

**INVISIBLE WORKER(S), INVISIBLE HAZARDS:
AN EXAMINATION OF PSYCHOLOGICAL AND PHYSICAL SAFETY
AMONGST FRONTLINE WORKERS IN LONG-TERM RESIDENTIAL CARE
FACILITIES IN THE 'NEW' GLOBAL ECONOMY**

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Abstract

Research has consistently demonstrated that the long-term residential care (LTRC) frontline workforce encounters a range of serious health and safety hazards and risks that result in physical and psychological injury, illness, absenteeism, and related costs. Using the lens of feminist political economy, this dissertation explores the risks workers encounter on the frontlines of LTRC, how these workplace risks are shaped by broader social, economic, political, and historical factors, as well as the ways frontline workers resist, challenge, or shape the conditions of their work in this setting. My analysis of primary data is informed by interviews with 17 frontline workers working within for-profit, non-profit, and municipal LTRC facilities within Ontario and 2 key informants. Restructuring and reform of health and social care services under neoliberalism have profoundly transformed the character, funding, organization, and delivery of LTRC. These changes have serious implications for workforce configurations, the conditions of work and care, workplace health and safety, worker control over their labour, and capacities for worker resistance to the conditions of their work. Within the LTRC organizational hierarchy, frontline workers are of marginal status. The frontline workforce is composed predominately of women – and increasingly marginalized immigrants and racialized groups, whose care labour on the frontlines is often naturalized, undervalued, and treated as unskilled and safe. This research provides evidence that restructuring and work reorganization processes, policies, and practices constitute a form of structural violence, which contribute to, intensify, and/or give rise to new sources of struggle, inequity, risk, violence, alienation, and exploitation on the everyday/everynight frontlines of LTRC.

Dedication

To the workers on the frontlines of long-term residential care

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List of Abbreviations

ADL – Activities of Daily Living
BSO – Behavioural Supports Ontario
CCAC – Community Care Access Centre
CHA – Canada Health Act
CMS – Centre for Medicaid and Medical Services
CMI – Case Mix Index
CQI – Continuous Quality Improvement
CUPE – Canadian Union of Public Employees
ERS – External Responsibility System
ESRTW – Early and Safe Return to Work
FTE – Full-time Equivalent
GATS – General Agreement on Trade in Services
HCA – Health Care Aide
HPRAC – Health Professions Regulatory Advisory Council
IMF – International Monetary Fund
IRS – Internal Responsibility System
JHSC – Joint Health and Safety Committees
LTC – Long-Term Care
LTRC – Long-term Residential Care
LOC – Level of Care
LHIN – Local Health Integrated Network
LTCHA – Long-Term Care Homes Act
MOHLTC – Ministry of Health and Long-Term Care
MOL – Ministry of Labour
MSI – Musculoskeletal Injury
NAFTA – North American Free Trade Agreement
OHS – Occupational Health and Safety
OHSA – Occupational Health and Safety Act
OECD – Organization for Economic and Cooperation and Development
PSW – Personal Support Worker
TQM – Total Quality Management
WHO – World Health Organization
WTO – World Trade Organization
WSIA – Workplace Safety and Insurance Act
WSIAT – Workplace Safety and Insurance Appeals Tribunal
WSIB – Workplace Safety and Insurance Board

Introduction

Over the last several decades, restructuring and reforms informed by neoliberalism, emphasizing standardized, measurable outcomes, efficiency, and greater flexibility have dominated the health and social care landscape in Canada (and elsewhere). Restructuring has meant significant cuts to public sector social and health care services. Reformers identify expanding health care costs and fiscal challenges as the impetus for austerity measures, arguing that rationalization, efficiency, and effectiveness are central to the improved organization and delivery of health and care. The impact of this reform direction and application of pro-market principles, processes, and practices to the health care sector ostensibly reduce costs, enhance quality, and improve efficiency have profoundly redefined, restructured, and reorganized the way healthcare, including long-term care (LTC), is delivered, care work is organized and controlled, by whom, and under what conditions. It has meant that risk, responsibility, and the cost of care have increasingly been shifted to individuals, families, and markets.

In Canada, a range of public and private ownership configurations characterizes the LTC sector. Excluded from the *Canada Health Act* (CHA), LTC constitutes part of the broader continuum of partially subsidized health and social care services and programs – “extended health services” – under provincial and territorial jurisdiction that are delivered in community and facility-based long-term residential care (LTRC) settings (Berta et al., 2006; Banerjee, 2007). LTRC facilities provide 24-hour on-site health, social, and personal care services on an ongoing, indefinite basis (Banerjee, 2007) to eligible seniors and individuals assessed using standardized criteria.

This dissertation is concerned with the workplace health and safety implications of restructuring and work reorganization trends for frontline workers working in LTRC facilities in Ontario. The project itself was in part motivated by my own experiences with health and safety on the frontlines of a non-profit and non-unionized AIDS hospice. I worked primarily in a full-time capacity at the hospice from 1997 to 2005, providing palliative care, outreach, supportive housing, and respite care services as I completed my college and undergraduate university studies.

“Frontline worker” is not a universal term used to refer to the workers who provide the hands-on care to residents within the LTRC environment. In Ontario, the provincial designation for these workers is Personal Support Worker (PSW). Elsewhere these workers are called health care aides, nursing assistants, care aides, direct-care workers, personal care attendants, residential care aides, certified nursing assistants, and personal care assistants – depending on country, province, region, or facility. My use of the term “frontline worker” within this dissertation reflects the language of the project’s participants in reference to themselves and the work they do, highlighting their direct involvement with and proximity to care within LTRC settings. Throughout interviews, in speaking about their care labour many participants repeatedly emphasized, “We are the frontline workers.”

The impact of the restructuring trends described above are gendered, racialized, and classed. Indeed, the neoliberal shift has relied on the gendered, racialized, and classed divisions of labour (Armstrong, 2009; Braedley & Luxton, 2010). In LTRC, women constitute “the backbone” (Noelker, 2001) of the workforce. Restructuring within LTRC has meant greater reliance on lean and flexible – contingent or precarious

work arrangements (such as part-time, casual), the transfer of care work to the lowest cost and least-specialized workers, and the transnational recruitment of racialized and immigrant workers (Eckenwiler, 2011). The frontline workers within LTRC are predominately women. It is an aging workforce – many of these frontline workers within LTRC are over 45 years old. Increasingly, this workforce is composed of racialized and marginalized immigrants, whose first language is not English (HPRAC, 2006; Armstrong et al., 2009; CUPE, 2012). Frontline workers are located at the bottom of the LTRC hierarchy, where historically, women and racialized groups have been segregated into the least appealing, least-specialized, and poorly waged aspects of health care work. Despite providing much of the direct care, frontline workers often lack input into decision-making, care practices (Armstrong & Daly, 2004), are not included in care team meetings, and their experience and contributions to care are undervalued and unrecognized (Kontos et al., 2009; Armstrong et al., 2009).

Reforms and changes in work organization have also meant significant workload intensification, greater risks, and an undermining of workplace health and safety for the workers on the frontlines of care. Indeed, a growing body of research indicates that trends in restructuring have adverse consequences for worker physical, psychological, emotional, and social wellbeing (Armstrong & Jansen 2006; Armstrong et al., 2009; Banerjee et al. 2008; Banerjee 2010). According to official reports, injury and illness amongst the Canadian healthcare workforce are at a rate that is more than twice the national average and injury amongst direct providers of care is significantly higher than all other healthcare occupations (Yassi et al., 2004; Yassi & Hancock, 2005). Prior research has revealed the extensiveness of violence occurring within the LTRC setting,

including verbal and physical assault and harassment (Banerjee et al., 2008; Morgan et al., 2008). According to research within Canadian LTRC facilities, frontline workers encounter physical violence on a daily basis (Banerjee et al., 2010; Banerjee et al., 2012). Workers report regular exposure to violence including sexism and racism within the workplace. While official reporting systems such as workers' compensation data reveal high rates of injury and illness amongst the health care workforce, this data is misleading. Official data are likely to understate the actual incidence and prevalence of injury and illness within this sector. The underestimation of illness and injury may be related to structural, theoretical, and methodological issues and/or bias. Moreover, the extensive underreporting of workplace injury and illness for numerous reasons including fear, lack of support, blame, and labour market insecurity is a phenomenon that is well established in the literature. This is particularly true for workplaces that are high demand and low control (Cox & Lippel, 2008) – characteristics that reflect the jobs that are frequently occupied by women (Armstrong, 2010; Daly et al., 2011).

Injury and illness are often normalized, individualized, and gendered. Historically, “women’s work” has rarely been considered in research that examines the relationship between work and health, reflecting narrow, male-centric assumptions about injury, illness, and risk (Messing, 1998; Daykin & Doyal, 1999). Care work is often naturalized, undervalued, and treated as unskilled and not dangerous. According to feminist researchers, work organization changes and the application of managerial practices within health and social care settings reinforce “gendered ideologies of care.” This includes the assumption that the care labour of women is natural, reliable, altruistic, and limitless (Baines, 2006; Baines, 2015). Gendered assumptions and expectations

reinforce the devaluation of frontline work as well as conceal the broader structural and organizational origins of workplace risk (Messing, 1998; Armstrong et al., 2009). Assumptions about women, women's work, and gendered ideologies of care reinforced by restructuring and work organization trends significantly influence health, safety, and wellbeing on the frontlines. Prior research has demonstrated that frontline workers are frequently encouraged to accept or tolerate working conditions that undermine their health and safety as a demonstration of an ethic of care and commitment (Gates, 1999; Baines, 2006; Banerjee et al., 2008; Morgan et al., 2008). Unsafe and risky work on the frontlines is frequently normalized as part of the job. Within a climate of neoliberalism, the shift towards privatization, including individualism and responsabilization (Gray, 2009) has meant that risk, responsibility, and blame for health and safety are increasingly transferred to workers.

Drawing on a feminist political economy perspective, this dissertation considers the following interrelated questions to examine restructuring and work organization and workplace health and safety of workers on the frontlines of LTRC:

- what are the health hazards and risks frontline workers encounter in the context of their care work?
- how are the hazards and risks frontline workers face related to larger structural factors?
- what are frontline workers doing to shape, influence, resist, and/or challenge the changing conditions of their work?

Chapter Descriptions

This dissertation is organized into seven chapters along with a conclusion. In Chapter 1, I locate LTRC within the broader federal and provincial care context. The discussion is primarily oriented to articulating the wider politics of care and regulatory

regime that underpins LTRC in Ontario in which workers on the frontlines are situated. This includes the legislative, regulatory, funding, ownership arrangements, and expanded role of the corporate sector. I identify significant transformations in resident base that have occurred alongside and in conjunction with austerity measures and restructuring trends under neoliberalism within LTRC (and elsewhere) with the aim of rationalizing costs and labour as well as developing and expanding the profit potential of this sector. This includes the rise of for-profit ownership and pro-market managerial principles and practices, the downloading and shifting of care and costs of care – which is further reinforced by changed eligibility criteria under the *Long Term Care Homes Act* (LTCHA) for resident admission. I highlight how these transformations have important implications, particularly for women who provide the bulk of unwaged and waged care. In LTRC, it is primarily women – and increasingly marginalized new immigrants and racialized groups who constitute the frontline workforce. I conclude the chapter by providing a profile of the workers who comprise the LTRC workforce and highlight the contentiousness surrounding the development of a PSW registry recently introduced by the province under the pretext of “transparency” and “accountability.”

Chapter 2 outlines the theoretical framework and conceptual resources I employ in this dissertation. I use feminist political economy as the analytic lens to frame my project in order to highlight the broader structural context that shapes the division of labour, organization of work, and experiences of workers on the frontlines of long-term residential care. I discuss feminist political economy as it has developed within the Canadian tradition, highlighting its main objectives and goals as well as identifying the ways the perspective influences and contributes to my project. The chapter draws

attention to critical questions relating to the gendered politics of evidence and the contradictions and tensions between evidence and workplace health and safety. Alongside my lens of feminist political economy, I draw on the social determinants of health, the concept of structural violence, and theories of the labour process in my examination of the gendered, racialized, and classed implications of restructured LTRC under neoliberal influences, particularly in relation to working conditions, health and safety, and resistance and struggle.

Chapter 3 lays out my study's research design and methodology. I begin the chapter by outlining the research questions and objectives that inform my project. I identify the project as using a feminist political economy approach shaped by feminist epistemology, and guided by feminist principles. Consistent with my feminist political economy approach, I use primary data from interviews with frontline workers with the aim of understanding, in their own words, their lived experiences with working conditions, health and safety, and resistance on the frontlines of LTRC, how these intersect with social location, and how these are linked to broader social, economic, and political contexts.

Chapter 4 articulates the broader context of workplace injury and illness within LTRC. I begin the chapter by mapping injury and illness trends within the frontline workforce. Violence is identified as one indicator of intensified risks in the context of lean and flexible work processes and practices. The chapter highlights the widespread underreporting of injury, illness, and violence within the LTRC sector. The chapter proceeds with discussion of critical issues regarding the nature of evidence – that is, what is counted, whose evidence counts, and how this evidence is used – drawing attention to

the limitations, assumptions, and biases built into official data and reporting mechanisms. In particular, I consider the gendered politics of evidence and the ways in which evidence influences care and work in LTRC. In this chapter, I argue that processes of responsabilization and individualization increasingly shift risk, responsibility, and costs for workplace safety on to workers. The chapter continues with discussion of the broader context of workplace health and safety on the frontlines. This discussion is centered on articulating the ways global forces, the state, unions, and employers shape and intervene in the production and organization of work and influence workplace injury and illness.

Chapters 5, 6, and 7 of this dissertation comprise the analysis of my project's primary data. This dissertation is concerned with how workplace health and safety on the frontlines is shaped by the broader historical, social, economic, and political contexts in which frontline workers are located. Using feminist political economy as an optic, these chapters provide a contextualized analysis of my empirical data – the experiences, accounts, and narratives shared by participants. The three analysis chapters are oriented to rendering the experiences of participants visible and revealing the gendered and racialized dimensions and implications of restructuring and work reorganization, particularly in relation to frontline worker health and safety and struggle in LTRC.

In Chapter 5, I begin my analysis of the implications of restructuring and work reorganization in relation to participants' accounts of expanding workloads on the frontlines of care. Workload intensification is understood to be shaped by various factors including inadequate staffing arrangements, changing resident base and levels of care, precarious workforce configurations, expanding documentation requirements, and constraints on worker control in a context of new rules, regulations, and time constraints.

Discussion in this chapter then turns to the impact of intensified workloads in relation to the provision of unwaged labour, insufficient training, and constrained opportunities for teamwork.

Drawing on participants' narratives, my analysis in Chapter 6 is oriented to the identification of various physical and psychological risks and hazards frontline workers encounter in LTRC. The chapter begins with a discussion of structural violence wherein broader structural conditions, including policy, processes, and practices that characterize restructured LTRC sector are understood as factors that profoundly contribute to risk, injury, and violence workers encounter. The context and conditions of care and work under the current LTRC regime are understood to prevent workers from providing the care they would like to provide and residents from receiving care and having their basic needs met. Following this, I discuss participants' experiences and perceptions with physical and psychological risks including various forms of violence on the frontlines.

In Chapter 7, I explore participants' experiences with management in relation to health and safety concerns and identify factors that operate to hinder risk and injury identification and reporting in LTRC. Next, I consider participants' perceptions and experiences with workers' compensation, revealing sexist and ageist assumptions and practices in the adjudication of claims. The constraints on reporting, return-to-work practices, and attendance monitoring programs contribute to the practice of workers continuing to work – despite risk, injury, or illness. The sickness presenteeism amongst frontline workers is further reinforced by non-replacement practices, gendered ideologies of care, and the normalization of precarious work derived from employer preferences for

a flexible workforce and oriented to rationalizing costs and labour while obtaining greater control over workers and the labour process.

Chapter 1: Long-Term Care

This dissertation is concerned with the health and safety risks frontline workers face in the context of their work, how these risks are related to larger structural factors, as well as the ways workers shape and resist the conditions of their work within long-term residential care (LTRC). This chapter is divided into several sections and is oriented to establishing the broader structural context – the relations of ruling (Smith, 1987; Smith, 2005) and politics of care in which frontline workers in LTRC in Ontario are situated. Relations of ruling are understood as historical, hierarchal, materialist, and discursive and operate in overt and covert ways (Smith, 1987; Smith, 2005). While ruling relations are omnipresent, they are often hidden and/or may not always be evident to the lived reality of individual workers and/or their experiences and understandings of the social world in which these workers are a part (also see Chapter 2). I begin the chapter with health and care in Canada, providing an overview of long-term care (LTC) and LTRC that comprises part of the spectrum of care and health services in Ontario. Following this, I then discuss austerity and health care restructuring and reform, the LTRC regulatory and funding environment, and the rise of for-profit ownership configurations. Next, I discuss the changing resident base in LTRC that is occurring alongside (and linked to) neoliberal restructuring of health and social care. Finally, I conclude the chapter with an overview of the LTC labour force and a profile of the frontline workers in LTRC. This includes a brief discussion relating to frontline worker education, wages, unionization, and the recently launched Ontario Personal Support Worker (PSW) Registry.

Health and Care in Canada

While the health and safety experiences and struggles of frontline workers are at the center of this dissertation, in the following discussion of health and care in Canada, I locate LTC within the broader care spectrum and map the larger care context and regulatory regime in which workers on the frontlines of LTRC are situated in Ontario.

In Canada, LTRC is essentially excluded from the scope of federal legislation, the *Canada Health Act* (CHA). This legislation defines Medicare and outlines publicly insured services. The *CHA* lays out five criteria that require provincial and territorial insurance plans to be publicly administered, universal, comprehensive, accessible, and portable. The provinces and territories must meet the terms and conditions of these principles in order to receive federal cash transfers to assist with health care system operation. Under the *CHA*, extra billing or the application of user fees are prohibited for services defined as medically necessary physician and hospital services. LTC is considered an “extended health service” whereby governments have no obligatory commitment to provide a standard range of services (Canadian Healthcare Association, 2009). The LTC sector consists of a broad range of public and private ownership (and increasingly corporate ownership) and administration configurations that creates a “care continuum” – an array of health and social services and programs (Banerjee, 2007) delivered in communities (i.e. home care, assisted living, community-based supports) and facilities (Berta et al., 2006). Formal health and care services in home and community care are provided by a range of health and social care labourers (e.g., nurses, physiotherapists, nutritionists, social workers, home support, personal care workers) on an intermittent or continuous basis. Home and community-based services may be

medical or non-medical (i.e., specialized, rehabilitative, palliative, or supportive) in nature. These services are provided to individuals with acute and chronic physical and mental health conditions and/or functional limitations.¹ Most home and community-based care recipients are women. In 2013-14, over 699, 000 individuals received publicly funded home care services.² During this period, the elderly constituted 58 percent of home care service users (Home Care Ontario, 2014).

Both the public and private sectors are involved in the funding (how services are paid for) and delivery (how services are organized, managed, and provided) of health and care services. No jurisdiction in Canada provides complete LTC coverage. It is only a partially subsidized service. Despite the fact that LTRC is an integral part of the continuum of care and health services, the sector, including the providers and recipients of care, is largely overlooked (Berta et al., 2006; Armstrong, 2013b). The *Royal Commission on the Future of Health Care in Canada* (Romanow Report) and *The Kirby Commission on Mental Health Report* (Kirby Report) – both prominent federal government commissions, were entirely silent on the LTRC sector in their respective reports.

Although the provinces and territories receive block funding from the federal government for health and LTC, the responsibility for design, funding, policy, regulation, and enforcement of LTC services falls largely within the jurisdiction of the provinces and territories. As part of neoliberal health care reform, restructuring, and decentralizing processes, such as regionalization, the responsibility for program development and

¹ Eligibility for publicly funded and administered LTC services is determined through provincially approved standardized assessment

² Individuals may be counted more than once if re-admitted or transferred.

delivery of LTC services resides predominantly with regional health authorities (Berta et al., 2006). These are apparatuses of governance and the scope of their role varies provincially and territorially. The decentralization and reorganization of administration and delivery of health and care through the establishment of regional authorities is rooted in the assumption that local organizations are better positioned than systems that are centrally organized to integrate and coordinate health services while at the same time efficiently and effectively maintaining quality, containing system costs, and rationalizing services. In Ontario, the province has a great deal of authority. Unlike other Canadian provinces, regionalization in Ontario has not devolved of traditional decision-making bodies. That is, health organizations governance structures (i.e. hospital boards, LTC boards, etc.) have remained intact. The Ministry of Health and Long Term Care (MOHLTC) also retains funding powers to health service providers. While individuals are admitted to facility-based care through regional authorities, policies are primarily set at the provincial level.

LTC is a partly covered, publicly funded system. In 2014, 3.9 billion was directed to LTC in Ontario, representing 7.8 percent of the overall health budget (OLTCA, 2014). The MOHLTC funds, administers legislation and regulations, oversees compliance with provincial health care policies, and manages the health care system. MOHLTC funded Local Health Integrated Networks (LHINs) were introduced by the MOHLTC in 2006, dividing the province into 14 health regions. The LHINs are the regional health authorities in Ontario. The LHINs official mandate is to fund and integrate health care within their corresponding regions in Ontario. Community Care Access Centres (CCACs) were established in 1996 by the MOHLTC and currently report

to one of the 14 LHINs in the province. The CCACs are authorized to determine service eligibility through assessment, manage health and service wait-lists, and co-ordinate access to LTC services. Entry into one of the 600-plus LTRC facilities within Ontario (OLTCA, 2014) is controlled by one of the 14 CCACs located throughout the province.

The exclusion of LTC from the provisions of federal legislation, specifically the *CHA*, and the absence of federal standards or a national pan-Canadian LTC policy has meant that extensive structural or system variations in service arrangements and classifications currently exist across and within the provinces and territories (Berta et al., 2006). In LTRC settings, this includes differences in relation to funding schemes (mix and levels of private and public funding), facility ownership configurations, regulation, and availability, access to, and provision of services. It also involves differences with resident accommodation costs or income-tested co-payments (e.g., preferred accommodation premiums for private or semi-private accommodation), user fees (e.g., medical and personal such as hearing aides, over-the-counter drugs, dentures, hygiene products), and residency needs assessment and eligibility criteria.^{3,4} There are also variations within and between provinces and territories regarding other continuing care services, such as home and community service provision (Berta et al., 2006; CUPE, 2009, Canadian Healthcare Association, 2009). These differences not only create multi-tiered access and uneven provision and quality of LTC services (OHC, 2008; CUPE, 2009, Jansen, 2011), they also influence the organizational production of care – LTC workforce

³ In Ontario, the standardized Resident Assessment Instrument for Home Care (RAI-HC) and Method for Assigning Priority Levels (MAPLe) are used to determine eligibility for long-term care services and priority or urgency for long-term residential care placement.

⁴ Expenses may also include the provision of care by Personal Support Workers that are privately hired by family to supplement the care received in long-term residential care resulting from insufficient staffing levels.

configurations (i.e. division of labour, staffing mix, staffing levels), working conditions, and health and safety.

Austerity and Health Care Restructuring

The nature and role of government has changed. Since the early 1990's, the government has used debts and deficits as justification for significant health system reform and restructuring and established the context for reduced government public spending on social and health programs (Armstrong & Armstrong, 2003; Baines, 2015). It has also established a new relationship with the corporate sector. This relationship has shaped and influenced policy directions as the language and the logic of economics are increasingly mirrored in health and social policy. The expanding role of the private, for-profit sector has been explicitly endorsed by proposals for health reform in Canada (e.g., Kirby Report). The underlying assumption of these proposals is that health care is a commodity and the private sector is best positioned to “modernize” the health care system, that is, to capitalize on and expand the profit potential of this sector. Increasingly, all levels of government are seeking alternatives to public delivery ostensibly to reduce mounting health care expenditures, operate more efficiently, and to improve service quality. Advocates of neoliberal reform and restructuring consider private, for-profit delivery of health care to be more “efficient” (in terms of resource management, profit maximization and cost minimization) and “effective” (in terms of quality, improving health) than its public, non-profit counterpart (Armstrong & Armstrong, 2003; Leys, 2009). In Canada (and elsewhere), there has been a growing shift towards “privatizing responsibility” (Ilcan, 2009). That is, health and care are increasingly regarded and treated as a private, individual responsibility, rather than a

social, moral, or collective responsibility. Individualism and the treatment of care as commodity are reinforced by government recommendations for individuals to initiate financial planning for their potential future LTC needs (i.e., save, purchase of LTC insurance). Over the last several decades, deinstitutionalization, dehospitalization, despecialization, early discharge, and outpatient trends have shifted the costs, labour, and risks of care. Increasingly, the responsibility for care has been pushed outside the realm of the terms and conditions underpinning the *CHA* and into the home, community, and market sphere. Restructuring and reforms resulting in cuts and closures, facilitates the privatized transfer of costs and labour to the home and market such as by allowing entrance of the delivery of health and care services by private, for-profit corporations.

The focus on financial pressures has shifted to include demands for sustainability (see *Ontario's Action Plan for Health Care*). Economic pressures are also coinciding with social and demographic shifts (i.e. changing age structures, an aging population). According to the provincial government, health system transformation is necessary to attend to the developing demographic shift. Cuts, closures, and system reorganization has consequently meant that formal and informal social and health care providers must seek care, support, and/or offload care for the aging and individuals with complex mental health and physical needs elsewhere. This includes residency within LTRC – regardless of whether this setting is equipped or the most appropriate placement. Because of restructuring and downsizing within the hospital sector (viewed by reformers as less viable or sustainable because of rising system costs), individuals with multiple care needs (e.g., post-operative, functional limitations, acute, chronic, terminal, palliative) who would have previously received care within the hospital setting are instead now entering

LTRC. Alternatively, they are being sent home or into the community where public funds are minimal and individuals are often conscripted into providing care without real choices and options or appropriate skills or adequate social, economic, emotional, and professional supports and resources (Aronson & Neysmith, 1996; Armstrong, 1999; Vogel et al., 2000; Armstrong, 2013). An absence of skill and preparedness may increase risk of injury and illness to both unwaged care workers and those being cared for. It also creates a situation where there is no recognized protection or formal compensation in the event that injury or illness occurs. Given that women are the main providers of health care (waged and unwaged), women have disproportionately assumed the burdens and risks relating to recent reforms aimed at restructuring and privatizing health and care services (Armstrong & Armstrong, 2005).

As the province imposes further austerity measures in an attempt to reduce health spending, governments' focus and the invoked rhetoric has increasingly been oriented towards all things "evidence-based", "outcome" driven, and promoting "healthy lifestyles", "home-based care", and encouraging "sustainability" and "market-based solutions." The current policy direction is about eliminating costs and facilitating market mechanisms and market management. *The Ontario Action Plan for Health Care*, introduced in January 2012, repeatedly employs this language to articulate their vision of transforming the health care system in this province. Under the dominant paradigm, scientific evidence is presumed to lead to economic system efficiencies and accountability (demonstrated through numerically defined measurement). Beyond failing to integrate gender into analyses, the emphasis on outcome measures (to assess quality) only captures what can be easily measured. Underlying the assumption that if "you

cannot measure it you cannot manage it” informing policy and managerial practice is the assumption that all things significant can be measured and/or done so precisely. The drive to shift care from institutions (i.e. hospitals, LTRC) to the home and the need to use best evidence also flowed from recommendations to inform Ontario’s Seniors Strategy in the report *Living Longer, Living Well*.⁵

While facility-based care was absent from the *Romanow Report* (2002), which detailed recommendations for extensive changes to the health care system, home care was identified in the report as “the next essential service.” Home and community-based post-acute, palliative, and mental health services were prioritized in the report, however, services specifically targeting the elderly was not identified as a priority area. “Aging in place” philosophies and the mantra “right care, in the right place, at the right time” have signalled a policy shift towards home and community-based, rather than facility-based care as governments move to reduce costs, shift labour, and facilitate market-based alternatives to make the system more efficient and effective. This shift in policy is now dominating agendas for health care reform in Canada and elsewhere (i.e. United Kingdom, Australia, United States). The emphasis on home and community care or “aging in place” and “right care, right time, right place” is one of three priorities outlined in *Ontario’s Action Plan for Health Care* (2012).⁶ By the governments’ own account, this plan is “obsessively patient-centred” – that is, supposedly oriented to individual

⁵ According to the report *Living Longer, Living Well* to the MOHLTC and the Minister responsible for Seniors, policy, programs, and services must be based on five principles: access, equity, choice, value, and quality.

⁶ As the province explains in the report, “At the heart of our action plan is a commitment to ensure that patients receive timely access to the most appropriate care in the most appropriate place. It’s about getting the greatest value for patients, allowing evidence to inform how scarce health care dollars are best invested and ensuring seniors receive the care they need as close to home as possible. [...] The most significant part of our plan focuses on ensuring patients are receiving care in the most appropriate setting, wherever possible at home instead of in hospital or long-term care” (Ontario’s Action Plan for Health Care, 2012).

needs and preferences. While the language of “patient-centred” sounds appealing, research suggests that in practice, patient-centred care is geared to shrink costs and control workers instead of improving care (Armstrong & Armstrong, 2003). According to the report, the “right care” means care that is “higher quality,” “better for patients,” and “less expensive.” The “right care” is determined through “best evidence” and “clinical guidelines.” This “best evidence” is also used to inform system decision-making and funding levels. Yet, in the feminist perspective, as Pat Armstrong and Hugh Armstrong (2004: 119) remind us:

Health care needs and the methods used of addressing them can never be precisely, scientifically established. As a result, the notion of being able to determine accurately what is the right thing to be done by the right person to the right person at the right time at the right place is simply inappropriate to health care.

Home and community-based care is also explicitly endorsed in the government’s 2012 economic plan, the *Commission on Reform in Ontario’s Public Services* (Drummond Report, 2012). The rationale and discourse used to justify this shift is predominately based on humanitarian and economic grounds – that is, it is less expensive (than hospitals, LTRC) and oriented to individual/consumer choice and preferences (also see Table 1). Seniors want to remain at home (Health Council of Canada, 2012).

Table 1: Average Per Diem Costs

Hospital Bed	\$842.00/day
Long-Term Care Bed	\$126.00/day
Care at Home	\$42.00/day

Source: North East LHIN (2011) HOME First Shifts care of Seniors to HOME. LHINfo Minute

The assumption is the home is the preferred, better, and cheaper place for care and seniors should remain in their homes as long as possible. Indeed, although many seniors

state this as their preference, current resource levels are grossly inadequate in terms of facilitating this. That is, although the site of care has shifted, resources to this sector have not. While there is no evidence to substantiate the claim that the home is a better or safer place for care, it is indeed cheaper for the provincial government in so far as many of the costs are shifted to individuals and labour is transferred or delegated to poorly waged and unwaged workers who are mostly women. As Stasiulis & Bakan claim (2005: 24), “women become the unacknowledged shock absorbers” of the “care deficit” (Hochschild, 1998) or the gaps created in public/private care. In other words, these “efficiencies” do not eradicate the need for care or the costs for care; rather care and costs are shifted to individuals and families, reinforcing the ideological construction of family care and individual responsibility and the changing role of government. It reinforces the low value and invisibility of care labour, primarily because women provide it and the setting in which care is provided.

The new assessment criteria used to determine LTRC eligibility also reinforces government privileging and/or bias towards “aging in place” and “community care” and the resulting transfer of costs, responsibility, risks, and labour to unwaged and poorly waged workers. This is particularly the case with the most recent slashing of budgets in home and community care where workers have been increasingly used as cheap sources of labour. While government emphasis is on provision of care within the home and community sector, as demand for this care rises, system cuts elsewhere have not been offset or corresponded with an increase in adequate resources to this sector. Home or community-based care continues to be treated as a supplement to family-based care (Health Council of Canada, 2012).

Long-Term Residential Care in Ontario

LTRC facilities provide 24-hour on-going and indefinite health, social, and personal care services (Banerjee, 2007). Nursing, supervision, and/or assistance are provided on-site to seniors and individuals with chronic mental and physical health issues (Berta et al., 2006; McGregor & Ronald, 2011). LTRC is intended for individuals whose capacities for independent functioning and self-care (medical, social, personal) is unsupported, hindered, or never acquired, whose needs surpass the capacities of home and community-based care (waged and unwaged) or assisted-living facilities, and who require supervised accommodation in a secure environment. Facility size varies across the province, with 40 percent of facilities classified as small – that is, fewer than 96 beds (OLTCA, 2014). Government owned facilities tend to be significantly larger compared to for-profit and non-profit facilities (Berta et al., 2006).

Long-term Residential Care Funding and Regulations

The MOHLTC funds and regulates all LTRC facilities in Ontario.⁷ The MOHLTC establishes provincial standards, policies, and regulations relating to resident services and LTC operation and it is responsible for managing the enforcement of regulations under legislation. MOHLTC responsibilities also include operator licensing, compliance, and inspection. The established legislative and regulatory standards in the province direct agreements between LHINs and LTRC operators. Currently, all LTRC facilities in Ontario are governed by the *Long-Term Care Homes Act, 2007* (LTCHA) and

⁷ In non-profit municipal homes significant revenue flows from municipal taxes.

its regulations.^{8,9} The *LTCHA* underpins the province's reforming of what constitutes accountability and care in the LTC sector. The legislation standardizes care and accountability, obliging LTRC operators to implement codes of conduct as well as non-enforceable guidelines through policies and practices at the institutional or organizational level. In Ontario, the LTC sector is densely regulated (Banerjee & Armstrong, 2015). Compared to other sectors within health care, LTRC is more heavily regulated in this province than elsewhere in Canada. At the same time, the LTRC sector has undergone the deregulation of standards (especially standards which may create barriers to profitability) that may facilitate less accountability and compromise care and working conditions. For instance, under the *LTCHA*, there is no legislated staffing and care standard within LTRC that obliges specific staffing levels or ratios or fixed hours of care per resident per day.¹⁰ This standard was eliminated in 1996 by the provincial government led by Mike Harris. Thus, while the sector is indeed heavily regulated, what is perhaps most crucial is what is (or is not) privileged as part of this regulatory regime, with what consequences, and for whom.

Regardless of provider arrangement, LTRC facilities obtain funding from three main sources: level of care (LOC) funding, supplemental funding (e.g., non-specific needs – high intensity care needs, pay equity, structural compliance, municipal taxes etc.), and revenue from preferred accommodation fees (e.g., semi-private or private).

⁸ The *LTCHA* came into force on July 1, 2010, replacing the *Charitable Institutions Act*, the *Homes for the Aged and Rest Homes Act*, and the *Nursing Homes Act*.

⁹ Numerous other regulations apply to this sector, including the *Health Care Consent Act*, *Substitute Decisions Act*, *Personal Health Information and Protection Act*, *Occupational Health and Safety Act*, and *Fire Code*.

¹⁰ The *LTCHA* requires that all LTRC facilities have a Director of Nursing and Personal Care (must be a registered nurse), a Medical Director (must be a physician), and that a registered nurse must be on duty at all times (24 hours a day, 7 days a week).

Funding through the MOHLTC is based on a daily rate per resident (per diem) model. Regardless of ownership arrangement, all LTRC facilities receive the same per diem amount for LOC funding (MOHLTC, 2014b). The LOC funding relates to resident acuity or facility standardized care requirements and costs as determined utilizing Case Mix Index (CMI) formula. The per diem funding system consists of four separate categories, which are known as “envelopes.” These include: Nursing and Personal Care, Program Support and Services, Raw Food, and Other Accommodation. Current policies outlining the conditions of funding and resource allocation arrangements allow facilities to retain provincial funding not spent from the Accommodation envelope. Unused funding from Nursing and Personal Care, Program Support and Services, and Raw Food envelopes must be returned to the government. Additional revenue accrued through provincial funding or resident co-payments for private and semi-private accommodations also go to the operator and into the Accommodation envelope. LTRC facility operators have been permitted by the province to transfer or redirect costs from the Accommodation envelope to other funding envelopes (such as Nursing and Personal Care). A reduction in costs associated with the Accommodation envelope has facilitated greater profits. The ability of operators to shift costs from one designated envelope to another has resulted in an undermining of direct care staffing budgets (which subsequently determine staffing levels and workload), supplies, and security, in order to accumulate profit that is derived from the Accommodation envelope (CUPE Ontario, 2008; Ontario Health Coalition, 2008; CUPE, 2009).

Non-Profit and For-Profit Ownership

LTRC facility ownership in Canada may be categorized as either non-profit or for-profit, which operate within the public and private sectors. Non-profit public ownership includes government (federal, provincial/territorial, municipal) and private non-profit ownership that consists of voluntary, charitable, and religious/ faith-based, and cultural organizations. For-profit ownership within the private sector includes facilities owned by a corporation, private organization, or individual (McGregor & Ronald, 2011). One obvious difference between non-profit and for-profit ownership configurations is that, in addition to the delivery of LTRC services, for-profit facilities must also derive their profits from these sources. The distinction between non-profit and for-profit is a crucial one, relating to the inherent tension or contradiction between the provision of care and the drive to generate profit. For-profit facilities may divert funds or cut costs from elsewhere in the system in order to retain these as profits.

The Rise of For-Profits and Pro-Market Managerialism

Although LTRC was once predominantly non-profit and administered by government and religious organizations (McGregor & Ronald, 2011), it is increasingly emerging as part of a competitive market-driven system informed by a paradigm that privileges infinite economic expansion and capital accumulation. More so than elsewhere in Canada, the for-profit LTRC sector in Ontario is on the rise (McGregor & Ronald, 2011). This is especially the case for the corporate sector in this province (Armstrong & Jansen, 2006; Armstrong et al., 2011; Armstrong, 2013b). Over the last decade and a half, there has been an evolving trend towards private for-profit corporate multinational or local LTRC chains (i.e., the acquisition of smaller for-profits by larger

for-profit corporations) (Canadian Healthcare Association, 2009) and the commercialization of ownership and management in for-profit and not-for profit facilities.¹¹

In Ontario, for-profit facilities currently constitute almost 60 percent of the LTRC facilities in the province (Mustard et al., 2010; MOHLTC, 2014a) (also see Table 2). The shift to for-profit dominance is particularly the case since 1999/2000. The for-profit transformation is understood as an impact flowing from the Ontario Health Services Restructuring Commission established in 1996 and the resulting Long Term Care Redevelopment Project (Berta et al., 2005). Currently, over half of the residents within LTRC in the province reside in facilities that are commercially owned, one-quarter live in non-profit facilities, and nearly one quarter live in municipally operated facilities (MOHLTC, 2014a).

Table 2: Ontario Beds and Facilities by Sector

Sector	For-Profit	Non-Profit	Municipal	EldCap	Total
Facilities	360	153*	103	15*	628
Beds	41, 842	19, 599	16, 433	264	78, 138

** Elderly Capital Assistance Program: 3 facilities have both EldCap and non-EldCap beds (EldCap beds are long-term beds in acute care hospitals)*

Source: MOHLTC, 2014a (LTC System Report for April 2014)

Since 1998, under the conservative government nearly two-thirds of new long-term care beds created in Ontario are in for-profit facilities (McGregor & Ronald, 2011). Many of the for-profit beds established were granted to major corporations such as Extendicare, Central Park Lodges, and Leisureworld (CUPE, 2009). The trend towards for-profit

¹¹ The top three long-term residential care chain operators in Ontario include Revera Inc., Extendicare, and Leisureworld Senior Care Corp. These corporations own 46, 35, and 34 long-term care facilities in Ontario, respectively (Care Planning Partners Inc.)

ownership is occurring elsewhere in the country where the growing number of private residential care beds in Canada is mirrored by a decline in the number of non-profit residential care beds (Parkland Institute, 2012). In many jurisdictions, health policy has shifted to contracting residential care by provincial health ministries to facilities that are profit-oriented. In British Columbia, there has been a 20 percent growth in publicly funded for-profit and an 11 percent decline in publicly funded non-profit beds since 2000. While Quebec has expanded beds in the for-profit sector, it has eliminated 7,632 public beds. Between 2000 and 2007, a 6 percent increase in for-profit beds occurred in Alberta (McGregor & Ronald, 2011: 4).

Prior research in the U.S. and Canada has established that ownership arrangements have significant implications for work and care conditions, including worker and resident health and safety (McGregor et al., 2005; Harrington, 2008). Research suggests that as a group, for-profit facilities are associated with inferior care, lower staffing levels or staff-to-resident ratios (McGregor et al., 2005; Berta et al., 2005; CUPE, 2009; McGregor et al., 2010; McGregor & Ronald, 2011; Harrington et al., 2011), and greater costs for residents (CUPE, 2009; McGregor & Ronald, 2011). Compared to other provinces in Canada, Ontario has the lowest staffing levels (OLTCA, 2014). Higher staffing levels are observed among non-profit publicly owned (McGregor et al., 2005) and municipal operators in the province (Berta et al., 2006).¹² Research has also provided evidence of the relationship between higher staffing and improved quality care for residents (Harrington, 2008) and lower injury rates amongst workers (Trinkoff et al., 2005; Cohen, 2009). For-profits are also characterized by greater workload intensity and

¹² Compared to other ownership types, government-owned long-term care facilities have higher nursing intensity and direct care staffing levels.

higher turnover amongst the workforce (Harrington & Swan, 2003; Castle et al., 2007; CUPE, 2009). Turnover amongst frontline workers is understood as a product and consequence of poor work and care conditions (CUPE, 2009). In Ontario, non-profit, charitable, and public facilities have significantly lower rates of complaints related to unmet standards and citations issued related to legislation and regulation violation than complaints observed in for-profit chain facilities (McGregor et al., 2011). Despite this evidence, the provincial government not only continues to subsidize the for-profit sector, as highlighted above, the government also facilitates for-profit expansion (McGregor & Ronald, 2011). The *LTCHA* has been criticized for its facilitation of smoother non-profit to for-profit conversion, especially for corporations. In this respect, the *LTCHA* has been argued to function primarily as a “licensing regime” that is oriented more to encouraging non-profit to for-profit conversion than it is to resident care (Baines, 2007) or the safety of residents and workers (CUPE, 2007).

At the same time, public sector non-profit facilities are increasingly implementing private sector management techniques (Banerjee, 2010; Armstrong et al., 2011; Baines, 2015; Baines & Cunningham, 2015) and cost reduction strategies and efficiencies (a product of chronic underfunding, regulatory pressures, and changing resident base) with consequences analogous to systems of care that are driven to generate profit (Baines, 2015). It has also included the merging of private sector relations within non-profit facilities, and thus non-profits have become more similar to profit-oriented facilities (Baines, 2004c; Baines & Cunningham, 2015). Moreover, governments are utilizing employment policies modeled on the private sector (Armstrong & Armstrong, 2009) to redefine what counts as care, to cut or minimize costs and increase efficiency (supported

by neoliberal assumptions about more efficient care delivery) in ways that are incongruent with workers' understanding and experience of the LTRC labour process.

The main method of generating profit and rationalizing costs is to minimize the size and costs of the workforce through changes to the division of labour, work organization, and scheduling (Armstrong & Armstrong, 2003; Armstrong et al., 2009). This includes leaner and flexible staffing, hierarchical work arrangements, the transfer of work from higher waged regulated workers to lower waged unregulated workers, workload intensification, and precarious work – part-time, casual, and unpaid work (or wage theft, including illegal deprivation of wages and benefits through various mechanisms). Cost reduction and greater profits is also facilitated through the elimination of aspects of care determined to be “non-value adding” such as difficult to measure intangibles such as social and relational care. The rationalization of costs among facility operators may also include the manipulation of the usage of incontinence products, pharmaceuticals, and physical restraints (Armstrong et al., 2009).¹³ These are frequently utilized to substitute for waged workers and to compensate for chronic staffing shortages and inadequate funding levels, which have not kept pace with changing resident profiles or the specialization and complexity of resident health, care, and staffing needs.

¹³ For-profit LTRC operators may also inflate costs or charge residents higher fees (CUPE, 2009; Canadian Healthcare Association, 2009) for personal services (such as haircuts) that fall outside of the accommodation fee that is set by the province. While charging resident higher fees for personal services may not be particularly lucrative in terms of generating profit – higher fees matter to residents struggling on fixed and/or low incomes. It may also matter to poorly waged workers who may (for various reasons) feel compelled or obliged to pay for these services out of their own resources for residents who are unable to afford these inflated service costs. In some cases, some workers will perform the services without charge (haircuts, foot care) for residents who cannot afford them.

Within inadequately funded and understaffed facilities, strategies to manage problems that are structural and organizational in nature have often given rise to new problems and unsafe care and work conditions, and/or aggravated existing ones. For instance, the administration of drugs to residents as a form of chemical restraint has become a normalized and routinized practice within persistently understaffed facilities. In an investigative report by *Toronto Star* reporters, David Bruser, Jesse McLean, and Andrew Bailey in April 2014, it was revealed that anti-psychotic pharmaceutical use rates in over 300 Ontario LTRC facilities averaged 33 percent for the first half of 2013.¹⁴ This usage rate of psychotropic drugs is almost twice the rate reported in the United States. According the *Toronto Star* report, facilities “struggling with staffing shortages, are routinely doling out these risky drugs to calm and “restrain” wandering, agitated and sometimes aggressive patients.” The greatest rates of chemical restraints cited in the report emerged from large for-profit chain operations, including a facility owned by Leisureworld and one by Caressant Care. At these facilities, antipsychotics were prescribed to 67 percent and 73 percent of the residents, respectively. This report echoes earlier research conducted by Hillmer et al. (2005) exploring performance in non-profit versus for-profit LTRC facilities. The data from this research revealed that for-profit facilities had higher rates of chemical restraints (antipsychotics) as well as greater use of physical restraints to subdue residents than non-profit facilities.

The broader structural policies and processes that inform the everyday/everynight practices and working conditions are profoundly relevant to frontline worker health and

¹⁴ Antipsychotics prescribed to residents with dementia are done so “off-label” with poor oversight. The efficacy of these drugs for seniors is questionable – and poses potentially dangerous and even fatal side effects (Bruser et al., 2014).

safety. Simply put, ownership and funding configurations that characterize the LTRC regime in Ontario matter. This broader context is important to understanding workers' experiences, as this context directly influences and shapes the production of care "on the floor" – such as how care work is structured, when and where care is provided, under what conditions, and by whom. This context is often incompatible with facilitating the conditions for good care and safe work. Feminist political economy offers a way of exploring the underlying complexity of these broader arrangements and its contradictions within the context of LTRC by revealing that the everyday/everynight practices on the floor are linked to conditions that facilitate rationalizing costs and profit generation, rather than safe care and work conditions. From a feminist political economy perspective, the experiences of workers are understood as both knowledge and evidence – providing insight into the wider social and structural context of the sector in which care occurs. Structural conditions and state policies are also understood to condition the mechanisms used to control the labour process and exploit labour as well as shape the nature of struggle and worker resistance over the conditions of work. The broader context of neoliberal restructuring is also significant to highlighting the implications of changing resident profiles for the nature of care and work. This includes changes that have compounded the risks frontline workers face – or have given rise to new ones, which may undermine worker (and resident) safety.

Consistent with other countries of the Organization for Economic Cooperation and Development (OECD), Canada's population is aging. The population of people over 75 in Ontario is expected to rise by 30 percent by 2021 (Auditor General, 2012: 186), creating greater pressure to meet the care demands of individuals requiring LTC. The

demand for facility-based care in Ontario is increasingly exceeding supply, creating what is largely regarded as a “long-term care crisis.” In part, the expanding and aging population – described as the “grey wave” or “demographic tsunami” – in conjunction with longer average life expectancies and medical treatment advances (Sharkey, 2008) are challenging existing health infrastructures and significantly fuelling the demand for residency within these facilities (McGregor & Ronald, 2011). This is occurring while public systems of support erode or are terminated. While there has been only a 3 percent increase in the number of beds created in the province between 2005 and 2012 there has been close to an 85 percent increase in individuals across Ontario waiting for a LTRC bed (Auditor General, 2012: 191). As of April 2014, there were 20, 388 eligible individuals on the wait-list for long-stay beds (MOHLTC, 2014), reflecting the inadequate supply of licensed facilities and beds to provide care for individuals requiring 24-hour care and services. It is also a consequence of neoliberal health system restructuring occurring within this sector and elsewhere. This includes dehospitalization and deinstitutionalization processes and practices that have facilitated a shift to LTC. In part, this shift has emerged because of the absence of augmented supports in the community or home to accommodate health and care needs following closures and cuts in hospitals and specialized institutional settings. The change from hospital to LTC (because the latter is less expensive to operate because it is only partly subsidized by government) reflects two manifestations of privatization – specifically, private for-profits provide more services and more costs are transferred to residents. In this context, the “long-term care crisis” can to some extent be understood as a manufactured one, linked to the changing role of the state, and emerging because of significant cuts, reform, and

restructuring in health and social care in a climate predominately shaped and characterized by neoliberalism.

In 2012, the median wait-time for LTRC placement was 98 days. This is almost three times the median wait-time reported in 2004/2005 (Auditor General, 2012: 200). Not much has changed. Facility time to placement currently averages 89 days (OLTCA, 2014). Yet, many individuals fitting the current eligibility criteria wait over a year for placement, with many other individuals waiting years. Some die waiting for placement (Auditor General, 2012). Although the provincial government publicly claims moderate success with reducing the time to placement within facilities (Ontario's Action Plan for Seniors, 2014), the most recent wait-time reductions may be related to stricter standardized eligibility criteria for resident admission enacted in 2010 under the *LTCHA* (Auditor General, 2012: 191).¹⁵ The new rules under this legislation stipulate that applicants must be assessed as “high” or “very high” in terms physical and cognitive challenges in order to be eligible for placement in Ontario facilities (OLTCA, 2014).

The Residents of Long-term Residential Care

Alongside the growing shift in focus towards “aging in place”/ “aging at home” – the modification of eligibility assessment requirements for new LTRC resident applicants – partly, a symptom or manifestation of restructuring and reform – to the LTRC sector has contributed to a dramatic change in the resident base in this setting.

Between 75,000 and 80, 000 residents reside in over 600 licensed LTRC facilities in Ontario (Sharkey, 2008; OLTCA, 2014). The average age of residents within these

¹⁵ Method for Assigning Priority Levels (MAPLe) is the current tool utilized by CCAC for assessment or prioritizing of service eligibility.

facilities is 82 years (CIHI, 2013). Women constitute the majority of residents (Banerjee, 2007; Baines, 2007; Armstrong et al., 2008, CUPE, 2009), where they occupy 69 percent of facility beds (CIHI, 2013). These women are often of low-income status (McGregor & Ronald, 2011). Based on 2011/12 reporting data, 7 percent of residents are under the age of 65 and 48 percent of residents are 85 and older (CIHI, 2013). A growing proportion of residents have some form of mental health issue (McGregor & Ronald, 2011), with 73 percent of residents possessing some level of cognitive impairment (Sharkey, 2008: 12). This includes 62 percent of residents with Alzheimer's and related dementias (OLTCA, 2014: 3). Increasingly, individuals are admitted to LTRC facilities in the later stages of disease and chronic illness trajectories, with greater dependency and complex care needs. Over 85 percent of residents are grouped within the mid-to-heavy care classification (HPRAC) (2012: 4). These residents require high levels of care, supervision, and assistance with one or more activities of daily living (ADLs) (Sharkey, 2008). Since 2008-09, there has been a substantial increase in residents requiring assistance with ADLs (OLTCA, 2014).¹⁶ While once infrequent, the number of residents requiring complex care, including catheters, feeding tubes, and dialysis, are also rising. In the last five years, the prevalence of chronic conditions (e.g., heart/circulatory diseases, bladder or bowel incontinence, hypotension, dementia) has significantly increased (between 5 and 12 percent), with more than 90 percent of residents with two or more diagnosed chronic disease conditions (OLTCA, 2014). On average, more than 40 percent of residents have six or more medical conditions (OANHSS, 2014).

¹⁶ For example, dressing increased 24 percent, toileting increased 22 percent, and personal hygiene increased 23 percent (OLTCA, 2014)

Almost half of residents exhibit aggression such as verbal abuse, physical abuse, socially disruptive or combative behaviours, “responsive behaviours”, and “resistance to care” (OLTCA, 2014). Currently, 35 percent of residents in Ontario facilities are considered moderately aggressive and 11 percent are classified as severely aggressive (OANHSS, 2014). Hunger, thirst, pain, or other symptoms of physical distress may also trigger or compound resident aggression (Robinson & Tappen, 2008) – which may become common issues in demanding, workload intense, and frequently inadequately staffed facilities. Along with the rise in mental health conditions among residents, the risks to resident and worker safety and wellbeing have also intensified. For instance, while aggression is often discussed exclusively in relation to mental health conditions, Alzheimer’s, other dementias, or cognitive impairment (OLTCA, 2014), restructuring and work reorganization may produce or escalate risky care and work conditions. This includes work organization changes (i.e. inadequate staffing levels, inappropriate staff mix, strict routines/regimes/schedules, “flexible” work arrangements) that interfere with care continuity and may provoke violence and create risk for both residents and workers. It may also prevent the implementation of practices and actions that could limit aggression and violence.

The LTRC physical-structural environment is often not conducive to the complex and specialized care needs of the residents or the health and safety of frontline workers. Close to 44 percent (or approximately 300) of LTRC facilities in Ontario, particularly those located in small communities and rural areas, fail to comply with the most recent design standards established in 2009 (OLTCA, 2014). For instance, inadequate or insufficient space (bedrooms, bathrooms, doorways) that characterizes many older

facilities often presents significant ergonomic challenges for workers to safely navigate and assist residents as well as manoeuvre accompanying supportive equipment such as wheelchairs, walkers, lifts, etc. without risk of injury. Crowding in four-bed wards that characterize many older facilities also introduces significant problems linked to infection control and the needs of residents with Alzheimer's or other dementias. Many of these facilities require extensive upgrades, redevelopment, or reconstruction to meet the current health and safety needs and security of residents and the workers (OLTCA, 2014).¹⁷ The physical site in which frontline workers labour and residents live is clearly important to working conditions and health and safety and must be considered alongside social, economic, political, and moral factors as well as the current resident base and their physical and mental care needs.

Women and the Long-term Care Labour Force

Women constitute the primary labour force in health care. Many of these health care workers are concentrated in home, community, and LTRC settings (Berta et al., 2013). The MOHLTC estimates that there are 90,000 Personal Support Workers (PSWs) who make up the bulk of this labour force, working in various community and facility-based settings throughout Ontario. There are approximately 60,000 health care workers working in licensed LTRC facilities in the province (Mustard et al., 2009; Berta et al., 2013). In Canada, 90 percent of the LTRC labour force is comprised of women (Armstrong et al., 2009). These women provide direct care (personal support workers, physical and occupational therapists, registered practical nurses, registered nurses) and

¹⁷ According to the *Enhanced Long-term Care Renewal Strategy*, over the next decade the province will assist facility operators with capital redevelopment projects to modernize facilities in order to comply with design standards by 2025.

“ancillary” or support work (dietary, laundry, cleaning, and clerical) (Baines, 2007; Armstrong et al., 2009) within this setting. Frontline workers/Personal Support Workers constitute the largest group of workers within the LTRC workforce (Canadian Healthcare Association, 2009). These workers account for 72.3 percent of the direct care staff working in this setting. Registered practical nurses and registered nurses represent 17.9 percent and 9.7 percent of this workforce, respectively (OLTCA, 2014). Given their overwhelming presence in the provision of care and their integral role that is a core component to the ongoing functioning of LTRC, these women have been characterized as the “backbone of the long-term care workforce” (Noelker, 2001). In Ontario, the frontline (PSW) LTRC workforce is estimated to be approximately 57, 000 (Health Professionals Regulatory Council, 2010). However, several factors present challenges to accurately estimating the size of the workforce in LTRC facilities. Data that would facilitate charting context and working conditions such as sector data and unionization within the LTRC workforce is either non-existent or incomplete (Laxer, 2013). Much of this has to do problems and/or inconsistencies originating with the way in which the workforce is counted and categorized.¹⁸

¹⁸ For instance, data sources frequently combine health care worker categories. Health Canada, for instance, does not recognize frontline workers as constituting a separate occupational category. Instead, these workers are aggregated with related occupations. Similarly, frontline workers fall under the rather general category of “unregulated care providers” by the College of Nurses of Ontario. Moreover, some employers only report on full-time equivalent (FTE) positions rather than the actual positions (full-time, part-time, casual) within facilities. The necessity for some workers to work at multiple facilities given employer preference for a flexible workforce (i.e. part-time, casual) within this industry sector further complicates capturing the actual size of this workforce. Estimating the size of the workforce is also confounded by variations in education and training (HPRAC, 2006). According HPRAC (2006), while many workers have completed programs through community or career colleges, some have minimal to no formal training outside of direct work experience and in-service training through employers.

The Workers on the Frontlines of Long-term Residential Care

Workers on the frontlines of care provide 24-hour assistance, seven days a week, across day, afternoon, and night shifts by full-time, part-time, and casual or contracted agency care workers who may or may not have unionized status. As indicated in the introduction of this dissertation, there is no standard term for frontline workers. While Personal Support Worker (PSW) is the most recent provincial designation for frontline workers in Ontario, depending on country, province, region or facility these workers are referred to interchangeably as health care aides, nursing assistants, care aides, direct-care workers, personal care assistants, residential care aides, certified nursing assistants, and personal care attendants.

Many of these frontline workers within LTRC are over 45 years old and are increasingly from racialized and/or marginalized immigrant groups, whose first language is not English (HPRAC, 2006; Armstrong et al., 2009; CUPE, 2012; Armstrong & Braedley, 2013). This trend is occurring elsewhere (i.e. United States, Denmark, Australia, France, and the Netherlands) (Korczyk, 2004). In Ontario, the frontline LTRC workforce in smaller cities, towns, and rural communities are often Caucasian and Canadian born. In contrast, workers in metropolitan areas are often from racialized groups – women of colour and immigrants (CUPE, 2011). Within the LTRC hierarchy, frontline workers are of marginal status. These workers are positioned at the lowest end in the division of labour and organization of direct health care work. Compared to other workers who comprise the health care workforce, LTRC frontline workers tend to have lower wages, benefits, job security, control, and decision-making capacity (Armstrong & Jansen, 2006; Lilly, 2008; Jansen, 2011; Daly et al., 2012). In Canada, frontline workers

are unregulated workers. Their work is not recognized as constituting a profession. As unregulated workers, a regulatory body does not monitor the frontline worker labour force. Frontline workers are required to operate under the direction and supervision of other regulated or licensed health care workers such as a registered nurse or registered practical nurse (Berta et al., 2013). The labour of frontline workers in facility-based settings is often trivialized, undervalued, and treated as natural and unskilled or is considered peripheral and ancillary to care (Armstrong et al., 2008; Armstrong, 2013b). It is assumed that the level of care – often described as personal support – within LTRC requires less skilled care than in hospitals. In part, this is understood as consequence of historical privileging of the hospital setting with respect to the medical-social valuation of health care in Canada (Lilly, 2008; Jansen, 2011). This often translates into a devalued and more poorly remunerated workforce than in hospitals (Armstrong & Jansen, 2006; Lilly, 2008). In her work, Pat Armstrong (2013a) highlights a racist component to this devaluation of LTC work where immigrants whose foreign credentials are unrecognized, are regarded as able to work in LTRC. That is, the assessment of foreign credentials is informed by assumptions about gender and race (also see Armstrong, 2009; Armstrong, 2013b).

The type of care provided and the responsibilities of frontline workers in LTRC have changed. Frontline work has shifted from work that primarily involved providing support and assistance to elderly residents with ADLs (such as, bathing, toileting, dressing, feeding and personal care) towards caring for residents with much more comprehensive mental and physical needs (Jansen, 2011; McGregor & Ronald, 2011; Berta et al., 2013). While the change in eligibility criteria for resident placement has

implications for access, higher level of care also has implications for workers. It may compound the already intense workload that has resulted from neoliberal restructuring within and outside of the LTRC sector. For frontline workers, this change has meant a broader scope of practice, more complex demands, and comprehensive responsibilities (Jansen, 2011; Berta et al., 2013), including delegated nursing or controlled acts. With the significant transformation in resident base – including more younger people, more men, and more people with complex care needs – this has meant requirements for more specialized care and more challenging physical, behavioural, and mental health demands (i.e., chronic disease management and dementias). The restructuring and reorganization of work and care is occurring in the absence of augmented resources, training, or improved staffing compositions and/or levels to accommodate and/or facilitate the needs of new residents who must fall into “high” or “very high” care classifications in order to be considered for entry into LTRC in Ontario.

Educational Standards, Wages, & Unionization

As of 2011, with limited exceptions, the regulation under the *LTCHA* requires that PSWs conform to one of three-educational standards. These are standards established by the Ministry of Training, Colleges, and Universities, the National Association of Career Colleges, and the Ontario Community Support Association. Although the *LTCHA* does not provide an hourly breakdown of class time and practical experience, it does stipulate that these must be a combined minimum of 600 hours in duration. Currently, PSW certificate training in Ontario may be delivered through community colleges, private career colleges, and boards of education. These programs differ in educational standards, including program length, curriculum, and practicum hours (CUPE, 2012). According to

Personal Support Network Ontario (PSNO) (2011), of the estimated 7, 000 annual graduates of PSW certificate programs in Ontario, 20 percent attended programs offered through the Ministry of Training, Colleges and Universities, nearly 45 percent attended private career colleges, and 35 percent attended programs through the Board of Education (adult learning or continuing education) or non-profit organizations. While having three standards instead of one is certainly confusing, the differences between these three educational standards may also influence the preference of facilities oriented towards profit for workers with the most basic training backgrounds in anticipation of acquiring cheaper labour (CUPE, 2012).

Wages for frontline workers vary within and between cities and towns, rural and urban areas, by employer and/or ownership type and sector (home, community, LTRC, hospital) and unionization status. Hourly wages for PSWs range from \$10.25 to \$20.00 with a median of \$14.00 (PSNO, 2014). For-profit LTRC facilities are more likely than their non-profit counterparts (public, charitable, municipal) to have poorer wages, minimal to no benefits (CUPE, 2012), and poorer collective agreements (Canadian Healthcare Association, 2009). Frontline workers in hospitals tend to have higher wages than LTRC frontline workers. The wages of frontline workers in the home and community care sector lag behind their counterparts in hospital and LTRC (Lilly, 2008; Armstrong et al., 2009). Compared to the LTRC and hospital sector, unionization tends to be lowest in the home care sector. In the LTRC sector, unionized workers typically have more job stability and lengthier work experience than their non-unionized counterparts (Daly et. al., 2012). Non-profit facilities also have higher unionization rates than for-profit facilities. In contrast to unionized frontline workers within LTRC

facilities, non-unionized frontline workers tend to have higher turnover rates as well as lower wages and benefits (CUPE, 2009). Unionization may also provide some opportunity for workers to engage in forms of activism and input into working conditions. Nevertheless, frontline work within LTRC is characterized by what Karasek and Theorell (1990) regard as “high-demand, low-control and low-support environments” (Daly et al., 2011: 273) with only modest space for workers to exercise autonomy (Daly et al., 2012) – that is, workers have limited control or latitude with respect to decision-making.

In a context of growing for-profit ownership of LTRC facilities in the province and practices that mirror the for-profit sector within non-profit facilities, the wages, education, and the unionization status of frontline workers matter. For-profit – and particularly corporate – ownership within LTRC have adverse implications for frontline workers. This includes greater exploitability and employment insecurity. It also includes a weakening of worker health and safety protections and union representation, protection, and advocacy. The effect is an undermining the ability of frontline workers to control and negotiate the conditions of their care work.

PSW Registry

In 2012, the MOHLTC launched a PSW Registry in Ontario.¹⁹ The Ontario policy requests the registration of all PSWs working in the publicly funded health care sector in order to collect information relating to education, training, experience, and

¹⁹ Other provinces have similarly established registries. In 2010, Nova Scotia initiated a voluntary registry and British Columbia implemented a mandatory registry for workers in publicly funded facilities. In 2011, Alberta began an employer-implemented directory (Estabrooks, 2014).

employment status.²⁰ The registry requires no associated fees from PSW registrants. It is currently voluntary although the government intends to make it mandatory for all PSWs employed by publicly funded health care employers. In the meantime, many LTRC workplaces are requiring registration numbers and proof of registration from new hires. The launch of this program followed heightened media attention, public scrutiny, investigative reports, and exposure of scandal, abuse, neglect, and fatality of residents occurring within some facilities in the province.²¹ According to the MOHLTC (2012), “the registry will promote greater accountability and transparency and will validate the contributions of PSWs [...] while helping to better meet the needs of the people they care for” as well as facilitate health planning in a way that is consistent with the government’s *Action Plan for Health Care*. According to Deb Matthews, the current Minister of Health and Long-Term Care, “Ontarians rely on the invaluable contributions that PSWs make to our health care system. The registry provides recognition for the vital role they play and improves access to Ontarians who are in need of their services” (www.pswregistry.org).

The registry is currently limited to frontline workers in the home and community sector. However, it is expected to expand to workers in LTRC and the hospital sector. The rollout of the province-wide registry program for PSWs was not without debate and concerns, particularly in terms of its main purposes, benefits, and/or underlying agenda.

²⁰ According to the PSW Registry website (www.pswregistry.org), the OCSA is collecting data for the following purposes:

- (1) To process [Registrants] application to participate in Ontario PSW Registry
- (2) To publish [Registrants] profile as part of the PSW Registry and to administer the Ontario PSW Registry
- (3) To assist employers of personal support workers to fill available positions
- (4) To assist clients and family caregivers in self-directed care
- (5) To produce aggregate reports (on an anonymous basis) for health and human resource planning
- (6) To inform [Registrants] of events and obtain input on matters of interest
- (7) As otherwise permitted or required by applicable law

²¹ Between 2003 and 2012, there have been 29 reported deaths of seniors related to resident-on-resident assault.

According to the CUPE and OCHU (2011), the function of the registry is disciplinary. It focuses exclusively on workers, rather than addressing core structural issues currently plaguing health care in the province, including privatization, underfunding, lack of care standards, health and safety risks for workers and residents, and regulation (CUPE, 2012).

The registry as it is currently established is not synonymous with professional registration. In contrast to regulated health professionals, PSWs are not regulated under the *Regulated Health Professions Act*. Professional registration typically encompasses certification or license, an independent regulatory body, and code of standards that govern health care practices and define scope of practice, as well as authority to respond to complaints and/or oversee the complaints process. In contrast, the PSW Registry is a database that is private-employer managed and oriented to counting and compiling names and personal contact information of PSWs in the province. It is unclear how the compilation of the database is understood by the Minister of Health and Long-Term Care to “validate” the “invaluable contributions” or function as “recognition” of the “vital role” of PSWs. It may, however, situate an already precarious and highly marginalized workforce in a situation that increases their precarity, exploitability, and strip them of formal grievance procedures. According to Katha Fortier, National Director of Health Care for the former Canadian Auto Workers (CAW) union (currently operating as Unifor), “it’s become apparent that this has all of the prejudicial aspects of professional regulation, yet absolutely none of the benefit.” The union is especially concerned that the registry “is nothing more than an attempt to find scapegoats in what could essentially be nothing more than a witch hunt, labeling PSWs responsible for abuse” (CAW, 2014: 3).

This consequence is consistent with a “blame the worker” response that has historically plagued the LTRC sector (and elsewhere) rather than meaningfully addressing structural or organizational factors and issues (see Chapter 4). It is a blame-shifting approach masquerading as recognition, accountability, and transparency.

While the PSW registry may function to create the illusion of the provincial government instituting a mechanism of accountability and transparency to respond to the abuse occurring within some facilities, the “out of control” (Banerjee et al., 2008) system-related risks, struggles, and abuses frontline workers and residents face are not problematized and remain unchallenged. That is, while the PSW registry is framed as reconciling what are reduced to recognition, accountability, and transparency issues or problems, the significant “pathologies and power” (Farmer, 2005) of the system, which may produce, and facilitate dangerous, risky, and exploitative and alienating work and care conditions, remain hidden and unchanged.²² The management of risk by the government is displaced to workers. The PSW registry is one example of the growing surveillance and monitoring of workers that is oriented towards a particular form of accountability. The Resident Assessment Instrument/Minimum Data Set (RAI/MDS) (standardized care processes, care formulas) and compliance with regulatory standards are other instruments or practices of accountability in which workers are especially subject to managerial surveillance in the execution of care plans (Kontos et al., 2010a).

²² The PSW registry has also had some more immediate implications for frontline workers. Aside from concerns relating to the purpose of the registry and how registry data would be utilized, CUPEs opposition to the registry also includes serious concerns related to inadequate policies and procedures for data security and the lack of government oversight. Currently, the Ontario Community Support Association (OCSA) is responsible for the collection, use, and disclosure of registrant personal information. According to CUPE Ontario, in late 2013, the Registry was subject to a serious privacy breach in which the personal information of 25,000 PSWs captured by the private employer-managed registry was compromised. Following the breach of personal information, PSW registrants subsequently became the targets of fraudulent telecommunications attempts to solicit registration fees and payments for insurance coverage.

In the current lean neoliberal climate, this often means the production of evidence (often limited in scope) that is acquired through counting or measurement (narrowly and rigidly conceptualized and operationalized) to achieve cost containment and slashing within the formal system (in immediate, economic terms).

Moreover, the PSW registry as it is presently administered leans heavily towards consumerism and the privatization of health and care. That is, what the Minister of Health and Long-Term Care terms “improving access to care services” is synonymous with facilitating the private purchase of care. For instance, individuals (read: consumers) who may require more care than that is allotted through the increasingly strict eligibility criteria of the publicly funded system may then contact and independently hire a PSW (read: independent contractors) from the registry and absorb the costs associated with the private purchase of care. This dynamic potentially creates a situation that is even more precarious and risky for an already invisible, undervalued, exploited, alienated, and marginalized workforce. Establishing mechanisms and tools that ease or facilitate the private purchase of care, such as the PSW Registry, are consistent with a broader neoliberal agenda that emphasizes individualization, economic rationalization, personal responsibility, consumerism, and/or care as commodity.

Conclusion

In Canada, the landscape of health and LTC has changed. Significant neoliberal restructuring and reform of health and social care services have profoundly transformed the nature, organization, and delivery of LTC in Ontario. Moreover, changes in the health and care delivery structures have transformed power relationships and the ways resources are allocated within these structures and what form these assume. At the core,

restructuring trends are informed by an ongoing impulse to “efficiently” rationalize costs, labour, and generate profit. The growth of for-profit corporate facility ownership within Ontario (and elsewhere in Canada) has coincided with escalating system costs that the government has sought to minimize and/or redistribute.

System and institutional transformations have influenced the current resident population in this setting – and growing complexity of resident care needs. These changes coupled with the trend towards for-profit (and corporate) ownership and use of managerial principles and lean operation strategies of the private sector have significant consequences for care and working conditions. For workers, this includes compromises and concessions to wages, training, unionization, as well as intensified and/or new risks. Restructuring and reorganization occurring within the LTC sector has in many ways reinforced and perpetuated the invisibility of frontline workers, care labour, and the risks and hazards at work. While these workers constitute a significant component of the LTRC workforce, the workers on the frontlines are positioned at the bottom of the health care hierarchy where their labour is often naturalized, undervalued, and treated as unskilled. This dissertation is concerned with the ways the broader structural – social, economic, and political context influences frontline working conditions in LTRC. This includes the production and exacerbation of unsafe conditions. This broader context also shapes workers’ everyday/everynight struggles to challenge or influence their working conditions. To this end, this chapter has provided an overview of the legislative, funding, and regulatory context of restructured LTC that forms part of the continuum of care and health services in Ontario in which frontline workers are located. In the next chapter of this dissertation, I articulate the theoretical framework and lay out the conceptual

resources I utilize in this project to analyze and provide further insight into these questions and inquiries.

Chapter 2: Theoretical Orientation

This chapter provides a brief orientating discussion of the theoretical framework and conceptual resources in which this dissertation is grounded. The chapter begins with a discussion of feminist political economy as the analytic lens employed in this research. Feminist political economy draws attention to the broader structural and organizational context, practices, and processes that produce and/or aggravate conditions that undermine the health, wellbeing, and safety of frontline workers (Banerjee et al., 2008; Banerjee, 2010) or situate workers in uncertainty and “at risk” (Beck, 2000). This is followed by a discussion of health care and the state under capitalism, particularly in the context of neoliberal restructuring and reform. While the consequences of neoliberalism are often contradictory – gendered and racialized assumptions about care work have reinforced and perpetuated inequality, sometimes creating new inequities, intensifying risk, while simultaneously obscuring, individualizing, and/or normalizing risk. Assumptions and ideologies about care labour are understood to shape policies, practices, experiences, and/or perceptions of care, and the organization and conditions of care labour. The next section of this chapter discusses the significance of considering the gendered politics of evidence and relations of ruling (Smith, 1987; Smith, 2005) in relation to workplace injury and illness. What constitutes evidence, how this evidence is used, under what conditions, by whom and with what implications is the primary focus of this section. Considered next are various theories of the labour process under capitalism that inform this project and facilitate thinking about the struggle between capital and labour in the restructured LTRC setting. Following this, the concept of structural violence (Galtung, 1979) is articulated. Structural violence is utilized in this dissertation to highlight the

various harms and inequalities workers (and residents) experience that result from exploitative social, political, and economic structures. These harms and inequalities are often pervasive, hidden, or normalized. Individuals most adversely impacted by structural violence are often blamed for their own work and life conditions and further marginalized and exploited. In recognizing that context – various conditions, relations, and factors such as gender, working conditions, distribution of resources, etc. have an important influence in shaping health and care, this dissertation draws on the social determinants of health approach to understanding health and wellbeing. Finally, I conclude the chapter with a discussion of restructuring and work reorganization trends and strategies employed to rationalize costs and control labour.

Feminist Political Economy

In this dissertation, a feminist political economy approach is employed to analyze workplace health and safety of frontline workers in LTRC in Ontario. This perspective provides an important lens for identifying, understanding, and making visible the unequal power structures, social relations – or relations of ruling (Smith, 1987; Smith, 2005) that underlie the organization of care work as well as influence the distribution of labour, resources, and material and social wellbeing within the context of LTRC in Ontario, Canada. For Smith (1987: 3) ruling relations are understood as materialist and discursive. It is a “concept that grasps power, organization, direction, and regulation as more pervasively structured than can be expressed in traditional concepts provided by the discourses of power.”

The roots of political economy are located in the work of Karl Marx. Over a century ago, Marx laid the foundations for considering the nature, origins, relations,

development, conditions, and organization of work under capitalism. Marx's orientation is historical-materialist, which attempts to "understand the dynamic of change in the transformation of production and reproduction with particular attention given to the tensions, struggles, and contradictions within societies and between them" (Clement & Williams, 1989: 6). One distinctive element (and driving force) of capitalism is the relentless search for profit. This pursuit for profit is recognized as having a profound influence on how and in what ways societies are organized. The source of profit under this arrangement is surplus value and is derived under capitalism from reduced production costs, such as unpaid wage-labour. This is labour beyond what is required for a worker to reproduce his or her labour power. Surplus value is the product of systematic and fundamentally exploitative relations that depend on this residual labour. The basic arrangements or relations of production and the need to produce surplus value are understood to explain the capitalist imperative to control the labour process as well as the origin of class struggle in capitalist society. The ongoing compulsion for profit compels capital to control the labour process and conditions of work to ensure this end.

The concept of alienation is at the core of Marx's work. His analysis of alienation stems from the "economic fact" in which the deterioration of the conditions of workers is inextricably linked to expansion on the capitalist end. According to Marx, in capitalist production the worker comes to be treated as indistinguishable from the material objects in which the worker produces. This distortion occurs under capitalism when the worker becomes fused to the product. The product of labour becomes external and hostile to workers and where work is ultimately turned against the worker. As Marx (1975) states,

Labor [sic] not only produces commodities; it also produces itself and the workers as a commodity and it does so in the same proportion in which it produces

commodities in general. This fact simply means that the object that labor produces, its product, stands opposed to it as something alien, as a power independent of the producer. The product of labor is labor embodied and made material in an object, it is the objectification of labor. The realization of labour is its objectification. In the sphere of political economy, this realization of labor appears as a loss of reality for the worker, objectification as loss of and bondage to the object, and appropriation as estrangement, as alienation.

According to Marx, the source of alienation is located in the division of labour of capitalist production, the market, and private property. Alienation is a consequence of the discrepancy between the productive power of labour and the workers' lack of control over the objects the worker produces in the production process. Alienated labour under capitalism assumes several forms. Workers are estranged from the products of their work, the process of work, from one another, and from oneself – that is, alienated labour strips away the very essence of what it is to be human. Although the concept itself has been subject to much debate, it continues to be useful (Miles-Tapping, 1992) – particularly in relating the consequences experienced within workplaces to social forces that exist peripheral to the workplace.

Feminist political economy in Canada emerged as an engagement between liberal and socialist feminist theoretical insights as well as political and feminist movements and the new Canadian political economy, a tradition characterized by its integration of a liberal political economy approach, such as that advanced by Harold Innis and inspired by Marxist influences (Luxton, 2006). The development of a distinctively Canadian feminist political economy since the 1970's was motivated in response to the gender blindness in classical or traditional analyses of political economy and the absence of a political economy approach that reflected the Canadian context. Feminist political economists offered a broad critique arguing that what had previously been theorized

about the economy, work, and labour reflected a white, male, value-laden, partial, and skewed way of knowing and generalizing about the world (Vosko, 2002; Corman & Luxton, 2007).

Like critical political economy, feminist political economy recognizes politics and the economy as deeply interconnected and where power is located within an historical and material context. This context is influenced by the dominant mode of production, such as global capitalism, structures of power, social and political relations, and paradigms. While its development in practice has been uneven, theoretically, political economy strives to adapt a “holistic approach” to identifying, analyzing, and understanding the means in which social relations are shaped and influenced by the interrelated linkages between politics, economics, and ideology (Clement, 1989; Luxton, 2006). Society is understood as a “totality” or an “integrated whole” – which encompasses the political, economic, and cultural – “where the whole is greater than its parts” (Clement, 1997: 7). It is also a framework for action and progressive social change. Thus, political economy is oriented to both theory and practice. I draw on the transformative potential of feminist political economy and the centrality of struggle to the understanding of capitalist control in order to identify and analyze the ways frontline workers contest, challenge, negotiate and resist the conditions and organization of their work in facilities of LTRC.

Feminist political economy, particularly as it has developed in the Canadian tradition, builds on this foundation and considers capitalism, the state, and patriarchal relations as central driving forces of women’s subordination and oppression (Armstrong & Connelly, 1999: 10). The state regulates the capitalist economy and the household. In

addition to facilitating capital accumulation and legitimation, the state also contributes to shaping and sustaining how labour is differentially structured or organized along the lines of gender in public and private spheres, influencing how and by whom this labour is done (Armstrong & Armstrong, 2003). The state is a “contested terrain” (Armstrong & Connelly, 1999) wherein the consequences for women are contradictory, producing benefits while at the same time reproducing and reinforcing subordination and oppression between and across women as well as with any one individual’s experience. A feminist political economy perspective attempts to illuminate and clarify the contradictions, conflicts, gendered assumptions, and effects that emerge from, reflect, and continuously transform social and political relations and dominant power structures. Moreover, a feminist political economy approach seeks to reveal important relations, dynamics, labour, production, and groups that are obscured or ignored. In the climate of neoliberalism, research has documented and argued that the application of neoliberal principles has profound and contradictory implications, locally and globally, along the lines of gender, race, class, and so forth between and within nations, workplaces, communities, and households.

Historically, the concept of gender in social theory was notoriously absent. Marx was widely criticized by social and liberal feminists for being sex/gender-blind. Second-wave feminism was particularly critical of early Canadian political economy for not incorporating gender as an organizing concept or key variable in analyses. This included the failure to theorize sex/gender systems as primary determinants of different modes of production and social formations. Rather than understanding gender as socially constructed, a social process, a social relation, or as a fundamental principle to the

organization of the labour process it was instead taken for granted and treated as a given element of social life (Armstrong & Armstrong, 1983; Smith, 1994: 409; Adkins, 1998). Even within the new Canadian political economy, gender remains un(der)theorized. Although “women” as a social category is recognized, this approach to political economy often fails to critically theorize gender and instead tends to simply “add-on” women to analyses (Bakker, 1989; Luxton, 2006). The problematic sex/gender blindness of early theorizing in political economy led social and liberal feminists to push the debate beyond class analysis and direct attention to how social relations are conditioned by economic structures as well as how gendered relations, structures, and the sexual division of labour are associated with differential configurations of labour process transformation in capitalist societies. Within feminist political economy, sex/gender systems are key determinants of different modes of production and social formations.

The primacy afforded to productive labour in dominant analyses of political economy rendered much of the unwaged work women engage in as hidden and ignored. Feminist engagement in political economy argues the “informal” economy, households, communities, and reproduction, and how these interact, must be treated at least as important as the “formal” economy, markets, and production and relevant to examination and analysis (Beechey, 1977; Armstrong & Armstrong, 1983; Jennings, 1993; Armstrong & Armstrong, 2005). Focusing on the specificity of women’s labour and the contribution of unpaid work of women, feminist academics contributed theoretically and empirically to the debate in terms of how domestic labour represents an essential and fundamental labour process to capitalist production processes. Moreover, such work by Marxist

feminists have expanded the notion of necessary labour as well as illuminated significant differences between waged work and unwaged domestic work.

Feminist political economy assumes oppression and subordination is not a natural or given aspect of labour and relations between men and women. The division of labour is social. The position of women is systematic and embedded within the capitalist structure of society (emphasizing the material basis in the relations of production and reproduction). Feminist political economy considers how and why sex/gender differences are infused in all facets of human activity (Beechey, 1977; Luxton, 1980; Armstrong & Armstrong, 1983; Glazer, 1993; Luxton & Corman, 2001; Vosko, 2002).

This perspective recognizes the participation of women in both waged and unwaged work – and how both may condition, reinforce, and shape the other as crucial to critical to research and analysis (Beechey, 1977). That is, this approach focuses on the interconnection between two distinctive labour processes wherein changes that occur within one process often influence and shape other labour processes. For instance, changes in the organization, scheduling, or remuneration of waged work constrain and shape domestic labour time, conditions, content, and organization. In this view, the separation of the family and household from other labour processes is understood as an artificial one (Beechey, 1977; Luxton, 1980; Armstrong & Armstrong, 1983).

In understanding the sexual division of labour as part of and essential – rather than on the fringe or peripheral – to capitalist production, feminist political economy works to broaden understandings about how waged work and unwaged domestic work condition one another in contextualized and historically specific ways. Feminist political economy challenges the analytical divide between the “public” and “private” sphere as

impermeable. Rather, the gendered division of labour in the home (or reproduction) both interacts with and reinforces the gendered division of labour (or production) in the labour market (Armstrong & Armstrong, 2005). In other words, feminist political economy points to social relations of gender and examines why labour is differentially organized along the lines of gender. It also considers the relationships between production and reproduction as fundamental features of analysis that are very much absent from prior theory and research. This interrelationship between reproduction and production is critical to an analysis of the implications of health care restructuring and reform.

While the division of reproductive labour across gender lines has been central to early feminist analyses and to understanding women's oppression, the racial division of reproductive labour and how this reinforced and is interconnected with the gendered division of reproductive labour, was largely rendered invisible or ignored. Gendered analyses of reproduction have tended to portray a universal experience of the division of reproductive labour or organization of work, overlooking how social location can profoundly shape the experience and responsibilities for reproductive labour. This is particularly true with respect to the distinct exploitation and subordination experienced by women of colour through domestic servitude and institutional service work (Glenn, 1992). Researchers arguing for an intersectional approach (elaborated below) have maintained that gender analysis fails to consider and examine how the continual reorganization of reproduction and production under capitalism may have differential implications for women in ways that depend on one's location in the race-gender-class order that may further reinforce the invisibility of particular women and their labour (Glenn, 2001).

Feminist political economists describe and analyze how women are segregated into gender or sex-typed workplaces or “female job ghettos,” both in the home and in the labour market. For some feminist political economists, it is the “segregation of women within rather than their exclusion from employment which is widely viewed as constitutive of gender in terms of the labour market” (Adkins, 1998: 41). Despite the appearance of changes in the position of women in Canadian society, feminist political economists argue that the nature and conditions of women’s work has remained significantly unchanged. Feminist political economy examines structural and economic factors that strengthen and maintain the division of labour by sex/gender and the interests served by this segregation (Armstrong & Armstrong, 1983). Women continue to be segregated into the least appealing sectors of the labour market, characterized by low wages, status, control, and security with modest opportunity for advancement or mobility, while simultaneously continuing to be responsible for much of the ongoing housework or domestic work and caring work in the home. In terms of content, the work that women do in the labour market often mirrors the work done in the home (Armstrong & Armstrong, 1983). In Canada, women constitute the majority of workers who provide a range of direct care and support services in this setting.

In short, there are several reasons that underscore why adapting a feminist political economy perspective is a particularly suitable lens to frame and examine my research. These relate to context, including who provides care, how care is understood, under what conditions care is provided, and who benefits and loses from the delivery and organization of this care, and related to this, why care is currently organized and delivered the way it is. In LTRC settings, it is women – and marginalized immigrants

and women of colour, who provide the bulk of frontline care to residents. This care is routinely defined as “personal support” and its portrayal as unskilled, not dangerous work, and as a natural extension of women providing this care, has implications for worker health and safety and strategies for resistance to working conditions. As highlighted in Chapter 1, there has been a shift to more for-profit facilities, and particularly corporate ownership in Ontario, as not-for profit and public facilities are deemed “less efficient” (McGregor & Ronald, 2011). In this arrangement profit is privileged as the motivating force, not care or working conditions. Finally, widespread application of market strategies and managerial principles of the private sector in the remaining not-for profit and public facilities in Ontario, while not profit oriented in the classic sense, are nevertheless organizing and delivering care in ways that are consistent with the view the “market knows best.” This arrangement produces consequences that are comparable to systems of care explicitly oriented to accumulating profit.

Intersectionality

Feminist political economy seeks to reveal the ways gender is embedded in interactions, relations, structures, and organizations. However, an exclusively gender oriented analysis that focuses on “women” fails to examine how the continual reorganization of reproduction and production under capitalism may have differential implications amongst women in ways that depend on one’s location in the race-gender-class order. This absence in analysis may further reinforce the invisibility of particular women and their work (Glenn, 2001). The similarities, differences, and inequities between and amongst women are fundamental to meaningful discussion and analysis of health care reform and restructuring, its implications for worker health and safety, and

means of worker resistance and contestation. Intersectionality has developed in anti-racist and critical feminist theory as a method to take up the dynamic interchange and intersection of institutionalized power relations defined by various “axes of domination” or relations of oppression. This approach reflects the notion that multiple forms of oppression interact to compound one another, each complex, and inseparable. This includes race, gender, class, ethnicity, nationality, language, and so forth that structure governing institutions, conditions of work, constraints, inequalities, divisions, and resistance (Brenner, 2000; Sugiman, 2001; Stasiulis & Bakan, 2005; Creese, 2007). Frontline workers provide care in LTRC facilities within the context and parameters of a society that systematically excludes and discriminates against workers in multiple, overlapping, and diverse ways as capital is continuously driven to expand, control, cheapen, and exploit labour and the labour process.

An intersectional analysis considers the diverse, significant, and meaningful differences in social positioning. This includes crosscutting, contradictory, and multiple identities and oppressions that exist amongst and between women, as well as the differential accesses to power amongst particular groups of women, or the existence of different feminisms. This perspective recognizes that there are multiple oppressions anchored in multiple social locations that are at once experienced and resisted. Increasingly, anti-racist theory and intersectionality has informed feminist political economy analyses and frameworks for action. The gendered organization of waged and unwaged care work and the implications that are created and/or intensified because of this organization are profoundly interconnected with race, ethnicity, class, language, and immigrant status. Feminist political economy is concerned with the ways restructuring of

work and health care may have differential implications for women depending on one's social positioning. For instance, "race" and the social process of racialization continue to influence and shape how labour markets are organized. Work is understood as a site where racism rooted in policies, practices, and social norms of Canada as a white settler society, operates to systematically perpetuate and reinforce ruling relations. The "white" social, economic, and political power of the West, racial inequality, and white privilege are continuously produced and reproduced (Creese, 2007). Racialization is understood to be multifaceted and uneven and is entrenched in the wider structures of power that vary across historical, economic, political, and social contexts.

This understanding of the importance of differential social positioning recognizes that the implications that emerge from health reform and work restructuring and reorganization are often not the same for all women and may be contradictory and unstable between and amongst women (and men). For instance, while flexibility could mean autonomy to more socially privileged workers, it could also signify insecurity, precariousness, and intensified work that is intensely more demanding for a woman, a worker of colour, or of immigrant or migrant status (Shalla, 1997; Munck, 2002: 97; Sharma, 2005). In other words, flexibilization and work intensification are gendered and racialized processes. Workers may also simultaneously experience privilege and oppression, shaped by constructions of difference in terms of race, class, and gender. Research has also shown that jobs are related to gendered, racialized, as well as sexualized workplace cultures that are neither static nor fixed, but rather historically contingent and contextualized (Sugiman, 2001).

Using a feminist political economy approach informed by intersectionality and anti-racist theory allows me to examine this situation more critically. While changes to the conditions, organization, and processes of labour may situate frontline workers in positions that compromise their health and safety, they also constitute a marginalized segment of the population – by virtue of gender, race, immigrant status, and language – whose health is most likely to be undermined by the current agenda of neoliberal health care reform and restructuring. This is particularly troubling given the influx of immigrant and racialized groups into the LTC sector (Armstrong, 2003). Given their marginalized status in a sexist, classist, racist, and capitalist society, these workers are unfavourably positioned to contest or challenge the conditions and organization of their work or meaningfully influence the policies and programs that impact them (Doyal, 1995; Messing, 1998; Morrow et al., 2007; Armstrong, 2009). The restructuring of care work in LTC and the promotion of a particular form of efficiency, coupled with pressures to reduce health care expenditures has often meant capital drawing on and transnationally recruiting marginalized and racialized groups (Eckenwiler, 2011). These groups are used as a source of cheap, compliant, or “docile,” flexible, and expendable labourers in order to rationalize costs, minimize opposition, and maintain control over the labour process.

Health Care and the State

The shift to a lean neoliberal state in Canada (and elsewhere) over the last several decades following the demise of the Keynesian welfare state has meant the reduction in public sector services, expanded opportunities for the private sector, and a greater role of the private sphere (Bakker, 1996; Armstrong & Armstrong, 2003; Braedley & Luxton, 2010). This shift has meant the burden of risks and the responsibilities for health care are

increasingly transferred from the state to individuals, families, and markets. The success of neoliberalism, as Judy Corman and Meg Luxton (2010: 163) suggest “rests on the widespread acceptance that individuals and households must absorb more of the work necessary to ensure the livelihoods and wellbeing of their members.”

A neoliberal policy framework is generally characterized by its opposition to direct government intervention in local economies, and instead strives to reinforce a free-market economy and capitalist social relations. This occurs by privileging deregulation, individualism, de-unionization, free trade, flexibilization (of labour markets, workers, sites, practices, organization, and work arrangements), privatization, financialization, and property rights. Neoliberal ideology encourages individualism – that is, the idea individuals are rational, self-interested, responsible, and autonomous agents who can be understood as separate, or in isolation from the economic, political, and historical context in which they live and work. The dominance of neoliberalism – as a system of processes, practices, and ideas – has largely facilitated capital’s compulsion to shift to for-profit delivery of health and care.

While restructuring occurring within LTRC has direct implications for workers’ health and safety in this sector, LTRC is also impacted by spin offs that are derivative of the state’s retrenchment and restructuring exercises occurring elsewhere within systems of health and social services over the last several decades. This includes cost containment strategies such as deinstitutionalization, the shift to community-based initiatives, applying pro-market managerial practices to the delivery and organization of all care whether public or private, and “dehospitalizing,” such as the shift to outpatient and day surgery and the premature release of hospital patients in order to reduce length of

stay. Many of these cost containment strategies are the manifestation of various forms of privatization.

Indeed, the privatization of health care has occurred in multiple ways. This includes for-profit health service delivery, public/private partnerships and the outsourcing and subcontracting services. Privatization also relates to the application of private sector principles and managerial practices to the ways health care is delivered and care work is organized in the public sector. In LTRC, the adaption of market strategies within public and not-for profit LTRC homes in Ontario has meant the driving force of profit is an apt comparison in these settings as care is organized and delivered in ways that mirror the objectives of the for-profit sector. Pro-market strategies privilege economic efficiencies and emphasize control of time, systematization, standardization, and the governance of details – has shaped the labour process in the non-profit sector creating intensified work and work organization that resembles the private sector (Baines, 2015). Consequently, the non-profit sector has in many ways reproduced the exploitative conditions, relations, and implications for resident and frontline worker health and safety that are characteristic of profit-oriented systems of care. Privatization is also reflected in a shift in the politics of care or ways health care is thought about and treated – for instance, as market commodity rather than a fundamental human right (Armstrong, 2001).

Almost a century and a half ago, Marx noted the relentless need of capital to continuously expand and seek out new markets as well as cheap and flexible labour for growth of capital, creation of profit. This also relates to the rise in the corporatization of health and care, where corporate multinationals have sought to appropriate more areas of the Canadian health care sector in the search for reduced labour costs and profit in this

sector (Fuller, 1998; Armstrong & Armstrong, 2003). This includes the trend towards for-profit corporate chain ownership in LTRC (Armstrong & Jansen, 2006; Banerjee, 2007). As research suggests, in many ways this drive for profit is often incompatible with good health care, the organization of care work, and the interests of workers.²³ That is, when the primary motivating force is to accumulate and optimize profit, it is often to the detriment of workers and residents, in ways that reproduce inequalities and undermine and compromise their health and safety. And finally, privatization also occurs in what is termed “work transfer” (Glazer, 1990; Pupo & Duffy, 2007) – that is, the shift in the delivery of care work from public institutions, such as hospitals, to the informal sector and private households.

This tendency towards work transfer (privatization) occurs in capitalist economies when it is in the interests of capital to rationalize costs or expand markets. This form of privatization is also associated with the decommodification and “deskilling” of work processes and it is both a strategy and outcome of restructuring work. This offloading of care work reinforces traditional assumptions about care, work, and home in ways that often exacerbate as well as give rise to new gender inequalities (Armstrong, 2005). This is particularly evident in the neoliberal shift to gender-neutral discourses and practices of “health promotion”, “prevention”, “community care”, and “home-care.” The way these trends in care are implemented with a focus on self-sufficiency, individual responsibility, and the will of the “invisible hand” marks a significant shift in values away from social investment and collective responsibility. These neoliberal policy directions of health care

²³ Canadian research regarding for-profit and non-profit childcare has reached similar conclusions. Research suggests that compared to non-profit childcare, for-profit childcare is more likely to be poorer in terms of both quality and access. The difference found in quality is related to the impact of cutting costs to staffing – such as, wages, benefits, staff/child ratios, in order to secure greater profits (Cleveland et al., 2007).

reorganization conceal who provides this care work, the relations involved, and the context and conditions in which this work occurs. This includes the differential social, economic, cultural, and political forces that influence lives and experiences, power imbalances between men and women, the gendered division of labour, assumptions about care, and the complexities involved in care. It is overwhelmingly women, and particularly women of marginalized social positioning who are expected to willingly undertake the burdens, responsibilities, and risks of care. They are obliged to compensate for reduced public provision and expenditure on services by assuming this care for both themselves and their dependents as well as absorb the social and economic costs and physical and psychological demands and risks of providing this care.

Care Work

Historically, care work has been regarded as “women’s work.” In occupational, community, and familial settings care work is profoundly structured along gender lines and relations. This is true whether this care is waged or unwaged or whether this care is provided in institutions, communities, or households (Armstrong & Armstrong, 2005). Feminist political economy is concerned with exposing and challenging dominant normative understandings of care by regarding care and its connection or association with women and femininity not only as a constructed phenomenon but also as an effect of institutions, discourses, processes, and practices. As Pat Armstrong and Hugh Armstrong (2004:10) point out, “caring can be understood as women’s work only within the unequal relationships, structures and processes that help create women as carers and undervalue this caring work.” This is compounded by the neoliberal shift that relies on the exploitation of the gendered, racialized, and classed division of labour (Daykin & Doyal,

1999; Neysmith, 2000; Armstrong, 2009; Braedley & Luxton, 2010). Indeed, frequently it is racialized groups, marginalized immigrants, and women of colour who occupy the lowest ranks of the social, economic, and political hierarchy (including both familial and organizational divisions of labour) who perform this care work (Doyal, 1995; Neysmith, 2000; Braedley & Luxton, 2010). This is also true in LTRC facilities (Armstrong, 2009), where the gendered, racialized, and undervalued – both symbolically and materially – nature of care work is revealed. As Tim Diamond (1992: 187) notes in his research, with regard to his frontline care work, management has inquired, “why would a white guy want to work for these kind of wages?”

Numerous feminist researchers have argued that managerial practices and changes to the organization of care work reinforce gendered ideologies of care – and in particular, the caring labour of women as endlessly expandable, natural, reliable, and altruistic (Armstrong & Armstrong, 2001; Baines, 2004a; Baines, 2006). Care work is naturalized. More specifically, care work skills, knowledge, responsibilities, and functions are conflated with the socially constructed and culturally devalued responsibilities of women. These are taken as “real” or natural and immutable. In LTRC, commitment to care is profoundly linked to gender regimes. As Armstrong et al. (2011: 123) argue, “Women not only feel responsible but are also held more responsible for the care deficit created by the combination of the increasing proportion of residents with major health issues and staff reductions.” Moreover, racialized groups and marginalized immigrants working in LTRC have been perceived as having an innate capacity to provide care and are constructed as “enthusiastic” to do so, especially across race and ethnic lines (Dodson & Zincavage, 2007; Duffy, 2007). This is particularly the case in LTRC where care work is

defined narrowly in relation to personal care tasks and is often equated with the care women provide for infants through “mothering” (Dodson & Zircavage, 2007).

In Lisa Dodson and Rebekah Zircavage’s (2007) research, the nexus of gender, race, and class among frontline workers is particularly apparent. Low status and poorly compensated jobs have been treated as the “natural” domain of racialized minorities, women of colour, and marginalized immigrants (see also Diamond, 1992). In this study, Dodson and Zircavage (2007: 921) found that LTRC frontline workers of colour were regarded by supervisors as “uniquely suited to their jobs” coming from a “culture of respecting the elderly...they are warm and patient...they have that approach.” As Dodson and Zircavage (2007: 906) further point out, the racialization of the care worker is a “dynamic that brings to mind the historical image of women of colour working as domestics, servants, and nannies” who are “expected to willingly sacrifice themselves and their families to the care of those who employed them.” Unsurprisingly, the researchers report that the “family construct” and racialized version of “part of the family” used to shape relations between frontline workers and residents and to construct care collapsed when the ideology was not advantageous to employers in ways that threatened worker efficiency, productivity, and employer control over the labour process. Filipinas working in LTRC are often constructed as workers who are “caring, obedient, and meticulous” (Eckenwiler, 2009), reinforcing assumptions about care as a natural ability as well as the preference for workers perceived to be naturally compliant and subservient. Frontline worker health and safety as well as mechanisms and possibilities of resistance must be situated within this context of globalized migrant and immigrant labour. Gendered and racialized assumptions about care and expectations to care,

legitimize the precariousness and exploitability of frontline workers in LTRC, and reinforce and reproduce social inequalities and introduce risks.

Gendered assumptions underpin social inequality. Essentialist ideologies of care not only decontextualize care work and configure labouring bodies as pre-social, pre-cultural, ahistorical, universal, and fixed, but they also mask the implications of restructuring for workers engaged in this labour. From this biological deterministic perspective, biological or anatomical difference naturally translates into distinct gender-specific behaviour, skills, and abilities – thus perpetuating notions of gender duality, essential difference, and reinforcing a two-sex/gender model in which gender follows from sex (Fausto-Sterling, 2005). Moreover, assumptions about women's bodies as inferior and unfit for “real” work and “women's work” as natural and infinitely elastic, function to reinforce and justify segregated work and the devaluation of this work, including poor compensation, benefits, job insecurity, and low status. The assumption that care work is natural to women reinforces the view that this work is also safe, physically undemanding, and unskilled work that any woman is capable of and is expected to do in any context by the simple virtue of being a woman (Armstrong & Armstrong, 2005; Baines, 2006). These assumptions serve to justify and reinforce existing relationships, structures, and hierarchies. They also maintain ignorance of hazards and risks and legitimize inaction.

Assumptions relating to the inherent capacity of women to provide care, and how these ideologies of care operate in conjunction with the reorganization and restructuring of care work in the context of neoliberal reform have been demonstrated to have important implications for worker health, safety, and wellbeing. Frontline workers are

expected to tolerate conditions of work that adversely affect their health and wellbeing in any context (Gates, 1999; Banerjee et al., 2008; Morgan et al., 2008), including the context of violence (Baines, 2006). In other words, emphasis has been placed on responsibilities of the worker – in ways that individualize and blame the worker and normalize care, including in risky and unsafe working conditions – without much consideration to the rights of/and responsibilities to the worker (see Chapter 4). It may also function to absolve the workplace of responsibility to rectify risks and hazards in the workplace as well as to mask the ways health concerns are inseparable from the conditions and organization of care work. While violence in the health care sector is not a new phenomenon, changes to what constitutes care, the organization of care work, and the transformation of labour processes and practices following health care reform may create the conditions in which violence directed towards workers by residents or other workers are more likely to occur either in frequency and intensity. In a study by Baines (2006), co-workers, management, and workers themselves perceived reporting incidents of client violence as contradictory to an “ethic of care.” The assumption that predominately women tolerate conditions of work that compromise their own health or situate them at risk as an acceptable way to demonstrate caring or commitment bolsters idealized representations of women, gender normative ideologies, and expectations of care. In particular, selflessness, self-sacrifice, compassion, and empathy are seen to be extensions of what women ostensibly do naturally. These changes also have implications for the quality of care and care relationships. Research suggests that in terms of care workers’ understanding of quality care, emphasis is frequently placed on the emotional dimensions and the moral value of the work in contrast to the technical aspects and

physical tasks involved (Daly, 2002: 262; Aronson & Neysmith, 1996).

One feature that remains central to care debates is the distinction between “caring for” and “caring about.” “Caring for” constitutes the concrete activities of care work, whereas “caring about” speaks to the emotional and relational aspects of caring. The significance of the distinction between “caring for” and “caring about” relates to the challenges introduced when assumptions conflate the expectation that women will care (and should) care for others if they care about them (Aronson & Neysmith, 1997; Himmelweit, 1999; Neysmith et al., 2004; Armstrong & Armstrong, 2004; Armstrong & Armstrong, 2005). In this context, care is understood as a “labour of love” (Luxton, 1980; Finch & Groves, 1983). Frontline workers in LTRC may be expected and/or compelled to risk their own safety or engage in unpaid work for residents they care for in order to demonstrate that they care about them.

The devaluation of women, “women’s work” and the reluctance to legitimize care has meant that women working in LTRC are in a disadvantaged position to influence the nature and organization of their care work. This includes shaping the policies and programs that affect them, the capacity to demand social rights and health and safety standards within their workplace, and recognition, legitimacy, and compensation for their work-related illness and injury.²⁴ In identifying the political economy, gender, and racialized relations as important power structures shaping the manifestation of health and safety amongst workers, I examine dominant assumptions about care and care work. This is to illuminate how these may operate to obscure the hazards and risks involved in care work and mask the ways these may be derivative of changes to the conditions and

²⁴ Access to compensation implies some form of temporary or permanent wage replacement or financial compensation, access to health care, pharmaceuticals, rehabilitation or retraining

the organization of this work in order to make visible the gendered, racialized, and devalued nature of care work in LTRC.

Science, Medicine, and Evidence

What passes for scientific rigor among researchers may in fact be as much a symptom of racism, sexism, or class bias as a burnt cross or a thrown stone, and may do as much psychological or physical harm (Messing, 1998: 55).

It is important to consider what constitutes evidence and exactly whose evidence in matters of health, policy, and research. In the West, science (and scientific knowledge) is considered one of the most authoritative and powerful paradigms. The model of science in which western allopathic medicine is grounded is informed by positivism and is characterized by the preference for objectivity, causality, replication, standardization, generalizability, precision, and measurement. Social theorists and feminist researchers have challenged several assumptions embedded within contemporary medicine and have problematized this view that positions science as objective or neutral and external to culture and social structure (Messing, 1998; Armstrong, 2001; Armstrong & Armstrong, 2003; Mykhalovskiy & Weir, 2004). What have historically been included as areas of rigorous scientific investigation reflects relations of ruling (Smith 1987; Smith, 2005). This includes notions and ideologies of what is valid and worthy of study, what counts as evidence, as well as how evidence will be interpreted and used, under what conditions, and by whom. Science and medicine may be used to reinforce and uphold ruling relations (Smith, 1987; Smith, 2005) as well as control over labour processes. In this way, what comes to constitute a legitimate workplace health and safety concern or what constitutes an efficient way to organize work is influenced by politics as much as it is by evidence (Messing, 1998; Barnettson, 2010). What constitutes evidence and how

evidence is used may not be compatible with and/or in the interests of worker health and safety. Given this context, frontline workers are challenged because their workplaces are not seriously recognized or responded to as sites of hazard and risk. This includes the conditions and organization of their work, the relations involved, the nature of care, and the space, equipment, and resources available.

Health concerns are connected and inseparable from the conditions that structure the organization of care workers' work. "Women's work" is often not considered in relation to workplace health. Historically, what constitutes and is recognized as an occupational injury and illness is often based on a male norm. These are injuries and illnesses that cause obvious physical harm, directly produced at work by work that reflect the sites and patterns of work that men are predominately engaged in (Diamond, 1992; Doyal, 1995; Messing, 1998; Daykin & Doyal, 1999; Baines, 2004b; Yassi et al., 2004). Consequently, less visible, chronic, cumulative and/or intermittent health concerns such as stress, depression, anxiety, burnout, other psychological issues and concerns linked to the conditions and organization of work may be treated as less credible and significantly more difficult than acute injury or illness claims to be legitimated as compensable. While these health issues can be challenging, they are less likely to be acknowledged, compensated, or revealed in official reporting mechanisms (Walters, 1983; Messing, 1998; Lippel, 2011). Occupational illness is often perceived to relate to "physical and psychological specificity" of women (Messing, 1998), "hyper-susceptibility" and life styles (Walters, 1985) or the personalities and coping styles of women workers rather than work conditions. When worker stress is recognized, it is typically the social responsibilities and/or multiple roles of the worker that are claimed to be causal (Lippel,

1999; Messing et al., 2000). In practice, what relates to work and home is frequently inseparable. As Donna Baines (2004b: 159) explains,

Feelings of intense stress [...] occur because of the way that new forms of work organization interrupt and disorganize home life, as well as how this new work organization interacts with enduring social assumptions that domestic work, and child and elder care are the private responsibilities of women.

Evidence matters. Evidence derived from official statistics does not consider labour market specificity – and in particular, the gendered division of labour and the particular types of work in which women are engaged that situate them at risk. When occupational health statistics adjust for sex this may obscure significant sex-based disparities (Messing, 1998). I explore how workplace injury and illness in LTRC have historically been defined and responded to, in what contexts, and by whom. Related to this, I consider how workplace health and safety has socially, ideologically, and politically been constructed, and who has benefited and who has been excluded from these understandings, and with what consequences for frontline workers.

Theories of the Labour Process and Capitalist Control

Labour process theory underscores the ongoing and fundamental responsibility of representatives of capital, such as management, to continuously transform the labour process through more “effective” and “efficient” means of control in order to acquire more and more value from labour – or productive labour when faced with the “crisis of profitability.” This theoretical orientation is important for considering how skill, control, and frontline worker autonomy are understood in the context of LTRC as well as the consequences of changes such as restructuring and the use of new management strategies for frontline workers. More broadly, labour process theory offers a means to examine the nature, context, and struggle for control over the capitalist labour process. This includes

attempts to explain why, how, and by whom the labour process is controlled, and by what mechanisms or means it is resisted or contested. It also offers ways to understand and make sense of how the struggle for control between labour and capital (or its agents) shapes and influences the ways in which skill is understood and under what conditions. It also assesses the impacts of the technologies utilized, and what interests are privileged, excluded, masked, or simply ignored. This work also underscores the significance of the relationship between control over work and health. In adapting a feminist political economy lens, my concern is to reveal the gendered labour processes of LTRC and what impacts these have on the experiences and perceptions of health and safety of frontline workers in these settings. The nature of these inquiries includes a consideration of who does what work, under what conditions and terms, and with what implications.

In particular, I draw on the labour process theories of Harry Braverman (1998[1974]), Richard Edwards (1979), and Michael Burawoy (1979) as well as Burawoy's (1985) analysis of the state or what he terms "the politics of production." Braverman (1998[1974]) argues that under capitalist management regimes there is an increasing trend towards the systematic degradation and deskilling of labour. This includes the separation between the conception and execution of work, decreasing worker autonomy and control over labour as well as increasing worker alienation. For Braverman, managerial control was essential to the organization of the labour process within monopoly capitalism. This system of managerial control of the labour process is fundamentally linked to the principles of "scientific management" and its origins reside in the work of Frederick W. Taylor. Scientific management includes the subdivision of tasks and the establishment of new technologies that are less reliant on workers'

specialized skills. It involves the application of “scientific” methods and techniques to control, calculate, and precisely measure work for making the production process more “efficient.” Characterized by Taylorized mechanisms of control and the impetus to reduce and cheapen labour, deskilling involves the redistribution, compartmentalization, and fragmentation of work tasks into simple routinized and standardized components that require less and less skill. This method of job division and control allows managers to divide work into small fragments or components that can be learned quickly and performed by expendable (and interchangeable) workers. For Braverman, this practice not only separates the worker from particular skills, knowledge, and creativity, but also from the power, status, and protection that accompanies skill and knowledge.

The labour process as articulated by Braverman appears as conscious one-sided design by agents of capital in which workers are passive victims in an inevitable process of degradation rather than the product of struggle between representatives of capital and that of labour. This depiction of the labour process veils many possible ways in which workers shape, appropriate, and moderate forms of managerial control (Burawoy, 1979; Stark, 1982; Smith, 1994; Wardell, 1999). I seek to move beyond Braverman’s analysis by emphasizing the gendered subjects of history, including the subjective components of care work as articulated by frontline workers’ interpretations and experiences with frontline work and means to resist the organization and conditions of their work within the context of a particular form of capitalism. This includes understanding the context in which care work occurs, the gendered nature of care, sexual division of labour, the relations of care, emotional labour, and their often-complex intersection. Moreover, this work provides a useful way of understanding the implications of a hierarchical division

of labour for frontline workers. Feminist political economy also encourages asking critical questions and problematizing the nature of skill by revealing the ways in which skill is constructed and defined socially, ideologically, and politically (Armstrong, 2013a; Armstrong, 2013b). That is, what constitutes skill is neither static nor absolute; rather, skill is socially created within a broader system of power relations.

While the notion of deskilling or separation of conception from execution presented by Braverman provides some insight into labour process control, it has been criticized as being overly simplistic. Drawing on Marx, Richard Edwards' (1979) conceptualization of control provides some further insight into why labour processes take the forms that they do and how systematic control of the labour process by capital is secured in order to realize profit and reproduce capitalist relations. The problem of control is ongoing and is constantly reproduced in diverse ways that are linked to changes in managerial techniques, use of technology, and worker-manager conflict. Emphasis is situated in the social relations of the workplace, and more specifically, how control and conflict transforms through contradiction that is produced by worker opposition.

Edwards discusses three main systems of control: simple, technical, and bureaucratic. Each relates to different phases of capitalist expansion that are utilized to manage workers.²⁵ Simple control is based on the power of direct supervision and the management of workers through fear and intimidation, such as “arbitrary rule” or “rule by supervisor command.” Technical control is constructed into the machine wherein capital can extract the most from potential labour power while also utilizing this

²⁵ Each strategy of control builds on the one prior with the aim to correct the limitations of the previous control strategy. In practice, the three types of control Edwards identifies coexist.

technology as a mechanism of control. Its origins relate to continuous flow production such as mass production or assembly line work however its scope also extends to the introduction of computer-based technology. Both technical and bureaucratic types of control are regarded as “structural” in the sense that they are located within the material structure and within its social structure, such as the social relations that are rooted in how production is organized and arranged in capitalist workplaces.

Bureaucratic control emerged in the context of class relations and class conflict, and for Edwards (1979), it constitutes the most significant transformation to the capitalist labour process. It refers to the social and organizational formalization and institutionalization of rules and hierarchal power such as job categories, work rules, job descriptions, promotional and disciplinary procedures, and so forth. According to Edwards (1979: 145), this bureaucratic system of control “institutionalized the exercise of capitalist power, making this power appear to emanate from the organization itself.” It establishes “the impersonal force of company ‘rules’ or ‘company policy’ as the foundation of control, such as “rules of law”” (Edwards, 1979: 131). In other words, the activities of workers are directed by universal application of rules wherein supervisors enforce the rules and evaluate work activities in accordance with the rules. While the rules are applied to all, workers have no input in the establishment of the rules. This system of control relies on an organizational logic of hierarchy and it is more individualized than other systems of control. For Edwards, bureaucratic control focuses on skills as well as on worker attitudes and behaviours utilized to produce the image of the “good worker.” That is, a worker who identifies, relates, and conforms to the firms’ objectives of productivity and profit and who can effectively “manage themselves.”

Edwards suggests the predictability of worker behaviour is increased within a bureaucratized system of rules and procedures, allowing for greater organizational control. According to Edwards, changes in the organization of control of the labour process emerge when a system of control is rendered problematic because it is no longer constructive to management in their attempts to achieve control – that is, eliciting the desired behaviour from workers that is conducive to increasing productivity and profitability. In part, this is attributed to active resistance and opposition from workers to assaults and threats on skills, autonomy, and discretion and to being treated like commodities. This creates a “crisis of control” for management. Management then strives for new methods and strategies to contain or resolve conflict and maximize control of worker productivity and profits. According to Edwards, this “crisis of control” is fundamentally connected to the “crisis of profitability.” Systems of control are then shaped by the social relations of production wherein new methods and systems of control generate new modes of resistance and conditions for worker-management opposition.

Whereas Braverman considered monopoly capitalism as the driving force and consolidation of the degradation of work in the twentieth century, Michael Burawoy (1979) instead understands monopoly capitalism as the regulation of work utilizing new methods or techniques of cooperation and control. He argues workers on the shop floor are not stripped of all aspects of discretion or conceptualization. According to Burawoy, the absence of managerial interruption in some aspects of the production process allowed workers the autonomy to organize their work in a way that reflected their individualized interests – such as through “games” or “making out,” yet also in a way that aligned them with management’s objectives and goals. For Burawoy, securing management control

over the labour process often occurs with worker participation and consent that is accomplished through subtle coercion, such as by presenting workers with [the illusion of] choice. According to Burawoy's theory of the labour process, workers perceive themselves as having choices in the context of their work. Yet, this raises important questions about the nature of choice as choice is often limited by the actual alternatives available to frontline workers – that is, the structural constraints and social and material boundaries in which choice operates. Feminist political economy recognizes the significance of this context and holds the view that choices are historically specific and are shaped, though not determined, by social, political, economic, technological, cultural, and ideological factors (Clement & Williams, 1989: 11). This perspective encourages attention to the complexity and contradictory nature of choice in revealing the structural constraints, processes, and practices in which choice operates. This includes both the context and the conditions of work. "Choice" is inseparable from material and social conditions (Vosko, 2010). As Pat Armstrong (2001:VIII) elaborates,

Political economy [...] assumes that people collectively and individually make their own history, although not under conditions of their own choosing or simply as a result of ideas that spring independently to their minds. People are social, actively formed within particular social locations and relations, rather than pre-existing autonomous individuals.

Burawoy (1979) takes on the absence of subjectivity in the work of Braverman and through the reinsertion of human agency into the analysis of the labour process, he attempts to explain how workers shape and operate on power and control at work under capitalism. While Marx and Braverman emphasized capitalist control through coercive means, Burawoy argued this understanding could not account for the level or degree of cooperation that operates within modern capitalist workplaces. Burawoy understands

consent as a configuration of work organization on the shop floor and not as a structural or inevitable feature of the production process. For Burawoy, consent – or the cooperation in transforming labour power into labour – is ideologically “manufactured” and practiced at the point of production and is achieved through the organization of activities on the shop floor. Indeed, for Burawoy, consent, consciousness, and resistance are all generated at the site in which workers enter into social relations. Feminist political economy permits the exploration of the transformation of capitalist coercion into the organization of consent amongst workers in the process of struggle as one simultaneously embedded in gendered and racialized relations and infused with gendered and racialized assumptions about care and care labour that have implications for frontline worker health and safety.

Collective bargaining, flexible labour, and ideologies of care such as appealing to worker morality, sense of duty to care, orientation to justice, natural responsibility and capacity, are some of the ways activities of work may be organized to give frontline workers the illusion of choice or participation in a manner that appears more favourable and empowering to workers. At the same time, they may obscure and secure the expropriation of unpaid labour and reproduce and legitimize the inequalities of capitalism, securing control over the context, conditions, and intensity in which workers labour. Arlie Hochschild’s (1983) work also demonstrates how management manipulates, appropriates, commodifies, and commercializes the personalities of workers – particularly what is stereotypically associated with “female emotion” – where they are treated as unskilled and exploitable labour power. Hochschild terms this “emotion work” or “emotional labour.” That is, “the work of trying to feel the appropriate feeling for the

job” (Hochschild, 1983: 118). It is the expectation workers mask authentic emotion and instead project emotions aligned with organizational interests, regardless of context. Her work on emotional labour is one example of the shift from traditional conceptualizations of skill to situate social interaction and feeling management as skilled work. In contrast to Braverman’s assumption in relation to how control and deskilling operates on the bodies of workers, Hochschild illustrates how service workers are required to manage or work on the emotions of their customers. This observation points to a shift away in emphasis from the production of things to service production and control of labour through interaction.

Emotion management is especially prominent within “feminized” service-producing industries that require face-to-face or voice-to-voice direct interaction. Because the performance of the worker appears as a natural ability that is fixed in the personalities of workers, the actual skill involved in emotion work is unnoticed and unrecognized as a form of skilled labour. Emotional labour operates to control labour through the efficient production of an emotional product while at the same time naturalizing this labour and concealing its oppressive dynamics, the capitalist system in which this labour is embedded, and its alienating consequences. The concept of emotional labour can be applied to workers on the frontlines of LTRC. The discrepancy that may exist between internal and external emotions may have adverse consequences for worker health, particularly in a context of work overload, lack of support and control over the conditions of their work. The research by Dodson and Zinbarg (2007) discussed above, demonstrates how frontline workers are encouraged by management to treat (care for and care about) residents “like family” – when not a threat to productivity,

profits, and efficiency – and then using this emotional commitment and attachment to exploit and control an undervalued, poorly remunerated, marginalized workforce.

Burawoy's (1985) analysis of the state highlights the ways in which the process and politics of production such as labour laws and unionization intervene and shape the organization of work alongside the labour process. The emphasis on consequences within law, legislation, and policy – by design or omission – may distract from exploring the processes, practices, and conditions that may support and enable the possibility for healthy, equitable, safe, and inclusive work conditions. Analyzing frontline worker health and safety from a feminist political economy lens allows me to make visible the structural conditions that deepen and/or produce unsafe workplaces. Moreover, feminist political economy can assist in revealing the processes, practices, discourses, and conditions that may function directly or indirectly to contribute to and/or create social inequality and legitimize, individualize and normalize workplace risk.

These theories are also important for considering how skill, control, and worker autonomy are constituted and the consequences of these changes for frontline workers, providing an important springboard for examining care work in the context of LTRC. They are also useful in terms of understanding how changes to the labour process and the politics of production may undermine the health and safety of frontline workers. As well, they facilitate revealing the ways consent (or dissent) is manufactured within the LTRC frontline workforce and with what implications and for whom. Considered alongside feminist political economy, these theories of the labour process also provide a means to explore the context in which frontline workers shape, reproduce, and/or resist ruling

discourses, social relations, processes, and practices as workers engage in and experience their frontline work.

Structural Violence

The tendency within provincial policy and institutional programs is to individualize problems and solutions, including worker training. However, this approach emphasizing individual factors, behavioural dimensions or individualized solutions often operate to decontextualize inequalities and to shift attention away from structural problems in LTRC. It encourages blaming frontline workers for injury, illness, bullying, harassment, and violence as well as inability to manage and keep pace with workload demands. Individualizing risks and workload pressures ignores the ways in which socially structured inequalities embedded within the social, political, cultural, and economic context of society shape care and work conditions as well as constrain resistance or opposition. A feminist political economy perspective with a focus on context allows for an analysis of frontline workers' risk beyond an individual-level analysis and instead locates workplace health and safety as informed by dominant power structures that shape societal relations.

This dissertation also builds on scholarship relating to the concept of structural violence (Galtung, 1969; Galtung, 1990; Farmer, 1996; Farmer, 2004; Banerjee et al., 2008; Banerjee, 2010; Armstrong et. al, 2011; Daly, et al., 2011). Structural violence refers to the indirect and hidden forms of violence and injustice that are longstanding, built into social structure and operate to hinder, obstruct, impair and/or diminish the capacity for people to reach their full potential and satisfy basic needs (Galtung, 1969). Structural inequalities are so deeply entrenched within economic and political structures

and social institutions they become normalized, individualized, and perceived as natural. The concept of structural violence is consistent with and is complimentary to a feminist political economy perspective, particularly with respect to the examination of systemic discriminations and oppressions, concerns with inequality, injustice and the aims of emancipation and social change as focuses of identification, analysis, and advancement. Structural violence occurs in LTRC when care is funded, work is organized, and policies and programs are designed in ways that hinder safe and just working conditions. As research relating to structural violence in LTRC suggests, “working under extreme conditions constitutes a form of structural violence itself – a structural violence that originates in large measure from the way long-term care work is organized and funded” (Banerjee et al., 2008: V). Feminist political economy and understandings of structural violence facilitates my identification of workplace risks and how these are related to broader forces. That is, I refer here to the macro and micro dynamics of gendered and racialized power that plays out in the everyday/everynight lives of workers. The concept of structural violence also facilitates establishing connections between the individual and interpersonal violence frontline workers experience on the ground and the broader structural forces that perpetuates and upholds this violence. I employ the concept of structural violence in this dissertation to make visible the market-based structures and relations that influence the creation and/or intensification and maintenance of unsafe, risky, exploitative, and alienating workplaces for frontline workers in LTRC.

Social Determinants of Health

Health, according to the medical model, is the absence of disease, illness, or injury. In contrast, the World Health Organization (WHO) defines health as “a state of

complete physical, mental and social wellbeing, and not merely the absence of disease and infirmity.” What constitutes health care in the context of the medical model is primarily limited to biological issues and chemical and surgical intervention with an emphasis on cure as opposed to care. Thinking exclusively in biological terms legitimates ignoring the ways in which socially structured inequalities embedded within the social, political, cultural, and economic context of society affect health, experiences, access to treatment, compensation, health care response, outcomes, and working or care conditions.

Constructing or defining health as an individual responsibility or problem where illness or injury are avoidable through behaviour or life-style changes fails to take into account the significant contextual and social conditions that exist beyond the individual (Sherwin et al., 1998) and instead acts to neutralize gender differences. It also justifies reductions in social expenditure and social programming. The so-called choices many women are confronted with in the current era of neoliberalism are shaped by gendered, racialized, and classed expectations in the context of inadequate systems of resources and social and material support. Representing the feminist position, feminist researcher Margaret Lock (1998: 49) argues,

Health policy that consists mainly of exhorting individuals to change their behaviour not only is shortsighted but, more ominously, indirectly protects those institutions that threaten individual health through discrimination, exploitation, pollution or iatrogenesis.

Much of what determines health resides outside the realm of modern allopathic medicine. A social determinants approach to health fits well with a feminist political economy perspective in its emphasis on the whole and the consideration of the consequences of social processes such as inclusion and exclusion and the implications of

unequal social structures on the health of the population. From this perspective, what constitutes health is not reduced to matters of biology (as with the medical model), but is also understood as socially produced or constructed. That is, social, physical, and psychological environments influence health in interaction with biological factors. Emphasis is situated on the social production of health, illness, and wellbeing. A social determinants approach to the study of health is focused on the ways social and economic conditions influence the health of individuals and communities as well as access and availability to resources (Raphael, 2004). Although the determinants of health approach emphasizes the social, it does not tell us much about power inequalities and political economy or the context in which these inequalities are located – globally, nationally, and locally.

From a feminist political economy perspective, to understand health and social inequality also requires a consideration of unequal gendered, classed, and racialized power structures and relations that characterize the organization of work, the division of labour, influence the distribution of wealth and resources, and impact material and social wellbeing in society. It also requires an understanding of the ways social location shapes the experience of and responsibilities for care work. Moreover, social researchers have also examined how the biomedical model colludes with the state and corporate forces to influence what is defined as illness. In others words, allopathic medicine has become infused with business interests and corporate agendas oriented to growth of capital, the pursuit of profit (Fuller, 1998; Armstrong & Armstrong, 2003).

Feminist analyses of women's bodies have sought to reveal the extent to which medical and scientific understandings of bodies are socially constructed. Moreover, this

work questions how these socially constructed understandings are utilized to perpetuate dominant ideology and sustain gender inequalities. Social context is integral to what constitutes health and illness. This context from the perspective of feminist political economy is historically and culturally specific as well as gendered. Thus, what is understood as health, disease, or illness, changes both across time and space. It is contingent on the gendered societies in which these understandings are constructed. From this perspective, what is labeled as “illness” or “disease” is not simply an objective biological determination pointing to anatomical dysfunction. Nor is what comes to constitute health and illness gender-neutral. Rather our understanding, experience and response to health, illness, and disease are highly social, gendered, and relational.

Transformations and Trends in Work and Labour

To understand restructuring of capital, work, and labour process transformations, it is important to situate these changes within the broader processes of globalization and neoliberalism. Globalization is often associated with a deepening or intensification of trade, capital, technology, and information flows and an intensification of mobility of labour and capital towards a more globally integrated economic system (Braedley & Luxton, 2010). In line with neoliberal ideology, this is to contain costs, ensure operational effectiveness, and reduce inefficiencies, at the same time as it increases accountability in this sector (Armstrong et al., 2001; Panitch & Leys, 2009). The portrayal of globalization in dominant discourse as natural, inevitable, and a universal force contributes to its appearance and treatment as apolitical and neutral to gender, race, and class. The current health care agenda in Canada increasingly privileges corporate interests and the interest of the state in generating a competitive economy oriented

towards goods and services export and foreign investment that is widely legitimated by the dominant global paradigm. This global policy agenda for health care was initially conveyed by the World Bank in 1993 when it recommended that government decrease involvement and level of health care expenditure, target it for the poor, and support the corporate sector (Uplekar, 2000: 899-90). The centrality of the World Bank in health care sector development, as opposed to the World Health Organization (WHO), is instructive as it further illustrates the new paradigm of health that is oriented towards business, viewing health and care as a source of potential profit (Armstrong, 2001).

Over the last several decades, researchers have pursued a broad range of issues to critically analyze the current transformations and trends in work that reshape and reconfigure labour in the context of what are considered increasingly turbulent times for labour in Canada (and elsewhere). This includes a shift in labour market structures, particularly the decline in manufacturing, and the ascendance of knowledge, information, and service economies. It also includes changes in the conditions and nature of work, especially the reduction in permanent and stable jobs that have led to increased precariousness, insecurity, un(der)employment, involuntary temporary, contract, part-time, “flexible,” contingent, and/or casual work-arrangements (Vosko, 2000; Vosko, 2010). The precarity has meant an erosion of workers’ rights, benefits, and compensation. It has also meant an assault on the mechanisms and powers to negotiate the terms and conditions of work through unionization and collective bargaining because the creation of labour market insecurity allows owners of capital to extract more labour and accumulate more profit, by shrinking and/or abandoning its commitment to workers.

Strategies to rationalize costs and labour in LTRC have included the imposition of lean and flexible work arrangements such as, part-time, casual work, a flattening of hierarchical structures, as well as the transfer of care work to the least cost and least specialized worker (Armstrong & Jansen, 2006). Flexibilization refers to the allocation of personnel, methods of production, and organizational structures with an emphasis on cost-effectiveness and efficiency. This is characterized in part by the reduction in higher-cost and skilled labour with differently skilled and lower-cost labour. Among the latter, this includes those with skills that are readily available on the market and those that provide increased “numerical” flexibility defined as part-time, casual, temporary, and subcontracted work (Harvey, 1989). And it can mean those whose skills are defined as natural. Flexible methods are assumed the most effective for the efficient navigation of unpredictability and uncertainty in relation to the production process (labour processes, labour markets, products, and patterns of consumption) and the elimination of “waste” (Moody, 1997). These methods of structuring labour ultimately allow representatives of capital to increase the ability to control, expand, and contract labour at will for the efficient facilitation of capital interests. LTRC has adopted these pro-market principles. It has meant job cutbacks for direct care providers, such as nurses, registered practical nurses, and frontline workers (PSWs) and ancillary support workers in cleaning, laundry, and food services. It has also meant the recruitment of marginalized immigrant care workers or the transnational flow of care workers from low-income regions such as the Caribbean and countries such as the Philippines and India to more economically affluent nations of Canada and the United States (Eckenwiler, 2009; Eckenwiler, 2011), pointing to the gendered and racialized dimensions of flexibility. Chronic understaffing, heavier

workloads related to time compression, intensity and pace of work, and reduced staff to patient ratios, worker absenteeism and sickness “presenteeism” (Daly et al., 2011) increasingly characterize workers’ experiences with standardized, routinized, and flexible work arrangements in an increasingly corporatized LTRC sector in Ontario. Moreover, it has meant depersonalized and fragmented care and work as well as an obscuring of the relations necessary to care work (Armstrong et al., 2011; Daly et al., 2011). Changes to the organization of work emphasizing flexibility are also occurring alongside changing resident profiles (see Chapter 1), including greater resident acuity levels, changing care needs, increased demands, and more comprehensive and complex care (Boyd, 1995; Armstrong, 2001; Armstrong & Jansen, 2006; Morgan et al., 2008; McGregor & Ronald, 2011). Frontline workers are also assuming more tasks derivative of job cuts in dietary and laundry services within some LTRC facilities. Of particular interest then is how and in what ways has the application of market-oriented principles and practices to the organization of care and LTRC work position workers in relation to risks and worker health and safety.

I examine the relationship between newer forms of work organization, care, and workplace health and safety of frontline workers in the context of globalized neoliberal reform. It means exploring the globalized expansion of exploitative relationships, structures, practices, and processes. In LTRC, conceptions of care have increasingly become the responsibility of management and disconnected from the execution of care labour by frontline workers. Yet, managerial control over staffing levels, decision-making, care regimes, and labour processes fail to take into account the context in which care occurs, the nature of care, the relations of care, and their often complex intersection.

In this way, standardizing care and care work while eliminating or fragmenting care may have the effect of removing personalized and relational elements of care and ignoring worker (and resident) variability. As well, it introduces new hazards and risks. Research has demonstrated that job control, worker support, job strain, precarious labour arrangements, and work organization can influence care worker physical, psychological, and social wellbeing (Karasek, 1979; Quinlan, 2007; Lewchuk et al., 2011).

Flexibility is often associated with the notion of improvement and claims that link flexible work practices and organization to empowerment and the enhancement of worker capacity to choose (Armstrong, 1996; Rinehart et al., 1997; Vosko, 2000; Yates et al., 2001; Vosko, 2002; Landsbergis, 2003; Pearson, 2004). However, there is little empirical evidence that “new” models of work organization operate to empower workers or that these systems of work organization represent a significant departure from Taylorist processes, relations, and principles (Moody, 1997; Rinehart et al., 1997; Rinehart, 2001; Yates et al., 2001; Baines, 2004a; Ostry & Spiegel, 2004; Thomas, 2007; Thomas, 2008; Pupo & Thomas, 2010). Under “flexible” configurations of work, such as lean production, work remains demanding, repetitive, and alienating wherein management retains control. Underlying flexibility is the notion that “time is money” and rationalization and efficiency are viewed as fundamental to the organization of work. Lean production techniques used within the auto industry have been argued to be more concerned with control than with the provision of conditions for the empowerment of workers to improve the “quality of working life” (Yates et al., 2001). It is a strategy utilized to intensify work and pressure workers (e.g., “management-by-stress”), not empower workers. These models utilized to organize work “are not concerned with

giving employees ‘power’ because they are in fact about ‘taking back control’ over the context and intensity in which employees work” (Yates et al., 2001: 520). This research suggests the scope of worker decision-making and participation is often limited to issues with a very narrow focus in relation to work at the point of production that does not genuinely empower workers.

Research in relation to the social service and public sector work has drawn similar conclusions about the nature of restructuring and the implementation of new managerial strategies and approaches, such as Total Quality Management (TQM) (Moody, 1997; Lopez, 2006; Armstrong & Armstrong, 2009) and Continuous Quality Improvement (CQI) (Armstrong, 1996). Increasingly, flexibility is often associated with efficiency. Flexible work arrangements are often framed as team-oriented, deployed to improve organizational efficiency and quality, humanize the workplace and to facilitate worker empowerment and capacity to choose. In practice, flexible practices are more about numerical, functional, and work time flexibility for employers as a mechanism to control labour and costs rather than as a means to improve the conditions of care and work. It is about getting care accomplished by using fewer workers and in less time. Indeed, research suggests these initiatives intensify workloads, amplify worker insecurity, restrict organizational mobility, conceal context, and diminish worker power (Armstrong, 1996; Rasmussen, 2004). Moreover, work sites characterized by flexibility may unsettle the continuity of care for residents and constrain the capacity for workers to manage and report on workplace risk (Armstrong, 1996; Baines, 2004b; Armstrong & Jansen, 2006). Other more recent practices utilized within the LTRC setting, such as resident-focused care have comparable implications for frontline workers. This model of care, promoted

using the language of quality, autonomy, choice, individualized care, and flexibility of care in a home-like environment for residents as care consumers, also endeavours to improve efficiency, rationalize costs and labour through flexibility and the reorganization of work.

Conclusion

This chapter provided a discussion of the theoretical framework and conceptual tools this dissertation employs. My project uses the lens of feminist political economy to examine health and safety of frontline workers within LTRC. In using this perspective, I strive to make visible the wider structural forces and organizational contexts that produce and reproduce inequality, shape the division and organization of care labour, and influence the everyday/everynight production, conditions, relations, resistance, experiences, and perceptions of care labour on the floor. Using a feminist political economy perspective allows me to locate frontline work within the broader context of health care restructuring and work reorganization. This framework of analysis encourages and is compatible to an exploration of the social determinants of health, structural violence, and theories of control over the labour process under capitalism within the context of neoliberal reform and restructuring. It also draws attention to differential and/or contradictory impacts and consequences of neoliberal restructuring and reform for frontline workers – that may be deepened or produced – as well as strategies of resistance and means of influencing the conditions of work related to social location or positioning in the race-gender-class order.

Chapter 3: Methods and Methodology

This chapter provides an overview of the study's methods and methodology. The first part of the chapter highlights the main research questions and objectives that underpin my research of workers on the frontlines of LTRC. Next, I locate my primarily qualitative project using the lens of feminist political economy as informed by feminist epistemology and guided by feminist principles. Following this discussion, I lay out the research strategy and research design that I employ in my study. In this section, I also provide a summary of the demographics of the frontline workers who participated in this study. Finally, the chapter concludes with a discussion of coding and qualitative data analysis.

Research Questions and Study Objectives

This study concerns frontline workers who provide personal care services to residents in LTRC facilities in Ontario. It is a qualitative exploratory project with several core objectives. The principal purpose is to foreground the experiences of frontline LTRC workers in relation to injury, illness, and violence in order to make visible the workplace health and safety issues faced by frontline workers in LTRC settings in Ontario. Second, this study explores the ways the organization of work in LTRC reflects broader political and economic shifts and macro social and structural change at the global level. Relatedly, this study considers how and in what ways state restructuring and reform in the health care sector is implicated in the reorganization of care work, and with what consequences for frontline workers. This includes exploring how structures, policies, discourses, practices, and processes shape and construct the experience of working conditions, illness, and injury of frontline workers. Finally, this study examines

the various strategies frontline workers' employ to negotiate, influence, challenge and/or resist ruling discourses, social relations, practices, and conditions of their work as these frontline workers engage in their everyday/everynight work activities.

Feminist Epistemology

The use of a feminist political economy perspective (see Chapter 2) to study the working conditions, health and safety, and resistance strategies of frontline workers in LTRC is informed by a feminist epistemology. The existence of and/or what constitutes a feminist methodology are matters of ongoing debate within social research. My position within this debate is aligned with researchers such as Sandra Harding (1987), arguing there is no distinct, all encompassing, uniquely feminist approach to methodology. In this research, I use a particular feminist perspective (as there are diverse feminist perspectives, or "feminisms") and methodology that informs the theory and analysis of my research. All stages of the research process were guided by broad feminist principles. My research is oriented to producing new knowledge and generating social change. It is firmly centered on understanding the location, diversity, and experiences of women and the meaning women give to these experiences within particular historical and social contexts, such as gendered and racialized structures of dominance and power relations within global capitalism. And finally, the research process was oriented towards minimizing and/or equalizing power dynamics.

Traditional positivist approaches to social research understand the social world as something that can be studied objectively. The social world and/or social life are treated as objective realities that can be objectively studied to produce objective social facts or objective knowledge (Carroll, 2004). Social life and social beings are understood as the

objects of research, as cases to be empirically observed and controlled through methods that are consistent with the scientific method. The emphasis of research and method is on objectivity, measurement, calculation, precision, quantification, prediction, replication, causality, and rigor.

Feminist and other critical social researchers have sought to unsettle and disrupt dominant positivist interpretations and understandings of the social world and social reality and to problematize the assumptions that underlie much of conventional social research and practice (Harding & Norberg, 2005). This includes questioning problem definition, the credibility of knowledge producers, and how social life is studied and interpreted. In doing so, they challenge epistemological and ontological assumptions about the nature of knowledge, what is understood to be knowable, ways of knowing and understanding, and the nature of reality that underlies traditional masculinist scientific orientations to social research. They reject positivist epistemology and its methodologies of what is knowable about the social world and how and by whom this becomes known – and also raising critical questions and problematizing who can be a “knower” (Code, 1991). This question reflects the historical marginalization, invisibility, and ignoring/exclusion of women as researchers, as participants and/or objects of study in the production of knowledge. For feminist and other critical social researchers, how the social world is understood, how it is to be studied, and understandings of who has the power to make claims about the social world is not independent of one’s own subjectivity, positionality, taken-for-granted assumptions, and biases. In particular, feminists and critical social researchers have challenged the claims of objectivity or value free research offered by dominant approaches to understanding the social world and the

production of knowledge (Smith, 1987; Harding & Norberg, 2005). Rather, for these researchers there is no value neutrality in social research (nor is this desirable according to many); rather it is inherently biased and value-laden. Knowledge, according to feminist epistemology, is always partial, situated, and contested (Haraway, 1988). Social, political, and historical context, experiences, and positioning shape theoretical orientation, worldview, philosophy of method, every day relations, and what is constituted as authoritative knowledge. Because knowledge is situated and partial, this may result in the privileging of some knowledge to the marginalization and exclusion of other knowledges and experience – for instance, the perspective of women (Smith, 1987), or other traditions and/or local knowledges of racialized women of colour and other historically marginalized and subordinated groups (Collins, 1992: 77-78).

Feminist social researchers hold assumptions about power relations and social dynamics that these researchers understand as operating in ways that facilitate and perpetuate dominant ways of knowing and reproduce unequal relations – or uphold ruling relations (Smith, 1987; Smith, 2005). This study is concerned with power manifestations and relations of ruling that have serious implications for the care work, working conditions, and health and safety of frontline workers, yet are rendered invisible or ignored and/or viewed in ways that are taken for granted, individualized, normalized, and naturalized.

In contrast to the positivistic epistemology of conventional social research, a feminist epistemology locates participants, not as objects of research, but rather as the subjects. The focus of research is situated in grasping the meanings people attach to their experiences, actions, and behaviours or issues and events within specific contexts, from

the perspective, positionality, and voice of those involved. It is concerned with understanding and making connections between meaning, experiences, and social and material realities and relations. Standpoint epistemology, such as that articulated by Dorothy Smith (1987), encourages a bottom-up approach to social research that intentionally counters the oppressive top-down orientation to studying and theorizing the social world that is prioritized and characterizes much of dominant social theory and research. The emphasis is on participant positionality, such as gender, race/ethnicity, language, immigrant status, sexuality, and so forth. Like feminist political economy, standpoint epistemology is dialectical – contractions and tensions are inherent and the whole is understood to be greater than its parts.

From a feminist epistemology, research participants are understood as the co-creators of meaning, knowledge production, and reality. The assumptions of feminist epistemology guide my bottom-up orientation to research and contextualized analysis of frontline care work through qualitative interviews. Women, and frequently marginalized immigrants and racialized women are the primary providers of frontline care to residents in LTRC settings and often in ways that are characteristic of precarious labour. Given their marginalized and devalued positioning or low status within LTRC hierarchies and the taken-for-granted assumptions and naturalization of care, frontline workers are often not thought of and treated as important, valued, or authoritative sources of knowledge about their own experiences with frontline care work and workplace health and safety. For instance, as indicated in Chapter 1, not much is known about the consequences of restructuring and reform women face in women-dominated sites of work, such as care work (Daly & Szebehely, 2012). This includes working conditions and health and safety,

risks, and hazards, as occupational health research tends to focus research on the sites and patterns of illness and injury in which men work (Messing, 1998; Baines, 2004).

In mainstream research, managers and supervisors are often consulted as the authoritative sources of knowledge about the working conditions of frontline workers, rather than the workers themselves who engage in this work. Within LTRC, frontline workers are often not consulted on care practices (Armstrong & Daly, 2004), are excluded from care meetings and struggle to have their experience and contributions to care-plans recognized (Kontos et al., 2009). Experiences, such as with violence, are frequently dismissed in ways that normalize violence as “part of the job” (Boyd, 1995; Shaw, 2004; Morgan et al., 2008; Banerjee et al., 2008; Daly et al., 2011) or individualize and blame workers, shifting attention away from structural and policy-related problems and the organization of care work. The marginalized lived realities or “lived experiences” (Collins, 1992) of frontline workers within LTRC is “ground zero” to this analysis (Campbell, 1998). In this study, frontline workers are understood as sources of knowledge who are best positioned to speak to and comment on experiences and understandings of care work, health and safety, working conditions, and strategies of resistance within LTRC. These understandings and meanings shared by frontline workers are seen as emerging from frontline work experiences that are also shaped by social location and the broader historical, social, economic, and political contexts and relations of ruling (Smith, 1987; Smith, 2005). Moreover, using feminist political economy as a method allows for connecting the personal with the political – and similarly for linking personal troubles to public issues (Mills, 1959[2000]). That is, the relationship between individual experience and the wider historical and social context.

Research Strategy and Research Design

This study explores the experiences of frontline workers in LTRC who are affected by provincial policies and managerial discourses, processes, practices, and systems of power. In addition to a review of the literature and government legislation, policies, and reports that provide the context for this study, I employ a qualitative research orientation. In particular, I use an individual semi-structured qualitative interview approach with frontline workers to explore their experiences and knowledge of care and work, health and safety, working conditions, and resistance working in the LTRC sector. These come in the form of narratives, accounts, recollections, and examples providing in-depth, detailed, and rich data. Thus, the emphasis of my methodological approach is on meaning in order to understand how participants, in their own words, view, interpret, and experience their frontline labour, working conditions, health and safety, and resistance in the LTRC settings and how these intersect with social location.

The interview process, the nature of this relationship, and the production of knowledge is understood as a joint undertaking of collaboration (Guba & Lincoln, 1994; Gubrium & Holstein, 2002; Hoffmann, 2007). The semi-structured interview guide (see “Interview Guide” Appendix B) includes a range of work-related topic areas covered in conjunction with more focused or structuring questions and probes informed by the literature, theoretical orientation, my own experiences as a frontline worker, and the nature of my research questions. In practice, interview participants are invited to participate actively in influencing the direction of the interview process as well as in shaping the overall content of the interviews. The interview process is a flexible and

open process that allows for the introduction of new questions and follow-up questions – sometimes shifting the interview in unanticipated directions. It offers the opportunity to ask critical questions of participants and to seek clarification from interview participants related to apparent inconsistencies or contradictions with what is being said.

As discussed in Chapter 2, feminist political economy encourages an exploration of the contradictions and tensions within the workplace attending to organizational demands, practices, and processes, and the ways in which these mirror and reproduce dominant assumptions and entrenched ways of knowing, and their intersection with gender, race, ethnicity, immigrant status, language or other social positioning.

In undertaking this research, quantitative and qualitative research are not viewed as incompatible, rather these approaches to social research are understood as complementary and/or mutually supporting. Nor are these approaches to data, collection, and analysis understood as explicitly feminist (or anti-feminist) in orientation. Indeed, quantitative data is utilized in this project to highlight the existence of problem(s) as well as to contextualize the rich data collected using qualitative methods, and in particular the data generated from in-depth semi-structured qualitative interviews. In the following discussion, contrasts identified between qualitative and quantitative approaches are made to articulate and make clear why a qualitative orientation to research was primarily utilized to inform my research strategy. It is perhaps important to highlight, should my research have been predominately quantitative in nature, this discussion (justification?) would likely not be necessary as quantitative data in many ways – in the hierarchy of evidence – remains privileged as the preferred, meaningful, ideal evidence/data or social facts arising from social inquiry. In line with my research objectives, using a qualitative

approach allows for the in-depth sharing of frontline workers' perceptions of risk and hazard, experiences of injury and illness as well as of bullying, discrimination, harassment, and violence within the LTRC settings. Consistent with my lens of feminist political economy, it also provides the broader organizational context and conditions of work that shape these experiences. Employing a qualitative research design permits the researcher to collect data that is generally not possible to obtain through quantitative methods. For instance, while quantitative data is utilized in this project to assist in mapping the institutional, labour force, and illness and injury contexts of frontline work, qualitative research is used to uncover data that are not amenable to quantification or data that cannot be meaningfully expressed or represented in numerical ways. Health care work is dangerous work and while it is "well documented that the healthcare sector is plagued by high rates of work injuries and illnesses, absences from work and related costs" (Yassi & Hancock, 2005: 33) (see Chapter 4), the nature and extent of these problems are likely understated or not revealed and seldom related to LTRC. The context underlying the numbers also remains concealed. Additionally, reliance on rates of absenteeism to indicate the prevalence of physical and mental health overlooks the sickness "presenteeism" that is widespread in LTRC workplaces (Armstrong et al., 2011). It also misses the circumstances underlying why workers continue to work despite risks or hazards related to the conditions of their work (Armstrong et al., 2008).

Quantitative data alone do not expose the many forms of structural violence (see Chapter 2), such as exploitation and marginalization that are built into and/or deeply entrenched within LTRC in ways that reinforce and reproduce ruling relations, and as a result, relying solely on quantitative data may facilitate the search for cost-cutting

efficiencies and profit. In addition, a quantitative approach may not capture the ways public policy and technology may be implicated in the violent working conditions and psychosocial hazards experienced by workers (Lippel, 2011).

A qualitative approach allows for obtaining data that would not be captured through official reporting mechanisms. This includes injury and illness that do not result in actual time-loss or are not reported. Indeed, quantitative data while important, valuable, and useful, it may obscure significant contextual factors relevant to the health and safety of frontline workers as well as social, structural, organizational, economic and political factors that may deter or prevent workplace and/or worker reporting of injury and illness (Messing, 1998) or violence, including discrimination, harassment, and/or bullying. It is this context my study seeks to expose and render visible. This research design and means of obtaining data are most appropriate in light of my own epistemological, theoretical, and methodological orientations and preferences, the nature of inquiry and the objectives and questions guiding this research. This study sought a particular type of data – in the form of experiences and meaning that are best captured through a qualitative methodological approach.

Research Procedures

Prior to data collection, an ethics protocol for this project was approved through York University Research Ethics Board (see “Ethics Approval” Appendix A). Following the ethics approval process, recruitment of LTRC frontline workers for this study got under way. Despite generating interest in the project, initial attempts to establish and maintain assistance with recruitment efforts were marked by a series of false starts, deferrals, organizational delays, and long silences. While this is perhaps the nature of

research (and life!), it became clear to me that gaining access through various gatekeepers and sponsors in order to recruit potential research participants did not have the momentum that was promising or encouraging. This required an ongoing reworking and broadening of my networking and recruitment efforts and strategies. This included establishing new contacts in order to generate broader interest and to further my access to and recruitment of potential participants for my study. Identification and access to LTRC frontline workers for possible recruitment and inclusion in my study sample was generously facilitated over the data collection period through multiple sources and opportunities. These include two national unions in Canada, attendance at union LTRC specific conferences, contacts within academia, several calls for participation through union locals to their LTRC worker memberships, various union representatives, contacts established through prior LTRC research, and key informants. This method of gaining access to potential research participants through multiple means may facilitate in capturing some of the heterogeneity of the workforce and diversity of frontline workers' experiences with health and safety more broadly across this sector from a range of workplaces than if directly recruiting within one or two facilities. My focus in this study is on frontline workers' experiences working within this system of LTRC more generally, not on specific facilities within this sector.

Participants for this study were recruited using a non-probability purposive sampling method. While snowball sampling was initially part of my sampling strategy, I selected not to actively use this sampling method in order to gain access and recruit research participants for my study. This decision was made in light of concerns some research participants expressed very early in the project in relation to confidentiality and

anonymity. In particular, I learned that their hesitancy and caution towards identifying and facilitating contact with other frontline workers as potential research participants was linked to their concerns in revealing their own participation to other workers who then might share this information elsewhere. It is a disclosure inherent to the practice and process of snowball sampling these particular participants did not feel comfortable with given their precarity and social location within the health care hierarchy.

Over the course of the data collection period, I obtained contact information from 57 frontline workers indicating interest in the project. All potential research participants who expressed an interest in the project were contacted by either email or phone depending on the nature of the contact information received from various sources. A description of the project was elaborated upon and attempts were made to generate further interest in the study. Of these, 28 responded and further correspondence and dialogue followed concerning the nature of the project, informed consent, availability, scheduling, and preference for interview format (face-to-face, phone, Skype) and location, as well as to address any questions or concerns. At least one follow up attempt was made by either phone or email to potential participants who did not respond to initial communication attempts through email or voice mail message.

Of the 20 interviews scheduled during the data collection period with frontline workers, two potential research participants did not show up to the scheduled interview and one cancelled twice and did not respond to a subsequent follow up request to reschedule. Active recruitment of research participants and data collection was halted once theoretical saturation was reached. In total, 17 semi-structured interviews with frontline workers were completed. In addition, two key informants were interviewed

using an unstructured interview format for background information and to assist with the identification of key issues and problems within the sector more generally. Their long-term familiarity and engagement with the culture of LTRC as well as workers' compensation systems also provided assistance in understanding broader issues not directly covered or not emerging from interviews with frontline workers.

Data in the form of semi-structured interviews with frontline LTRC workers (n=17) and unstructured interviews with key informants (n=2) were collected between March 30, 2012 and January 23, 2014. Informed consent was received from all participants. Interview participation was voluntary and participants could refuse to answer any questions asked. Consistent with the priority and obligation to maintain and protect confidentiality, individuals, workplaces, and organizations in this study are not identified (see "Informed Consent" Appendix C).

Of the 17 interviews with frontline workers, eight were conducted in person in parks, coffee shops, shopping centers, or at participants' places of residence. Research participants were asked to identify their preference for interviews – where they would feel most comfortable in speaking about their working conditions and experiences as frontline workers in the LTRC sector. These locations generally aligned with their pre-shift and post-shift work rhythms and routines. For instance, if they usually grab a coffee and sit on a park bench after work to decompress, I was invited to meet them there with coffee in hand for our interview. For some, this was not the case. When asked what they would be doing if not speaking to me about their work, a few indicated they would be crashed out on the couch after a long and difficult shift, exhausted, dead asleep with the television on – adding the interview was a "welcome disruption" to their routine. While

space was also offered at one union local to conduct interviews, this space was located a considerable distance from research participants as to not be feasible or of practical utility. Nine interviews with frontline workers were completed over the phone. Given the nature of the research inquiry and frontline workers' positioning within the LTRC hierarchy, selecting more neutral locations and modes of interviewing also avoided the dynamics, interferences, reservations, and "outing" that may be of concern and problematic in conducting interviews at their places of work. Two key informant interviews were conducted. One was in person, the other by phone. Interview participants and key informants each received a \$10.00 gift certificate, approved by Research Ethics, as an inducement/incentive for participation in this research.

All participants authorized digital recording of in-depth qualitative interviews. Interviews ranged from 1.5 to 3 hours in duration. Following each interview, digitally recorded interview data was personally transcribed in verbatim form. In total, approximately 36 hours of recorded interview data was transcribed. All data from participants collected for this research, informed consent forms, transcripts, digital recording device, and demographic information is securely stored in a locked file cabinet to which only I have access. All relevant data stored electronically is password protected.

The frontline workers who participated in semi-structured qualitative interviews identified working in a range of for-profit, including those part of a corporate chain, not-for profit, and municipal LTRC facilities located within large metropolitan areas, moderate and small cities, towns, and rural communities throughout Southern, South-western, and Northern regions of Ontario. Interview participants identified worker designation and training as either Personal Support Worker (PSW) or Health Care Aide

(HCA). Several participants identifying as HCA further noted either being grandfathered in or receiving additional training through PSW-HCA bridging programs.

In this study, all frontline workers interviewed identified as female. Of the 17 frontline workers interviewed, nine identified as being from racialized groups based on country of origin, immigrant status, language, ethno-racial self-identification, and/or skin colour. Twelve of the participants identified English as their first language. Seven of the participants are between the ages of 35 and 44, five between the ages of 45 and 54, and five between the ages of 55 and 64. The participants have an extensive history of frontline care work in the LTRC environment. This study included three frontline workers with more than 25 years of experience, six with 20 to 24 years of experience, five with 11 to 15 years experience, and three with less than 10 years of experience. Most participants indicated their entire work history has been within the same LTRC facility. Eleven frontline workers identified as full-time, one as temporary full-time, four as part-time, and one as a casual agency worker. All but one of the frontline workers interviewed is of unionized status, through CUPE or Unifor (formerly CAW). Two full-time frontline workers and one part-time frontline worker indicated at the time of their interviews as currently being on sick/disability leave from their respective places of LTRC employment. This study included ten frontline workers who regularly work the day shift, three who work the afternoon/evening shift, one participant who works the night shift only, and three who work a mix of days, afternoons, and the occasional night shift. Most frontline workers reported they were required to work weekend shifts at some point during their shift/schedule rotation.

The logistics of scheduling interviews and the challenges with this often provided some insight into the everyday/everynight realities of frontline workers. For instance, several frontline workers whose interviews were scheduled immediately following their scheduled shifts were significantly delayed in arriving at interviews because of having to remain at work, often unpaid. Others had to cancel and reschedule interviews several times because they were called in to cover a shift at the last minute. These situations often provided important entry points into interview discussions about the conditions of their frontline LTRC work.

Context is critical to research oriented to feminist political economy. The interview guide used for qualitative semi-structured interviewing covered a wide range of questions and probes of care, work, health and safety, and resistance related topics. Interview participants were asked open-ended, direct and indirect questions about care work histories and practices, organizational structures and contexts underlying workplace hazards and risks as well as frontline worker experiences related to types and/or nature of work hazards, workplace violence and illness and injury in the LTRC setting. This included questions aimed at revealing what frontline workers experience and perceive as psychologically and physically dangerous and/or psychologically and physically safe workplaces and conditions. Closed-ended questions were asked in relation to demographic and background information related to workplace status and care histories (see “Interview Guide” Appendix B). Key informants, both involved in advocacy in different capacities in LTRC, were asked to discuss what they consider and/or understand as the major issues and/or challenges with health and safety for workers in LTRC as well as own their experiences with advocacy in the LTRC sector.

The qualitative interviews were often animated, at times emotionally charged, and periodically injected with humour as workers described their working and care conditions, recalled specific incidents and events, and recounted stories of their experiences and the relations on the frontlines of care. The interviews allowed me to get a sense of these workers, the everyday/everynight realities they face, their care work conditions, histories, and backgrounds. This method also allowed me to explore frontline worker narratives (Gubrium & Holstein, 1998), how they understand the care work they do, how they talk about themselves as frontline workers and the people to whom they provide care, at work and beyond. Frontline workers discussed the changes, struggles, and challenges to their work and care, what they thought and how they felt about these, as well as what these meant, for themselves, their co-workers, and the residents they provide care. They talked about how they got there and why they stay. And they talked about how they make meaning. These broader questions provided a rich description of frontline workers' knowledge and experiences related to LTRC work. Whether the cases selected represent the population is an unknown with purposive sampling. However, in using this methodology and data collection strategy the objective is not representativeness. Rather, it is to gain a deeper understanding and to make visible care workers' individual experiences in relation to work conditions, hazard, risk, workplace safety, resistance and the ways workers shape the conditions of their work, and to reveal the ruling relations (Smith, 1987; Campbell & Gregor, 2002) that shape and influence this experience in LTRC settings.

The frontline LTRC workforce in Canada is comprised predominately of women. It is an aging workforce – many are 45 years and older, who work in roughly 600 LTRC

homes operating in the province of Ontario (Sharkey, 2008). These are composed of a mix of for-profit, corporately owned, and not for profit charitable, and public operated facilities that provide 24-hour frontline staffing, seven days a week, across day, afternoon, and night shifts by full-time, part-time, casual or contracted agency care workers who may or may not have unionized status. In general, frontline workers in Ontario working in large metropolitan areas are frequently from racialized groups – women of colour and/ or marginalized immigrants. The frontline workforce in smaller cities, towns, and rural communities are often Caucasian and Canadian born. This study did not specifically target specific ownership, facility location, worker demographic, and employment status characteristics of the frontline LTRC workforce for study inclusion through sampling methods and strategies. However, the resulting sample for this study does in many ways reflect or capture the diversity of the frontline workforce (demographics, employment status, shiftwork, union representation) and variety of facility ownership profiles of LTRC facilities operating in Ontario. That is, the sample for this study is heterogeneous in that it captures the range and types and/or the diversity of the workforce and various ownership configurations of LTRC operating within this sector.

Coding

Codes and coding is a significant aspect of qualitative data analysis. Coding is a process of categorizing, collapsing, condensing, and simplifying large amounts of data (as well as the complexity of this data) in a practical way. This includes the textual material, such as or transcripts derived from qualitative interviews in order to make it more manageable for purposes of analysis. The method of coding and the application of

codes is also an analytic process with the aim of questioning the material, illuminating broad theoretical aspects and issues (Emerson et al., 1995: 150) and to “capture the qualitative richness of the phenomenon” (Boyatzis, 1998: 31). This is accomplished through open, selective, and focused coding and analytic categorization in order to identify emergent themes, ideas, issues, trends, patterns, generate abstract categories, and make analytic sense of the data. All digitally recorded interviews were transcribed and then coded with the purpose of identifying key issues, patterns, contrasting themes, and concepts to explore links between lived experience and social structural processes and practices (Smith, 1987).

Thematic coding is not an absolute given or fixed process. Rather it is understood as influenced, though not necessarily determined, by ontological and epistemological commitments, theoretical orientations, and social positioning (Denzin, 1994). These orientations and commitments enter into and shape all aspects of the research process (Guba & Lincoln, 1994). While coding is desirable, and indeed necessary, there is a risk of fragmenting and decontextualizing care workers’ everyday/everynight lived experiences of their care work conditions in the process of coding and segmenting qualitative interview data that come in the forms of narratives, stories, recollections, or accounts, for the purposes of illustration and illumination in analysis. This process may preclude me from being able to tell their whole story in my final analysis (Coffey & Atkinson, 1996).

My claim is not that data itself, the coding of this data, or that qualitative analysis of data reveals or uncovers an objective “Truth.” Rather this qualitative study offers one critical interpretation or explanation of the evidence – qualitative data of workers’

experiences – anchored in a feminist political economy orientation and guided by a feminist epistemology to reveal an understanding of how working conditions, health and safety, and resistance are experienced and shaped by frontline workers in LTRC settings. And relatedly, how these experiences are linked to and influenced by broader systemic and structural conditions, forces, ideologies, and discourses.

Conclusion

This chapter has outlined the methods and methodology utilized in this project. Semi-structured interviews with frontline workers were conducted to explore these workers lived experiences and perceptions of hazards and risks in the context of their work, how these hazards and risks are related to larger structural factors, and the ways frontline residential care workers shape and/or influence, resist/challenge the conditions of their work.

Chapter 4: Feminist Political Economy of Workplace Injury and Illness

This dissertation is concerned with the risks LTRC frontline workers experience in the context of their work, how broader structural forces influence these workplace risks, and the ways workers shape or resist the conditions of their work. I begin the chapter mapping injury and illness trends amongst the health care workforce. This includes an overview of injury and illness for frontline workers as well as a brief review of relevant literature. Following this, I discuss violence experienced by workers as one indicator of the production and intensification of risk in the restructured LTRC environment. In the second part of this chapter, I examine the wider context in which frontline workers are situated. Drawing on feminist political economy, my primary focus of this chapter relates to establishing the broader structural forces that influence workers' experiences with workplace risk on the floor. To this end, discussion in this section considers the ways global forces, the state, unions, and employers shape and intervene in the production and the organization of labour, and with what implications for the health and safety of frontline workers.

Trends in Injury and Illness amongst the Health Care Workforce

The Canadian health care workforce encounters a range of serious workplace health and safety hazards resulting in physical and psychological injury and illness, absenteeism, and associated costs (Yassi & Hancock, 2005). Since 2000, the growing complexity of care, significant health care restructuring and reform, reduced resident care beds, and intensified workloads in an aging workforce have been reported by the provinces as factors that contribute to greater risk of injury amongst workers (Occupational Health and Safety Agency for Healthcare in BC et al., 2004).

Occupational risks among health care workers related to ergonomic issues linked to patient handling, patient and/or resident violence, infectious agents and allergens, are considerable (Yassi et. al., 2005). Official reports based on workers' compensation data in Canada indicate injury and illness among the health care workforce are at a rate that is more than twice the national average and injuries among workers providing direct care are significantly higher than all other health care occupations (Yassi et al., 2004; Yassi & Hancock, 2005). This is particularly the case for workers on the frontlines in LTRC (Armstrong et al., 2009). The most frequent workplace injuries amongst the health care workforce are those categorized as “traumatic injuries and disorders” which constitute 85.4 percent of overall workers' compensation claims. These are followed by “systemic diseases and disorders” and “mental, stress, and anxiety related disorders” at 6.8 percent and 0.9 percent, respectively (CIHI, 2007). In contrast to full-time workers in other occupations and industry sectors, the health care workforce has the highest absence rates (CIHI, 2007; Dabboussy & Uppal, 2012).

LTRC frontline workers also report higher rates of musculoskeletal injuries (MSIs) compared to workers in other occupations (Trinkoff et al., 2005). MSIs may be either acute – that is, resulting from a single event – or develop gradually through activities that involve repetition, excessive force, and awkward postures and strain (i.e., bending, reaching) (Health Care and Health and Safety Association of Ontario, 2003). In Canada, MSIs constitute the greatest time-loss claims reported among health care workers consequent of inadequate equipment, resident room configurations as well as stemming from work organization factors within the healthcare setting (Yassi et al., 2005; Mustard et al., 2010). The annual rate of compensation claims in Ontario is

approximately 16 per 100 full-time equivalent (FTE) workers. Of these, one third results in lost-work days (Mustard et al., 2009). In comparison to other occupational groups, issues and disorders relating to mental health have been identified as more of a problem for health care workers (Alamgir et al., 2007; Banerjee et al., 2008). Despite the high rates of injury and illness amongst the health care workforce revealed through official reporting systems, the phenomenon of underreporting has been well established in the literature. That is, the extent workers are injured and become ill because of their work and working conditions is grossly underestimated. This is especially true for women workers who frequently occupy positions characterized by high demand and low control (Lippel, 1999; Cox & Lippel, 2008).

Frontline workers have reported feeling at risk. Workers experience stress, anxiety, burnout, fatigue, pain, overwork, and the inability to provide the necessary quality care given the structure, organization, and conditions of their work (Yassi & Hancock, 2005; Zeytinoglu et al., 2007; Banerjee et al., 2008; Morgan et al., 2008; Armstrong et al., 2011; Daly et al., 2011). The stress that workers experience may be intensified by psychosocial pressure, workload, physical work, and lack of control over working conditions. Research suggests that rather than reducing or eliminating work conditions that are a source of stress, workers are expected and encouraged (by themselves, co-workers, and management) to adjust to or tolerate poor working conditions. Frontline workers are also frequently blamed for the negative consequences that arise from these conditions. This includes working conditions that adversely affect worker health and wellbeing, such as violence (Gates et al., 1999; Gates et al., 2005; Banerjee et al., 2008; Morgan et al., 2008; Daly et al., 2011). The endemic violence

occurring against workers within LTRC is one marker of new and intensified risks workers experience in the context of neoliberalism and work reorganization aimed at rationalizing costs and labour through lean and flexible practices and processes.

Violence as an Indicator

Violence transpiring within the health care setting is a growing concern. In North America, the extent of violence against workers in LTRC is staggering. The most prevalent physical manifestations of violence amongst the health care workforce are “surface” wounds, including abrasions and contusions, resulting from assaults by residents/patients (Occupational Health and Safety Agency for Healthcare in BC et al., 2004). In Canada, 33 percent of all incidents of workplace violence occur in health care and social service settings (Statistics Canada, 2004).²⁶ In Ontario, 58 percent of all stress-related claims were attributed to violence, with a steady rise in claims attributed to post-traumatic stress (Yassi et al., 2005: 335). In British Columbia, Neil Boyd’s (1995; 1998) research indicates that care workers have a greater risk of injury arising from workplace violence than that experienced by the province’s police officers. Yet, like injury and illness, most instances of violence arising in LTRC are not reflected in official reporting mechanisms (Boyd, 1998; Robinson & Tappen, 2008; Banerjee, 2010). Research suggests that 60 to 80 percent of the violence in LTRC goes unreported (Gates, 2005: 119). This is particularly true of violence against workers that does not necessitate medical assistance or intervention (Gates et al., 1999; Gates et al., 2005).

Frontline workers may experience violence – such as physical and verbal assault, harassment, and threats – regularly from those for whom they provide care (Morgan et

²⁶ According to the Bureau of Labour Statistics in the United States, frontline residential care workers have the highest incidence of assault among the labour force (Gates et al., 2005).

al., 2008; Banerjee et al., 2008; Daly et al., 2011). In Canada, research indicates that frontline workers experience physical violence on a daily basis (Banerjee et al., 2012). Consistent with other research (see Boyd, 1995; Boyd, 1998; Gates et al., 1999; Gates et al., 2005; Banerjee, 2008; Daly et al., 2011), Debra Morgan and her colleagues (2008) found that violence towards frontline workers by residents typically transpires during the direct provision of basic care (i.e. feeding, bathing, changing, dressing, ambulating, transferring, and turning). Using extrapolated data from their research that included 138 frontline workers, Donna Gates (2005: 124) and her research team projected the frequency of resident to worker assault over the period of one year as totalling 16, 224 assaults, 117 assaults per worker, and 806 injuries. The violence frontline workers experience is often gendered and racialized. Indeed, workers report experiencing sexism and racism, including sexual harassment, discrimination, and bullying on the frontlines of care (Banerjee et al., 2008).

A few relatively recent Canadian studies have examined the relationship between care work, neoliberal restructuring, and violence against workers by service users in social service (Baines, 2004b; Baines, 2006) and residents in LTRC settings (Armstrong & Jansen, 2006; Armstrong et al., 2011; Daly et al., 2011; Banerjee et al., 2012). This research indicates that changes to the organization and delivery of care in these settings may themselves account for the mounting violence. The demanding health care environment often shapes the context of violence toward frontline workers by residents. For instance, work organization changes resulting in heavy workloads, intensified work pace and demands, insufficient staffing, standardization, and routinization, may situate workers in positions where unmet immediate resident health concerns and care needs

may exacerbate resident violence against workers. Within dominant Western allopathic health care approaches, care is often narrowly defined within policy and limited to basic medical need and bodily functioning and maintenance (i.e., concrete, measurable or practical tasks and procedures) (Armstrong & Armstrong, 2003). Under this model, care is assumed amenable to numerical quantification and standardization. However, this assumption leads to the routinization of care (where the allocation of care is based on a fixed unit of time for the provision of specific care work tasks and procedures and regimenting how, where, and when care work is done) is problematic. The standardization and routinization of care may undermine the ability of workers to control or influence the timing and pacing of their work. As a result, worker (and resident) variability, discretion, and skill are ignored and rendered invisible (Armstrong et al., 2001; Armstrong & Jansen, 2006). It is also potentially dangerous. Routinizing and standardizing care may intensify and/or create new risks for workers (and residents).

Although violence occurring within LTRC in North America is widespread, the rate and context of violence occurring within LTRC is not uniform across countries. This understanding was amongst the findings of a recent university-based international study (see Banerjee et al., 2008). This study compared LTRC in three Canadian provinces (Manitoba, Nova Scotia, Ontario) and four Nordic European countries (Denmark, Finland, Norway, Sweden). The investigators of this research reported that in contrast to their Nordic counterparts, Canadian workers on the frontlines of care are almost seven times more likely to experience physical violence in the context of their work. The researchers identified staffing levels as one key difference in the levels of violence experienced by workers in these countries. The variation in violence experienced by

workers in these countries suggests violence is not an inevitable or inherent characteristic of this work (Armstrong et al., 2011). It also suggests that the expectation that workers accept resident physical violence – or what Morgan et al. (2008) refer to as workers “taking the hit” – is not as intensely routinized and deeply normalized as “part of the job” in Nordic facilities as it is in Canadian facilities.

From a feminist political economy perspective, violence also profoundly depends on context. The wider social, economic, and political contexts in which this work is organized are central to understanding the nature of violence and assumptions of risk. This includes structural and institutional processes and practices, as well as gendered and racialized ideologies, assumptions, and dominant discourses about care, care work, residents, and workers that both shape and are shaped by the method of organization. The variations of physical violence experienced by workers in the countries studied may be reflective of structural violence. That is, the violence workers face within the Canadian context is a consequence that arises from policy and funding decisions, care approaches, and the organization of care work. Importantly, the international research discussed above challenges entrenched assumptions that violence is an inescapable or unavoidable consequence of care work or that it is simply a consequence emerging from worker carelessness or recklessness (i.e. care worker error, inappropriate approach). Violence is preventable. In this view and consistent with core feminist political economy objectives, the differences in rates or patterns of violence between these countries also points to the possibility of transforming LTRC and care work in Canada. It also highlights the significance of a frequently undervalued and underutilized form of evidence that is deemed to lack authority in official system and institutional regimes of

governance – that is, the evidence derived from workers themselves that is rooted in their own everyday/everynight experiences, accounts, and encounters on the frontlines.

My primary focus of the remainder of this chapter explores the broader context in which frontline workers are located. In particular, my discussion now turns to exploring the ways ruling apparatuses – global forces, the state, employers, and unions – shape and intervene in the production and organization of care work in particular ways and impact the health and safety of frontline workers.

Global Forces

Policies and practices have material and social consequences. This includes shaping the labour process and the conditions of work in capitalist society in ways that may reinforce power relations and perpetuate gendered and racialized stereotypes, practices, and processes that undermine workplace health and safety. Health care reforms in Canada have adverse implications for working conditions in the health care sector. Neoliberal restructuring and reform of the delivery of care and work organization within LTRC has in many ways expanded and deepened historic hierarchies, disparities, and divisions, locally and globally. In response to pressures to rationalize costs and control labour within the LTRC sector, frontline workers are increasingly subject to exclusionary, coercive, exploitative, and alienating discourses, policies, and practices that reflect, reproduce, and perpetuate relations of ruling (Smith 1987; 2005). This includes the maintenance of sexism, racism, and classism embedded in broader Canadian society.

Health care restructuring and reform in Canada is fundamentally linked to global forces. This includes international trade pressures that privilege corporate interests in the expansion of capital and the promotion of reduced social spending by governments

(Hankivsky, 2004b). Integral to globalization and transnational relations is the integration of markets through treaties and trade agreements, such as the North American Free Trade Agreement (NAFTA), the General Agreement on Trade in Services (GATS), and the development of organizations, such as the World Trade Organization (WTO), the International Monetary Fund (IMF), and the World Bank. The existence of these international organizations and multilateral trade agreements has been argued to orchestrate and protect the growth of capital. They exist as apparatuses of governance – and more specifically, as an “enabling framework” (Teeple, 2000) that facilitates capital at the global level (Panitch, 2003). In protecting capital and facilitating its expansion, these international trade agreements may obstruct democratic processes and impede government sovereignty. This includes hindering state capacity to enact legislation and regulations that facilitate equity, improve working and living conditions, and workplace health and safety. As Eric Tucker (1996: 66) explains,

Globally, the balance of power has been shifting in favour of capital since the enactment of health and safety reforms in the late 1960s and 1970s [...] nation-states are conceding the formal legal authority to regulate capital by entering into trade agreements...or forms of economic union which assign authority to less democratically accountable, supra-national bodies.

Neoliberal economic globalization trends and the liberalization of trade and the service sector through these international agreements may have important consequences for women’s health, women’s equality, and women’s care labour within (and outside) LTTC. As the next section of this chapter explains, trade agreements may facilitate and reinforce the privatization of care – either through the for-profit corporatization of LTC or in ways that transfer the labour, costs, burdens, and risks of LTC to women, particularly women of colour and racialized new immigrants.

Privatization: Shifting the Costs, Risks, and Work of Care

The labour of women is crucial to global economic policies, including unwaged and waged care work (Eckenwiler, 2009). For women who constitute the bulk of the labour force in health and LTC and as the main recipients of care (Banerjee, 2007; Armstrong et al., 2008, CUPE, 2009), the growing emphasis on the elimination of non-tariff barriers such as laws, regulations, licensing standards, and qualifications have important consequences for policy at the state and home level (Hankivsky, 2004b).

In Canada, as governments move increasingly to privatize LTC – by encouraging the employment of market-based private sector principles and practices, delivering these services on a for-profit basis, or transferring the costs and work to the “private” sphere of the home, this sector becomes more susceptible to the terms and implications of these agreements. This is particularly the case with GATS and NAFTA. Once foreign investors have entered the LTC market, it is difficult for government to reverse the process of privatization. These trade agreements “lock-in” established levels of privatization (Labonte, 2003; CUPE, 2009) by triggering penalties and requiring significant financial compensation to any corporate interest claiming loss of opportunity by governments that either retract on trade agreements or enact legislation and/or regulations that obstruct or undermine corporate interests oriented towards capital accumulation, generation of profit (Hankivsky, 2004a). Consequently, the states’ ability to act independently of global capital is increasingly constrained. Trade agreements may confine government preference for local providers (Williams et al., 2001) and may commit governments to further the processes of health and care services privatization. These multilateral agreements facilitate global economic liberalization – and in the

process shape and change the nature of capitalism and its relationship to the state. This includes weakening government control over public policy and decisions (Leduc Browne, 2000; CUPE, 2009). Trade agreements may reinforce power relations, and reproduce and maintain structural and social inequities. This includes the degradation of labour and health protection standards (Smith, 2000; Hankivsky, 2004b) that further oppress, subordinate, and alienate workers and situate them at risk.

According to researchers such as Lisa Eckenwiler (2009), multinational profit-driven corporations and international bodies may have more power to influence and shape the agenda for health and care than either state governments or global health organizations such as the World Health Organization (WHO). As the Canadian state enters into trade agreements and aligns itself with the powerful corporate lobbyists, foreign investors, international lending bodies and transnational corporations facilitating global capitalism, the social and material wellbeing and the workplace health and safety of workers are increasingly subservient to the competing interests of economics and corporate agendas. The LTRC workforce is becoming more precarious and racialized under the impulses of global capitalism and the practices and processes influenced by a neoliberal ideological framework – with women of colour and racialized immigrants increasingly inserted into employer-driven flexible work arrangements characterized by exploitation, risk, and uncertainty. As discussed below, immigrant and racialized workers are increasingly utilized as cheap sources of labour in order to facilitate capital expansion, generate economic efficiencies, and as a means to rationalize costs (and labour) within an inadequately funded health and care system that has emerged through state retrenchment and disinvestment in relation to health and social care.

Transnational Trade in Care Labour

Working conditions consequent of international treaty rules and agreements may adversely influence social, health, cultural, and gender-based conditions of care labour. Indeed, in the last few decades transformed and new divisions of care labour have emerged between the family, the market, and the state. Economic globalization and the retreat of the state in the reproduction of the labour force have shaped the global division, provision, and organization of gendered and racialized care labour and migrant and immigrant patterns – or what Kathryn Braun and Colette Browne (2008) refer to as the “feminization and colorization” of labour in LTC. In the process, economic globalization has both fuelled and perpetuated gendered, sexist, racialized, and cultural stereotypes and inequities (see Chapter 2) creating a new cheap LTC labour economy. The gendered, racialized, and classed implications of public sector retrenchment and austerity measures, structural adjustment policies, and trade agreements in nation states of the global South has influenced and reinforced the gendered division of labour, power imbalances, and cultural norms that prescribe who performs this care work, where, and under what conditions. Increasingly, the demands, responsibilities, risks, and burdens of care have been shifted to poorly waged and unwaged women. Restructuring and reform of care has meant the reorganization of this work in precarious forms (what reformers term “flexible”) as well as through significant reductions and cuts to public care provision and spending. As a result, restructuring and reform has also meant the decommodification and/or privatization of care and care labour. While public policy discourse is predominately framed in gender-neutral terms (such as “individuals” “community” or “home-based” care) it is predominately women who are expected to compensate for care

deficits through unwaged labour created by the erosion of public sector services. In other words, women are increasingly relied upon, coerced, and/or forced to subsidize capital and the state through their unwaged labour.

The transnational movement of workers to wealthier countries – such as Canada, United States, and United Kingdom which have their own particular commitment to neoliberal efficiencies oriented to global capital – in search of work reflects the restructuring at home and abroad of economic and social policies. Neoliberal reforms and their relationship to the expanding and widening of poverty and inequality in low-income countries has also fuelled the restructuring and global transfer of (re)productive labour to richer countries facing a demand versus supply “care crisis” at the same time as governments exercise significant restraint in public sector spending (see Chapter 1). In the global North, the care sector has largely been reorganized with feminized and racialized immigrant patterns performing a central function in undertaking what is often dirty, dangerous, and difficult work. The phenomenon of redistributing the labour of women from poorer countries to wealthier countries to satisfy care (and reduced cost) demands has been termed by researchers as “global care chain” (Hochschild, 2000; Braun & Browne, 2008). Global care chain captures the interaction between the processes of capitalism, globalization, feminized migration, gender relations, care, and emotional labour. Immigrant and migrant workers are increasingly utilized as a flexible and inexpensive source of labour to facilitate and sustain neoliberal policies, processes, and austerity measures implemented in wealthier destination countries. This includes immigrant women pursuing work within expanding LTC markets to support themselves

and/or their families' survival and economic wellbeing (Eckenwiler, 2011; Eckenwiler, 2012).

The restructuring of care labour has been claimed by researchers to be a reflection or manifestation of a “new imperialism” (Hochschild, 2000) – or as Lisa Eckenwiler (2011; 2012) argues, a global phenomenon that generates and maintains structural and social injustice. More specifically, the global reorganization, redistribution, and transformation of care through the use of immigrant and migrant care workers is understood to produce and reproduce structural violence (see Chapter 2), marked by gendered and racialized divisions of labour, inequities in care, poor working conditions, and weakened health and safety protections. Moreover, this phenomenon has been argued to facilitate “care drain” (Hochschild, 2000). That is, the transnational redistribution and restructuring of women's labour power has seriously compromised the care capacities of source (supply) countries where, historically, gendered power relations, cultural norms, gender roles, and the sexual/gendered division of labour have often meant reliance on the unwaged and poorly waged care labour of women.

Weakened health systems, the creation of gaps in the provision of care, and care labour insufficiencies has in turn triggered a redistribution and transformation of care labour. According to Mona Harrington (1999: 21),

We are heading towards hardening inequality in the creation of a new, low-wage servant class to do our caretaking for us [...] depending on these workers, we create not just a servant class but one made up of racial and ethnic minorities.

The consequence of this new care economy is a reproduction of social and material inequities for poorly waged and unwaged care workers, especially women, which further reinforces an undervaluation of care as well as perpetuates health inequities and

disparities within poor source countries (Eckenwiler, 2011). As Nancy Yeates (2011: 230) argues, the transnational trade in care labour

Reflects a basic inequity of access to material resources arising from uneven development globally, but reinforces these inequalities by redistributing care resources from those in poorer countries for consumption by those in richer ones.

The transnational recruitment of migrant and immigrant labour into LTRC has important implications for the health and safety of these workers. Research has demonstrated that compared to their Canadian-born counterparts, immigrant women workers face exposure to factors that place them at a greater risk for workplace injury or illness (Premji et al., 2008a; Smith & Mustard, 2010; Premji & Lewchuk, 2014; Premji, 2014). The gendered and racialized composition of this workforce may also situate workers as more vulnerable to systemic discrimination and as a source of exploitable labour power. Immigrant and migrant workers may be particularly vulnerable to unsafe, exploitative, and oppressive working conditions given their marginalized social location, the undervaluation of care work, and gendered and racialized assumptions and ideologies about care work. Because of their marginalized social location in a context of increasing labour insecurity and precarity, migrant and immigrant workers may be ill positioned to resist, challenge, or refuse the conditions of their work that may be unsafe. Furthermore, immigrant workers in particular may be less likely to report workplace injuries. The likelihood of non-reporting is heightened if these workers have poor job security, are employed under precarious work arrangements (increasingly becoming the norm in LTRC), and are uninformed and/or have poor knowledge of their social and participatory rights (Tucker, 2013). Given their precarious status within the care sector, these workers may also

experience greater challenges or barriers in accessing and/or navigating the bureaucracy of the compensation system.

The State

In Canada, responsibility and legal authority for the enactment and enforcement of occupational health legislation resides mainly with the province.²⁷ The *Occupational Health and Safety Act* (OHSA) in Ontario came into force in 1979.²⁸ It was intended to provide more effective and encompassing state regulation and workers' statutory protection against workplace health and safety hazards (Smith, 2000; Lewchuk, 2013). The Ministry of Labour (MOL) is the regulatory enforcer of *OSHA* provisions. While numerous amendments have been made since *OHSA*'s initial passing, *OHSA* has essentially retained its basic structure and purpose. The present occupational health and safety arrangement is commonly referred to as the internal responsibility system (IRS). This system of governance emerged from the 1976 Royal Commission on Workplace Health and Safety Report. Under this arrangement, responsibility for health and safety is understood as internal to the institution (Smith, 2000; Tucker, 2013). Under the IRS, workers have three rights: the right to know about health and safety hazards in the workplace, the right to participate, and the right to refuse unsafe work. The IRS is characterized by organization-level systems (such as Joint Health and Safety Committees [JHSCs] to be discussed in more detail later in this chapter) to deal with hazards in the workplace. This system replaced what is often called the external responsibility system (ERS), which placed greater emphasis on government regulations and enforcement (by government or delegated agency such as the Worker's Compensation Board). The

²⁷ The *Canada Labour Code* applies to workers who work under federal jurisdiction.

²⁸ Health care organizations were not covered under Occupational Health and Safety legislation until 1980.

current “government-at-a-distance” approach underpinning the IRS utilizes a participatory rights framework and is guided by the principle that every individual shares some responsibility for workplace health and safety (Smith, 2000) – and that employers and workers are best positioned to be familiar with and deal with workplace risks (Barnetson, 2010). One assumption underpinning the principle of shared responsibility is that workers and employers share common interests (Tucker, 1996). In Ontario, commitment to this philosophy of shared responsibility is reflected in ongoing legislative and program support. For instance, *Safe at Work Ontario* is one MOL initiative that embraces IRS philosophy in its specific direction at *OHSA* awareness, enforcement/compliance, and partnership.

Currently, numerous regulations, legislation, and standards in Ontario are intended to have an impact on the operation of LTRC, the conduct of employers, and the health and safety of frontline workers. Yet, there is a lack of research relating to policy and legislative initiatives and/or discussion of the ways these may affect working conditions or exploring the risks that may be created and/or intensified for workers in these settings. In the next section of this chapter, I briefly consider the role of the state and its relationship to capital in shaping the conditions of work and influencing worker health and safety within workplaces.

The Role of the State

Vincente Navarro (1976) argues that the relationship between capitalism and the health requirements of the population is contradictory. For Navarro (1976), the concentration of capital and the expansion of the state are the central objectives of capitalism. The state’s primary governing role is the administration of economics. The

state intervenes in the health care sector in order to facilitate capitalist objectives of capital accumulation (O'Connor, 1973; Teeple, 2000; Panitch & Swartz, 2008). This includes the regulation and management of workplace risk (Barnetson, 2010) – which in contemporary flexible labour configurations has been shifted to the worker (Beck, 1997). Pressures and demands emerging from labour also shape the nature of the state's response (Teeple, 2000; Storey & Tucker, 2006). As Gary Teeple (2000: 187) maintains, the existence of the state “is relative to the demands of capital accumulation and to the character of class conflict.” The historical development of the state is rooted in the nature of class struggle whereby the regulation of labour for the purposes of capital is facilitated. In Ontario, the move several decades ago towards establishing occupational health and safety legislation coincided with pressures and demands from labour as well as growing acknowledgment of the substantial costs increasingly absorbed by the state resulting from workplace injury and illness.²⁹ Workplace injuries and illnesses were viewed by the state as undermining the productive capacity of labour (Smith, 2000).

From a Marxist orientation, occupational health and safety legislation can be understood not primarily as a humanitarian response to improve the working conditions of individual workers, but mainly as a manifestation of the state's role in the creation and maintenance of the conditions necessary to accumulate and expand capital (Walters, 1983). This includes the significance of the renewal and reproduction of labour power through maintenance of worker health and productivity by reducing workplace hazards and managing perceptions about risk. In other words, the initiation of health and safety

²⁹ According to the mid-1970s government report by then Health Minister Marc Lalonde, governments were spending an estimated \$750 million treating workers who became injured or ill in the workplace (Smith, 2000).

legislation in Ontario did not simply arise from and/or exclusively reflect state commitment, concern, and benevolence toward the health and safety of workers themselves or solely as a response to workers' demands and prolonged struggle for safer and healthier working conditions. In recognizing the structural contradictions of the capitalist labour process and link between health and productivity, through legislative and regulatory controls the state sought to intervene and alter the reproduction of labour power. State intervention was predominately oriented to reducing rising health costs stemming from workplace injury and illness and to lessen workplace hazards that affect capital accumulation and productivity (Walters, 1983: 417-421; Barnetson, 2010). Although the state can be a site of resistance, the fundamental and contradictory relation of capital to labour remains. As Vivienne Walters (1983: 423) reminds us, "concessions to labour do not alter existing class relations; although they may have a humanizing effect, they do not change capitalist relations of production."

Over the course of the last several decades, in a climate increasingly dominated by neoliberalism, the character of state interventions in health care, occupational health and safety operation, and tactics to workplace health and safety regulation, have been altered. As noted above, this includes greater prominence given and emphasis directed towards self-reliance/self-governance for employers and occupational health and safety management systems (i.e. IRS). These changes to the nature and role of the state in workplace safety are also occurring in a context of a weakening labour movement and this presents a significant threat to worker health and safety (Storey & Tucker, 2006). According to Robert Storey and Eric Tucker (2006: 159),

The advances made by workers and unions in the course of struggle through the 1970's and 1980's – struggles that can be captured in the phrase 'writing the

workers in' – have either been turned back via government legislation or made relatively benign by ascendant corporate OHS agendas that leave little or no room for worker/union participation. Workers are, in short, being 'written out' of OHS regulatory policies and programs.

The implications of this shift for workers are concerning. For some researchers, particularly those drawing on Marxist influences and insights, the assault on workers' rights are consequent of a political campaign waged by corporate interests to control and silence labour in order to protect and expand capital. It has meant the rights of workers to safe and healthy workplaces are increasingly subordinated to corporate compulsion to accumulate and expand capital and rationalize costs. It has also meant the risks and costs of health and safety are increasingly transferred to workers and families, and absorbed or subsidized by the broader public (Smith, 2000; Morgenson, 2006).

Restructuring of LTRC work coupled with reduced health care expenditures has often meant drawing on a cheap, contingent, and "unskilled" workforce in either poorly waged or unwaged capacities. It has also meant upholding sexism and racism in order to intensify profit and minimize costs. As frontline workers increasingly face insecure and non-standard work arrangements, are treated as "unskilled", undervalued (materially and symbolically), and where care labour is naturalized (as an inherent capacity of women and racialized groups), and risk as inevitable, the ability of workers to resist restructuring and exploitation is dulled and/or muted. This includes the power to articulate concerns related to working conditions, report on injury and illness, demand equitable compensation as well as opportunities for inclusive involvement and participation in decision-making regarding the conditions of their care work. Restructuring processes and practices emerging from the privileging of economic efficiencies and/or expansion of capital, contributes to the instability, marginalization, exploitation, and alienation of

frontline workers, the invisibility of their LTRC work, and the safety risks that the conditions and organization of their work creates or deepens.

Responsibilization and Individualization

The notion of individual responsibility is closely related to the assignment of fault. Historically, within organizational practice, the existence of workplace hazards and risks have been denied, suppressed, ignored, and distorted. According to some researchers, as governments restructure and reconfigure their role in line with enabling and facilitating neoliberal agendas, workplace safety is undergoing a process of “responsibilization” (Gray, 2009). Emphasis is placed on the responsibilities of the worker in ways that individualize the problem, blame the worker, normalize unsafe working conditions, and deflect responsibility for injury and illness away from the structure and organization of work. Blaming the worker is simply cheaper for the system. Increasingly, systems of internal responsibility focus on the responsibilities of workers without recognition of hierarchical structures, fundamental workplace power imbalances, and the limitations on workers’ capacity to control their working conditions and their ability to freely practice “individual responsibility.” This includes constraints on meaningful worker participation, voicing of complaints, demanding legally protected/ state-enforced safety rights, refusing unsafe work, asking questions, or requesting information about working conditions and workplace risk (Smith, 2000; Storey & Tucker, 2006; Gray, 2009; Lewchuk, 2013).

LTRC facility operators are not likely to improve working conditions when the dominant assumptions and narratives define, construct, and frame workers themselves as the problem. Thus, the emphasis on individual responsibility is also problematic in that it

effectively excludes other alternatives, actions, or responses. For instance, it omits social and structural solutions or a critical examination of context, including the burdens and risks experienced by women living in societies that are classist, sexist, and racist. Moreover, dilution of employer responsibility through IRS (Drache & Glasbeek, 1992), employer resistance and opposition to responsibility (via official mechanisms or informal tactics), loose and/or weak enforcement of IRS (oversight, accountability), and intrinsically uneven employer-worker power relationships (despite neoliberal discourse of “equal partnership”, “joint/shared responsibility”) has situated workers in a position of reliance on poorly monitored and enforced ERS (Vosko, 2009). This includes MOL inspections and orders in relation to their health and safety issues and concerns. Given the growing insecurity of work characteristic of contemporary labour configurations, changes to the employment relationship and workers’ relationship to the state, workers may be fearful or reluctant to report workplace risk.

Research conducted by Debra Morgan et al. (2008: 338) suggests that the emphasis on care worker “error” and “carelessness” or the tendency to blame the worker for structural problems – reducing these situations to faulty or pathological individual worker attributes or behaviours, masks organization and system-level factors that contribute to violence. In particular, the response workers encounter in relation to their reports of resident violence implied that they are responsible for causing resident violence because of “an inappropriate caregiving approach.” That is, while risk and violence are considered part of the job, workers simply need to be more responsible risk takers and more appropriate care workers as violence diffusers. Blaming workers also conceals how the conditions and organization of work are themselves structurally violent. This

includes the ways working conditions prevent workers from providing the type of care they consider essential to their work and as necessary to meeting the basic needs of residents. In reducing resident violence to something that merely arises from presumed improper individual worker actions, behaviours, or approaches, the social, political, and economic factors – the root causes – that influence the organization of work and harm or disadvantage workers and residents are obscured. That is, the broader relations of power, hierarchical social arrangements, and economically and politically driven processes and forces that shape the organization and conditions of work and care remain invisible. At the same time, structural inequalities within this setting are strengthened and perpetuated. Structural violence is at work when frontline workers (and residents) are harmed, disadvantaged, or diminished in a context in which they have no control, such as how, when, and under what conditions their work (and care) is organized or funded. Given the broader structural context, the extent, or scope of workers’ “partnership rights” and/or voice under the current IRS of the *OHSA*, in practice, are important considerations. The next section of this chapter briefly considers the limitations and challenges of JHSCs, which is particularly relevant in restructured workplaces such as LTRC that are characterized by insecure work configurations.

Joint Health and Safety Committees

In many countries, including Canada, JHSCs (and Health and Safety Representatives) have been mandated within occupational health and safety legislation to assist in the identification of workplace health and safety issues. In Canada, the prevention of and compensation for injury and illness related to the workplace falls primarily under provincial jurisdiction. In Ontario, JHSCs underpin the IRS and have

been a legal requirement since 1978 in workplaces with 20 or more employees. The composition of JHSCs includes individuals who represent the workers and employers. JHSCs have a limited responsibility within workplaces as JHSCs can only develop and submit recommendations to management. The power and responsibility to follow through with committee recommendations resides with the employer (Smith, 2000). While employer obligation to develop written policy relating to occupational health and safety is established in the *OHSA*, the implementation of specific measures and procedures to address workplace safety (safe work practices, safe working conditions, hygiene, infection control, biological, chemical and physical hazards and waste disposal) are developed in consultation with the JHSC and are reinforced under health care regulation.

Although few empirical studies have examined the effectiveness of JHSCs within the workplace, research does suggest that unionized environments are more likely to facilitate effective representation, appropriate communication, and management attentiveness to recommendations established by the committee (Yassi et al., 2013: 425). Some research suggests unionization may facilitate greater willingness and confidence amongst workers to report workplace injuries and illness and to submit compensation claims. Unions can provide assistance, support, and information as well as reduce concerns about reprisals and employer backlash. However, other research indicates that the relationship between union status and filing claims is not statistically significant (Shannon & Lowe, 2002). While CUPE Ontario (2010: 5) has argued that JHSCs are “the most effective way to instil a culture of safety in the workplace”, the experience of the union is that in practice many JHSCs function inadequately and lack effectiveness,

with the tendency to privilege employers and marginalize worker representatives on committees. There is no evidence that the mere presence of JHSC within organizations is adequate to ensuring better occupational health and safety behaviours or that the existence of joint committees results in improvements in rates of injury and illness amongst workers. The effectiveness of these committees depends on several factors, such as the amount of worker training and the degree of worker empowerment (Tucker, 1996).

Given the uneven nature of workplace power relations, dynamics and hierarchies of control in a context of intensified workload pressures on workers, JHSCs are generally not regarded as a substitute for either regulation or government enforcement (Yassi et al., 2013). Control over the workforce may be established through the pretence of participation in matters of workplace health and safety wherein JHSCs are portrayed to create equality (while simultaneously supposing equality already exists). That is, JHSCs may operate to give the illusion of equal partnership amongst employers and workers and provide only the appearance of worker participation. Devoid of real power and meaningful and equitable partnership and participation, JHSCs may function as a means or process of “manufacturing consent” (Burawoy, 1979) amongst workers wherein legitimacy and consent are secured through participation while simultaneously concealing the relations of production. That is, the uneven relationships, structures, and terms in which JHSCs are established under the auspices of capitalism. At the same time, frontline workers remain separated from control over the conception and execution of their care labour, reinforcing exploitation, reproducing power relations, conditions of alienated labour, and maintaining the status quo within capitalist workplaces.

Emphasis on worker training and education within provincial policy similarly generates the impression of actively “doing something” to advance accountability and improve LTRC working and care conditions. As discussed in the following section, the exclusive focus on training and education is limited in that it narrowly defines the scope of the problems – and thus, confines the solutions – within LTRC as predominately residing with faulty workers. It is also one example of the processes and practices of individualization and responsabilization characteristic of neoliberal frameworks occurring within LTRC workplaces (and elsewhere).

Frontline Worker Training

Research has demonstrated that factors such as inadequate staffing levels (see Banerjee et al., 2008) and high worker turnover have significant influence in shaping and/or contributing to resident violence and aggression. Despite this evidence, worker training as well as violence policy development have instead dominated legislative initiatives as well as management and human resource strategies to contain violence and aggression within LTRC (Daly et al., 2011). While, employers are mandated by the state to provide training and retraining, the content of these are left to the discretion of the employer. In Ontario, responsibilities to address violence and harassment in health care workplaces are specified in the *OHSA* and *Health Care and Residential Facilities Regulation* but do not offer specific guidance and/or standards on their implementation. Similarly, while the *LTCHA* identifies numerous topic areas that workers providing direct

care to residents are required to receive training and re-training at the organizational level on an annual basis, these too are vague.³⁰

In Ontario, the emphasis within policy and programs has been to focus on correcting individual and behavioural aspects (e.g., Robinson & Tappen, 2008). Government and organizational strategies oriented to the documentation of violence and the modification of workers' skills, conduct, and activities to diffuse violence and minimize injury and illness rather than to changing the broader structural and organizational context and processes that undermine health and safety or situate workers at risk in the first place. By relinquishing the employer or the wider system of any responsibility, these strategies reinforce the assumption that violence, injury, and illness are inevitable workplace hazards, situating responsibility with the worker. Thus, while workplace health and safety are recognized on the surface, the broader structural processes, relations, and practices in which risks are rooted within LTRC remain unacknowledged and unchanged.

Many initiatives and programs framing health care reform in Canada claim to be informed by “evidence-based” clinical knowledge and practices. Yet, policy and education, prevention, and training programs are not developed simply based on scientific evidence. These are also politically informed decisions and are an exercise of power. The emphasis on “evidence-based” decision-making conceals the political nature of this process. As Julianne Cheek (2011: 698) argues,

Neoliberal-derived thought emphasizes and prizes competition, efficiency, effectiveness, and excellence. It also emphasizes accountability. The

³⁰ These include: abuse recognition and prevention; mental health issues; behaviour management; minimization and application of restraints; palliative care; falls prevention and management; skin and wound care; continence and bowel management; pain management; equipment and device training.

proliferation of incessant numbers of government-driven reviews of all aspects of public institutions under the guise of ensuring value for money is symptomatic of the outworking of this audit culture. It is a culture based on narrow and audit-derived notions and measures of output and accountability ostensibly to demonstrate and legitimize claims of effectiveness and excellence.

In LTRC, the recently introduced Behavioural Supports Ontario (BSO) project is a quality improvement approach. It utilizes “client centered” and “care-giver directed care” models of care and emphasizes “partnership”, “collaboration”, “accountability”, and “knowledge transfer and exchange” using “evidence-based care and practices” among local, regional, and provincial organizations. This project involves the provision of skills training to health care workers (OANHSS, 2013), including workers on the frontlines of LTRC, in techniques to attend to the needs of individuals with “responsive behaviours” related to dementia, addictions, mental illness, other neurological conditions. The BSO program includes specialized units, mobile teams, and internal facility staff. Since the program began in 2011, \$103 million has been invested and 14, 000 workers have received specialized training and 475 new frontline hires (OANHSS, 2013). While specialized training is critical given the current complexity of resident needs, the underlying structural and organizational factors that shape risk for workers (and residents) remain unaltered. In other words, current trends in policy, education, and training as the only mechanisms or levers for change do nothing to address deeply embedded structural violence that is built into and permeates LTRC. This includes how this industry is funded, how care is delivered, and how care work is organized.

Unions in particular have expressed concern with respect to the dilution of frontline worker health and safety training that has occurred over the last several decades. While training is mandatory, there is an absence of standards outlining health and safety

training and information in LTRC. The emphasis on worker training is consistent with a broader neoliberal agenda that privileges an individualized solutions and problems approach (Bakker, 1996; Gray, 2009). It is hostile to supporting workers in ways that would challenge factors that reinforce violence and the normalization of risk within these settings. This is not to suggest worker training is irrelevant or unnecessary. My point is this direction is misguided in that it is of little utility for workers to be trained (e.g., to prevent or diffuse violence or properly lift and transfer residents) in ways they are unable to implement in practice given the unchanged conditions, assumptions, and context that underlies their work. It is even more troubling that workers are systematically blamed or vilified for failure to adhere to programs and policies when the origins of disconnect are structural or organizational in nature and beyond the control of workers who occupy the lowest positioning or rank within the LTRC hierarchy.

The normalization of risk and the assumption that workers – and particularly women workers, will tolerate conditions of work that compromises their own health and safety because they are committed to care (Baines, 2006; Morgan et al., 2008; Daly et al., 2011) masks the risks of care work. It also conceals the consequences of neoliberal capitalist restructuring while reproducing the status quo and deflecting attention from alternatives. Focusing exclusively on individual factors connected to health and safety further perpetuates the notion that the health and safety issues of workers are not subject to institutional and societal responsibility and action. It also obscures the ways health and safety concerns are inseparable from the conditions and relations that structure the organization of their work (Armstrong & Jansen, 2000; Armstrong et al., 2011; Daly et al., 2011).

Evidence plays a critical role in decision-making. What constitutes evidence, how it is used, and what counts as injury, illness, and violence have important implications for the workplace health and safety of frontline workers. The next section of this chapter considers the challenges and/or limitations of using workers' compensation data as either a reliable indicator of injury and illness trends or as an indirect measure of workplace health and safety practices.

Evidence Matters

In Canada, rates of injury and illness, such as the figures reported at the beginning of the chapter, are commonly based on workers' compensation data. This evidence is often utilized to measure the safety performance of individual workplaces and the overall rates across jurisdictions are typically employed as a means to evaluate trends, assess changes following the introduction of policies and legislation (Shannon & Lowe, 2002) as well as influence prevention priorities (Cox & Lippel, 2008). While workers' compensation data are the most comprehensive and accessible source for tracking workplace injury and illness, numerous factors limit this evidence as a reliable indicator of injury and illness trends amongst the health care workforce or as an indirect measure of health and safety practices within these workplaces. These factors include non-reporting (especially for women workers) and the reluctance or willingness to pursue claims by workers (Storey, 2009). According to research, intimidation, fear, blame, loyalty or commitment (Messing, 1998; Shaw, 2004; Baines, 2006; Morgan et al., 2008; Armstrong & Armstrong, 2001), employer inducement (Smith, 2000), and precarity of work are other significant factors that may hinder the reporting of injury, illness, or violence by workers (Cox & Lippel, 2008).

The failure of workers to report or submit a claim reinforces the view amongst governments that LTRC workplaces are not problematic, thus providing justification for not examining and/or implementing adequate prevention efforts within this setting. The reliability of compensation data may also be influenced by conceptualization and operationalization issues. For instance, what counts as injury, illness, and violence, by whom and under what conditions is not clearly defined (Messing, 1998; Cox & Lippel, 2008). That is, the extent to which workers' experiences of workplace injury and illness are evaluated as credible and legitimized (materially and politically) from the perspectives and practices of ruling apparatuses (Smith, 1987; Smith, 2005) or forces of power are not specified. Currently, the workers' compensation system utilizes the biomedical conception of injury and illness. Constraining what constitutes an injury or illness by the workers' compensation system also operates to limit employer liability, responsibility, and accountability.

Conservatively, it is estimated that 40 to 50 percent of injuries and illnesses related to work are missing from workers' compensation statistics (Cox & Lippel, 2005: 10). In their research, Rachel Cox and Katherine Lippel (2008) demonstrate how the work-related illnesses and injuries of women workers are likely to be under-represented in statistics on workers' compensation. This is especially true for the health care sector where women are overrepresented and precarious forms of labour are widespread. Based on the results of a national population survey of Canadian workers in 2000, researchers Harry Shannon and Graham Lowe (2002) found that for those likely to be eligible (i.e. modified duties, treatment and/or time-lost) for workers' compensation benefits 40 percent (+/-8 percent) did not submit a claim. In this context, official data such as

workers' compensation statistics can at best be regarded as a partial and unreliable indicator of total costs arising from compensable claims of workplace injury and illness rather than as a measure that captures injury and illness trends actually occurring in health care worksites. Given the gaps and limitations of workers' compensation statistics, using this data as a valid measure of workplace or industry performance or to establish prevention priorities and/or strategies ignores the risks of working in the health care sector and the experiences of workers (Cox & Lippel, 2008). Moreover, governments may utilize this data politically in ways that give the impression of improved work conditions. The production of evidence is related to the production of knowledge (or "facts") and the socio-political construction of reality. As Bob Barnettson (2010: 78) argues,

Data derived from OHS and workers' compensation programs can provide "evidence" that things are safer. Unfortunately (for workers), the measures used, however, obscure the actual injury rate, and erroneously suggest that workplaces are increasingly safe.

This is particularly troubling for workers in this women-dominated sector that is also plagued by "flexible" insecure and non-standard work arrangements – factors that are understood to hinder reporting – which in turn may render workers' compensation data as an even less reliable measure of injury and illness trends. Although workers' compensation statistics are understood as problematic (i.e., what this data captures or measures [or doesn't] and how this data is used, with what implications, and for whom), as the next part of this chapter examines, the workers' compensation system as a component of relations of ruling (Smith, 1987; Smith, 2005) is subject to concerns of systemic gender bias. This is particularly disconcerting for the workers who seek recognition and compensation for their workplace injury and illness. Under this system,

frontline workers own lived experience – or “knowledge from their bodies” (Smith, 2000) is subordinated to sexist institutions.

Workers’ Compensation and Systemic Bias

Injury, illness, and risk are often normalized, individualized, and gendered (Messing, 1998). Many researchers have demonstrated that since its inception, the workers’ compensation system in Ontario has been organized and operated in ways that are systematically biased against women workers who are injured at work (Messing, 1998; Lippel, 1999; Storey, 2009). Situated within the context of the broader political economy of capitalist production and labour market relations, the workers’ compensation system is understood as an apparatus of government. It is defined as an “institutional/administrative manifestation of structural relations of embodied dominance” (Storey, 2009: 76) in the management of worker injury and illness. The compensation system facilitates political and economic aims of curtailing conflict and reinforcing capital accumulation while simultaneously attempting to manage and control ill or injured worker behaviour. The political character of injury and illness recognition through compensation (and prevention) mechanisms functions as a significant source of legitimization. Historically, the workers’ compensation system has been oriented towards clearly definable, visible, acute, and extended periods of injury and illness subject to “objective” measurement by medical standards that are generally consistent with the patterns and sites of work in which men participate (Diamond, 1992; Doyal, 1995; Messing, 1998; Daykin & Doyal, 1999; Baines, 2004b; Yassi et al., 2004).

Not only has the underreporting of injury and illness in LTRC been identified as problematic, so too has the invisibility of illness and injury experienced among women

workers in LTRC settings. This invisibility highlights one of the limitations of the IRS philosophy regarding workers' "right to know" that extend beyond government and corporate silencing of workplace dangers and risks. It includes the exclusion of woman-dominated work from examination (Messing, 1998). As Doug Smith (2000: 90) maintains,

The right to know does not do a worker any good if no one has been bothered to investigate whether a job or task is dangerous in the first place. And it is often the case that the jobs that go unexamined are the jobs that are held by women.

While research has demonstrated that job control, worker support, job strain, precarious labour arrangements, and the organization and conditions of work can influence workers' physical, psychological, and social wellbeing (Quinlan, 2007; Lewchuk et. al., 2011), the *Workplace Safety and Insurance Act* (WSIA), however, does not typically accept these as legitimate or compensable occupational health concerns. Moreover, research undertaken over the decades (see Karasek, 1979; Lewchuk et al., 2011) has shown the relationship between work organization, job control, and social support, and health outcomes such as depression and anxiety. Nevertheless, claims for compensable workplace illness and injury in Ontario are often limited by restrictive eligibility criteria and assumptions. As Bob Barnettson (2010: 182) points out,

It is expected that the mechanism of injury will be discernable, the injury will manifest itself at the time of or reasonably soon after the injury occurs, and the course of treatment of the injury will be broadly similar from one person to the next. Where these assumptions are not met, additional scrutiny and barriers occur.

There is no provision under the *OHS Act* for workers to refuse work that is dangerous or harmful to mental health (Lippel, 2011). The workers' compensation system – the *Workplace Safety and Insurance Board* (WSIB) in Ontario – generally only recognizes

mental health claims that follow a traumatic event such as post-traumatic stress. Stress, anxiety, depression, and burnout related to the conditions of work are not recognized. Consequently, workplace standards and compensation guidelines exclude much of the injury and illness that is chronic or cumulative and develops gradually (Lippel, 2011). Requiring a greater compensation threshold than is necessary for acute physical injuries or mental injuries linked to physical work-related injuries has significant consequences for workers seeking compensation and/or legitimacy of work-related illness and injury in their work sites. Workers may be unable to make claims on the state for social rights, may be denied legitimacy and compensation for injury and illness, and may need to continue to work injured or ill and in the same problematic conditions that gave rise to injury or illness – which may further contribute to and exacerbate care worker injury.

In addition to the limits of the biomedical model, the undermining of the equality of women workers is reinforced and perpetuated by a system that orients its decision-making and adjudication of claims based on gendered assumptions. As discussed in Chapter 2, this includes assumptions about “women’s work,” (e.g., natural, safe, benign), women’s bodies (e.g., biologically predisposed to particular injuries, inferior, not fit for “real” work), what constitutes injury and illness (e.g., acute, visible), and what constitutes evidence (e.g. standardized, measurable). Such assumptions reinforce the view that care work does not pose psychological or physical hazards and risks (Messing, 1998). Research has also demonstrated that employers remain hesitant to accommodate women workers who are injured on the job. This includes scheduling that takes the gendered nature of domestic work into consideration or through provision of modified work duties (Lewchuk, 2013). Gendered assumptions about women as secondary wage earners may

further reinforce systemic bias in decisions relating to workplace injury and illness compensation claims (Storey, 2009). As Wayne Lewchuk (2013: 104-105) argues, “large, hierarchical, class, gender, and racialized organizations such as the WSIB are integral to the perpetuation of societal classed, gendered, and racialized inequities.”

The practices employed by these organizations have more to do with the power and legitimacy afforded to institutions and regulatory apparatuses in which they emerge than with efficacy, equity, and evidence (Messing, 1998; Smith, 2000; Armstrong & Armstrong, 2003; Panitch & Leys, 2009). Accordingly, as Karen Messing (1998: 153) states “women may find themselves in a [white] man’s world, where their biology, their jobs, and their social situations are alien to those who will judge them.” This observation points not only to a male-skewed or myopic sexist science that ignores women, but it also positions the legitimacy afforded to scientific (and medical claims) as problematic. Research also suggests that not only are women’s health problems under-compensated, but prevention efforts in sites where women are employed (and where precarious work arrangements are standard) are less common than in sites in which men are employed (Cox & Lippel, 2008). For workers who constitute the LTRC workforce, the current compensation system for workplace injury and illness claims largely renders the workers, the work, and workplace injury and illness invisible.

Psychologically and Physically Safe Work Environments

Psychosocial risk factors within the workplace have received international consideration, including the WHO’s *Global Plan of Action* where it recommends:

The assessment and management of health risks at the workplace should be improved by defining essential interventions for prevention and control of mechanical, physical, chemical, biological, and psychosocial risks in the working environment. Such measures include also integrated management of... improved

occupational safety, health-impact assessment of new technologies, work processes...

In Canada, recent developments in case law, tribunal decisions, and legislative changes imply that some employers have the legal obligation to provide and maintain not only physically safe work environments for employees but also ones that are psychologically safe (Shain, 2009; Shain, 2010). Psychologically unsafe workplaces include conditions that allow harassment, discrimination, verbal abuse, unfairness and disrespect as well as working conditions that are characterized by high demands and pressures and low control. More recently, new obligations have been imposed on employers to conduct risk assessments and develop programs and policies to prevent workplace violence and harassment (such as bullying) as well as acknowledge psychological harassment as a source of workplace violence.³¹

The federal government in Canada has also recently established a voluntary national workplace and psychological health and safety standard. This standard, entitled *Psychological Health and Safety in the Workplace: Prevention, Promotion, and Guidance to Staged Implementation* is intended to provide a systematic approach for employers to identify and address psychological hazards in the workplace. The corporate case for psychologically safe workplaces is frequently made using neoliberal rhetoric of “social responsibility”, “cost effectiveness”, “efficiency”, “risk management”, “productivity”, and “recruitment and retention.” Beyond concerns relating to the voluntary nature of workplace policies and standards with respect to mental health, some researchers have pointed to challenges relating to the effectiveness of standards that are designed without an analysis of gender, and more specifically, consideration for the

³¹ These provisions were introduced under *OHSA* in 2009 and came into force in June 2010.

specific situations of women workers and the differences among and between women workers (Messing et al., 2000). Other researchers have highlighted as problematic the lack of strategies and/or relatively weak mechanisms of enforcement for existing standards (Vosko, 2009), which can create the illusion of protection, without any promising impact or challenge to the current state of affairs. Although legal redress that holds employers liable may be important, it also masks complexity and ignores context. Focusing exclusively on employer responsibility decontextualizes the workplace and disconnects issues of workplace safety from the broader social and political context, ideologies, and assumptions in which workplace risks and hazards are rooted. Thus, legal redress is limited in that it does not address structural conditions that deepen and/or produce unsafe workplaces. It may also function directly or indirectly to contribute to and/or create social inequality—and legitimize and normalize risk in the workplace.

The emphasis on consequences for employers and employees within law, legislation, and policy distracts from examining the processes, practices, and conditions that may facilitate healthy, equitable, safe and inclusive work conditions for workers. Along different lines, although the social determinants of health may be institutionally recognized, how it is implemented in practice may be distorted and inevitably emphasize, privilege, or eliminate some social determinants of health over others, reframing these as “individual responsibilities” or rendering these invisible. In particular, the structural relations of power and the production and reproduction of power that shapes the social determinants of health may be overlooked, dismissed, or ignored.

Provincial health and safety policy and regulation changes and restructuring reforms in health care workplaces in Ontario have primarily emphasized equipment

safety, programs directed at the prevention of MSIs such as use and installation of lifting devices (i.e. overhead ceiling lifts, mechanical floor lifts), electronic beds, other resident handling equipment, institutional no-lift policies, and return-to-work/modified duty programs. These changes, including the dependence on technology, such as mechanical devices as a cost-saving strategy to optimize effectiveness, tend to reflect the capitalist necessity to increase labour power efficiency in order to achieve maximum profit (Miles-Tapping, 1992) and reduce costs. While the MOHLTC committed \$80 million to the purchase, installation, and worker training on 14,000 mechanical lifts between 2004 and 2006 in Ontario (Institute for Work & Health, 2007a), a systematic review of prevention programs revealed these devices have had only a modest impact in reducing worker musculoskeletal injuries (Institute for Work & Health, 2007b). Research suggests work conditions – such as work organization, staffing levels, resident room configurations, and workload demands – have hindered the effectiveness of this technology in practice (Armstrong & Jansen, 2006).

The dramatically restructured LTRC context that increasingly relies on the production of evidence and evidence-based science both shapes and is shaped by technology. While the technology itself may not be problematic, the context and the relationship to this technology may manufacture and/or exacerbate risks. This includes consideration of the larger context of power and control. That is, who decides how, when, and under what conditions technology is (or is not) utilized or alters work processes, practices, relations, and worker exposures to structural, physical, and psychosocial risks and hazards. The adverse implications of technology are clearly revealed in the research of Pat Armstrong and her colleagues (2009) with frontline

workers following the introduction of new incontinence product technology set in an expenditure reducing policy context that restricts their usage. As these researchers (2009: 131) explain,

After discussing ‘diaper police’ and efforts to hide unused diapers, and concluding that they ‘don’t feel good’ about being forced to keep residents in wet diapers, [focus group participants] drew attention to a technological innovation that may serve cost conscious employers in the short run, but certainly does not serve incontinent resident or those caring for them. In these new diapers, “there’s a line at the top. Once that line changes colour, they’re 75 percent.’ The technology, not the worker or the resident decides.

In this instance, although cost efficient, allowing technology to dictate (un)acceptable urine saturation levels may create or intensify risk for both workers and residents as well as reinforce their undervaluation. Moreover, this situation provides a clear example of structural violence. That is, the context and conditions of care and care work prevent or hinder workers from providing care and residents from receiving care – that is, having their basic needs met.

Following the implementation of these programs, Ontario initially reported a decline in injury rates in 1996, however, after 2000, a gradual escalation in injury rates was reported (Occupational Health and Safety Agency for Healthcare in BC et al., 2004). The emphasis on safe behaviour practices and programs such as mandatory two person lift policies ignore context including workplace social relations, hierarchical structures, and the organization of work. These approaches to injury and illness prevention may serve to locate and offload blame, responsibility, and discipline exclusively with the worker for unsafe acts and not working or behaving responsibly. Yet, they are often imposed in a context where processes shaping working conditions and the organization of work constrain workers’ capacity to adhere to health and safety regulations and

institutional rules such as mandatory two-person lift policies. The emphasis is on the faulty or pathological worker, not the faulty or pathological system. In short, social policy may increase psychological and physical risks workers are exposed to in ways that may create or intensify dangerous and stressful conditions and jeopardize resident care. Moreover, methods and technology utilized to increase “efficiency” and “cost-effectiveness” may reproduce inequitable workplace relations and worker alienation. As argued by Carole Miles-Tapping (1992), alienation operationalized and measured in terms of “stress” can be understood to refer to the lack of congruence between needs, abilities, and workplace demands.

Experience Rating Programs

In Ontario, the Experience Rating program, administered by WSIB was established during the mid-1980's following private sector lobbying ostensibly to make workplaces safer. Employer assessment rates are not related to employers' actions oriented towards making workplaces safer, preventing work-related injury and illness, and/or reducing risk for workers. Rather, the premiums that employer's pay is determined by average injury rates and duration/costs of claims compared to overall industry rates. Experience rating schemes do not consider injury, illness, or disease that develop gradually, over an extended period. The premiums paid by employers constitute most of workers' compensation funding so employers seek to keep these low (Barnetson, 2010). The experience rating system is an incentive driven program where employers who minimize (reported) workplace injuries and costs to the workers' compensation system are able to pay reduced rates. The program has been regarded as highly controversial since its introduction, particularly by organized labour and injured workers

in that it is understood to create inducements for employers to conceal, misrepresent, not report, contest claims, as well as put workers at risk through forced return to work before they are capable such as with Early Return to Work (ERTW) programs. Management may further exploit the incentive system and reinforce and perpetuate a culture of silence, rather than providing incentives for meaningful health and safety changes and prevention initiatives within the workplace (Storey & Tucker, 2006; Storey, 2009). This includes threats, pressure, intimidation tactics, and/or the provision of incentives not to report injuries in order to reduce workers' compensation premiums paid by employers (Shannon & Lowe, 2002).

In 2008, an investigative report by *Toronto Star* journalists David Bruser and Moira Walsh exposed flaws of the experience rating system, and in particular, the ability of companies to receive large rebates through the program – even in the event of death of a worker. The then Premier Dalton McGuinty called the rebates an “embarrassment”, with Steve Mahoney, chair of WSIB, claiming prompt action would be taken to remedy the issue. In part, this exposure led WSIB to hire consultants Morneau Sobeco to review the experience rating system and make recommendations. In the issued report, Morneau Sobeco (2008: 9) claims “one of the potential unintended consequences of the Experience Rating program is that some employers may achieve improved performance by not reporting injuries.” Morneau Sobeco (2008: 9) further point out the disconnect between the Experience Rating program and an employer's legislative obligations under *OHSA* and the *WSIA* stating, “employers may be entitled to rebates for “performance” as defined by the Experience Rating programs while at the same time being non-compliant with their regulatory obligations.” In late 2014, a follow-up report by the Ontario Federation

of Labour revealed the WSIB continues to reward dangerous employers by issuing rebates to companies at fault for worker death or injury in the workplace. More than this – while employers derive economic benefit from worker injury, illness, or death – workers are absorbing the costs. Beyond benefitting employers, Robert Storey and Eric Tucker (2006) argue non-reporting by workers permits governments to exaggerate claims regarding the success of workplace health and safety strategies – and thus, reinforce and maintain the status quo. That is, the fallacy is that owing to newly established health and safety policies and programs, fewer workers are becoming injured or ill. As Bob Barnettson (2010: 126) points out, in this context “the state appears responsive to the demands of workers without significantly impacting the capital accumulation process.” The focus is on narrowly defined measurable outcomes – not the processes, practices, and relations that may influence and inform these outcomes. This limited emphasis may distort safety and conceal injury and illness in Canadian workplaces (Cox & Lippel, 2008; Barnettson, 2010).

Employers

Work Organization

Organizational practices such as restructuring, newer systems of work organization such as flexible and quality management initiatives, and the use of contingent labour have been argued by reformers to improve profitability or efficiency, offer greater flexibility, responsibility, and opportunities for learning for workers. Evidence suggests, however, that these trends in the organization of work and retreat from the standard employment relationship may pose increased risk of workplace illnesses and injuries. Views and perspectives of workplace risk between employers and

workers are often contrasting or contradictory – the former understanding risk as natural and as an economic concern (maximizing profit, minimizing costs), and the latter understanding risk as a reflection of employer decision-making – that is, workers regard risk as imposed (Barnetson, 2010). This includes decisions relating to where, when, and how care is provided, and under what conditions.

Strategies to rationalize costs and labour have included changes to the employment relationship such as lean work arrangements (part-time, casual, multiple jobs), intensifying work, flattening organizational structures, as well as shifting of care work to the least cost and least specialized worker. It has also meant the elimination of “non-value added” activities and interactions from the tasks and routines of frontline care work, which do not contribute to cost-savings and/or profits. According to capitalist logic, rationalization along with this kind of efficiency and effectiveness are fundamental to the organization and delivery of care. In line with neoliberal ideology, this is said to contain costs, ensure operational effectiveness, minimize inefficiencies, and increase accountability (Armstrong et al., 2001; Panitch & Leys, 2009). While this may seem to align with the objectives of health advocates, the current agenda for reform has occurred in the absence of evidence to substantiate that these reforms or work redesign contain health care expenditures or improve care (Armstrong et al., 2001; Armstrong & Armstrong, 2001), research suggests the opposite. That is, the imposition of market principles to health care delivery and the organization of care work drive up costs while reducing efficiencies. The effect is compromised care for residents alongside new risks and intensified hazards for workers (Armstrong & Armstrong, 2001; Armstrong et al., 2001; Landsbergis, 2003; Ostry & Spiegel, 2004; Yassi & Hancock, 2005; Gates et. al.,

2005; Banerjee et al., 2008; Daly et al., 2011). Using pro-market principles to organize the provision and delivery of care may manufacture and/or intensify inequitable, exploitative, alienating, and risky (i.e., physical, social, emotional, psychological, relational, political, moral, and economic) work and work arrangements for workers, reinforcing their marginalization and undermining their capacity to make claims on the state.

Flexible work practices and lean work arrangements such as TQM and CQI may undermine the health and safety of residents and frontline workers and place them at risk. Research also suggests that precarious work arrangements are linked to rising injury and illness rates as well as heightened exposure to hazards, diseases, and work-related stress (Cox & Lippel, 2008; Lewchuk et al., 2011). Other more recent practices utilized within the LTRC setting such as resident-focused care have comparable implications for workers. This model of care is widely promoted by reformers using the language of the new economy such as “quality”, “autonomy”, “choice”, “individualized care”, and “flexibility of care” in a “home-like environment” for residents as “care consumers”, and also endeavours to improve efficiency, effectiveness, reduce costs and labour through flexibility and the reorganization of care work.

Unions

Unions emerged in the struggle between capital and labour and are a central labour market institution (Rinehart, 1987). In Canada, women currently constitute over half of the unionized workforce (Statistics Canada, 2014). In Ontario, 28 percent of workers belong to a union. In 2012, 74 percent of unionized workers in Canada were employed in the public sector. Within the private sector, unionization rates are among

the workforce is declining. In 2012, 17 percent of workers were unionized, down from 21 percent in 1997 (Statistics Canada, 2014). Workplace hazards have long been an issue and concern for workers. Nonetheless, before government legislative control over workplace hazards, organized labour did not identify and/or seriously prioritize workplace hazards for workers as a key mobilizing issue (Walters, 1983). Mechanisms of enforcement and monitoring peripheral to the workplace have historically hinged on workers and union activism for their efficacy. Storey and Tucker (2006) maintain worker activists remain central to union and worker mobilization as well as to generating broader public support around legislation and enforcement policy directed at health and safety and the conditions of work. Indeed, as Leo Panitch and Donald Swartz (2008: 143) explain,

The relations of class power in a capitalist society are asymmetric; nevertheless, the power that inheres in collective labour always remains a constituent element of such a society, and it is upon this basis that the potential for social change arises.

This is particularly true following the neoliberal assault on workers through the extension of a neoliberal policy framework and market restructuring over the last several decades. The neoliberal state and market reform have significant implications for organized labour. This includes growing precarity and work intensification – and consequently, increased vulnerability (produced by employment status or the changed nature of the employment relationship), and the weakening of workers power, labour rights, and protections.

Labour unions are increasingly concerned about the ways WSIB reforms, and health and safety system changes over the last several decades have facilitated a culture of silence and the underreporting of workplace injuries through intimidation and the

expectation workers return to work before they are healthy or capable to do so. According to Storey and Tucker (2006: 170), the “reluctance of workers to report their injuries is in many instances being preceded by an unwillingness of workers to confront employers over hazardous working conditions.” In addition to workplace pressures or institutional norms to not report injury, workers also feel pressure stemming from their employers and their coworkers to relinquish their right to refuse work that is unsafe (Storey & Tucker, 2006). In this context, unions are increasingly faced with the challenge of overcoming the dynamics and multifaceted factors and relations shaping the reluctance of workers to report their work-related injuries and illnesses, to raise concerns about workplace health and safety, and to refuse unsafe work. The problem of non-reporting is further amplified under the neoliberal state with the intensified use of lower cost and precarious forms of labour, and the recruitment of marginalized immigrants and racialized workers within LTRC who are unfavourably positioned to report on injury and illness and resist and/or refuse the unsafe conditions of their work. Unions in Canada are historically self-governing and independent of government or employer influence. While government intervention in labour relations has a long and varied history, neoliberal restructuring, including the growing shift to privatize or contract out health and social care has undermined care labour, labour rights, intensified the material and symbolic undervaluation of women workers, particularly women from racialized and immigrant groups (Cohen, 2009). It also poses a significant threat to unionized, public service sector jobs. According to CUPE, “wages, benefits, workload, job security, funding and service cuts or gaps, and attacks on bargaining rights” are amongst the most prioritized issues for workers within LTRC. Placing pressure on the state and employers to improve

workplace safety and produce structural change is constrained by limited resources, the compensation system, and the absence of reliable data relating to workplace injury and illness (Barnetson, 2010). Unions themselves have struggled to allocate resources and come to terms with the multidimensional experiences and diversity of the LTRC workforce. Over the last several years union campaigns have focused efforts on the conditions of care – such as promoting a legislated minimum care standard of four hours per resident day as a means to address poor work conditions. The trend towards profit-oriented facilities in Ontario and the necessity to accumulate capital and/or maximize efficiencies has meant a reduction in staffing levels, reorganization of workers or alterations to skill-mix, and degradation and plundering of wages.

Staffing Levels Matter

One primary mechanism utilized for generating profit in LTRC is by cutting labour costs and more specifically by instituting a reduction in staffing levels. The decrease in the level of staff has serious implications for working conditions and resident care conditions (McGregor & Ronald, 2011). As noted above, compared to public or private non-profit facilities, for-profit facilities in North America typically have lower staffing levels. This is particularly true with direct care provision (McGregor et al., 2005; Berta et al., 2005; CUPE, 2009). The implementation of for-profit sector practices to the organization and delivery of LTRC aimed at cost reduction and efficiency, including the leaning and “deskilling” of the LTRC workforce, has influenced staffing levels in non-profit facilities. Whether for-profit or non-profit – staffing levels, working conditions, and education and training within LTRC have not reflected the drastically changing resident demographics, including psychosocial and physical complexities (Ontario Health

Coalition, 2008).

Enhanced staffing levels in LTRC is often emphasized and prioritized by organized labour as one possible solution to minimize the manifestation of workplace injury, illness, and violence and the adverse outcomes for residents (CUPE, 2009). Unions that represent workers on the frontlines of care in Ontario have focused campaign efforts on exposing what dominant health care reformers consistently fail to grasp: care work conditions are inseparable from care conditions (Jansen, 2011). According to CUPE (2009: 31), “good working conditions are a prerequisite for good caring conditions.” This echoes other research (see Sharkey, 2008; McGregor & Ronald, 2011; Harrington et al., 2011) demonstrating a positive relationship between staffing levels, working conditions, and quality of care. Higher overall staffing levels have also been shown to be associated with lower injury rates among workers (Trinkoff et al., 2005; Cohen, 2009). Frontline workers have indicated in research conducted by Armstrong et al. (2009) that inadequate staffing is a central concern. These workers report feelings of inadequacy and experience mental and physical exhaustion and insufficient sleep from excessive workloads and demands.

In Ontario, no minimum staffing level currently exists. Unions and resident advocates have increasingly argued for an amendment to the *LTCHA, 2007* for a legislated care standard. As noted above, calls for a minimum 4 hours of care per resident each day that is adjusted for resident acuity level and case mix have been central to union efforts to improve staffing levels, working conditions, and quality of care and life of residents in LTRC. This level is based on extensive research highlighting the relationship between high staffing levels and improved resident outcome measures

(McGregor & Ronald, 2011), and particularly the comprehensive national study conducted by the Centres for Medicaid and Medical Services (CMS) commissioned through United States Congress. Between 1995 and 2002 under the Progressive Conservative government, public funding for for-profit facilities experienced a sharp increase in Ontario. While the Ontario government has reported greater funding over the last several years, this has not resulted in higher direct care staffing levels. In fact, evidence suggests while funding in this sector has risen, there has been a reduction in direct care hours (CUPE, 2009: 12).

Conclusion

Absences due to illness and injury amongst the health care workforce are rising. Research suggests that working conditions have a significant impact on injury, illness, and violence occurring within LTRC facilities. In Canada, the growing violence within the LTRC setting is one manifestation or symptom of restructuring and reform.

This chapter explored the ways global forces, the state, employers, and unions intervene in the production and organization of care and influence workplace health and safety. In part, the transnational flow of immigrant care workers is facilitated by trade agreements that privilege capital expansion and encourage the privatization and commercialization of health and care. These agreements may enable the encroachment on governments' legislative and regulatory authority, reinforce sexism and racism, and maintain social inequity privileging profit over care and work conditions. Neoliberal restructuring and reforms have facilitated a shift towards individualization, normalization, and responsabilization of risk. The effects of this change are to decontextualize and individualize inequalities and ignore structural disadvantage—often

in ways that reinforce and/or give rise to new sources of exclusion, marginalization, inequity, and risk. The degradation and undervaluation of care work is linked to assumptions about care, and in particular, the endless capacity of women to provide unwaged and waged care labour in any context.

Structural factors and relations are significant to conditioning our understanding of what constitutes, is recognized, and is responded to as a legitimate occupational health and safety concern—and conversely, what is excluded and/or ignored, and under what circumstances or conditions. In this view, the gendered politics of evidence – or what evidence becomes privileged, and how and what ways evidence is used to inform health and safety decision-making, matters. Although workers’ compensation data may provide evidence of workplace injury and illness, the data itself is limited by socially constructed definitions of injury and illness and the biases and assumptions built into these definitions. As such, workers’ compensation data may conceal and distort as much as the data reveals about contemporary workplace injury and illness.

While the current legislative and regulatory OHS regime in Ontario may give the appearance of protection, it is flawed in its concentration on consequences for employers and workers rather than on structural and organizational practices, processes, and decision-making. This reductionist and individual action oriented approach operates to discourage and undermine critical examination of the origins of risk within LTRC settings. That is, it ignores the broader forces and processes of workplace risk that underlie and shape the organization of frontline work.

Chapter 5: Transformed Conditions on the Frontlines of Care

In the final three chapters of this dissertation, I draw on qualitative data from semi-structured interviews with 17 frontline LTRC workers and unstructured interviews with two key informants to explore the transformed care and work conditions within Ontario LTRC. The frontline workers who participated in interviews for this project are seasoned workers. Many of them have more than two decades of experience working in for-profit, non-profit, and municipal LTRC facilities located in rural communities, cities, and metropolitan regions of southern, southwestern, and northern Ontario (see Chapter 3 for further participant demographics). Given their extensive history working on the frontlines of care, these workers are well positioned to comment on and share their experiences and insights with respect to the ongoing transformations, including restructuring, work reorganization, regulatory requirements alongside significant changes in resident base occurring over the last several decades. Most of the workers I spoke with are very passionate about their work and view this work as extremely important. While many of these workers state they love this work, they are deeply troubled by the conditions of work and care, including the ongoing devaluation, degradation, and dehumanization of residents and workers under this care regime. My use of care regime draws on Michael Burawoy's (1985: 8) theorization of the relationship between state and the shop floor in his explanation of how factory regimes extract more labour from workers under capitalism. Like Burawoy's factory regime, I conceptualize care regime as composed of the labour process (the organization of care work) and the political and ideological apparatuses of production (systems and relations that regulate the production of care). I use the concept apparatuses of care production in conjunction with Dorothy

Smith's (1989; 2005) concept of ruling relations, in my understanding of LTRC regimes as gendered and racialized – where the processes of racialization and gender are produced and reproduced on the floor. While Burawoy (1979) emphasizes the centrality of worker consent in his framework, participants' accounts in this study suggest that management control of the labour process is obtained through coercive mechanisms as well as through worker cooperation.

The changes within LTRC flowing from neoliberal practices, processes, and discourses have significant gendered and racialized dimensions and have important implications for workers. Using the lens of feminist political economy, the final chapters of this dissertation are oriented to revealing the implications of these transformations for the everyday/everynight working conditions of workers. The remaining chapters are also concerned with exploring the ways these workers negotiate, influence, challenge, and/or resist the conditions of their work. In doing so, my analysis within these chapters endeavours to make visible the experiences and struggles of frontline workers within LTRC.

In this first of three chapters analyzing the primary data, I explore the impact of these transformations for the working conditions of workers organizing my discussion in relation to workload. I understand their workload as multifaceted and shaped by numerous factors that are interconnected and overlapping in many ways. Drawing on participant interviews, I discuss several of these influences and transformations that have contributed to the intensity of workloads on the frontlines. These include changes to facility staffing arrangements (understaffing, short-staffing, worker availability), workforce configurations, documentation requirements, resident base, levels of care, and

worker control (work organization, rules and regulations, changes in delivery, decision-making). Following this discussion, I consider the implications of intensified workloads in relation to frontline worker unwaged labour, training, and teamwork.

Impossible Workloads

The work is tiring. It's really demanding. Too much demands from the residents. Sometimes you will see all those call bells from the residents going at the same time or one right after the other and another one is still going. One starts going and they all start going. The workload is impossible [Interview 10: 9]

This quote is just one of many I could use to illustrate heavy workloads. Without exception, participants in this study describe working in conditions that are fiercely demanding, inadequately staffed, and marked by heavy, intensified, and stressful workloads. Participants share their experiences with changes to funding, staffing levels, resident population, and the levels and complexity of resident care within LTRC. These workers explain what these transformations have meant for their workloads, their relations with others, and their experiences with and understandings of health, safety, and risk on the frontlines of care (the main focus of Chapter 6). The workload intensification participants describe has been shaped by various structural, regulatory, funding, and organizational changes within the LTC sector and within the health and social care sector more broadly. In Chapter 1, I discuss these transformations and lay out the broader social, economic, and political context, which underpin these shifts. In this chapter, my focus turns to the narratives and discussions offered by the participants in this project in order to understand these changes as they have been experienced and given meaning from the perspectives of the workers.

Many of the workers participating in this project indicate that the context for care, working conditions, and the organization of work have drastically changed over the last

several decades. Given their long service, for many their experiences preceded the era of LTC reform and restructuring underpinned by neoliberal principles, processes, and practices. Throughout interviews, participants reflected on and contrasted their experiences of the time they initially began their work within the LTRC environment (for-profit, non-profit, municipal) with their current experiences on the frontlines of care, highlighting significant differences. These include changes to resident base and levels and complexity of care. As this participant illustrates,

When I first started there [28 years ago], a lot of them were not high levels of care. They weren't high risk. They weren't complex. There weren't a lot of behaviours. Their refusal was more gentler. Like, 'I'm not taking a bath, get the hell outta here.' And that was it. But never so much as an aggressive behaviour as you see now [Interview 4: 4]

Another identifies changes to level of care upon resident admittance and the care level disconnect – or the expansion of resident care needs amidst the contraction of care provision resources,

When I started over 10 years ago, there were hardly any wheelchairs in the home. People walked. People talked. People could communicate. The people are staying home longer now – they are getting homecare, and they are not coming in until it's absolutely necessary. So, the level of care has increased tremendously and the level of care available has decreased tremendously [Interview 7: 6]

Participants also highlight significant changes to staffing ratios, wherein frontline workers are responsible for expanding and more complex resident assignments.

According to one participant,

When I first started out doing this job [almost 20 years ago], I had 7 residents and I was able to have those people shining. They were nicely dressed, with hair combed, teeth brushed. I mean, even if it wasn't their shower day, they could get a shower cause I had time. These are the things that we want to do [...] Now per worker, it's anywhere from 10 to 13 residents. And most of them are total care. It's impossible [Interview 11: 13]

Higher care needs, with less staff have meant less time spent relating with residents, engaging with them, and providing personal care. One participant remarks:

Years and years ago [participant has worked in long-term care for 15 years], I used to be able to get my work done and I could take a resident for a walk around the block on a nice day. Spend

time with them, or be able to sit down with residents one-on-one and talk with them for 20 minutes...Like, I could take them outside and sit in the gazebo, get some fresh air, and visit. Now? No way. You don't have the time to do any of that now [Interview 3: 18]

Participants' comments point to the transformed nature, dynamics, relations, and context of care within this setting. Workers repeatedly describe not having enough time and not having enough staff to provide the appropriate level of care to residents. As Armstrong et al. (2009) indicate in their research, not enough time is symptomatic of not enough staff to correspond to workers' workload. In the next section of this chapter, I discuss persistent understaffing within LTRC facilities as one factor that profoundly shapes the working conditions on the floor and share participants' experiences of this change and its implications for frontline worker workload.

Staffing

Chronic Understaffing

I find the whole make-up of my job right now to be demanding. There is just not enough staffing in the building at all...you know, to do the workload, to care, and do the things that are expected of us. There are a lot of demands. It's intense. We just don't have the staffing to do it [...]. The staffing – that's the one thing that's real different. For us, the ones that have been in this work for years and years, it's like, where is the staffing gone? [Interview 6: 8]

As the participant highlights in the above quote, workload increases experienced by workers are in part related to transformations in staff to resident ratios. This change has meant fewer workers responsible for more residents each of whom often requires more complex, higher levels of care. Regardless of ownership type (i.e., non-profit, for-profit, municipal) all participants involved in this project report working in chronically understaffed conditions. In Ontario, the current staffing levels and lean work arrangements are a product of several factors – many of which are elements of ruling relations (Smith, 1987; Smith, 2005). These include compliance with provincial rules

and regulations³², organizational decisions regarding the allocation of resources within a context of funding constraint (i.e., in order to maximize “efficiencies”), corporate interests (in the case of for-profits), assumptions and expectations about care (the politics of care), care work (the production and conditions of care). Other factors include care users (who receives), and care workers (who provides).

Although participants report some variation in terms of the degree of staffing reductions between facilities and across shifts (e.g., day/afternoon/night) within facilities, all participants indicate the workload increases they experience are in part related to cutbacks in the number of workers on the floor responsible for resident care. In general, reductions in worker staffing levels are more pronounced for participants who indicate working in for-profit facilities than for participants who indicate working in either non-profit or municipal facilities, in keeping with the research. Participants repeatedly describe their experiences with workload and its intensification in relation to expanding resident assignments and higher care levels amidst workforce reductions. According to the participants, workload intensification through higher, more demanding, and complex resident loads, without corresponding augmentation to staffing levels has produced greater time constraints on their care labour with residents. This finding is consistent with other research that highlights the inadequate staffing on the frontlines in Ontario LTCH facilities in relation to workload demands (Armstrong & Daly, 2004; Armstrong & Jansen, 2006; Banerjee et al., 2008; Armstrong et al., 2009; CUPE, 2009).

These shifts in staffing levels coupled with higher resident physiological and psychological care needs profoundly impact work satisfaction amongst workers and

³² Under the *LTCHA*, 24-hour staffing is required. Ontario has no provisions for minimum staffing requirements in long-term residential care facilities.

constrain their management of and/or control over their care labour and it limits the autonomy and discretion workers are able to exercise on the frontlines of care. As this participant shares,

Workload is horrible. The resident to staff ratio is horrible [...] I used to feel good when I went home after my job because I had felt I had done a very good job, right. Now because the workload has increased and we haven't had an increase in staffing I feel like absolute shit going home [...]. You can't be doing multiple things, be in multiple places at once. Some things you can't multi-task. We have an 11 to 1 ratio and it is sickening [Interview 1: 2-3]

While participants locate some of these changes to their workloads to overall government cutbacks within the sector, some participants also express deep frustration, questioning who and what becomes subject to budgetary slashing by the MOHLTC and within LTRC institutions. In particular, participants highlight the seemingly selective economic restraint and skewed orientation to economic efficiency demonstrated in relation to the allocation of resources within the LTC sector. In elaborating on this criticism, participants emphasize the hypocrisy of what they perceive as a bloated government bureaucracy and management structure that has been created, while at the same time, their numbers on the floor shrink, their hours are cut, their wages stagnate, their workloads increase, and their risks rise. In the words of one participant,

The Ministry has created a nice big bureaucracy with highly paid people in big positions but when it comes to the delivery of care, who is providing? These workers are making hardly anything for these jobs and they are breaking their backs doing it – and it's mostly women over the age of 50 [KI Interview 15: 13]

While workers are expected to take a wage freeze, “responsible” management of compensation does not extend to LTRC home executives. The uneven or imbalanced management and governmental structure underpins and reinforces assumptions about the nature of care, care work, and decision-making. Frontline workers are often not regarded and treated as important, valued, or authoritative sources of knowledge. This difference also reinforces their invisibility and their experience of devaluation within the gendered

and racialized LTRC hierarchy, where historically, women and racialized workers have been segregated into the least attractive, least specialized, and poorly waged aspects of health care work.

Working Short-staffed

Not only are workers working in conditions that are consistently understaffed, most participants in this project report workers are also working short-staffed as workers are routinely not replaced by management when absent. One worker claims,

They [management] get pissed off and if too many people have been calling in sick, they may replace the first person and then won't bother to replace the second one and then they say, 'oh well, we tried' [Interview 1: 8]

According to participant discussions, short staffing can be understood in part as a product of ruling relations (Smith, 1987; Smith, 2005), including facility management budgeting decisions that seek to maximize economic efficiencies and/or rationalize costs and labour, shifting risk and responsibility to workers. In the words of one participant,

I got 13 residents or up to 18 if they are short a worker, then I have to pick up more residents. That's ridiculous. And the administrator will say, 'work short. I'm not giving out overtime, so you girls are going to have to work short' [Interview 11: 13]

Resident care needs and requirements remain the same regardless of the number of workers on the floor. The practice of not replacing absent workers means that already overloaded workers on shift are assigned additional residents and thus required to further compensate for the chronic worker deficit on the floor. Below, one participant describes her experience and frustration about how this management practice in chronically understaffed facilities intensifies and complicates the management of her workload.

The worst thing is when we are short on staff because they add on top of what you are already doing. They will divide the residents of that particular staff up among the other workers to pick it up. So, that's the thing cause now you get more frustrated cause how can you manage? Already not enough time to finish your workload and then on top of that they go, 'here's some more!' [Interview 10: 14]

Short-staffing also constrains workers time and capacity to attend to resident needs and demands, compromising care to residents. According to this participant who works the day shift,

We started doing our timing with residents – came up with the 7 minutes with each resident in the morning. If you take one staff away, what do you think is going to happen? Not much in the way of care [Interview 5: 17]

Another participant who works the afternoon shift shares a similar concern,

Always understaffed, sometimes short-staffed. There are days when four people are there caring for 80 people. That's crazy, eh? Busy, busy days! What kind of care are people getting those days? They are getting a lick and a promise and here's your dinner because that is all you can do [Interview 7: 9]

Insufficient staffing also puts workers at risk. This management practice facilitates minimizing expenditure on labour. It also shapes and is shaped by ruling relations (Smith, 1987; Smith, 2005), including gendered assumptions, practices and processes, about the nature of care work and the gendered devaluation of care labour as natural and limitless. In the process, it systematically ignores the skill, physical labour, and stress involved in frontline work (see Chapter 2). One participant draws attention to an important point about frontline work and the underlying assumptions that care work is women's work and women are expected to do this work, regardless of context.

I hate to be sexist but they have no males that work there. Very seldom do you see a male working in a nursing home, that busy of a job. But you know what I mean? It's all women orientated, mostly. It's mostly a job that women would take. But um whether that's just the way it's worked out [...] But I don't think a man would last. They would never, you know, they would never be able to handle it – to take all of it. Because women tend to take on more than a man, you know, be able to handle more – whether it's at home or whether it is in certain jobs – you know? It's just expected of us [Interview 16: 17]

Some participants attribute the source of non-replacement of absent workers to government funding decisions and resource reductions which in turn influence facility management decisions not to replace staff on the floor,

When we work short-staffed, [...] this is tough, because I have my assignment but then I have to assist in picking up the others, which is unfair but I still do it [...] But then when I am finished I

am dead meat. I am tired [...] I am not sure who is responsible. Actually, first of all: it's the government. Cutting back, they always cutting back monies [Interview 14: 16]

Although important, this understanding is only part of the issue. Other participants also highlight the growing for-profit presence (corporate, chain, management) within the LTC sector and its influence on shaping government policies, programs, and practices within LTRC. That is, they identify the fusion of corporate power and government decision-making, constituting a significant ruling relation (Smith, 1987; Smith, 2005) within LTRC. Although frustrated with the conditions of their work, some participants are complicit with management and government decisions based on claims necessitating economic restraint and suggesting that there is no alternative to the existing state of affairs. According to one participant,

Their [management's] hands are tied [...] so you got to understand, I mean the Ministry has their hands tied too. Whether it's funding, whether it's supplies, staffing... whatever – it doesn't matter. You know, I have a boss, that boss has a boss, and that boss has a boss, you know, it's all domino effect, right. So, you just have to accept it as it is [Interview 7: 16]

This is one example that highlights the obfuscation of responsibility and the subverting of accountability many participants describe occurring within their facilities in relation to government and institutional cutbacks which obscures ruling relations (Smith, 1987; Smith, 2005) and the political nature of restructuring. Yet, care and work does not have to be organized and designed in the way that it is currently. Research comparing LTRC in Canada and Scandinavian countries discussed previously in this dissertation (see Chapter 4) provides evidence of promising alternatives and possibilities within this sector (see Banerjee et al., 2008; Armstrong et al., 2011; Baines & Armstrong, 2015).

At the organizational level, these mystifications and distortions are also shaped and perpetuated through language and practices on the floor. Despite widespread short-staffing occurring across facilities regardless of ownership type, several participants

indicate they are not permitted by management to employ language that would suggest the facility is short-staffed. Instead, workers can only say that they are “busy” and that they will “be with there [with the resident] soon.” In other words, workers are directed to utilize ambiguous language in ways that conceal staffing and workload issues as well as shift where responsibility lies. Some participants are not prepared to co-operate or reinforce this misrepresentation that requires workers to accept responsibility and the brunt of frustration emerging from encounters with residents and resident family members for issues and decisions beyond their control. As this participant confides,

You know, sometimes I say it. Even though I know we are not supposed to cause we have to keep the secret, support City Hall. But at the same time, my conscience is bothering me. Residents, families, they get bad perception of me, bad perception of the other staff. They get mad at us, that we are not doing our jobs, we lazy. So, I tell we are short-staffed [Interview 9: 14]

For this participant, it is important to shape perceptions of the conditions of work in ways that communicate that the incapacity to meet resident demands is not a problem residing with workers themselves (as the narrative constructed by management implies), but is rather a broader problem with origins that are structural and organizational. In the process of attempting to influence understandings by sharing the “secret”, this worker also attempts to shape the current conditions of her work by minimizing the possibility of being the target of resident and/or resident family frustration. This is one example of worker agency and resistance on the everyday/everynight frontlines of care that I return to later in the chapter.

Lack of Available Frontline Workers

Workload increases are also the result of the shortage of available workers to assume short-notice coverage of vacant shifts. It is not always possible to locate frontline workers who are available and/or willing to accommodate facility replacement requests.

Some participants explain that the inability of workers to cover a shift was in part a product of employer replacement practices. For instance, participants indicate that in some facilities management practice involves an automatic non-replacement of the first worker absence. Consequently, when attempts to replace workers are eventually initiated, frontline workers receiving the call-in are aware that the floor by this time is currently short by a couple of workers, signalling that the resident assignment for that shift will be greater and the workload more demanding. This management practice has the effect of deterring workers from taking on replacement shifts, while at the same facilitating further workload intensification for workers currently working on the floor. As this participant explains,

They don't replace the first call in. So, when they do start calling, you know that they are down two bodies and then people don't want to come then. Like, they know how hard they are gonna have to work and how much they are gonna run. So, forget it [Interview 8: 15]

Other participant discussions further highlight the importance of understanding the conditions of the work itself in order to understand why workers may be absent in the first place and/or may not be readily available and/or amenable to cover particular shifts. This includes the largely ignored and/or dismissed problem of resident-to-staff violence construed as part of the job, or the fault of the worker. The hierarchical and lateral bullying, intimidation, and harassment occurring amongst and between workers are often unaddressed and/or minimized (see Chapters 6 and 7 for an elaborated discussion). As this participant explains,

Sometimes workers don't want to come because of the residents. They know it is a hard group. They are difficult. They know who is calling in sick and they know the section they work and they don't want to work in that section and with those ones – that hurt or abuse. So, they are not gonna answer [...] you know, just to escape that section, like the residents and the workers. Some staff too, they are really getting bad, like bully [Interview 10: 11]

A few participants understand the unavailability of staff as an issue that reflects “generation” and “work ethic.” By this, they mean divide or discrepancy between older workers with extensive LTRC work histories and younger, relatively new recruits. As one participant who has worked on the frontlines for almost 25 years elaborates,

Short staffing is a huge issue in long-term care [...] The new generation has a different view on work ethics, I guess you could say. When I was younger and I was part-time, I worked everything that I got handed. I’d work a day shift, a night shift, and evening shift all in the same week. I was put back and forth. I was doing double shifts. I would jump through hoops. The new generation today, they don’t have those work ethics. Work is kinda on the side-burner. I dunno, they just don’t want to work or don’t have to work. We work short-staffed a lot [Interview 18: 12]

Considered from the perspective of feminist political economy, the situation is far more complex and layered than this. As emphasized throughout this dissertation, context matters. This includes the social, economic, and political context in which frontline workers historically work and live. Participant narratives underscore the importance of this context. That is, working short has more to do with the context and conditions of work than work ethic. Unlike their older counterparts, younger workers enter LTRC work within the context of a volatile labour market that demands having and managing multiple jobs with several employers across different sites of care. These are precarious employment conditions that offer little or no commitments to workers (Vosko, 2000; Lewchuk et al., 2011). These conditions are also not likely to manifest, encourage, or facilitate worker commitment to any one employer or LTRC facility. This uncertainty and precarity reinforce relations of ruling (Smith, 1987; Smith, 2005) and the politics of production (Burawoy, 1985), shaping both the conditions of work and worker expectations.

Several participants also highlight the gendered division of labour within families and the gendered social norms and expectations with respect to care responsibilities that

shape their shift un/availability. Other participants indicate that many of the women who are part-time and casual within their facilities are also single parents, wherein the nature and unpredictability of contingent work which provides only minimal notice creates additional challenges including financial barriers for these workers to secure child care arrangements. Moreover, the conditions of work have changed significantly. Many participants repeatedly describe this change in terms of an intensification of work within a context of transformed resident base, levels of care, funding restraint and/or fiscal discipline, profit generation, and changing government regulations and management rules, policies, and practices. These changes constitute part of the new ruling relations (Smith, 1987; Smith, 2005) or apparatuses of care of the LTRC regime. These transformations fuel the deterioration of work and care conditions and the degradation of worker control and decision-making.

Unlike their older counterparts with decades of experience within a changing LTRC landscape (and the layer of security or protection seniority may provide), many younger workers have not experienced a period of more promising times and conditions within this sector. Nor are these precarious part-time and casual positions within facilities merely transitional or interim in nature that will inevitably lead to more stable, secure, full-time positions. Rather, given current conditions, these positions are quite likely permanently precarious in terms of security, wages, benefits, and risk. These conditions shape practices and the parameters in which these workers navigate the changing landscape of work. Though not exhaustive, these differences in conditions of work (including violence, bullying, harassment), gendered responsibilities and norms, gendered and racialized labour market flexibilization, and managerial practices offer a

more contextualized understanding of why these workplaces are short-staffed and why workers are unavailable, than explanations that de-contextualize short-staffing and blame-shift to an entire workforce demographic. In other words, such explanations absolve institutions from any responsibility and obscure the structural and organizational factors that create, contribute to, and reinforce short staffing practices.

Frontline Workforce Transformations

Increases in workload are also a product of transformations occurring within the LTRC workforce. As highlighted above, this includes the growing reliance on a part-time or casual workforce by employers within this setting. On the floor, this preferred hiring practice contributes to further pressures, demands, and workload increases for overburdened full-time workers to assist and/or train and orientate such workers. These part-time and casual workers often lack familiarity with residents, care regimens, organizational practices, and rules, given their new, casual, part-time, or agency worker status. Even if they have worked in the same facility, they may lack continuity with particular residents and units. Many of these precarious workers have either limited or no guaranteed hours negotiated within their employment contracts. As a result, they must acquire and manage several jobs often within the LTC sector, which subsequently limits their availability for shifts at any one facility. As this worker explains,

A lot of part-time PSWs work a lot – sometimes at two or three different places and figuring out those shifts at all those places and a lot of places won't always work around it, it is very hard for them. They are trying to make ends meet and going from one place right to the next... So, they can't always be available [Interview 16: 1-2]

Moreover, the current recruitment and hiring practice that relies on casual or part-time workers has contributed to retention issues, as the turnover amongst these workers is particularly high. As this participant elaborates,

At our facility, we are full-time or casual. We have tried to convince the administrator to go back to the days when we were either part-time or full-time... because they have to work 16 shifts a month to maintain their benefits. People are more apt to be there and stay, right. And maybe they won't be taking as many other jobs, cause a lot of our casual girls have other jobs [Interview 8: 8]

This is particularly an issue with for-profit facilities as participants report these facilities tend to remunerate workers less than municipal or non-profit facilities and thus for-profits are not the preferred choice should workers need to decide between working at one facility over another. As this participant states,

Turnover is a real problem for our part-time. Our full-time staff has been there 20 to 30 years, [...] but part-time because they are not getting enough hours, or their other job interferes too much, or their other job pays more because they are working for a government or non-profit home and not a for-profit like ours [Interview 5: 27]

Other research has also linked lower staffing levels with higher rates of turnover and staffing levels are lower amongst for-profit facilities than within municipal or non-profit facilities (McGregor & Ronald, 2011). Reflecting the transnational flow of care workers from poorer countries to wealthier countries (Eckenwiler, 2011; Yeates, 2011), several participants link transformations of the workforce and the precarious nature of this work to the growing racialized, immigrant composition of the part-time and casual workforce, particularly within cities and metropolitan areas. According to one participant contracted through an agency to work in facilities,

Workers are coming in from Jamaica and Trinidad and they are getting tossed in long-term care facilities [...] they are starving these women. They are getting paid at the lowest end of the scale – We are being paid at the lowest end of the scale. And they are only getting part-time, casual work [Interview 17: 18]

Standardized Documentation, Point-of-Care Systems

If you didn't write it down, it didn't happen [Interview 16: 9]

Like the woman quoted above, most participants in this project discussed mounting documentation and reporting requirements as mandated by the MOHLTC. The shift towards more and more data collection reflects reform and restructuring directions

that emphasize minimizing inefficiencies through standardizing, monitoring, and measuring specific outcomes. Workers report that the recently established documentation requirements for reporting on resident care are extremely time consuming and significantly contribute to the growing intensity, demands, and pressures of their workloads. While the time commitment for documentation has significantly increased, participants report that managements have made no provisions, interventions, or modifications to frontline workers' shift responsibilities to accommodate this change. Rather, workers are responsible for integrating time-consuming documentation requirements into their already time-pressed and time-structured shift workloads. Many participants express concern that documenting and/or reporting on resident plans of care per MOHLTC and institutional standards profoundly infringe on the time these workers are on the floor working with residents. As one project participant describes,

When we went to the RAI-MDS, we have three pages front and back of documentation there [...] The Ministry has taken almost a good hour out of my residents care to do documentation [...] it shouldn't take as much time as it does away from the resident. We have to spend too much time documenting everything and not being able to be with the residents [Interview 4: 25]

While some participants in this study have more flexibility in terms of when documentation can occur, many indicate working in facilities where point-of-care (POC) electronic standardized documentation systems (or real time documenting) have been implemented. This system requires workers to record care as it happens, ostensibly to improve efficiency, reduce errors, and facilitate information sharing. However, many participants share their struggles and challenges with increased amounts of documentation required as well as the timing of and/or time for documentation given their workloads and organization of work that often means inflexible timeframes for care. This is one of aspect of ruling relations (Smith, 1987; Smith, 2005), wherein textual and

technological practices condition work and frontline workers. Below one participant describes how standardized, efficiency-based POC systems operate in practice on the care floor given the conditions and organization of their work in ways that create further tensions with competing workload demands and resident routines,

As far as they are concerned if you didn't tick it, you didn't do it. Documentation shouldn't be that complicated [...] And now it's point-click-clear, so every time you come out of doing something for a resident ... and you have to go right to the computer which isn't always possible [Interview 4: 25]

From the perspective of many project participants, management's main concern is that frontline workers confirm/provide evidence that the defined care work is accomplished at the specified time. This evidence is in the form of standardized documentation requirements mandated by funding bodies, which according to participants do not reflect the realities and specificities on the floor and the nature of care. Nevertheless, responsibility resides with workers. As this participant highlights,

So, work gets backed up [...] and you might get questioned why the work isn't getting done but you are dealing with certain residents... but they don't care about that. They just want to make sure the work is done. Charting stuff, the charting stuff is the legal part. They want it done [...] the legalities are taken care of, okay. But on the floor, it's another story [Interview 17: 19]

In response to this form of managerial control – or what Richard Edwards (1979) terms “technical control” (see Chapter 2) – workers struggle to find new ways to influence POC system technology and monitoring and to resist the potential implications that emerge from failure to comply with documentation requirements. Some participants explain that because of the intensification of work and their more demanding workloads, they do not have the time to complete some of the work that they are required to document. This situation has resulted in the falsification of documentation by workers in order to avoid consequences and blame for workload and work organization problems peripheral to their

control. As this participant and frontline worker union representative with over two decades of experience on the frontlines highlights,

I think the government needs to get back on track on mandating how documentation is done, because we lie about a lot of the crap that gets done that we don't really do. We don't want to, but we have no real choice. There are things that we say we do, but have absolutely no time to do [...]. The onus is on the healthcare worker. The health care worker gets disciplined. So, if you don't sign it, you are in trouble. It ends up where we are falsifying documents, really. That is what we are doing. Consequences, discipline, over things we don't have control over. There's too much work, and no ability to do it. If you don't complete your flow sheets, you're in trouble. So, it's like I don't have a say in what needs to get done, but I sure will get into trouble if I say it's not done [Interview 1: 4-5]

While the falsification of documentation facilitates immediate frontline worker interests in evading blame and punishment, the completion of documentation (albeit sometimes falsified) by workers may also inadvertently reinforce assumptions that their workload is reasonable as workers are able, according to official documentation, to complete their required shift work. That is, the practice of fabricating documents (and cutting corners – discussed below) given the conditions of work and their location within the health care hierarchy, places workers in a troubling situation that may inadvertently undermine their concerns about their working conditions (e.g., excessive workload, understaffing, safety) and reinforce the invisibility of these conditions. Frontline workers themselves become implicated in ruling relations (Smith, 1987; Smith, 2005) legitimization through their everyday/everynight activities. But the situation poses further challenges and contradictions. Participants also discuss the broader consequences of not documenting and reporting on all aspects of care as these inform MOHLTC, CMI funding formulas. According to one participant,

Everything in long-term care is tied to the budget and, you know, to the case-mix indicators, the CMI, you have to be sure to capture this stuff [...] The new stuff that they are doing, the RAI-MDS – evaluations and processes. Everything is tied to the budget [Interview 2: 2]

This includes funding and/or staffing reductions in for-profit, municipal, and non-profit facilities. As reflected in this participants' comment,

If your CMI goes down, cause things aren't reported, then you are going to put yourself in the position where someone is going to lose a position [Interview 5: 28]

While some participants are aware that lower CMIs were likely to trigger funding cuts, participants are also sceptical of institutional understandings that higher CMIs lead to improved funding and staffing levels. As this worker explains,

And here we are now with the RAI-MDS, they claim this is gonna do wonders for us, this is going to um get over the changes with the resident, we'll see improvements and the level of care will change and [...] this will bring more funding into the building, into the nursing home. The RAI-MDS has been out now for years, we got higher CMIs...and I don't know if anyone has ever received any additional funding from this form of documentation [Interview 4: 20]

Beyond the impact of documentation requirements on worker time with residents, some participants spoke to the bureaucracy of documentation itself, questioning how documentation is used and whether it is effective. This uncertainty compounds the frustration these workers experience in the allocation of time away from resident care to allow for its completion, especially when documentation efforts appear futile as there is no indication this leads to improved work and care conditions on the floor. As one participant with ten years experience working in one municipal facility states,

The amount of charting that we do at the end of the day, I have no idea how it is effectively implemented. I don't know. We also fill out a whole behaviour sheet at the end of our shift on every resident and what's done with it is beyond my scope but what I do know is I sure don't see anything change for the better [Interview 7: 11]

Along similar lines, participants' narratives further emphasize the politics of evidence. This includes critical questioning of the underlying intent of documentation and what forms of information are privileged or selected for capture within documentation. In considering this, a few participants understand documentation and data collection as primarily industry serving. As one key informant indicates,

All this documentation. Data collection. To what end? Why are they collecting data? There is all this data that are being collected but I am not sure to what purpose and I am not sure that it is for the right purpose [...] it has less to do with care than it has to do with the industry looking good. It is for the good of the industry. So, one more wasteful thing going on with government [KI Interview 15: 10-11]

In this account, government and institutions do not develop documentation as an instrument for the objectives of accountability, transparency, and quality care. Rather, documentation is understood as the merging of corporate influence with government decision-making. In the perspective of feminist political economy, documentation and the collection of data using “efficient” (standardized), and “effective” (evidence-based) knowledge and practices can be understood as reflections of power, operating to legitimize and justify the documentation and data collection itself and its architects, reflecting and reinforcing growing corporate interest within the sector. On the floor, documentation has meant an increase in workloads for workers and less time for resident care. It also creates greater opportunities for risk, injury, illness, and violence. Documentation and data collection, not residents, workers, or the relations between them are privileged in the current care regime.

Downloading and Expanding Frontline Worker Workload

While reductions to frontline staffing levels have resulted in intensified workloads for workers, cuts and changes to staffing configurations elsewhere within the system of LTRC also expands the workloads of frontline workers on the floor. For instance, staffing reductions within “ancillary” services such as dietary and laundry has meant that some of the work that was previously the responsibility of workers in these areas has now been shifted to the workers on the frontline of care. In the narrative below, one worker describes expanding workloads in relation to the contraction of dietary workers and their hours occurring within some facilities over the last few years,

The workload is getting so much heavier. There are more demands on us. We are PSWs and Health Care Aides ...but we also do dietary work, we have to – like on top of taking care of residents, we have to pour the milk, juices, tea, coffee, we deliver the cereals in the morning for breakfast, we deliver the meals at lunchtime, we have to take the orders. We have to clear the dining room tables. This is a dietary job – but we are doing it cause dietary hours got cut a few years back... That's our job now too. That's what they do – cut staff and then put the workload on the frontline workers [Interview 6: 8]

This facility staffing and work reorganization change has ultimately meant heavier workloads – more work, with fewer workers to do it – and within the context of strict timeframe parameters in line with MOHLTC standards.

Transformations in Resident Base

The intensification of work and workload increases experienced by workers on the floor also reflect changes in the resident base derivative of austerity measures occurring elsewhere within the health and social care system and changed eligibility criteria for resident admission under the *LTCHA* (see Chapter 1). Many participants indicate a dramatic increase in residents with complex cognitive, psychological, and physical challenges. Below, one participant shares her observations and experience with current trends in resident populations.

Now, it's changed, it's no longer a seniors home. It is no longer homes for the aged. It's not a home, it's a facility [...] they have all types of people coming in with mental problems, physical problem, and the ages varies and some of them speak other languages and it is really difficult for us to communicate [Interview 14: 10]

Other participants point to factors influencing and reinforcing this demographic shift including costs, cutbacks, and closures. According to one participant,

It's not just the elderly anymore, it's [...] we are dealing with younger... because of the closure of beds in mental health, so more mental health, younger residents [Interview 6: 5]

Participants highlight the implications for their workload and working conditions given the changes to resident base. This includes health and safety on the frontlines. As this participant indicates,

We have people coming in with catheters, feeding tubes. We never had that kind of stuff before. The lifts, the people who need to be lifted now is astronomical. It has massively changed. It wasn't like that before... and there are people with infections, need to be changed more often, we never had that – or lactose, or c-def., or e-coli... never had that before but it is all the time now. And it makes for huge amounts of work more work [...] more dementia, more aggression. Big time [Interview 1: 27]

Importantly, while workload pressures related to resident care, demands, and physiological and psychological or cognitive needs have expanded, staffing levels and resources that would support these transformations and shifts, have not.

Constraints on Worker Control

Work Organization

The increase in workload is also influenced by the organization of frontline work. How the work on the floor is organized has changed. Most participants describe their frontline work as rigidly structured, constrained by strict timetables, schedules, and care agendas – either determined at the institutional level or passed down by MOHLTC – regardless of context. This includes differences among workers (e.g., skill, experience) and residents (e.g., physiological and psychological needs and preferences). Long-term workers often recounted their earlier care work experiences and relations with residents and discussed their frustration with current policies and practices shaping work and care conditions. They spoke of their resentment and anger towards changes to the organization of their care work in ways that purge the relational and emotional components from care. Participants' accounts highlight the effects and implications of broader social, economic, and political transformations on experiences and relationships within LTRC facilities. According to many participants, their work has been reduced to physical tasks – the “body work” of care (Twigg, 2000; Twigg et al., 2011) and activities that can be easily monitored and tracked, that are to be executed within the standardized

and routinized parameters of government along with institutionally determined timeframes that coincide with efficiency expectations.

The efficiency focus (articulated in increments of time) that underpins care timetables and scheduling tasks such as meals, bathing, sleep, personal care, activities, requires work to be completed within pre-determined and fixed amounts of time. This practice encompasses the compression of the time for care and the timing of care because of efficiency-inspired standardized routines. This approach to care organization constrains workers' discretion and control over the nature and pace of their work. As indicated above, this inflexible and tightly scheduled arrangement does not consider or privilege variability in worker skills and experience or variability in resident needs. In particular, it ignores the flexibility and time that may be required when working with residents with complex physical and mental health issues. Given the changes in resident profiles, including the complex physiological and psychological issues that characterize the LTRC population, these efficiency constraints in both time for care and the timing of care often pose significant challenges and risks for many residents and workers.

In connecting workers' working conditions to resident care conditions, participants discuss how these changes adversely affect and/or obstruct their ability to exercise care practices and/or provide the standard of care that they feel residents need and deserve (also see Chapter 6, in relation to structural violence). They describe the context, including their struggles and tensions to comply with "impossible" care timelines and schedules given cutbacks and staff reductions in which they are required to provide care to residents as "sickening", "disheartening", and "disgusting." Rather these workers are situated in a position that requires them to process residents rapidly, creating a care

context that is increasingly dehumanizing, devaluing, and risky for workers and residents. Indeed, participants indicate that insufficient staffing and the lack of time to and for care introduces hazards and risks, including creating and/or intensifying violence and aggression from residents (also see Chapter 6 and 7 for further elaboration).

While participants discussions highlight how frontline workers maintain some very limited forms of control over how they work and reshape work processes on the frontlines of care (also see Daly et al., 2012; Day, 2014), the organization of care labour within LTRC evokes the comparison to Fordist production, assembly line labour. Indeed, most participants use the language of manufacturing and industry processes, frequently contrasting the current arrangement and organization of care to that of “factory”, “assembly line”, or “production line” work and to “giving car washes.” Participant descriptions reveal deep contradictions with the “home-like environment” descriptions promoted by government and facility operators. In the words of one participant,

It’s a factory...production line. It’s like a meat factory. Rushed and processed. It’s set up so they aren’t given the time to be treated like people or treated with dignity. It is wrong. It is a production line and that is just sad [Interview 1: 16]

In the comment above, the participant describes the organization of care work and structuring of care as an arrangement that is dehumanizing and demoralizing for residents and frontline workers. But under the current care regime, standardized and routinized efficiencies are privileged – getting the work done, with the least amount of workers, with the least amount of specialization, at tightly structured times, in the least amount of time. Some participants state management and supervisors explicitly reinforce and encourage this production line approach to organizing and structuring care.

The administrator says, ‘it’s got to run like a production line.’ You know, you have to. You have to do this. You have to get them in the dining room on time – and if you don’t you will be talked

to, you will be spoken to about it. So, wow. It is just so frustrating that he expects that [Interview 11: 2-3]

Care work is more than instrumental actions and the completion of physical tasks. Unlike industry processes, care is a relationship where social interaction and communication between residents and workers are key aspects of this work – these are central to the care labour process. Participants spoke of their struggles and tensions with having to rush residents, of not being able to apply the care practices in which they are trained, and how they want more time for social and emotional care with residents, to be able to attend to their emotional and social needs. That is, to be able to talk with and listen to residents. This crucial relational and emotional aspect of care has been excluded or defined out of current practices and approaches to organizing care. According to this participant,

It's disheartening because you didn't have the time that people need. The physical care that we give is awesome. But the mental and emotional care we give – we don't have time to do it, right. If someone wants to sit and have a conversation with us for 5 minutes, we are never going to get that 5 minutes. And even if we did try to sit and have that conversation, somebody is going to holler – or somebody is going to interrupt it or somebody else is going to come along and go I wish I had 5 minutes to sit down. You know, it's just. Yeah, it puts everything behind [Interview 7: 5]

In the interview excerpt below, one participant describes the form of care they used to be able to provide under different conditions, what constitutes care today, and highlights structural and organizational barriers to the type of care they want to provide to the residents.

Residents feel like we just don't have time to listen to them. And they're right – we don't. We don't have the time for them. It's not that we don't want to have time. We just don't have the staff, we don't have the time, we don't have the support and everything is on a timetable [...] back in '89 when I went into long-term care, we had time. I had time. I could actually sit down and talk with the residents, get to know them, and talk to them about their family life. We had time to do all this. It was seen as important, we had the staffing – and now? No way. No way. No time. Nope. Not a chance. The staffing is just not there. The health care system is just not the same. The staffing is not there, and those things... just being able to sit and chat, not considered important anymore. They say they are putting money into long-term care. I don't know where the money is going but it's not towards care or staffing. These elderly people deserve better than what

they get... And they need the proper amount of staff in the building to take care of them
[Interview 6: 8]

Participants also emphasize contradictions and tensions with respect to MOHLTC and facility language of “home-like environment” and the focus on residents’ rights with the reality of decision-making authority. As this participant explains,

If it is a home, then they should be able to, you know, stay in bed, get up when they want to, eat when they are hungry. Not because it fits with when people in the offices thinks they should eat, and shower, and sleep, and get toileted [...]. It’s an institution. Government says, it’s their home but it’s an institution because home ain’t like this [Interview 6: 25]

Other participants highlight the rigid structure and/or inflexibility that operate within many LTRC facilities and the lack of resources including staff to appropriately facilitate and support residents’ rights. According to one participant,

Workload and stress has intensified because the levels of care have gone up, they haven’t given us any additional means of trying to cope with it and uh [...] it’s the demands and it’s because they have really pushed the residents’ rights. They have the right to go on the toilet whenever. They have the right to do this, to do that – Great! But when do we find the time to accommodate those rights? [Interview 18: 9]

Although participants understand the need for residents’ rights, frontline workers highlight challenges and contradictions that emerge between residents’ rights and workers’ rights. Participants share that workers’ rights are often not acknowledged, are devalued, or are frequently undermined. In the words of one participant,

It is kinda like customer service, the customer is always right [...] and the resident is still the resident – they has all the rights. It doesn’t matter what they say or do to you, or even if they swing at you – and knowingly doing so. There is nothing you can do about it. And that is not right. What about my rights? That’s worker abuse [Interview 7: 4]

Participants also express frustration with how rigid timelines occasionally conflict with other activities such as recreation occurring within the facility, which may create and/or exacerbate conflict among facility workers and residents. According to participants, given the production line approach to the organization of care there is also no time or flexibility built into pre-established schedules for workers to manage the all too common,

unplanned and unpredictable interruptions, interferences, or spontaneous events to the flow or “production of care.” As this participant explains,

There are some days, you know, someone falls, or someone is sick, and you have to send them to the hospital. Then everything gets all screwed up. We try to prioritize but... Other than that, there is nothing else we can do. Nothing else. There are some days, I look up at the board and there are like four or five call bells going all at once on my unit [Interview 6: 7]

Others highlight what these frequent interruptions to scripted production of care processes mean for the completion of care tasks. According to one participant,

When something interferes with something you are trying to get done – it is just not going to get done. You know, like somebody falls. Somebody gets out the front door and you end up having to chase them down the sidewalk. It’s Chaos. Everything gets backed up [Interview 7: 2]

Importantly, these diversions from rigidly structured timelines for resident care intensify workload and time pressures for frontline workers on the floor who then need to manage and respond to non-scheduled events, all the while maintaining the tightly scripted production of care timelines on the floor. With responsibility shifted to workers, frontline workers often offset or attempt to compensate for deviations or disruptions to fixed care labour processes organized by management, passed down from MOHLTC by forgoing waged and unwaged breaks.

Devaluation and Decision-making on the Frontlines

Many participants share how they feel extremely devalued and not respected within the LTRC hierarchy. According to this worker,

People don’t want to come to work. They are only going to survive. They don’t really want to be there because of the conditions, the situations, or the way managers talk to staff. Some of the managers are really rude. Some are just horrifyingly rude because you are just PSW. Some of them will let you know that is just all you are. You know, you don’t have an opinion [Interview 11: 10]

Despite having direct day-to-day contact with residents, participants report they are not listened to, are not included in decision-making processes, and struggle to have their

experience and contributions to resident care-plans recognized. As this participant highlights,

We are the frontline workers. We know these people – inside and out. We work with them every day. So, that’s when I feel frustrated. We don’t feel valued. They don’t ask us what we think and when we go to them, they don’t listen [Interview 6: 21]

According to participants, management makes the decisions regarding care.

We don’t have any say in anything. It’s their way or the highway and that’s it. We say well, I need you to take a look at this person and they say, ‘yeah, whatever.’ Two or three weeks later, it’s still the same. They don’t listen, they don’t follow-up [...] we have no input. We are the ones doing the work. We are the ones that know what is reasonable, what is good. But that’s it. No input. The decisions are made by management [Interview 13: 5]

Below, one participant highlights that worker concerns and observations are not acknowledged and/or acted upon.

We can tell them what we need, what we would like in order to do our jobs right, but we get told this how they work, this how to do things, they don’t listen [Interview 5: 17]

Indeed, most participants indicate that frontline workers are not consulted on care practices, processes, and tools. Other workers indicate their experience, skills, and insights are devalued or ignored. For some, as long as facilities receive funding there is no need or incentive to change the status quo. As one participant indicates,

The environment is set up to collapse. But so long as they are getting their money, the funding from the Ministry, they are getting the rents from the residents; they think all is well [Interview 17: 10]

According to participants’ narratives, transformed organizational and management structures have meant conceptions of care, what counts as care, and when and under what conditions and timeframes care is accomplished, are decisions increasingly made by management and detached from the execution of care labour by these workers on the floor. The disconnect between conception of labour and execution of labour underpinned Harry Braverman’s (1998[1974]) “deskilling thesis,” where he articulates this separation as the systematic process of degradation of labour in order to facilitate capital

accumulation and management control under monopoly capitalism. According to Braverman, in the struggle to gain control of the labour process management needs to dispossess and appropriate this knowledge from workers through the application of “scientific management methods.” This includes the continuous and systematic breakdown of work, dissolving the unity of mental and manual labour (see Chapter 2).

But the divide between management and frontline workers was not always so pronounced according to some participants. As one participant explains,

We used to have influence. They used to come to us. They used to ask what we think, what’s your opinion, and stuff like that – even when we had a problem we’d go to them and say – so-and-so needs this, or is feeling like this, I think maybe you need to look at the medication or whatever and they would listen, look into it. They took us more seriously. And now, it’s different, it has changed [Interview 13: 2]

While several participants indicate that management claims to have “open door policies” and did listen to their concerns, this is often perceived as empty “management speak” by frontline workers – a guise of inclusion, not the reality. Workers repeatedly describe having no input into decisions about how their care work is organized and structured on the floor and no follow-up from management occurs to their complaints and concerns despite “open door policies.” As this participant shares,

You may be asked by a manager, ‘how do you think this is going to work?’ Why are they really asking me? You’re not gonna really listen, you aren’t gonna do anything, you know, put into action anything I say. This is something they have to do. They have to ask but really, it’s just lip service. And frontline workers, we know. We don’t have degrees but we know what works and how it can work, and how your way won’t work. Your way won’t work. It is not practical. They won’t listen to us. They would never put anything into action that we suggested. It will never materialize. Not ever [Interview 11: 10]

Participants regularly spoke of the ways managerial practices and the organization of work hinder the application of skill and the development of knowledge necessary to do the work of care on the frontlines (also see Armstrong, 2013b). Participants also talked about the symbolic and material devaluation of their work. While workers in the employ

of for-profit facilities point to wage differences with those in non-profit and municipal facilities, virtually all participants in this study regardless of facility operator type or location express that they are not appropriately or adequately compensated for their work.

As this participant elaborates,

I have yet to run across a PSW that thinks she is well enough paid [...] I think we deserve more for the working conditions that we are put in. Um, I look at it this way, a person working on an assembly line building a car makes twice as much money as I do and I am taking care of a human life [...] and I just don't think that we are compensated enough for that or the emotional drainage that we suffer [...]. And I don't begrudge anybody working on an assembly line and making a good wage. They should have that. I just think that comparison wise, they are dealing with a hunk of metal, and I am dealing with a human life [Interview 18: 18-19]

Care work is gendered and racialized work because it is low paid and associated with women's work and domestic servitude. Gender and race become part of the new ruling relations (Smith, 1987; Smith, 2005) of LTRC work.

New Rules and Regulations

Greater constraints on worker control have also emerged through new rules, regulations, guidelines, and policies – of ruling apparatuses, including the MOHLTC, facility operators, management, or supervisors. For example, participants highlight how the new standardized rules regarding residents falls under MOHLTC regulation conflicts with residents' preferences or the knowledge frontline workers have of residents, as these are eliminated from standardized procedures. As one participant explains,

Like, we have a lady who will sit herself to the floor... because she has the big carpet in her room and she sits there and she reads her newspaper [...] and she will scoot around on the floor on her butt. But because of the new rules, if we don't see her put herself to the floor, she's considered a fall. We gotta go through the process, treat it as a fall [Interview 4: 12]

While the new rules dictating the treatment of resident falls calls into question the validity and reliability of this measure, it also has implications for worker workload expansion, including reporting requirements that take workers off the floor and away from resident care.

Under the *LTCHA*, LTRC facilities are now required to implement minimal use of restraint policies. While this appears to be in the interest of residents, there has been no provision of additional resources and especially of extra staff to facilitate the shift to minimal restraints and to prevent the implications that can emerge from this change for residents, such as an increased risk of falls. This shift also has implications for workers, as chronic understaffing and short staffing has meant that in the face of minimal restraint policies, these workers experience workload intensification. As one worker suggests, this includes greater demands,

Since the government cracked down on the no-restraint, since it has made the no-restraint policy, we are being pulled even more [Interview 1: 2]

It also means greater risks for residents and more work, including documentation requirements for workers. As one states,

We are trying to go restraint-free, but we have a lot residents that are high fall risk, high risk for falling, so we have one with a tray, even so much as a bedrail, we have to document it. Constant safety checks [Interview 5: 31]

Documentation obligations remove workers from the floor, further exacerbating risk for unrestrained and unsupervised residents. It also situates workers in a position where they risk allegations and responsibility for the neglect of residents. According to this participant,

That is the rule of the Ministry now but that wasn't the rule of the Ministry five years ago. You had to have those restraints on them or it was neglect if you didn't. But the rules change. Now it's abuse if put them on, and its neglect when something happens without them. So, cause there isn't extra staff, in some homes there has been an increase in falls because this is their new rule, their new standard [Interview 4: 43]

Participants also point to tensions and contradictions in official understanding of abuse and neglect of residents under the *LTCHA*.

You know, you have less staff on the floor but you still expect those staff that are there to get the same amount of work done and we will penalize someone for abandoning a resident or abusing a resident because you didn't provide the care for them is out there all over the place. I could do the

whole interview just talking about stories about how people are ignored on one hand but then held up on investigations by doing nothing more than trying to get the job done. I have heard a lot of groups starting to use the phrase of 'the time to care, time for care'. The ability to care is one thing but providing the proper amount of time to care is also essential [KI Interview 19: 2]

According to some participants while the conditions of work and heavy workloads often mean they have no choice but to neglect residents, the real abuser is the government,

I always think that it is a shame that our government treats our elderly this way. I think they are the biggest abuser of our elderly. It's not the people that work there. It's the people that govern everything that says this is what you are doing, this is the amount of money you get, this is what is going to this home to take care of this and do this [Interview 4: 5]

For others, the abusers are the corporations that own facilities that privilege profit before resident care. As this participant states,

They can do that, as a company. But I can't. It's okay for them to be abusive like that. Denying stuff. But me, well, I could lose my job for being abusive or neglectful cause there's not enough staff. There is absolutely no accountability – these companies. The Extendicare's, the Rivera's, the big chumps that own these homes should be held to higher standards than the rest of us. It's abuse. They are taking their money and not providing for them [Interview 4: 23]

Some participants discuss their frustration with hierarchy, bureaucracy, organizational rules, and policies, including their confusion with the frequent changes to these, especially when there is high turnover within corporate management and facility administration. These rules and regulations operate as mechanisms of control or as a means of managing workers, and reflect the form of "bureaucratic control" Richard Edwards (1979) characterizes in his typology of systems of control in capitalist workplaces (see Chapter 2). According to this participant,

Management in that place has changed EDs [Executive Directors] and DOCs [Directors of Care] so many times in the last 12 years, so many times that I have lost track there are so many times [...]. The running joke now is how long will they stay. They just come, change things, and then leave [...] Every time new management comes in there are new rules. Something that was perfectly fine before now becomes not allowed or is insubordination or whatever. They sit in the office. They have no idea what we do. What care is involved. Or what we do on this floor. It is even to the point where they tell us now that we aren't even allowed to have drinks on the floor. I feel they don't appreciate us. They don't care. It's ridiculous. Seriously, we can't even have a drink when we get thirsty. We have to go to the water cooler on the other side of the building to drink from a Dixie cup. And they sit cozy in their office and they got a little bar fridge and can have a drink whenever they want. But for the girls on the floor busting our butts – and it gets dry in here, and we are constantly moving, we don't get a chance to stop. But we can't have a drink.

We change hands a lot. We get new management and then they come up with new rules, this is one of the new rules from them. It was never like that before. We were allowed to take a bottle of water on the floor with you before. Now, the rule is no drinks on the floor [Interview 6: 20]

Although the problems are more intense with for-profit owners, the push to apply for-profit techniques and practices everywhere put everyone at risk.

Transformations in the Delivery of Care

Participants also highlight their frustration with neoliberal and/or capitalist influences, including the rise in for-profit, corporate ownership. Economic efficiencies and profit are seen as the central priority not care or work conditions. As this worker explains,

Most of these long-term care facilities, they are owned by real estate conglomerates. Pay us for the room you are in and we'll throw in nursing and thrown in laundry and we'll throw in housekeeping. And yes, they have to follow protocol, and yes, they have to get funding from the MOHLTC but there is still profit [...] they are in it to make money. This is huge profits [Interview 17: 16]

This orientation towards efficiency, rationalization, and profit is not compatible with safe work and care conditions. However, this is not exclusive to the for-profit facilities but also non-profit facilities as the LTRC funding arrangement as it has developed in Ontario (see Chapter 1), promotes pro-market practices – or the application market-based principles to the delivery of care within the sector more broadly.

Resistance and Struggle

The forms of resistance frontline workers engage in their everyday/evernight activities on the frontlines of care include “working smarter, not harder” and employing “tricks of the trade” to accommodate resident needs and preferences in the face of rigid time structures. This includes the organization and prioritization of work in ways that are counter to prescribed timetables. Some workers spoke of resisting managerial pressures that infringed on breaks and unwaged time. For instance, workers resisted managerial

and supervisory pressures for the completion of training requirements during unwaged time by removing forms and educational materials from their designated break areas. Others highlighted their attempts to shape the conditions of their work by ignoring managerial directives to employ particular language in communications such as the worker who shared the short-staffing “secret” of LTRC with residents and residents’ families despite management instructions to state they are “busy” and “will be with the resident soon.” This worker resisted the conditions of work as well as resisted assuming responsibility for these conditions.

The forms of resistance, struggle, and negotiation frontline workers initiate in relation to the conditions of their work also include confrontations with representatives of bureaucratic structures and challenges to the hierarchal configurations within LTRC. Participants who report active involvement within their respective unions as frontline worker representatives not only concentrate on articulating their workload concerns and challenges to facility supervisors and management, but they also direct these concerns and their demands for greater transparency and accountability towards Ministry officials. Participants’ comments underscore how these workers view their working conditions as interrelated to/and inseparable from resident care conditions. In one participant account, workers collectively express their concerns by directing their questions regarding inadequate funding and insufficient staffing level, factors that these workers understand to profoundly influence the conditions of care and work – to Deb Matthews, the current Minister of Health and Long-Term Care. According to this participant who is also a union chairperson with a decade of experience working on the frontlines of a municipal facility,

We used to have a lot more workers. With the government implements, there is no money for this, and no money for that... You just can't provide the care with that staffing. Like, I hate Deb Matthews. That woman is something else. She actually held a public health care meeting [...] and a bunch of us from work went and a bunch of residents families. We started asking questions, concerning funding, resident care, staffing levels – I mean all of it. And she turned away. Left the floor and did not return. So, that's sad. She walked away. Didn't say anything. She wanted nothing to do with it [Interview 7: 15]

Another participant, following repeated disregard and/or indifference by supervisors and administrators towards frontline worker concerns regarding poor staffing levels and its consequences for care and work conditions, decided to instead voice these concerns – and her challenge – elsewhere. Below, this participant who is a union representative for frontline workers with over 20 years experience working within LTRC provides her account of how this interaction between herself and the CEO of the for-profit company where she works unfolds.

So, I said [to the CEO], you really need to look at your staffing issues in here really badly. He said, he 'gives the running of the facility to the administrators and how they see fit.' I said, tell you what, I will give you my weeks holidays. I will give up my holiday pay. I will work through my holidays. Let me care for you as a resident here as the administrators in here see fit, and then you can tell me we don't need more staff. He just laughed at me and walked away [Interview 1: 23]

In conveying their concerns to Ministry and corporate officials, one worker was dismissed with silence; the other with laughter. The nature of these responses, reflect and reinforce these workers' positionality within LTRC and the perception that management – not frontline workers, are the valued and authoritative sources of knowledge and decision-making regarding the organization of work and care. Indeed, the ways these participants were dismissed in these specific instances are consistent with many participants' accounts of how frontline workers are generally treated within the LTRC hierarchical environment. From the perspective of feminist political economy, the symbolic and material devaluation of care work is related to and its association with “women's work” and with servants, particularly racialized and immigrant workers.

Women constitute the majority of frontline workers within facility-based care. The restructuring of care work in LTRC and the promotion of a particular form of efficiency, coupled with pressures to minimize health care expenditures and labour costs has often meant capital drawing on disadvantaged and racialized groups to be utilized as cheap, flexible, and expendable labour (Eckenwiler, 2011). These patterns situate workers at risk. It undermines control over their care work and exposes workers to injury and violence, including sexism and racism. This invisibility extends beyond the workers on the frontlines to the LTRC sector more broadly. As discussed in Chapter 1, this includes the historical ambivalence and marginalization of LTC within public policy debates (Armstrong et al., 2009), its absence from the political agenda (Berta et al., 2006), and long-standing lack of government transparency and accountability to public subsidizers. While understanding how frontline workers resist conditions is important, understanding the ways frontline workers' are constrained in resisting the conditions of their frontline work is quite revealing.

For many workers, assertions of concern and/or complaints directed towards governmental and/or organizational authority regarding the conditions of care and work and the implications of these conditions are very rare. According to many participants, it is far too risky for workers to do so. This is especially the case for frontline workers who are of marginalized social location, who perceive uncertainty and insecurity with their current positions, and who indicate a lack of support, trust, and/or experience disconnect from their respective labour unions. Workers' identify numerous reasons for this disconnect, including negative experiences with unions, lack of union presence within facilities, failure of union representatives and officials to return workers' calls, and the

perception of some workers that “we pay our dues and they do nothing” and that “the union is in bed with management.” According to one key informant and union official, “cultural background” differences and “language issues” present a significant and ongoing organizing and representation challenge for unions.

Many participants in this study provide numerous reasons and examples that underscore why they and other workers are deterred and prevented from articulating concerns to management and supervisors regarding work and care conditions (e.g., inadequate staffing levels, heavy workloads, and issues of health and safety). Explanations participants shared within interviews include the growing racialized and immigrant composition of the frontline workforce, uncertain knowledge of rights, fears related to the insecurity of work, and cognizance of their low positionality and precariousness within the hierarchy of the health care system. In the words of one of the participants,

When you look around in the home, you see most of the staff there are immigrants, from different countries. From west India, South America, China, wherever. You very rarely have a PCA [Personal Care Assistant] that is Canadian. Canadians know their working rights [...] The Canadians speak up. You get women, immigrants who are very happy to get a job and they have their family back home to support. And so, they come in and do the job, regardless if it is wrong, bad for them. They don't want to say very much. They don't want to push the limit. Some places you are not allowed to talk back and stuff like that [...] they don't want to rock the boat [...] This system, it's set up to get away with stuff [Interview 13: 12-13].

The accounts and experiences participants share point to a broader social, economic, and political system that contributes to and reinforces the silencing and exploitation of these workers, the devaluing of care work, the normalization of unwaged work, and the undermining of worker autonomy, decision-making, and control on the frontlines of care. This restructured system of care establishes job insecurity as the standard and reproduces social inequalities. It treats predominately female workers as unskilled, care labour as

limitless, positions workers as disposable, reinforces the alienation of workers, and situates workers at risk. Employment insecurity has long been used as a mechanism of control to enforce compliance amongst workers. As discussed later in this chapter, LTRC operators increasingly strive for greater workforce flexibility, control, and minimization of costs. In practice, this has meant greater reliance on part-time and casual staffing arrangements.

Workload Intensity and Cutting Corners on the Frontlines

Frontline workers, particularly those with greater security and seniority, attempt to influence, negotiate, and resist working conditions in which they had little input, or decision-making power around the organization, resources and/or tools to be used. Such efforts are evident on the care floor through conforming to or cooperating with documentation requirements, through falsification and through resorting to non-compliance and/or rule and policy breaking. Similar to Michael Burawoy's (1979) conceptualization of worker discretion and autonomy and how it manifests on the shop floor and contrary to Braverman's deskilling thesis, frontline workers on the LTRC floor continue to have some space outside managements' view to exercise some individualized control over the organization of their work while at the same time upholding management objectives. With an emphasis on more and more documentation in a context of inflexible time parameters, more residents per worker, and the growing complexity of physical and psychological care, workers report having to learn "tricks of the trade," ways of "working smarter, not harder," and negotiating with residents and co-workers. They attempt to make routinization of care work less routinized. This includes ongoing attempts to prioritize, organize, and multi-task their work in ways to be more in line with resident

routines and needs. While frontline workers lack input into formal organizational aspects of the workplace such as care planning and decision-making, frontline workers maintain some limited forms of control over how they work. Some frontline workers learn to play the game. This understanding draws on Michael Burawoy's (1979) use of the "games" metaphor to illustrate an important feature of the labour process on the shop floor. That is, in viewing the LTRC labour process as a game, frontline workers' assume some control over the labour process through their participation in "games" – or "working smarter, not harder" and through employing "tricks of the trade" as well as greater autonomy despite managerial control, rules, and constraints. Nevertheless, frontline workers' participation in "games" on the LTRC floor also generates consent to their exploitation.

According to many participants, the conditions of work also means workers cut corners.

It's all about cutting corners now [...] we lie about a lot of crap that gets done that we don't really do. We don't want to, but we have no real choice. There are things we say we do, but we have absolutely no time to do [Interview 1: 4]

One participant elaborates on what the practice of cutting corners on the care floor typically entails,

Every day you are cutting a corner on something...somebody is not getting to the bath, to the bathroom. Somebody is not going be laid down. Sometimes they are not washing their face and hands in the morning. They are just doing mouth care because they are cutting corners because they spent too much time with one person so they gotta rush to the next. Right down to the dressing it affects, cause they put the clothes on sloppily – they are crooked, sideways, or whatever. Sometimes they wouldn't have time to brush their hair, you know, all the personal care aspects is not happening. You know, and bottoms aren't being washed because they are in such a hurry [Interview 5: 24]

For some participants, cutting corners is a necessary practice in order to avoid repercussions, trouble, and blame, including accusations from supervisors and management who do not listen or take seriously workers' concerns regarding their

intensified workloads with no provision of time and resources to complete it. This includes workers being told they have “poor time management”, “lack organizational skills” or they are “too old to do the work.” In particular, some workers resist the standardization, routinization, and structuring of their work by management and administrators who do not seem to grasp or understand either the practice of care or the relations of care. As this participant remarks,

We try to tell them put your uniforms on and come work on the floor and see how it feels, see how your ideas don't work – see for yourselves what doesn't work. That is what we tell them. Because they have no idea what's going on. No idea! [Interview 5: 23]

Others comment on the need for non-compliance and to break rules and policies that they deem inconsistent with the realities with LTRC. Other participants state rule breaking is a response to policies that fail to reflect what they deem as important to quality care. This includes the nature of resident needs, staffing, competing and conflicting demands – or the realities on the floor in the ongoing care of residents. According to one participant,

These people that work in administration work in a bubble. They have no idea what goes on, you know – on the floor. They're set about their own little ways of doing anything. Like, they say, 'now, this is the way you are supposed to use the slider to get a person rolled over.' And we said, okay you try it then, cause it doesn't work. And they look at us, all confused, and say, 'but it is supposed to work.' [...] No, it doesn't. This flimsy piece of material that you bought that is supposed to slide, doesn't work, it doesn't do anything [...] And they went and bought a whole shitload of them so they still want us to use them. But it's useless. It doesn't work at all [Interview 17: 8]

Several participants frame their rule breaking, resistance, and non-conformity to institutional policies in terms of what they perceive as morally just. Others claim breaking rules and policies was essentially a pro-active measure to avoid adverse implications of care delays, including behaviours, humiliation, and violent outbursts from residents that may situate these workers at risk. While it is mandatory to have two staff to operate mechanical lifts, many participants report that this is not possible given the conditions of their work, including insufficient staffing, support, and time pressures.

Participants provide several explanations as to why they break the rules and policies specifically around mechanical lifts. These explanations relate to understaffing and/or the unavailability of support or assistance. As this participant explains,

The policy is you have to have two – but lack of staff. When you call one, they are busy, when you call the other – no, they can't come because of whatever. And you cannot take care of someone unless you have two people. I risk it [Interview 14: 6]

In some instances, participants reveal it was more than this. Rule breaking occurs in a negotiation or trade-off of risks in order to minimize some risks to frontline workers and minimize the risk of suffering and uncertainty for residents at the same time increasing other risks to workers and residents.

It's not because we are trying to be a rebel. It's because we know that if the resident pees or voids in her pants she will be so humiliated she is not going to want to do anything, because she is just too embarrassed by it. [...] So, you put yourself at risk for being disciplined. Because if you get caught using it with only one worker – it is an automatic one day suspension. If you get caught or the Ministry of Labour walks in you may get fined three or four hundred dollars. Because you think you are doing the right thing by putting her on the toilet [Interview 4: 27]

Participants highlight that management privileges feedback and criticisms from residents and residents' families over workers' own accounts. Workers find it necessary to respond to family members' requests, and sometimes this means breaking the rules. According to this participant,

Now, I will tell you something – people do have to use that lift alone. You just have to take a chance. Because a family member is coming to take their mom out, they are waiting on you, your team member, your buddy is giving a shower and meanwhile the family member is yelling, 'well, we told you we were coming at a certain time, and we expected mom would be ready.' And then they go to the nurse manager and complain and then the nurse manager will come all pissed off and ask what's your problem – it's just a pile of stress [Interview 11: 6-7]

Importantly, this constitutes part of a broader system of complaints within LTRC and operates as a mechanism of management and supervisory control over workers. In the account above, management control and resident/resident family control/influence are interrelated and reinforce one another (Bélanger & Thompson, 2013: 446). Rules, in this instance, are broken in order to circumvent the clash that may emerge between the

ignored conditions of work of frontline workers and the partiality given to resident and family demands by management and supervisors. This is an important point in relation to the “struggle for control.” That is, in contrast to the bilateral employment relationship between workers and employers in traditional understandings of the factory labour process, the labour process within LTRC is shaped by management direction as well as through exchanges with residents, and residents’ families, which complicates the organization of work for frontline workers. These various influences shaping the labour process on the frontlines may be uneven as well as conflicting or incompatible.

Many participants report inadequate supplies, products, and equipment create inefficiencies and increases frontline worker workload pressures. For example,

We are supposed to have more lifts but cause of finances we can’t get more. And what we need too is more slings. We don’t have enough slings, so it is backing our work up too – trying to find a sling [...]. On our floor – seems to not have quite a few things and especially linens and towels and things like that [...] sometimes they are just cutting back on staff and when they cut back it is bad [Interview 13: 14]

Worker struggles with supervisors and management are sometimes consumed with challenging and negotiating restrictions and/or securing the provision of adequate supplies, products, and equipment for their work through internal and external mechanisms. One participant elaborates on this ongoing struggle,

We have to fight for everything. Everything we have, we have to fight for. And it’s like, wow. This is becoming a struggle. It really is [...] Constantly. Constantly. It’s a constant battle. It comes down to it wasn’t in the budget this week [...] That’s what it boils down to. They don’t order stuff; they let us run out – like hand sanitizer. Hand sanitizer, hello, we are in outbreak, we have been after you to order some and now we are out – we are completely out of hand sanitizer and sanitizer for our machines. It’s unacceptable [Interview 18: 17]

Some workers anticipate the struggles related to product shortages and supply inadequacies through stockpiling supplies.

As for products, we may go a week and things are short [...] we have to make do with what is there. You make do. The staff get pretty smart sometimes, what they do is stash a bottle of cleaner, or linen or whatever somewhere. We start hording and stashing things [Interview 13: 14]

Other participants explain they break rules when the rules and restrictions are considered incompatible with morality, good care, and residents' rights. Workers highlight their struggles around incontinence briefs for residents which has led to refusal to comply with institutional rules that they find "cruel" and "disgusting", as this participant explains,

With this product, you are only supposed to change a resident if they are 75 percent wet, at the blue line. Nobody can morally do that! In the home that I work at – the workers, a good 90 percent of them refuse to do that [Interview 4: 21-22]

Other participants discuss their struggles with their employers regarding various product and equipment shortages within their workplaces that place workers and residents at risk. For some participants, part of this struggle means having to explicitly remind employers of their legal health and safety responsibilities. As one long-time worker and union representative who identifies as heavily involved in union activities highlights,

I am not afraid. Like, we were going into outbreak [increase in disease occurrence] and we had no supplies. We asked for them. Nothing. Then we were in outbreak and still no supplies. Finally, I looked at him [the employer] and I said, 'oh, doesn't the employer according to *Health and Safety Act* have to furnish up the supplies and the equipment in order for us to do our job correctly?' [Interview 18: 8]

Unpaid Labour on the Frontlines of Care

This chapter has discussed the transformed workloads of frontline workers and the numerous factors that contribute to and reinforce this intensification. For some frontline workers the consequences of intensification and growing labour market precarity include participation in unpaid labour. This includes working through breaks, coming in before shift start, or remaining past shift end in order to complete work and/or to accommodate changes to work organization, staffing deficits, and facility rules regarding resident care.

Breaks

The intensification of frontline worker workload and rigid scheduling of care plans has implications for the ability of these workers to take either paid (two 15 minute/rest) or unpaid (one 30 minute/meal) breaks. Many participants in this study describe having to frequently postpone or miss their breaks either completely or in part.

We need them. But there is some days where we don't get our last break of the day because we have run into a mess or someone is dying and we don't leave them or – there always seems to be a scenario that will happen [Interview 18: 3]

Other participants discussed how they utilize their breaks, including their unpaid meal break to work on documentation that could not be accomplished during their regular shift activities or to ensure staff coverage on the floor. As one participant explains,

Sometimes our breaks get screwed. Like, most times we are always late or don't get 'em. We have a staff room where we can go and get off the floor [but] a lot of the times we are taking our breaks on the unit because we need to get the documentation done and you can't leave the residents, right [Interview 1: 4]

According to some participants, given the organization of work, management and supervisors will appropriate and/or utilize worker breaks as an opportunity to become updated on resident care or to fact check information.

They will come in [to the staff room] and ask about certain residents – 'has this person gone to the bathroom?' 'This person is complaining of this, is this a true fact?' You don't really get your lunch or a break. Oh yeah, and they will come in there to eat lunch too and we will tell them no shoptalk, this our time, but that doesn't stop them [Interview 5: 5-6]

Several participants indicate that break taking is an issue that has created as impasse among workers – a “real sticking point” – with some workers resolute on taking them and some frontline workers routinely working through their breaks. While most participants discuss the context underlying why some co-workers routinely missed their breaks, participants who are full-time, who have seniority, and are actively involved with and feel supported by their union are better positioned to resist and/or ignore pressures to

work through their breaks than frontline workers who occupy more precarious positions and feel unsupported in the workplace. According to one participant who is also union representative,

The work is so much and hard sometimes that you just have to keep going and going and going. But I am entitled to my break and I will take it no matter how much work there is [...] But other staff that I know – they usually work right on through their break because they don't have the time – they say, 'too much work, too much work' and they don't take their break. Well, that's nobody's fault but theirs own. They should take their break and that's it. But the work is so much and hard sometimes that you just have to keep going and going and going. But I am entitled to my break and I will take it no matter how much work there is [Interview 13: 2-3]

The participants' comment above is instructive, providing one example that demonstrates the ways workers may simultaneously experience privilege and oppression (Sugiman, 2001) on the frontlines of LTRC. Observations by participants also reveal contradictions and inconsistencies within worker understanding. This includes the tendency towards individualization and responsabilization despite what these participants simultaneously understand and describe as structural and organizational problems. That is, fault, blame, and responsibility for missing breaks are located exclusively on workers themselves, rather than on the conditions that shape and reinforce these forms of unwaged and exploited labour. This is despite the context of heavy workloads and the challenging conditions of work. It contradicts how the conditions of work are experienced, influenced, and responded to differently on the basis of social location, employment status, positionality, and security, or how these differences also shape experiences and practices within the workplace.

Participants' narratives also reveal the ways consent to unwaged work is manufactured on the care floor. Given workload increases without the provision of additional time and resources to do the work and the requirement to provide evidence of this work through documentation, some participants indicate that they regularly remain

after their shift to complete their documentation. Participants indicate this practice is typically on an unwaged basis.

We are given a lot of tasks to do and unfortunately some of them aren't getting done and some of them are just a guesswork okay cause you got to put something down. So, at the end of the shift you may be there for 30 to 45 minutes more, some places may pay you for that, but most places don't. Like, ours doesn't [Interview 17: 3]

In these situations, workers are constructed by management as the problem (e.g., poor time management, older in age, lacking in speed, productivity) not their excessive workloads or the increased demands of the work. As this participant explains,

I stay late to complete documentation...it's not paid either. They aren't that generous. They say, 'it's your problem that you didn't get it done, should have managed your time better' [Interview 5: 29]

The expectation that workers provide care and compensate for shortages in staff, time, and supplies is often gendered – that is, an extension of what women do naturally. Some participants' discussions also reinforce the notion that women and racialized groups are natural providers of care. As one key informant states,

I think women are drawn to it because they are naturally caregivers [...] I have heard that the Filipino women are amazing caregivers, maybe it's a cultural thing, I don't know – and they are very loved in the nursing homes. Filipino. Because they are nannies, and they sort of come from this, it's what they do. That's how they see themselves, as caregivers – and I think that's a great thing [KI Interview 15: 3]

Participation in unwaged labour was also generated on the floor in relation to morality and gendered ideals about care. Beyond working through waged and unwaged breaks in whole or in part, some participants indicate that they also routinely come in to work before their shift begins or remain well past the end of their shift in order to complete work. In contrast to Burawoy's notion of "games" where workers on the factory line work harder and faster to finish the work, workers on the frontlines of care work harder and faster during waged time as well as "consent" to unwaged time in order to make the work more manageable. For some workers, coming in early or staying late

was especially the case following the elimination of an overlap between shifts by management. Some participants explain that they come in earlier or remain at work beyond the end of their shift because it is the right thing to do as it facilitates the transition between shifts (i.e., shift change) and the transfer of resident care between frontline workers. As this participant indicates,

We don't have overlap anymore. They cut that. I know the union don't want us to stay beyond our time but it's just my conscience. It's just my conscience. I stay [Interview 9: 17]

According to participants, unwaged labour is often expected by management and normalized as part of the job. Along similar lines, several other workers describe regularly coming in early or staying past the end of their scheduled shift in ways that reflect gendered ideologies and expectations towards care. This includes humanness and empathy in the context of an indifferent care regime. According to this participant,

I am compensating for what the system don't do and won't allow us to do [...]. They play on our empathies. But if you didn't do stuff like that, you aren't human. You are in the wrong line of work [Interview 1: 6-7]

Other workers explain their participation in unwaged labour as a sense of commitment to residents and guilt.

You don't want to do it but you do it and then you feel guilty [...] I stay late and wonder if they will give me overtime and then I say to heck with it at least I am happy and I have done a good job and I feel good (Interview 14: 18)

According to one participant unwaged care is a response to a care regime that privileges some aspects of care over others.

We have one lady, her bath day is twice a week, but on Saturday bath, she wants me to French braid her hair. And I have to stay after work to do it. I don't have time through the day [...] it's important and a priority to her but it's not a priority for the Ministry. Her self worth, her self-esteem – like she wants to go to church Sunday, she wants her hair done, and she wants it to look nice [Interview 8: 19]

Other participants locate their refusal to provide labour beyond their scheduled shifts in response to managements approach to “off-the-clock” risk and responsibility.

I don't come in early because if something happens, something happens to me – like if I had an accident or got injured or something, I'm not covered. That is what we were told. So, some people just do it to get the work done, come in early and it is at their own risk. They [management] say that's their choice [Interview 10: 2]

Management has knowledge of the practice of unwaged work and the conditions of work that demand, encourage, and reinforce it. However, rather than facilitating conditions that would render this “choice” of unwaged work and uncovered risk amongst frontline workers unnecessary, risk and responsibility are instead transferred entirely to the worker and constructed by management as choice. Constructing “off-the-clock” work as choice also serves to justify not compensating workers for overtime – or wage theft. Participants further discuss how they often provide for residents with their own resources and unwaged time. This includes purchasing residents coffee and donuts, buying residents' personal hygiene products, haircuts, and gifts, or going shopping, sewing clothes for residents, and participating in advocacy work with the aim of improving LTRC. Participants' explanations often reproduced gendered ideologies of care. That is, care as natural, limitless, and altruistic. Several workers commented on this. In the words of one,

I mean it's hard, like we are people right, and that's what we do. They become our family, they become our... and it's like a job and you have the heart to do it. And if they need something, there is a lot of staff that will go above and beyond. Over and above their actual job and come in and help out and volunteer [...] because that's what they are here for – the residents, right [Interview 16: 27]

While workers are not permitted to accept gifts from residents, gifting by workers to residents, purchased during their own time and using their own resources, is a practice management normalizes and encourages in ways that perpetuate and reinforce gendered roles and constructions of care and nurturing. According to one participant,

They have a little booklet at the nursing home for the staff to sign-up to give a resident a gift because they might not get a gift for Christmas. So, here these girls are busting their butts and then still giving more out of their own pocket. They don't have to but lots of people do. They

sign-up and buy somebody a gift. You don't want to see somebody without, right [...] we do have a lot of staff that will do a lot of stuff on the side for residents [Interview 16: 26]

Some participants describe differences in unwaged labour and provision of resources amongst staff in terms of “work ethic” and “generation” – or the “young” and “old.” As one older participant who has worked in LTRC for almost 30 years comments,

The old and the young... the work ethic is so different in the younger than it is in the older workers. It just a big divide. There are the older workers who are committed, will go that extra mile. I'll stay late, come in early... and like I have residents that I bring Tim bits and coffee to every morning [Interview 4: 7]

In this participant account, to have a good “work ethic” workers should demonstrate this commitment through self-sacrifice, self-exploitation, gifting, and endless care. And as elaborated upon in the Chapter 7, this demonstration of commitment, self-sacrifice, and infinity elastic care includes working despite injury and illness, violence, and risk. Other participants, particularly workers who identify as being actively involved in their respective unions and/or perceive themselves to have union support, resist these pressures to subsidize care and resource deficits with their unwaged labour and own resources.

According to one of these participants who identifies as a union representative,

I am outta there. They don't pay me for a second more. That's it. When they stop the pay, I stop the work. That's it. See ya [Interview 6: 4]

The nature of unwaged labour in the context of intensified workloads is important to consider. While unwaged labour is shaped by the conditions and nature of work as well as by gender, unwaged labour also conceals these problematic conditions of work. The intensified workloads, staffing level inadequacies, and the lack of time to provide good care are hidden. On this point, one participant argues the provision of unwaged labour does not make worker workload and staffing concerns visible; rather the provision of unwaged labour by workers in order to complete their work operates to reinforce and maintain the status quo. In the words of this worker and union representative,

Some people routinely start their shift a half an hour early – just to get their ducks in order, right frame of mind, start the day fresh, so they don't have to rush off the hop. That's their choice. But I think, you add up a half an hour for every shift that they work, over time, that's a lot of money. That's a lot of time they aren't getting paid for, right [...] If you need to come in early all the time to get your job done, this is a problem. But if they don't complain – and some also just work through their breaks – nothing is going to get done. You will never be able to... Like, you can't build a case for more staff, when workers are going to do it free. Things won't change that way [Interview 16: 26-27]

While this participant frames this decision of unwaged work as “choice,” in understanding this situation from the perspective of feminist political economy, it is important to underscore that choice is inextricably tied to and shaped by social and material conditions in which frontline workers live and work as well as by gender. In this view, framing unwaged work as “choice” masks the constraints on workers in the context of precarious, insecure, and devalued work; that is, the social and material conditions that influence choice. This includes fear of reprisal, blame, and insecurity of work – or what Richard Edwards (1979) terms simple mechanisms of control utilized to manage workers. The significance of these influences for frontline workers may also be shaped by their social location and positioning within the LTRC hierarchy and perceived union support on the issue of unwaged labour. As participant discussions repeatedly highlight, for some workers the “choice” to engage in unwaged work may be between holding onto a job and not having a job at all.

While some of the unwaged labour workers undertake is explicitly coercive and shaped by the conditions of work and the social, economic, and political context in which this care work is located – other participants understand their unwaged care work in terms of obligation, commitment, and responsibility, rendering the coercive aspects of this engagement subtler. Some participants are prepared to self-exploit and self-sacrifice in order to improve the conditions of care for residents. Whether participants engage in

unwaged labour is also shaped by the nature of worker opposition. That is, participant consent or refusal to partake in unwaged labour varies between workers in ways that appear to be based on the source of what participants understand themselves to be resisting and/or supporting. Some participants who do not engage in unwaged work locate their refusal as supporting better work conditions and the principle of workers' rights. They resist further exploitation through unwaged labour but also seek to expose current conditions in anticipation that alternative conditions of work and care are possible. Not participating in unwaged work is understood as exposure of problematic working conditions – or at least working in ways that will not perpetuate the concealment of these conditions. Unwaged work would not make problematic working conditions visible; unwaged work increases their exploitation and masks problematic conditions.

Other participants who engage in unwaged labour were more likely to frame their participation in terms of commitment to residents, quality care, and their identities as good care workers. For these workers, participation in unwaged labour is understood as a form of compensation for indifferent systems and uncaring institutions which compromise quality care and undermine and/or debase their identities as care workers. In this context, the conditions of work and worker moral valuation of these conditions in relation to their gendered identities as frontline workers was sufficient to generate participation in unwaged work and consent to exploitation (see Burawoy, 1979). While unwaged labour creates space for some workers to feel more in control of their care labour and in ways that salvage their identities as care workers within the context of uncaring systems, their participation in unwaged labour at the same time reinforces their exploitation and further secures management control over the conditions and intensity in

which they work. This is consistent with research on unpaid and/or volunteer labour in the social services sector that found while workers “increased their own rate of exploitation” these workers “simultaneously provided themselves with a space in which they could operate with a sense of integrity and moral conviction” (Baines, 2004a: 19). Moreover, unwaged labour may also weaken bargaining power and reinforce gendered assumptions that care labour does not require greater compensation because of its intrinsic rewards or emotional motivations.

Training

Given heavier workloads, speed-up, and inadequate staffing within facilities, most participants report frustration in not being able to properly apply or utilize their training on the floor. According to one veteran worker,

I tell the new PSWs that are in school to throw that idea of that nice towel and how to wash training out the window because that is gone. You are literally, ‘hi honey, how you doing?’ Take the covers off, do the front, wash them totally, but as quick as you can, roll them over wash their back. Then diaper next. That aspect of dignity is gone. It makes you feel like crap [Interview 1: 5]

Under the *LTCHA*, facilities are mandated to develop and implement interdisciplinary training programs to frontline workers³³ (also see Chapter 4). From the perspective of some participants, in-service training and workshops do not coincide with their experiences on the floor. Below, one participant comments on the utility and application of training within the facilities in which they work.

It’s a waste of time. Waste of time. In fact, a lot of people just stop going to those training meetings because it’s a joke. I would rather be at work, catching up – you know, changing our residents, or doing my flow sheets, than wasting a half an hour or 45 minutes at a meeting and nobody is gonna benefit from it. Absolutely nobody. It’s frustrating. It’s enough to make you

³³ These include: Abuse recognition and prevention; Mental health issues; Behaviour management; Minimization of restraints; Palliative care; Fall prevention and management; Skin and wound care; Bowel and continence management; Pain management; Application, use, and potential dangers of restraints by physical devices; Application, use, and potential dangers of personal assistance devices. The minimum requirements for each of these programs are detailed in the regulations.

sick too, mentally. You just go home with all that bouncing around in your head [Interview 11: 10-11]

Another remarks that instruction is oriented to basic information not to practical application on the floor,

They try to teach us about some behaviour – and we say, ‘well, why don’t you come upstairs and meet, work with this person for a week, and tell me how to work with this person?’ And they go, ‘oh that’s not what we are here for.’ Well, then, you are wasting my time and I need to go back upstairs to work [Interview 7: 12]

According to some participants, there are also contradictions between what they are instructed to do through facility in-service training and the directions of immediate supervisors and/or registered staff in practice on the floor. This discrepancy creates further tensions and barriers for workers in the application of training to their workloads on the floor. As this participant indicates,

Even though we all went to the in-service and the in-service said we got to do this – doesn’t matter. It’s the nurse way or nothing. Their way or nothing. And that’s another reason why some people don’t want to go to in-service because what’s the point? We go down there they tell us this stuff and we come back up here and we can’t even use it – not at all [Interview 13: 6]

Other participants note that the training they receive is highly inadequate. Many indicate they are unprepared and untrained to manage the higher levels and more complex care needs of residents who are now populating facilities. This is particularly the case regarding residents who have significant mental health needs and/or residents who require more specialized care, assistance, and support – staffing or otherwise. According to this participant,

Most of these PSWs... we are taught courses, we are given the Reader’s Digest condensed version of what Alzheimer’s and what dementia is, what the strokes are. They don’t quite understand, most are not trained to deal with what long-term care has become [Interview 17: 11]

For some participants in-service training and facility workshops are futile unless broader issues of work organization, workload, and the inadequacies with staffing levels and time are addressed. As this participant points out,

It is great they want to teach us how to deal with behaviours but if they aren't going to go deeper and see why the behaviours are occurring and reoccurring then they can in-service and talk about it until they are blue in the face. Like, it's not our approach because the resident has already been triggered because health care aides have had to ignore them three times, as they are with other residents. And they have been sitting in a soaking wet Depend forever. So, it is great to want to teach us how to deal with those behaviours but if the time is not given to address the behaviours or prevent the behaviours, well it just makes no sense [Interview 1: 12]

One key informant notes the inadequacy of government measures, programs, and “right care, right time, right place” initiatives such as Behavioural Supports Ontario (BSO) for managing behaviours associated with mental illness, dementia, addictions, and neurological conditions,

The BSO is a complete Band-Aid. You don't want to hire enough staff, you don't want to hire full-time staff – okay, bring in a mobile unit and train all these transient workers. I have nothing good to say [...] you need full-time staff who have the training, mental health training – and that's not something you teach in a weekend workshop [KI Interview 15: 4]

Several participants also share their thoughts and insights on workplace in-services, and in particular, given the conditions of their work, the challenges of applying or putting into practice the gentle persuasion approach – or as one participant refers to it “therapeutic lying” – currently offered to workers. As one comments,

Like the gentle persuasion crap, take a half an hour to sit that person down and gently persuade. Well, yeah right, in a perfect world, right. If I had that half an hour time period nine out of ten times that's not gonna happen. You just don't have the time to take a half an hour. You ain't going to get it. If you did use it, the bosses would wonder what was holding you up, why you can't get the rest of your work done [Interview 3: 16]

Other participants indicate that while the approach is effective when time or efficiency constraints are not an issue and when frontline workers are allowed some flexibility and use of discretion with resident care regimens, other barriers affect its relevance and application. As this participant points out,

I just heard about GPA [Gentle Persuasion Approach] within the last couple of years but I have been using the GPA almost my whole career [...] I have been telling people that I have run out and plucked the eggs outta the hatchery that morning for breakfast to get them to eat. I've been telling them that I have baked all night long so they could have fresh muffins in the morning. I've been using that technique my whole career. I will take the 10 minutes and de-escalate the person because every episode is just that – it is an episode. It's short-lived [...]. And it's proven – and it does work on some people. But – and this is important, it does not work on people with

psychiatric history, which is unfortunate, because that is the population we are getting into the homes now [Interview 18: 11-12]

Participants further discuss challenges with how in-service training is implemented. Many participants explain these are scheduled during their shifts but often without additional staffing coverage on the floor. Participants also highlight workers remain responsible for resident care even if management pulls them from the floor to participate in training. Ironically, this arrangement requires workers to leave residents unattended during their shifts in order to attend educational in-services such as “residents’ rights”, “proper resident care practices”, and “abuse and neglect of residents.” Other participants state that management and supervisors expect workers to complete these in-services during their breaks or to attend on an unwaged basis on their scheduled days off – which some workers state has not been very successful.

They are unpaid. A lot of the girls are tired and they want to just go home. And for the casuals, they are usually on the floor or at their other jobs. If they have a chance to pick up a shift somewhere else, they aren’t coming in for unpaid in-services or workshops [Interview 8: 13]

Below, one participant highlights the reasons underlying why workers attend in-services and workshops at their respective facilities on scheduled days off.

There is people that go in for the meetings, training on their days off because they don’t want to rock the boat. They want to do what is right, so they just do it [Interview 16: 26-27]

A few participants identifying as union representatives provide examples of how they resist and challenge the organization of mandatory workplace in-services by refusing to attend and by removing training and educational material from their staff room placed there by management. According to this participant,

If they want me to do all that in-service and it’s required then they should be paying me. But it’s hard to get them to do that. I know a couple years ago they tried to tell staff they couldn’t come to work unless they had it done. It’s almost like they were bullying the staff – and it’s a threat, ‘you can’t come to work unless you complete the training on your own time and we aren’t gonna pay you to do it’ [...] Now, they will bring the in-service stuff into the staff room, like, when staff are in there on their breaks. I was like, what? I don’t think so. I’m not doing in-services on my break. Get out of here. Like they will bring the paperwork into the staff room and leave it there

for staff to complete on their breaks. I'm sorry. I don't want to listen to a video of work stuff on my break. So, I'm not watching that video [Interview 16: 12]

Teamwork Approaches: Contradictions and Tensions on the Floor

Previously I discussed work organization changes that intensify workload for workers on the frontlines of LTRC. Work organization changes also influence how frontline workers work together. In this section, I discuss tensions and contradictions that emerge in teamwork or the team-based approaches to care work employed in facilities. These tensions and contradictions are created in the context of expanding workloads amidst workforce reductions, workforce reorganization (and downloading), greater resident loads, and changing resident profiles. Care work is constructed by management as a collaborative and co-operative effort in which frontline workers are essential resources to meeting organizational objectives in care provision. Many participants highlight the importance of teams, use the language of teamwork when speaking about their frontline work, and indicate management repeatedly tells them they are supposed to always work as a team,

You have to work as a team, if we don't we are screwed. You are really screwed. If you can't rely on your partner when you tell her, you are going to be ready in 5 minutes and need her - then you are done. If you have to go and search, and search, and search...it throws everything off [Interview 1: 24]

Despite reproducing the language of teams and teamwork, many participants claim that given the organization and conditions of work, in practice, they often work alone.

According to one participant,

Nine outta ten times you are working by yourself. We are also taking on two to three extra residents usually, which puts our ratios up, and a lot of times you don't have your partner there to help you because they also have 12 to 13 residents as well now to take care of...and then a lot of short-cuts are done [Interview 5: 10-11]

While this is the case across all shifts, the experience of working alone is especially the case for workers on the night shift where staffing is further reduced. Cutbacks and

reductions in workers on the frontlines and elsewhere coupled with working chronically understaffed and routinely short-staffed have made opportunities for teamwork less possible. Frontline workers are doing more and more work, with fewer workers, time, and resources to do it. This finding has parallels with research in other sectors. For instance, research conducted at the Toyota auto plant revealed that teamwork approaches to flexible, lean, just-in-time production processes are coercive in nature and operate primarily to generate workers' "consent" to exploitation (see Thomas, 2007; Thomas, 2008).

According to participants' narratives, the increased use of part-time and casual staff also introduces unfamiliarity between co-workers and with care agendas, and workloads. The practice of hiring part-time and casual workers undermines teams and places further pressures on overloaded, full-time workers. Participants point to the inconsistency amongst co-workers as an important dynamic that threatens or undermines teamwork possibilities and creates conflict. Participants indicate some workers will refuse to assist particular workers and some workers will refuse assistance from particular workers. According to workers' accounts, these tensions between co-workers are at times fuelled by racial discrimination and what are frequently labelled as "cultural tensions and differences." They are also influenced by differences in seniority, status, and experience. According to this participant,

We usually have a partner but... this is mean to say... but depending on who your partner is – you may have help one day, then the next day someone may not be wanting to help you. It's not consistent, so there are certainly times you are always working alone [Interview 5: 4]

According to some participants, poor communication between registered staff and frontline workers also undermines the teamwork approach to care.

The communication is very, very poor in that place. That is one of my biggest beefs too is how poor communication is. They [registered staff] always forget to tell us something. Communication is just very bad [...] when something goes wrong the registered staffs blame it on the PSW or Health Care Aide. The communication is so bad in nursing – we don't know what one hand is doing to the next hand [Interview 6: 23-24]

In the context of facility or organization hierarchical dynamics, workers' discussions also reveal how the team approach often does not extend to the inclusion of all workers in team meetings. Below one participant discusses the deliberate exclusion of frontline workers from meetings with registered staff within her LTRC facility.

The RNs said, 'nope, we don't want them. We don't want our meetings with the PSWs and Health Care Aides.' They don't want that. So, we have separate meetings. We have the PSW team meetings and then the DOC has one meeting with the registered. And my answer to that was, no they don't because then they can't blame us for things that are their fault because we will be sitting right there. That's why they don't want us at the meetings. The nursing department, that's all of us – the whole lot of us. The RNs can't do their job without us. We are the frontline workers. They can't do their job without us so why can't we all be at a meeting? [Interview 6: 25]

The lack of input into decision-making from frontline workers regarding working conditions and the organization of work makes teamwork ineffective. The manner in which the workforce has been organized has more to do with management control of the workforce than with collaboration or teamwork. Teamwork operates to secure the assumption of risk by frontline workers on behalf of the facility. One participant states,

Management's job is to cover for themselves, just to control their workers and they don't really care about teams...all they care about is that the job is documented as being done. That's it [Interview 2: 22]

Along similar lines, some participants state that while management emphasizes the teamwork approach, in practice, management does not adapt this approach.

The managers – huh, that's another story. They talk the talk – like they say, we are all here, we are all here as a team, we need to work together as a team. I dunno what team. They don't help do anything, they preach it but they, no, no – can't [...] management they just don't. I don't think they care enough about, you know working together like a team. Even though they say team this and team that or whatever, their actions – it just doesn't show [Interview 6: 17]

Conflict and tensions develop on the floor when care work is organized and structured in ways that undermine teams and is understood as one symptom of problematic working

and care conditions. Given employer hiring practices and preferences for a flexible workforce, some frontline workers have multiple jobs at different facilities, creating tensions amongst co-workers struggling with heavy workloads. According to this participant,

They tired. They don't perform their work. Especially those who work night shift at other place and when you see them they are kinda dragging – and their eyelids are [squints]. You can see them dragging themselves. I say to them, I know you work other place ... we have quite a few part-timers. That's the thing too – they are working 16 hours. From one place and then come to next place. They come to work and they kinda neglect the thing or always asking help from you. That's the thing too, it tire you out too. Some staff are really taking advantage. Especially those who work on other floor, other unit, or at other home, they come to work but they expect you to help them out cause they are tired – so they use you too [Interview 10: 15]

For some participants the conditions and organization of work means that conflict and competition – rather than teamwork – between co-workers is inevitable. As this participant suggests,

There is always somebody that, you know, that isn't doing their fair share and isn't pulling their weight. So then, frustrations build. And there is frustration because you can't get everything done. So it's just, you know, things build and then sometimes they blow [Interview 8: 10]

Conflicts between workers are understood by some participants to emerge when there is an apparent workload or resident assignment imbalance between workers on the floor.

As one participant highlights,

My load right now is very heavy and other staff it's like they are on vacation. So, that's the way it is. And it's not right. Back in the old days, that wouldn't happen. Everybody would have an even load, you know [Interview 13: 5]

For several participants, conflict on the floor among frontline workers sometimes draws on gendered, ageist, and sexist stereotypes. According to some participants, women “bitch” and “talk about each other” and constantly “give each other lip.” Along similar lines, other participants attribute tensions on the floor to age and biology – being old and being a woman – rather than to structural and organizational issues that influence workload and time. According to this participant,

You get the odd person who is a little catty here and there – and you get a bit of ...well, over the years, you get the menopause. You have to realize we are working with all women. You have the odd person that is just a bitch no matter what you do. That's just the way they are. And like the women thing, like we all have PMS or they are older and they are menopausal [Interview 16: 21]

The normalization of sexism and ageism and the pathologization of women are widespread among participants – attaching culpability to “old” and “hormonal” women instead of the pathological system of care in which these women work. Conflict on the floor also occurs in relation to the degree of experience between workers. As this participant explains,

If it is somebody new and you know they just finished the course and sometimes they think they know a bit more than everyone else cause they just finished it. So, at times there's an edge there, it's tense. There's some conflict. You know if they are working and trying to tell someone who has been there for 20 or 25 years how to do it, there's tension. To that, my favourite is, 'I've forgotten, more than you know' [Interview 8: 16]

Tensions and conflict also arises on the floor from workload pressures that encourage workers to cut corners. While all participants in this study indicate they inevitably cut corners or take short cuts, there are clearly limits among some frontline workers as to what and how much or how often is acceptable or tolerable. As this participant indicates,

Like if you see one worker cutting too many corners, you know, you are going to get caught. That usually triggers some confrontation between workers. And if they are both strong personalities, it can really escalate. It might trigger something explosive [Interview 1: 16]

Conflicts are also evident in the failure of management to follow protocol and go by seniority when filling shifts and positions, allowing some workers to jump cue. According to some participants, this practice shapes, contributes to, creates, and/or intensifies racial and ethnic tensions within the workplace. In the words of one of the participants,

I am just trying to survive. But you know its dog eat dog. We have Filipino jumping seniority, getting full-shifts ...And we have people who were hired before her and still only get four hour shifts, but she get full-shift [...] I ask nurse manager about it and it was because she have a baby to support. It doesn't work like that. You have to be fair to everyone, go by seniority [Interview 9: 18]

The teamwork approach to care coupled with commitment, fear, and uncertainty is effective in pressuring frontline workers to work despite illness or injury (see Chapter 7), to work through their breaks, and to continue to work past the end of their shifts to complete documentation or assist workers following the elimination of shift overlap in some facilities. It is used by management to blame workers for breaking-rules (“not working as part of team”) and discourage refusal of unsafe work (see Chapter 7), shifting attention away from the organization of work, the standardized and routinized approach to care, and excessive workloads that may preclude workers from working in teams, working safely, or the applying their training. Managerial emphasis on teamwork is compounded and reinforced by gendered expectations and assumptions that in many ways manufacture consent or dissent among workers. Given the organization and conditions of work, the teamwork approach operates to exercise control over these workers rather than treat them as skilled and valuable care collaborators. Moreover, the emphasis on teamwork obscures where decision-making authority and powers reside and the lack of autonomy surrounding how and when workers carry out their shift activities. In the everyday/everynight shift work on the floor, the notion of teamwork simultaneously conceals and reproduces the alienation of workers and the exploitative and risky conditions on the frontlines of care. This finding mirrors research that has examined the team concept employed in workplaces as a component of lean production within the hospital (see Armstrong & Armstrong, 2003) and manufacturing (see Moody, 1997; Rinehart et al., 1997; Thomas, 2008) sectors.

Conclusion

The intensification of work of the frontlines of care has been shaped by numerous factors, including structural, regulatory, funding, and organizational transformations within the health and social care sector. This includes greater for-profit ownership, management, and use of pro-market principles and practices within this sector. Drawing on participant interviews, this chapter provides a contextualized understanding of what these changes have meant for workers and their workloads. The current care regime systematically strips frontline work of relational and emotional components of care, substituting it with flexible, standardized, and routinized approaches to the organization of frontline work and care. These changes also have significant implications for teamwork, unwaged labour, workers' resistance and struggle over the conditions of their work and care in this setting. Social location and frontline worker labour market positionality and status within the LTRC hierarchy shape the experience and perceptions of these conditions as well as the nature and consequence of resistance and struggle on the frontlines over the conditions of work and care. Workers with seniority, who have full-time status, who are actively involved with and/or feel supported by the union, are better positioned to articulate concerns and influence, negotiate, and resist the conditions of their work. In contrast, workers who are precariously employed and who are disconnected and/or feel unsupported by their union are less likely to vocalize their concerns and resist the demanding conditions of work and care.

Given current hiring practices of facility operators oriented to greater control through flexibility in workforce organization, this precarious labour force is increasingly composed of racialized and/or from marginalized immigrant women. These

transformations also have implications for unwaged labour. Gendered ideologies of care and assumptions about care workers operate to reinforce the provision of unwaged work in order to compensate for care system deficits emerging from inadequate funding, chronic understaffing, and routinized and standardized care agendas amidst changing resident base. Consequently, worker exploitation is reinforced and reproduced and conditions of care and work are further rendered invisible.

The next chapter considers the physical and psychological risks frontline workers encounter within LTRC as well as explores how these risks can also be understood as largely structural in origin – that is, a product of the way LTRC work is currently organized and funded.

Chapter 6: Risk: Injury, Illness, and Violence on the Frontlines of Care

Work organization, restructuring, and changing resident demographics have meant intensified physical and mental demands for frontline workers. These changes have occurred alongside an aging and increasingly racialized and marginalized immigrant LTRC workforce. While prior research has documented the relationship between workload and health, not much is known about how workloads impact women. This is particularly the case in feminized or women dominant worksites such as LTRC. Gender is understood as a context that profoundly influences the experiences of frontline workers on and off the floor. This includes assumptions about care, care workers, and perceptions and experiences of risk, injury, illness, and violence. There is also not much known about how gender intersects with “race”, immigrant status, or language in producing differential health and safety risks or how social location influences resistance and the consequences of resistance to the conditions of work.

In this chapter, I continue my primary data analysis of workers’ experiences on the frontlines of LTRC. In particular, I explore conditions of work in relation to workers’ health and safety and foreground workers’ understandings and experiences of physical and psychological risks in the context of restructuring and reform. As with the previous chapter, I aim here to render frontline workers’ struggle and resistance to the conditions of their LTRC work visible.

The chapter is organized into several sections. I begin the chapter with a brief discussion of how current conditions of work and care within this setting constitutes a form of structural violence that contributes to the risk of injury, illness, and violence on the frontlines of care. Drawing on Johan Galtung’s (1964; 1969) conceptualization, I

understand structural violence as the product of capitalist relations wherein inequalities such as classism, racism, and sexism within institutions and structures systematically operate to obstruct individuals from reaching their full potential and satisfying their basic needs. In the next section of this chapter, I explore participants' accounts of physical risks within facility-based LTRC. I then consider participants' experiences and perceptions of various forms of violence – physical, verbal, racism, sexual, and bullying and harassment. Following this, I discuss psychological risks frontline workers' encounter in their care labour. Participants share their experiences with emotional labour, stress, mental exhaustion, death of residents, and their struggles separating home and work. While I discuss physical risks and psychological risks on the frontlines of care separately, it is important to note that the division is somewhat artificial. That is, physical risks can become psychological risks and psychological risks may become physical risks.

Structural Violence

The participants' experiences and accounts of risk, injury, illness, and various forms of violence to be discussed in this chapter are also descriptions of forms of structural violence – for residents and workers, stemming from broader structural and organizational conditions of work and care within the LTRC sector. Drawing on the work of Johan Galtung (1964; 1969), Paul Farmer (2005: 7) describes structural violence as a “symptom of deeper pathologies of power and are linked intimately to the social conditions that so often determine who will suffer abuse and who will be shielded from harm.” The risks to frontline worker health and safety on the frontlines of care are in many ways derivative of how facility-based LTRC is currently organized and funded.

Conditions and risks within LTRC are understood as products of ruling relations (Smith, 1987; Smith, 2005) – the broader social, political, and economic context, decision-making, and the historical ambivalence towards this sector – including those who labour and those who live within facilities – more generally. The organization of work and its intensification on the frontlines of care reinforce and create new risks for workers, including risk of injury, illness, and violence. This is particularly the case when workers are harmed, disadvantaged, or otherwise diminished in a context where they have no control or input over how, when, and under what conditions their work is organized. Changes associated with restructuring also reinforce workers’ alienation as well as produce and reproduce inequality. They prevent residents from having their basic needs met and workers from providing the type of care they would like to provide. These harmful outcomes for workers and residents are not necessary. In line with feminist political economy, this understanding moves beyond individual-level forms of blame shifting and assumptions that frontline work has to be as dangerous and as risky as it currently is. According to this participant,

They act like nothing can be changed to fix it. The CEO at Extencare makes I think 1.8 million last year. That’s a lot of money. That’s a lot of care. A lot of hands-on workers, a lot of people that could be properly toileted, fed, bathed instead of sitting in a pissy diaper. I think that is what people really have to look at... not that staff is being abusive and neglectful but why they are considered abusive and neglectful, needs can’t be met [Interview 1: 26]

Physical Risks

Labouring on the frontlines of LTRC is demanding, risky, and dangerous work.

Health care workers are listed as the number one injury rate in Ontario. They have more injuries than the mining industry and the forestry. Manufacturing is even less than that, in terms of injuries. It’s not what normally people think. ‘Oh, so you work in long-term care? Oh, it’s nice, and clean, and safe and, you know, we stand around and talk to people all day and make people feel good.’ If they work one day as a PSW, I am confident that more people would respect the work that actually happens. It’s risky work [KI Interview 19: 20]

As the participant above underscores, dominant assumptions about care work, the gendered context of care, its association with domestic work or “women’s work”, and its treatment as natural, unskilled, and simple work – that is, something women do “naturally”, mask the risks and hazards involved with this labour. Yet, the high documented injury rates this participant identifies do not tell the full story. As discussed in Chapter 4, workplace injuries within this setting are grossly underestimated through official counting and unrecognized and/or not legitimized through compensation mechanisms (Lippel, 1999; Cox & Lippel, 2008).

Discussions with participants in this project reveal the many physical risks and hazards that are associated with work on the frontlines of care. While the physical nature of hands-on care presents some element of risk, the way in which frontline work is organized, particularly in terms of workload and control, has significant implications that shape risk and workers’ health and safety on the frontlines. In the context of neoliberal-inspired efficiencies and profit-driven policies, processes, and practices, newer forms of work organization such as flexibilization and intensification in many ways do not facilitate working conditions that are conducive to the health and safety of frontline workers. Under the current care regime – intensification of work, routinization, and standardization of care erodes workers’ control over care work practices and reinforces and/or manufactures risk of injury and illness. In the next section, I document specific forms of risk and their relation to restructuring and work practices.

Risk Associated with Staffing Arrangements

Participants in this project consistently report chronic understaffing within LTRC facilities because of overall government cutbacks within the sector, the use of pro-market,

efficiency-oriented managerial practices and principles, assumptions about care and care workers, greater for-profit ownership, and an absence of minimum LTRC staffing regulations. Understaffing within facilities of LTRC significantly contributes to the nature and frequency of risks workers encounter on the frontlines. Throughout interview discussions, participants repeatedly describe the physical risks that emerge from workload intensification amidst staffing reductions. Many workers describe the intensity in which they work as a “mad rush” an “insane pace” “crazy fast” and “rush, rush, rush.” The speed up associated with intensified and greater workloads create risks for frontline workers and residents. As one participant explains,

[Management needs to] stop asking for the impossible because that just creates accidents. Like when you have to rush, haste makes waste, you know [...] more residents, more complexity, and we got less workers to do it all and that poses a big risk. Someone usually ends up getting hurt whether it's the worker or the resident [Interview 11: 12]

Risks that arise in relation to work organization are poorly regulated through health and safety legislation. Several workers highlight the physical risks that arise from the physical demands and intensity of care. As one elaborates,

I tore my rotator cuff. I tore that a few years ago from an injury from work. And that is what it is. We have the potential for injury because we are rushing – because we are trying to get all this work done in a span of eight hours, you know. We're rushed. It's very hard [Interview 6: 4]

The rationalization of costs and labour in conjunction with regimented care undermines frontline worker efforts to provide individualized care to residents that reflects and/or supports their needs and preferences. According to this participant,

We all don't work the same [...] they said we should be leaving the old school and be more task focused. But that is so full of baloney because there is so much to do you can't be just resident-focused all the time because there is so much to do, right [Interview 1: 6]

The risks associated with understaffing are compounded by changes to the resident base and levels of care and constraints on the time for care and the timing of care. Others note facility staffing reductions and work intensification create risk of infection-related

illnesses. This is particularly significant in the context of a health care environment where infection prevention and control is critical. According to this participant,

They just see to cut staff and everything has to be a mad rush. If you are doing this crazy mad rush – how much cleanliness are you gonna have? [Interview 9: 19]

While government regulation and institutional parameters require frontline workers to operate within a model of care that is task-oriented as well as routinized and standardized, there is currently no regulation within Ontario that specifies the appropriate staffing arrangement to facilitate quality care and safe work and care conditions (see also Chapter 1).³⁴ According to participants, frontline workers are taking on greater, more complex, and demanding resident loads, as well as assuming more tasks because of facility staff cuts and the transferring or downloading of work that was previously the responsibility of other workers such as dietary and laundry. Moreover, workers are required to do this work in less time and within more restricted timeframes that are dictated by Ministry and facility imposed guidelines and schedules. Excessive workloads and competing demands impacts worker focus, attention to responsibilities, and their ability to labour in ways that minimize and/or avoid risks as this participant illustrates,

Sometimes we are working with up to 15 or 16 residents. And that's the hard part, being in that dining room at the allotted time, when you are constantly doing four extra people. So, you're just moving too fast, and you might be cutting corners, you know you aren't as careful as you should be [Interview 8: 9]

Moreover, rushing increases risks and can upset residents, who then often become risks.

As this participant elaborates,

When you rush them they get anxious and they will fight with you. And this is where the safety comes in cause those guys can really hurt you and they have hurt. People are off because of residents. Like, a lot of workers are off or have been off because of residents, you know. We get

³⁴ Staffing is not among the indicators used to measure quality within long-term residential care. Current indicators in Ontario under the *LTCHA* include: wait times, incontinence, activities of daily living, cognitive function, pain, falls, pressure ulcers, restraint use, medication safety, health human resources and infection rates.

abused by these guys... because they don't like it when you do certain things like rush them, pull them, you know, to get them sitting up. Oh it's crazy, it's crazy [Interview 11: 2]

Work organization factors such as frontline staffing intensity and levels within facilities not only affect workload and the time with residents, but also have implications for the time available to orientate and train new frontline workers. According to this worker,

There is no time for job shadowing, really. You got to get in there right off the hop. If you think you are going to come in here and stand there to watch what is happening, there is no time for that. Get your hands dirty. Sink or swim [Interview: 7: 6]

The lack of time can result in inadequate orientation to care processes, practices, and routines on the floor that place workers and residents at risk of injury or illness. Orientation shifts within LTRC facilities are typically distributed across day, afternoon, and night shifts. While participants report some variability in the amount of orientation provided to new workers between facilities – the standard at some facilities is three, others have four, with a few facilities providing five or six orientation shifts – there is no flexibility in the number of orientation shifts for workers at any given facility regardless of context. LTRC work is assumed to involve little skill and require little training. According to many participants, the quantity and quality of orientation shifts new workers receive is insufficient. One participant describes it this way,

When a new staff member comes in umm, they get five orientation shifts. Two days, two evening and a night in our home, that is all they get. So, they are shadowing the staff that is on. After that then they are on their own. But it's just not even enough time to tell them or show them everything that they need to know [Interview 18: 12]

This is especially the case given intensified workloads, time pressures, and levels and complexities of resident care that currently characterize LTRC facilities. This arrangement positions many new workers – many of whom are hired on a part-time or casual basis per employer preferences for a flexible workforce oriented to cost

containment – unfamiliar and unknowledgeable with residents and their complexities, as unprepared and at risk. According to one worker,

They shadow us for the first shift and then the second shift we usually let them have hands on with us, and we work side-by side, and then they get two orientations to each shift – so two days, two afternoons, and then two midnights. And sometimes I really feel that is just not enough – especially with the ratio of residents to staff we have now and how fast we have to move [Interview 5: 7]

As workers explain, workforce flexibilization that aims to improve economic efficiencies and increase the production of care on the floor can also increase health and safety risks for frontline workers. New workers are increasingly thrust into the realities and demands of rapidly changing LTRC environments that do not reflect in class training or resemble their practicum experiences and responsibilities. Below, one participant describes the four-week unwaged practicum for student placements at the facility in which she works.

The first day students are there, they shadow, then after that they do small tasks, and by the end, they get maybe two or three residents that they take care of on their own. They could never, and they would never take on a full resident load or groups of residents. Usually it is two or three but that depends on quality of life, needs of the resident, you know [Interview 3: 6]

While responsible for two or three residents during practicum training, new workers enter LTRC environments with the expectation that they manage the complexity and responsibility of full assignments following only a few shifts of orientation. As this participant states,

There is five days of orientation. The first few they just shadow. Then after that you give them tasks to complete and of course by day five it's expected they be able to do it all [Interview 3: 6]

As a result, participants claim new frontline workers are left often on their own to struggle and figure out the inner workings, processes, and policies of the facility and care practices on the floor with residents, practices that are important for avoidance of risks to workers and residents.

Although residents' needs and preferences are variable, under the current care regime facility-based care is standardized and routinized. Contradictions and tensions between residents' rights and "home-like environment" arise in relation to current regulations and approaches to care.

The resident doesn't want to get up for breakfast. And if she doesn't want to, why should she? Some don't eat breakfast in morning and never have, and now that they are here, all of sudden, they are made to get up for something they don't want, you know. And then we get punched and yelled at [Interview 11: 3]

As this worker illustrates, this situation puts workers at risk and ignores residents' preferences. Residents may not always understand, may refuse, or resist care and assistance from someone they lack rapport and familiarity with or who have not had the necessary opportunity to understand and know resident's individual needs, preferences, and complexity. This may be compounded by significant cognitive, psychological, and physiological challenges. According to participants, the growing diversity of the resident population without appropriate training and time also creates difficulties that may heighten risk of injury or violence. This includes the rising number of residents with Alzheimer's or dementia and residents requiring specialized psychiatric care. Significant challenges and difficulties may also arise between residents and workers who do not share a common language – a barrier that may create risk of injury for workers and residents. The changing composition of the workforce also generates difficulties for workers entering restructured environments. This includes the growing utilization of racialized and immigrant workers within the sector. This is particularly the case within facilities in major cities and metropolitan areas where racialized and immigrant populations are more heavily concentrated. One participant who occupies a temporary full-time position within the facility in which she works suggests hierarchy, racialized

dynamics, and communication or language use on the floor between workers compound the insufficient orientation, training, and mentorship provided to new frontline workers of marginalized status given the transformed and intensified conditions of work and care.

According to this participant,

At the home, they will train them for only three shifts – day, evening, night shift. One day, one evening, one night. Three shifts total. Not enough. It's not time to learn, understand [...] also because staff don't give information to other people. They don't, they only help their own people, in their own language. They don't talk – Haitians they talk only in the Haitians language. I don't mean just Haitians... it same with some other cultures too - they don't help other people, they don't talk, advise, or anything. So, orientation should be more for the minority people, because we don't get help, they don't advise us. For minority people, orientation should be more [Interview 12: 3]

The contradictions between rhetoric and reality are apparent with respect to the team model to care or “pulling together” and “working as a team” on the floor emphasized by management (see Chapter 5) and the orientation of new workers. The teamwork approach is undermined by the conditions and organization of work, which may produce and reproduce racialized – racial, cultural, language dynamics, and privileges or exclusions and divisions on the floor. Participants frequently identify challenges on the frontlines as originating with racialized groups rather than the way in which the work is organized. That is, workers – not work organization are deemed a barrier to teamwork. The standardized approach to orientation is consistent with broader managerial approaches that ignore context and expect the worker to uniformly adapt to the workplace and conditions of work rather than modify or adjust the workplace to the worker. The treatment of care work as unskilled, workers as non-variable and interchangeable, and residents as static and fixed objects to be quickly processed through standardized and routinized care practices, reinforce the devaluation of care and disposability of workers and the dehumanization of residents. It also situates workers and

residents at risk of injury, illness, and violence. Frontline workers may also be exposed to different forms of risk and oppression on the frontlines of care. As I elaborate upon later in this chapter, this includes the extensive racism that historically oppressed and disadvantaged groups such as women of colour and marginalized immigrants encounter within the LTRC environment.

Along different lines, contradictions between MOHLTC mandated facility training and practice are also evident. Participants indicate they are not always able to utilize or apply facility workshop and in-service training they are required to receive. This is particularly the case given the context of understaffing and short-staffing, time constraints, inadequate supplies or equipment, contradictory or conflicting instructions from supervisors amidst a broader gendered workplace culture that pushes predominantly female frontline workers to care for residents regardless of circumstance, personal cost (see Chapter 5), or implications for health and safety. This broader context situates workers on the frontlines of care at risk of injury or illness as well as violence.

All participants indicate they struggle with LTRC changes and the implications for their workload, risk, and health. Several participants with extensive histories on the frontlines of care share that they “work smarter, not harder” where their skills and experience-based “tricks of the trade” facilitate their management and struggle with workload intensification on the frontlines of care. Again, Burawoy’s (1979) metaphor of “games” is useful in highlighting the ways frontline workers maintain some control over the labour process and autonomy in the face of government and institutional rules, managerial control, and constraints. As this participant who has worked in LTRC for over twenty years highlights,

You need to hustle. You need to be thinking when you are done do this, you have to then go do this and this, and that may be interrupted. You need to know before you get into the room exactly what you need to do and what you are going to need. I am going to do this, this, and this, so I will need, this, this, and this and take it with you so you are not back and forth. It's all about organization, right. You have to be more than organized to do the job. There is no room for back tracking if you forget something. But this comes with experience, right [Interview 1: 6]

Lacking experience, appropriate training, support, and job security, newer workers are less well positioned to manage, control, and/or resist the intensification of work and standardization and routinization of care. This context may also exacerbate worker alienation and health and safety risk on the frontlines.

Changes in Resident Base and Levels and Complexity of Care

Residents now entering LTRC have complex care needs and require higher levels of care. As discussed in Chapter 1, the changing resident base is in part derivative of significant restructuring and reform policies, processes, and practices within health and social care more generally as well as changes to eligibility criteria under *LTCHA*. Participants' narratives underscore how the changing resident population in LTRC results in intensified physical demands placed on frontline workers. Greater physical demands create the potential for greater physical risks in their everyday/everynight care labour, especially when time and Ministry regulations and institutional timetables not residents' needs or frontline worker experience and skills dictate the pace and nature of care. Participants describe increased resident loads and higher levels of care, resulting in greater physical demands within the context of time compression and structured time for care. According to this worker with two decades of experience on the frontlines,

Per worker, anywhere from 10 to 13 and most of them are total care because the unit we work on is a total care unit ... and it's a very, very heavy unit. And that's why they call it a heavy unit because nobody can... most of the people on that unit cannot do anything for themselves and so to get them in the dining room in that little bit of time. I'm telling you, it is impossible [Interview 11: 2]

Many participants also state the growing resident obesity within facilities as one factor that has significant implications for the physical demands and the risks of care labour in chronically under-resourced facilities. This includes staff, supplies, equipment, time, supervision, and training. As this participant explains,

It's a lot of strain just trying to roll these larger residents. And you should always do this with two people – and it's not always possible. Because if the resident falls back. You know, that is how a lot of girls get hurt. Their shoulders, their arms, back. That is a lot of weight falling back on them [Interview 2: 22]

As noted above, the organization of work, the nature of resident demands, and resident characteristics has meant frontline workers are put in a position where safer execution of care practices are impeded by work organization factors and conditions beyond their control.

Facility equipment also impacts the physical workload of frontline workers and risk on the frontlines. While some of the work has been mechanized wherein assistive devices such as mechanical lifts facilitate reduction in the need to manually lift, reposition, and transfer residents, risk for injury remains in using mechanized equipment. But such devices can also create new risks. Below, one worker illustrates the potential for musculoskeletal injury in the operation of equipment given the conditions care work, including higher levels of care and resident characteristics within the LTRC setting.

The machines are rated for 400lbs – but seriously try putting that weight on and not struggle having to push and pull it by yourself [...] the obesity of our resident is a big concern. Obesity is huge. And we are expected to move these people from point A to point B. Even pushing them in wheelchairs, like it really strains and hurts your back [Interview 18: 4]

The above participant account highlights the physical demands and risk factors associated with MSI. This includes strained posture and magnitude of force involved with push and pull actions required in the execution of care practices to manoeuvre residents, machines, or assistive devices. The nature of the physical demands frontline workers encounter

may be repetitious and of variable duration. As participants' discussions suggest, changes to the character and tempo of care work such as speed-up or intensification and standardized and routinized care within rigid institutional time parameters, undermine workers' control and aggravate risk in their everyday/everynight experiences on the floor.

Physical Space

Facility design and structure have implications for frontline worker workload as well as for risk on the frontlines. Workers report that the physical space required to conduct their work is highly inadequate. Participants expose the contradictions between how care should be provided and how the physical space is organized. All participants working in older facilities report that these facilities are not designed in ways to accommodate the changed physical needs and capacities of residents now entering LTRC. This situation places workers and residents at risk. Participants who work in newer facilities also express concerns in this regard. According to one worker who has worked in both older and newer facilities,

The new homes you see that are being built now are built to the nines, they are beautiful, they are pretty, and they are brand new. But they don't function any different than the older homes. It is just prettier [Interview 4: 7]

Participants indicate that crowded, cramped, cluttered, and confined spaces create risks and challenges. Many participants state small resident rooms are especially problematic. Many workers indicate they struggle to provide personal care as well as manoeuvre the necessary equipment – wheelchairs, commodes, lifts, and other assistive devices – in the provision of care. According to this participant,

Clutter is a big issue for us. The management, they just keep letting them bring in huge lazy boy chairs that we have to push and move to get to their clothes to get them out of drawers. It's pushing and shoving to get a wheelchair, a commode, and a walker in there. Then they get this china in there and it's all over the nightstand – and you accidentally bump it and there are flowers everywhere. There is just not enough room for all this stuff plus the staff. We need to be able to give them care. It's creating a major hazard. It's horrible. You are tripping. It's just – our rooms

are small. We have wardrooms still, which are four in a room, and the duals, and then we have singles. Putting a big lazy boy, and a dresser, night stand, wardrobe, garbage, and a magazine rack and all the pictures and all the knick knacks, a walker, and a wheelchair and trying to get a commode in there. And then you get a 240lb man and all that stuff and then two staff members. It's tight! [Interview 8: 18]

There is a dual character underlying the conditions of work and the conditions of care. For instance, while improved working conditions could facilitate producing better care conditions for residents, participants also underscore the tensions that emerge between the conditions of care and the conditions of work. These tensions are apparent in relation to residents' rights and workers' rights. In other words, the nature of the relationship between working conditions (workers' rights) and care conditions (residents' rights) can be understood as complimentary as well as contradictory. Workers also draw attention to the ways in which selective "home-like environment" principles and practices may not be compatible with and/or counter to safe care and work conditions. As this worker illustrates,

They seem to be able to bring whatever they want and we'll have to work around recliner chairs, tables, laptops, stereo systems, it's just...I know they have rights and I know they have the right to be as homey as possible, I just think they are getting so carried away with it in long-term care. Like the amount of stuff a resident can bring into the home is unbelievable. It's posing a risk to our health [...] we can't manoeuvre [Interview 18: 7]

According to participants, workers' rights to safe workplaces are subordinated to residents' rights to personalized space. In addition to the risks these conditions introduce to workers on the frontlines, some participants are especially concerned about the fire hazard these cluttered and crowded conditions present,

The rooms are so fire hazard. The residents – they are hoarders. You cannot even put a basin of water because it is so packed. And I will go to the team leader and say I can't work like this, suppose we have a fire? [Interview 14: 11]

In a context of chronic understaffing, greater resident load, and higher levels of care, participants state this situation is a "disaster waiting to happen." Several participants refer to LTRC facility fires in recent past, such as the fire in Orillia, Ontario in early 2009

in which four residents were killed. Following an inquest into the fire, LTRC facilities have been recently mandated to retrofit facilities with automatic sprinkles by 2019 (OANHSS, 2015). Currently, more than one third of facilities in Ontario are without fire sprinklers (Auditor General, 2015). The occurrence of fire within LTRC is very real and worrisome for some participants – particularly should fire occur in smaller communities or on the night shift where staffing levels are significantly lower than on day or afternoon shifts. As this agency worker explains,

You are only one person dealing with on some occasions, sometimes 18 people for that shift. You are on your own. Look out if anything happens on graveyard shift. You are the only person on the floor. What happens if there is a fire? And in the smaller communities, all we have is a volunteer fire department [...] my big worry is that if there are not enough people on the floor in the event of a fire. And fires do happen by the way. There was a big fire a couple years ago. I was on the afternoon shift and it was pure adrenaline getting people out of there [Interview 17: 21]

Participants also report the entrances to the bathrooms are often not wide enough to accommodate wheelchairs and lifts. The bathrooms themselves are often too small for the worker(s) and resident as well as any necessary equipment. As this worker elaborates,

Like our building is really old, very out-dated...we have the old slide doors for the bathroom doors that are not wide enough, so whenever we have someone on a lift we are forever banging the lift off the door, and the lifts are constantly hitting and getting wedged in the door, it's completely unsafe [Interview 5: 6]

Other participants describe the narrow hallways that characterize the older facilities in which they work as not safe or conducive to the navigation of large equipment and operation of small, motorized vehicles that are increasingly utilized within facilities.

Workers and residents are put at risk. As this participant explains,

And now we are having a lot of people come in with scooters. Our home is not built for scooters and that is a huge issue in our home, getting run over by a damn scooter – it happens all the time. Cause they are coming in everywhere now. And the hallways are so narrow. It's an old home, it's not meant for stuff like that [Interview 18: 10]

The space and structural issues participants identify are further compounded by the rapid pace and strict timeframes in which these frontline workers are required to work. Over the next decade under the *Enhanced Long-term Care Renewal Strategy*, redevelopment projects to facilitate compliance with design standards are in progress. Although redevelopment to address physical constraints and building limitations are important, these changes do not compensate for the lack of frontline workers on the floor who struggle with intensified workloads, higher levels of care, standardized and routinized care, and less control over the conditions and organization of their work.

Risks Associated with Insufficient Equipment, Supplies and Resources

Many participants report that the availability, accessibility, or appropriateness of equipment (such as mechanical lifts, bathing chairs, slings) and supplies (such as gloves, incontinence products, sanitizer) within facilities are inadequate, insufficient, or poorly maintained. Lack of equipment and supplies for workers to assist residents means workers already pressed for time must search to locate mechanical lifts, assistive devices, gloves, incontinence briefs, or slings as well as other workers to assist as required under two-person lift policies – or do without. Supply, equipment, and product shortages also create health and safety risks for residents and frontline workers. As one participant highlights,

I would say the diapers aren't as good now. They are cheaper. I think they went to a different kind. The ones before were better. Because it is privately owned, they can use whatever they want. We have same basic supplies, but some things they have changed, the products. It's like going from high quality to no-name brand, you know. Certain stuff. [...] We use these cheap vinyl gloves that rip and tear. We don't have expensive stuff [...] and they cut back on things – like even Kleenex. They cut back on that because it was too much of a cost. It's Kleenex [Interview 16: 25]

Other participants point out the creation of various forms of risk in the context of inadequate or inaccessible resources such as staff or supplies and new government

policies regarding minimal use of physical and chemical restraints. As one participant explains,

There are risks for us with the no-restraints. We've had residents that have come in that have come from the hospital that really haven't been dealt with like with the mental aspect like they are physically threatening and you can't, like years ago you used to be able to set them in a chair with a tray, which was a restraint. But now, the medication, seatbelts, putting them in a chair with a tray any thing like that is a restraint and you have to have a doctor's order for that, right and consent from the family [Interview 16: 7]

Without adequate staff and supplies to support no-restraint policies, residents and workers are put at risk. Despite management's emphasis on working as a team, in the context of inadequate staffing levels, time constraints, the nature of resident demands as well as moral predicaments and gendered ideologies about care, in practice frontline workers may have little choice on the floor but to cut corners and break rules. As discussed in the previous chapter, this includes use of equipment to facilitate resident lifts and transfers by themselves, or to lift and transfer residents without the use of equipment regardless of lift protocols or policies in place. The context that shapes this situation puts both the worker and the resident at risk of injury. As this participant notes,

It's a huge safety risk, nine outta ten times you are working by yourself. You are also taking on two to three extra residents, which puts our ratios up, and a lot of times you don't have your partner there to help you because they also have 12 to 13 residents as well now to take care of. And then a lot of short-cuts are done, um, a lot of lifting is going on that shouldn't be done because it should be done by a lift [Interview 5: 10-11]

While insufficient provision of the necessary equipment and supplies presents health and safety risks to workers and residents, some participants indicate the equipment within facilities is often not adequately maintained or replaced when necessary, which can result in worker or resident injury. According to this union representative,

Most of the injuries my co-workers suffer in my workplace right now is due to mechanical failures. Poor equipment [...] every injury this past year has all been due to poor equipment. And they do equipment audits all the time and I don't know how these things are getting missed. Probably because they are getting audited and not doing anything about it, obviously – or sorta temporary fixing instead of replacing [Interview 18: 9]

The risk of injury for workers and residents in utilizing equipment is compounded when a resident does not cooperate, is unable to cooperate, or is only able to offer limited cooperation. One participant commented,

Equipment is good only as long as it is working but it can malfunction – sometimes the equipment malfunctions. Residents not always cooperate... doing someone in a lift you could hurt yourself or the resident [Interview 3: 8]

The workload intensification and speed-up that characterizes restructured, and reorganized frontline work amplifies the physical demands of this work and the risks of injury. Despite the adverse health implications of intensified workloads and speed-up associated with lean production, these practices are not regulated through *OHSA*. Research in the auto industry (see Moody, 1997; Rinehart et al., 2001; Thomas, 2007; Thomas, 2008) similarly suggests lean production practices create intensified work pace and workload demands. In the section below, I discuss the nature and context of frontline worker injury in the production of care on the floor within LTRC.

Injury on the Frontlines

According to participants' accounts, the types of injuries frontline workers experience on the floor are numerous. These injuries may have immediate onset, which emerge from a single incident or gradual onset, which arise over an extended period – these are more frequently associated with injuries that transpire in the provision of care. Many of the injuries frontline workers encounter are MSIs such as strains and sprains that are related to physical demands of workloads on the frontlines of care. As one participant elaborates,

It's your knees, your hips, your back, your neck – everything. You are constantly going... And you have re-injuries on top of that. And we've had people who have injured themselves and have never been able to come back. There is the long-term wear and tear. In the old days, we used to lift heavy people – so, that's arm underneath the residents, arm and under their leg with another staff on the other side and we would lift them that way. So, staff age range now is late-40's, over 50. So, now you are seeing the effects of that. Bad knees, bad hips, and bad backs... It's the

worst job for a woman, nursing home work. What we have done to our body, with the lifting, running around on the cement floors all the time, and the wear and tear of the body [Interview 16: 7]

Other participants indicate these physical risks are often related to tasks that require repetition, force, or awkward positioning. According to this frontline worker,

A lot of it is a repetitive task, doing the same thing over, and over, again, muscles just gives up. Girls, a lot of girls are having all kinds of things – rotator cuffs in their shoulders, those things because of the lifting and the turning and the re-positioning and all that sort of stuff. You are literally taking on people [Interview 17: 6]

Participants’ discussions also emphasize the unpredictable nature of care labour and its relationship to workplace injury. As indicated in the previous chapter, participants repeatedly contrast the current organization and delivery of care within facilities to assembly line work. While factory work has its own complexities and nuances, unlike production on a factory line, residents are not passive in production of care processes. Residents may assert their autonomy, have other ideas, may not understand, may act, or react in ways that resist care practices and agendas, or in ways that are incompatible or counter to the objectives and intentions of frontline workers. As discussed in chapter 5, this highlights an important point in relation to how residents constitute an important element in shaping the work environment and influencing the labour process. As this worker explains,

Especially with Alzheimer or dementia the residents are always beating, or pinching, or biting at the workers. They don’t understand or they forget what it is you are trying to do or that you are trying to help them with. Sometimes they can be very aggressive [Interview 3: 8]

Unlike, factory work, the labour process within LTRC (and service sector more generally) is shaped not only through management direction and technology, but also through interactions with residents, which complicates the organization of work for frontline workers. In the service sector, “service triangle” or “trilateral relationship” is commonly used to distinguish between the worker and employer dyad to describe the

employment relationship (Bélanger & Thompson, 2013). In this sense, the “struggle for control” emerges between workers, residents, and management.

The element of unpredictability and uncertainty or where residents and workers are not “on the same page” with care processes, care manoeuvres, communication, practices, and time constraints imposed by Ministry and institutional bodies may intensify and/or create risk of injury for both workers and residents. One participant illustrates this challenge,

You are taking their briefs off and they are pulling them up. You are moving forward and they pushing back. You trying to clean, they grabbing at you, pulling your hands. You move this way and they go the other way [...]. Like, you have to use every part of your body to make it work [...] it's very hard. It's hard [Interview 13: 3]

Participants' accounts clearly underscore that frontline work is more than “body work” (Twigg, 2000; Twigg et al., 2011). Care is a relationship embedded in social relations. Communication, collaboration, coordination, and negotiation between resident and worker are critical, as are the context and conditions of care and work. As discussed above, this risk may be exacerbated when residents and workers are rushed in care interactions. It may also be intensified under current institutional approaches to care where relational, social, and emotional care is ignored over the emphasis on physical or instrumental tasks. As this participant elaborates,

The residents are so complex and their behaviours are all over the place it makes it a little more different, excitable, crazy. Something new everyday. Everyday. They have a lot of stories to tell you. They want to talk. They want to tell you about themselves. They want to tell you about their families. Some just want you to talk to them because they don't have anybody. But we have to rush, so...it's sad [Interview 4: 2]

Care processes and practices may be impacted by resident physiological, cognitive, or psychological challenges. Rushing care may also exacerbate frontline worker workload pressures and stresses that impede the safe execution of care manoeuvres and practices. While resident cognitive, physiological, or psychological

challenges may be consistent, these may also be erratic or episodic which means establishing and executing a predictable and regular care routine between residents and workers is not always possible. Workload and time constraints imposed by standardized and routinized government parameters together with institutionally established timeframes that align with efficiency expectations ignore complexity and variability and situate workers and residents at risk. This is particularly troubling when workers are responsible for more resident assignments because of overall funding constraints and work organization changes, facility understaffing and short staffing, and where standardized and routinized care agendas dictate the production of care on the floor. During participant interviews, workers consistently report that multiple, simultaneous, and competing demands characterize their work. Below, one key informant illustrates how workload, understaffing and short staffing combined with strict time pressures and timeframes may create and/or intensify risk of injury.

In the process of pushing somebody to the dining room uh, somebody is trying to push one resident in a wheelchair while also trying to pull another one behind you and then all of a sudden they may feel their knee go pop. Or they are trying to get two residents to the dining room because the race is on to get them there before 8:30 because of mandated requirements by the Ministry... and um they may be working short and they get them there. And then they go to stand up and can't move because their back has given out [KI Interview 19: 3]

The organization of work and approach to care that characterize LTRC facilities also intensify and create new risks for violence on the frontlines. In the next section, I discuss workers' experiences of violence within restructured facility-based care.

Violence on the Frontlines of Care

The nature of violence workers experience on the frontlines of care is physical, verbal, sexual, and racist. Like other psychological and physical risks, violence on the frontlines is also understood principally as a manifestation of structural violence – a

consequence of social, economic and political processes, policies, relations, and practices that shape funding, care arrangements, and the organization of work and conditions of care on the frontlines of care. Below, I present participants' experiences and perceptions of violence within LTRC. While the various forms of violence workers encounter may occur alone, participants' accounts and experiences reveal the types of violence often overlap, occur simultaneously, and/or are combined accounts of violence, all of which have adverse implications for workers' health and wellbeing.

Physical Violence

On a daily basis. Violence – it really happens daily. Every shift. It occurs a lot. Aggression is huge. Residents think absolutely nothing of hauling off and decking us, right [Interview 1: 3]

The above participant quote highlights the extent of physical violence frontline workers experience working within LTRC. Indeed, these descriptions are consistent with many participants' accounts and experiences that reveal physical violence as constant and ongoing, particularly during the provision of direct personal care. Research in Canada has documented similar findings regarding the extent of physical violence within the LTRC setting (see Banerjee et al., 2008; Banerjee, 2010; Armstrong et al., 2011). Participants repeatedly state they are at risk; many report working in conditions of persistent uncertainty. Workers indicate that the violence they experience is often “unpredictable” – it “just happens out of the blue.”

I don't feel safe. No, not safe at all. Like I said, anything can happen. I can go in and anything can happen [...]. No, I don't feel safe. The residents are often unpredictable... you never know what they are gonna do and that's it [...] one time, I was doing a resident, she was okay but then I bent down over her and next thing I know she had my hair, she had a fistful, and she would not let go and she kept pulling and pulling. By the time I managed to get away, my head was on fire. It hurt so bad [Interview 13: 4]

Participants describe having been kicked, punched, hit, slapped, pinched, beat, bit, choked, and spat on by residents. They have objects, diapers, and feces thrown at them.

Their uniforms are ripped. Their wrists or fingers are grabbed, twisted, and turned. Their hair is pulled and yanked. Their faces and arms are scratched, clawed, and gouged by fingernails. In the words of one worker,

There is days when you are scratched, and bit, and spat at in the face, and beat up [...] There is a lot of behaviour, a lot of behaviour. Some of them are physically aggressive behaviour and some are just resistive and combative [Interview 4: 13]

The accounts of physical violence that emerge from participants' discussions also suggest that the bodily sites of abuse by male residents are occasionally deliberate and gender-specific. The intensification of work and standardization of care not only heightens risk of injury through the physical demands of care work but it also increases violence-related injury and risks. As this participant illustrates,

A lot of injuries happen especially with girls that are working really fast and you are dealing with people who are aggressive [...] you are trying to get them done and you have to do it quickly, you could turn around and get it in the face or something like that or the stomach. I know this one girl she got badly punched in the face, her glasses dug into her face she ended up getting a scar. The glasses got totally broken and the facility would not help her with buying a new pair [Interview 17: 6-7]

Other participants indicate the physical design of facilities in which they work is inadequate and staff are not equipped or trained to manage violence-related risks.

According to this participant,

Very violent – the residents, it's very dangerous. Um sometimes, it's necessary to take three or four girls off the floor to do one resident. We do not have a lock-down unit and we are also not specialized or have training in working with major behaviours [Interview 5: 13]

Verbal Violence

The nature of verbal violence is often sexist, misogynistic, and racist. Participants describe frequently being cursed at and called derogatory names by residents. Workers are referred to as “bitches.” They are called “stupid.” They are called “fucking idiots.” They are told they are “fat” and “ugly.” And they are referred to as “cunts” and

“whores.” Participants also report verbal abuse from residents’ families. According to one participant,

You have some that are just not nice people, at all. They verbally abuse, and they will write letters on you and not just send them to your administrator but straight downtown to the General Manager. They take it to the top [Interview 11: 5]

A few participants indicate they do not view verbal abuse as violence. According to one participant,

Mainly for me, what I consider violence... is if I get kicked or slapped. Words I can kinda brush off or shrug off, I guess [Interview 18: 15]

Like the participant quoted above, several participants indicate having “thick skin” and try not to take the verbal attacks “personally” rather they just “let the verbal stuff slide.”

Similarly, this participant shares,

There is lots of verbal. I don’t take it personally. I mean you consider where it is coming from, right. The person, the disease, what kind of day they have had – so it’s not personal. Um, and most of the time it’s not even intentional. So, you have to let that roll off. Now, everyone has a breaking point. You get to a point where it is just hard to let it roll off, with some people. And some they absolutely mean it, and they are intentional... and I just walk away [Interview 7: 7]

Sexual Violence

While the sexual harassment and violence workers on the frontlines encounter have been observed, this form of violence has not received much examination within research or attention within government or institutions. Many participants spoke of residents commenting on their bodies. Others share how male residents expose themselves to workers. Several state that residents “grope and grab” workers or “touch their breasts” and “squeeze” and “pinch their ass.” Workers describe incidents where residents have “ripped their tops.” Some participants report they are instructed by male residents “in need of a woman” to “sit on their face” or to “crawl into bed” with them. Another worker shares how male residents attempt to “force and push” the faces of female workers “into their laps.” In the words of one participant,

I have a 38-year resident that calls you in the room as he is ejaculating. That's happened. Oh god, that's happened a lot. In order for him to have his pleasure and get a kick out of it, he has to call you in the room to ask you to do something. When you start hearing the moans and the groans, you know what he is doing. And of course, you are disgusted, and you walk out and leave. Some people can't handle it – one girl came out of there screaming [Interview 4: 18]

Participants frequently minimize the nature of the violence they are subjected to. This downplaying is reflected in their use of euphemistic language to describe sexual violence such as residents “hitting on,” “coming onto” “flirting” with female workers, or referring to this violence as merely “inappropriate” or “unacceptable behaviour.” The sexual violence perpetrated by male residents reflects and perpetuates a culture of misogyny and reinforces gender inequalities. Sexual violence threatens, violates, objectifies, degrades, and dehumanizes women. Many frontline workers do not feel safe at work.

Racist Violence

The hierarchically structured power relations that characterize capitalist society are mirrored in experiences on the frontlines. When asked about racism, one participant responds,

The situation that I said, looking at it that way with all of us there together – most of us staff there are immigrants, from different countries, working-casual, part-time. That is the only way I can put racism into it... this system [Interview 13: 13]

This account points to the drive to expand capital and maximize efficiencies through labour market flexibility. In practice, it has meant drawing on workers who have historically been treated as “cheaper” and “unskilled” forms of labour power. It has also meant the normalization of contingent or precarious work.

One participant questions the hiring practices of the LTRC facility in which she works. According to this participant, the facility is discriminatory as they only employ certain people of colour based on prejudices and stereotypes held about Black women.

Right now, it is 90 percent Filipino here. And I can't... for the longest time I've seen Tibetans, Indians, Chinese ... and if they hire Black people, it's not the Jamaican. They don't hire Black people like me, the Black people they hire are African. So, they won't hire Jamaicans like me anymore, or other Black people from the West Indies [Interview 9: 13]

But many participants struggle to recognize or acknowledge institutional or systemic racism embedded within policies, practices, and social norms within residential care. One participant precludes the possibility that other frontline workers could possibly experience racism and discrimination by co-workers and management – despite her co-worker's claims to the contrary – because of the diversity of the workforce in the facility in which she works. According to this participant,

Our workplace is very multicultural – like we have Italian staff members, Filipino staff members, Island girls from Jamaica and Trinidad, Somali girls, Caucasian girls, Asian girls, Spanish girls – our workplace is so multi-cultural that ... differential treatment because of their race or ethnic background, no absolutely not. Do they try to claim that? Yes, absolutely. But does it happen? No – not because of their ethnic background because it's multicultural here [Interview 4: 30]

Another participant claims,

It has never been an issue. Like, we have girls of colour, we have Hungarians, Portuguese, and no one has ever mentioned that they have been discriminated against [Interview 18: 16]

However, workforce inclusion does not mean the elimination of processes, policies, and practices that systematically facilitate exclusion or reinforce, perpetuate, and uphold social inequality within the workplace. One participant who identifies as a woman of colour states she personally has not experienced discrimination by employers on the basis of race and cannot relate to other workers who in her words “play” the “race card.”

According to this participant,

You have people that claim discrimination [...] they say management don't like black people, they are trying to get all the blacks out, you know. And they are not disciplining the Filipino staff [...] I have heard other blacks working in here say they get trouble, treated different because they are black. I know there is some people who don't want to work and they play that race card. For me, I have never experienced that. They say there is bias towards black people, and I said, what am I, I'm Black and I have not discovered that bias [Interview 2: 16]

Some participants' accounts imply workplace violence, such as bullying and harassment stems from racialized groups who represent the majority of workers within

the facilities in which they work, obscuring the broader conditions and relations of power that shape the organization of work and production of care. Several participants frame racism, racialized dynamics, and social relations on the care floor as cultural and language or communication tensions and differences. According to one of these participants,

Language because there are some staff that are accustomed to speaking very loud and the resident, resident family and the bosses take that as – take that different, you know. And the person is like well I don't see any problem, that's the way I speak. And they say no, you are speaking too loud and they can't see the difference [Interview 13: 12]

However, reframing this as “cultural” or “communication and language” differences operates to legitimize and/or minimize it as problematic. It ignores the context and relations of power in which difference is produced and reproduced. Below, one participant shares her understanding and frustration towards workforce cultural and language differences,

They don't communicate [...] there is an imbalance in nationality in there and it is mostly Filipino who have the weight [...] If you can speak English, but will speak only Filipino to your co-worker when I am right there ...it makes me feel like they are talking about me, like they have something to hide. Why can't they speak English? They speak English for their interview and to residents. But when around others, they speak only Filipino. I don't speak Filipino. They speak English when they got hired, what is the problem? It's one thing if you speak to resident when you share language then that's a different matter. So, I find that's not a good situation. It's exclusion. You come into the facility you will see the disparity with the nationalities in there [...] It can be very stressful and there shouldn't be just all Asians working there because Canada is not all about all Asians. It is all about all people. That is the Canada I came to [...] Risks, it is really staff against staff. This one wants to show that they can do the work, and this one wants to say this one is too slow. So, that is what I am up against. Staff against staff. You can complain but you know what? It is going back somewhere. And it's mostly Filipino in there and they can hurt you. They can gang up and hurt you [Interview 9: 17]

The racialization and antagonism between or amongst minority groups and/or marginalized immigrants during participant interviews was common. Several participants spoke of their anger and frustration about their own experiences of racism and discrimination on the frontlines of care while also expressing resentment and biased beliefs, prejudices, and stereotypes about other immigrant and/or racialized workers.

All participants highlight explicit forms of racism between individuals, particularly verbal racial violence from residents and residents' families directed at frontline workers. Participants report that "racial slurs", derogatory names, hateful comments, and racially charged terms such as "niggers" "ethnic black bitches" or "chinks" directed at frontline workers by residents are persistent and ongoing. This is especially true for workers working within larger cities and metropolitan areas where there are higher concentrations of marginalized immigrants and racialized workers. In a participant's words,

Some of the older residents don't want to be touched by black people. They call them slaves and niggers and stuff like that [...]. What seems to be common now because some of the residents, because some of the girls are coming from Pakistan and India and have accents that are very strong, and we have a few Muslim care workers [...] anyway she said, 'I don't want those turbine heads looking after me.' And we keep seeing more of that as the workers are coming from Iran or Iraq or wherever and getting this. It gets bad and out of hand [Interview 1: 20]

Racialized violence hinges on power structures and relations of power – that is, a hierarchy of dominance. Like other forms of verbal violence, participants state they try not to take racist violence "personally." According to several participants, the racial violence they encounter and experience on the frontlines of care is deeply embedded and is considered an inevitable and unchangeable feature of their work – "that's just the way it is," particularly when working with an "older generation" where it is "just their mentality" from that era. One participant states,

It is cultural diversity training and you know, if somebody was born in that war era, they are going to respond to you in a certain way. That is their mindset, they are not going to change – You can't change them but what can you do? Well, you can change you [Interview 2: 18]

Yet, cultural diversity training is about awareness, inclusion, and acceptance of diversity, not tolerance, understanding, and/or acceptance of racism as this account suggests. Racism is often minimized and as coming from residents who had simply "lost it", have "psychological issues" or were "not very cognitively intact." These accounts, however,

do not explain the blatant racism directed at frontline workers from younger residents and residents' families, nor do they render the effects or consequences of racism and violence on frontline workers' health and wellbeing visible.

While the violence workers experience in this sector is certainly not new, neoliberal-inspired transformations of labour processes exacerbate the violence by residents towards frontline workers. The extensive violence currently occurring within this sector is understood as one indicator of new and intensified risks workers on the frontlines experience in the context of work reorganization aimed at rationalizing costs and labour through gendered and racialized workforce flexibility processes and practices.

Indeed, many participants in their accounts are clear that much of the violence they experience on the frontlines is in part a consequence of the current conditions and organization of work and care. Participants indicate that because of inadequate funding, insufficient staffing, profit and for-profit principles and practices, constrictions on time for care and timing of care flowing from government and institutional timetables, frontline workers are rushed and residents are hurried or delayed. According to participants, this broader context has meant residents are not getting their physical, emotional, and social needs met. Adequate and dignified care is "impossible" under these conditions, as one participant explains,

They [employers] don't give a shit about their needs. They only care about the profit being made, to hell with care. Their [residents] needs aren't being met. Not a shock that it irritates the hell out of them. It would piss off anyone. And they are far away from family or they never visit, their spouse is dead, they have no family, their friends are all dead, and they end up being ignored. And you are the ones supposed to be caring for them. But we can't in the way that we want to. They may have never had a stranger look at their bottom before, and all of a sudden, you are stripping the covers off of them and washing them. You are a stranger. And you are rushed and there is only so much a person can take. And a lot of the time, they are at their limit. The behaviours are triggered because they are not getting their needs met, right. They are not getting the attention or the care that they need. Not even close. So, the behaviours are going to escalate. But that doesn't matter. They [managers] are clear they are not going to give us extra staff. Nope. The worker gets the brunt of that, right. I truly believe that a lot of the behaviours are because their needs are

not being met... And, you know what? They can't at all be met given the circumstances [Interview 1: 16]

As participants' narratives highlight, frontline workers often excuse the violence they face on the frontlines. Many are empathetic. Participants often regard violence as understandable, reasonable, and unsurprising given the context of care, including undignified, degrading, and dehumanizing conditions. Participants state they and any other human being would be "pissed," "ticked" and would "fucking bite back" if cared for under similar conditions in which social, emotional, and physical care is regularly disregarded or left undone. Working conditions are inseparable from care conditions – frontline workers and residents have a shared interest in safe conditions and adequately funded facility-based care. Like physical violence, participants are empathetic to the verbal abuse from residents, often locating verbal abuse in relation to disease, cognitive decline, and the poor conditions of care. Some, however, express that the verbal abuse they encounter repeatedly is wounding and indeed very painful whether it is intentional or not. As this participant shares,

[Residents] will tell us to shut the fuck up and call names. And I try to kinda ignore that, but I know its abuse. And it hurts. It really hurts your feeling that you really want to help but you get constantly abused like that [Interview 10: 10]

While recognizing the broader context that underlies why some residents may lash out and direct violence towards staff, participants' accounts suggest that the invisibility of residents' violence towards workers in part relates to the stereotypical "cute" and "sweet" frail elderly image that is incompatible with violence. According to one participant,

I think people forget that they are human beings and they are not all cute and sweet, you know. They can turn on you in a minute – and knowingly so. And it makes it sound like they are wild dogs and I certainly don't mean that either, but they may not be so cute and sweet anymore. And there is the possibility they may never have been cute and sweet [Interview 8: 21]

To be clear, this is not about blaming the resident for violence. Just as placing fault on the worker for violence conceals broader structural conditions, so too does faulting the resident for violence obscure structural conditions that may underlie and/or exacerbate violence on the frontlines. Although the characteristics of workers, residents, and workplaces are important, as indicated above injury, illness, and violence within this sector must be located in the broader structural and organizational context in which these occur. Other participants highlighted the ways they attempted to mitigate the risks of violence by prioritizing their work in ways to meet the needs of the most vocal and demanding residents (or residents' families). While this practice worked to minimize conflict and abuse, workers indicate this often meant that less vocal and the least demanding residents had to wait longer for care or simply go without.

Bullying and Harassment

Participants repeatedly describe bullying and harassment in the workplace. Several participants report that they have been targets of persistent and repeated workplace bullying. Others state that bullying and harassment is a widespread and major problem within their facilities. Some indicate that although they have not personally been bullied, they are nevertheless deeply troubled and affected by the hostile and toxic climate bullying and harassment creates in the workplace.

Some of the workplace bullying occurs between frontline workers. Other participants report extensive hierarchical, gendered, and racialized bullying from registered staff, supervisors, and management. Participants also report experiences of bullying, discrimination, and harassment from residents and residents' families. Participants spoke of ongoing intimidation, marginalization, verbal abuse, work sabotage,

offensive conduct, withholding assistance, and excessive demands. They state they have been cursed at, yelled at, shouted at, and screamed at. They have been called derogatory names and threatened with bodily assault. They have been targets of eye-rolling, obscene gestures, and gossip. They have been subjected to exclusion. They have had their personal property vandalized or damaged. Several feel they are unsafe in the workplace because of their experiences with workplace bullying. As one elaborates,

I don't feel safe. I was paranoid for a while after incident. I don't want her [co-worker] to suddenly show up in the room and I will be cornered and can beat me half to death without anybody [...] Sometimes I am kinda paranoid. Like, when this person is attacking me all the time and bullying me [Interview 10: 17]

Participants report bullying amongst staff, often referred to in the literature as “horizontal violence” or “lateral violence” is common. The bullying between workers however is occasionally hierarchical in nature or status-oriented in terms of worker employment position (full-time, part-time, casual, agency) and/or linked to seniority. For instance, participants frequently mention the bullying between frontline workers with seniority and frontline workers with less experience, positional rank, and security within the frontline worker hierarchy. According to this participant,

You see a lot of that there is a lot of bullying on the floor and it's usually because of seniority. These girls can't be touched.... So, all the old timers, some girls have been there for 20 years and they start bidding on the sections, and halfway through the shift they are standing at the nursing station twiddling their thumbs and gossiping. So, the way the environment is, it is set up for that [Interview 17: 10]

While recognizing the conditions of work in which bullying occurs, some participants downplay bullying on the frontlines and locate bullying within gender-stereotypes explaining that bullying is just a by product of “emotional” older women. According to this participant,

Like, we've had bullying and harassment that kind of thing because sometimes they don't realize the extent how they are making someone else feel – cause you can in a place like that, because these are older women. But you also get emotions and some can come across as being mean and

that, and bossy, telling staff what to do. And some people are more leaders and come across as being bullies. There is intimidation. People that want things done their way. And some people can be really intimidating. And sometimes, I think staff don't realize what they are being like. It is so hard and busy in there that it's sometimes hard to stop and think. You do get emotional, people get emotional, people get upset, like tensions are high and it happens [Interview 16: 22]

The above account assumes leadership and bullying are on the same continuum, different degrees of the same thing, not contradictory. Given the conditions of work, bullying becomes a normalized and inevitable component of how the work gets done – “it happens.” Participants more secure in their positions and actively involved with union activities discussed how they handled the situation of bullying and harassment with other frontline workers. For example,

I've had harassment...and she was also rude and I finally said to her, you know what? That's harassment. And I copied the policy on harassment and gave it to her. Not a lot of people would go that far in dealing with a situation, they would be intimidated [...] but I gave her the sheet of paper with the harassment policy and she ripped it up in front of me [...] But you know, ever since then I haven't had a problem with her [Interview 16: 23]

Many participants discussed the bullying workers experience from supervisors or registered staff that is in part rooted in the unequal power and hierarchical structures and arrangements that undervalue frontline workers' skill and knowledge and discourage and/or obstruct involvement or consultation in work organization, care planning, and decision making. It is also a product of perceived gender, generational, and racial and ethnic differences, which serve to justify and reinforce discrimination, harassment, intimidation, and exploitation. According one participant,

It is like back in slavery time long time ago [...] they think because I am Indian that I am a damn idiot. They don't know how to talk, like they don't talk like they would talk to their own people. It's very stressful [...] Because I don't speak much English uh I don't understand their slang and those stuff, the slang way of talking is really bossy and really maltreated the staff. The slavery generations are maltreated. Sometimes for their own people they will, they will do everything. But for us, even though we work there, sometime they wouldn't pay us for a week [Interview 12: 5]

Others describe bullying within the context of gendered and hierarchical power imbalances.

This guy had a real disrespect for women, real intimidating and he would have a meeting with girls in his office, close the door, they would feel that this meeting wasn't the way they would want it to be so they would want to leave and he would hold the door and say you can't leave. Blocked them from leaving cause he wasn't finished talking [KI Interview 19: 14-15]

As the participants indicate, the impact of bullying are far-reaching and affect everyone in the workplace, not just the workers targeted. In the words of one participant,

It [bullying] was a huge, huge, huge issue. It went from being like a snowflake to being like this monstrous snowball [...] it does a lot of damage in a home. The management at the time did not deal with it. But the new management finally dealt with it and the problems went away. It was a charge staff, an RN, she was intimidating [...] she demeaned girls, she would intimidate... a lot of it was intimidation. She would intimidate a lot of the girls, she would mock and make fun of them in front of other staff it was really quite ignorant [...] it was always worse because when she was on shift she would get the RPN going at the same time. And both of them would kind of tag team and it was just a nasty mess. It was a nasty mess [...] needed a knife to cut through any of the tension here. But the girls were scared of her [Interview 18: 14]

This account also draws attention to the collusive and mobbing aspects of bullying. Several participants use terms such as “cliques”, “groups”, or “communities” to describe the bullying and intimidation by more than one person. Other participants highlight the emotional and physical consequences and harm from ongoing mistreatment. The experience of bullying and harassment can create significant isolation and stress. The shame and fear one participant experienced with being a target of harassment by a supervising RN prevented her from revealing the situation to others, including her family. As this participant elaborates,

I have been bullied and harassed. I was harassed continually for two years. That's why I am on afternoon shift now. I was on days and my RN, I was harassed daily by her to the point where I had very high blood pressure [...] my blood pressure then was off the charts and my poor doctor – he kept trying to level it out, give me different pills and stuff like that – but I just kept having to go in. It was from work and it was so bad, cause we had conflict [...] But I was harassed. Daily. And I was even afraid and ashamed to tell my family that because they know me as someone who doesn't stand for stuff like that but at work – well, different. I was being harassed [Interview 13: 11]

When bullying and harassment is a consequence of the way in which work is organized, this finding can be understood in relation to research on work organization and stress

where less secure employment or uncertain work and support is linked to poorer health outcomes (Lewchuk et al., 2008; Barnettson, 2010; Lewchuk et al., 2011).

Other participants describe what they understand as employer bullying in relation to the organization, supervision, and conditions of work. That is, the organization or employer itself is the bully. As a participant points out,

This is the way it is, do it. And when you don't do it, there is a meeting. They [management] try to drill it in us even more that this has to happen [...] and it just creates a lot of anxiety among the workers, like all of us. It's like wow. I don't even know how to put it into words. It's just really – the atmosphere is just really... it is not a nice atmosphere at all. I mean it made me sick. So, what happens if they [residents] don't eat by 8:15? We'll have a meeting... then another meeting. It's intimidating is what it is, you know, I feel intimidated by these meetings. By all these managers, telling you to do something that is next to impossible. It is absolutely intimidating [Interview 11: 3]

The culture of blame that holds frontline workers responsible for the violence they experience also constitutes a form of bullying – and indeed, structural violence.

Many participants indicate having respectful and supportive relationships and exchanges with residents' relatives. While all participants indicate that some resident families are supportive, these comments are more common for participants who indicate working in facilities in rural communities or smaller towns where frontline workers and resident families have greater familiarity with each other within and outside the residential care setting. That said, according to participants, bullying, harassment, and discrimination from some residents' families is a regular occurrence. While sympathetic to their frustration, workers resent the blame and displaced anger directed towards them. As this participant shares,

Family come in, give you a look, and treat you like you are a piece of crap. I can understand the family's side of it because they want their parent taken care of properly. Sometimes I can understand their frustration but it is not a cause for them to be mean and malicious or vindictive or disrespectful to the staff [Interview 4: 33]

Participants report ongoing demands from the relatives regarding how and when care will be provided puts greater pressure on frontline workers in the context of understaffing and places frontline workers at risk. Several participants report threats, intimidation, and harassment from relatives of residents in their demand for immediate care for their family member. These participants' accounts illustrate the role resident' families may have in shaping the labour process alongside management, workers, and residents – creating conflicts, tensions, and ambiguities within these (albeit uneven) relationships.

Psychological Risks

It is widely recognized that the organization of work also creates psychological risks. Research conducted over the last few decades (see Karasek, 1979) has demonstrated the relationship between work organization, job control, and social support, and health outcomes such as stress, depression, and anxiety. While research that examines the impact of occupational stress on health has been increasingly common, much of the earlier research paid little attention to the experiences of women, particularly within women dominant sectors. High stress conditions of work are characterized by poor remuneration, high demands such as excessive workloads and inadequate time, and low worker control in relation to decision-making and autonomy (Karasek, 1979; Karasek & Theorell, 1990). Research has also examined health outcomes associated with working conditions and stress. This includes the impact of precarious work on worker health (Lewchuk et al., 2008) or “employment strain” – that is, the interaction effects of employment relationship uncertainty, employment relationship effort, and employment relationship support (Lewchuk et al., 2011). Precarious work or labour insecurity is

related to significant increases in poor health, depression, and anxiety (Lewchuk et al., 2008; Lewchuk et al., 2011). Reported levels of stress are often greater in “caring work” where there is direct responsibility for others in contrast to work that encompasses the operation or handling of inanimate objects (Doyal, 1995).

Women often occupy high demand and low control occupations (Armstrong & Armstrong, 2010; Daly et al., 2011). High demand and low control is consistent with participants’ accounts and experiences of their working conditions on the frontlines. Transformations in the LTRC workforce and employer preference for part-time and casual workers also create enormous stress for frontline workers who are forced to work at multiple facilities, often without sick-time or benefits, or control over scheduling.

Emotional Labour

Frontline workers engage in significant emotional labour on the frontlines of care. The concept of emotional labour (Hochschild, 1983) – or the expectation that workers conceal real emotions using expressions that outwardly portray positive emotions is relevant to understanding the emotional health of frontline workers (also see Chapter 2). Participants frequently comment on the considerable amount of emotion work they have to perform on the frontlines of care in order to manage the conditions of their work and maintain “the caring role.” Participants highlight the stress of the ongoing management of emotions in the context of high demands, low control, an absence of support, and violence on the frontlines of care. Emotional labour and emotion management on the part of workers highlights the important role of the resident in shaping the labour process on the frontlines of care alongside management. The regulation and management of emotions by workers that align with gendered constructions and assumptions about care

and nurturing is one mechanism of organizational or workplace control. In the execution and/or manufacture of emotional labour in line with social and organizational expectations, frontline workers reinforce these as “natural” abilities and further perpetuate the undervaluation of emotional labour associated with “women’s work.”

Participants’ accounts also emphasize their emotional labour as an important skill they employ in the management and regulation of the emotions of others in their struggle to shape and influence the poor conditions of their work. According to one long-time worker on the frontlines of care,

I’m the type of staff that no matter what is going on in personal life, I try and not bring it to my job. I may be tired and cranky – but when I walk in them doors I better put a fake smile on my face. I don’t care if it is fake. I am going to walk in my residents’ rooms and give the biggest fake smile, even though I don’t feel like smiling – because if I come in with a scowl on my face I know they are going to be scowling right back and I know I will be in for one hell of a day. So, I put a smile on my face no matter what, whether I am feeling down in the dumps or not. Like, today I was exceptionally tired and I am off tomorrow, and I thought you know what, I don’t really want to be here but I will not show them that. I go in there, I put on a happy face, and I’m going to go about my job. And that’s what I did and I went home at the end of the day and you know what all my residents were happy with me today. So perfect, job well done. So, that’s how I know at the end of the day I’ve done something good and I feel good about that [Interview 18: 17]

This account illustrates contradictions with emotional labour. That is, while an exploitable and undervalued labour power, emotional labour may simultaneously have both beneficial and adverse consequences for the conditions of work and workers’ health and wellbeing.

Other participants highlight the importance of social location with respect to emotional labour. One participant points out not only the gendered aspects of emotional labour but also the racialized and classed dimensions. That is, the differential expectations of behaviour and emotions, which emerge in relation to who is engaging in emotional labour on the frontlines of care and with whom. For this racialized worker of immigrant status, emotional labour meant maintaining not only a caring role with

residents but also one that encompasses servitude, which requires her to be submissive, obedient, pleasant, and to “keep her head down.”

Stress, Anxiety, Depression and Burnout

Participants repeatedly state that understaffing, excessive workloads, intensified work, and emotional and physical demands of their work create many mental, emotional, and physical symptoms of stress and burnout. In the words of one participant,

You are seeing burnout a lot faster. I have this one guy umm who has worked in our facility for maybe seven years and it was funny after maybe three years we were sitting down in the staff room and he says I am getting burnt out. I said burnt out? I said you are 25 years old – you are a fit guy, what the hell is the matter with you? He goes I don’t know how you do this – you must be a different breed of people. I took offense to that [...] the younger generation is not going to be able to do it. They are not going to be able to take the stress that is just getting worse. In the last five or six years there has really been a decrease in the care and it’s because of the more requirements that are needed from us. It’s stressful and it isn’t getting any better [Interview 1: 7]

Many participants recount their experiences with chaotic, intense, and demanding working conditions and the psychological and emotional impact of these working conditions. Below, one frontline worker shares her “breaking point” moment.

I’m running around and um it was so bloody hot... It was 54 degrees in the tub room, like the residents are cold, they have circulatory problems, and they don’t move around, and they are given their baths and they want scalding hot baths and the girls are sweating their heads off giving baths [...] Anyway, I was driving home and I said to myself, what is that awful smell? It smells like shit! And it was. *It was*. I had put a peri-cloth I used to wipe up somebody’s feces instead of throwing it in the laundry, I had wrapped it – I thought it was the towel I had used to soak down, to keep our heads cold in the bloody hot tub room. I had actually wrapped a peri-cloth full of feces around my neck. I was too busy to notice this until I got in the car and I was driving. And that is when I started crying my head off and couldn’t stop. I seriously couldn’t stop. I thought this is too much! I’m burnt out [Interview 17: 12]

Other participants stress how the changing resident base and nature of demands and preferences for care are a constant source of stress, conflict, and tension between residents and frontline workers. According to workers, these are incompatible with the current organization of work and approach to care. One participant elaborates,

We don’t have the time – we don’t have the staffing or the time. The residents coming in, the younger people – I say younger, they are 60. They want things done at a slower pace, we have so much to accomplish in so little time, and they don’t care. They don’t want to hear any excuses from us. They don’t want to hear, you know what I would really love to do that but I have nine or

ten other people. They. Don't. Care. This is my time and you are going to take your time with me. It takes me 25 minutes for you to help me get dressed and washed – then you are going to take the 25 minutes... So, right now, I would say our levels don't reflect the dynamics of the people that we have in the home. Because they do require – maybe not always more care but slower care. They want their care slower. They don't want wham-bam-thank-you-ma'am, and there you go [Interview 18: 6]

This participant account also highlights the “struggle for control” over the labour process that transpires between workers, residents, and management. Other participants highlight the ways in which the commotion and noise level of the LTRC environment impacts their health and wellbeing on the frontlines of care. As this participant describes,

The noise in that place... you really hear it at mealtime and at our facility because everybody is integrated into one large dining room, it is very loud and very noisy. To me, that is just – it just drives me nuts at mealtime. It's extremely stressful. I am trying to talk to my residents very calmly and get them to eat and the place is just like a zoo [Interview 18: 13]

While many participants state that continuity of care is important, participants' narratives also reveal tensions and contradictions that emerge with continuity of care in the context of high demands and low control. Participants state that consistently working with the same residents with complex needs and demands is exhausting, stressful, and draining. One frontline worker describes the situation this way,

Like, I do understand the idea around continuity of care. I get that. But sometimes you got to think about the workers. And being a small home we should be able to rotate through our whole building every once in awhile and know every resident and their needs. These people can be here a long time, right. It's a lot to face the same residents hurting you every day [Interview 5: 23]

This is particularly an issue in the current context of understaffing, heavy workloads, higher resident demands and complexities of care, including dementia care, which can be very stressful and wearing. These conditions of high stress, competing demands, and low control are also alienating for workers on the frontlines of care. Many participants discuss the struggle and stress of not being able to provide the dignified and quality care that they are trained to provide and that residents deserve. In the words of one participant,

Our jobs are emotionally draining. It really weighs heavily on us. And we are all in health care for a reason because we want to be there, make a difference –well, most of us. We want to make a difference to residents’ lives and to see how they are treated, not by us but because of the damn system – it pisses us off, and that weighs heavily on us. So, I think we have a lot of emotional baggage that is really stressing us out. And then see and hear all these scandals in government and you think, you just blew how much money and that could have been spent on health care? It’s just emotionally draining and frustrating [Interview 18: 17-18]

The situation of systemic neglect and abuse of residents is a consequence of lean, intensified work arrangements, and standardized and routinized care oriented to economic efficiencies and/or profit. This situation creates deep frustration, stress, and suffering for frontline workers.

Death of Residents

It’s emotional, mental draining. Emotionally, we get attached to them [Interview 3: 8]

Participants repeatedly discuss the relationships and attachments they develop with residents. Indeed, frontline workers often spend many years providing care to the same residents. Many participants refer to residents endearingly as “my people” and describe them as “a part of my family” or being “like family.” As these participant share,

They are my entire grandmas and grandpas that I never had. I would say they are my surrogate family – and I am theirs however you want to look at it [Interview 4: 3]

Inevitably, residents die. Changes in resident base such as higher acuity levels and complexity of care means resident deaths may occur more frequently and the possibilities and moments for frontline worker grief will become more common.

Home/Work

Many participants note that management actively discourages the intersection of work and home stating that when it comes to matters of the home, workers are expected to “leave it at the door.” Other participants note how facilities have policies prohibiting cell phones on the floor to facilitate this division. According to some participants, it is

impossible to bracket the stresses of home when at work. Frontline workers indicate they often cannot wait to finish their stressful and demanding shifts. According to one worker,

You don't feel like coming back in. When I'm done, it's a relief when I finally finish. But then you know you have to be back again tomorrow. I cannot perform any more I am too tired. All I want to do is to sleep. I can give no more, no [...] I get home from work I get into my pyjamas and lie down on the couch or on the carpet [Interview 10:6]

Nevertheless, workers report it is extremely hard to leave the stress of frontline work at work. Several participants discuss the ways stress of frontline work bleeds into their personal lives.

It's so hard. It's hard not to bring your home life to work, so that's another stress. For me, I was missing out on my children's lives. So, I started to feel like I was the absent mother [Interview 16: 19]

The blurring of work and home has important implications for social, physical, emotional, and psychological wellbeing. A participant states,

I have trouble sleeping at night. And when I do sleep, I dream of residents. I tell everybody at work it's no wonder I'm tired, I work all day and then I'm working half the night cause there are buzzers going in my head. And yeah, I can't shut it down, still processing it [...] Like, it goes on and on in my head. I just can't walk out and forget it. Nope, I can't. I do try. And I'll talk to my kids and they'll say, 'it's done Mom, it's done.' But it just doesn't stop. Because you know, you think, because you are dealing with human beings, you think, how could I have done this better? [Interview 8: 6]

One worker highlights her struggle to separate work and home,

I used to worry about that place all the time. Umm I've got so much going on in my life like I've got grandkids and family and so on my days off that's what I concentrate on. I don't let it run my life any more. It did at one time and it got to the point where I was like you know what I am really feeling stressed because I am always talking work, thinking work, working work – oh my god, I got to give it up. And it is hard to detach from that because it's the nurturing. But instead of worrying about that now I nurture, I nurture. I take care of the family. I just – my days off are my days off and I distance myself from the home and I pour everything I have into my grandkids and my daughters and everything and we have fun days on my days off. Cause if you don't this job will eat you up. It really does [Interview 18:18].

Other participants share how they feel after a shift, their struggles with the physical and emotional demands of this work and their mental and physical exhaustion.

Drained. Totally mentally and physically exhausted. It's exhaustion. It is not even feeling tired. You're exhausted. I come home and sleep for a good two hours after work. I just sit down on the couch and it's just like oh my god. It's just like this big weight that is just dragging me down for a while. It's like wow. It is very exhausting [Interview 18: 17]

A number of participants emphasize their challenge and struggle with the muddling of home life and work and the implications for physical and psychological health and unwaged care work. One says,

When I come home, it's like I'm very tired. Like, I don't have a brain. When I come home there is pain here, and here, and here. It's like nothing inside [...] I come from a country we not used to these jobs. We don't need to work, maybe a garment job. It is hard. Life is hard here. Right now I find when I come home I am like useless for my family. It's like a no use of a life. It is very heavy... The family life, so we cannot function when we come home for two, three days. The muscles, body tired, depressed mood. Everything is painful. Neck. Back. Everything. It's like dead body. You have dead body when you come home. I am good for nothing. I realize I shouldn't be like that. My child suffers. I ignoring child and ignoring my other work [Interview 12: 16]

Like most frontline workers, these women go home to another job – or their second shift. Women most often assume much of the responsibilities relating to home and child rearing (Armstrong & Armstrong, 2010). Waged work and unwaged labour at home impose constraints and barriers within which frontline workers negotiate and manage their everyday/everynight lives. One participant describes her need for personal time and space following waged care work and assuming responsibilities for care work at home.

My husband used to pick me up from work. And I had to tell him to stop picking me up. Because when I would get in the car, he would start talking about what's going on at home and all this stuff and I yelled at him. I said I don't want to hear it. I just want peace and quiet. Please just give me some peace. So, I stopped him from picking me up after that just so I have some downtime [Interview 13: 8-9]

Another frontline worker shares how she transferred to the night shift as a way to manage the stresses, responsibilities, and demands of her care work in the home and care work on the frontlines. A few participants state they are often too busy and consumed on the job to even think about matters of home life. According to this participant,

It's hard on your mind – you have to be able to shut it off when you walk in the building and shut the work off when you walk back out, right. If you have any stress in your life, you don't even have time to even think about. It's so busy – like, it's go-go-go-go [Interview 16: 5]

But even for these workers, once home, the boundaries between home and work often collapse. Below, this participant discusses her own health concerns and challenges following her decision to arrange her waged labour around the wellbeing of her family by transferring to the night shift at the facility in which she works.

I got to the point where enough was enough and my family had to come first. And in order to sacrifice for my family I took the midnight shift... and it's hard to do the midnight shift. The work on the shift isn't as hard or busy as days or evening but working nights is hard because it is harder on your body. I don't eat properly. I don't feel like eating healthy foods, there's a hormone that makes you feel like you crave more stuff, you crave more carbohydrates because you are higher on that... oh god, my hormones are thrown out of whack too. And, like you don't sleep the same during the day as you would at night [...] it's hard on your body and that to flip back and forth and you aren't getting decent anything. You aren't rested, your mind, body – it's not rested. I'm not functioning properly. It's very difficult, that's another aspect [...] you get so overtired that you're... it's like the walking dead [...]. I can't drive, I can't function properly – like if I did get into an accident it would be careless driving, like it would be like I'm impaired because there is that sleep deprivation [...] Working nights also puts a damper in my social life [Interview 16: 19- 20]

Conclusion

The conditions of work and care within LTRC are understood as structurally violent. Many of the risks that arise in this setting are a consequence of policy and funding decisions and the organization of work. There are numerous physical and psychological risks associated with frontline work. Yet, the degree of risk and injury on the frontlines are often obscured and run counter to dominant assumptions about care work. The physical risks frontline workers encounter in their everyday/everynight care labour include repetitive movement and over exertion associated with resident lifts, repositioning, and transfers as well as in relation to assistance with resident ambulation and personal care such as feeding, dressing, and bathing. Physical risks of care work are associated with the degree of effectiveness in communication and coordination between workers and residents in the execution of care procedures. Equipment failures, poorly maintained machines, and the hazards related to working within older buildings with

inadequate layouts and space for the needs and levels of care characterizing current resident populations may require workers to labour in confined, awkward, and cramped spaces.

These challenges are compounded by an orientation to care that privileges economic efficiencies and/or profit, not care and work conditions. The intensification of work on the frontlines of care poses serious physical risks, which may impede the safe execution of care work practices, such as proper lift procedures or manoeuvring equipment. Gendered constructions of care, approaches to care, understaffing, short staffing, and inadequate orientation and training create and exacerbate risks yet the implications of workload intensification and speed-up are often concealed as workers struggle to make up for government and institutional cutbacks oriented to maximizing efficiencies and/or profit. Moreover, frontline workers are regularly exposed to violence, bullying, and harassment. The violence frontline workers encounter is physical, verbal, sexual, and racist and is understood as fuelled and aggravated by the organization of work. There is also the risk of infection or injury that are related to the physical demands of this work that are further compounded by the lack off staff but also the inadequate provision of basic supplies such as gloves and sanitizer or functioning equipment. The emotional labour required of frontline workers, and the organization of work characterized by high demands and low control creates and/or exacerbates psychological risks as well as worker alienation. This includes experiences of stress, depression, anxiety, burnout, and exhaustion. Moreover, given gendered expectations of care, frontline workers struggle with the demands of care on the frontlines and care work at home.

The next chapter of this dissertation explores institutional and organizational responses to participants' health and safety concerns and participants' perceptions and experiences with reporting injury, illness, and violence as well as examines factors that shape sickness presenteeism on the frontlines of care.

Chapter 7: Health and Safety: Invisibility on the Frontlines of Care

In this final chapter, I continue my primary data analysis of workers' experiences and struggles on the frontlines of LTRC. The chapter is organized into several sections. First, I explore participants' perceptions of management's response to workplace health and safety concerns and their experiences and struggles with reporting workplace risks, including injury, illness, and violence on the frontlines of care. I then discuss participants' experiences with Workplace Safety Insurance Board (WSIB) claims and return to work practices provided by their employers. The limits on reporting and return to work practices along with facility attendance management programs contribute to the "sickness presenteeism" amongst frontline workers I discuss in the next section. Following this, I discuss frontline workers' perceptions of workplace health and safety committees. I conclude the chapter with a brief discussion of what psychologically and physically safe LTRC workplaces look like from the perspective of workers on the frontlines of care.

The participants of this project express deep concern with respect to their health and safety in the LTRC setting. From their perspective, the health and safety of workers on the frontlines of care is not a management priority. As one participant elaborates,

I just find that the employers don't care about employees – like your health or your safety or anything as far as I'm concerned [...] Management don't give a damn, they have another agenda to fill. I know they don't care about residents and I know they don't care about employees. I mean every one of those managers, not just one. Every one of them. It's pretty bad there [...] The City has cut back, I know they have done all that but it's, they cut back and never thought about, you know, the mission and the statement and all of this is resident and safety, and the residents come first but you wouldn't think that is the case the way they want you to work there. You wouldn't think that the residents or safety is important or comes first or a priority. To me, it's not – they are just looking I think – management and them are just looking at the numbers, you know, trying to keep everything down, and keep the big bosses really happy by keeping down the numbers, and it's just impossible. And I don't feel safe. A lot of us don't feel safe working under those conditions [Interview 11: 7]

As participants' discussions highlight, frontline workers expend a considerable amount of energy and time struggling with employers to secure the most basic of supplies and resources to do their work. While the discourse of health and safety amongst employers is prominent, actions that reflect this discourse are not. According to this key informant,

Care, the work environment, working safely, are all really great phrases that get said a lot by employers but when it comes down to the actual production of work – it is just get it done. And the general employer attitude is, I don't know how you are going to do but don't let me catch you doing it wrong because I am going to punish you for it. But if you are doing it wrong and I don't actually catch you... then some of the employers turn a blind eye to that [KI Interview 19: 2]

The above quote is consistent with other participants' accounts of how frontline workers, who in the absence of support and appropriate resources, are expected to “figure it out” on the frontlines. The completion of work is prioritized over how and under what conditions the work is accomplished.

Below, one key informant highlights the treatment of frontline workers as disposable commodities in the drive for greater profit. That is, injury and illness are treated as an expected and accepted consequence of lean production of care processes within the current gendered and racialized care regime of profit-oriented LTRC, wherein the need to generate profit shapes the labour process, organization of work, and under what conditions. As this participant elaborates,

With the for-profits in the industry, if they could automate care or turn into robot the health care workers would be out for sure. Because the job is physical and it requires people to do it they seem to think of the workers as a commodity that is exchanged based on wage for cash or profit margins or something. Once you become injured, you become disposable and they want to get rid of you. Bring on the next group of people that they won't take care of and who will get hurt and injured. The employer knows there are lots of people to take the worker's place. It's a disposable work culture that just keeps turning people out like product. That's staff, not the residents [KI Interview 19: 20]

Similarly, another participant states the profit impulse is privileged over residents and workers. The drive for profit, facilitated and reinforced by state policies, processes, and practices, dictates the organization of work and approach to care within LTRC.

How can you justify a CEO making almost two million dollars when residents are neglected and workers get hurt because there isn't enough workers and then workers get fired because somehow it is their fault. How can the government allow that? That is so very wrong. When you are taking away peoples' dignity to get profit, it is just wrong [...] Profiting over the safety and dignity of others. It's just wrong [Interview 1: 26]

Although the participants quoted above limit their criticism to for-profit facilities, it is important to emphasize that the drive to employ for-profit techniques, maximize efficiencies, and reduce costs across the sector, places workers and residents at risk. This includes reliance on flexible and lean work arrangements (part-time and casual workforce, chronic understaffing, and short staffing), and approaches that emphasize standardization and routinization of the production of care. Participants' discussions emphasize that government funding cuts and institutional efficiencies regardless of facility ownership type have disastrous implications for relations, the conditions of care and work, and health and safety on the frontlines of care. Connecting working conditions to care conditions is central to current union efforts to improve workplace health and safety. According to one key informant and union official,

I have heard a lot of groups starting to use the phrase of 'the time to care' – 'time for care.' The ability to care is one thing but providing the proper amount of time to care is also there. And that's why we do a lot of work on trying to campaign to the government bodies for a measurable level of care – a minimum standard of care that is mandated that all residents would have to have (KI Interview 19: 2)

While this connection is important – workers' rights and residents' rights may be conflicting. Frontline workers' rights to safe working conditions need to be understood alongside but also as distinct from residents' rights to good care conditions. The health and safety of frontline workers is important in and of itself.

In terms of the physical environment, several participants state management routinely ignores their complaints about respiratory problems as well as poor building ventilation, heat and humidity, water leaks, and the presence of mould within facilities. Similarly, participants state that management consistently dismisses frontline workers' safety concerns in relation to poor building security, and overcrowded, cramped conditions that impede the safe execution of care and/or create further health and safety risks for residents and workers on the frontlines. According to this participant,

The space concerns, management doesn't listen to them. If they have a concern and they bring it up to the employer, they just shrug their shoulders and walk away. They don't even deal with it [Interview 18: 8]

Another participant shares that despite frontline workers' reports and repeated complaints to management, malfunctioning equipment is not replaced and instead remains on the floor. When one worker sustained serious injury when using this equipment, the blame was transferred to the workers involved when the injury occurred. As this participant explains,

The company said, 'well, that shouldn't have been on the floor, where did that lift come from? How come it was on the floor? And this lift had been on the floor for years, but all of a sudden, they want to act like they had no idea that this lift was on the floor and it was being used. The blame was of course put on the workers [Interview 4: 29]

The approach management employs to workplace health and safety is often short sighted where decisions are tied to immediate economic costs. As this participant states,

They [management] look at very short-term. If it is not in the budget, pass on it cause it is gonna cost me. Oh my goodness, it is going to cost me \$2,000 for that but not look in the long run. What if you have three people get injured on that piece of equipment or faulty equipment or something – it'll cost more [...] but they don't see the long-term effect, they just see what's at the moment. It's pretty darn frustrating actually. It is very frustrating. Health care is not – like I said, I started 24 years ago and it has really changed over the years – and you would think that it would change for the better – but it just hasn't [Interview 18: 8-9]

Several participants describe employers as being more concerned with the appearance of LTRC facilities than with the work and care conditions within facilities. Below, one participant elaborates on this concern,

We had an outbreak and I said to them [management] why can't we wear gloves while we are feeding, you know, to prevent more people getting sick with this flu? Their response was, 'it doesn't look good' [...] They have their pretty little pictures and their brochures that they put out – come and live with us here, this is what it is supposed to look like, okay. It is about how it is supposed to look, not about the reality in long-term care [Interview 17: 8]

In this account, aesthetics are privileged over workplace health and safety, including infection control and prevention. This is one example of the contradictions and tensions between the “home-like environment” rhetoric of institutions and government and the experiences on the frontlines of LTRC. While frontline workers are regularly trained in infection control as part of Ministry requirements – in practice, the application of this knowledge is constrained by decision-making processes and interests that have little to do with care, the realities of LTRC, or workplace health and safety. According to a participant,

Management started going off on how we went through 22, 000 gloves last week [...] We looked at her and said you are the one that is pushing infection control. You have had us in three meetings in the last two weeks about infection control. So supply the gloves, or we don't come to work [Interview 7: 13]

Several participants express frustration that mandatory facility inspections under MOHLTC regulations to monitor standards compliance are mere formalities that do little to improve overall facility conditions and quality of care. Below, one participant raises an important point in relation to evidence and the criteria used to measure and assess quality of care in LTRC.

The Ministry has got this new system of rating homes [...] 95 percent are what you call substantially compliant. So, they measure what they want to measure and they say everything is fine in those 500 plus homes. Well, they are not. They are not [KI Interview 15: 14]

Participants report that it is common for facility operators to be informed of Ministry inspections times and dates prior to the inspectors visit. For example,

LTCs are not supposed to know that the inspectors are coming but obviously, somebody is tipping them off. I think it is certain inspectors who are cozying up with the administrators, who are telling them they are coming... so make sure everybody is there, right [KI Interview 15: 10]

According to some participants, this practice allows management to up the staffing levels for inspection dates in order to facilitate an impression of work and care conditions that differ substantially from their experiences on the floor. From the perspective of participants, facility violations flagged by inspectors are often trivial in nature compared to broader structural and organizational problems that underlie poor conditions of work and care. As one key informant elaborates,

PSWs tell me that sometimes the stuff the inspector picks up on just makes them want to scream. The inspectors have a tendency to go in and look at the small stuff. But yeah, look what staff are doing, working short again, we don't have two people doing lifts like they are supposed to have and then get into trouble for it when they don't – and the inspectors are talking about toothpaste? I can't imagine. And absence of staff, always understaffed, everyone is screaming – residents, workers – help me! Help me! Why isn't that being charted or picked up by the inspectors? [KI Interview 15: 13-14]

Several participants discuss their ongoing struggles in trying to affect change. This includes having their health and safety concerns acknowledged, supported, and addressed by management and supervisors, and their working conditions improved. While workers are required under the *OHSA* to report hazards in the workplace to employers, according to participants these are not routinely investigated or followed up on by management and several participant's report they are consistently disregarded. This is unsurprising given that health and safety concerns related to work intensification are poorly regulated and are often normalized as part of the job, and enforcement mechanisms are weak and/or non-existent. Moreover, many frontline workers are

reluctant to report on and/or confront employers regarding health and safety issues.

According to one participant,

I'm sorry, health and safety, I wish everybody was more involved in it at the home than just me. It seems like I got the biggest mouth [Interview 18: 7]

When management does act to address a problem it usually results in the assignment of fault to the worker. Long-term frontline workers, particularly those who have job security within full-time positions and are involved in union activities, are put in a situation where they are reporting the same health and safety concerns repeatedly. Long-time workers and union representatives within their LTRC facilities elaborate on their ongoing struggle with management to take the health and safety concerns of frontline workers seriously. As one says,

If you don't push with management – if there is something that you see going on and you are like, you know what? I am documenting, I'm constantly reporting it, and they still aren't doing anything. You have to tell them hey listen, if you don't do this, then I am going to make a phone call. I have rights. And only then, that's when you see, they get serious enough and decide that they need to do something [Interview 6: 16]

In response to the continual dismissal of building and physical structural concerns by management, frontline workers feel they have no other recourse but to anonymously complain to the MOL. One participant explains,

Some workers ended up calling the Ministry of Labour, and the Ministry of Labour people showed up and they found asbestos in certain parts of the building. And they found mould in certain parts of the building – like in the bathrooms, in the closet because of leaky taps...something growing in behind the wall. They have tub room problems all the time and they have something leaking all the time [Interview 16: 31]

Unlike mandatory facility inspections conducted under MOHLTC regulatory requirements, MOL health and safety inspections regarding *OSHA* compliance are usually unannounced. Many workers, however, are reluctant to report on facility and working conditions to employers or government bodies. Participants state that frontline workers, particularly workers who do not have active involvement with the union,

workers who lack job security, or workers who are uncertain of their rights are often too fearful of backlash to complain or file grievances with management or expose the conditions of their work that place them at risk and impact their health and safety.

According to this participant,

If they complain, they may not have a job. Or they don't know any better. Sometimes they just don't know any better and they get caught in a situation, they get put in this place and they don't know what to do because of the authority and that kind of stuff. They don't want to have their job in jeopardy [...] and you hear of all the talk of what happens to whistle-blowers, right. So, you also have to be careful, right. You don't want to lose your job so a lot of people are very reluctant to speak up and complain and do stuff like that, right [Interview 16: 30]

Despite this context, one key informant and union official indicates,

There is a large amount of people who are English as a second language and culturally are not – sometimes it can be frowned upon for speaking out – in a broad stroke. And in a union environment speaking out is second nature... But a lot of people – and that's one of the things that I am very cognizant of is that speaking is very much not what they want to do. They would rather suffer in silence than have a problem addressed that was attached to that [KI Interview 19: 1]

Contrary to what this participant states, workers likely do not prefer to “suffer in silence.”

Rather, the consequence of not remaining silent given their precarious positioning is very real for workers and is prohibitive. Within the LTRC sector, racialized and marginalized immigrants are increasingly recruited into insecure work arrangements such as casual or part-time positions that further constrain their ability to articulate workplace concerns. These arrangements facilitate and reinforce management control over workers and the labour process – or what Richard Edwards (1979) terms “simple mechanisms of control.” One participant highlights the ongoing implications of contingent and insecure employment trends for frontline workers,

People are not going to resist it, not be able to resist their working conditions. And the care isn't going to be there. They are not going to be able to say anything, they are going to do what they can, but they will be cutting corners more just to keep a job [Interview 1: 25-26]

This finding corresponds to research that has been conducted within the automotive production industry. In particular, the dynamics and implications of intensified work,

working time intensification, and time-discipline strategies that characterize flexible, lean, just-in-time, production processes that seek to establish and maintain management control over labour and the labour process – including the organization of work and time (see Thomas, 2007; Thomas, 2008). Other participants indicate the changed composition of the LTRC workforce, union disconnect, and lack of knowledge of health and safety rights as factors that underlie and shape the reluctance of workers of immigrant status – who are increasingly amongst the most precariously employed – from bringing concerns about the conditions of their work forward to the union. According to this participant,

They don't utilize the union. Some of these people didn't have unions from where they come, they don't... Like, if you are not accustomed to something you are not going to use that thing. Or they come from a place where you are just supposed to respect the bosses and do what the bosses say without question – that's it. Union is something different. If they Canadians, the union would be in there. You get these workers from other countries and that's not how it is. They don't complain [Interview 13: 16]

Underreporting of Injury, Illness, and Violence

Participants' accounts reveal that many workers do not report their experiences of workplace injury, illness, or violence. There are several reasons for non-reporting that emerge from participant discussions that underscore the reluctance to report injury within their facilities and/or to complete required documents to initiate WSIB claims. Many participants state time constraints are a significant barrier to workers reporting on their injuries within their respective LTRC facilities. As this participant elaborates,

Sometimes workers don't feel like filling out a report because they know they are not really... Like, you don't have the time. You just keep up with the work [...] they are so scared too that once you fill it out it goes to WSIB and WSIB is not going to pay you, you know. Some staff has this sort of instinct already that, 'oh what's the point in filling them out cause so many get denied' [Interview 10: 6]

Several participants describe the poor support they receive from registered staff supervisors as a significant barrier that impedes workers from reporting on their workplace injury. As this participant elaborates,

The RNs and the RPNs are so overworked too and they are the ones that have to sit down and go over an incident report with you so the girls don't bother with it because the registered staff don't have that kind of time to waste on an employee – they just scoff at them. And that's how it is put to them – they are clear, 'don't waste my time.' And that is one of the biggest barriers [...] That's how things slip, that's how it looks like it's maybe not a big a problem as it is, it slips under the radar [Interview 18: 10]

While workers responsible for resident care are overburdened at all levels within the context of funding constraints and work re-organization, worker locus of control is in part related to positionality in organizational social structure. This has particular implications for frontline workers located at the bottom of the institutional hierarchy who must report to others. The above participant account draws attention to implications of underreporting of injury and illness within health care workplaces (see Chapter 4) and is consistent with research that notes significant underreporting of injury and illness compounds the invisibility of risk on the frontlines of care (Lippel, 1999; Cox & Lippel, 2008). That is, the extent of injury and illness is obscured and rendered invisible to LTRC employers and by way of institutional and official data collection mechanisms.

Participants' narratives highlight that concerns and complaints about the violence they experience on the floor is minimized, ignored, or not seriously addressed by management. Moreover, participants state that while frontline workers are to report violent incidences that occur to supervisors, registered LTRC workers do not document incidents consistently – or at all. As this participant elaborates,

Okay, this sounds horrible but at our place, we know which RN to report things to and which RN will follow through with it. Like you will report an incident to one of them and you go in the next day and it is not even in the report, you know. And we are being harped at all the time to chart behaviours but with certain behaviours we also have to report it to the RN, you know, if it's socially inappropriate or physical... and they aren't even charting it. And it's been reported to management but um it still continues. And then you get frustrated – and it's not just me um the other staff say what's the point? [Interview 8: 11]

While documentation and measurement is emphasized under the current care regime (see Chapter 5), according to participants, attending to the substance of the documentation

itself is not prioritized. Documentation and other forms of data collection are treated as ends in themselves and not as a means to improve care and work conditions. Participants express frustration that even if inclusion in institutional documentation data collection mechanisms occurs, these incidents do not trigger internal investigation, follow-up, or attempts to manage or address violent working conditions by management. According to one,

We report, we document. Then what? What happens? The answer is nothing. Nothing. It just goes in the chart – that's it. We document, we report, we tell them, then nothing [Interview 6: 16]

Participants' discussions emphasize a culture of tolerance with respect to violence. Workers' experiences with physical violence on the frontlines of care with residents are frequently dismissed by managers, supervisors, and at times by co-workers in ways that normalize violence as a routine aspect of the job. For instance,

I get punched, or get kicked, and stuff like that, right [...] If I'm hurt then, you know, it just comes with the job, that's what they said. It comes with the territory. It's not supposed to be but that's the way it is [Interview 13: 4]

Frontline workers provide numerous examples and incidents in which they describe how they are regularly criticized and regarded as at fault for the resident violence they encounter on the frontlines of care. One of these participants elaborate,

I have this one manager that scoffs. Like, 'how did she get hit?' 'What did she do to provoke it?' So, right away, it's not the resident that has a problem, it's the staff that has a problem. That's how management has approached these situations. It's the worker's fault [Interview 18: 10-11]

The worker, not the conditions of work on the frontlines of care or the assumptions that shape those working conditions is the exclusive focus of inquiry. Blaming the worker, questioning the actions and/or approach of workers when violence is experienced, and the normalization of violence as part of the job, is dismissive, coercive and situates workers at further risk. Blame is reflective of processes of individualization and responsabilization of risk (see Chapter 4) – it threatens the worker's control over her/his

labour and conditions of work. The shift towards responsabilization and individualization of risk on the frontlines has meant that the responsibility and consequences for health and safety and risk are ultimately placed on workers, despite having no input into the organization of work, decision-making, or resident care plans or agendas. Along similar lines, this participant states,

They ask if it was your approach, 'it must have been your approach that triggered the resident.' That's how they deal with it. The managers are oblivious [...] Like one time, I had a resident, and he said to me, 'you fucking bitch' and grabbed me so hard...like in my crotch. I gasped from the pain and I dropped to my knees. I was in tears and I told my manager that he had grabbed me so hard I think he even ripped my underwear. She goes, 'well, what did you do that you got grabbed? Like, how close were you? Why did you let yourself get grabbed *there*?' [Interview 1: 19]

In the above account, the supervisor not only blames the worker for the violent assault but also questions how the worker could possibly allow herself to be assaulted in the bodily location that she was. According to participants, like injury and other forms of violence, while they are required to document incidents of sexual violence, management does not follow-up, address, or take sexual violence in the workplace seriously.

We have to chart it and uh, and that's basically it. I mean we tell the residents that they are totally sexually inappropriate and uh and sometimes, they get nasty, vile. As far as management no, they don't really do anything about it [Interview 8: 12]

Below, one participant shares her experience with ongoing sexual violence from younger male residents. While the worker reported and documented the violence directed at her and other female workers, she received no support from management. The situation continued and the worker then attempted to manage the situation herself. When the resident complained to family about the worker, who then reported the encounter to management claiming to be offended by the approach the worker used in response to the residents' repeated sexual violence, it is only then that management initiated follow-up regarding the situation. The response by management was to issue a warning to the worker as well as threaten her with further discipline. In the words of the participant,

They [a few male residents] keep calling saying, ‘needs sex, needs sex.’ So, it’s like calling, want sex, saying my name... and they touch the back of other nurses but they cannot move fast like me, you know, the 50 or 60 year old ladies, chubby ladies. So, one day I answer call. I couldn’t stand for it because I can’t, couldn’t anymore – they always call me like that, always playing with their sex – So I say, go fuck yourself, don’t call me. Stop. And I got in big trouble for saying. But I told it. I report it so many time before. I report it before all time and they didn’t seem like understand. Managers didn’t seems like they understand it. They didn’t care. They didn’t take it seriously, like verbally and physically aggressive, sexual. It didn’t seem like understand because they don’t, won’t. Even though they are wrong, they will... the blame will come on us [Interview 12: 20]

The workers’ response to abuse directed at her – not the residents’ violent behaviour, managements’ refusal to acknowledge sexual violence, or the conditions of work – is regarded by management as offensive and reprehensible. As with other forms of violence, workers are expected to “lighten up”, “shut up”, maintain their “good worker” and gendered caring role and ignore, tolerate, and accept ongoing sexual violence as a condition of their work – and in the process reinforce its invisibility.

One participant contrasts the blame put on workers for workplace violence with the treatment of women who experience domestic violence, suggesting that one knows better than to question and blame a woman for violence experienced in the context of an “intimate partnership.”

Like we’ve had staff get injured and she [the DOC] treated them like a bag of shit, like it was their fault [...]. That’s how she treats the staff [...] she acts like it was your fault. You’d never do that to a woman that got hit at home – like say, ‘what did you do wrong? What did you say?’ [Interview 16: 15]

While the participant underlines an important point about blaming the worker – the fact is, women who experience violence by partners or otherwise, are routinely blamed and belittled for provoking violence and viewed as deserving of the violence that is inflicted upon them (DeKeseredy, 2011; Johnson & Dawson, 2011; DeKeseredy & Dragiewicz, 2014). Nevertheless, the comparison is instructive. Blame undermines and silences the experiences of women (DeKeseredy, 2011). Measures to address gendered workplace violence must necessarily go beyond the poorly resourced and work organization

problems of restructured and reformed workplaces under neoliberalism. This includes the recognition of gender-specific forms of risk as well as the need to address power inequalities in which gendered forms of violence are normalized within the workplace and elsewhere. While reporting of violence by workers is essential – in order for frontline workers to do so, the broader gendered context of violence or violence against women, sexism, misogyny, and the wider culture of tolerance and the culture of blame in which workplace violence is embedded must also be confronted and challenged.

Several participants struggle with and question the culture of blame and culture of tolerance operating within facilities. That is, the perception that violence is “part of the job” and the placement of fault on the frontline worker for being a target of violence. As this participant shares,

There is a lot that you have to put up with, accept, and move on. Should you have to? No, but there is – it just seems pointless sometimes. It seems pointless that the resident got upset and punched a worker in the face. And, you know, cut another workers’ eye. And the managers, all they want to know is how you approached them. Seriously? Does it have to always be that I approached them wrong? I don’t totally accept it, you know, that it is part of the job. I know that this can happen, sure. But is it something that we should be comfortable with and something that we should just think is normal? And that we should just accept it and move on? [Interview 4: 19]

From the perspective of feminist political economy, both blame and tolerance underline gendered assumptions of care and reinforce expectations that the care labour of these women is endlessly expandable, altruistic, self-sacrificing – and that they should continue to work in any context (Armstrong, 2001; Baines, 2004; Baines, 2006; Baines, 2015). It constitutes a form of ideological control over workers. As noted above, this response fails to engage with the conditions of work, the gendered and racialized inequalities that shape work and care conditions that engender violence within this setting. Blame for violence and the assumption that it is just “part of the job,” reproduces and perpetuates the disposability and devaluation of predominately female workers on the frontlines of

care. Like workplace injury, participants' discussions reveal that many workers do not routinely document or report incidences of violence. The blame and the normalization of violence and/or the perception that it is part of the job discourages frontline worker reporting of workplace violence and reinforces its invisibility. Indeed, participants state workers are scared to report violence because there is little support and acknowledgment from supervisors or management and they are likely to be regarded as at fault for resident violence. Participants also point to time constraints for the failure of frontline workers to report their experiences of violence – that is, the frequency of violence is so relentless and common within facilities, workers already pressed for time given their demanding workloads simply do not have the time to constantly report its occurrence.

Well, lots of times I get pinched or swatted and I don't bother. I'd just be writing reports all the time. And people swear at me all the time, name call all the time. So, I just don't bother reporting any of that, no time [Interview 3: 14]

Another participant reports that as union representative she tries to actively encourage other workers to report violence while recognizing the conditions of work often prohibit this in practice,

A lot of the time stuff gets brushed off because it happens all the time so you really don't have the time to deal with it [...] the biggest barriers really to reporting is timeframe and support. Like, you don't have the time and we have a lot of girls who don't feel they are going to be supported, so they don't bother [Interview 7: 9- 10]

Like physical violence, verbal abuse is often not documented. Many participants explain that verbal abuse is so frequent, accepted, and normalized they do not report it. Nor do they have the time to report ongoing and continual abuse.

The prevalence and normalization of violence and the conditions in which violence occurs further reinforces its absence within official data collection, its acknowledgment as a widespread problem within the LTRC sector, and failure to

understand violence as a symptom of structural conditions, including the financing and organization of work itself. Participants report that many workers are also reluctant to report the racial discrimination and racialized violence they experience. According to one participant, this is particularly the case for recently immigrated workers.

They don't say anything. Especially the newer immigrants that come to Canada because they don't think they have a right or any rights when a resident is really, really, nasty to them [...] Some workers just suck it up, and take the abuse and racial slurs at the start [Interview 1: 21]

While a few participants indicate management investigates racism from residents directed towards frontline workers, most participants report management expects them to ignore racist and ethnic comments, taunts, slurs, and assertions of hate from residents. Participants report supervisors and managers routinely dismiss their concerns and rarely intervene – with some managers and supervisors who explicitly claim that older residents have a right to express animosity and are entitled to their “opinions.” As this participant shares,

I told my manger about the Jewish issue, situation, you know, the resident who told me it was fortunate for me that my family survived because all the fucking Jews and Poles should have been eradicated. And she said, ‘you know what, they are old, they have a right’ [Interview 1: 18]

According to many participants’ accounts, workers are typically left to manage violence and risk on their own. Sometimes this means the application of narrow and temporary solutions to the organization of their work where other workers act as “buffers” and/or assume responsibility of the care of residents for co-workers who are targets of racism.

As this participant explains,

I know a couple of our coloured girls they can't go into a couple of the residents' rooms because they are – well, they [residents] are bigots. And they let it be well known. Because they say, ‘they have no place here and they should have never abolished slavery.’ That is how they talk to these girls. So, we tell the girls, yeah, don't even go near that room. We will deal with it. Other workers pick-up [...] we always make sure that they aren't put in those situations [Interview 18: 16]

One participant heavily involved in union activities as a union representative states the Executive Director at the facility in which she works only chose to address the racism and hate directed at frontline workers when eventually confronted with the threat of human rights action by workers. According to this participant,

He was extremely racist to black people. And I am a woman of colour and we have got a lot of us in our workplace... a lot of ethnic, women of colour. And he would say to some of the ladies of colour, he just, oh my god, everyday was like, 'you fucking nigger go back to where you came from, you're not fucking touching me,' and he knew exactly what he was doing [...]. So, I took myself and four other women of colour up to the EDs office and I said enough is enough. You do something or else I call human rights and I said we don't have to come to work and be treated like this and you do absolutely nothing about it. We have documented it, we have charted, and that's it. It goes nowhere [Interview 6: 16]

Other participants indicate the frontline worker who encounters and complains of racism from residents is occasionally relocated elsewhere in the facility by management. According to this participant,

Sometimes if it [racism] is bad enough that worker is displaced to a different floor, sometimes they just accept it and move on [...] The issues, aren't really dealt with. They are just masked over by saying, okay you can no longer work on the floor with this person so we will put you on another floor [Interview 4: 31-32]

The participant's comment above suggests that in management's view, some levels of racism are acceptable – it is only when racism is “bad enough” that something is done. As this participant points out management handles the situation by removing the worker, not addressing racism. While racialized workers may be the targets of on-going violence and suffer enormously with anxiety and depression with little or no workplace support or acknowledgement, participants' discussions underscore that racist violence is difficult, risky, and stressful for all workers.

Like other forms of violence, participants indicate management does not do much to address workplace bullying and frontline workers are subsequently left to manage and cope with bullying and harassment on their own. As this participant explains,

I got bullied too, with a big person. But I learned to stand on my own, I know that I sorta blame management too because I am trying to report about all the stuff she did to me, but the management don't do much. I have some weakness she says and then she did this to me [raises fist to face, jabbing motion] and she called me stupid f'n idiot [Interview 10: 11]

Other participants discuss reasons underlying why frontline workers do not report bullying and harassment in the workplace. According to this participant,

You don't rock the boat. They all have each other's backs [...] There are certain places some PSWs don't want to work in because the bully-system is so bad, you know [...] you got people in there that are intimidating the newer workers, so they don't want to work there. So there is a culture in some homes [KI Interview 15: 11]

One participant shares the consequences of reporting on workplace bullying between workers on the floor,

I turned out to be a snitch because there was stuff going on [...] I have gone in and reported bullying on the floor [...]. That's the older workers that are really pushing on young ones – but they are protected by their seniority in the union [...] They left me waiting for my lifts, they knew I had residents to put to bed at night and they left me waiting. I'm sitting there, half my people aren't in bed – I'm like can anybody give me a hand here? 'Nope we're busy, we're busy, we're busy.' So, I had to do something illegal and put them in the lifts myself [Interview 17: 9]

Another participant discusses how she feels powerless, unsupported, and fearful of reporting on the bullying and harassment she currently experiences from registered staff to management or union representatives or officials.

It's not easy [...] No one will respect me. No one will treat me as a human being [...] that why education is important. Otherwise better be a welfare mother or staying on the welfare and raising many children is better than working as a PSW [...] So, we can't report it, we can't report it. They turning their back, so we cannot do anything. We cannot report anything, because they are telling – it will harm more and more, instead of better condition of work. It will harm and damage more. They will try to get rid of us. So, they will do more thing like that, they will degrade, maltreat. What can you do? So, negative effect. Oh, and can't go to union, oh union don't do anything either [Interview 12: 14]

According to some participants, maintaining divisions, rather than teamwork between workers on the floor is conducive to the realization of management objectives of control and getting the work done. As this participant shares,

It's like the lynch situation back in the day when the slave master come up and to solve the slave problem [...] all you have to do is put mistrust into your slaves and you will have no problem. Put the young against the old, the old against the young, the male against the female, and you will have no problem because everyone will be snitching on each other, you know whom to whip. So, it is kinda like that [Interview 9: 12-13]

One participant points to the organization and conditions of work that underlie bullying and harassment. Like the participant above, she also underscores how bullying facilitates management's goals of maximizing efficiency and work intensification through conflict and competition between workers on the floor. As this participant states,

When you overload and over burden, yes, you are going to have friction on the floor. Yes, you are going to have conflict. Yes, you are going to have bullying – and yes, according to management, it works. They are not going to get rid of the bullying because they know that those tough birds that are beating on the young chicks are making them work. They are making them do their job. The way the system is set up right now, it is not healthy [Interview 17: 22]

In the above account, productivity on the floor is secured through bullying and can be understood as one form of labour process as “game” (Burawoy, 1979) – albeit a version that is very unsettling and disturbing. Nonetheless, bullying allows some workers greater autonomy and control while simultaneously facilitating the objectives of management and reinforcing the exploitation of workers. From the perspective of feminist political economy, government policy, gendered and racialized workforces, and age, gender, and race dynamics created on the care floor are utilized in ways that facilitate the production of care and sustain labour control on the frontlines of LTRC. The organization of work separates workers' interests on the care floor – at the same time, the broader relations of power and exploitation are obscured. In the face of “impossible workloads,” bullying is one example of the ways workers themselves may attempt to ensure care labour productivity. At the same time, bullying reinforces their exploitation and maintains the status quo of high demands and low control. That is, the culture of bullying on the care floor or “fractions” between workers (Edwards, 1979) operates to uphold worker productivity in the context of cost cutting, understaffing, strict time pressures, and heavy workloads, securing management control of the labour process in the production of care.

Many frontline workers state they are targets of blame by residents' families for the poor conditions of care. Other participants indicate workers are told they are "going to get fired" or "be out on their ass" for not heeding the demands of relatives of residents in the provision of adequate and immediate care. Many participants discuss requiring a "witness" in their interactions as management routinely has greater confidence in residents and residents' relatives than frontline workers. Given understaffing and heavy workloads within facilities, having another worker present during interactions is challenging. Several participants report that they are expected by management to ignore, "move on", "suck it up" and "get over" abusive, hostile, and intimidating treatment by families of residents. According to one participant,

You are always taught that if there is an issue with the family member doesn't matter if that family member is nose-to-nose with you. Basically, you have to say, I can get the charge nurse for you and walk away from the situation. After you have been humiliated, after you have been threatened by a family member saying, 'so, whose ass am I going to kick today?' [...] And there is just not a lot of stuff that can be done for stuff like that. But I tell them [managers], I am just going to let you know that if she comes and she does something like that again – I will call the police. They say, 'you are calling the police because she threatened to kick the workers ass?' It's silly, it's stupid, you want to tell this woman to grow up. You can't go around threatening and behaving like that. Others are so intimidated by family, they won't say anything, they will let them talk to them like that. But we were told that we could say please don't talk to me that way or in that manner and then kinda take yourself away from it. But for a lot of girls they won't. They are so humiliated by it. Some of them cry. Some of them leave and go home. And yeah, sometimes it is very hard [Interview 4: 18]

Other participants indicate that management will displace frontline workers to work in other areas of the facility in order to appease residents' relatives. Participants also report that male frontline workers and frontline workers assumed to be LGBT are refused to care for residents by residents or residents' families – "they don't let them touch them," highlighting the ways residents' families not only discriminate but also how they too constitute an important element in the labour process, shaping the conditions of work on the frontlines. According to this participant,

You have family coming in to say that they don't want to have the male nurse to look after their mom because they are Muslim and that puts pressure on us. And – there was one woman there and she said she don't want the male nurse to look after her because he is gay [Interview 9: 9]

Rather than address work conditions that are a source of stress or burnout, workers are instead often expected and encouraged to adapt, learn to cope, accept, or tolerate chronically understaffed, under-resourced, and violent conditions of work that adversely affect their health and wellbeing.

While relations and attachments between residents and workers – reinforced by gendered ideologies and assumptions of care – may be used and exploited to extract more commitment, unwaged labour, and personal resources from workers (also see Chapter 5), these attachments are ignored and/or expected to be abandoned when they do not facilitate institutional objectives of maximizing efficiencies and/or profit. For instance, participants report there is no recognition of these relations upon the death of a resident. In particular, frontline workers share that there is no support or assistance to help them cope with the emotional grief and stress following a resident death. They are expected to “get over it” and “move on.” Participants discussed how these relations and attachments are displaced by the corporate, efficiency model when a resident dies, and the primary objective is to get the next resident on the waiting list in the room as soon as possible.

For example,

Someone dies. The next day the bed is stripped, the closets are empty, and then, there is someone new in the bed. That is hard. That is really very hard sometimes [...] But it is a business, right – there is no room for mourning, there is no time to have an empty bed, there is no support to help you get past it, you are expected to find your own way of dealing with it, and move on. I think that is why some people have issues somewhere down the road because most people that do what we do have a big heart and put a 100 percent into the care and love what they are doing and take it seriously and they care for them like loved family [Interview 4: 9-10]

Workplace Safety and Insurance Board

The workers' compensation system is understood as an apparatus of government (see Chapter 4), situated within the context of the wider political economy of capitalist production and labour market relations. Several participants discuss the "horror stories" and challenges of co-workers who had been through the process of filing a claim through workers' compensation. The requirements, intimidation, and scrutiny these workers' experience, and the onerous and lengthy bureaucratic process operate to deter other workers from filing claims. Instead, workers continue to work despite injury. As this long-time frontline worker indicates,

What happens is because of troubles with workers' compensation a lot of girls will work through their injuries, won't report [Interview 17: 6]

Participants' discussions suggest the challenges with having workplace injury claims approved through WSIB are relatively common. One long-time worker who in her capacity as union representative assists co-workers with completing their injury claims, and if necessary, their appeal processes should their claim be initially denied. This participant's direct experience with the injury claims process provides some insight with respect to the nature of injury claims of her co-workers within the facility, including the nature of the workers' claims that are typically challenged or denied.

At work, three girls are off right now where the employer is denying their claims. I'm a union rep so I have to go through the appeals. WSIB, almost 60 percent of the time they deny a claim. They hate paying. If it is shoulder, the rotator cuff from pulling, repetitive type injuries. Or elbow injuries and carpal tunnel, they really try to fight those. They fight those. It is a really hard claim to get through [...] They don't give up easy. It is a fight to get claims through [Interview 1: 14]

A key informant in this project similarly echoes this difficulty. In his ten years of experience working directly with frontline workers across the sector providing advocacy, assistance, and support with workplace injury claims, "less than 50 percent of these

injury claims are accepted.” Denial of claims on the basis of lack of evidence or disputation of the nature or origins of injury triggers a lengthy appeal process through WSIAT [Workplace Safety Insurance and Appeals Tribunal]. According to this participant, this process may lead to an abandonment of the claim by the worker. Another participant locates the reluctance of workers to report on injury and illness to the intimidation of the system itself and refers to the bureaucracy of this process as a “paper trap.” In the words of this participant,

Mountainous paper work. It is very overwhelming and very intimidating process if you are not used to something like [...] it's a paper trail – or paper trap is what it is. And I think they do it to intimidate you so you don't do it [...] It's not even worth it. It's a hassle. The compensation is there for the employer, not the employee. It's an insurance company being paid, and they don't want to pay out. It's a lot of hoop jumping [Interview 18: 4]

The participant in the above quote raises an important question in relation to who benefits and whose interests are privileged through apparatuses of government such as workers' compensation systems. As participants' discussions suggest, frontline workers are in a precarious situation. Injured workers are up against a seemingly biased workers' compensation system that does not recognize particular forms of injury, particularly those that are chronic or cumulative and do not want to compensate workers, and facility employers that want to keep their expenditures low – in particular the premiums paid to WSIB. As with public and social programs, austerity measures within WSIB aim to contain costs through stringency with workers and workplace programs. Under the austerity agenda, risks and costs of injury are increasingly shifted to workers, and wealth is redistributed to owners of capital, away from workers. It protects capital, not workers. Below, one key informant discusses WSIB claims processing changes, the scrutiny workers face with their workplace injury claims, and the problem of claims abandonment

by workers, which is reinforced under transformed processes and practices in the adjudication of workplace injury claims.

If you are injured or ill, you haven't got a lot of the abilities or energy to make this your focus. The focus is I want to get better. So, now you are being asked to do paperwork and answer phone calls and do interviews over the phone. And you are dealing with a lot of questioning of whether or not this actually happened, or it happened as bad as you said it did, and it makes you upset and you go, you know what, you just want to hang up – click. And WSIB is satisfied because they won another one because someone just basically walked away from their claim. And it used to be that when you made a claim you were immediately connected to a case manager who did this first interview and worked out whether or not all the files were proper and you got all the forms in place and – you know forms 6, form 7, form 8 – doctor, employer, worker reports. And then work out whether or not it was approved. Well they half that off. Now they have an eligibility worker who does the initial interview with you over the phone to see if this is a valid claim. And they will question you like you are in a court of law – you know, are you sure this is what happened? [KI Interview 19: 19]

Several participants highlight barriers that relate to finances and the prolonged process time for claims and appeals. A few participants note barriers related to the distance of rehabilitation and physiotherapy services that may be required to maintain WSIB compensation benefits under their return to work plan – an issue of accessibility that is particularly relevant for workers in smaller or rural communities. As this participant states,

They feel they wait too long, you know, to get anywhere. And meanwhile they are concerned about how they are gonna pay the bills and stuff like that. And because of where we live, they have to drive an hour to physio and back. So, they find that hard [Interview 8: 12]

Care Work on the Frontlines and Care Work at Home

The resemblance or similarities between care labour in the home and care labour within LTRC also create challenges for women in having their injuries attributed to the work they do on the frontlines of care. As this participants shares,

I couldn't prove that I hurt my back at work. I didn't feel it until the next day – but in the meantime, I was also bathing my son, like I was crouching over the bathtub, so I decided not finish the WSIB paperwork because of the stories, I didn't want to go through that. So, I went on unemployment/sick leave for that [Interview 5: 8]

One key informant also highlights assumptions about gendered work and responsibilities.

In his decade of experience with advocacy in relation to frontline workers' injury claims,

employers and apparatuses of government such as WSIB utilize “women’s work” or care work within the home as a way to dispute cause, weaken, and/or delegitimize claims of frontline worker workplace injury. According to this participant,

The questions that come out sometimes in sessions [with WSIB] where they want to know if you garden because that can be a determining factor or if you got young kids in the house could be a reason why you have low back or shoulder injuries because you lift the kids [KI Interview 19: 19]

Within LTRC, the repetitive and physically demanding nature of the work has meant that symptoms of injury may be gradual and incremental, making the source of the injury less clear or obvious than injuries that are acute in nature. Given how workplace injury may develop overtime, workers may be uncertain to the origins of their injury and as a result fail to report injuries to employers and file claims through WSIB. As one participant states,

With my knee injury, I never filled out WSIB papers because it came on gradual and I never related it to work. But when I finally saw a surgeon and he asked what do you do? When I told him and he is all like, ‘oh, so where’s the paperwork?’ But I didn’t have any. But really, this is my problem because I didn’t attribute it to a work injury. It came on gradual. And so I was off for six weeks when I had it repaired and then I blew it out again, so now I am still just working and walking on a really bad knee [Interview 7: 11]

One participant recounts her experiences and difficulties with establishing causal evidence according to narrow WSIB standards and criteria that her injury was a workplace injury.

I pulled a hamstring walking down the hall but WSIB won’t cover me because I wasn’t doing anything to do it, I was just walking. I was like but walking is part of my job, we have to walk a lot, always quickly going from point A to point B. But they see my injury not from doing my work. They turned me down [Interview 3: 15]

Despite the physical demands of this work, often requiring workers to bend, twist, turn, lift, push, pull, contort themselves and otherwise assume awkward positions in repositioning and transferring residents, manoeuvring equipment, assisting with ambulation, and providing personal care, workplace injury is often attributed to age – not the conditions of work. One key informant shares his advocacy experience for a frontline

worker with a workplace back injury claim, which captures the questionable logic of causation, discriminatory and/or gendered assumptions and biased practices influencing WSIB claims adjudication.

One lady, she is only 36 years of age, she suffered a back injury from work, and the caseworker is saying the only reason she got injured is because she is old. According to WSIB, it's an age-related injury so her claim was denied. According to WSIB, she's old. In the process, it could be almost two years to get an appeal heard at WSIB... Cause WSIAT is so backlogged [KI Interview 19: 9]

Besides what seems like a redefinition of what constitutes “old,” the ruling is also contrary to the well established “thin skull doctrine” protected under *WSIA*. This principle means that entitlement to compensation for an injury cannot be ignored because of a pre-existing condition (i.e., degenerative, age-related pathologies) of the worker. It also highlights assumptions about the nature of LTRC work – that is, care work is assumed “safe” unless you are getting “old.” Age – or the aging process is deemed responsible, not the work-related injury or the conditions of work in which injury occurs. Enabled by provincial policy and situated in the context of broader austerity measures in the province, critics – including unions and injured workers argue WSIB is systematically slashing benefits paid out to injured workers in an effort to rationalize costs. In part, it has meant WSIB decision-making is more aggressively centred on disputing causation – a practice that threatens workers’ rights, perpetuates devaluation, and reinforces frontline workers as a disposable workforce. Insecurity, fear, and disposability are also coercive mechanisms of control, used in the struggle for management control of the labour process. These factors profoundly impact whether workers report their workplace injury or illness.

Return-to-Work Practices

Several participants report that WSIB initiatives such as the Early and Safe Return to Work (ESRTW) program – one example of WSIB cost containment programs – have meant workers are being sent back to work before they have recovered from their injury. According to some participants, employers actively push frontline workers to return to regular duties before they are ready. Below, one participant shares her experience with injury and return to work practices,

Right now, I'm on sick leave. I had returned [...] on modified duties and that worked out really well and then a new administrator came and took me off – told me if I can't do full-time duties then I should go on long-term disability. So, I guess that is what I will be doing because he said there is no modified work there [...] I don't think that the management cared one little bit because they told me to go back on full duties before I'm ready – or go on long-term disability. What is that? That hurt me so bad. I was thoroughly depressed about that [...] they kinda force you back to work when you injure yourself at work. The nurse manager is always calling to see when you are coming back, when are you coming back to work, what did the doctor say? Even if you give them a doctor's note, they are still calling and harassing you. And I know that comes from the administrator [Interview 11: 8-9]

Other participants claim that physicians' reports are disregarded by WSIB, and expected recovery dates are privileged regardless of whether these coincide with workers' actual experience with their injury and recovery process. Once back at work, participants state employers ignore physician directives or loosely interpret restrictions and limitations, further situating these workers at risk. One participant shares,

There are difficulties. It's huge. Return to work, some employers need to be more educated on return to work. Seriously. They have ...some of them have some really weird ideas about return to work. And modified duties, or what constitutes modified duties, or completely disregarding the instructions from the doctor. It never stops [KI Interview 19: 7]

Workers who return to work before they are able also risk re-injury and/or exacerbating existing workplace injuries. One participant shares her experience with inappropriately modified work and the resulting aggravation and/or complications to her injury as well as her employer's response.

I fell at work and I did a lot of damage on my elbow [...] then they put me on modified duties but they weren't proper modified duties. Like, they were still having me do 11 residents, just no lifting. So, I was constantly trying to compensate for it and developed tendonitis [...] I went to the surgeon and I ended up having to take six weeks off and bosses were pissed, just pissed right off [Interview 1: 14]

Advocates for injured workers, including one key informant who participated in interviews suggests that in the last several years there appears to be a systematic denial of claims to workers by WSIB on the basis of pre-existing injury in attempts by WSIB to reduce costs. This practice fails to apply the “thin skull doctrine” principle (discussed above) that is protected under *WSIA*. Return-to-work policies and practices that put workers back to work before they are capable place these workers in a position where they may not only become re-injured but their claim to subsequent injuries may be denied on the basis of a pre-existing condition. That is, the workplace injury that required these workers to be compensated and accommodated in the first place. From the perspective of feminist political economy, workers are confronted with WSIB and employers who want to safeguard the bottom-line. Both are focused on economic incentive and/or maximizing efficiencies through compensatory cost reduction, not injury reduction. The power imbalance between workers and employers, the gendered nature of workplace injuries, the nature of WSIB experience rating, the devaluation of care work, worker disposability, and biased return to work practices oriented towards maintaining productivity not worker safety, situate frontline workers in an extremely disadvantaged position.

While employers have a duty to modify the work or the workplace to accommodate the worker under *WSIA* and in compliance with human rights legislation, one key informant discusses the implications that result from changes to WSIB policy around work reintegration or early and safe return to work (ESRTW) programs. Under WSIB policy, modified work duties only have to be “suitable,” not meaningful and

respectful. This change has meant what constitutes “suitable” work is at the discretion of the employer so long as the work is “safe”, “restores pre-injury earnings as closely as possible” and are within the workers limitations or “functional restrictions” (www.wsib.ca). As this participant states,

WSIB changed rules 10 years ago or so. It used to say modified work had to be meaningful and respect to the dignity of the worker. Now, it has to be just within the restrictions. It could be anything. They have cut back the rules so much on that, they are really disadvantaging the worker, and assigning meaningless stuff when there could be very good productive work done instead. But the employer doesn't have to look at that now [KI Interview 19: 7]

Given the loosely defined “suitable” modified work standards under WSIB policy, other participants describe what they perceive as degrading and punitive modified work assignments that operate to control worker behaviour. That is, deter workers from reporting on and filing workplace injury claims. Below, one key informant describes a worker's struggle with the nature of the modified work assignment flowing from the elimination of “meaningful” and “respectful” from modified work standards under *WSIA*.

The power door was broken so the employer put one of the injured workers at a table in the front lobby with paper and a counter and they were to count people coming in and going out. Seriously, that was her shift. But the employer says that's the work that they want to offer, and WSIB approved it [...] I had arguments with the employer saying, you could have this person sitting with residents, or helping feed, or any number of other things that have value to the residents in the facility and are within the workers' injury restrictions. But no, they choose to pay her a month to sit and count people. It's punitive. Seriously, they are just trying to embarrass the hell out of them and discourage others from filing a claim [KI Interview 19: 7-8]

The above example also emphasizes the devaluation of relational care (social and emotional) within LTRC. Given the emphasis on measurement within the current care regime, it is interesting that the nature of “suitable” modified work the employer selected in this instance mirrors this orientation towards counting instead of resident care.

According to participants, workers who are on modified duties within their facilities are often not replaced on the floor for the work that falls outside of their injury limitations and work restrictions. The practice of non-replacement of workers on

modified duties creates workload intensification, pressures, and risks for workers on the floor. As one participant states,

A lot of the work falls on us because they don't replace them [...] they are still on the floor, but there are some things that they just can't do. So, the work that they can't do falls on the rest of the staff members [Interview 6: 4]

Participants' narratives highlight that the practice of not replacing workers also produces resentment and tension amongst workers on the floor who are required to pick up the additional workload of the worker(s) who are on modified duties. According to this participant,

Injured at work, I dare not say because they put us on light duty. The workers' compensation, the occupational people put you on light duties. You have to report to work but you sit there folding wash clothes and the girls that are on the floor get upset because they are short [...] so it creates some animosity on the floor. So, you are doing light duties and the other girls are sweating their butts off, working short [Interview 17: 6]

It also places these workers at risk. Several participants similarly explain that frontline workers do not report injury or illness and file claims because of the nature of non-replacement practices within LTRC facilities and the tensions this practice creates amongst workers on modified duties and those on the floor having to work short. As this participant explains,

You don't want to do a WSIB claim because then you think your co-workers are going to get pissed off at you for now having to do your work. So you are damned if you do, damned if you don't [Interview 1: 12-13]

Current work organization practices, including non-replacement of absent workers within LTRC not only introduce intensified or new risks, these practices also extract more labour from workers through intensification as well as diminish workers' control over their care labour. Other participants reveal that work modifications offered through the employer do not take other demands such as those of home, family, and childcare into account when scheduling – and WSIB supports this practice. One key informant

indicates he frequently encounters this form of “accommodation” that takes no account of family responsibilities of women who are injured on the frontlines of care and require modified work duties. If a worker refuses the modified work offered by the employer, which WSIB has approved, WSIB discontinues income and health benefits for worker non-cooperation. As this participant explains,

I get this a lot...the employer will say to a worker, ‘with your injury – if you really need to have lighter work, I am going to move you to the overnight shift.’ And the worker says, ‘well, I’ve got two kids at home, I’m a single mom, I can’t work the night shift.’ And the employer will say, ‘that’s the only work that we have available for modification.’ And WSIB supports the employer every single time. It doesn’t matter what your family situation is outside the workplace. If the work is within your restrictions then WSIB will approve it. Whenever and whatever they offer that modified work, if it is within your restrictions, you do it. And to refuse to do it they cut you off – loss of earnings and health care benefits from WSIB. That’s the carrot and stick approach [...] and unless you have been through the WSIB ringer uh, it’s hard to comprehend the pressures and disadvantages that are forced upon you by way of the system [KI Interview 19: 8]

This is troubling for women on the frontlines of care. Women constitute the bulk of frontline workers within the LTRC sector. For workers with children, sex/gender divisions of labour within the household often mean arrangements for care reside with women. For women with dependants, their ability to assume waged work is contingent on their ability to also secure and afford childcare. Participants’ discussions also reveal that many of these workers are also single parents making this practice especially constraining, challenging, and unaffordable for these workers.

Attendance Management Policies and Practices

Attendance monitoring reflects the drive toward enhanced efficiency within restructured LTRC workplaces. According to some participants, attendance management programs trigger an organizational response to consecutive absences regardless of context. While through collective bargaining some unionized workers have been able to negotiate sick days into their contracts, employer attendance monitoring practices undermines this benefit. Participants state attendance management systems that operate

within facilities reinforce the practice of continuing to work despite injury or illness, as workers are fearful of repercussions from management. Several participants struggle with the assumptions that inform attendance monitoring within facilities. This includes the idea that frontline workers take advantage of and/or inappropriately use sick time.

Participants also highlight the individualizing effects of attendance monitoring. These practices ignore structural and organizational reasons and the conditions of work that may generate or influence worker absenteeism. According to one participant,

If you use your sick time you are hauled into the office, right. They blame us for taking time off or abusing sick time. And it's like last week, I just cared for ten people that were sick and now I'm sick and need to be off. It shouldn't be that shocking. But they don't get it. Like, I have people puking on me that have the flu, we are in outbreak, and I am abusing sick time if I am off with the flu after caring for them? Of course, I am probably going to get the flu. Hello, I am human! [Interview 1: 13]

The treatment of frontline worker absence as sick time abuse, illegitimate, or suspicious, shifts focus away from broader structural conditions and the nature of frontline residential care work itself, including the implications of high-demand and low-control work. One key informant describes a questionable attendance management program currently in operation within one LTRC facility. This program is understood to reinforce and encourage frontline workers not to report workplace injury. As this participant explains,

It has developed a program to give incentive to the staff not to report injuries or have sick calls and they do it as a reward for the department. And if one person in the department has an injury claim, that department gets taken off the balloting for a prize at the end of the month [...] So then the co-workers are on others not to file a WSIB claim. And it is entirely illegal. They cannot provide an incentive to prevent people from reporting an injury. Then they say, 'well, we are not doing it so they don't report, we are doing it to reward them when it doesn't occur' [...] they call it their 'attendance management program.' And I said, no, it's not attendance management it's prevention of reporting incidents in the workplace [KI Interview 19: 4-5]

This is a rate-based incentive system. With incentive from employers, frontline workers effectively pressure, regulate, and/or police each other to not report injuries. Workers participate in this process and are rewarded as a group for unwittingly facilitating reduced

employer premiums through lower injury claims while at the same time maintaining the status quo. This includes unsafe conditions of work, the invisibility of workplace injury and illness, and their disposability on the frontlines of care. Without significant change to the conditions and organization of work, the incentive system described above may create and maintain the illusion of safe practices by establishing low injury rates through non-reporting, while at the same time, enabling the rationalization of costs, control over the labour process, and exploitation of workers.

Sick or Injured but at Work: Sickness and Injury Presenteeism

Many participants report routinely going into work either ill or injured – a practice that masks the conditions of work and injury and illness rates within the sector. In this section, I contextualize “presenteeism” by highlighting several factors that shape the widespread practice of workers continuing to work on the frontlines of care despite injury or illness. As discussed in Chapter 5, chronic understaffing plagues LTRC facilities and management routinely does not replace frontline workers when absent. As a result, several of the workers state they continue to work because of the guilt they would experience for leaving their co-workers short on the floor and residents to suffer knowing that they would not be replaced on the floor if absent. A participant describes injury and illness presenteeism in this way,

A lot of girls do get hurt. I would say that three out of the four girls I work with today are hurting. We are constantly working injured. One girl, her shoulder is screwed up, the other it's her back, and it's my neck. It's scary. I am surprised there are not a lot more claims than there is. They have changed it so you are still working on the floor. So, no one wants to be working on modified duties because if you can't do it – they are not replacing you. If I can't do four or five of my residents my co-workers got to pick them up. You are putting more onus on your co-workers by taking time off... which 90 percent of us don't want to do unless we are really, really desperate and really hurting, injured, and we just can't struggle through it [...] They don't want to be a burden on other workers. If they have a claim and are off, it affects everyone. So, they will suck it up and pop the Tylenol and Advil and struggle through their shift injured [Interview 1: 15]

Gendered ideologies, expectations, and assumptions about care often shape and reinforce this practice of working despite injury or illness. Participants highlight that the typical response from management to worker injury is to dismiss, ignore, minimize, and/or blame.

The LTRC workforce is aging (see Chapter 4). Several older participants highlight that many of these older workers continue to work despite injury because management and supervisors claim they are “too old” and “should retire.” For many participants, this suggestion is a blatant threat and mechanism of control, which operates to silence older workers. According to participants, workers have no choice but to conceal their workplace injuries as they are in no position to retire or find alternative work. Below, one participant elaborates on the drive for profit and the rationalization of costs and labour within LTRC and discusses the treatment of frontline workers as disposable where age, not the conditions of work, is treated as responsible for workers’ injuries on the frontlines of care.

It is all about profit. They have had to cut into the budget more because they have had to replace you. They don’t like paying twice. They are not very giving. And if they tell you that... I have had an administrator tell an older girl that has been taking more sick time because her back is killing her, that has said to her she needs to retire. I think it is time for you to retire [...] It’s the older ones. Us older ones are more likely to keep working [...] you will see them popping Tylenol like candy. Everyday [...] and they don’t want to be a burden on us and they don’t want anyone saying they should retire. Because the reality is, they can’t. The attitude is, if you can’t do the job then get out of here. You see them down in the staff room putting the ice packs and the heat packs on their shoulders or on their backs [Interview 1: 13-14]

Some participant’s frame working despite injury or illness as a reflection of frontline worker dedication and commitment. According to this participant,

You are putting yourself at risk, putting others at risk [...] but you also know those staff who are committed. You know, you honestly have staff there they call in sick and then you have the dedicated ones who come in sick or not. They come in. They don’t book off on their weekend. I am one of the people. The only time I would call in sick is if I was infectious because I wouldn’t want to put other people at risk but you have people who just stay home cause they aren’t feeling well or are really stressed or whatever [Interview 2: 4-5]

In this account, self-sacrifice or placing oneself at risk is a demonstration of commitment and dedication. While risk to the worker is recognized, it should nonetheless be ignored. Moreover, intense stress and not feeling well are not legitimate reasons for missing work. The only reasonable absence, according to this participant, is one that would otherwise put others at risk. That is, the risk to others is privileged over the risk to the frontline worker. Similarly, another participant draws on gendered assumptions and expectations of care in her description of what constitutes a worker who does not care – leaving the contrast between workers who do care implied.

I mean there are some workers, we have the odd worker that don't care and they will call in sick for absolutely no reason because their stress levels are sky high and they just don't want to be there. And that is what is happening in our home, a lot of them are there for the paycheques now, they are not there for the care [Interview 5: 10]

In other words, women who care should be selfless. The experience of high levels of stress on the frontlines of care is normalized. This “care ethic” becomes a central part of the gendered “politics of production.” Numerous forces and relations shape what constitutes a legitimate absence. This includes employers and workers in the context of particular gendered, racialized, historical, political, and economic conditions. In these accounts, frontline workers – not the volatile, demanding, and stressful conditions of care work or the gendered and racialized inequalities that influence work conditions, including injury, illness, risk, and violence – are deemed problematic for their lack of alignment with gendered constructions of care that includes the demonstration of self-sacrifice and altruism, regardless of context.

While some participants acknowledge the context that underlies why frontline workers continue to work even if injured or ill, they also highlight the workload increases

and pressures that remain with a worker who is sick but at work. According to this frontline worker,

Some will come in sick cause they don't want to leave us short, but you are no good to me sick. I am still picking up the slack because I know they aren't well –and they mean well coming in to help, they just as well have stayed home because you are sick so, you know. You know though, damned if you do, damned if you don't [Interview 11: 14]

This participant highlights the impossible double bind this situation puts workers. Many participants repeatedly point to the financial constraints, age, child dependency, and the absence of benefits as reasons why some workers do not report injuries and continue to work despite injury or illness. As one explains,

A lot of them are getting older, so compounded with age... you know age and history, so most of them are single earners, head of their own households, so they have no other providers, so of course when they are sick they are going to come in. Who else is going to pay the rent, food? So they come in [...] some people have no choice. They have to come whether they are stressed, whether they are sick, they have to come in because they are the sole provider for that household, you know. So, I am going to work with pain, illness, injury, if I don't have anyone else providing my family with an income, you know. It's not a choice [Interview 2: 5]

One participant contracted through an agency to work in LTRC facilities highlights,

Most employees at least get one day off a month as a sick day. We don't even have that benefit. I am on my 21st day straight of a 25 day schedule. And I work split shifts. If I take a day off, it's a day I don't get paid [Interview 17: 23]

Some participants discuss how management and supervisors re-direct and shift the attention away from non-replacement practices by instead faulting the worker who is injured or ill as to why workers have to work short-staffed. As this participant states,

They [management] come on to the floor and 'guess what, you are all working short today because your co-worker decided to be sick today, if you got a problem with that, don't want to hear it, you take it up with them tomorrow.' So, they tend to blame the person who is sick and deflect the blame for not replacing them [...] that happens on a normal or regular basis or the 'you know what, you have an injured worker on your floor, you have to pick-up their workload.' You could go to them and say, I can't, it's too much. I'll get hurt. 'Too bad' they say, 'you have to do it' [Interview 1: 16-17]

This management practice reinforces the assumption that women's labour is infinitely elastic. Moreover, the idea that frontline workers are to blame for being too ill to work and the construction of taking time off for sickness as a "choice" reinforces the idea that

women should self-sacrifice and continue to work no matter what, even in the context of injury and illness – if they really care.

Health and Safety Committees

Several participants state the health and safety committees within their facilities are adequate and that frontline worker health and safety representatives are “on things quickly” and “nothing slips under them.” Yet, at the same time, participants repeatedly report being at risk, feeling unsafe, and experiencing injury or illness. Participants describe a situation where workers are frequently injured and exposed to violence. As a component of the IRS, labour-management committees such as health and safety committees are one mechanism to support the participatory rights of workers and are established to encourage co-operation between employers and workers (see Chapter 4). In the case of health and safety committees, the purpose is to manage and improve workplace health and safety. Participant discussions suggest health and safety committees may create the illusion of participation (Burawoy, 1979) and facilitate “working safe” discourse and some limited form of “safety culture” visibility. At the same time, significant health and safety risks, particularly those that are structural and organizational, remain less visible, unacknowledged, and unchanged.

The impact of health and safety committees on the everyday/everynight health and safety conditions on the frontlines of care is limited – particularly when health and safety risks emerging from understaffing such as violence are related to the organization of work and funding arrangements. According to many participants, problems are identified but are not often taken seriously or adequately addressed and corrected by facility operators. One participant suggests employer involvement and interest in

workplace health and safety extends only to the basic fulfilment of legislative requirements under *OHS*A,

I just wish health and safety in long-term care was taken more seriously by managers because it seems that they only worry about it because they are told they have to – like, it's just a mandated thing that they have to have, right. They have to have a health and safety committee, they have to have it [...] I think my managers at the present, if they weren't made to have a health and safety anything in the home, they wouldn't. They wouldn't if it wasn't mandated. And why do we have to? Well, because nobody has taken it seriously enough that it has to be mandated, right. Or nobody would want it in the home because obviously it costs money [Interview 18: 19]

Participants highlight that in the context of cost cutting and maximizing economic efficiencies, employers more frequently ignore safety committee recommendations to improve the health and safety conditions of workers. Some participants view health and safety committees as entirely ineffective. According to this participant,

The health and safety committee is a joke and it's just a way to get out of work. And I'm like I know cause you guys don't really do anything – you come and you check, you check, you check but nothing really gets done about anything. Really and truly, it doesn't [Interview 11: 7]

Other participants highlight the limited role and responsibility of committees who are tasked with the identification of uncomplicated and/or basic hazards and safety issues within the workplace. According to one participant,

It's about mainly making sure your hands are washed, make sure things are not dropping, make sure you wear the right shoes, things like that – slip and fall, umm different things. Making sure the lifts are in working condition – they go around and check the lifts sometimes see if working properly, bed rails are in working condition cause sometimes the bedrails get loose, drop, and bang and stuff. They are pretty good at responding to some things [Interview 13: 14]

The responsibilities of health and safety committees and the issues they take on, while important, do not reflect the broader concerns related to the organization of work and approach to care participants consistently identify in their workplaces that situate them at risk. Unequal relations, top-down or hierarchal decision-making, and devaluation of frontline work undermine the sort of management-labour collaboration regarding workplace health and safety that is envisioned under *IRS*.

Workers' Perspectives: Physically and Psychological Safe Long-term Care

I asked participants what a more psychologically and physically safe LTRC workplace would look like to them. Some frontline workers such as the participant quoted below could not even imagine the possibility.

Is that even possible? Oh my, I have no idea to be honest with you. I don't even think that would be possible. More psychologically and physically safe working in long-term care... That's a hoot. I don't think it would be possible [Interview 3: 7-8]

Other participants in this project have numerous suggestions that highlight their belief that LTRC does not have to be organized and designed the way that it presently is or that frontline work has to be as risky and dangerous as it is currently for workers and residents. Participants highlight more funding, more staff, reduced resident loads, more time to care and more time for care, more resources, and more respect, acknowledgement, and support from management, and the elimination of for-profit ownership, as means to improve health and safety on the frontlines of care.

More Frontline Workers on the Floor

Overwhelmingly participants indicate that more staff on the frontlines of care would facilitate a more psychologically and physically safe workplace. In the words of one,

A lot more time to take care of the residents properly. If you had all your proper equipment and enough equipment, you wouldn't hurt so much at the end of the day. And more staff. You need more workers when you are doing all of this [...] My ideal care situation would be to have an extra person on the floor, so be able to spend that time with the residents. If we had 15 minutes per resident in the morning, it would be the ultimate. Because then you actually get that time, you don't have to rush. It would be nice to have a floater on the floor. And it would be really nice to have the time to spend one-on-one with residents [Interview 5: 24]

More Funding

Participants point to the need for increased government funding for LTRC. Importantly, participants highlight that enhanced funding is to be directed towards greater frontline staffing levels. According to this participant,

Government puts more funding so there is more staffing and stuff, you know, to take care of these elderly people, they deserve it [Interview 6: 26-27]

Reduced Resident Loads

Participants state significantly fewer residents assigned per worker would be physically and psychological beneficial to both workers and residents. This is particularly important given the complexity and higher level of care required by many residents now entering LTRC environments. As this participant suggests,

A 7:1 resident to staff ratio would be a good environment where you are not rushed, and proper care can happen. Also, umm, yeah 7 to 1 because then residents would be able to be toileted more often, like actually when they need it, do proper care on them. Be able to brush their teeth if they have their own teeth, give the men a proper shave, talk to them, psychologically that would be a blessing. Physically, we could be able to do the work. It would be so much better [Interview 1: 8]

The account underscores how the conditions of care and inseparable from the conditions of work.

More Time to Care and More Time for Care

Linked to greater funding, staffing levels, and reduced resident loads highlighted above, participants state more time with residents to provide adequate, dignified, quality care is critical to a more psychologically and physically safe LTRC workplace. For example,

If we had more time to spend with residents, we could relax them enough to work with us instead of against us. It would make a huge difference to residents psychologically and physically and to us physically. We can't get that, and he can't get that when he is forced to rush because there isn't the time [Interview 7: 7]

More Respect, Acknowledgment, and Support from Management

Participants indicate the need for improved management and organizational relations and practices. Frontline workers want to be treated with respect, their work valued, and their contributions on the frontline of care recognized. Several participants express that greater respect, acknowledgment, and support from management would go a long way in facilitating more psychologically and physically safe conditions of work on the frontlines of care.

Management taking better care of their worker. Your voice being heard, you know. Our management has meetings and says you know – how are things going? What’s going on? What do you need? But it’s not there. It doesn’t matter how much you voice it – it is not there. [Interview 7: 6]

More Resources

Some participants highlight the need for sufficient equipment, supplies, and appropriate resources as necessary to improve health and safety. As this participant suggests,

If you had all your proper equipment and enough equipment, you wouldn’t hurt so much at the end of the day [Interview 5: 7]

Eliminate For-profit Ownership and Operation of Long-term Care Facilities

Several participants highlight that profit and pro-market principles and practices are incompatible with care and have no place within the publicly subsidized LTRC sector.

No long-term care home should be privately owed for profit. It should be all government run because these privately, for-profit owned homes they don’t care [Interview 6: 24]

Conclusion

In the current context of insecurity and labour market risks, frontline workers are exposed to greater risks, yet these risks are also more likely to remain invisible and/or treated as the fault of the worker by management and supervisors. The lack of support

and acknowledgement that workers receive from institutional authority regarding their health and safety reinforces their subordinated position and undervaluation within the gendered and racialized LTRC hierarchy, where historically, women and racialized workers have been segregated into the least attractive, least specialized, and poorly waged aspects of health care work. Blame and normalization operate to individualize the problem and shift attention away from the broader structural, organizational, and gendered context and policies, processes, and practices that may create and/or intensify conditions that further exploit workers and subject them to injury, illness, and violence. The culture of blame and tolerance of violence absolves management from responsibility to act. Structural constraints, hierarchical arrangements, and the organization of work limit the ability of frontline workers to articulate their health and safety concerns on the floor and report on injury, illness, and violence. These constraints alongside gendered ideologies of care, financial barriers, and return to work and staffing practices by employers contribute to the frontline worker sickness presenteeism in facilities of LTRC. Participants actively involved with union work are more likely to express concerns about the conditions of work or pressure employers for remedy. However, workers who are precariously employed, are fearful of backlash, and who feel disconnected from their union and unsupported in challenging retaliatory actions from employers, often conceal their workplace health and safety concerns from management and supervisors. Participants indicate that greater government funds, staffing, resources, respect, and acknowledgment from management and the rejection of for-profit policies, processes, and practices would facilitate improved health and safety on the frontlines of LTRC.

Conclusion

My research exploring the workplace health and safety implications of restructured LTRC for frontline workers had three interrelated objectives. The first objective of my research was to render the experiences and perspectives of frontline workers and the conditions of work visible – especially in relation to physical and psychological injury, illness, violence, and risk encountered on the frontlines of care. The second objective of this study was to consider how risk and hazard on the frontlines are linked to the broader historical, social, political, and economic context in which workers on the frontlines are situated. Lastly, this research had the objective of illustrating the ways frontline workers have resisted, challenged, and shaped the conditions of restructured LTRC frontline work.

The conclusion of this dissertation is organized into several sections. First, I provide a synthesis of my findings and highlight my arguments informed by feminist political economy. Second, I discuss theoretical contributions and implications of my research, particularly as it pertains to feminist political economy, structural violence scholarship, and theories of the labour process. Third, I identify and discuss main limitations of the results of my research. Fourth, I highlight key findings and identify elements that have relevance for policy and bargaining initiatives. Before concluding, I discuss areas for future research.

Synthesis of Research

Although the impacts of neoliberal restructuring and reform are frequently contradictory, current trends in health and social policy reform may – by design or omission – reinforce, legitimize, and obscure more fundamental inequalities, particularly

those linked to gender, race, and class as well as render the risks of this work invisible. Globally, these relations and inequities are enacted in international institutions and multinational corporations; locally they are manifested in national and provincial policies, programs, workplaces, communities, and households. In using feminist political economy as a lens, this analysis offers a consideration of how the organization of work within LTRC is shaped by and shapes historical, political, economic, and social relations – locally and globally.

Global economic reforms and trade agreements seek to protect and expand capital, encourage privatization, and commercialize health and care. These agreements undermine health by placing constraints on state capacity to enact legislation and regulations that facilitate workplace health and safety if these obstruct corporate interests in capital expansion, and profit generation. Within Ontario, privatization, including for-profit ownership and management of LTRC, is expanding. The extensive use of market strategies and managerial principles of the private sector in the non-profit and public facilities generates implications comparable to systems of LTRC oriented to accumulating profit. This includes using lean flexible work arrangements to intensify work effort and minimize employer costs while increasing control over workers. The extension of pro-market principles to organizing care also expands social inequalities and produces and/or exacerbates workplace risk.

In Canada, policies, practices, and processes of privatization shift the responsibility, costs, and risks of care. Given that women provide the bulk of waged and unwaged care, women are disproportionately impacted by these developments, emphasizing the changing/reduced role of the state, strengthening corporate interest and

profit generation. In LTRC, women constitute the “backbone” of the workforce (Noelker, 2001). Alongside reduced health and social care spending and industry demands for a cheap, “unskilled,” and flexible workforce the LTRC labour force is increasingly influenced by global neoliberal economic reforms that encourage the transnational flow of immigrant labour from poorer countries to richer ones to meet rising care needs (Eckenwiler, 2011; Eckenwiler, 2012)

This research indicates frontline LTRC workers encounter numerous physical and psychological risks. Work on the frontlines is mentally, emotionally, and physically laborious. Indeed, it is risky, dangerous, and violent work. Many of the physical and psychological risks workers encounter are shaped by the broader social, economic, and political context in which these workers on the frontlines labour. This dissertation outlines specific types and experiences of risk these frontline workers face in relation to gendered and racialized restructuring and work organization processes, policies, and practices. These include lean and flexible staffing, privatization, workforce transformations, downloading, and routinization and standardization alongside a more complex and demanding resident base because of health and social care reform and restructuring occurring within LTRC and elsewhere.

Within LTRC environment, work reorganization, restructuring, and changing resident demographics and complexities of care have meant the frontline worker workloads and the physical and mental demands of this work are increasingly intensified. Frontline workers are required to do more work, with fewer workers, and in less time. These transformations have occurred alongside growing precarity and insecure work arrangements and an aging as well as racialized and marginalized immigrant LTRC

labour force. These changes have meant that frontline worker autonomy, control over their labour process, resistance, and possibilities for teamwork are increasingly constrained, creating space for new and/or intensified risks and hazards. Importantly, in a climate dominated by neoliberal agendas these risks and hazards are more likely to be rendered invisible – ignored and individualized – understood as part of the job, treated as the responsibility, fault, and pathology of predominately female workers or blamed on workers’ gendered responsibilities outside of LTRC. Consequently, the broader structural and organizational arrangements that shape risk, injury, illness, and violence, are obscured. Frontline workers are situated in a position where they are required to “figure it out” on the frontlines without sufficient resources, which places workers (and residents) at risk. This includes inadequate funding, support, training, supervision, staff, and regulatory protections.

In Ontario, the “government-at-a-distance” approach to health and safety has meant that health protection of workers is largely in the domain of workers’ compensation systems and workplace health and safety committees. This is very troubling for workers who are located at the bottom of the LTRC social and organizational hierarchy. As with many feminized worksites, this work is characterized by high demands, low control, and poor support and where gendered assumptions reinforce the treatment of this work as natural, unskilled, and not dangerous.

Evidence matters. Limited, biased or male-skewed understandings of what constitutes evidence of injury and illness and under what conditions informing workers’ compensation adjudication processes and practices excludes much of the injury and illness that workers on the frontlines encounter. This is especially the case for risks that

are a result of precarious workforce configurations and work intensification processes and practices as these risks are particularly poorly regulated. This includes the physical and mental risks associated with work organization, lack of support, training, job strain (Karasek, 1979), employment strain, and job insecurity (Lewchuk et al., 2011). LTRC is a workplace that is increasingly designed and organized in ways that are without commitment to frontline workers – including security, protections, and benefits associated with standard employment relationships. These broader conditions also shape frontline workers strategies, mechanisms, and capacities for resistance and ability to influence the conditions of their work. Frontline workers, particularly workers who lack job security and experience disconnect from their unions are placed in a position where they must ignore, tolerate, and/or accept risky conditions on the frontlines.

In a context of cost cutting, sweeping austerity measures, workers' compensation systems along with employers are increasingly oriented to protecting the bottom-line – maximizing efficiencies through minimizing expenditures, not injury reduction. Within Ontario, health and safety committees are established under IRS philosophy of shared participation, interests, and responsibility for workplace health and safety. Yet, these programs are rooted in the context of fundamentally unequal relationships between workers and employers where the emphasis is on controlling workers, rather than workplace health and safety. This is particularly problematic in a context of lean, intensified, and precarious work where insecurity is increasingly established as a labour market norm and used as a powerful mechanism to control and silence workers on the frontlines. Given these conditions, many frontline workers are not in a position where

they can exercise the right to refuse unsafe work – relatedly, these workers are also poorly positioned to report on unsafe conditions as required by *OHSA*.

Significance of Research Findings and Theoretical Implications

My research offers several important contributions to prior research and scholarship. In the discussion below, I focus my contributions in the ongoing conversation regarding LTRC primarily in relation to feminist political economy, structural violence, and theories of the labour process.

This dissertation builds upon and supports previous research within LTRC using the lens of feminist political economy to understand the conditions of work and care within the context of neoliberal restructuring (Armstrong et al., 2001; Armstrong & Daly, 2004; Armstrong & Jansen, 2006; Armstrong et al., 2009; Banerjee, 2010; Daly et al., 2011; Daly & Szebehely, 2012; Armstrong & Braedley, 2013). It expands feminist literature in relation to precarious work, which highlights the growth of precarious work as gendered and racialized (Vosko, 2010). This study suggests gender and race have become important components of the new ruling relations (Smith, 1987; Smith, 2005) and the production of care within LTRC. It also contributes to understanding the gendered consequences of the neoliberal shift that increasingly transfers risk, responsibility, and cost of care to women (Brodie, 1996; Armstrong & Armstrong, 2003; Luxton, 2006; Armstrong et al., 2009; Braedley & Luxton, 2010). My findings also extend existing research exploring the gendered impacts of restructuring for frontline workers' health and safety (Armstrong & Jansen, 2006) and the relationship between working conditions and mental and physical health (Karasek, 1979; Lewchuk et al., 2011) – particularly in the context of feminized worksites, connecting these to broader

structures, social relations, and forces. This context deepens and/or manufactures risk, injury, illness, and violence on the frontlines of LTRC and reinforces a culture of blame, tolerance, and silence. It also contributes to understandings of restructured LTRC labour processes along the lines of gender, race, and immigrant status as well as how restructuring practices, policies, and processes work to sustain broader inequalities. Findings from this study go beyond research highlighting the extensiveness of violence against women within LTRC settings, by providing contextualized discussion of frontline workers' experiences and perceptions of violence – particularly sexual violence, racism, and bullying and harassment. The significance of social location is also revealed. Social location influences the nature of risk, the ways frontline workers resist, challenge, and shape the conditions of their work, as well as the implications or consequences of this ongoing struggle. It connects the personal with the political, linking risk, injury, and violence to social structures, relations, and policies as well as provides insight to the extent to which unions, workers' compensation, and health and safety committees shape the capacity of workers' to resist and shape working conditions.

In addition, my dissertation builds upon and contributes to structural violence scholarship (Galtung, 1964; Galtung, 1969; Farmer 1996; Farmer, 2004). This is particularly the case with existing research conducted in the LTRC setting (Banerjee et al., 2008; Banerjee, 2010; Armstrong et al., 2011; Daly et al., 2011), where the concept of structural violence is used to shift the focus from individual workers and workplaces in understanding injury rates, risk, and violence to a consideration of broader structural factors. This includes the way institutions and structures, which constitute the care and regulatory regime of LTRC, impede workers from reaching their full potential, and

residents from having their basic needs met. The conditions of work and care within LTRC are shaped by broader social, economic, political, and moral decisions related to how we think about care and the responsibility for care – the nature of care, how it should be organized, practiced, experienced, by whom, for whom, and under what conditions.

Neoliberal-inspired reform and restructuring within LTRC care has fuelled existing social inequalities, often making these inequalities wider and deeper. The devaluation of care work is profoundly linked to assumptions about women's work and the nature of care, and in particular, to notions about the endless capacity of women to labour in any context (also see Armstrong & Armstrong, 2005; Baines, 2006; Baines, 2015). Within LTRC, the current conditions of work and care are a product of decisions that are quite far removed from the frontlines of care, have little to do with care, and are in many ways incompatible with health, equity, safety, and inclusiveness. The decisions informing policies, programs, and practices privileging particular forms of evidence have the effect of legitimizing and reinforcing exclusion and oppression of marginalized groups. They also obscure the ways assumptions about gender, care, risk, injury, or violence are inseparable from the conditions that structure the organization of frontline work. Ruling relations (Smith 1987; Smith, 2005) and the broader structural "pathologies of power" (Farmer, 2004) have created, reinforced, and legitimized a sick system under the guise of "effective" and "efficient" care. It has meant the rights of workers to safe and healthy workplaces are obscured by corporate compulsion to accumulate, protect, and expand capital and rationalize costs. Workers increasingly absorb the risks, responsibility, and costs of health and safety. Yet, it is clear that while the current work and care conditions within LTRC are quite disturbing, degrading, and dehumanizing – for

workers and residents – conditions within this setting can be improved. Indeed, this belief in the potential for transformative change underlies feminist political economy and understandings of structural violence. Risk, injury, illness, and violence are not natural or inevitable elements of frontline work – they are predominately a product of the way LTRC is currently financed and organized.

LTRC is a “contested terrain” (Edwards, 1979) – where the struggle for control between employers and workers over the labour process within this setting assumes numerous forms. Management struggle for control over the frontline labour process may be maximized through multiple mechanisms and strategies. This includes control through bureaucratic means such as technology, documentation, rules, and regulations, coercive strategies such as precarity, insecurity of work, and reprisal (i.e. threat, intimidation, fear, blame) that reinforce workers’ silence, and the ways consent of the frontline workforce is manufactured on the floor (Burawoy, 1979) through commitment underpinned by gendered assumptions and ideologies of care. These mechanisms and strategies facilitate management control over workers and labour processes, reinforcing and perpetuating frontline worker alienation, devaluation, and exploitation.

Within LTRC, the delivery of care is treated like a production process analogous to “assembly-line” work. Throughout this dissertation, I have referred to this delivery and organization of care as the “production of care.” Yet, in contrast to factory processes, care is relational. It is a social process. Under the current care regime, the social and emotional elements – the caring content – are defined out of what constitutes care in its emphasis on standardization and routinization models of organizing work which privilege the measurable physical and instrumental tasks of care. Unlike

manufacturing, the frontline worker labour process extends beyond workers and employers in this setting. Frontline workers' experiences and accounts highlight the important role of residents and residents' families alongside management and technology in shaping and negotiating their everyday/everynight labour on the frontlines.

At the same time, new mechanisms of control generate new strategies and modes of worker resistance. Frontline workers resist intensified, efficiency-oriented, standardized, and routinized approaches to care through rule breaking, prioritizing, and negotiating care practices to be more in line with individual resident needs and preferences – although these too may introduce new risks and hazards. Workers also shape and/or contest these conditions by refusal to reproduce some forms of industry language, by “working smarter, not harder,” and through employing experience-based “tricks of the trade.” Frontline workers – particularly those who are precariously employed, are coerced into providing unwaged labour in order to keep their positions. Other workers are often compelled by a “gendered ethic of care” – guilt, moral obligation, and duty to compensate for insufficiencies in the system of LTRC. In the process of resisting a system perceived as antithetical to care and organized as production or “assembly-line” work, frontline workers subsidize and compensate for deficits in this system with their own unwaged labour and resources. Meanwhile, they absorb the physical and psychological demands and risks of providing care. Elsewhere this has been referred to as the “compulsion-coercion continuum” (see Baines, 2004). Inadvertently, these workers reinforce and reproduce their subordination and exploitation, shifting the focus away from structural, policy-related problems and the organization of frontline work. This includes the ways frontline work has been stripped of its social and emotional

caring content under lean and flexible arrangements and standardized and routinized care approaches. Workers, particularly those with greater job security, active involvement, and perceived support with their respective unions, resist ongoing pressures to provide unwaged labour that is understood to conceal system inadequacies, reinforce exploitation, and maintain the status quo. While speaking to the broader social and material conditions that shape unwaged labour for some workers these “decisions” are simultaneously framed as individual choice. They thus obscure the uneven relations in which the terms of unwaged labour are rooted, and reproduce and reinforce the individualism, personal responsibility, and victim-blaming central to neoliberalism.

Limitations

One objective underpinning this qualitative project was to develop a deeper understanding of frontline workers experiences and perceptions of working conditions within LTRC settings. The study offers rich, deep description in relation to this objective, foregrounding the voices of the workers who do the frontline work.

All research suffers from some limitations. Data for this research was obtained using a purposive sampling method. This method is understood to limit or restrict the extent to which findings may be representative beyond the sample. That is, the extent to which broader generalizations can be drawn from the results. While theoretically, the potential for non-representativeness is indeed a research limitation in using non-probability sampling, in acquiring a deeper understanding as one on the main goals of this research – in practice, whether my findings are representative or generalizable is less concerning. My methodological approach in this qualitative study was oriented towards meaning in order to understand how participants, in their own words, view, interpret, and

experience their frontline work, working conditions, health and safety, and resistance within LTRC settings. My decision to use this sampling method reflected my ontological and epistemological orientations, research objectives and questions, and the resources and means accessible to me.

Secondly, although the sample was small, in-depth interviews allowed for intensive exploration of experiences, issues, and struggles on the frontlines of care – providing the opportunity through data immersion and analysis to reveal the richness of experience, the centrality of the voices of those who do the work, and recognition of contradictory experiences. Despite challenges with participant recruitment, particularly in a context increasingly characterized by risk and uncertainty, including insecurity, fear, and precariousness – project participants shared significant and sensitive information regarding their experiences on the frontlines of care. Moreover, the resulting sample for this study was heterogeneous in the sense that it mirrors the diversity of the LTRC frontline workforce. This includes frontline workforce demographics (age, experience, country of origin, immigrant status, language, ethno-racial self-identification) employment status (part-time, full-time, casual, agency) shiftwork (days, afternoon, nights, weekends), and unionized status. I am confident the experiences and perceptions of working conditions on the frontline of LTRC are not exclusive to the participants of this project but resonate more broadly with frontline workers in this setting.

Implications for Policy and Collective Bargaining

My decision to recruit for my sample across the sector (as opposed to sampling purposively from within one or two specific facilities) allowed me to identify and explore frontline workers' experiences and perspectives from a range of facilities located in

different regions across Ontario with different size and ownership configurations such as for-profit, non-profit, or municipal. This focus on frontline workers within the sector rather than frontline workers within specific facilities assisted my interest in developing a deeper understanding of the range of health and safety issues facing workers' within this sector.

This research has contributed to understandings of LTRC work relations, structural conditions, and transformed labour processes within the LTRC sector in ways that have implications for policy, particularly for those who seek to advance the conditions of frontline workers through legislative activities and bargaining. This includes demands for meaningful health and safety standards and protections within LTRC settings, recognition of LTRC workplaces as sites of risk and hazard, as well as promoting legitimacy and compensation for physical and psychological health conditions.

Greater staffing levels are frequently suggested in policy and research circles as well as in union campaigning as imperative to improve the conditions of work and care in the LTRC environment. My research interpreted through the lens of feminist political economy reveals that although improved staffing levels within facilities of LTRC are critical, greater staffing levels is certainly not adequate. Measures to address gendered and racialized injury, illness, risk, and violence must go beyond the inadequately resourced, work organization, and arrangement problems of the sector that are created and/or intensified by neoliberal-inspired reform. This includes consideration of the nature and context of care, recognition of gender-specific and racialized forms of workplace risk, and the need to address broader power and structural inequalities and mechanisms of exclusion in which structural forms of violence are normalized,

individualized, and justified and/or legitimized within institutions of LTRC (and elsewhere). These considerations, though certainly not exhaustive, are important, particularly in light of the mounting shift towards privatization, commodification, and standardization and routinization of care as well as responsabilization and individualization of risk. This is occurring alongside growing flexibilization processes – labour insecurity, non-standard work arrangements, and precariousness within and between nations that has emerged and intensified for frontline LTRC workers under gendered, racialized, neoliberal restructuring and reform. These changes have important implications for the injury, illness, and violence reporting, by whom, under what conditions, and with what consequences. My findings highlight the need for broader structural and policy action that go beyond the workplace in addressing risk, injury, illness, and violence on the frontlines of LTRC. It is clear that for critical change to occur this requires a significant paradigm shift.

Future Research Directions

This research draws attention to several areas to undertake in future research. One area of potential research includes exploring strategies to reconcile risk, injury, and illness identification with risk, injury, and illness intervention within LTRC. That is, while this research provides insight into frontline worker experiences with risk, injury, illness, and violence and the broader factors that shape and influence these experiences, as well as workers' perspectives regarding what more physically and psychologically safe workplaces look like, the most appropriate ways to intervene or implement change demand further investigation. Comparative research that demonstrates the ways context creates conditions is also an important direction for prospective studies of working

conditions on the frontlines of LTRC, which could be further complimented with survey research. Another area of research exploration relates to more fully considering the role of the union in workplace health and safety struggles amidst the changing landscape of health and social care. This includes exploring union challenges in the struggle to organize workers and offer new alternatives and strategies – particularly in a LTRC context characterized by growing privatization, work reorganization, workforce transformations, resident demographic shifts, and precarious work arrangements that obscure, normalize, and/or individualize risk and position workers as disposable. Contemporary unions are confronted with the need to address broader processes, practices, and relations that shape the reluctance of workers to report their work-related injuries and illnesses, to voice workplace health and safety concerns, and to refuse unsafe work.

Conclusion

While dominant approaches recognize workplace health and safety, they are misguided in that the broader structural and organizational processes in which injury, illness, risk, and violence are rooted on the everyday/everynight frontlines of care remain invisible and unchanged. The corporatization, standardization, routinization, individualization, and responsabilization that underlies the current care and regulatory regime shaping workers' experiences and conditions of work ignores structural disadvantage. This is often in ways that reinforce and/or give rise to new sources of exclusion, marginalization, inequity, risk, and hazard that compromise workers' rights, constituting a form of structural violence. This includes the rights to subsistence and

wellbeing, and equitable, safe, inclusive, and healthy work conditions within the LTRC environment.

Appendix A: Ethics Approval



Certificate #: STU 2011 - 130

Renewal Approved: 10/04/13

Renewal Approved: 10/11/12

Amendment Approved: 05/16/12

Approval Period: 10/04/13-10/04/14

Memo

OFFICE OF RESEARCH ETHICS (ORE)

5th Floor,
York Research Tower,
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Tel 416 736 5201
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To: Andrea Campbell, Department of Sociology, andreaca@yorku.ca

From: Alison M. Collins-Mrakas, Sr. Manager and Policy Advisor,
Research Ethics
(*on behalf of Duff Waring, Chair, Human Participants Review
Committee*)

Date: Friday October 4th, 2013

Re: Ethics Approval

Invisible worker(s), invisible hazards: an examination of
psychological and physical safety amongst frontline care workers in
long-term care facilities in the 'new' global economy

I am writing to inform you that the Human Participants Review Sub-Committee has reviewed the request for renewal of approval re the above project, and, finding that there are no substantive changes to the methodology or the risks to the participants or participant pool or any other aspect of the project, no further ethics review is required and renewed approval is granted.

Should you have any questions, please feel free to contact me at: 416-736-5914 or via email at: acollins@yorku.ca.

Yours sincerely,

Alison M. Collins-Mrakas M.Sc., LLM
Sr. Manager and Policy Advisor,

Office of Research Ethics

RESEARCH ETHICS: PROCEDURES to ENSURE ONGOING COMPLIANCE

Upon receipt of an ethics approval certificate, researchers are reminded that they are required to ensure that the following measures are undertaken so as to ensure on-going compliance with Senate and TCPS ethics guidelines:

RENEWALS: Research Ethics Approval certificates are subject to annual renewal. Researchers are required to submit a request for renewal to the Office of Research Ethics (ORE) for review and approval.

Failure to renew an ethics approval certificate or (to notify ORE that no further research involving human participants will be undertaken) **may result in suspension of research cost fund and access to research funds may be suspended/withheld;**

AMENDMENTS: Amendments must be reviewed and approved **PRIOR** to undertaking/making the proposed amendments to an approved ethics protocol;

END OF PROJECT: ORE must be notified when a project is complete;

ADVERSE EVENTS: Adverse events must be reported to ORE as soon as possible;

AUDIT:

More than minimal risk research may be subject to an audit as per TCPS guidelines;
A spot sample of minimal risk research may be subject to an audit as per TCPS guidelines.

FORMS: As per the above, the following forms relating to on-going research ethics compliance are available on the Research website:

Renewal

Amendment

End of Project

Adverse Event

Appendix B: Interview Guide

Invisible work(ers), invisible hazards: physical and psychological safety amongst frontline long-term care workers in the 'new' global economy

Principal Investigator: Andrea Campbell

Preamble:

The main purpose of this interview is to discuss your experiences with care work, working conditions, health, psychological and physical safety, including risk and violence in relation to your work as a personal care assistant in long-term residential care settings. Your participation is completely voluntary and you may choose to stop participating at any time, for any reason, if you so decide. All information you supply during the interview/focus group will be held in confidence. This information will be safely and securely stored and only the researcher will have access. As indicated on the consent form, your name will not appear in any report or publication from this research.

I would like to start by asking you to share information related to your working background as a frontline worker (Probe the following)

- ☐ How long have you worked as a care worker?
- ☐ How long at current location?
- ☐ Employed full-time, part-time, casual
- ☐ Overtime? (paid/unpaid)
- ☐ How secure is your work?
- ☐ Do you work elsewhere, have another job?
- ☐ What influenced your decision to become a care worker?
- ☐ If worked elsewhere in long-term residential care what were your reasons for leaving?

Describe your work day/night. What is a typical workday for you like? (Probe the following/examples when appropriate)

- ☐ How many hours do you normally work in a day?
- ☐ Do you work with the same staff and residents on a day-to-day basis? What difference does this make?
- ☐ Workload e.g., staff-resident ratios, resident characteristics and acuity levels – has this changed?
- ☐ How would you describe the work you do?
- ☐ Are you able to exercise discretion, autonomy or control with decision making, do you have say or input into how, when, where work is done or the amount of time it takes to complete this work?
- ☐ How are care updates/changes communicated?
- ☐ Breaks (are these structured, are workers permitted to leave work site for breaks? Are there a designated space/area to take breaks) Do you ever skip or forgo breaks – are they ever interrupted?
- ☐ Are you able to complete your work, get it done?

☐ Do you feel pressured in your work? In what ways and in what situations do you feel most pressured?

What about stress? Overwork?

☐ Is your work physically demanding? What aspects of your work are most demanding?

☐ Do you have sufficient time to perform particular tasks related to your work?

☐ Are there times you feel rushed in doing your work? (Examples)

☐ Do you feel your workplace is short on staff or understaffed?

☐ Do you work alone?

☐ Is your sleep affected by your work?

☐ Are your food choices, eating habits affected by your work – or when, what, how you eat?

☐ Do you experience competing demands or tensions with your work? How do you prioritize or negotiate these?

☐ How satisfied are you with the care you give? Has this changed overtime? What would make your care work more satisfying? Less stressful?

☐ Are you responsible for training or providing orientation to new workers? Volunteers?

How do you know when you have done a good job?

What does a psychologically and physically safe workplace mean to you?

What risks to health (e.g., physical, mental, emotional, wellbeing) and safety do you come across in your work setting?

(Probe the following)

Physical setting (e.g., space, people, equipment)

☐ Work organization (rules, regulations, policies, shifts, scheduling)

☐ Other risks of illness or injury (examples)

☐ Frequency/form

☐ Have the types/forms of risks changed?

Do your working conditions affect your ability to carry out your work?

Do the conditions of your work or the way it is organized affect your relations with others with whom you work? (e.g., residents, co-workers, supervisors, resident families)

Do your working conditions affect your relationships with family or friends? Does it affect your ability to form or establish new relationships?

Do your working conditions affect your ability to perform and/or pursue other interests or work? (e.g., leisure, social activities, exercise, education, housework, other responsibilities) (Probe for examples)

Do you use the skills as you have learned them in your education and training?

(Probe – identify skills – how used/not used)

Do you do work in which you have not been trained? If yes, is this expected or required?
(Examples)

How likely are you to continue to work when you are ill or injured?

(Probe)

- ☐ Context, situations –When or under what conditions are you most likely to continue to work?
- ☐ Do you have sick time/benefits?

Are workers replaced when they are absent?

(Probe)

- ☐ Staffing levels/working short-staffed?
- ☐ What does this mean for your workload and your ability to get your work done?
- ☐ What does this mean for your health and safety?
- ☐ What does it mean for your ability to provide the type or quality of care you would like to?

How supportive is your manager, administrators or other direct-care workers when you are ill or injured? (Probe - organizational culture around illness/injury, institutional discourse - examples)

How is injury reported within the long-term care facility in which you work?

(Probe the following)

- ☐ Process/Protocol (Is this what actually happens?)
- ☐ Effectiveness of reporting mechanisms
- ☐ Barriers to reporting
- ☐ Personal experiences/examples

What do you consider violence to be?

Have you experienced violence or harassment within your workplace? (Probe the following/ examples)

- ☐ Residents
- ☐ Resident families
- ☐ Supervisor, Management
- ☐ Other workers
- ☐ Other sources of violence or harassment
- ☐ Institutional “rules” that generate/foster/escalate or reduce violence or risk of violence
- ☐ Effects

Do you feel safe at work?

- ☐ Are there particular situations or tasks that make you feel unsafe – or less safe?
- ☐ Do you do anything to make yourself feel safe?

Have such incidents resulted in time-loss?

What is the reporting process/protocol for “incident” reports? Is there follow-up by supervisor/other/debriefing?

(Probe the following)

- ☐ Would you report an incident? File a grievance? Why or why not?
- ☐ Are there incidents e.g., physical, sexual harassment, verbal abuse, discrimination, harassment, bullying that you would be more likely/less likely to report?
- ☐ Does the direct source of the violence/harassment/discrimination make a difference in whether you report? (e.g., co-worker, supervisor, resident, resident family) If yes, why is this?
- ☐ What are your experiences (positive and negative) with reporting?

Have you ever required care, treatment, support, or advice – medical, professional or otherwise – following these or other experiences and incidents?

Have you ever reported an injury to WSIB (if yes probe example(s), process effectiveness, support of supervisor/management, barriers to reporting)?

Have you (or others with whom you work) experienced differential treatment or discrimination because of gender, race, language, immigrant status or illness and injury? (by residents, supervisors, coworkers)

(Probe the following)

- ☐ Nature of differential treatment (examples)
- ☐ Differences with shifts/workload/promotion/advantages/privileges/reporting opportunities/ expectations/other?
- ☐ Supports?

Are there opportunities or requirements for training or re-training within your workplace?

(Probe the following/examples)

- ☐ Type of training, status, is the training mandatory or is it voluntary?
- ☐ Remuneration – paid/unpaid, offsite/on-site, when offered (during or outside of regularly scheduled shifts)?
- ☐ Is there support or accommodation by supervisors/management to participate in sessions?

Does this training have practical application and/or relevance to work?

Does the facility in which you currently work have supports or resources to address unsafe working conditions, psychological and physical safety in the workplace?

(Probe/examples – policies related to anti-discrimination, workshops, educational programs, union sponsored/supported programs).

To what extent are these supports/resources appropriate, relevant, and/or useful?

Is there a health and safety committee within your workplace? Does the committee respond to and address health and safety issues?

Is your union involved or proactive in workplace health and safety issues?

In what ways do you think you personally influence/shape/challenge/resist the conditions of your work?

Are there adequate supplies to perform your work? Is equipment accessible?

Do you ever go into the workplace when not scheduled? Do you go in to work early or stay beyond your scheduled shifts? Perform work when not on shift (Probe personal/supervisor/management/co-worker expectations/ attitudes/ towards unpaid labour)

Do you feel you are compensated appropriately for the work you do and the conditions under which you do this work? Why – why not?

Do you feel appreciated, valued, or respected for the work you do?

In your current work setting, how would you describe your working relations with co-workers? (e.g., PSWs, supervisors, management)

Do work conditions allow you to work together as a team? (Probe the following)

- ☐ Situations, when this is/or is not the case, has this changed?
- ☐ Workload
- ☐ Stresses
- ☐ Confidence/trust
- ☐ Strategies
- ☐ Conflicts/problems related to background, training, age, language, race, experience

Do your supervisor(s) seek input from you in terms of how your work is structured, organized, or carried out? (e.g., resident care, scheduling, training)

Are there any further comments you would like to make?

Demographic – age, race/ethnicity, immigrant status, language, education, title

Appendix C: Informed Consent Form

Project: Invisible worker(s), invisible hazards: physical and psychological safety amongst frontline long-term residential care workers in the ‘new’ global economy

Principal Investigator: Andrea Campbell
York University
4700 Keele Street
2071 Vari Hall
Toronto, ON M3J 1P3
andreaca@yorku.ca

I, _____, understand that I am being asked to consent to participate in a research project conducted by Andrea Campbell, a Doctoral Candidate in the Graduate Program in Sociology at York University. The main objective of this project is to explore front-line care worker experiences and/or perceptions of care work, working conditions, health, psychological and physical safety, including risk and violence in long-term residential care settings. To be clear, this study is not inquiring about individual health records or specific workplace(s), rather this research is concerned with individual experiences of workplace safety and conditions of care work more generally.

I understand that I am being asked to participate in an individual and/or focus group interview. I understand the duration of the interview and/or focus group discussion is not anticipated to exceed one hour. I understand that I will receive a “Tim Horton Gift Card” in the amount of \$10 for my participation in this research.

I understand that my participation in this study is completely voluntary and that I may choose to stop participating at any time, for any reason, if I so decide. If I decide to stop participating, I understand that my decision not to continue participating will not influence my relationship or the nature of my relationship with the researcher, or with staff at York University either now or in the future.

I understand that my decision to stop participating, or to refuse to answer particular questions, will not affect my relationship with the researcher, York University, or any other group associated with this project. In the event I decide to withdraw my participation in this research information generated from my participation and all associated data will be promptly destroyed wherever possible. I understand that if I stop participating, I am still eligible to receive the promised inducement, a \$10 “Tim Horton Gift Card”, for agreeing to be in this research project.

I understand all information I supply during the research will be held in confidence and unless I specifically indicate my consent, my name will not appear in any report of the research.

I understand that confidentiality will be provided to the fullest extent possible by law. Data will be collected using handwritten notes, audiotape and/or a digital recording device. I understand that I will be asked for permission to record this meeting and it is my right to refuse to give permission. I understand that any audio recording of this meeting will be used for accuracy and exclusively for the purposes of this research and nothing I say can be attributed directly to my place of work or myself.

I understand that in the transcript or any other write-up of this research, my identifying information will be altered and my real name will not be used. I understand that data collected for this research will be securely stored in a locked file cabinet in which only the researcher has access. I understand that data stored electronically will be password protected. I also understand data from my participation in this research will be securely stored by the researcher for a minimum of two years and this data will be destroyed when no longer required for research purposes.

I understand that no risks are anticipated from my participation in this study. I understand that the aim of this research is to identify health hazards related to care work within long-term residential care. I also understand that if I decide to voluntarily participate in this study, I may not benefit directly.

I understand that if I have any questions about the research in general or about my role as a participant in the study, I may contact Dr. Pat Armstrong (dissertation supervisor) by e-mail at patarmst@yorku.ca.

I understand this research is in accordance with and conforms to the standards and guidelines of the *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans* (http://www.pre.ethics.gc.ca/pdf/eng/tcps2/TCPS_2_FINAL_Web.pdf). I also understand this research has been reviewed and approved by the Human Participants Review Sub-Committee, York University's Ethics Review Board. I understand that if I have any questions about this process, or about my rights as a participant in the study, I may contact the Graduate Program Office in Sociology, York University (telephone 416-736-5013) or the Sr. Manager & Policy Advisor for the Office of Research Ethics, 5th Floor, York Research Tower, York University (telephone 416-736-5914 or e-mail ore@yorku.ca).

I understand that a summary of findings from this research once completed will be made available to me should I request a copy.

I consent to participate in the project "Invisible work(ers), invisible hazards: physical and psychological safety amongst front-line long-term residential care workers in the 'new' global economy" conducted by Andrea Campbell. I understand the nature of this project and wish to participate. I understand I am not waiving any of my legal rights by signing this form. My signature below indicates my consent. I have been provided with a copy of this consent form.

Participant Signature

☐ I authorize the audio recording of this interview.

Date

Principal Investigator Signature
Andrea Campbell

Date

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