“The Poor Carer”: Ambivalent Social Construction of the Home Care Worker in Elder Care Services

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ABSTRACT
In this article, we examine the social construction of the home care worker from the perspective of various professionals in the elder care sector in Ireland. The research, using the Grounded Theory method, involved focus groups with 31 participants comprising health and social work professionals as well as care agency managers and policy planners. The social construction of the elder care worker is characterised by ambivalence. We connect the concept of ambivalence at the micro level of human relationships to structural factors that are driving the ambivalence. Ambivalence towards home care workers is shaped by structural factors including the precariousness of care work, the commodification of time, and the stipulated personalisation of services. The irreconcilable contrasts between portrayals of care workers as both ‘good’ and ‘bad’ are indicative of deep contradictions in the expectations that contemporary care systems direct at paid caregivers. Ambivalence arises from the commodified and dispensable status of care workers, and fundamental transformations in their training, working conditions and pay are required to move away from this ambivalence and towards care workers’ equal status with professionals in the care sector.

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Introduction
In this article, we examine the social construction of the formal home care worker from the perspective of various professionals in the elder care sector in Ireland. We use the terms carer, formal carer, paid carer, paid caregiver and care worker interchangeably. Formal care can be understood as social care services paid for by care recipients, family members or the State (Health Research Board, 2017). Social care refers to “care by public organizations and private companies for people in society who need special help in order to live comfortably, for example help with washing or eating” (Cambridge English Dictionary); the closest equivalent term in the United States context is ‘home care’. This article focuses on formal carers who enter the homes of older people and assist them with activities of daily living and with household

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tasks. The social construction of the formal carer has received limited attention in the literature and there is little research on the social construction of formal (paid) carers from the perspective of other (‘professional’) service providers such as social workers, community nurses, policy planners and care agency managers. Furthermore, the extensive body of theorising on informal (family) care contrasts starkly with the paucity of theorising on formal care, despite the fact that in Ireland, and indeed worldwide, growing numbers of older people are receiving formal care in their homes (Timonen, 2009).

Drawing on qualitative data from focus groups, we highlight the social construction of the carer as characterised by a high level of ambivalence. The concept of ambivalence is associated with psychoanalysis and psychology and their emphasis on individual experience in isolation from the broader social and cultural contexts that people belong to (Hillcoat-Nallétamby & Phillips, 2011). We seek to address this by linking the ambivalent views expressed towards paid carers to broader structural factors within the political economy of elder care work, thereby approaching ambivalence in this article in terms of structured ambivalence (Connidis & McMullin, 2002).

**Context and background: evolving home care services**

Government policy for older people in Ireland is to support them to live in their own homes for as long as possible. Family carers are recognised as key enablers of this goal (Care Alliance Ireland, 2014). The government’s National Carers’ Strategy, published in 2012 (Department of Health, 2012), marked a significant milestone in the recognition of family carers (Care Alliance Ireland, 2012). In contrast, little attention to date has been paid to the regulation of home care services and the recognition of formal home care workers (Timonen, Doyle, & O’Dwyer, 2012).

The home care system in Ireland originally relied on not-for-profit organizations, supplemented with a low level of public sector provision that was introduced in a piecemeal manner (Genet et al., 2011; Mulkeen, 2016; Timonen & Doyle, 2007). In recent decades, there has been rapid growth in the home care sector, with many for-profit companies emerging and entering the Irish system (Timonen et al., 2012). It was estimated that approximately 150 companies were involved in home care provision in Ireland in 2010, the biggest among them being US- and UK-based franchises (Migrant Rights Centre Ireland, 2015). Formal state-funded home care in Ireland consists mainly of home help and home care packages (these have been recently re-named ‘home care supports’). Home help in Ireland used to be limited to non-personal care, such as cleaning, cooking and shopping, but is increasingly oriented towards personal care, such as bathing and dressing. Home care packages include personal care, and can also include elements of medical care, for instance physiotherapy and chiropody (National Economic...
and Social Council, 2012), but such medical care tasks are not carried out by care workers whose focus is on social care tasks as defined above (personal care and household tasks).

The process of accessing home care in Ireland is typically initiated by public health nurses employed by the (public sector) Health Service Executive (HSE) who carry out assessments of older people, often following an alert by a General Practitioner (primary care doctor in the community). Home care can also be applied for from an institutional setting, such as a hospital where social workers initiate the application. Following approval, home care providers (public, private or not-for-profit, depending on the area) are allocated clients whose needs they are expected to meet within the hours allocated (Care Alliance Ireland, 2014).

**Ambivalence**

As this is a Grounded Theory study, we did not start out with any particular theoretical or conceptual framework; rather, ‘ambivalence’ as the core category that encapsulated the social constructions of ‘the carer’ emerged from the data as explained in the next section. Ambivalence connotes an affective position of uncertainty or indecision amidst contrasting options, or the simultaneous experience of contradictory views or feelings (Broom, Kirby, Kenny, McCartney, & Good, 2016). Smelser defines the term as ‘the simultaneous existence of attraction and repulsion, of love and hate’ (1998, p. 5). Most empirical analyses on ambivalence have centred predominantly on interpersonal relationships at the expense of broader political and socio-structural explanations (Hillcoat-Nallétamby & Phillips, 2011). Consequently, the locus of ambivalence is typically seen as residing within the individual rather than stemming from the relationships in which they engage.

In this article, we begin at the micro level (accounts of individual experiences and perceptions) but take the additional step of linking the micro and macro levels. Our analysis is informed by the concept of structured ambivalence which emphasizes how social structures generate ambivalence. Structured ambivalence was outlined by Connidis and McMullin (2002) who developed and elaborated it in the context of family relations. Hillcoat-Nallétamby and Phillips (2011) also argue that ambivalence is arises from complex, dynamic figurations of relational experiences which are patterned by the temporality of relational histories and socially structured dimensions of human existence. Conceived of in this way, ambivalence becomes a manifestation of contradictions, which stem from social actors’ transactional engagement with others, within social contexts and structures that give rise to the contradictions. In this framework, ambivalence is therefore at the nexus of individual, group and social structural influences. In line with Connidis and McMullin (2002), we adopt the definition of ambivalence as “structurally created contradictions that
are experienced by individuals in their interaction with others … a variable feature of structured sets of social relationships” (p. 559, our emphasis). Understood in this way, ambivalence is not a symmetrical ‘half good, half bad’ constructs but rather its manifestations in aggregate amount to a contradictory picture of a group or a phenomenon, and these contradictions in turn point to underlying social structures that generate the ambivalence. Further, when individuals experience ambivalence, they have to negotiate it through the use of their agency – this can mean choosing acceptance (inaction) or attempts to alter the situation that is giving rise to ambivalence. In the context of our work on home care in Ireland, we found the concept particularly useful when interrogating the perceptions of care workers that emerged from our Grounded Theory study.

**Materials and methods**

The material reported here emerged from the Irish strand in a Horizon 2020 European project, (SoCaTel) that seeks to respond to the needs of the growing ageing populations in Europe by improving the accessibility and responsiveness of care services for older adults in the community. The materials used here pertain to an early stage in the project, conducted in the spring and summer of 2018. The majority of focus groups (FG) were conducted in the Dublin area, where 13% of the population are aged 65 years and over (broadly in line with the share of 65+ in the general population in Ireland). Ethics approval for the study was obtained from the university research ethics approval committee in December 2017.

The study involved a total of 104 participants who took part in 21 focus groups and three in-depth interviews (these three interviews were exceptionally arranged on the grounds that two policy planners’ schedules could not be aligned with a group schedule, and one family carer had extremely limited availability outside her 24/7 caregiver role). The participants were diverse, ranging from older adults using or potentially using care services, to policy planners, and a wide range of service providers. The number of participants in each focus group ranged from three to seven, the typical number of participants being four. Purposive sampling was initially utilised to recruit participants who corresponded to different stakeholder groups, and subsequently theoretical sampling was employed to saturate key concepts that were emerging from the data, with a focus on the original purpose of the research i.e. better understanding of issues around access to and usability of community elder care services.

The research events were held at times and locations that were convenient for participants. Written informed consent was obtained from all participants. As per the tenets of Grounded Theory (Timonen, Conlon, & Foley, 2018), we employed a lightly structured interview guide and remained reflexive throughout the data collection, generating a detailed memo after
each interview/focus group. Focus group discussions and interviews lasted 60–90 minutes; all were audio-recorded, professionally transcribed verbatim, and anonymised.

The findings presented in this paper pertain to a sub-sample of 31 participants who are various health care and social work professionals, agency directors and policy planners, as distinct from the home care workers who do not have mandatory professional qualifications or registration in the current Irish care regime (Table 1). We focus on this sub-sample because in the course of a further interrogation of the dataset (beyond its original purpose), we detected distinctive talk pertaining to care workers in the focus groups conducted with the various professionals. Further analysis of this strand of talk gave rise to codes that were indicative of previously undetected category: that of ambivalence. In line with the GT method, we employed abductive reasoning to make sense of this pattern. Abduction refers to the tracing of antecedents for observed phenomena (Timonen et al., 2018). We discovered that while some basic requirements have been introduced in Ireland for those who wish to gain employment as home care workers, the sector is not professionalised and the requirements are not consistently enforced as the sector remains unregulated. Hence, it is possible and meaningful to distinguish between the ‘professionals’ in elder care – such as social workers, public health nurses and agency managers (who also have better terms and conditions of employment and higher salaries) – and the home care workers.

As we wished to interrogate the social construction of the care workers by the ‘professionals’, we limited the sample, for the purposes of this article, to the ‘professionals’, as presented in Table 1. (For the purposes of this article, we also excluded from analysis the older persons’ focus groups in our sample: while the older people did comment extensively on their care workers, their positionality and experiences were very different from the professionals and merit a separate analysis).

As can be seen from Table 1, the gendered profile of different groups among the professionals is reflected in our sample; men feature in the company director and policy planner categories. In the analysis below, we make little reference to gender – not because it is unimportant, but because

| Method (number) | Gender (f/m) | Participants |
|----------------|-------------|--------------|
| Focus group (1 & 3) | 9/0 | Public health nurses (nurses working in the community) |
| Focus group (2) | 4/0 | Multi-disciplinary primary care team (physiotherapist, occupational therapist, private home care manager, community nurse) |
| Focus group (4 & 13) | 2/5 | Home care company directors |
| Focus group (7) | 5/0 | Health care professionals (geriatrician, public health nurse, clinical case manager and advanced nurse practitioner) |
| Focus group (11) | 4/0 | Social workers |
| Interview (17 & 20) | 0/2 | Policy planners |
among the professionals included in this sample, the social construction of
the care worker did not evince any gendered profile i.e. similar (gendered)
characterisations of the (mostly female) care workers were presented by the
men and women among the professionals. Another important feature of the
care workforce – the fact that many are immigrants – was occasionally
referenced by the participants, but they were guarded in their commentary
on the origin or ethnicity of care workers, hence this is another potentially
significant aspect that we are scarcely able to comment on in analysing the
data. We acknowledge these as limitations of our study and data; a different
research design would have been necessary to unearth the significance of
gender and ethnicity in greater depth and nuance.

Each transcript was read and analysed using Grounded Theory methods;
this involved constant comparison between data, looking for similarities and
differences between conditions and consequences surrounding key events, and
identifying patterns (concepts and categories) in the data (Timonen et al.,
2018). We coded the data using open, axial and focused coding, wrote analy-
tical memos that captured our coding of the contradictory portrayals of care
workers, and then pursued theoretical saturation for these descriptions in the
data, which yielded the core category of ambivalence. We mapped these
tensions onto structural factors in the Irish care regime, thereby linking the
micro level representations of care workers with the macro level structures that
drive the ambivalence evident in these representations. Our method is there-
fore an illustration of how, in Grounded Theory, an existing dataset can be
used to theoretically sample for additional concepts that go ‘over and above’
the original purpose of a study, and to achieve theoretical saturation around
a category that sheds new light on social processes at work.

Results

The findings are structured as follows. Three dimensions of ambivalence
were identified from the professionals’ accounts: a) expectations on the
individual attributes of a carer, b) expectations on what a client-carer rela-
tionship should be like, and c) carers’ use and management of time.
Following an outline of each dimension, we link these ambivalences to
structural factors that drive them. Lastly, we present our argument regarding
the origins of these ambivalences, and outline potential policy changes that
could address the sources of ambivalence towards care workers.

Attributes of a carer

Ambivalence emerged when juxtaposing different characterisation of the
carer, by the same respondent or in the same focus group. The data contains
negative descriptions of the carer not being a “true carer” and doing it just
for the money, but also emotional characterisations of the carer as almost saintly and heroic on their devotion to their clients and their job. Participants also sympathised with the little recognition that carers get and the difficult job they do. The discrepancy between the “fantasy” of how home care is advertised in the media and government discourses and the reality of what happens when care workers enter people’s homes resonated with a group of home care directors:

Director 1: [...] This is not going in and making a cup of tea and getting your lovely granny up out of bed. [...] we have all these lovely pictures and brochures of all of that happening. That’s not the reality; the reality is you [the carer] could be given out to, shouted at, verbally abused, physically abused.

Director 2: Racially abused.
Director 1: Spat at, kicked at. (FG4 – Home care directors)

In the same focus group, the story was told of a male care worker, in his 50s, who keeps working in the care sector despite the humiliation of seeing his 18-year-old child earning more than him in retail:

Director 1: … he’s [the carer] in his 50s […]. And he came in to me and he was teary-eyed and said to me: ‘[name of Director 1] how can I go home every week knowing that I’m getting €11 an hour based on 20 hours a week, sometimes I only get 10 [hours], sometimes I do 12, how can I look my wife and my kids, my kid is working in Lidl (discount supermarket) and my child is earning more money than me’.

Director 2: 18 [years], just finished his Leaving Cert [secondary school diploma] and was out-earning his dad.
(FG4 – Home care directors)

The comparison with the retail industry came up frequently in participants’ accounts. Many of the professionals questioned why someone would go into care work, because in retail – which has similarly low entry requirements – workers have guaranteed hours, stay in one place for the duration of their shift, and engage in predictable tasks. Participants agreed that carers deserve better pay and conditions and that many carers are at a constant risk of poverty due to unpredictable changes in working hours. The home care role was described as “a very flat occupation” (FG2) and – in comparison with carers working in nursing homes – with very little scope for career progression. The directors cited above (FG4) regretted that “unfortunately” they were not able to give carers “a pension’ or ‘pay them enough money”, let alone help the carer “to get a mortgage”.
The professionals also outlined the exhausting type of work carers do, constantly on the move, not knowing where they will be next week or how many hours they will work. Participants felt it was unfair that carers are only paid for the visits they make (that is, not for any calls that are cancelled with sometimes very short notice when, for instance, an older person goes into a hospital, or for the time spent in transit between homes). A carer that relies on one client for the bulk of her or his hours is left in a very precarious situation if that client dies or goes into hospital:

[... ] So if they [carers] have a client that might be a very big homecare package, who goes into hospital. Then those carers ... have no work for the four weeks, while the person’s in hospital.

(FG3 – Public Health Nurses)

In many cases the professionals implied that only someone saintly or heroic would take on care work, as the working conditions are so bad. This dimension became clear when we analysed social workers’ reluctance to recommend a particular agency to their client, because they construed the quality of care as highly dependent on the attributes of the individual carer. Home care directors also expressed the view that systems in place are only as good as the care worker providing the care. In this construction, care is something that emanates from the person of the caregiver, not something that an organization or rules can foster or enforce. In this depiction, the individual carer assumes enormous responsibility:

And to be honest in my experience [...] with the home care agencies, like it comes down to the actual person that is visiting the [older] person, that’s where the quality is ... you couldn’t say one home care agency is better than the other, it’s all about the actual person [carer] (FG11- Social workers)

Participants spoke about the “proper caring person” as someone who is essential for the entire process of care provision, yet remains elusive. The professionals described a good carer as someone who has a strong vocation and friendly disposition. The good carer is someone with altruistic motives, who is “not there just to make money” (FG3). Social workers spoke of the good carer as “exceptional” (FG11), almost as a rare pearl; a find. The reablement team spoke about good caregivers being like “gold dust” – difficult to find and to hold on to – as many will look for better opportunities such as working in nursing homes or hospitals, which offer better career progression:

... caregivers are like gold dust in the current circumstances. You know it’s a national problem. And you can’t get the carers. And you’re competing against nursing homes, other care companies ... they decide to go into hospitals and you know it’s a finite resource and that’s a problem across the board (FG2- Reablement team).

In contrast, we also heard the view that taking such a precarious job signals wanting to suit oneself, being selfish and self-centred. Accounts were relayed of
carers who were not considered really caring, whose main reason for taking the job was that they “really enjoy the flexibility” that care work gives them, “don’t want to be available ’til five o’clock” and do not want to work over the weekend or public holidays (FG2). This was portrayed as a choice that suited the carer’s lifestyle or family situation; for instance, reference was made to carers who are mothers and want to be at the school gates in the early afternoon to bring their children home (FG2 and FG4). The implication is that while such (largely gendered) behaviours were understandable, a good carer should have a vocation to care and not take the job just to earn money, to have flexibility or to work on their broader skills. The comment below is a thinly-veiled allusion to the immigrant status of many care workers:

Unfortunately, sometimes they’ll name it to you, they want to improve their English. Which you kind of think that’s not quite the occupation to be doing it really, you know (FG2 – Reablement Group)

**Carers’ relationship with their clients**

The second key dimension of ambivalence pertained to the expectations around the type of relationship the client and the carer should have. In some of the participants’ accounts, the carer was portrayed as someone who should be like a family member or a close friend, someone who shares the care recipient’s interests or personality. Professionals expressed the sentiment that carers should have the potential to become friends with the client. Home care directors, in particular, explained that in order to provide better quality care it is important “to match” the carer with the client. However, this was not always easy to do, as “on paper all the carers are identical”; they tend to similar (basic levels of) training. Home care directors highlighted that “some carers … are brilliant” and they can send them “to anybody” whereas others are more difficult to match (FG13).

Despite wanting and wishing for a close “match” between carers and clients, in many discussions there was an implied distance when referring to carers – a them and us. For example, participants used words such as “girls” or “from abroad” to refer to carers. This presented a problem for “matching”, as someone perceived to be different and foreign was also represented as having more difficulties in connecting with older people. Professionals explained how older people found it very difficult to understand foreign carers and that many had a problem with them in “the nicest sense” and this was a problem to be addressed because “we have so many” foreign carers (FG2). Much of participants’ talk was about personalising the care in line with the wishes of older persons (Lloyd, 2010), however, many times in the same account, the carers were depicted as anonymous, constantly changing (due to rapid staff turnover) and even threatening in their foreignness. It is this distancing from the carer
that points to a less trusted carer; the collusive carer who gets too close to the care recipient and presents a danger:

I think it’s also very important that there’s multiple points of contact into the clients. Because […] it [client’s lack of contact with other people beside the carer] is a problem that would generate some concern for me. Particularly where you have the home help services, where there’s only one carer going into a person, any time from one to five times a week (FG13 – Home Care Directors).

This sentiment is in contradiction to the generally highly-valued idea of continuity of care (Saultz & Lochner, 2005), that is to say, the enduring relationship between a client and a known and trusted carer (Lloyd, 2010). Some participants spoke about the importance of having various carers and that all clients need to have an alternative point of contact with the organization “so that if there is anything that is collusive” (FG13), it could be picked up by another member of the agency. Concern over the “collusive” carer therefore seemed to outweigh the importance of cultivating long-term relationships between caregivers and care recipients. This amounts to yet another ambivalence: on the one hand, carers should be like family and friends, on the other hand, they must not get too close and cannot really be trusted.

There were other extreme portrayals of how a carer can present a hidden danger for the older person, such as anecdotes of carers who neglected or stole from clients, and even failed to feed them:

… there was a carer as well before Christmas that couldn’t make the food for the patient […] And … the patient wasn’t getting fed because the normal carer was on holidays over Christmas (FG3 – Public Health Nurse)

The stories of these morally questionable carers were sometimes mixed in with expressions of sympathy and attempts to understand such behaviour. These home care directors explained that some carers would take money from their clients because they feel “undervalued”, “under huge stress” and “get tempted”:

Director 1: […] when I do a safeguarding investigation around financial abuse the care assistant does break down and advices you that they were going through a rough time; they’ve seen an opportu-nity, they were in a wrong place and they took it. And all it comes down to, well I didn’t have hours last week, I needed to pay for.

Director 2: They didn’t go out to buy a Chanel handbag, they took it to buy shopping.

Director 1: To buy shopping. […]

Director 1: To feed their child. (FG4- Home Care directors)
This is a particularly clear example of ambivalence: while stealing from a client is clearly a major disciplinary and safeguarding issue that potentially undermines the company, the directors nonetheless portray the carers they catch stealing as martyrs who are simply trying to feed their children. In their role as senior managers, the home care directors did take action to initiate disciplinary action against carers who breached rules or under-performed but while doing so, they also harboured a large measure of understanding of the positionality of the carer (which in turn stems from the structural condition of low pay and unpredictable work hours). In line with the definition of ambivalence provided above, the directors simultaneously experienced ‘negative’ (e.g. annoyance, concern for the reputation of the company) and ‘positive’ (compassion, empathy) emotions which together yield a contradictory picture of how they view the home care workers.

**Carers’ use and management of time**

The third dimension of ambivalence centred on the relationship between care and time (see also McDonald, Lolich, Timonen, & Warters, in press). Participants empathised with the hard-pressed carer who had no autonomy and flexibility on how to allocate their hours. Public health (community-based) nurses compared this with their own role, where they have the power to decide how long they need to spend with a client, sometimes spending an hour “and sometimes you mightn’t have to spend that long at all” (FG3). There was an overwhelming sense that the system was unfair to carers who were not very well supported:

[...] they [carers] are on a timer. You know they may be here for an hour; in the meantime, they have to sign in, sign out. And be someplace else, within ten minutes you know. And then if they’re late going into the next patient or whatever, you know it can be sort of problematic for the poor carer. I mean they’re not a very well supported. (FG1 – Public Health Nurses)

In contrast to the carer who rushes around to meet the demands of her or his clients, there is the depiction of the carer who is not sympathetic to the client’s needs, does not manage time properly and ends up rushing a client who should not be rushed:

… we had to get a different carer in. Because they were rushing with the personal care and he has Parkinson’s. So, he couldn’t be rushed …. I suppose it’s maintaining dignity and patience …. Not to be in a hurry …. (FG3 – Public Health Nurses)

We heard several accounts of carers who are portrayed as ‘time thieves’, for instance, a carer who is supposed to be at the client’s house for an hour but “only comes for ten minutes” (FG3). This was identified as a problem in those cases where the agency had not set up a proper monitoring system. Participants expressed trepidation that without proper controls it was difficult to know how many clients were being robbed of their allocated care
time. The professionals referred to technology, existing or imagined, as something that could play an important role in monitoring carers to “eliminate cheating” (FG13). Home care directors relayed how they use technology to generate “proof of presence” reports (FG13), which identify and quantify how many carers have clocked-in punctually at their clients’ houses. As one director explains, these reports can be used to generate a list of those carers who are not complying:

… a list of carers who aren’t clocking in, on a frequent basis. And I will be making calls to them later today, to ask them … why weren’t you clocking in? (FG13-Home Care Directors)

Participants in this group spoke of a pilot system where carers could see their rota two to three weeks in advance. Carers would make future plans based on their free slots, however, these plans later on clashed with the needs of the home care agency. In this case, technology gave “too much” information to carers and the managers took action to rein carers back in, allowing them to see their schedules only a few days in advance. Again, ambivalence is manifest in these accounts that prevaricate between wanting to keep care workers informed and helping them through more up-to-the-minute scheduling, yet also viewing aspects of their behaviour as unpredictable, unreliable and inconvenient from the point of view of running a care agency.

Discussion

We now turn to discussing the structures behind the ambivalences, under three headings that reflect the three dimensions of ambivalence identified above.

The hero in a failing system

Professionals placed a lot of faith in the ability of the carer to deliver good quality care, despite of – and because of – the difficult working conditions. It was expected that ‘good’ carers would be able to overcome this environment in a heroic manner to deliver high-quality care. Participants empathised with the carer and seemed to indicate that only a hero or a saint would take this type of job as the working conditions are so bad. They were even prepared to forgive serious issues – such as stealing from a client – because they understood the carers’ precarious situation.

Postle (2002) has pointed out that the “reality” of managing care work differs greatly from the “rhetoric” about care in the community, especially when influenced by restricted resources and operating within a market of care. Much of the “cost saving” in the Irish care regime comes from contracting out, whereby care providers compete for contracts awarded by the public sector HSE (Migrant Rights Centre Ireland, 2015). This outsourcing was introduced
mainly to reduce the overheads involved in direct employment of care workers. These competitive pressures are linked to the sector’s low-pay, zero-hour contracts and poor working conditions (Rubery & Urwin, 2011) and generate many of the ambivalences experienced by the professionals.

Furthermore, the low status of care work means that people with limited opportunities are more likely to turn to this type of position, mostly women and increasingly migrant women. The ‘selfish’ caregiver is connected to this disfranchised status and the difficulty to gain other, better-paid and more valued employment, which in turn stems from these (largely female, often immigrant) workers’ position in the labour market and the home care system with its precarious terms and conditions of employment (Doyle & Timonen, 2010).

**The carer is (not) like a friend or family**

Another source of ambivalence centred on the expectations around what type of relationship the carer and the client should have. Home care directors spoke about the ideal carer as someone who could be “matched” (FG13) to clients, largely on the grounds of personality and temperament. However, at the same time professionals put a distance first, between themselves and the carers, and second, between the carers and the clients. Many implied that carers were very different from the clients, for instance in being “foreign”, “from abroad”. There was a more sinister side to these differences, where carers could become a danger if they got too close (the collusive carer construct outlined above).

This ambivalence regarding the carer-care recipient relationship is not surprising. The blurring of boundaries and expectations is key to how government policy and the media promote home care. For example, advertising portrays the carer from a particular agency as someone who “shares your love for classical music” and can become “best of friends” with the client (Lolich, in press). One approach to combating anonymity in service provision characterized by clients being served by multiple professionals without any continuity or familiarity with their needs is to portray personal service encounters through constructing pseudo-relationships between clients and carers (Gutek, 1995, p. 71; see also Lloyd, 2010).

The blurring of boundaries is intrinsic to the home context (Stacey, 2016). Relationships and expectations between care recipients and care providers are obscured when the boundaries of home and work are not clearly marked. Care workers often share the marginalized social status of their clients, albeit on different grounds (for instance, the care worker is marginalized due to low income and the care recipient due to ageism). Where both the “employer” and worker are relatively disempowered by their respective ethnicity, age, ability or socioeconomic status, the usual employer/employee hierarchy is blurred and the work relationship is more apt to mimic informal caring bonds than is the case in other care work settings (Stacey, 2016).
Claims to kinship ("she is like a daughter to me") can be used between paid care workers and older people as a means of authenticating paid care and explaining its emotional content (Kay, 2013), hence reinforcing rather than challenging public and private oppositions.

Home care providers in many systems are under pressure from funding bodies and regulatory procedures to narrowly construct care in ways that preclude its relational, emotional and social characteristics (King, 2007). However, subjecting care to managerial and market logic creates tensions between the provider organization, care recipients and care workers. Care is a contentious term: it can be difficult to distinguish between caring about and caring for, between care as work and care as emotion, and care as practice and care as disposition (Lloyd, 2012). We detected ambivalence in participants’ accounts on how close the relationship between the care worker and the care recipient should be. Some participants saw continuity as the basis for forming good caring relationships. Others alluded to the caring relationship as potentially collusive, with connotations that there is a hidden danger for the care recipient if they become too close to one carer.

The ‘poor’ rushing carer

Participants’ accounts pointed to carers’ use of their time as a source of ambivalence. The professionals empathised with the carers who were under time pressure to do everything they needed to do but also resented the fact that some carers were rushing their clients.

This perception of the carer is influenced by the spatial and temporal obstacles that care workers face in moving from one house to the next and the control mechanisms (schedules, signing in and signing out) used by the provider organizations (Bolton and Wimberley, 2014). Time or cost of travelling between clients is not taken into account by the HSE’s payments to home care organizations and the latter, in turn, do not cover carer workers’ transit costs. Travel is therefore not registered as working time. Hence, without sufficient time to provide all the care required, carers often have to decide what care can actually be provided to which clients (Bolton & Wibberley, 2014).

Davies and Drake (2007) argue that private providers must exploit the opportunities offered by information technology, such as optimised rostering with real-time interactive control of care workers’ schedules. Electronic monitoring and communication systems can be used to track care workers and to monitor the time spent in clients’ homes. The schedule as a control mechanism acts as a form of work intensification, where the pace of work is monitored remotely through the verifications (e.g. clocking in and out) submitted by the worker to electronic monitoring systems (Baines & Van Den Broek, 2016). While the introduction of technology to the care delivery process is at an incipient stage in Ireland (Lolich, Riccò, Deusdad, &
Timonen, in press), participants in this research expressed an interest in using more technology to monitor carers and to eliminate cheating. Community care nurses imagined an IT device that would enable the remote monitoring of carers. Home care directors discussed technology as something that had the potential to discipline and punish carers who do not adhere to the regime of clocking in and out. However, one participant claimed that “carers are notorious for just not doing what they’re supposed to be doing” (FG13), explaining that carers often did not tag in and out of a house, rendering the system useless.

New public management (Hood, 1991) has standardised work practices in the name of efficiency and cost rationalisation. However, in the process it has reduced professional discretion, making it difficult to act on individual and social issues outside of the outcome targets required in funding contracts (Gray & Webb, 2013; Lavalette, 2011; McLaughlin, 2005). Some professionals we talked to thought that carers should be empowered with flexible use of their time to adjust their schedule as they deem necessary for delivery of good care. For instance, if a client is having “a slow day, they can stay with them” (FG3). However, in the context of reduced resources, interventions that are relatively easily achieved through technology tend to replace open-ended, relationship-based interventions (Dustin, 2007).

There is a clear disconnect between people in charge of allocating care (the HSE), the organizations that deliver care (private, not-for-profit and public organizations), and the challenges experienced by people on the ground (various professionals and care workers). The HSE decides which clients receive funded care, the levels of care and the provider, through a “random generator” process that allocates care hours to home care providers (FG4). Once the care service is in place, the HSE remains responsible for reviewing the care of the clients they fund. However, there was a sense among the professionals that once the agency had been tasked with delivery, the HSE no longer was responsible for the care. The agency directors who are responsible for care delivery felt they have little power in terms of shaping or re-defining the care they were providing. As a result, the participants felt that there was no ownership of the care delivered, and also little scope to use their agency in a meaningful way within a structure that was in many ways inimical to provision of good quality care. Furthermore, in Ireland there are no rules in place to govern relationships between middle management and care workers (for instance, regulations about number of workers per manager), further adding to the picture of a system where lines of accountability are blurred and individuals have to make the ‘best of a bad situation’. Against this background, it is not surprising that many of the professionals focused the expectations of good quality care on the care workers, the least powerful group among the actors involved in the care process.
Conclusions

Our findings contribute to the concept of structured ambivalence within the context of formal care by revealing three dimensions of ambivalence towards care workers in the perceptions of professionals in the health care, social work, agency management and policy sectors: (1) beliefs about the attributes of a good carer, (2) expectations placed on the client-carer relationship, and (3) carers’ time management. It would of course be simplistic and incorrect to assume that there was a golden age of care work when dedicated carers invested plentiful time into building holistic and meaningful relationships with older people receiving care. However, recent transformations in welfare states, the increased dominance of managerialistic practices in the public sector and the push for aging in place policies have greatly intensified the pace of work for home carer workers and generated new, or starker, ambivalences among stakeholders (Tanner, 2010). The seemingly irreconcilable contrasts between portrayals of carers as both ‘good’ and ‘bad’ are indicative of the deep contradictions in the expectations that contemporary care systems direct at paid caregivers. Structured ambivalence serves as the conceptual frame that helps us to explicate the processes we detected in the data; as the ambivalence is structurally created, it “can be solved only through fundamental change in structured social relations” (Connidis & McMullin, 2002, p. 566). Hence, in this concluding section we point to aspects of the current care policies and structures that must change for the ambivalences to be alleviated or eliminated.

Notions of home care are founded on an idealised version of care in the family (Brooking, 1989) which is upheld as the gold standard for caring practices in both institutional and domiciliary contexts (Exley & Allen, 2007). Such presuppositions do not acknowledge the complex reality of (home) care and mask some inherent tensions, for instance between closeness and intimacy, and the fact that the care relationship may not have been planned or wished for by either party. The home care industry promotes itself on the basis of the “friendship” (Lolich, in press) it can provide to its clients in the safe and familiar environment of their own home. This creates cognitive dissonance among the different stakeholders, where the promised emotional connection does not materialize.

The micro environment – the home of an older person – plays an important role in shaping interactions in what is a unique workspace (Bolton & Wibberley, 2014). The home environment assumes a level of intimacy and implies a level of trust; however, paid carers are neither family nor friends, they are initially strangers and sometimes have characteristics that are very different from the care recipient (age, ethnicity, and so on). Relationships with a carer in a nursing home are mediated by the institution’s polices and routines which generally provide some level of support and assurance to all parties. However, relationships in home care – in Ireland and many other countries – are not as obviously
mediated and do not have a visible safeguarding mechanism, and it is therefore not surprising that many of the participants’ concerns revolved around issues of control and trust.

At a macro level, social work and other forms of care work are changing significantly as welfare states in many countries are restructured under conditions of austerity (Baines & Van Den Broek, 2016). The utilisation of market mechanisms – in areas that previously were considered outside the market – generates some of these tensions. Managerial practices in the public sector have brought about restructured and rationalised workplaces, with a major emphasis on accountability. The world of relationships, intimacy and care is usually considered separate and even hostile (Zelizer, 2000) to the world of money and markets. However, some of these tensions emanate from trying to trace a sharp division between money and intimacy that does not capture the multiple relationships that ordinary people have (Edin & Lein, 1997; Epstein, 2005; Zelizer, 2000). Zelizer (2000) has given examples taken from court rulings – of monetary compensation given to a spouse after a divorce or the annulment of a will because the children had been side-lined from an inheritance even though they had cared for an ailing parent – to argue that intimate relationships and economic transactions are closely, regularly, and routinely intertwined. Because we generally treat market and emotional concerns as diametrically opposed, tensions can appear in relationships that are simultaneously inside and outside market-like or monetary transactions (Ertman, 2009).

Some of these tensions could be addressed by building greater trust in formal carers, repositioning them in the public eye akin to other qualified care professionals. The structures that give rise to the “morally questionable” carer, who resorts to stealing because she does not have enough money to feed her child (as construed above), could be solved by offering higher pay, full-time contracts and job security. Training and education for carers could also help to modify the care context and prevent issues of neglect and poor care. Giving carers more control over their schedules is another structural reform that would help to avoid the need to economise on time. For instance, carers could have the autonomy to distribute their hours among clients on a more flexible and responsive basis. This would allow carers to make judgement calls regarding, for instance, when a client needs more attention and adjusting her or his time use accordingly.

There will always be a need for accountability and some level of monitoring and control in human services; but this is reconcilable with carers being empowered to make more decisions. Greater job security, predictability of working hours and higher pay are among the structures where policy-driven change would resolve or at least significantly ameliorate the structured ambivalences we have outlined. In addition, it is important to allocate time for emotional support of care recipients as part of the carer’s job description. This, again, requires proper training and education, for both managers and
carers (McDonald et al., in press). The suspicions around collusive care could be avoided with proper management systems, feedback mechanisms and communications channels, which need to be open, regular and effective. As a result of such structural and policy changes, the status of the carer would be transformed from commodified and dispensable, to agentic and valued; this, in turn, would be reflected in a different social construction of carers, and different behaviours by and around carers: they would effectively become professionals among other professionals. As current structures drive the ambivalences we detected, only reform of those structures can lead to the dissipation of those ambivalences.

At the policy level, it is important to educate the general population on the value that care has for society. We need to apply what feminist theorists have referred to as an ethic of care (Held, 2006). Unlike virtue ethics (Clifford, 2014) that focuses on the individual qualities of carers (e.g. “exceptional”), an ethic of care sees care as a collective responsibility. It puts the focus on the political dimension (Tronto, 2013) and on the system context in which care work is performed (Bowden, 1997), as well as on the power relationships characterising care giving and receiving care (Barnes, 2012). An ethic of care defines care as more complex and more challenging than is implied by an emphasis on the personal qualities required by individual caregivers (Ward & Barnes, 2016). Ambivalences do not reside within the individual but they are part of the relationships in which professionals, carers and clients engage and they stem from the wider organizational and structural context in which they operate. Resolving ambivalences around “the poor carer” – in Ireland and elsewhere – is a system-wide task where policies around training, pay and working conditions can make a difference.

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