University of Alberta

A Critical Theory Approach to the Analysis of Home Care Policy in a Regional Context

By

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The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies and Research for acceptance, a thesis entitled *A Critical Theory Approach to the Analysis of Home Care Policy* submitted by *Susan Maxine Duncan* in partial fulfillment of the requirements for the degree of *Doctor of Philosophy*.

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Dedication

I dedicate this thesis to the support and love of my family and friends. I have had the good fortune of long and meaningful relationships with two Grandmothers – Mildred Kate (Neighbour) Bunyan and Pearl (Paschak) Angus inspired me with their strength, love, and belief in the importance of education. My parents, Allan and Trudy Duncan, provided their love and supported me in achieving my educational goals. Richard Hunter was there for me in so many ways; most important was his faith in my abilities. My sister Lori, always a confidante, provided endless encouragement. My friends in Vancouver, Kamloops, and Edmonton deserve special thanks for being there when I needed them and for providing needed distractions and insights along the way.

Abstract

This research takes the form of a critical policy analysis of home care in one provincial health region. Critical theory is the research tradition guiding this study, and the critical theory approach to policy analysis has been adapted from the works of policy and organizational theorists. Three characteristics distinguish this critical policy analysis: first, an analysis of the interaction of the context, process, and content of policy proposals in home care; second, an analysis of the ideologies and values underlying policy perspectives and issues – and third, an analysis of the dynamics of organizational change in regional home care. The method of study includes thematic and comparative analyses of perspectives derived from interviews with decision-makers, health care providers, and public advocates, and from policy documents.

This thesis contains three papers, each of which addresses one aspect of a critical policy analysis of home care in one Alberta health region. In Paper 1, I propose and develop the case for a critical theory approach to the analysis of health policy and present the theoretical underpinnings of the methodology. Paper 2 is a critical analysis of the policy process in regional home care as it relates to the context and the content of policy proposals. Paper 3 is an analysis of the dynamics of organizational change in regional home care.

Findings of the study revealed that the delivery of home care in one health region was evolving in the direction of a medical model of care. Tensions in values of efficiency, equity, choice, and responsibility underpin the policy issues and the perspectives of the different policy and organizational actors: decision-makers, health care providers, public advocates, and program managers. This exploration reveals how

the content and process of policy in home care interacts in important ways with political, economic, social, and historical contexts.

As a whole, the three papers that comprise this thesis achieve the purpose of contributing to the development of a critical theory approach to policy analysis in health. It exposes important connections between contexts, power, and peoples' experiences. In so doing, it deepens our understanding of home care, and the importance of ongoing inquiry into how policy and organizational processes change over time. Finally, there are recommendations for the development of a critical theory approach to health policy analysis that can promote the inclusive participation of citizens in progressive public policy for the 21st century.

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The Capital Health Authority granted me the opportunity to conduct my research within the organization. I acknowledge the value of the contributions of the participants in this study who shared their insights and commitment to home care.

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Chapter One

Introduction

Creation of public policy, and specifically health policy, is a dynamic process as decision-makers, citizens and health care providers seek to influence its course amidst challenging contexts. Pal (2001) broadly defines public policy as "a course of action or inaction chosen by public authorities to address a given problem or interrelated set of problems (p.2)". Public policy is or should be the most pervasive of public decision-making processes in a democratic society. In our society, market discourse dominates public policy (Stone, 1997). As a consequence, full and inclusive debates of policy issues and options are more limited. As well, policy scholars point to the increasing pluralism in values underpinning decisions in public policy domains including those of economics, education, environment and health (Lomas, 1990; 1997; Sabatier & Jenkins-Smith, 1999; Stone, 1997). Over the past two decades, there appears to have been more focus on health policy decisions and governments are making a variety of complex changes. Most often referred to as health care reform, there is wide debate as to the actual meaning of the term and whether changes are those that will improve health care delivery and the health of populations.

Walt (1996) makes the point that health reforms are "process oriented" and "aimed at restructuring relationships between public and private sectors, managers and policy makers, providers, and consumers" (p.226). Further, successful implementation of health reforms involves a thorough understanding of change and the ability to analyze and deal with uncertainties in policy processes (Walt, 1996). Policy analysis should therefore allow the researcher to conduct a holistic analysis of policy-making and to draw conclusions about how the various elements influence policy implementation (Walt, 1996). The identification of contextual influences such as dominant political and economic ideologies, and the values of actors involved in the process are fundamental to the analysis of policies in health care. Whereas health policy analysis to date has focused more on the content of policies and their effects on health care delivery systems, more research is needed that focuses on the dynamics of the interaction of context, process, and content of public policy and organizational processes (Collins, Green & Hunter, 1999; Pettigrew, 1987; 1988; Walt, 1996).

Of late, nursing has focused attention on policy influence and advocacy as an area of practice. More often, nurses emphasize the significance of nursing research findings for influencing policy related to health and health care. Less attention, however, has been devoted to policy analysis as a form of nursing research. This distinction is important in areas of health policy where nurses are among the main stakeholders and should direct the policy research agenda. Home care is one such area where nursing is an integral and large component of program delivery and where significant policy changes are taking place. Nurses' advocacy and influence on behalf of home care, I propose, could be more significant if informed by a critical analysis of issues, processes, and contexts in home care policy. Toward this end, this thesis represents a critical theory approach to policy analysis in one regional home care setting in the province of Alberta.

This introduction to the thesis will include an overview of the theoretical underpinnings leading to the explication of a critical theory approach to health policy analysis. Developments in regional, provincial and national home care policy will be discussed. I then provide an overview of the study purpose, method and limitations. Finally, I provide an introduction to the three papers that constitute this thesis.

Theoretical Underpinnings

The face of policy sciences has changed over the past two decades. Originating as a multidisciplinary field of inquiry within the umbrella of the social sciences in the 1950's, policy sciences focused primarily on rational and empirical modes of analysis in the positivist tradition. Pal (2001) presents an overview of the critical commentary of the positivist origins of the policy "movement":

> "The standard definition of policy analysis therefore clearly carries with it some cultural and historical baggage. Even if we substantially relax the definition to include a wider variety of ways of knowing and thinking, it is hard to escape the core assumptions that analysis will demand, at minimum, (1) expertise, (2) reliance of western science, (3) deductive logic, (4) measurement, (5) clear and replicable steps or stages. For the last fifty years, this model of rationality has been challenged and criticized for what it leaves out. So what's wrong with being rational? (p.21)".

Pal (2001) goes on to describe three perspectives that challenge the model of rationality. First, there is the perceived lack of rationality in the policy process. In reality, policymaking is an incremental process wherein decision makers "muddle through" the challenges of the real world (Lindblom, 1959 cited in Pal, 2001, p. 21). Second, policy processes are value laden, a perspective that is ignored or negated in the rational model. A third perspective is that policy analysis has "relatively little influence on policymaking" (p.22).

Recent changes in the policy sciences are in response to these perspectives on the limitations of the rational model. Changes have been characterized by some as post-positivist (Fischer, 1995; Pal, 2001), interpretive (Yanow, 2000) and as post-modern or critical (Forester, 1993; Pal, 2001; Stone, 1997). Deborah Stone (1997) in her discussion of "policy paradox" refers to the pervasiveness of context in understanding policy processes, particularly those of the political and economic forces in society. She makes the plea that the policy process be acknowledged and practiced as political process, instead of what she perceives as the lack of public deliberation and democracy in decisions that are predominantly market driven. Over the past two decades, Frank Fischer and John Forester have taken up the challenge of developing a new approach to policy analysis. In recent works, Fischer (1995; 1998) has suggested that policy analysis and evaluation should evolve as a political process and proposes a method of analysis that is rooted in critical theory. As well, there has also been a recent call to focus on the interaction of the elements of context, process, and content in the analysis of policy and organizational processes (Walt & Gilson; 1994; Walt; 1996; Pettigrew, 1987; 1988). Only recently, however, have methods of health policy analysis focused on the contexts of policy-making, the values underpinning policy proposals and processes, the identity of policy actors and the dynamics of problem definition and agenda-setting relative to policy content (Collins et al, 1999; Lomas, 1990, 1997; Rachlis, 2000). To my knowledge, the ideas of Forester and Fischer with respect to critical theory and policy analysis have yet to be applied to health policy analysis. However, they have captured my attention as being relevant and applicable to policy analysis in regional home care.

I refer to critical theory in the tradition of the Frankfurt school of philosophy, drawing on interpretations of the work of philosopher Jurgen Habermas (Fischer, 1985;

Forester, 1993; Morrow, 1994). I propose that the worldview and research tradition of critical theory can and should inform health policy analysis. Most fundamentally, "methodologies based on a critical theory perspective provide a critique of ideology, attempt to reveal hidden power imbalances to achieve emancipation, and endeavor to ensure that knowledge is available in the public domain (Mill, Allen & Morrow, 2002, p.115)". This perspective is both timely and crucial given the current contexts of health policy debates.

For this thesis, I propose three characteristics that distinguish a *critical* policy analysis. First, a critical policy analysis is directed toward exposing connections between policy context, process, and content of policy proposals. Whereas traditional policy analyses entail the deductive evaluation of the relative merit of the content of various policy proposals, critical analyses focus on the interplay of the processes and contexts that influence how policy problems are defined, why they are placed on the agenda, and why certain policy instruments are considered. Second, a critical policy analysis exposes the ideologies and values underlying policy issues and their proposed solutions. The critical analyst exposes the inclusiveness or exclusiveness of the debate based on the understanding of how issues are understood and framed by the various policy communities such as those groups of actors from government, private sector, pressure groups, advocacy groups, media or academics who seek to influence the course of public policy (Pross, 1995 cited in Pal, 2001, p.242). This also includes an analysis of differences in values expressed with respect to policy issues and ideological tensions expressed by various policy actors. Third, a critical analysis exposes the reality of organizational processes, particularly as they relate to how policies are experienced by people in their daily environments. In matters of health and health care, it is important to understand how patients, consumers, and front line health care providers experience the reality of policy problems and solutions. Here, I refer to the concept of organizational capability to implement policies that represent proposals for change and reform in health care (Greenwood & Hinings, 1996; Hinings, Greenwood & Cooper, 1999). This concept provides the theoretical framework for examining the connection between policy proposals and the analysis of values, interests and power of policy actors at all levels of the organization. It extends the critical analysis to the domain of the lifeworld where

according to Habermas, policies intersect with the reality of public life and the experience of citizens (Layder, 1994).

Drawing on the recent work of policy and organizational scholars, I have adapted Pettigrew's (1987) and Walt's (1996) framework to guide this critical analysis of home care policy. The framework consists of a triangle, with the three points depicting the elements or dynamics of policy analysis as context, process, and content. Context directs the analyst to consider political, economic, social, and historical influences. Process includes the analysis of values associated with policy proposals and of the policy actors or communities who are part of the policy debate and agenda setting. The third element of content includes the problems and the instruments as they are proposed and implemented by governments and organizational decision-makers. The interior of the triangle represents the interaction of the three elements of context, process, and content as the crux or nexus of policy analysis. In this thesis, I work with these elements of context, process, and content and extend their application within a critical theory approach to policy analysis in home care.

As a final note, I acknowledge that the ideological perspective of the researcher does and should influence "research in the critical tradition" (Kincheloe & McLaren, 2000, p.292). Ideological perspectives of researchers include personal values as well of those of the discipline or profession. Patton (2002) refers to the use of critical theory in qualitative research as "orientational inquiry" wherein the theoretical or ideological perspectives direct all phases of the research process and must therefore be explicit up front (p. 129). In this study, the tenets of critical theory as well as the researcher's perspective and values with respect to health care delivery are acknowledged as "ideological orientation" (Patton, 2002, p.129). It follows that this critical policy analysis of home care is also influenced by the values of the discipline of nursing with respect to health care delivery, which are described as congruent with those of primary health care (Canadian Nurses Association (CNA), 1998; 2000; McWilliam, 2000; Ogilvie & Reutter, 2003). The principles of primary health care as defined by the World Health Organization (WHO, 1978) and identified by the CNA (1988) include: accessibility to services, appropriate technology, public participation, health promotion and intersectoral collaboration. These principles constitute the profession's ideological perspective on

what constitutes true health care reform, and therefore influence this critical analysis of home care policy.

Developments in Home Care Policy

Underlying the purpose and approach to this research is the question: *why* a critical theory approach to the analysis of *home care* policy in particular? The answer to this question relates to both the central concerns of nursing as a discipline and to the dynamic state of home care and policy developments in the field today. Home care constitutes "an array of services which enables clients, incapacitated in whole or in part, to live at home, often with the effect of preventing, delaying, or substituting for long-term care or acute care alternatives (Health Canada, 1990, p.10)". McWilliam (2000) points out that nursing care is integral to home care and "nurses have the opportunity to provide leadership in linking primary health care principles to evolving in-home services (p.145)". Thus, it is both timely and significant that the discipline of nursing, with its emphasis on primary health care, focus research and leadership on influencing policy in the area of home care.

The principles and values of primary health care are not unlike those contained in the Canada Health Act. For example, both encompass principles that reflect Canadians' values: universality of access, affordability, and a comprehensive range of health services that are delivered within a publicly administered system. At the time of this study, the home care sector resides outside of the Canada Health Act. This raises many unresolved questions with respect to home care policy development at all levels of government and contributes to the dynamic context of home care policy. Indeed, care of people in their home is a global policy concern as societies grapple with the challenges arising from changing demography and patterns of health and illness.

In their critique of the challenges and opportunities associated with primary health care, Ogilvie and Reutter (2003) point out particular challenges associated with its implementation including: "the need to balance a focus on the accessibility to health services with a greater emphasis on those determinants of health that lie outside the health care system (p.458)". As well, these authors describe how the principle of community participation poses challenges, as the emphasis should be to elicit participation in the political process of determining the basic configuration of health

services and not merely in how they should be delivered (Ogilvie & Reutter, 2003). These broader concerns of primary health care are also relevant to home care policy. Findings of this study and others suggest that social determinants of health such as housing, finances and social support are germane to the policy debate in home care (Coyte & McKeever, 2001; Parent & Anderson, 2001; Hollander & Prince, 2002).

Origins of Home Care Delivery in Alberta

Historically, the Coordinated Home Care Program in Alberta originated in 1978 and it was administered by the boards of health around the province (Alberta Health, 1992). But before that time, in 1972, the Edmonton Board of Health (EBH), now part of the Capital Health Authority, the region selected for this study, had developed a community home care program. This first home care program in Alberta was based on a broad mandate of social and health care and was later considered to be a model for the provincial program. Originally, the purpose of the program provided by the EBH was broadly conceived with the mandate to provide comprehensive health and social services to people who were elderly, chronically ill, disabled or who for reasons of illness were unable to assume tasks of daily living.

Over time, the provincial home care program evolved to become more accessible to a broader range of the population:

> "When the Coordinated Home Care Program was introduced in 1978, the emphasis was on maintaining elderly persons independently at home if a need for professional health services was needed. ... In 1984, the government expanded the program to serve seniors who required only support services. More recently, Alberta Health took a major step toward making Home Care a program for all Albertans requiring community care, regardless of age or disability. In July 1991, the program was expanded so persons under 65 years of age could gain access to support services regardless of their need for professional health services (Alberta Health, 1992, p.1)."

Regionalization in 1993-94 initiated rapid and dramatic change in health care delivery in Alberta.[1] The EBH reported an increase in admissions to the home care

[1] The creation of seventeen health regions in 1994, and a business plan that directed an 18% reduction in health spending, has resulted in large reductions in acute hospital services (Saunders, Bay & Alibhai,1998).

program as well as an increased number of long-term care clients who were in the community with greater clinical needs (EBH, 1993). Despite this increased need, the Board reported a decrease in admission of long-term clients from 51 per cent of all home care admissions in 1991, to 37 per cent in 1993. Thus, the onset of regionalization marked a significant departure in the types of demands on the program and a shift in priorities from care of people with long-term needs to those with immediate needs following discharge from hospitals.

At the time of this study, regional home care services in the Capital Health Region continued to be legislated within the mandate of the Public Health Act as well as the recently enacted *Regional Health Authorities Act*, which defined new responsibilities and relationships with the Minister of Health and Wellness. Services were organized according to the needs of four population groups: 1) short term stay 2) long term care 3) palliative care and 4) children's services. Case management and program delivery was organized to provide services in these four main areas and there was also considerable program development in areas such as sub-acute and home parenteral therapy.

Provincial policy

At the time of this study, the provincial government launched the Long-Term Care Review process, culminating in the Final Report of the Policy Advisory Committee in November 1999, titled "Healthy Aging: New Directions for Care" (Alberta Health and Wellness, 1999a; 1999c). The report identifies vision, values, and recommendations for the development of a system of continuing care in the province. Although the report focuses on the population of seniors, the recommendations and values also have significant implications for the development of home care in general. The report lays out the policy issues and options to be considered by the provincial government with respect to the future development of continuing care services, of which home care is an already significant component. Within the report, home care is envisioned as playing an even greater role in order to meet the growing demands. The release of the report was followed by a regional response to the recommendations contained in the report (Alberta Health and Wellness, 1999d).

National policy

In the national context, the National Forum on Health has provided one of the most comprehensive visions of policy reform in home care, basing recommendations on the overriding principle that "home care should be considered an integral part of publicly funded health services (1997, p.21)". In their report, the National Forum described home care services as comprehensive, including "professional services, medical supplies, homemaking and attendant care, and maintenance and preventive care (p.21)". Since then, the federal government has recognized the growing diversity of home care programs across the country and the challenges of increased demand for home care (Health Canada, 1999). They have entertained various policy options that have included the targeting of funds to the provinces to develop home care within the public health care system. To date, these options have not been acted upon and the recommendations of the most recent Commission on the Future of Health Care in Canada (2002) will likely mark the next phase of policy development for home care in Canada.

Summary

In summary, these highlights of the development of home care in the Capital Health Region are related to its pre-regionalization origins in the boards of health and in the provincial home care program in the province of Alberta. Recent and ongoing policy developments in the federal government are also a relevant context, considered as background to this analysis. The main policy initiatives that frame this analysis of home care policy in a regional context are those contained in the provincial report of the Long Term Advisory Committee (Alberta Health and Wellness, 1999a; 1999b; 2000) and the responses of the Capital Health Authority (CHA, 2000) that followed. Therefore this analysis focuses primarily on home care in a regional context, bearing in mind the interrelationships between regional and provincial governments in particular and extending to the national context.

Study Purpose, Method and Limitations

Purpose and Objectives

The purpose of this research is to gain insight into the interaction of the context, process, and content of home care policy in one provincial health region and thereby contribute to an understanding of how a critical theory approach to health policy analysis

may inform the policy process and contribute to health reforms. The research has as its objectives to: 1) explore policy and organizational issues in home care from the perspective of various stakeholders including health care providers, public advocates and decision-makers; 2) identify ideological tensions underpinning policy issues; 3) explicate policy agendas in regional home care and analyze their congruence with primary health care principles; and 4) explore the organizational dynamics of change in regional home care.

Method

The research takes the form of a critical policy analysis. The unit of analysis for this study is the sub-system of home care within a regional health system in the Canadian province of Alberta. The period of data collection was June, 2000- June, 2001. Sources of data included: interviews with decision-makers, health care providers, and public advocates; a review of government documents including program and regional reviews and policies; and current literature depicting political, economic, social, and historical contexts of home care policy. Overall, 30 regional, provincial and national documents were analyzed (Table 1-1). Another data source was the field notes recorded throughout the research process. These notes contained data related to observations and reflections on what was happening in the field and were also a record of analytical decisions.

In this study, there were two levels of decision-makers; first, those who represented the provincial government or the executive level of the regional health authority; and second, those program managers who were situated at the middle management level. Health care providers were those participants who were involved with clinical practice including case management. A total of 23 interviews (N=23) were conducted with 4 executive level decision-makers, 11 program managers, 4 health care providers and 4 public advocates. Many of the participants were nurses and social workers. In most instances, the entire interviews were tape recorded although there were two instances when the interviewer honoured a participant's request to not tape the entire interview and another participant's request to stop taping during the interview. In both instances, with the permission of the participants, the researcher made detailed notes during and following the interview and entered these into the project database.

Selection of participants was determined through consultation with academics and with public advocacy and organizational leaders in the province. This strategy is known as intensity sampling wherein "one selects participants who are experiential experts and who are authorities about a particular experience (Denzin & Lincoln, 1998, p.23)". Participants were asked in interviews about their understanding and experience of what they believed to be the most prominent policy and organizational issues. Further, they were asked about the policy processes that were most influential in home care in the regional context including their beliefs about the issues that were and were not on policy agendas, the inclusiveness of decision-making, and influences in the policy process (see Appendix A for interview schedule).

Perspectives and values of decision-makers were also identified in policy documents, legislation and other sources that represented the provincial and regional policy agendas for home care; for example, the regional response to the provincial government's policy proposals for long-term care reform (Alberta Health and Wellness, 1999d). Sampling of publicly accessible documents pertaining to home care policy included national, provincial, and regional reviews, positions and policies. Identification of these key documents was an iterative process wherein interviewees identified and alerted the researcher to sources of information that were considered to be relevant to understanding the policy making process in home care at the agency, regional, provincial and national levels.

Data analysis

The analysis of data from interviews and documents involved the four cognitive processes of comprehending, decontextualizing (synthesizing), theorizing and recontextualizing (Morse & Field, 1995). There was an ongoing comparison of the findings with existing theoretical perspectives, such as those identified within a critical theory approach to health policy analysis. The "sensitizing concepts" of a critical theory approach -- policy context, process, and content -- guided the interviews with participants and the analysis of interviews, documents and literature (Patton, 2002, p.279). In essence, this means that the researcher looks at the data through a critical theory lens.

The interviews were transcribed, checked with the tapes and then read in their entirety. Similarly, documents were read completely before beginning qualitative

analysis. Interviews were coded using NUD*IST 5 (Richards, 2000). Documents and interviews were grouped according to their source, designated by actor and organizational affiliation: senior decision-maker (provincial / regional), program manager (public regional), program manager (private regional agency), health care provider, and public advocate. Individual interviews were entered into the project database NUD*IST 5, and identified as belonging to one of the designated groups of interviews.

Interview transcripts and documents were analyzed by first identifying text that referred to the proposed directions, priorities and policies with respect to home care (content). Text and discourse that referred to the contexts of policy and organizational issues were identified and coded. As well, words or phrases that represented the ideological stance or values associated with home care policy were identified (process). Interview transcripts were also analyzed thematically. Themes related to resource allocation, and the value and meaning of home care emerged as "significant concepts" that were continuous across interviews (Morse & Field, 1995, p.140)". This critical analysis also included the identification of the points of difference and agreement between the groups in terms of their perspectives on home care policy and organizational issues. Differences and or ideological tensions were identified within and between the various data sources. Yanow (2000) describes how a central question of the policy analyst becomes that of how "policy issues are framed by the various parties to the debate? (p.11)". It was therefore important to understand how the frames were revealed in the discourses of the policy actors – decision-makers, providers and public advocates framed (Yanow, 2000, p.12-13).

Issues of methodological rigor were addressed. First, data analysis was managed with the assistance of a qualitative software program, NUDIST 5 (2001). As well, literature sources were entered and managed within a bibliographic reference database, ProCite 5 (2000). Transparency of the data analysis was ensured through the recording of analytic decisions about the relationships between the data and the theoretical perspectives. Second, theoretical and analytical decisions were discussed with members of the thesis committee during the research process. Third, the reliability and validity of data was strengthened by using interviews, documents and field notes, making it possible for the interviewer to relate and confirm events and perspectives across the different data

sources (Patton, 2002; Sandelowski, 1986). Finally, I have acknowledged the a priori existence of a critical lens and the ideological "biases" inherent in my approach to this research. This is an important declaration to make when the research is conducted within a critical theory approach and where the researcher "has the explicit agenda of elucidating power, economic and social inequalities" (Patton, 2002, p.549).

Ethical and organizational approval

The study received both ethical and organizational approval. Ethical considerations included ensuring that the consent of study participants was fully informed and completely voluntary; the protection of the anonymity of participants and the confidentiality of information. Study participants were recruited by a letter of information inviting them to participate. Interested participants were asked to return a signed letter of permission to the researcher, granting the researcher permission to contact by phone to discuss further details of the study. Those interested were then contacted by the researcher and full informed and written consent was obtained at that time (see Appendix B for Letter of Information and Consent). To protect the anonymity and privacy of participants, it was important to not report information in a way that would disclose the identity of the participants. With respect to confidentiality, the researcher honoured participants' requests to not report information that was disclosed during some interviews. In these instances, the taping was stopped or those sensitive excerpts were erased.

As a researcher in the area of health care policy, I became aware of the sensitivities associated with studying health systems during a time when health care is a pivotal area of political attention and influence. It was important to develop relationships with senior decision-makers in order to access interviews and documents that were not publicly available. It did become more difficult to access data when one of the administrators who had been an advocate of my study resigned her position. It is important to acknowledge the sensitivity of policy research in a regional context and how those relationships with key stakeholders are key to its success. This will also be a consideration in the reporting and publication of findings. As requested by the Capital Health Authority, the anonymity of the region will be protected in future publications beyond this thesis.

Study Limitations

Limitations of this study relate primarily to the accessibility of data, the inclusiveness of the data collection process and the time allotted for the study. First, with respect to the accessibility of data, I was limited in my ability to access interviews with board members and legislators. Interestingly, it was reported by some participants that home care issues did not often reach the agenda of the board as it was preoccupied with institutional and acute medical-surgical treatment issues that were perceived as imminent and publicly sensitive. Although the perspectives and values of government legislators are represented in the documents that were reviewed, the analysis would be richer if these data also included interviews with board members. I acknowledge, as well, that participatory research methods directed toward a mutual exploration of policy issues and perceptions would also enhance the depth of understanding of differences among policy actors (Morrow, 1994). Admittedly, considerable resources are needed to facilitate the participatory aspects of a critical policy analysis, and the sensitivities associated with research in health policy were factors that limited the inclusiveness of the research approach. Further development of a critical theory approach to health policy analysis according to participatory and collaborative methods is discussed in the conclusions and recommendations of this thesis.

A second limitation is that I did not interview clients and families who are recipients of home care and whose perspectives and values as policy actors are likely the most underrepresented in the policy arena. The reason for the decision to not include clients and families as study participants was that recipients of home care represent diverse population groups, each with unique needs and perspectives with respect to the delivery of home care. To capture this diversity of client perspective was considered to be beyond the scope of this study. Given the focus of the study on policy and organizational issues, I anticipated that both interviews with public advocates, and the analysis of the documents of public advocacy groups would capture some of the policy and organizational issues and perspectives that were of concern to the recipients of home care. I do however, fully acknowledge the value and importance of including participants who are living the experience of home care, particularly in a critical theory approach where the goal is one of exposing power differences among actors.

The Three Papers

This thesis includes three papers: the first paper is an articulation of methodology and method; the second paper is the analysis of the home care policy agenda including ideological tensions, perspectives and values of actors; and, the third paper is an analysis of the dynamics of organizational change in regional home care.

In Paper 1, I propose and develop the case for a critical theory approach to the analysis of health policy, with regional home care as the unit of analysis. To set the stage, I refer first to the current dynamic context of health policy in Canada, as I develop the case for policy analyses in health and health care that are based on a critical theory research tradition and that best attend to the elements of context, process, and content. Further, I present the theoretical underpinnings of the methodology and method, including the most relevant tenets of critical theory in the German tradition and drawing on writings of policy and organizational theorists. In this paper, the findings are presented to illustrate the crux of the analysis, focusing on the elements of context and process as they interact with the content of current policies. I conclude with implications of a critical theory approach and recommendations for its development.

Paper 2 is a critical analysis of the policy agenda in regional home care. Here, I analyze the policy issues that are both on and off the official policy agenda of decision-makers and how they compare to the perspectives of other actors as well as the tensions in values underpinning the various perspectives on the most important issues. Relating to Figure 1, this paper focuses on process: actors, values and policy agendas in home care from a critical perspective. I analyze how current and proposed home care policies relate to the values of decision-makers as they are represented in the Final Report of the Long-Term Care Review Committee (Alberta Health and Wellness, 1999a; 1999b; 1999c; 1999d). Finally, I analyze the congruence of these policy agendas with the values and principles of primary health care which are foundational to nursing practice.

Paper 3 focuses on an analysis of the dynamics of an organizational change process that is occurring in home care. In particular, I refer to the work of theorists Hinings and Greenwood (1987; 1988) and Greenwood and Hinings (1996), drawing on their model of the dynamics of organizational change. I analyze the capability of the RHA to undertake change in home care delivery that is consistent with the set of values

associated with its mission and with those of primary health care. An analysis of organizational change and capability is consistent with a critical theory approach as it focuses the researcher on the organizational dynamics of values, interests and power relations in the organizations that are charged with policy implementation (paper 1). An important part of the analysis is the interaction of these dynamics with the political, economic, social, and historical contexts (Greenwood & Hinings, 1996). Most important, this analysis potentially leads to practical insights and recommendations as it focuses on the day-to-day context and experience of people who are both providing and receiving care in the system.

Summary

Home care uniquely evokes our experience and understanding of health, illness, care, home, family and community. Most important, policy issues in home care today confront our rights and obligations as individuals, family members, community members and citizens. It brings into focus more than health care; it encompasses how we live and die and how we care for others in our most immediate social contexts. Perhaps most important, the myriad of home care policy issues represent deep and philosophical dilemmas which are rooted in ideologies and yet require practical solutions. It is this paradox of complexity and practicality that home care evokes. It is the quest for practical solutions that will make a difference to how people care and receive care in their most immediate life circumstances.

My hope is that this thesis makes a contribution to understanding the philosophical dimensions of the policy issues, the importance of a critical stance in understanding them and how to begin to understand and re-frame intensely ideological debates such that consensus and solutions are possible. This thesis provides an example of how critical theory can inform policy analyses in health by exposing important connections between contexts, power, and peoples' experiences. In so doing, it deepens our understanding of policy and organizational processes in home care, as an increasingly vital area of health care, and one that will continue to be important and dynamic in the health policy arena in the 21st century.

Table 1-1: Selected Policy Documents

Source / Affiliation	Jurisdiction: Regional	Provincial	National
Public	• Seniors' Community Health Council (1999): Response to the Report of the Long Term Care Review Committee. • The Society for the Retired and Semi-Retired: Directory of Senior Services (1999).	• Provincial Health Council of Alberta: 1998 Annual Report Card to the Legislature. • Government of Alberta Health Summit (1999) Final Report.	• National Advisory Council on Aging. (2000). Position on Home Care. • CARP's Report Card on Home Care 2001.
Provider	• Regional Nursing Best Practices Committee: (Terms of reference and minutes of meetings) • "Dylan's Story": a narrative of policy impact on an infant and family.	• Alberta Association on Gerontology (1999) Response to the Report of the Long Term Care Review Committee. • Alberta Association of Registered Nurses (1998). Guidelines on the Delegation and Supervision of Client Care.	• Canadian Nurses Association: (1998) National Home and Community Care for Canadians Development • Canadian Health Services Research Foundation (1999): Issues in the Governance of Integrated Health Systems.
Decision-Maker	• Capital Health Authority Business Plans: 1997/98 – 1999/2000; 2000 /01 – 2002/03. • Capital Health Home Care / Regional Continuing Care Structure (2000) Regulations and Data. • Capital Health Region (2000) How Healthy Are We? A report from the Medical Officer of Health. • Capital Health Continuing Care (2000) 10 Year Strategic Plan: Response to Alberta Health & Wellness.	• Alberta Health Annual Reports: 1989 – 1999 • Alberta Health (1992). Home care in Alberta: New Directions in Community Support. • Government of Alberta Business Plan (1994) • Alberta Health and Wellness (1999) Long Term Care Review: Final Report of the Policy Advisory Committee • Alberta Health and Wellness. (1999). Questionnaire on the Final Report of the Long Term Care Policy Advisory Committee Final Report. • Alberta Health and Wellness. (2000). Strategic Directions and Future Actions: Healthy Aging and Continuing Care in Alberta. • Alberta Health and Wellness (2000). Continuing Care Strategic Service Plan Phase 1 Expectations.	• National Forum on Health (1997). Final Report. • Health Canada (July 1999): Home Care Development, Provincial and Territorial Home Care Programs & Systems

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Chapter Two

Paper 1: A Critical Theory Approach to the Analysis of Health Policy

"Efficiency or cost-effectiveness, has become an end in itself, a value often more important than others. But elevating efficiency, turning it into an end, misuses language, and this has profound consequences for the way we as citizens conceive of public life"

(Stein, 2002, p.3)

"We need to reconsider in a profound way, a foundational ethical question: How should we live together? Nurses are strategically placed – by our history, our education, and our experience in working across diversity and caring for all—to contribute to discourse exploring this question."

(Austin, 2001)

"Some 70 years after its development in Frankfurt, Germany, critical theory retains its ability to disrupt and challenge the status quo"

(Kincheloe & McLaren, 2000, p.279).

The discipline and professional practice of nursing has as its primary mission to be responsive and relevant to the health needs of people and society. At the heart and soul of this mission are the Codes of Ethics of national and international nursing associations. Recent revisions to these codes have reaffirmed nurses' ethical responsibilities for the contexts and organization of health care and for influencing broader social forces for societal health (American Nurses Association, 2001; Canadian Nurses Association, 2002; International Council of Nurses, 2000). This means that nurses must continue to engage in political activities that result in policies for both optimal practice environments and public health systems that deliver quality care to all peoples (Austin, 2001; Drevdahl et al, 2001). If one accepts that nursing practice encompasses social activism and policy advocacy, it follows that research into the policy process is essential to the development of the discipline. Consequently, nurse scientists in this 21st century call for the application

of postcolonial, critical and environmental research traditions and methods to develop nursing knowledge for influence and change (Mill, Allen & Morrow, 2001; Reimer Kirkham & Anderson, 2002). To further this research agenda, it is crucial that nurses examine the utility of concepts and theories of policy, organizational change and critical theory.

While public policy demands the attention and involvement of nurses (International Council of Nurses, 2001), the creation of public policy is highly complex. Stone (1997) attests to the complexity of policy processes that should be most fundamentally a deliberation of core community values of equity, efficiency, security and liberty. However, the current reality is that market related discourse dominates public policy and decisions are predicated on efficiency as a core value in health, health care and other key areas of public concern. Health economists also identify the limitations of economic models for the analysis of policy for health and health care (Ament & Baltussen, 1997; Robinson, 1999). In Canada, the recent national commission on health care cited Canadian values as key determinants of health services policy for the 21st century (Commission on the Future of Health Care in Canada, 2002).

Much of the recent emphasis placed on the relationship between nursing and public policy has come from a decade of intense health services restructuring spurred by fundamental questions about the sustainability of public services and values. In this context, nurses have worked to influence the direction of care congruent with the values of the discipline and the principles of primary health care (Rodger & Gallagher, 2000). As well, nurses have also realized their roles in influencing public policy outside the healthcare sector that influences health (healthy public policy) (Milio, 1988; Reutter & Williamson, 2000) and through dissemination of research findings (Browne, 1999; Ciliska et al, 1999; Giovannetti & O'Brien-Pallas, 1998). Despite these efforts, nurses and others have observed that sound policy proposals based on best available evidence do not readily reach the policy agendas of decision-makers. Instead, many can attest to the apparent senselessness of policies that are discordant with evidence about best practices and nursing values. Scholars have responded to the need to better understand and influence public policy processes by reflecting on nursing's connections with post-positivist research traditions and the contribution of critical theories to policy and

economic analyses (Austin, 2001; Peter, 2000; Reutter, Neufeld & Harrison, 1998; Reutter & Duncan, 2002; Wells, 1995).

It is clear that nurses must be attuned to processes of policy and organizational change in order to advance the science of change and influence. As well, policy analyses and research that are compatible with nursing ethics and the aims of social justice must encompass, but not be dominated by purely economic considerations. However, there are questions about how nurses should engage in policy work: What paradigms or world views should guide nurses' work in policy research and analyses? Further, how should policy analyses undertaken by nurses guide or direct nurses' efforts to influence and change public policy? How might this work contribute to a science of change and influence for the 21st century?

The author undertook a study that was based on a critical theory approach to health policy analysis, focusing specifically on home care as the unit of analysis. Home care policy demands the attention of nurses as it uniquely evokes our experience and understanding of health, illness, care, home, family and community. The purpose and objectives of the study refer to the identification and analysis of the context, process, and content of home care policy. The purpose of this paper is to describe the methodology of a critical theory approach to the analysis of health policy, drawing on the selected findings of the study. I begin this explication of a critical theory approach to health policy analysis by describing shifts in thinking in the field of policy studies. I then explore the theoretical underpinnings of critical theory as a research tradition as it relates to policy analysis. Developments in home care policy and their relationships to primary health care are then described. The ensuing description of this current study illustrates the application of a critical theory approach to health policy analysis, drawing on selected findings related to home care policy in one Alberta health region. Finally, conclusions about the evolution of a critical theory approach to health policy analysis and the role of the discipline of nursing are offered.

Background

Shifts in Policy Studies

Whereas "public policy is a course of action, or inaction chosen by those in authority to address a given set of problems (Pal, 1997, p.1-2)", "policy analysis is an

application of a rigorous intellect to the process of policy-making (p.12)". The face of policy sciences has changed over the past two decades. Originating as a multidisciplinary field of inquiry within the umbrella of the social sciences in the 1950's, the policy sciences have focused primarily on rational and empirical modes of analysis in the positivist tradition. Pal (2001) presents an overview of the critical commentary of the positivist origins of the policy "movement":

> "The standard definition of policy analysis therefore clearly carries with it some cultural and historical baggage. Even if we substantially relax the definition to include a wider variety of ways of knowing and thinking, it is hard to escape the core assumptions that analysis will demand, at minimum, (1) expertise, (2) reliance of western science, (3) deductive logic, (4) measurement, (5) clear and replicable steps or stages. For the last fifty years, this model of rationality has been challenged and criticized for what it leaves out. So what's wrong with being rational? (p.21)".

Three themes in the policy studies literature are particularly relevant to criticisms of the rational model. They include first, a shift in a focus from policy problems to the analysis of the relationships between policy context, process, and content; second, recognition of how policy processes are underpinned by tensions in core community beliefs and values; and third, attention to the influence of political, economic, social, and historical contexts.

The first theme refers to "the analysis *of* policy versus the analysis *for* policy; the former as a description of variables and the latter as a prescription for action (Janovsky & Cassels, 1996, p.13). Research that focuses on the process of policy-making includes an analysis of the actors involved in the policy process. Leading policy scholars refer to the increased pluralism of public policy processes involving diverse communities of actors (Sabatier & Jenkins-Smith, 1999; Pal, 1997; 2001; Stone, 1997). Policy processes influence the content of policy including the definition of problems and issues, and the instruments available for implementation and evaluation (Howlett & Ramesh, 1995, p.13). Examining how issues become recognized and part of policy agendas, how they are defined as problems and whose interests are heard or represented in policy decisions are fruitful areas of investigation (Rochfort & Cobb, 1993; Stone, 1989). The question of

how social problems are constructed and whether or not they are considered as part of the policy agenda is a fundamental part of the analysis (Hilgartner & Boss, 1988).

The second theme is an increased awareness of how public policies (or programs) can be conceptualized as values or belief systems (Forester, 1993; Sabatier & Jenkins-Smith, 1993; 1999; Stone, 1989). One well-developed theory, the advocacy coalition framework, identifies three levels of values and beliefs held by various actors in the policy process (Sabatier & Jenkins-Smith, 1999). The first level refers to a "deep core of shared belief systems that include basic ontological and normative beliefs, such as the relative valuation of individual freedom versus social equity (Sabatier & Jenkins-Smith, 1999, p.121). A second level consists of policy core beliefs that relate more specifically to the policy issues, for example, what is believed to be the causes and solutions to what some refer to as a lack of sustainability in health delivery systems (1999). A third level refers to a more specific and localized set of beliefs consisting of the perceived seriousness of problems and causal factors. It is postulated that of the three levels, deep core beliefs are resistant to change while the second and third levels are more amenable to influence and change over time (Sabatier & Jenkins-Smith, 1999).

The third theme refers to the consideration of contexts such as the globalization of markets and the shifting responsibilities of governments with respect to the delivery of public goods (Pal, 2001; Stein, 2002). In a recent and provocative analysis of the "cult of efficiency", Stein (2002) submits that public policy in areas of education and health are blindly focused on efficiency as an end, without reflection on the social ends of these efficient measures. Cultish devotion to reducing costs of health care has directed restructuring efforts of the past decade and has prevented the implementation of meaningful reforms. Brodie (1999) identifies three ideological foundations that have influenced the dismantling of social programs including health care – those of privatization, decentralization, and individualization. In most Canadian provinces, decentralization has meant the transfer of responsibility for health care to regional health boards (Church & Barker, 1997); privatization has shifted the balance between the public and private provision of health care and this is particularly evident in the delivery of home care (Coyte & McKeever, 2001); and individualization has meant the shift to

increased family and individual responsibility in the delivery of health services (Alcock et al, 1998; Gregor, 1997).

In summary, shifts in the field of policy studies described in the previous section of this paper have been characterized by some as post-positivist (Fischer, 1998; Pal, 2001), interpretive (Yanow, 2000) or by others as post-modern or critical (Forester, 1993; Pal, 2001; Stone, 1997). In the health policy arena, there has also been a call to attend to dimensions of process and context in policy research (Walt, 1996). However, only recently have methods of health policy analysis focused on critical contexts of policy, values of various policy communities, and the dynamics of problem definition and agenda setting (Collins et al; 1999; Lomas 1990; Lomas & Rachlis, 1996). Finally, it is clear that these shifts in policy studies implicate the need for broader, more encompassing approaches to policy analysis and research. This means that policy analysts must consider approaches to policy analysis that facilitate a critical insight into values and dynamic contexts of the 21st century. One such approach or research tradition is that of critical theory.

Critical Theory and Policy Analysis

The worldview and research tradition of critical theory can and should inform health policy analysis. I refer to critical theory in the tradition of the Frankfurt school of philosophy, drawing on interpretations of the work of philosopher Jurgen Habermas (Fischer, 1985; Forester, 1993; Morrow, 1994). Most fundamentally, "methodologies based on a critical theory perspective provide a critique of ideology, attempt to reveal hidden power imbalances to achieve emancipation, and endeavor to ensure that knowledge is available in the public domain (Mill, Allen & Morrow, 2002, p.115)". This perspective is both timely and crucial given the current contexts of health policy debates. The researcher engages in a critical examination of the discourse surrounding policy and organizational processes and seeks to expose the dominant values and ideologies associated with policy-making (Forester, 1982; 1993). Further, a critical theory of power is integral to the analysis as it exposes the connections between the "dominant hegemony and ideology that shape discourse and reality (Kincheloe & McLaren, 2000, p.283)".

I propose three characteristics that distinguish a *critical* policy analysis. First, a critical analysis is directed toward exposing connections between policy contexts,

processes and the content of policy proposals. Whereas traditional policy analyses entail the deductive evaluation of the relative merit of various policy proposals, critical analyses focus on the interplay of the processes and contexts influencing for example how policy problems are defined, why they are placed on the agenda and why certain policy instruments such as taxation or privatization are considered. Second, a critical policy analysis exposes the ideologies and values underlying policy issues and their proposed solutions. The critical analyst exposes the inclusiveness or exclusiveness of the debate based on the understanding of how issues are understood and framed by the various policy communities; those groups of actors from government, private sector, pressure groups, advocacy groups, media or academics who seek to influence the course of public policy (Pal, 2001, p.242; Yanow, 2000). Third, a critical analysis exposes the reality of organizational processes, particularly as they relate to how policies are experienced by people in their daily environments. In matters of health and health care, it is important to understand how patients, consumers and front line health care providers experience the reality of policy problems and solutions. Here, I refer to the dynamics of organizational change and the capability of organizations to implement policies for reform in health and health care (Greenwood & Hinings, 1996). These dynamics provide a framework for examining the connection between policy proposals and the analysis of values, interests and power of policy actors at all levels of the organization. This extends the critical analysis to the domain of the lifeworld, where in Habermas's definition, policies intersect with the reality of public life and the experience of citizens (Layder, 1994).

As a final note, I acknowledge that the ideological perspective of the researcher does and should influence "research in the critical tradition" (Kincheloe & McLaren, 2000, p.292). Ideological perspectives of researchers include personal values as well of those of the discipline or profession. Patton (2002) refers to the use of critical theory in qualitative research as "orientational inquiry" wherein the theoretical or ideological perspectives direct all phases of the research process and must therefore be explicit up front (p.129). In this study, the tenets of critical theory as well as the researcher's perspective and values with respect to health care delivery are acknowledged as "ideological orientation" (p.129). It follows that this critical policy analysis of home care is also influenced by the values of the discipline of nursing with respect to health care

delivery, which are described as congruent with those of primary health care (Canadian Nurses Association (CNA), 1998; 2000; McWilliam, 2000; Ogilvie & Reutter, 2003). As such, these principles of primary health care - accessibility to services, appropriate technology, public participation, health promotion and intersectoral collaboration (CNA, 1988), constitute the profession's "ideological" perspective on what constitutes true health care reform.

In summary, critical theory is the grand theory guiding the policy analysis. The theoretical perspectives include those of critical theory as a research tradition; the interaction of context, process, and content; values discourse and tensions; the analysis of health policy agendas including primary health care; and care delivery and organizational processes. Walt & Gilson's (1994) model of health policy analysis and Pettigrew's (1987; 1988) model of organizational change both include the elements of context, process, and content. Drawing on the work of these policy and organizational scholars, I have adapted a framework to guide this critical analysis of home care policy.

[Insert Figure 2-1]

Figure 2-1 is a triangle, with the three points depicting the elements or dynamics of policy analysis as context, process, and content. Each element includes policy concepts that are central to the analysis. Policy context directs the analyst to consider political, economic, social, and historical influences. Policy process includes the analysis of values and discourse associated with policy proposals and of the actors who are part of the policy debate and agenda setting. The third element of policy content includes the problems and instruments as they are proposed and implemented by governments and organizational decision-makers. The interior of the triangle represents the interaction of the three elements of context, process, and content and it is this interaction that represents the crux of the policy analysis. In this study, I work with these elements of content, process and context and extend their application within a critical theory approach to policy analysis in home care.

Developments in Home Care Policy

Underlying the purpose and approach to this research is the question: *why* a critical theory approach to the analysis of *home care* policy in particular? The answer to this question relates to both the central concerns of nursing as a discipline and to the

dynamic state of home care and policy developments in the field today. Home care constitutes "an array of services which enables clients, incapacitated in whole or in part, to live at home, often with the effect of preventing, delaying, or substituting for long-term care or acute care alternatives (Health Canada, 1990, p.10)". McWilliam (2000) points out that nursing care is integral to home care and "nurses have the opportunity to provide leadership in linking the principles of primary health care to evolving in-home services (p.145)".

Primary health care principles have been identified as the ideological underpinning of a nursing perspective and position with respect to the evolution of a national home care program (CNA, 1998; 2000; McWilliam, 2000). The Canadian Nurses Association (CNA) has released two policy papers confirming the position that home care must be included within the legislative framework of the Canada Health Act (CNA, 1998; 2000). Thus, it is both timely and significant that the discipline of nursing, with matters of primary health care, as central concerns, focus research and leadership on influencing policy in the area of home care.

The principles and values of primary health care are not unlike those contained in the Canada Health Act. For example, both encompass principles that reflect Canadians' values: universality of access, affordability, and a comprehensive range of health services that are delivered within a publicly administered system. At the time of this study, the home care sector resides outside of the Canada Health Act. This raises many unresolved questions with respect to home care policy development at all levels of Canadian governments and contributes to the dynamic context of home care policy. Indeed, care of people in their home is a global policy concern as societies grapple with the policy challenges arising from changing demography and patterns of health and illness.

In their critique of the challenges and opportunities associated with primary health care, Ogilvie and Reutter (2003) point out particular challenges associated with its implementation including: "the need to balance a focus on the accessibility to health services with a greater emphasis on those determinants of health that lie outside the health care system (p.458)". As well, these authors describe how the principle of community participation poses challenges, as the emphasis should be to elicit participation in the political process of determining the basic configuration of health

services and not merely in how they should be delivered (Ogilvie & Reutter, 2003). These broader concerns of primary health care are also relevant to home care policy. Findings of this study and others suggest that social determinants of health such as housing, finances and social support are germane to the policy debate in home care (Coyte & McKeever, 2001; Parent & Anderson, 2001; Hollander & Prince, 2002).

In summary, there is indication that nursing's perspectives and ideals with respect to the evolution of Canadian home care policy are based on primary health care principles. Further, nursing's extensive and continuous involvement in the delivery of home care should be the basis for considerable policy influence and disciplinary development. This will require attention to the ideological underpinnings of the home care policy debate such that perspectives and values are acknowledged as determinants of the policy process. Thus, the disciplinary perspective would be enhanced by a critical theory approach to policy analysis.

Description of the Study

Purpose and Objectives

The purpose of the study was to gain insight into the interaction of the context, process, and content of home care policy in one provincial health region. This research will contribute to an understanding of how a critical theory approach to health policy analysis may inform the policy process and contribute to health reforms. The research has as its objectives to: 1) explore perspectives on policy and organizational issues in home care from the perspective of stakeholders including health care providers, public advocates and decision-makers; 2) identify ideological tensions underpinning policy issues; 3) explicate policy agendas in regional home care and analyze their congruence with primary health care principles; and 4) explore the organizational dynamics of change in regional home care. The unit of analysis is the home care sector in one provincial health region. The period of data collection was June 2000 – June 2001.

Data Sources

Data were derived from four main sources: semi-structured interviews with decision-makers, providers and public advocates in home care; government documents, institutional, program and regional reviews and policies, media, annual reports and other

documents; literature related to the current political, economic and social contexts of policy-making; and field notes.

In this study, there were two levels of decision-makers; first, those who represented senior levels of the provincial government or the regional health authority and second, those program managers who were situated at the middle management level of their respective organizations. Health care providers were those participants who were involved with clinical practice including case management. A total of 23 interviews (N=23) were conducted with 4 senior level decision-makers, 11 program managers, 4 health care providers and 4 public advocates. Many of the participants were nurses and social workers. These participants were selected on the basis of their experience with home care. This was determined through consultation with academics, and with public advocacy and organizational experts who had considerable experience with home care in the province of Alberta over time. This strategy is known as intensity sampling wherein "one selects participants who are experiential experts and who are authorities about a particular experience" (Denzin & Lincoln, 1998, p.23).

Participants were asked in interviews about their understanding of the most prominent policy issues. Further, they were asked about the policy processes that were most influential in home care in the regional context including their own beliefs about the issues that were and were not on policy agendas, the inclusiveness of decision-making, and influences in the policy process. The perspectives and values of government decision-makers were identified in policy documents, legislation, and other sources that represented the policy agenda for home care.

Sampling of over thirty documents pertaining to home care policy included national, provincial, and regional reviews, positions and policies (Table 2-1). The identification of these key documents was an iterative process wherein interviewees identified and alerted the researcher to sources of information that were relevant to understanding the policy making process in home care at the agency, regional, provincial and national levels. Participants from the various policy communities were also asked to identify further sources of data, both individuals and documents, that could inform the research questions. There was a high degree of corroboration in the data collection sources (people and documents) that were recommended.

[Insert Table 2-1]

Data Analysis

Documents and interviews were grouped according to their source, designated by actor and organizational affiliation: decision-maker (provincial / regional), program manager (regional), program manager (private regional) health care and public advocate. Individual interviews were entered into the project database NUD*IST 5, and identified as belonging to one of the designated groups of interviews. In this study the analysis of data from interviews and documents involved the four cognitive processes of comprehending, decontextualizing (synthesizing), theorizing and recontextualizing (Morse & Field, 1995). Moreover, there was an ongoing comparison of the findings with existing theoretical perspectives, such as those identified within a critical theory approach to health policy analysis. Both of these data sources were analyzed according to the concepts of policy context, process, and content. As well, the interview transcripts were analyzed thematically. Themes related to resource allocation, and the value and meaning of home care emerged as "significant concepts that were continuous across the interview (Morse & Field, 1995, p. 140)".

Analysis of policy texts and discourse associated with policy issues directs the researcher to the use of language and the meaning and values associated with the perspectives. Yanow (2000) describes how a central question of the policy analyst becomes that of how "policy issues are framed by the various parties to the debate? (p.11)". Frames are revealed in the "different policy discourses – different language, understandings and perceptions—and potentially different courses of action, but also different values, and different meanings (Yanow, 2000, p.12-13)". The critical policy analysis of home care also included points of difference and agreement between the groups in terms of their perspective on policy issues, identification of priorities and policy agendas, values and ideological tensions. There is also an emerging literature on the use of narratives as a powerful means of conveying values and ideologies underpinning complex policy debates (Stone, 1997; Yanow, 2000). Metaphors and symbols are also indicative of meaning and values associated with policy issues, proposals and positions. For example, in this study, participants referred to the experience of being "at the table", the table signifying power and inclusiveness in policy decision-

making and of how policy initiatives and issues "bubbled up" from the level of care delivery within the organization.

Findings

To further illustrate a critical theory approach to health policy analysis, I first present an overview of some of the major findings that emerged in the analysis of the data. Figure 2-2 depicts some of the themes as they relate to the triangle of policy context, process, and content. I then focus on the analysis of the interaction of the elements of context, process, and content of home care policy in the region.

[Insert Figure 2-2]

Context

The contexts of home care policy are depicted as historical, political, economic and social. In the historical context, one can trace the origins of home care policy and programs to the beginnings of Canadian health care in 17th century New France (Ross Kerr, 2003). Prior to the medicalization and institutionalization of health care in the early 20th century, health care was indeed focused on home and community care. Consistent with these early developments, home care in the province of Alberta was initially conceived and developed as a program oriented to meeting both health and social needs of people with long–term illnesses and disabilities. Within the context of regionalization however, this emphasis has shifted to a medical orientation, giving priority to meeting the post discharge needs of clients with acute illnesses. Thus, the historical context emerged as significant in that the origins of home care programs in Canada and in Alberta were initially conceived and developed within a social model of care, one that encompassed social support, personal care, homemaking and health care.

Neoliberal ideology is dominant in both the political and economic contexts of Alberta (Cooper & Kanji, 2000; Government of Alberta, 1994; Murphy, 1996; Harrison & Laxer, 1996) and as such these contexts are interrelated. Neoliberalism is a political ideology that is rooted in capitalism and favours market solutions in all aspects of public life. It endorses measures such as "the erosion and dismantling of public services, campaigns of state deficit – and debt reduction, and the introduction of free market principles" (Carroll & Shaw, 2001, p.196). The Government of Alberta's (1994) business plan with respect to health care delivery is congruent with the tenets of neoliberalism, and

as such it is pervasive in its influence on home care and all sectors of the health delivery system. This plan calls for increased efficiencies with the goal of seeking financial contributions for universal health programs. Market influences are valued, and believed to lead to further efficiencies in the provision of the provincial public services (Government of Alberta, 1994). In summary, the plan has shifted the dominant model and values of public health to a corporate model wherein efficiency is a core value.

The influence of inter-governmental relationships was also identified as a relevant political context. The analysis of findings revealed the need for standards and legislation in home care, at all levels of government. The interrelationship of regional, provincial and national jurisdiction for health delivery was at issue here. For instance, it was evident that a national home care program and legislation was needed to address issues of increasing diversity and disparity among programs across the regions, provinces and the country. However, the move to a national program was problematic. If the federal government was to develop policy and legislation for programs that were not included in the Canada Health Act, then it would run the risk of acting out of its jurisdiction (Pal, 2001; Shapiro, 2000). During the time of the study, as in many points in history, there was tension between provincial and federal governments with respect to health care jurisdiction. As well, provinces were delegating responsibility for the development of community health care programs to regions, most often without the concomitant development of core provincial program standards. Thus, increasing diversity among home care programs *within* provinces was also identified.

Finally, the social context was described as one in which there were shifting patterns of population health and family structures. These factors influenced the type of care that was required in homes and the community, and the shifting balance of family responsibilities relative to their resources and abilities to provide care for family members. An analysis of social contexts indicates that decision-makers view supportive care in the home as first and foremost the responsibilities of individuals, families and communities (Alberta Health and Wellness, 1999a.; 1999b; 1999c; 1999d; Capital Health, 2000). As home care becomes defined separately from personal care and homemaking, responsibility for the later increasingly falls to unpaid caregivers, predominantly women. Women and women's roles are most affected in this social

context and they are the majority of care providers in society. Both paid and unpaid caregivers stand to receive minimal or reduced compensation and other resources when health care systems are privatized (Armstrong et al, 2002). However, findings of this study and others indicated a level of public expectation for a comprehensive range of home care that was formerly, and should continue to be, available (Penning & Keating, 2000; Scott, Horne & Thurston, 2002). Public expectation for care was seen to be increasing and would continue to increase as citizens become more consumer oriented and able to articulate their needs politically.

Process

Turning to the bottom left angle of the triangle, findings related to the analysis of policy process are identified. Policy process includes the perspectives and values of the policy actors and the tensions in values underpinning the policy issues associated with the definition of home care in a public health care system. The values of equity, choice, universality, efficiency and responsibility for care underpinned the policy issues and agendas. One area of tension that emerged in the analysis existed between the values of choice and universality. The value of increasing choice for citizens in the realm of housing, enhanced services and supportive care was recognized in the development of a second tier of services that can be accessed primarily in the private sector via user pay arrangements. Few would argue with rights to access enhanced services, particularly in later life. However, Stone (1997) sheds light on "[t]he major dilemma of policy in the polis [as] how to get people to give primacy to these broader consequences in their private calculus of choices, especially in an era where the dominant culture celebrates private consumption and personal gain (p.23)".

Another finding related to policy process was a level of disconnect between the issues and values identified at the level of care delivery, and the framing and definition of policy agendas by the regional and provincial decision-makers, depicted as policy content on the right angle. A major theme was the emergence of a medical model of home care that represented a shift in the meaning and values of home care when contrasted with a social model of care that had been developing prior to regionalization. The content of policy proposals during the time of the study, however were more aligned with a social model and also reflected some of the principles of primary health care. This analysis is

based on a comparison of policy and organizational processes with policy content including the proposed directions and instruments as they are implemented, proposed and anticipated.

Content

Policy content was identified in the policies that were implemented and proposed, including an analysis of those problems or issues that were both acted upon and not acted upon and the associated policy instruments. Here it was significant to understand which problems reached the government's policy agenda and how the discourse framed the problem definition. Policies that were implemented included the integration of home care services within the umbrella of continuing care and the further blurring of boundaries between the sectors of health care such as acute care, home care and long-term care. It was also apparent that the policy instrument of increasing private sector involvement in continuing care was underway. On the other hand, there was no indication of a concerted policy initiative to respond to resource allocation and care issues. Discourse associated with problem definition related primarily to the growing demands for home care services and the importance of "unbundling services" in order to offer greater public choice in care delivery.

However, themes of resource allocation and the value and meaning of home care were present in the discourse of the policy actors, as represented in the interior of the triangle. The disconnect between policy as implemented and the issues and perspectives of those in the organization who both provide and receive care is a significant point of analysis in a critical theory approach. Pal (2001) points out that a policy is a guide for action and is not necessarily implemented as designed. He cites the work of Mintzberg and Jorgenson (1987) who describe the unintentional strategies that emerge or bubble up from all corners of an organization (cited in Pal, 2001, p.5). Thus, the analysis of policy and organizational processes is a culmination of policy context, process, and content and represented in the interior of the triangle. Further discussion of findings related to policy and organizational processes and the disconnect between policy issues and agendas will be presented in papers 2 and 3 of this thesis.

Context, process, and content interaction

The analysis of context, process, and content interaction pertaining to home care policy is complex. Here, I present a beginning level of understanding of this interaction as identified in this study. It is a snapshot of one aspect of this complex interaction. Each of the contexts – political, economic, social, and historical is part of this analysis of home care policy. Historical and social contexts are particularly germane to the need for home care based on demographic and population health factors as well as the expectations of the public as influenced by previous models of home care. Political and economic contexts in Alberta are pervasive in health and other forms of public policy (Carroll & Shaw, 2001; Cooper & Kanji, 2000; Taft, 1997; Taft & Steward, 2000), and are intertwined in their influence. In this paper, I focus on the political and economic contexts derived from neoliberalism as it interacts with policy content and process in home care.

As discussed, neoliberalism in health care in the province of Alberta has meant the introduction of a business model to health policy and organizations, emphasizing efficiency, individual responsibility and choice as integral values. A finding of this analysis is that the dominant political ideology is pervasive in its influence of a disconnect between issues and values related to the experience of home care on the front line or micro organizational level and the content of policy agendas, as implemented and proposed by decision-makers. Also relevant to the analysis is the power of the various actors to influence the policy debate and to contribute to the framing of policy problems related to resource allocation and the value and meaning of home care. Although findings indicate that resource allocation in home care was inadequate to meet ever-increasing demands, it as also apparent that the dominant policy agenda was not one of securing additional public funds and resources for home care. Instead market solutions were preferred and consistent with policy solutions and instruments. As examples, further privatization of services and the introduction of user pay arrangements for homemaking and personal care services were proposed as policy instruments.

Relating to the theme of resource allocation, participants provided poignant descriptions of care in an efficiency-oriented system:

> ... the case coordinator can approve services up to such and such a limit and they are supposed to be trying to limit the amount that is spent. ...I mean it is certainly understandable because you've got to balance the budget, but from a moral perspective when the focus is on saving the dollars, rather than providing the care, I think there is a problem with that ... what's in the client's best interest? Now [the client's interest] it's far from the top of the list of decision-making criteria. It's ...what's it going to cost us? What's the political fallout of this? Can I get this approved? Oh, and what does the client need? We seem to have turned things upside down. So I see it very much as a financially driven decision process as opposed to a client care driven process.

The actual agenda then was one of the medicalization of home care, evidenced by an increasingly narrow definition of health care based on the episodic treatment of illness. This is clearly a departure from the social model of home care that had evolved in the historical context and one that is currently supported by providers and public advocates who are closest to the care delivery system. The medical model however was seen to be most consistent with the values and priorities of decision-makers and actors who held the most power in the system. Physicians, for example, have been identified as "policy elites" with the power to influence directions and priorities (Lavis, 2002). Within a regional health care system, physicians and regional executive decision-makers were seen to be preoccupied with medical and acute care priorities and this also influenced the lack of attention to home care resource allocation issues. Thus, the medical model and the priority of providing treatment oriented professional services to people who were recently discharged from hospitals became dominant in home care. This is an important theme that relates to the discussion of the policy processes of problem definition and agenda setting to be explored in Paper 2.

Finally, there was a trend toward growing inequities in the system based on one's ability to pay for an additional array of choices in the realm of continuing care. This was likely driven by the government's perception that if home care were to be universally provided to all aging and aged citizens in the future, it would be catastrophic for the public purse. In spite of this, government discourse also conveyed the valuing of health promotion and equity in the delivery of health care (Alberta Health and Wellness, 1999a;

1999b; 1999c; 2000). However, proposed policy problems and solutions were again highly influenced by ideology. It was suggested in the government policy proposals that user pay options and subsidies be integrated within home care delivery systems (Alberta Health and Wellness, 1999b). These policy instruments are once again in keeping with the fundamental tenets of neoliberal ideology. Perhaps most important, it was apparent that the discourse of public advocates and providers who witnessed the impact of growing inequities in service delivery and their effects, particularly among the least powerful and most vulnerable in society, was not recognized within the dominant policy agendas. In all likelihood, it is here that the differences between the values and meaning of home care between public, providers and decision-makers are greatest, and characteristic of the interaction of the elements of context, process, and content.

Conclusions

Returning to the purpose of this research, it is important to conclude this paper with a discussion of the implications of a critical theory approach to health policy analysis and its relevance to the discipline and practice of nursing. This approach is still in its infancy in the discipline of policy studies. Forester (1993) points out, "the promise of a critical theory of public policy analysis is its potential to show how policies will alter public life and how citizens may or may not participate in the theoretical and practical discourse of policy-making (p.152)". Fischer (1995) proposes that policy analysis and evaluation should be "grounded in a transformational perspective (p.xi)". Further, he proposes first and second level evaluations of policy based on a critical theory tradition, which includes technical and empirical level of evaluations as well as evaluations of how the policy does or does not contribute to social goals, or align with social values. A contemporary example of this approach is perhaps the recent values based policy process of the Commission on the Future of Health Care in Canada (2002). For home care, this means that policy analysis would entail not only the evaluation of cost effective delivery mechanisms but would ensure that these evaluations are grounded in questions of social relevance and values such as equity, universality, choice and responsibility. The discourse pertaining to the ideology of social choice would be facilitated by the second order question: "Do the fundamental ideals or (ideology) that organizes the accepted social order provide a basis for a legitimate resolution of conflicting judgments (Fischer,

1995, p.18)?" In the case of home care in the province of Alberta, the ideology of neoliberalism could be held accountable for how well the tension in the values of home care held by diverse policy actors can be acknowledged and resolved.

To develop an inclusive approach to the acknowledgement and resolution of values tension, Fischer (1995) advocates a discursive and practical exchange between policy actors that transcends issues of power and domination in policy processes. Stone (1997) concurs that consensus building in policy processes is key to resolving boundary tensions and to re-framing policy agendas and solutions for the public good. This means re-framing the political process as one that is valuable in policy processes. In order to do this, advocates for the reform of health policy must base strategies designed to influence policy on a full awareness and analysis of dominant ideologies and core values of decision-makers.

Also important to consider is evidence suggesting that decision-makers will ignore policy proposals that are not framed as compatible with their ideology and that it is therefore easier to challenge beliefs about how health services should be delivered, than to confront tensions in core values (Bryant, 2002; Sabatier & Jenkins-Smith, 1999). Understanding the differences between impenetrable values and those perspectives that can be influenced are important outcomes of a critical theory approach to policy analysis and are also an area for further research (Sabatier and Jenkins-Smith, 1993; 1999). This means that policy analysts must attend to these incompatibilities and tensions in their analyses. With respect to findings of this study of home care policy, this would mean that policy proposals for the support of universal home care programs should be framed in the language of efficiency. For instance, supportive arguments should refer to the cost of administering user pay options or the false economy inherent in not providing those personal care services that ultimately prevent utilization of more costly services. Nurses and others have known for some time that they must speak the language of economics in order to influence decision-makers on matters related to the delivery of quality care. However, consistent with the ideas of Fischer (1995) and Stone (1997), this does not mean that society should not engage in a full and informed debate of the core values underpinning policy options in home care. On the contrary, once values are understood

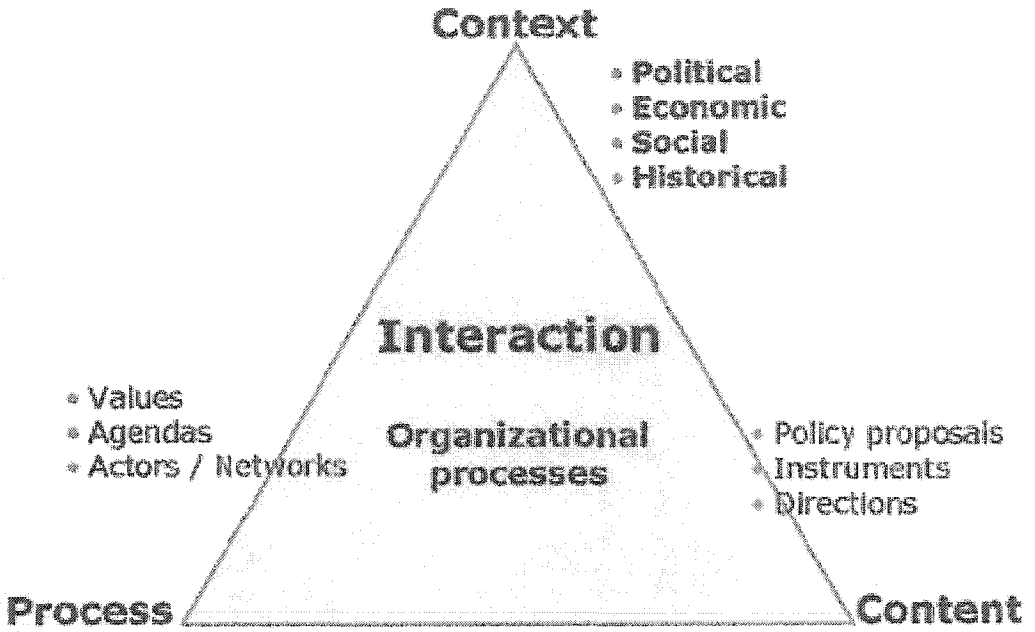
and acknowledged, there is potential for building consensus and coalitions for policy options that are rooted in concern for social justice.

A question remains – that of what nursing, as a practice discipline, can best contribute to a critical theory approach to health policy analysis in home care? In response, nurses have first hand knowledge and bear witness to care in family, home and community settings. Nurses and other providers of home care experience the tension in values that play out in the realm of efficiency driven processes. It should be that nursing's values orientation, ethics and intimate proximity to care are the basis of their contributions to policy analysis and influence, as well as the focus of the development of the discipline with respect to policy processes. I return to an earlier claim by nurse theorists that critical theory approaches to research can facilitate inquiry that is aligned with central values and concerns of the discipline (Mill et al, 2002; Ray, 1992). Further, nurses' experiences with participatory research methods can facilitate inclusiveness in public policy processes, especially among participants who lack power in knowledge development. A critical theory approach to policy analysis compels nurse researchers to include voices and perspectives of those individuals and groups who are involved in care as providers and clients and are not "at the table" in public policy processes. Most important, it is the critical perspective that nurses can support and bring as the guiding perspective in policy research and analyses. In this way nurses and others who experience home care can contribute to the authenticity, morality and inclusiveness of the policy debate, and therefore ensure that care and caring are central to the home care policy agenda.

Table 2-1: Selected Policy Documents

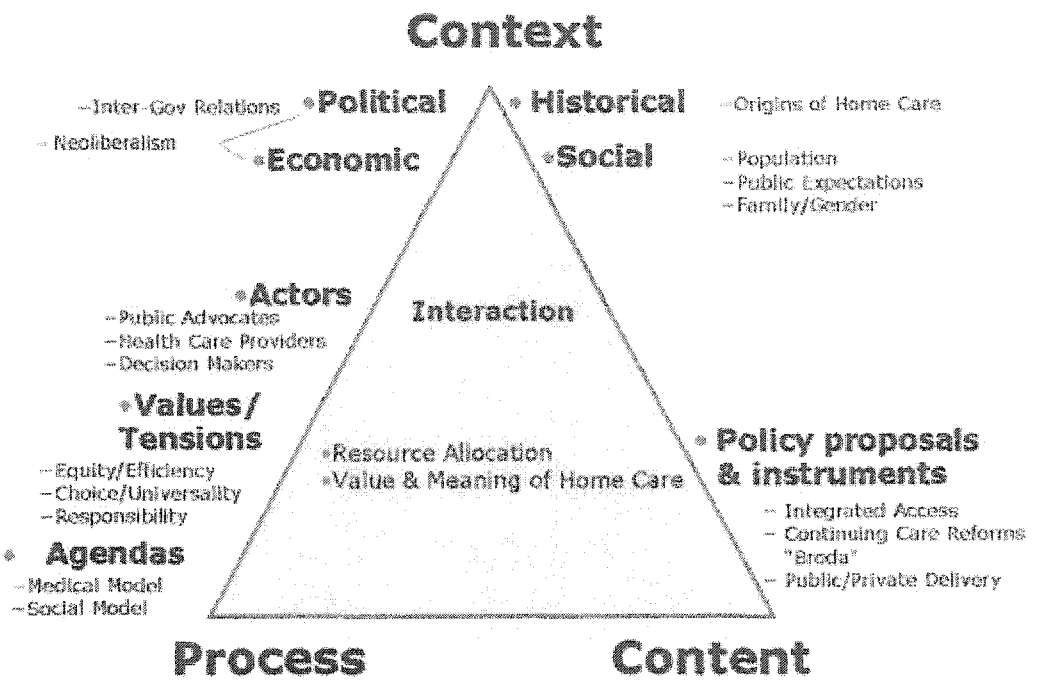
Source / Affiliation	Jurisdiction		
	Regional	Provincial	National
Public	• Seniors' Community Health Council (1999): Response to the Report of the Long Term Care Review Committee. • The Society for the Retired and Semi-Retired: Directory of Senior Services (1999).	• Provincial Health Council of Alberta: 1998 Annual Report Card to the Legislature. • Government of Alberta Health Summit (1999) Final Report.	• National Advisory Council on Aging. (2000). Position on Home Care. • CARP's Report Card on Home Care 2001.
Provider	• Regional Nursing Best Practices Committee: (Terms of reference and minutes of meetings) • "Dylan's Story": a narrative of policy impact on an infant and family.	• Alberta Association on Gerontology (1999) Response to the Report of the Long Term Care Review Committee. • Alberta Association of Registered Nurses (1998). Guidelines on the Delegation and Supervision of Client Care.	• Canadian Nurses Association: (1998) National Home and Community Care for Canadians Development • Canadian Health Services Research Foundation (1999): Issues in the Governance of Integrated Health Systems.
Decision-Maker	• Capital Health Authority Business Plans: 1997/98 – 1999/2000; 2000 /01 – 2002/03. • Capital Health Home Care / Regional Continuing Care Structure (2000) Regulations and Data. • Capital Health Region (2000) How Healthy Are We?: A report from the Medical Officer of Health. • Capital Health Continuing Care (2000) 10 Year Strategic Plan: Response to Alberta Health & Wellness.	• Alberta Health Annual Reports: 1989 – 1999 • Alberta Health (1992). Home care in Alberta: New Directions in Community Support. • Government of Alberta Business Plan (1994) • Alberta Health and Wellness (1999) Long Term Care Review: Final Report of the Policy Advisory Committee • Alberta Health and Wellness. (1999). Questionnaire on the Final Report of the Long Term Care Policy Advisory Committee Final Report. • Alberta Health and Wellness. (2000). Strategic Directions and Future Actions: Healthy Aging and Continuing Care in Alberta. • Alberta Health and Wellness (2000). Continuing Care Strategic Service Plan Phase 1 Expectations.	• National Forum on Health (1997). Final Report. • Health Canada (July 1999): Home Care Development, Provincial and Territorial Home Care Programs & Systems

Figure 2-1: Context, process, and content as Applied to Health Policy Analysis



(Adapted from Pettrigrew, 1987 & Walt, 1996)

Figure 2-2: Context, Process, and Content of Home Care Policy



Adapted from Pettigrew, 1987 & Walt, 1996

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Chapter Three

Paper 2: *A Critical Analysis of the Policy Agenda in Regional Home Care*

Public policy is a dynamic process of making choices about courses of action or inaction in areas of public life such as finance, education, environment and health (Pal, 2001). Public policy is most interesting when one considers the processes of how problems are defined, and then how or if they capture the interest or attention of decision-makers to become part of policy agendas. Policy analysts contend that "not only is there a degree of arbitrariness about what is to be taken as a serious problem, but controversy often surrounds how a given issue will be understood" (Rochfort & Cobb, 1993, p.56). Malone (1999) notes "policy ideas are often put forward as solutions to problems defined in ways that call for just those solutions rather than others" (p.19). Ultimately the determination of policy problems and agendas is largely influenced by politics and other social, historical and economic contexts (Collins, Green & Hunter, 1999; Howlett & Ramesh, 1995; Stone, 1997). What is required then is a deeper analysis of how problems are defined and how they come to be part of official policy agendas.

Presently, insights into the policy processes of problem definition and agenda setting are particularly important in health policy. This is because provincial and federal levels of Canadian government are preoccupied with the reform of health care delivery systems. Health policy agendas over the past decade have included shifts to regional governance, institutional downsizing and an insidious erosion of community care and public health systems (Casebeer, Scott & Hannah, 2000; Mitton & Donaldson, 2002; Lomas & Rachlis, 1996). Governments have framed the problem as one of an unsustainable public health care system. As a solution to this problem, some provincial governments are proposing changes that include a greater role for the market in the provision of health services. Consider the following excerpt from the Alberta Government's recent Report of the Premier's Advisory Council on Health (2002) as an example of the discourse framing the problem and its solution:

> "There are serious flaws in the way the system is organized. It operates as an unregulated monopoly where the province acts as insurer, provider and evaluator of health services. There's little choice or competition. The focus is more on

> hospitals and health providers and less on people who need health services. As Albertans, we have little choice but to go where the public health system points us and wait in line if we need to."

In the wake of this provincial report, as well as those of the Commission on the Future of Health Care in Canada (2002) and the Canada Senate Report (2002), Canadians await the deliberations of federal and provincial governments as to the direction of public health policy and ultimately the fate of the Canadian public health system. In the case of home care, a sector of health care that is the subject of this paper, the overarching question is one of how the delivery of care in the home is recognized as a part of a health care policy agenda. Further, it is important to understand how problems and issues related to home care delivery are identified and described.

Home care constitutes "an array of services which enables clients, incapacitated in whole or in part, to live at home, often with the effect of preventing, delaying, or substituting for long-term care or acute care alternatives (Health Canada, 1990, p.10)". There has been a consistent call for a national care program that is based on the principles of primary health care: accessibility to services, appropriate technology, public participation, health promotion and intersectoral collaboration (Canadian Nurses Association, 1998; 2000; Government of Canada, 2000; McWilliam, 2000; National Forum on Health, 1997). The principles and values of primary health care are not unlike those contained in the Canada Health Act. For example, both encompass principles that reflect Canadians' values: universality of access, affordability, and a comprehensive range of health services that are delivered within a publicly administered system. At the time of this study, the home care sector resides outside of the Canada Health Act. This raises many unresolved questions with respect to home care policy development at all levels of Canadian governments and contributes to the dynamic context of home care policy. Some governments are taking steps to introduce a greater role for the private, for-profit sector in home care and the introduction of user fees for some services. Increasingly, we see greater diversity in home care programs across regions and provinces, leaving one to question how or if a national program of home care with consistent funding and standards is a goal. Overall, we are challenged to ponder the sustainability of home care, in fiscal and human resources, amidst projections of the

increased care demands and expectations of a future society. Indeed, care of people in their home is a global policy concern.

In their critique of the challenges and opportunities associated with primary health care, Ogilvie and Reutter (2003) point out particular challenges that have implications for home care policy. They contend that a major challenge associated with the implementation of PHC includes: "the need to balance a focus on the accessibility to health services with a greater emphasis on those determinants of health that lie outside the health care system (p.458)". As well, these authors describe how the principle of community participation poses challenges, as the emphasis should be to elicit participation in the political process of determining the basic configuration of health services and not merely in how they should be delivered (Ogilvie & Reutter, 2003). These broader concerns of primary health care are also relevant to home care policy. Findings of this study and others suggest that social determinants of health such as housing, finances and social support are germane to the policy debate in home care (Coyte & McKeever, 2001; Parent & Anderson, 2001; Hollander & Prince, 2002).

Health Canada (2002) has announced that a Primary Health Care fund of 800 million dollars will be allocated for the development of provincial and territorial health systems and services. It is possible, therefore, that a policy window for primary health care reform may now exist if the often separate streams of health care problems, policies and politics converge at this critical juncture in the future of health care (Kingdon, 1995). However, despite the rhetoric and the potential of a policy window, it remains unclear as to how or if the directions or recommendations of government will honor these principles in the area of home care or other health care sectors. Critics claim that there is considerable uncertainty and ambiguity in the government discourse on primary health care (Ogilvie & Reutter, 2003). As well, there has been considerable inertia in implementing policy agendas that are based on primary health care principles. It is certain however that governments are making changes to the accessibility, funding and nature of home care. It is therefore timely for the policy analyst to assess the relationships between home care delivery, primary health care principles, political contexts and policy agendas.

The author undertook a study which was a critical policy analysis of home care in one provincial health region. The purpose of the study was to gain insight into the

interaction of context, process, and content of policy in home care. In this paper, I focus on the analysis of the policy process as it interacts with policy content and consider the contexts that are influencing the policy agenda in regional home care. I begin with an introduction to the methodology of a critical theory approach to the analysis of health policy; and a description of the study method. I then focus on the presentation and discussion of selected findings based on my analysis of various data sources including policy documents, interviews and literature pertaining to the policy process in one provincial health region. Finally, this discussion extends to how a current policy window related to primary health care in Canada can or should relate to policy processes in the area of home care.

A Critical Theory Approach to Policy Analysis

This research takes the form of a critical theory approach to health policy analysis. I propose three characteristics that distinguish a *critical* policy analysis. First, a critical analysis is directed toward exposing connections between policy context, process, and content. Whereas traditional policy analyses entail the deductive evaluation of the relative merit of various policy proposals, critical analyses focus on the interplay of the processes and contexts influencing policy content including how policy problems are defined, why they are placed on the agenda and why certain policy instruments such as taxation or privatization are considered. Second, a critical policy analysis exposes the ideologies and values underlying policy issues and their proposed solutions. The critical analyst exposes the inclusiveness or exclusiveness of the policy debate. This includes an analysis of how issues are understood and framed by the various policy communities; those groups of actors from government, private sector, pressure groups, advocacy groups, media or academics who seek to influence the course of public policy (Pal, 2001, p.242: Yanow, 2000). Third, a critical analysis exposes the reality of organizational processes, particularly as they relate to how policies are experienced by people in their daily environments. In matters of health and health care, it is important to understand how clients, families and front line health care providers experience the reality of policy problems and solutions. Here, I refer to the dynamics of organizational change as they relate to reform in health care (Hinings & Greenwood, 1988; Greenwood & Hinings, 1996).

[Insert Figure 3-1]

Drawing on the work of policy and organizational scholars, I have adapted a framework to guide this critical analysis of home care policy (Pettigrew, 1987; 1988; Walt & Gilson, 1994; Walt, 1996). Figure 3-1 is a triangle, with the three points depicting the elements or dynamics of policy analysis as context, process, and content. Each element includes policy concepts that are central to a critical theory approach. Policy context directs the analyst to consider political, economic, social, and historical influences. Policy process includes the analysis of values and discourse associated with policy proposals and of the actors who are part of the policy debate and agenda setting. The third element of policy content includes the problems and instruments as they are proposed and implemented by governments and organizational decision-makers. The interior of the triangle represents the interaction of the three elements of context, process, and content and represents the crux of the policy analysis. In this study, I work with these elements of context, process, and content and extend their application within a critical theory approach to policy analysis in home care.

Method

The unit of analysis for this study is the sub-system of home care within a regional health system in the Canadian province of Alberta. The period of data collection was June, 2000 – June, 2001. Sources of data included: interviews with decision makers, health care providers, and public advocates in home care; a review of government documents including program and regional reviews and policies, and current literature depicting political, economic, social, and historical contexts of home care policy. Another source of data was field notes containing observations and reflections on what was happening in the field, as well as a record of analytical decisions. In this study, there were two levels of decision-makers; first, those who represented senior levels of the provincial government or the regional health authority and second, those program managers who were situated at the middle management level of their respective organizations. Health care providers were those participants who were involved with clinical practice including case management. A total of 23 interviews (N=23) were conducted with 4 senior level decision-makers, 11 program managers, 4 health care providers and 4 public advocates.

Many of the participants were nurses and social workers. Overall, 30 regional, provincial and national documents were analyzed (Tables 3-1).

Participants were selected on the basis of their experience with home care. This was determined through consultation with academic, public advocacy and organizational experts who had considerable experience with home care in the province of Alberta over time. This strategy is known as intensity sampling wherein "one selects participants who are experiential experts and who are authorities about a particular experience" (Denzin & Lincoln, 1998, p.23). Participants were asked in interviews about their understanding and experience of what they believed to be the most prominent policy and organizational issues. Further, they were asked about the policy processes that were most influential in home care in the regional context including their beliefs about the issues that were and were not on policy agendas, the inclusiveness of decision-making and influences in the policy process.

Perspectives of decision-makers were also identified in policy documents, legislation and other sources that represented the provincial and regional policy agendas for home care; for example, the provincial government's policy proposals for long-term care reform and the response of the region to these proposals (Alberta Health and Wellness Long Term Care Review, 1999a, 1999b, 1999c; 1999d). Sampling of publicly accessible documents pertaining to home care policy included national, provincial, and regional reviews, positions and policies. National documents were sampled to identify national perspectives on home care as they related to provincial and regional policy. Public advocacy groups such as the Canadian Association of Retired Persons (Parent & Anderson, 2001) also produced reports that were national in scope.

Interview transcripts and documents were content analyzed according to the policy and organizational concepts of context, process, and content (Figure 2-1). Thematic analysis of interview transcripts and was done using qualitative analysis software (N*UDIST 5). Themes emerged as "significant concepts" that were continuous across interviews (Morse & Field, 1995, p.140). This analysis also reveals the values based discourse of participants, and in particular the tension in values underpinning the policy issues. A more complete description of the method of study is contained in the Introduction to this thesis and in Paper 1.

Findings

The Policy Agenda of the Provincial Government

The policy agenda of the Alberta provincial government with respect to delivery of health care was most clearly identified in the shift to a business model as laid out in its first business plan in 1994. The business plan marked the beginning of discourse pertaining to the goals of: efficiency in the delivery of health services; reallocation of monies to the community sector; increasing personal responsibility for health care; and increasing user fees to subsidize the funding of public health programs (Government of Alberta, 1994). In one respect, there is a contradiction between the goals set out in the plan and what had actually transpired five years later. The reality has been that the reallocation of resources intended for community services did not occur (Alberta Health and Wellness, 1999a; 1999b, 1999c; Capital Health, 2000a, 2000c, 2000d; Provincial Health Council, 1998).

During the period of this study, the main policy initiative of the provincial government was the Long-Term Care Review process (Alberta Health and Wellness, 1999). This process culminated in a final report that has come to be known as "the Broda Report" and the subsequent identification of strategic directions and future actions (Alberta Health and Wellness, 1999a, 1999b, 1999c; 1999d).

The purpose of the Long-Term Care Review was to address the needs of an aging society and this was evident in the discourse contained in the report:[2]

> "Think about what Alberta will be like when there are more grandparents than grandchildren! Clearly there are implications not only for the future of our health system and continuing care in particular, but also for families, communities and our society as a whole (Alberta Health and Wellness, 1999a, p.3)."

The committee claims to have engaged a variety of publics in its consultations and identifies "highlights of the various views and trends" in four main areas including: 1) increasing the ability of people to remain in their homes or "age in place", 2) de-linking or unbundling social services, health and housing services to allow people more choice, 3) increasing the funding that goes directly to individuals and 4) increasing the role of the

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[2] Predictions that by 2016, 14.5% of Albertans will be over 65 years and this will rise to 25% by 2031 (Alberta Health and Wellness, 1999a, p.3).

private sector so that people can "age in place" (Alberta Health and Wellness, 1999a, p. 9). The discourse of increasing choice for people is evident throughout the report, as is the support for healthy aging including health promotion and the prevention of illness. Seemingly, the "unbundling of services" as referred to by study participants, could lead to a greater array of choices for clients of health and social services. Unbundling meant the decoupling of health and social services, therefore enabling clients to receive one set of services (e.g. housing support) without having to qualify for health care. In this way the access to an array of services would be facilitated by not making the receipt of services in one sector contingent on having an identified need and qualifying for services in another.

Increased support for home care was also identified by the committee as "a first priority so that more people can receive the care they need at home rather than in facilities" (Alberta Health and Wellness, 1999a, p.22).[3] However, the report also clarifies changes to the definition of home care and distinguishes between professional services that should be continued at no cost to the individual and the personal care component of home care for which there should be "the introduction of consistent charges" (p.30).[4] Further, the committee recommended that "charges for the assistance to the daily living component of home care services should be based on the average cost of daily living services of $13.00 per hour, with minimum and maximum caps in place based on income" (Alberta Health and Wellness, 1999c, p.76). In making this recommendation, the committee tried to reach a balance between its concern for equity and the fiscal bottom line. The committee clearly was concerned about the sustainability of the home care system in the face of what they expected could be a cascade of costs related to the personal care and homemaking needs of an aging society.

There is reference to the implementation of primary health care models in the report with the following definition provided:

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[3] Within a national range of 2-6% for the period 1997-98, Alberta allocated 3.3% of its total health budget for home care for a per capita investment of $53, ranking among the lowest of the provinces and territories; (Health Canada, 1999, p.25-26).

[4] Coverage for home care in Alberta included no charge for professional services and case coordination or personal care. Charges for home support were assessed at $5 per hour to a maximum of $300 per month depending on income; (Health Canada, 1999, p.67).

> "Primary health care is care that is provided at the first level of contact with the health system – where people first enter the health system and where services are mobilized and coordinated to promote health, prevent illness, care for common illness and manage health problems. It is a comprehensive approach that addresses not only illness and injury, but also prevention programs, promotion of good health, and strategies to improve the health of the population" Alberta Health and Wellness, 1999c, p.22).

Although not part of this definition, there is some reference in the report to the other principles of primary health care such as intersectoral approaches, and affordability of services. Interestingly, the report also calls for "a clear link between health care and other community services" (p.22); however this recommendation seems to, at least in part, represent some contradiction to other recommendations that there be a tighter distinction made between health care and support for daily living.

One year following the release of the report, nine strategic directions were identified to begin the implementation of the recommendations, with the province coordinating the actions of the 17 health regions. Those directions once again confirmed the goals of "healthy aging" and "aging in place" (Alberta Health and Wellness, 2000, p.6). As well, the direction of "coordinated access" was identified to facilitate "a single point of entry" to continuing care services and to address the growing diversity in the delivery of regional home care programs throughout the province. The development of human resources skill and supply, and the need for primary health care models of care for the elderly were also identified as strategic directions to be implemented by the regions. The strategic directions document concludes with reference to the supports needed to implement the vision including the standards, information systems, accountability measures and the policy instrument of new legislation.

The Policy Agenda of the Capital Health Authority

The Capital Health Authority (CHA) was one of Alberta's 17 regional health authorities, formed in 1994. The CHA's Business Plan for the period of study referred to a new framework based on the core businesses, one of which is the provision of supportive care including home care (Capital Health, 2000a; p.4). Further, the CHA identified the mission of home care as one of "promoting health and supporting

independence of individuals and families in their communities". In its business plan, the region identified home care services as one of its highest top short-term priorities, recognizing current unmet needs and service limits that fail to meet client needs and expectations (Capital Health, 2000a).[5] Also confirmed in both regional and provincial reports, as well as in national research, is the trend that people with short term needs for more acute hospital replacement care receive home care services most readily. Regional and provincial home care budget allocations for these services have increased to the detriment of allocations for long-term care and palliative care in the home (Alberta Health & Wellness, 1999b, p.34; Capital Health, 2000a; Coyte, 2000; Parent & Anderson, 2001).

In their written response to the Report of the Long-Term Care Committee, decision-makers at the regional level identified improved system integration as a response to problems with access and continuity. Regional policy discourse is that the goal of "integrated access" will include the creation of an "umbrella organizational framework" which encompasses all continuing care services, including home care (Alberta Health and Wellness, 1999d; Capital Health, 2000b). Resources had been committed toward a pilot project for the implementation of "integrated access" including models, policies and procedures. Integrated access was also seen as the main strategy to address the need to expand home and community services and future actions toward this goal also includes the "introduction of increased system flexibility by promoting further unbundling of care services vs. housing-related community supports" (p. 11). A regional perspective on the financing options facing the provincial government is that cost sharing for some services should be pursued, ensuring that subsidies are in place for those who

[5] Provincially, there has been an increase of 29% in the provision of home care hours per 1000 population1994-95 to 1996-97 (p.5). Regionally, in 1999, there was an average of 8,032 home care clients who were provided services per month representing an increase of 191 clients per month compared to 1998 (Capital Health, 2000e, p.38). Allocations for community and home based expenditure was reported as 6.32% of the total regional health budget and this decreased to 6.25% in 1998/99, followed by an increase to 6.69% in 1999 /00. At the same time, the region reported an increase in both the numbers of clients of all ages receiving home care per 1000 population in every category of home care except for palliative care (Capital Health, 2000d, p.45).

cannot afford the higher fees (Alberta Health and Wellness, 1999d; Capital Health, 2000b).[6]

The home care wait list of approximately 400 clients (Capital Health, 2000a) emerged as a policy strategy to address the issues of supply and demand. This strategy, a response of the system to reduced supply in the face of increased demands, allowed the system to prioritize and provide services first to those people who are determined to have more immediate post-discharge acute care needs. This had, in turn, resulted in diminished levels of services to other populations, specifically people with chronic illnesses and the seniors who were waitlisted.

Finally, there was a trend toward increased expectations of families to assume responsibilities of home care across the programs including post-hospital discharge, palliative care, children, seniors and long-term care. This was noted in the discourse surrounding the vision statement of the region: "The vision and mission for community care services are grounded in a belief that continuing care, particularly Home Care, is intended to augment a person's support system, thereby maintaining their independence in the community. This framework for service is often at odds with public expectations and feelings of entitlement that conflict with Community Care's service mission and available resources." (Capital Health, 2000b, p.8)

The RHA acknowledged limits to the capacity of families to assume the demands of home care and also that increasing numbers of people, particularly seniors, lacked family or community support. An estimated 30% of seniors in the region live alone, the majority are elderly women and this trend is expected to increase (Capital Health; December 2000d). Policy discourse also acknowledges that, "prevention of caregiver burnout is extremely important in delaying entry into a care center and thereby further increasing bed demand" (Capital Health, 2000b, p.5).

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[6] Approximately 25% of seniors in the region had an income below the Low Income Cut-Off (LICO in 1995, compared to an overall provincial figure of 18% (CHA Environmental Scan, 2000d, p.5). An Edmonton study indicated that the average income of seniors varied by age with about 45% of people aged 70-79 and 39% of people over 80 indicating that they had enough money to meet their basic needs; (Society for the Retired and Semi-Retired Steering Committee, 1999 cited in Capital Health, 2000e, p.37)

Participants' Views

The themes of resource allocation and the meaning and value of home care were predominant in the responses of the participants. It is also apparent in the analysis of the interviews that the participants across the groups of organizational managers, program managers, case managers, managers of private contract services and public advocates held similar views on the elements of policy context, process, and content. There were some points of divergence among the groups and these will be pointed out here and in the ensuing analysis when the policy issues as perceived by participants are compared with the more formalized policy agendas of decision makers.

Resource Allocation

The main policy issue identified by the health care managers, providers and client advocates related to the allocation of both human and fiscal resources for the delivery of home care in a regional health system. There were four main themes related to the issue of resource allocation including: *supply and demand* of resources within home care, *boundaries* of home care, *efficiency based decision-making* at the level of care and a *false economy.* Table 3-2 contains examples of participants' responses that pertain to each of the themes related to resource allocation.

[Insert Table 3-2]

Supply and demand.

The theme of supply and demand in the home care sector was described by almost all participants and their descriptions were consistent with the findings in the documents. Supply and demand pressures were identified in two main areas: fiscal resources and human resources. The area of human resources was noted as significant throughout the analysis of both interview transcripts and documents and will be further discussed and related to the analysis of organizational capability in paper 3 of this thesis. The situation with respect to fiscal resources referred to earlier in this paper was validated in budget documents and in interviews with study participants. The data confirmed a situation that could only be described as a situation where demand exceeded supply. RHA expenditures on home care had not substantially increased as a percentage of total budgetary expenditures on health care during the post regionalization period and had therefore not kept pace with the increases in demand for home care services that had occurred during

the same post regionalization period. Increased demand for home care services was influenced by contextual factors: the rising public expectations for the level of services, the population health trends influencing the numbers of people with disabilities and chronic illnesses who were at home, and the increased numbers of people who required acute care in the home as a result of hospital restructuring. Also indicative of the demand for home care services in excess of resources available, was the emergence of a "wait list" of about 400 clients. The majority of those clients who were waitlisted were those with "long term" needs for care. Whereas some participants saw the wait list as a "planning strategy", others viewed it as troubling and unethical.

Boundaries.

Participants described the second theme as one of how home care had flexible or undefined boundaries between health and social services. Increasingly, case managers were being asked to make distinctions between health care, personal care and homemaking services, and to make difficult decisions about the boundaries of the care that could be provided with the resources at hand. This discussion of boundaries also extended to those between health and other areas of public policy. Some referred to the relationship between peoples' needs in areas of housing, transportation, and income or social support (determinants of health) and their needs for home care in the form of professional health care services. While these other needs that were increasingly defined as non-health services may not have been as visible during short-term hospital stays, they were seen as very influential to the mandate and work of health care providers who bear witness to how these factors determine the health of individual and families at home. There were several examples of how these "environmental" and "social" factors influenced the health care of individuals who lacked adequate housing, basic transportation and family or other supports. Since regionalization, home care had responded more to immediate and acute health care needs at home. The policy direction seemed to be in the direction of "unbundling health and social services" which was in reality, a move to defining the boundaries much more tightly than it had been.

Efficiency-based decision-making.

The third theme emerged as participants described how the value of efficiency was driving case management decisions. With respect to determining individual client

needs and allocating resources, case managers were seen to have increasingly difficult jobs as they were required to work within restrictive budget allocations. Many referred to the current provincial government policy of the maximum allowable $3000.00 monthly allocation or "cap" per client. Participants perceived the cap as a parameter that was open to some interpretation in the field. As a guideline, the "cap" was described as a *not* useful policy in determining allocations for the diverse client situations and needs that were beyond comparison in terms of variables that influenced the levels of needs and their determination. However, the flexibility in interpreting the guideline was seen as essential to decision-making in practice as case managers attempted to address issues of equity and equality. They perceived that not all *like* cases required equal resource allocations, therefore allowing them to discriminate and allocate more resources to those most in need. Overall, there was a consensus that the current funding per capita allocation of $3000.00 was an inadequate policy guideline in need of change.

Out of concern for the question of how sustainable home care would be in the future, health care providers and managers in both the public and private sector acknowledged the importance of placing some fiscal limits on the public provision of supportive services. However, they also depicted the complexity of the issue, and the often-unclear differentiation of those services that are health care, and those that support daily living. On the other hand, public advocates tended to view the issue of sustainability somewhat differently. Discourse indicates that while there is acknowledgement of fiscal pressures, there is also concern that some cost-sharing options will disadvantage lower-income peoples' access to a sufficient quality of care. Some public advocates questioned the premise that publicly funded assistance to daily living is not sustainable, and instead point to need to re-consider priorities in budget allocations. In their response to the Alberta Government's Report of the Policy Advisory Committee, the Alberta Association of Gerontology (2000) asked "Is it ethical to charge people for the personal care they need which results from a health problem? This group viewed supportive care as a strategy to empower seniors, and pointed to a contradiction between recommendations that may limit access to these services, and the commitment to health promotion and prevention as expressed in policy documents.

A false economy.

The fourth theme of a false economy related to those decisions that were made to improve efficiency and instead resulted in the cutting of those services that supported people to cope with a variety of significant health challenges while at home. Thus, the false economy was operative in those decisions that resulted in people seeking more expensive forms of care. Services that were thought to support less expensive forms of care in the long run were most often in the realm of personal support, homemaking, or other social services. However, some case managers and program managers viewed decisions about the allocation of homemaking services as problematic and ambiguous. This ambiguity arose because these services were most likely to be the sources of client dissatisfaction and complaints. Dissatisfaction resulted from differences in public expectations of the standard of services such as house cleaning and meal preparation, and the reality of what could be provided in a resource constrained environment.

Participants recounted examples of how case managers and clinicians were able to identify innovative cost saving solutions to the use of expensive medical supplies and in other areas of clinical practice. One participant illustrated the connection between micro and macro-level allocation decisions in the example of the family of an infant who had been discharged to home after receiving a lifesaving treatment at a cost of almost one million dollars. The infant was discharged with significant health care needs including the need for full-time ventilator support and care on a continuous "24/7" basis, much of which was delegated to family members. Whereas the cost of the medical intervention itself had received little scrutiny, the case manager working with the family was challenged to advocate for a minimal increase in respite hours for the family, who was in turn facing challenges coping with the life altering circumstances surrounding the care of this infant in the home. It was reported that respite was allocated to this family on the condition that they would agree to use the time to obtain family counselling. This participant went on to describe her feelings about how difficult it was to secure those services that would actually prevent families from breaking up or developing more serious health and social problems in the long-run. Through their description of scenarios such as this, participants in this study identified the challenges and impact of allocation decisions made within and between the various health care sectors and within the various levels of organizational decision-making.

Value and Meaning of Care

Participants described changes in the value and meaning of home care that they had noted since regionalization. The predominant themes related to *a shift to a medical model of care*; a concern for *a loss of continuity* in home care; a concern for the *standards of care*; and an expectation that *families assume a greater responsibility* for the care of clients who are at home. Table 3-3 contains examples of participants' responses that pertain to each of the themes related to the value and meaning of care.

[Insert Table 3.3]

Shift to a medical model of care.

Participants in this study described a shift from a model where the broader social picture was considered part of the home care mandate to a medical model where only immediate health care related to the medical condition or treatment regime would be met. It was noted that home care is being asked to take on more of the provision of acute care in the home, resulting in a focus on specific tasks that were related to the immediate illness instead of a holistic consideration of emotional and social needs of clients and families. This change led to reflections on how home care was becoming increasingly task oriented.

Also identified was how policy-makers lacked an understanding of the true nature and challenges of home care. For instance, one participant recounted the following statement made by a senior policymaker that in effect conveys this lack of appreciation for the challenges of home care: "if they [PCAs] worked in an institution or a nursing home, the aides could do five or more baths an hour, while in the home setting, they would likely only do one bath". This same senior policy-maker reportedly did not support the recommendation that PCAs working in home care be paid for their time to travel between home visits or be compensated to the same degree as their institutional counterparts. This lack of understanding of the true nature of how home care was different than an institutional setting was seen to be contributing to the medicalization of home care, and to the inadequate resource allocation and valuing of care providers in this sector.

Continuity of care

With respect to the theme of continuity of care, participants expressed concern that some clients, especially those who were older and socially isolated, were falling through the cracks. Case managers described the change in their practice as spending less time with people and not attending to certain areas of potential health need because of the lack of time and resources to address them. Participants provided narratives that depicted situations where clients experienced a loss of continuity of care across settings of care and in their relationships with care providers.

The dimension of continuity in relationships was described as the importance of presence or someone "just caring". This continuity was seen as someone in the system who could maintain meaningful contact with clients who were at home over time, regardless of whether they had an immediate need for a specific professional task. Most often, it was the PCAs who had continuous contact with clients. However, their employment schedules, contracts and staff shortages interfered with the agencies' abilities to honour continuity of relationship when assigning clients. At the same time, this continuity was acknowledged as important for quality care and for efficiency. Overall, there was concern expressed for the sustainability of human resources in the system. This question of sustainability was evident in the employment and work lives of PCAs who were seen as being undervalued for the challenges of their work and whose wages were less than their institutional counterparts.

Standards of care

Changes in the focus and direction of home care also extended to a concern about the standard of care provided. This concern was primarily related to the delegation of care that previously had been within the domain of professionals to unlicensed care providers and family members. Participants described concerns for the overall skill mix of care providers and the difficulty in providing an integration of the services of both professional and unlicensed care providers, both of which were required to maintain standards of care. There was acknowledgement of the dedication and commitment of both professional and non-professional staff, however the lack of training and support of personal care aides was a concern for most.

Increased family responsibility for care

Another theme was an increasing reliance on families for the provision of home care. Many participants referred to the growing challenge of engaging families in care or finding comparable support for those individuals who did not have family. Some participants referred to government expectations of women to assume caregiving responsibilities for family members. Family caregiving was also related to the previous theme of eroding standards of care, in lieu of the burden on families when home care clients were unable to access appropriate levels of professional care. Further, it was felt that issues related to family burden and the overall mental health of the family unit were less likely to be explored and addressed by overworked case managers.

Summary of Findings

These above findings related to discourse on policy issues of resource allocation and the value and meaning of care shed light on how they are experienced at a regional level. The issues are complex and interrelated. It is important to note that the participants' descriptions were based on real life scenarios from practice whereas the policy discourse in documents generally lacked this dimension of reality. However, there was agreement among the groups of public advocates, providers and policy makers that the top priority issue was resource allocation, both in fiscal and human resources. There are however, tensions among the values underpinning the issues and proposed solutions differed. These tensions are discussed as an important element of policy process in regional home care.

Discussion

Referring back to the description of a critical theory approach to health policy analysis, this paper focuses on the analysis of the policy process. However, elements of context and content also interact with process in important ways and are therefore part of this discussion. Therefore I begin this section with a discussion of the political, economic, social, and historical contexts of home care policy. I then move to the analysis of the tensions in values underpinning the policy problems as perceived by participants and the proposed agenda of policy makers with respect to regional home care. This discussion then moves to an analysis of the emerging policy agenda in regional home care, both as it relates to the elements of context and content, and to the principles of primary health care as a preferred policy paradigm.

Contexts

Elements of the political, social and economic contexts of home care policy were relevant at the time of this study. As such, this section of the paper represents both the presentation of findings and the beginning of the analysis of how policy context interacts with policy process to influence content.

In the historical context, home care in the province of Alberta was initially conceived and developed as a program oriented to meeting both health and social needs of people with long–term illnesses and disabilities. Within the context of regionalization however, this emphasis has shifted to a medical orientation, giving priority to meeting the post discharge needs of clients with acute illnesses.

The political context is one of neo-liberal ideology and it is interrelated with the economic context in Alberta (Cooper & Kanji, 2000; Government of Alberta, 1994; Harrison & Laxer, 1996; Murphy, 1996). Neoliberalism is a hegemony that is rooted in capitalism and favours market solutions in all aspects of public life. It therefore endorses measures such as "the erosion and dismantling of public services, campaigns of state deficit – and debt – reduction, and the introduction of free market principles" (Carroll & Shaw, 2001, p.196). The Government of Alberta's (1994) business plan with respect to health care delivery is congruent with the tenets of neoliberalism, and as such it is pervasive in its influence on home care and all sectors of the health delivery system (Taft & Steward, 2000). Participants in this study were aware of the influences of the political hegemony and some made specific references to its influence on expectations of families as well as the definition of home care services. As well, some participants noted the political sensitivity around health care generally and how this had politicised decision-making both at micro and macro organizational levels. Some participants referred directly to the example of Bill 11 – *The Health Care Protection Act,* also known as the "Private Hospital Bill", that was passed in the Alberta Legislature in 2000. They expressed uncertainty as to how far this ideology would extend in its influence in home care policy. However, most participants anticipated that it would impact the definition of publicly funded home care.

Neoliberalism also relates to the social context of home care policy. While demographic and population health factors influenced the type of care that was required

in homes and the community, the political ideology also influenced a shifting balance of family responsibilities relative to their resources and abilities to provide care for family members. A relevant feature of the social context is that the provincial government views supportive care in the home as first and foremost the responsibilities of individuals, families and communities (Alberta Health and Wellness, 1999a; 2000). The relationship between political and social contexts is most emphatically seen in the impact of home care policy on women's roles (Scott, Horne & Thurston, 2002). For example, as home care becomes defined as separate from personal care and homemaking, more of these latter responsibilities fall to women to assist family members who are chronically ill or aged. As well, women are the majority of care providers in society including family members and PCAs who receive no or minimal compensation for their contributions to care.

Finally, the influence of inter-governmental relationships was also identified as a relevant political context. Findings revealed the need for standards and legislation in home care at all levels of government. In particular, there was support for a national home care program, with standards needed to address issues of increasing diversity and disparity among programs across the province and the country. However, an analysis of the political context also revealed that if the federal government was to develop policy and legislation for programs that were not included in the Canada Health Act, it ran the risk of acting out of its jurisdiction (Pal, 2001; Shapiro, 2000).

Tension in values

Three areas of tension between values are relevant to this analysis of the policy process. The first area of tension is related to the value of equity, referring to how a society should determine the boundaries of entitlement and limits to the provision of scarce resources (Stone, 1997). The tension is between the value of equity and the limits to resources. A second area of tension exists between the values of efficiency and quality in home care services. Third, there is tension between the values of individual self-sufficiency and government responsibility in the delivery of home care.

Equity

The first area of tension is rooted in the value of equity, defined by Stone (1997) as "distributions that are regarded as fair even though they contain both equalities and

inequalities (p.42)". Fair distribution of home care resources depends on how fundamental questions related to individual entitlement, human rights, and the scope of health services are resolved. Study participants were able to articulate in a sophisticated way the complexities of determining an equitable or equal distribution of scarce resources in a system that was seen to have increasingly restrictive boundaries of entitlement. Their examples also pointed to the contradictions and paradoxes inherent in the issues of societal and individual determinations of entitlement and choices, leading us to question: Will Canadian society define and maintain a public system of home care that the majority of people could access and be satisfied with? Or, is it more likely that the bar or standard of a public system acceptable to the majority will be lowered in favour of those who would opt instead for access to the array of choices provided in a user pay, private system? The real question is whether the two systems (public and private, for profit) can co-exist without causing the ultimate demise of a universal public system.

Tensions in determining equity also lead us to consider the values of universality and choice in the delivery of home care services. Arguments in favour of shifting universally provided public programs to user pay and private programs refer to how these reallocations can then result in more equitable service delivery to the poor, as well as provide a greater array of choices to those who can afford to access the programs (Government of Alberta, 2001; Rachlis, 2000). However, critics of this approach argue that markets developing in the wake of universal programs eventually lead to inequities, as support for the public system wanes (Bashevkin, 2002; Coyte, 2000; Rachlis, 2000). These are vital determinations of how accessible those services that are not strictly health-related will be to those who are unable to pay. Subsidies to low income people comprise a policy instrument that will likely preserve some of the equity in the system of care. However, critics point out that over time, eligibility requirements are likely to tighten, and access to what may be considered a range of comprehensive social and personal supports may be eroded (Armstrong et al, 2002; Bashevkin, 2002).

As the findings indicate, the discourse of choice is prevalent in both provincial and regional policy documents. It is interesting to consider, however, how the value of increased choice within an array of unbundled or delinked home care services plays out in real life scenarios. One might consider the fundamental challenges of determining

what these choices actually mean for low, medium and high-income seniors? Or, in the example of the family of an infant who requires intense and continuous home care, we might ask: Is the family able to continue to choose to access those services and a level of care that will make a difference to their quality of life?

Efficiency

Organizational and political theorists have described these tensions between efficiency, productivity and quality in both private and public organizations (Mintzberg, 2002; Stein, 2002). Stein (2002) asks us to consider the question of efficiency with respect to the provision of public services: "What are we to be efficient at? (p.41)". In recent years, the health sector has embraced a business mode of operation, making reference to regional health services as core businesses. Political contexts have focused efforts on the reduction of public services, forcing an efficiency model that emphasizes cost containment as the primary goal. Providers and clients also acknowledge a level of appreciation of the challenge of sustainability and fiscal limits to what governments can provide. However, they are also more inclined to present the subtle complexities of an efficiency orientation, including the danger of a false economy when quality care issues are not considered. If policy-makers were also able to understand and acknowledge the tension that exists between efficiency and quality care, then their understanding and insight may lead to policies that are successful in both cost containment and the provision of quality home care.

The themes related to the value and meaning of care contrasted with the business discourse contained in policy documents. For instance, one may note a difference between the discourses of *care* vis-à-vis the discourse of *service*. What happens to the continuity of care when services are unbundled or de-linked to allow the individual more choice within the various programs? How does this address the issues of presence, knowing the client and the continuity of relationships in care? More insight is needed into how policy agendas will confront the issue of increased medicalization and decreased comprehensiveness of home care. These questions relate most fundamentally to how care is valued within the system and in society, the contributions of family, women and informal caregivers, and if there will be meaningful public participation in determining the scope of home care services. Public advocates clearly have a contribution to make in

this respect and yet it was unclear if they will have a strong and formalized role in home care policy reform.

Individual and Public Responsibility

A third tension exists between the values of personal responsibility and collective (or governmental) responsibility for the provision of health services. There is a growing emphasis on personal responsibility and self-sufficiency with less reliance on government provision of services. This mandates a level of family and community support when individual levels of self-sufficiency are decreased due to disability, illness or normal aging. Critics acknowledge how this impacts families and identify gender implications of public policies that identify women as primary informal and most often unpaid caregivers (Armstrong et al, 2002; Brodie, 1999; Gregor, 1997). Policy discourse in both provincial and regional contexts identifies the need for more support for informal and family caregivers within the array of "unbundled or de-linked services". However, there is less acknowledgement of those people who are isolated and lack social supports and little identification of policy options that would address the gender issues and ultimate sustainability of informal and family caregiving. In this instance, the governments' policy is to provide resources only when voluntary instruments in the form of family and community, or market forces do not address the policy issue (Howlett & Ramesh, 1995, p.84).

Summary

Tensions in the values of equity, efficiency and responsibility underpin key policy issues in regional home care. There is some evidence that governments recognize the tensions. However, there was less indication that emergent policies were actually based on an in-depth analysis of values or of how they played out in the delivery of care and services. It may be noted that the tensions in values also correspond with the gray areas of public policy where choices are most conflicted and difficult. The experience of those living the tensions is perhaps most clearly articulated in the day-to-day scenarios and narratives of those people who are closest to the experience of care. The tensions that exist in these complex determinations are also about the relationships and the level of skill and understanding needed to determine and negotiate care between patients, families and care providers. It has implications for the roles of nurses, social workers, case

managers and others in the system to advocate for a vision of care that recognizes the importance of continuity in relationships and the time, skill and resources to negotiate care within a variety of family and home contexts (Aronson & Neysmith, 2001; Keating et al, 1997; Ward Griffin, 2002). It remains to be seen whether future policy agendas will address the real dilemmas of equity, efficiency, quality care and responsibility as they exist at a values level and play out in the lives of home care recipients.

Policy Issues and Agendas

A central question underpinning this analysis refers to whether there is a connection, or disconnection between the policy discourse and issues of participants, and the policy agendas and discourse of decision-makers. This analysis reveals the issues in the participants' descriptions of resource allocation, valuing of care and the experiences of families and other caregivers. There was a level of disconnect between these issues and the emerging and proposed policy agendas. At the heart of this disconnect was a shift in the dominant policy paradigm from one that was a social model of care in the pre-regionalization period to one that is currently evolving as a medical model of care. As we have seen in this analysis of a policy agenda, there was a shift in the policy focus that contributed to the reshaping of policies surrounding the delivery of home care, including the goals of care as medical as opposed to social, and the primacy of efficiency as a value.

What remains is the question of the relationship between the emerging policy paradigm of a medical model in home care and the principles of primary health care. In response to this question, one first observes that the vision for the development of long-term care and home care as it is laid out in the policy documents of Alberta Health and Wellness (1999a; 1999b; 1999c; 1999d; 2000) and the CHA (2000a; 2000b) correspond at least in a rhetorical sense to PHC principles. However, upon closer scrutiny, there are some distinctions to be made between the emerging medical paradigm in home care policy and one that is based on PHC principles. It is this comparison that points to differences between what is happening with respect to regional home care policy and what should happen if policy agendas were congruent with a PHC policy paradigm. Table 3-4 is a summary of some of the key points of difference that correspond with elements of policy content and process.

[Refer to Table 3-4]

When one compares the elements of policy content and process associated with the two paradigms, it is evident that there are points of contrast between medical and PHC paradigms. The elements of policy content in the medical model includes a policy problem that is framed as a potential catastrophic burden of home care on the public purse, leading to a solution that involves the control of public expenditures in the delivery of services. This in turn, leads to policy instruments that favor market efficiencies, user pay options and subsidies. The PHC paradigm on the other hand frames the care demands of the elderly and chronically ill as a community challenge. When framed as such, this challenge calls for broad based community solutions including a comprehensive range of health services that can be affordable to the community and society. It calls for policy instruments that are intersectoral, legislative and regulatory to ensure public ownership and funding of the system overall.

With respect to policy process, the medical and PHC policy paradigms are distinguished by different emphases on combinations or patterns of values. The medical paradigm favors efficiency and choice in the delivery of home care services with priority given to the acute, treatment oriented health services over chronic or long-term care in the home. Efficiency is largely realized through the introduction of market forces, and equity is achieved through subsidies. Within a PHC paradigm, the value of equity is actualized through universality of access to a range of health services as well as efficiency in the provision of services that are sustainable and affordable to a community. Finally, actors who influence the policy process in the medical paradigm are generally those who may be characterized as policy elites such as MLAs, cabinet ministers, organizational leaders, physicians and others who may be part of an inner circle of policy-makers (Lavis, 2002). The PHC paradigm is based on a principle of public participation and this should be realized to its fullest extent in the inclusion of diverse publics in policymaking in home care (Ogilvie & Reutter, 2003).

Conclusion

A critical theory approach to policy analysis can expose the reality of policy agendas and tensions in their ideological underpinnings. In this paper, the approach was used to also analyze the relationship between a regional home care policy agenda and the philosophy and principles of primary health care. If, as shown here, the crux of the critical policy analysis is the interaction of context, process, and content, a central realization must be that the political context of the provincial government of Alberta and its inherent ideology of reduced funding, privatization of public services and individual responsibility may well be on a collision course with primary health care philosophy and goals. Therefore, the strategies to influence current policy and organizational processes including the agendas of care, efficiency, productivity and self-responsibility in health care must be developed with full awareness of the political contexts and ideologies. Awareness of discourse and values tensions in ideology is the first step in securing an agenda for change and reform.

There is research to suggest that governments will ignore policy proposals that are not framed as compatible with their ideology (Bryant, 2002; Sabatier & Jenkins-Smith, 1999). Given the strength of political agendas, one must conclude that it will be very difficult to respond to a policy window for the development of a home care delivery system that is based on PHC principles. This analysis suggests that PHC principles can make a difference to the quality of home care because a PHC framework espouses the goal of equity in the allocation of resources. However, the development of the regional system of home care at the time of this study was *not* proceeding in a way that one could conclude was fully in support of PHC principles. That is, regional home care was not evolving in the direction of: a broad definition of health services that included personal care, family support and prevention services; appropriate technology including maximizing the potential of human resources; public participation in determining the scope of home care services; intersectoral collaboration that addressed the determinants of health such as housing, labour standards, income; and increasing accessibility to a wide range of home care services that was not dependent on ability to participate in user pay options. This is not to say that PHC principles were not addressed in part in both provincial and regional home care policy as proposed and implemented; indeed, all levels

of governments do express some support of PHC in their documents. However the full potential of PHC must be actualized as a philosophy of care. It is the philosophical tenets of PHC that appear to be in contradiction of political ideology and of the current government. Therefore, one must also conclude that provincial and federal legislation is the policy instrument that could most effectively control the impact of market ideology and encourage intesectoral collaboration in the direction of healthy public policy. Such legislation is essential to ensure that PHC principles are the foundation of home care policy.

Finally, if the goal of policy actors is to influence policy agendas towards the values and goals of primary health care, more research into strategies for policy influence and organizational change is needed. A further key to change may be found in the power of the narrative, and there is some beginning evidence that points to the power of anecdotal evidence in persuading policy change, although the political identity of policy actors also influences how influential they will be (Bryant, 2002). More research is needed to understand the effects of these variables in policy and organizational processes.

Table 3-1: Selected Policy Documents

Source / Affiliation	Jurisdiction		
	Regional	Provincial	National
Public	• Seniors' Community Health Council (1999): Response to the Report of the Long Term Care Review Committee. • The Society for the Retired and Semi-Retired: Directory of Senior Services (1999).	• Provincial Health Council of Alberta: 1998 Annual Report Card to the Legislature. • Government of Alberta Health Summit (1999) Final Report.	• National Advisory Council on Aging. (2000). Position on Home Care. • CARP's Report Card on Home Care 2001.
Provider	• Regional Nursing Best Practices Committee: (Terms of reference and minutes of meetings) • "Dylan's Story": a narrative of policy impact on an infant and family.	• Alberta Association on Gerontology (1999) Response to the Report of the Long Term Care Review Committee. • Alberta Association of Registered Nurses (1998). Guidelines on the Delegation and Supervision of Client Care.	• Canadian Nurses Association: (1998) National Home and Community Care for Canadians Development • Canadian Health Services Research Foundation (1999): Issues in the Governance of Integrated Health Systems.
Decision-Maker	• Capital Health Authority Business Plans: 1997/98 – 1999/2000; 2000 /01 – 2002/03. • Capital Health Home Care / Regional Continuing Care Structure (2000) Regulations and Data. • Capital Health Region (2000) How Healthy Are We?: A report from the Medical Officer of Health. • Capital Health Continuing Care (2000) 10 Year Strategic Plan: Response to Alberta Health & Wellness.	• Alberta Health Annual Reports: 1989 – 1999 • Alberta Health (1992). Home care in Alberta: New Directions in Community Support. • Government of Alberta Business Plan (1994) • Alberta Health and Wellness (1999) Long Term Care Review: Final Report of the Policy Advisory Committee • Alberta Health and Wellness. (1999). Questionnaire on the Final Report of the Long Term Care Policy Advisory Committee Final Report. • Alberta Health and Wellness. (2000). Strategic Directions and Future Actions: Healthy Aging and Continuing Care in Alberta. • Alberta Health and Wellness (2000). Continuing Care Strategic Service Plan Phase 1 Expectations.	• National Forum on Health (1997). Final Report. • Health Canada (July 1999): Home Care Development, Provincial and Territorial Home Care Programs & Systems

Table 3-2: Participants' Descriptions of Resource Allocation Themes in Regional Home Care

Themes	Excerpts from the Interviews
Supply and Demand	"...when we think back to Klein when he moved everything and said that care will be provided in the community, we don't need all of these institutional beds, we don't need all of these acute care beds ... And, but it wasn't reality... there wasn't enough dollars and if you want to care for people in the community, you have to put more money into the community" (Participant B1, Regional program manager) "...we've seen the program go from about 5000 clients at the time of regionalization to about 8000 clients now with the same number of professional staff trying to meet the needs and in the meantime we've seen all kinds of advances in medical technology and we've seen people coming home from hospital earlier, sicker, we've seen people coming home from continuing care centers that you know ten years ago it would never even have been a option for them to go home to the community ..." (Participant B4, Regional program manager) "the fiscal resource shortage is more related to the fact that we are very much *not* like a facility. Where a facility has 26 beds on a unit, because they can't put two people per bed or three people, or they don't bunk the beds, or at least they didn't when I was in acute care, we don't have that option, we have to meet the needs of our population and our clients regardless if it's a $200 need or a $3000 need. So we're likened to a facility without walls and we can't say know, we have to serve the population" (Participant B5 Regional program manager) "I would say that the changes in home care are volume, acuity, complexity, supply and demand issue, and I don't even think, I don't believe that age is a contributing factor...um, shorter hospital stays which are a good thing, a philosophical shift in value, federally, provincially and locally – complicated answer, complicated question." (Participant D2, Manager, Private Contract Agency)

Themes	Excerpts from the Interviews
Boundaries	"I think that the issues around things are clearly health care services are fairly clear cut. Where I think the boundary is so much more blurred is around the more typical support services" (Participant A3, Regional senior manager) "Transportation is another area that doesn't fall within the home care mandate but yet we have tremendous expectations placed on us to ensure that people get to doctors' appointments, get to the hospital if they need to, that if they need to go to the hospital for outpatient surgery that we've got someone that can stay with them, you for 24 hours after, so that often they go in for day surgery and they don't really need anything in the way of services, it's just they need someone to be there and there's a difference between those situations, you know where you're really just needing someone there for the sake of companionship where we really can't help, to the situations where yes, if you need someone for specific tasks and services, you've got identified needs and then we can schedule ..." (Participant B4, Regional program manager). "Case management, which we do in home care is all inclusive. It looks at the client and addresses the client's needs regardless of whether the need is a home care need, as in putting in a personal care support or linking with a financial support for them so our case management philosophy to me makes it the natural place for the money to reside. And the issue is having that boundary spanning authority and autonomy so that you can link and make decisions that effect other programs" (Participant, B6, Regional program manager). "...you know it's [the line between personal care and home making is fairly clear] but it's often up to the case manager to make that decision. You know personal care is looking after the individual himself. Homemaking is looking after the house and the environment. But, you know, some case managers are hesitant to make that clear in a bold statement to the client. Definitely ... and the regional health authority is looking at assessment tools and how they could standardize the practice of providing care and what the needs are and what the government will really provide for, but it is very subjective. . It's very hard to be objective in this line of work in assessing" (Participant D3, Regional manager in a private agency)

Themes	Excerpts from the Interviews
Efficiency-based decision making	"...the case coordinator can approve services up to such and such a limit and they are supposed to be trying to limit the amount that is spent.....I mean it is certainly understandable because you've got to balance the budget, but from a moral perspective when the focus is on saving the dollars, rather than providing the are, I think there is a problem with that – what's in the client's best interest?. Now [the client's interest] it's far from the top of the list of decision-making criteria. It's, what's it going to cost us? What's the political fallout of this? Can I get this approved? Oh, and what does the client need? We seem to have turned things upside down. So I se it very much as a financially driven decision process as opposed to a client care driven process." (Participant C1, Public advocate) "The case managers, when they are putting in services have to determine the monthly cost that will be involved, they have to monitor those costs on an ongoing basis. And again, you know ethically, it places the professional, I think, in a very difficult position, where you see the need for services and you are a professional caregiver who provides care, but at the same time you are expected to pull the purse strings ...? (Participant E2, Regional provider) " I think we're supposed to teach people how to do their dressings, and I think we're supposed to play a little bit more hardball than we do, but I don't think it's always backed up, higher up. You get somebody call in and complaining, and often times we're told yes go ahead and do what they want, their MLA called so...And that happens a lot. People are supposed to buy their own supplies, we don't push that anymore at all because it just wasn't happening – people can't afford and you know they make a big ta-do about it and then you get enough people who don't get backed up and after awhile you say: 'Well why them and why not this other person?' So you kind of let that go. I remember a long time ago they talked to us about getting people to pay for their supplies and I don't know anybody who teaches anybody that anymore. (Participant E4, Regional case manager).
False Economy	The homemaking part, I mean to me, it is neither here nor there in that you'd think that there would be other ways to creative and manage those kinds of needs, but then I also recognize that sometimes it's the break between someone staying at home and not staying at home, and if that's the case, it makes more sense to provide then to say, 'No, we're not going to do it' and then have them go to long-term care when they maybe really don't need to be there." (Participant B3, Regional program manager)' "Oh, the personal care for the number ... we costed it out for the children that were - we used two criteria: we thought that if they were over 50 pounds because people are not supposed to be lifting over 50 pounds, so that meant that there probably needed to be some support, whether it be a lift, whether be it something, that means that it's more than just saying, Okay lets get them dressed for the morning. There's some heave-hoeing taking place there and what we're finding with families, their backs breakdown, their shoulders break down and then they are not able to provide for their children and they end up having to go the foster care, and it may not cost the health care system, but it costs us as

False Economy	taxpayers. It doesn't matter where it comes from as far as I'm concerned. It costs us all if we're jeopardizing those families' physical well-being, not to mention their mental well-being ...So the cost of that was negligible compared to what else might happen ... we costed it out, and it was under $10,000 a month (for all families on the program), I mean, that's nothing, that's ten days in the hospital for one child. You know, so if you look at it that way" (Participant B8, Regional program manager) "I mean, I think it is unethical when somebody is at home with a need, to delay providing a service is really problematic, and I think often results in much more expensive treatment being required...and I think there are some other issues around sort of prevention that in the early days of home care, homemaking was available and some of the other things that helped maintain people in the community and not require advanced traditional health services, and I think those have gone by the wayside" (Participant C1, Public advocate) P: Well, it's a big issue for me because after the Broda report it came out that said they were going to build fewer nursing homes which I go along with, I think this is a great idea, but I maintain, and the council has maintained that if we don't have better home care we will not be able to succeed with that idea at all. So that to me is the big issue because what I know now is that people do not get any help from home care, you know of a support type of thing. They get medical attention, like nursing care, rehab, and this kind of thing, but they don't get ... like if they just need somebody to come in a help them get dressed in the morning or something of this kind. There is no help for that. We know that there are people who can't afford to pay for that. The biggest number of seniors in Alberta, and I can't remember exactly the year but I think it was 1996 ... I think it was '96, the median income to the middle, you know half above and half below in among seniors was $16,000 a year. Well, on that kind of an income you obviously cannot afford to pay somebody to come in. You have to have that available to you and if they want people to stay in their own homes then they have to provide this kind of care, at least to people who can't afford it. (Participant C2, Public advocate). "We do some really creative things. Our nurses are so frugal ... But constantly the issue ... the question comes up: maybe we should make clients pay for their dressings. And we've always argued that if you had to pay for your dressing and I wanted to use a $10 dressing, you're going to really balk, but you're willing to pay for gauze which requires twice a day nursing visits, but a $10 dressing might require every second day nursing visits, which saves us a lot of money in staff costs. So if we provide the products, we can make better use of our nursing staff resource" (Participant E1; Regional provider)

Table 3-3: Participants' Descriptions of the Themes of Value and Meaning of Home Care

Themes	Excerpts from the Interviews
Shift to a Medical Model of Care	"...I think the expectation is there, both for people who are being discharged out of acute care who have short-term needs. I think we are probably a little better positioned to respond to the short-term needs, um more aggressively than we are for the senior who has long-term support needs." (Participant A3, Senior manager). "It's the medical model, now, whereas I don't think originally it was. It had much more of a community flavour to it and prevention flavour to it, and now it has a treatment flavour" (Participant, C1, Public advocate). "...in you own home, you are on your own, unless you come home from hospital and have an identified health care need, you will not get services. The only kind of home care that gets supported is acute care substitution or palliative care." (Participant C4, Public advocate). "...I guess some of the policies that have been driving me nuts lately is.... the fact that there seems to be more of a movement to try to do hospital nursing, be a hospital nurse in the community, and I don't know if that is written policy, but it seems to be a policy that seems to be unwritten and we are trying to function like we're a hospital ward in many ways, and we're not." (Participant E3, Regional provider). "Well, I guess I could see the way it is heading and I don't know that I agree with it, um, home care, it doesn't have any kind of ceiling, it accepts anybody who is referred, so anybody from you know, community or hospitals, and it seems to be taking alot more and more acute patients, as the hospital emergency rooms get full and they need beds, and you know they kind of figure out who can go home and so you're getting , you know more and more acute people home, and I see sort of it becoming more of a hospital without walls, as opposed to when I started, there were a lot of services in place, homemaking, personal care, a lot of that and although that's still part of it, it seems to be less of a part of it than it used to be." (Participant E4, Regional provider) "...going back to 1994, the first Capital Health Authority in the throes of cutbacks and reorganization, wanted money reserved, put into and maintained in home care and public health -- but the acute care is very sexy as you know. So when you get down to the policy issues, it takes a great deal of will politically to stay the course" (Participant D2, Regional manager in a private agency)

Themes	Excerpts from the Interviews
Continuity of Care	"One of things that gravely concerns me is that even when we send them home and more or less the frail, elderly population, they may have a frail caregiver in their home, they may be the caregiver for someone, we don't have the ability to have anybody to just go in and do a check, without anything specific -- that to me has always been very difficult to comprehend if we are moving to community care, like we can't put a referral in to home care with nothing specific: 'Gee, would you just please go in and check on Mrs. Jones, you know, she's had surgery done, she's still a bit tired, we want to be sure she's still eating we want to be sure she's okay'" (Participant B1, Regional program manager). "Change, it certainly is significant, relationships with caregivers, trust, um, even affection because I think that these people can get very close, when you're in trouble and somebody helps you, there is a dimension in relationship that isn't there at other times, and if they really help you, well..." (Participant C3, Public advocate). "You know that you just go in and you do your dressing and you leave -- I don't know if it's not that you fully assess, but you kind of leave people to cope as best they can until a crisis happens -- like the more time that you spend with someone, and as you talk to them, things come up, issues come up, but if you're dashing in and dashing out, you don't realize that there's a problem because you're not --I don't know if it's that you're not paying as much attention, or that you don't take the time -- you know most people can manage these things, but you could be providing them some resources or making suggestions or that type of thing --so unless, they're really having a hard time, you just leave them to cope with it."(Participant E2; Regional provider) "...or, you have somebody that you know they're non-insulin diabetic but you're not seeing them for that, you're seeing them for a wound, you may ask them once what their sugar is like and it sounded okay, and then you never bother checking it again, and they could be getting into trouble and you're not really following it, because you're not there for that. So you're not being as holistic and they may other needs that you're just, you kind of touch upon". (Participant E4, Regional provider)

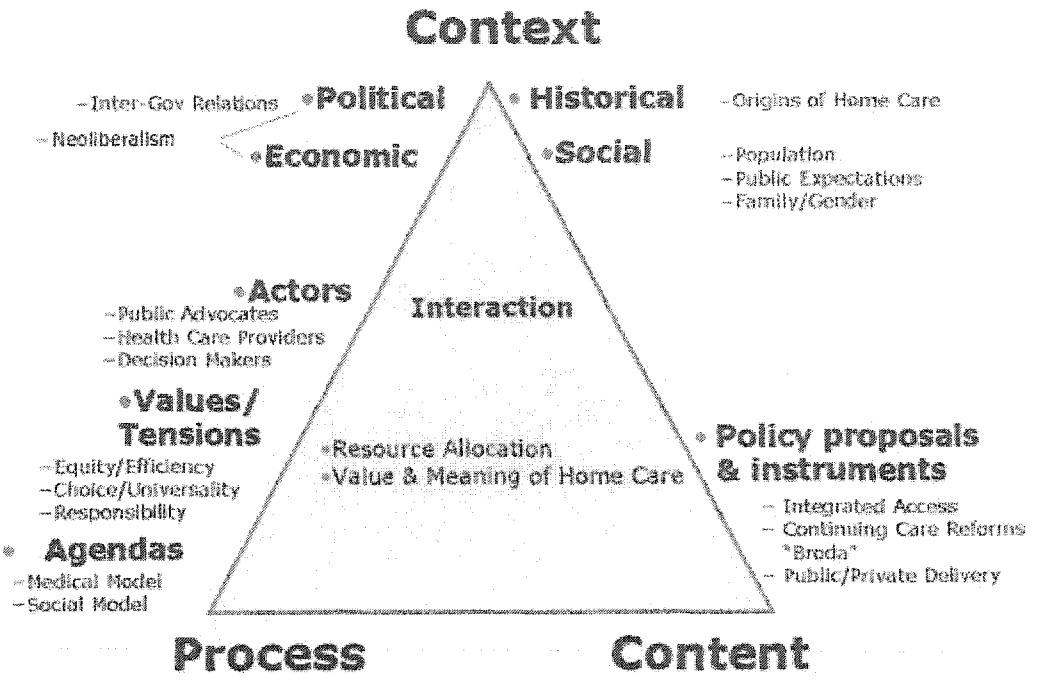
Themes	Excerpts from the Interviews
Standard of Care	…so we are in home care, at the point where we are having to support people in their homes who probably are at a far higher level than what home care can manage them for any length of time -- but you know it's not a high level of care that is going into the homes of these individuals. Certainly if they need some professional care as well, then professional staff go in, but that ongoing 24 hour a day monitoring that's required is done by caregivers who are not trained and have no formal education. And that's um, I think that's always a difficult thing for people in home care to deal with the fact we have such ill people in their homes who are in fact being cared for by such low level types of caregivers, if not just by their families." (Participant E2, Regional provider). "…you know -- the provision of care is being, what's the term, I guess brought down, like a dressing change that may in the past be done by a nurse, would now be done by an aide. There's a lot of delegation of tasks. I think it's been done wisely thought I think there are things that can be done, to a point. Sometimes I think it's being pushed beyond that, and paediatrics would be the case that I would look at – children on ventilators, I just cannot agree that they can be looked after by an aide level, an unlicensed caregiver and I 'm seeing that happening in the home." (Participant D3, Regional manager in a private agency). "…in the ten years I've been, ten years ago nothing in the manual was delegated, nothing the nurses did, and so we've moved from that, PCAs give injections, they give all kinds of stuff in self-managed care" (Participant E1, Regional provider). "…the policy issues, there's some big ones, you know, like standards, competencies and education for staff, certification for tasks, how the acuity is going to be addressed with LPN and RN services, which has been very, very, very slim in the past, mostly that work has been done by home care staff themselves, but we're seeing more of a referral in that regard". (Participant D2, Regional manager in a private agency).
Caregivers / Family	"…and so, what's happened then in the Edmonton area, we do have a large number of complex children, you know, quite complex children. Like, they're living at home with trachs and they're ventilator dependent, and the care needs are significant and -- for us, we have a hard time recruiting and retaining staff to put them into these situations to give parents some relief. And if we don't, the burden on the parents is huge. Even if we do …." (Participant A2, Regional manager) "…really often you think of home care being a program that is carried on the backs of women, on the backs of – because women are the primary care providers, on the backs of low-paid care providers who are primarily women, and I know that's been brought forward too by several of our own staff who can see it as a feminist issue." (Participant B4, Regional program manager).

Caregivers / Family	"…families have responsibilities and most families do accept those responsibilities, but sometimes families need a bit of help. We have now moved to the point where the biggest number of husbands and wives in a family are working, they don't have the time they used to have. There was a time when the wife didn't work and maybe she had time to go and help out, her mother and dad or in-laws or whatever. That time is not there anymore – they've got children to take care of, they've got community responsibilities, they've got their work issues, they've got their own home and their own neighbourhood, and then they've got their parents. I don't think we recognize what this -- and I think that maybe that is one of the problems with some of our own MLAs, they don't really recognize the problem. They just don't understand it. You see, our government has this funny little notion that families have responsibilities, and that's true, families have responsibilities and most families do accept those responsibilities, but sometimes families need a little bit of help." (Participant C2, Public advocate) "…[I] look at family support, what family is able to do [for the home care client]. I don't have a lot of clients who have a great big pile of family support. You know, a lot of my clients have been estranged from their families for years and years and years, so." (Participant E3, Regional provider).

Table 3-4: A Comparison of Medical and PHC Policy Paradigms in Regional Home Care

Elements of Policy Content and Process	Medical	PHC
Problem Definition	• Aging and chronic illness as a burden of care • Potential for catastrophic costs to the public purse • Need to define boundaries between health and non-health services	• Aging and chronic illness as a community issue and challenge • Reduced capacities of systems to cope with increased demands • Health and health care must be broadly defined to realize goals
Goals	• Efficiency / Control of public expenditures • Immediate treatment / medical care needs as a system priority • Health promotion and prevention are goals but not fully realized as health services	• Provision of a comprehensive and accessible range of services • Provision of a broad range of health services that are affordable to community / society
Instruments	• Market efficiencies: contracting out of all but narrow scope of treatment oriented health services • Private responsibility / user pay for a increasingly wider range of services • Subsidies	• Intersectoral initiatives / Healthy public policy • Public ownership and funding of system • Develop system capacity (human resources, community resources, less costly "upstream" services)
Values	• Efficiency: entrepreneurial initiatives • Increased choice in services (health care, housing, personal care) • Equity through subsidies	• Equity, including universality of access • Efficiency / Affordability • Individual and community responsibility (social justice)
Actors	• Policy process dominated by policy elites and political interests	• Public participation in policy processes

Figure 3-1: Context, Process, and Content of Home Care Policy



(Adapted from Pettigrew, 1987 & Walt, 1996)

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Chapter Four

Paper Three: *Health Care Reform and the Dynamics of Organizational Change in Regional Home Care*

Health care systems are undergoing large-scale organizational change. By definition, large-scale organizational change is a transformation or reorientation of an organization that will lead to a significant alteration in its performance (Mohrman, Ledford & Mohrman, 1989; Nadler & Tushman, 1990). Such change processes in health care policy and organizations have received some attention by researchers (Casebeer & Hannah, 1998; Casebeer, Scott & Hannah, 2000; Denis et al, 1996; Pettigrew, Ferlie & McKee, 1992) However, further study is needed in order to understand how proposed health care reforms interact with organizational change processes. The general rhetoric of health care reform is characterized as a transformation in organizational values and types from those based on medical treatment models of care to those that also emphasize health promotion, illness prevention and the health of populations. It would appear, however, that most of the actual change process in health care organizations has been structural in nature.

These structural changes in health services delivery have included regionalization of health services and the downsizing of hospitals.[7] Within the health care system, this restructuring has, in turn, resulted in change in the delivery of community health services, as more people require care in their homes and other settings. Among the changes in community health services has been a shifting of priorities and focus in the delivery of home care. Home care has been high profile in the media reports of a "system in crisis" leaving patients and families without basic services (Picard, 2002). By definition, community home care programs consist of "an array of services which enables clients incapacitated in whole or in part, to live at home, often with the effect of preventing, delaying or substituting for long-term care or acute care alternatives" (Health Canada Federal / Provincial Working Group on Home Care, 1990). Whereas the goal of health care reform is framed as a shift from the predominant curative perspective to one that

[7] In Alberta, 1991/2 – 1996/1997, there was a 19.6% decrease in the number of hospital discharges and an overall 21% decrease in the province wide length of hospital stay (Saunders et al, 1999).

also encompasses health promotion and a focus on the health of populations, findings of this study and others point instead to a shift to a more medical treatment focus in home care. This also differs from what was historically a home care service that emphasized supportive care of populations. Researchers implicate several factors for this shift including the politicization of health care, restructuring, increasing entrepreneurial activity and the undervaluing of home care relative to acute care in resource allocation decisions (Coyte, 2000; Coyte & McKeever, 2001; Parent & Anderson, 2001).

The five principles of primary health care (PHC) have been widely endorsed as the ideological basis of health reform: public participation, accessibility, health promotion and illness prevention, appropriate technology, and intersectoral collaboration (Canadian Nurses Association, 1988; McWilliam, 2000; National Forum on Health, 1997). Health promotion principles, also part of primary health care, focus attention on a broader definition of health and on the determinants of health such as employment, income and education that exist outside of the traditional health care settings (World Health Organization, 1986). As proposals, the content of policies associated with home care regionally, provincially and nationally reflects some of the ideology of PHC.

Research into change in the delivery of home care points to a different reality than one implicated in the discourse and ideology of health care reform (Coyte & McKeever, 2001; Gallagher et al; 2002; Gustafson, 2000; Hollander & Prince, 2002). Therefore it is timely to understand the nature of the change that has occurred and its influencing factors. Organizational and policy theorists acknowledge the importance of the contexts of politics, economics, social factors and history in understanding the dynamics of health system change. Greenwood & Hinings (1996) assert that change in organizations is actually a function of how intraorganizational dynamics interact with external contexts. In their model of organizational change, they consider the dynamics that both precipitate and enable change. This model and others hold promise for understanding how change processes like health reform can be either thwarted or enabled.

Questions guiding the discussion that is the subject of this paper include: What values underpin the models of care that are emerging in home care? How do the interests, values and the power of the actors involved in home care influence the nature and direction of change? How does the concept of organizational capability to enact change

such as health reform apply to regional home care? And finally, how do political, economic, social, and historical contexts interact with the intraorganizational dynamics of change? In response to these questions, this paper focuses on the analysis of the change process that is occurring in home care and on the capability of the organization to undertake change that is compatible with a pattern of values that are associated with primary health care.

The discussion of the dynamics of organizational change in home care is based on the selected findings from my study which took the form a critical policy analysis of home care in one provincial health region. The purpose of the study was to gain insight into the interaction of the context, process and content of home care policy. In this paper, I will first highlight some of what is known about change in health systems. I then provide some background to the study and introduce the conceptual model of organizational change adopted for this analysis. By organization, I am referring here to both the organizations that are responsible for influencing and making policy and the organizations that deliver home care programs in a regional health system. These include the regional health authority (RHA), public advocacy groups that exist within the region, and private contractors of home care services. Since the RHA is a component of the provincial health system, this analysis also includes the organization of the provincial ministry of health. Finally, I offer recommendations for influencing change in policies and organizations, and for further research.

Change in Health Systems

Regionalization

The current era of health system change in Canada was initiated over the past decade with provincial reviews of health care systems (Church & Barker, 1998; Mhatre & Deber, 1992). Regionalization has been the most common form of restructuring that has been undertaken in some form by all provincial governments in Canada, with the exception of Ontario. In theory, regionalization of health care has been associated with the goals of improving co-ordination of a range of services within a defined geographic area, improving the relevance of service delivery to local needs, improving efficiency of service delivery and facilitating local or regional participation in planning (Bagdley, 1982).

Recent studies have examined the progress of this first wave of regionalization in Canadian provinces (Casebeer & Hannah, 1998; Casebeer, Scott & Hannah, 2000; Lewis et al, 2001; Lomas, 1997; 2001; Mitton & Donaldson, 2002; Phillipon & Wasylyshyn, 1997). Several observations have been made including the divided views among regional board members as to the motive and performance of regional boards relative to health reform agendas. In Alberta, for example, 67% of board members who responded to a survey reported that devolution of health services governance to the region was motivated largely by the government's desire to offload budgetary decisions (Lomas, Veenstra & Woods, 1997). Lewis et al (2001) studied the only publicly elected regional board members in Saskatchewan, finding that 56% of the board members surveyed agreed with the statement that there was no clear vision for health care reform. Casebeer et al (2000) reported similar findings in Alberta regions where health managers reported a lack of a clear definition of goals regarding the proposed shift to a health based model of care and community based care. Health Canada's (1999) synthesis report on home care programs in the country also identified regionalization as a significant context of this community health program and that there was increasing diversity in regional home care programs within and between provinces.

Within regionalized health systems, researchers also describe the increasing politicization in priority and resource allocation (Boutilier et al, 2001; Mitton & Donaldson, 2002; Taft & Steward, 2000). Political and economic contexts have become increasingly influential to health policy and organizational change. Although researchers have recognized the pervasiveness of these contexts, few studies have focused on the analysis of the impacts on models of care, organizational values and actual change in health service delivery. However, these early investigations seem to indicate that health care restructuring initiatives do not represent change in the fundamental values and processes of health reform.

Home Care

Relevant to this study of home care within a regionalized health system is the question of how, if at all, primary health care principles underpin changes in home care. This question is important if one concurs with leading national and international bodies that PHC is the essence of reform in health systems (Canadian Nurses Association, 1988;

National Forum on Health, 1997; World Health Organization, 1978). If the answer to the questions was yes, we would expect to see for example, that there are opportunities for the public to participate in the decisions about the financing of basic personal care and homemaking services. And we would also expect to see the principle of accessibility extended beyond those most immediate medical services to also include access to living conditions that support health. Emerging research would indicate that these basic principles are not prevalent in emerging regional and provincial home care systems (Coyte, 2000; Hollander & Prince, 2002; Parent & Anderson, 2001). These issues are particularly salient as demands for care are rising within an era of fiscal and other changes to the delivery system.

A Critical Theory Approach

I propose three characteristics that distinguish a *critical* policy analysis. First, a critical analysis is directed toward exposing connections between policy context, process, and content (Pettigrew, 1987; 1998; Walt, 1996). Second, a critical policy analysis exposes the ideologies and values underlying policy issues and their proposed solutions. The critical analyst exposes the inclusiveness or exclusiveness of the policy debate. This includes an analysis of how issues are understood and framed by the various policy communities; those groups of actors from government, private sector, pressure groups, advocacy groups, media or academics who seek to influence the course of public policy (Pross, 1995 cited in Pal, 2001, p.242; Yanow, 2000). Third, a critical analysis exposes the reality of organizational processes, particularly as they relate to how policies are experienced by people in their daily environments. In matters of health and health care, it is important to understand how clients, families and front line health care providers experience the reality of policy problems and solutions. Here, I refer to the dynamics of organizational change as they relate to reform in health care (Hinings & Greenwood, 1988a; Greenwood & Hinings, 1996). According to these theorists:

> "Organizational arrangements are constituted in accordance with members' values and interests; but the act or organizational design is the privilege of *some,* not all organizational actors. To understand why this happens requires us to examine how certain groups are enabled by their position in an organization to effect change. ... As a starting point we

argue that there are two generic dynamics to the process of being heard and prevailing in the political struggle: power and capability" (Hinings et al, 1999, p.147-8).

Conceptual Model of Organizational Change

For this analysis of the dynamics of change in regional home care, I have adapted a conceptual model of understanding organizational change from the work of Greenwood & Hinings (1996) (Figure 4-1). The model directs the analysis of how external contexts (politics, economics, social, historical) interact with the intraorganizational dynamics. The relevance of these contexts to home care policy is discussed in Paper 1 of this thesis. The intraorganizational dynamics include those that both precipitate change (value commitments to ideas and orientations, interests) and enable change (power in systems, and organizational capability in areas of leadership, skill, knowledge and resources) (Greenwood & Hinings, 1996; Hinings et al, 1999). The precipitating dynamic of interests provide the pressure for change as different actors become dissatisfied with how their interests are addressed in the organization. Values comprise a dynamic that in essence is the commitment to a direction for the change. Power is a "force" by which change is influenced; organizational actors develop and use power to direct change (Pfeffer, 1981, p.7). The capability of an organization to implement change is an enabling dynamic of the change process and an important consideration in health systems. Two main elements of capability should be considered including: 1) the organization's ability to articulate a vision of the change and, 2) the necessary resources and leadership skills to "generate commitment and excitement over the prospect of change" (Hinings et al, 1999, p.149). An analysis of how these elements play out in the regional organization of home care is important to understanding why some changes are occurring, while others are not. This conceptual model directs the analysis of findings related to organizational change in regional home care in the next section of this paper.

[Insert Figure 4-1]

Method

The unit of analysis for this study is the sub-system of home care within a regional health system in the Canadian province of Alberta. The period of data collection was June, 2000 – June, 2001. This unit of analysis is appropriate given the shift to a

regionalized system of governance within health care over the past decade. This temporal perspective associated with regionalization is important in order to place in context some of the phenomena of interest; for instance patterns of resource allocation and changes in the organization of home care that have bearing on the current situation. According to policy theorists, the sub-system is an appropriate unit of analysis because it allows the researcher to identify actors, organizations and processes associated with policy and change within a regional organizational structure (Sabatier & Jenkins-Smith, 1993).

Data Sources

Sources of data included: interviews with decision-makers, health care providers and public advocates in home care; a review of government documents including program and regional reviews and policies, and current literature depicting political, economic, social, and historical contexts of home care policy. A total of 23 interviews were conducted (N=23) and over 30 regional, provincial and national documents were analyzed (Table 4-1).

Participants were selected on the basis of their experience with home care. This was determined through consultation with academic, public advocacy and organizational experts who had considerable experience with home care in the province of Alberta over time. This strategy is known as intensity sampling wherein "one selects participants who are experiential experts and who are authorities about a particular experience" (Denzin & Lincoln, 1998, p.23). The 23 participants were organizational leaders, program managers in the regional health authority and private contract agencies, health care providers and public advocates. Many participants were nurses or social workers working in various roles including program managers, case managers and organizational leaders. Participants were asked in interviews about their understanding and experience of what they believed to be the most prominent policy and organizational issues. Further, they were asked about the policy processes that were most influential in home care in the regional context including their beliefs about the issues that were and were not on policy agendas, the inclusiveness of decision-making and influences in the policy process.

Perspectives of decision-makers were also identified in policy documents, legislation and other sources that represented the provincial and regional policy agendas for home care; for example, the provincial government's policy proposals for long-term

care reform and the response of the region to these proposals (Alberta Health and Wellness Long Term Care Review, 1999a; 1999b; 1999c; 1999d; Capital Health Region, 2000a; 2000b). Sampling of publicly accessible documents pertaining to home care policy included national, provincial, and regional reviews, positions and policies. National documents were sampled to identify national perspectives on home care as they related to provincial and regional policy. Public advocacy groups such as the Canadian Association of Retired Persons (CARP, 2001) also produced reports that were regional, provincial and national in scope (Seniors Community Health Council, 2000, Parent & Anderson, 2001; Provincial Health Council of Alberta, 1998).

Dynamics of Organizational Change in Home Care

In this section, I draw on findings of the current study, and on the analyses presented in papers 1 and 2 of this thesis. The analysis of intraorganizational dynamics - interests, values, power and capability is relevant to our understanding the nature of change in the organization of regional home care and how change can be enabled in the direction of health care reform.

Precipitating Dynamics

Interests

For Hinings and Greenwood, "interests refer to the relationship between an individual or group and the distribution of organizational resources" (1988, p.54). The allocation of resources in an organization is largely a function of the values and power of those actors who can influence decision-making according to their interests. Resources in health care are reportedly scarce and study participants described critical challenges in fiscal and human resources. There are different sets of interests expressed by the actors involved with the delivery of home care. Thus these findings indicate how the interests of the different actors including the provincial government, organizational decision makers, health care providers, public advocates, physicians and private contractors vie for scarce resources in the delivery of home care.

Provincial government

First, the interests of the provincial government with respect to delivery of health care were most clearly identified in the province's Business plan as a shift to a business model and the dominance of values of efficiency, self-sufficiency and decreasing public

sector involvement in financing (Government of Alberta, 1994). The goals defined in the business plan marked the beginning of discourse around three main themes: efficiency in the delivery of health services; reallocation of monies to the community sector, increasing personal responsibility for health care and increasing user fees to subsidize the funding of public health programs. In one respect only, there is a contradiction between the goals set out in the plan and what had actually transpired five years later. The reality has been that the reallocation of resources intended for community services did not occur (Alberta Health and Wellness, 1999a; 1999b; Capital Health, 2000a; 2000b; Provincial Health Council, 1998).

Another set of interests with respect to the provincial government's provision of health care were those expressed in the work of the Long-term Advisory Committee on Long-Term Care (Alberta Health and Wellness, 1999a; 1999b; 1999c). The work of this policy advisory committee culminated in the Broda report, headed by MLA David Broda. The report has been regarded as a visionary document outlining progressive policy for the development of continuing care, including home care. The discourse contained in the report includes statements of values, most of which are consistent with those of primary health care and population health and wellness. Alberta Health had been charged with the implementation of the recommendations in collaboration with the health regions and is moving forward with clarifying the vision and its implementation. "Broda" was perceived by some participants at senior organizational levels as having a beginning influence on the RHAs with respect to the development of home care. However, it was recognized by those same participants that the most important recommendations of this committee could not be realized without resources, both within the ministry and within regions.

While there was and currently is an expectation that the provincial and federal governments should play a pivotal role in creating the vision for home care and for ensuring consistent standards and accessibility across regions and provinces, some participants expressed concern that this was not forthcoming to the extent needed. Within the Ministry of Alberta Health and Wellness, there was a vision for change in the delivery of home care that could have been characterized as transformational health reform. It was felt by some participants that the recommendations in the Broda report supported this vision for change in continuing care; however there were few resources allocated to

support the staff in their work to provide needed leadership and support to the regions.[8] As previously discussed, the vision and commitment to health reform was most evident as discourse within the policy documents associated with the Long-Term Care Review (Alberta Health and Wellness, 1999a; 1999b; 1999c; 2000).

Regional decision-makers

Organizational decision-makers supported the shift to community based services but were unable to realize the allocation of resources to community programs. They recognized that the change process had been characterized by downsizing, cutting positions and changes in home care leadership. However, they also identified promise in the directions that could result, and primarily supported the view of an integrated system of continuing care. Referred to as the "integrated access initiative" it was intended to put a positive spin on the change process, emphasizing the goals of flexible boundaries between services and programs, improved client access and referral, ultimately leading to the goals of efficiency and quality care. Leading health policy analysts in other national and international jurisdictions also identified the importance of the integration of service delivery, the goals and challenges of which are similar to those of regionalization itself (Forest et al, 1999).

In the move to an integrated system of continuing care, decision-makers also identified a concomitant separation of the functions of case management and the provision of care that was of concern to some staff at field and program levels. Some organizational decision-makers attributed the concerns of staff to their preference of a stronger focus on the *care* component of the home *care* program. Some participants felt that the separation of the two functions resulted in a favoring or valuing of case management over care. As well, some participants perceived that staff concerns could be attributed to how staff copes with change in their roles and function. One administrator described her perception of how health care providers responded to change: " ... often the front-line people are not too interested in it [change] at a high conceptual level, so we talk to them and they're bored and they don't want to hear it".

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[8] A reported 0.42% of a total $4.429.3M provincial health budget was allocated for system development in 1999. (Alberta Health and Wellness Health Resourcing Branch, 1999b, p.11)

The Region identified three priority issues related to the development of human resources within the organization including: 1) recruitment and retention of professional and support staff in Home Care, 2) a higher level of geriatric expertise and, 3) the threat of unionization of support / contracted agency staff (Capital Health, 2000b, p.23). The planning document containing reference to these issues was unclear regarding decision-makers' levels of awareness of the issues related to the threat of unionization or of strategies that they had identified to address these issues. In the same document, there was however reference to how home care professionals and support staff are encountering complex home environments that present: 1) safety risks and concerns for staff 2) spousal / elder abuse and 3) cultural / language issues (p.24). This indicates a level of awareness, if not a plan to address, the growing challenges and complexity faced by the providers of home care.

Regional program managers and providers of home care

Study participants who were at the middle and field levels of the organization expressed a wait and see skepticism with respect to the integrated access initiative. They also identified that adequate resource allocation was key to its success. In general, health care providers described their interests in health care reform as the securing of fiscal and human resources to provide quality home care to the populations of children, seniors and those with chronic and short-term illnesses (Paper 2).

Challenges and issues in human resources were the most compelling. The increased complexity and acuity of care had led to the need for increasing levels of expertise and knowledge at the level of care. This complexity was inherent in the new practice skills required to provide acute care in the home as well as complexity in the relationships between patients, families and different levels of health care providers within a constrained resource environment. As well, there was a need to access and use knowledge and evidence to support complex decision-making and the development of standards of care in areas of infection control, wound care, diabetes and other areas involving new diseases and treatments. Participants described a loss of disciplinary focus and support associated with restructuring and regionalization and this was seen to impact the level of professional practice expertise and support.

At the same time, participants described the reality of shortages of both professional and non-professional care providers. Shortages resulted in the trend to delegate increasingly complex levels of care to those least prepared to provide it (Paper 2). There was growing concern for the support and training of patient care aides (PCAs) as well as for their inadequate compensation. One program manager described the expectations of recently hired PCAs to provide care to people who were dying at home without orientation or preparation for the challenges of this experience. Ongoing support and education was identified as a need for all levels of care providers in home care, while the ability of the organizations to provide this was challenged by a lack of both fiscal and human resources.

Public advocates

Similar to health care providers, the interests of public advocates were to sustain a level and quality of home care while responding to the increasing demands. In general, public advocacy groups supported the interests and policies of "Broda" with some reservations related to the equitable provision of services that were not clearly within the narrow definition of health services (Alberta Association on Gerontology, 2000; Seniors Community Health Council, 2000). In particular they expressed a growing concern for those most vulnerable seniors who lacked family, social support and income to access needed supports and services not covered by Alberta Health. The interests of the most vulnerable seniors requiring services were dependent on the advocacy groups to represent their interests.

Physicians

Physicians were not directly involved in the administration or delivery of home care on a regular basis. As in other parts of the health care system, they do function as gatekeepers to the system, although not to the extent of the exclusive role that they play in hospital admissions. Their lack of involvement and therefore interest in home care was seen by some participants to inhibit their motivation to advocate on behalf of the interests of home care, in contrast to physician advocacy for resources and issues in the institutional sector.

Private contractors

Finally, there was reference to the growing interests of the private, for-profit sector in home care. These interests were represented by agencies who contracted the services of PCAs to the RHA, and by the growing entrepreneurial interests in seniors' housing and supportive living. With respect to the first set of interests, participants described the human resource challenges that private contractors faced in hiring and retaining workers. This was largely attributed to their inability to provide competitive salary and working conditions relative to other service sectors including food services. These agencies were also challenged to ensure the quality of their services to clients through the hiring of skilled professional staff to supervise, train and support the PCAs. Participants described how problems with securing adequate labour contracts for PCAs needed inter-ministerial solutions between the ministries of Labour and Health and Wellness. At the time of the study, there was some collaboration underway between the two ministries with respect to these pressing human resource issues.

Participants also identified the need for inter-ministerial solutions to the growing presence of private contractors in seniors' housing and support services. In particular, the private sector was proceeding with the development of "higher end" housing and care projects for seniors. While perceived as positive in meeting the need for more client choices in housing, there were also several emerging problems. These problems related primarily to the private contractors' failure to consult the RHA on standards for new housing developments. There were examples of how this lack of consultation left some seniors without adequate bathroom facilities. This in turn resulted in the need for home care involvement to address the issue on a case-by-case basis, placing a further drain on already strained resources. Similarly, it was reported that some contractors promised services that were not delivered, again resulting in increased demands for public home care resources. The interests of the private contractors were respected by the RHA and negotiations were reported to be underway to develop partnerships that would acknowledge the respective interests of public and private providers of seniors' housing, home care and support services.

Values

A key element in the analysis of organizational change is the identification of patterns of value commitments to one or more policy and organizational directions in the

delivery of home care services. In home care, we see the emergence of patterns of value commitments or "interpretive schemes" that embody different and competitive archetypes of service delivery organizations or systems. In Paper 2, I discussed how the values of equity, efficiency, choice, universality, and responsibility, and the values of PHC pattern within the medical and PHC models of care. As well, in home care there are values that pattern with a social model of care, a model that had been gaining ground prior to regionalization and hospital downsizing. Aligned with the social model is a broad definition of health and health care, encompassing a range of client centered care that is health promoting, preventive, rehabilitative and curative. The social model contrasts with values that pattern within a medical model and is more aligned with the values of primary health care and health promotion. Although PHC has not been realized as an organizational archetype in regional or provincial health care delivery, the discourse and values of health care reform proposals do refer directly to PHC in the case of the provincial delivery of long-term care (Alberta Health and Wellness, 1999a; 1999b; 2000). Policy documents of the RHA do refer to elements of PHC as a preferred delivery model for some components of the system, however the discourse is not as pervasive in its relation to home or continuing care delivery at the regional level.

The medical model on the other hand is predicated on a narrow definition of health care, one in which the health system responds almost exclusively to the most immediate treatment needs. It is less inclined toward a broader focus on health promotion, prevention, family health and the quality of life over time. However, it is important to note that the patterns of values within each of the models are not entirely dichotomous. Social and PHC models also include the values of efficient and cost effective care delivery and medical models also include the value of quality care. Rather, it is as Grinspun (2000) points out the primacy and emphasis on values within each of the competitive models that is different. The contrasts between medical and primary health care models are presented in Paper 2 of this thesis. The ensuing discussion of values relates how the organizational groups are committed to the interpretive schemes underpinning medical, social or PHC organizational archetypes.

The provincial government

The values underpinning the policy process of the Alberta government have been previously established as those aligned with a neoliberal ideology, and the values of efficiency and market competitiveness in the delivery of public services. As previously discussed, this is in contrast to the values of social or PHC models. However, the policy discourse of population health and health promotion, as well as PHC as a model for reform was also evident in the Alberta government's report on strategic directions arising from its review of long-term care (Alberta Health and Wellness, 1999a; 1999b; 199c; 1999d; 2000).

Regional decision-makers

The RHA did not make explicit reference to PHC as the vision for continuing care in the region. However, the RHA's statement of vision, mission and values does refer to the promotion of health and well being and accessible quality services (Capital Health, 2000a; 2000b). As well there is reference to partnerships with other sectors such as education and housing. Thus, it appeared that the pattern of values commitment with respect to home care was aligned with a social model of home care. However, at the time of this study, the organization was changing in the direction of a medical model of care. The value of efficiency in the delivery of acute institutional care was increasingly important to decision-makers in the face of increased demands and pressures in that sector; thus the pattern of commitment was in this direction.

Public advocates

Public advocates and organizational actors who are closest to the delivery of care are more committed to a social model of care. They viewed the change in the direction of a medical model of care as regressive when compared with the pre-regionalization context of a home care program that had been evolving to meet social needs as well as the needs for professional health care and medical treatment.

Physicians

Some participants perceived that a majority of physicians were committed to the values that patterned with a medical model of home care. Although physicians perceived the value of a more comprehensive array of services as in a social model of care, they would support a more limited scope of entitlement to public services in the face of scarce resources. There was the view that for most physicians, access to medical and acute

institutional care would be the priority and therefore access to home care that facilitated the earlier discharge of patients from hospitals would take priority.

Private contractors

Private contractors who were engaged in entrepreneurial initiatives in the areas of housing and the provision of homemaking and other social services may be most committed to a medical model in the public health care system. The medical model of home care in the public system would open the opportunities for private contractors to develop a market for the provision of those services that fell outside the scope of treatment or health services provided by professionals.

It was a somewhat different situation for those private contractors who hired PCAs and contracted their services to the RHA. These providers were in support of a social model of care as they recognized the significant contribution of health care providers in their employ. They were, at the time of this study attempting to garner the support of the RHA for the valuing of the contribution of PCAs to a social model of care.

Summary

In this analysis of regional home care, it appeared likely that there was a level of commitment, at least in some of the policy discourse, to a model of health care reform based on PHC values. As well, the interests and values of some actors were supportive of what had been an organizational archetype that patterned with a more comprehensive social model of care. However, the pattern of values commitment of key organizational actors such as provincial and regional decision-makers seemed to be most aligned with a medical model of care. Therefore, it may be said that the commitment of actors in regional home care was competitive: between a medical model of care favored by some groups and a social model of care favored by others.

Enabling Dynamics

Power

Power is the ultimate determinant of which values or "interpretive scheme", and whose interests will prevail in the organization of home care services (Hinings et al, 1999, p.148). The different actors or policy communities in regional home care hold different levels of power to influence the directions of the policy and organizational change processes according to medical, social or primary health care models.

Descriptions of the policy process provided by participants refer to the themes of influence, politics and decision-making in a regional context. In general, power was seen to have been concentrated in the government, the executive of the health region, and with physicians. This concentration was seen to be enabling organizational change in the direction of the medical model and the values underpinning its archetype. The potential for power was also recognized in the coalitions that were developing. Providers of home care were seen to have less influence at the macro level of decision-making, however they had maintained some jurisdiction over field level decisions. I will provide a summary of how the findings of this study related to the dynamic of power held by the various organizational actors: the provincial government, regional decision-makers, regional program managers and health care providers, physicians, public advocates and private contractors.

Provincial government

Power within the organization of home care was seen increasingly as tied to the political context, and the ideology of the provincial government with respect to the delivery of health care and other public services. Study participants referred to the public debate over Bill 11 *(The Health Care Protection Bill).* the enabling legislation for private hospitals. It was, however, recognized that the government may be reticent to introduce further user fees and privatization of home care services during the period of public debate. However, privatization of public services was seen to be consistent with the ideology of the government, and therefore inevitable.

Participants recognized the political context of health care as increasingly pivotal to the concentration of power and the direction of change. However, they also recognized that governments were sensitive to the electorate with respect to its perception of how the government was managing health care problems and issues. For instance, field level participants referred to the growing politicization of decision-making seen in the power of clients to contact MLAs to influence case management decisions. It may be interpreted from the interview data that it is in this area of political sensitivity to public opinion over health care that the public may have some influence on decisions regarding the allocation of home care resources. However, the pressures within the acute care system were viewed as dominating the interests of the government and they in turn exercised their

power to relieve tensions in that part of the system. It was the surgical waiting lists and emergency room waiting times that commanded most of the media attention and were most in the public eye.

Regional decision-makers

Some participants perceived a concentration of power at the executive level within the regional system of health care delivery. Participants referred to a decreased awareness and consideration of the practice level reality in organizational decision-making. Program managers and organizational leaders in home and continuing care referred to their roles as advocates, having to continually present the challenges of supply and demand to policy-makers. Nurses who were clinical practice experts and in consultant roles were not part of the management structure during the period of data collection for this study. Some organizational decision makers referred to the organizational structure as under revision and that the relationship between practice and management was under review. They also described the importance of communicating the RHA's valuing of care to the front line health care providers. Turnover in the position of the Director of Home Care within the region was quite possibly an indication of a lack of power in the position. This may be interpreted as how it had become increasingly difficult for a senior program manager of home care programs to fulfill a vision of home care that was consistent with both the values of a social model of care and a corporate regional model.

Regional Health Authorities do hold some decision-making power and could therefore reallocate resources to support the movement to a model of care based on primary health care principles. Participants who had knowledge of the workings of the RHA reported that the RHA had a limited focus on the issues in home care due to the "sexier", more commanding challenges in the delivery of acute, surgical and institutional care. There was some indication that those home care issues that did garner the policy-makers' attention were those that related to the capacity of the hospitals in the region to discharge and therefore admit patients in a timely fashion.

Regional program managers and health care providers

As a result of a hierarchical concentration of power in the RHA, health care providers are generally seen as lacking the power to influence organizational directions

and resource allocations. They do however have the power to support or not support policy agendas at the level of implementation. In another paper, I have discussed how providers may interpret policy in order to comply with values of equity, and quality care, and how this in turn may result in unintended policy consequences (Paper 2). In this way, field level health care providers held some power in field level decision-making.

Physicians

Physicians were perceived to have considerable power to influence decision-makers in both the government and the health region. In the words of one participant "It is the physicians who can cause a CEO to lose their job so they are going to pay attention to their priorities". Although physicians and other health care providers were not appointed to the RHA boards, physicians were appointed as board "participants". At the time of this study, there were four prominent physicians who had been invited to sit as non-voting members of the board (Capital Health, 2000a). Other health care provider groups were not represented among the eleven appointed "community and medical leaders" who were invited to sit as board participants. As previously discussed, the interests of physicians were seen by study participants as those emphasizing increased resource allocation in the acute and institutional areas of emergency care and surgical waiting lists. Thus, it was likely that the power of physicians within the regional organization also influenced the supremacy of the medical model of care.

Public advocates

Public advocacy groups promote increased resources for home care and support the values underpinning a social model. Participants representing advocacy groups identified the competitive struggle with the medical model and worked to articulate the values and tensions to policy-makers. At the time of data collection, there was a beginning coalition of groups who were concerned about seniors' access to health care and seniors' health with respect to housing, equity and other issues. It was recognized that where public advocacy groups had in the past worked independently on issues, there was now a need to coalesce and collaborate with respect to advocacy initiatives on behalf of seniors. One participant described the increasing influence of lobby groups and coalitions:

> "...so when you get down to the policy issues, it takes a great deal of will politically to stay the course, when its against public tide or against groups who have a vested interest in an alternative, it's hard to maintain that tide, you know, that flow to say no, this is where we're going ... So often times what I've seen in the last eight or nine years is that it has been influential people who have a background in home care, some experience in home care, and it's been lobby groups, or for example, The Canadian Nurses Association, or the Alberta Nurses Association, or seniors' groups or people with disabilities for example, who have put the heat on, so to speak"

Private contractors

A coalition of private agencies who contracted the services of the PCAs was also forming. Managers in these agencies had conducted focus group interviews with PCAs to determine their perspectives and concerns about their work. As well, they were planning to also work together to collate and present these findings to an inter-ministerial committee on labour and health that had been struck to examine these issues. In this way, they were working as a united front to influence action on what was perceived as inadequate compensation and other supports for PCAs in the regional system.

Organizational Capability in Home Care

This preceding discussion has implications for the analysis of values, vision and leadership in the organization, for critical issues related to power and advocacy, and for resources allocated toward the provision of quality home care. According to Greenwood and Hinings (1996), the capability of organizations to enact change in home care, or their capacity for action depends most fundamentally on "having a sufficient *understanding* of the new conceptual destination, its having the skills and competencies required to function in that new destination, *and* its having the ability to manage to get to that destination (p.1040)". Organizational capability in home care thus encompasses this ability to articulate a vision of care as well the ability to secure the resources needed to manage the change. These resources include fiscal, human, knowledge and information technology. Thus, organizational capability in the realm of home care encompasses the elements of vision, leadership and resources.

Vision and leadership

The need to both clarify and articulate the philosophical perspective on care in home care is likely the most crucial contribution of leaders in the current system. I have described how the values of a primary health care model do underpin some of the discourse in regional and provincial policy documents. However, the policies as implemented did not support the re-focusing of home care to a primary health care model, nor do they result in the reallocation of resources to community care.

According to the conceptual model of organizational change, leaders must grapple with the notion of competitive interpretive schemes and how this relates to the vision, mission and values of the organization and the nature or content of the proposed change. The competitive interpretive schemes associated with primary health care and medical models may be further dichotomized within a regionalized health system when regional boards must attend to priority issues in the delivery of acute, institutionally based care. In their recently released landmark national study of home care, Hollander and Prince (2002) describe a "key conceptual dichotomy (p.7)" as pervasive in continuing care and call for a "best practices system that enshrines, in policy, a vision statement which affirms decision-makers' beliefs in a community oriented, integrated service delivery system (p. 39)".

"Leaders play a key role in developing, maintaining and altering the interpretive scheme of an organization (Hinings & Greenwood, 1988, p.60)". Thus, as organizational leaders, the Chief Executive Officer (CEO) and the executive team have the potential to influence the model and values of home care delivery. There were some differences in how participants perceived the power of executive leaders to influence the policy agenda in home care. Some participants expressed that the current executive team had insight into home care issues and would advocate for increased resources, while others reported that home care issues were not well represented in regional policy decisions of resource allocation and program directions.

There is a need for different types of leadership including leaders who have disciplinary expertise, for example knowledge and skill in home care nursing, within a regional system of home care. Instead, there seemed to be a growing separation between practice or disciplinary expertise, and the management and leadership functions within the regional organization, leading to an under-representation of practice issues at senior

organizational levels. Overall, it may be that as social and PHC models of care are undervalued, so is the very expertise that is needed to provide quality care. Business and efficiency models may have a greater propensity toward downward delegation of care and responsibility, perhaps because decision-makers may lack evidence or may not value information about how the growing complexity and volume of care needs in home care relates to crucial elements of capability: vision, leadership, fiscal resources and human resources including knowledge and expertise. As well, decision-makers who are schooled primarily in business and efficiency models may lack knowledge and vision for the implementation of PHC models.

Resources

Many participants identified the prominent role of information technology and knowledge in the delivery of home care. Information technology was seen as essential to the acquisition of adequate resources for the delivery of home care. Participants also described how the development of information systems in home care had not kept pace with developments in the institutional sector of health care, referring to home care as the "poor country cousin" when compared to the institutions. Further, participants described an overall lack of infrastructure in the areas of technology, information and knowledge and described related challenges in securing adequate funding when they lacked the data to support increased resource needs. At the same time, study participants welcomed the promise of technology in the system. For instance, they acknowledged the opportunity to advance access to various types of expertise through tele-medicine. Overall, technology represented an important aspect of organizational capability to improve access to information and knowledge for the delivery of quality health care.

Summary

Referring back to Figure 4-1, there are two main points to be summarized from this analysis of the dynamics of organizational change in regional home care. First, one may conclude from this analysis that there was both interest satisfaction and dissatisfaction with the organizational archetype based on the medical model, among the different organizational actors. As well, it appeared that the medical model had achieved ascendancy in terms of the patterns of resource allocation that had persisted with regionalization. Differences in values among the organizational actors may be interpreted

as a competitive pattern of commitment between a medical model and a social model of care (Hinings & Greenwood, 1988a). Change in the direction of a PHC model in regional home care would have represented transformational change within the organizations and it appeared that a minority of actors fully articulated their support and understanding of the model in its entirety, although there was some support for PHC values in provincial policy documents.

A second point may be made with respect to the concentration of power within the organization. There appeared to be a concentration of power within certain actors including executive decision-makers, politicians and physicians. The values commitments of these same actors were most aligned with the medical model of care and this contributed to the patterns of resource allocations that supported its ascendancy over a social or PHC model within regional home care. This competitive pattern of values commitment influences organizational capability to implement change as the vision for change was somewhat ambiguous and conflicted. There was capability in the form of the vision and expertise of the organizational leaders in regional home care, particularly with respect to the social model of care. However, there also seemed to be a lack of resources to enact transformational change. Deficiency in the form of information technology appeared to be a significant factor in organizational capability.

Interaction with Contexts of Change

This discussion so far has focused on the intra-organizational dynamics of change. However, as depicted in Figure 4-1, these interact in important ways with political, economic, social, and historical contexts. We can see from the model of organizational change that the interaction of contexts and intraorganizational dynamics are key to understanding the nature and direction of change in regional home care. In short, pressures for change originate both in the contexts, and when interests are not satisfied within existing organizational forms (Hinings et al, 1999).

Further to this analysis, it is apparent that the entire power structure of community health care vis-à-vis institutional care is weaker and therefore lacking in influence, resources and development, a point reiterated by Denis et al (1999). This lack of power relates not only to the political ideology of neoliberalism, but also to historical context as one where institutional, medically oriented health care has been valued in society. This

represents a status quo commitment to the medical model that has been valued in health care generally and one that is currently supported within political and economic contexts. Privatization, a hallmark of neoliberal ideology, has implications for women who comprise the majority of home care recipients and providers (Armstrong et al, 2002). Thus, the interaction of political ideology and social context also relates to the organizational dynamics where interests of health care providers such as PCAs and others who are less powerful, including patients and families, are increasingly marginalized (Bashevkin, 2002; Murphy, 1996).

With respect to the economic context, it has been suggested that the allocation of resources to support the implementation of progressive public policy, including health policy, is influenced heavily by the provincial economic picture (Cooper & Kanji, 2000). It may be that in times of surplus, a beginning implementation of the recommendations of the Provincial Long Term Advisory Committee (Alberta Health and Wellness, 1999c) were supported fiscally, while an expectation of a downturn in oil revenues or other economic change would stall any initiatives for change in home care or long-term care policy. This point warrants further analysis of the relationship between the finances of the province, debt reduction, and the type of change occurring in the health sector.

A final point on the political context relates to the present day sensitivities of governments to the public critique of health care delivery. Health care is the Achilles heel of governments. Therefore, they respond fiscally to current pressures in health care most clearly depicted in the media – the emergency room, surgical waiting lists and beds. The perspective that home care is first and foremost an individual and family responsibility detracts from the government's sense of responsibility in this sector of health care. They are less likely to respond to the evidence of need. This sensitivity to the politics of health care is transmitted to the regional level as the health authority is charged with presenting a positive image of health care delivery to the media and the public, and with damage control. This may result in decreased attention to the less visible needs of people in their homes and in decreased motivations to engage in discussions and processes of community involvement with respect to needs and issues that may surface and cause political strife (Boutilier et al, 2001; Taft, 1997). A more serious consequence of not responding to the interests of those on the front line of home care delivery is the

demoralization of health care providers in their mission to provide quality care (Gallagher et al, 2002). This is a serious consideration because of the evidence that health systems face a most imminent health human resource shortage in most professional and non-professional fields (Health Canada, 2002).

The Utility of the Conceptual Model

In summary, the conceptual model of organizational change (Figure 4-1) has utility for understanding organizational change in regional home care. In particular, the interaction between the organizational dynamics and the external contexts seem particularly important to understand. It is this interaction that influences the capability of the organization to change in a particular direction. Some aspects of this interaction seem particularly significant to our understanding of home care. These include the dynamics of power relations among organizational actors within the political context of home care. As well, it would appear that the non-linearity of interactions among the dynamics is significant in understanding how change in the direction of one organizational archetype or another may occur. Finally, these findings suggest that knowledge in the form of information technology is important to the understanding of the dynamic of capability within home care. I will comment briefly on each of these points.

First, the interaction between the power of organizational actors and the political context is particularly important to understand given the pervasive influence of political ideology on health care systems. For instance, if we understand that change to a primary health care model represents a radical, transformational change in home care, it follows that leaders must have the requisite vision, values, knowledge and skill. The findings of this study would indicate that the concentration of power in regional home care was among actors who are least likely to support the values underpinning a PHC model. These same values of powerful actors are most congruent with the dominant ideology of neoliberalism and it is most likely that they will attain and maintain power in the organization. This begs the question as to how leaders with a vision of PHC can attain power and influence change. I therefore contend that this interaction is a particularly significant feature of critical theory and the conceptual model of organizational change. It has implications for further research and possible refinement of the model as well as for the design of strategies for influencing change.

On the second point related to the utility of the conceptual model, the theorists acknowledge the non-linearity of organizational change that may be considered transformational or radical (Greenwood & Hinings,1996), such as how change to a PHC model of home care would be characterized. This non-linearity requires that we understand that "different combinations of interactions between precipitating and enabling dynamics are possible (Greenwood & Hinings, 1996, p.1047)". Referring to Figure 4-1, it appears that there is no direct link between interest dissatisfaction and power, therefore establishing the link between values and power as essential to influencing change. However, in this analysis, it appeared that the more powerful were less likely to hold values fundamental to PHC. Therefore, it is important to understand how dynamics of interests, values and power may interact or *oscillate* such that transformational change may be possible in contexts where dominant values are competitive with those patterning with the preferred change. Once again, the interaction of the enabling dynamic of power with the other intraorganizational dynamics appears to be quite important and is again supportive of the critical theory approach wherein power relations are central.

Finally, several participants in this study commented on how information technology in home care had not kept pace with the institutional sector, and how it was increasingly important to have information about supply and demand in order to secure needed resources for the delivery of home care. Within the model of organizational change, information technology is conceptualized as a form of knowledge and an important element of organizational capability. The interaction between information and power is also significant to this model because of how access to information may influence organizational interests and decision making in resource allocation. It follows that this interaction may also prove to be an increasingly important aspect of a critical theory approach to conceptualizing the dynamic of organizational change in the 21st century.

Conclusions and Recommendations

I conclude this discussion with recommendations for how to consider and influence change in regional home care. These recommendations relate to power and influence; leadership, vision and care; and further research into organizational change.

Finally, I comment on the utility of a critical theory approach to policy and organizational analyses.

Recommendation 1: Power and Influence

This first recommendation relates to a central purpose of a critical theory approach to policy analysis -- that of identifying and acting to counter the power deficits that are evident in home care and identifying strategies for influencing change. To do this, we must carefully consider the question: Whose voices and interests are recognized when decision-makers implement models of care that are aligned with the patterns of values such as those contrasted in this study? Further to this question, I identify three strategies that may serve to realign power with the values and interests that are compatible with a primary health care model: a) raising the awareness and therefore the power of the public to engage in debate over the policy issues in home care and how their interests are satisfied or not by decisions (power) that influence change in the direction of one model or another, b) increasing support for a PHC model of care among organizational actors that do hold power, and c) supporting the enactment of legislation and regulations that support the development of regional home care organizations that embody PHC principles.

First, it is crucial to reaffirm that the PHC principle of public participation is particularly important if the interests of providers, citizens, families and public advocates are to be realized in home care. One example of a policy area where the public must be heard is rooted in the private, for profit, provision of home care services and the inequities that result. The public must be first made aware of the issues and of the broader social implications. The question for leaders is: How can meaningful dialogue be encouraged about the more hidden effects of these directions? As we have seen in the findings of this study, the work of coalitions may be particularly significant to the support of a home care system that reflects the principles of primary health care. The power of coalitions may lie in their potential to engage the public in dialogue and participation in policy and organizational decision-making. As well, it is important for the public to have the power to elect those members of the RHAs whose interests and values with respect to models of care are in line with the public interest. At the time of this study, the issue of elected versus appointed board members was a source of political debate.

A second influencing strategy is to enlist the support of those policy actors who have power. This means that the interests of powerful actors must be realigned to support the allocation of resources in support of comprehensive care, public participation and the valuing of human resources. This may involve exposing politicians, policy-makers and physicians to narratives and other forms of evidence that illuminate the experiences of others that are separate from their own, thereby increasing their understanding of how one model of care or another impacts the lives of people both working in the system and receiving care (Reay, 2000). As organizational and policy theorists indicate, it is unlikely that the values of decision-makers will shift in response to change strategies (Greenwood & Hinings, 1996; Sabatier & Jenkins-Smith, 1993). However, some forms of evidence may influence decision makers to become more dissatisfied with how the system is functioning to meet the needs of people. As the conceptual model for understanding change indicates, this interest dissatisfaction may influence some change in how decision-makers allocate resources to support the model of care representing the status quo, or alternatively a shift to a PHC model.

Regional and provincial decision-makers are influenced by contextual factors in their ability to initiate change in the direction of PHC models of care. An important strategy is to enact federal legislation that will ensure that future development of provincial and regional continuing care systems are consistent with the principles of the Canada Health Act and those of PHC. Recognizing the urgency of issues related to home care, nurses at the Biennial Meeting of the Canadian Nurses Association in June 2002, passed a motion to lobby for the enactment of parallel legislation in the form of a federal Continuing Care Act. This legislation is key and if enacted, must be supported by a significant and stable infusion of funds to allow provincial systems to evolve according to those principles that will ensure equity and quality of care in the development of home care systems. As well, standards and targeted funds for home care within regional systems are needed to deter the growing diversity of home care across regions and the threat to universality as a Canadian social value with respect to health care. This is in keeping with the most recent recommendation of the Commission on the Future of Health Care in Canada (2002) with respect to home care. The recommendations of the Commission mark the beginning of what appears likely to become a "national platform" for home care in Canada (p.171). By

all intentions, this does appear to be a positive move, although legislative support is recommended for only the coverage of "post-acute home care services including medical management and rehabilitation services (p.171)". This recommendation seems to be lacking the teeth that will be needed to move forward with a National Home Care program that will address the comprehensive health and social needs of people who are elderly, chronically ill, or disabled (Rachlis, 2003).

Recommendation #2: Leadership, Vision and Care

A strong and affirmative vision of a regional home care system that embodies the principles of a PHC model must be championed by leaders in the region. It is vital that a vision of care, and an ability to transmit the vision be such that the interests of organizational actors become aligned with the values underpinning a primary health care model (Greenwood & Hinings, 1996). It is more likely that program and practice leaders within the regional organization will be most knowledgeable and skilled in the implementation of such a model. Therefore the vision for the change is also more likely to come from within the organization than from politicians or board members. In particular, this vision must encompass a broad understanding of health and its determinants as well as the commitment to inclusiveness in individual and community participation in all levels of decision-making. Mohrman and colleagues (1989) call for "large-scale organizational change that involves learning and understanding", and therefore a change process that is in essence, one of "shared inquiry" (p.294).

This understanding of the need for different change processes has implications for those leaders who seek to influence policies and their implementation that reflect the values of health reform. These leaders and others must engage in dialogue and change tactics beyond those required to implement or command structural change and attend also to the relational, social and learning elements of the organization. Further, Quy (2001) suggests that the nature of these change processes or interventions should vary with the temporal context or the phase of the reform process.

A transformational leader is needed to establish and articulate a vision of reform and change in home care. However, research findings from the study of change of district health units in Britain also point to the need for leadership that is more "subtle and pluralistic" (Pettigrew et al, 1992, p.279). In the case of home care, leadership is beyond

what more than one transformational leader can provide and instead encompasses the skills of team building so that a small group of leaders can respond to health system change as a "long-term process that is based on a commitment to planning and attention to the resolution of a pattern of interwoven issues (Pettigrew et al, 1992, p.279)". In the process of conducting the current study for example, it was apparent that strengths of the current system of home care are the expertise, insight and experience of the current group of managers at all levels of the system. These strengths are needed and should be nurtured as a significant element of organizational capability for enacting transformational change.

Recommendation #3: Research

Ongoing research is needed into the nature of organizational change and how it corresponds to both the external contexts of change and the interaction with the intraorganizational dynamics of change. The model of organizational change used in this analysis provides significant direction for ongoing research. As previously indicated, the critical theory approach is based on the centrality of power in understanding and influencing organizational change. This leads to key areas of further inquiry and theory development. The question is one of how do we influence powerful actors to support change in directions that are not supported by their values? Researchers may be guided by the work of Sabatier & Jenkins Smith (1999) and Lomas (1990) which indicates that while core values are impenetrable, influence may instead be most successful at the levels of actors' beliefs and interests. This research may have some timely implications for governance models that imply a *hands off approach* to policy making in health care and therefore distance decision-makers from the *business* of health care delivery. We must understand, for instance, if this *hands off approach* influences a disconnect between the beliefs and interests of decision-makers, and those of people who are recipients of or in need of home care.

Researchers must work to understand the different levels of potential influence and to identify the strategies that are most successful. In home care, we must understand how for instance, actors' beliefs about home care, can be influenced by stories and or numbers that most clearly illustrate how peoples' needs are met or not met. And finally, the question of how leaders with vision, knowledge and skill in developing primary

health care organizational models attain and use power in regional home care, is an important area for future research into organizational change. Most significant, it is important to develop the science of *influencing change* in home care and other sectors of health care; the role of interests, values, power and capabilities can be studied in various contexts with respect to the development of a primary health care model as the preferred outcome.

Finally, this study was conducted within the sub-system of home care within one provincial health region. There is a need for further research to explore how this analysis relates to the experiences of other health regions in Canada and in other temporal contexts. This is important given the dramatic and rapid shifts in the political, economic, social and economic contexts of health systems and society, making it difficult to generalize across studies until the science of organizational change in health and health care is further developed.

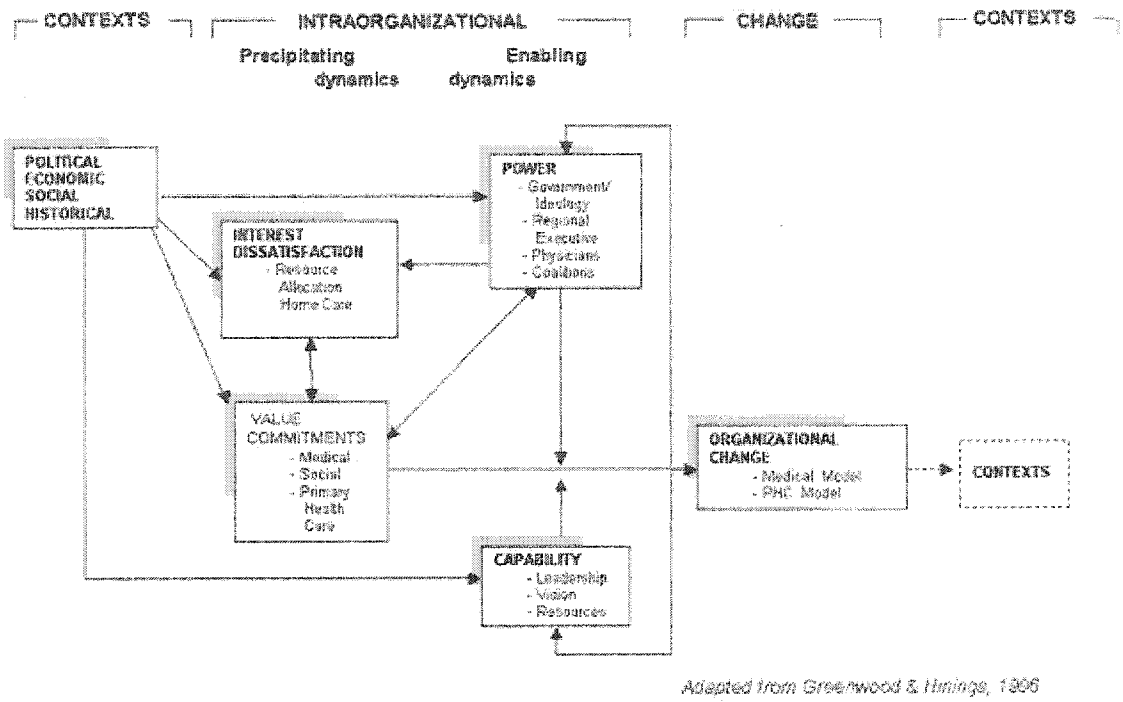
Conclusion

This analysis of organizational change in regional home care has been undertaken in the spirit of critical theory. Such an analysis is appropriate because it is organizations that develop and implement policy, such as that implicated by health reform discourse. Policy and organizational change in the direction of primary health care represents a process of transformational change and it must be studied as such. Further, transformational change, in essence, most fundamentally represents a shift in power relations and it is this dynamic that is key to understanding how change is enabled. Critical theory, as a research tradition predisposes an analytical approach that exposes exclusivity in power relations and critiques the status quo. By exposing these dynamics, a critical theory approach can contribute to our understanding of how a process of transformational change in home care can occur.

Table 4-1: Selected Policy Documents

Source / Affiliation	Jurisdiction		
	Regional	Provincial	National
Public	• Seniors' Community Health Council (1999): Response to the Report of the Long Term Care Review Committee. • The Society for the Retired and Semi-Retired: Directory of Senior Services (1999).	• Provincial Health Council of Alberta: 1998 Annual Report Card to the Legislature. • Government of Alberta Health Summit (1999) Final Report.	• National Advisory Council on Aging. (2000). Position on Home Care. • CARP's Report Card on Home Care 2001.
Provider	• Regional Nursing Best Practices Committee: (Terms of reference and minutes of meetings) • "Dylan's Story": a narrative of policy impact on an infant and family.	• Alberta Association on Gerontology (1999) Response to the Report of the Long Term Care Review Committee. • Alberta Association of Registered Nurses (1998). Guidelines on the Delegation and Supervision of Client Care.	• Canadian Nurses Association: (1998) National Home and Community Care for Canadians Development • Canadian Health Services Research Foundation (1999): Issues in the Governance of Integrated Health Systems.
Decision-Maker	• Capital Health Authority Business Plans: 1997/98 – 1999/2000; 2000 /01 – 2002/03. • Capital Health Home Care / Regional Continuing Care Structure (2000) Regulations and Data. • Capital Health Region (2000) How Healthy Are We?: A report from the Medical Officer of Health. • Capital Health Continuing Care (2000) 10 Year Strategic Plan: Response to Alberta Health & Wellness.	• Alberta Health Annual Reports: 1989 – 1999 • Alberta Health (1992). Home care in Alberta: New Directions in Community Support. • Government of Alberta Business Plan (1994) • Alberta Health and Wellness (1999) Long Term Care Review: Final Report of the Policy Advisory Committee • Alberta Health and Wellness. (1999). Questionnaire on the Final Report of the Long Term Care Policy Advisory Committee Final Report. • Alberta Health and Wellness. (2000). Strategic Directions and Future Actions: Healthy Aging and Continuing Care in Alberta. • Alberta Health and Wellness (2000). Continuing Care Strategic Service Plan Phase 1 Expectations.	• National Forum on Health (1997). Final Report. • Health Canada (July 1999): Home Care Development, Provincial and Territorial Home Care Programs & Systems

Figure 4.1: Model for Understanding Organizational Change in Regional Home Care



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Chapter Five
Conclusion

The purpose of this study was to gain insight into the interaction of the elements of context, process, and content of home care policy in one provincial health region. Moreover, I intended that the study would contribute to our understanding of a critical theory approach to health policy analysis. Underpinning this study was the ideological perspective that the values and principles of primary health care (PHC) are the essence of what constitutes progressive public policy in health reform (CNA, 1988; Epp, 1986; National Forum on Health, 1997; Whyte & Stone, 2000; WHO, 1978; WHO, 2001).

The critical theory approach to the analysis of policy in home care has been adapted for this study from theoretical perspectives within the fields of the social sciences, nursing, political science, policy studies and organizational analysis. This chapter of the thesis includes first, a summary of each of the three papers that constitute this thesis, paying attention to how they are related to one another. I then draw some conclusions about the development of critical theory as a methodological approach to policy analysis. This is followed by a discussion of implications for home care policy and finally, I draw some conclusions about the implications of this study for the discipline and professional practice of nursing.

Paper 1

In Paper 1, I presented the underpinnings of the methodology, linking critical theory to policy analysis. I began by discussing shifts in policy studies that have been described as post-positivist (Fischer, 1998; Pal, 2001), interpretive (Yanow, 2000), critical (Fischer, 1998; Forester, 1993) and postmodern (Stone, 1997; Pal, 2001). In Paper 1, I drew on the works of policy and organizational theorists to adapt a framework of a critical theory approach to policy analysis in which the analysis is focused on the interaction of the elements of policy context, process, and content (Collins, Green & Hunter, 1999; Pettigrew, 1987; Walt & Gilson, 1994). Paper 1 is foundational to the exploration of policy process in Paper 2 and the dynamics of organizational change in Paper 3.

In Paper 1, I applied the critical theory approach to policy analysis to a regional home care program. I presented selected findings related to context, process, and content of home care policy. Political, economic, social, and historical contexts were relevant to home care policy in the region of study. Findings related to policy process included the ideological tensions underpinning the policy issues and proposals. Policy content was identified in the policies that were both implemented and proposed. The analysis of the interaction of policy context, process, and content revealed that the political and economic context of neoliberalism was influencing a particular ideological perspective in home care.

Finally, In Paper 1, I have acknowledged that a critical theory approach is a methodology in development and I do not claim to have fully expressed its potential in this study. The essence of a critical theory approach is that policies be evaluated for their contribution to social goals and their alignment with social values. This means also that questions guiding policy analyses must refer to the goals and instruments associated with the values of efficiency, effectiveness and social justice. This can only be realized through a discursive and practical exchange between policy actors who have more or less power (Fischer, 1995), and I concluded that this is an area for further development of both methodology and method.

Paper 2

In Paper 2, I focused on the analysis of the policy process including the perspectives and values of policy actors, tensions in values and the emerging policy agenda in regional home care. Taking direction from both the tenets of critical theory and the ideology of PHC, I examined themes in the voices of the study participants and the discourse contained in policy documents at regional, provincial and national levels of decision-making. Paper 2 is comprised of two main points of analysis. On the first point, I compared the policy agenda as it was playing out in regional home care with what was proposed (policy content), and how it was influenced by the relevant contexts. The second point was a comparative analysis between the regional home care policy agenda and the values and principles of PHC. The analysis in Paper 2 contributed to insight into the ideological underpinnings of policy agendas, and the values and tensions in values as they play out among the various actors and positions. Also described in Paper 2 was the

interaction of the political, economic, social, and historical contexts with the policy process, and the content of policy proposals and initiatives in home care.

There were several conclusions and recommendations that emerged in the analysis of the policy agenda in Paper 2. Perhaps most significantly, I was able to identify the ascendancy of a medical model of care in regional home care and describe how it contrasted with a PHC model of care. The perspectives of participants from various levels of the organizations contributed to gaining a depth of understanding of how the policies were playing out in the lives of people. The medicalization of home care was a departure from what previously had been a social model of care and is exclusive of most of the values and principles of a PHC model. Relevant to this understanding of how these various models differ, is the realization that the political context of neoliberalism stands in contradiction to the ideology of PHC. The heart of this contradiction lies in the tensions between the fundamental values of equity, choice, universality, efficiency, and responsibility. These tensions clearly underpinned the policy issues in regional home care. The analysis of ideological tensions underpinning the policy process was facilitated by a critical theory approach to this policy analysis.

Paper 3

In Paper 3, I analyzed the dynamics of the organizational change process that was occurring in home care within the region of study. The conceptual model of organizational change developed by Greenwood & Hinings (1996) focused the analysis on the dynamics of interests, values, power and capability. The model directed a holistic analysis of the interaction of the intraorganizational dynamics of change in regional home care and the political, economic, social, and historical contexts.

Key findings of this analysis related to how the intraorganizational dynamics, in interaction with the political, economic, social, and historical contexts, were influencing organizational change in the direction of a medical model of care. There were several important findings discussed in Paper 3. Among these was the finding of the concentration of power among certain actors and this was significant to understanding how change was influenced in the political context. As well, aspects of organizational capability, such as vision, leadership, resources, and knowledge, were important to understanding the nature of the change that was occurring.

Based on the analysis of the dynamics of organizational change in home care, I was able to make recommendations in the areas of power, influence and leadership. The recommendations related to power and influence also resonated with those contained in Papers 1 & 2 – as being fundamentally related to the importance of enhancing public participation in policy and organizational processes. A recommendation for transformational leadership in home care also encompasses the vision of a PHC model of care, and a commitment to engage participants at all levels of the organization in shared inquiry.

Finally, in Paper 3, I have discussed the utility of the conceptual model for further research into organizational change in home care. On further reflection, I note that the findings of this study pertaining to the interaction between intraorganizational dynamics and the contexts of change, attest to the non-linearity and complexity of these interactions (Greenwood & Hinings, 1996). Therefore, researchers must strive for a *holistic* understanding of the interaction of context, process, and content in the analysis of policy and organizational change (Collins, Green & Hunter, 1999; Greenwood & Hinings, 1996; Walt, 1996; Pettigrew, 1987). Further, as Hinings (1997) has pointed out, researchers must consider how the "role of time" is central to studying policy and organizational processes that *"unfold over time" (p.497).* In this study, the historical context of home care proved to be significant in identifying a shift from a social model to a medical model of care over time.

Critical Theory as a Methodological Approach

Drawing on my experience in this study as well as current literature, I identify two main points about the evolution of the methodology and method of a critical theory approach to health policy analysis. First, I contend that critical theory is a socially progressive methodological approach for the analysis and reform of public policy in the 21st century. I refer to the conceptualization of critical theory in the tradition of Habermas as most inclusive of ways of knowing and types of knowledge (Morrow, 1994). Second, I refer to the development of participatory methods as those that are most inclusive of voice and actors, both with and without power in policy and organizational processes (Fischer, 1993; McWilliam, 1997).

It is important to acknowledge that critical theory as a methodological approach to policy analysis is inclusive of different forms of knowledge. In this regard, policy analysis that is rooted in Habermas's version of critical theory attends very well to "normative implications of public policy" and it also encompasses knowledge production in the technical-empiricist, historical-hermeneutics and emancipatory traditions (Morrow, 1994; Mill, Allen & Morrow, 2001; p.112). Fischer (1995) describes the essence of a critical theory approach as one "of integrating the *normative* evaluation of a policy's goals with the kind of *empirical* work already characteristic of policy evaluation (p.6)". The normative evaluation is realized through the analysis of ideological discourse and by asking the question "*Do the fundamental ideals (or ideology) that organize the accepted social order provide a basis for a legitimate resolution of conflicting judgments? (p.18)*". Ideological discourse was shown to be significant in this critical policy analysis of regional home care. Therefore, a fundamental component of a critical policy analysis is to ask the question of whether the dominant political ideology was providing a basis for resolving values based tensions in the allocation of resources in the delivery of home care services. By pursuing this question, Fischer (1995) asserts that we seek ways to make "informed choices about social systems and their respective ways of life (p.22)". This extends the realm of a critical theory approach to policy analysis to one of questioning the social order wherein public policy goals are determined.

On the second point, further development of policy analysis within a critical theory tradition should encompass participatory methods and the pursuit of emancipatory knowledge as it relates to the conception and implementation of public policy. In this study, we have seen how the multiple and diverse perspectives related to the policy issues are underpinned by tensions in the fundamental values of equity, choice, universality, efficiency, and responsibility. The main limitation of method in this current study was the lack of authentic dialogue and understanding among the various actors pertaining to ideologies, values and issues related to the delivery of home care. Had dialogue over the policy issues and values between actors (decision-makers, public advocates, health care providers) been part of the research method, I acknowledge that the methodology of a critical theory approach would have been more fully realized. The development of opportunities and methods for expanding the dialogical potential of a critical theory

approach is an area where I feel we must continue to work and there are some current examples of how this can be done (Commission on the Future of Health Care in Canada, 2002; McWilliam, 1997). Further development of a critical theory approach holds the promise of the democratization of policy processes (Fischer, 1993).

Implications for Home Care Policy

The analyses of the policy agenda in regional home care (Paper 2) and the dynamics of organizational change (Paper 3) have several implications for the development of home care policy. The analysis of the tensions within the fundamental values of equity, choice, efficiency and responsibility, in how we allocate and deliver public goods and services, was revealing of what may be at stake within our communities. Power relations at regional and provincial levels of health governance indicate that a strong federal role for the governance of health care generally and home care specifically is also needed (Rachlis, 2003). By acknowledging the vital and prominent role of federal legislation and governance in health, we may increase the chances that ideologies of PHC and health promotion will exist in the contexts such as those that have been examined here.

The finding of the medicalization of home care has significant implications. Policy analysts must find ways to convince decision-makers of the contradictions inherent in the discourse of health policy reform and the reality of how policy agendas stand in opposition to values of equity, authentic choice and community. The discrepancies between a neoliberal ideology and the values and principles of PHC are fundamental to understanding why there is inertia in proposed policy reforms. The awareness of these discrepancies must be promoted within diverse groups of people in society, and arguments to change the social order must be presented as part of a critical theory approach to policy analysis. As well, arguments for change in the direction of PHC must be constructed at the appropriate level of belief or value to correspond with the identity, ideological orientation and relative power of those who we seek to influence (Sabatier & Jenkins-Smith, 1999).

Finally, a fundamental implication of this critical analysis is that home care policy must transcend the borders of health care policy to other aspects of public policy that are germane to the promotion of health. By defining home care as medically oriented

professional services that are "unbundled" or disengaged from other services or goods that also promote health, we may well be rejecting the most fundamental premises of health and health promotion as defined by the World Health Organization (1978, 2001) and by the Government of Canada (Epp, 1996; National Forum on Health, 1997). Described as a model of health care most aligned with a moral stance of social justice, PHC is essential for the promotion of human health to include the conditions of living such as adequate income, housing, and access to public services (Ogilvie & Reutter, 2003).

The Discipline and Professional Practice of Nursing

I return to earlier discussions of the implications of a critical theory approach to policy analysis for the development of nursing practice and nursing science. Nursing is positioned to contribute to the development of policy science and to the practice of policy development and influence because of its privileged proximity to people in matters of their health and health care. It has been observed that the act of everyday nursing is political because it illuminates the changes that must be influenced in the interests of quality care (McIntyre & Thomlinson, 2003). This is an important realization in home care where nurses play a pivotal role in its delivery and bear witness to the everyday needs and life circumstances of people in their most intimate settings of home and community.

This policy analysis of home care adds to the recognition of how the critical lens can help distinguish the salient issues as experienced by people involved with home care within the organization and the community. It is also in this area that nurses, because of their values orientation and connections to people and systems of care, can contribute to the development of a critical theory approach by promoting inclusiveness in public policy processes, especially among those people and communities who are vulnerable and who lack power in our health systems and in society as a whole. In so doing, nurses can contribute to the emancipatory aims that are so fundamental to a critical theory approach to policy analysis. The fulfillment of policy advocacy roles, identified as significant to nursing roles and nursing codes of ethics, depends on the development of a *critical* science of influence and change to guide professional practice.

Earlier, I referred to the work of nursing and critical theorists who have argued that critical theory as a research tradition is foundational to the development of nursing knowledge (Mill, Allen & Morrow, 2001). However, there are questions and issues related to the preparation of nurse researchers in critical theory and policy analysis. These areas of study must then be foundational to the education of nurses at graduate and undergraduate levels (Reutter & Williamson, 1998; Reutter & Duncan, 2003). As well, interdisciplinary links between nursing, health promotion, policy studies, ethics, and organizational analysis are necessary if we are to educate researchers who can advance the critical policy research agenda in health and other areas of public policy. It is crucial that nurses and others researching from a critical perspective are able to influence the kinds of questions in policy analyses. In so doing, they ensure that it is not only efficiency ends that are sought through research, but also that the equity / efficiency trade off is challenged and ways of delivering comprehensive, high quality programs are also identified as preferred outcomes (Jackson, 2000).

Finally, it also significant that a critical theory approach is inclusive, rather than silent, on the values and ideology of a discipline. Working within a critical theory perspective, nurses can project a vision for the development of home care as progressive public policy reform. This vision can and should be informed by the ideological perspective held by the discipline of nursing. In the case of home care, it is the values and principles of PHC that constitute the ideological perspective. It is my hope that this work can make a difference by taking a step forward in making the connections between a critical theory approach and health policy reform.

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Research Project: An Analysis of the Policy Process in the Organization of Regional Home Care Services

Interview Schedule

The following questions will guide the interviews with research participants:

- What policy or organizational issues come to mind when you think of home care?

  Probes:
  What are essential home care services?
  How should the needs for home care services be determined?
  Who (what groups of people) are most in need of home care services?
  Who should be responsible for the delivery of home care?

- How is home care changing? What are the most important influences?

- Who are most affected by changes in home care?

- What individuals or groups are involved in making decisions about home care policies? How have they been able to influence policy directions?

- What policies are acted upon or have the most potential to be acted upon and why?

- What is the role and perspective of the Regional Health Board in making policy decisions about home care?

- What policy directions in home care do you think are most important?

  Probes:
  With respect to the recent announcement of increased allocations of monies for home care and long term care…?

- Can you recommend any other sources of information that are important to understanding home care policy?

Dear _____

Re: Research Project: *An analysis of the Policy Process in the Organization of Regional Home Care Services*

I am a nurse conducting research for my doctoral thesis at the University of Alberta. For this research, I am studying the change in the policies and organization of home care services in the Capital Health Region. I intend that this research will contribute to our understanding of how policies for the delivery of home care are evolving and how they can and should be influenced for the delivery of quality health services. Insight into the policy process can help us understand and work with the perspectives of the public, home care organizations and government on proposed changes in home care.

In order to learn about the most important issues in home care policy, I am seeking the participation of persons who are involved in home care and have insights into the field that they are willing to share. Individuals who are interested and agree to participate in the study will be contacted by me to schedule an interview that will be approximately *45* to 60 minutes in length. The interviews may be conducted in an office at The University of Alberta or at a place and time that is most convenient to the participant. Alternatively, the interviews may be conducted by telephone. During the interviews, participants will be asked questions about their perspective on current issues and changes in home care. A second follow-up interview may also be needed. All interviews will be tape-recorded and then transcribed into written form for analysis.

I am inviting your participation in this study because of your involvement with home care in your capacity as a _____. Your decision to participate or not participate in this study is entirely voluntary and this decision will in no way affect your employment status or any other affiliation. If you agree to participate, you have the right to withdraw from the study at any time or to choose not to answer any of the interview questions that may be asked. Only my research supervisor and I will know the identity of participants.

Confidentiality of information will be protected in the following ways. First, all names or identifying information will be removed from tape-recorded interviews before they are transcribed into written form. Second, no real names or other identifying information will be associated with either the interviews or in the presentation or publication of findings. Third, the data will be kept for five years after the study has been completed in a secure place that is accessible only to me. If secondary analysis is conducted with the study, further ethical approval will be sought first.

With assurance of the protection of participants' anonymity, there are no anticipated risks to individual participants. The benefits of participating are related to the purpose of the study and the opportunity to provide an important perspective on home care in this time of change.

If you are interested in participating in this study, please contact me directly. I will then call you and we can talk further about the study. If you choose to participate, we can then set a time for the interview. You will be asked to sign a consent form before the interview begins.

Please contact me if you wish further information about the study:

Researcher:
Susan M. Duncan RN, BScN, MSN
Doctoral Candidate
Faculty of Nursing
University of Alberta
T6G 2G3

Research Supervisor:
Dr. Phyllis Giovannetti RN, PhD
Faculty of Nursing
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If you wish to comment about the research to someone who is not involved with the conduct of the study, or if you have any concerns about the conduct of this study please contact:

Dr. Janice Lander
Associate Dean, Research
Faculty of Nursing
The University of Alberta

Sincerely

Susan Duncan