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Received: 2 March 2020 | Revised: 9 December 2020 | Accepted: 11 January 2021

DOI: 10.1111/hsc.13305

ORIGINAL ARTICLE

Health and Social Care in the community

WILEY

Tension between reality and visions: Lessons from an evaluation of a training program of paid elder care workers

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Funding information
The National Insurance Institute, Research and Planning Administration, Division for Service Development- Demonstration Fund

Abstract

The present study is based on a 3-year evaluation of an Israeli training program for local paid elder care workers, called, 'community care'. Interviews were conducted with all stakeholders involved in the program, including program developers, facilitators, funders, trainees, dropouts, graduates, employers and older care recipients. Qualitative thematic analysis was used. Analysis was supplemented by quantitative data concerning the program's inputs, outputs and outcomes. The program had multiple strengths, including a substantial funding stream and a highly skilled and committed team. Yet, out of 130 participants, 94 completed the program and 31 worked as care workers afterwards. Three main challenges to the efficacy of the training program were identified. A first challenge stems from the gap between the program's vision and real-life requirements and constraints. The second challenge concerns a disagreement between stakeholders concerning the definition of the new community care profession as an opportunity to empower trainees and encourage personal growth versus the community care worker as being no different from the traditional direct paid carer. A third challenge concerns the program's lack of integration between personal/physical care on the one hand and emotional and psychological care, on the other hand. The findings stress the importance of adequately conducting a needs assessment prior to embarking on a new social program and the tension between an ideal prototype and real-life constraints. The findings also stress the necessity of top-down processes, supported by the government to the development of a new profession of community elder care.

KEYWORDS

evaluation research, home care, local care, long-term care, migrant care, nursing home, training programs

1 | INTRODUCTION

With the growing population of older adults, the reduction of childbirth and the entrance of women into the workforce, the reliance on paid direct elder care has become common, worldwide (Bueren, 2018; Coogle et al., 2006; Zarit et al., 1993). Because paid direct elder care is considered a low status job, with limited opportunities for advancement and poor working conditions, including low salary and benefits (Dong et al., 2017; Lightman, 2017), many countries experience a shortage of local paid direct elder care workers on top of the shortage of informal, unpaid, carers (Swanson-Aprill et al., 2019). Migrant care workers, who come from less affluent countries tend to replace the local workforce and assist family members and friends in the provision of elder care (Da Roit & Weicht, 2013; Lamura et al., 2010). However, many states, including Israel, where the present study takes place, view the reliance on migrant care as problematic (Shamir, 2013).

In light of these shortages of direct elder care workers, there is a plethora of research on training programs to improve the state of the

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long-term care workforce (Nolan et al., 2008). The goals of many of these programs is to empower and train the long-term care workforce in order to improve the quality of care provided to older adults and as a result, their quality of life (Coogle et al., 2008; Gallup et al., 2018; Walters et al., 2017). These efforts reflect an attempt to turn direct paid long-term care into a profession with standards and a clear body of knowledge (Kelly et al., 2013).

These social trends have inspired the development of a program, called, 'community care.' The program aimed to develop elder care as a respectable profession, by training local Israelis to work with older adults. Based on documents provided by the program developers, the training program aimed to improve the status of older adults through the creation of a multidisciplinary care profession, which meets the physical demands of older adults, in addition to social and emotional care needs, while taking into account their life experiences and promoting their self-esteem and social value.

1.1 | Long-term care in Israel

Only 2% of older Israelis receive care in institutions (Meyers-JDC Brookdale, 2018). Financial support by the state for the purpose of institutional care is limited and is provided only to individuals who have substantial financial needs, in addition to substantial care needs. In contrast, the state provides substantial financial support to assist older adults with disability to stay in their homes (Schmid, 2005). Israel is one of the first states to initiate a long-term care insurance law, which aims to allow older adults to stay in their homes for as long as possible through the provision of support in the form of home care services, adult day care services or incontinence products. At certain levels of care assistance, cash benefits rather than long-term care services also are available. In 2017, 16.1% of older Israelis were entitled to receive financial support through the long-term care insurance law, which is most often (69% of recipients) used towards the purchase of home care services (National Insurance Institute of Israel, 2017).

Two options for home care services are available: live-out and live-in care. Live-out care is provided by local Israeli workers who usually care for older adults, who have better physical functioning and fewer care demands than those cared by live-in workers. Under these circumstances, care is provided for several hours per week. Currently, about 70% of the home care workforce in the country is local (Zeira & Levi, 2016). Older adults who have more substantial care needs, on the other hand, usually rely on a live-in care worker (Ayalon & Green, 2015). According to the state's regulations, all migrant care workers must be live-in. This coincides with the migrant in the family model that is very common in Mediterranean and Asian countries (Bettio et al., 2006; S. Michel & Peng, 2012).

1.2 | The present study

In this paper, we introduce the main lessons gained from the evaluation of an Israeli training program with a focus on the tension between visions and reality (See Appendix 1 and Supplemental Table S1 for further details concerning the program). We use the analysis of program processes and outcomes as a platform to raise awareness to and better understanding of the complexity inherited in training the direct paid long-term care workforce. At the same time, we also raise awareness to some of the challenges inherited in program evaluation. It is important to note that several meaningful themes identified in earlier stages of program evaluation have already been reported elsewhere (Shinan-Altman et al., 2019). It also is important to note that the program evaluation described in this paper, started after the training program has already been in place. Hence, the evaluation team was not part of the needs assessment process and the development of a logic model.

What is known about this topic:

- Direct elder care is a low status job with poor working conditions and limited opportunities
- There is a high demand for paid elder care worldwide

What this paper adds:

- Needs assessment is a necessary step in program development and implementation
- Policy change has to combine top-down and bottom-up processes
- It is essential to bridge the gap between social and emotional care and personal/physical care

2 | METHODS

2.1 | The stakeholders

We interviewed program developers, individuals responsible for operating the program and relevant target populations, including trainees, graduates, dropouts, prospective employers and older adults. See Table 1 for a summary of the different interviews conducted and the timeline of these interviews.

2.1.1 | Program developers

The operator organisation was a non-for-profit organisation, that specialised in community and social activities with youth. This organisation was the main body responsible for program development and implementation. The funders also contributed to program development. The funders were two governmental offices: The National Insurance Institute of Israel and the Ministry of Labour, Social Affairs and Social Services, in addition to a non-governmental organisation (JDC Eshel). At least two other governmental offices were involved in providing financial incentives and in tailoring the program: the

TABLE 1 A summary of the different data sources obtained as part of the evaluation process

Data source	Count	When?
Individual interviews with developers	10	Early stages of the evaluation process and mid-term
Individual interviews with lecturers	12	First and 6 months into the training program
Individual interviews with instructors	14	First and 6 months into the training program
Individual interviews with employers	18	Mid-term of the evaluation process
Interviews with older adults	4	Mid-term of the evaluation process
Focus groups with trainees	8 (7 interviewees in each) 4 (5 interviewees in each) 1 (15 interviewees) 2 (8 interviewees in each) 2 (6 interviewees in each)	First month and end of each training program
Interviews with dropouts	32	Upon quitting the training program
Interviews with trainees	27	First month and end of training program
Interviews with workers	18	Six months after completion of program
Interviews with graduates	15	Six months after completion of program
Interviews with candidates	10	During selection meetings

Note: It is possible that the same person was interviewed as a candidate, when first considered the training program, as a trainee, while attending the program and as a dropout, in case she quit the program before its official completion or a graduate after completion of the program. In addition, the same person could have participated in focus groups and/or an individual interview. The numbers listed represent the number of interviews rather than the number of different stakeholders interviewed.

Ministry of Health and the Ministry of Economy and Industry. In addition, local municipalities provided the facilities for the training program and employers were involved in the development of the program and in the identification of potential trainees during later stages of the program.

2.1.2 | Program operators

Instructors were employed by the operating organisation. They were responsible for providing counselling and supporting the trainees throughout the training program. These individuals were mainly involved in the social aspects of the program, including the development of a sense of social cohesion among participants. Lecturers in the fields of gerontology, geriatrics and nursing were responsible for the delivery of professional contents.

2.1.3 | Target populations

Several stakeholders were identified as the main target populations of the training program. These include, program participants (including dropouts and graduates), older care recipients, their family members and direct care workers (the latter two groups were not interviewed as part of the evaluation research).

2.2 | Quantitative measures

We collected demographic data, including age, gender and education from stakeholders. In addition, we collected information concerning the number of enrolled participants, the number of participants who dropped out of the program, the number of individuals who completed the program and the number of trainees who continued to work in the field after completing the program.

2.3 | Qualitative interviews

Interview guides with developers and the operating team addressed their vision for the program, their views concerning assets and limitations of the program, as well as potential ways to improve it. Program participants were asked about their decision to join the program, the perceived benefits of the program, their interest in

working with older adults, strengths and weaknesses of the training program and future career aspirations. Dropouts were queried about reasons for quitting the program and graduates who worked in the field were specifically queried about the relevant skills acquired during the training program and future career prospects. Employers and older care recipients were queried about their familiarity with the program and their experience working with trainees and graduates. They also were asked about their motivation to employ graduates of the program. In some cases, the same interviewee was interviewed more than once. In addition, in some cases, the same interviewee was interviewed in different roles, for instance, as a trainee, a graduate or a dropout. Stakeholders were interviewed either face-to-face or over the phone, with the exception of program participants who were interviewed in focus groups while on training. Interviews were recorded and transcribed verbatim.

2.4 | Analysis

The study was approved by the ethics committee of Bar Ilan university and all participants signed a consent form prior to participating in the study. Interviews were analysed thematically by the first author. We used open-coding with no attempt to pre-impose a particular coding scheme on the data (Scott & Medaugh, 2017). We started with basic descriptive coding, for example, 'personal care is degrading' and moved to more interpretive categories over time, for example, 'a divide between personal and emotional care' (Elliott & Timulak, 2005). We employed constant comparisons, going back and forth between data sources, for example, interviews from different respondents, between time periods, for example, interviews with the same stakeholder over time, and between different groups of stakeholders, for example, employers versus trainees (Memon et al., 2017; Sheard & Marsh, 2019). See Appendix 2 and Supplemental Table S2 for further details concerning the analysis and sources of trustworthiness.

3 | FINDINGS

In total, 130 individuals participated in seven training programs. Of these, 94 completed the training and 31 worked as care workers at follow-up (not necessarily as community care workers). Table 2 presents the characteristics of the participants in each of the seven training programs and the outcomes of each of the training programs. As can be seen, the first three programs consisted of very young trainees with an age range of 19–25 years and high school education. The latter four programs consisted of substantially older trainees with the oldest being at the age of 69. Although the average number of years of education was about 13, there were several participants with university education. The majority of participants in all seven programs were female.

Table 3 presents the characteristics of program developers who were interviewed for this study. Table 4 presents the characteristics of employers who were interviewed for this study. Table 5 presents the characteristics of lecturers, instructors and older adults who were interviewed for the study.

The analysis is focused on tensions between stakeholders' visions and reality. The main tensions are illustrated by the following themes: (a) what are the desired program characteristics: a clash between the program's vision and real-life requirements and constraints; (b) what constitutes elder care: a disconnect between the focus of the community care worker on social and emotional care versus personal care; and (c) what are the career trajectories of community care workers: a view of community care workers as having multiple opportunities to affect and shape their own life versus the workers as a disempowered population with limited opportunities. See Figure 1 for a visual illustration.

3.1 | The gap between the program's structure and real-life constraints

The program in its initial conception consisted of more than 900 hr of training in geriatrics and gerontology. This was done to ensure that the program was equivalent to other re-training programs (in various fields) offered through the Ministry of Labour, Social Affairs and Social Services. Following feedback by the evaluation team, a second round of programs, consisting of 760 hr over a 6-month period was offered. However, this too was viewed as being too lengthy. An instructor stressed the toll this takes on employers: "There were employers who considered this program for their employees, but

TABLE 2 Characteristics of the participants in the different programs

	N started the program	*N* dropped out	*N* work in as elder care workers	Age M (range)	Education M (range)	% women
Program 1	19	4	0	20.9 (20–25)	12.5 (12–13)	85.7%
Program 2	21	6	0	19 (19–20)	12 (12–12.5)	85.7%
Program 3	14	6	0	21 (19–22)	12 (12–12.5)	100%
Program 4	19	3	5	50.2 (34–56)	12.4 (10–18)	75.1%
Program 5	19	5	7	42.36 (31–64)	12.7 (10–16)	89.4%
Program 6	18	6	7	47.05 (32–66)	13.16 (12–18)	77.2%
Program 7	20	6	11	56.2 (37–69)	12.8 (12–16)	86%
Total	**130**	**36**	**31**			

TABLE 3 Characteristics of program developers interviewed as part of the evaluation process ($N = 10$)

Institute	Position	Sex
The National Insurance Institute of Israel	Responsible for nursing care	Woman
The National Insurance Institute of Israel	Responsible for innovative program development	Woman
JDC Eshel	Responsible for program monitoring	Woman
Ministry of Economy	Responsible for the development of the program	Man
Ministry of Labour, Social Affairs and Social Services	Responsible for retraining programs	Woman
Ministry of Labour, Social Affairs and Social Services	Responsible for pedagogic development	Man
The operating organisation	Manager	Woman
The operating organisation	Former manager	Woman
The operating organisation	Program developer	Woman
The operating organisation	Program developer	Woman

you know, not everyone would send employees for two-three days a week, she wouldn't want to send them out for five days per week, for a period of two months and then for another three days per week. This is not… you know, agencies have said to me, 'I cancel the worker by letting her join the program'".

Consistently, a manager of a continuing care retirement community had stated that it was unacceptable to 'give away' her employees for such a lengthy period. She was only interested in training for several hours per week. Trainees added to this challenge the fact that it was difficult for them to consume theoretical knowledge for such a lengthy period of time, 'it is hard to sit still. Even if it is not a huge number of hours. It is not the same as I used to have at the university, until 9 p.m. And the challenges are daily. Every day, and concentration too, I am not as young as I used to be and it is difficult'.

An added concern was raised by an instructor. Apparently, during the program, the trainees were on unemployment and welfare support. However, the financial assistance they received was deemed inadequate: 'I think that a main weakness is the inability of our target group to pay for its living. I mean, to hold on for six months during the program. I think they need some additional financial support. There are many people who would have liked to do this and take part in this program. Many people were accepted, but only later did they understand that they could not afford this. The state has to invest in the ability of people to focus on this profession. This requires more money more resources from the state'.

Considering these outcomes, a representative of the National Insurance Institute had expressed her disappointment with the program, 'which has been too theoretical', in her view. She claimed that the training should be more practical, so that trainees would receive supervision on the job. She further claimed that neither the name, community care worker nor the number of hours of training, meet the needs of the field for direct care workers. She added that the lack of experience with older adults of the non-for-profit organisation was reflected in the hesitation the trainees felt about the provision of physical care. According to her, elder care must include physical care at its core and training should not exceed 60–70 hr.

3.2 | The essence of elder care is the provision of emotional and social care versus personal/physical care

The challenge of making a connection between social/emotional (e.g., addressing loneliness, providing enriching activities) and personal (e.g., assistance in activities of daily living, such as bathing or transferring) care is clearly articulated in the report of one of the trainees. This trainee views her profession as either composed of social and emotional care or of personal care. She cannot make the connection between the two types of care in her mind nor in her actual experience in the field: 'The truth is that care itself is less interesting for me. These contents of how to shower and how to- this is trivial, personal care, physical care. I really liked the other tools you could use with them. The art and I don't remember, the occupation…'.

In interviews with the developers of the program and from reviewing the advertisements and program curriculum produced by the direct developers of the program (the non-for-profit organisation), it became clear that indeed, the connection between personal and social/emotional care was not made explicit and the emphasis of the program has been only on social and emotional aspects of care. The limited connection between social/emotional care work and physical/personal care was echoed in an interview with a lecturer (who is external to the program): 'They (instructors) should prepare them to the real profession. Which is taking care of people with very substantial care needs especially when it comes to the physical care of the person. After the physical care has received the priority, the person feels very comfortable with the body, then you can become creative. I think that in this program, the priorities have shifted'. The lecturer expresses her dissatisfaction with the fact that personal care does not receive as much attention as emotional and social care. Her view of elder care is that first and foremost, one's physical needs have to be fulfilled and only afterwards can all other needs be addressed.

This perspective was concurred by an employer, who had claimed that community care workers are unwilling to provide basic personal care, which is most needed: 'When we have a shortage of workers and I need a replacement, it is clear to her (community care worker) that she should not be doing that. For her, it is already a disgrace. So I said that my mistake is from the beginning, I should have told her that when there is a sick worker, she needs to cover for her. But now, you cannot really turn over the wheel. It is considered a disgrace to provide care for the residents. And this really bothers me. A lot!'

TABLE 4 Characteristics of employers interviewed as part of the evaluation process ($N = 18$)

Position	Age	Education	Sex
Chief unit nurse in a continuing care retirement community	Not reported	BA nursing	Woman
Chief unit nurse in a continuing care retirement community	44	BA law, nursing certificate	Man
Chief nurse in a continuing care retirement community	59	MA gerontology	Woman
Deputy director of a nursing home	29	Certified nurse	Man
Customer relations in a home care agency	49	High school	Woman
Manger of a home care agency	Not reported	Physician	Man
Manager of an adult day care centre	45	MA gerontology	Woman
Chief unit nurse in a continuing care retirement community	Not reported	BA nursing	Woman
CEO of a continuing care retirement community	46	BA nursing	Woman
A social worker in a home care agency	36	BA social work	Woman
Worker in a home care agency	49	High school	Woman
Social worker in a home care agency	37	BA social work	Woman
Worker in a continuing care retirement community	59	MA gerontology	Woman
Manager of an adult day care centre	38	BA	Man
Social worker in an adult day care centre	64	BA	Woman
Social worker in a home care agency	41	BA	Woman
Chief nurse in a continuing care retirement community	59	BA	Woman
Manger of a home care agency	50	MA	Woman

TABLE 5 Lecturers, instructors and older adults who were interviewed as part of the evaluation process

	Age	%Women	Education
Lecturers ($N = 4$)	48.7 (31–77)	75%	18.25 (15–25)
Instructors ($N = 11$)	31.8 (29–35)	91%	15.8 (12–18)
Older adults ($N = 4$)	80 (70–85)	75%	Not reported

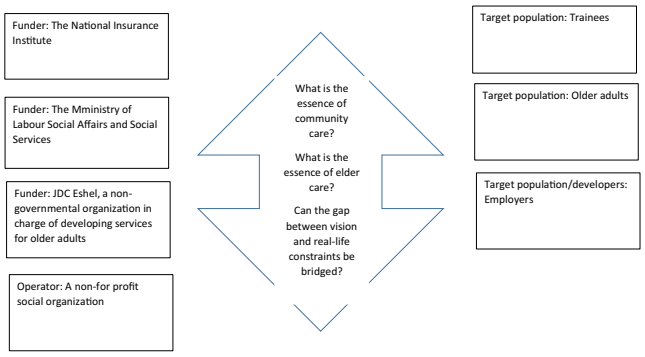

FIGURE 1 A map of the key stakeholders involved in the program and their struggle to establish common needs and vision for the program

Although the majority of older care recipients interviewed were unable to point the difference between a community care worker and a traditional care worker, one interviewee expressed adamantly, his support of the program and the rationale for intense training prior to approaching human beings, as stated in his own words: ' … the majority (of direct care workers) are those who had no training. Perhaps the National Insurance Institute can have this as a precondition for home care agencies. You do not take a person who did not go through training, just like you do not get a license for a gun without being trained. You do not receive a driving license without going through a test. You do not get many different types of licenses. You do not get a license to be a plumber or an electrician without…so taking care of people? I do not know if you should give a test, but training for sure should be a must'.

3.3 | The community care worker can do everything versus the community care worker is just a care worker

The view of community care as a means to turn elder care into a profession, which brings respect, growth and empowerment to the carers and older adults, alike, was very adamantly stated in all interviews with the non-for-profit organisation in charge of developing and operating the program. As stated by a representative of

the non-for-profit organisation: 'We are creating a new profession, which enters the job market'. A similar sentiment was echoed by some, but not all the funders involved in the program.

In addition to the view of the new profession of community care as a respectable profession of utmost importance that comes from the heart, instructors also spoke about the importance of empowering the workers, so that they can create a social change and fight for the recognition of their profession: 'It is important to inspire them (trainees). What type of workers are they going to be? We have had many conversations about social equality, the value of human beings, human beings as social beings, conversations about the union of care workers, the fight of the care workers, respect for human beings. Many conversations that were inspired by the goal of creating a strong motivation, strong values, and identification with the job'. The instructor does not talk about older adults and their needs, but instead views care workers as a disempowered social group, which should learn how to advocate for itself as a main priority.

A trainee has stressed the great contribution the program has made to her personal growth, way beyond the skills required to provide elder care: 'I have utterly changed. In the past, I used to be whatever people told me to be. Even about myself, I would not say no. Now, even during meetings I can speak up. How do you say? My self-confidence has improved'.

Trainees have generally bought into these ideas: 'The goals of this job are: a community worker is not like a regular worker. She is a mix between a community worker, and an occupational counselor and a social worker- who takes care of older adults. She is there to listen to older adults. To help them with everything. She is not a regular carer'.

These very positive reports and intentions have met reality. A program developer, who belonged to the non-for-profit organisation, during one of the recruitment meetings has explicitly stated that she would accept anyone to the program, given the limited appeal the profession has at the present time. The research assistant who had observed the meeting added that clearly, the motivation that had brought in many of the candidates was an urgent need for money, rather than care for older adults or self-empowerment strategies.

Similarly, the real conditions of the job did not meet trainees' expectations as they were required to perform personal care to the most part. Workers were not reimbursed substantially more than traditional direct paid carers, despite having gone through extensive training. The following is a quote of one of the employers: 'They (employers) gave them (community care workers) more. I remember they received two Shekels (half a dollar) above everyone else. With regard to salary. And, regarding the fact that they (trainees) were told (by social instructors) they should not be cleaning (older adults). But. this is incorrect'.

4 | DISCUSSION

Although the number of older adults continues to grow, our ability to extend healthy longevity remains limited at best (Partridge et al., 2018). Worldwide, there is a shortage of paid and unpaid direct carers for older adults (Isaksen et al., 2008; Swanson-Aprill et al., 2019). At least some of the reasons for this are due to the low status associated with the provision of care for older adults (Anderson & Anderson, 2000). Moreover, paid elder care offers limited future for advancement on the job and often goes with very limited financial compensation (Jokela, 2018; Pelzelmayer, 2018). In light of the growing need for paid elder care workers, the present study reports on the evaluation of a training program, which aimed to develop a new profession of community care workers who provide care to older adults.

Our findings clearly point to gaps or discrepancies related to the development and conceptualisation of the training program. These include its lengthy structure, which does not allow workers to work and earn a living during the training, the focus on social and emotional aspects related to care at the neglect of direct personal care and the promise for prosperous career trajectories in the face of very limited working opportunities in real life. As discussed below, there are various reasons to these discrepancies, with a major one being the fact that the evaluation team entered the process late, when the program was already operating.

A basic step in any program evaluation should be needs assessment (Scriven & Roth, 1978). Needs assessment usually consists of identifying and interviewing all stakeholders involved in the development of the program, as funders, designers, advocates, operators or potential targets in order to better understand what population/s should be targeted and what their needs are. In this program, the evaluation team was hired after the first training programs were already in place. Hence, no preliminary needs assessment was conducted and important stakeholders such as direct care workers and older adults were not involved in the initial development of the program. Our analysis shows that the gap between the visions of the different stakeholders and the gap between visions and the constraints imposed by real-life demands were too wide to bridge within the 3-year evaluation period of the program. Conducting a needs assessment prior to embarking on program design and implementation might have helped to bridge these gaps.

The present evaluation shows how certain structural features of the program, imposed by the different stakeholders involved, were deemed inadequate in retrospect. A lengthy, highly intense and costly program prevents trainees from working while training and keeps the workers away from their prospective employers. It also covers a substantial body of knowledge that may not be of use for that workforce. The emphasis on theoretical rather than practical knowledge further removes the foundations of the program from the real-life goals of providing elder care. In this regard, it is important to note that in the United States, among those states that require the pre-training of direct care workers, the minimum average number of training hours is 22.5 (Kelly et al., 2013). In Israel, no requirements are in place, but governmental training programs of direct care workers offer about 70 hr of training. Hence, the present program was exceptionally lengthy due to artificial constraints put forth by one of the funding agencies.

The findings highlight the gap between vision and real-life constraints. In real life, human beings must have their basic needs met, before any additional needs can be considered (Maslow, 1943). In the case of older care recipients, basic needs represent activities of daily living, including bathing, feeding and transferring. These basic needs should be fulfilled with respect, empathy and concern. Yet, they must be fulfilled before social and emotional needs, such as the alleviation of loneliness or leisure time activities, can be addressed. As the shortage of care providers who are willing to deliver these basic needs is high (Aluttis et al., 2014), it makes little sense to develop a designated workforce, which offers social and emotional support while neglecting care recipients' most basic needs.

The non-for-profit organisation that initiated and designed the program had offered a very innovative and almost utopian vision of the profession called, 'community care' and of what elder care constitutes. Consistently, some of the funders, the social instructors and the trainees believed that by going through an extensive training program, which provides skills for life, way beyond physical care, the entire field of elder care would change. The rationale for this follows the very strong interconnection between the worker and the care recipient (Yates et al., 1999). If the employee is satisfied with her employment conditions and views the job as meaningful, her ability to provide elder care is enhanced and as a result, the quality of life of the older care recipients is improved as well (Isaac et al., 2011). This is consistent with the empowerment theory, which suggests that the empowerment of care staff, results in greater empowerment of care recipients, which subsequently contributes to their quality of life (Spence Laschinger et al., 2010).

In contrast, some of the funders and certainly employers viewed the main needs of the field of long-term care as resulting from a shortage of direct care providers whose main role is to change diapers, feed older adults and bath them when needed. They viewed social and emotional activities as nice to have, but lower on the hierarchy as the most basic needs have to be fulfilled first (Maslow, 1943). Workers' empowerment and growth were not in their lexicon as the real-life needs of older adults have to be fulfilled first.

The creation of social change does not happen in a vacuum. This is why so many stakeholders have been involved in the program design and implementation. When it comes to 'paying the bill', so to speak, even the best training program cannot create a societal change alone. Similar to others (Fylling et al., 2019; Timilsina et al., 2019), our evaluation suggests that changes cannot be based only on bottom up processes, from the non-for-profit organisation to employers, but should combine top-down processes. Employers and employees alike have stated that without clear regulations by the state, there is no real incentive to absorb a new profession, which is costlier and may not meet the most basic needs of the market. As the private, for-profit, long-term care sector was unable to identify the added value in the program, the developers had made an explicit request from the state to intervene and advocate for societal change. This has not yet happened and the state has not regulated or mandated elder care training. Hence, subsequent implementation of the program and the absorption of community care workers in the workforce have not taken place.

While reading this paper, it is important to acknowledge its limitations. First, the team started the evaluation only when the program was midway. As a result, no formal needs assessment was conducted. Important stakeholders such as direct care workers already employed in the field and employers were not included in the initial stage of program development. Another limitation of the study concerns the fact that follow-up discontinued after 3 years. Although this is an extended period of time, in order to create a social change, more time might be needed (Rotmans et al., 2001). It also is important to note that although this evaluation program has a strong longitudinal component as it spanned over a period of 3 years and relied on data collected from the same and from different individuals multiple times over this period, the focus of the qualitative analysis presented in this paper is not on change versus stability, which can be assess via longitudinal qualitative research (Ayalon et al., 2018). Instead, we strive to bring a coherent picture concerning the limited ability of the program to meet its intended goals, unrelated to a particular point in time. Future research will benefit from examining the data using longitudinal qualitative methods in an effort to identify changes over time (Nevedal et al., 2019). Finally, the program was developed within the unique Israeli context which may not allow for generalisation. Nonetheless, we believe that there are several lessons to be learnt from the evaluation of this program, including the importance of needs assessment and reaching a common ground prior to embarking on a new social program. Another major lesson concerns the fact that even an excellent program cannot overcome structural social constraints. Oftentimes, both top-down and bottom-up processes need to take place in order to create a social change (Njøs & Fosse, 2019).

ACKNOWLEDGEMENT

This evaluation was supported by a grant from the National Insurance Institute, Research and Planning Administration, Division for Service Development- Demonstration Fund.

CONFLICT OF INTEREST

The authors have no conflict of interest.

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SUPPORTING INFORMATION

Additional supporting information may be found online in the Supporting Information section.

How to cite this article: Ayalon L, Shinan-Altman S. Tension between reality and visions: Lessons from an evaluation of a training program of paid elder care workers. *Health Soc Care Community*. 2021;00:1–10. https://doi.org/10.1111/hsc.13305