3 Homes for Care

Reconfiguring Care Relations and Practices

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The devolution of long-term health and social care into the homes of Canadians is changing the meanings, physical conditions and spatio-temporal ordering of both domestic life and health care work in such homes. When services are required for months or even years, the home must function simultaneously as a personal dwelling, a setting for domestic life and a site for complex, labor-intensive care work. Blurring the boundary between the public sector of health care and the private sphere of the home may well be cost-saving from the perspective of the state but brings into play a set of dynamics that complicates the transference of professional and institutional functions and discourses into homespace. Furthermore, the returning of care to the home discounts the heterogeneity of homespaces within which care is provided, not only in terms of the home's materiality, but also as a space redolent with social and symbolic meanings.

In this chapter, we take up the heterogeneity of homespace and the various tensions between the 'public' and 'private' in the context of the provision of long-term home care services in Ontario, Canada. These services allow the frail elderly and people living with chronic illnesses or disabilities to stay in their homes and age 'in place'. Mol (2008) and others have recognized the complexity of care relations and practices, and here we expand on such analyses. We draw on interviews and visual data taken from a multi-disciplinary project, which focused on the conditions and dynamics underpinning care in the home. Using a mix of methods, although primarily qualitative, the study explored the different experiences of care giving and receiving, the material conditions of the home and the meaning of home to different sets of participants in the research. We take the home to be a material and discursive site, with its spatial arrangements, location, amenities and furnishings interpreted through discursive constructions of 'family', gender, health/illness, ability/disability that frame dominant representations of the home.

In the analysis we focus on the micro dynamics of care to explore how homespaces are 'brought into being' as caregiving spaces through the practices of routinized care. Informed by Foucault's ideas on disciplinary power, our analysis argues that care spaces are constructed, negotiated and maintained through spatialized social and material practices of power and resistance. These practices are performed within specific

discursive fields, social interactions and inanimate objects that signal a particular ethic of care.

The chapter is organized as follows: we begin with a brief discussion of themes within the care literature pertinent to our argument. We provide a short description of the study's methods to indicate the source of our data, following this with a section on general features of working conditions for paid care workers and how these provide ambiguities and tensions for the practices of care giving in the home. This acts as a context for the case study we use to unpack the various dynamics and practices in play as a home is 'brought into being' as a carespace. We conclude with comments is on how the practices and processes discussed may contribute to understanding of the home as a specific spatiality of an ethic of care.

CARESCAPES, POWER AND AN ETHIC OF CARE

The home is now an established component of contemporary carescapes, which bring together various sets of players into the orchestration and practice of long-term health and social care (Barnett 2005). The emergence of the home as a central site in the provision of care necessarily shifts how paid care can be delivered, including how spaces of care may be reconfigured as they function as both a paid workplace and the care recipient's home. While the home may be viewed as a micro-scale materiality, in fact it is also deeply inflected by relations originating in sites and scales beyond its material boundaries. Nettleton and Burrows (1994) for example, describe the location of care in the home as a "re-spatialisation" of disciplinary power as the state manages particular bodies—bodies defined in terms of their frailty or disability or the failing bodies of the chronically and/or terminally ill. Certainly the tentacles of the state, in the form of policy guidelines and directives, reach deep into the organization and daily practices of care and the formation of care relations in the site of the home (England and Dyck 2011a). Care agency constraints on time allocated to tasks and the legal demarcation of job category boundaries, for example, set a context in which care is delineated in scope and content.

Another strand of literature, particularly when informed by feminist scholarship, is the elaboration of care as a relation, specifically in the context of the notion of an ethic of care. Tronto (Fisher and Tronto 1990; Tronto 1993) has been especially influential in putting forward a research agenda concerning how we might think of ethical care. Her concept of care is intended to provide a broad framework for moral, political and policy decisions, but has resonance for our specific focus on home-based care. Here the well-rehearsed distinction between 'caring about' (relational, therapeutic emotional labor) and 'caring for' (task-oriented, physical labor) comes into play. This distinction refers to the analytic separation (although empirically they may overlap) of the emotional dimension of a care relationship and the physical tasks of care work, such as those of 'high touch',

intimate body work. Healey (2008) comments on family caregiving as an ethical act; family caregivers do not necessarily see it as an obligation or burden. Here we see the overlap of caring about and caring for. There is little work on formal care providers in similar terms, although Bondi (2008) emphasizes the importance of addressing the relationality of caregiving work—a relationship between paid care worker and care receiver that will be power-inflected and emotionally laden.

In home care work, the paid care worker/care recipient relation differs from that in the institutional setting of a hospital or long-term care facility. The worker's workplace is the care recipient's home and home health care work blurs the boundaries between home and paid work, further complicating the work relation. Meanings of the home are destabilized as it becomes a workplace for the paid caregiver while also remaining central to a care recipient's sense of identity and everyday routines. The work relation has a greater potential to be shaped by intimacy, affective labor, ideologies of the family, as well as public discourses about health care in the home setting. Dyck et al. (2005) explore the negotiation of this relationship, focusing on the material, social and symbolic reconstructions of home. Their focus is primarily on the care recipient. In this chapter we take up the perspective of the paid care workers to help explicate more fully how attention to the practices of care can give insight into the emotional and power-inflected relationships that underwrite the constitution of the home as a carespace. We consider how the intertwining of the materialities of home, employment contracts and the emotional dimension of care complicate the notion of ethical caregiving. In effect, we are dealing with a set of work relations that are complicated by antagonisms and ambiguities based on the merging of 'public' work and 'private' home spheres, including their emotional complexity.

The Study

Data for our analysis are drawn from a broad scope study on home care, which placed the home as central to the organization and experience of care giving and care receiving. It was conducted by a research team including sociologists, nurse researchers and geographers.[1] Sub-teams explored the experiences of paid care workers, family caregivers and care receivers, along with a detailed investigation of the various homespaces of care recipient participants in the project. Seventeen cases were recruited in both urban and rural areas of Ontario. These included some children, but care recipients were primarily adults with chronic illness or disability. This chapter draws only on adult cases. Analysis involved coding of interview transcripts and field notes, with cross-comparison across cases. Initially we will draw on a range of cases to make our general points, but later in the chapter focus particularly on one case to draw out the processual dynamics of constituting carespace. This allows us to trace detail within the case to elaborate the articulation of local and wider processes signaled in the thematic analysis of the interview transcripts.

FRAMING HOME CARE: CONTEXTS, MATERIALITIES AND EMBODIED PRACTICES

Structuring Care

The context of the study—Ontario, Canada—is one where restructuring of home care since the mid-1980s has incorporated managed competition. The province was divided into Community Care Access Centres (called CCACs), which are regionally based organizations that govern the delivery of home care services and assess potential clients needs for care services in their region. Agencies delivering home care services now compete for contracts from the CCAC. The introduction of managed competition into home care ushered in a number of large, private, for-profit corporations that in some parts of the province came to control the majority of the market-share at the expense of non-profit organizations, such as the Victorian Order of Nurses that had provided home nursing services for decades. Managed competition is not only put into practice at the level of policy-making but it also impacts upon the work experiences of those whose job it is to provide care to the care recipient, sometimes on a daily basis. Paid care work can be rewarding, but the introduction of managed competition means more and different work for workers, increasing workloads and increasing stress. Cost-savings have been achieved by reducing the number of visits by home care workers and reducing the duration of those visits. This has also been the case for non-profit agencies that increased the workloads of their workers, which for many meant more stress and less job satisfaction (Armstrong and Armstrong 2003; Aronson and Neysmith 1997; England et al. 2007).

Working Conditions, Practicing Care

In addition to the effects of community care organization on the day-to-day demands made on paid care workers, the specific materialities of homes may sometimes present difficult conditions or raise ambiguities for care workers as they perform their work. Furthermore, the emotional dimensions of care work are sharpened in the home setting. Finally, agency regulations also shape what happens in the home as workplace, setting limits, for example, on time allocated to specific tasks or a limit on what tasks are covered in a care package. Such regulations may place workers in a dilemma if they perceive a resultant compromise in the quality of care provided. These three aspects of care provision in the home are signaled below.

Given the high correlation between disabling health conditions and poverty, high demands are exacted from households in which living,

working and housing conditions may be less than optimal because space and amenities are scarce and resources are stretched or absent (McKeever et al. 2006). Homes are not designed as healthcare spaces, and while some provide adequate working conditions for care workers (and family caregivers), others do not.

Some homes in the study were cluttered and cramped, with doorways too narrow for wheelchairs or for client-lifting equipment, and may have limited space for workers to prepare medications or bathe clients. However, there were also homes that had been renovated to accommodate the client's care needs (for example, ramps, roll-in showers and an intercom system), or the family was affluent enough to move to more appropriate housing.

For workers, care recipients and family members, homespace becomes a space of ambiguity, with tensions between its designation as a site for paid care and as a home where private lives are conducted outside the view of the public eye. The following examples show how such ambiguity is expressed by care workers and clients, and how professional performance signifiers may be compromised. For example, a physiotherapist indicates the way social norms associated with entering a home as private space can complicate a worker's positioning:

> I take off my shoes. Ahm, but it's something you're not quite comfortable with, I'm a professional. I'm professionally dressed, I'm treating them, giving them medical advice, and standing in my socks . . . I find that a little weird.

Another worker, a Registered Practical Nurse (RPN), comments on the poor working conditions of one home:

> I have never been in such a filthy home in my entire life . . . it bothered me from the first day I went in and it bothers me every time I go in. It's unbelievably dirty . . . And I've always felt unsafe that way because of the uncleanliness.

At the same time, care recipients note the uneasy mix of public and private life, which is reflected in the organization and care of home space:

> It's very, very difficult to open your door to somebody and then in your own home, you know, have a shower or a bowel treatment with a total stranger.

In one home a notice over the wash basin directed at care workers coming into the home signals this reduction in privacy: "Please make sure that the taps are completely off."

Other issues emerge due to the specific location of some homes in rural areas where the quality of the water supply is unpredictable, especially in the summer. Home care regulations are generally not sensitive to the particularities of locality and can create additional tensions for workers, exemplified in the following quotes:

> [T]hey have a [policy] for dressings right now where they won't supply sterile bottles of saline, you know. Well, if you tried to make sterile saline with [client's] water, it comes out rusty brown, and, ah, you know, it's terrible. You wouldn't want to be putting that in a wound. (nurse employed in a rural area)

> She needed care and she didn't have any water, so we used to haul the water from the Laundromat . . . And then the office says we're not allowed to do that . . . but what are you supposed to do? (nurse employed in a rural area)

Such quotes indicate an unsettling of established meanings of 'home' and 'work' which need to be negotiated through the everyday practices of care work.

Despite difficult work conditions in some homes and, in some instances, a client's dissatisfaction with work done, many of the nurses and homemakers drew on discourses of family and friendship in describing a relationship with clients. Such comment indicated a positive affective climate for the provision of care. For example:

> Like you're part of the—you become part of the family . . . I just think that we're friends after all this, all this time. Like she wants to know what's going on with my kids all the time. . . . They're very much part of her existence. (nurse)

One worker, a homemaker without health care training, saw the content of her work as consistent with 'mothering work', seeing her own experience of reproductive work in her own home as transferable to working for clients in their homes. She commented:

> I can say that I am . . . a very skillful homemaker. . . . I haven't taken a course, so I . . . the only thing that I did, I apply everything that I know already to do at home, into . . . her home. (homemaker)

These comments suggest that care provision in the home includes a dimension different from that of institutional care: the worker as part of the client's social world—bringing in 'outside' news as a quasi-friend or one that brings domestic skills to the maintenance of the client's homespace.

Yet regulatory issues specific to home care shape how the materiality of care practices is actually played out. One homemaker spoke, for example, of the constraints placed on her that prevent her from doing work that she feels is integral to the spirit of care:

> In a house where you have a little old lady living by herself that's full of arthritis . . . if we're not allowed to move the chair that she sits in to get the crumbs underneath, or wipe off the top of the fridge . . . she ends up hiring someone in to do the work I feel we should be doing for them. (homemaker)

Other workers 'bend the rules'; expressions of emotional care were used to rationalize such action. For example, one homemaker interpreted the decision she made as being an integral part of the care needs of the client:

> Like ah, we're not supposed to do windows. But I had a client that all she did was sit and look out the window. So I cleaned the area so she could see out the window. Now that isn't windows, that's ahm, ah, what do you call it, ah, fun time for the client, you know. That's her only [entertainment] . . . because she never went anywhere . . . but she sat looking out the window. So I always kept the window clean for her . . . it was a health issue, as far as I'm concerned, the health of the person. (homemaker)

The quotes in this section of the chapter are suggestive of the varying conditions under which paid care work takes place. They also indicate how the relationship between care worker and care recipient, and the specificity of what constitutes care work, are located within regulatory frameworks and particular locales. The employer may be an agency or, in a few instances, a care recipient using a direct payment scheme. Care workers may be employed by a number of agencies, or a client may be served by more than one agency, which further complicates issues of authority and autonomy in relation to both care worker and care recipient. Other factors, such as continuities or transiency in caregivers also impinge on how the care relationship may be managed.

In the rest of the chapter, we discuss one case example to further unravel the negotiation of care work, its regulation and the care relationship. This closer focus helps us to illustrate the constitution of homespace as care space and to comment on how the complex materialities and social practices of care involved are closely implicated in the production of an ethic of care—one that includes both caring about and caring for.

HOME SPACE AS CARE SPACE: AN ETHIC OF CARE IN PRACTICE

We draw on data from one case to illustrate the interwoven dimensions of care and how these are actively reflected upon and addressed by care workers and family caregivers in their everyday care practices. The case is one where the care recipient, 'Andrew', has complex care needs, and

at the time of the study was no longer able to speak (and therefore not able to be interviewed). His adult son lived in the same house and was the primary caregiver. The house was described by one worker as atypical in its particularly poor conditions, although another commented that there were others the same or worse. The nurse, registered practical nurse (RPN) and homemaker were interviewed. Although the care recipient was not able to participate in an interview, we see this case as useful in throwing into sharp relief the non-uniform, and sometimes difficult, conditions under which care is given and the vulnerabilities of both caregivers and receivers.

We look at the negotiation of rules, the emotional work of the care worker/care recipient relationship and the communication between the workers and family caregiver. Such negotiation shows considerable tension between the desire to provide good quality care and the constraints imposed by the particularities of home space and the regulatory framework of home care. The case of Andrew demonstrates the complexity of creating a care space that can meet the conditions of ethical caring. What is achieved is done partly by challenging regulations and bringing a bit 'extra' into the caregiver/care recipient relationship.

Care Work and Emotional Labor

Asked about the rewards of caregiving work in general, Andrew's homemaker stated:

> It's great! You're helping somebody to be self-sufficient . . . there's a lot of vacuuming and scrubbing and stuff like that, but if you put it in—that you're helping somebody to stay in their own home, you know, if you look at it that way it's a worthwhile job, you know.

Her comments were echoed by the RPN and other care workers in the study. Keeping a person with care needs comfortable for as long as possible at home—a place familiar to them and where they, as far as possible, can continue to choose to do things they enjoy when they like and in an environment where they have some control—necessarily creates a relationship between care worker and client that is potentially quite different than might be seen in a hospital or other formal care setting. While a hospital, for example, is laden with power relations visible in the design of its institutional setting, its routinized activities and the assembly of practice personnel, the home as a symbolic site mediates such relations and routines. Its prime association is with the person residing there, often over a long period of time, and its usual location in a neighborhood setting all shape the care worker/client relationship. As the RPN noted, when asked about her relationship with the client, someone to whom she has provided care for several years:

> Ah, it's still provider/client [relationship] but ahm, you know, I guess you shouldn't get that involved in—in a situation like that, but it's very difficult not to, especially when you're in a home; it's different and you see what his life is like. . . . you develop a closeness with them, you know. . . . It's not a professional thing to do, but when you're in close proximity to someone for that period of time . . . you do get involved in their life . . . You can't help but get involved with them.

So while workers valued the need to maintain professionalism on the job, the intimacy of care and its association with a 'life-in-context' seemed to bring an additional dimension to how they interpreted and practiced their work. Of course, emotional attachments can be forged in any care relationship in any setting, but when care is provided in the home, the emotional labor of care work may be recast. Workers are often working in less than ideal conditions and in the attempt to create a professionally appropriate environment that also respects the emotional (caring about) as well as physical (caring for) needs of the client, tensions emerge around the negotiation of tasks and the regulations circumscribing these. Andrew's case was particularly problematic in terms of its physical safety due to especially unsanitary conditions—for both client and care worker. Not only is the client's body vulnerable in such conditions, but so too is that of the carer.

Workplace Environment as a Place of Risk

The care workers were uniform in their opinion of the workplace conditions of Andrew's home. One dimension was that of the conditions of the home itself, which incorporated risk for the care worker in particular, although potentially also for the client. A second dimension was the rural setting in which the home was located, which brought problems in creating a safe environment for care.

The homemaker described how the circumstances of the family caregiver, the client's son, had changed, which had effects on what jobs were allocated to her:

> The general condition of his home has changed in the last . . . five years that I've been going there . . . Now Home Care has taken us out of the home to do vacuuming, scrubbing dishes, and cleaning. . . . Our main job is, ahm, [the client] himself, his care. Like we make sure he's clean, dry, bedding, his room, vacuum, dusting, we just pertain to his room now. We used to look after the whole house.

Since this change the cleanliness of the rest of the home has deteriorated, and the RPN describes her uneasiness in these terms:

> There's garbage everywhere, dirt, the bathroom is filthy, ahm, you know, Andrew's room is not bad because the homemakers, ah, you know, try and keep it clean. But ahm, I hate having to go into any other section of the house.

The nurse similarly points out the poor conditions of the home, although, again, notes the contrast to the client's own room which is the responsibility of the homemaker:

> . . . normally there are cases of empty, ahm, ah, the nutritional stuff substance that [the client] takes in through his gastrostomy tube . . . a person-high stack of empty cans. [The client's] room itself is kept clean, the homemakers do that, but they're only responsible for the space that he's using.

The RPN commented on the difficulty in preparing medications in such conditions:

> You try and keep the area where you're preparing his meds and his feed like, I have a small area there and you try and keep that area clean because the rest of the counter is just a disaster.

Later in the interview the nurse notes a further complicating factor, that of an uncertain water supply which is from a well. This makes housecleaning and care providing tasks more difficult at certain times of the year. She noted:

> the problem is that because they're on a cistern . . . there's often a problem with water availability. You may not have had any rain so therefore you don't have any water, which means that like even something as simple as washing your hands can be difficult, and then somebody says "well I wouldn't want to touch the towels that are in the bathroom anyway." And I usually do wash my hands in the bathroom, but then we also have a hand sanitizer.

Water problems make all the care workers' tasks more difficult. The homemaker recounted:

> the water is not always—they don't have the water to do stuff with, so sometimes, ahm, we don't even have water to bath Andrew. We have to—they have water in a jug and we pour the water in, we have to heat the tea kettle to get warm water sometimes. . . . His well went dry because the position that they're in, the wells went dry so we had special stuff for sterilizing our hands so we don't have to wash them. Because they had the water tested and there was a bacteria in the water so we had to use sterilization.

There is a clear potential for health hazards in working in poor conditions. In this case, the RPN spoke of the fear of infection due to the dirtiness of

the home and commented on the odors from garbage that had not been disposed of. In other cases, smoking can be problem for a care worker, as well as instances of pulled muscles through lifting heavy clients. In the case discussed here, the main problems primarily concerned hygiene.

NEGOTIATING RISK

In order to manage these conditions and problems with water supply, care workers talked of the bedroom of the client as a relatively safe, clean environment. Nevertheless, care workers had to 'bend' the rules in order to achieve a satisfactory standard for providing the care. As the homemaker said:

> as a homemaker my first instinct is to clean the bathroom totally, but we've been told no. Andrew is our care, and we have to shut our eyes to the other, if that's how they want to live, and that's how they want to live. But every once in a while I'll clean that sink up and the taps.

The RPN also spoke of the homemaker's role in keeping a level of cleanliness in parts of the house which the care workers need to use, but Andrew does not:

> Like you can't wash your hands in the bathroom because the towels are so dirty. . . . We counted one time; three and a half months before the towel was taken down. And only because the homemaker took it and washed it, you know. And actually her responsibility is not that part of the house; it's only for Andrew's stuff. She does all his laundry, his towels, his sheets, his gown, all his stuff. But she couldn't stand it anymore. She took the towel and washed it.

But perhaps a bigger issue is the water supply, and here all the care workers are put in the position of bringing water in. The nurse carries a jug of water in her car as a matter of course. The homemaker says they each bring a jug of water from their own homes for the client's use—for preparing his medication and feeds—during the month of August when the well water is low. It is stored in the kitchen, so the kitchen needs to be used even though it is off-bounds for cleaning by the homemaker. All the care workers routinely carry antiseptic hand cleanser to avoid using the facilities in the house.

TEAMWORK AND BOUNDARY CROSSINGS

Teamwork was part of the picture of creating an environment suitable for providing appropriate physical care for Andrew. This was not prescribed

team work, but a matter of the care workers informally negotiating tasks. Cleanliness, for example, was facilitated by the homemaker using her own initiative to wash a bathroom towel. The handling of soiled bed linen was another task where care workers had to make decisions about the bounds of their work. The RPN talked of having to wash out particularly badly soiled linen, rather than putting it in the laundry basket. She would bring water into Andrew's room and wash it in a basin there, as it was not possible to do it in the bathroom or kitchen. She would then let the homemaker know and she would launder it. A communication book was the main way of communicating among the different care workers. Occasionally the care workers may meet each other on the way in or out of the home, in which case they may discuss the client briefly.

The family caregiver, the son of the client, was incorporated into how tasks were handled. Despite complaints about his poor housecleaning the care workers made an effort to get along with him. The RPN noted that the son would help her move the client, for example when she was suffering from an elbow injury, and would also pick up things the caregivers need. He also monitored the medical equipment and alerted the RPN or nurse if there seemed to be a problem. Structurally, the relationship between care workers and family caregiver is an ambiguous one: all are concerned with the client's care but each is located differently in a moral field that contextualizes how a professional relationship is enacted, together with particular expectations of what 'care' entails. Spatially it may also be fraught with tension, especially in this case where the carespace within the home is surrounded by the homespace of the son—with different notions of how this should or can be maintained.

Quality of Care?

Despite the various difficulties in working in this home, the care workers were unanimous in believing the client was receiving good care. While this was defined in terms of 'set up' and Andrew's ability to remain at home, so focusing on the physical, practical dimensions of care, there was also clearly an emotional side to the ways in which care was provided. This related not only to aspects of the hands-on body work but also to the 'extras' that were given. For instance, there was evidence that care workers continued to converse with the client despite his loss of speech. The nurse said, "I always put in a little gab here and there either to get a smile out of him or . . . just some kinda response." But the extras were sometimes technically outside the rules. Commonly, care workers would phone in to let the agency know they were planning to do something 'extra' and get approval, but other times this was not deemed necessary.

The care workers were well aware of regulations concerning what care and services could be provided, knowing also that they were not allowed to receive gifts or money from clients and must keep the relationship on

a business level. However, as noted earlier, it is hard for care workers not to have some emotional involvement with client and family caregivers. There is a blurring between gifts and being considerate and concerned for someone, which we can see to different extents. The context also makes a difference. For example, the nurse will go out of her way more for palliative care patients and will pick up medications or pharmacy items on her own time, particularly if the client or family members have difficulty doing this. Other expressions of care took the form of a more conventional gift, although without monetary value. A clear distinction is also made between the blurred area of gifting and other rules. For example, the homemaker said:

> If I have [vegetables in the garden] I bring some stuff in for them. That's about it. . .. 'Cause I try to keep it on a business level, because it's not, ah, (sigh) if you—if you take it past the professional, you're the professional in the home so if you take things personal, which is very hard not to do, but I try to keep it at a business level.
>
> *Interviewer:* And why do you do that?
>
> *Homemaker:* Because of my job and that's what we're told to do. I mean, ah, I suppose I could lend a little bit more help like ah, you know, (but) what we're not allowed to do is (not always clear) if he [client's son] wanted to go to town and it's raining, could I give him a ride into town or could I loan him my car, I don't do that. And he doesn't ask.

The capacity to give 'an extra thought' can be seen as texturing a care relationship in ways not envisaged in the formal concept of care assumed by regulations and rules, based on the notion of caring for without the dimension of caring about. While there is insufficient data in this study to do more than speculate, it seems it may be the care workers in the less-skilled sector of care work, essentially transferring domestic labor skills from their home to another's, who find this type of gifting more compatible with a homemaking care mandate than for those providing nursing or other health professional skills.

DISCUSSION: MATERIALIZING CARE

The empirical material here illustrates that the everyday practices of care that bring together caring for and caring about are the mode through which care is 'materialized'. In our study the homes of care recipients simultaneously are workplaces for caregivers. They are also at a point of articulation of local and wider processes which, in a range of larger scales or contextual features, shape how the home is brought into being as a care space. These

include national economies, regional restructuring of care provision and the specific homes and neighborhoods that provide the physical site of the actual care. Some care workers are international migrants, falling at the bottom of a hierarchy of care work, so also bringing in global processes into the home of care receivers (Datta et al. 2010; England and Dyck, 2011b).

The data show the complex negotiation of care work as workers interpret and put into practice agency rules about eligible tasks and manage the affective as well as the corporeal dimensions of the care relation. The dual vulnerability of care workers and care recipients is evident—but in different ways. Vulnerability can relate to material bodies, a social self or valued identity. The vulnerable body and social 'self' of the care recipient is an area where both a professional relationship on the part of the care worker and the affective dimension of the relationship come into play. Quasi-friendships or detached professionalism result in different experiences of the care relationship and may create different climates in which an ethic of care may flourish. Care workers are also vulnerable. Their bodies are vulnerable when doing heavy work or working in conditions that generally could be considered unhealthy (smoky, cluttered or dirty environments). As a low-paid member of a workforce with little security, they are also vulnerable to marketplace forces and are administered from a distance through labor regulations and agencies' rules. While such regulations are in place ostensibly to protect the worker, they also bring areas of ambiguity that can place the worker's job at risk.

It was noted at the start of the chapter that the care relation is inflected by both power and affect or emotion. One aspect of this power is realized through the specific relationship of a worker/care recipient. But power also enters the care relation through practices and procedures emanating from beyond the care site—in the policies and regulations devised to shape the meaning given to 'community care' and put into practice by those working for agencies working within those policies and regulations. As Foucault famously stated, there is always potential for resistance where there is power. In negotiating rules, workers in effect are resisting power in Foucauldian terms. But this may come with a penalty. There is little space for the emotional dimension of care work in the labyrinth of regulatory mechanisms, and considerable ambiguity in the interpretation of some acts of care. A small kindness outside the bounds of eligible tasks can, for example, lead to dismissal. If a worker is in the dilemma of the care worker who noted the contradiction between providing care and not being allowed to carry water, then how is an ethic of care to be realized? Body work and the workspaces of the home are 'invisible' yet regulated through rules and procedures. While one care worker (as above) phones in to check before doing a task about which she is not sure, others do not. The invisiblized space of the home as a paid work site is both a benefit and a negative in its ambiguity. At best it is a way for those most vulnerable in society to continue living and ageing in a dignified and respectful way, with needs responded to as required, at worst a replication of rigid bureaucracy, exploitation of workers and lack of control for those with perhaps little remaining in most areas of their lives.

The identification of care needs and the responsibility for provision of these is enacted through care agencies, although the circumscribing of eligible tasks and employment conditions of care workers (such as 'casual labor' contracts, low pay and regulations that hinder their definition of quality care) affect the level of quality of care. These care workers certainly can provide competent care, in the sense of appropriate body work for clients, but it is through going beyond what is prescribed that the initial care tasks can be translated into care that meets emotional and social needs of clients, as well as simply physical care. Workplace conditions (of the home) may also compromise the safety of the worker. The vulnerabilities emerging in the study reported here suggest there is the potential for the care of the client and the safety of the worker to fall beneath acceptable standards in such hidden spaces, although in this study there was no evidence of this. It was through professionalism, and careful negotiation of homespaces and clients' needs, that on a personal, case-by-case level, clients received high-quality care. It is at the point of institutional and regional organization that an ethic of care needs to be comprehensively explored—what rules and mechanisms promote or inhibit its enactment?

An ethic of care needs to be inclusive of both carers and care recipients. There also needs to be awareness of intersections of gender, class and 'race' in understanding the mechanisms of power in emotionally laden labor with the need of a rich vein of work in tracing such intersectionality to fully comprehend the power and affective dimensions of care work and how these are materialized through different scales. International comparison is also important if we are to get away from addressing the home as merely a local site for care—a commonsense way to provide for the vulnerable. That 'local site' is far from local, in that the practices taking place there are shaped by layers of decision-making and processes at different scales. What 'best practices' can be generated at what levels of government, local community and user involvement? How can we ensure that power and emotion-laded relation is materialized in ways that emulate an ethic of care that respects the dignity and needs of both parties to the dyad? These questions need to be at the center of policy development and practice.

NOTES

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REFERENCES

Armstrong, Patricia and Hugh Armstrong. 2003. *Wasting away: The undermining of Canadian health care.* 2nd ed. Oxford University Press: Toronto.

Aronson, Jane and Sheila Neysmith. 1997. The retreat of the state and long-term care provision: implications for frail elderly people, unpaid family carers and paid home care workers. *Studies in Political Economy* 53: 37–65.

Barnett, Clive. 2005. Who cares? In *Introducing human geographies,* 2nd ed., edited by Phillip Crang, Paul Cloke, and Mark Goodwin, 588–601. London: Arnold.

Bondi, Liz. 2008. On the relational dynamics of caring: a psychotherapeutic approach to emotional and power dimensions of women's care work. *Gender, Place & Culture* 15(3): 249–265.

Datta, Kavita, Cathy McIlwaine, Yara Evans, Joanne Herbert, Jon May and Jane Wills. 2010. A migrant ethic of care? negotiating care and caring among migrant workers in London's low pay economy. *Feminist Review* 94: 93–116.

Dyck, Isabel, Pia Kontos, Jan Angus and Patricia McKeever. 2005. The home as a site for long-term care: meanings and management of bodies and spaces. *Health and Place* 11: 173–185.

England, Kim and Isabel Dyck. 2011a. Managing the body work of home care. *Sociology of Health and Illness* 33(2): 206–219.

——— 2011b. Migrant workers in home care: Responsibilities, routes and respect. (unpublished paper available from the authors).

England, Kim, Joan Eakin, Denise Gastaldo and Patricia McKeever. 2007. Neoliberalizing home care: Managed competition and restructuring home care in Ontario. In *Neoliberalization: Networks, states, peoples,* edited by Kim England and Kevin Ward, 169–194. Blackwell/Antipode: Oxford.

Fisher, Berenice and Joan Tronto. 1990. Towards a feminist theory of caring. In *Circles of care, work and identity in women's lives*, edited by Emily Abel and Margaret Nelson, 35–62. Albany: State University of New York Press.

Healey, Stephen. 2008. Caring for ethics and the politics of health care reform in the United States. *Gender, Place and Culture* 15(3): 267–284.

McKeever, Patricia, Helen Scott, Mary Chipman, Kathy Osterlund and Joan Eakin. 2006. 'Hitting Home': a survey of housing conditions of homes used for long term care in Ontario, Canada. *International Journal of Health Services* 36(3): 521–533.

Mol, Annemarie. 2008. *The logic of care: Health and the problem of patient choice.* London: Routledge.

Nettleton, Sarah and Roger Burrows. 1994. From bodies in hospitals to people in the community: a theoretical analysis of the relocation of health care. *Care in Place* 1: 93–103.

Tronto, Joan 1993. *Moral boundaries: A political argument for an ethic of care.* New York: Routledge.