2016

CARING IN TRANSITION: HOME CARE WORKERS' EXPERIENCES OF CARE RELATIONSHIPS IN SHANGHAI, CHINA

Liu Hong
Wilfrid Laurier University, hongliu.fudan@gmail.com

CARING IN TRANSITION:

HOME CARE WORKERS' EXPERIENCES

OF CARE RELATIONSHIPS IN SHANGHAI, CHINA

by

Liu Hong

DISSERTATION

Submitted to the Faculty of Social Work

in partial fulfillment of the requirements for

Doctor of Philosophy in Social Work

Wilfrid Laurier University

Abstract

This dissertation reports a qualitative study of 23 care workers in the home care program for older people in Shanghai, China. Using grounded theory methodology, a model was developed to account for care workers' experiences of relationships with older clients. Care workers were found to resist the image of care work as demeaning labour performed by lowly migrant workers and re-construct care as valuable work for those in need accomplished by a caring self. As a mechanism of care relationship formation, care workers engage in *tuning*, a dynamic process of identity negotiation that shifts in between two contrasting states: *dissonance* occurs as a care worker's self-concept is perceived to be rejected in interaction with an older client; *consonance* is reached when self-concept is in congruence with a situated identity negotiated and formed through interaction. Care workers' narratives revealed that the process of tuning involves both managing emotion and referencing cultural symbols and imageries. The model suggests that the interplay between the relational and instrumental aspects of care is key to understanding home care work. In particular, *scope* of work and *time* management for a home care dyad are shaped in a relational context. Instrumental care work in turn, influences how a care relationship is developed.

The emergent model was compared with three extant theories on home care relationship: the boundaries thesis, the emotional labour thesis, and the welfare institution thesis. It contributes to the literature by unravelling an underlying mechanism of relationship formation at the interpersonal level. Its implications for home care policy, services, and research in the Chinese context and beyond lie in its theoretical and practical applicability.

Keywords: home care, elder care, care relationship, identity, self-concept, China

Dedication

To

My Four Grandparents

Acknowledgements

This dissertation study would not have fructified without the guidance of my advisor Dr. Anne Westhues, co-advisor Dr. Rianne Mahon, and committee members Dr. Sheila Neysmith, Dr. Weizhen Dong, and Dr. Lea Caragata. I want to thank my External Examiner, Dr. Ito Peng, for her constructive input. I am also greatly in debt to Dr. Carol Stalker's support during my doctoral journey at Wilfrild Laurier University.

Table of Contents

Introduction

This dissertation delves into the issues of care relationships between home care workers and their older clients in the context of Shanghai's new publicly funded home care program. Home care, located at the intersection of impersonal public work and intimate private life, gives rise to an intricate site of love, reciprocity, friction, and struggle, which however is invisible to the public eye. Outsiders are therefore often baffled by the verifiably "good" and "bad" relationships as outcomes, while the process of arriving at these relationships remains obscure. This study attempted to contribute to the understanding of home care relationships by theorizing the process of relationship formation. A model, entitled Relationship Tuning or simply the model of tuning, was developed to account for the formation, negotiation, and perceptions of care relationships through the lens of care workers' self-concept and situated identity. In this dissertation, I attempted to delineate a picture that reflects the complex dynamics within a care dyad, revealing that care work cannot be understood as circumscribed by organizational rules and agency guidelines decreed by the managers, the care agencies, the funder, or other authorities that play a role in the making of care policies. Care work is tailored at the discretion of the care worker on the basis of the contingently defined needs. Moreover, it is provided in an interpersonal context where the care worker's self-concept, the identity of the care worker, and the social status of care work all come into play. Cultural meanings are drawn on by the care workers and a language of family is used to make sense of the care relationships of interest.

In Chapter One, an analysis of the social, economic and cultural contexts of elder care work in urban China is provided as a backdrop for the current study. Population

ageing and family structure challenges stimulated governmental initiatives under the banner "socialisation of care", making elder care a public matter. The home care program in Shanghai as an exemplar case is introduced.

In Chapter Two, I examine the literature on care work in general and home care work specifically, with a view to situating the current study in a broader academic context and debates within the subject area. The literature review also helps to delimit the research boundaries and narrow research questions. At the end of this chapter, I discuss the research questions for this study.

Chapter Three explains the research methodology for this study. The first half of the chapter introduces the site and participants and outlines the process of the fieldwork. The second half discusses some methodological and conceptual issues pertinent to the implementation of grounded theory (GT) methodology.

Chapter Four and Chapter Five report research findings. Chapter Four deals with the self and identity issues in care relationships and introduces "identity harmony" and the model of "Relationship Tuning". The process of formation of a care relationship can be understood as a dynamic oscillation between "dissonance" and "consonance", states in which identity comes into conflict and congruence with care workers' self-concept. Care workers are found to employ culturally informed strategies in tuning out dissonance and turning in consonance. In Chapter Five, management of instrumental home care work is discussed in light of care relationships. Instrumental work is provided in an interpersonal more than an institutional context. Care relationship in practice often determines the scope and time of home care work.

Chapter Six recapitulates the model of tuning by delineating the process of care relationship formation and termination. Following the exposition of the model, I discuss the theoretical relevance of this model with regard to three extant theories on care relationships. The "boundaries" theory explains boundary formation in the organizational context of home care. The "emotional labour" theory deals with the mechanism and consequences of emotion management in service work. The "institutional" theory looks at relationship outcomes as a result of varying care delivery and funding systems. The model of tuning contributes to these three extant theories by suggesting intra- and inter- personal lenses of care workers' identity negotiation. To close the discussion, I consider the implications of this study for elder care work in the transitioning Chinese society, addressing issues such as the filial principle of Chinese society, migration, care workers' conditions, and quality of care.

As a conclusion, Chapter Seven considers the limitations of the current study and makes suggestions to elder care related policies and programs, social work practice in this area, and future research.

To avoid conflation of language, GT or GT methodology will be used hereinafter to refer to grounded theory as the methodological choice of this study, while "emergent model" will be used to refer to the substantive model of Relationship Turning developed in this study.

Before moving to the main text, I would like to say a few words about my personal experience related to this study. My interest in the topic originated from the personal experience as a grandson in a traditional Chinese extended family and observer of the family care arrangement for my grandparents. In the mid-1990s, the co-residence

arrangement of my extended family ended as a result of urban housing policy reform in China and the advent of private ownership of properties, leaving my grandparents on their own in the original family home. My grandmother, who passed away in 2013 at the age of 93, had been bedridden for 15 years following several strokes. My grandfather was in relatively good health until he had a stroke and passed away within the year at the age of 93 in 2010. My grandparents' five children and their spouses alternated care duty with each couple taking turns to stay with my grandparents and providing the necessary care. Soon, however, my grandmother required a live-in carer due to her deteriorating health. My grandfather preferred migrant workers from the countryside of Anhui province, where my ancestors settled. We called them "aunties", but relationships between the seniors and the aunties were not always rosy. Over the 15 years, we had at least six aunties, most of whom did not stay more than one year. Ultimately, however, a live-in carer proved insufficient as both seniors needed care and constant companionship. For innumerable nights, my father and his siblings dozed in a reclining chair beside my grandparents' beds after a long day of work.

The story of my family is not a rare case in Shanghai, the city where I live. Urban Chinese families are experiencing difficulties in caring for elders in the face of dramatic and rapid social transitions. The single-child policy and the consequent changes in family structures have brought particular challenges to the care of the baby boomer generation, who will enter their 70s in the coming decade. How will Chinese society respond to the demographic changes? How do we continue to provide good care to older people? Bearing these questions in mind, I began conceptualizing this study with the general objective of *understanding care workers' experiences of providing good care,*

defined in relational terms, in the context of the home care program for seniors in Shanghai.

Chapter One: Research Background

1.1 Demographic Trends and Elder Care in Urban China

Long-term elder care in urban China is now facing two major challenges: the advent of an ageing population and change in family structure. Shanghai, one of the four direct-administered municipalities in China exemplifies these challenges. In 2013, 17.9% (2.57 million people) of its 14.32 million registered population were aged 65 or older and 5.0% (0.72 million people) of the total population were frail elderly (aged 80+) (Shanghai Research Center on Aging, 2014a). Life expectancy grew from 73.4 years in 1978 to 82.5 years (80.2 for males and 84.8 for females) in 2014 (Shanghai Bureau of Statistics, 2014).

The second challenge is changes in family structure that have led to reduced family capacity to provide care for elders. On the one hand, the average household size has been declining in China since 1982 (Zeng & Wang, 2003). In 2013, the average household size was 2.7 for Shanghai, reduced from 3.8 in 1978 (Shanghai Bureau of Statistics, 2014). It had been projected that since 2013, 80% of people turning 60 are parents of single children (Shanghai Research Center on Aging, 2014b). At the same time, the number of elder-only households, that is, older people living alone or living only with their spouse, is escalating, and while financial support remains relatively unchanged, children's assistance with the daily activities of older parents tends to be reduced when they do not live together (Sun, 2002). In 2013, about 0.24 million or 6.1% of the population aged 60 or above were living alone, whereas 0.9 million or 23.3% were living in elder-only households (Shanghai Research Center on Aging, 2014a). The frail

elderly (80+) seemed to be worst off: 0.25 million or 35.0% were living in elder-only households (Shanghai Research Center on Aging, 2014a).

On the other hand, the "4-2-1" family structure is on the rise, in which one middle-aged couple provide for their four older parents and a child. As a direct effect of the one-child policy over three decades, this structure is predicted to prevail when the first single-child generation reaches its middle age (Ikels, 1990; Settles & Sheng, 2008; Zavoretti, 2006; Zhang & Goza, 2006). In 2020, this population will be sandwiched between the care needs of the old and the young.

The combined force of population ageing and changes in family structure therefore has placed a higher priority on policy and practice pertaining to familial care for the older people in China. In the pre-reform period prior to the 1980s, the majority of older people in need were expected to co-reside with family members for care, except those who were never married or divorced without children, in which case they would be cared for publicly or collectively. The pre-reform welfare system perpetuated the traditional care arrangement within the family by allowing women to retire at an earlier age[1], while extending universal medical and pension benefits for old age through employment.[2] Since the 1990s, much of the pre-reform welfare institution has been replaced by a new system comprised of publicly sponsored social insurance schemes (Hong & Kongshøj, 2014), but the traditional care arrangement with the family as

[1] The Chinese retirement age for women: 50 (workers), 55 (managers); for men: 60 (workers and managers)

[2] The rural system differs from the urban one. Within the urban system, fluctuations were seen in the benefit level and coverage in varying periods in the thirty-year history prior to the economic reform in late 1970s.

primary carer is largely unchanged. Care for senior members of the family is still considered a family responsibility. Table 1.1 summarizes family responsibilities toward the elderly enshrined in the Chinese national and local legislations.

Unsurprisingly, care activities in Chinese families were and continue to be gendered. It is women--both daughters and daughters-in-law--who assume most of the caring responsibilities for the elderly in families (Whyte & Qin, 2003; Zhan, 2005). However, it is no longer possible to rely on women's care role in the family. In addition to the reasons explained above, there is a move to raise the official retirement age. The municipal government of Shanghai has piloted a project named "flexible pension age" (Shanghai Municipal Human Resources and Social Security Bureau, 2010), which allows men and women to remain employed and raise the pension ages by five years above the original retiring age. Traditional familial care, heavily relying on female family members, will be further challenged if similar policies become the norm.

While evidence at the local level is still lacking, unmet or undermet care needs among elders have been documented in national studies. The 2005 China Longitudinal Healthy Longevity Survey, based on a representative national sample, reported that 7.1% of urban elders aged 65 or over require long-term care services and 52% of these elders have unmet care needs (Gu & Vlosky, 2008). This finding is supported by another study where 81.3% of urban elders (age 60+) with self-reported limitations in their activities of daily living (ADL), mobility, or instrumental activities of daily living (IADL) did not receive adequate assistance (He, Sengupta, Zhang, & Guo, 2007).

Table 1.1. Family responsibilities toward the elderly in Chinese national and local (Shanghai) legislation

	Legislation	Article	Obligations
Supporters	Law of the People's Republic of China on Protection of the Rights and Interests of the Elderly (national, effective 1996, amended 2009)	10, 11, 16	Adult children; elder spouse; elder siblings brought up by the potential care recipient
	Regulation on Protection of the Rights and Interests of the Elderly (Shanghai, effective 1998)	9	Adult children; adopted children; step-children; grandchildren whose parents are incapable; elder spouse; elder siblings brought up by the potential care recipient
	Marriage Law of the People's Republic of China (national, effective 1981, amended 2001)	21, 27, 28, 30, 39	adult children; grandchildren whose parents are incapable; siblings
Supporters' responsibilities	Law of the People's Republic of China on Protection of the Rights and Interests of the Elderly	11, 12, 13, 14	To provide for, to take care of, and to comfort; to meet basic needs; to pay medical (physician and hospital care) expenses; to provide nursing care; to arrange housing; to farm
	Regulation on Protection of the Rights and Interests of the Elderly	10, 11, 12, 15,	To provide for; to comfort, to create a harmonious and loving family atmosphere; to meet basic needs; to maintain standard of living; to pay monthly alimony; to provide nursing care; to arrange housing; to farm
Legal reinforcement	Constitution of the People's Republic of China (national, effective 1982, amended 2004)	49	Adult children's support responsibility towards elderly parents
	Criminal Law of the People's Republic of China (national, effective 1980, amended 2011)	183	Supporters who flagrantly refuse to fulfill support responsibilities can be sentenced to imprisonment for a maximum of five years, criminal detention or public surveillance (probation).
	Law of the People's Republic of China on Public Security Administration Punishments (national, effective 2005)	45	Accountable supporters who abandon the dependent who cannot live alone are subject to detainment for a maximum of 5 days, or a warning.

1.2 The Changing Shape of the Care Diamond

Demographic and family structure changes have prompted a reform in elder care, which over the past two decades has been guided by a principle of "socialising care" (*She Hui Hua*, literally "to make care a matter of the society" in the Chinese language). National and local governments in China have promulgated a series of policy directives on elder care, acknowledging that the former public elder care services, organized by the government and the collectivity, were "underfunded, inadequate, and of low quality", and no longer able to meet the growing needs of the elderly (State Council of the People's Republic of China, 2000). The government envisioned a new "socialised care system" funded by various "social sources". Private ownership of social service agencies, both for-profit and non-profit, was encouraged, while publicly sponsored services were to serve only as "models" or "templates". It called for the establishment of a care market, and development of home care services was prioritized under the slogan of "ageing at home".

In theory, this implies the reshaping of the elder care diamond (Jenson & Saint-Martin, 2003; Razavi, 2007) from the previous family-state dyad to a mix of family, state, market, and voluntary sector provision. In practice, in Shanghai, elder care reform has featured increasing municipal government involvement in formal home care services financed by user fees and public subsidies, organized and provided through accredited for-profit and non-profit care agencies. These care agencies are highly reliant on government subsidies transferred through two channels. First, the government shoulders capital costs and appropriates an annual subsidy for care agencies to cover mandatory training, minimum wage, and social insurance contributions for the employed care

workers. Second, about half of the service users receive need- and age-based public support in the form of care vouchers (Shanghai Bureau of Statistics, 2010). At this stage a home care market is just emerging. There is not yet a sign of a strong voluntary sector that could play a significant role in care provision. The reform can thus be described as having an expanding but still limited role for the government in the care diamond, involving setting standards for home care services, creating incentives for participation in a home care market, and providing subsidies for care. Unlike its Western counterpart, the Chinese reform in home care is not a concomitant of de-institutionalisation. It is the government creating a new public domain of elder care and moving away from the definition of elder care as a sheer private matter.

1.2.1 Home care as publicly funded work

In the course of this reform, socialising care in the Chinese context means publicly supporting some care activities that have been traditionally provided by the family or through other private means; that is, to turn home care for older people into a type of publicly funded paid work. At this time, the prevalent types of care services involve assistance with ADLs, IADLs, and other household chores, while nursing care that requires more advanced professional knowledge is still rare. Industries of this kind have been described as being characterised by low-skilled, labour intensive work, which is associated with low wages, precarious employment, and rare opportunities for advancement (Burbridge, 1993; Fujisawa & Colombo, 2009). In Chinese cities, such jobs are viewed as low status, and are most often performed by rural migrants and laid-off urban workers (International Labour Organization [ILO], 2009; Li, 2008). The urban home care reform thus unsurprisingly capitalizes on the supply of rural migrant female

workers from economically less developed provinces. While it is difficult to accurately count the number and proportion of migrant workers in the care sector, a 2004 national survey recorded a total 120 million migrant workers in China, slightly over 10% of whom work in the social service sector (Li, 2008). A more recent estimate reported that China has approximately 9.7 million domestic workers[3] (ILO, 2013), and 90% of them are female migrant workers and laid-off urban workers (ILO, 2009), with the former preponderant. The rural-urban wage difference is predicted to continue to be an incentive for migration in the coming years (Herd, Koen, & Reutersward, 2010).

1.2.2 Definition of care worker

Since this dissertation is a study of "care workers", this term warrants a clear definition. The English term care worker may refer to an array of types of work in the Chinese language. The most common ones, widely used in the media and frequently mentioned by the participants of this study, are the listed in Table 1.2.

Up until the fifth edition of the authoritative Contemporary Chinese Dictionary published in 2005, *bao mu* had been defined as "a female person hired to care for children, or to do housework". The old and the ill were first added in the 2012 sixth edition, recognizing the reality that care for the old can be performed outside of the family context and in an employment relationship. The gendered nature of care is reflected in the female radical of these Chinese characters. Today, a male caregiver is sometimes referred to as a "male *bao mu*" in the Chinese mandarin. It should be noted

[3] The great majority of domestic workers in China are privately hired to perform care tasks as well as housework. Publicly subsidised home care employment is a relatively new phenomenon. However, it should be noted that the home care workers are coming from the same migrant worker population.

that private care work, such as *bao mu*, *jia zheng*, and *zhong dian gong*, existed prior to "socialisation of care". In fact, many participants in this study had been employed in these kinds of care and domestic jobs.

Table 1.2. "Care worker" in the Chinese language

Chinese word	English translation	Definition in Contemporary Chinese Dictionary
Bao Mu	A baby-sitter, a nanny, a housekeeper, a caregiver	A woman hired to care for children, seniors, or ill persons, or to do housework.
Jia Zheng	Homemaking, housekeeping	The business of managing housework, usually excluding personal care.
Zhong Dian Gong (*Xiao Shi Gong*)	Hourly work, an hourly employee	This term is formally defined by the Chinese labour laws as types of flexible employment paid hourly (not exceeding four hours a day and twenty four hours a week). It has been used to mean housekeeping and care work performed and paid on an hourly basis. The term may be literally translated to "labour paid by the hour", which implies the precarious nature of such work.
A Yi	An aunt, a housekeeper, a nanny (this term was most frequently used by the participants)	*A yi* in some Chinese dialects means a sister of one's mother. It can generally be used by a child to refer to a non-kindred female person about the same age as his or her mother. It is another (can be slightly euphemistic) word for *bao mu*.
Fu Wu Yuan	An attendant, a service person, a waiter/waitress	The word literally means "someone who serves". The managers according to the "guidelines" refer to the care workers as the "service staff", a name the care workers never used to make reference to themselves.

In this study, participants used these words interchangeably, and I use care worker as a uniform translation of all these terms when they are used to refer to home care workers for the elderly. In participants' quotes, I preserve the Chinese *pinyin* so it is clear that they were making references to larger groups of care-related occupations.

1.3 The Case of Shanghai

I have been using urban China to refer to the cities of China as if they are homogenous. In fact, Chinese cities are diverse in culture, socio-economic development, and policy initiatives. National framework policies are usually highly abstract and call for local responses that are more specific and practical. The formulation, implementation, and funding of working policies and programs are under the jurisdiction of local governments. As a result, social policies vary across provinces and direct-administered municipalities, and their adequacy and effectiveness are subject to the commitment of local authorities. For policy-informed research, it is therefore meaningful to examine local variations as well as a national picture. A number of factors justify the selection of Shanghai[4] as the research site for this study. The practical factor is that my personal network in and familiarity with Shanghai promised easy access to the field and research participants. This practical consideration however should not shroud the value of Shanghai being a suitable site for this research. Shanghai is one of the most economically developed and populated regions in China, facing the gravest population ageing problem. For these reasons, Shanghai has played a leading role in piloting ageing policies. The major urban social security systems now in place nationally (e.g. urban pension scheme and health insurance) were piloted in Shanghai (Dong, 2003). As noted above, in elder care and home care, Shanghai has also been the pioneer in the formalisation of home care. Shanghai is an important case also because it is the city that draws the greatest number of migrant workers (Li, 2008). Migration and care have

[4] Please find demographic information about Shanghai and Yangpu district in Appendix 1.

become intertwined phenomena, and will continue to be of academic interest. These factors together make Shanghai a favorable site for a fruitful thesis research.

1.3.1 The home care program in Shanghai

A brief review of the home care program in Shanghai is needed for readers who are not familiar with the care reform in Shanghai. While official data on the home care program are not available, the figures reported in the following sections are based on policy documents and program data gathered for this study during fieldwork. The public data on the program history and characteristics were collected from the statistical yearbooks and research websites of the government of Shanghai. The data on the workforce were recorded during the conversations with managers and interviews with the participants, and they reflect agency-specific conditions.

In the wake of national level socialisation of care at the turn of the millennium (State Council of the People's Republic of China, 2000), the city of Shanghai issued a directive on the development of home care, *Opinion on Developing Home Care* (Shanghai Civil Affairs Bureau, 2001). For the first time, a "comprehensive development" of a home care system was outlined to initiate home services for the older population "in the vicinity of their homes" and in a "user-friendly" and "professional" fashion. To achieve these goals, a multi-level system with extensive coverage that provides various kinds of services was proposed.

During the subsequent two years, small scale pilot projects were carried out across the districts in Shanghai, culminating in the issue of another policy document in 2004 in which a clearer picture of a home-based system emerged. The 2004 *Notification on Accelerating Home Care* (Shanghai Civil Affairs Bureau, 2004) outlined a blueprint

for home care services in Shanghai, and set concrete goals for development in subsequent years.

Since 2004, home care in Shanghai has developed steadily. Beginning in 2007, the Civil Affairs Bureau of Shanghai planned annually for the development of home care, explicitly setting out the tasks and goals for the following year. In 2009, a needs assessment tool was introduced, undergirding standardized procedures for intake and determination of eligibility for financial subsidies (Shanghai Civil Affairs Bureau, 2009). In 2010, the *Specifications for Elderly Home Care Services in the Community* (Shanghai Bureau of Quality and Technical Supervision, 2009), a complete guideline for service standards, was put into effect.

Target population. Home care services in Shanghai are targeted to people aged 60 or above.[5] While all people aged 60 or above can request service, what they receive is conditional on demonstrated need, such as ADL assistance on bathing and maintenance of personal hygiene, meal preparation, housekeeping, laundry, and errands such as banking and shopping.

A uniform assessment tool is used for this purpose by care managers. In principle, applicants are assessed on five aspects of ADL: eating, personal hygiene, dressing and undressing, voluntarily controlling urinary and fecal discharge, and mobility. Cognitive, emotional, and visual functioning are rated by self-report. Socio-economic information and the person's health history are also gathered. The assessment

[5] Home care services are available to younger people with disabilities. This client population is much smaller, and not every care worker has younger clients with disabilities. In addition, the services for this population are funded through a different channel. This study focuses on the older population.

results, together with the applicant's housing and family conditions, serve to classify applicants into one of three levels of care needs: light, moderate, and intensive. In practice, I noticed during the fieldwork that the assessment tool was not always formally used to facilitate the care arrangement.

Care service agencies. The services are delivered through three types of home care agencies: Elderly Home Care Agencies, Elderly Day Care Centers, and Elderly Dining Service Centers. The Elderly Home Care Agencies, previously Home Care Service Centers, are the organizers and providers of the home care services. Their main responsibilities include consultation (introducing services), application processing, assessment, and case management. Elderly Day Care Centers provide day care respite services and run recreational facilities. Elderly Dining Service Centers provide meals-on-wheels services. This study focused on care work organized and provided through Elderly Home Care Agencies, hereinafter referred to as "home care agencies" or "care agencies". The majority of the home care agencies were formerly privately owned *jia zheng* centres and *bao mu* placement agencies. After the placement agencies were incorporated into the home care program, their operational costs were funded by the local government. In addition to managing the government-sponsored home care program, these care agencies still place care workers in homes of clients who are not financially subsidized by the home care program. The latter kind of service is not limited to elder care, and it may involve what is traditionally considered *jia zheng* work. In this study, the participants and the care managers referred to this kind of placement as "private hires", differentiated from the "public hires".

Administration of care agencies varies across the 17 districts in Shanghai. In Yangpu district, the social welfare department of the district government directly supervises the agency managers and oversees the operation of the care agencies, while service quality control is partially contracted out to a private management company. This company holds care workers accountable by conducting regular telephone checks on the clients and operating a hotline that receives complaints and compliments regarding care services. It is also the management company that devises technologies for care work. For example, shortly before this study, an electronic "attendance card" was introduced to keep track of the hours spent by each worker in each client's home. A hand-held device is carried by the worker, and each of her clients holds a swipe card. At the beginning and end of each visit, a client swipes the card and records on the system the total hours worked by the worker. The start and end must also match the allocated time slot, otherwise the worker is subjected to a warning or penalty. Managerial tools as such allow the company to monitor care work and thus control the service quality, but they do not directly engage in handling cases, which is solely the responsibility of the care managers. Information is shared with the care managers in case of complaints and misconduct. Moreover, clients and their families seem to prefer communicating with care managers. The fact that the care managers I met know most clients or families personally supports this view. Care managers, therefore, are at the center of service management.

Home care workforce. The workforce that provides the hands-on services is mainly comprised of rural migrant workers and local laid-off workers. Training is mandatory. The municipal government regulates and subsidizes, but does not directly

provide the training, which is contracted out to non-governmental organizations. Currently, care workers are classified according to three skill levels--Basic, Intermediate, and Advanced--which is consistent with the national occupational classification (Ministry of Human Resources and Social Security of the People's Republic of China, 2002). Although skill levels are not matched with the care need levels of recipients, the Basic level of skills is a minimum requirement. All participants in this study held the Basic skill certificate. Research and systematic analysis on the training programs is still lacking. It has been reported, however, that similar training for homemakers (*jia zheng*) and maids (*bao mu*) falls short of the standards that would typically be expected in developed countries (Wu *et al*., 2005).

Size of a care agency depends on service needs of the area. A smaller agency in this study employed about 87 workers, among whom 17 were local workers. A larger agency employed about 225 workers, 25 of whom were local workers. It is estimated that 10-20% of the employees in the three agencies I visited were local workers. This number could only be approximated because the actual number of migrant workers at each agency shifts constantly as people join and quit the job routinely. Turnover was a concern expressed by all of the managers with whom I talked. While reliable data on rate of turnover are unavailable, one manager told me that at her agency roughly one third of the care workers were newcomers who had been employed for less than six months. The gender composition in the workforce is lopsided. For example, at one agency of 225 care workers, 3.6% or 8 workers were male.

Financing. It is important to note the government's attempt to link elder care reform to employment promotion policies. Formal services under the home care program

are subsidized by a government employment program. In addition to the operational costs of the care agencies, employed care workers who have local residency are entitled to social benefits through enrolment in public insurance schemes. If a local care worker works 130 hours or more in a month, the insurance premiums are covered by the government. In practice, all local care workers took the 130 hours as a minimum requirement of the job and worked toward qualifying for the insurance enrolment.

Income for local workers is comprised of two parts. The primary component is a pay-by-hour wage, typically based on the municipal minimum wage, 12.5 Yuan/hour ($2.5 Canadian) in 2013, although it may vary among agencies. A fixed rate monthly subsidy of about 1000 Yuan for all local care workers tops up the pay-by-hour wage. The two parts of income combined guarantee a local worker about 2,600 Yuan ($520 Canadian) per month. For a full-time equivalent local care worker who works 40 hours a week, typical income would be around 3,000 Yuan per month, which is lower than the city average of 5,036 Yuan, but higher than the municipal minimum wage of 1,620 Yuan of the same year. Most local participants who mentioned their income earned more than the guaranteed 3,000 Yuan, because of working private hires, which pays higher than the minimum wage.

The migrant workers, in contrast, are not entitled to these benefits and subsidies. However, they are sometimes paid at a slightly better rate: up to 15 Yuan/hour ($3 Canadian), while the actual rate variesacross agencies. To reach the income level of 2,600 Yuan, they would need to work about 173 hours a month. Their monthly income based on 40 hours of work is 2,400 Yuan. Consequently, migrant workers work extra hours to make up for the income gap. Most migrant worker participants in this study

worked more than eight hours a day, seven days a week. One participant proudly told me her monthly income was over 6,000 Yuan, which means she must had been working more than 10 hours daily, even when better compensated private hires are factored in.

In addition to the public funds for operational and wage costs, the government directly supports older people by subsidizing service fees according to level of service needs. The public subsidy scheme for the elderly clients operates at the municipal level and was first modelled on an older means-tested system that provided a safety net of care for those aged 60 and above without family support. The later development of the scheme featured the addition of an entitlement category for the 80+ population, under which a monthly income threshold is set.[6] This appears to mean that the home care benefit is moving toward recognizing needs, while extension of coverage is not a priority. Table 1.3 has a summary of the care benefit scheme as of 2013 in Shanghai. It should be noted that this policy area is undergoing continual changes. The benefit levels quoted in Table 1.3 thus serve to contextualize this study rather than reflect the most up-to-date figures. By the time this study was conducted, there were 23,237 older persons, 7.8% of the 299,200 seniors aged 60+ in Yangpu district[7], receiving home care services, among whom 4,590 or about 20% were publicly subsidized clients. The remaining 80% were those referred to as private hires by the participants, but as explained previously, private hires are not limited to elder care.

[6] Due to their age and history of employment, this client population tends to be excluded from the recently established health care and pension schemes available to urban retired workers (Hong & Kongshøj, 2014).
[7] Please see demographic information for Yangpu district in Appendix 1.

Table 1.3. Level and eligibility for public subsidy of home care services in Shanghai by 2013

	Subsidy by level of care need Yuan ($Canadian)/month			
Age	Light	Moderate	Intensive	Eligibility
60+ (including 80+)	300 (60)	400 (80)	500 (100)	Applicants must be on social assistance (640 Yuan or $128 Canadian per month for 2013).
80+	150 (30)	200 (40)	250 (50)	Applicants must be elders who live alone or live solely with elder partners; Their monthly pension income must fall below the municipal (urban) monthly pension average (2,964 Yuan or $592.8 Canadian for 2013); Recipients in this category will pay at least 50% for the services.

1.3.2 A typical day for a care worker in the home care program in Shanghai

Much has been said about the characteristics of the home care program in Shanghai at the policy and agency levels. I would like to depict a typical day for a care worker, using a timetable. I compiled Table 1.4 based on multiple participants' accounts of their daily routines. Each participant's experience is unique, but there are common threads across cases. The time-table thus serves a heuristic purpose rather than being understood as a particular case. Lucy is a fictional care worker.

Table 1.4. A typical day for a care worker

Time	Activity	Notes
5:30 AM	Wake up, Do her own laundry,	Most clients prefer work being done in the morning. Lucy has to get up early.

	Start rice congee in slow cooker, Organize apartment.	
6:30 AM	Do grocery shopping, Bring breakfast to eat with Auntie Wang.	Lucy bought groceries as her husband will come home for dinner. She also bought breakfast from a street vender to share with the first client she would visit today.
6:50 AM	Drop off groceries at home, Leave apartment for work on moped.	Ten minutes on the road. Ten to fifteen minutes is typical of the distance between two clients' homes. Lucy prefers clients in the vicinity of her neighbourhood, although not everyone is like her.
7:00 AM	Arrive at Auntie Wang's, Eat breakfast with Auntie Wang, Clean Auntie Wang's apartment: wipe down table and surfaces, mop floor, clean dishes, wash clothes, air out beddings, and make bed.	Auntie Wang is 88 years old. Living by herself without children, she is in the light-needs category. Lucy visits her twice a week for 2 hours, helping her with housework that has increasingly become prohibitive. Like many elderly client, Auntie Wang does not own a washing machine. Lucy washes clothes by hand.
8:50 AM	Leave Auntie Wang's apartment and head for Auntie Li's home.	Auntie Wang usually lets Lucy leave early if the work is done. It takes 10 minutes to get to the next home.
9:00 AM	Arrive at Auntie Li's home, Help Auntie Li take a bath, Make bed, wash clothes, wipe table, mop floor, Talk to Auntie Li, Cook meal for Auntie Li	Auntie Li is 92, living by herself. She does have children, but they all live in other districts and only visit about once a week. Lucy visits her five days a week for 1.5 hours. In the moderate-needs category, Li needs assistance with some ADLs. Today, Lucy helped her take a bath, which is not done daily. Li enjoys chatting with Lucy.
10:25 AM	Leave Auntie Li's home and move on to the next client, Uncle Zhang.	Auntie Li and Uncle Zhang live in the same neighbourhood.
10:30 AM	Make bed, wash clothes, wipe table, mop floor, Refill medicine at hospital, Withdraw cash from bank, Buy groceries on way back, Cook lunch for Uncle Zhang.	Uncle Zhang is 90, living by himself without children, and his care needs level is intensive. He has entrusted his key and bank card to Lucy, who visits him daily. Today, uncle Zhang needed a refill of his medication for hypertension. On the way home, Lucy withdrew cash and bought food to cook.
12:00 PM	Go home and eat lunch, Rest briefly.	Lucy does not always come home for lunch. In cooler seasons, she sometimes brings a

		lunchbox to clients' homes, or cooks more and eats with clients.
1:00 PM	Arrive at Auntie Tan's, Wipe table, mop floor, wash clothes, clean windows, Talk to the couple.	Auntie Tan is 78 years old and living with her husband who just turned 80. Tan has a disability, but since she is living with her husband, she only receives partial subsidy. Now Lucy visits the old couple five days a week, one hour each time to help with some light housework. Today Lucy noticed the windows are quite dirty, so she cleaned them. She also decided to advocate for the couple for a higher level of financial assistance as Auntie Tan's husband turned 80.
2: 10 PM	Leave Auntie Tan's and head for Auntie Ma's.	Auntie Tan's husband is very talkative. Lucy was late for the next home again for this reason. She should have left 10 minutes earlier.
2:20 PM	Arrive at Auntie Ma's five minutes late, Wipe table, mop floor, wash clothes including Ma's son and daughter-in-law's, Clean shared areas in the apartment.	Auntie Ma is 83 and in the light-needs category. Although she lives with her son and daughter-in-law, the relationship between Ma and her daughter-in-law seems to be tense. Lucy visits her Monday to Friday for one hour, but never finds enough time to do the work expected of her. Auntie Ma looks forward to seeing Lucy every day, and is much attached to her. Lucy finds herself in the middle of mixed laundry and politics between a mother-in-law and a daughter-in-law.
3:15 PM	Leave Auntie Ma's and head for Auntie Bao's.	Lucy worked efficiently today, so she could leave Auntie Ma's on time.
3:30 PM	Arrive at Auntie Bao's. Wipe table, mop floor, wash clothes, Chat with Auntie Bao, Prepare a meal before leaving, Head to Uncle Zhang's.	Auntie Bao is 85 and is in the light-needs category. She can manage her own life quite well, but occasionally she needs some assistance from Lucy. Although Lucy only visits for one hour and a half, twice a week, Auntie Bao enjoys Lucy's company, because she was one of Lucy's earliest clients.
5:15 PM	Arrive at Uncle Zhang's, Clean dishes from lunch, Prepare a light meal, Head home.	Uncle Zhang has two hours of service per day. Lucy divides it into three visits. In the afternoon, she prepared a quick meal for Uncle Zhang.

5: 35 PM	Arrive home, Prepare dinner, Eat dinner with family.	Lucy's rented apartment is in the same neighbourhood as Uncle Zhang's. It takes three minutes to get home.
8: 00 PM	Visit Uncle Zhang, Wash dishes, Help Uncle Zhang clean up and go to bed.	This is the last visit to uncle Zhang. Sometimes, Lucy gives uncle Zhang a bath before he goes to bed.
8:20 PM	Return home.	This concludes a day of work for Lucy.

1.4 Summary

In the face of population ageing and a quick change in family structure, urban China is now challenged by growing elder care needs, which have previously been met by female family members who retired at a relatively earlier age. The past decade saw a governmental initiative to reform the elder care sector in response to these challenges. Under the banner "socialising care", limited but expanding involvement of the government in organizing and funding care work has characterized the Chinese urban care reform. Home care began to be recognized and formalized as a publicly funded type of work. Shanghai, a major city that pioneers in many areas in the Chinese social reform makes an exemplary case. The home care program in Shanghai, in its ten years of operation, has extended to cover more clients, raised its benefit levels, and put in place sounder regulations. The home care workforce is primarily comprised of rural migrant workers and urban laid-off workers. There is evidence to suggest that these care workers are subject to long hours of work and minimum level of reimbursement. This study will venture to understand the experience of these workers in the context of the home care program in Shanghai. In the next chapter, I will set a larger context for this study through a review of literature on home care and care relationships.

Chapter Two: Setting the Larger Context: A Literature Review

2.1 Research on Home Care in China

As the making of elder care policy unfolds in urban China, information is urgently needed about home care services. Unfortunately, research in this field is sparse in the Chinese context. The majority of the literature on Chinese elder care focuses on the problems of traditional care provision (e.g. familism, filial piety, intergenerational relations), and on familial care arrangements in the face of economic reform and demographic changes (e.g. Chen & Silverstein, 2000; Gu, Dupre, & Liu, 2005; Leung, 1997; Li, Long, Essex, Sui, & Gao, 2012; Sun, 2002; Zhan, 2002; Zhan, 2004; Zhan & Montgomery, 2003; Zhang & Goza, 2006). When analysis centres around formal care services, it is institutional care that receives the most attention (e.g. Guan, Zhan, & Liu, 2007; Shang, 2001; Zhan, Feng, & Luo, 2008; Zhan, Liu, Guan, & Bai, 2006; Wong, 2008).

In recent years, some research articles on the provision of care services in elders' homes appeared, but their number is still limited. For example, Chappell (2008) explored differences between family care givers and hired nannies[8] in their commitment to providing care for elders, and concluded that "contracting out filial piety" causes a loss of the emotional aspect of care. Xu and Chow (2011) examined the national policies on community-based care service delivery, and argued that the delivery system was likely to suffer from under-professionalisation and low quality, but failed to define these terms.

[8] "Nanny" is the term used in the article. In the Chinese language, bother hired care givers for children and elders are called "*bao mu*", which can be most appropriately translated as "nanny".

Wu and his colleagues described the early development of community-based care service agencies in Shanghai at the turn of the century (Wu, Carter, Goins, & Cheng, 2006). On the more recent development of formalization of home care policies and programs, I found only one entry in the thesis and dissertation database of relevance. Wang (2011) analyzed the home care service delivery in Pudong district of Shanghai. Based on structured interviews with the nine elderly clients, three care givers (two care workers, one relative), and two agency managers, the author explored the problems in service delivery and utilisation. She concluded a lack of competition in service delivery may cause lower satisfaction among service users. Her findings also suggested economic status, not need, is often the determining factor for service use.

Aside from this body of literature, an extensive search was made for government policy documents and unpublished research from local research institutes and think tanks such as the Shanghai Research Center on Aging and the China Research Centre on Aging. While this grey literature contains less analytical work, it provides abundant statistical and background information for this thesis research.

Thus for a number of reasons, home care literature in the Chinese context is inadequate in view of the need for an understanding of the phenomenon and information for policy making. Studies that use secondary survey data suffer from limited sources (e.g. Chinese Longitudinal Healthy Longevity Survey and National Census). Since formal home care services were not available until recently, information about them is largely absent from these surveys. Small-scale, locally focused studies tend to place an emphasis on cultural analysis--intergenerational relationships, gender roles, and their association with care practice. Research that probes interpersonal interactions and

meaning-making processes, uncovering how human agency is exercised under the influence of cultural, social, and economic forces is still rare (Zhan et al., 2008). In the field of formal home care, no account of the experiences of either care givers or care receivers is currently available.

Research on home care in the Chinese context thus needs observation on two levels. On the macro level, we need an accurate picture of who is providing the care and who is receiving the care, their socio-economic status, needs, and so forth. Insofar as a mixed economy of care is concerned, accounts of how care institutions are produced through the interplay among the political forces, economic conditions, ideology, historical path of the welfare institution, and other socio-political forces will also be useful. On the micro level, we need to know about care as an interpersonal process. For example, how the caring process is taking place under the organization of formal work, the providers' and receivers' perceptions of the care, how their well-being is affected by the care, so and so forth.

2.2 Literature Review in the GT Traditions

The state of research in the Chinese context calls for the use of a methodology that allows formulation of locally generated models of explanation. Accordingly, this thesis took the micro approach and studied care as a social process involving interactions and meaning-making at the level of individuals, using GT methodology.[9]

[9] Justifications for the use of GT and practical considerations in the research process are discussed in Chapter Three.

I acknowledge that there are diverging views on the place of literature prior to empirical study in GT methodology (Dunne, 2011). The literature-free camp contends that early preoccupation of theoretical approaches in the substantive field of study risks undermining the originality and local relevance of concepts and theory arrived at in a GT study. GT researchers are warned against, in Dey's (2007, p. 176) words, "ploughing an established theoretical furrow". Glaser & Strauss (1967, p. 37) went as far as to suggest that no literature should be reviewed prior to data collection and analysis.

Counter-arguments to the literature-free camp are many. In essence, those who argue in favour of familiarity with literature prior to empirical study commonly point to the benefits of a literature review and the infeasibility of skipping such a review against the norm in academia. Most importantly, a literature review helps provide a rationale for the study by identifying research gaps and sensitizes the GT researcher to the phenomenon under study (Coffey & Atkinson; 1996; McGhee, Marland, & Atkinson, 2007). Furthermore, it is unreasonable to assume that researchers cannot be aware of and therefore refrain from forcing established but irrelevant concepts onto data (Urquhart, 2007).

In this study, I followed a path similar to the one Dunne (2011) used in his own doctoral study. This approach involves first, a literature review prior to fieldwork to contextualize the GT study and to facilitate formulating, focusing, refining, and justifying research questions (p. 119), and second, continuous engagement with literature along with the fieldwork to identify relevant but previously missed theories and to enrich data analysis.

This approach to literature, required by GT, was not a linear process. It involved going back and forth between context, policies, and literature: questions emerged from reading the literature, more literature was read with the emerging questions in mind, and yet additional literature was reviewed along with data collection and analysis--a recursive process that may not be readily reflected by the traditional linear layout of a dissertation.

2.3 General Inquiry into the Care Literature

An inquiry into care is inevitably informed by theoretical and practical interests--utility for policy-making, concerns for the well-being of the elders and care workers, values such as gender equity, theories concerning labour market, and welfare state theories, for example. Even for a GT study, a researcher cannot enter the field as a blank slate. I started exploring the Western literature with a broad and practical interest: *how is the provision of good elder care shaped in the context of formal home care services*? As a general survey of the Western literature on care suggests, care as a social process is complex and a variety of theoretical and philosophical lenses have been drawn on to analyze care.

I identified four research interests in the care literature that have been pursued by economists, ethical theorists, practitioners, policy-makers, and other care researchers. Care as a multi-dimensional concept entails at least the following elements: 1) care is both physical and emotional labour (Chichin, 1992; James, 1992; Neysmith & Aronson, 1996); 2) provision of care is shaped by a mixed economy (Evers & Svetlik, 1993; Sipila, Anttonen, & Baldock, 2003); 3) care needs to be understood under ethical/normative frameworks (Mahon & Robinson, 2011; Noddings, 2002; Tronto, 1993); 4) care concerns the well-being of care givers as well as care receivers (Biegel & Blum, 1990; Stadnyk,

Fletcher, Eales, Fast, and Keating, 2008). These dimensions will be addressed in the following sections, in an organization that mirrors the logic of my research focus and the arrival of the research questions.

First, I will look at "good care" understood through an evaluative framework of structure, process, and outcome, and critique the inclination to over-emphasise outcome and ignore the emotional/relational dimension of care work. Next, I will review the existing literature on the emotional/relational aspects of care, and identify research gaps. Third, care work will be examined in broader social, political, and economic contexts, in particular in the contexts of marketisation and globalisation. Finally, I review theories explaining the mechanism of how care work and care relationships are shaped in the organizational and socio-politico-economic contexts. Research questions that guided the fieldwork of this research follow this review.

2.4 Good Care as Outcome: "Quality of Care" and Its Measurement

"Good care" in itself carries a normative sense, and it is only loosely used in the literature beyond philosophical discussions. In research-based literature, and in particular in the field of evaluation of care, the term "quality of care" is ubiquitous, and "good quality care" is sometimes a substitution for "good care". While commentaries on the quality of care suggest its importance as the ultimate concern for any study of care, further examination reveals, despite the frequent appearance of the term, its meaning is equivocal. It has been used to mean a specific set of standards/criteria of care formally adopted for evaluating care work, or taken loosely to refer to anything between an ideal model of good care and an acceptable minimum standard of care.

Brechin (1998, p. 171) noted that good care today is mostly construed in relation to quality of life of care receivers understood in terms of measurable outcomes. Prominent in this line of work is Donabedian's work (1981, 1988). Donabedian was prompted to engage in research by the widely perceived difficulty of grasping the meaning of the term "care quality" in medical care practices. He systematically discussed how the process of care provision should be conceptualized and then assessed, distinguishing structure, process, and outcome (SPO) as three distinct, yet conceptually connected, dimensions for the assessment of care quality. On the structural dimension, material and manpower input, facility, environment of care, and other organizational characteristics associated with the provision of care are at issue. The process of care refers to the actual activities through which care is provided. These involve technical activities that aim to achieve certain care goals (e.g. health outcomes, completion of certain ADLs or IADLs, cleanliness of house, etc.) and development of interpersonal relations such as clear communication intended to facilitate the technical activities. The last dimension, direct effects of care, is care outcomes which are indicated by changes in patients' health status, knowledge, behaviors, and satisfaction. According to the author, to be useful the three levels must be thought of as causally linked--namely good structure is conducive to good process, which ultimately contributes to good outcomes.

Assessment of care quality in medical settings and beyond has largely followed Donabedian's line of thinking (see for example Kramer, Shaughnessy, Bauman, & Crisler, 1990). In institutional long-term care, the SPO approach to the evaluation of care quality is predominant, as a number of systematic reviews and meta-analyses in North American and European contexts found that the majority of the care quality indicator

systems under review adopted this approach (Castle & Ferguson, 2010; Comondore et al., 2009; Compas, Hopkins, & Townsley, 2008). In home care settings, quality indicator systems based on the Minimum Data Set (MDS) have been developed (Hirdes et al., 2004).

However, four major critiques of this approach to the assessment of good care can be raised. First, a large number of sets of diverse quality indicators exist, reflecting the reality that there is no consensus as to what quality of care or good care should be taken to mean in practice. Second, differences in scores based on quality indicators may not identify real differences in actual care quality due to the low differentiating power of the measures (Castle & Ferguson, 2010). Such indicators further suffer from "ascertainment bias" (Mor, Angelelli, Gifford, Morris, & Moore, 2003), which happens when better staffed and higher quality institutions may more actively look for deficits in certain clinical signs and symptoms as measured by process and outcome indicators. As a result, these institutions will systematically appear worse in the corresponding areas of care quality than those which do not actively seek out problems. A similar issue occurs when reputable care institutions, which provide better quality care in a certain area, could attract more residents with that condition. Good care, through more vigilant assessment, could turn into "bad" care.

Third, in line with Donabedian's preference for outcome measures, since the 1960s there has been a tendency to prioritise outcome measures in care quality assessment (Castle & Ferguson, 2010). In particular, assessment based on MDS pushes the idea that outcome indicators are the only valid measures for care quality, particularly in home care settings where the structural or institutional dimension is covert and process

hard to monitor. The structural and process dimensions of SPO models tend to be considered in virtue of their presumed contributions to the physical and medical outcomes of care. As Donabedian (1988) acknowledged however, the presumed causal links between the structural, process, and outcome dimensions call for explanation. This problem is mirrored in the findings from research on interventions to improve care quality. It has been difficult to identify any activities at the organizational level that result in improvement in care quality as measured in outcome terms (Wagner, van der Wal, Groenewegen, & de Bakker, 2001; Werner & Konetzka, 2010).

A fourth critique of these quality indicators is their inability to identify good interpersonal care process. These quality indicators are measured at the agency/organization level, which means individual variations are not taken into account or are averaged out, and good care provided by any individual worker can thus be ignored. There have been efforts to include clients' voices regarding quality of care. Care recipients and their families can file complaints through report cards and ombudsmen (Allen, Klein, & Gruman, 2003; Stevenson, 2006). However, again, these complaints focus on deficiency. While, client satisfaction surveys have the potential to elicit care receivers' views about good care, unfortunately this approach is less common, due to the challenges in administering them, for example vulnerability and frailty of clients, difficulties in measurement and data collection, and lack of training for the care professionals to listen to clients (Applebaum, Straker, & Geron, 2000; Castle & Ferguson, 2010).

2.5 Care as Process: Emotional/Relational Aspects of Home Care

While issues of care quality in institutions have been widely documented and quality standards established, there is still no generally accepted definition of home care quality. An important characteristic of home care that makes defining quality more difficult is a division between home services emphasizing nursing care and those featuring social care and support for IADLs[10] (Vaarama et al., 2008). Some efforts have been made to develop quality indicators in home nursing care in accordance with their counterpart in institutional settings. An internationally accepted approach is to establish quality indicators on the basis of MDS, a set of measures of elder care recipients' functional and health statuses (e.g. Hirdes et al., 2001; Hirdes et al., 2004). It is noteworthy that, as MDS focuses on physical functions and health, home care quality indicators so constructed tend to focus exclusively on health and medical outcomes.

Care quality as understood in outcome terms and assessed at the organizational level does not adequately explain the complexity of care provided in home settings. This care differs in its activities and goals from medical practices. Indeed, home care, in particular social care, for the elders has been found to be unique in some respects. For example, the activities of home care are often associated with supporting ADLs and IADLs of the elders (Applebaum & Phillips, 1990, p. 445). Due to the nature of home care services, which by definition involves "low-tech" personal support work, home-making, and chores, many in-home care activities are not subject to regulations and guidelines. Home care services are usually provided on a one-on-one basis and care

[10] The focus is on social care in this section.

agencies tend to have much less control over the actual conduct of care of individual care workers than in institutional settings (Barer, 1992; Eustis, Kane, & Fischer, 1993). From time to time, in-home care seeps out of the boundary of formal work, entering into informal personalised domains characterised by performance of tasks outside of duties, contribution of extra time, and gift-giving (Applebaum & Phillips, 1990; Aronson & Neysmith, 1996). However, it is erroneous to assume such "low-tech" home care is easy and less of a concern with quality, for home care recipients assess the quality of care in a much broader sense than merely the technical aspect of care (Eustis et al., 1993). For example, research has found that for the elders who are physically restricted to their homes, home care workers' presence provides a comforting companionship or friendship, which is sometimes more valuable than the technical aspects of care work (Eustis & Fischer, 1991; Piercy, 2006).

This leads us to a rich body of literature on the relational and emotional aspects of care. Using the concept of emotional labour, a term originally coined by Hochschild (1983/2003) to describe the phenomenon of manipulation of emotion in the service industry, researchers have examined the performance and repercussions of care work as emotional labour. For instance, Kaye (1986) found that care workers perceive strong emotional and affective demands from their elderly clients. This kind of demand for informality out of formal care relationships can be explained by the unique features of home care and the characteristics of the elderly clients: unclear boundaries of job responsibilities, development of a sense of companionship, and care work happening in the private and intimate environment of clients' homes (Eustis & Fischer, 1991). The relational and emotional aspect of care is not unilateral (Barer, 1992). A Canadian survey

on home care workers showed that emotional labour is associated with job satisfaction of care workers, and its absence is conducive to stress (Denton, Zeytinoglu, Davies, & Lian 2002). These findings resonate with other empirical studies that reiterate the intrinsic value of emotional caring and a good relationship with the elderly clients on the part of care workers (Berdes & Eckert, 2007; Chichin, 1992; Feldman, Sapienza, & Kane, 1994; Howes, 2008; Neysmith & Nichols, 1994). In fact, the satisfaction and sense of reward stimulated by the emotional association with the elders and being caring are sometimes regarded as important factors that motivate home care workers to stay at their jobs (Brannon, Barry, Kemper, Schreiner, & Vasey, 2007; Faul et al., 2010; Howes, 2008; Iecovich, 2011; Kemp et al., 2008).

Such empirical evidence backs some philosophical commentaries in nursing, care-giving, and other public services, which lend themselves to an argument against a simple reduction of interpersonal relations to a means towards a technical end, as propounded in Donebadian's framework (e.g. Griffin, 1983; James, 1992; Standing, 2001; Tronto, 1993). Griffin (1980) distinguished between the activity aspect and attitude or relationship aspect of care. He characterised the attitude of caring as a "long-term disposition" that mediates the technical activities that instrumentally support the care receivers. The emotional aspect therefore qualifies the instrumental activities as caring activities, and should drive the latter (Griffin, 1983). For the same reason, James (1992) put emotional labour on a par with physical labour in the formula of care, advocating for care provision systems that do not subvert or inhibit the emotional component of care. Kitson (1987) went further to examine lay-caring relationship and its interpersonal and

emotional characteristics, arguing for a re-evaluation of quality of professional-caring relationship in accordance with the former.

The above review of the relational/emotional dimension in home care and care-giving in general highlights the inadequacy of the conventional views towards care and good care through medical, institutional, and managerial lenses. Again, a reduction of quality of care to the assessment of outcomes fails to capture the multifacetedness of home care activities. Donabedian (1988) assumed linear causal links between structure, process, and outcomes. But how do structural factors influence processes? What kind of service delivery system yields best care outcomes? These questions have not been answered. Moreover, can all care activities be reduced to practical means towards good outcomes? If some characteristics in the processes of care are intrinsically valuable and merit efforts to preserve and promote them, how would we do it? These issues would be neglected in home care if quality of care was assessed only by the quantification and measurement of outcomes.

2.6 Valuing Good Care: Broader Contexts of Care

There are reasons to be concerned about the tendency to neglect these important issues of care processes in view of the growing appeal to managerial standardization and cost-effectiveness in home care in the wake of public funding cuts and care system restructuring (Aronson, Denton, & Zeytinglu, 2004; Aronson & Neysmith, 1997; Denton et al., 2002; Martin-Matthews & Sims-Gould, 2011). I would now like to move beyond the dyad of care giver and receiver, and look at some broader issues that shape the care relationship. These issues are largely ignored in the practice of quality assessment and the literature on care quality, in which care institutions are viewed as closed systems.

Structural factors in SPO models are confined to the immediate context of the institution; thus the influence of larger social and economic conditions (e.g. neo-liberalism and global labour migration) cannot be considered.

Thanks to work of feminist political economists and care researchers in theorizing care work, we can say something about the politico-economic context that affects care as a social process. Care as a social activity and a series of economic phenomena came into public view as Western industrialised societies experienced a decline in the male bread-winner tradition (Lewis, 1992). Growing participation of women in the labour market, accompanied by a lagging evolution of division of care work inside the family, prompted the question of how to institute a model of elder care that simultaneously meets care needs and advances gender equity (Fraser, 1997; Knijn & Kremer 1997). A variety of policy measures have been engendered, first to compensate or support care work previously provided in families that was invisible to the public, and second to promote care services that relieve families' care burden.[11] These policies, especially the second stream, coupled with the discourses of neo-liberalism and welfare pluralism, favour marketisation and some forms of monetisation of care (Ungerson, 1997), which seems to have become a global trend in the developed world. Currently, neo-liberal discourse and marketisation of care is not confined to "liberal" welfare regimes, but is spreading to traditionally "social democratic" regimes, as evidenced in elder care and child care (see for example Brennan, Cass, Himmelweit, & Szebehely, 2012; Mahon, Anttonen, Bergqvist, Brennan, & Hobson, 2012). Mediterranean and East Asian countries too have

[11] My comprehensive paper contains a review of these policy measures in the Western contexts.

joined the movement (see for example Abe, 2010; Bettio, Simonazzi, & Villa, 2006; Peng, 2009; Ungerson & Yeandle, 2007). Marketisation and monetisation is more absolute in elder care than in child care, perhaps because there is a social investment concern in the case of child care, whereas in elder care, care tends to be viewed in an entirely instrumental fashion (Brennan, Cass, Himmelweit, & Szebehely, 2012).

Ungerson (1997) cautioned that monetisation potentially alters the caring relationship, relegating care to disadvantaged social groups along the lines of gender, class, and ethnicity. On the moral front, despite the fact that care in the family is idealised and often modeled on--committed, attentive, affectionate, filial, and so forth[12] (Noddings, 2002)--the exact same norms are not to be expected in paid care services (Meagher, 2006). [13] On the contrary, care as service is widely disdained and classified as dirty low-class work (Anderson, 2000; Hochschild, 2000; Isaksen, 2005; Tronto, 2006). For example, the ageing bodies of elders are associated with decay and death, and care work for them with dirt and disgust (Isaksen, 2005; Twigg, 2000). Tronto (2006) further illustrated how consumerist logic and language can undermine care as a social value in society, creating a general indifference toward care that has been provided as formal services. This causes a universal devaluation of care work in the society, which in turn affects the process of care work and care experiences at the micro level and limits the possibility of good care.

---

[12] Ironically, only if we set aside problems associated with familial care here (e.g. the patriarchal norms that coerce women into, but exempt men from hands-on care.), it is possible to talk about "idealised" care in the family.

[13] Counterarguments have been made to justify a "rich and thick" market (Folbre & Nelson, 2000), which requires deliberate regulations. I will return to this point later.

At the same time, care, as labour and social production suffers from slower productivity increases relative to other economic activities in the same society, which results in high opportunity costs on the part of the care workers. Two consequences follow. First, if wages for care workers were to keep up with the prevailing pay standard, care employers would have to lower care standards and reduce staffing as there is a limit to passing on the costs to care consumers. Second, if wages for care workers do not keep up with those in other sectors of the economy, retention of care workers becomes an issue. As continuity of the care giver and receiver relationship is crucial, high turnover makes it difficult to provide good care (Eustis & Fischer, 1991; Kitson, 1987).

Although evidence from the home care setting is lacking, for-profit nursing homes were found to be more under-staffed than non-profit ones across the US, Canada, and the UK (Comondore et al., 2009). At the same time, turnover in the home care industry is conspicuous (Stone, 2004), despite the fact the non-pecuniary rewards, as mentioned earlier, may act as a counter mechanism that keeps the workers at the job (Morris, 2009). In addition, in a given care market, the costs of turnover tend to be outweighed by the costs of retaining a stable workforce (Burbridge, 1993), and employers are not interested in investing for retention. It is the elderly clients who eventually bear the consequence of turnover, since for them changing providers always comes at a great cost (Brennan, Cass, Himmelweit, & Szebehely, 2012).

In the face of a worker shortage, care industries turn to cheaper sources of labour to sustain adequate supply. Developed care markets across the world, in North America, Europe, and Asia, have been drawing migrant, mostly female, care workers from economically less developed countries to provide elder care in homes (Bettio, Simonazzi,

& Villa, 2006; Browne & Braun, 2008; Fujisawa & Colombo, 2009; Huang, Thang, & Toyota, 2012; Kofman & Raghuram, 2009; Lopez, 2012; Michel & Peng, 2012). This phenomenon has been extensively documented in the literature on the "global care chain" (Hochschild, 2000; Williams, 2010; Yeates, 2004), and its implications for the provision of good care are two-fold.

This literature reminds us that the logic of cost containment unbridled by deliberate regulations runs contrary to the logic of care. Costs are not reduced, but made invisible by being shifted from the underprivileged to the more underprivileged, and specifically from the "local women" to the "foreign women", as migration reinforces the gendered nature of care (Browne & Braun, 2008; Razavi & Staab, 2010; Yeates, 2012). For example, Shutes and Chiatti's (2012) research in the UK and Italy demonstrated that in both home and institutional care for elders, migrant care workers are those who have accepted lower wages and poorer employment conditions, and thus absorbed the impact of cost reductions. Again, cost containment measures lead to the further devaluation of care (Hochschild, 2000) and the danger of what Folbre (2006) calls a "low-road" strategy of care.

Another point highlighted by the care chain phenomenon is that a picture of care is incomplete without considering the welfare of the care workers. Care ethicists may say that when migrant care workers leave their families behind and care needs go unmet in their country of origin, the "surplus care" (Hochschild, 2000) provided in the destination country is undesirable due to its implicit exploitation of the migrants. Care intersecting the divides of paid/unpaid work and rich/poor countries connects people across the globe. Taking into consideration migrant workers' needs "as both carer and cared in the

destination and origin countries" seems to be a premise of genuine good care (Kofman & Raghuram, 2009, p. 16).

While it is admittedly difficult to directly alter the conditions in the countries of origin, measures can be taken to attend to migrant workers' needs in the destination countries. Here, Williams' (2001) framework for work/life balance is useful. She distinguished three areas of personal lives and mapped out their needs in each: *personal time/space* and what is needed for the care of self and maintenance of the body, mind, and soul; *care time/space* and what is needed to care for others; *work time/space* and what is needed to gain economic self-sufficiency. For care workers, the second and third areas to some extent overlap. In the same vein, Daly (2001) maintained that care givers should be secured with "opportunities to provide high quality care" (Daly, 2001, p. 48), and the conditions of work, workers' social protection and job support, and their abilities to self-care should be considered as integral parts of care quality. These arguments are in line with ILO's Decent Work agenda, and its aspiration to extend social protection, to promote rights at work, and to support unionisation (ILO, 2013).

Care as a social process is subject to a series of economic and moral conditions in a society. As Razavi (2007) rightly pointed out, the question is not so much about whether monetisation and marketisation are deleterious to care, but how to sustain a market of "rich and complex social relationships, aspects of reward, appreciation, reparation, gift and so on" (Folbre & Nelson, 2000, p. 133-134). Monetisation is not necessarily commodification. For many, an answer lies in a policy commitment to create an environment conducive to good care, which entails legitimisation of care work, both

recognising care as a social good and valorising care work through policy support (Daly, 2001, p. 49).

2.7 How Is the Provision of Good Care Shaped?

The above survey of the literature leaves us with a question: if care is shaped in a broader socio-politico-economic context, *how* is it shaped, or through what mechanism is it shaped? There is general agreement in the care literature that organization of home care work under restructuring and funding cuts tends to "depersonalize" care work, pursuing efficiency at the cost of personal connections and emotional devotions between care workers and their elder clients (Aronson & Neysmith, 1996). This phenomenon can be explained by Tronto's (1993) theory of caring as a process. In brief, "caring about", "taking care of", "care-giving", and "care-receiving" are the four phases that a well-rounded care process should entail, corresponding to four moral elements of care: attentiveness, responsibility, competence, and responsiveness. Tronto (1993, p. 109) was concerned with the impact of a fragmentation of care, especially the separation of "caring about" and "taking care of", and called for an "integrated" model of care. The direct care givers, in Tronto's case nurses, are not in a position to make decisions about, thus not to take care of, patients' needs but at the same time may be committed to, thus care about, the patients in carrying out care (Tronto, 1993, p. 109). Disintegrations alike happen in home care when home care workers are only expected and allowed the time to go into elders' homes and "get the work done". The "care-giving" is at the risk of being isolated from "caring about" and "taking care of". The realities that care needs and care work in home care are often "negotiated" and that such negotiation is realized in the maintenance

of relationship have been largely overlooked (Martin-Matthews & Sims-Gould, 2011; Neysmith & Aronson, 1996).

For example, in their attempt to explain the mechanism of a negotiated care relationship, Mahmood and Martin-Matthews (2008) describe the process of providing care as a constant management of the boundaries between the three dichotomous realms and an ongoing negotiation of the meanings of home. They maintain that care workers and elder people with their families create an "intermediate domain" of care in between the two territories of the public-formal-work, governed by a culture of professionalism, and the private-informal-home, characterized by affective relationships (Mahmood & Martin-Matthews, 2008; Ward-Griffin, 2008). Sometimes they use the strategies of clear separation between the two territories, but at other times integration of the two, resulting in a continuum of separation and integration on which the care relationship is actively negotiated and maintained (Martin-Matthews & Sims-Gould, 2011; Sims-Gould & Martin-Matthews, 2010). This process of creating and interpreting an intermediate care domain is shaped in an organizational context informed by a broader environment (e.g. policies of various levels of government, guidelines for work in the public sphere). In the case of restructuring and funding cuts, the intermediate domain is at risk of being forced toward separation, that is, a rigid demarcation between the two territories. Good care relationship is consequently subjugated to institutional constraints (Mears & Watson, 2008; Neysmith & Aronson, 1996; Sims-Gould & Martin-Matthews, 2010).

From an institutional point of view, welfare states theorists suggested an alternative explanation of care relationships: a specific welfare system is conducive to a

particular type of care relationship. In general, this type of explanation can be summarized in the following analytic framework:

Care Regime = Care Nexus + Care Outcomes + Social Justice Outcomes

This model was modified from Gough's (2001) formula for understanding welfare regimes. This type of explanation considers the interrelationships between the components on the right side of the equation. When applied on social care, this model is particularly interested in the causal tendency between types of care nexus, typically featuring mixed roles of the state, market, and family (Evers & Svetlik, 1993; Razavi, 2007), welfare outcomes, such as rights to receive and provide care (Knijn & Kremer, 1997), and social justice outcomes, such as gender equity (Fraser, 1997) or equal treatment of care workers (Razavi & Staab, 2010; Shutes & Chiatti, 2012). The care relationship, in this respect, is considered at the intersection of care outcomes and social justice outcomes, for it concerns both the welfare of the care workers and the clients.

Ungerson (2005) developed a taxonomy of care relationship derived from qualitative data collected from European countries, which allowed international comparisons. The author attempted to link diverse funding and delivery systems in home-based elder care to types of care relationships that ensue in the varying systems. In sum, four common types of relationships were found across European countries: cold, cool, warm, and hot. The main argument is that different funding and delivery systems are conducive to specific kinds of care relationship. The "direct payment" system is liable to foster cold relationships. The "regulation and credential" system gives rise to cool relationships. Warm relationships are associated with the "commodified informal

care" system, and hot relationships are said to characterize the "grey labour" system. I will return to a detailed examination of this theory in Chapter Six.

2.8 Research Questions

The socio-economic conditions described above shape how care work is perceived and performed on the micro level. In fact, many of the conditions are found akin to the context of today's urban China under the forces of economic restructuring and rural-urban migration. It was explained earlier that care reform in China was initiated by the government in an attempt to create a public domain of care and to shift the view that care is a private matter. Then how is home care work shaped by the current fashion of provision in the context of China? This interest led me to explore care provision as a process of maintaining (good) care relationships, and I settled on people who provide hands-on care, in home settings. I ask the general question: *how are care relationships perceived and maintained by home care workers?* Specifically, my thesis research will address the following questions.

1. *How do home care workers perceive their care relationships with elderly clients in the context of home care services in Shanghai?*

2. *How do home care workers maintain (good) care relationships? That is, what strategies do they use to maintain (good) care relationship?*

3. *From the care workers' point of view, how is the maintenance of care relationships with the elderly clients shaped by the organizational and structural context of care work?*

2.8.1 Rationales

The rationales for proposing these questions warrant explanation. In this section I will focus on doing so and leave philosophical and methodological issues for the subsequent

section. I would first like to clarify what this study is not about. The purpose of the present study is not to develop a set of standards against which "quality of care" or "good care" can be codified in the context of interest. The participants in this study, as in any study that involves open-ended interviews, were expected to express normative views about what constitutes "good care" and "good care relationships". These views are important, as they give us a sense of an ideal of what and how care should be and help illuminate the disparity between ideal and reality. It is however not my primary task in this study to use these views to formulate a set of working criteria like in the summative evaluations based on the SPO model. If I were to do this, the elders' views would be indispensable and also family members' views, care managers, and maybe those of other practitioners' too. Instead, the focus of this study is to understand how care relationships are perceived and maintained on the part of the home care workers. It points to care workers' experience of maintaining care relationships.

The key words used here need explanation. I started my literature review with a general interest in "good care", which led me to a more widely used term "quality of care". As was noted in the quality of home care literature, the relational/emotional aspect, although recognised as an integral part of care, is often ignored. Aside from the technical aspect, care work is best understood by examining its relational/emotional dimension. Thus to understand the provision of good care, from this perspective, is to grasp how a good care relationship is formulated and sustained. In this study, care relationship refers to both the technical performance of care work on a contractual basis and to how the two parties are bonded in the care process, their interaction beyond the formally defined tasks and duties. Since care is viewed as a process, a care relationship is

not static. It features active maintenance through interaction, in the process of which meanings arise and actions accordingly ensue.

Admittedly, this issue of maintaining a care relationship can be approached from the perspective of various parties--from care workers, elder people, and maybe even elder people's families. Considering the limit of resources and time, it is only possible for this thesis research to focus on one primary perspective. I chose the perspective of the care workers because it is the care workers who maintain direct contact with the elders, and at the same time their care as a kind of formal work is shaped by the structure and context. They are therefore mediators between the social structures of care and the elder population. As has been demonstrated in the discussion of marketisation of home care and migration of care workers, this population stands in the forefront of the reshaping of the care diamond.

The general research questions can be sub-divided into three working questions. First, how is a care relationship perceived? To perceive is to evaluate the worth, the significance, and value of the experience of the care relationship. It follows that the perceptions reflect meanings assigned to the care relationship and care work, and in fact the task of the research is in part to uncover these meanings. Moreover, people act according to designated meanings of the antecedents, the objects, and the anticipated consequences of the action.

So the second question follows: how is the care relationship maintained? In the literature, the term "strategy" is often used to describe actions care workers take to manage care relationships (e.g. in Mahmood & Martin-Matthews, 2008). I borrow this term to indicate "what is done" by care workers to maintain care relationships. The third

question is logically inseparable from the second. As care work, care relationships, and actions do not exist in a vacuum, it is meaningful to ask: how is the maintenance of a care relationship shaped by its context? What I mean by context in general is the home care program in Shanghai and the provision of care as formal work.

This is still too broad and abstract for the purpose of research. From the survey of the literature, a few areas were identified to delimit the scope of this question, such as agency policies, job descriptions, and other working conditions, including social protections. My rationale is that it would not be very fruitful to ask care workers to directly comment on the care policies but it is meaningful to ask them about their experiences, interpretations, and attitudes about the immediate environment in which they work and interact with elderly clients on a daily basis. One caveat needs to be added. This question could be read as: social forces and structure and arrangement of care cause behaviours and interactions between people, and then determine the practice of care. This deterministic view is that of the SPO model and of the evaluation literature, but not exactly what I mean. I believe that external conditions do influence the practice of care, but not in a "stimulus-response" fashion, in which human agency is given no place. Again, I adopt the view that these influences take effect in an interpretive fashion. Care workers in their interactions with elderly clients, with peers, with managers, and with clients' families, interpret what care work means to them and act according to these meanings.

Chapter Three: Research Methodology and Implementation

3.1 Choice of Methodology

To tackle the research questions laid out in the previous chapter, GT methodology appears the most logical choice. Diverging traditions and approaches exist under the banner of "grounded theory": the original or classic GT developed by Glaser and Strauss (1967) and elaborated by Glaser (1978; 1998), the Straussian approach (Strauss, 1987; Strauss & Corbin, 1990; 1998), the constructivist GT advocated by Charmaz (2000, 2006), and Clarke's (2005) situational analysis--diverge in epistemological views, place of literature, and analytical schemes. Yet all GT approaches subsume an array of methods of data collection, analysis, and theorization that systematically facilitates the generation of concepts and theories from data (Glaser & Strauss, 1967). For example, Charmaz (2006) used the term GT rather liberally, and described it as a "container" made up of neutral guidelines for research, leaving the "what and how" that researchers pour into the container to depend on their academic orientations (Charmaz, 2006, p. 9). In this study, I use GT as a set of methods that guide my research process. Specifically, they are simultaneous data collection and analysis, substantive and theoretical coding, constant comparison, memoing, theoretical sampling, and theoretical saturation. I will explain how these methods were intended to answer the research questions later.

GT is appropriate for this study of care because of its focus on change in social life and social actors' viewpoints on interaction and process (Strauss, 1987, p. 6). Care is a concept that inherently encapsulates changes ensuing at various levels of social infrastructure and day to day lives across the private-public, informal-formal, and familial-societal boundaries (Daly & Lewis, 2000; Knjin & Kremer, 1997; Neysmith,

1991). The realm of care is constantly shifting as social policies and services are directed toward managing and altering the provision of care (Daly, 2002). It is of central importance that this study could successfully depict and theorise the process of maintaining good care relationships in a developing context.

3.2 Research Site and Participants

The target participants of this study are workers in the home care service program in Shanghai. Through contacts at a local university, I was in touch with an official at the Social Welfare Department of the Yangpu district government. In June 2013, I was referred by the official to twelve care agencies in Yangpu district, of which three responded. I subsequently visited the agencies' offices and informally interviewed the managers, while information about the study was distributed in person and through an invitation letter (see Appendix 3) disseminated by the managers. During these visits, documents regarding care policies, job guidelines, and service regulations were obtained from agency managers and reviewed.

An in-depth interview with care workers was used as the primary data collection method. Twenty-three care workers who were interested in participating in the study contacted me as directed in the letter of invitation, and all of them were interviewed between June and September 2013. Table 3.1 contains a summary of participant information. Among the 23 participants, 22 are female, and one male. I will use the female pronouns *she* and *her* throughout the rest of the following chapters to refer to a care worker, as the large majority of the participants and study population is comprised of female workers. Nine (39.1%) participants are of local origin (born in Shanghai and have local *hu kou* or residency), and the remaining 14 participants are migrant workers from

Table 3.1. Demographics of research participants

Case Number	Pseudonym	Sex	Age as of 2013	Origin	Education	Years in Home Care	Years in Other Types of Domestic Service Prior to Home Care	Number of Elderly Clients
1	Ping	F	48	Anhui*	Elementary	9	11	7
2	Lin	F	50	Anhui	Junior High	9	11	4
3	Yun	F	52	Anhui	Senior High	9	6	5
4	Zhang	F	47	Shanghai	Senior High	5	0	7
5	Jian	F	43	Sichuan	Junior High	9	10	6
6	Yin	F	48	Shanghai	Junior High	9	4	5
7	Lan	F	58	Shanghai	Junior High	7	3	6
8	Tang	F	46	Jiangsu*	Junior High	8	0	8
9	Gu	F	46	Jiangsu	Elementary	8	0	17
10	Mei	F	42	Hubei*	Junior High	1	0	2
11	Huo	F	42	Anhui	Elementary	4	2	6
12	Lian	F	49	Shanghai	Junior High	9	0	10
13	Jia	F	52	Jiangsu	Junior High	7	3	6
14	Fang	F	44	Chongqing*	Junior High	7	6	13
15	Tian	F	25	Anhui	Junior High	3	0	20
16	Jun	F	57	Shanghai	Junior High	10	0	1
17	Chen	F	50	Shanghai	Senior High	7	0	6
18	Chao	F	59	Anhui	Elementary	3	10	9
19	Hui	F	56	Jiangsu	Elementary	8	0	9
20	Shan	F	43	Anhui	Elementary	5	0	4
21	Han	M	59	Shanghai	Junior High	2	0	9
22	Sun	F	53	Shanghai	Elementary	4	0	7
23	Lili	F	43	Shanghai	Elementary	4	11	5

* “Non-local wives” are those who married a local husband and had lived in Shanghai for ten years. They gained local residency and are entitled to local social security benefits.

other parts of the country. The majority of the non-local participants are from Anhui and Jiangsu, two provinces near Shanghai. Four of the 14 participants who were migrants married a local husband, and consequently gained residency in Shanghai. On average, the participants were 48.3 years of age at the time of interview. Although a number of older participants had reached the official eligible age of retirement (50), none of them was receiving a pension by the time of the study, for they had not contributed to the scheme for 15 years, the minimum contribution required for pension eligibility. While the migrant care workers are not entitled to the local pension, the local workers had all been laid off at some point in time and therefore failed to meet the minimum requirement of contribution. Indeed, most local workers had been recruited through re-employment programs at the street level of government, and many said being able to pay into the social insurance program had been a strong incentive for them to accept this work.

Most of the participants had lower levels of education. Fifteen (65.2%) of the participants completed the nine years of compulsory education, and 3 (13.0%) completed 12 years of education and graduated from high school. By 2013, the participants had been employed in the home care program for 6.4 years on average. About half of them, mostly migrant workers, had worked in some kind of domestic service jobs prior to the home care program, with an average 7 years of experience in those kind of work. All of the participants had had at least one year of experience in the home care program, and it is thus reasonable to believe that they had adequate experience to draw on during the interviews. At the time of interview, the average "public hire" caseload (i.e. publicly subsidized clients) for the participating care workers was 7.5 clients. Caseload varied significantly among the 23 participants, with a range of 1 to 20 clients. It should be

added that caseload numbers were reported by participants based on memory, and therefore may not be accurate. However, they should be adequate to generate a general picture of the sample. During the fieldwork, I also found that many participants had long-term client relationships. One manager told me that one quarter of the care workers under her supervision had served the same clients continuously. This information however is not reflected in Table 3.1.

A definitional problem arose during the study: not all participants would tell me what kind of hire, public or private, it was before she reflected on a relationship with a client. I adhered to three principles as remedies: first, I ensured during the consent process that the participant understood this study is about relationships with elderly clients. Second, I let the participants talk uninterrupted if it was clear or could be inferred that they were referring to a relationship with an elder client regardless of the nature of the hire. Third, I quickly confirmed with the participant out the nature of the hire and whether the relationship was with an elderly person. I attempted not to interrupt a participant's sharing. In fact, participants' attitudes toward elder clients in public and private hires were not significantly different. Participants occasionally talked about relationships with non-elderly-clients in private hires. Such data later proved to be meaningful as a comparison with narratives on relationship with senior clients.

Case managers at the care agencies typically conducted home visits to check on the elderly clients. I was allowed to go along on these visits. I visited twenty two homes of elders. Most of the time, I remained a quiet observer, but I did speak with six older people about their relationship with their care worker. I also observed interactions between care workers and managers during visits to the agencies. These were not formal

and structured data collection methods, but in the three months of fieldwork I developed rapport with the people I encountered at the care agencies. These observations provided a rich layer of understanding of care work, which from time to time inspired the data analysis process.

3.3 Research Design and Implementation of GT Methodology

The key research components in this study involved initial data collection, substantive and theoretical coding, constant comparative method, memoing, theoretical sampling, and theoretical saturation. These components will be explained in light of GT methodology. It should be noted that in practice, these components overlap temporally, and this study moved back and forth between some of them.

3.3.1 Initial data collection

In-depth interviews that typically lasted 1.5 to 2 hours were conducted with each of the 23 care worker participants. Initial data collection in GT aims to preliminarily generate concepts that give the research a direction for sampling and further data collection. Glaser and Strauss (1967) suggested that one start with some concepts pertinent to the field of study, and use open-ended, passive-listening interviews to elicit what the participants have to offer. As the interviewing unfolds, the initial concepts may be abandoned if the data demonstrates that they are irrelevant. These initial concepts are what Blumer (1986) called sensitising concepts. According to Blumer, such concepts cannot be definitively operationalised, but they give researchers "clues and directions where to look" (Blumer, 1986, p. 148). Sensitising concepts are discipline specific and derivative of certain traditions, paradigms, and discourses.

The case of care is a particularly complex one, as a variety of disciplines take an interest in it. My formulation of research interest was influenced by the traditions of policy research and care research. Welfare regime analyses play a large part in the former, whereas feminist politico-economic and ethical analyses are prominent in the latter. I have identified four themes pertaining to care above, and these themes embody a number of sensitising concepts. For example, the mixed economy theme implies the divide between *public* and *private* domains, which elicits the conceptualisation of *work* and *home*. The ethics theme suggests *values* and *norms* regarding care relations. The theme of well-being of care providers suggests concepts such as *working conditions* and *organization of work*, which both concern the *needs* of care workers. The social status of care workers, being migrants or laid-off workers, speaks to their *social location*, which subsumes *class*, *gender*[14], and *regional* differences. Interactionism highlights human *agency*, which sensitises me to how care workers exercise agency in the context of formalised and marketised care work.

I embarked on the initial data collection with conversations with care workers that allowed them to talk freely about their experience of providing care to elderly clients. I acknowledged the contention that even the least structured interviews have structures, and the salient feature of unstructured interviewing is that "the responsibility of determining the structure is given to the interviewee" (Gillham, 2005, p. 45). While

[14] Though gender analysis is prominent in the care literature, I did not include gender as one of the themes earlier, because I think it is a higher order concept, like class and ethnicity, which deals with socially constructed difference in human societies. Indeed, every theme I identified can be approached from a gendered point of view.

letting the participants lead the way, I needed to guard against drifting too far away from the general area of care and the issues of interest. After all, interviews are "conversations with purposes" (Kahn & Cannell, 1957, p. 149), and the nature of GT research determines that we need to "narrow the scope of the interview topic to get specific data" (Charmaz, 2000, p. 29). Therefore, I developed an interview agenda (please see Appendix 2) with guiding questions.

For example, at the beginning of the interview, I asked participants to describe *a typical day of work in elders' homes*[15], and to reflect on their relationships with their clients. I directed the conversation to explore in a deeper way how a care relationship is developed, by asking participants to describe *what it is like to enter a new client's home and develop a relationship*. To elicit participants' reflection, I asked them to recall their *initial experience of becoming a home care worker*, and to compare it to the current experience. I focused on meanings they attached to their work and care relationships, and how these may have changed over time. I paid attention to any account of incidents where decision-making and actions were required such as conflicts of interest or views between participants and their clients. I also probed into how their experience was shaped in the work context by talking about the environment of their work and how they interacted with people beyond the care dyad. For example, I asked questions such as *how does the work environment help you to do good work or make it hard to do good work?* Starting from these questions, I was able to explore *how* their experiences of maintaining care relationships are affected, informed, or shaped in the context of work.

---

[15] Please see Appendix 2 for all interview questions.

Apart from gathering information, the purpose of these guiding questions was also to establish rapport with the participants, which is considered crucial in conducting efficient and fruitful unstructured interviews (Zhang & Wildemuth, 2009).

3.3.2 Concurrent data analysis and substantive coding

All interviews were audio-recorded, and initial interviews were transcribed within one week of the interview to enable concurrent data analysis. Data analysis was facilitated by NVivo and began concurrently with data collection. After two interviews, I started coding the data substantively (Glaser, 1978), line by line. The aim was to identify emergent general categories or concepts[16] and to condense the data with these categories. Again, the initial concepts that had been developed were constantly checked against new data to determine their relevance, and they were discarded if deemed not useful. I attempted to retain the words coming directly from the participants, as "*in vivo* codes" (Strauss & Corbin, 1998, p. 105), so that categories developed in this fashion "best capture its imageric meaning" (Glaser, 2002, p. 24). This process was recursive and continued for about ten to twelve interviews.

3.3.3 Theoretical coding: constant comparative method

As categories emerged and become richer, I started theoretical coding. Theoretical coding is a process of conceptualizing relations between conceptual categories in GT (Glaser, 1978; Glaser & Strauss, 1967). Whereas substantive codes are direct conceptualizations of empirical materials, theoretical codes are conceptualizations of how substantive codes relate to each other (Glaser, 2004, p. 12). Categories were compared at

[16] A category, interchangeably a concept, is a basic conceptual element of a theory.

the incident[17] level, and theoretical codes were designated to associate categories and to help integrate them into an emerging theory.

Paralleling coding, the constant comparative method is a defining feature of data analysis in classic GT (Glaser & Strauss, 1967, p. 102). In general, there are three kinds of comparisons that I constantly undertook in coding and conceptualization (Glaser, 2004). The first type is comparisons between incidents. If I were to code an incident into a category or property[18], I would compare this incident to previous incidents coded in the same category or property (Glaser & Strauss, 1967, p. 106). This kind of comparison most frequently happened in substantive coding, as its purpose was to "establish the uniformity and conditions of a concept" (Glaser, 2004, p. 14). The second kind of comparison was made between a concept and new incidents. In doing this, concepts were developed and further grounded in data, until they reach the status of "saturation" (Glaser, 2004, p. 14). In the third type, comparisons were made at the conceptual level. This typically happened in the later stage of this study, in particular concomitant with theoretical coding, as emergent concepts became full-fledged.

Accompanying constant comparisons is writing memos. All GT schools highlight the crucial role of memoing in conceptualization and theorization. In my previous qualitative research experience, I found that memoing, coupled with drawing diagrams, could significantly facilitate my thinking by visualizing mental processes. This analytic

---

[17] In GT, an incident is an action, event, or process observed. When associated with concepts and properties, an incident becomes an indicator, which embodies, substantiates, and enriches the conceptual entities.

[18] A property or a sub-category is a subsidiary element of a category, and usually represents one conceptual dimension of the category.

tool was particularly helpful in situations where I had to operate at the conceptual level trying to sort out conceptual frameworks. For the current study, memos were kept of the observations during fieldwork and at any moment as thoughts about the study in general and about conceptualization in specific came to me. I also wrote memos after every session of substantive and theoretical coding in order to consolidate theoretical thoughts. I recorded my questions and puzzles during coding and thoughts on categories and their relations. They were then used during subsequent data analysis, as a reminder of analytical ideas.

3.3.4 Theoretical sampling and theoretical saturation

In GT, further information gathering beyond the initial collection of data involves sampling according to theoretical interests. As categories emerge, later interviews are usually guided by theoretical sampling with a view to developing and elaborating these categories and their relations by eliciting comparative evidence. Ideally, this should be done through carefully selection of participants by theoretically relevant characteristics.

In this study, a sampling difficulty was caused by the self-selected nature of participation. In other words, the study allowed limited choice of interview participants. This shortcoming was compensated to the extent that the subsequent interviews could still generate theoretically rich data by tilting the interview toward theoretically interesting questions. For example, I put more weight on care workers' self-concept and the formation of situated identity in later interviews. Generally speaking, later interviews tended to be more structured than the initial ones. In the meantime, I conducted a kind of re-sampling, that is "collecting data from collected data" (Glaser & Strauss, 1967, p. 71).

I looked for retrospective evidence in older transcripts that supported, enriched, confirmed, or rejected theoretical ideas.

The point when this process of joint data collection and analysis appropriately concluded was when theoretical saturation was achieved. Glaser and Strauss (1967, p. 61) suggest that this point is reached when "no additional data are being found whereby the researcher can develop the properties of the categories", or incidents can be used interchangeably. After about twenty interviews, a general model had emerged in my analysis. And at the data collection front, I clearly felt that I could start predicting the direction of conversations with participants, although I did not attempt to direct them in the ways predicted. I was aware that my research and the theory to be generated would be limited by resources and time, but I was also comfortable with the decision to stop collecting data.

3.3.5 Ethical issues

Measures were taken to ensure that the presence of the researcher and the study did not cause any risk to participants' well-being and interest. I usually started a conversation with the consent procedure. I explained what this study was about and asked the participant to read the consent form. I invited the participant to express her/his expectations and concerns. We then had a brief discussion about these issues if necessary. The participants then were reminded of their right to withdraw from the study at any time unconditionally. Each participant who agreed to continue was asked to sign an informed consent form (please see Appendix 4).

Interviews were held in places where privacy, safety, and confidentiality could be protected and tape recording would not be prohibited by noise. Participants had three

options for the location of the interview: in a room at a local community centre, in a room at the social work department at a local university, or at a place at their choice. All participants chose to meet me at their local community centre. To protect confidentiality, I assigned a numeric code and a pseudonym to each participant and avoided using their real names in the report. With the consent of participants, interviews were audio-taped. I transcribed all 23 recordings. Interview recordings and transcripts were stored in a password-secured electronic file. No printed transcript was preserved. Personal contact information was collected for the purposes of follow-up interviews and dissemination of research findings, and it, with other identifying documents, was stored separately from collected consent forms and data.

A 50 Yuan honorarium (about $10 Canadian[19]) was given to each participant. This was to compensate for participants' time and any transportation expenses. This was not intended to constitute an undue inducement to participate.

An important point needs to be made about anonymity of participants. Potential participants were informed about the study by word of mouth and through the distribution of the letter of invitation by the managers. People who chose to participate contacted me directly. However, in practice, it could not be guaranteed that the managers were completely unaware of who was participating because of the culture at the casual care agency offices and close relationships between the managers and the workers. For example, I observed that when care workers came to the office, they often chatted with

[19] Based on exchange rate of 1 Canadian Dollar to 5 Yuan. Throughout this document, the same exchange rate is used. Where helpful to the reader, values in the Canadian currency are provided in parentheses.

the managers. Several of my participants voluntarily disclosed their participation and conversations with me to the care managers. The general principle of this study was that measures were taken to prevent participants from undue pressure being exerted by their managers, economic loss, and other social and political risks caused by participation. It was practically infeasible and culturally unwarranted to put a restriction on participants' voluntary sharing, which would only have raised suspicion on the part of the participants.

Ethical issues in knowledge transfer are present. As data for this study were collected in the Chinese context and in the Chinese language, but the final report is written in English and mainly targeted to English-speaking academics, knowledge transfer and reciprocity will require deliberate efforts. A seminar will be organized to report the findings of this study at the social welfare department or the local university after my defense. I will prepare a summary in Chinese, and aim to share the findings with the Chinese academic community in a domestic conference. I will also distribute a translated executive summary of the research findings to the participants who indicated that they wish to receive it.

3.4 Implications of Symbolic Interactionism

In the section on research questions in Chapter Two, I outlined a number of assumptions about the caring process, specifically about human agency, action, interaction, and meaning-making. These assumptions fall in line with the views of human actions expounded in the Mead-Blumer version of symbolic interactionism (SI) (Blumer, 1986), to which GT is indebted (Strauss & Corbin, 1998, p. 9). I would like to highlight two central canons of SI that have important implications for my research. The first one is:

> The "worlds" for people, that is the setting, the surroundings, and the texture of things that confront them, are composed of "objects", defined as anything that can

> be indicated, pointed to or referred to. Meanings associated with the objects are social creations formed in the process of definition and interpretation through human interaction (Blumer, 1986, p. 10-11).

According to this doctrine, for care workers, care relationships can be considered objects that build up their everyday lives together with other objects in the context of care work. The meanings of these objects are created through care workers' interactions with their elderly clients and other people in their lives, such as co-workers, managers, and clients' families. Meanings are not viewed as intrinsic as a property of an object, nor are they conceived as a simple expression of some psychological state (Blumer, 1986, p. 4). It is therefore crucial to elicit care workers' reflections on their substantive experience of interactions with others with regard to care work, in order to identify these objects and uncover the meanings created in the interaction.[20] In fact, Blumer (1986, p. 69) pointed out that understanding the life of a group of people rests on identification of meaningful objects that make up their life.

The second canon is: "People act on the basis of meanings of objects that comprise their world through a process of "self-indication" in which they identify, inspect, think about, and work out a plan of action toward the meaningful objects" (Blumer, 1986, p. 5, 50, 69).

The implication is that care workers do not passively respond to the structural and organizational environment as if responding to a stimulus. In like manner, maintaining care relationships as a process is not passively altered by its context; it is care workers as

---

[20] My interview questions in Appendix 2 explain how I went about eliciting the information in fieldwork.

agents who take account of things they note, and act in accordance with their own interpretations of the things (Blumer, 1986, p. 16). This means that it is important to identify the objects constituting the world of care work. Moreover, to provide an explanation of how a care relationship is maintained and shaped in its context is to account for how the care worker interprets (i.e. creates meanings for) the objects in the context of the care relationship, and what are the experiences of acting in reference to the interpretations.

These canons provided working principles for the data collection and analysis in GT. However, meanings are not readily available to the recollection and reflection of the care workers. Berger & Luckman (1966, p. 71) discussed habitualisation of frequently repeated actions, in which "meanings become embedded as routines, taken for granted by the actor". By the same token, Charmaz (2000, p. 34) advised researchers to be conscious of "entering the implicit world without explicit words". For GT researchers, the remedies lie in two practices, as Charmaz suggests. First, she suggests that targeted questions be asked in the interview process to elicit pertinent responses. Second, she advises that the researcher take advantage of the concurrent collection-analysis process, thoroughly study interview recordings and transcripts, and direct subsequent research activities to explore specific meanings and actions of informants. Nevertheless, GT researchers can never claim completeness or comprehensiveness of the research product, as Strauss and Corbin (1994, p. 279) reminded us that the end product of GT methodology, though grounded in the multiple perspectives of actors, is itself an interpretation of the theorist and hence temporal and provisional.

A related issue is the abstraction of individual experience. For example, personalities of the care workers I encountered during this study are diverse. Their approaches to work are different: some portrayed themselves as conscientious and meticulous, while some provided no clue as to how they had been carrying out the care work other than that they "tried to do good work". No one described herself as a "bad" worker, but the "goodness" is a matter of degree. In the same vein, elder clients appeared to be diverse by the participants' accounts. Some older people were described as affable, some as grumpy, some easy-going, and others as fastidious. Many participants told me that their relationships with the clients depended on a simple factor, "match": a good match results in a good relationship and a bad one a bad relationship.

I will not list the adjectives used by participants to describe themselves and their elderly clients. I do not mean to discredit participants' *in vivo* account of their own experience. However, it takes more than description and categorization to account for "match", if the term is found truly helpful in summarizing care relationships. The emergent model presented in the coming chapters is woven together by actions and interactions and by the process of negotiating identity and maintaining self-concept, while the individual characteristics described above are subsumed in the model. I acknowledge that the emergent model is not capable of accounting for all possible personal traits. This means individuality inevitably gives way to a more abstract pattern of interactions and interpretations, to the extent that any individual experience may not readily stand out even when the person is quoted. Throughout this dissertation, participants' quotes have been selected for their clarity and coherence, rendering them convincing support for the points I am making. However, they are not "unique" in the

sense that they reflect patterns in the data. All the points being made, except for the one on harassment (please see Chapter Four) are backed by saturated data--in practice, it means I found no more new information on these points and usually I had at least five to six interchangeable quotes from different participants. In this sense, the development of the model was a process of abstraction. I entrusted this abstraction to the constant comparison method throughout data analysis with a view to achieving both depth and breadth of analysis. To balance the abstraction, I will from time to time come back to an *in vivo* account of the care relationship of what participants do and think.

3.5 Key Concepts in the Emergent Model and Methodological Considerations

Self and *identity* are two key concepts weaving together the participants' narratives in this study. Given the ubiquitous use of the two concepts in the psychology and sociology literature, these concepts warrant a contextual definition. To begin with, in social psychology and sociology, a distinction is made between the subject "I" and the object "Me" in discussing self. This tradition began with William James (1890) who conceptualized the self into two components: 1) the metaphysical "I" or "pure-ego" that can be said to exist as an experiencing entity, and 2) the empirical "me", an object of self-referent thoughts, which consists of the material, social, and spiritual contents. George Herbert Mead (1934/1972, p. 90) made a similar distinction, detailing the "me" as the object of the "generalized other". In Mead's theory, self as an object arises from play and games among children or in social experiences of adults where one draws on socially meaningful symbols to communicate with others. One internalizes the generalized other, the crystallized general attitudes of a given community to which one belongs, and during interactions calls out the same response in the "me" as an object as much as in others; and

in so doing one is able to predict others' response as well as contribute to a harmonious functioning of the community. Mead's conceptualization of self provided a foundation for symbolic interactionism. In the literature on self, it is the "me" that has received most attention, whereas the "I" has been historically left for philosophers to explore (Faunce, 2003, p. 24). One exception could be Cooley's (1902) theory of the looking-glass self, in which the self is not only an object evaluated or imagined to be evaluated, but an active agent that wields influence and controls interactional outcomes.

In this study, the term self refers exclusively to an object, in line with the "me" in the conceptualization of James and Mead. It is used to refer to an image, idea, or perception about a care worker that is recalled, presented, and articulated by the very person. Self represents "who I am" and "what kind of person I am" in the opinion of the care worker. I use *self*, *self-concept*, and *self-image* interchangeably to refer to this objectified attitude toward oneself. This definition of self is congruent with Rosenberg's (1979, p. 7) conceptualization of "thoughts and feeling referenced to one's self as an object". While the emergent model presented here does not focus itself on the genesis of the self, its stance toward the origin of self claims allegiance to the interactionist view that self is rooted in social interactions. When the agentic component of the self, in the sense of Mead's "I", is referred to, I simply use "care worker", "person", or "participant" to point to the agent who engages in social interactions with clients in care relationships, with me in interviews, and with others in everyday life.

The conceptual relation between self and identity is at best contentious, if not ambiguous, in the literature. Identity has been used in conjunction with self (e.g. in Giddens, 1991), considered a subsumed component of self (e.g. in Faunce, 2003), treated

in substance as a synonym of self (e.g. in Breakwell, 2004), and distinguished from self to emphasize social rather than idiosyncratic aspects of a persona such as being a member of a group (e.g. in Snow & Anderson, 1987; Stone, 1962; Tajfel, 1974). In this study, the concept of identity is concerned with a person situated in social contexts and social relations. Identity defines who the person is and in part circumscribes how the person should behave in social interactions. Different from the relatively stable self-concept as already discussed, identity is malleable and negotiated in specific relationships. In particular, the relational role that a participant assumes forms a large part of her "situated identity". The concept of identity complements the self-concept by considering the care workers as persons who actively negotiate their identities in the course of developing and managing care relationships at work.

This study depicts a relationship between self and identity in the following way. The prevailing conception of care work and migrant workers in the Chinese society perpetuates a disdained social identity of care workers. This social identity is a label that entails a negative image of demeaning work done by provincials. The care workers' narratives reconstructed home care as valuable work performed by a caring self. This concept of a caring self forms the core of the care workers' identity negotiation process in their relationship building with older clients. When the stigmatized social identity of care worker is perceived to be perpetuated, and the concept of a caring self rebuffed or rejected, a state of identity or relational dissonance arise. In contrast, when a situated identity is negotiated in congruence with the concept of a caring self, a state of identity or relational consonance originates. The two states may be considered together and called identity harmony, a figurative term referencing the tuning of a musical instrument.

Two themes are salient. One is attributes of the self. Being a "compassionate"[21] person is an image care workers constantly presented of themselves in this study. A compassionate person is a caring person. While the job of every care worker is to *take care of* the elderly, a compassionate care worker *cares about* clients and takes initiatives to satisfy their needs. She is emotionally devoted and she is physically committed. She can even sacrifice her own well-being for the welfare of the seniors. Another theme draws on identities of the participants. "Care worker" and "surrogate daughter" are the two main identities that powerfully regulate care workers' behaviours and interactions in care relationships. There is a tendency for care workers to distance themselves from the social label of "migrant worker who does demeaning jobs". By installing positive images to replace the negative ones attached to the "menial work of care" and rejecting a subordinate role in care relationships, they maintain an identity of dignity. In many relationships, care workers embraced a new identity as the surrogate daughter of a client. The new identity of surrogate daughter brings dignity beyond what work relations would have allowed.

The issues of self and identity call for dignity of home care work and in care relationships. Dignity , in participants' language, means being respected as an equal person, their work being recognized, being accepted in the clients' home as "one of them", and the possibility to take pride in one' work. The word dignity as an encapsulating term is therefore used in a liberal way, rather than to refer to philosophical

---

[21] It should be noted that while *compassionate* is a proper translation of the original Chinese word "*guan xin*" used by the participants, meaning sympathetic and willing to help, *caring* may be a better word to encompass the desire and action to meet another's needs or alleviate another's distress.

and normative considerations of certain qualities inherent of human beings. Closely related to self-concept, dignity may be viewed as a precursor to self-esteem. A person with dignity is more likely than one without to view him- or her- self highly. It is unnecessary to go further into the established realm of psychological terminologies. Of relevance is the fact that dignity characterizes a positive state of the self-concept and a dignified identity is what care workers strive to maintain. When care workers face challenges to a dignified identity, the image has to be reiterated and defended at work. A dignified identity can also be substantiated through shifts in roles, as in the case of becoming a surrogate daughter.

3.5.1 Theoretical appropriateness of key concepts

It should be noted that the concepts introduced above were not "applied to" the data, but "earned" their way into the results. Let me take "identity" as an example to provide a brief account of how concepts found their ways into the analysis. After the first few interviews, I started looking through the transcripts and breaking down the data into small bits in substantive codes. Before long, my attention gravitated to a group of actions and narratives in the data that were labeled "*dignifying*" behaviors. *Dignifying* instances were found in the data where, for example, participants attached value to their work, highlighted the importance of their presence at clients' homes, and took pride in the social insurance or income they had earned. I then designated subcategories of *dignifying*. For example, "source of dignity" distinguished internal dignity, which was concerned with the intrinsic value of care work, and external dignity, which spoke to external symbolic characteristics ascribed to the work and the person that enhance their status; "defending dignity" captured the various actions of participants to shore up dignity

and prevent indignity. For the purpose of theory development, *dignifying* for a moment did seem to be a fitting category.

However, as more data came in, it fell short in two ways. First, it could not account for a more general pattern of participants' self-referenced recounting. Second, focusing on this core category did not contribute to weaving together the other important categories developed through analysis. For example, "becoming a surrogate daughter" as another main category was certainly in some way related to "dignifying", since constant comparisons between the data and concepts revealed, at the level of indicators, that the two categories overlapped. In short, the data called for a concept of stronger explanatory power, one that could consolidate the emergent categories under a broader encompassing network and account for patterns in larger segments of the data.

Theoretical coding (Charmaz, 2006; Glaser, 1978) as an analytic process helps introduce theoretical concepts into the analysis when data calls for that introduction. Theoretical codes are particularly helpful when analysis comes to a quandary in which substantive codes, individually meaningful, together show a perplexing picture. A theoretical code "weaves the fractured story back together again" (Glaser, 1978, p. 72). Identity and self were in one of the theoretical code families proposed by Glaser (1978, p. 76). Their arrival was nevertheless logically dependent on the substantive codes, rather than the other way round. To repeat, they were found to fit to the data. As the reader will see, some of the substantive codes, such as those formerly grouped under *dignifying*, are retained in the emergent model, but the category *dignifying* itself gave way to the concepts of identity and self.

For this study, the concepts of self and identity, introduced as theoretical codes, shed light on the underlying structure of participants' narratives about their relationships with clients and the roles they assume in the relationships. From discord to harmony, from a contracted worker to a much needed daughter, from life to death, ostensibly discrete events find their interconnectedness in light of self and identity. Actions and interactions in the management of instrumental care now made better theoretical sense, and categories about them fit better in the theory. The concepts of identity and self shuffled the organization of the substantive codes, reconnecting them into a coherent whole.

Furthermore, as I sifted through the data again through the analytic lens generated by the theoretical codes, I was prompted to treat interviews as constructive social encounters, rather than a container for immutable facts about what the participants think and what they did, because I could not ignore the ongoing construction of self and identity during the interviews.

3.5.2 Interviews as social encounters

Self and identity issues prevail throughout the tuning process of care relationships. The metaphor of tuning in itself is intended to capture the active adjustment and negotiation of identity. From a constructionist vantage point, self is "in the making" through social interactions (Marvasti, 2008, p. 317). Since I am speaking of *construction* of self by the care workers, it must be acknowledged that the participants were also constructing the self as they described themselves during the interviews, presenting and imparting images of the self that reflected the relatively stable beliefs they held toward themselves. A conundrum regarding the status of the interviews thus followed: Should they be treated as

objective and accurate accounts of the interactions and the process of construction of self throughout care relationships? Or, should they be viewed as a *part* of the process of construction of self, an extended arena where the participants continue to draw and further elaborate their images of self?

Sliverman (1993) compared the two approaches. In the first approach, interview responses are scrutinized in light of their truth or falsehood. Data's correspondence to an external reality is of central concern. The status of the participant is analogous to a "vessel" that passively contains answers to subject matter that can be elicited by the interviewer in an "unbiased" fashion (Gubrium & Holstein, 2002, p. 13). Neither the subjectivity of the participant nor the interviewer should be considered when data is analyzed. In the second approach, interviews are analyzed as a channel granting us "access to the repertoire of narratives used in producing accounts" (Silverman, 1993, p. 108). Accounts in this case are treated as having been narrated in such a way that they are a means to moral and motive ends. Researchers and respondents are therefore both treated as active participants in the social encounter of an interview (Warren, 2012).

I took the latter approach. During the interviews with the participants, most of the participants engaged at a high level in self-evaluation. They compared themselves to others, presented themselves as compassionate persons, and depicted care as dignified work. They did these while responding to my questions, sharing their feelings, explaining the agency and care policies--construction of images of selves was part of their interaction with me. As passive an interviewer as I am, I reframed, nodded to, confirmed, and affirmed their presentations of self. In this sense, I participated in the construction of their selves too. In hindsight, I also internalized some of the norms

regarding family roles and children's responsibility and general attitudes to the elders. For example, the Confucian ideal "to honour seniors as we do our own old parents" was inculcated during my childhood, and to today I tend to believe that treating all seniors like our own parents is morally desirable and should characterize any kind of relationships that involve caring for an older person. Therefore, the interviews were very much social encounters where the participants and I mutually engaged in constructing the key concerns of this study and the substance of care relationships around self, roles, and identity.

Chapter Four: Tuning: An Identity Work in Care Relationships

One can speak of an active relationship beginning when a care worker meets her elderly client for the first time. A dynamic relationship, from beginning to end, evolves through time. It can last weeks, months, or years if the care worker remains in this type of employment, but even the most short-lived dyads tend to move through at least a few visits. What would usually occur over a longer span of time, in this case is crammed into a shorter period, with increased interactional "density". A process that we may call "tuning the relationship" or in short "tuning" characterizes the development and management of such dynamic relationships.

Tuning is a process through which a care worker learns about her client, establishes rapport, and determines the tangible specifics of care work at the particular home. Most importantly, it is a process where the care worker's identity, role, and self-concept are subjected to adjustments in response to situational conditions. In short, in the process of tuning, the care worker finds out about the fit between the client and herself. Tuning usually leads to a decision about if and how a care relationship will continue; it is vital that a care relationship is well tuned for it to last long.

The process of a musician tuning the strings of a musical instrument is a good analogy here. In its simplest form, the purpose of tuning is to bring two strings to consonance. The two strings could have begun being separated by a random dissonant interval that could create an unstable and clashing sound; after the tuning, they are expected to vibrate more or less in harmony. It is equally possible that the two strings began in a fairly harmonious manner, and therefore required only a small amount of tuning. In some cases, the musician might lament "this guitar is un-tunable!" expressing

frustration over the difficulty of bringing two strings into harmony despite diligent efforts. She tries a piece of music on it and then complains that "it is unplayable". She may bear with it and continue for a while or she may abandon the instrument immediately.

Tuning a care relationship resembles the process of tuning an instrument. On the part of the care worker, tuning a relationship is to bring herself into harmony with the client and to align her care work to the client's needs. What was termed "identity work"[22] (Snow & Anderson, 1987), the process of negotiating identity and maintaining a certain sense of self, is performed as well as tangible care work. Both of these two types of work are important, and indeed, they are intertwined and cannot be understood with the absence of either. In a care relationship, identity work is the soul that animates the flesh and blood of tangible care, whereas without manifestations in the latter, the soul is empty.

4.1 Care Work = "Provincials'" Work = Demeaning Work: Care Worker as a Social Identity

Who are care workers? What does being a care worker symbolize? How do care workers respond to the reality of being a care worker? These questions set the premises for a discussion about the relationship between a care worker and her elderly client. Human relationships in the view of the interactionist tradition involve reflexive communication about one's self and consequently negotiation of identity. For my

[22] In the following chapters, I use the term "identity talk" to describe the participants' narrating of their identity work.

participants, this process of searching and negotiation for self and identity appears fundamental and underlines the instrumental aspect of a care relationship. Therefore, I shall begin the exhibition of findings by examining the identity and image of self, possessed, enacted, and shunned by my participants. These identities and process of identity management were implicitly and explicitly interspersed throughout the accounts of participants' experiences. GT methodology allowed me to take the data apart and re-assemble the bits and pieces of experiences into a coherent story that captures the characteristics and processes of identity management of my participants.

The majority of the participants, who are migrant workers, had worked in either homemaking or care work as privately hired *bao mu* or *zhong dian gong* prior to the inception of formal government organized home care around 2003-2004. By the time the home care service was introduced, hired care work had largely been undertaken by migrant workers, and the image of care workers is entrenched in the stereotype of rural to urban migrants held by local people. "Provincial" is the word used by the local people toward migrants, underlining an overt derogation. Recalling her experience of settling in this unwelcoming metropolis in the early 1990s, one participant commented on the local reception of migrants:

> *We were from out of town. And we (this group) had made a negative impression on Shanghai [people], not a very positive image. One thing is theft and another is robbery. Very bad image… Some cases were on the news, a zhong dian gong pilfers, a bao mu steals. (C09, L.153-158)*

Migrant workers' image was described as uneducated and treacherous. In the early years of the economic reform, migrant workers were called "peasant workers", an implied inferiority to "urban workers" as a result of the systemic duality of Chinese

society since the 1950s. *Bao mu*, of the lowest status among the city jobs, is relegated to this marginal group. The participant continued:

> *Our [care] work is the lowliest, the lowliest job in Shanghai. People were kind of looking down [on this job]. [One] senior said it all. I said: "your granddaughter doesn't seem to care to talk to me, like she despises me or what?" [The senior] said: "maybe somewhat. First, you are from out of town, and second, doing this kind of work is very, very miserable, pitiable." (C09, L.158-162)*

The "miserable and pitiable" care work is closely associated with the identity of migrant workers, and sometimes people may not even bother to differentiate between the identity of care worker and the identity of migrant worker. When I asked about experiences of discrimination, one migrant participant shared a conversation she had overheard between residents living in the same neighbourhood:

> *Participant: Now we've heard [in my neighbourhood] some people say: "don't bother making friends with those provincials." [Because] some older ones are really nice to me. "Gee, what do you get from them?" they said, "she could disappear at any time." They just look down on you, provincial bao mu.*
> *Interviewer: Look down on provincials or bao mu?*
> *Participant: Don't provincial and bao mu mean the same thing? (C18, L.503-508)*

For local people, doing care work means to lower and align their own status with the migrants, which for many is disgraceful. A local participant felt humiliated to be a care worker. "Doing this kind of work is after all embarrassing. You'd be ashamed to tell other people. Because it was all those migrants being *zhong dian gong*, now doing it as a local is like a cut below [the locals]". This humiliation is more tangible than an intra-psychic struggle. Care workers, particularly locals, may face pressure from inside and outside of the family as resistance to the identity of a care worker. The data are

replete with participants' stories about the disapproval of their husband, rebellion of children, and raised eyebrows of neighbours and friends about their work. One participant told me that her daughter would never reveal at school that her mother is a care worker, because of fear of losing face. Her daughter later brought this up with her: "if my classmates came to know my mum does *jia zheng*, it would be embarrassing." The participant said her daughter would never invite any friends home. The daughter's sense of shame can possibly be pardoned when other cases are considered. Another participant disclosed that her daughter, once engaged with a local young man, was forced by his parents to break up with him when the young man's parents learned that her mother was a *zhong dian gong*.

More likely than the kind of silent rejection of a teenage daughter and disapproval of potential relatives by marriage, many care workers face stronger pressure from their husbands. One woman married to a local husband complained:

> *My husband doesn't like me doing this line of work. He said, like this kind of work is losing [face]. Shanghai people, you know, Shanghai men are touchy about their face. But what can I do? I have a child [to take care of]! It is not that I want to do this. I have a child, I have no choice… Sometimes he fights with me not letting me go [to work]. What could I do if he doesn't let me go? [I] just called [clients] and asked for leave. If I can't do it this time, I'll do it next time, or just put it off. Right? Sometimes [he] bickers, sometimes loses his temper: "What kind of job is this? What a terrible job!" Blah, blah. "[The job] sounds awful, pays little, and is a drudge. Why do you have to do this?" Like I had other choices. (C10, L228-230; L.259-263)*

Being a relatively new migrant worker, she acknowledged that the local sentiment is strong against care work and attributed this to his husband's sensitivity to face-saving. As a "half" local, she herself does not regard care work highly. She would have opted to

do something else, had she had other choices. She went on to tell me about her acquaintances living in the same neighbourhood, who are like her, non-local wives.

> *Participant: Those non-local wives in our neighbourhood, like me, they are all from out of town. They look down [on this job]. They would rather idle at home, if their husbands earn enough. Sometimes I said: "I can hook you up with some work." They wouldn't do it. "It doesn't sound so nice", they all went like that. They didn't want to do it, like despising? That's about it.*
> *Interviewer: "It doesn't sound so nice" you said. So what does "not so nice" mean?*
> *Participant: When you tell others about this job, [they say] "garbage job", [their response is] like one word: "Quit!" (C10, L.277-286)*

Difficulties in adjusting to the new identity as a care worker prevail, among both locals and migrants. A typical reaction was to conceal their identities from relatives and neighbours. Some revealed that up until the day of the interview, no one beyond their immediate family knew about their work. For instance, one participant from the neighbouring *Jiangsu* province said she did not tell people that she was a *bao mu* when she visited her hometown. For some participants, working for elderly clients living in the same neighbourhood is still a taboo. One participant who claimed to have overcome this taboo recalled that when she started as a care worker ten years ago, she actively sought clients living a few kilometers away from her own neighbourhood so she would not be seen doing care work by acquaintances. Another one told me she is still not taking in clients living in the same apartment building because of her husband's "firm objection". Still others who are not able to hide the fact that they are care workers may feel embarrassed when this identity is publicly revealed. One confessed that when she walked her clients in wheelchairs in the neighbourhood compound, she would always lower her

head, tuck her chin in, and be anxious about being seen by neighbours she knew. She said: "I was so afraid they recognized it was me!"

By concealing the care worker identity, participants resist being associated with a social label that carries demeaning connotations. The person who is doing the care work is not "recognized as me", and the "care worker" is kept apart from where "I" live and whom "I" know. Concealing the kind of work they do prevents care workers' self-images from being spoiled by doing menial work. This concealment in public is a matter of degree. Not every care worker hides her occupation, and the degree to which one tries to hide may depend on how reflective she is about her identity, how much she internalizes the prevalent attitude toward care work, and how much pressure she bears from her immediate social groups, such as families, friends, and neighbours. In general, it is likely that local workers are more likely to hide their work than migrant workers as migrant workers mostly live in rented apartments and do not know their neighbours as well as the locals who all own properties and are more closely tied to the neighbourhoods. At the same time, migrant workers are more likely to hide the fact that they work as care workers in the city from relatives back in their hometowns.

4.2 Reconciling with Care Work: An Identity Talk

Care workers, facing adverse social attitudes about nannies and housekeepers, and family pressure, may start a care job with an unsettled mind, questioning the value of the work they do and constantly needing some kind of justification. In the course of many years of immersion in care work, they come to terms with being care workers, resolve the psychological disquiet aroused by doing what they believed to be a demeaning job, and finally settle with a positive self-concept characterized by the dignity they find in their

everyday engagement in caring for seniors. This settling has been ascribed to the changing views about care work in their immediate social interactions and on a general societal level. In what follows I attempt to show how care workers deal with the negative social identity attached to care work and restore their dignity through their narratives about everyday care work and accounts of care relationships with elderly clients.

4.2.1 Reconstructing demeaning work: the elderly clients "in need" and the "needed" care work

A care worker compares her own socio-economic condition with a client's, as she enters the client's home. Since the home care subsidies are only given to the elders who have low income and minimal family support, care workers for the most part make downward comparisons that evoke their sympathy.

For participants who know the client well, to describe the life conditions of the impoverished elderly is "heartbreaking". The hardship of the lives of the clients stimulates a strong sense of sympathy on the part of the care workers, which in turn shores up the value of care work. One local participant, a single mother, tried to demonstrate to me that her elderly client on social assistance could not eat properly and lived a life harder than her own. She enumerated the monthly spending of the client:

> *Five hundred and seventy Yuan a month, pays hydro and gas, cable, landline, and also rent. Six bills. She is very thrifty, she wouldn't even turn the TV on. No fridge either. Electricity, about 10 Yuan per month. Water, 6 or 7 Yuan a month? Then, cable, 25 Yuan every month, firm. … Landline, 25, firm. Rent is about 60 to 70. After all these, 200 [is paid]. With the 370 left, what do you expect her to eat? Excluding twenty pounds of rice and one jar of cooking oil for one month, all [she could buy] is reduced to leftover groceries. Nothing [good] to eat. It's heartbreaking. Not even 10 Yuan a day for food. Sometimes, I saw her getting*

those flavoring packets for instant noodles. She got it and made it [into a soup]. That is heartbreaking… Some seniors with children are ok, but a number of others are wretched. Not just me, many care workers' [clients] are like this. [We] all buy things for them out of our pockets. We do this line of work, how could we abandon the elders, even if we wanted to? Had we not known them, once knowing, we all feel sympathetic. Like I told my daughter: "now mom does zhong dian gong for a living, but our life does not come near theirs." I teach these things to my kid. This is because [the clients] don't have social security. So we do this job, and feel it deep down. (C23, L.41-62)

This quote shows the condition of a typical older person on social assistance in the city. Of course they may receive support from other private sources, such as their cohabiting children, but given the means-tested nature of social assistance, the children of assistance recipients would often be no better off. At the same time, it should be noted that the elder person mentioned above represents the worst cases among home care clients. Some of the homes I visited during fieldwork did fall under this category. A dark, musty, and squalid bachelor suite is typical of their housing situation. However, some other clients are eligible for subsidized services on the basis of their old age or deteriorated health. Their living conditions are noticeably better--more spacious and tidier--than those on social assistance. Their superior economic conditions can also be easily identified by the availability and quality of electrical appliances in the homes. Care workers are observant of the diversity of conditions, comparing the conditions to their own. The visibly impoverished conditions of a client's home tend to arouse sympathy, and a gap between "their" and "my" conditions calls for care. As the preceding quote shows, the care worker internalizes a sense of responsibility to herself by emphasizing the poorer condition of the client. Her statement "unable to abandon the

elders", reveals a sense of moral responsibility. Downward comparisons with clients can be conducive to a stronger affective and moral bond with them, which in turn increases the inherent value of the work the participants do.

It is not only local care workers who make downward comparisons. Migrant workers, who are disadvantaged compared to the locals, also do. I asked one migrant worker to compare her experience of working for well-off families in her early years in the city and her later experience of caring for older clients in home care. She said:

> *Even the duster cloths are different. Like poor people, she uses worn-out t-shirts with patches on them. When they are completely worn-out, she tears them apart and gives them to us [as duster cloths]. We understand. She couldn't bear to use a new towel [as a duster]. Sometimes we bring towels [for the clients] to use. We don't despise the poor. We'd rather think how to help them, to give them something, because we lived a hard life. It hurts when others look down on us. You know? … We always thought, one day if we got richer, we wouldn't look down on the poor. (C09, L.273-279)*

Being a migrant worker was once a despised hard life, but now it is transformed to become a source of compassion and care. This migrant worker, in her words, suggests how the participants find meaning in their work by comparing the past self and the current client.

As hardship among the elderly clients is prevalent, the majority of my participants make such downward comparisons. In addition, elderly clients in public hires are more economically disadvantaged in comparison to clients in private hires, and are therefore more likely to be the target of downward comparisons. Four aspects of the life conditions of clients were most frequently referred to by the participants: poor housing, low income or lack of social security, absence of kin support, and physical infirmity. Comparisons

commonly are made when a care worker visits a home for the first time. They can also be prompted by everyday interactions. For example, one participant told me that one of her clients, a 90-year-old lady, was too destitute to afford any proper kind of food other than noodles. One day on a rare occasion the old lady wanted to eat fish, so the care worker went off to the market and asked for two "tiny four-to-five-inch long fish". The fish were so small that the vendor could not even weigh them. In the end, the vendor gave the fish to the lady for free. The participant lamented the poverty of the old lady, and attributed it to the lack of old age security, with which she juxtaposed the fact that upon retiring, she herself would have a pension that would put her in a much better economic position than the client. The thought that she is better off than the client summons a desire to extend a helping hand to the client. The care work for the participant is thus regarded as "helping", and more valuable than "just any work".

The elderly clients in home care are in need. Participants portrayed their work as meeting the needs of the elderly clients that would have otherwise been left untended. They feel their work is needed in society. One said:

> *I can't take a day off. Seniors have been used to you coming routinely. They think "she is going to come today", they are used to that. … Seniors look forward to you. Some neighbours told me: "you see, he (a client) has been sitting there, looking to the direction you come from. He was waiting for you, so anxiously." Seniors count on you to help them with housework. They need us. They really need us. … They would ask you to come earlier, so after the work is done you can talk to them. When you have to leave for the next home, they wouldn't want you to go. … These seniors are lonely. They want someone to talk to, to be company. Families are close, but they (seniors) can't count on them (families). So they have to count on us. Right? (C14, L449-467)*

In this case, the senior clients are perceived to rely on the care worker to have housework done and to gain intimacy, especially when there are no co-resident family members. Overall, participants feel they play a crucial role in the lives of their clients. They are "counted on". The perception of being needed enhances the perceived value of work, which counterbalances the disdain inflicted by the care worker as lowly identity. This effect can be illustrated by the following excerpt from one participant's comment on the discrepant views held by the younger generations and the seniors who need care. I asked how she feels about the attitude of the general public toward care work. She responded:

> *The younger generations look down on us, but the seniors like us. Without us, they (seniors) wouldn't know how to survive. But if you talk to those younger people like me (43 years old) or even younger, or those who do office work. If they hear you are working in home care, they show a disgusted face. Completely different [from the seniors]. … The seniors always go, 'Lili, Lili (pseudonym of the participant), thank you, what would I do without you…' It is so comforting when you hear them say that, because sometimes when you first go to their homes, they don't have a washboard, no mop, not even a hanger lift (a tool for lifting hangers). And you buy these things little by little for them. Your feeling is like, the seniors really can't live without me. (C23, L.321-330)*

Washboard, mop, and hanger lift are some of the most essential tools for maintaining a living space. The fact that some senior clients could live without these tools would be unimaginable for many, and for the participant here is a veritable sign of neediness. Like the previous participant, this lady believed that senior clients are dependent on her. In addition, she found the clients' acknowledgement of such dependence comforting. Such acknowledgement helps to counter the contempt shown by the "office workers" and others like them. Helping those who are weak and in need instills a sense of value into the once demeaning care work.

4.2.2 A caring self doing good work

In the previous section, I expounded the idea that care workers reconstructed home care as work for those in need, through comparing their life conditions with those of the clients. Now I turn to care workers' claims to be a particular kind of self. It has been observed that making downward social comparisons evokes a compassionate sentiment on the part of care workers. Here I will continue to explain how *caring* is woven into the participants' narratives about their self-concept as a character that undergirds care relationships. In my interviews, the participants reported that a caring self is the foundation of their care relationships with the elder clients. They actively identified themselves with a caring person in their accounts about relationships with clients. Consider the following quote from one participant about an episode in which she displayed caring toward the client.

> *Sometimes as the seniors get older, when they display a sign of illness, we sense it: her colour isn't right, or her voice doesn't sound normal. One day, this old lady, it looked like her blood pressure was high. I measured her right away and I said: "Aunt, did you take the medication [for hypertension] today?" She said: "I don't know. I probably did." Her son would leave the medicine out there in the morning, and I sometimes check if she has taken it. Now I saw it (medicine). I said: "Aunt, are you feeling dizzy today?" She said: "I kind of feel dizzy." I said: "You did not take your medicine." So I gave her the drug. I then waited for twenty minutes, because I was worried. This twenty minutes is not in my hours, but it is my duty. She said: "Lin, don't you need to leave? You can leave if things are done." I said: "Aunt, today I'll stay longer for a bit and chat with you." So I waited, but I couldn't tell her that I was worried about her dizziness. Because if I stressed that, she would start getting anxious. She asked why I did not leave, I just said I could stay and chat with her. After twenty minutes, I asked: "Are you*

feeling better?" She said: "I'm fine." It meant the medicine had taken effect. This is how I care for this old lady. (C02, L.324-336)

All care workers care, in the sense that they carry out activities described in regulations governing home care and stipulated in an oral contract between the care agency and the clients, such as cleaning, washing laundry, and cooking. The caring self however, can be manifested beyond these instrumental tasks. To begin with, the administration of medication is not part of the job responsibilities of home care workers. It therefore makes sense to acknowledge that the care worker quoted above was observant of her client's physical status even though she was not obligated to be. She also needed the knowledge about what is "normal" and what is not to make a decision in the face of given evidence of possible high blood pressure, and this required continued attentiveness to a need. As the need was identified, she worked toward meeting it. She checked on the old lady, not in a blunt or disturbing way, but rather carefully, minding the client's potential emotional response, which might result in deterioration of her health already at stake. Smoothly and unobtrusively, the need was taken care of. Being caring also comes with a cost, which in this case meant sacrificing twenty minutes of her own time. She did not hesitate to describe this sacrifice as part of her "duty", an idea I will return to in Chapter Five.

For many, caring is an essential quality for doing good care work. However, it is difficult to pin down the origin of this quality. For some, it originates from their "conscience". Illustrative is this participant who showed her pride when claiming to be the "best *bao mu*" in her neighbourhood:

Wherever I work, I get along with people. You care about her with your conscience. If you don't mind dirty and smelly work, and are hard working, she

must be happy. I have very good relationships with the seniors. Among so many bao mu in this neighbourhood, I am the best! Why? Everyone likes me because I have a positive attitude. I don't mind they are dirty and I am caring for them. So your relationships will last long! … If you don't do good work, people don't want to keep you, right? (C18, L.9-12; L.59-63)

Interestingly, many participants, like the one quoted here, portrayed themselves as more "caring" than other care workers, or alleged others are less "caring". During interviews, I often heard accounts about peer workers "slacking". One participant, for example, told me that some of her co-workers always avoid clients whose home requires a heavier workload or filthy tasks, but she never did so, because she is "conscientious". Another participant said some people she knows would never want to contribute one extra minute beyond the working hours, while she would not make shrewd calculations about time, because she is more "ready to help". Yet another said her co-workers spoke lightly of the job and revealed that they always skimped on the work and killed time on their cell phones, a work ethic she could not agree with.

Doing care work may inflict a stigmatized identity shunned by the participants, but caring and compassionate qualities involved in the same work are desirable characteristics. A caring self seems to counterbalance the self-image threatened by the identity of care worker. As I will explain later in this chapter, the self-concept as caring accords well with the role of a surrogate daughter, which calls for affective relationships that involve mutual caring.

4.2.3 Reward as a symbol of dignity

Care work may be viewed as demeaning and inferior, but care workers find dignity in decent economic rewards; in their own words "we win our own bread". In the

interviews, the participants presented an image of themselves as self-reliant and thus deserving respect. The following quote is from a local worker who took pride in living off her own labour. Her comments highlighted the presentation of a dignified self-image by asserting self-reliance:

> *[Those who] don't do this kind of work always feel superior. Right? They would say: "you are zhong dian gong, you do jia zheng, bao mu" and something like that. … But we are used to that, and ignore it. Like I said, no matter you look down on me or look up to me. I do my own work, and I am not begging from you. People are practical nowadays. If I have income, it's none of your business. … Those people on social assistance, they play mah-jong at home all day. How comfortable they are! You live your comfortable days, I do my work. At least I earn 100 Yuan from work today. You play mah-jong and you are on social assistance, but you earn nothing. I can go eat at a restaurant today if I feel like it. Can you afford that? You can't. You can despise me all you want, but I'll do it. We (care workers) all take it this way. Don't be bothered by it. (C17, L.582-595)*

For care workers, decent income works as a shield against the socially imposed sense of inferiority. They feel a sense of control of life as they become economically viable through work. The fact that this participant attempted to distance herself from the mah-jong playing social assistance recipients, although partly reflective of the stigmatizing effect of social assistance in that context, does reveal the effect of self-reliance on elevating self-concept. With the pride she takes in her labour, she could dismiss the scornful pressure incurred by the identity of being a care worker.

A similar mechanism was utilized by care workers to mitigate the stigma of being a migrant worker. Migrant workers, instead of comparing themselves to social assistance recipients, routinely tried to distinguish themselves from the stereotyped "provincials". One participant commented on being a migrant care worker in today's Shanghai, and said

that it does not matter what a person does in Shanghai as long as she relies on her own labour, "not stealing, not mugging". She was echoed by another migrant care worker:

> *It is a different time now. People don't mind. Work is work, as long as you don't steal, you don't plunder. You do respectable work, and you should be happy with the money. You earned it by your sweat. Right? Better than breaking the law and doing those [unlawful deeds]. You reap what you sow. Who cares what other people say? (C13, L.425-428)*

In the same vein, these participants find themselves buffered against the judgement passed on their identity as care workers. Indeed, for both migrant and local care workers, being able to "win their own bread in a respectable way" signifies the dignity of care work, and again, redresses the negative view toward care workers.

While it is evident that both migrant and local participants find this kind of psychological compensation for doing a demeaning job by shoring up a dignified self-concept, there is a difference between the two groups in that they tend to draw on different sources for dignity. The migrants tended to take pecuniary reward as a key symbol of dignity, while the locals regarded the social security entitlements as a source of dignity. One migrant worker said:

> *People are practical, very realistic, because home care now pays OK. … After all, it's about salary. Now this line of work pays OK, so you think, "it's not too bad." We are not like bao mu in old times. Our social status, I should say, is higher than before. Financially, the income is OK, four, five thousand a month is OK. (C03, L.367-371; L.391-394; L.410-414)*

Elsewhere in the interview, she mentioned she began working as a privately hired *bao mu* in 1998, six years before entering the home care job. Comparing now and then, she concluded that the social status of care workers is higher now, and she clearly

equated higher status with higher income. Some participants who grappled with their care worker identities told me now they feel relaxed to tell neighbours and friends about their work, because now "their income is quite good". A similar point of view is expressed by another migrant worker, although in a less explicit way:

> *After all, we earn more than bottle washers at restaurants and shelf stockers at supermarkets. If we are hard working, our income can be higher than theirs. Then we can afford to buy stuff we want, and life becomes easier. That's all it is about. You should work hard! Life will be good. Work hard. That's it. (C05, L.374-378)*

She said she was satisfied with the current job, because it pays better than other lower status jobs that are often taken up by migrant workers, and also she earns more by working hard. Indeed, among the care workers I talked to, migrant care workers generally had higher monthly income than the local care workers, by around 30%, despite the additional subsidies for local workers in the home care programs. They achieve this by working longer hours and taking up more private hires than locals.

For many local workers, home care is a kind of "government-funded job". The perception that they work for the government and the fact that they are entitled to subsidies for pension and health care premiums coalesce to give rise to a sense of higher status. The following quotes from a conversation I had with one local participant illustrates this point:

> *Interviewer: Do you think home care work is different from other kind of care jobs?*
> *Participant: They are different. I think there is a difference. We have a manager and we have a "mother" agency. If we didn't do well, someone would hold us accountable. The other (private hire) sounds less credible.*
> *Interviewer: Do you tell people this when they ask about your work?*

Participant: Yes. If someone asks me what I do. I always say I work in home care for the street (level of government). The street (level of government) hired us to do home care. It's different from other kinds.
Interviewer: When you say from the street, you mean you work for the street government?
Participant: Just to be more credible. It's not like in those private jia zheng, people steal stuff. In home care, can we be grabby? No, we absolutely can't be.
Interviewer: So when you tell people this, you feel …?
Participant: Different. Sent by the street. And I contribute to social security.
Interviewer: What are people's responses when you tell them you are sent by the street and have social security?
Participant: People consider this (care work) a job! People look at you differently. You are doing this for the social security, like those who do cleaning work, security guards, or work in supermarket. Same idea. They do it for social security and for a better life. Different, really different. So I appreciate this job a lot. (C12, L.305-353)

"Public work" enhances the perceived credibility and status of the job, and is demarcated from work in the private sector by this participant. Note how the bottle washer and shelf stocker jobs are viewed differently by this local participant and the migrant worker quoted above. Other conditions being equal, the migrant worker is likely excluded from social security coverage, whereas the local worker would usually be entitled to benefits. In fact, for the locals, the entitlement to social security symbolizes a "formal job" and warrants a sense of dignity. The prevailing attitude regarding care work, be it *jia zheng*, *bao mu*, or *zhong dian gong*, entrenched in a low-status, precarious and informal image, could be shaken up when care work is recognized as a formal job associated with equal benefits.

For migrant workers, it is a different story. They often complained about the injustice of being excluded from the social security schemes:

> *We'd appreciate if they gave us benefits. For example, when we get old, we will have some security. Without security, we are uncertain about the future… People from out of town like me have done this work so many years. To be fair, I think, I have my opinion. Why is there such a big difference between us (locals and migrants)? They get benefits and we don't have regardless how well we do. We can't compare to the locals. We are discontent. (C11, L.396-401)*

As a result, migrant workers feel "they cannot compare to the locals", which in part explains why they are more likely than the local participants to present themselves as hard working. The fact that the migrants tend to work longer hours, means that they often have to seek dignity at the expense of their own time and health. These differences highlighted that since care workers draw on available resources to support their self-concept and identity, the structural inequality of the current program policy constitutes an obstacle for migrant workers in their identity talk. It in part explains an overall pattern in the data that migrant workers are more sensitive to identity issues and thus vulnerable to identity dissonance, an issue I will discuss in the next section.

To summarize, reconciling with care work is a process that care workers are apt to go through as they come to terms with the identity of care workers. Care workers in this study constantly constructed themselves as compassionate persons and caring about their elderly clients, whose recognized needs are then drawn on to establish the value of care work. By acting on their compassion and engaging in helping those in need, care workers feel a sense of dignity that counterbalances the stigmatized identity of care worker. In addition, they actively look for compensation in care work. Although the compensation often appears in economic terms, care workers' narratives unveiled the

presentation of a dignified self who does dignified work. For local workers, "public work" and entitlement to social security benefits foster an additional sense of dignity; whereas for migrant workers, who are denied access to social security, income is the only external source of affirmation. The sense of dignity gained offsets the discrepancy between the self-concept and the demeaning identity of care worker.

The above analysis provides a backdrop to the care relationships of interest in this study. Indeed, from an interactionist point of view, identity and self-image play a central role in social interactions. I argue that an analysis of self-image and social identity is essential to understanding care relationships and the situated identities in such relationships, since the state of self-concept constantly needs shoring up in everyday care work and in interaction with elderly clients. In other words, this sense of dignity is also situated in individual pairs of care dyads. In some care dyads, care workers are able to maintain the desirable self-concept, whereas in others, they may find it difficult to do so.

4.3 Identity Dissonance in Care Relationships

I have established in the previous sections that care workers reconstruct care work as dignified work for those in need by a caring self. In doing this, they resist the negative social labels laid on care work as demeaning and care workers as provincial and lowly. Care workers carry these views about self and identity in care work and interactions with elderly clients on a daily basis. It should not be surprising that sometimes their views of self-concept and identity are not accepted. In these instances, identity dissonance transpires. In this section, I will explain four types of identity dissonance: moral tests, discrimination, undue demands, and harassment. The four types are intended to be illustrative rather than an exhaustive list of possible instances of dissonance. Dissonance

has an important bearing on a care relationship and instrumental care work. What is common to all forms of dissonance is that a care worker's proffered *self* is rebuffed and kept in abeyance by the reaction and attitude of the elderly client she serves. She feels mistrusted, frustrated, and occasionally deprived of the basic respect of being treated as an equal.

4.3.1 Moral tests

A challenge frequently experienced by care workers involves scenarios where a worker's probity is put to a test. Care workers often perceived these moral tests to be premeditated by clients. Senior clients are said to have deliberately set such tests to test the care worker's reaction and to expose their dishonesty. A typical example of such a test is when the client leaves cash somewhere in the house and waits for the care worker to pick it up. One participant told me how she reacted to such tests:

> *She (client) leaves cash out, on the floor or somewhere. One Yuan here and one Yuan there. She checks if you put it into your own pocket. You should pick it up and give it back. [And say:] "Grandma, you dropped money. See, you dropped it here." [They would say:] "Oh, I didn't know I dropped it." Actually, she did it on purpose. It is a test of your honesty. You know? If you are dishonest, if you just came [from the country], and are foolish over money, they (clients) would want you gone. Is your reputation not worth a few Yuan? … You can't take stuff. If you do, you couldn't work in that neighbourhood with this shame. … You must liberate your mindset. Many migrant workers don't understand this. They can't resist temptations. Many people are like that, but we've been here long enough, and so we understand. We have a higher moral standard. Those who just came from the country are different. (C18, L.195-209)*

The participant discounted the claim of ignorance made by the client, and interpreted the incident as a test. The participant also goes on to suggest that such tests

are specifically set for migrant workers, whose integrity as their social label suggests, is under question. She suggested a "correct" response that, as a rule of thumb, one should return the money and confirm that she noticed cash left in the house. In doing so, her integrity is defended. For her, failing to meet such a test means falling into disrepute and consequently losing the moral ground of being a care worker. Furthermore, as care workers often do, she compares herself to others, whom she wanted to distance herself from. Her "mindset has been liberated" in that her morality stood the temptation of money; therefore she is distanced from the ordinary social group of migrant workers, and her dignity is bolstered.

A moral test can sometimes last an extended period of time and does not require any specific action as a response. Another worker shared an experience when one of her clients left a bundle of one hundred Yuan bills beside a telephone. She never communicated with the client about the cash, but whenever she picked up a phone call for this client who suffered from hearing loss, she was reminded that she was facing a moral test. She told me proudly that over the eight years of work in home care, no complaint was filed against her. Care workers like her took pride in the moral integrity that is reflected in passing such tests.

Premeditated moral tests are perceived to pose a direct challenge to one's dignity. However, they also offer opportunities for care workers to demonstrate integrity and strengthen relationships with clients who administer such tests. Once care workers successfully defend their dignity, the two parties can form a closer relationship based on trust.

Moral tests are not always premeditated. They can occur as result of an event in which a client's property is missing, and the client accuses the care worker of theft. In such cases, care workers feel a strong obligation to prove their innocence. One participant told me one time she was called at 10 o'clock at night by a client who said a newly purchased cell phone was missing. The fact that she was the only person who visited the house that day implicated her. Anxious, she rushed over to the client's home to help look for the phone and found it tucked under the bed sheet. She was relieved at the recovery of the phone, because had it not been found, she would always be a suspect. "How can I not be anxious? No one else visited, except me," she said. Incidents of missing valuables are common, typically cell phones, jewelry, and cash. A moral test does not need to be initiated on purpose or overtly administered. When the care worker perceives a real threat to her dignity, she takes it seriously and acts to safeguard it. As in the case where the participant "anxiously" looked for the phone, she needs to respond to it quickly to establish her innocence. Passing these tests is essential not only to maintain trusting relationships but as well to sustain a dignified self.

In other cases, elderly clients made apparently false accusations about property losses and culpability on the part of the workers. If the clients involved were perceived to suffer from dementia symptoms such as loss of memory and lucidity, care workers tended to disregard the incidents, which therefore did not constitute moral tests.

4.3.2 Discrimination

Care workers can feel discriminated against as a result of client prejudice. Discrimination is perceived to be a threat to the care workers' presented self-concept. The following case is a telling example of interpretations made by care workers as they

perceive discrimination. This participant spoke of her experience of using a washroom at a client's home with a hint of indignation:

> *Occasionally, I used the washroom in her home. This is rare. We are careful. Especially me, I don't like using others' washrooms. But sometimes it happens. You start off from her home in the morning, you have to use hers. When she uses the washroom, she just leaves the door open. When you use it, she would say: "remember to flush! Close the door! It stinks!" We are healthy and young. How can we be stinky? She is just paranoid. It makes you very uncomfortable when she says that. You (client) are over eighty years old, and you could not even clean your dishes well. We don't even mind feces on your clothes when we hand-wash your laundry. It's just using your toilet. Do you need to say that? It makes me unhappy. It seems she looks down on you, because you are from out of town and because you are doing this job. (C03, L.95-108)*

Notice that the participant held that she is healthy and young, and by claiming "disliking others' washrooms", defended her hygienic habit as cautious. It therefore followed that the client's repulsion was unjustified and constituted an outright challenge to her dignity. She then went on to say that the work she does for the client was rather more "unsanitary", and reinforced the image of a helping person. The mismatch between this image of self and the client's reaction is ascribed to the client's prejudice against migrant workers and people who do care work. During the interview, I explored whether the client explicitly expressed the said prejudice toward migrant workers and care workers. "Of course we could feel it. We feel it right away when she said it. If she says something like that, how can you not feel it?" responded the participant. While the comments made by clients are open to different and perhaps even contrary understandings, care workers interpret them in a self-referenced way. Care workers

appeared to be sensitive to prejudice and discrimination due to their identity dilemma and wanting dignity at work.

It was not uncommon that participants told stories about feeling discriminated against when they used the washroom in clients' homes. Seniors' responses differed from case to case but ranged from reminding and warning, like in the above case, to changing and washing the seat cover after workers' use, and even to refusing use of the toilet. These events may involve the application of double standards by the clients, as in the case above. To give another example, one participant felt insulted when her client demanded that she take off her shoes when she comes into the house, while the client never took off her own. The participant resented the fact that she was not treated equally. It can be speculated that migrant workers are more likely to face discrimination, given that more instances of discrimination were reported by this group in this study. However, this should not be generalized, because these incidents are subject to interpretation, and the participants who feel more insecure about their identity may be susceptible to interpreting such incidents as indications of prejudice and discrimination. If discrimination is perceived, the care relationship is likely to be harmed.

4.3.3 Undue demands

The preceding types of challenges to the dignified identity of care workers may be referred to as personal. The following types concern work and can be summarized in participants' words as "I do not have to do it, they treat me inhumanly". Care workers often reported that clients and families peremptorily demanded that certain tasks be performed, or asked care workers to perform tasks that were perceived to be disrespectful, demeaning, and occasionally dangerous. One participant shared an

incident that happened a few days before the interview in a family where she worked for a male client who co-resided with his wife and adult children:

> *Participant: That day, I was hand washing laundry. I had given him a rubdown, and then I was doing laundry, while he was bathing his feet. Granny (client's wife) was there and his two children. Granny was going to dry his feet when he was almost done. The children said: "leave it, leave it [to the care worker]." What does that mean? You tell me. I was pissed right off. I wanted to quit. You children are responsible. Why are you telling others to do it? Why does it have to be [the care worker]? This made me mad. I told the manager I'll quit.*
> *Interviewer: So you did quit.*
> *Participant: Not yet. I am still working for them, but I really don't want to continue. I am not going to be happy [with the family].*
> *Interviewer: You think their attitude is …*
> *Participant: Very disrespectful. At least you children were there, you should help. It's not all our responsibility. Not we zhong dian gong's responsibility. … They shirked their responsibility.*
> *Interviewer: And you feel shifting off responsibility to you is disrespectful.*
> *Participant: Of course it is! I was mad. I came to see the manager right away [and said] I'll quit. I was very mad. (C08, L.65-75)*

The participant was emotional while she was recounting the event, resolving to end working for this family. While it is impossible to analyze in detail the interactional process from her accounts, the sense of disrespect that led to her emotional eruption can be understood. The care worker had completed the tiring work of a rubdown, and now she was loaded with a second heavy task, from which she could not share time to attend to yet another relatively easier task, drying feet, which could be completed by the family. The family however, refused to assume the responsibility and declined help with the task, failing to treat the care worker fairly. As other participants who encountered similar

scenarios put it bluntly: "they think we are just *zhong dian gong*, so they load everything onto us."

Co-habitation of elderly clients and their adult children often complicates the nature of requests to perform tasks, and in these cases boundaries of responsibilities are blurry. "Children want you to do their chores too", commented another participant, "they give a smiling face, if you do it. If not, they are not going to speak in favour of you. They would file complaints to the agency and say 'she refuses to do this and that.'" Incidents abound in the data that care workers experienced undue demands, for example, being told to kneel down to wipe the floor instead of using a mop, stepping outside to clean window panes without protection on the second floor and above, and washing dishes intentionally left for a week. Care workers facing undue demands find their dignity threatened, as they feel they have been treated unequally and unfairly. More so if the tasks could have been performed by the client or family members, or the requests are made with the assumption of a subordinate status of the care worker. One participant's comment was illustrative: "we should not have cleaned the windows. She (client) should not have asked us to do this. Think about it. Do they treat us as human? It's 40 degrees outside. Would they let their daughter clean them? Impossible!"

I will deal with this issue in greater detail in Chapter Five. Here it can simply be noted that all participants in this study carried out tasks outside of job descriptions for certain clients. Hence, a request to do extra work alone does not constitute a perceived challenge to the care workers' dignity. Other factors are at work: perceived needs of a specific client, her means to meet these needs, and the manner of the request. Above all, interpretation of all these factors by the involved care worker is crucial as to whether a

request is “disrespectful” and thus constitutes an undue demand. In defining undue demands, a care worker gauges the fitness of her identity in the situation. Responding to undue demands offers a potential opportunity for care workers to reiterate a dignified identity.

4.3.4 Harassment

Harassment in the form of inappropriate touching is another kind of challenge to care workers’ dignity. A few words are in order before I explain this kind of challenge. Harassment is rarely voluntarily disclosed by the participants. In fact, only two participants reported such incidents. Each of the two harassment incidents involved one client and happened only once. According to the two participants, harassment rarely happens. The data does not allow an overall inference about the prevalence of harassment. At the risk of violating GT’s canon of theoretical saturation, I do not purport to account for the whole picture of harassment as a threat to dignity in home care in this study. However, I believe, incomplete as this account is, it helps us to begin to probe this sensitive issue in the Chinese context.

If harassed, a care worker would protest directly to the perpetrator, but at the same time tend to play down the seriousness of the harassment by denying the lucidity of the perpetrator. She might then seek an external adjudicator, either a family member of the client or the agency manager, in order to restore justice and deter recidivism. The following case is a good example. One participant told me that she was harassed while bathing an eighty-year-old male client. “He is different from other old men,” said the participant, adding “he has Parkinson’s disease and needs a bath daily.” After the harassment happened, she tried to communicate with the harasser:

> *[I said:]"Grandpa, this is not good. I am younger than your daughter. You have a daughter, and she is older than me. I am here to care for you. I come here to make money, to work, but not to prostitute." He understood, if he did. (C18, L.136-139)*

By comparing herself with the daughter of the client, she sent a clear message that the harassment was immoral. Note the link between harassment and her identity. The harassing behaviour was regarded not only as an inappropriate physical assault, but as an infringement on her identity. She then asserted her self-concept that she is a dignified person who cares for a living, not a prostitute, which is immoral and despicable by her undertone. However, the message was delivered as a one-way announcement rather than a dialogue, as she did not expect that the old person would actually "get it". To prevent harassment from recurring, the care worker brought the issue to the children of the client:

> *Later I told her son, and said: "your dad did this. He shouldn't have. If he doesn't stop, I will quit." … His son said: "Sorry, ma'am, he is confused, he has dementia. Don't stoop to his level." Then me, didn't I just bear with it? Just treat him as sick. He is sick, I am not. If you are too serious with him, you are sick too. Just pretend he got illness.… What else can you do? Unless you quit being a bao mu. (C18, L.126-130)*

Since one cannot quit the job to renounce the identity of care worker, she has to "bear with" the insult. Here defending dignity involves a psychological process of controlling one's emotion. More about managing emotions will follow in later sections. For purposes here, the participant employed the strategy of lowering the harasser to a mentally incapable status and discounted his behaviors as caused by "sickness". As a lucid person would not "stoop down" to arguing with an intellectually impaired person, it

is therefore justified that the harassment not be taken too seriously. The practical aspect of the matter, prevention of recidivism, is referred to an external adjudicator, in this case the perpetrator's children, who restored justice by an apology.

4.4 Strategies for Tuning out Dissonance

In the previous section, I explained the most frequently reported experiences of dissonance in care relationships and focused on the mechanisms by which dissonance impacts the self-concept and social identity of care workers. Where dissonance has been lodged, it must be mitigated. The importance of a dissonance-free state in the continuation of a care relationship can never be overstated. Dissonance, to care workers, is like a grain of sand in the eye, which induces an emotional discomfort, irritating the everyday interactions between the two parties involved. Most care workers, except those whose immunity to emotional disquiet had been fortified through years of experience, tended to see difficulty in continuing to care with unresolved dissonance. Care workers acted to tune out dissonance. In the following, I will explain three types of strategies used to tune out dissonance.

4.4.1 Disregarding

"Every bit of care work is about mood", one participant said. Maintaining a good mood is an essential aspect of the everyday interaction between care workers and their clients. At the least, to maintain a good mood outbursts of head-on friction with clients must be avoided in the face of dissonance. A quote from one participant summarized this point well:

> *I must ignore her. Although I felt [emotional] discomfort, if I did not spit it out, it'd still be fine. If I said something, starting a fight, why would I see you (the*

client) again? You wouldn't want to see my face any more either. (C17, L.567-569)

Her response, in this case to an undue demand, was intended to downplay the tension aroused in the care relationship. To avoid a fight, she said she simply ignored the client's request, did her job, completed her time, and left the client's home without open friction. She found it difficult to maintain the care relationship when such friction occurred. Many other participants shared the same sentiments. Consider my conversation with another participant:

Interviewer: When you felt agitated, did you express it in some way?
Participant: No, no.
Interviewer: So you felt it internally.
Participant: Yes, irritated. But of course I would never show it. If I did, she (the client) must be unhappy too. Now that I had decided to work for her, we would see each other every day. If [I] feel unhappy, I bury it in my heart. At least, on the surface, you need to appear cheerful with her. … It's a long time ago. Yeah, I did felt unsettled, irritated. I am used to it now. I have seen so many [clients] in these years, so I am used to it. They say all they want to. I disregard it.
Interviewer: So you wouldn't have head-on frictions.
Participant: No, never, no.
Interviewer: You said "you would see each other every day", do you mean once there is friction, it is hard to face them?
Participant: Right, right. Because it would make my work unhappy. If I became unhappy with someone (a client), it'd be pointless to go on. (C15, L.254-270)

The quote above illustrates the point that care workers make an effort to hold back their responses to the emotional discomfort provoked by dissonance. Frictions are to be eschewed so that "face" can be preserved. By face, I mean the literal translation of "*mian zi*" in the Chinese language, the social front of a person. In a loose but adequate sense,

what I said in Chinese, translated into "making it hard for the *face*", means the subsequent interaction between two people can be jeopardized. For our purpose, it is perhaps less helpful to explore at length the Chinese psychology of face than to acknowledge that, for the participant, a history of friction undermines a smooth care relationship. Happiness, as reflected in the above quote, is perceived to be an essential emotional state for a lasting care relationship. In contrast, unhappiness is a sign of a care relationship going haywire. "Happy" and "unhappy" are the words this participant, indeed many participants, used during the interviews. While they might sound pedestrian, the participants did not seem to need more sophisticated words to describe what they perceived as a simple rule of care relationships. The course chosen by care workers, when dissonance arises, is a rather rational choice: an open clash causes unhappiness therefore it is to be avoided.

To prevent open friction, care workers employed the strategy of disregarding the incident. Like the quoted participant, care workers do take offence, yet the irritation is digested internally--in her words, "bury it in her heart". Her emotional response is regulated by deliberately playing down the incident and at the same time focusing on the instrumental work. Here is one participant's account of how this regulation plays out:

> *Some people say: you are in a good mood. I tell them: I am always happy, nothing can make me unhappy. This is the way [to do care work]. I can't live with a disgusted face all day. I see you (a client) but I can ignore you and do my job--I don't talk to you. I can just walk out, right? I can't help if you dislike me. (C04, L332-327)*

By limiting interaction and thus emotional investment in a care relationship, the disregarding strategy works to reduce the care relationship to an instrumental task and to

maintaining an ostensible peace. Care workers who employed this strategy became emotionally impassive to the extent that they appeared to be immune to the dissonance, which would otherwise have caused emotional reactions that might have escalated the friction.

Participants revealed that they developed this strategy over years of experience and exposure to many types of clients. They become "used to" it. Based on this claim, we have reason to believe that older workers are more experienced in handling dissonance and less susceptible to emotional disquiet than novices. In fact, some participants claimed that they were much better at disregarding and maintaining happiness than when they first started the care job.

4.4.2 Justifying

The strategy of disregarding works well for those who can suspend the unpleasant experience and limit their interaction with the client by reducing the care relationship to solely instrumental work. A relationship of care is maintained "on the surface". For others, there needs to be a more profound strategy at a deeper psychological level to eradicate the belief that the dissonance is inflicted on the worker intentionally by the client. This strategy involves justifying the behaviours of elder clients. The most common justification employed by the participants was resorting to the belief that "elders are childlike" or "elders should be treated like children". In fact, the majority of the participants at some point during the interview spontaneously mentioned this attitude toward the elderly, portraying older people's disposition and behaviours as resembling those of children. The image of older people resembling children is illustrated below.

First, older clients were described as wayward and sometimes capricious, like children. Consider the following quote:

> *She (client) felt sick, so she asked me to get some over-the-counter medicine. The rain was pouring. I got the medicine for her. I said: "why don't you take your medicine?" "No", she replied. Just like a child, "No". I said: "you were the one who told me to buy it (medicine), and now you are the one who does not want to take it. What do you mean?" She said: "you drop it here, just drop it here." … If I knew you (client) were not going to take it, I wouldn't have gone out in the pouring rain to get the medicine for you. Right? (C12, L.101-108)*

I could not confirm if the client had been truly sick and did not want to take the medicine for no reason. It can be interpreted that the participant felt her time and effort were spent in vain because of the client's caprice. She called it childlike. Typically, when care workers handled a childlike client, they deferred to him/her and "let it go". The following quote illustrates this attitude:

> *When you handle older people. Let them be. Give way to them. They are getting old and they are like children. You don't want to argue with them. You think you can straighten them out? (C06, L.130-135)*

On a similar note, older people were perceived to be pure and should be appeased like children. The following quotes from two participants support this point.

> *As the saying goes, "the older, the younger". Wheedle them like kids. Some older people you should care for them as children. "You look so young!" "You have a good memory!" They like compliments. (C01, L.248-251)*

> *When older people are not happy, you should try to appease them. … She will be happy. Older people are like children. They like to hear pleasing words. They would be happy. (C09, L.337-340)*

Moreover, some older people were described as cognitively impaired. An instance was examined above of sexual harassment where the participant said she would not argue with the client because she discounted his mental capacity. Whether or not the perpetrator was mentally impaired could not be substantiated. Yet the fact that the participant chose to believe that he was constituted a sufficient justification to perceive the offence as less severe. Here is another participant's comment on older clients' cognitive abilities:

> *Some older people are mentally impaired. Sometimes, you just have to treat them as kids. Try to please them. If you feel wronged, you take it too seriously. You can't take what they say too seriously. (C03, L.105-107)*

Still other participants emphasized older people's lack of self-care ability, depicting them as children needing constant care. Here is an example:

> *Some older people are like kids. They can't take care of themselves. They don't keep track of the time, and they don't know it's time to eat. I take care of her all-around, not just doing the assigned work. (C22, L.79-81)*

The idea of depicting older clients as in need is not new and has been examined in the foregoing discussion on care workers' construction of care work. In addition to being in need and having reduced cognitive ability, wayward behaviours and a simplicity seen as typical of young children contributed to an overall image of an older person as dependent, capricious, and blithe. It may be argued that to liken the elders to children is to impart a negative view of old age. The point here however is that care workers talked about their older clients as mischievous kids, whose mischief therefore becomes venial and more pardonable. The rule that governs this justification seems to be taken for granted: no one should take offence at innocent children. This justification offers an

opportunity for the care workers to regulate their emotional reaction. Instead of diverting their attention away from interaction and thus irritation itself as a feeling, which is prominent in the strategy of disregarding, justifying as a strategy helps reconstruct the cause of irritation.

To further explain this strategy, I want to draw on Hochschild's (1983/2003) analytic framework for understanding how different kinds of emotions come to be felt. Her main thesis is this: as we experience a social event/influence, a state of emotion is evoked. The feeling of this emotion is not only a signal of our renewed knowledge of the social world, but a sign that reflects our previous expectations about it and selective perception of it, which are shaped by inculcated cultural rules. In other words, the feeling, and thus the naming, of an emotion as a response to an external influence is dependent on our expectations and perceptual foci. Hochschild (1983/2003, p. 235) laid out five general categories of perceptual focus: 1) what I wanted, 2) what I see as having now, 3) the perceived causal agent of an event, 4) the relation of myself to the causal agent, and 5) whether I approve or disapprove of an event. Different emotions can be felt from the same event, as the focus of perception and expectation shift.[23] Let us suppose a case of dissonance, at which a care worker takes offence. The emotion of indignation felt is evoked in the following manner. What the care worker wanted was dignity at work, and she sees that in an event of dissonance, she has been deprived of what she wanted. The causal agent of the event is an older client, whose intent is perceived to defy the

[23] The author (Hochschild, 1983/2003, 234-235) offered an illustration of how felt emotions can shift from sadness, to nostalgia, compassion, pity, and to frustration and anger, in a hypothetical case of responding to the death of a close friend killed in a car accident.

worker's assumption that the client should show due respect. The self-image of the worker was rejected, and her relationship with the client was overshadowed by the social identity of care worker, of which the care worker disapproves. The focus of attention is twofold: on the causal agent, namely the older client and the malicious intent, and on the relationship with the client. The justifying strategy works to shift the expectations and focus. The malicious intent is dismissed by the image of simple-heartedness and reduced cognitive capacity. The troublesome event is thus interpreted as something close to mischief. In consequence, formerly provocative events are interpreted as less self-referenced. Older people's inability to self-care is prominent in the narratives of the relational facet. At the centre of perception is not so much the undermined dignity; a reinforced sense of "a caring self doing valuable work" comes to the fore. The focus of attention is on the gains. In the end, the strong disapproval is also dissolved into a neutral stance. Table 4.1 has a side-by-side comparison of modes of emotional perceptions with and without the regulation of the strategy of justification.

Table 4.1 Strategy of justification and regulation of emotion (categories in bold are perceptual foci)

	I want	I have	Causal agent	Relation to self	(Dis)approval
Unregulated by justification	Dignity	Loss of dignity	Malicious, intentional	Self-image rejected, negative identity perpetuated	Disapproval
Regulated by justification	Dignity	Value of work	Mischievous, inadvertent	Innocuous to self-image	Neutral or even positive self-image

The resultant emotion is a complex one. The participants often used the phrase "*mei ban fa*", literally "can't be helped", to describe the state of emotion regulated through justification. A less colloquial term in Chinese is "*wu nai*", which may also be

translated into “can’t help it, but…”, a feeling of helplessness and pity in the sense of disappointment, mixed with acceptance and surrender to the inevitable such as brought on by fate or a natural force. While it is inaccurate to say the regulated emotion is a joyful one, it is safe to conclude that it is more peaceful than indignation and irritation.

As to the question of how the parallel between the young and the old is adopted, the participants unanimously gave a simple answer: from a Chinese expression “*lao xiao lao xiao*”, or “old young old young” verbatim. For the purpose of this thesis, a search on the Chinese search engine Baidu was performed with the key words “*lao xiao lao xiao*” in Chinese. One hundred million entries were returned. While it is difficult to pin down the origin of this saying, as it is not included in any dictionary, it seems to be a widely used colloquialism, which means “the old are like the young”. In the first one hundred entries, “as the saying goes, *lao xiao lao xiao*” and “*lao xiao lao xiao,* the older the younger” are the most commonly found sentences. There is little evidence suggesting the downplaying strategy of justification is systematically taught. However, two managers did mention “*lao xiao lao xiao*” during our conversations, and they both used it in informal exchanges exhorting care workers to be more patient with clients. We thus have reason to believe that the language is a reflection of the general discourse in the cultural context.

4.4.3 Terminating

Now let us revert to the principle toward care work mentioned at the beginning of this section: “every bit of care work is about mood”. Facing dissonance, care workers employs regulation of their emotional response to mitigate the discord and to maintain a sanguine view about the relationship. Much has been said about how care workers

regulate their emotional responses. We must not forget that the relationship results from the input from both sides of a care dyad. Care workers may feel they have no option but to terminate a care relationship that has gone sour, despite their efforts at disregarding or justifying. When "things do not work out", the participant quoted above continued, the mood in which care work is carried out will be spoiled:

> *You will have to face it (discord) the second day, unless you quit. If you continue, you will have to face it. So a bad mood has to be temporary. You refresh your mood the second day and are friendly when you go to [client's] home. But if you keep trying to be friendly, and they aren't, your mood is going to be spoiled. (C04, L.468-472)*

Consider the following case of termination, in which a care worker felt that her client showed little understanding and did not allow her any discretion about how to manage her time. The incident began with the participant suffering heat stroke. Since the woman for whom this participant worked had refused to share her home phone number, the worker could not reach her to advise the client that she would miss a visit. During the next visit, the client scolded the worker for keeping her waiting. The two had an exchange of words, and the following is the worker's account of the conversation:

> *I suffered heat stroke, otherwise I wouldn't have asked for a leave. She did not want to share her number. I felt I was wronged--everyone else shared their number, why didn't you (the client)? If something comes up, I'd let you know and we could arrange a shift. I could come tomorrow if today doesn't work. She said her son is a businessman, so her number can't be shared. She went: "Are you going to be sick every day?" She responded like that. I said: "Auntie, this is not about sickness. We could coordinate if something happens. You are not giving me any elbow room." I was uncomfortable about that. I was sick, and it was severe. And, it was only one time. ... I felt she was unsympathetic, very cold. (C09, L.449-470)*

This incident happened in the second month of her work with this client. The participant appeared to be disappointed with the unsympathetic attitude of the client toward her sickness, which she regarded as deserving sympathy as well as a legitimate reason for a leave of absence. As she attempted to explain the inconvenience caused by the client's not sharing the phone number, not only did the client refuse to understand, but insolently dismissed her. The dismissive tone implied both that her story of heat stroke was flimsy, and that *even if* it were true, it did not warrant the disclosure of the telephone number. "It's been only one month", the worker lamented in frustration, apparently being somewhat at loss as to how to fix the relationship. "I think maybe because I am not a local, she can't be all that trusting". She was quite tentative when she tried to understand why the client treated her that way: "I thought it would get better if I tried to communicate, but no. It remained that way". The care worker ultimately requested termination of the care relationship. It seemed that when dissonance was set in a downward spiral, a remedy was a mutual effort to soothe it. However, the two parties might not be successful if mistrust and fatigue with the friction have permeated the relationship.

In the same vein, some participants believed that the first few visits are crucial in setting the tone for an ensuing care relationship. One participant said that she knows at first contact "whether she will get along with a client, because she has seen so many clients." Many other participants, while not claiming to be prescient, agree that "if the first number of visits go well, the later cooperation (between worker and client) will be good." For workers whose tolerance is low toward instances leading to dissonance, the care relationship is liable to break down prematurely. An "ice-breaking" period at the

beginning of a care dyad is critical. This may be attributed in part to the personalized nature of home care work, which requires an intensive initial orientation in a new work environment for the care worker. Chapter Five will have more on the personalization of care work. In the rest of this section, I will focus on the abrupt termination of care work.

Dissonance may well occur after the initial visits and beset an already agreeable relationship. The following case features a care dyad terminated in the fourth year. The client, who opened one of the rooms in her apartment as a small Mah-jong business, lived with her two sons. The care worker's responsibility was to take care of the old lady, but increasingly she was asked to do extra work, from washing the sons' clothes to wiping the floor with her bare hands. One day, she was asked to clean a bamboo mat, which had not been part of the routine in the past. She murmured in her local vernacular, which she claimed is not understood by the client, "worked my butt off, paid little, and now you load more on me". The next day, the client filed a complaint, on which the worker commented:

> *This is great! I've always wanted to ditch this client. But I was shy of asking. I have put up with her, on and on. Now that she wants me out, I am so happy. When the agency called and told me "They don't want you, they are seeking someone else", I said "That is great! Let her find someone." (C20, L486-489)*

According to the participant, the primary reason for her wish to quit was that while the client was affluent enough to afford a mop, she was told to clean the floor by hand. When a care relationship harbours not respect but stress, termination comes as a relief. In this case, the participant welcomed the serendipity that she was fired and sarcastically extended her wish for the client to find someone else, whom she believed

would suffer the ordeal in her place. It was the client who demanded termination, but the care worker who welcomed it.

Complaints appear to be conducive to termination. Among the participants I interviewed, no care relationship survived a client complaint. A complaint can be filed through two channels. The first is directly through the care agency to the care managers. The second is through the hotline, and the complaint is directed back to the care managers at the local agency. Irrespective of the channel chosen, care managers are the authoritative referees. Managers tend to be pacifiers. They mediate between the two parties with the intention of conciliating. Unless the offence on the part of the client or the misconduct on the part of the worker is deemed serious, the care relationship is considered worth saving. Therefore, immediate termination is not a standard decision in the wake of a complaint. However, the workers usually decline to return to work pretending that nothing has happened.

Two kinds of incidents can be distinguished. In the first kind, the subject fully anticipates a complaint. As has been discussed in the case of disregarding, open friction jeopardizes subsequent interactions. The following quote highlights the point that a complaint does similar damage to a care relationship:

> *If you did not call [the manager], we could've talked out of the problem. Now that you called, why would I work for you? For what? To fawn on you? I quit, and you find someone else. (C17, L.304-306)*

In this case, termination became inevitable, as the worker saw continuation as ingratiating. The second kind of complaints are unanticipated and to a certain degree a surprise to the worker. One participant told me that a female client complained that her hospital visits were often unaccompanied. The participant claimed that in fact, she has

taken the client to the hospital three times, and she had even given up her own time to do that. She was infuriated by the injustice:

> *I took her to the hospital three times to see ophthalmologists. My feelings were hurt. I quit, I just quit. I felt deeply hurt. How did I not go? I had another private client after her and I missed that [giving up income]. So I spent half a day at the hospital. She said no one took her [to see the doctors]. It's unjust. Can't be reasonable? I quit. (C08, L.520-528)*

This complaint caught the worker by surprise. She had fulfilled her responsibilities at the cost of her own time and income, but her contribution was unjustly disputed. A feeling of betrayal could be sensed, a sentiment that is shared by other care workers:

> *Nowadays, some older people overly protect their own rights and interests. If she is unsatisfied, she makes a complaint. But we as care workers sometimes feel wronged. We think everything is alright at your (client's) home, and we did all the work. And then you still complain about me behind my back. I would feel offended. (C04, L. 498-501)*

Care workers take offence at unanticipated complaints, loathing the unilateral breaking of mutual sincerity. They believe dissatisfaction should be communicated face-to-face so that trust can be maintained between the two parties. "Two-faced" clients who tell on them "behind their back" are intolerable. One participant summarized it all:

> *I don't want to work for this client. But if I have to, let me give you a heads-up: She (the client) will say "the worker is not good"--I know she will! She wouldn't say it in front you (the worker), but she talks behind your back. (C06, L.77-82)*

In a nutshell, complaints are liable to cause termination of care, not due to regulations, but because of the mistrust lodged between the worker and the client. Even when it is a

client who filed a complaint, the worker is usually the one who is determined to end the relationship.

4.4.4 External factors influencing termination

Above, I examined three types of strategies for tuning out dissonance. The first two operate at the psychological level while the last engages the service system. Since termination marks the end of a care relationship, it can be considered the last resort. If we turn the logic round, ease of termination may influence how often and how much the other two strategies are used.

Among the participants of this study, proactively requesting termination is said to happen infrequently. As the clients of the home care program tend to be the oldest old, the most commonly reported situation in which a care dyad comes to an end is the death of a client. Other reasons offered for ending a care relationship include conflict in allocation of time for multiple clients in a particular day, relocation of a client, and deterioration of the worker's health, all of which generate substantive changes in the arrangement of care work. These reasons are of a different nature than termination of a care relationship in view of friction or a complaint.

The participants did not ascribe proactively ending a care dyad to economic motives, however, this does appear to be an important consideration. In 2013, the average hourly rate for public cases was between 12.5 and 15 CNY, whereas the pay in private hires can be anywhere between 15 and 25 CNY. The difference between the hourly rates of private cases and public cases creates a strong incentive for the workers to shun the latter. However, there are unspoken rules that care workers are expected to accept any client assigned to them, and that it is the job of the manager to strike a balance

between private and public in their caseloads. Fairness in the assignment of cases is at the discretion of the managers. While these rules apply to both local and migrant care workers, the local workers view abiding by agency rules as obligatory, because they are formally hired and their social benefits paid through their employment. The migrant workers tend to see the rules as a tradition that has no binding power over their work, and thus their compliance is purely based on the principle of mutual reliance and cooperation: the agency relies on their labour and they rely on the agency's referral of clients.

Now that the rules have been explained, let us return to the worker who took joy at the client's request for termination, but had been "shy of asking" for termination. She said:

> *I had wanted to quit for a while. But I was afraid to ask, because they (managers) would say "you want all the high-pays (private hires) and ditch the low-pays (public hires)". We rely on the agency to refer clients. Think about it, what if you only want the high-pays? So you've got to take some low-pays. Otherwise they (agency) would be unhappy. (C20, L482-486)*

The participant believed that the agency would penalize her if she appeared to be picky and overtly defied the caseload rule. In reality, to ensure continuity of care, the managers do take into consideration individual character and current caseload when assigning new cases. This is mostly done through personal acquaintance and memory, rarely with the aid of a computer and a systematic system of records. During my visits to a manager's office, I observed at least three occasions in which a new client or client's family came in to inquire about care service. As the manager learned about the visitor's request, she picked up the phone and called several workers who she thought would be a good fit, with the visitor waiting on the side. The business was done, informally and

efficiently, in ten minutes. All the care agencies I visited operate in this manner. Personal acquaintance and a good reputation are thus powerful constraints on care workers' conduct. In the case of termination, like the one quoted above, many care workers feel obligated to commit to a care relationship unless it breaks down beyond repair. In consequence, applying the strategies of disregarding and justifying is essential in handling dissonance.

In the previous sections, I explored three strategies for tuning out dissonance: disregarding, justifying, and terminating and looked at the structural constraints on termination of care. As termination involves the care system, it can only be used as a last resort, whereas the other two strategies are logically more likely to be drawn on in the face of dissonance. In the next section, I will focus on consonance, the flip-side of dissonance.

4.5 Consonance in Care Relationships

Consonance can be understood, in its first sense, as the antithesis of dissonance. A relationship beset by incidents that lead to dissonance or that is haunted by unresolved dissonance cannot be said to be in consonance. A lack of dissonance is therefore a precondition of consonance. In the second sense, the state of consonance in care relationships, in the participants' words, can be described as "being a surrogate daughter". It is a state where the two parties of the care relationship cooperate in harmony in the provision of care. Care workers in consonance used language to describe the relational aspects of care. Instrumental care giving was enriched by the meaning embodied in the interactions of everyday care. This language was a familial one and it depicted a state of consistency between care workers' self-images and their identity in the

specific context. It is only meaningful to speak of dissonance and consonance in dyadic care relationships. A care worker may find consonance in their relationship with one specific elderly client, but still be troubled by dissonance with another. The word "situated" thus may be indicative here.

Consonance, in essence is parallel to the situated identity of surrogate daughter. Again, daughter will be used instead of child when I refer to a consonant relationship, as in "being a daughter", because of the preponderance of female workers in the care industry and in my participants. In the third sense, consonance and surrogate daughter is an ideal state of the care relationship. It captures a common language that has been chosen to describe care relationships, but it may or may not be representative of any specific case of care dyad.

4.5.1 The absent children

To explicate consonance in care relationships, I shall begin with a cultural backdrop with regard to expectations of children's role toward older parents in China, which in the participants' identity talk is a precursor to the narrative of being a surrogate daughter. Let us first revert to the notion that care is perceived by care workers to be valuable work for those in need, through a caring self. As I have noted, the three components--valuable, in need, and caring--are closely related. Moreover, as the clients are in need, this elicits a sympathetic and conscientious reaction from the worker, which can be said to be a foundation for caring work to take place. The economic predicament of the older people, mirrored in their housing and nutrition conditions, has been mentioned. There is still another crucial factor that contributes to the perception that the older clients need and deserve care. It is the absence of children.

In a literal sense, absence of children means a state in which an older person lives alone, either due to separation from children or being childless. In the figurative sense, it means children who live with older parents fail to fulfill their filial role of caring for the parents. Given the nature of the home care program, it is common that the clients live without children. During the interviews, all participants spontaneously mentioned at some point that the majority of their clients live alone. Since children are expected to be primary care givers, that older people are living alone is often interpreted as children shirking the responsibility of care. The following quote illustrates the perception of a care worker about care responsibility being circumvented by children:

> *To tell you the truth, there is quite a lot of work for these older people nowadays. For example, we have to shop for daily necessities[24] for them. Because although they have a number of children, one thing is they (children) are busy with work, and second thing is they don't care for the seniors that much. Why? Because if there is more than one child, they tend to shirk responsibilities between the siblings. Let me tell you my honest thoughts--we work for these older people so we know. All of them have four to five children. But in such hot weather, they rarely come to visit their seniors. The best children would only come once a month. Those unfilial ones will not even come once a month. (C22, L.39-46)*

It might be helpful to contextualise this quote. Prior to the interview, the participant had declined a number of new clients referred by her manager. Four of her clients had either passed away or opted out of the program, which brought her caseload to seven. She found that her workload was not reduced, though. In her words, "she served

---

[24] The participant used the term "*you yan jiang cu*", literally meaning cooking oil, salt, soy sauce, and vinegar, which symbolize the basic necessities in the Chinese language. The term refers to but is not limited to condiments.

fewer, but cared more". The reasons for her perception of an increased workload with fewer cases could be ascribed to the older age of the clients, which is usually due to the fact that a worker commits to a client for longer time. I will return to the issue of workload when I discuss instrumental care in the next chapter. The point I want to underscore here is the assumption that children could have shouldered more responsibility in taking care of the ageing older parents. In the hot weather, the older parents may need extra attention and tangible care such as more frequent baths. The infrequent visits thus would not suffice. For this participant, one visit per month seems to be inadequate to warrant being considered a filial child. While not every participant described absent children as unfilial, the view that children did not fulfill their roles was shared. For instance, consider another participant's comment on the absence of children:

> *The seniors I am helping, oldest 95, youngest 93, five of them. … Sometimes I sit back and think about their lives. There is one saying. How does it go? You sacrificed for family, but you are not rewarded by family, by children. I think no matter how busy children are, they should at least visit every week, and rotate between siblings. This would have helped. If the seniors need something. Like some of them in poor health--my observation is if you feed them with milk for one week, they would look healthier, they would look more vigorous. It makes a difference. … Or if they (senior) falls at home, and you (worker) call their children. They (children) really take their time, and do not arrive until the afternoon. You are vexed, but they do not even seem worried! (C23, L.161-171; 191-193)*

The oldest old who deserve additional attention and care from the children are unrequited. This dire reality, to the care worker, has created a predicament in their old age. Absence of children is not viewed as a neutral state, but a misfortune that the elderly clients have to suffer. Recall one participant's account of an elderly client's monthly

expenses on food in the previous section on the reconstruction of demeaning care work. The above quote is another example of potential malnutrition threatening an elderly client. The participant, who is the primary caregiver of the older person, claimed to have better knowledge of her health than the client's neglectful children. Note the juxtaposition of the reaction of children and the worker in the event of a fall. The participant clearly believed that the children should be more concerned than she is. The same can be said about the nutritional state of the client.

The care workers' accounts of conversations with their clients are full of references to absent children. Indeed, the absence of children as a frequent subject of chitchat between care workers and elderly clients may have reinforced the view that children have not fulfilled their filial roles. Another participant told me that she often heard elderly clients complain about their absent children. Consider what she said about older people's sentiments:

> *Let me tell you. It is now common that [older people] talk about their children, talk about how their children are bad. Across the board. Most old people are not satisfied. They say, "I had a hard life raising you kids". Many have four or five [children]. "Sent you to school, to university. What hardship it was", they would say, "I earned so little, a few tens of Yuan a month. I had to get up before dawn to buy groceries and make breakfast for you. I sewed all your clothes and shoes late into night as well. And I had to go to work the next day." They felt very hard at that time. "But now that I am old, you children live in large apartments, and life is easy. How can you leave me all alone here?" They feel [it is] unfair. They think their children are heartless and ungrateful. (C03, L227-236)*

A recent amendment to the Rights Protection Law of Elderly People in China stipulated the requirement that children who live separately from their older parents are obligated to "visit the parents often". While the implementation and enforcement of the

law may be subject to practical constraints, the cultural expectation of children's responsibility to take care of parents in old age can still be seen as prominent in the Chinese context.

To be fair, not all children are as unfilial as the above quotes suggest. Sometimes physical distance inhibits children from responding promptly to older parents' needs. The absence of children could also be a result of incapacity, not of neglect. One participant's involvement in an emergency scenario helps elaborate the point that care responsibilities that should be assumed by children often fall on care workers due to practical realities. The participant recounted an emergency episode:

> *There was this senior, who lives with her husband. She went to the bathroom at night and did not want to turn on the light. So she fell. [She was] 80 years old, and got fractures. Her husband reacted quickly and called the daughter. The daughter does not live here. She (daughter) called me in the middle of the night. I was startled by the phone--no one would call at this hour, one o'clock in the morning. She said, "There is an emergency. My mom fell. Can you check on her? I live too far away." I hopped on my moped in pajamas. As I arrived, the husband was panicking, and said, "she fell, she is going to die!" I called her name, and she said she could not get up. I helped her up, and she had already soiled her pants. … I cleaned up, changed her clothes, laid her down. Then I called her daughter. I said, "It's OK. But she is having some back pain when I touched her. You may want to take her to hospital." Later they found a fracture. So they say, "You are so helpful, you run ahead of our daughter." They (children) live too far away. Not that they don't want to come. It was difficult to get a taxi at that hour. I live nearby, ten minutes to the most distant, five or six minutes to the closest, right in the neighbourhood. (C01, L.57-69)*

In this emergency, the absent daughter could not make it to her parents' in time, and had to call on the care worker for help. The care worker, who lived nearby reacted in

a timely manner. She filled the gap as the daughter raced to the scene from a distant location. Similar to a scenario where a child takes his or her time, the responsibility of providing timely help inevitably rests on care workers. Proximity to clients' homes further ties care workers to the care responsibility.

As participants spoke about the absence of children, the same kind of sympathy was displayed as in their description of elderly clients as in need. "Piteous" was the word often used to describe the life conditions of these older people. While the discussion so far has been concerned with older parents living separate from children, it should be noted that childless clients were regarded as just as piteous as the former. In fact, childlessness is rare among clients 80 years old or older. Yet another possibility is that an older person or couple do live with children, but the children do not fulfill the expected filial roles. A case of neglectful children has been discussed in the section on undue demands. As one participant commented, "If the children are present, they should bear the most responsibility. You can't just shove it all to society. We are just here to help, and we can't be with her (the client) all day". In the case where a child fails to fulfill filial roles, he or she is absent *de facto*.

In summary, living in solitude, being childless, and living with neglectful children can all be described as a state of absence of children, which to the care workers is a misfortune in old age. The ramification is two-fold: psychologically, care workers respond with pity and sympathy; instrumentally, this means care responsibilities that should have been assumed by children fall onto the shoulders of the care workers. In the next section, I will consider the role of a surrogate daughter against the backdrop of the forgoing discussion on absence of children.

4.5.2 A surrogate daughter

A surrogate daughter fills the void left by absent children, who are deemed to have failed to fulfill their filial roles in their parents' old age. In the previous section, I established that when children are absent, care responsibilities fall on the shoulders of the care workers. In case of emergencies, care workers are readily accessible because they tend to live in the vicinity of clients' homes. The Ping (C01) quote in the previous section illustrated the critical role a care worker could play in an emergency. I shall present another case experienced by a different participant with an elderly client whose children were not available, omitting most of the details of the incident of a fall to focus on the relationship before and after the incident. The client involved, whose only son and daughter-in-law had passed away, was addressed by the participant as "granny":

> *I often said: "Granny, let's eat some wontons for lunch today, just two of us. I am not going home. Let's get some wontons". So I said: "it's on me". I buy it and cook it here, and then eat with you (client). This is very common. She might say: "I have been letting you pay too much". I said: "that's OK. Just eat. Not a big deal". Just like that, since we had been together for a long time. And later on, wasn't it me who did all the chores for this old lady, like withdrawing and depositing money? (C12, L.190-196)*

To talk about casually sharing food and not worrying about cost was to demonstrate intimacy, but it was also to set up the rhetorical question as to who became the primary caregiver for this solitary woman. The participant used the term "*kai men qi jian shi*", translated into "all the chores", literally meaning the "seven necessities of daily

life"[25]: firewood, rice, cooking oil, salt, soy sauce, vinegar, and tea. I felt her sense of pride when the participant announced that she was entrusted with banking errands, as this was taken to signify a trusting relationship more typical of kinship. "So you did all the chores", I responded with a reserved confirmation. "Do you say this is home care service?" she continued:

> *But the scope is wider, not just helping her with chores. Later this old lady got sick. This one night, one night I couldn't sleep well. I did not know why. Just couldn't sleep tight. And it was three o'clock at night. In October, it was raining. Pouring rain. Pouring cats and dogs. And she called at 3 A.M. She fell. She fell on her own. It was raining so hard outside. What should I do? "Lian (pseudonym of the participant), I fell", she said, "please hurry up and come." What should I do? I was afraid myself, so I asked my husband: "come with me". My husband said: "are you asking me to come with you in this pouring rain?" I thought if he came with me, and if something happened, I could stay [with the client]. I said: "I'm leaving by myself, if you are not going." Then, I put on a rain jacket and went on my own. She actually had a fracture, not a stroke. (C12, L.201-214)*

The scope of work broadened, as the care worker fulfilled the role of the absent children. She stood by to respond to the client's needs and reacted immediately when called on despite the atrocious weather. Unlike Ping (C01), who could leave the older client to the daughter who was on the way, this participant had to be prepared to stay if circumstances required it. She was initially anxious and then relieved as she found the lady had not had a stroke. On the second day, the old lady was sent to a hospital, needing

[25] Today, this term is widely used to refer to the basic necessities and chores of Chinese families and is believed to originate in the Song dynasty around the 12th century BC (Huang, 2000, p. 354).

surgery. According to the participant, the old lady did not have enough savings to pay for the operation, which was not covered by any insurance. The participant went on:

> *So, no surgery. Now that she returned home, I could not stay with her all the time. I had to work for other clients. So I put other clients on hold, and helped her alone. I stayed in her apartment for three or four days until she was sent to a nursing home. This old lady stayed in the nursing home for three years. But in the beginning, I visited her every month. I visited her all the time and brought her stuff, all out of my own pocket. No one forced you to go, neither was it forbidden. It's just that after so many years, there is this affection. When I first visited, she always said thank-you. I said, "Thank whom? Thank for what?" Later she became: "Lian, I am not going to thank you, I have nothing to thank you with". When she left (died), I went to the crematory to see her off. Like this, one senior after another. (C12, L.234-247)*

Although the care relationship circumscribed by the home care program officially ended as the older client left the hospital--without the surgery, she would need more intensive care that the home care program could not provide--the care relationship continued. When a mother returns home from hospital, the daughter takes care of her; so did this caregiver. When the bonding power of the formal system dissolved, the relationship rooted in affection continued to flourish. The participant told me she has "seen off" six or seven elderly clients. She said it without much emotion, as if she had peacefully accepted her role to attend the last moments of her elderly people.

Through the case presented above, I attempted to delineate the caring roles a care worker assumes in place of the absent children of an elderly client. The participants reported that they often contribute their own time to respond to clients' requests beyond their job descriptions. I return to the issue of arrangement of instrumental care in the next chapter. Here I want to focus the analysis on the identity of a surrogate daughter.

In talking about the experiences of taking up responsibilities left behind by absent children, care workers started to use familial language to describe their relationships with the clients. Table 4.2 contains some exemplary quotes that highlight the imagery of what is perceived by care workers as a parent-child relationship.

On the one hand, care workers likened their service for an elderly client to taking care of older parents. On the other hand, they perceived that their filial care was reciprocated by parental sentiment. It is through these mutual confirmations of a child-parent relationship that the situated identity of surrogate daughter emerges. This identity may not be prominent in all care relationships. Rather it is located in the specific relational context of a care dyad. In other words, a care worker may use the language of child-parent to describe a relationship with one client, and at the same time refrain from doing so with regard to another client. Some participants did use the plural person during the interviews, as shown in Table 4.2 and many of the quotations provided above, which may leave an impression that they are speaking generally about all relationships. Two counter arguments can be offered here. One is that most participants would refer to specific clients when asked to give a detailed account of interactions that happed. This has been supported by most quotes in this section. Another consideration is that some participants interchangeably used “I” and “We” and “S/he” and “Them”, when personal pronouns are concerned. It seemed to be a common habit to substitute collective pronouns for singular ones.

Table 4.2. Imagery of parent-child relationships

	Treating elderly clients as parents	Being treated by elderly clients as child
Exemplary quotes	These older people need us to help them. We must serve them whole-heartedly, as our own parents (C02, L.79-81). I am filial to my parents from the bottom of my heart--I think I must treat them well. Parents' love is more than you can pay back. Right? Then to the elderly [clients], I feel the same. I truly do. (C03, L.164-165) We are like daughters. To the clients, I am a daughter. Their children are not available, and we can be their children. We can do everything for you (client), as long as we can. (C05, L.196-201) I am very gentle to them (clients), and think of them as my mother. Because my mother died early when I was 13. It always feels warm around them. (C14, L.28-37) To some clients, I say, "Mom, how are you feeling today?" "Mom, what do we need to do today?" "Mom, see you tomorrow." Our relationships are quite casual. (C17, L419-421) You must take good care of them (clients) as your parents. I have a few clients I bathe. Their children never come. They only think of us [when they need help]. (C22, L.111-113)	I have a few clients who do not call my name, but "daughter". "Daughter, good that you came. You should call me Mom." Actually my parents already passed away. I said, "I don't have a mother. You can be my mother." (C01, L.51-54) I am not living with my mom. Some elderly clients are very kind to me, making me feel like they are my mom. (C08, L.298-299) If you treat them like parents, they will treat you like children. When the temperature is high, they know I am hot. They would bring a fan and flap for you. They would give me a popsicle, watermelon. They do it as if their own daughter is tired, just like parents. (C10, L.146-149) She (client) said, "you are dearer than my daughter." She is always like that. She is very close to me. (C11, L.209-215) My client said, "this is our youngest daughter!" That means the old person is nice to me. Am I not happy if she treats me like daughter? (C13, L76-77) "My two daughters cannot compare to you", this client said. And she wanted to pay me extra, but I refused. (C20, L. 179-180)

More importantly, this identity defines the ideal role care workers play in a care dyad, that is how a care worker should take care of a client and how the care should be responded to. It thus depicts an ideal interactional model in the course of developing and managing care relationships. In this state of care relationship, we may speak of consonance, in the sense that harmony is found between the two parties, and above all, the self-image of care workers is consistent with the situated identity of surrogate daughter. A caring self finds its resting place in a child-parent relationship: care work cannot be more valuable than what is provided to parents; and the best reward for care is parental benevolence and reassured dependence on the care.

However, not every care dyad nurtures a surrogate daughter. It has been said that dissonance is the antithesis of consonance. A care relationship fraught with dissonance does not simultaneously allow for consonance. In the next section, I shall expound the meanings of surrogate daughter and the resultant consonance in a care relationship.

4.6 Tuning in Consonance

In the forgoing analysis, I depicted the imagery of a surrogate daughter filling the role of absent children. Now I would like to examine the interpersonal dynamics in a worker-client dyad, which sheds light on the process through which the situated identity of surrogate daughter and consonance are arrived at. Note however that the interactions discussed here are by no means "causes" of a relational consonance. Indeed, it is impossible to single out causes of certain relationship statuses in this study. They are woven into the identity talk and the narratives of consonance in the narratives of the participants.

4.6.1 Confirmed intimacy

To explain the process of tuning in consonance, it is necessary to start with confirmation of intimacy, an interactional process that can be considered the precursor of consonance. Recall that complaints about children is a common theme in chitchat between care workers and clients. Such conversations often become an occasion to confirm intimacy. Consider what the following participant has to say about becoming aware of older people's loneliness and beginning to establish intimacy:

> *Older people are very lonely. Their children do not have time to be their companions. Do you know that? I know this because I do this work. You must talk to the older people. Just keeping your nose to the grindstone will not do. … One time an auntie I work for told me: "If I die, you will be the first to know." I said "why", so I asked her. "My son doesn't come to visit me", she said. I tried to comfort her and said, "That's because you are healthy. If you are not, they won't [leave you alone]. They have their own challenges. They don't have time." Some older people say, "Huo (pseudonym of the participant), you are better than our children!" I said, "That's not true. I only come every second day, and I talk to you and do chores for you." I said, "Your children are busy with their own lives, and they will visit you when they are free." I did not understand the loneliness of older people. Now I know. … We focused on tasks before, and did not sympathize. Now that we've done this long enough to know, the older people are all very lonely. So I always chat with them while doing work. (C11, L.167-182)*

In the first half of the quote, notice how the seeking and giving of consolation between the client and the worker pivots around the son of the client, who was said not to visit his mother. The client first began forecasting who would be the one to witness her last moment. The meaning of the forecast became clearer as she brought her absent son into the conversation. The worker's response focused on the absent son, assuming that

postulating a justification for the absence of the son would be the best consolation to offer to the client. In the second half of the quote, the participant generalized the kind of consolation seeking to a larger group and acknowledged a common sentiment that signifies the central role of children in the happiness of elderly clients. She started to "sympathize" and "chat with them" during work. Conspicuous of this interaction is the fact that the care worker chose not to affirm what the client had said about the absent child, although she holds the belief that the child could have visited more.

Acknowledging that the loneliness of older people stems from the absence of children, the care worker responded to the seeking of consolation by justifying the cause of the distress. Being non-judgemental toward absent children often provides an opportunity for care workers to confirm intimacy with elderly clients. As one participant concluded, a care worker should not "spice up" older people's complaints about children, but should try to "soothe" them. This participant said:

> *She (client) tells me everything. I try to console her, "Their (children's) work is busy. Don't worry. You have me." Say positive things. If you spice things up, they are already angry at their children, and you provoke her, it's going to get worse. … It's impossible that all children are good. You know. Some never visit. She (client) cannot get over it. I talk to her, and she is dearer to me than to her children. (C09, L.340-345)*

The care worker turned the occasion into a confirmation of intimacy through assuring her availability to the elderly client. She was also trying to be sensitive to the client's emotional needs and responded in a way that prevented further agitation. She found that her intimacy with the client could be strengthened through these interactions. Needless to say, intimacy is not something that can be added onto or removed from a

relationship overnight, but has to be established and maintained through daily interactions.

4.6.2 Acknowledgement of care relationship

Consonance seeks acknowledgement that the care provided by workers is appreciated and that the care relationship is honoured. Writing an honouring letter (a letter of appreciation to the agency) is a typical way for elderly clients to express appreciation. For example, one participant told me some of her clients wanted to send an honouring letter:

> *[Some] say they would write an honouring letter. I said, that's not necessary. I said, these formalities can be saved. As long as you acknowledge that I did well. With all the experience in this work, I feel this is a responsibility. (C22, L.383-385)*

The care worker accepted the acknowledgement but thought the formality was unnecessary. Indeed, care workers place more value on the interpersonal and relational acknowledgement that usually involves verbal confirmation, such as "you are dearer than my daughter", "my daughters cannot compare to you", and "I don't have anything to thank you with". These quotes have been discussed previously. Common to these verbal confirmations is a clear expression of elderly clients' dependence on the care the workers provide. Recall that one participant said: "The seniors can't count on families. So they have to count on us" (C14). The roles of surrogate daughter are embodied in the dependence of clients.

I examined the seeking and giving of consolation between one participant (C11) and her client. "If I die, you will be the first to know" can be interpreted both as a plea for consolation and an acknowledgement that the care worker was the sole caregiver, on

whose care the client is dependent. Indeed, the expression evoked a sense of sympathy in the care worker, and accordingly her awareness of the emotional needs of the clients were raised. The following is another participant's account of clients' expressed dependence:

> *Many clients said, "Thank you! I don't know how to thank you!" Many asked how old I was and when I was going to retire. They were afraid that I would stop working for them when I retire. "When will your daughter get married? Will you look after grandchildren, and not come?" [said clients.] I said, "I would still come while I look after grandchildren. I will continue. Don't you worry." They were worried that I would quit. A new care worker would be unfamiliar. Most clients I worked for, I saw it through. (C01, L.76-82)*

The clients were concerned with retirement of the care worker because it potentially meant the ending of their relationship. A unique relationship, which has been developed over years of care, cannot be replaced by a random care worker, who happens to fill the vacancy. The sense of dependence is thus specific to a relationship. "I had this 90-year-old lady, who passed away. Her daughters were not well either, so it was me who cared for her every day." The participant continued:

> *I went to see her in hospital with her daughter. I said, "Do you recognize me?" She said yes. "Who am I?" I asked. She said, "You are my daughter." Her daughter was unhappy on the side, scolding her: "She is your daughter, then who am I?" The old lady said: "You are my mom!" Her daughter did not treat her well, and sometimes lost her temper [at mother]. She (client) had always said: "Why are you so mean? Are you my mother?" So she was being sarcastic in her last moment. … As she said that, I burst into tears. I felt so sad. I thought, how sad. There was a tie between us over this long time. Now that she was dying, I felt so sad. I said: "You will be fine. You will return home, and I will still take care of you." She said, "You are my good daughter". (C01, L.82-95)*

The participant started with appreciation expressed by clients, but smoothly transitioned into a narrative of serving as a surrogate daughter for a specific client. In the last moments of the client, a mother-daughter relationship was honoured. In the end, to re-instill hope to a dying person, the best that could be offered by the care worker was a future that involved the continued care relationship. Notice how the interaction between the true daughter and the client was woven into the participant's account and contrasted with the surrogate relationship. The identity of surrogate daughter was undergirded by the acknowledgement of care and honour attached to the relationship in the presence of an "absent" daughter.

In the same vein, care workers are counted on to address clients' psychological needs. I have discussed the quote from Huo (C11): "We focused on tasks before, and did not sympathize. … The older people are all very lonely. So I always chat with them while doing work". Chat is the most mundane, yet the most telling interaction indicating the state of a relationship between a care dyad. Chatting is often a process of showing sympathy and extending care, and the fact that care workers are often the only people for the elderly clients to share with is perceived to be another sign of dependence. One participant had a story about a client who lost her only son:

> *This lady, when I first started with her, lost her son, only son. Every time I visited, she cried. The son is lost, just cry. … This family without children is pitiful. They don't want anything from others, but they need someone to talk to. That would help. They don't want others to buy them stuff. They don't need. When I first started, she cried at every visit. And later she would tell me everything: happy things and unhappy things. (C08, L.280-293)*

Listening is helpful, and as is the case of Huo (C11), consolation becomes an integral part of care work. For many care workers, to be a confidant with clients is a sign of a "good relationship". This point can be further illustrated by the quote below:

> *To be in a good relationship with you (worker) is to tell you everything about her (client's) family and the children. Which child is filial, who is not. They would tell you all. Anything in the family. Today, they would tell you things that happened yesterday. Good and bad, she tells you. (C05, L.115-118)*

It should be noted that sharing goes both ways. Care workers confide in elderly clients too. The following participant said not only did she find listening helpful, from time to time she also needed a listener:

> *Sometimes I had a fight with my husband, I would tell her (client). If she had something happy or unhappy in the family, she would tell me. I did the same. It was like mutual support. (C08, L.301-304)*

The relationship is not a one way street. The idea of dependence thus should not be stressed so far that a view of interdependence is lost. In consonance, a care relationship is a safe environment that both parties take solace in. Participants' accounts are the most powerful in illustrating this point, and here is another one:

> *Sometimes when I felt unhappy, I went to the lady. I would feel much relieved after talking to her. Sometimes I bickered with my son. I would say, "I am going to stay with the senior tomorrow, with them, with auntie." Sometimes I said this to myself. I joked with the lady, "I am going to move into your place". She said, "Come, come. You sleep in my bed". (C02, L.410-414)*

The analysis above is not intended to impart an impression that care relationships are only honoured at the end of a client's life or through mutual emotional support. A care relationship can be honoured by instrumental care work, through trust. I have

touched upon this point above. For instance, the discussion on moral tests in relationship dissonance highlighted the antithesis, i.e. absence of trust, which clashes with the self-image held by care workers. Recall Lian's (C12) account of being a surrogate daughter: "Wasn't it me who did all the chores for this old lady, like withdrawing and depositing money?" Being requested to do banking tasks is an important sign of trust, which in turn reflects a close relationship. On a similar note, a key to the apartment or making a cash deposit is a symbol of faith. To entrust a key to a care worker is to put faith in her; and this kind of trust is characteristic of family relationships. A quote from one participant puts it in a nutshell:

> *Some seniors wouldn't tell their own daughters where things (money) are, but they tell me. She (client) said, "Please remind me it is here, and don't tell my daughter. She's probably going to take it." She (daughter) is not going to take it actually. She (client) is just suspicious. I said: "Are you not suspicious of me"? She said: "You are not going to take it. For so many years, when did I lose things?" (C01, L.137-140)*

4.6.3 Reciprocity of care

Reciprocity is another characteristic of consonance in the care relationship. The fundamentals of reciprocity can be summarized by a simple principle: "Others will do the same good to you as you did to them" (C14, L.67). One participant elaborated this point:

> *Like this client I take care of, I sincerely treat her as my mother. I bring home-made soup over, and dumplings too. I feel quite natural. She said: "You are so kind to me". I said, "This is natural." Some food, what a big deal! She is very kind to me too. Because whenever I visit, she would give me chilled drinks. She is kind to me. And I think I should be kind to you if you are kind to me, just like my mother. When I cooked something, I would ask: "would you like some"? If she said yes, I would bring some. Just like she is treating me as her child. If they had*

something, they would give it to us. Regardless of what food it is. They think of you. Right? (C04, L.278-287)

Reciprocity is embodied in everyday interactions such as sharing food. As reciprocity ensues, it becomes natural to give. Giving and sharing is rewarded by further input into the virtuous cycle. Moreover, the meaning of reciprocity, as illustrated by this participant's account, is not confined to the substantive value of the tokens exchanged, in this case food. Reciprocating symbolizes thoughtfulness. She knows that the client thinks of her, and to her, this reciprocity and regard can best be explained in the language of mother-daughter.

Reciprocity is often reflected in the sharing of food and the exchanging of gifts. I have discussed some examples of this above. Some insights can also be gained from the refusal to accept a gift. Consider this participant's narrative of refusing a client's gift and her reasoning:

This senior wanted to give me gifts. I thought, now we can make our own living, but her income is little. Sometimes, she got gifts for me. I said, "I cannot take it. You are in such hardship. You don't have a pension. Because we can still live off our labour, and we earn more than you do. I don't know about the future, but now I am in a better condition. You should keep this for yourself." Sometimes, they gave me gifts during the Chinese New Year. I mostly refused. If they are in a good financial situation, I would accept it. If they are not in a good situation, not that I dislike their gifts, they are good, I would think: "you don't have a pension, and your children are not doing very well either, and you don't have many children. I don't have the heart to eat your food." I cannot accept their gifts. (C05, L.159-169)

Prior to making the above statement, this participant was talking about her contribution to cleaning supplies at a clients' home. The giving of gifts was thus seen by

the client as part of an exchange. In this case, gifts were refused, not to reject reciprocation, but to show consideration of the client's financial condition. The principle of reciprocity was not undermined, but on the contrary reinforced by the extra thought put into what would have been a more straightforward instance of giving and receiving. As the clients thought of the participant as they offered gifts, the participant also thought of them as she decided to accept or refuse the offer. Although in the end nothing tangible was exchanged, care was made evident.

Aside from tangible gifting, reciprocity also means reciprocated care, that is, the elderly client cares about the worker. The following quote illustrates the kind of consideration some older people show to care workers. The participant said:

> *I rarely asked for leave. But when I was going home for the Chinese New Year, the senior went: "OK. OK. Have a safe trip. Take it easy." They are very considerate. "You only go home once a year, so stay for a few more days." Older people care about me very much. … I was very happy to hear that. I thought they care about me so much, more than their children. (C09, L.359-365)*

Going home for the Chinese New Year is almost a cultural pilgrimage. And the client was perceived to be understanding in that the request for leave was granted at her own cost. The consideration of the client is interpreted as caring about the participant, a sign of reciprocity. The participant continued:

> *She often phones me, cares about me. "Eat properly. Be good to yourself. Eat well. Don't be frugal. It's so hot. How can you not eat?" We don't have an air conditioner at home, and this year is extremely hot. We rented the place, and we couldn't install an air conditioner because of the power capacity. The senior called me: "Sleep early. If you can't sleep tight at night, you should watch your health. How are you going to manage a whole day of work in such hot weather?" She said I should be careful. (C09, L.402-408)*

The client expressed concern for the participant's health after learning that her lunch is a bottle of milk and a pack of biscuits. The older person might not be able to offer any tangible support to the worker, but she could extend her concern. As with the consideration in granting the request for leave, the participant's care work was reciprocated.

Shanghai was struck by exceptionally great heat in the summer of 2013, when the majority of the interviews for this study were conducted. For this reason many participants provided examples of clients caring about their health during the extreme weather. To illustrate reciprocity of concern, here is an instance in which one participant suffering a medical condition felt her care was reciprocated by a client:

> *If I miss a visit today, I could have just make a phone call and said: "Mom (client), I am not coming today." I could make something up, but I did not. I must go, even in the pouring rain. Because this is a duty. Even when I am sick. I have high blood pressure, and this time it went over two hundred [mm Hg]. I took medication, and I still went to her (client's) home. I felt I could make it. The senior loves you (participant). When you are sick she cares about you: "Daughter, are you feeling better? Be careful! It's too hot today." She would reverse [the relationship] and care about you. It is such a comfort. (C22, L.229-237)*

The participant emphasized her own care toward clients, in the face of extreme weather and medical conditions. However, her care would not have been complete if it were not reciprocated by the senior's love and care. In her words, the care relationship was reversed, in the sense that the carer became the cared.

Note that in all the quotes above, participants used the language of parent-child or mother-daughter. In fact, as was highlighted in Table 4.2, consonance in care

relationship can be described in a familial language. The identity of surrogate daughter is symbolized by the care reciprocated by the clients in a parental manner.

Two questions still beg to be answered in the principle of reciprocity in a care relationship: who should be the first to do good to the other and what if either one of the two parties refuses to reciprocate? When they talk about reciprocity, care workers seem to stress the importance of initiating reciprocity, in believing that "if you do good to others, others would do the same to you", while downplaying the fact that care is not always reciprocated. It is evident in the previous discussions that when a care relationship becomes deadlocked, it becomes difficult for the two parties to cooperate to create the virtuous cycle of reciprocity. Again, dissonance harms a care relationship by interrupting the cycle of reciprocity, which fuels healthy dynamics in a care dyad.

4.6.4 Family ritual

Reciprocity was examined above as a characteristic of consonance in care relationships. Reciprocity can be understood as a tangible reward for care in the form of gifts, care reciprocated between the carer and the cared, and an embodiment of the situated identity of surrogate daughter. In this section, I describe how consonance and the identity of surrogate daughter are further substantiated in the event of death of a client. The departure of an older person makes possible a family ritual in which the care worker is symbolically acknowledged as one of the family.

I will focus on my conversation with one participant who witnessed a number of clients' departures. Her experiences were representative of many other care workers. When we were discussing the topic of the status of care work, the participant started with a typical comment on absent children:

[I think] society is in a great need of care workers. I think I am honoured [to be a care worker]. I took care of so many older people. I dressed them up as they passed away, and the children were all very grateful. The children did not care for them: "She (client) pooped!" "Auntie, she peed!" They didn't take care, and it's all our (care worker) job. (C18, L.532-536)

Dressing the deceased preserves their dignity. To be able to do this is an honour for the participant, especially when the children were not available to do it. She went on:

I had a client, who died in hospital. In the end, it was just me who attended to his last moment. When his children came from out of town, they were very kind to me. They said: "you did what we children should but could not do." Recently, when they visited Shanghai, they phoned me and sent one thousand Yuan to me. They said: "You did what we couldn't do. We did not get to witness his last moment, but you did. My father will bless you." He died at 96. (C18, L.536-541)

The participant used the term "*song zhong*" in the Chinese language, translated as "attending on his last moment". Attending upon a dying senior member, particularly parents, is considered a family ritual that requires the participation of children or juniors in the family in Chinese culture. Seeing to one's parents' departure, and traditionally also burying them, is a filial obligation. The participant, in attending to the ritual and fulfilling the filial obligation, completed the symbolic ceremony of becoming a family member. She continued to recount another case:

This old lady. Her family did not want her to die in hospital, so she died at home. It was also me. Every morning I gave her a wipe down. She died around 7 in the morning. This morning, her daughter told me to buy groceries with her. She said, "let's go together." "Don't go yet", I said, "your mom looks unusual this morning." She said, "what's wrong?" I said, "come take a look. She looks different from the past days." I noticed, and she did not. As we were talking, she passed away. Her daughter started crying. I said, "there is only you and me

> *here. Don't cry, and give me a hand." I said, "find her some clothes to put on while her body is still warm." I treated them all as my own parents. I dressed them up as they departed, and I attended them in their last moments. (C18, L.543-552)*

The participant claimed to notice the unusual signs in the dying person, to which the daughter was oblivious. Then she appeared calm and reacted quickly as the woman passed away. Attending a dying senior as she would her own parents is symbolic of playing the role of a daughter and hence becoming part of the family. When asked about *song zhong* for clients with whom intimate relationships had been built, participants appeared to be sad, but at the same time all of them showed this sense of honour.

Attending a dying person in her last moments is the most important family ritual in Chinese tradition. Other smaller ones are ubiquitous in day-to-day care relationships, such as giving and receiving red envelopes during the Chinese New Year and sharing moon cake during the traditional mid-autumn festival. Common to these rituals is their significance in symbolically acknowledging a close relationship. In participants' words, it is the state of relationship of "being one of them/us". The quote below serves to illustrate this dynamic:

> *Some older clients don't have children living with them. So when other people ask her, "who is this (worker)?" "This is my daughter", some people say that. I felt pleased to hear that, because she accepted me as one of them. Of course, I am very nice to them. But if they treat me as one of them, I would be sincerely happy. (C15, L.152-157)*

To be one of them is to be accepted and treated as a family member--a daughter. Not every care worker becomes "one of them" in every care dyad, but it is certain that when

they are, the care relationship is likely one of acceptance, acknowledgement, dependence, and reciprocated care and love.

4.7 Summary

In this chapter, I began by exploring care workers' narratives on the social identity of care worker, capturing the depiction of care work as socially disdained, provincial, and demeaning. The care workers, in their narratives engaged in identity talk, that is, they reconstructed care work as valuable work for those in need provided by a caring self. Then I moved on to examine the two polar opposites of an identity negotiation that care workers engage in through the care relationships that they form with older people. On the one end of the continuum, identity dissonance occurs when a care worker's self-concept is perceived to be rejected in the interaction with an older client. On the other end, identity consonance happens as the self-concept is in congruence with the situated identity of a surrogate daughter. The two poles considered together characterize a dynamic process of identity negotiation. Moreover, the strategies of disregarding and justifying for tuning out dissonance and the quality of acknowledged and reciprocated care in consonance were considered. In general, care workers draw on cultural symbols and imageries to describe the tuning processes. Lastly, I examined how care relationships may end in a different fashion in accordance with the specific state of identity harmony.

In the next chapter, I will probe into the instrumental aspects of home care. The provision of tangible care, as it will be demonstrated, can be better understood in light of the relational aspect of care, specifically the identity work.

Chapter Five: Tailoring Instrumental Care Work

Care relationships are bounded by agency policies and general guidelines that stipulate how care work is to be conducted. Such configurations, however, are often not sufficiently specific to govern the care relationship with individual clients. Every care dyad calls for a more personalized plan for the work to fit the needs of the elderly and the specific environment of the home. The majority of the participants stated that "every elderly client is different". In this chapter, I will attempt to link the previous discussion on the relational issues to the instrumental aspect of care work with a view to demonstrating that instrumental care work is best understood in a relational context.

5.1 Delimiting Duty

Home care work as a service is delivered within the bounds of government guidelines and agency policies. The scope of care work is circumscribed by job descriptions. In reality, however, in the delivery of care services certain tasks are performed by some workers, but not by others. Certain tasks are prohibited by agency rules, yet the rules are constantly broken. For some dyads, care extends beyond normal working hours, while for others, time of work may be inflexible. In this section, I expound on the idea of "duty", in the participants' language "*fen nei*". The process of delimiting duty is simultaneously about instrumental work and a matter of self and identity.

In the first few interviews, following the initial interview guide, I set out to explore how care workers maintain the boundaries of their work. However, the question "what are the boundaries of your work" constantly received the reply "there are no boundaries". To the care workers, care work reaches to where recognized needs extend. One participant thought her work involved anything that needs to be done:

> *[My work] is to do laundry, dust, mop the floor. For some seniors, you get medicine for them. Pay bills, buy groceries, like all these. Like wiping off straw mats. Wash her hair, give her a bath as well. … Anything in her house that needs to be done, we do our best to get it done, just to reduce her burden. Because she is getting old and immobile. Sometimes seniors have trouble moving their limbs. (C05, L49-56)*

Despite the bounds set by job descriptions, when care work is performed in individual homes, what in fact is done is subject to the discretion of the worker. A principle, as expressed by this participant, is to "reduce the client's burden", a term defined by the client's unmet needs. Recall that care workers construct care work as "work for those in need". They attach value to their attentiveness to clients' needs and their work toward meeting the needs. A compassionate and caring self is embodied in the attentive and accommodating disposition. At times, the actual tasks present no difference from what is formally defined as care work, while on other occasions work may extend beyond the job description. For example, some participants recognize talking and chatting as a need, and therefore intentionally maintain conversations with clients:

> *They need it (chat). Sometimes, as soon as we come in, they start talking about what had happened in the family. They tell us everything. They just need someone to talk to. I have two clients, they would talk all along till I leave. Older people need to talk. (C08, L.169-271)*

Other participants echoed her views, stating that talking as a need ought to be recognized as an integral part of care work. Here is what another participant had to say about the need for chatting:

> *Doing chores is not the most important. Chatting is. Yes, there are chores to do--dirty clothes need to be washed. But you'd better finish the chores fast and save some time to be with her (client). (C14, L.459-460)*

As chatting is a need, it may even be seen as a higher priority if a client prefers to chat than to getting all the chores done. Apart from the critical role that chitchat plays in care relationships, discussed in the previous chapter, recognition of the need to chat illustrates the malleable nature of care work in individual contexts. Unmet needs are often ascribed to the absence of children, and the role of care workers is to fill the gap left by the absent children, thus they become surrogate daughters. Indeed, participants use the word "*fen nei*" to describe the kind of work they bear an obligation to do. This word can be translated into "duty" in the English language, but the original expression in Chinese contains the connotation of responsibilities circumscribed by certain social roles. "*Nei*" means "inside", whereas "*fen*" means a social role. Literally, the phrase means "within my social role". The implication is that the scope of care work is shaped by the role assumed by the worker in a care relationship. Much has been said in the previous chapter about the caring self and the relational dissonance and consonance. The following discussion will further elucidate how the instrumental and relational aspects of care work are intertwined and the former shaped by the latter.

Duty is most salient when the tasks involved contravene formal rules and regulations set by the agency. For example, the agencies have rules against leaning outside to clean windows on the second floor and above for the sake of safety. For the same reason, care workers are told not to dust surfaces that cannot be reached without standing on a chair or table. Bathing a client in the absence of a family member is prohibited. The care managers' interpretation of the window cleaning and bathing rules is that no liability should be borne by the care workers or the agencies to avoid an accident that results in injury to employees or clients. Such rules set boundaries for the

instrumental care work, yet it is the breaking of these rules that underscores the relational aspect of care. One participant's reasoning for breaking the window cleaning rule is typical:

> *We still clean up the windows for them. We all do. Every home. Although you know you are not supposed to, but the windows are dirty, you cannot just ignore it. … If you don't help her, and she is old, who is going to clean them? Nobody. So although we say no window cleaning, no window cleaning, we still clean. Windows are dirty, and if you don't clean, and she is too old to clean, are you going to ask her children? They are not going to come clean the windows. … I cannot bear to see the dirty windows, so I'd still clean for her. (C05, L.475-484)*

This participant focused on the client's need, acknowledging that old age made it impossible for the client to do herself. Children were brought into the reasoning to demonstrate the necessity of care work in the absence of familial support. Thus what ought to be done for a client cannot be prohibited by rules.

This point warrants an additional example. When I asked another participant about her view and her response to the bathing rule, she disagreed with the logic behind the rule:

> *I don't think I am worried about the risk [of a fall]. … Call the families? It would not be good work. [Whenever] a client needs to be bathed, are you going to ask her family over to stand by the side? It would be too rigid. [To be] too rigid is to shirk your own duty and shove it onto other people. Families attending, so we would not be liable? You can't do this. You know. Families would also be annoyed. … Most seniors live by themselves. To ask the children to come back and stand and watch. Is it possible? … You just have to be careful [when giving a bath]. (C14, L.133-140)*

In her opinion, following the agency rule and refusing to bathe a client would involve shirking her duty. For the care worker, the cornerstone of a care relationship is not the pre-determined rules, which place a higher priority on agency liability than meeting the seniors' care needs. A conscious decision to go against the rules implies fulfilling a duty at the care worker's own risk, which may be alleviated by "being careful". In so doing, the care worker made a claim that she indeed cares about the client. To be caring, she would go so far as to confront the rigid rules that constrain her good work and her relationship with the client.

The above two cases suggest that duty, or *fen nei* work, can extend to undertaking prohibited tasks. When this happens, a client's needs and the worker-client relationship override the boundaries set by agency rules. Here duty reaches a territory unregulated by formal rules. Yet another participant told me a story of an elderly client and her middle-school-aged grandson:

> *[There was] a granny upstairs, whose son and daughter-in-law both died and left a grandson,… a junior high school student. When I first visited, that granny told me my work is to do everything in the house. She couldn't walk out of the house. So you take on the seven necessities. … All the shopping, if the family needs anything, I buy everything. … I do everything, including going to the kid's school parent meetings.*[26] *… The kid is the same age as my daughter. All the parents' meetings since junior high and then in the professional school. … My daughter was jealous, "[why do you] go to his meetings with alacrity, but you never attended mine!" My daughter graduated from university last year. I said: "He*

[26] Parent-teacher meetings or interviews.

doesn't have a mom and dad. You have dad, and dad can go." I went to all his meetings. (C12, L.149-164)

Attending a client's grandson's parent meetings is certainly not listed in the job description. The boundaries of work, if they exist at all, lie far from the job description and prohibitions one would assume to delimit these boundaries. Where there is a need, there is a duty. Such duties can range from household chores to performing certain tasks on behalf of a client, such as banking or attending a grandson's parent meetings. In fact I would further argue that attending a grandson's parent meetings is somewhat different from tasks such as paying bills or withdrawing cash "on behalf of" the client. Going to a parent meeting assumes an unambiguous custodial role. In doing so, the care worker takes on part of the parental role assumed by the grandmother. She shares responsibility for the youth who "doesn't have a mom and dad". In so doing, the participant in a long lasting relationship figuratively become a surrogate daughter to the client. To do *fen nei* work is to fulfill what a daughter would normally do in taking care of the parents, or in this case, the grandson.

If duty, or *fen nei* work, is fulfilled because it is within the limits of the social role, i.e. a surrogate daughter, when tasks are regarded as "outside" the limits of the social role, they cannot be said to constitute a duty. Participants' accounts confirmed this hypothesis. Another Chinese phrase, "*fen wai*" was used in these cases. The phrase thus can be translated into "outside of a social role", the antonym of *fen nei*. Some care workers would use *fen wai* to describe the same tasks as others took on as *fen nei* tasks, such as cleaning windows. Consider the following quote:

It is not our obligation to clean the windows. [Clients] should not ask us to do this. Think about it. Under this heat, if it is your (client's) daughter, would you

ask her to clean? This is how I look at it. I think you would not have the heart to ask your children to clean. How would you? There is a rule against this. Plus this extreme heat. I probably would clean it for you if it was not this hot. (C09, L.142-145)

This participant did not consider cleaning windows her obligation. Hear what she said at the end--that she would not mind cleaning after all. Her whole ambivalence evolved out of an interpretation of the attitude the client held toward her. She felt she was not treated the same as the clients' children in that the same concern that the parents would have extended to the children was missing in her relationship with the client. Her care was not reciprocated, and she, in that case, was not a surrogate daughter. The same task, cleaning windows, therefore lay outside her social role. The participant justified her refusal by citing agency rules.

By the same token, tasks circumscribed by the job descriptions can sometimes cause contention, and care workers may re-draw the line of duty on the basis of the state of their relationship with a client. The following account depicted a relationship fraught with friction inflicted by what the worker perceived to be the client's lack of care about her.

Many clients know our job is laborious, and they understand. But some do not, they are inconsiderate. This one is very typical. This client told me to do everything at home. I said: "I did not even dump my mom's spittoon.[27]" It is filthy. Now I have to dump this for her. She could have disposed of it after use. She waited [for me] to dump for her. (C04, L.231-234)

---

[27] Chinese spittoons are commonly used as a night commode.

Discontent is apparent in her description of "they load everything onto me", quoted in the previous chapter. Recall that undue demands potentially cause dissonance. She went on to recount a case of friction around doing laundry:

> *Then she asked [me] to wash the bedding, the cover, and the blanket by hand. Do you think you can do it? I told her, "I can take these home and machine wash them. It's OK to use my machine." I said it's OK, don't worry about the [extra] time. I will work the same hours here at your home. So, I was going to wash your bedding on my own time. Right? She would not allow it! Just this client. They would tell [me] to wash the blankets by hand. Can you imagine? (C04, L.235-240)*

Doing laundry is part of the care work. It should be noted that many clients do not have a washing machine at home, and it is therefore common that care workers do light laundry by hand, for example on a washboard. However, to ask one to hand wash bedding, as with the request to dispose of urine and feces in the spittoon, is a sign of inconsideration, and lack of due respect and reciprocal care. The participant could refuse to do certain work, not because it is difficult, but because of the lack of respect and mutual care in the relationship.

The analysis above showed that duty in care work is determined, to the extent that care workers' narratives reach, by "*fen*", the social role one assumes in a relationship. What is to be done and what is not, i.e. the scope of work, therefore is not entirely a matter of rules set to delimit the formal boundaries of home care work. Care workers' constructions of care work, the caring self, and mostly saliently being a surrogate daughter as a situated identity in a care relationship are all at play.

What lies between breaking the rules and feeling disrespected can perhaps be described as the tepid care relationship. If the care worker leans toward maintaining a

good care relationship, they might break the rules or accept certain tasks outside the job description. If the care workers are more instrumental and practical, they would use agency rules to defend their refusal to do certain tasks and define clear boundaries to their work. As some would say "we are just here to do our job". These care workers tended to feel that it is a contract that bonds them and their clients rather than a relationship.

5.2 Time Management

In this section, I discuss the issue of time management in care work, making four key points. First, managing time in care work requires flexibility. Second, care work at individual homes is structured to seniors' needs. Third, a care worker's personal life is often adapted to care work. Fourth, time management has a crucial influence on care relationships. I begin with "working hours" and then "care hours", before moving on to the issue of time and relationships.

5.2.1 Working hours

In the home care program, the length of each visit ranges between one and two hours. Number of visits can be anywhere from once a week to daily. Most home care agencies do not keep a formal record of each visit. Attendance at work is mostly maintained on the basis of a care workers' ethics and mutual trust between the care worker and her client, although in some areas in the district hand-written time cards had been used to track hours of work. This practice is loosely overseen, and the cards could often be filled out in an *ex post* manner. Care workers and clients thus enjoy considerable latitude around time management, as long as the total hours stipulated on the care contract are filled. Given the flexibility, time management tends to be geared to the needs of clients

and the amount of work the care dyad agreed on. One participant shared her opinions on time management in the home care program:

> *It's altogether this much work. Sometimes we work overtime, but other times we have extra time. ... Sometimes she has errands for us to run--buy groceries, pay bills. There could be a long queue. Say, to refill medicine, there could be a long line. In that case, we would go overtime. Sometimes we go overtime, sometimes we don't. So it is flexible. If you get medicine today, you are going to be late. She (client) would let you spend less time at home, or do less housework. This is not unusual. It's up to you. You do your best to finish what is most needed today. Get done what should be done. That would do. (C05, L.461-468)*

The participant depicted what has been echoed by many care workers, a typical scenario of time allocation in a care dyad, which calls for mutual understanding and cooperation between the care worker and client. The worker relaxes the boundaries of working hours and is willing to go over time to accommodate the contingencies at work. She uses discretion with the limited time to help with the "most needed" tasks while the client acknowledges the worker's contribution of time and also relaxes the rules around work to be done, so the worker could "do less" and leave on time. On the whole, the concessions given by the two parties appear to be equal, allowing a flexible but fair allocation of time at work. Another participant's quote further illustrates this point. She has a client who lives in a smaller apartment, which needs less time than officially allocated to complete the work.

> *Her apartment is small, and I can usually get the work done in just a tad above one hour (out of two hours). So I said, "Auntie, I still have time to do some more work for you". "It is OK. You are not very well paid. Just go". She said", I do not pay you out of my pocket". The home care program does pay little, now 14 Yuan an hour (about $2.8 Canadian). It is 20 Yuan (about $4 Canadian) for*

private hires now. She said, "you are not paid well, and I am not the one who pays. Just go home early, so you can rest." I felt very happy. This time I left early, I had it in mind, and next time I stayed longer for her. If all the work was done, I would look for new work: "Auntie, I am going to clean the windows for you". "Clean the windows?" "Fall is almost here, and we will not have too much rain. I will clean them for you". So she said, "OK, you can clean them if you want". (C.20, L.135-143)

It is important to caution against the impression that workloads in the home care program are low. The point highlighted in this quotation is that time allocation is flexible, and time management is a matter of mutual understanding and care between worker and client. Notice in this case that the client showed sympathy toward the worker in an acknowledgement of the low pay in the home care program, implying that the worker does not "owe" her time. The client also extended concern for the worker in telling her to rest. Recall the discussion on reciprocated care and surrogate daughter. The worker, instead of taking the benevolence of the client for granted, sought to repay her by making up the time. It is worth clarifying that the worker did not literally mean "next time", but rather in any visit that follows, she would not be oblivious to the fact that the client had let her go early. As there was only "altogether this much work", the worker looked for more work to fill the time. She then identified a need of the client that would usually go neglected: with less precipitation in the fall, the windows would become dusty sooner. So she cleaned the windows, and that was her way to repay the time allowed and the concern extended by the client.

Working time in a care dyad is tailored to meet the client's need and to accommodate the home-specific arrangement of care, and at the same time reflects the state of the worker-client relationship. On a higher level, for each care worker,

management of working hours is a matter of juggling between a number of clients' needs and requests. The case in "a day for a care worker" was a snapshot of how a care worker would typically manage a day of work and the distribution of time. A care worker cares for individual clients, yet she is faced with the issue of managing time for her entire clientele. Apart from the unpredictable delay due to certain tasks, as discussed above, the challenge of time allocation is two-fold.

Firstly, it is not uncommon that a care worker divides a two-hour block of a daily visit with a client into three or four shorter visits, so that the client's needs can be better attended to. This kind of time arrangement usually occurs for older clients who have lost mobility or need to be frequently checked on. A good example was captured in "a typical day for a care worker" (Table 1.4), where the care worker made three visits to a client. For a typical client who needs support for most ADLs, a worker would visit for the first time early in the morning and help the client out of bed, prepare breakfast, and clean up; around noon she would cook lunch for the older person; and in the evening she would visit again to make the last meal and provide personal hygiene care. All three short visits are fit in between longer visits to other clients.

Secondly, not every senior client appreciates the idea of flexibility, and those who do not may ask care workers to arrive and leave punctually. Such demands for punctuality may give rise to tension between the care worker and client. The following quote illustrates a participant's annoyance caused by the rigidity of one of her clients about time.

> *I am not a kind of dawdling person. I am there just to get the work done. If I get it done, you (client) should allow flexible hours. No matter what work, I get it done for you. But then, you should also [be flexible]. Because for us, if you let us*

> *go earlier, it is not much of a gain for myself, but I could go to the next home earlier. So it is really not different for us. But she (client) does not allow it. (C04, L.397-403)*

The participant did not see leaving early as "a gain for herself", because working time for her is the total hours she works for her entire clientele in that day, which inevitably involves some adjustments around time to accommodate irregularities. There is a clear discrepancy of perception about working hours from the point of view of the worker and presumably the client: for the latter, the working hours are the two hours that the worker spends at her home. Another participant's comment resonates with the participant quoted above:

> *Some older people demand you to be there by when and when. Well, in such hot weather, I could not sleep in the morning, so I went there earlier, thinking I could return home earlier for dinner today after the whole day's work. Some older people are cranky. She said you came too early, and that is not OK. Some tell you to be there by eight and you have to be punctual. This is pretty frustrating. This is not like checking attendance at a factory. I am not loafing on the job. I would still do all the work for you. Right? No, she does not like it. If she keeps being that way, how am I supposed to continue? (C09, L.184-190)*

Care workers may feel torn between the flexibility required by care work and some elderly clients' demand for punctuality. Notice both this and the previous participant emphasized that they are not dilatory, but conscientious about time allocation during working hours. Recall the discussions on the self-image of care workers; I wish to point out that this is another instance where care workers' narratives about care relationships and care work often gravitate toward maintaining their own self-image as conscientious and caring.

5.2.2 Care hours

In the section above, I discussed time management during working hours and the flexibility the home care work calls for. The implications for the care relationship will be further elaborated in the subsequent analysis on the concept of care hours.

While care work at individual homes is tailored to accommodate seniors' needs, a care worker's personal life is often adapted to care work. In a sense, allocation of time is akin to fulfilling "duty", both of which involve traversing the formal boundaries set by rules and regulations. As care workers' lives are centered on care, it should not be surprising that they often contribute their own time to caring for the seniors--in their words, working "extra hours". In the previous chapter, a number of quotations have already touched upon the issue of working extra hours, such as in the cases illustrating the role of a surrogate daughter. I will not repeat the same cases here, although the reader is encouraged to revisit some of them for an imagery of a surrogate daughter standing by to respond to elderly clients' emergency and everyday needs.

Due to the flexibility of care work, defining extra hours is as difficult as defining working hours. Without formal tracking of hours worked, it is nearly impossible to regulate home care work in a rigid time frame. The actual amount of time devoted to taking care of a client often deviates from the stipulation in the contract. I propose to call the actual hours needed to take care of a client "care hours" to reflect the fact that, in practice, it is often the amount of care that defines hours of work rather than the other way round. Consequently, clients who need intensive care and continuous attention tend to require more care hours than formally allocated, whereas clients who need regular care, often just house chores, usually require fewer hours than allocated.

I have already explained the strategy of dividing work per diem for a client into shorter visits within the working hours. In reality, this strategy often requires care workers to work extra hours. The following quotation showcases another example of care work seeping into a care worker's personal life and becoming part of the care worker's daily routine beyond the normal working hours:

> *To care for these poor clients, it is a different mentality. You have to give more and be sympathetic. They are really pitiful. Our hearts are soft. When you go there, you can tell from her eyes that she was yearning for you. "You are finally here. I have been wanting to pee so badly." When you hear that, how are you going to feel? She yearns for you to help her pee, to help her go to bed at night. … [I visit her] perhaps more than four times. I live in the apartment building behind her. She is on the first floor and I am on the third floor. Every time I come down, I swing by her home: "do you want to pee?" When I return home, I drop by. I don't know how many times a day. If I stay for even just a few minutes, she is relieved. If I am there, even she does not want to pee, she is happy. Like this, more than four times, maybe seven or eight times a day. (C18, L. 437-448)*

By "poor clients", our conversation referred to older people who live in solitude and have a meagre income. The participant frequently checks on the client during the day and helps with toileting. To do this means "giving more" time. The participant seemed to be very observant of the psychology of the older people, and by elaborating her observation, she claims to be sympathetic in caring for the clients. The time management and working extra time, rooted in sympathy, was a demonstration of her devotion to care work and her clients. Notice that this kind of time management is made possible by the proximity between the participant's and the client's residences, which as I mentioned before, is a common condition reported by many participants, unless one is

troubled by the perceived social derogation of care work from neighbours and only chooses to take on cases away from her own neighbourhood. In fact, if a care worker lives close to most of her clients in the same community, her care work would literally turn the neighbourhood into a nursing home or a retirement home; and each client's home is a ward, between which the worker shuttles to complete the job. Again, the actual care hours for each client may not be the same as the hours formally allocated, and to complete the job thus involves coordinating multiple clients' needs. Another participant's comment is helpful to further illustrate this point:

> *I am busier and busier now. ... Some clients call me at 11 in the evening. ... But if they call, I have to go check it out, even if it is past midnight. ... Sometimes [in the day], you need to give a heads-up to the client you are working for: "Mom", I call [this client] mom, "I have to check [another client] out". I put the work down and darted out to the other client. So honestly, this work is not burdensome. Why? Because it is not burdensome if you are caring, because they (clients) are seniors. (C22, L.104-115)*

Apart from what has been described as strategies and realities in home care work, it may be seen from the above quote that care workers can be faced with contingencies that interrupt the work at hand. The care work is on-demand, and care hours are expansive, including time spent to react to an elderly client's one-time requests. Time management could involve much *ad hoc* discretion. Many care workers commit to the clients they care for and always stand by. The following quotation provides another example of a care worker promising to clients that she would be available on request:

> *One of my clients lives with her children, and she is OK, because her children treat her well. The other four all live by themselves. So I said, "if something is up, call me. I will be here." "You are busy. That's OK", they would say. I said, "my moped is fast, and I am always around nearby." Because sometimes they*

are fragile, you worry about them all the time. What if they fall? (C23, L.183-187)

In the absence of the client's children, care worker's time management must accommodate contingencies that arise out of the clients' fragility. This quote also bridges the issues in time management and the discussion on absent children and the role of surrogate daughter.

5.2.3 Time and care relationships

It should be clear by now that care work revolves around a senior's needs, and a care worker's personal life accommodates the provision of care. For that very reason, managing time is an essential element of the process of providing care, and thus crucial in determining the state of care relationships. The implications of time management for care relationships can be discussed at two levels: personal and institutional.

On the personal level, care workers generally prefer the flexibility in home care work. Some of them rely on the flexibility to find a balance between work and life. This is evident in the younger participants, who from time to time juggle child care and work. One participant told me she quit from several jobs, such as saleswoman at a department store and nurse's assistant in a hospital and finally settled in the home care program for this reason. She said:

I have control over time at work. If my kid comes home from school, I can tell my client, my child is coming home, I need to leave now. Then I can make up the time when my child is not home. I can make adjustments around time. (C10, L. 253-255)

Not every care worker has child care needs, but the same flexibility is appreciated by many. The following quotation from another participant highlights this point:

> *This is one thing good about this job. If there is something, you can switch to another time. Right? If I have errands to run in the day, I would give her (client) a heads-up that I am going in the evening, or the next day. It's all good if we get along well. Some even said: "If you have things to do today, you don't have to come." This is those in a good relationship with me. I said: "I will come. I am forty some and you are ninety some. It should be me to accommodate you, not the other way." She was very happy to hear that. Like this, we are in a good relationship. (C14, L. 359-364)*

For the participant, allowing the flexibility is a sign of the senior's understanding and thus strengthens a good relationship. However, she did not take it for granted. Her response was to reinforce the image that proper social decorum was displayed by a junior toward a senior. In the process, they completed the reciprocation of care. To use another participant's words, flexibility is maintained through "mutual understanding", and care workers should "strive to avoid asking for leave, unless for very important issues".

On the part of the elderly clients, as I mentioned, flexibility is not always desired. The quotation (C09) in the previous section about some clients' demands for punctual arrival is illustrative. Other clients may not allow one to leave early. Rigidity around time on the part of a client can be interpreted by workers as a sign of lack of understanding, and hence unhelpful to the development of a good relationship. The following quote expands on this point:

> *No flexibility, then you are not going to ask me to do any extra work. Within the limits of my job, I do the work for you. Like this client, she has one hundred Yuan monthly benefit, so two one-hour visits every week. But she is very rigid around time. She would not be happy if I leave early. So for the first number of visits, I felt she was very calculating. I did not think too much--I would fill the whole hour. ... She wants you to do everything for her. ... You look at the clock and think it is about time. She is the calculating kind, and she already planned out*

everything for you, and she looks at the time and says you mop the floor, wipe this, clean that. ... If you do work fast, she thinks you still have time to do more. ... Well, she has every right to ask you to do more. And what if she files a complaint here [at the agency], saying "this worker slacks"? ... But if she calls me to ask a favour, some extra work, I would surely refuse. A good relationship is about heart for heart. I would not help her with extra work. (C17, L.155-178)

For this participant, a good care relationship is hindered by rigidity. Moreover, rigidity around time reminds care workers of "checking attendance at a factory". This tends to happen with clients whose benefit levels are low, and allocated time is limited. Given the nature of housework and chores, the care hours needed for these clients are not necessarily shorter than those for clients whose benefit levels are higher. I heard a number of participants allege that some other care workers, but never the speaking person, rid themselves of clients with lower benefit levels. It is also reasonable to believe that given limited hours with such clients, care workers would have less opportunity to bond with them through chitchat and spending time together, inhibiting the virtuous cycle of reciprocity of care. This point brings us to the impact of time management on the care relationship at an institutional level.

Months prior to this study, some agencies in the district introduced an attendance card policy, and two of the agencies I visited were part of the initiative. Under the new policy, a magnetic stripe card carrying a client's information is sent to each client for the purpose of recording the care worker's hours. Each care worker is given a handheld card reader, which must be carried on all visits. Upon visiting and leaving a home at set times, the client swipes the card on the worker's reader, so that the latter's attendance is recorded. Swiping can only be registered around the set times, with a short grace period, and swiping the card at other times does not count toward the worker's attendance. The

implementation of the system at the time of my interviews had stirred much resentment among care workers for its technical instability, such as allegedly unreadable cards and malfunction of the device. Some care workers simply found it too challenging to use. However, the most profound impact was on the management of time in care work. The following account of a participant attests to the limits placed on flexibility by the implementation of the attendance card:

> *The card is annoying. Like some older clients would call you, "can you bring me something, something on the way?" The time would all be my own. You can't go to her home and swipe the card first, before getting the things. I don't like the card. You can't manage everything so perfectly. ... If time were flexible, we could manage work by ourselves. Now it restrains you. ... Some clients want you to come in the morning. They don't like afternoons. But how many homes can I visit in the morning? Not many. Say you start at 6:30 AM. Two hours each client. At maximum, two and a half clients. ... They all want me to come in the morning, but I don't have the flexibility to do that. (C06, L.241-262)*

Care workers are managers of care in the sense that they tailor care work to meet clients' needs and manage time to accommodate clients' care hours. A rigid time frame deprives a care worker of the capacity to make discretionary decisions for her entire clientele. As the above participant explained, the morning hours could be managed so that more clients who prefer help in the morning could be served by combining reduced length of visit, multiple visits, and other arrangements agreeable to both parties. On a similar note, if an individual client makes a request that the worker finds hard to refuse, she feels unable to manage the task due to the inflexibility of the new system, which means she would have to contribute her own time if she were to accept the request. The

same dilemma can be illustrated by another participant's comments on the attendance card:

> *It's usual to have gains and losses (of time). Work more or work less, that's the norm. Like this old man. Now his workload is light, but whenever he needs more (care), say he gets sick, I will pay back. Because I owe him. Right? Why do you have to make it so rigid? So uptight? People should not be so uptight with each other. ... Like this old lady I worked for. She was so kind to me. Later she was sick, fracture. She was bed-ridden, and could have ulcers. Her daughter said, "can you give her a rub-down every day?" She was really nice to me. ... I came every day to rub her. Then her daughter wanted to give me money, but I refused. I said, "I don't want it." When I was sick, she allowed me leave of absence. Now that [she is] sick, how can I take [her] money? ... I am repaying what I owe. ... It is unnecessary to use a machine. Like, "OK, we are done today, the card is swiped". ... Sometimes they call you, and you cannot say, "I am already done. Wait until next time of card swiping." You cannot possibly say that. (C12, L.650-665)*

As the care hours change according to the needs of a client, care work cannot be confined to an inflexible and impersonal time frame. If such a constraint is applied, it inevitably means care workers from time to time will have to go overtime to stand behind care relationships to which they choose to commit. Moreover, using the attendance card means substituting the rigidity of a schedule, monitored by a machine, for reciprocity based on mutual affection, care, and commitment. A clear message was conveyed through "OK, we are done today, the card is swiped": conscientious completion of care cannot and should not be constrained by the action of swiping a card.

The managerial motivation behind the attendance card is understandable. It is conducive to a more complete and better kept record of service provision and it holds care workers accountable. Potentially, it helps to reduce or prevent absenteeism.

However, the conundrum is this: any institutional change could potentially make care work more equitable among clients, but fail to effect the same desirable change in every care dyad. Implementing a rigid time frame may increase the overall, in a statistical sense, compliance to working hours, yet it loses sight of the fluidity in the actual conduct of care work, care hours required in each client's care, and the interpersonal exchanges that characterize a care relationship.

5.2.4 The "hour-pay" paradox

Before closing this section, I would like to raise another issue pertinent to institutional changes around time. It is unique to the context of the home care program under discussion; nevertheless it is telling about a paradox care workers and elderly clients are faced with in such programs.

Over the past decade, the hourly rate for home care workers and the levels of care benefit for older clients have both risen in Shanghai. However, a closer examination reveals that the improvements in welfare for both parties may not have been as rosy as intended. Paradoxically, an increase in care workers' salary and an increase in seniors' care benefits can offset each other. The participants of this study reported that confusion around hours of work and misunderstandings between the worker and the clients were often caused by the changes in salary or benefit levels described above.

A hypothetical case can be helpful here. Care worker, X, works at an hourly rate of 10 Yuan for an elderly client, Y, who receives a care benefit at the level of 300 Yuan per month. In this case, X provides 30 hours of service to the client, that is, one hour a day. In order to offer a better livelihood for care workers, the hourly rate of care work increased from 10 to 15 Yuan per hour. However, this is not achieved by additional

funding, but by reducing the workload of care workers. As a result, X needs to work only 20 hours for Y after the change. It is obvious that neither of the two parties directly benefited from the change--Y loses 10 hours of service and X does not earn more because of the change in hourly rate. If X is lucky, she can find another client to fill her surplus hours. If not, she would have to seek other jobs, usually housekeeping or *jia zheng* outside the home care program to increase her income. In the former case, X's net income from the home care program rises, however at the cost of her client's 10 hours. In the latter case, her net income increases, but not because of the nominal increase in the hourly wage of home care.

Later, a 150 Yuan increase in the care benefit for Y is granted because of her deteriorating health condition. With the new 450 Yuan benefit, at the rate of 15 Yuan per hour, Y is now entitled to 30 hours of service from X again. However, due to X's tight schedule, she may not be able to squeeze in an additional half hour of work without having to give up other clients on the same day. Then Y may be re-matched with a new worker because she needs more time, while X's schedule cannot accommodate that need. In that case, X will be paired with other clients to fill the hours. In the end, X's net income is likely to remain the same even with an increase in Y's benefit level. The general public and government, in contrast, continues to be content with an illusion that older people are better covered by the home care programs, and care workers are paid more to do the work.

5.3 Summary

In this chapter, I discussed the management of instrumental care work around the issues of scope and time. It was argued that the relational aspect of care, in terms of care

worker's self-concept and situated identity, is interwoven with the instrumental aspect of care. The two aspects of home care should therefore be examined together. In any given care dyad, instrumental work is tailored to the extent that the relationship harmony is manifested. The concept of duty or *fen nei* in Chinese, reflecting a care worker's social role in a specific care relationship, powerfully regulates the delimiting of scope of care work. At times, actual work performed traverses the formal boundaries set by agency rules and job descriptions. At other times, the care workers limit duty within the official guidelines. What is or is not part of duty can best be understood as being defined by the relationship status of the dyad. In general, relationships in consonance are conducive to broadened scope of work, whereas dissonance effects the opposite, constraining scope of work to the bare minimal. On a similar note, management of time of work mirrors the situated identity of surrogate daughter. Two types of hours were distinguished. Working hours are time officially allocated to a client. These hours are usually used flexibily to accommodate home-specific arrangements of care. Flexibility of time management in the home care program allows care workers to juggle between multiple clients and their own personal needs. Actual hours required for caring for a specific client, called care hours, seep out of the fixed working hours. When consonance is tuned in and a situated identity of surrogate daughter is assumed in a specific care relationship, the care worker tends to integrate the caring for the client into her personal schedule. This usually means extra hours worked. Scope and time of work can both be sites of contention. Care workers may be frustrated by clients' requests regarding scope and time, interpreting them as undue or as a sign of lack of reciprocation. In these cases, care relationships can be harmed. Not only do care workers and clients demand control over these parameters of

care work, but the management also does. Time is liable to become a managerial tool for exerting control over care workers. Unfortunately, rigidity of time can inflict difficulties for the frontline and endangers care relationships. It can be expected that managerial advancement in the direction of higher efficiency will continue to pose challenges to care that happens in decentralized homes.

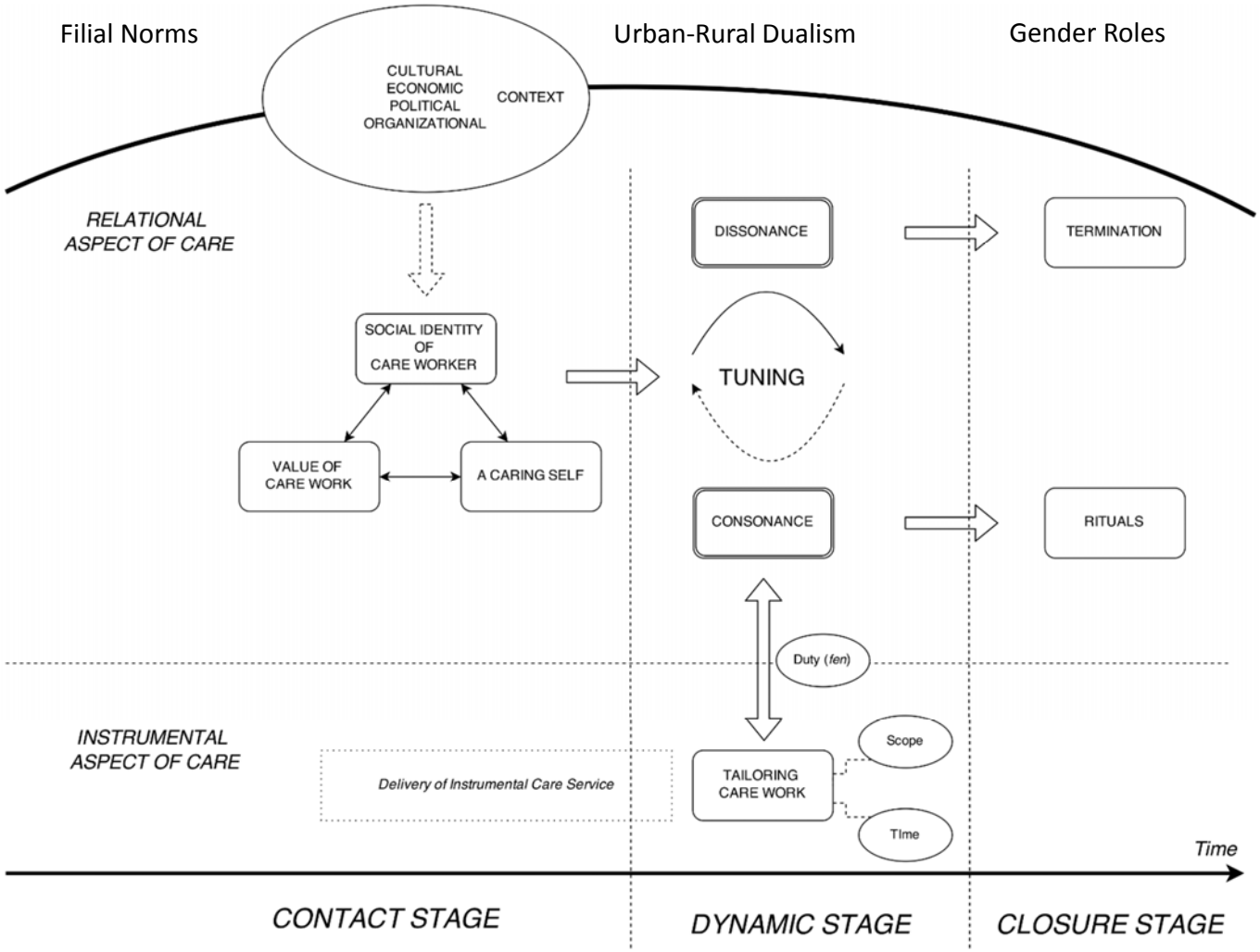
Chapter Six: Discussion

In Chapters Four and Five, I discussed the research findings on care relationships in the home care program in Shanghai from the perspective of care workers' identity work and how it is intertwined with instrumental work. I attempted to delineate a picture that reflects the complex dynamics within a care dyad, revealing that care work cannot be understood only as a circumscription of organizational rules and agency guidelines decreed by the managers, the care agencies, the funder, or other authorities that play a role in the making of care policies. Care work is tailored at the front line at the discretion of the care worker on the basis of the contingently defined needs. Moreover, it is provided in an interpersonal context where the care worker's self-concept, the identity of the care worker, and the social status of care work all come into play. Cultural meanings are drawn on by the care workers and the language of family is used to make sense of the care relationships. The purpose of this chapter is three-fold: first to recapitulate the findings in light of the emergent model, second to respond to the research questions posed in Chapter Two, and third to discuss the emergent model's implications in light of three extant theories on care relationships and in the broader moral and economic context of care reform in China.

6.1 The Emergent Model

Relationship Tuning, a model that accounts for care workers' experiences in the home care program in Shanghai emerged from this study's findings presented in Chapter Four and Chapter Five. Figure 6.1 gives an overview of the emergent model, which can be read from two directions.

Figure 6.1 Model of Relationship Tuning in Home Care in Shanghai



Vertically, three levels can be distinguished: delivery of instrumental care work at the bottom, care workers' identity work or relational aspect of care work in the middle, and the care environment on the top that encapsulates the immediate organizational and broader socio-economic context. The bottom two levels are parallel, as the findings have demonstrated the intertwined nature of instrumental and identity work in care relationships. They are linked by a double arrow to indicate this dynamism. At a higher level, both instrumental and identity work are shaped in socio-economic, cultural, and organizational contexts.

Reading horizontally, from left to right, the model depicts the temporal dimension of a care relationship. From beginning to end, a care relationship evolves through time. It could span weeks, months, and typically years. It is therefore possible to think of a care relationship along a temporal line, distinguishing three "stages" in the development of a care relationship. The first stage on the far left is the initial *contact stage*. When a care worker is matched with a client, she carries the social identity of care worker, a certain view toward care work, and a self-concept to the ensuing care relationship. These components can be understood as the preconditions of identity work in a care relationship, in the sense that they exist prior to the first visit and lay a foundation for the identity work. Several factors are of interest here. First, the status of care work and care workers in Shanghai is lodged in the socio-economic context of rural-urban migration and urban economic re-structuring. Laid-off urban employees, migrant workers, and a duality of rural and urban welfare systems are the characteristics of the period in which the home care program was launched. Care workers, due to the preponderance of migrant workers in the industry at the beginning of commoditized care work, were

associated with the lower social status of "provincial peasant workers". Care work was portrayed as lowly and demeaning. Second, care workers engage in active identity talk, through which care is reconstructed as valuable work provided to people in need by a caring person. Third, dignity of care work is therefore restored. Monetary rewards and social benefits are perceived as social recognitions of the dignity of care work. In turn, perceptions of the dignity of the work strengthen the identity talk and the reconstruction of care work.

It is impossible to pin down the length of the contact stage, which could range from one visit to a few months until one or a series of instances trigger a state of dissonance or consonance. Some care relationships tend to be "interaction rich" while others are relatively uneventful. Due to this variability, it is difficult to pinpoint a time frame for evolution of this initial stage into the next stage.

The next stage, in the middle of Figure 6.1, can be called the *dynamic stage* of the care relationship, where both identity and instrumental aspects of care are actively tuned and tailored. A large proportion of my analysis in Chapters Four and Five centered on this stage, which is most emphasized in the emergent model. On the identity front, the core concept "identity harmony" subsumes two states of care relationship in light of the care worker's identity and self-concept. While dissonance can appear in various forms, a common thread in dissonance in care relationships is the rejection of a care worker's presented self-concept by the elderly client's attitudes and reactions toward the worker and care work. Care workers tune out dissonance using the strategies of disregarding and justifying. Termination of the care relationship is the last resort in resolving dissonance, as it is resisted by organizational practices and rules.

The flip side of dissonance in the care relationship is consonance. A care worker in a care relationship in consonance locates herself comfortably in a situated identity of surrogate daughter of an older person. Familial language is drawn on to give meaning to the care relationship. Consonance, described as being a surrogate daughter, is an ideal state of care relationship in the home care program being considered. Tuning in a state of consonance relies on the collaboration of both care worker and elderly client, in the sense that mutual efforts have to be made to reciprocate care. From the care workers' point of view, acknowledged relationship and reciprocated care are the other two crucial conditions for tuning in consonance. When care work comes to an end during relationship consonance (in contrast to termination in the face of relationship dissonance) the death of an elderly client constitutes an occasion for family ritual, through which the care worker's identity is substantiated by being symbolically recognized as part of the family.

As the relational states of dissonance and consonance may characterize care relationships, tuning represents the dynamic process of shifting between the relational states. While it is accurate to say that the usual direction of tuning is moving away from dissonance toward consonance, as implied in the language "tune out" dissonance and "tune in" consonance, the possibility of relapse should never be ruled out. In the model diagram, a solid arrow is used to indicate the general direction from dissonance to consonance and a dashed arrow for a potential relapse. The two arrows together form a loop that symbolizes tuning as a dynamic process.

On the instrumental front, care work is tailored to suit the relational dynamics of the care dyad. At the center of the delivery of instrumental care work are the two aspects:

scope and time. It warrants clarification that tailored work begins to emerge at the contact stage, as individual needs of clients must be met. However, instrumental care work tends to be delivered according to job descriptions in a uniform manner at the contact stage, while tailoring work gradually becomes more prominent as a care relationship evolves into the dynamic stage. This is a general tendency, which is not evident in all care dyads, since care work is always to meet needs and needs are usually contextually defined. At the risk of oversimplification, the model serves to illustrate that on the one hand, care workers describe the scope of care work using a language of "duty" or "*fen*", and that on the other hand, the time of care work is managed in a personal rather than institutional frame. Both aspects of instrumental care are entangled with care workers' situated identities.

On the far right of Figure 6.1 is the *closure stage*. In this stage, a care relationship comes to a conclusion, which is determined by the state of relationship in the preceding stage. Dissonance may lead to termination of a care relationship, an abrupt closure of care service. Consonance, in contrast, may lead to an ending of a relationship characterized by family death rituals where the worker's care is acknowledged and the worker symbolically accepted as a member of the elderly client's family.

I speak of these three stages as an analytic distinction rather than a hard reality that corresponds to the experience of every care worker I interviewed. The arrows in Figure 6.1 do not imply causal relations. The model does not claim to be all-encompassing and account for every possible aspect of care relationships experienced, perceived, and recounted by the participants. Yet it is an attempt at a snapshot of care

relationships *from a particular point of view*, that is, the perspective of self and identity reflected in the identity talk of the care workers.

6.2 A Response to Research Questions

In qualitative inquiries, approaches to research and specific methods of data collection are often determined by how research questions are stated (Charmaz, 2014; Creswell, 2013). It is also suggested that research questions can lead a study to begin broadly, and through data collection the questions are refined (Strauss & Corbin, 1998, p. 41). I believe, irrespective of the level of flexibility around research questions allowed in a given GT study, the final model should respond to the initial research questions. In essence, the emergent model should be capable, in its parts or as a whole, to answer the research questions that were initially proposed and served to guide the research process through which the said model is generated. In what follows, I wish to respond to the research questions in light of the emergent model.

The core question for this study was "*How are care relationships perceived and maintained by the workers in the home care program in Shanghai?*" Breaking down this general question, I asked three focused questions. The first question is "*How are care relationships perceived by a care worker?*" To begin with, the home care service in this study should be understood as instrumental care work conducted in a relational frame. To the care workers, a care relationship is perceived primarily as personal association with an elderly client, the quality of which is appraised in accordance with the state of identity harmony. Generally, the social label of "care worker" connotes menial work and has acquired a lowly and subordinate social status associated with rural-urban migrant workers who were treated as second-class citizens in the cities during the early years of

economic reform and domestic migration. Care workers however rejected this social identity and restored the dignity of care work in their narratives. They constructed a self-concept as a caring a person, and substituted the concept for the negative images associated with provincial peasant workers. This identity talk is shown in the contact stage of the emergent model.

Care workers brought the constructed self-concept to care relationships and the care work they did. Identity harmony thus becomes a key concept which captures care workers' perceptions of care relationships. A relationship can be perceived as beset by dissonance, the negative state of identity harmony characterized by the rejection of the positive self-concept. Another relationship can be viewed as characterized by consonance, the positive state of identity harmony, in which the care worker rests on a situated identity in congruence with a caring self. The language of family, or surrogate daughter, symbolizes the perceived harmony in the care relationship, which is described as intimate, acknowledged, and above all reciprocated. The endings of care relationships differ as the perceived harmony varies. Only endings of relationships in consonance are described in a ritualized manner. That is, the traditional family ritual of attending on the last moments of an elderly person signifies the role of the care worker, whose symbolic acceptance as a family member reaffirms the situated identity of surrogate daughter. In comparison, relationships in dissonance can be terminated abruptly, marked by bitter frictions and long-lasting perceived injustice. The issues of identity harmony and ending are captured in the second and third stages of the model.

It seems that care workers are ready to draw on a daughter-parent relationship as a moral analogy between the two parties in a care dyad. The moral aspect consists in the

reciprocation: the child's commitment to the parent's well-being and the parent's benevolence to the child. The ideal of a daughter-parent relationship can be juxtaposed with a master-servant or a supervisor-subordinate relationship. A power difference is always there, as in all three types of relationships. A daughter does submit to her parent, but not in the same way in which a servant with trepidation bows down to the master and a subordinate half-heartedly defers to the supervisor. The submission of a daughter to her parent is ideally not due to fear and political correctness but love and reverence. The parent is not a superior who condescendingly commands. Being in need, s/he rather counts on the person with lower status and power. The interdependence tips the seesaw of power back and forth.

The second question is "*How are care relationships maintained/managed by a care worker?*" This question is addressed in terms of the dynamic process of tuning and tailoring care work, the second stage of the model. As the home care service is instrumental work provided in a relational frame, the two integral parts cannot be considered separately.

Tuning, and specifically tuning out dissonance and tuning in consonance, is a process of managing a care relationship. I noted in the model the general tendency toward consonance in tuning as no one looks to destroy a care relationship on purpose. In the face of dissonance, tuning involves deliberate strategies by care workers to disregard and to justify the perceived offense. Preventing open friction and hence maintaining a positive mood are the ultimate goals in downplaying dissonance. The other strategy for tuning is to justify older clients' offensive actions. On the one hand, care workers resort to a cultural view that "older people are childlike" (*lao xiao lao xiao*), and

in doing so help themselves to normalize the elders' behaviours. On the other hand, they regulate their emotional response by shifting attention from perceptions of malicious intentions of the elderly clients and a negative self-image to the mischievous nature of the seniors' behaviours and the value of care work. Occasionally, care workers do try to terminate a care relationship if it is deemed beyond repair. However, termination is subject to organizational constraints, and hence it only occurs as a last resort.

To care workers, tuning in consonance is a process of arriving at a situated identity in congruence with a care worker's self-concept. In the first place, intimacy between the care worker and the client is confirmed, through casual chitchat. The absence of children, a common theme of chitchat, often offers a starting point for the confirmation to ensue. Secondly, the care relationship is acknowledged, by expressed dependence, which lends itself to a narrative on the roles of a daughter. Thirdly, and critically, care is reciprocated. The combination of these fuels a situated identity of a surrogate daughter, a morally lauded position for the care worker.

The intertwined relationship between instrumental and relational aspects of care is crucial to understanding care relationships. To be pertinent to the research question, my argument here is that the management of instrumental care work is simultaneously a matter of care workers' self and identity in care relationships; thus it should be considered in relation to the process of tuning. The scope of work and allocation of time are apt to shift according to "*fen*", a social role. The boundaries set by organizational rules and job descriptions are constantly traversed. Or, in the language of the participants, "there is no boundary" to begin with. Duty and time permeate to the extent the depth of a relationship reaches.

I want to mention the analogy of tuning a musical instrument here again to illustrate the process of tuning care relationships. The purpose of tuning an instrument is almost always to bring an instrument into harmony. There could be a standard pitch, set by an electronic tuner or the oboist. This ideal is the state of consonance in a care relationship, the objective or end result of tuning. However, the analogy of tuning a musical instrument should not be pressed too far, because in reality, every care worker interprets her relationship with a particular client differently. Thus tuning does not conform to a standard formula.

The last research question is "*How is the maintenance shaped by the organizational and structural contexts?*" Prior to and during the contact stage, the social status of care work and the social identity of care worker and migrant worker are of central importance to the prospective care relationship. The home care program came into existence against the backdrop of the Chinese urban economic reform and rural-urban migration. In the complete commoditization of care work in the early years, the social status of care work was aligned to that of its providers, migrant workers, who at that time in urban development were regarded as low in status. Care work symbolized a demeaned status and menial labour, and was to be conducted by "provincial peasant workers". Care work was so disdained that for those laid-off urban workers who undertook such jobs, it was in their best interest to do it secretly. Many in the home care program concealed the fact that they were a care worker in the home care program for a period of time.

Recognition of care work in the forms of monetary rewards and social benefits appears to counter the negative image associated with care work and care workers. In

general, as migrant and local care workers' income grows, their perceived status is raised through comparisons with peers and social groups alike. Entitlement to social benefits, for local care workers, further strengthens the view that care work is recognized and valued by the society. In a similar vein, "public work" shores up a positive image of care work. For both migrant and local care workers, working for the government boosts the value of care work. These contextual parameters are all at play in the restoration of dignity of care work and the formulation of a caring self, which influence identity harmony in the later stage of the evolution of a care relationship; therefore their importance cannot be underestimated.

In the dynamic and closure stages, perception and management of the care relationship are shaped by the cultural context in a number of ways. The meanings of identity consonance are derived from a cultural language, in this case one of daughter's roles. The participants' narratives on absent children and surrogate daughter revolved around the cultural expectation of children's commitment to parents in old age. A cultural ritual, attending on an older person's last moment or "*song zhong*", signifies the relational closeness and reinforces the situated identity of surrogate daughter. Care was not viewed as a service provided for a client who needed support, but seen as help provided to an older person who is not supported by his or her family. In the narratives of the participants, care is entrenched in familial ties and responsibilities. In a similar fashion, cultural context is relevant to dissonance. Care workers drew on cultural attitudes toward older people in justifying the latter's offensive behaviours.

The last aspect to consider is the immediate organizational context: management at the level of the care agency and rules on care work as a formal job. As we have seen,

job descriptions that circumscribe the scope of care work have little power in practice to regulate care workers' actual conduct as to what or what not to do. Unless the client feels his or her right to service and interests have been infringed upon and consequently files a complaint, a care relationship can continue free from organizational scrutiny. In contrast, flexibility of time is crucial in the management of care at the level of care workers, for it allows care to be tailored to meet individual needs and that such tailored care work can be juggled between multiple clients. The increased surveillance imposed by the care agencies, through the implementation of the attendance card, erodes the control around time previously enjoyed by the care workers. On a similar note, institutional changes around benefit and salary levels, in the name of increasing the welfare of care workers or elderly clients, can disrupt care workers' time management, causing mistrust between workers and clients and discontinuity of care relationships. These changes may be relatively infrequent and less intrusive than other measures such as the attendance card, yet they unveil the powerlessness of both parties in a care relationship. I discussed the organizational constraints on terminating care in Chapter Four. In addition to the agency regulations and job descriptions, informal practice and unspoken rules are crucial in the organization and delivery of care work. However, this environment is shifting as an organizational structure continues to grow, converting the informal to the formal and exposing the implicit to the explicit power of the organization.

In sum, socio-economic, cultural, and organizational contexts all shape how the care relationship is perceived and maintained at various stages of the life-cycle of a care dyad. At the core, in the process of tuning, care workers draw on the cultural context to enrich the meanings of care relationships. Instrumental care is managed accordingly on

the basis of informality and flexibility. In the meantime, organizational controls can undermine the latitude, and potentially break the tie between tuning and tailoring care work, which is indicated by the vertical double arrow in the dynamic stage in the model.

6.3 The Emergent Model and Extant Theories on Care Relationships

The emergent model of turning care relationship is a contextually specific snapshot of the micro world of care work in Shanghai. It extends an explanation on care work as an interpersonal process, thus contributing to closing a gap in the literature in the Chinese context. Since this study is informed by Western literature, a discussion is warranted on the implications of the emergent model in light of extant theories in the subject area. Three relevant theories that can account for care relationships in the home care setting are to be discussed: the "boundaries" theory, the "emotional labour" theory, and the "welfare institution" theory. The three models represent varying theoretical approaches to the issue of interest. The "boundaries" theory takes an organizational perspective, modeling the changing interpersonal arrangements of care in an organizational context. The "emotional labour" theory is rooted in the tradition of sociology of work and social psychology. It focuses on explaining the regulation of emotion in the service industries. The "welfare institution" theory originates from an interest, primarily in political science, in accounting for the diverging care outcomes of welfare institutions. The emergent model makes contributions to all three models.

6.3.1 The "Boundaries" theory

The first type of explanation of home care relationships can be called the "boundaries" model. This model draws on the analytic framework of work-life balance (such as Nippert-Eng, 1996; Williams, 2001) and the management of space and time in care work

(Twigg, 2008). According to this explanation, care relationships are viewed as shaped by a process of--or as a resultant state of--negotiation between the care giver and the care recipient on the intersection of three pairs of dichotomous social domains: public versus private, formal versus informal, and work versus home. The boundaries theory maintains that in the process of relationship building an intermediate domain is created, and the integration and separation of the public-formal-work and private-informal-home are constantly being negotiated between the worker and client (Mahmood & Martin-Matthews, 2008).

The emergent model resonates with the boundaries explanation and agrees with the view that care workers actively negotiate and determine work and non-work, action and inaction, and engagement and detachment in caring for their elderly clients. The contention that care relationships in home care settings are susceptible to the increasing organizational control around time is shared.

Yet the boundaries theory falls short of explaining the mechanism, or the psychological process, behind the integration and separation of the dichotomous realms. For instance, in Mears and Watson's (2008) study, the forming and transgression of the work and non-work boundaries were described as consequences of professional and regulatory requirements on the one front and care workers' disposition and personal attachment to elderly clients on the other. The authors' exploration nevertheless stopped there, leaving readers to wonder how care workers reconcile the tension between professional and organizational creeds that demand clear boundaries and interpersonal associations that traverse these boundaries. On a similar note, Mahmood and Martin-Matthews (2008) rightly acknowledged that care activities are generated in the

socioeconomic and cultural contexts interpreted by care workers. Their work, however, failed to explore how these contexts play out on the intra- and inter-personal level in the process of tangible care provision.

The emergent model contributes to the boundaries explanation by offering a culture-specific account of the mechanism through the lens of identity negotiation. While universal generalizability is not claimed, the emergent model suggests a potentially fruitful line of analysis, along which the boundaries theory may further its thesis at the intra- and inter-personal levels. Focusing on unraveling the issues of self and identity at the intersection of social, economic, and cultural contexts, the emergent model contends that the primary process of relationship development in the home care setting occurs when a care worker's image of self seeks to find harmony in the identity negotiation process. A "good" relationship is apt to ensue if the situated identity is in congruence with the self-image. The boundaries negotiation is a concurrent, if not subsumed, process in relationship building.

A bolder interpretation of the emergent model may be suggested: in a developing context, where the dichotomies of social domains are blurry and institutional constraints relatively lax, the "boundaries" did not readily manifest themselves in the fashion described by the boundaries theory. As the participants of this study put it, "there is no boundary". The concept of boundary comes from Western industrialized societies, in which a formal care relationship takes place within a pre-set demarcation between work and life. In the context of this study, however, the normative authority of "boundaries" is not as powerful. In a care relationship, the care worker rather more actively engages in defining "Who I am" in the relationship. The concept of "*fen*", the social position of a

person, highlights this point. The interface between "*fen nei*" and "*fen wai*", i.e. within and beyond a social position, may be interpreted as a "boundary". I would argue that this boundary is determined *ex post*, rather than being *ex ante* or pre-determined as often found in the boundaries theory discussed above.

6.3.2 The "Emotional Labour" theory

The second extant theory I will consider is the theory of emotional labour. Home care work is characterized by relational, affective, and emotional input (Chichin, 1992; Griffin, 1983; James, 1992; Neysmith & Nichols, 1994). "Emotional labour", a term coined by Hochschild (1983/2003), is thus often used to describe the nature of such work. Hochschild (1983/2003, p. 7) defined emotional labour to involve "inducing or suppressing feeling in order to sustain the outward countenance that produces the proper state of mind in others". In relation to this theory, I wish to address two questions. The first is concerned with the theoretical connotation and relevance of the concept "emotional labour", and the second deals with the consequences of such labour.

While the term "emotional labour" has been aptly used to refer to the emotional elements of home care work, its theoretical applicability warrants an examination. In the workplace, when the management of emotion is regulated, and rules of such regulation are institutionalized through a series of training, rewards, and punishment, one may speak of emotional labour. At the core of emotional labour is the process of "transmutation" of the naturally private emotions and acts into standardized public routine practices under the scrutiny of organizational surveillance (Hochschild, 1983/2003, p. 19). Two types of acting were described as commonly employed in the inculcation and practice of management of emotion: surface acting and deep acting. To put it crudely, surface acting

requires manipulating another person's perception about how one feels, whereas deep acting involves manipulating one's own perception about how one feels. While the former inevitably entails a certain level of deception, the latter is said to take a toll on the actor's psychological well-being. Since emotion is a clue to the identification of self in a specific social situation (Hochschild, 1983/2003, p. 30), the acting away of genuine emotion is liable to result in alienation of self.

The question is: do home care workers manage their emotions the same way as the proverbial factory boy who converted his arms into an extension of the production machinery, which ultimately served to increase the profits of the employer of the factory? Or do they manage their emotions the same way a flight attendant suppresses her anger at an insult by a passenger in order to remain calm? For the boy, his labour was sold for a wage, so was the ownership of his arms; for the flight attendant, her emotion was commodified and the ownership of her feelings thus belonged to the management of the airlines.

The emergent model may offer a tentative answer to the above questions. Home care work in this study may not conform to the definition of emotional labour in its strict sense. In the case of Shanghai, home care work is subject to minimal managerial control. In the first place, job training for care workers in Shanghai is not as stringent as described in the Western literature on service jobs, especially those of higher status such as flight attendants and it provides little systematic guidance on the management of feeling. Secondly, although periodic feedback from clients is part of the management routine, only general satisfaction information is solicited, which hardly addresses any specifics about everyday interactions. When individual cases are concerned, the management

usually finds itself dealing with a complaint or even an already broken relationship, the potential consequence of which has been illustrated in Chapter Four. Thirdly, an incentive and disincentive mechanism as to scripted emotional display is absent. In essence, care workers do not receive an accolade in case of a good relationship with a senior client, nor would they be penalized for a frayed relationship, unless serious misconducts or violations of law were involved. The worst scenario is termination of a relationship, which bears minimal cost to the worker if she can fill her required hours with a different client. Conditions of a similar nature have been described of home care work in the West (Barer, 1992; Eustis, Kane, & Fischer, 1993).

In general, home care workers in Shanghai are not held accountable for the display of proper or improper emotions toward elderly clients. Moreover, competence in emotion management is not explicitly a selection criterion for prospective care workers. In these two senses, emotion in home care work in Shanghai is not commercialized in the way Hochschild (1983/2003) has described. Yet, emotion work or emotion management can still be found in the labour of home care. The mechanisms for tuning out dissonance were introduced in Chapter Four. In handling frictions and in maintaining self-image, the regulation of emotion and the shifting of the perceptual foci are essential. It can be concluded that some surface acting is involved in maintaining care relationships, in particular during episodes of dissonance. For home care workers, manipulation of emotion aiming to maintain good relationships gives way to the retention of a consistent self and the identity work the emergent model has accounted for. In the process of tuning in consonance and formation of the situated identity of surrogate daughter, reciprocity of care hinges on coordination between attention given to emotional expressions of the

clients and genuine emotional displays that signify the caring self. However, since care workers have control over their emotion by and large in a spontaneous way, abiding by culturally expected feeling rules such as "older people are childlike", or more generally "treat seniors with the reverence due to your own parents", it seems unwarranted to assume a profusion of managerially scripted deep acting in home care.

Therefore, emotion work is more authentic and thus more self-reflective in home care work than in the kind of emotional labour performed by flight attendants discussed by Hochschild (1983/2003). Emotion tells a care worker about what is going wrong and right, and reflects "who I am", that is a clear self-image, *vis-a-vis* a situation involving interaction with a senior. Throughout the interviews, I never heard of any instance where care workers grew weary and cynical about their job because they could not be themselves in the work. Alienation of self should not be expected to be a prevalent phenomenon in the home care setting. In sum, the concept of "emotional labour" in the home care scenario in Shanghai and perhaps in more regulated settings elsewhere, should be applied with an examination of the contextual parameters--for instance, level of standardization and managerial control, stringency in training and monitoring of performance, and processes of recruitment and dismissal.

Next, I shall examine some of the ramifications of emotion work in home care in light of the emergent model. Firstly, it should be noted that to say emotion work in home care differs from Hochschild's (1983/2003) account of emotional labour of flight attendants is not to discount the value of the emotional investment of the care workers. In fact, the emergent model shows that emotion work is crucial in developing favorable relationships between the care workers and elderly clients in the home care setting. This

setting, apart from its distance from managerial controls, resembles Theodosius' (2008) description of the profession of nursing, where emotion work is considered an essential part of the collaborative relationship between nurse and patient, and the exchange of emotions "promotes trust and mediates power balance" between the two parties (Theodosius, 2008, p. 48).

In home care, the trust and power balance can be described in a language reflecting the culturally sanctioned daughter-parent relation, which I have discussed in the previous chapters. As much spontaneous and culturally natural as it may have been depicted, the kind of emotion work in home care should not be taken for granted and consequently be invisible.

In the care literature, emotional devotion and relational bonds have been associated with job satisfaction or attributed as an intrinsic amenity of doing home care work (e.g. Benjamin & Matthias, 2004; Berdes & Eckert, 2007; Chichin, 1992; Feldman, Sapienza, & Kane, 1994; Howes, 2008). Such connection ought to be made empirically rather than normatively, as it may appear that intrinsic rewards are sufficient to justify substandard pecuniary rewards. In fact, job market conditions measured in unemployment rate or respondents' assessment of alternative job prospects and compensation rate proved to be more important predictors of intentions and behaviours of retention among home care workers (Brannon, Barry, Kemper, Schreiner, & Vasey, 2007; Denton, Zeytinoglu, Kusch, & Davies, 2007; Dill & Cagle, 2010; Morris, 2009). These studies indicate that although intrinsic rewards may provide some leverage, tangible financial difficulties or better job opportunities would constitute stronger incentives for care workers to quit.

One argument that can be made is that the emotional components should be recognized and compensated. Scholarly attention has been paid to the invisibility of emotional labour and lack of remuneration for emotional skills following Hochschild's original theory (Steinberg & Figart, 1999). The thesis of wage penalty is relevant here. Adapting from England and Folbre's (1999) definition, wage penalty happens when a care worker "forgoes the potential earnings from working the same hours in another paid job" (England & Folbre, 1999, p. 41). One explanation on the wage penalty in home care suggested by the authors is consistent with the theme of intrinsic reward in the care literature. The explanation can be summarized in the following way: first, care work carries an intrinsic reward. Second, this intrinsic reward constitutes an amenity for prospective and current workers in the care industry, who prefer care work over other jobs for this amenity. Third, when care labour is oversupplied, employers tend to select and retain more of those who would accept the job for lower pay.

The findings of this study suggest that the public home care workers in Shanghai may become emotionally invested in their relationships with elderly clients, which makes it difficult for them to part with such clients. Over time, the system is apt to retain those who are closely associated with clients. It should be noted that the remuneration level of home care work in Shanghai is publically set at the level of the municipal minimum wage.[28] The level of income for the home care workers is thus expected to be much lower than the city average. The local care workers are compensated through supplementary remunerations, which bring their income to a moderate level, though still

[28] The minimum hourly rate in Shanghai when the study started in 2013 is 14 Yuan, about $2.8 Canadian.

below the general standard. Migrant workers take up more clients through both public and private hires in order to be on a par with the locals, meaning that they have to work more hours than local workers for the same income. At the same time, as the wage gap between private and public hires widens, care workers forego more income if they remain in the public hires. In this sense, the wage penalty is inflicted on the care workers who remain in the public home care program.

6.3.3 The "Welfare Institution" theory

The above two models both addressed relationship issues in home care and proffered an explanation of individual care workers' decision making at the interface of the organization and clients. The emergent model is located at the convergence of the two models at the level of care workers' self-concept and their situated-identity, shaped in interactions with elderly clients. In this section, I examine the third model, which looks at the relationship issues in home care from the broader context of welfare states and service provision systems. The model is based on Ungerson's work (1997, 2005), that attempted to link a taxonomy of care relationship to funding and delivery systems of care.

The first funding and delivery system is called the "commodified informal care" model. Compensation is paid to informal caregivers, including relatives, friends, and neighbours, in essence transforming informal care work into publicly funded employment. The delivery of care in this model still relies on the informal relationships, though care labour is now publicly compensated and regulated. Around-the-clock care is provided on the basis of one-on-one pairs, that is, one care giver usually cares for only one care receiver. Informal care givers are expected to perform care tasks equivalent to those in professionally defined care packages (Da Roit & Le Bihan, 2010). Such

payment systems can previously be found in Scandinavian countries (Ungerson, 1997) and in the recent Dutch scheme (Glucksmann & Lyon, 2006).

The second system might be called the "regulation and credential" model. Funds are paid to care recipients to cover care service costs, while care recipients are able to choose their care givers. Although some variations exist, it is generally expected that a formal employer-employee relationship is managed through a care agency. Care providers are regulated in this system too, while care workers are expected to qualify by holding credentials. Tangible care work is provided on the basis of one-worker-to-many-clients, characterized by short visits. The French system falls under this model (Ungerson, 2005). The public home care program in Shanghai resembles this system in its regulations around funding and recruitment and the roles that care agencies play.

The third system, called the "direct payments" model, is similar to the second in that the payments are also highly regulated, but close relatives and co-residents are prohibited from being involved. Care workers employed through the combined use of personal networks and care agencies are paid directly. Care workers in this system may not be equipped with credentials as in the French system. Both worker-client ratios and hours of work vary according to the circumstances of particular care dyads. The UK system is of this type (Christensen, 2012).

The fourth system is the least regulated and depends on the supply of care labour in a grey market. In this "grey labour" model, care benefits are paid to eligible care recipients but no rule is set for recruitment. Care recipients tend to choose freely from their personal networks in a grey market teeming with undocumented migrant workers (Fujisawa & Colombo, 2009; Kofman & Raghuram, 2009). This system results in care

workers being hired to provide 24/7 care in a one-to-one dyad. The Austrian and Italian systems fit this type (Bauer & Österle, 2013; Ungerson, 2005). The grey market is similar to the one that has dominated the care industry in Shanghai. Many participants in this study used to work, or still work, in a grey market.

Ungerson (2005) also proposed a fifth model, where a traditional care allowance compensates households that have older adults. As this type of compensation functions as a complementary pension, it does not alter who provides care significantly. I thus exclude it from the analysis that follows.

Four types of care relationships are said to occur with different likelihood in the four care systems explored. The first type is "cold" relationships, which are characterized by minimal involvement between worker and client and occasional discontent and resentment. The two parties generally hold no feeling toward each other, and termination of the care relationship is easy and brings no negative emotional repercussions. The "direct payments" system is more likely to be associated with this type of care relationship because in such systems care recipients have full power to employ and dismiss, rendering care relationships a "master-servant" type, with respect often missing (Christensen, 2012). Pure contractual and hierarchical work relations were regarded as the reason that these cold relationships have a propensity to break down. In this study, many participants described their relationships with non-elderly-employers in private hires in such a manner. Fewer participants mentioned that they encountered such relationships in public hires. In particular, cases of strong relational dissonance followed by a quick termination resemble cold relationships.

The second type is "cool" relationships, in which both sides show respect but restrained feeling, acknowledging the task-oriented nature of the relationship. Care dyads are often matched and arranged by care agencies, and thus termination of a relationship is also relatively easy if it frays. This type of relationship is associated with professionalism and is more likely to prevail in the "regulation and credential" systems, where care payments are regulated and care workers are hired through outside agencies. Most participants in this study who worked in private hires seem to have experienced this kind of relationship with non-elderly-employers. They described it as "I am just here to do the job". In the public home care program, cool relationships are not uncommon, especially at the outset of new relationships. However, as years go by, cool relationships are apt to become warm relationships, if no relational dissonance occurs.

In the third kind, "warm" relationships, both sides of a care dyad value the companionship of each other. Care is often two-way. Relationships of this kind usually endure and are unlikely to suffer from a sudden breakdown. It should be unsurprising that the "commodified informal care" systems are more conducive to this type of care relationship. In these systems, not only have the two parties shared personal histories, but the one-to-one nature of such relationships allows ample time for bonding and communication. Even for dyads that initially started anew, as time elapses, warmth emerges. In the current study, most care relationships in which consonance is achieved exhibit warm relationships. As the situated identity of surrogate daughter replaces the employee status, the same kind of emotional and affective connection characterizing kin and friend relations becomes prominent.

The last type of relationships feel "hot". This may seem like a positive tendency in comparison to the last three types but hot relationships may not always be pleasant. They share the common trait that they last a long time, while some have survived past or ongoing frictions. Despite such adversities, hot relationships are not easy to end. For care recipients, retaining a familiar worker may be a primary concern, whereas the care givers are often stuck in a relationship due to their immigrant status. As in a warm relationship, both sides did or do have genuine affective investment in a hot relationship. However, the usual condition of co-residence renders the care workers highly dependent and vulnerable to exploitation. This type of relationship is almost exclusively found in the "grey labour" systems. In the case of home care in Shanghai, care relationships repaired from dissonance may be characterized as hot, although no participants felt that they had been stuck in a relationship. As time passes, heat cools down, and hot relationships may eventually become warm. Interestingly, no participant mentioned a hot relationship with people in their private hires. This may be because care workers did not report feeling stuck in any particular relationship, suggesting that they were rarely hesitant to move on if a relationship failed in a private hire.

While some level of agreement is reached between the welfare institution model and the emergent model, as each of the four types of relationships finds a somewhat fitting place in the home care case of Shanghai, some critiques of the model are also warranted. First, there are service systems where two or more types of relationship coexist. For example, while cold relationships are considered typical in direct payments systems, why is the UK system also conducive to warm relationships (Christensen, 2012)? Second, some types of relationship can be found in all types of service systems.

An example would be warm relationships. While it is fair to say that warm relationships are more likely to be found in the "commodified informal care" systems, warm relationships do occur in all systems described by Ungerson (2005).

A shortcoming of the theory is that despite its ability to associate service systems and relationship types, it does not venture to explain how these relationship types are formulated. The emergent model helps to fill this gap by unraveling the interactional process. For instance, the cool type--the default relationship state of the Shanghai case--can develop into cold or warm types by entering relational dissonance and consonance respectively. A cold relationship fraught with dissonance, if not terminated, may be tuned out of dissonance and eventually become a hot or even a warm relationship. However, it should be acknowledged that neither the welfare institution theory nor the emergent model suggests whether the cool type is indeed the predominant relationship type in Shanghai's home care program. Questions of this sort can only be answered by surveys with representative samples.

Developed in the politico-economic tradition, the welfare institution thesis holds a somewhat deterministic view toward care relationships. Ungerson was interested in finding regularities in the occurrence of types of relationships in corresponding welfare institutions. This line of research would be more fruitful if the agency of care workers were taken into account. For example, studying the cultural rules, as opposed to the behavioural laws that govern interactions between care givers and care receivers. The current study touched upon this issue by examining some of the feeling rules that shape the experiences of maintenance of self-concept and the negotiation of a situated identity among home care workers in Shanghai. From a broader point of view, the self and

identity issues are contextualized in the socio-economic and cultural environments, which can be compared between countries and societies. Following this line of inquiry, an institutional explanation derived from comparative studies should be both promising and meaningful.

6.4 Care in the Transitioning Chinese Society

The emergent model makes a contribution to the three theoretical approaches to understanding the worker-client relationship in the home care context. This study however, in itself only reflects a small part of the whole story of the developing home care industry in Shanghai and elder care in the Chinese context because of its micro focus. In the past three decades, elder care has been transformed in the midst of the grand socio-economic transition of the Chinese society. It has evolved from a family practice to a type of work. There is no reason to believe that the changes in the organization of elder care will cease. What does this study suggest about these conditions of care? What can we speculate about the prospect of the care market and care work in China? What about quality of care? These broader issues are discussed in this section.

I want to begin by discussing the moral principles underpinning elder care in the Chinese context. Ageing, to the traditional Chinese persons, could perhaps be represented by what Lin (1937, p. 198) described as the "ultimate earthly happiness", for in a society where "the whole conception of life is based upon mutual help within the home" (Lin, 1937, p. 199), people never truly get to enjoy life until they grow old and retire from the toil of life to being served and revered by their juniors. Confucian classics and other essays on filial piety offer a comprehensive prescription of children's

responsibility toward aged parents. For example, as documented in The Classic of Filial Piety:

> The service which a filial son does to his parents is as follows: In his general conduct to them, he manifests the utmost reverence. In his nourishing of them, his endeavor is to give them the utmost pleasure. When they are ill, he feels the greatest anxiety. In mourning for them dead, he exhibits every demonstration of grief. In sacrificing for them, he displays the utmost solemnity. When a son is complete in these five things, he may be pronounced able to serve his parents. (The Classic of Filial Piety, Chapter 10)

An ideal person, in Confucian morality, propagates this kind of service and reverence beyond the family. "Treat with the reverence due to age the elders in your own family, so that the elders in the families of others shall be similarly treated", so said Mencius when asked about principles of governance (Mencius, King Hui of Liang 1). It is hardly a question that this filial principle was upheld as the moral foundation of the Chinese society.

Living through the revolutions of the twentieth century and being stripped of its mystic and religious sentiments, has this moral principle survived in contemporary China and to what extent is it relevant to care work? These questions may be discussed on two levels--societal and individual. On the societal level, it may be argued that familial elder care arrangement in the pre-reform days reflected this principle. However, this could be misleading. Before the 1990s, child care was a public responsibility while elder care was mostly a private matter. Care in the pre-reform time was strategically organized so that women in their prime were relieved of child rearing responsibilities and could take on the care of unproductive elders after their retirement. This arrangement cannot be romanticized or ascribed to any collective moral commitment to traditional familial

ideology. In fact, similar conditions of a predominant family role in elder care were found in the USSR (Ucko, 1986), suggesting that such arrangements were primarily concerned with economic productivity in the communist states.

In contrast, the post-reform arrangement of care is more reflective of the filial principle at the societal level. With the closure of the state-owned-enterprises, child care provision at the workplace came to a halt in the 1990s. However, instead of investing in child care, the Chinese government announced its strategic plan for elder care around the millennium. These decisions were not reached under political pressure from any specific social group, and thus should be interpreted as mirroring the ruling party's ideology, which values care for the old as a moral priority. This initiative should certainly be welcomed, yet with a certain degree of skepticism. The Chinese "socialisation of care" seems to lean toward supporting the family in the provision of care, with no reference to older people's right to care.

In fact, the current situation in Shanghai is similar to the Japanese elder care system prior to the introduction of Long-Term Care Insurance (Abe, 2010). Both systems provide a safety net for those most economically disadvantaged or without family support, providing limited assistance to the great majority of families that need help with elder care. In Japan, the advent of the rights-based Long-Term Care Insurance was the result of women's political mobilization, shifting gender relations, and demographic challenges (Peng, 2002). The same political path may not be expected in China because of its dissimilar political system. However it may be hoped that the Chinese government will eventually move beyond a residual role in subsidizing the poor and the oldest old and be more proactive in funding and organizing care work. In

addition, policies that support family care--such as flexible working hours and elder care leave--also have an important role to play. In that case, elder care in China would come to resemble child care in the West. This would require the society to truly hold onto a moral commitment to the elder population, rather than to mask an agenda of economic development with rhetoric about "embracing family traditions".

While these changes can be hoped for, in the foreseeable future, most care responsibilities will still fall on unsupported families. Given the aforementioned trend of the 4-2-1 family structure, it is reasonable to forecast that filial piety will continue to be "contracted out". Care workers will be hired from a growing care market teeming with migrant and laid-off urban workers. This phenomenon requires consideration of the filial principle at the level of the individual. Rich care relationships are possible despite rigid rules and contracts. Care workers in China may still draw on the generalized filial principle in describing their relationships with older people. It is clear that a parent-daughter relationship fuels a long-term commitment on the part of the care worker, akin to the "warm" type of care relationships between friends and relatives in the European states. If this quality of compassion and sympathy is valued, measures need to be taken to preserve it. This study suggests that publicly organized home care work upholds a sense of dignity among the care workers, as this would help to raise the perceived value and status of care work. It may also be expected that care workers would feel more confident and proud of their care work, and therefore more committed, if the prevailing attitude toward this kind of jobs has become more positive. Furthermore, public funding may help to circumvent the potential master-servant type of power dynamics in care

relationships, allowing room for reciprocation. All the above would potentially encourage good care relationships.

How can these conditions be realized? I would argue that it is a matter of the government's commitment to formalizing and valorising elder care work. For some people, elder care, unlike child care, may not be seen as an investment in the future, but of sustaining decaying bodies and defferring death. In a sense, elder care work may not be as intrinsically attractive and valuable as child care work. This view associated wih ageism may begin to seep into Chinese mentality and practices of care. However, if a morality that elevates the value of caring for the old survives in Chinese society, there is no reason not to encourage this. Elder care can be valuable and valued work. Again, it takes governmental initiatives to valorise care, instead of solely capitalizing on the society's "moral dividend" of the filial principle.

The devalued status of care work in urban China, in part due to the three decades of rural-urban disparity of development and stigma associated with the migrant care workforce, is unfortunate. Today, the adverse social identity of a care worker can be a great impediment to good care relationship. It seems implausible that any "marginal worker" who has not yet decided to enter the home care industry will be primarily motivated by intrinsic rewards prompted by the filial principles, although some of the participants in this study did say, in hindsight, that they enjoyed working with older people. The question of whether the intrinsic rewards of home care constitute an amenity that attracts new employees more than similar jobs do can only be definitively answered by empirical means. However, it is possible to say something about the moral dividend in relation to the declining demographic dividend--some scholars estimated that China

has reached the Lewis turning point (Cai, 2010; Zhang, Yang, & Wang, 2011), where rural labour surplus is depleted.

Two scenarios can be hypothesized. In the first case, supply of care labour continues to be adequate. In this case, the home care industry is more apt to capitalize on the moral dividend of the Chinese society, retaining care workers who wish to dedicate themselves to the role of surrogate daughter and forego some income. A wage penalty will prevail if this happens. Nationally, rural migrant workers' wages have been rising since the turn of the millennium, steadily until 2007 and in double digits after 2008 (Yao, 2014). Wages in publicly funded care work increased during this period, but they still lag behind increases in other sectors. The Shanghai case offers an example of how a wage penalty can be imposed on home care workers. Arguably when home care is valorized by the government, it is possible to lift the wage penalty or at least to mitigate it. However, if care work is viewed as only marginally important and worth the minimum wage, such a penalty will be perpetuated. The same can be said of social benefits. Migrant care workers who had served in the home care program for almost a decade are still excluded from proper coverage of social insurance programs. At the intersection of the rural-urban dualism and gendered segregation in the labour market, the predominantly female care workers therefore suffer a double inequity. Decision-makers seem to be influenced by two ways of thinking. On the one hand, they are ready to reap the fruits of the moral assets of Chinese society, yet they do not recognize the value of these moral assets or think they should be compensated. I did not find any sort of "sacred cow" argument (England & Folbre, 1999) around the status of care, love, and filial feelings in Shanghai. No taboo exists against pecuniary reward for love and care. On the other hand, the

government is concerned with the well-being of the older population, in this case the care receivers, at the cost of neglecting the care givers.

The problem with this view is that care is treated as a univariate equation, in which the seniors are the only unknown. One example of the solution to this kind of equation may be seen in the rising care benefit levels for the older population over the past decade. The public is content with this increase, for it apparently confirms the society's moral commitment to the care of older people as a collective, as the slogan "senior-revering-society" goes. However, care is at least a bivariate equation involving the two unknowns of the care giver and the care receiver. I would further argue that an important parameter of this equation is the care relationship. The point of equilibrium can only be found when attention is given to both unknowns in the equation. In practice, we will be able to avoid pitfalls like the "hour-pay" paradox discussed in Chapter Five only when we recognize the nature of the care equation.

In the second case, if the care labour supply declines, care agencies will begin to feel pressure about obtaining enough quality manpower to meet the needs of an increasingly larger elder population. Managerial measures to regulate care work are likely to be put in place to increase efficiency. The effects of organizational downward pressure on frontline work are not new in the home care field (Aronson & Neysmith, 1997).

A general theoretical approach to understanding these effects has been expounded by Lipsky (1980/2010) in his original work on street-level bureaucracy. In relation to my current discussion, his thesis can be summarized as follows: service workers at the front line are often sandwiched between a scarcity of resources allocated for fulfilling

policy and organizational goals, and the demands of the clients they serve in a face-to-face manner. Meanwhile, they enjoy a great deal of latitude in making discretionary decisions that directly determine the amount and quality of services and benefits each client receives. Given pressure from both ends, they are apt to come up with their own coping strategies that serve to first, reconcile the disparity between organizational goals and clients' needs, and second, better protect their own working conditions. In the end, frontline service workers "authorize" social policies by exercising discretion rather than passively implementing them. Initially described as a characteristic of public service work by Lipsky three decades ago, the street-level bureaucrat effects have now been found in service organizations both in the private and the public domains. The managerial culture in the private sector, in its constant demand for efficiency and advancement of tools to monitor performance, only exacerbates the pressure on frontline workers and reduces their responsiveness to clients' needs (Brodkin, 2012; Jewell, 2007).

A good example can be cited from Lindhorst and Padgett's (2005) study of the interactions between frontline welfare workers and female welfare clients in the face of implementation of a new family violence program. The program required welfare workers to proactively screen for violence victims and provide information on and referral to the program. However, as the researchers discovered, welfare workers under organizational pressure tended to focus on areas of work and clients' needs that were associated with their own accountability, while screening for domestic violence victims was sidelined. Even when instances of violence were disclosed by the clients, the need for family violence support was completely discounted by the workers in order to speed up case processing.

The welfare workers in this case were too busy to "care about" the clients' needs aside from what would be credited on accountability measures. The home care workers in Shanghai will likely face a similar situation, in which they will find themselves pressured to "take care of" clients' needs by the growing managerial measures. The implementation of the attendance card is an example of such measures, which eventually shift the dynamics of relationships between worker and client. There will be less "rule-breaking", less on-call visits, and perhaps less staying over. There may also be less "caring about" and "taking care of", in Tronto's (1993) sense, clients' needs that fall outside of program descriptions. Care workers may be forced to ignore the emotional needs of the older people and attend only to more tangible needs. If the value of emotional bonds, the attentiveness to needs, and a sense of responsibility in care relationships are recognized as pivotal aspects of quality of care, it is anticipated that care quality will suffer.

In Shanghai, the two disadvantaged groups--care workers and older people--are ensnared in a situation where improvements in the conditions of the two parties may cancel one another out in practice. Care is viewed as a magic black box--little is fed into it, but the best is hoped to come out--and what happens inside it does not seem to concern the public. To say the least nevertheless, care is not a moral haven. As Tellis-Nayak & Tellis-Nayak (1989) contend, care workers and elderly clients, who are both powerless to change the larger environments of care work, are apt to "make each other the ready target of their discontent and resentment caused by an institutional indifferent commitment to their welfare" (Tellis-Nayak & Tellis-Nayak, 1989, p. 312). Interpersonal relationships

in care work will ultimately manifest institutional problems, the resolution of which can give hope for the salvation of caring in the transition of the Chinese society.

Chapter Seven: Conclusions

7.1 Relevance of the Emergent Model

The emergent model dwells on the process of care workers' identity work in relationship building, highlighting the central position of the concept of a caring self and identity harmony. Care workers' narratives on care work and the social identity of care worker revealed a constant reconstruction of these concepts. They offered a revamped conceptualization of care work as valuable work for those in need provided by a caring self. The concept of a caring self is borne in care relationships, and being constantly substantiated. Accordingly, care workers constantly tune care relationships between the two poles of identity dissonance and identity consonance. In the former, the spoiled social identity of care worker interpreted as provincial and demeaning is perpetuated, and the concept of a caring self is rebuffed. In the latter, a new situated identity of surrogate daughter is negotiated, with which the self-concept is reconciled. Tuning is therefore a dynamic process of identity negotiation, through which care relationships are adjusted. Disregarding and justifying were identified as strategies employed in tuning out dissonance, while acknowledgement and reciprocation of care were found characteristic of tuning in consonance. Care workers often drew on a cultural language and interpretations in recounting these tuning strategies and relationship characteristics.

The emergent model also accounts for the instrumental aspect of home care work in light of the relationship building. It argues that the provision of tangible care work cannot be fully understood in the circumscription of job descriptions and agency rules, but should be construed with regard to care workers' situated identity and roles. These issues were addressed in Chapter Four and Chapter Five.

It was then shown in Chapter Six that the emergent model is also apt to capture the dynamic process of relationship building in home care work. Three stages of development can be distinguished: contact stage, dynamic stage, and closure stage. It was observed that the progression of relationship building pivoted around care workers' identity work. Moreover, care relationships may end in two contrasting manners. Relational dissonance often foretells an abrupt termination, while relational consonance may lead to an honoured care relationship embodied in the family rituals of *song zhong*, or attending on a senior family member's last moment.

The emergent model is also relevant in its theoretical contribution to the literature, discussed in Chapter Six. For the boundaries thesis, it unravels an underlying mechanism of traversing boundaries at intrapersonal and interpersonal levels. Considering home care as emotional labour, the emergent model offers an explanation for the socio-economic repercussions of performing emotion work in care relationships. It offers some insights into the emotion work in home care in relation to the process of tuning out dissonance and tuning in consonance. It suggests a more fruitful line of inquiry for the welfare institution thesis, one which takes into account the culturally specific interaction rules that influence relationship outcomes. At the individual level, the emergent model conjoins the three extant models, with which the worker-client relationship in home care can be further understood.

Rooted in the Chinese context, the emergent model reflects the filial norms, gender roles, and urban-rural institutional dualism in contempary Chinese society. At the risk of over-generalization, it could be argued that the model is transferrable for understanding care relationship management in similar cultural contexts, for example

East Asian societies under the influence of Confucianism and some Southern European strongholds of family norms. The child-parent analogy implies a set of filial repsonsibilities in these contexts, but may not carry the same weight in another. In that case, the model could be said to be transferrable in an abstract sense--care workers may resort to prominent cultural narratives and imageries in a given society to depict relationships undergoing tuning.

7.2 Limitations of the Study

Despite the relevance of the emergent model, it bears a number of limitations. Being a theory purporting to explain relationship building in home care, this study took up a focused, but admittedly limited, approach: the perspective of the care worker. Older people's stake in care relationships is equally important, and their input is no less valuable than that of the care workers. If a more objectivist orientation had been taken, accounts of interaction used as data should at least be checked against the other party's recollection, in the spirit of triangulation. Even with a constructivist approach, elderly clients' narratives could have contributed to a well-rounded interpretation, in particular if the analytic focus were to unveil the cultural parameters that undergird the day-to-day interactions. Given the limited time and resources, this potentially fertile approach was deemed too ambitious for a dissertation study. Moreover, this limitation is somewhat mitigated by the fact that the emergent model accounts for issues of self and identity of the care workers. The data collected solely from the workers, while limited in scope, have been sufficient to generate this focused explanation.

A related danger is victim blaming. A one-sided story from the perspective of care workers may leave the reader with an impression that the elderly clients are trouble-

makers, given to sexual harassment, undue demands, discrimination, and so on. The instances and quotes included in this study should not be evaluated by their truth values. Nor should one quickly make a judgement. The cases and quotes, being recounted by the care workers, were already interpretations of what had indeed happened. Therefore, my analytic style was to focus on interpreting how and why a participant said something, in particular connecting what was said to the self-presentation and identity negotiation of the speaker. Moreover, treating interviews as a social encounter, I was aware that the interviews themselves were occasions where "facts" about care relationships were being constructed. Again, the reality that care recipients' voices were not included constitutes a drawback of this study.

Another limitation of this study has to do with the characteristics of the participants. Although the distribution of the participants did not seem to be skewed to experienced workers, the self-selected sample does not reflect the full spectrum of care workers in the Shanghai home care program. If one third of the home care force work is not retained for longer than half a year, as one manager told me, the sample for this study is biased toward more experienced workers. The emergent model thus may not capture the experience of short-term care workers. The practical implication is a more serious concern here--it is unknown if the emergent model is capable of explaining why some workers quit the job before building long-term relationships. This question can only be answered by studying the one third of care workers who choose to leave care work within six months.

This problem is an issue of theoretical sampling, to use the language of GT methodology. As discussed previously, the self-selected nature of the sample created a

barrier to conducing true theoretical sampling. For example, the emergent model did not claim to account for male care workers' experience, although the one male participant in this study did not provide any data contradicting the model generated through a female lens. To extend this model to include the male perspective, future work needs to purposely sample male participants. In the same vein, applying the emergent model in local contexts other than the Yangpu district warrants a scrutiny of the organizational context. Cross-regional and cross-cultural applications of the model should be taken up cautiously in that the general theoretical structure of self and identity negotiation could be put to the test of new data and thus modified and reformulated, whereas the contents of the theory concerning specific socio-economic and cultural parameters should be replaced or at least examined to determine if the theory is supported in the new context.

7.3 Implications for Practice

For the home care program in Shanghai, this study generates first-hand information on how care work is conducted at the level of the individual care worker, a phenomenon that has not received any academic attention. The research findings suggest several potential areas of improvement in the relatively new program.

Training should prepare workers to handle friction with clients. Although this study does not suggest any direct measure to prevent identity dissonance, it is clear that the handling of frictions can result in diverging relationship outcomes. Therefore, in training, knowledge of the psychology of older people could be strengthened. For example, care workers could be more prepared to identify symptoms of dementia and other cognitive conditions. With this knowledge, care workers may potentially be able to distinguish a degenerative condition associated with old age from personality. This kind

of education does not need to be theoretical, but should impart knowledge and skills so that frictions caused by the early symptoms of mental impairment are not mistaken as a threat to identity harmony. Similarly, older people's moods and emotional needs can be more easily identified apart from personality. In this way, it is hoped that care workers can be more understanding and less susceptible to threats to their self-concept. Similar training for case managers should be made available in order for them to be better prepared to mediate frictions, to match cases, and to retain workers.

At the agency level, certain kinds of support should be available to care workers. For example, the help may be organized in the form of self-help groups that provide emotional support to workers who encounter friction and dissonance in care relationships. It could also become a forum where personal experiences of care work could be shared among employees. In addition, this may prove to be an efficient approach to provide ongoing training for newer workers. At the same time, this study suggests that increasing managerial control around time with the purpose of regulating service and thus to boosting efficiency may be counter-productive. The nature of the care needs of the clients and the flexibility preferred by many care workers suggest that care workers' discretion may be essential to achieving both efficiency and effectiveness. This study also suggests that clients and care workers should be more engaged in case management. To facilitate case management, needs assessment tools could be used in combination with care workers and managers' practical knowledge.

At the levels of municipal and district government and policy-making, changes can be made to improve the home care program. The foremost institutional change needed is better coordination between different departments and levels of the

government. Setting the hourly rate of care work falls under the jurisdiction of the Human Resource and Social Security Bureau, whereas the home care benefit scheme for the seniors is administered by the Civil Affairs Bureau. As the findings of this research demonstrated, the "hour-pay" paradox can be in part imputed to the scattered systems that govern the home care program. Aside from the scattered system, this study suggests that the general reception of care work is crucial in the delivery of care service. An elevation of the status of care work through better compensation and social benefits is likely to be successful in retaining workers. Importantly, it would also serve to help enhance the perceived dignity of care work, which may in turn strengthen the concept of a caring self.

Implications for social work as a new profession in China should also be noted. At the level of practice, the role of social workers in care case management can be explored. Social workers' psycho-social expertise may contribute to case management through the assessment process and identifying social needs of clients and their families. Social workers could also manage support groups for care workers and mediate interpersonal frictions. Apart from social and emotional support, social workers could work to remove barrier to access to resources for older clients. This study found that care workers often played the role of advocate for their clients, who were not aware of the available benefits for example, when they become entitled to a higher level of subsidy due to older age or deteriorated health. With their knowledge of the welfare system, social workers can help clients and care workers locate public resources, such as government subsidies, volunteers in the community, and other types of services provided by non-governmental organizations. It may also be the case that, as the entire care system develops, coordination between different types of services may become an issue.

Social workers can play an important part in managing admission, discharge, and transfer of senior clients from and between home and health care institutions such as hospitals and nursing homes.

Social work as a new profession in China has begun to carve its niche in the care system. Services provided by certified social workers have emerged in the areas of community and hospital-based care and at the street level government bodies. This trend prompts social work education in China to gear toward the field of care and equip graduates with field-specific knowledge. Social work educators may proactively seek placement opportunities for students in these new fields and provide prompt guidance as students navigate the care system.

7.4 Future Research

This study suggests a fruitful line of inquiry to expand our understanding of the mechanisms underlying care relationship building. Following GT methodology, the emergent theory can be tested, reformulated, and revised in light of data collected in other contexts of home care, and across different cultures. In a like manner, this theory can be cautiously applied and examined in other types of care provision: elder care in institutions, child care services, nursing care, and medical care. This kind of generalization demands constant comparisons between new data and the existing theory and between new data and existing data, with a view to modifying and adapting the theory instead of confirming and refuting.

On a similar note, a gender lens can be applied to future studies. With only one male participant, this study was unable to make a meaningful comparison between female and male care workers on their views toward identity harmony and tuning. Although the

one male participant in this study did not appear to be distinctive from the rest of the sample, it would be unwarranted to assume that female and male care workers engage in tuning in a uniform manner. To extend the emergent model to male care workers, theoretical sampling of men and careful constant comparisons are necessary. However, a paucity of male care workers in home care may constitute an ethical issue of such research. Measures to ensure voluntary participantion and anonymity would have to be considered.

Yet another line of inquiry would be to quantify some of the concepts generated from this study. An example would be to include measures of care workers' identity in care relationships and measures of intention of retention, together with other care work related variables and demographic variables, in a survey based on a large sample. The new model that includes identity measures as a predictor could then be compared to an older model in which known predictors of retention, such as pecuniary rewards, non-pecuniary rewards, job hazard, professional development, self-efficacy in work, supervision, communication, and so forth (Brannon, Barry, Kemper, Schreiner, & Vasey, 2007; Kemper et al., 2008; Morris, 2009), have been used to account for intention of retention. It must be noted that these known variables have been empirically developed, but not deductively tested in a single sound theoretical framework. Therefore, lack of theory should raise some concerns in this applied field of inquiry.

In the Chinese context, however, researchers should not feel stymied by the lack of theory. As mentioned earlier, an accurate picture of home care is still lacking: who are the care givers, who are the receivers, their socio-economic conditions and needs. These preliminary inquiries are essential for decision-making and policy planning.

At the same time, social work researchers may emerge as a new voice in the field of care research. The application of a qualitative research methodology combined with an ecological view of services and policies in social work research (Westhues, 2006) may bring a unique perspective to the Chinese academy, which is now dominated by government agendas, large-scale studies, and data mining. Most meaningfully, social work research that aims to connect personal and interpersonal issues to the socio-political and cultural environments lends itself well to policy advocacy. Countries around the world differ in their stage of development, political system, culture, and traditions, hence it is wise to be strategic when it comes to advocating for systemic changes. However, I believe social workers across the globe, in creating these changes, hold on to something universal at the core of the profession--the commitment to social justice.

Appendix 1: Shanghai and Yangpu District

	Shanghai	Yangpu District
Administration	Directly administered municipality, municipal government (comparable to provincial level in Canada)	District government (comparable to county level in Canada)
Divisions	19 districts including 1 county	12 streets including 1 town (comparable to township level)
Area	Total: 6,340 square km Urban: 5,299 square km	Total (all urban): 60.61 square km
Population (2013)	Registered (local residents with *hu kou*): 14,323,400 Total (including migrants who have stayed longer than six months without *hu kou*): 24,151,500	Registered: 1,089,500 Total (based on 2010 census): 1,313,222
GDP[29] (2013)	Total: 2.16 trillion Yuan ($432 billion Canadian or $348 billion US[30]) Per capita: 90,092 Yuan ($18,018 Canadian or $14,531 US)	Total: 138.17 billion Yuan ($27 billion Canadian or $22 billion US) Per capita: 105,214 Yuan ($21,043 Canadian or $16,970 US)
Employers' monthly income (2013)	Municipal average: 5,036Yuan ($1,007 Canadian)	
Ageing population (as a percentage of registered population)	60+: 3.88 million (27.1%) 65+: 2.57 million (17.9%) 80+: 0.72 million (5.0%)	60+: 0.30 million (27.5%) 65+: 0.19 million (17.8%) 80+: 0.06 million (5.5%)
Retirees' monthly pension income and coverage (2013)	Municipal average: 2,964 Yuan ($592.8 Canadian) 2.6 million, 67.2% urban elders aged 60+ covered	
Exchange rate	$1 Canadian ≈ 5 Yuan	

Source: Shanghai Bureau of Statistics, 2014; Yangpu District Bureau of Statistics, 2010; Yangpu District Bureau of Statistics, 2013

[29] GDP data are directly quoted from official sources. Due to differing calculation methods and sources of information, GDP figures may not match other widely cited estimates.
[30] Based on an exchange rate of 1 US Dollar to 6.2 Yuan.

Appendix 2: Interview Agenda[31]

To start the conversation:

1. Thank you for agreeing to participate; clarification of any concerns about participation.
2. I'd like to ask some questions about your background. Could you tell me:
    a. Where is your hometown?
    b. (For migrant care workers) How long have you been living in Shanghai?
    c. How long have you been working at this agency?
    d. How did you find the job here at this agency?

I'd like to ask some questions about your work now, and your relationships with the older people you care for:

1. Can you describe a typical day of work in clients' homes?
2. What is it like to work in someone else's home?
3. How would you describe your relationships with your clients?
4. What is it like to go into a new client's home and start a care relationship?
5. Can you recall some of the first visits to an elder person's home? What was your experience like and how do you compare it to how you feel now?
6. Have you had any conflicts or disagreements with clients? If so, how did you handle them? What do you think led you to handle it that way?

---

[31] The Interview Agenda in English is a verbatim translation from the Chinese original. The English version was reviewed and approved by the Wilfrid Laurier University Ethics Review Board, and the Chinese document was used in the study.

7. Have you talked about your care work and care relationships with other people, say your friends, co-workers, your supervisor, manager, or clients' families? If so, how do you think they have influenced the way you work?
8. What would you say about your current work environment? How does it help you do good work or make it hard to do good work?
9. What do you think is the prevailing attitude in society about the care work you are doing? How does that affect the way you feel about your work and the way you do it?

To further explore a topic:

1. Can you talk more about …?
2. Please tell me an incident of …, from your own experience or what you have learned?

To keep the conversation on track：

What you said is very interesting. Thank you. We can come back to this issue later. Do you mind talking about (focus of question posed)?

To conclude:

1. Based on your experience, what do you think could be done by the agency to promote better relationships between you and your clients?

2. Do you have any concerns and suggestions about the home care services in Shanghai?

3. Is there anything else you would like to share or discuss about your work?

Thank you

Thank you for making time to meet with me today.

访谈提要 (Interview Agenda in Chinese)

开始对话：

1. 感谢参与；释疑。
2. 我问一些关于你自己的问题：

a. 你的老家在哪里？

b. （对外地护理员）你来上海多长时间了？

c. 你在这个养老服务机构工作多久了？你觉得这个单位怎么样？

d. 是怎么找到这里的工作的呢？

现在我想问一些关于你的工作和你与老人关系的问题：

你可不可以描述一下从早到晚的工作？

在别人家里工作是一种什么样的感觉？

你和老人的关系怎么样，能不能介绍一下？

到一个新的老人家工作，开始一段新的关系，是怎么样一个过程？

你能否描述一下最开始做这份工作时，去老人家服务的情况？你现在的感受和当时比较起来怎么样？

你和老人之间有没有过什么分歧或者矛盾？如果有的话，你是怎么处理的？你觉得你为什么会那样处理？

你有没有跟其他人，比如朋友，同事，领导，老人家属，聊过你自己的工作还有跟老人的关系？如果有，你觉得这些人对你的工作方式有什么影响？

你对你现在的工作环境有什么看法？环境对你的工作是有利还是不利？

深入探讨某一议题：

1. 你可不可以就……问题说得更详细一点？
2. 你可不可以举个关于……的例子，你听到的或你自己亲身经历的都可以。

如果被访者过度偏题：

谢谢（以上所说的），这个很有意思，一会我们可以继续谈这个话题。我可不可以请你谈谈……？

总结：

1. 根据你的经验，你觉得服务机构还可以做些什么让你和老人的关系更加良好，工作更加顺利？
2. 你对居家养老服务还有什么其他的意见和建议？
3. 还有什么问题你想讨论一下？

感谢：

感谢你的时间和参与。

Appendix 3: Information/Advertisement Letter[32]

Dear Care Worker,

My name is Hong Liu, and I am a doctoral student in the Faculty of Social Work, Wilfrid Laurier University, in Canada and my thesis advisor is Dr. Anne Westhues. I would like to invite you to participant in my doctoral thesis research. This is a study about the home care services for elders and care workers in Shanghai. I am interested in your experience of managing care relationships with your elderly clients and your working conditions. I hope that both care workers and elderly clients will benefit from improved experiences in the service process. This study will also be a starting point, offering some theoretical guidance to future research in care workers' working conditions, relationships with elderly clients, and physical and psychological well-being. Moreover, the findings will potentially inform policy and program development in home care for elders in Shanghai by offering insights into how the government could facilitate the care work in homes and promote good care relationships.

If you agree to participate, I will conduct an interview with you for about one hour. In the next three to four months, I may contact you once or twice. These follow-up interviews will be shorter than the first one. You can decide where the interview will be held. If you do not have a specific place in mind, we can meet at your community centre, the district social welfare department, or at the social work department of Fudan University.

Participation in this study is voluntary and anonymous. During the interviews, you may also refuse to answer any question, or withdraw from the study at any point. You will not be penalized in any way if you choose not to participate or withdraw from the study midway. There is a 50 Yuan compensation for your time and contribution and any transportation expense incurred from participation.

Your participation will be a great help to my thesis research. The information you share will also be a valuable contribution to the research, policy, and practice of home care for elders. I will summarize and share with you the research findings. If you are interested in participating, please contact Hong Liu at 15000044115 or lhong@wlu.ca. I look forward to and appreciate your participation!

Principal Researcher: Hong Liu
Signature
Date
Note: This project has been reviewed and approved by the Wilfrid Laurier University Ethics Review Board.

---

[32] The Information/Advertisement Letter in English is a verbatim translation from the Chinese original. The English version was reviewed and approved by the Wilfrid Laurier University Ethics Review Board, and the Chinese document was used in the study.

介绍信 (Information/Advertisement Letter in Chinese)

亲爱的护理员：

大家好。我叫洪浏。我是加拿大罗瑞尔大学社会工作学院的博士研究生，我很高兴地邀请你参加我的博士论文研究。这是一个关于上海市居家养老服务和护理员的研究。我想请你分享在工作过程中的经验和体会，比如与老人的关系，对工作环境的感受。通过这个研究，我想了解如何进一步改善居家养老服务，让你和你照顾的老人都能从中得益。同时，这个研究也将作为一个起点，让我们更多地了解护理员的工作状态，与老人的关系，生理和心理健康等问题。并为将来的政策制定提供参考意见和一些初步的理论依据。

如果你愿意参加我的研究，我会对你做一个访问。时间大约在一个小时左右。在未来的三四个月中，视需要我可能会再访问你一到两次。时间可能会短一些。你可以随你的方便选择接受访问的地点。如果你没有合适的地点，我们也可以在社区中心，区民政局居家养老部，或复旦大学社会工作系会面。

你的参与是完全自愿和匿名的。即使在参与过程中，你也有权在任何时候拒绝回答我的问题，或者选择退出访问。如果你选择不参加或中途退出，也不会受到任何惩罚。如果你接受访问，可以获得 50 元现金以补偿你贡献的时间和交通费用。

你的参与将是对我论文研究的极大帮助。你所分享的信息同时也是对老龄工作和家庭照顾的研究、政策和实务的贡献。在研究结束后，我会将研究结果整理并送发给你们。如你有意参与，请电话或电邮联络洪浏：15000044115，lhong@wlu.ca。期待并感谢你的参与！

研究员 洪浏

签名

日期

注：此项研究已获得罗瑞尔大学研究伦理审查委员会的批准。

Appendix 4: Informed Consent Form[33]

WILFRID LAURIER UNIVERSITY
INFORMED CONSENT STATEMENT

Project title:
Caring in Transition: Home Care Workers' Experiences of Care Relationships in Shanghai, China

Principal Investigator: Liu Hong, lhong@wlu.ca
Dissertation Supervisor: Dr. Anne Westhues, awesthue@wlu.ca

You are invited to participate in a study about home care services for elders in Shanghai, and specifically care workers' experiences of managing care relationships with their elderly clients. Information collected in the study will potentially inform policy and program development in home care for elders in Shanghai by offering insights into how the government could facilitate the care work in homes and promote good care relationships. This study will also be a starting point, offering some theoretical guidance to future research in care workers' working condition, relationships with elderly client, and physical and psychological well-being. This study is being conducted in partial fulfillment of the requirement for the doctoral degree in social work that the principal investigator, Liu Hong is working toward at Wilfrid Laurier University, Waterloo, Ontario, Canada.

Information:
You are requested to participate in a one-hour-long, one-on-one, face-to-face interview with the principal investigator. During the interview, you will be asked to talk about your experience of providing care in elderly clients' homes and how you perceive and maintain care relationships with your clients. However, you will not be asked to disclose any personal information about your clients. If you agree, you may be contacted once or twice in the next three to four months to further discuss and clarify specific issues raised in our conversations. If you do not wish to be contacted after the initial interview, your decision will be respected. With your consent, the interviews will be audio-recorded. Later these recordings will be transcribed into texts for analysis purposes. Only the principal investigator and his thesis advisor have access to the recordings and transcripts.

Risks:
Participation in this study does not involve any foreseeable social or physical harm to you. Nevertheless, if you experience any discomfort during the interview, please feel free to let the interviewer know, and he will provide any necessary support, reschedule or

[33] The Informed Consent Form in English is a verbatim translation from the Chinese original. The English version was reviewed and approved by the Wilfrid Laurier University Ethics Review Board, and the Chinese document was used in the study.

cancel the interview. Please be reminded that participation in this study is voluntary. If you feel uncomfortable responding to any questions during the interviews, you may refuse to answer, or withdraw from the study at any time.

Benefits:
There is no direct social or health reward for participation in this study. However, this study can potentially contribute to the policy-making in elder care reform in Shanghai. It is hoped that through participating in this study, care workers' voices will influence subsequent policy making. During the interviews, participants will have an opportunity to express their opinions, concerns, and suggestions about home care practice. Moreover, this study will contribute to the international scholarship on the issues of care work and fill a knowledge gap by linking the organizational and structural contexts of care work and care relationships. This study also partially fulfills the principal investigator's degree requirement.

Confidentiality:
Your participation is voluntary and unknown to any third party. An alphanumeric code will be assigned to each participant and real names will not be used throughout this study. Interviews will be conducted in places where privacy, confidentiality, and safety can be protected. Both the interview recordings and transcripts will be tagged only with codes, and stored in a password-secured electronic file. Printed transcripts will be locked in a cabinet. Personal contact information and other identifying documents will be stored separately from collected consent forms and data. Some of the transcripts may be available to the Advisor and the members Dissertation Advisory Committee of the principal investigator for review. Audio recordings of interviews, communications, printed transcripts and other printed documents and information forms will be destroyed by the researcher once the dissertation is completed. Transcripts stored electronically will be deleted in eight years from the beginning of the study by the researcher. With your permission, I may quote what you said in the interviews in the dissertation, journal articles, presentations, and research reports, but your name and the name of your agency will not appear. Please let the researcher know if you wish to review your quotes. You will be contacted, if your quotes are to appear in the dissertation, journal articles, presentations, research reports, or any type of subsequent publications. A copy of an excerpt of the text containing the quotes will be sent to you through e-mail or regular mail, and you can decide if the quotes should be kept, modified, or deleted. If you do not want to be quoted at all, please let the researcher know. You can still participate in this study without being quoted.

Compensation:
You will receive a compensation of 50 Yuan for your time, contributions, and any transportation expenses incurred from participation in the initial interview. If you withdraw from the initial interview prior to its completion, you will still receive 50 Yuan.

Contact:
If you have questions at any time about this study or the procedures, you may contact the principal investigator Liu Hong at lhong@wlu.ca, and 15000044115. This project has

been reviewed and approved by the University Research Ethics Board. If you feel you have not been treated according to the description in this form, or your rights as a participant in research have been violated during the course of this project, you may contact Dr. Robert Basso, Chair, University Research Ethics Board, Wilfrid Laurier University, (519)884-1970, extension 5225 or rbasso@wlu.ca.

Participation:
Your participation in the study is voluntary; you may decline to participate without penalty. If you decide to participate, you may withdraw from this study at any time without penalty and without loss of benefits to which you are otherwise entitled. In order to withdraw from the study, please contact the researcher Liu Hong with your request. You may do so in person, in writing or through telephone contact.

Feedback and publication:
A seminar will be organized by the principal investigator to report the findings of this study at the social welfare department of local government or at one of the local universities. Research findings will be shared in the Chinese academic community in a domestic academic conference and possibly at international conferences. It is expected that results of the study will be presented in academic journal articles too. An electronic copy of an executive summary of the findings in Chinese will be available to all the agencies and the government departments involved. Upon request, a copy of the executive summary of findings in Chinese will be available to the general public. If you wish to be invited to the seminar or receive a copy of the executive summary, please indicate below.

Follow-up contact and quotation (please check where appropriate):

I agree to have the interviews tape-recorded: Yes_____ No_____

I can be quoted in a non-identifiable way: Yes_____ No_____

I want to participate without being quoted: Yes_____ No_____

I can be contacted for follow-up interviews: Yes_____ No_____

I want to review my quotes: Yes_____ No_____

I want to receive a copy of executive summary: Yes_____ No_____

I want to participate in a seminar: Yes_____ No_____

Consent:
I have read and understand the above information. I have received a copy of this form. I agree to participate in this study.
Participant Print Name _____ Signature_____Date_____
Researcher Print Name_____ Signature_____ Date_____

知情同意书 (Informed Consent Form in Chinese)

罗瑞尔大学 知情同意书

项目名称：变迁中的照顾：中国上海居家养老护理员的照顾关系体验
研究员：洪浏，lhong@wlu.ca
博士论文导师：Anne Westhues 博士，awesthue@wlu.ca

我很高兴地邀请你参与这个关于上海市居家养老服务和护理员的研究。我想请你分享在工作过程中的经验和体会，比如与老人的关系，对工作环境的感受。通过这个研究，我想了解如何进一步改善居家养老的政策和服务，促进良好的照顾关系，让护理员和老人都能从中得益。同时，这个研究也将作为一个起点，让我们更多地了解护理员的工作状态，与老人的关系，生理和心理健康等问题。并为将来的政策制定提供参考意见和一些初步的理论依据。此研究也是我在加拿大，滑铁卢，罗瑞尔大学的博士学位论文。

信息：

如果你参加我的研究，今天我会对你做一个访问。时间大约在一个小时左右。在此过程中，我将会问及关于为老人服务的体验，以及你和老人的关系。 但你不需要提及任何老人的具体信息。如果你同意，在未来的三四个月中，视需要我可能会再访问你一到两次，时间可能会短一些。如果你不想再次接受访问，我也会尊重你的决定。如果你不介意的话，我需要对谈话录音。之后我自己会把这些录音转录成文字稿。这些录音和稿件会被储存在有密码保护的电子文档内或者锁在柜子里。这些录音和匿名文稿只有我和我的博士答辩组教授可以回听或者阅读。

风险：

参加这个研究应该不会对你产生负面影响。 但如果你有什么不适、反感或者其他问题， 请及时告诉我。我乐意为你提供帮助，并改期或取消访谈。参加这个研究是自愿的。你也有权在任何时候拒绝回答我的问题，或者选择退出访问。

受益：

参加这个研究也不会给你带来任何立即可见的好处。但我希望这个研究可以为将来上海的养老事业发展做一点贡献。通过这个研究，我希望护理员的声音可以被社会听到。在研究过程中，你将有机会表达你自己的看法，意见和建议。另外，这个研究也将对有关照顾的学术文献有所贡献，使我们对照顾关系有更深入的了解。同时，这个研究也是本人博士学位的一部分。

保密：

你的参与是完全自愿和保密的。我会给每个参与者一个代号，你的真名或你的工作单位完全不会出现在任何文稿和报告中。 访谈的地点也是安全保密的。所有访谈录音和文字稿都是匿名的，并且会用密码妥善保存。打印的文字稿会锁在柜子里。个人信息资料会和访谈资料分开存放。部分匿名文稿会呈交给我的博士答辩

组阅览。录音，通讯记录，打印稿和信息表都会在论文完成时销毁。电子版文字稿会在研究开始之后八年内被销毁。在你同意的前提下，我可能会在博士论文，学术期刊论文和学术报告中引用我们的对话。但引用都将是匿名的。如果你想审阅你的引文，无论是在博士论文，学术期刊论文或是学术报告中，请告诉我，我会把你的引文通过电子邮件或平邮发给你。你可以决定这些引用是否需要修改或者不予公开。即使不愿意被引用，你依然可以参加这个研究。

酬谢：

你将获得 50 元现金以补偿你贡献的时间和交通费用。如果你中途退出，你依然可以获得 50 元酬谢。

联络：

如果你对整个研究过程有疑问，请发邮件给洪浏：lhong@wlu.ca，或致电 15000044115。此项研究已获得罗瑞尔大学研究伦理审查委员会的批准。如果你觉得以上内容并未付诸实践，你可以联络罗瑞尔大学研究伦理审查委员会的主席，Robert Basso 博士：+1-(519)884-1970，转 5225，或者通过电子邮件 rbasso@wlu.ca。

参与：

你的参与是完全自愿的。如果你选择不参加或中途退出，不会受到任何惩罚。如果你想退出研究，请通过任何方式联系洪浏。

反馈和发表：

研究的结果将通过一个学术报告会发布，地点将在民政局或大学。学术研究结果也会在中国和国际的学术会议上发表。学术期刊也是可能的发表平台之一。居家养老中心和区民政部门会得到一份摘要。社会人士也可向我索取中文摘要。如果你想受邀参加研究报告发布会，请在下面注明。

追访和引用（请选择）：

同意访谈录音：是_____否_____
可以匿名引用：是_____否_____
参加研究，但不想被引用：是_____否_____
可以追访：是_____否_____
需要审阅引文：是_____否_____
需要一份摘要：是_____否_____
愿意参加研究报告会：是_____否_____

知情同意：

我已经阅读以上信息，并收到此表格。我愿意参加这个研究。
被访者姓名_____ 签名 _____ 日期_____
研究员姓名_____ 签名 _____ 日期_____

Appendix 5: Demographic Information Form[34]

Participant Code

Gender

Age

Hometown

Education

Care worker certificate level

Number of year(s) in home care

Number of year(s) in other care jobs

Number of social care agencies served

Name of current home are agency

Workload (hours per day)

Number of elderly clients served

[34] The Demographic Information Form in English is a verbatim translation from the Chinese original. The English version was reviewed and approved by the Wilfrid Laurier University Ethics Review Board, and the Chinese document was used in the study.

被访者信息 (Demographic Information Form in Chinese)

被访者代号

性别

年龄

籍贯

学历

护理员级别

居家养老服务工作年限

其他护理服务工作年限

服务过的养老机构总数

当前居家养老机构名称

当前护理工作量（小时数）

当前护理老人

References

Abe, A. K. (2010). *The changing shape of the care diamond: The case of child and elderly care in Japan*. Programme on Gender and Development, Paper No. 9. UNRISD, Geneva.

Allen, P. D., Klein, W. C., & Gruman, C. (2003). Correlates of complaints made to the Connecticut Long-Term Care Ombudsman Program: The role of organizational and structural factors. *Research on Aging, 25*(6), 631-654. doi:10.1177/0164027503256691

Anderson, B. (2000). *Doing the dirty work? The global politics of domestic labour*. London and New York: Zed Books.

Applebaum, R., & Phillips, P. (1990). Assuring the quality of in-home care: The "other" challenge for long-term care. *Gerontologist, 30*(4), 444-450. doi:10.1093/geront/30.4.444

Applebaum, R. A., Straker, J. K., & Geron, S. M. (2000). *Assessing satisfaction in health and long-term care: Practical approaches to hearing the voices of consumers*. New York, NY: Springer.

Aronson, J., & Neysmith, S. M. (1996). You're not just in there to do the work. *Gender & Society, 10*(1), 59-77. doi:10.1177/089124396010001005

Aronson, J., & Neysmith, S. M. (1997). The retreat of the state and long-term care provision: Implications for frail elderly people, unpaid family carers and paid home care workers. *Studies in Political Economy, 53*, 37-66.

Aronson, J., Denton, M., & Zeytinoglu, I. (2004). Market-modelled home care in Ontario: Deteriorating working conditions and dwindling community capacity.

Canadian Public Policy-Analyse De Politiques, 30(1), 111-125. doi:10.2307/3552583

Barer, B. M. (1992). The relationship between homebound older-people and their home care workers, or the *pas de deux* of home care. *Journal of Gerontological Social Work, 19*(1), 129-147. doi:10.1300/J083v19n01_08

Bauer, G., & Osterle, A. (2013). Migrant care labour: The commodification and redistribution of care and emotional work. *Social Policy and Society, 12*(3), 461-473. doi:10.1017/S1474746413000079

Benjamin, A., & Matthias, R. (2004). Work-life differences and outcomes for agency and consumer-directed home-care workers. *Gerontologist, 44*(4), 479-488. doi:10.1093/geront/44.4.479

Berdes, C., & Eckert, J. M. (2007). The language of caring: Nurse's aides' use of family metaphors conveys affective care. *Gerontologist, 47*(3), 340-349. doi:10.1093/geront/47.3.340

Berger, P. L., & Luckman, T. (1966). *The social construction of reality: A treatise in the sociology of knowledge*. New York, NY: Penguin Books.

Bettio, F., Simonazzi, A., & Villa, P. (2006). Change in care regimes and female migration: The 'care drain' in the Mediterranean. *Journal of European Social Policy, 16*(3), 271-285. doi:10.1177/0958928706065598

Biegel, D. E., & Blum, A. (Eds.) (1990). *Aging and caregiving.* Newbury Park, CA: Sage Publications.

Blumer, H. (1986). *Symbolic interactionism: Perspective and method*. Berkeley, CA: University of California Press.

Brannon, D., Barry, T., Kemper, P., Schreiner, A., & Vasey, J. (2007). Job perceptions and intent to leave among direct care workers: Evidence from the Better Jobs Better Care demonstrations. *Gerontologist, 47*(6), 820-829. doi:10.1093/geront/47.6.820

Breakwell, G. M. (2004). Identity change in the context of the growing influence of European Union institutions. In R. K. Hermann, T. Risse-Kappen, & M. B. Brewer (Eds.), *Transnational identities: Becoming European in the EU* (pp. 25-39). Oxford, UK: Rowman & Littlefield.

Brechin, A. (1998). What makes for good care? In A. Brechin, J. Walmsley, J. Katz, & S. Peace (Eds.), *Care matters: Concepts, practice and research in health and social care* (pp. 170-88). London, UK: Sage Publications.

Brennan, D., Cass, B., Himmelweit, S., & Szebehely, M. (2012). The marketisation of care: Rationales and consequences in Nordic and liberal care regimes. *Journal of European Social Policy, 22*(4), 377-391. doi:10.1177/0958928712449772

Brodkin, E. Z. (2012). Reflections on street-level bureaucracy: Past, present, and future. *Public Administration Review, 72*(6), 940-949. doi:10.1111/j.1540-6210.2012.02657.x

Browne, C. V., & Braun, K. L. (2008). Globalization, women's migration, and the long-term-care workforce. *The Gerontologist, 48*(1), 16-24. doi:10.1093/geront/48.1.16

Burbridge, L. C. (1993). The labor-market for home care workers: Demand, supply, and institutional barriers. *Gerontologist, 33*(1), 41-46. doi:10.1093/geront/33.1.41

Cai, F. (2010). Demographic transition, demographic dividend, and Lewis turning point in China. *China Economic Journal, 3*(2), 107-119. doi:10.1080/17538963.2010.511899

Castle, N. G., & Ferguson, J. C. (2010). What is nursing home quality and how is it measured? *The Gerontologist, 50*(4), 426-442. doi:10.1093/geront/gnq052

Chappell, N. (2008). Comparing caregivers to older adults in Shanghai. *Asian Journal of Gerontology & Geriatrics, 3*(2), 57-65.

Charmaz, K. (2000). Grounded theory: Objectivist and constructivist Methods. In Norman K. Denzin & Yvonna S. Lincoln (Eds.), *Handbook of qualitative research, 2nd edition* (pp. 509-535). Thousand Oaks, CA.: Sage Publications.

Charmaz, K. (2006). *Constructing grounded theory: A practical guide through qualitative analysis*. London, UK: Sage Publications.

Charmaz, K. (2014). *Constructing grounded theory* (2nd ed.). London, UK: Sage Publications.

Chen, X., & Silverstein, M. (2000). Intergenerational social support and the psychological well-being of older parents in China. *Research on Aging, 22*(1), 43. doi:10.1177/0164027500221003

Chichin, E. R. (1992). Home care is where the heart is: The role of interpersonal relationships in paraprofessional home care. *Home Health Care Services Quarterly, 13*(1-2), 161-177. doi:10.1300/J027v13n01_08

Christensen, K. (2012). Towards sustainable hybrid relationships in cash-for-care systems. *Disability & Society, 27*(3), 399-412. doi:10.1300/J027v13n01_08

Clarke, A. (2005). Situational analysis: Grounded theory mapping after the postmodern turn. *Symbolic Interaction, 26*(4), 553-576. doi:10.1525/si.2003.26.4.553

Coffey, A., & Aktinson, P. (1996). *Making sense of qualitative data: Complementary research strategies*. Thousand Oaks, CA: Sage Publications.

Comondore, V. R., Devereaux, P. J., Zhou, Q., Stone, S. B., Busse, J. W., Ravindran, N. C., … Guyatt, G. H. (2009). Quality of care in for-profit and not-for-profit nursing homes: Systematic review and meta-analysis. *British Medical Journal, 339:b2732*. doi:10.1136/bmj.b2732

Compas, C., Hopkins, K. A., & Townsley, E. (2008). Best practices in implementing and sustaining quality of care: A review of the quality improvement literature. *Research in Gerontological Nursing, 1*(3), 209-216. doi:10.3928/00220124-20091301-07

Cooley, C. H. (1902). *Human nature and the social order*. New York, NY: C. Scribner's Sons.

Creswell, J. W. (2013). *Qualitative inquiry and research design: Choosing among five approaches* (3rd ed.). Los Angeles, CA: Sage Publications.

Da Roit, B., & Le Bihan, B. (2010). Similar and yet so different: Cash-for-care in six European countries long-term care policies. *Milbank Quarterly, 88*(3), 286-309. doi:10.1111/j.1468-0009.2010.00601.x

Daly, M. (2001). Care policies in Europe. In M. Daly (Ed.), *Care work: The quest for security* (pp. 33-56). Geneva, Switzerland: ILO.

Daly, M. (2002). Care as a good for social policy. *Journal of Social Policy, 31*, 251-270. doi:10.1017/S0047279401006572

Daly, M., & Lewis, J. (2000). The concept of social care and the analysis of contemporary welfare states. *British Journal of Sociology, 51*(2), 281-298. doi:10.1080/00071310050030181

Denton, M., Zeytinoglu, I. U., Davies, S., & Lian, J. (2002). Job stress and job dissatisfaction of home care workers in the context of health care restructuring.

International Journal of Health Services, 32(2), 327-357. doi:10.2190/VYN8-6NKY-RKUM-L0XW

Denton, M., Zeytinoglu, I. U., Kusch, K., & Davies, S. (2007). Market-modelled home care: Impact on job satisfaction and propensity to leave. *Canadian Public Policy, 33*, 81-99. doi:10.3138/G551-755V-12W7-2551

Dey, I. (2007). Grounding categories. In A. Bryant & K. Charmaz (Eds.), *The SAGE handbook of grounded theory* (pp. 167-190). London, UK: Sage Publications.

Dill, J. S., & Cagle, J. (2010). Caregiving in a patient's place of residence: Turnover of direct care workers in home care and hospice agencies. *Journal of Aging and Health, 22*(6), 713-733. doi:10.1177/0898264310373390

Donabedian, A. (1981). Criteria, norms and standards of quality: What do they mean? *American Journal of Public Health, 71*(4), 409-412. doi:10.2105/ajph.71.4.409

Donabedian, A. (1988). The quality of care: How can it be assessed? *The Journal of the American Medical Association, 260*(12), 1743-1748. doi:10.1001/jama.1988.03410120089033

Dong, W. (2003). Healthcare-financing reforms in transitional society: A Shanghai experience. *Journal of Health, Population, and Nutrition, 21*(3), 223-234.

Dunne, C. (2011). The place of the literature review in grounded theory research. *International Journal of Social Research Methodology, 14*(2), 111-124. doi:10.1080/13645579.2010.494930

England, P., & Folbre, N. (1999). The cost of caring. *Annals of the American Academy of Political and Social Science, 561*, 39-51. doi:10.1177/000271629956100103

Eustis, N., & Fischer, L. (1991). Relationships between home care clients and their workers: Implications for quality of care. *Gerontologist, 31*(4), 447-456. doi:10.1093/geront/31.4.447

Eustis, N., Kane, R., & Fischer, L. (1993). Home care quality and the home care worker: Beyond quality assurance as usual. *Gerontologist, 33*(1), 64-73. doi:10.1093/geront/33.1.64

Evers, A., & Svetlik, I. (Eds.) (1993). *Balancing pluralism: New welfare mixes in care for the elderly*. Aldershot, Hants, England: Avebury.

Faul, A. C., Schapmire, T. J., D'Ambrosio, J., Feaster, D., Oak, C. S., & Farley, A. (2010). Promoting sustainability in frontline home care aides: Understanding factors affecting job retention in the home care workforce. *Home Health Care Management & Practice, 22*(6), 408-416. doi:10.1177/1084822309348896

Faunce, W. A. (2003). *Work, status, and self-esteem: A theory of selective self investment*. Lanham, MD.: University Press of America.

Feldman, P. H., Sapienza, A. M., & Kane, N. M. (1990). *Who cares for them: Workers in the home care industry*. New York, NY: Greenwood Press.

Folbre, N. (2006). Demanding quality: Worker/Consumer coalitions and "high road" strategies in the care sector. *Politics and Society, 34*(1), 11-32. doi:10.1177/0032329205284754

Folbre, N., & Nelson, J. A. (2000). For love or money--Or both? *Journal of Economic Perspectives, 14*(4), 123-140.

Fraser, N. (1997). *Justice interruptus: Critical reflections on the "postsocialist" condition*. New York, NY: Routledge.

Fujisawa, R., & Colombo, F. (2009). *The long-term care workforce: Overview and strategies to adapt supply to a growing demand.* OECD Health Working Papers, No. 44, OECD Publishing. doi:10.1787/225350638472

Giddens, A. (1991). *Modernity and self-identity: Self and society in the late modern age*. Stanford, CA.: Stanford University Press.

Gillham, B. (2005). *Research interviewing: The range of techniques*. New York, NY: Open University Press.

Glaser, B.G. (1978). *Theoretical sensitivity*. Mill Valley, CA: Sociology Press.

Glaser, B. G. (1998). *Doing grounded theory: Issues and discussions.* Mill Valley, CA: Sociology Press.

Glaser, B. G. (2002). Conceptualization: On theory and theorizing using grounded theory. *International Journal of Qualitative Methods 2002, 1*(2), 23-38.

Glaser, B. G. (2004). Remodeling grounded theory. *Forum: Qualitative Social Research, 5*(2), Art. 4.

Glaser, B., & Strauss, A. (1967). *The discovery of grounded theory: Strategies for qualitative research.* New York, NY: Aldine.

Glucksmann, M., & Lyon, D. (2006). Configurations of care work: Paid and unpaid elder care in Italy and the Netherlands. *Sociological Research Online, 11*(2). doi:10.5153/sro.1398

Gough, I. (2001). Globalization and regional welfare regimes: The East Asian case. *Global Social Policy, 1*(2), 163-189. doi:10.1177/146801810100100202

Griffin, A. P. (1980). Philosophy and nursing. *Journal of Advanced Nursing, 5*(3), 261-272. doi:10.1111/j.1365-2648.1980.tb03351.x

Griffin, A. P. (1983). A philosophical-analysis of caring in nursing. *Journal of Advanced Nursing, 8*(4), 289-295. doi:10.1111/j.1365-2648.1983.tb00328.x

Gu, D., Dupre, M. E., & Liu, G. Y. (2007). Characteristics of the institutionalized and community-residing oldest-old in China. *Social Science & Medicine, 64*(4), 871-883. doi:10.1016/j.socscimed.2006.10.026

Gu, D., & Vlosky, D. A. (2008). Long-term care needs and related issues in China. In J. B. Garner & T. C. Christiansen (Eds.), *Social sciences in health care and medicine* (pp. 51-84). New York, NY: Nova Science Publisher.

Guan, X., Zhan, H. J., & Liu, G. (2007). Institutional and individual autonomy: Investigating predictors of attitudes toward institutional care in China. *International Journal of Aging and Human Development, 64*(1), 83-107. doi:10.1016/j.socscimed.2006.10.026

Gubrium, J. F., & Holstein, J. A. (2002). From the individual interview to the interview society. In J. F. Gubrium & J. A. Holstein (Eds.), *Handbook of interview research: Context and Methods* (pp. 3-32). London, UK: Sage Publications.

He, W., Sengupta, M., Zhang, K., & Guo, P. (2007). Health and healthcare of the older population in urban and rural China: 2000. *International Population Reports*, P95/07-2. Washington, DC: U.S. Census Bureau.

Herd, R., Koen, V., & Reutersward, A. (2010). C*hina's labour market in transition: Job creation, migration and regulation.* (OECD Economics Department Working Papers, No. 749). OECD Publishing. doi:10.1787/5kmlh5010gg7-en

Himmelweit, S. (2005). Can we afford [not] to care: Prospects and policy. Gender Institute New Working Paper 15. Retrieved from http://www.genet.ac.uk/workpapers/GeNet2005p11.pdf

Hirdes, J. P., Fries, B. E., Morris, J. N., Ikegami, N., Zimmerman, D., Dalby, D., … Jones, R. (2001). InterRAI Home Care Quality Indicators (HCQIs) for MDS-HC Version 2.0. Retrieved from http://www.aissystems.com/development/heti/as3/hc/admin/data/printouts/Home_Care_Quality_Indicators.pdf

Hirdes, J. P., Fries, B. E., Morris, J. N., Ikegami, N., Zimmerman, D., Dalby, D., … Jones, R. (2004). Home Care Quality Indicators (HCQIs) based on the MDSHC. *Gerontologist 44*(5), 665-679. doi:10.1093/geront/44.5.665

Hochschild, A. (2000). Global care chains and emotional surplus value. In W. Hutton & A. Giddens (Eds.), *On the edge: Living with global capitalism* (pp. 130-146). London, UK: Vintage.

Hochschild, A. R. (2003). *The managed heart: Commercialization of human feeling*. Berkeley, CA.: University of California Press. (Original work published 1983)

Hong, L., & Kongshøj, K. (2014). China's welfare reform: An ambiguous road towards a Social Protection Floor. *Global Social Policy, 14*(3), 352-368. doi:10.1177/1468018113513914

Howes, C. (2008). Love, money, or flexibility: What motivates people to work in consumer-directed home care? *Gerontologist, 48*, 46-59. doi:10.1093/geront/48.supplement_1.46

Huang, H. T. (2000). Fermentations and Food Science. In J. Needham (Ed.), *Science and Civilisation in China* (Vol 6: Biology and Biological Technology). Cambridge, UK: Cambridge University Press.

Huang, S., Thang, L. L., & Toyota, M. (2012). Transnational mobilities for care: Rethinking the dynamics of care in Asia. *Global Networks, 12*(2), 129-134. doi:10.1111/j.1471-0374.2012.00343.x

Iecovich, E. (2011). What makes migrant live-in home care workers in elder care be satisfied with their job? *The Gerontologist, 51*(5), 617-629. doi:10.1093/geront/gnr048

Ikels, C. (1990). Family caregivers and the elderly in China. In D. E. Biegel & A. Blum (Eds.), *Aging and caregiving: Theory, research, and policy* (pp. 270-284). Thousand Oaks, CA: Sage Publications.

ILO (2009). *Factsheet on domestic workers in China*. Retrieved from http://www.ilo.org/asia/whatwedo/publications/WCMS_114256/lang--en/index.htm

ILO (2013). *Domestic workers across the world: Global and regional statistics and the extent of legal protection*. Geneva, Switzerland: International Labour Office.

Isaksen, L. W. (2005). Gender and care: The role of cultural ideas of dirt and disgust. In D., Morgan, B. Brandth, & E. Kvande (Eds.), *Gender, bodies and work* (pp. 115-126). Burlington, VT: Ashgate.

James, N. (1992). Care = organization + physical labor + emotional labor. *Sociology of Health & Illness, 14*(4), 488-509. doi:10.1111/1467-9566.ep10493127

James, W. (1890). *The principles of psychology*. New York, NY: H. Holt and Company.

Jenson, J., & Saint-Martin, D. (2003). New routes to social cohesion? Citizenship and the social investment state. *Canadian Journal of Sociology, 28*(1), 77–99. doi:10.2307/3341876

Jewell, C. J. (2007). *Agents of the welfare state: How caseworkers respond to need in the United States, Germany and Sweden*. New York, NY: Palgrave Macmillan.

Kahn, R., & Cannell, C. (1957). *The dynamics of interviewing*. New York, NY: John Wiley.

Kaye, L. W. (1986). Worker views of the intensity of affective expression during the delivery of home care services for the elderly. *Home Health Care Services Quarterly, 7*(2), 41-54. doi:10.1300/j027v07n02_05

Kemp, C. L., Ball, M. M., Perkins, M. M., Hollingsworth, C., & Lepore, M. J. (2009). "I get along with most of them": Direct care workers' relationships with residents' families in assisted living. *Gerontologist, 49*(2), 224-235. doi:10.1093/geront/gnp025

Kemper, P., Heier, B., Barry, T., Brannon, D., Angelelli, J., Vasey, J., & Anderson-Knott, M. (2008). What do direct care workers say would improve their jobs? Differences across settings. *The Gerontologist, 48*, 17-25. doi:10.1093/geront/48.supplement_1.17

Kitson, A. (1987). A comparative analysis of lay-caring and professional-(nursing) caring relationships. *International Journal of Nursing Studies, 24*(2), 155-165. doi:10.1016/0020-7489(87)90057-5

Knijn, T., & Kremer, M. (1997). Gender and the caring dimension of welfare states: Toward inclusive citizenship. *Social Politics, 4*(3), 328-361. doi:10.1093/oxfordjournals.sp.a034270

Kofman, E., & Raghuram, P. (2009). The implications of migration for gender and care regimes in the South. Social Policy and Development Programme Paper Number 41. United Nations Research Institute for Social Development. Retrieved from http://oro.open.ac.uk/19811/

Kramer, A., Shaughnessy, P., Bauman, M., & Crisler, K. (1990). Assessing and assuring the quality of home health-care: A conceptual framework. *Milbank Quarterly, 68*(3), 413-443. doi:10.2307/3350112

Leung, J. C. B. (1997). Family support for the elderly in China: Issues and challenges. *Journal of Aging & Social Policy, 9*(3), 87-102. doi:10.1300/j031v09n03_05

Lewis, J. (1992). Gender and the development of welfare regimes. *Journal of European Social Policy, 2*(3), 159-173. doi:10.1177/095892879200200301

Li, L. W., Long, Y., Essex, E. L., Sui, Y., & Gao, L. (2012). Elderly Chinese and their family caregivers' perceptions of good care: A qualitative study in Shandong, China. *Journal of Gerontological Social Work, 55*(7), 609-625. doi:10.1080/01634372.2012.703165

Li, S. (2008). *ILO Working Rural migrant workers in China: Scenario, challenges and public policy,* Paper No. 89, Geneva, Switzerland: Policy Integration and Statistics. Retrieved from http://www.ilo.org/wcmsp5/groups/public/---dgreports/---integration/documents/publication/wcms_097744.pdf

Lin, Y. (1938). *The importance of living*. New York, NY: Reynal & Hitchcock.

Lindhorst, T., & Padgett, J. D. (2005). Disjunctures for women and frontline workers: Implementation of the family violence option. *Social Service Review, 79*(3), 405-429. doi:10.1086/430891

Lipsky, M. (2010). *Street-level bureaucracy: Dilemmas of the individual in public services* (2nd ed.). New York, NY: Russell Sage Foundation. (Original work published 1980)

Lopez, M. (2012). Reconstituting the affective labour of Filipinos as care workers in Japan. *Global Networks, 12*(2), 252-268. doi:10.1111/j.1471-0374.2012.00350.x

Mahmood, A., & Martin-Matthews, A. (2008). Dynamics of carework: Boundary management and relationship issues for home support workers and elderly clients. In A. Martin-Matthews & J. Phillips (Eds.), *Aging and caring at the intersection of work and home life: Blurring the boundaries* (pp. 21-42). New York, NY: Taylor and Francis.

Mahon, R., Anttonen, A., Bergqvist, C., Brennan, D., & Hobson, B. (2012). Convergent care regimes? Childcare arrangements in Australia, Canada, Finland and Sweden. *Journal of European Social Policy, 22*(4), 419-431. doi:10.1177/0958928712449776

Mahon, R., & Robinson, F. (2011). *Integrating the ethics and social politics of care*. In R. Mahon & F. Robinson (Eds.), *Feminist ethics and social policy: Towards a new global political economy of care* (pp. 178-183). Vancouver, BC: UBC Press.

Martin-Matthews, A., & Sims-Gould, J. (2011). My home, your work, our relationship: Elderly clients' experiences of home care services. In C. Benoit & H. Hallgrimsdottir (Eds.), *Valuing care work: Comparative perspectives* (pp. 107-124). Toronto, ON: University of Toronto Press.

Marvasti, A. (2008). Interactional constructionism. In J. A. Holstein & J. F. Gubrium (Eds.), *Handbook of constructionist research* (pp. 315-330). New York, NY: The Guildford Press.

McGhee, G., Marland, G.R., & Atkinson, J. (2007). Grounded theory research: Literature reviewing and reflexivity. *Journal of Advanced Nursing, 60*(3), 334-342. doi:10.1111/j.1365-2648.2007.04436.x

Mead, H. (1972). *Mind, self and society from the standpoint of a social behaviorist*. Chicago, IL: University of Chicago Press. (Original work published 1934)

Meagher, G. (2006). What can we expect from paid carers? *Politics & Society, 34*(1), 33-53. doi:10.1177/0032329205284755

Mears, J., & Watson, E. A. (2008). Boundaries blurred and rigid at the front line of care: Care workers and the negotiation of relationships with older people. In A. Martin-Matthews & J. Phillips (Eds.), *Aging and caring at the intersection of work and home life: Blurring the boundaries* (pp. 147-164). New York, NY: Taylor and Francis.

Mencius, Liang Hui Wang 1 (J. Legge, Trans.). Retrieved from http://ctext.org/mengzi/liang-hui-wang-i

Michel, S., & Peng, I. (2012). All in the family? Migrants, nationhood, and care regimes in Asia and North America. *Journal of European Social Policy, 22*(4), 406-418. doi:10.1177/0958928712449774

Ministry of Human Resources and Social Security of the People's Republic of China (2002). *Yang lao hu li yuan guo jia zhi ye biao zhun* [National Occupational

Standards for Elder Care Workers]. Beijing, PRC: Ministry of Human Resources and Social Security.

Mor, V., Berg, K., Angelelli, J., Gifford, D., Morris, J., & Moore, T. (2003). The quality of quality measurement in US nursing homes. *Gerontologist, 43*(Suppl. 2), 37-46. doi:10.1093/geront/43.suppl_2.37

Morris, L. (2009). Quits and job changes among home care workers in Maine: The role of wages, hours, and benefits. *Gerontologist, 49*(5), 635-650. doi:10.1093/geront/gnp071

Neysmith, S. (1991). From community care to a social model of care. In C. Baines, P. Evans, & S. Neysmith (Eds.), *Women's caring: Feminist perspectives on social welfare* (pp. 272-299). Toronto, ON: McClelland &Stewart.

Neysmith, S., & Aronson, J. (1996). Home care workers discuss their work: The skills required to ''use your common sense''. *Journal of Aging Studies, 10*(1), 1-14. doi:10.1016/s0890-4065(96)90013-4

Neysmith, S., & Nichols, B. (1994). Working-conditions in home care: Comparing three groups of workers. *Canadian Journal on Aging, 13*(2), 169-186. doi:10.1017/s0714980800006000

Nippert-Eng, C. (1996). *Home and work negotiating boundaries through everyday life*. Chicago, IL: University of Chicago Press.

Noddings, N. (2002). *Starting at home: Caring and social policy*. Berkeley, CA.: University of California Press.

Peng, I. (2002). Social care in crisis: Gender, demography, and welfare state restructuring in Japan. *Social Politics, 9*(3), 411-443. doi:10.1093/sp/9.3.411

Peng, I. (2009). The political and social economy of care in the Republic of Korea. (Programme on Gender and Development, Paper No. 6). UNRISD, Geneva, Switzerland. Retrieved from http://mercury.ethz.ch/serviceengine/Files/ISN/111354/ipublicationdocument_singledocument/19eefe79-945c-42f8-8b60-e725695b8a35/en/006.pdf

Piercy, K. W. (2000). When it is more than a job: Close relationships between home health aides and older clients. *Journal of Aging and Health, 12*(3), 362-387. doi:10.1177/089826430001200305

Razavi, S. (2007). The political and social economy of care in a development context: Contextual issues, research questions, and policy options. (Programme on Gender and Development, Paper No. 3). Geneva, Switzerland: UNRISD. Retrieved from http://www.unrisd.org/80256B3C005BCCF9/(httpAuxPages)/2DBE6A93350A7783C12573240036D5A0/$file/Razavi-paper.pdf

Razavi, S., & Staab, S. (2010). Underpaid and overworked: A cross-national perspective on care workers. *International Labour Review, 149*(4), 407-422. doi:10.1111/j.1564-913x.2010.00095.x

Rosenberg, M. (1979). *Conceiving the self*. New York, NY: Basic Books.

Settles, B. H., & Sheng, X. W. (2008). *The one child policy and its impact on Chinese Families*. Retrieved from http://www.hdfs.udel.edu/files/pdf/OneChildPolicy.pdf

Shang, X. (2001). Moving towards a multi-level and multi-pillar system: Changes in institutional care in two Chinese cities. *Journal of Social Policy, 30*(2), 259-281. doi:10.1017/s0047279401006249

Shanghai Bureau of Quality and Technical Supervision (2009). *Specifications for elderly home care services in the community.* Shanghai, PRC: Shanghai Bureau of Quality and Technical Supervision.

Shanghai Bureau of Statistics (2010), *Shanghai Statistical Yearbook 2009*, Shanghai, PRC: Shanghai Bureau of Statistics.

Shanghai Bureau of Statistics (2014). *Shanghai Statistical Yearbook 2013*, Shanghai, PRC: Shanghai Bureau of Statistics.

Shanghai Civil Affairs Bureau (2001). *Guan yu quan mian kai zhan ju jia yang lao fu wu de yi jian* [Opinion on comprehensively developing home care services]. Shanghai, PRC: Shanghai Civil Affairs Bureau.

Shanghai Civil Affairs Bureau (2004). *Jin yi bu tui jin shen hua ju jia yang lao fu wu gong zuo* [Notification on accelerating home care services]. Shanghai, PRC: Shanghai Civil Affairs Bureau.

Shanghai Civil Affairs Bureau (2009). *Guan yu jin yi bu gui fan ben shi she qu ju jia yang lao fu wu gong zuo de tong zhi* [Notification on regulating community and home care services]. Shanghai, PRC: Shanghai Civil Affairs Bureau.

Shanghai Municipal Human Resources and Social Security Bureau (2010). *Ben shi qi ye ge lei ren cai rou xing yan chi ban li shen ling ji ben yang lao jin shou xu de shi xing yi jian*. [Opinion on a flexible arrangement of old age pension for skilled urban workers]. Shanghai, PRC: Shanghai Municipal Human Resources and Social Security Bureau.

Shanghai Research Centre on Ageing (2014a). *2013 nian shang hai shi ren kou he lao ling shi ye jian ce long ji xin xi* [2013 Statistics on the ageing population and services in Shanghai]. Retrieved from http://www.shrca.org.cn/5489.html

Shanghai Research Centre on Ageing (2014b). *Shang hai, 80 sui ji yi shang gao ling lao ren zeng su tu chu* [Shanghai: Rapid increase in population aged 80 and above]. Retrieved from http://www.shrca.org.cn/5600.html

Shutes, I., & Chiatti, C. (2012). Migrant labour and the marketisation of care for older people: The employment of migrant care workers by families and service providers. *Journal of European Social Policy, 22*(4), 392-405. doi:10.1177/0958928712449773

Silverman, D. (1993). *Interpreting qualitative data: Methods for analysing talk, text, and interaction*. London, UK: Sage Publications.

Sims-Gould, J., & Martin-Matthews, A. (2010). Strategies used by home support workers in the delivery of care to elderly clients. *Canadian Journal on Aging, 29*(1), 97-107. doi:10.1017/s0714980809990353

Sipila, J., Anttonen, A., & Baldock, J. (2003). The importance of social care. In A. Anttonen, J. Baldock, & J. Sipila (Eds.), *The young, the old, and the state: Social care systems in five industrial nations* (pp. 1-25). Northhampton, MA: E. Elgar Pub.

Snow, D. A., & Anderson, L. (1987). Identity work among the homeless: The verbal construction and avowal of personal identities. *American Journal of Sociology, 92*(6), 1336-1371. doi:10.1086/228668

Stadnyk, R., Fletcher, S., Eales, J., Fast, J., & Keating, N. (2008). *Employed family/friend caregivers to adults with disabilities: The impact of public policies on caregivers' costs*. Retrieved from

http://www.rapp.ualberta.ca/en/Publications/~/media/3D4F2FEA48B4437FBC856416D0B35E28.pdf

Standing, G. (2001). Care work: Overcoming insecurity and neglect. In M. Daly (Ed.), *Care work: The quest for security* (pp. 15-32). Geneva, Switzerland: ILO.

State Council of the People's Republic of China (2000). *Guo wu yuan ban gong ting zhuan fa min zheng bu deng bu men guan yu jia kuai shi xian she hui fu li she hui hua yi jian de tong zhi* [Circular of the state council on accelerating the socialisation of social welfare]. Beijing, PRC: State Council.

Steinberg, R. J., & Figart, D. M. (1999). Emotional demands at work: A job content analysis. *Annals of the American Academy of Political and Social Science, 561*, 177-191. doi:10.1177/0002716299561001012

Stevenson, D. G. (2006). Nursing home consumer complaints and quality of care: A national view. *Medical Care Research and Review, 63*(3), 347-368. doi:10.1177/1077558706287043

Stone, G. P. (1962). Appearance and the self. In A. M. Rose (Ed.), *Human behavior and social processes* (pp. 86-118). Boston, MA: Houghton Mifflin.

Stone, R. I. (2004). The direct care worker: The third rail of home care policy. *Annual Review of Public Health, 25*, 521-537. doi:10.1146/annurev.publhealth.25.102802.124343

Strauss, A. (1987). *Qualitative analysis for social scientists*. New York, NY: Cambridge University Press.

Strauss, A., & Corbin, J. (1990). *Basics of qualitative research: Grounded theory procedures and techniques.* Newbury Park, CA: Sage Publications.

Strauss, A., & Corbin, J. (1998). *Basics of qualitative research: Techniques and procedures for developing grounded theory*. Thousand Oaks, CA: Sage Publications.

Sun, R. (2002). Old age support in contemporary urban China from both parents' and Children's perspectives. *Research on Aging, 24*(3), 337-359. doi:10.1177/0164027502243003

Tajfel, H. (1974). Social identity and intergroup behaviour. *Social Science Information/Information Sur Les Sciences Sociales, 13*(2), 65-93. doi:10.1177/053901847401300204

Tellis-Nayak, V., & Tellis-Nayak, M. (1989). Quality of care and the burden of two cultures: When the world of the nurse's aide enters the world of the nursing home. *Gerontologist, 29*(3), 307-313. doi:10.1093/geront/29.3.307

The Classic of Filial Piety, Chapter 10 (J. Legge, Trans.). Retrieved from http://ctext.org/xiao-jing

Theodosius, C. (2008). *Emotional labour in health care: The unmanaged heart of nursing*. London, UK: Routledge.

Tronto, J. (1993). *Moral boundaries: A political argument for an ethic of care*. London, UK: Routledge.

Tronto, J. (2006). Vicious circles of privatized care. In M. Hamington & D. C.Miller (Eds.), *Socializing care: Feminist ethics and public issues* (pp. 3-26). Lanham, MD.: Rowman & Littlefield Publishers.

Twigg, J. (2000). Carework as a form of bodywork. *Ageing and Society, 20*(4), 389-411. doi:10.1017/s0144686x99007801

Twigg, J. (2008). Clashing temporalities: Time, home, and the bodywork of care. In A. Martin-Matthews & J. Phillips (Eds.), *Aging and caring at the intersection of work and home life: Blurring the boundaries* (pp. 229-243). New York, NY: Taylor and Francis.

Ucko, L. (1986). Perceptions of aging East and West: Soviet refugees see two worlds. *Journal of Cross-Cultural Gerontology, 1*(4), 411-428. doi:10.1007/BF00118734

Ungerson, C. (1997). Social politics and the commodification of care. *Social Politics, 4*(3), 362-381. doi:10.1093/sp/4.3.362

Ungerson, C. (2005). Care, work and feeling. *The Sociological Review, 53*, 188-203. doi:10.1111/j.1467-954X.2005.00580.x

Ungerson, C., & Yeandle, S. (2007). *Cash for care systems in developed welfare states*. London, UK: Palgrave.

Urquhart, C. (2007). The evolving nature of grounded theory method: The Case of the information systems discipline. In A. Bryant & K. Charmaz (Eds.), *The SAGE handbook of grounded theory* (pp. 339-360). London, UK: Sage Publications.

Vaarama, M., Pieper, R., Frommelt, M., Muurinen S, Sixsmith A, Hammond M., & Ljunggren, G. (2008). The concept of quality of long-term care. In M. Vaarama, R. Pieper, & A. Sixsmith (Eds.), *Care-related quality of life in old age: Concepts, models, and empirical findings* (pp. 102-124). New York, NY: Springer.

Wagner, C., van der Wal, G., Groenewegen, P. P., & de Bakker, D. H. (2001). The effectiveness of quality systems in nursing homes: A review. *Quality in Health Care, 10*(4), 211-217. doi:10.1136/qhc.0100211

Wang, Y., (2011). *Home care for older people in China: A case study of Shanghai* (Doctoral dissertation). Retrieved from The HKU Scholars Hub. (b4587483)

Ward-Griffin, C. (2008). Health professionals caring for aging relatives: Negotiating the public-private boundary. In A. Martin-Matthews & J. Phillips (Eds.), *Aging and caring at the intersection of work and home life: Blurring the boundaries* (pp. 1-20). New York, NY: Taylor and Francis.

Warren, C. (2012). Interviewing as Social Interaction. In J. Gubrium, J. Holstein, A. Marvasti, & K. McKinney (Eds.), *The SAGE handbook of interview research: The complexity of the craft* (2nd ed., 129-143). Los Angeles, CA: Sage Publications.

Werner, R. M., & Konetzka, R. T. (2010). Advancing nursing home quality through quality improvement itself. *Health Affairs, 29*(1), 81-86. doi:10.1377/hlthaff.2009.0555

Westhues, A. (2006). Becoming acquainted with social policy. In A. Westhues (Ed.), *Canadian social policy: Issues and perspectives* (4th ed., pp. 5-26). Waterloo, ON: Wilfrid Laurier University Press.

Whyte, M. K., & Qin, L. (2003). Support for aging parents from daughters versus sons. In M. K. Whyte (Ed.), *China's revolutions and intergenerational relations* (pp. 167–95.). Ann Arbor, MI: Center for China Studies, University of Michigan.

Williams, F. (2001). In and beyond new labour: Towards a new political ethics of care. *Critical Social Policy, 21*(4), 467-493. doi:10.1177/026101830102100405

Williams, F. (2010). Migration and care: Themes, concepts and challenges. *Social Policy and Society, 9*(3), 385-396. doi:10.1017/S1474746410000102

Wong, L. (2008). The third sector and residential care for the elderly in China's transitional welfare economy. *Australian Journal of Public Administration, 67*(1), 89-96. doi:10.1111/j.1467-8500.2007.00571.x

Wu, B., Carter, M. W., Goins, R. T., & Cheng, C. (2005). Emerging services for community-based long-term care in urban China: A systematic analysis of Shanghai's community-based agencies. *Journal of Aging & Social Policy, 17*(4), 37-60. doi:10.1300/j031v17n04_03

Xu, Q. W., & Chow, J. C. (2011). Exploring the community-based service delivery model: Elderly care in China. *International Social Work, 54*(3), 374-387. doi:10.1177/0020872810396260

Yangpu District Bureau of Statistics (2010). *Shang hai shi yang pu qu 2010 nian di liu ci quan guo ren kou pu cha zhu yao shu ju gong bao* [Communiqué on the 2010 6th National Census for Yangpu District]. Retrieved from http://tjj.shyp.gov.cn/Pages/DeailsInfo.aspx?InfoId=64817

Yangpu District Bureau of Statistics (2013). *2013 nian shang hai shi yang pu qu guo min jing ji he she hui fa zhan tong ji gong bao* [2013 communiqué on statistics on economic and social development of Yangpu district]. Retrieved from http://tjj.shyp.gov.cn/Pages/DeailsInfo.aspx?InfoId=101016

Yao, Y. (2014). The Lewis turning point: Is there a labour shortage in China? In S. Fan, S. Kanbur, S. Wei, & X. Zhang (Eds.), *Oxford Companion to the Economics of China (pp. 388-392).* Oxford, UK: Oxford University Press.

Yeates, N. (2004). Global care chains. *International Feminist Journal of Politics, 6*(3), 369-391. doi:10.1080/1461674042000235573

Yeates, N. (2012). Global care chains: A state-of-the-art review and future directions in care transnationalization research. *Global Networks, 12*(2), 135-154. doi:10.1111/j.1471-0374.2012.00344.x

Zavoretti, R. (2006). Family-based care for China's ageing population: A social research perspective. *Asia Europe Journal, 4*(2), 211-228. doi:10.1007/s10308-006-0060-8

Zeng, Y., & Wang, Z. (2003). Dynamics of family and elderly living arrangements in China: New lessons learned from the 2000 census. *China Review, 3*(2), 95-119.

Zhan, H. J. (2002). Chinese caregiving burden and the future burden of elder care in life-course perspective. *International Journal of Aging and Human Development, 54*(4), 267-290. doi:10.2190/gyrf-84vc-jkck-w0mu

Zhan, H. J. (2004). Willingness and expectations: Intergenerational differences in attitudes toward filial responsibility in China. *Marriage & Family Review, 36*(1-2), 175-200. doi:10.1300/j002v36n01_08

Zhan, H. J. (2005). Aging, health care, and elder care: Perpetuation of gender inequalities in China. *Health Care for Women International, 26*(8), 693-712. doi:10.1080/07399330500177196

Zhan, H. J., Feng, X., & Luo, B. (2008). Placing elderly parents in institutions in urban China: A reinterpretation of filial piety. *Research on Aging, 30*(5), 543-571. doi:10.1177/0164027508319471

Zhan, H. J., Liu, G., Guan, X., & Bai, H. G. (2006). Recent developments in institutional elder care in China: Changing concepts and attitudes. *Journal of Aging & Social Policy, 18*(2), 85-108. doi:10.1300/j031v18n02_06

Zhan, H. J., & Montgomery, R. (2003). Gender and elder care in China: The influence of filial piety and structural constraints. *Gender & Society, 17*(2), 209-229. doi:10.1177/0891243202250734

Zhang, X., Yang, J., & Wang, S. (2011). China has reached the Lewis turning point. *China Economic Review, 22*(4), 542-554. doi:10.1016/j.chieco.2011.07.002

Zhang, Y., & Goza, F. W. (2006). Who will care for the elderly in China? A review of the problems caused by China's one-child policy and their potential solutions. *Journal of Aging Studies, 20*(2), 151-164. doi:10.1016/j.jaging.2005.07.002

Zhang, Y., & Wildemuth, B. (2009). Unstructured interview. In B. Wildemuth (Ed.), *Applications of social research methods to questions in information and library science* (pp. 222-231). Santa Barbara CA: Libraries Unlimited.