Bridging Policy and Research in Eldercare

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RÉSUMÉ

On a vu surgir un nouveau paradigme de soins continus qui repose sur des postulats quant aux avantages du partage des soins et de la prestation de soins axés sur le client. Ces postulats situent carrément la corrélation entre les soins structurés ou non au programme des objectifs. Les auteurs décrivent la façon dont la recherche actuelle peut enrichir le débat engendré par le nouveau paradigme et proposent une recherche éventuelle alimentée ce même paradigme. Ils affirment que la théorie constitue un outil important d'explicitation du programme des objectifs et font appel à la théorie de l'écologie humaine pour illustrer le développement de la recherche en regard de l'élaboration des politiques. Enfin, ils décrivent les obstacles à franchir pour que la politique et la recherche s'enrichissent l'une l'autre.

ABSTRACT

A new paradigm for continuing care policy has emerged that is based on assumptions about the benefits of caring partnerships and client-centred care delivery. Such assumptions place the interface between formal and informal care squarely on the policy agenda. The authors describe how existing research can contribute to the debate stimulated by the new policy paradigm and suggest future research that is informed by the paradigm. They argue that theory is an important tool to make policy agendas more explicit and they use human ecology theory to illustrate how theory can frame the development of research to address policy. Finally, they describe barriers to be overcome in order for policy and research to inform one another.

Introduction

In this paper we argue that: (1) a new paradigm for continuing care policy has emerged, a paradigm that places the interface between formal and

informal elder care squarely on the policy agenda; (2) while existing research has much to offer the debate stimulated by the new policy paradigm, future research that is informed by the new policy paradigm is needed; (3) there are barriers which must be overcome if eldercare policy and research are to inform one another; and (4) that theory can frame the development of research to address policy.

Fuelled by population aging, federal and provincial deficits, and changing social expectations regarding responsibilities for eldercare, the provision of health care for an aging population has become a key policy issue of the 1990s. In the current socio-economic climate there are many incentives for reducing formal support and placing more of the responsibility for meeting seniors' needs on the shoulders of informal caregivers. Yet, evidence that families and friends already provide extensive support to seniors and are becoming increasingly stressed because of their caregiving activities, suggests that we may already have reached a threshold with respect to how much support informal caregivers can provide (Finch, 1986; Hansson et al., 1990). At the same time, current trends such as the rapid growth of the oldest segment of the elderly population, higher divorce rates, lower fertility rates, and increased female labour force participation are likely to combine to further reduce the capacity of the informal system to meet the growing demand for such assistance. A careful examination of the place of informal support as it relates to social policy is critical.

The Eldercare Policy Environment

Social policies reflect the value systems and societal structures of the society in which they are developed (Brooks, 1993). Value systems are not static, but evolve along with changes in contexts. Values about the provision of eldercare have changed dramatically during this century. These changing values provide the backdrop for our discussion of paradigms which frame contemporary eldercare policy.

The early part of this century was typified by the view that seniors should be cared for by family members. According to Eichler (1988, p. 381), social policies of the time were "characterized by very limited local responsibility for the poor and indigent". Society assumed responsibility only when the family's resources were exhausted. Assistance, it was believed, "fosters indolence and dependency" (p. 381). This emphasis placed on family care emerged from a rural tradition of small, closely knit communities that had few formal health services (Keating, 1991). Family members were highly interdependent because geographic mobility was low, extended family members lived in close proximity to each other, and there were few alternatives to informal family care for seniors.

By mid-century, a system of formal care for seniors had developed. During this period, the professionalization of eldercare occurred in the context of placing greater value on public responsibility for all citizens and the development of Canada's "social safety net" (Clark, 1993; Eichler, 1988). Resi-

dential care for frail seniors was part of this context. Such residences were often called nursing homes and the seniors living there were referred to as patients. For the most part, services were provided by health professionals with technical expertise. A major emphasis, in nursing home care, was placed on meeting the needs of the very ill (Chappell, 1993). While families were still viewed as the ideal source of support for seniors living in the community, they were not major players in either the planning or provision of care to seniors in residential care.

The 1990s view is that care by family members is ideal (Schwenk, 1993). Much of the mid-century development of professional residential care for seniors is now viewed as having resulted in an undesirable combination of the medicalization of aging and separation of frail seniors from their families and communities (Alberta Health, 1993; National Advisory Council on Aging (NACA, 1992). In response to growing dissatisfaction with this approach, there is an increasing emphasis on keeping seniors in the community and helping them maintain connections with their informal networks because the latter are seen as most responsive to their needs. In this new view, residential care occurs within the community where an attempt is being made to make the interface between institutions and communities more open (Alary, 1990).

Personal autonomy of seniors is also a contemporary value. According to Clark (1993) Canadians have a particular approach to enhancing autonomy. He argues that government initiatives such as the Seniors Independence Research Program embody "specific collectivist principles in their approach to supporting the quality of life of older persons by emphasizing the essential interdependence of the elderly in defining their needs and how to meet them . . . Personal autonomy is enhanced not by appealing to individualism but rather by developing collective solutions to pressing community problems" (p. 491). Eichler views this set of collectivist principles as a "social responsibility model" in which society assumes responsibility for adults who are unable to meet their own needs "for reasons of accident, sickness, old age, or mental or physical handicap" (Eichler, 1988, p. 150).

The new policy paradigm of care for frail seniors emerges from this contemporary value stance concerning eldercare. The paradigm has two basic tenets of "caring partnerships" and "client-centred" care. According to the first tenet, the best care emerges from "caring partnerships," a collaborative effort in which services are provided by people with varying informal and formal relationships to a senior. Caring partnerships represent a shift from earlier beliefs that either family members or paid professionals were best suited to provide care to seniors, depending on the setting.

The value placed on caring partnerships is evident in federal and regional policy and goal statements. For example, the National Advisory Council on Aging has stated that the success of care to seniors is largely dependent on the interaction and co-ordination of caregivers (NACA, 1992). Alberta Health, in a recent statement regarding continuing care, identified two types of partnerships: collaborative service arrangements among commu-

nity agencies and facility-based services; and partnerships between clients, family members and formal service providers. "Individuals and families (are) recognized as partners in developing a service plan, and in the planning and evaluation of programs, policies and services" (Alberta Health, 1993, p. 12).

The second tenet of the new policy paradigm is that care should be client-centred. This represents a shift away from seniors as patients who were expected to be relatively passive recipients of services provided by those with professional expertise. In contrast, "seniors as clients" are expected to "negotiate the amount of risk they are prepared to accept, taking a more active role in deciding what services they will receive and how and when they will receive these" (Alberta Health, 1993, p. 8). Clients now are seen as partners in caring and as primary decision-makers regarding seniors' care.

The new paradigm appears to reflect current values of supporting families and other informal caregivers in their attempts to provide care to frail seniors and of empowering seniors to control the amount, type and mode of delivery of eldercare services. Thus the interface between formal and informal care is the cornerstone of the new paradigm in which clients, family and friends, collaborate with a variety of paid workers to provide the array of services required by the client. The client-centred approach provides evidence of at least an implicit recognition of agency on behalf of the older person. This is a welcome advance when compared to the past tendency to treat older persons as dependent and passive individuals who merely react to various situations imposed by circumstances or others.

However, the new paradigm also carries a subtext, a different set of beliefs which arise from the press of "demography and dollars" (Keating, Kerr, Warren, Grace, & Wertenberger, 1994). The aging of the population, especially among those over age 80, and the upcoming retirement of the baby boom generation have led to concerns about Canada's ability to continue to provide formal services to a growing number of Canadian seniors (Chappell, 1993). Thus, the subtext of the new paradigm is the belief that the amount of public support previously provided to frail seniors is no longer affordable, and that more responsibility for eldercare must be carried by informal caregivers and by seniors themselves. Such a subtext could play out in this new policy paradigm, with its emphasis on partnerships and client-centredness, by shifting even more responsibility for meeting seniors' needs from formal caregiving partners to the client and informal caregiving partners.

Evidence of this subtext comes from two sources. The first is provincial and regional business plans in which shifting the locus of care to the community is advocated, with the desired result of reducing the residential care population and making remaining residential care arrangements more community oriented by involving professionals, volunteers, family members and friends. In British Columbia, partnership serves as one of the four basic principles of the government's health policy (Province of British Columbia,

1993). This client-centred and partnerships-oriented model of community care is seen as better and cheaper than residential care. More than a decade ago, Rimmer (1983, p. 132) articulated this issue. "Community care is seen as both preferable in terms of the quality of life it can provide in contrast to that in residential provision, but it is equally often justified on the grounds that the cost of community care services are [sic] less than those of equivalent institutional provision."

The second source of evidence of this subtext is the reduction in the amount of government support to formal and institutional eldercare services in the absence of a concurrent infusion of money into the community/informal sector (Chappell, 1993; Evans, 1994). In combination, these two moves seem destined to reduce the ability of the formal sector to participate in caring partnerships while increasing expectations regarding participation of other partners, including informal caregivers, volunteers and clients themselves.

The ways in which the "partnerships and client-centred" paradigm will be played out seem to be in place. A key question is whether the new approach will lead to more responsive care to clients who take part in care decisions within partnerships responsive to their individual needs or whether "client-centred" care is really a metaphor for increased individual and family responsibility with little formal support.

How Can Existing Research Inform the New Policy Paradigm?

One way to build bridges between research and policy is to allow existing research on eldercare to inform ongoing policy reform. By viewing research through new lenses, guided by new assumptions of client-centredness and partnerships, we may arrive at a better understanding of the efficacy of the new policy paradigm for Canadian seniors, their informal caregivers, and the public. Reinterpreting prior research in this way may also help us to identify as yet unidentified gaps in knowledge and so inform the agenda for future research.

Two examples of how current theory and research findings can be applied to assessing the costs and benefits of implementing the new paradigm. The first is related to the interface between formal and informal care. Theories about the interaction between formal and informal caregivers can shed light on the ways in which caring partnerships are likely to operate under the new policy regime. The second example is the insight from the literature on self-care by frail seniors regarding how policy might influence seniors' involvement in their own care.

The Interface Between Formal and Informal Eldercare
The mid-century tradition in Canada of segregating residential eldercare (provided mostly by health professionals), from community eldercare (provided mostly by family and friends), is reflected in a largely segregated literature about the nature of formal and informal care (Chappell & Bland-

ford, 1991). However, a small body of theory and research is emerging in which the relationship between informal and formal care is addressed specifically. A critical analysis of this body of literature helps clarify the partnerships paradigm in two ways: it provides a history of assumptions about the nature of formal-informal caring partnerships; and it provides evidence that ideology can be more powerful than data (and that the subtext may be more important than the text).

In the past two decades, two very different theories about the relationship between formal and informal care have evolved. According to one school of thought, formal and informal care are competitive and potentially overlapping and formal care is considered to be a substitute for informal care. The assumption is that if formal care is available, informal caregivers will withdraw or reduce their participation in caregiving (Chappell & Guse, 1989). This model is congruent with the contemporary argument that the reduction in public expenditure on formal eldercare services will benefit seniors (and taxpayers) by increasing informal sector involvement in care (Alberta Health, 1995).

In contrast, formal and informal care are viewed by some as relatively distinct and independent forms of care that are complementary to one another (Chappell & Guse, 1989). This complementarity may take two forms. Formal and informal caregivers may "specialize" with respect to the types of tasks they perform for seniors, with the formal system providing more technical services requiring specialized training, while emotional support and less technical activities such as household work are the province of the informal system (Cantor, 1991). Alternately, formal and informal care may be complementary if informal care is the preferred "first line of defense" and formal care is sought only when informal support is absent or no longer adequate (Chappell & Guse, 1989). This model could be the one that is most true to the spirit of the partnerships assumption, that elders will be best served by co-operative arrangements among formal and informal caregivers, as long as formal care is available before informal resources are exhausted.

Empirical findings may be interpreted as providing some support for both of these models. For example, family caregivers who are receiving high levels of formal support are more likely to institutionalize relatives with Alzheimer's disease than those receiving lower levels of formal assistance (Keating & Willoughby, 1991). This finding could be interpreted as supporting the argument that informal caregivers will reduce their involvement in caring if formal assistance is readily available. Thus, from a public expenditure perspective, the best "partnership" model would be one in which little or no formal support is available. However, findings from the same study show that, over most of the process of the disease, family caregivers were caring alone and called on formal assistance only when stretched beyond their caring capacity. Thus, ongoing formal support could allow informal caregivers to allocate their caring resources over longer periods of time, a scenario more consistent with the notion that formal and informal care are

complementary.

Other research seems to support the theory that formal and informal care are complements to rather than substitutes for one another. There is, for example, ample evidence that the vast majority of assistance received by seniors is provided by informal caregivers, even when the senior is also receiving care from the formal system (Hanley, Wiener, & Harris, 1991; Stone, 1991). Others have failed to demonstrate either a cross-sectional correlation between the use of formal and informal services (Chappell, 1987) or, in longitudinal research, that informal caregivers abandon their responsibilities when formal services are added to the mix of help being provided to seniors (Connidis, 1989).

On the contrary, there is evidence that informal caregivers who are providing high levels of assistance in the absence of formal support, reduce their caregiving over time (Gottlieb, 1991). The evidence also suggests that formal care is a last resort, sought only when informal caregivers are no longer able to meet all of the senior's needs, either because their own human and material resources are exhausted or because the senior's needs have increased to the point where they exceed the capacity and/or expertise of informal caregivers (Walker, 1991; Keating & Willoughby, 1991). Moreover, research has shown that the provision of formal care can actually prolong the provision of informal care and/or delay institutionalization of an elder (Defriese & Woomert, 1992; Tilson & Fahey, 1990).

On balance, the available evidence for over a decade has offered better support for the complementarity of formal and informal care than for the notion that they are substitutes. It "countermands the policy position that increasing the availability of formal services will encourage families to relinquish their caregiving role" (Noelker & Bass, 1995, p. 362). Yet the substitution model seems well ingrained into current ideologies about the interface between formal and informal care (see, e.g., Alberta Health, 1989). At least at the political level, there appears to be a rejection by policy-makers of scientific evidence about caring partnerships.

Client's Involvement in Care
Research on clients' self-care is related, for the most part, to clients' ability to manage day to day activities on their own. Much of this literature is focussed on services required to support seniors who cannot function independently (Fast, Keating, Oakes, & White, 1994). This research has been useful in targeting those seniors who may need some assistance from others. In fact, functional status has long been viewed as one of the major criteria which determine eligibility for continuing care (Mahurin, DeBettignies, & Pirozzolo, 1991).

One of the shortcomings of this research in informing the "client-centred" paradigm is that less attention has been paid to how clients are proactive in managing their own care. Most research on "self-care" has been on activities of daily living. A major assumption of this research has been that if a senior can no longer do a task, he/she is dependent, since others

must provide that task or service (Chappell & Havens, 1985). Thus, eldercare traditionally has been seen as services provided to those who cannot do tasks for themselves (Fast et al., 1994).

If the definition of self-care is broadened to include control over decisions regarding care, other research literature can be used to help understand clients' involvement in caring partnerships. For example, Timko and Moos (1989) have found that clients will have better outcomes if they have more control over care decisions. Similarly, Keating, Fast, Harlton and Oakes (1996) found that control over decisions about services received and the manner in which services are delivered is a critical determinant of seniors' independence. In fact, seniors reported that having no control over decisions about how those tasks got done was more likely to make them feel dependent than being unable to do a task themselves. These findings suggest that clients can be partners in caring by influencing the services provided to them. Ultimately, such findings could be used to support an argument for close involvement of seniors during both the development and implementation phases of eldercare policy reform.

These research findings support the assumption that client-centredness in delivery of eldercare services is a desirable goal. Findings also have implications for how a client-centred approach should be implemented. For example, involving clients in the design of service delivery programs is more likely to result in programs that meet needs as clients perceive them. Similarly, allowing individual clients to determine to the greatest extent possible, what services will be provided to them, by whom and in what way is likely to result in better outcomes for clients.

In sum, existing research on the formal-informal interface and on client-centred care provides substantial evidence for the new policy paradigm. Yet this evidence appears not to be reflected in policy implementation. For example, the reduction in funding to formal health care has led to increased caregiving demands on informal caregivers. This suggests either that the ideology driving current policy implementation corresponds more closely to what we have called the "subtext" – which is that more responsibility for eldercare must be carried by informal caregivers and by seniors themselves. Alternately, policy-makers do not look to the research literature to inform policy decision-making.

How Can Researchers Be Responsive to the New Policy Paradigm?

Policy-makers rarely are explicit about the values, beliefs or assumptions that guide their decisions. In the context of this discussion, this means that there is lack of clarity about whether the "text" or "subtext" best describes current eldercare policy. As a result, researchers lack the necessary structure, common language and clarity with respect to concepts and relationships among concepts that are necessary to design and execute policy-relevant research. We are thus hampered in our efforts to assess the

efficacy of existing paradigms and to develop alternate paradigms as values, beliefs and assumptions change. Both tasks are important to fostering research-policy links. In searching for structure, language and conceptual clarity, researchers typically turn to theory. Making the implicit explicit in this way is one important contribution researchers can make toward bridging the gap between research and policy.[1]

Toward Conceptual Frameworks for Future Research on Eldercare Policy
When doing policy-relevant research, the assumptions of the theory selected to frame the research must be consistent with the assumptions of the policy being investigated. We have described the current eldercare policy paradigm as characterized by assumptions about the benefits of caring partnerships and client-centred service delivery. In pursuing research intended to inform policy based on these assumptions, we require a theoretical framework that helps to clarify the concepts of "partnerships" and "client-centredness" and to visualize the nature of caring partnerships and the factors likely to influence those partnerships. There are a variety of frameworks suitable to this purpose, each of which might lead to different kinds of conlusions about the appropriate policy agenda. In the following section of the paper we demonstrate that human ecology is one such compatible theory and we illustrate how it can be used to frame a research agenda that informs the new policy paradigm.

The focus of human ecology theory is on the context in which people live their lives. A basic assumption of human ecology theory is that individuals influence and are influenced by these contexts or environments in which they live. Thus, individuals are both actors and reactors (Bristor, 1990). Individuals are in direct interaction with some of these contexts or environments, often called the near environment. Typically these environments include the physical setting in which people live and the individuals with whom they are most involved on a daily basis. Interactions with other environments are less direct. These more distant environments include societal institutions such as work, school and government (Bubolz & Sontag, 1993).

An ecological model of the eldercare environment would have three key contexts: the client, the client's caring environment and the more distant policy environment. In keeping with the new paradigm, clients are placed at the centre of the model. The focus is on clients' quality of life which is "the extent to which basic needs are met and values realized" (Bubolz & Sontag, 1993, p. 437). Quality of life is a product of the client's interactions with the caring environment and with the policy environment from which eldercare policies and programs emerge. Agency on behalf of the older person is assumed.

The caring environment comprises people who provide services to the client. These include members of the formal and informal sectors who interact with the client in order to meet his/her needs. The boundary between the client and the caring environment is permeable, because the

client also is part of the caring environment. The explicit focus of such a conceptualization on the interaction of caring partners can produce advances in policy based on assumptions of partnerships and client-centredness, and in research that can inform such policy.

The policy environment forms the outer ring of the model. This environment includes the value system from which policies and programs are developed. Such a conceptual model thus requires the explicit exploration of values and ideologies that shape policy and research. The model's emphasis on interaction encourages closer attention to how the values or ideologies of today's society shape institutions such as formal and informal support systems, and to how the older person or client, and his or her caring environment influence, and are influenced by, current policies.

The ecological framework has several implications for both research and policy development regarding eldercare. Three major new areas of enquiry fall logically from the framework. The first is to clarify concepts which are fundamental to the new paradigm. The second is to determine the nature of caring partnerships. The third is to explore ways of understanding whether services are client focussed. The framework also requires new research approaches and methodologies that will more fully inform the current policy debate.[2]

New Research to Clarify Basic Concepts
The ecological framework identifies new concepts basic to eldercare policy that is evolving from the new policy paradigm and motivates some rethinking of more established concepts. Two of these concepts are discussed here to illustrate the importance of ongoing conceptual clarification: eldercare and the costs of eldercare.

Perhaps most basic to research related to eldercare policy is the concept of eldercare itself. An holistic view of care provided by a set of partners requires a set of shared meanings about what is meant by care. Several researchers have expressed a need for clearer conceptualization of eldercare. For example, Cantor (1991, p. 344) believes "the term is used indiscriminately to include a wide variety of populations, degrees of disability, and types of assistance," while Neysmith (1991, p. 273) sees a "segmented, fractured discussion of caring". They believe that lack of conceptual clarity limits theory building and social policy deliberations and results in policymakers, academic disciplines, and service professionals using different language and contrasting theoretical frameworks for analysing the issues.

Researchers frequently conceptualize caregiving in terms of specific tasks provided to an elder (Abel, 1990). By analysing the chores that caregivers perform, researchers have demonstrated that caregiving is labour-intensive and includes endeavours previously dismissed as routine domestic activities (Abel, 1990). However, researchers do not always agree on the categories of tasks (Stone, Cafferata, & Sangl, 1987), making it difficult to compare across studies and across stakeholders who have differing views of tasks as essential or peripheral.

If researchers are to help inform policy concerning eldercare and develop methods to gather data provided to clients by a variety of caring partners, there must be a consistent definition of what tasks and services are included in the "eldercare basket". Recent findings from a focus group study involving the full spectrum of caregiving partners (seniors, informal caregivers, volunteers, formal care providers and policy-makers) illustrate how concepts can be redefined in light of ecological assumptions about eldercare partners. Keating, Fast, Harlton and Oakes (1996) found agreement among partners that eldercare consists of a set of tasks and services that help maintain or enhance seniors' independence. However, the partners' opinions on which tasks were essential differed. For example, while federal policy-makers believed that personal care is the most important eldercare task, seniors thought that housework and household maintenance were most important in maintaining independence.

These findings suggest that the operational definition of eldercare must be made explicit even if it differs depending upon the empirical or policy question being addressed. For example, if the goal is to determine whether informal partners are substitutes for formal partners, a set of tasks defined by formal caregivers might be most appropriate. If the goal is to determine whether services are client-centred, seniors' lists of tasks might be chosen.

A second concept requiring clarification is that of the costs of eldercare. Costs traditionally have been evaluated in a sector-specific manner. Thus, economic costs are usually measured for public sector expenditures on formal eldercare (Berk & Chalmers, 1981; Federal/Provincial/Territorial Working Group on Home Care, 1990) while psychological costs, often conceptualized as caregiver burden, are more often measured for informal caregivers (Parker, 1990).

The new ecological framework requires an acknowledgment of all of the costs to members of caring partnerships. Valuing economic costs across all caring partners is an essential component of the evaluation of the cost effectiveness of the new paradigm. Recent work on the development of a taxonomy of costs associated with informal caregiving shows that all stakeholders experience costs when family and friends take on eldercare responsibilities, but that a different set of costs are likely relevant for different stakeholders (Fast, Keating, Williamson, & Oakes, 1997).

There are economic costs associated with the caring work of each of the partners. Although we have good methods to evaluate the economic costs of formal care, there has been less work in the valuing of the costs of informal care. Yet informal caregivers have several categories of expenses. These include out of pocket expenses associated with the purchase of goods and services for the senior (Collins & Stommel, 1991; Muurinen, 1986) and employment related expenses such as reducing hours of work in order to provide eldercare (Scharlach, Lowe, & Schneider, 1991). Clearly, it is necessary to calculate the economic value of services of all the caring partners in order to determine the circumstances under which caring partnerships are cost-effective. Informal care is not free (Wood, 1991).

The work of Fast, Keating, Williamson and Oakes (1997) illustrates how the costs of caring partnerships can be calculated. They have described costing methods for services from all partners relying largely on adaptation of techniques from other disciplines. Techniques for estimating the value of unpaid work which have been developed by household production economists, are used to determine the economic value of eldercare services provided by unpaid caring partners. As well, methodologies commonly used by labour economists are being adapted to the measurement of employment-related costs incurred by informal elder caregivers. Initial results support the usefulness of such adaptations and suggest the importance of measuring characteristics and consequences of caregiving partnerships.

New Research on Partnership
One of the more important characteristics of the ecological framework is its holistic view of the eldercare environment. It removes the focus of attention from the caregiver-care-receiver dyad and provides a framework for investigations aimed at identifying the caring partners, the caring partners' roles in meeting seniors' needs, and how caring is done in a particular policy environment. As well, it provides a framework for investigating within-environment questions, such as how the circumstances and actions of one caring partner affect those of other partners. Placing the client at the centre explicitly acknowledges the client-centred assumption of the new paradigm and prompts such questions as how various caring partnerships affect clients' quality of life.

There are several ways in which questions about the nature of the partnerships within the caring environment might be addressed in order to better inform policy concerning caring partnerships. One approach is to track all services provided by a group of service providers to a set of target clients in a variety of circumstances.[3] Findings from this type of partnership enquiry can address policy questions about the interface between formal and informal caregivers. They will provide information on circumstances in which there are different amounts of services provided by paid and unpaid caregivers, on the relationship between distribution of eldercare responsibility and outcomes for various partners, and on the limits of resources in the paid and unpaid sectors.

One of the most important changes in mind set required under the current policy paradigm of caring partnerships and client-centred care is the notion that seniors are partners in meeting their needs. The assumption of "client as partner" requires methods that will assess clients' involvement in their care along with the involvement of other caring partners. This requires broadening measures from clients' involvement in ADL tasks to all services which are considered part of eldercare.

A second approach is to explore beliefs about caring responsibilities. An understanding of how caring partners respond to the policy agenda is critical to the implementation of policies that assume the existence of such partnerships. There are important questions that need to be asked about the

reaction of each of the partners to the new paradigm. If families face new limits on their ability to care for their older members, do they assign caring responsibility to other members of the caring environment? Do formal caregivers with increasing responsibilities see client and family partners as responsible for many tasks, or do they worry about loss of their professional caregiving role and thus assign major caring responsibility to themselves? Do clients living in residential settings assign a high level of responsibility to other caring partners, absolving themselves of responsibility? Do clients who enter programs such as assisted living, assign higher levels of responsibility to themselves when service contracts are an explicit part of the care plan?

An analysis of staffing patterns in continuing care facilities and in community organizations can provide data about the magnitude of caring capacity within the formal sector. There have been two recent changes in staffing in many parts of the country. Declining budgets have required reductions in the number of employees in many organizations. As well, in many jurisdictions there has been a shift from professional staff to multi-skilled workers who are expected to provide a broad range of eldercare services (Kane et al., 1990). The proposed theoretical framework suggests a need to investigate the implications of these changes for other caregiving partners and for client outcomes.

Parallel questions can be asked about the implications of changes in family circumstances and relationships for other caring partners and for client outcomes. For example, what is the impact of the increased incidence of seniors living alone in the community and of declining fertility rates on the distribution of responsibility for elder care among caring partners? Recent research on siblings indicates that they are more likely to provide support to those without a spouse or children (Connidis, 1994). Further, the sibling tie is characteristically different from that between spouses or between parents and children, so siblings are likely to take on a different role in the caring partnership. Yet, this is an informal network tie that rarely receives much attention because of an emphasis on a narrow set of potential family caregivers, especially spouse and children.

This approach to the study of caring partnerships has several clear advantages. It can defuse the potentially divisive debate between researchers and policy-makers about whether families are doing enough. This can be accomplished in several ways. It can provide the first comprehensive assessment of all services provided to clients. It can reduce the need to categorize caregivers into formal and informal sectors. This is important in an era in which the boundaries between formal and informal care are being blurred. For example, in some jurisdictions family members may be paid to provide services to a relative and people are taking seniors into their homes in adult foster care but are not being paid for the time they spend caregiving. Such a research agenda acknowledges the assumption of the client as an active partner.

New Research that Is Client-centred
The client-centred focus of the new paradigm brings client outcomes to the forefront in eldercare policy and program development. However, the ecological assumption of individuals as both actors and reactors also requires a shift in focus from traditional outcome measures in which seniors tended to be viewed as patients who received services aimed at maintaining their health and functional status. From this perspective, successful patient intervention was best assessed through measurement of outcomes such as clients' physical health and functional status. In contrast, a "client" is someone who chooses a set of services to enhance or maintain quality of life. Thus assessment of positive outcomes for a client would emphasize satisfaction with services received and quality of life as perceived by the client.

The shift toward more person-centred approaches requires an increased awareness of the attitudes and beliefs of the client or consumer. If programs are client focussed, clients presumably choose whether to enter a residential program or to remain in the community. For those who choose residential care, satisfaction with the services provided and the manner in which they are provided may be paramount to their continuation in the program. There has been little assessment of consumer satisfaction within the new "client-centred" paradigm. However, there has been a long tradition of development of consumer satisfaction theory and instruments outside of the field of population aging. This is an area in which cross-disciplinary research would greatly benefit the development of new outcome measures in service to seniors.

The ecological assumption of "client as actor" needs to be tested in the context of client-centred services. Clients who are involved in care decisions are in a position to influence the type and quality of services they receive. As well, beliefs about opportunities for mastery of their environment may also be a good indicator of client-centred care. Whether residents believe that they are encouraged to be self-sufficient, that they can influence the rules and policies of the facility if they are in residential care, or that they know what to expect, can all be seen as indicators of a setting in which clients believe they can influence their care.

These new research questions are informed by the new paradigm which we have made explicit through the human ecology theoretical framework. Other frameworks might lead to somewhat different approaches to addressing the paradigm. However, from a research perspective, the best way to inform the new paradigm is through the use of theory to make implicit assumptions explicit.

Barriers/Facilitators to the Research-Policy Connection

The approaches to research described above can provide solid information concerning the efficacy of the new paradigm and provide the impetus for redefining the paradigm. However, the actual contributions of this and other research to policy depend on numerous factors. Some of the issues that can

facilitate or hinder the contribution of research to policy include: the timeliness of research findings; the willingness of researchers and policy-makers to work at the interface; and the availability of resources to allow researchers to ask the right questions.

Making Timely Connections

The timeliness of research can have a powerful influence on the effectiveness of the research-policy connection. Policy-makers often criticize academic research as cumbersome and time-consuming. A typical view is that by the time we know the answer, the question is obsolete. Such a view is not without merit. The demands of academic standards for research, the continually shrinking pool of funds for research and infrastructure, increasing teaching and administrative workloads for academic staff and time-consuming research grant preparation and review processes, all contribute to the time lag between identification of a knowledge gap and dissemination of research results (Chappell, 1995).

Reducing the time lag requires team work. Researchers need to be aware of emerging policy issues. This requires extensive networking among academic, policy, and practice communities and requires a willingness on the part of granting agencies to develop application, review and administrative procedures that facilitate researchers' ability to react quickly to emerging policy issues. Potential users need to understand the implications of the competitive research grants process and the need to maintain research standards.

One way to reduce the time lag is for researchers to use existing data sets. It is not always necessary to start from the beginning to develop research that reflects new theoretical and methodological approaches that will inform the new policy paradigm. For example, Statistics Canada has been proactive in involving researchers as consultants in the development of its national surveys as well as in making data sets available in a timely fashion. As a result of such a process, the 1996 General Social Survey has a wealth of information on caring partners and on the costs and benefits of caring. Timely access to these data sets and ongoing partnerships between Statistics Canada and university researchers in the analysis of national data sets could greatly reduce the question-to-results time lag.

Working at the Interface

While we applaud the encouragement of both dialogue and collaboration between researchers and those who develop and implement policy, we are concerned that it is assumed that it is largely researchers' responsibility to make this connection work. Yet the bridging of policy and research in the area of eldercare can be facilitated by those in policy positions as well. Those best able to translate policy-relevant research findings into such as those outlined in this article are often the policy-makers and implementors. For this translation to be effective, there must be a system in place in which someone is designated to the task of extracting policy-relevant research

findings and presenting them to the politicians, who are the ultimate policy-makers, in a manner that enhances the possibility of their adoption. The federal Office of Aging and Seniors has such a structure and a staff who are knowledgeable about both research and policy processes. Groups such as this can be in key positions to work at the interface in the translation of research to policy. They can also work at the policy-research interface informing researchers of new policy initiatives which require rigorous testing by researchers.

Asking the Right Questions

Researchers have a unique vantage point in their consideration of the broader context in which policy and services operate. This vantage point allows them to do arm's length analyses of current policy initiatives such as the research agenda suggested in the previous section of this paper. Recent strategic funding initiatives of major research granting agencies in Canada have provided opportunities for such work. A major goal of the Seniors Independence Research Program has been to build effective linkages between research and policy (SIRP Advisory Committee, 1996). Similarly, the Social Sciences and Humanities Research Council has used strategic grants to encourage research in areas deemed to have particular policy relevance. The main advantage of this approach is that policy questions can be targeted and research-policy links made explicit.

While useful in encouraging targeted, policy relevant research, a large commitment by major funding bodies to strategic policy research presents a risk because researchers may become more reactors than actors. If researchers are required to orient too much of their work toward existing situations, policies and programs within an existing value system, we will lose the opportunity to anticipate the future. This suggests a need to cast our research and policy evaluation net beyond those policies that are directly related to eldercare service delivery to encompass policies that will have implications for the future well-being of seniors. It suggests too, a need for longitudinal research that will help identify and evaluate factors (including policies) which, across time, contribute to or detract from the quality of life of seniors.

Researchers are, of course, products of their social world and not immune to its influence. But, researchers may be better able to take a broad perspective than those who are serving on the front lines and who must deal with current challenges.

Conclusion

In this paper we have highlighted ways to bridge the gap between policy and research in the area of care to seniors. The perspective has been unequivocally that of researchers. In our view, despite opportunities for bridges, connections between research and policy are often tenuous at best. We have argued that bridges can be built through making paradigms explicit and

then systematically evaluating their efficacy. Evidence-based policy development is surely a worthy goal.

In this era of cost containment and health care reform, attention to the integration of informal and formal care in the community is unavoidable. Research in the area is to a large extent guided by applied questions of importance to policy-makers. It undoubtedly has important implications for policy. However, the process of translating research findings into policy is neither simple nor straightforward because of the deep-rooted nature of the change necessary to address caregiving. In the words of John Myles (1991, pp. 83–84), "modern welfare states including pension systems, unemployment insurance, and family allowances were mainly designed to smooth out these ups and downs in the economic life course. The new challenge for social policy is to find ways of smoothing out the ebb and flow of the "caregiving crunch" of the contemporary life course".

We believe that the key policy issues that need to be addressed fall into three categories: research to clarify concepts such as what are the costs of eldercare; research to clarify the nature of caring partnerships; and research that is client-centred and focusses on issues such as consumer satisfaction.

Improving research-policy links is essential if we are to develop evidenced-based policy. Making policy assumptions explicit through the use of a theoretical framework; decreasing the time between the identification of a gap in knowledge and the dissemination of research results; working at the interface between policy and research to translate knowledge; and anticipating as well as responding to policy agendas can help move us toward more effective research-policy bridges.

Notes

1   Similarly, policy-makers can help bridge the policy-research gap by being more explicit about the values, beliefs and assumptions that underlie policies.
2   Other theoretical frameworks which have different basic assumptions might lead to quite different areas of enquiry. For example, feminist theory with its assumptions about the importance of gender, might lead to a focus on the inequitable consequences for women of caring partnerships. These might include the downloading of caregiving responsibilities to women who are informal caregivers and the movement to lower paid, multi-purpose caregivers (mostly women) among paid or formal caregivers.
3   This approach to understanding caring partnerships is being used in a program of applied research, Evaluating Programs of Innovative Continuing Care (EPICC), funded under the Seniors Independence Research Program. This program of research is run by a group of researchers and policy-makers in Alberta. Program collaborators include representatives from each of the models of care as well as a seniors' consultation panel.

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