). She seems a little agitated especially if the young man (apprentice, I guess) takes his hand away from her hand. She kisses and touches his hand. She seems very much needing these contact/touches and I'm very impressed that I saw various staff members touching her very kindly and allowing her to kiss and touch their hand, arm. I ask the apprentices if they sit with the residents … every day or if they have other duties.… They say that they are sitting there every day and that they are supposed to sit there and that they don't have many other things to do during this time of the day.[69]

67. Nursing social worker, interview by Norwegian site visit team member, Norway Site C, May 2014.

68. The flipside of these staffing arrangement are the precarious working conditions of the 1 € worker. This workfare program in general is highly criticized in Germany.

69. Field note from Germany A site visit, April 2014.

In this home, social care was imbued throughout the care work. Workers of all qualifications engaged in social care, but the capacity to do so was set within the organization's active resistance to the constraints imposed by the German model that espoused cost containment, even while it was more interpretive in privileging professional standards and ethics. In addition, even though subject to critique, the facility had more people available to care by employing people subsidized by the state to get job re-training.

In summary, these examples from the three countries reveal differences between the integration of social care with medical care and bodywork, and the relative priority afforded to relational care. Each also illustrates how workers and organizations operated in ways that were reactive, responsive, or resistive to the pressures in order to meet the needs of the situation. Social care was a clearly defined episodic activity in the Ontario sites, while in the German one we visited there were blurry boundaries between health and social care, and in the Norway sites, social care was an integral part of health as an important alternative to medication and also a way for care workers to find meaning in their work.

Health Care: Medications

Medicine dispersal usually happens close to dining times. There are some commonalities amongst the jurisdictions: medication dispersal usually involves nurses taking out a medications cart, moving from resident to resident, and often crushing and mixing tablets with soft food. This is usually one person's responsibility per unit.

In the Canadian jurisdictions, giving medications is a regulated act; thus, there are strict regulations that distinguish it from bodywork such as washing, dressing, and toileting. Only nurses, usually Licensed Practical Nurses (LPN), are permitted to perform medications dispersal and to ensure medication consumption. We observed that while medication rounds occurred, RNs' work involved computer- and paper-work and addressing complex health needs. Meanwhile, if it was the morning, care aides were getting people up by providing the vast majority of body care and transport to the dining room for breakfast. Like breakfast, lunch and dinner involved serving, feeding, and bussing tables. In order for the LPNs to avoid being called upon to do frontline care work such as moving residents requiring two people while dispensing medicines, many organizations allowed signs on medicine carts that indicated that no one was to talk to nurses while doing medications work. Doling out medicines usually happened while residents were being brought to the dining rooms and it was done in an assembly line fashion, with nurses responsible for as many as 32 residents. Nurses stood over residents who were usually sitting in a passive position at a dining table waiting to be served their meal. In terms of work organization, care aides complained about declining teamwork due to the nursing staff no longer having the time to help with bodywork when care aides were most pressed for time during the mornings. The lack of extra hands often meant that care aides reacted by moving residents – even those who needed

two people – without a partner. Care aides argued that managers knew about this but ignored their reactions because everyone knew that the work could not be completed otherwise, like the "mock routinization" described by Lopez.[70]

In one German home, medications were secured at night, but out in the open in the Great Room during the day where residents and nurses spent most of their time together, much as you might find in a person's own home. When it was time to consume the medicines, the nurse gave the medications to the resident, poured more water into the residents' cup, and then walked away – but not out of the room – and dispensed medicines to another resident. Care aides and apprentices sitting at the table calmly ensured that the medicines were consumed, sometimes with gentle words, other times by "consuming" something themselves by drinking, thereby turning medicine time into an opportunity for social connection with a resident with dementia. German regulations allow the qualified care worker to use professional judgment and this enabled the work to be seamless, natural and very home-like – very different from the highly clinical encounters we observed in the Canadian context. In this example, the qualified care worker delegated only the role of watching the consumption of the medicines, while she remained in the room but *not* standing over the person. Each person providing care understood that the resident was to take the medicines, but done in this way, the resident could take them when ready as the care aide was there to spend time with the resident. The German home was less hierarchical and the division of labour was less rigidly enforced. This site followed a *Hausgemeinschaften* model where eight to twelve residents live in one unit; thus there is a better staffing ratio in a facility following this concept, but also because the site where we observed trained a large number of apprentices who provided extra sets of hands. German legislation is weighted in favour of half of the staff being qualified care workers in terms of staffing intensity and more dependent on their professional judgment compared with the Canadian jurisdictions. Compared with other homes in Germany, this site actively resisted the state imposed care gap due to austere funding by having more people around to provide care. The organization's actively resisted under-staffing by having more "hands" available to provide care who would not be considered full-time staff, and thus not subject to the rules about having half of the staff as nurses, and allowing the type of social care that they wished to provide to flourish. With the work more distributed, in combination with more workers, there was more flexibility to resist narrow job definitions, and to respond to residents' needs in a timely and relational way, while still maintaining a complement of nurses comparable to similar facilities.

In one Norwegian site, high staff to resident ratios allowed for the work to be responsive to residents' needs. Medication dispersal happened during quiet times, when residents were resting in their rooms. The nurses were unhurried

70. Lopez, "Efficiency and the Fix Revisited," 225.

in the process and took time with each resident. The process happened outside of the main space where dining and socializing occurred unless a resident happened to be in that space. The nurse chatted with the eight residents for whom s/he was responsible, about one-quarter to one-fifth the number of residents that nurses were responsible for in Canadian facilities.

Food: Meal Times

Congregate mealtimes are a common feature of residential care, but there was tremendous variation when we compared mealtimes between Canadian and European sites. While all of the sites were subject to government's safe food handling regulations, Canadian regulations are highly prescriptive with respect to who could cook and touch raw and cooked food, with Ontario the most prescriptive with respect to how many hours the dietary servers must work, and where the food preparation takes place. Central kitchens prepared the food to be ready for a certain time, which largely determined the work schedules of others such as front line care workers who were not a part of meal production. Even though some dietary workers set and cleared tables, it was usually care aides who did so, and also brought residents to the dining space, offered food choices, delivered the prepared food, helped residents with eating and drinking, scraped the plates, and cleared the tables. The autonomy and dignity of both workers and residents were compromised because often there were between twenty and thirty people in a single dining room. The regulatory goal was that each resident would be fed without delay; however, the resident numbers were burdensome and residents often waited for everyone to be brought to the space, for medicines to be dispensed and for the food to be served.

Facilities had to interpret frontline work organization within the confines of prescriptive dining regulations; this was often done by requiring care aides to record the quantities of food and drink consumed by each resident at each and every meal. With each care aide responsible for between eight and twelve residents who usually did not sit together, timely and accurate recording was a practical impossibility, and there was a great deal of resistance that accompanied this job function. In some places, care aides were required to enter information into computer programs directly following the dining hour when they could otherwise be engaging with residents. In other places, "tick-boxes" on paper were filled in at the end of the shift. Care aides revealed that they reacted to the constraints by estimating and sometimes copying the previous day's input, raising serious questions as to the reliability of the data and showing the extent to which this documentation was less important than other tasks that competed for their time. Facilities reacted to regulations about when residents should eat by documenting residents' preferences in care plans. For instance they only allowed someone to sleep-in and receive a later continental breakfast if they could "care plan it."

While following European regulations for safe food handling, in Germany and Norway food could be prepared freshly on the unit or re-heated from food

prepared in central kitchens. The unit stoves were used at predictable though not fixed times in relation to the residents' needs. The result was the smells of food wafted through the air. We observed that the workers also engaged the residents in the work. For instance, one care worker in Germany set the table while the residents passed the cutlery. The residents' participation made "activation" a normal part of the day and not a defined and separate activity. The residents also hand-washed and put dishes in the dishwasher. In this site, when potatoes were left from lunch, the workers asked residents what should be done with them; they participated in decisions about how the potatoes would be cooked later that night. One of the residents who liked to clean up, collected the dirty dishes from the table and was allowed to wash and put the dishes away. We watched and the staff did not re-wash the dishes afterwards. Staff cut apples and shared them at the table, while also eating a slice themselves to stimulate the social nature of dining. Residents could have wine or other alcohol at the table. Residents swept floors and workers did not re-sweep. Residents cut and workers did not re-cut. For supper on the dementia unit, a family member helped prepare potatoes and an omelette. The food was soft, easy to chew and swallow, smelled palatable, and included thin slices of cucumber. There was a single plate of bread, cheese, and meat for the table, and people chose what they wanted from it. Bottles of water were left on the table and residents poured water for one another. This *Hausgemeinschaften* model places emphasis on residents' involvement in housekeeping, keeping a more home-like atmosphere, having smaller groups and the presence of at least one care worker always in the common space.

Discussion and Conclusions

We found marked jurisdictional differences both in terms of regulatory approaches and how care was provided on the frontlines. How regulations structured frontline care work was evident when we compared how activity, medication dispersal, and dining were performed in the Canadian, German, and Norwegian jurisdictions. In this section, we locate each jurisdictions' position on the prescriptive – interpretive regulatory axis, discuss frontline reactive, resistive, and responsive care work organization, and propose an analytic framework that links the regulatory form to frontline work organization.

Prescriptive and Interpretive Regulatory Axis

Prescriptive regulation identifies what should be done and which staff should do it *and* delineates when and how they should do it. In contrast, interpretative regulation is more open-ended; it identifies that care should be provided but not which staff should do it, nor when and how it should be done. Germany's legislation is focused on delineating national, regional, local, and family responsibility. Care is defined and care workers are expected to provide care that is "in accordance with the generally recognized state medical and

nursing knowledge."[71] However, as our ethnographic study showed, facilities can engage in rule bending to accomplish their care goals. In Norway, the legislation is highly interpretive. As Mia Vabø and colleagues argue, "eldercare is regulated not by special laws but by general legislation. Care services are offered to all citizens in need of care, regardless of age, income, family relations and so on."[72] The Norwegian Act identifies that health services are a municipal responsibility, but health professionals' responsibility to carry the services out according to their professional standards (§ 4-1). The European Acts we reviewed are similar in ascribing agency to health professionals, and thus relying on professional standards and ethics as a framework. The Canadian context is more varied. The most minute care tasks are detailed in Ontario's prescriptive legislation, including from how to handle continence care and residents' weight changes to how often linens should be laundered. In contrast, Manitoba's legislation is interpretive, with broad categories of care work laid out and general guidelines provided. For instance, soiled linen should be collected "regularly;" surfaces cleaned "as often as necessary;" meals offered "at reasonable intervals" in each 24 hour period and nursing services "organized and available to meet residents' nursing care needs, in accordance with guidelines approved by the minister and consistent with professional standards of practice."[73] However, on the issue of pharmacy and medication management, the Manitoba legislation is quite prescriptive. In British Columbia, the Act is more interpretive around care: staff assist with activities of daily living (eating, mobility, dressing, grooming, bathing, and personal hygiene), consistent with the "health, safety and dignity of persons in care." It is more prescriptive with respect to facility design elements and dining hours but still remains more interpretive than Ontario in allowing for more time during the morning rush and "brunch" on weekends and holidays. Table VI summarizes these findings.

Overall, we noted the following associations: prescriptive regulatory environments tend to be accompanied by a lower ratio of professional to non-professional staff, a higher concentration of for-profit providers, a lower ratio of staff to residents, and a sharper division of labour. On the other hand, interpretive regulatory environments tend to have higher numbers of professionals relative to non-professionals, more limited for-profit provision, a higher relative ratio of staff to residents, and a relational division of labour that enables

71. Germany, *Social Code (SGB) - Eleventh Book (XI) - Social Insurance (Article 1 of the Law Of 26 May 1994, I, P 1014). Section 11. Rights And Duties Of Care Facilities*, accessed 2 February 2015, http://www.gesetze-im-internet.de/sgb_11/__11.html.

72. Mia Vabø, Karen Christensen, Frode Fadnes Jacobsen and Håkon Dalby Trætteberg, "Marketisation in Norwegian Eldercare: Preconditions, Trends and Resistance," in Gabrielle Meagher and Marta Szebehely, eds., *Marketisation in Nordic Eldercare: A Research Report on Legislation, Oversight, Extent and Consequences* (Stockholm: Department of Social Work, Stockholm University, 2013), 164.

73. Manitoba, *Personal Care Homes Standards Regulation, Man Reg 30/2005*, accessed 7 March 2015, http://canlii.ca/t/k8q4.

the care to be more fluid and responsive. In one US study, it was found that higher numbers of nurses produced fewer "deficiencies" in care.[74] With higher numbers of professionals around to guard against deficiencies, a jurisdiction's regulatory tendency towards interpretation might reflect its reliance on professional ethics and frontline judgment as its overarching regulatory benchmark.

Responses from the Frontline

As we found when considering the example of music therapy in Ontario, highly prescriptive regulation seems to impact frontline care workers' abilities to perform teamwork and integrate health and social care. Geraldine Lee-Treweek argues that when we consider the care and the worker separately, it is easier to identify the space for resistance as an everyday strategy to control and "get through" work. For example, private nursing homes' workers controlled their work by making the care depersonalized, engaging in non-compliance or selective adherence to tasks, and coming to their own conclusions about residents' behaviours.[75] In the German site, resistance was not an individual struggle; it was taken up by the organization. Hiring many apprentices helped to provide more social care overall, and it enhanced the working and living environment. Indeed, as has been demonstrated aptly in other sectors, the adoption of new public management involving heavy regulatory oversight and onerous reporting requirements has significantly changed the university environment from a collegium to a workplace.[76] How states choose to govern has implications for the quality of the workplace.

Indeed, how care workers retain decision latitude within highly prescriptive structures is demonstrated by several studies of frontline care, all conducted within highly regulated systems. Rule breaking has emerged in the literature as an important coping mechanism. For instance, Canadian care aides' decisions when performing dementia care were found to be discordant with organizational and legislative rules,[77] which led aides to break rules in order to be able to provide care. Furthermore, this occurred, on a case-by-case basis, with supervisors' complicity. In some Canadian facilities, the only time LPNs are on the floor is during the medication dispersal. They are behind desks, filling in paperwork at other times. To allow nurses to concentrate during

74. Hongsoo Kim, Christine Kovner, Charlene Harrington, William Greene, and Mathy Mezey, "A Panel Data Analysis of the Relationships of Nursing Home Staffing Levels and Standards to Regulatory Deficiencies," *Journal of Gerontology: Social Sciences* 64B, 2 (2009): 269–278.

75. Geraldine Lee-Treweek, "Women, Resistance and Care: An Ethnographic Study of Nursing Auxiliary Work," *Work, Employment and Society* 11, 1 (March 1997): 47–63.

76. Rosemary Deem, Sam Hillyard, and Mike Reed, *Knowledge, Higher Education and the New Managerialism* (New York: Oxford University Press, 2007), 229.

77. Pia C. Kontos, Karen-Lee Miller, Gail J. Mitchell, and Cheryl A. Cott, "Dementia Care at the Intersection of Regulation and Reflexivity: A Critical Realist Perspective," *The Journals of Gerontology Series B: Psychological Sciences and Social Sciences* 66B, 1 (April 2010): 119–128.

Table VI: Nature of Regulation

	Canada			Germany	Norway
	Ontario[1]	**British Columbia**[2]	**Manitoba**[3]	**North Rhine / Westphalia**[4]	**Oslo & Bergen**[5]
Prescriptive / Interpretive	**Prescriptive** with respect to who does what and how with every task from meal hours to number of baths is prescribed in detail in the legislation and additional criterion are applied as part of the compliance process.	**Interpretive** with respect to what and how tasks are done; Prescriptive, with respect to dining hours.	**Interpretive** with respect to who does what and how it is done. For example, the act calls for "at least three full meals or equivalent are offered to each resident at reasonable intervals in each 24-hour period" giving staff and residents flexibility to plan and execute their day. Prescriptive with respect to medications.	**Interpretive** with respect to how tasks are done and Prescriptive with respect to funding. Additional rules are set at the regional level so that there is variation within and between regions.	**Interpretive**, and set at the municipal level.

1. Ontario, *Long-Term Care Homes Act.*

2. British Columbia, *Community Care and Assisted Living Act.*

3. Manitoba, *Personal Care Homes Standards Regulation.*

4. Germany, *Social Code (SGB) – Eleventh Book (XI.)*

5. Norway, Ministry of Health, *Law on Municipal Health Care.*

medical dispersal, facilities have allowed the use of do not disturb signs, which may in fact further weaken their connection with non-professional staff and allow for rule-breaking. Similarly, in the US, Lopez reports informal patterns of work depart significantly from official procedures designed to protect the health and safety of Long-term Care Facility workers and residents, underlining the routinization of rule-breaking. Furthermore, with insufficient federal funding, which limits facilities' ability to hire sufficient staff to meet basic care standards, care aides (nursing aides) could not complete work on time and thus engaged in a mock routinization of the work that broke or bent important care rules and compromised quality of care.[78] We noted that rules were broken and bent when workers needed to actively react or resist in order to attend to the needs of the situation. Similarly, Ryan DeForge and colleagues identify care workers' "workarounds" as a way to address workplace structures

78. Steven H. Lopez, "Culture Change Management in Long-Term Care: A Shop-Floor View," *Politics and Society* 34, 1 (March 2006): 55–80; Lopez, "Efficiency and the Fix Revisited," 225–247.

to show how reacting to mandated practices helps workers to provide care.[79] Donna Baines notes that the context within which care work occurs means that care workers toil on a "compulsion-coercion continuum." This happens because care workers often perform unpaid work to keep their jobs while at the same time feeling a compulsion to do so because of a sense of duty, obligation and genuine care.[80]

By examining government regulation and the care planning processes in LTC facilities, one study found a large time burden created by the formal care planning process and documentation, observing that "fear of citation" can lead facilities to write less specific care plans.[81] Jennifer Black and colleagues reporting on LTC dietitians surveyed in British Columbia found the majority (54 per cent) perceived implementing new residential care regulations increased their workload, thus suggesting they did comply with the regulations.[82] In our study, Canadian facilities used care plans to document any deviations from official rules, and documentation took up the majority of LPN and RN time demonstrating that the nurses used care plans as a means to depart from the official rules.

We found that the most highly privatized jurisdiction had the most prescriptive regulation. Studies have shown higher quality is associated with non-profit and public facilities. Public and non-profit facilities more often increase the number of care workers as they fund the work from other sources of funding. As one German site illustrated, having apprentices available to supplement care is an active form of resistance to conditions of under-funding, and provides a calmer and more therapeutic environment in which to provide care. Also of note, the European facilities we examined had smaller units and did not amalgamate their dining spaces into larger ones. Instead the spaces were congregate but intimate and more on the scale one would find in a large family home.

Other studies have shown that even highly detailed regulations can be interpreted in different ways. Regulation and external oversight can be primary drivers of improvement initiatives in LTC,[83] although the content

79. Ryan DeForge, Paula Van Wyk, Jodi Hall, and Alan Salmoni "Afraid to Care; Unable to Care: A Critical Ethnography Within A Long-Term Care Home," *Journal of Aging Studies* 25, 4 (December 2011): 415–426.

80. Donna Baines, "Caring for Nothing: Work Organization and Unwaged Labour in Social Services," *Work, Employment and Society* 18, 2 (June 2004): 267–295.

81. Cathleen S. Colón-Emeric, Deborah Lekan-Rutledge, Queen Utley-Smith, et al., "Connection, Regulation, and Care Plan Innovation: A Case Study of Four Nursing Homes," *Health Care Management Review* 31, 4 (2006): 337–346.

82. Jennifer L. Black, Rebecca Dunham, and Tamar Kafka, "A Study of Challenges and Opportunities: For Long-term Care Dietitians in British Columbia," *Canadian Journal of Dietetic Practice and Research* 74, 3 (September 2013): 131–137.

83. Sarah Forbes-Thompson, Tona Leiker, and Michael R. Bleich, "High-Performing and Low-

and consequences of regulations are not always apparent to frontline staff or administrators[84] and interpretations can vary. For instance, one study that investigated in-house puréed food production in an Ontario LTC found variation in how government guidelines were interpreted.[85] In Germany and Norway, frontline workers had responsibility for far fewer residents, and provided customized food plates when residents were ready to eat.

Do more prescriptive rules, regulations and oversight of LTC improve or diminish care? There can be serious problems with abuse, deficiencies and violations[86] and regulations can be a guard against these. But there is a downside to heavy and highly prescriptive regulation. Julianne Payne and Jeffrey Leiter examine hospital and nursing home management comparing Australia and the United States. They found managers perceived increased regulation and reporting as obstacles in the context of declining state support, market competition and increased client demands.[87] Likewise, Nancy Foner argues that bureaucratic rules associated with medical care complexity and state regulation interfere with nursing home aides' abilities to provide compassionate and supportive care.[88] In our study, we found that highly prescribed rules led to work that was inflexible and incongruous. In contrast, the flow of the day was calmer in the German and Norwegian sites where there was less paperwork and more time to provide health *and* social care.

Given that more prescriptive regulation tends to occur in jurisdictions where care aides are in more regular contact with the residents and far outnumber nursing staff, it is not surprising that some studies conducted in similar jurisdictions have found that formalization – "the degree to which rules and

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Performing Nursing Homes: A View from Complexity Science," *Health Care Management Review* 32, 4 (2007): 341–351.

84. Black, Dunham, and Kafka, "A Study of Challenges and Opportunities," 131–137; T. J. Legg, "Staff Development: The Neglected Discipline," *Nursing Homes Magazine* 56, 3 (2007): 28–35; Catherine E. DuBeau, Joseph G. Ouslander, and Mary H. Palmer, "Knowledge and Attitudes of Nursing Home Staff and Surveyors about the Revised Federal Guidance for Incontinence Care," *The Gerontologist* 47, 4 (September 2007): 468–479.

85. Nila Ilhamto, Katrina Anciado, Heather H. Keller, and Lisa M. Duizer, "In-House Pureed Food Production in Long-Term Care: Perspectives of Dietary Staff and Implications for Improvement," *Journal of Nutrition in Gerontology and Geriatrics* 33, 3 (August 2014): 210–228.

86. Donna R. Lenhoff, "LTC Regulation and Enforcement: an Overview from the Perspective of Residents and Their Families," *The Journal of Legal Medicine* 26, 1 (February 2007): 10–11; Nicholas Castle, "Nursing Home Deficiency Citations for Abuse" *Journal of Applied Gerontology* 30, 6 (December 2011): 719–743.

87. Julianne Payne and Jeffrey Leiter, "Structuring Agency: Examining Healthcare Management in The USA and Australia Using Organizational Theory," *Journal of Health Organization and Management* 27, 1 (2013): 106–126.

88. Nancy Foner, "The Hidden Injuries of Bureaucracy: Work in an American Nursing Home," *Human Organization* 54, 3 (Fall 1995): 229–237.

procedures are followed by the organization and employees in carrying out different activities" – was positively correlated with job satisfaction among long term care staff.[89] Indeed, another found that certified nursing aides and licensed vocational nurses in nursing homes accepted regulatory oversight as important for providing good care.[90] It is possible that, in the presence of less formal training and no self-regulating body, care aides may like the clearly delineated job roles that come with more prescriptive regulations; however, acceptance is different than adherence, and as mentioned above there have been plenty of studies that demonstrate the myriad workarounds that care aides put in place in order to get the job done.

An important consideration may also be the extensive initial and specialized training for care aides as is done in the European settings. When considering training, Kihye Han and colleagues found that certified nursing assistants in LTC were more satisfied with their jobs if they worked in states with stricter regulation requiring additional initial training hours.[91] Other scholarship suggests that staff do follow, make an effort to follow, or should follow, rules and regulations in the course of their work. Katherine McGilton and colleagues, for instance, found charge nurses in LTC perceived a need to "balance competing resident, family, staff, management, and regulation demands, while completing all of their responsibilities."[92]

Lessons for Care Work Regulation & Frontline Care Workers

Our findings show how the regulatory approach to staffing and administrative funding is highly prescriptive in Ontario while the regulatory and funding orientation in Norway tends to be more interpretive. German facilities also have some latitude to interpret regulations. As a result, care work in Ontario tends to be very task oriented with definite divisions of labour that hindered workers' abilities to provide quality care. In other words, the prescriptive regulations did not promote a high standard of relational care, nor did they promote good working conditions. Instead, regulations promoted reactive work organization. We found that resistive work organization emerged within conditions of austerity when interpretive regulations conceded to professional judgment and

89. Gauri S. Rai, "Job Satisfaction among Long-Term Care Staff: Bureaucracy Isn't Always Bad," *Administration in Social Work* 37, 1 (2013): 90–99.

90. Barbara Cherry, Alyce Ashcraft, and Donna Owen, "Perceptions of Job Satisfaction and the Regulatory Environment among Nurse Aides and Charge Nurses in Long-Term Care," *Geriatric Nursing* 28, 3 (May 2007): 183–192.

91. Kihye Han, Alison M. Trinkoff, Carla L. Storr, Nancy Lerner, Meg Johantgen and Kyungsook Gartrell, "Associations between State Regulations, Training Length, Perceived Quality and Job Satisfaction among Certified Nursing Assistants: Cross-Sectional Secondary Data Analysis," *International Journal of Nursing Studies* 51, 8 (January 2014): 1135–1141.

92. Katherine S. McGilton, Barbara Bowers, Barbara McKenzie-Green, Veronique Boscart, and Maryanne Brown, "How do Charge Nurses View Their Roles in Long-Term Care?" *Journal of Applied Gerontology* 28, 6 (December 2009): 737.

organizations then had flexibility to provide care. Organizations also loosely interpreted rules around who was to be included as staff so as to increase the number of bodies without affecting the need to hire even more nurses than would be considered standard. Finally, we found a more responsive model accompanied regulation that was more interpretive, privileged professional decision-making, and provided funding sufficient to meet most residents' needs.

Baines and Daly argue that the forms of resistance that are associated with feminized work are often overlooked because they are not large scale, highly visible strategies.[93] However, care workers do resist overbearing and punitive regulation in order to attend to the needs of the situation. Thus, care workers who retained more decision latitude and the opportunity to engage in more relational work geared to better meet the timely needs of residents and co-workers experienced more responsive work organization. The more interpretive regulations in Norway yielded more responsive work organization and hold promise for the provision of relational care that is supportive of workers' and residents' needs. Sharmila Rudrappa elevates individual acts with her concept of "radical care work," which describes her findings of racialized, female workers going from being "passive recipients (of normative gender ideologies) to active agents who participated in making a more equitable world."[94] As a consequence, it is important not only to look at common strategies for resistance, but also to identify how the orientation of regulation offers different spaces for resistance.

In some countries with growing private-for-profit sectors, there is a desire to heavily regulate in order to better control the care provided. What this analysis, however, shows is that the form and content of regulation matters greatly for the ways that front line workers can care, and that de-professionalizing this sector may increases the need for prescriptive regulation that in turn hinders the provision of good quality, flexible care.

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93. Donna Baines and Tamara Daly, "Resisting Regulatory Rigidities: Lessons from Front-Line Care Work," *Studies in Political Economy* 95 (Spring 2015): 137–160.

94. Sharmila Rudrappa, "Radical Caring in an Ethnic Shelter: South Asian American Women Workers at Apna Ghar, Chicago," *Gender and Society* 18, 5 (October 2004): 599, doi: 10.1177/0891243204268131.

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