They Deserve Better

The long-term care experience in Canada and Scandinavia

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Chapter 1
Introduction

They Deserve **Better**

The long-term care experience in Canada and Scandinavia

Canada has had long-term residential care facilities for well over a century.[1] Given that many more people are living well into old age and a growing number are surviving with severe disabilities or chronic conditions, we are likely to have them for a long time yet. Equally important, long-term residential care is growing as a source of profit, further increasing the likelihood of residential care in the future.

Yet long-term residential care is largely invisible in Canadian policy debates. It is missing from the Canada Health Act, the legislation that sets out the principles on which our public health care system is based. It is also missing from our most recent national investigation of health care, the Commission on the Future of Health Care in Canada (the Romanow Report).[2] As Whitney Berta and her colleagues make clear in their analysis of long-term residential care, "policy around [the]nature and quality of LTC care for the future is virtually absent from the political agenda."[3] And too often, long-term residential care is missing from our minds as well. Based on her research in the field, Nancy Guberman concludes that "It is so socially depreciated as an option that it is more like a non-choice."[4] Indeed, most of our efforts as a nation and much of that as individuals are focused on keeping ourselves and others out of long-term care facilities rather than on the work and care within them. It is time to change the options.

In this book, we focus on the conditions in long-term care, in an effort to draw attention to the places where a quarter of a million people live and where more than a quarter of a million people work. [5/6] While the proportion of the population living in long-term care facilities has not changed significantly over the last century, the numbers working and living in them have grown enormously. These are critical institutions in our society, and a critical indicator of how we view the elderly and disabled. And by this measure, we do not make the grade. As one worker eloquently put it, "They deserve better."

Our analysis here is based on four central assumptions. First, both the residents in long-term care facilities and their care providers deserve to be treated with dignity and respect. While the health care worker quoted in our title is referring to residents, she could be talking about care providers as well. How we treat those who work in long-term care is an important indicator of the value we place on the care for the residents. Without, for example, offering providers the opportunity to shape their work in response to residents' individual needs, it is difficult for them to deliver appropriate care not to mention to treat residents with dignity and respect.

This point is related to our second assumption, namely, that the conditions of work establish the conditions of care. There is an integral relationship between how the work and workplace are organized, how employees are treated, and the quality of care. Without decent conditions of work, it is difficult indeed to provide quality care. For example, the increased use of diapers as a way of reducing the staff required to take people to the toilet often contributes to the physical violence frustrated residents direct towards care workers.

Our third assumption is reflected in our methods as well as in our analysis. We assume that those who work in facilities and are in contact with residents on a daily basis provide an excellent source of information on the conditions for work and care. This includes not only the entire range of nursing and therapy staff but also personal support workers as well as housekeepers, maintenance and dietary aides who play a critical role in the team effort to provide safe and effective care. These workers can, for example, help us see the injury and illness that go unrecorded in official data or the difference between formal staffing levels and the actual number of people involved in providing care.

Finally, all these assumptions come out of an approach that understands health services within the context of broader political and economic systems that are global as well as national, regional and local. Long-term care, for instance, is one of the areas highlighted in international trade agreements, underscoring its growing importance as an area for profit-making in health and social care. Long-term care, and health systems more broadly, are cross cut by significant power differences, which are in turn usually related to gender, racialization, and class. These systems shape how care is conceived, organized, and delivered. Because we see these forces as important, we locate long-term residential care within the context of not only health care reforms and an aging population but also in relation to

ideas about markets and policies that promote profits. In doing so, we seek to show that there are indeed choices being made. And alternatives are possible. Because we see similarities among the pressures different countries face and options in the way these pressures are addressed, we developed a research strategy that allowed us to compare developments not only within Canada but also with Scandinavia. The Scandinavian countries, like Canada, have a public health care system and a large, growing elderly population, so they offer a useful point of comparison. In surveying the three provinces of Ontario, Manitoba and Nova Scotia, we sought to capture similarities and differences in Canada as well. While all face a considerable increase in the elderly population, they have responded in different ways in terms of residential care.

In order to develop a picture of long-term residential care, we draw on four different types of sources. First, there are numerical data taken from surveys distributed to unionized workers in the three Canadian provinces identified above and in four other countries; Denmark, Finland, Norway and Sweden. (For ease of discussion, use "Nordic" and "Scandinavian" interchangeably to identify these four). The initial questions for the survey were developed as part of a project on long-term care in Scandinavia. By distributing a similar survey in Canada, we were seeking to explore the similarities and differences in long-term residential care conditions. The survey was translated into English and then revised in consultation with the major health sector unions. The Canadian Union of Public Employees, the Canadian Auto Workers, the National Union of Public and General Employees, the Service Employees International Union, and the Canadian Federation of Nurses Unions offered feedback on the questionnaire, helped distribute the survey, organized focus groups and commented on our analysis while keeping enough distance to ensure that the workers' responses and our report were not inappropriately influenced by them. Many questions were literally the same in order to ensure comparability; some were slightly different and some were specific to Canada. Our survey methods are described more fully in Appendix A.

Second, we analyzed comments written into the survey by participants, expanding on their answers and filling gaps in the questionnaire. In some cases, workers were asked to comment on their answers. In other cases, the respondents went beyond the simple alternatives offered by writing in the margins in a way we had not anticipated. Transcribing these comments allowed us to see the patterns and to see issues we had not seen before.

The commentaries bring life to the numbers generated from our analysis of the survey data.

Third, there are quotations taken from focus groups of workers who were asked to assess our survey results and to offer additional elaboration or criticisms. Once we had done a preliminary analysis of the survey data, we wanted to find out if our analysis resonated with the experiences of workers not answering the initial survey. For the most part, those involved in the focus groups said conditions were worse than the survey data indicated. Their comments encouraged us to explore some additional areas and allowed us to provide here some specific examples of the broader patterns.

Finally, there are references to other research conducted in or on long-term care facilities in Canada and abroad, data collected by statistical organizations, and research on the broader contexts within which long-term residential care is located. This literature helps us locate developments in long-term care within global as well as local developments. It also allows us to reinforce our findings with those conducted by other researchers and to expand on our data through comparison with other investigations.

Our emphasis is on working conditions – broadly defined – and the consequences for both residents and providers in Canada. We focus on working conditions because these are the conditions for care, and they reflect our assumptions about dignity and respect for both residents and providers. After setting the context, we begin by looking at issues related to the number and distribution of workers. Staffing levels emerge as the single most important issue for these workers, a result that confirms other research in the field. Canadian workers consistently report that there are not enough people and not enough of the appropriate mix of workers to provide adequate care. The low staffing ratios are made worse by the failure to replace people on leave. This means both heavy workloads for those who are there and frequent overtime, some of which is unpaid. Added to this is a lack of autonomy and choice, making it difficult for workers to develop their own strategies to deal with individual needs and work overload. Shift work, irregular schedules and involuntary part-time work are also identified by these workers as critical issues, along with pay and benefits that are inferior to those for similar positions in hospitals. The physical structures and organization also often create barriers to good care and safe work. All of these factors contribute to the heavy physical and emotional demands of the jobs.

These conditions, the workers say, have negative consequences for providers and residents. They have no time to care, leaving them too often feeling stressed and inadequate. Diapers, for example, go unchanged in ways that encourage incontinence, and residents are put on medications as a substitute for care. The speed and intensity of the work, combined with overtime and multiple part-time jobs, contribute to the very high illness and injury rates, which cost employers as well as workers. These conditions also contribute to the violence against providers that is frequent and frequently severe. Workers report going home exhausted, mentally and physically, at the end of their shifts, and this exhaustion, along with the irregular hours, makes it difficult to balance household and paid work demands.

Most of these patterns have been reported before and are too often seen as necessary consequences of dealing with long-term care and the rising number of those with such needs. However, the comparative data from within Canada and from the Nordic countries show that there is little that is necessary about this kind of work organization or these kinds of consequences for residents and workers.

Long-term residential care in Canada is our primary focus. However, comparisons with Nordic countries serve to identify critical factors in providing quality care. These comparisons help reveal the extent to which the nature of care work, along with the pressures from growing numbers who need care, construct the conditions of work. Although comparisons are possible only in some areas, given differences in facilities and occupational categories in each country, the comparable data indicate that there are options for workers, residents, and policy-makers. There are significant differences among and within countries, suggesting there are real choices to be made. Our research indicates there are other ways of constructing conditions of work and care, ways that can mean greater dignity and respect for both workers and residents. Residents and workers deserve better. These comparisons show that better is indeed possible.

Chapter 2
Long-term Residential Care

It is difficult to offer a simple description of long-term residential care in Canada, let alone in comparison with other countries. Part of the problem has to do with the way lines are blurred among hospitals, home care and residential care, with home and residential care often lumped together in policy, in administration, and in data. Part of the problem results from the exclusion of long-term residential care from the Canada Health Act, leaving provinces and territories to design their own principles for their often quite different systems. Part of the problem is related to the wide range of facilities, methods of payment and regulation, and kinds of ownership that may exist even within jurisdictions. Part of the problem is also linked to reforms in health services that make long-term care a constantly changing set of services, especially in the face of the pressure to reduce costs and create profits. And part of the problem results from our reluctance to come to terms with the need for such facilities and for improving the quality of care provided within them.

Some similar problems exist in discussing Scandinavian facilities. As the Organization for Economic Cooperation and Development (OECD) concludes in its international report on *Long-term Care for Older People*, "long-term care still lags behind acute health care when it comes to measurement and quality improvement strategies."[7] By drawing on a variety of sources, it is nevertheless possible to develop the description that follows of the organization, residents and workers in long-term care. The description, however, must be approached with some caution.

This chapter starts with a definition of long-term care in order to develop the basis for the analysis that follows. The subsequent sketch of the pressures and histories that shape the structure of residential care begins with developments in the roughly thirty-year period after World War Two. These brief outlines set the stage for a description of current forces at work, as well as for both the differences and similarities in responses to them. The chapter ends with portrait of those who live and work in these facilities. In these latter sections, we also show how the respondents in our survey reflect overall patterns in the facilities, setting the stage for the analysis that follows.

Defining Long-term Residential Care

What do we mean by long-term care? The answer may seem obvious, but it is actually quite a complex question with a variety of answers. It is useful to look more closely at the definitions used in various sources because they can help us clarify the issues for investigation, policy and practice.

The OECD defines long-term care as:

> *a range of services for persons who are dependent on help with basic activities of daily living over an extended period of time. Such activities include bathing, dressing, eating, getting in and out of bed or chair, moving around and using the bathroom, often in combination with rehabilitation and basic medical services.*[7]

Because this definition would include services provided in the home, the OECD provides another definition for the kind of residential services that are the focus of this book. Referred to by the OECD as either long-term care institutions or nursing homes, they are defined as:

> *Places of collective living where care and accommodation is provided as a package by a public agency, non-profit or private company. Residents may or may not be charged separately for care services and accommodation.*[7]

While it is useful to consider this definition because it is the basis of the international comparative data used here, it is also important to note that the definition remains broad enough to include the growing number of private residences that are without public support or scrutiny in Canada. Addressing this distinction, Statistics Canada has a somewhat more restricted definition of residential care facilities, the preferred term in current data. They are: "facilities with four beds or more that are funded, licensed or approved by provincial/territorial departments of health and/or social services."[5] This is the definition we rely upon in this book but it should be noted that this more narrow definition still encompasses an incredibly diverse set of institutional forms, differing around size, ownership, acuity of residents, and models of care. For instance, this definition encompasses small, home-like settings as well as large-scale facilities with several hundred beds. It encompasses not-for-profit and charitable homes, private "mom and pop" operations, as well as corporate chains owned by private equity firms, the hospitality industry, and the like – all with an intense commitment to the extraction of profit.

In short, the definitions of residential care used by the OECD and by Statistics Canada allow us to make comparisons among and within countries, but such comparisons need to be treated with caution because what is being captured can vary with the definition. It can also vary with both the social policy context and care reforms, issues considered in the next section.

Developing Approaches to Care

Debates continue about the specific forces that have contributed to the different approaches to the development of social programs, among and within countries.[8-10] There is agreement, however, that the Great Depression and the war that marked its end were significant turning points. Capitalism had failed not only the general population, but also many owners. Not surprisingly, then, there was a consensus among a majority on the need for some restrictions on markets in order to prevent such a collapse from happening again. At the same time, fascism had been defeated, leaving either socialism or welfare capitalism as the alternatives. People in Western nations experienced benefits from shared responsibility through state involvement, and demanded better conditions after the sacrifices made during the war period.

The economic boom that followed, itself supported by state intervention and the expansion of social programs, contributed to the further development of those programs. But the political, economic, ideological and social conditions within each country contributed to somewhat different trajectories in each of them. The multiple factors and their varied outcomes in terms of health care services in general, and long-term residential care in particular, are too complex to detail here. It is possible, however, to provide a brief sketch to lay the background for the analysis of current conditions in long-term residential care.

Both Canada and the Nordic countries have a tradition of multiple, mainly local, voluntary and religious health and social services. And both introduced universal health care programs, albeit in somewhat different forms and located within different approaches to social programs overall and within different histories.

In Canada, health care and social supports in general are the responsibility of the provinces and territories. Before the Second World War, both health and social services were provided by a largely uncoordinated mixture of charitable, religious and municipal bodies, with some small, privately-owned facilities, especially in long-term care. Care was primarily understood as the responsibility of families and charitable or religious groups, as well as local communities. It should, however, be noted that the survival rates for those with severe disabilities were quite low, and it was not common to live into old age with extensive care needs.

Moreover, it is important not to romanticize care in earlier times, because there is no strong evidence that it was always there for those in need or that the care provided was good care. This is a particularly important point in relation to women, because it is too often assumed that women willingly, lovingly, and effectively provided such care in the past.[11]

As was the case elsewhere, Canada emerged from World War Two with a population expecting more support from governments for a better life and with a sense of shared responsibility as well as of shared risk. The economy was booming and unions were growing in strength, as well as in commitment to social issues. Women's organizations were also active. But the memory of the Great Depression was still there. The result of these combined forces was a significant increase in social investment. Health care was a priority, although difficult to achieve given that it was a provincial responsibility and that the federal government had the most financial resources.

Canada began universal public care in 1957 with hospital and diagnostic services, followed nearly a decade later by medical care. The enormous expansion of hospitals and doctor services that came in the wake served to make access to services more equitable and to increase paid employment opportunities, especially for women. These programs were loosely based on an insurance model, with governments primarily using general taxes to pay for services already in existence. In order to get around the fact that provinces have jurisdiction over health care, the federal government offered to pay for half of the costs for doctors and hospitals if provinces followed principles that ensured this care was universal, accessible, comprehensive, portable among jurisdictions, and publicly administered. One result was what physician David Naylor calls public payment for private practice, albeit mainly for private practice that was not investor-owned.[12] Another was an emphasis on hospital and physician services, along with a medical model for care.

As sociologist Gregg Olsen put it, "compared to its Swedish counterparts, the Canadian health care system, like its welfare state generally, is geared more toward cure than care."[13] Equally important, health care was not centrally linked to a larger, public, integrated commitment to state involvement in social supports. Universal public pensions, introduced in 1951, did help support some care for the elderly, and there was some housing built for the poor, but there remained a strong belief in family responsibility for long-term care.

Neither the Hospital and Diagnostic Services Act nor the Medical Care Act, nor even the 1984 Canada Health Act that brought them together covered residential long-term care. Provinces were encouraged to put their money into hospitals and doctors, where the federal government would cover half the bill. Writing in 1978, economist Lee Soderstrom concluded that "there is a scarcity of information on the operation of nursing homes, which is symptomatic of the lack of public interest in nursing homes in the past."[14]

At the same time, however, there was growing pressure to provide more public support for, and surveillance of, long-term care facilities as an alternative to hospital care. In spite of federal financial support for care in hospitals, they were both expensive and in short supply relative to demand. The prohibition against fees for hospital care meant there could be no cost recovery, and long-term patients were a particular problem. Moreover, the cost of hospital care was increasing. This partly reflected the fact that the women who provided most of the care in the hospitals began to organize and successfully demand adequate wages for their work. But it also resulted from the rapid rise in physicians' income, as well as from the growing expenditures on drugs and technologies primarily produced by the for-profit sector.

And the numbers requiring care were growing as more people lived into old age and with disabilities. In the mid-1950s, politicians (sounding remarkably like politicians today) were claiming that the "astounding increase in the number of persons living beyond 65 years of age is the greatest social problem of our day."[15] Their care requirements were also increasing just as more women moved into the labour force in response to the rising demand for their labour, their growing need for income, and changes in attitudes, as well as laws about women's work. This massive movement into the labour force, combined with falling birth rates, meant there were fewer women available to provide care at home. It should be noted that much of the complicated care that was starting to be sent home had never been done there

before, and women had never been called on to provide care for so many elderly and disabled.

One place women went to work was in nursing homes, where it was assumed that women knew how to provide custodial care because they were women. Meanwhile, media publicized the emerging complaints about conditions in the largely unregulated long-term nursing home sector where small, for-profit private operators were not uncommon. Several high-profile cases of neglect, including testimony before a federal Senate Committee on Aging, served as triggers for government action.[16] Unions were also becoming active in this sector, pressing for better conditions for work and care, even though it was hard to organize facility by facility in nursing homes, as the law required.

Initially, there were lines drawn between what was called "custodial" care and medical or health care. Ontario, for example, introduced legislation that required all municipalities of a certain size to set up public homes for the aged. These homes, and the charitable non-profit ones, also regulated and funded by the social services ministry, were initially expected to provide personal care only, and this care was mainly for the frail elderly, most of whom were women. If you required medical care, you went to hospital, and if you left the hospital with more than what was defined as custodial care, you went into a nursing home rather than a home for the aged.

By the mid-1950s, however, these homes started to take residents who required more extensive, long-term intervention. The pressure to do so came from governments and hospitals, in part at least because these homes were not covered by the Canada Health Act and thus residents could be charged fees that were prohibited under the Act. The pressure also came from the nursing homes, with municipal homes "often seen as 'dumping grounds' for patients whom nursing homes and charitable homes refused to take."[17]

Meanwhile, a provincial investigation in response to growing public outrage and to calls from employers for a level playing field resulted in the government introducing regulatory and licensing legislation in 1966. At the same time, the provincial government paid a per diem rate to private homes for nursing care. The pressure for higher rates from the for-profit operators prompted the Minister of Health to tell the cabinet:

> *I have learned to my bitter sorrow that they are concerned about one thing only, making as much money as possible and giving as little as possible in*

return to the patients...[The] sooner this is gotten into on a public basis, the sooner we will be able to provide good quality care for this segment of the population.[18]

In spite of this recognition, the government responded to pressure from the owners and did not in the end introduce publicly-owned nursing homes in Ontario. Smaller provinces such as Manitoba, with more populist traditions, did so, however. Ontario, also like the other two provinces in this study, failed to make long-term residential care an insured service similar to that provided in hospitals.

In 1972, however, Ontario did introduce an Extended Care Plan. It provided coverage for medical services in private long-term facilities, but not for accommodation, and allowed for fees to be charged according to a schedule set by the government. Manitoba also funded nursing home care as an insured service, but Nova Scotia failed to do so.[17] This funding for medical services reinforced a tendency to approach care in medical ways, and to restrict residences to those with needs defined as medical. The earlier distinction between homes for the aged that were described as "custodial" and nursing homes that involved more "bed care" was eroding, not to be replaced by a notion of social care, but rather by one focused more on hospital models.

By the mid-1970s, the federal government had become very worried about the blank cheque it was offering provinces and set about placing limits on the total amount it would pay for hospital and doctor care. A new Established Program Financing Act (EPF) set limits on how much provinces would receive for hospital and doctors care. It:

also included a new transfer for the Extended Health Care Services Program. This group of health care services, defined as nursing home intermediate care, adult residential care, ambulatory health care and the health aspects of home care, were block funded on the basis of $20 per capita for fiscal year 1977-1978, and subject to the same escalator as insured health services. This portion of the EPF transfer was made on a virtually unconditional basis and, unlike the insured services transfer, was not subject to specified program delivery criteria.[19]

Because this new federal money had no strings attached, provinces could spend it in any way they chose, even using it for other services. As a result, this funding model failed to significantly change access to residential care

across the country or to make these services more similar. This program of federal funding was abolished in 1996, marking the end of what was in effect very limited federal support.

In summary, Canadian governments at the municipal, provincial, and federal levels expanded funding for, and the regulation of, residential long-term care facilities in the period following the Second World War. But they did so reluctantly, in response to pressure, and in a largely piecemeal fashion. These facilities were not fully integrated into an overall health or social service scheme. While the post-war universal federal and Quebec pension plans helped Canadians buy some care, it tended to be poor care, and the absence of alternative, adequate public home care and low-cost housing gave those with extensive care needs few attractive options.

When state support was extended to long-term care facilities, it was focused on medical care. What was usually termed custodial care was still thought of as a private, family responsibility and nursing homes were considered to be appropriate for those situations, as the Ontario Minister of Health put it in 1967, "when the families cannot, or will not, any longer maintain them." Certainly there were significant provincial variations. By 1986, Ontario insured nursing home services under both health and social service ministries, reflecting a division between medical and social care, and the majority of facilities were for-profit. In Manitoba, there was significantly more public involvement in ownership. Only a third of the homes were for-profit and services were insured by the health ministry. Nova Scotia failed to provide any insurance coverage, and was second only to Ontario in the proportion of homes owned by for-profit organizations.[17] But none of them began from a social care model based on public ownership, nor a recognition of the integral relationship between the conditions of work and the conditions of care. And many still carried the marks of their origins as places for the poor who had no alternatives, with women making up the majority of those with no options.

Not surprisingly, this was a period of expansion in the Nordic countries as well. As was the case in Canada, local responsibility and decision-making created significant variations among facilities. But there were significant differences in how Canada and the Nordic countries addressed the basis on which they built care. For one thing, almost all their care facilities were non-profit to start with, and government intervention in this period ensured

this was the case. In Scandinavia, public ownership was not only seen as an appropriate solution, but also developed as one.

The somewhat different approaches to long-term care in each of the Nordic countries reflect their specific histories.[20] In all the Scandinavian countries, until the 1950s, public care for older people was more or less synonymous with old-age homes – traditional institutions with low housing standards, limited access to care services and strict, authoritarian routines, clearly marked by their historical roots in the poor law period. The old-age home was more or less the only alternative for ordinary old people who could not manage on their own.

The interplay of three reforms in the 1950s gave elderly people a new choice: increased universal pensions, state subsidies for improving the standards in housing and home-help services. Thanks to the combined effect of these reforms, fewer people had to move to an institution as a result of low income, a non-functioning dwelling or a moderate need for practical help in daily life.

The Nordic countries had already formulated an "aging in place" policy in 1950s or early 1960s. In all the countries, the home-help services soon became very popular in all social groups, and they were in practice an important part of the formation of the universal welfare model in Scandinavia – a publicly financed (or strongly publicly subsidized) service offered to and used by rich and poor alike.

For the elderly with larger care needs, however, neither the old-age home nor the home-help services were enough. An increasing number of beds in long-term care hospitals and nursing homes were built for this group of frail older people. Usually these facilities were organised in a medical tradition with high nursing standards compared to the old-age homes but they often looked like a hospital, and the residents usually lived in shared rooms and had little privacy. Again, in line with the idea of universalism, there were and are very few fully privately-financed nursing homes in Scandinavia. Instead, the same facilities are used by all social groups, based on health support needs.

From the 1970s in Sweden, a decade later in Denmark, and even later in Norway and Finland, a new form of adapted housing with access to care was introduced in all the Nordic countries. Different concepts were, and are, used: service houses, assisted dwellings, and sheltered accommodation. The

diversity of concepts covers what is also a fairly diverse reality. Facilities usually consist of apartments with normal housing standards (1-2 rooms with kitchen, bathroom etc). The number of apartments in each facility varies but in all of them service and care are offered according to need – not as a package as in the traditional institutions. The help needed can be provided by the ordinary home-help staff or by staff located in the buildings. Usually, although not always, there are also collective services such as laundries, restaurants and spaces for leisure activities.

Starting in Sweden in the 1980s, a type of a modern institution was introduced: the group home for people with dementia. They are characterised by their small scale (6-10 small apartments sharing a combined kitchen and dining room), high staffing ratios and a home-like setting. These facilities may be seen as an attempt to combine high housing and high caring standards; securing both the need for privacy and independence and the need for safety, care and nursing. A similar ambition can be seen in the Danish concept of nursing flats, introduced in 1993. These are typically two-room apartments with private bath and kitchen, and with the same amount of nursing and care available as in a traditional nursing home.

Today in all the Scandinavian countries there are different types of residential care for older people who can no longer manage to stay in their own homes. In all these countries there has been a decline in the number of places in traditional institutions in relation to the aging population, and in all the countries there has been an increase in facilities where the residents have a small apartment and can receive extensive care. But there are also differences within Scandinavia in these respects.

In Denmark, according to the most recent statistics from 2007, there are around 32,000 nursing flats, 15,000 places in nursing homes or protected housing and 30,000 apartments in serviced housing for the elderly. The nursing homes have to a large extent been replaced by nursing flats. From an international perspective, the housing standard is very high, and the residents are regarded as tenants in all the facilities, even in nursing homes. Denmark differs from other Scandinavia countries in that many municipalities organize the services in such a way that the same care worker provides help to people in nursing homes or nursing apartments, as well as to people in their ordinary dwellings.[21]

In Sweden since 1992, only one concept is used in legislation and statistics: "special housing." Altogether, there were 95,000 places in 2007, a decline of 20 per cent since 2000.[22/23] This term covers what were previously known as nursing homes, as well as all other publicly subsidized and needs-assessed combinations of accommodation and care. At the local level, older concepts like nursing home or old-age home are still used, together with newer concepts like care dwellings, housing for older people, or, in particular, group homes for elderly with dementia – the most frequently used concept for residential care in today's Sweden.[24] In contrast to the rest of Scandinavia, all forms of residential care are covered by the same legislation: the Social Services Act. The idea of "aging in place" also covers residential care, and residents are (in principle) not supposed to move between different forms of housing with increasing need; 24/7 nursing and care services are to be offered in all forms of "special housing."[25]

Compared to other Scandinavian countries, the traditional nursing home has a much stronger position in Norway. In 2007, there were 39,000 places in nursing homes and 2,000 places in old-age homes.[26] These places are regarded as institutions. At the same time, there were 31,000 older persons living in assisted housing.[26] Unlike the rest of Scandinavia, Norway has seen an increase in nursing home places, while the total number of places in residential care has been reduced in relation to the aging population.

As is the case in Norway, Finland makes a distinction between institutions and assisted housing. In 2006, 19,000 persons lived in residential homes for older people, or what could be called old-age homes. The other form of institution is the bed wards for long-term care in health care centres: nursing homes in a hospital setting where 11,000 older persons resided in 2006. Close to 28,000 lived in sheltered housing for older people, 19,000 of them in sheltered housing with 24-hour assistance. Deinstitutionalisation started relatively late in Finland, but since the early 1990s there has been a shift from old-age homes to service housing.[27]

To summarize, the Scandinavian countries differ in the ways residential care facilities are conceptualized and organized, as well as in the mix of different types of facilities. In all these countries, however, an increasing number of the residents live in private apartments in facilities where help is provided on a 24/7 basis.

Care in These Times

Canada and the Nordic countries have been facing similar pressures in recent years. The number of elderly, and their share of the population, have been growing significantly, although the proportion that is elderly is higher in the Nordic countries than in Canada. The number of people surviving with severe disabilities is also growing. These pressures form the basis for the richly descriptive series of articles appearing in *The Toronto Star* recently under the perhaps misleading title "Boomer Tsunami."[28] In the series, author Judy Steed offers not alarms of fiscal crisis, but rather a wide range of concrete policy proposals drawn from both Canada and Scandinavia. Meanwhile, the talk of a crisis resulting from an aging population sounds very much like the claims made 50 years ago by the Ontario Minister of Health, quoted earlier.

Partly based on arguments that welfare state social supports are no longer sustainable under these conditions, all governments have faced growing pressure from international corporations and from international bodies such as the World Trade Organization to adopt practices taken from the private sector, to reduce services and to hand over whole sections or parts of public services to the private, for-profit sector. Long-term care has been identified as a profit-making area in trade agreements, and the rapid growth in corporate facilities is the result.

In addition, there is significant support in high-income countries for de-institutionalization. Care in the home is understood as preferred by those with care needs and as cheaper for governments, although there is some evidence that some elderly may prefer facility care and a lot of evidence that care at home is cheaper because the costs are borne mainly by women through unpaid labour.[29,30] There are, however, significant differences between Canada and the Nordic countries that are related to their histories, their attitudes towards care, and their support for public services, differences that are briefly explored here.

The Overall Context For Care

The 1984 Canada Health Act marked the end of positive social program intervention on the part of the federal government. Increasingly, social programs were attacked as undermining individual responsibility and collective economic development. Increasingly, public programs were singled out as

inefficient and ineffective. The growing government debt and deficit were blamed on reckless government spending on social programs, in spite of evidence to the contrary.[31] Indeed, tax cuts and a faltering economy were more much more important causes. Governments, partly in response to those seeking new areas for investment, adopted the philosophy of New Public Management. According to this philosophy, governments were to hand over as much as possible to be done by the for-profit sector, and any responsibilities that remained in government hands should be based on business principles.

Following this approach and responding to concerns about deficits, the federal government began putting controls on health care spending. In 1996, the Canada Health and Social Transfer lumped together all federal contributions to provincial welfare, education and health care, and reduced the total sum by an amount equal to what the federal government had previously given for welfare. The money earmarked for extended care was gone. In fact, provinces and territories now had the right to spend the money in any way they wanted, although there was significantly less to go around. These cutbacks, combined with economic troubles in their own jurisdictions and a shared commitment to market solutions, prompted provincial and local governments to follow the federal lead. Health care became a major target for reforms, given it was such a large share of public spending and a public resource that offered opportunities for private investment. Although the financial pressures on governments eased with the growing economy and rising oil prices, at least until recently, these approaches to government continue to set the stage for developments in long-term care.

The Residents

Clearly age matters in long-term care, considering that 82 per cent of those in such Canadian facilities are over age 65.[5] According to the Organization for Economic Cooperation and Development, 13 per cent of Canada's population is now 65 years of age and over, compared to 15 per cent in the Nordic countries.[32] Baby boomers will reach the key ages of 65 by 2011, 75 by 2021, and 85 by 2031.[33] The proportion of the population around the age of 85 is of particular significance for long-term care planning, given that the average age of admission has increased from 75 years in 1977 to approximately 86 years now.[34] Indeed, by the year 2031, Statistics Canada estimates the proportion of the Canadian population above 85 will almost double, as will the proportion of Canadians between the ages of 75 to 85 (see Table 1).[35]

Table 1: Proportion of Canadian elderly, 2006 & 2031

	2006		2031*	
Province	**75 to 84 (%)**	**85+ (%)**	**75 to 84 (%)**	**85+ (%)**
British Columbia	4.92	1.82	8.49	3.08
Alberta	3.66	1.27	7.38	2.50
Saskatchewan	5.44	2.40	8.81	3.17
Manitoba	4.94	1.99	7.64	2.66
Ontario	4.63	1.48	7.51	2.63
Québec	4.88	1.56	8.86	3.23
Newfoundland & Labrador	4.44	1.49	10.82	3.44
New Brunswick	4.86	1.89	10.27	3.61
Nova Scotia	4.84	3.58	9.98	3.43
PEI	4.69	1.95	9.63	3.14
Canada	**4.67**	**1.60**	**8.12**	**2.87**

Source: Statistics Canada, 2005, *Population Projections for Canada, Provinces and Territories*. Ottawa: Minister of Industry.
*Estimated total Canadian population in 2031: 39,029,400

The fear that this disproportionate growth of the elderly population will overwhelm the health care system has been used to justify reforms and new polices aimed at expanding care through the private sector and through private means. Yet, while the number of facilities and residents has been growing in Canada, the proportion of Canadians living in long-term care facilities has not risen significantly. According to Statistics Canada, "there were 4,1999 residential care facilities in Canada serving 230,550 residents at the end of the 2004/2005 reporting year."[5] This represents less than 1 per cent of the population, a proportion no bigger than a decade before and lower than it was in the 1960s. This is the case even though Canada puts more of its public money for long-term care into residential facilities than into home care.[7]

While it is the case that the elderly are the most likely to be in long-term care facilities, it is also the case that the overwhelming majority of the

elderly are not in such facilities. Equally important, those in the baby boomer generations are healthier and wealthier than any previous generation and thus are less likely to need such care. So there is not a strong basis for panic about rising demand in residential care, especially if we develop better prevention strategies for the elderly, such as the means for the more effective handling of drug prescriptions and more public supports at home. However, if the elderly do need extended care, they are less likely than previous generations to have children living near them, both because they had fewer children and because children now tend to live farther away.

At the same time, the relatively stable proportion of the population in residential care does not simply reflect a healthier population. It is partly the result of new policies for younger people with disabilities that keep them out of residential care by providing alternative kinds of supports. It also reflects more stringent criteria for admission to care. There is a new emphasis on home care, and it has become much harder to get into residential facilities.[36] Nearly 40 per cent of those in residential care are now over age 85, and most have complicated medical needs and often some form of dementia.[5] There is some provincial variation, but the overall patterns are the same.

Nearly two-thirds of the residential care population is female, and women account for more than three-quarters of those 85 and over. While there is some provincial variation, women are the overwhelming majority in all provinces. This over representation of women reflects not only their greater longevity, but also the fact that women are more likely to be poor and alone in old age and thus require institutional care, while men are more likely to have wives to care for them at home.

The Scandinavian age and gender pattern in residential care is similar to the Canadian one. Reflecting the older population in the Scandinavian countries, however, the residents are somewhat older and the proportion of women is higher. For instance, in Denmark, half of the residents in nursing homes and nursing flats are 85 years or older.[21] Also half of the residents in Norwegian nursing homes and old-age homes are 85 years or older.[26] In Swedish residential care facilities, the residents are even older: 58 per cent are older than 85 years and 70 per cent are women.[23] Finnish residential care is even more dominated by women: 74 per cent of the residents are women.[27]

In terms of the proportions of elderly living in residential care, there are large differences within Scandinavia, but the coverage is probably lower in Canada than in any of the Scandinavian countries.[7] In Sweden, 16 per cent

of the oldest population (80+) live in residential care (a decline from 24 per cent in 1993) compared to 19 per cent in Finland, 21 per cent in Denmark, and 25 per cent in Norway.[37,38]

That these long-term care facilities are mainly places for women is not new. But what is new in Canada, besides the more complex care needs of residents, is the increasing cultural and racial diversity of residents and of workers. Canada's population has shifted dramatically, with post-war immigration from a much broader range of countries, and these immigrants are now reaching old age. More people of Aboriginal origin are surviving into old age. Homes once geared primarily to a white Anglophone and Francophone population now must accommodate a wide range of cultural practices and, too frequently, deal with racism.

The population in Canadian residential care facilities has also altered significantly as a result of governments closing many chronic care and psychiatric hospitals and placing more stringent limits on length of stays in acute care hospitals. Some of this change was a response to the demand from various patient advocacy groups for deinstitutionalization. Some of it was designed to save money by shifting care to facilities where staff was lower paid and fees could be charged. But what it has meant is that those with the most complex needs were sent from these hospitals to residential care facilities, facilities previously devoted almost exclusively to the elderly. There are more men, and more younger men who had previously been cared for in hospitals. They are physically stronger and sometimes more violent than the female elderly. And there are more residents with major psychiatric health problems.

Similarly, Scandinavian countries have been closing psychiatric and acute hospitals. However, people under the age of 65 rarely live in facilities aimed at older people. Thus a mix of frail older people and younger persons with psychiatric disorders may be less likely in Scandinavian residential care. There is also a general goal in all the Scandinavian countries to have separate facilities for older people with dementia, with other facilities for frail older people who are not cognitively impaired. Yet in practice there are often large numbers of elderly with dementia in most facilities in all the Scandinavian countries. For instance, 79 per cent of the residents in Finnish health centre wards have moderate to severe cognitive impairment (73 per cent of the residents in old-age homes).[27]

In summary, the increasing proportion of the population that is elderly and the growing number of people of all ages surviving with major disabilities, combined with hospital reforms, smaller families, and women's labour force participation, means the demand for long-term residential care will remain. While there is little reason to panic about massive increases in the demand for this kind of care, there is reason to address conditions in these facilities given that we will still need them in the years to come. There is also reason to consider the consequences of major changes in the residential population. All these changes significantly alter both the skills required by care providers and the work demands.

The Facilities

The physical structures of buildings reflect and reinforce approaches to care. They also establish conditions for care, enabling or limiting workers' daily tasks and their relations with residents, as well as with other workers. It is therefore useful to describe briefly what long-term care places look like in Canada and the Nordic countries.

Many of the facilities in Canada look like hospitals, albeit with larger TV rooms and bucolic names that evoke a carefree serenity. In Ontario, just over half the homes have more than 100 beds. Even with significantly smaller populations, Nova Scotia and Manitoba have 48 per cent and 37 per cent of their beds, respectively, in such large residences.[5] However, one in ten of the residences in Manitoba and Nova Scotia have fewer than twenty beds, compared to only 3 per cent in Ontario. In contrast, homes for persons with "mental disorder," to use the Statistics Canada term, tend to be much smaller in all three provinces. Not surprisingly, the approach to care tends to be different in smaller facilities.

Large facilities can mean a broader range of services and activities for residents, more support and more opportunity for union membership among workers. But they can also mean a facility that feels much more like an institution than a home. This is particularly the case if residents lack rooms of their own. In all three provinces, there are single and double rooms, and some still have rooms accommodating four residents. There is a history of extra charges for single rooms, making privacy a privilege and one less likely to be available to women, who are more likely to be poor in old age. Recently, some jurisdictions have expanded the number of private rooms, and Nova Scotia has dropped the additional fee.[39] But Ontario has

allowed owners to designate up to 60 per cent of their facilities as "preferred" accommodation, and these private rooms may remain empty while there are waiting lists for the "basic" or semi-private rooms. Not everyone has their own bathroom, even if they do not share a room. Regardless of individual accommodation, there are usually large, communal dining halls where residents take their meals, long hallways and large recreation rooms centred on a television, although there may also be additional specialized service rooms.

Many of the facilities were constructed in a time when the majority of residents were frail elderly women who primarily required support with the activities of daily living. Although the facilities often looked like hospitals, residents were sent to hospitals for more complex care. Now, many residents require complex care and equipment in facilities designed for other purposes. In other words, they often look like hospitals without providing appropriate spaces for providing more complex care. At the same time, they are called homes although frequently without providing the kinds of spaces associated with homes. While all three Canadian jurisdictions in this study set out detailed requirements for the physical space and for safety standards, these requirements do not necessarily meet the current needs of residents and staff. Nova Scotia now says it has shifted from a welfare model to an independence and autonomy model, but this is only slowly being reflected in the structure of long-term care. And, although all three provinces inspect facilities in an effort to ensure standards are met, Ontario recently reported that as many as 60 per cent of the facilities were violating those standards.[40]

The Scandinavian facilities are usually more home-like than hospital-like. This is especially the case with Danish and Swedish facilities, while Finnish old-age homes and wards in health centres usually are bigger and have more hospital traits.[41] Facilities in Denmark and Sweden particularly are smaller than in Canada. On average, there are 32 residents in a residential care facility in Sweden today. One-fifth of the residents in Swedish facilities live in small units with ten places or less for persons with dementia.[24] Even in a large facility, not more than ten people usually live on the same floor. Meals are generally served in a combined kitchen and dining-room on the floor rather than in a large common dining-hall.

In Denmark and Sweden, virtually all older people in residential care have their own private room or small apartment. Private furniture, usually with the exception of the bed, is the rule. In Sweden today, only 1 per cent of the

elderly in residential care share their room/apartment with another person other than a spouse. More than 90 per cent of residents have a private bathroom, and more than three out of four also have private cooking facilities, usually a kitchenette.[23] The housing standard is lower in Finnish old-age homes and even more live in the health centre wards.[41]

In sum, in Canada there are some new facilities that provide most residents with private rooms and their own bathroom. Some have attractive recreation facilities. Some are constructed to allow easy access for wheel-chairs, to have lifts in the bathroom, and to have space for providers to work as teams to provide care. But too many are inadequate to the task, and too many look like hospitals rather than homes. In contrast, Scandinavian countries have focused on developing apartment-style facilities with significantly more privacy and a more home-like atmosphere.

The workers in our Canadian survey were employed in a wide range of facilities, although few work in small establishments, given the distribution of unionized workers. The Scandinavian care workers in the survey worked in all kinds of facilities, reflecting the different mix of more traditional institutions and home-like setting in the four Scandinavian countries. In Norway, a majority of the respondents were working in nursing homes, while the respondents in the other countries were more evenly spread between nursing homes, assisted housing, group homes for persons with dementia, and old-age homes. In general there were only minor differences in working conditions and work-loads among these kinds of facilities. The one significant exception was Finland. The Finnish care workers in the health centre wards had a more demanding work situation than any of the other groups of the Nordic workers.

The Ownership

Ownership not only reflects notions about who can most effectively provide care and pressure from those interested in making money; it also often influences the quality of care. A British study, for example, showed that for-profit ownership limited choices for both residents and providers, while a Canadian study has shown that staffing levels are lower in for-profit facilities.[42,43] Long-term residential care involves a significant expenditure, making it both an area of concern for taxpayers and an area of interest for those seeking profit. According to Statistics Canada, in 2004/2005 the "industry generated $12.6 billion in revenue and expenses, about $1 billion

more than in the previous year."[5] All organizations seek to be as efficient as possible in order to control costs, but for-profit firms not only have to save money; they also have to make money. It is important, then, to know who owns what in long-term care.

Forty per cent of the long-term care beds in Canada are in facilities owned by for-profit companies.[5] Although in the past many of these facilities were owned by families and often called "mom and pop" operations, today they are increasingly owned by large, often international corporations. In Ontario, 55 per cent of the approved beds are in for-profit facilities. Three-quarters of the for-profit beds for the aged are in facilities with 100 beds or more, and the for-profit homes for people with mental disorders tend to be disproportionately large as well. In Nova Scotia, 37 per cent of the beds are in for-profit facilities, and these, too, tend to be large operations. Three-quarters of the for-profit beds for the aged are in facilities with 50 or more beds. Manitoba, however, is different. Only a quarter of the beds there are in for-profit facilities, although almost all of them are in places with 50 or more beds. Manitoba has long had a greater commitment to public ownership, with 37 per cent of their beds in public hands compared to only 20 per cent in Ontario.

By tradition, the vast majority of residential care facilities in Scandinavia are publicly run. Since the early 1990s, however, there has been an increase in private actors in the publicly-financed elder care services in all the Scandinavian countries, especially in Sweden and Finland. In 1993 in Sweden, 3 per cent of the staff in the publicly financed elder care services were employed by non-public employers, mainly by not-for-profit organizations. In 2005, the proportion working in for-profit establishments was 11 per cent, and it was 3.5 per cent in not-for-profit organizations. There is a clear tendency towards corporatization. The largest companies in the Swedish elder care sector today are owned by international private equity firms.[44,45]

In Finland as well, privately managed (but publicly financed) elder care has increased and is today more widespread than in Sweden. Unlike Sweden, the main part of Finnish non-public elder care is carried out by non-profit organizations. In 2002, not-for-profit organizations were responsible for 45 per cent of the places in service housing and for 11 per cent of places in old-age homes. For-profit companies had 11 per cent of the service housing and 1 per cent of old-age home places.[27]

In short, long-term care facilities in Canada are increasingly owned by large companies seeking profit. There are, however, significant variations in ownership across the provinces included in our surveys, with Manitoba having the lowest level of for-profit ownership and Ontario the highest. This distribution has consequences. For example, according to Berta and her colleagues, residents requiring more complex care are mainly in the public facilities, creating heavier workloads in them.[3] It may also mean cutbacks on staff, especially in areas such as cleaning that can be contracted out and can, as we see below, be areas where money can be made as well as saved. The workers in our Canadian survey came from for-profit, not-for profit, charitable and municipal homes, although the results make it difficult to analyze the data along these lines.

Compared to Canada, private sector involvement in elder care in Scandinavia is still comparatively small, and the limited research in the field has not shown any systematic differences in the working conditions between publicly and privately run facilities.[46] The relatively small private care sector in Scandinavia is reflected in the response pattern of the care workers, with very few privately employed care workers in Denmark and Norway, somewhat more in Sweden and Finland.

The Funding

"Who pays for care" influences access to care, which in turn affects who lives in residential care facilities and under what conditions. Funding also has an impact on care providers, not only because it determines what resource are available, but also because it shapes the relationships in care. It is important, then, to identify who pays for care.

Even though a growing proportion of residential care facilities in Canada are owned by companies seeking a profit, and thus are in private hands, long-term residential care is funded primarily out of government coffers. Provincial governments have made considerable capital investments in the buildings themselves, although in Ontario municipalities have done so as well. In all three provinces studied here, general taxes pay for what are defined as health care costs, and residents pay a fee to cover some aspects of what are defined as accommodation services. There are limits placed on the fees that can be charged, and subsidies are available for those not able to pay them. Health care needs, rather than money, primarily determine

who enters care in all three provinces, although Nova Scotia until recently applied means tests before entry and still does so for the subsidies, as other provinces do. All three provinces have moved to a regional health authority and a single access point for determining entry into a range of continuing care services, including residential care. This coordination can help promote care at home, better integration and more equitable assessment; but it can also restrict options. The criteria employed to identify needs and sort individuals become of paramount importance here. And if the individual is refused entry, there are few if any publicly-funded options available. It should also be noted that all three provinces administer long-term care through their Health Departments, indicating that they are understood as health facilities rather than as social services.

What provinces mean by health care costs is mainly determined by a case mix index, which is a tool designed to asses patients' level of care needs. In Ontario, a person from outside the facility who is trained by the government classifies the residents, while in Manitoba levels of care are usually self-assessed by the facility or in partnership with a representative from the regional health authority. In both cases, the assessment is done a year in advance of funding. "Thus the funding provided to a nursing home to meet its needs as determined in 2004, is sent to the home in 2005, a year later. However, by that time, many residents will have reached a more deteriorated condition, needing even more care. Administrators and front-line workers alike were critical of this aspect of the system."[47]

In Ontario, the nursing and personal care costs are determined by the classification system. There are also set amounts for program and support services, raw food, and accommodation costs which include facility costs, administration, housekeeping, building and operational maintenance as well as dietary and laundry services. Unused money for anything other than the accommodation envelope must be returned to the province, a strategy intended to ensure the money goes to care. Thus, accommodation is the only place the province officially leaves open to profit-making, and this fee is paid by the resident. In Nova Scotia, however, accommodation costs paid by the resident include charges for salaries, benefits and operational costs of maintenance, dietary, housekeeping, management, administration, capital and return on investment. In Manitoba, as one of our focus group participants explained, fees can be charged for a whole range of services:

the residents have to pay for the foot care nurse on their own. It's not provided by Manitoba Health. So they're sitting in a care home getting the care they're supposed to get but they can't get their toenails cut. They have to pay somebody ten bucks to come in and cut their toenails

The growing numbers of private investors in health care have guaranteed payment from governments. But they also have significant restrictions on where they can make a profit and on how they can run their facilities. Profits can come from selling services such as hair cuts and from charging for special activities, with provincial variations in who can be charged for what. They can also come from the extra fees for private rooms and for other services defined as non-medical. Additionally, profits can come from providing fewer and lower paid staff than other facilities, especially in areas defined as accommodation. However, two of the three provinces included here have a set minimum on the number of total care hours, and all three require a Registered Nurse on staff. There is more flexibility on the rest of the staff mix.

Public funding for elder care services in Scandinavia is clearly generous from an international perspective. Among the countries compared in the 2005 OECD report, Sweden spends the largest proportion of Gross Domestic Product (GDP) on elder care. Even when the fact that Sweden also has the largest proportion 80 years and older is taken into consideration, Swedish public spending is the most generous, followed by Norway.[7] The OECD concludes:

Norway and Sweden stand out in this comparison with substantial higher spending than any other country. Although both countries also have the highest population shares of very old persons, the high expenditure numbers are also due to the generous program design in both countries. Comparatively high spending levels in these countries are illustrated by the generous services provided for residents in nursing homes. Both countries offer more amenities, such as single room and well-equipped housing infrastructure, compared to other countries.

Sweden and Norway are the only Scandinavian countries included in the OECD report, but, according to recent Scandinavian statistics, Swedish spending on elder care services as a percentage of GDP is still the highest, followed by Denmark and Norway, while Finland spends substantially less.[38] It is difficult to compare the staffing statistics among the Scandinavian countries, but one attempt shows that the staff in elder care (full-time equivalents) in relation to the number of persons 65 years and older in the population is much lower in Finland than in it is in any of the other

Scandinavian countries.[48] In terms of resources, then, Finland seems to be somewhere between Canada and the other Scandinavian countries.

In Scandinavia, the residents pay a fee to the local authority, not to the facility. Compared to Canada, the user fee is much lower, although there is a considerable variation within Scandinavia. In Finland, the user fees account for 19 per cent of the costs in old-age homes; in Sweden user fees only account for 5 per cent of the total costs for elder care.[49,50] In Denmark, there are no user fees for care services at all (neither in home-based nor in residential care), while Swedish residents pay the same kind of fee in residential and home-based care, according to care needs and the individual's income. This fee is capped to a maximum of CD $270 per month, and low income elderly are exempted from paying fees. The residents pay for housing costs and food in the same way as in ordinary housing, and the same kind of a state-financed housing allowance is available for all elderly in Sweden, independently of whether they live in their personal home or in a residential care facility.

In short, Canada does spend a considerable amount of money on long-term care, although not nearly as much as the Scandinavian countries. In Canada, the amounts are determined by a formula that leaves some room for profit in investor-owned facilities, but the profit is intended to come mainly from the fees paid by residents. In Scandinavia, the privately run facilities are reimbursed by tax money according to the care needs of the resident. Thus the possible profit of a private facility is not affected by the financial situation of the residents.

The Workers

Long-term residential care is labour-intensive work. Care cannot easily be mechanized, although physical restraints, diapers and medications are not infrequently used to reduce the need for paid labour. The mix and titles of providers, their regulation and training vary significantly among and even within jurisdictions, partly as a way of organizing work to limit costs. But the number of employees is large in both Canada and the Nordic countries. According to Statistics Canada, in 2004/2005 "The industry employed some 110,456 fulltime and 97,492 part-time workers, who accumulated 414 million hours of paid work."[5] The report later says there is "the equivalent of 212,474 full-time equivalent personnel," suggesting the actual numbers may be higher. In Scandinavia, with the exception of Finland, there are no official

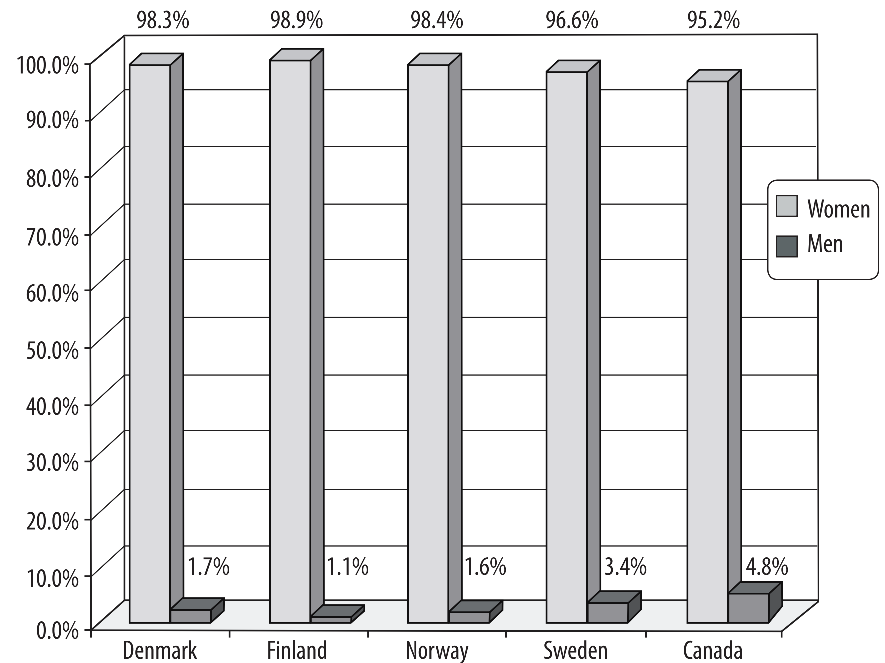
statistics on residential care staff. The total work force in Scandinavian that cares for older and disabled persons in home-based or residential care is estimated to be more than 450,000 full-time equivalents, with the majority in residential care.[48]

Because the official statistics on workers in residential care are so limited, we rely here mainly on our survey respondents in Canada and the Nordic countries.

What is common across all the jurisdictions in our survey is the allocation of long-term residential care work mainly to women. The female predominance within this labour force reflects assumptions about women's "natural" capacities and often leads to much of the work, especially in long-term care, being both defined and paid as unskilled. It also reflects the continuing structural discrimination in the labour force that segregates work into men's jobs and women's jobs. Women's jobs are, in general, paid less and are less highly valued.[51] Yet the fact that there are variations across jurisdictions in the share of care work going to women challenges the notion that there is something inevitable about the segregation or natural about women's skills.

Our survey results allow us to see some of the variations across national borders. The comparisons between countries are based on responses from direct care workers, focusing on PSWs and LPNs and their equivalents in the Nordic countries. More than nine out of ten workers are women in both Canada and the Scandinavian countries, although the proportion is slightly higher in the Scandinavian countries (Figure 1). Clearly, long-term care is understood as women's work, although the differences in training and work assignments indicate that the assignment of this care work to women is not simply or even primarily about biology. These patterns were also reflected among our survey respondents, as Figure 1 shows.

Figure 1: Gender of direct care workers, comparing countries



In Canada, another form of segregation is also evident. A significant proportion of these workers is from immigrant and/or racialized communities. Nearly a quarter of the survey participants in Manitoba were born outside Canada, although the proportion in Nova Scotia was quite small (Table 2). Scandinavian countries have much smaller numbers of foreign-born workers. The exception is Sweden, where 14 per cent of the survey participants were born outside the country.

Table 2: Proportion of workers born in Canada or abroad

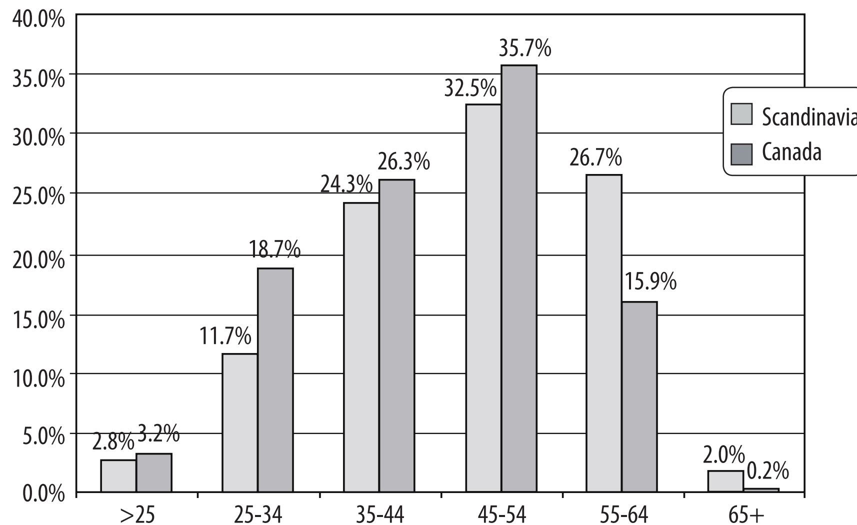
Were you Born...	Manitoba (%)	Ontario (%)	Nova Scotia (%)
In Canada	75.6	86.7	96.0
Outside Canada	24.4	13.3	4.0

As is the case with gender, this pattern also reflects the structuring of opportunities to practice and limits on alternatives for these women. Too often, when women migrate to Canada, the credentials they have earned

abroad are not recognized here. Yet there is an assumption that, because they are women, they can provide the kind of care required in long-term facilities.

In Canada and in Scandinavia, the workforce in long-term care is not young. In 2006, the average age of registered nurses (RNs) in Canada was 45, and one in three was 50 or more years old.[52] A similar pattern is evident for licensed practical nurses (LPNs), whose average age is 44. Personal support workers are not any younger, and most have at least a decade of experience working in this sector. This age distribution is reflected in our survey respondents(Figure 2). The Nordic participants are somewhat older than their Canadian counterparts, but in both groups at least half the labour force is 45 or older.

Figure 2: Age of direct care workforce in long-term residential care



There has been considerable attention paid in Canada to the aging of the RN workforce and the implications for care in the future. But very little attention has been paid to the other workers within the sector, those performing most of the care work. Yet personal care is the most physically demanding work in residential care, and the demands are increasing just as the workforce is aging. The lack of attention may be linked to the assumption that any woman can do the work and that many women from immigrant and/or racialized groups will be prepared to do it, given their limited options in the labour force.

The other common factor in the long-term care labour force is the assignment of most of the work to those who in Canada are called personal care providers or personal support workers (PSWs). However, it is important to understand their work within the context of the entire long-term care labour force.

In Canada, the regulation and training of health care providers is a provincial responsibility, and so is the regulation of residential care. Provincial variations exist in the kind and amount of formal training received by staff and in how they are regulated.

The greatest consistency is found among RNs. All provinces require RNs to write the Canadian Registered Nurse Examination (CRNE) administered by the Canadian Nurses' Association. Except in Manitoba, there is now a requirement for entry-level RNs to have a university degree. Registered nurses are a minority of the labour force in long-term care and more often occupy managerial or specialized clinical positions. All provinces in our study now require that at least one RN be on duty in a facility, but it is not uncommon for only one RN to be on the shift.

Changes over the past few years in how health professionals are regulated have introduced greater flexibility in scopes of practice, with more workers able to perform more complex aspects of care. Increasingly "only tasks judged to carry serious risk of harm, if performed incorrectly, require a license."[53] On the one hand, this means that RNs are still required to provide certain aspects of care or to assign or delegate others to do so. And these delegated tasks have become increasingly frequent as more complex care is provided in long-term residential care settings. On the other hand, it means more of the work can now be performed by those with fewer years of training.

Licensed Practical Nurses (LPNs), or Registered Practical Nurses (RPNs) as they are called in Ontario, are more likely to be practising in long-term facilities than RNs. The trend is to require a two-year college diploma for LPNs/RPNs to enter their profession, although there is variation across provinces. These individuals are also regulated and required to write an examination in order practise as a LPN/RPN. They too may be licensed to perform more complex aspects of care, such as dispensing medications, and a range of such tasks can be delegated by RNs. Many homes also employ dieticians, therapists and social workers of various sorts, almost all of whom have university preparation and are provincially regulated.

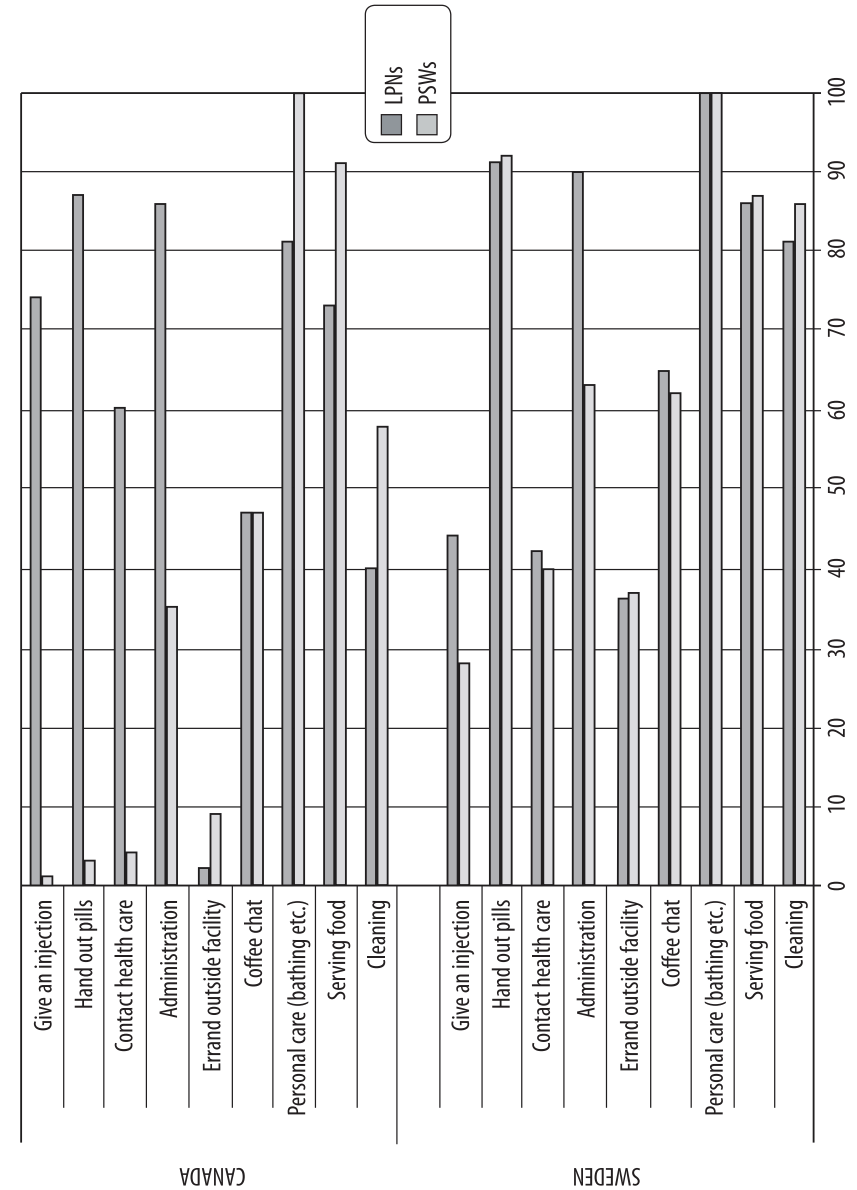
But the bulk of the work in Canadian long-term care facilities is provided by Personal Support Workers (PSWs) or Health Care Aides (HCAs). While provinces now offer college training programs for these workers, many are trained on the job and there is little formal regulation of their work. According to the Long-term Care Association of Manitoba,

> *The majority of the work of an HCA is in assisting the residents with the activities of daily living such as bathing, dressing, meal-time, mobility and elimination. The HCA works closely with the resident and provides the direct care needed. The HCA is a valued member of the care team.*[54]

This simple description, however, hides the complex range of tasks undertaken on a daily basis by these workers and the ways their work has become even more demanding in terms of skills in recent years.

There are important differences between the Nordic countries and Canada in the way long-term care work is organized and the tasks performed by various workers. The Canadian long-term care workforce, as elsewhere in the health sector, is highly stratified. Not only are there clear labour hierarchies, but tasks are specifically allocated among job categories. RNs, for instance, typically and increasingly, perform managerial and administrative duties, whereas LPNs and PSWs provide the bulk of the hands-on care, with LPNs handling the more medical tasks and PSWs tending to the more personal forms of bodily care. In Nordic countries, by contrast, we find a less stratified division of labour, although there are significant differences among countries, with Finland coming closer to Canada. In particular, Swedish care workers, whatever their job title, usually do the same work as that done by both personal support workers and LPNs, in addition to several other tasks which, in the Canadian context, are carried out by Registered Practical Nurses, as Figure 3 shows.

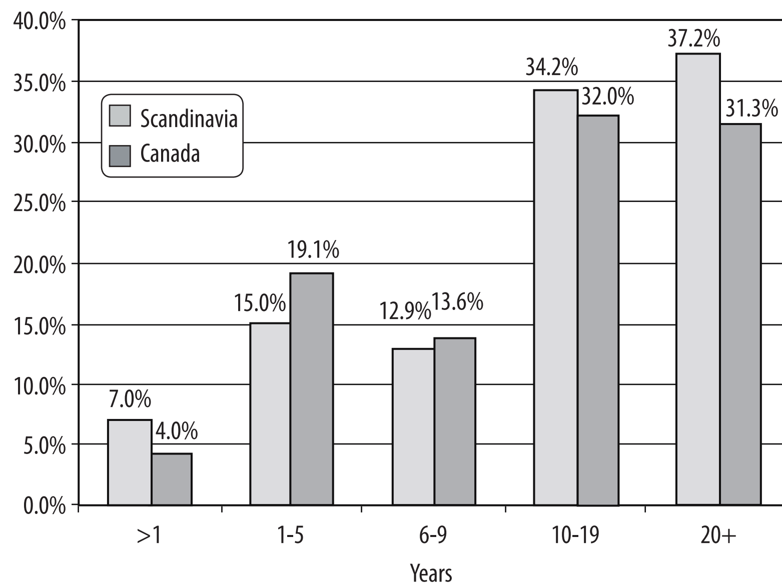
Figure 3: Division of labour among direct care workers in Canada and Sweden



These differences in the division of labour pose challenges for comparative analysis. Given the nature of the tasks performed by the Nordic workforce, for the purposes of the international comparisons we use the combined experiences of PSWs and LPNs to contrast with the Nordic respondents. And for ease of reference we use the term "direct care workers" to refer to the combination of both PSWs and LPNs. This combination allows us to capture the bulk of the Canadian labour force and the overwhelming majority of our sample. The limited number of RNs employed in Scandinavian long-term care and the absence there of specific cleaning or other support staff means we cannot compare these occupational categories across international borders. However, we can look at the more detailed division of labour for the Canadian data.

One important similarity between Scandinavian and Canadian care workers is their length of service. As Figure 4 shows, workers in long-term care are highly experienced. The Nordic workers are somewhat more experienced, but a majority in both surveys have been providing such care for more than ten years, and a third have been doing so for more than 20.

Figure 4: Experience of direct care workers caring for the elderly in Canada and Scandinavia



In sum, residential care facilities in both Canada and the Nordic countries have female-dominated and highly experienced labour forces. In Canada, the workforce is more regulated and hierarchical, with a clearer division of labour, but most of the direct care is provided by PSWs and to a lesser extent by LPNs, with supervision by RNs. There are some variations among provinces and, other than the requirement for at least one RN on staff, facilities make most of their own choices about the number and skill mix of staff. There is less division among tasks in Scandinavia, although Finland comes closer to the Canadian case. Nevertheless, comparisons are possible across borders by combining PSWs and LPNs in Canada.

Conclusion

Canada has a history of viewing long-term residential care as "custodial," provided mainly for indigents and others who have no alternative. Today, admission to publicly-funded services is restricted mainly to those with complex care needs, yet much of the old legacy remains in the approach to the funding and organization of care work. Canada also has a history of private, for-profit and charitable provision of nursing home care, with more public involvement in care for the frail elderly. Today, there is even more for-profit provision, much of which occurs in large facilities owned by major corporations, mainly with public funding. Manitoba stands out as a province with limited for-profit delivery and more public facilities.

There is a tendency for provinces to integrate services into single facilities, although Nova Scotia still has facilities referred to as homes for the aged. And while many of these facilities are called homes, they often look more like hospitals and provide only limited privacy for the residents. The approach to care is reflected in and reinforced by the organization of work, with the allocation of most care to personal care providers who often lack formal training or regulation. While this does not mean they are unskilled or untrained for the job, in a country that places a strong emphasis on regulation and formal training in health care, this practice indicates the relatively low value attached to this work. The fact that most of the work is done by women reinforces this evaluation. Governments talk about the need to treat residents with dignity and respect, and the need to provide them with autonomy and choice. Some facilities work hard at doing just that, in part by treating their staff with dignity and respect. However, current funding,

staffing, and ownership patterns make it difficult to reach these goals, as we show in the following chapters.

In contrast, long-term residential care in the Nordic countries tends to be based on a social model. Apartments have become the norm, with special facilities for those who have dementia. Care is publicly funded and, although the overwhelming majority of facilities remain in public hands, there is some creeping privatization. As is the case in Canada, the work is done mainly by women who bring a great deal of experience to their job. However, except in Finland, there is significantly less division of labour among the workers in long-term residential care.

Chapter 3
Staffing

In its report on long-term care for older people, the Organization for Economic Cooperation and Development identifies quality as a major issue in long-term care. The report goes on to say that it "is unlikely that better quality will be sustainable in the future with current staffing levels in long-term care."[7] In making this claim, the OECD is reflecting a wealth of research and echoing the arguments made by care providers throughout the Western world.[55] Most of this research has been done on nurses, including Registered Nurses and on Licensed Practical Nurses, but research focused on the entire workforce shows similar results. A low staff-to-patient ratio means poor working conditions and poor care. This research demonstrates a strong relationship between the number and mix of staff, and the quality of care, as well as a relationship with worker turnover, morale, job satisfaction and worker health.[56,57] One study talks about the "quantitatively diminishing rate of the services, when staff levels decrease."[58] In other words, as may seem obvious, fewer workers mean less care.

Taking this as a starting point, we begin the chapter by looking at the staffing levels in long-term care, as reported by the official data available. These data suggest that staffing levels do not meet established standards for care. But even these numbers overstate how much direct care will be provided, because the numbers often include staff not involved in direct care, those who are absent due to illness, vacation and leave, and positions that have not been filled. In addition, these data do not tell us how often staff work alone when they provide care, rather than in the teams the literature indicates are necessary for both safety and good care. After exploring these issues for the Canadian and Nordic workers in our survey, we move on to examine workload and work pace. The chapter ends with a discussion of how workers are pressured to take on extra shifts and unpaid labour as a way to fill in the gaps in care.

Staffing Levels

While there is little debate about the need for more staff, there is some debate about how much staff and what mix of workers are necessary in order to treat residents with dignity and respect. In the United States, an expert review of the literature on this issue concluded that 4.55 hours of direct care per day, including 1.15 RN hours, is required to provide quality care.[59] We could not find any research that did a similar assessment to determine what the appropriate level would be if the entire staff was included. Yet it is clear

that, in large workplaces at least, some managerial staff is required. Equally important, those who cook, clean, do clerical, maintenance and laundry work in such facilities both provide essential services and free time for those who provide more direct care. If this entire range of staff is included, the numbers would have to be much higher than the 4.55 hours set out as a minimum for direct care.

Some provinces at least have recognized that staffing is a critical issue and have established minimum requirements. In Manitoba, the regulations require that a minimum of 3.6 hours of direct care be available per resident every day from Registered Nurses, Registered Psychiatric Nurses, Licensed Practical Nurses, and health-care aides.[60] In Nova Scotia, the direct care minimum is 3.25. Ontario currently has no minimum staffing levels, although there have been standards in the past. While it is useful to have standards, none of these provincial requirements meet the minimum of 4.55 direct care hours set out by the U.S. panel.

We do not have very good data on the extent to which the provinces in this study meet or exceed either their own minimum or the 4.55 hour standard. A 2007 Statistics Canada report on residential care facilities suggests that Canada more than meets the minimum staffing levels. According to this report, overall there were 4.9 hours paid work hours per resident in Canadian facilities, and in homes for the aged, there were 4.7. But, as Statistics Canada points out, these data may include some hospital and outpatient services that are outside the facilities, suggesting the numbers exaggerate the actual paid staff hours in residential care. These numbers also include everyone who works in long-term care, not solely the staff providing hands-on care; and, as we noted above, the expert figure of 4.55 was intended for nursing staff only.

According to data produced by the employers in Ontario, they only provide an average of 2.6 hours of care each day compared to the 3.8 paid staff hours indicated in the Statistics Canada report.[61] Moreover, these numbers on staff hired do not tell us how many of those counted are actually at work. As one letter to the editor put it, "paid hours include vacation time, statutory holidays and sick leave, and are therefore significantly higher than worked hours, which reflect hands-on care."[62] Averages also hide significant variations among facilities, variations that can mean quite broad differences in the level of care. In British Columbia, for example, the total staffing hours can vary between 3.5 and 4.4 hours per resident per day, depending on whether residents are defined as having lower or higher care needs. Equally

important, the number of hours worked by "direct care" staff varies between 2.5 and 3.2 hours per resident-day in that province. In short, these data do not reflect the reality of staffing in long-term care.

Table 3: Total LTC paid hours (all staff) per resident day, by province

Province	97/98	98/99	99/00	00/01	01/02	02/03	03/04	04/05	05/06
Québec	5.2	5.3	5.5	5.8	6.0	6.0	6.0	6.9	6.6
Saskatchewan	4.8	4.7	5.1	5.4	5.4	5.6	5.4	5.7	5.7
Nova Scotia	4.7	4.7	5.0	5.2	5.3	5.6	5.6	5.6	5.7
Manitoba	4.9	4.7	4.7	5.0	5.0	5.1	5.1	5.1	5.2
Alberta	4.6	4.7	4.8	4.9	5.2	5.3	5.0	5.2	5.1
NF & L	4.4	4.6	4.2	4.2	4.5	4.6	4.3	4.6	4.8
New Brunswick	3.9	3.9	4.0	4.1	4.2	4.2	4.3	4.2	4.2
PEI	3.8	3.7	4.2	4.1	4.1	4.1	4.1	4.0	4.2
Ontario	3.3	3.4	3.4	3.4	3.4	3.5	3.6	3.7	3.8
British Columbia	3.3	3.5	3.6	3.6	3.6	3.6	3.5	3.5	3.7

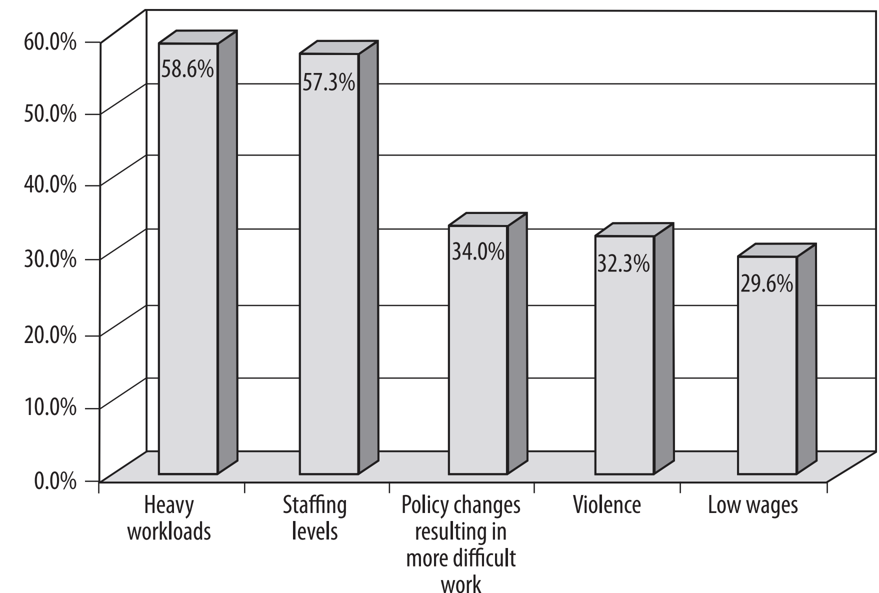
Source: Ontario Health Coalition, 2008, *Violence, Insufficient Care, and Downloading of Heavy Care Patients*, drawing on Statistics Canada RCFS data for Accumulated paid hours during the year per resident-day. "Accumulated paid hours" refers to the total paid hours (including paid holiday and other paid leave) for all full-time, part-time and casual employees who have had salaries or wages paid to them by the facility.

Although there are critical questions to be raised about the extent to which these numbers reflect actual care time, the similarity in criteria used across Canada suggests we can have some confidence that they reveal actual differences in patterns, if not differences in actual numbers among the three provinces included in our survey. While Statistics Canada reports a Canadian average of 4.7 total staff hours per resident-day, including "direct care" and "general services" such as administration and support staff, the average number of hours is significantly lower for Ontario and higher for Nova Scotia and Manitoba (Table 3).[5,63]

In contrast to the situation in Canada, there are no minimum requirements for overall staff levels or for RNs in the Nordic countries. This reflects the different role of RNs in Denmark and Sweden, in particular, and the different division of labour noted earlier. It also reflects a different approach to care that is reflected in staffing levels. The staff-to-resident ratio in Sweden is 5.2 hours for direct care staff per resident and day, and rises to 5.6 hours when managers, physio- and occupational therapists are included.[24] The Nordic countries sustain these higher ratios even though Sweden has many more elderly in need of care, with 5 per cent of their population over age 80 compared to 3 per cent in Canada.[7] Arguably, higher staff levels are not impossible to maintain as the proportion of the elderly grows.

The responses by workers in our survey challenge the Statistics Canada data that suggest we are successfully meeting the criteria for adequate direct care staff. Their responses also reinforce research that identifies staffing levels as critical to both working conditions and quality of care.[64] Figure 5 makes it very clear that workers' biggest concern is not wages, even though their wages are low, especially when compared to the hospital sector. Rather, they are most concerned about the staffing levels and workloads that have a direct impact not only on them but also on the care they can provide.

Figure 5: Canadian direct care workers' concerns



When we asked workers what changes they would recommend in this sector, the call for "more staff" was overwhelmingly the Number One recommendation. The call for more staff was so urgent and compelling that it effectively drowned out most other considerations. It would appear that, until staffing levels are addressed, everything else is secondary.

These concerns may be dismissed by those who suggest that all workers in health care would complain about workload and staff levels, whatever the conditions. However, differences in responses among provinces suggests that we are not simply capturing what any worker would say about their jobs. Although workers in all provinces are concerned about staffing levels, their responses on staffing vary significantly from province to province. For example, 90 per cent of the providers in Ontario say they do not have enough time to care for residents when they are working days during the week, while this is the case for 77 per cent of those in Manitoba and 71 per cent in Nova Scotia. These differences in the level of concern reflect provincial differences in staffing levels for direct care. The differences also reflect the variations in the number of residents cared for during each shift by the survey respondents. On average, an Ontario direct care worker reported caring for 20.8 residents when working a day shift during the week. Her colleague in Manitoba and Nova Scotia provided care for on average 15.5 and 17.4 residents, respectively.

Since the staffing level is much higher in Scandinavia and also, with the exception for Finland, there is a less complicated division of labour, it is not surprising that Danish, Norwegian and Swedish care workers report that they provide care for significantly fewer residents than their Canadian and Finnish colleagues. Neither is it surprising that far more Canadian care workers find that they do not have time to care properly for their residents (see Table 4).

Table 4: Residents to care for when working days during the week, comparing countries and direct care workers

	Canada	Denmark	Finland	Norway	Sweden
Number of residents helped during a shift(Average)	19.6	6.2	15.0	7.7	8.5
Find that too many (%)	80.5	25.3	48.3	33.4	28.6

One PSW was among many who expanded on the staffing issue, helping us see what staffing ratios look like on the ground:

> *"There are two PSWs for 24 residents, on an average we have 36 transfers to/from bed, toilet, w/c [wheelchair] before breakfast. Seven two-person transfers after breakfast -- feeding, serving, and allowing time for breaks on average 4 baths a day on our shift, transporting to from dining room after each meal, look after residents' needs, doing treat cart, making beds, etc… Then transportation to lunch, serve, toilet, lag down 7 residents, check reposition, etc. Do books before end of shift."*

This comment, written into a survey, is just one of many drawing a dramatic picture of the excessive workloads that result from too few people caring for too many.

In sum, official Canadian statistics often hide staffing levels well below what research indicates is necessary in long-term residential care. Not surprisingly, then, staffing levels and the heavy workloads that result are the most critical concern for the workers in our survey. The Nordic workers are also concerned about staffing and workloads, but the numbers who are concerned are lower than in the Canadian survey, reflecting the higher staffing levels in Scandinavian countries.

Working "Short"

The official staffing numbers also hide the reality of how many care providers are actually at work. The problem of insufficient staffing levels is compounded by the fact that even these inadequate staffing levels are not met due to chronic short-staffing. Indeed, "working short" appears to be the norm in long-term care. Almost half of the respondents worked short-staffed on a daily basis. Over a third reported that they were working short-staffed on a weekly basis. Only 12 per cent said their workplace was short-staffed less than once a month. There were, however, provincial variations which suggest that working so short-staffed is not inevitable. As Figure 6 shows, workers in Manitoba were less likely than those in the other two provinces to say working short is the norm.

A dietary aide neatly summed up the problems created short-staffing:

> *I feel this industry is overworked and stretched to its maximum. Health becomes an issue when these situations go on for long period of time when*

staff is short – and I mean really short – the same amount of work is expected to be done. I'm sorry it cannot be done well under these conditions.

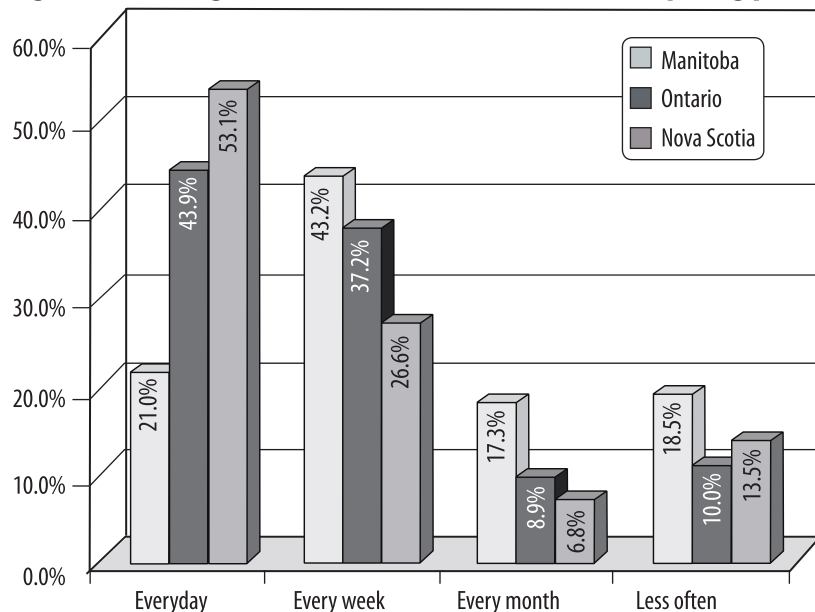
She was far from alone in experiencing a problem that many workers in our survey felt compelled to write about. An RN, for example, said, "We are expected and told we must work short-staffed (RNs and RPNs), but especially RNs." A PSW, in her survey response, echoed these concerns: "In my particular home the average work force is over 50, we are required to do more, work short, take more courses, vacations turned down because of inadequate staffing, etc." Focus groups had a similar story to tell:

In our facility mandatory overtime is at least twice a week. So the least senior staff member has to stay. They don't have enough staff. People have left. They try not to replace staff and force the staff to work short so they expect four people to do the work of five which used to be six. They've cut back on all areas in staffing. It's terrible.

Focus group participants remarked on how they are also short-staffed because many vacancies are yet to be filled.

However, the problem seems clear: "Never mind being sick or on vacation. Period. We're short-staffed." "It's a cost- saving measure for them if they don't replace the person."

Figure 6: Working short due to illness or vacation, comparing provinces



Emergencies and illnesses arise that can mean temporary short-staffing in any organization. But our comparative data indicate that the high incidence of short-staffing reported by the Canadians in our survey is not a necessary outcome. The Nordic respondents were much less likely than their Canadian counterparts to report working short (Table 5). Indeed, the numbers show a stark contrast, with just 15 per cent of the Nordic respondents compared to 46 per cent of the Canadian respondents saying they worked short-staffed more or less every day. Even though sickness and resignations may be difficult to predict, the Nordic data clearly indicate that it is possible to do a much better job at ensuring there are people to provide care. These data also indicate that differences in staffing levels as officially reported are even greater, given that more of those counted are actually present in the Nordic countries.

Table 5: Direct care workers working short, comparing countries

Country	How often do you work short-staffed?				
	More or less every day (%)	Weekly (%)	Monthly (%)	Less often (%)	Never (%)
Denmark	23.1	31.1	21.9	18.2	5.7
Finland	12.4	26.9	31.4	26.2	2.9
Norway	13.6	32.4	18.5	31.2	4.2
Sweden	12.0	29.7	22.8	32.3	3.2
Scandinavia	15.4	30.0	23.8	26.7	4.0
Canada	**46.2**	**34.4**	**8.2**	**9.2**	**2.1**

Short-staffing is particularly a problem in Canada. It should nevertheless be noted that short-staffing is a problem in Nordic countries as well, where 45 per cent of workers report they work short-staffed at least once a week.

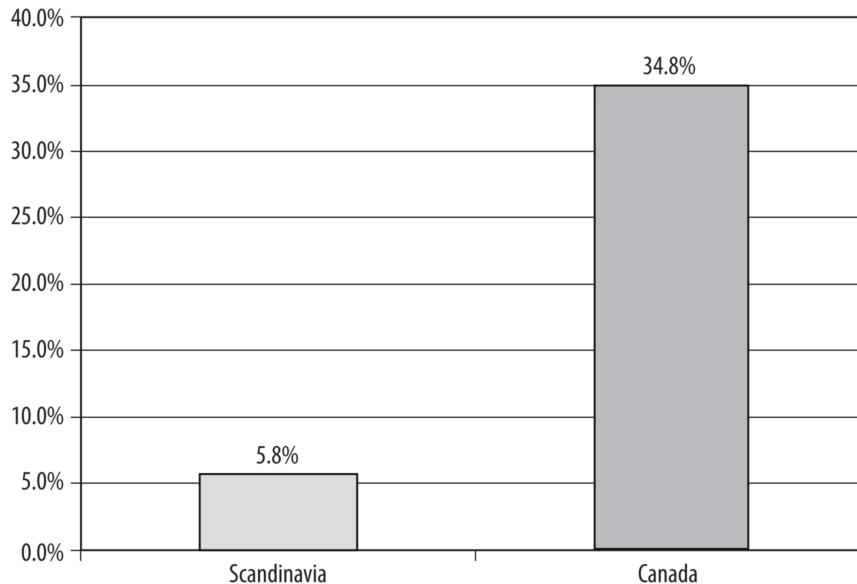
Working Alone

Another indicator of inadequate staffing may be the extent to which care providers are required to work alone (Figure 7). Working alone is not necessarily a problem. However, it can be an issue with residents who have high care needs and with those who are suffering from dementia, as is the case

for most residents now in both Canadian and Nordic facilities. Or working alone may create difficulties when people have to be moved out of bed without the aid of a lift and when workers need support from colleagues for other reasons such as dealing with a resident who is violent. Yet working alone seems to be the norm in Canadian long-term care facilities. Over half the staff report that they work alone all or most of the time.

Because working alone may not in itself be a problem, we also asked respondents if they too often felt they alone were responsible for the residents in their care (Figure 7). Among those responsible for direct care, nearly a third of the Canadian respondents strongly agreed that this was the case. Once again, there are significant differences with the Nordic countries. Only 6 per cent of those in Nordic countries strongly agree that they are too often left alone with residents.

Figure 7: Proportion of direct care workers who "strongly agree" that they are too often left alone to care for residents in Scandinavia and Canada



These major differences between Canadian and Nordic workers may reflect higher staff levels in the Nordic countries. They may also result from the greater autonomy experienced by workers in Nordic countries, with autonomy allowing them to experience working alone as a strength. We will return to the issue of autonomy in the next chapter.

Workloads and Work Pace

Given the inadequate staffing levels and the normalization of working short-staffed, it should not be surprising that the Canadian long-term care workers report having to cope with excessive workloads. The majority of workers in all occupational categories said they had too much to do all or most of the time. As Table 6 shows, however, there are provincial variations. Ontario workers are the most likely to say they have too much to do all or most of the time, with 63 per cent saying this is the case.

These workloads push care workers to their limits, forcing them to sacrifice quality of care. Not only do care workers complain they are unable to offer the level of dignified, compassionate care they believe to be important, but they also report having to rush the care they do provide. There is simply too much to do and too little time to do it in. Indeed, the majority of staff reported that there was almost always too much to do. There was little difference among job categories. All report having too much to do: being continually rushed, "on a treadmill," "almost like Speedy Gonzales shooting all over the place" and "running around like a chicken with their head cut off." "You're always busy running. Like there isn't enough time...you can get the tasks done, but you're running all the time. You feel like you're on a treadmill all the time. You're rushing to try and get the requirements finished."

Table 6: Canadian direct care workers having too much to do on the job

Have too much to do in your job	Manitoba (%)	Nova Scotia (%)	Ontario (%)
All or most of the time	49.4	41.5	62.6
Sometimes	46.0	52.4	33.2
Rarely	3.4	5.3	3.4
Never	1.1	.8	.8

Once again, variations by province suggest that these are not just "usual" complaints that any worker could make. Ontario workers are much more

likely than their counterparts in Nova Scotia and Manitoba to say they almost always have too much to do.

These numbers – extreme as they are – do not come close to conveying the crushing workloads, the stress, or the frantic pace of trying to care under current working conditions. In the following remarks we hear an LPN and an RN describe their harried days and the impact these working conditions have on their ability to care for residents and themselves:

LPN: *"My job as a charge nurse is extremely busy, with 45 residents to give meds to, plus treatments, plus answering the phones, plus replacing staff, plus tending to emergencies that should arise in a shift, plus dealing with doctors. I often wonder how I do it full time. Not to mention all the new paper work that is added on. No wonder I don't sleep well."*

RN: *"Because our clients require more care, with not enough staff to do it, my days are very hectic and not fulfilling. E.g., when we have 10 people that need to go on a toilet and only two staff to get them there, it is very frustrating – who goes first and who waits until they are incontinent? Do we flip a coin? And who is last to get up in the morning and not have breakfast until 09:30? Do they take turns?"*

Canadians are not alone in saying they have too much to do. Those in Scandinavia frequently say this, too. However, as Table 7 shows, while 58 per cent of the Canadian LPNs and PSWs report they very often have too much to do, only 40 per cent of the Scandinavian respondents checked this answer. At the other end of the spectrum, one in ten Scandinavian respondents said they rarely or never had too much to do, compared to fewer than one in 20 Canadians. The differences between the Scandinavian countries should, however, be noted. In Finland – the country where fewer resources are spent on elder care and where the care workers care for more residents per day – almost as many care workers as in Canada report that they have too much to do.

Table 7: Direct care workers having too much to do, comparing countries

	All or most of the time (%)	Sometimes (%)	Rarely (%)	Never (%)
Denmark	30.2	53.2	14.6	2.0
Finland	50.6	44.0	4.5	0.9
Norway	39.2	53.4	6.7	0.7
Sweden	40.0	50.5	8.9	0.6
Scandinavia	40.2	50.2	8.5	1.1
Canada	**57.8**	**38.2**	**3.4**	**0.5**

When asked what tasks workers wanted more time for, direct care workers in both Canada and Scandinavia stressed that they did not have enough time for the relational aspects of work: they wanted more time to talk and listen to the residents. As Canadian workers put it:

"More time to listen to residents concerns about how they feel." LPN

"Listening when they want to socialize and talk when they are lonely." PSW

"Sitting and chatting to our residents, listening to their concerns/fears and also to their stories/history of their life." PSW

In Scandinavia, similar calls for more relational care were heard:

"Time to stay close to those who are anxious and unhappy. Let the residents take the time they need to feel good and to do their things in peace and quiet." LPN (equivalent)

"Have more time to talk and sit with those residents who are confined to bed. They are too often alone in their apartments." PSW (equivalent)

Besides these shared concerns around what both Canadian and Nordic care workers wanted more time for, there were also some striking differences. More than half of the Canadian workers expressed a desire for more time to engage in personal care work – the daily tasks that form the base of their working days. Their comments reflected not only the excessive workloads and the severe time constraints, but also the routinized and task-based organization of their work. Many reported that they felt badly about rushing the residents and wanted time to talk and listen while doing personal care,

while others stressed their own workload, and many mentioned both, as the following comments inserted into questionnaires indicate:

"Getting residents ready for the day - bathing - feeding all. There is not enough time in the day. 45 mins. to get 12 residents for breakfast!!! How do you think that works?" PSW

"32 residents per floor - 3 people to care for them because of routines that need to be followed. No time to do a lot when asked - need to wait (ex. if bathing someone needs toilet)." PSW

"Care for resident (feed) so they can eat hot meals. Toilet every 2 hours not when able, have social activities with residents with time allowing, allow resident to have more than 10-15 min. baths, from start to finish." PSW

"To be more social and not rushed while caring for residents. Don't like the feeling of assembly line care." PSW

"Bathing - I work a 4-hour bath shift to bath, dress, trim nails, etc for 7 residents/day plus other duties. It is so fast that they are getting a 'car wash' to fit them all in." PSW

In contrast, only a few of the Swedish care workers mentioned that they wanted more time for personal care, and those who did often mentioned grooming rather than basic body work. For example, they wrote in "put rollers in their hair, fix their nails - A lot of small things that you never have time for." (Swedish LPN equivalent). The Swedish care workers instead stressed that they wanted more time to take the residents out from the facility for a short walk or to engage in recreation or rehabilitation. This was mentioned by more than 60 per cent of the respondents, often in combination with time to talk and listen.

"I would like to have more time to go for a walk with the residents. It is terrible that those who can't go out by themselves never will get out of doors." LPN (equivalent)

"Go for a walk with the residents. It should be natural to get out in the fresh air once a day for everyone." PSW (equivalent)

"To go out for a walk, shop or for a cup of coffee. To socialise/talk more." PSW (equivalent)

"More staff in nursing and care. The quality would increase with more hands. We would have time to do more than solely the nursing tasks – give the old people a 'gilt edge' in their daily life." PSW (equivalent)

"To just be able to sit down and talk in peace and quiet. Have the time to go for a walk. To simply read a newspaper or play games, or just sing together." LPN (equivalent)

"More staff to every floor so you can do the nursing and care more peacefully, and to have time to go out for a walk every day with those who want to, bake a cake for the afternoon coffee with the residents, and cook the meals from scratch." PSW (equivalent)

Time to "go out" was hardly mentioned at all by the Canadian care workers, and only a few mentioned that they wanted more time to participate in recreation with the residents. The difference in the responses seems to reflect the different level of workloads. Under current conditions, the Canadian care workers could not even contemplate doing more than the bare essentials. But the different response pattern probably also reflects the different division of labour and the more health-care-oriented focus in Canadian long-term care facilities. Social activities like going for a walk or taking a resident out for a coffee is rarely a task for the Canadian workers, and they did not seem to think that it could be otherwise.

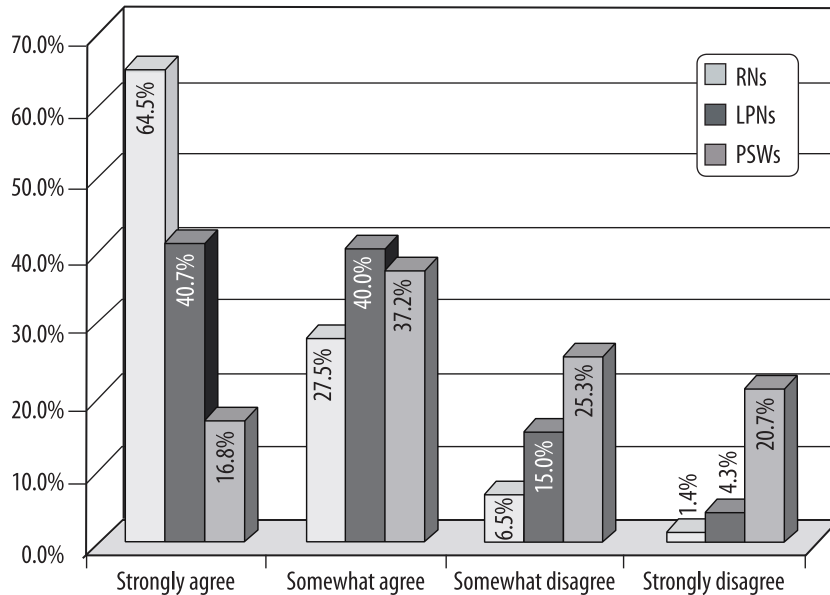
In addition to the problem created by low staffing levels, there are pressures created by new demands on workers. One new demand comes in the form of changes to paperwork." In our focus group discussions, workers commented on the increased documentation required by governments concerned about accountability. This concern partly reflects the emphasis on cost-cutting. But it also reflects a response to complaints about the quality of care. This new level of documenting is supposed to ensure that residences meet provincial standards.

Unfortunately, the need to document means more work and less time to engage in actual care work. Because this strategy fails to address the primary problem of understaffing, it can become counterproductive. Expressing her frustration, one staff member told us, "I believe the government has forgotten about giving quality care and instead is focused on how much paperwork they can create for us."

Concern around the increase in "meaningless" paperwork was commonly reported by the Canadian respondents. Three out of five long-term care workers agreed that more and more of their time was being spent with meaningless paperwork, with over one quarter strongly agreeing with this statement. The problem of meaningless paperwork is even worse for those

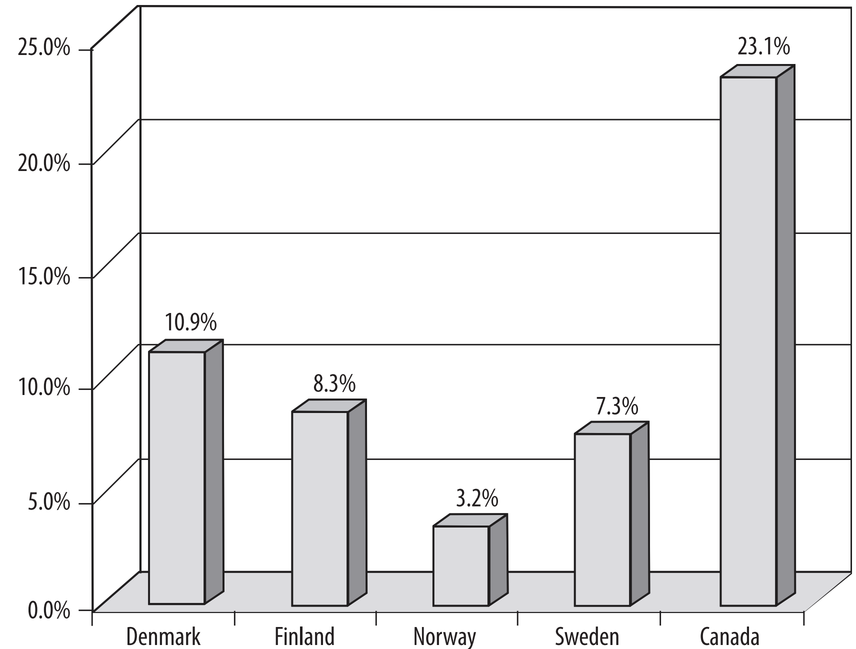
engaged in nursing. As Figure 8 indicates, two-thirds of RNs strongly agreed that their time was being wasted in this manner, and this was the case for 40 per cent of the LPNs. Unlike other issues such as working alone, this was a bigger problem for licensed workers, who supervise care work.

Figure 8: More and more working time used for "meaningless" paperwork



Here there is a sharp contrast with the Nordic countries. Only 7 per cent of the direct care workers in Nordic countries strongly agreed that more and more of their time was spent on paperwork that does not seem very meaningful, compared to 23 per cent in Canada (Figure 9). While this may appear to be a leading question, 41 per cent in the Nordic survey strongly disagreed with this statement, while only 16 per cent of the Canadians did so. In other words, the differing responses suggest that the question does not lead to a single answer. Concern about "meaningless paperwork" is obviously a bigger issue in Canada.

Figure 9: Direct care workers who strongly agree too much time is taken up with "meaningless paper work," comparing countries



Additional paperwork, without additional staff or other forms of trust or support, fails to ensure quality of care, as the care-givers explain in the following comments taken from the survey:

> *"I often feel the bottom line, or how it looks on paper is more important than what actually gives residents a better quality of life."* RN
>
> *"Too much time is spent documenting to meet compliance standards and classification. I wish I could spend more time with residents doing actual nursing care – i.e., prevention, health, teaching, palliative, etc. – to improve their quality of life."* RN
>
> *"The ministry of health seems determined to cut our funding even further with unrealistic policies that must be backed up by flow sheets, upon flow sheets."* PSW

At least as important as the increased workload is the change in the resident population. Many respondents report that, when they began working in long-term care, there were chronic care hospitals and a significant

number of psychiatric hospitals as well. The majority of residents in long-term care facilities were frail elderly women who primarily required support with the needs of everyday living. As we noted earlier, current residents have much more complex care needs, often combined with significant cognitive impairment.[34,65,66] Many have to be physically moved from bed to chair to bath. The result is that each resident requires considerably more care and more complicated care than in the past. As one RN with over 25 years of experience put it: "I've worked in long-term care for my whole professional career. Long-term care has evolved and the work is much heavier, with more demanding residents – the elderly's needs are increasing." And this means increasing demands, as the following PSW explains:

> *This work is very, very hard on your physical body with the resistive and uncooperative residents that come into these homes for care. Alzheimer's and dementia residents sometimes just don't understand what you are doing to them, even when you tell them what you are doing with them. They can hit, kick, scream, and this sort of thing goes on when you're changing diaper or bathing residents.*

When asked about recommended changes for long-term care, one personal support worker wrote that: "We have older people living longer - sicker - heavier work load - the change would be to have more time to give to these people." A housekeeper echoed the sentiment: "More hours - residents are being badly neglected."

In addition to emphasizing the increased workloads, respondents also identified the importance of additional training in order to cope more effectively with residents who are coming in "older and sicker." This change in residents' needs could provide more opportunities to learn new things. This does indeed seem to happen. Only a minority of respondents in both the Canadian and Nordic surveys said they rarely or never had training offered, while half said this was sometimes the case. In the written comments and the interviews, however, some Canadian workers noted that chronic understaffing often prevents them from attending the training sessions already being offered, and that some employers offered few opportunities for training.

For Canadians in our survey, paperwork that seems meaningless adds to an already heavy workload and often means they have no time to take up the opportunities for the training that is increasingly necessary as residents' needs rise. Neither meaningless paperwork nor a lack of training seem to be such big issues for the Scandinavian respondents.

Taking on Additional Shifts and Doing Unpaid Labour

With low staffing ratios, short-staffing and heavy workloads, workers tell us that putting in additional shifts is common. One-third of all Canadian workers told us they put in at least one additional shift in the two weeks prior to the survey. As part-time dietary aides work the least hours, it is not surprising that we found they are the most likely to take on additional shifts. RNs, who are much more likely to have full-time jobs here, are the least likely to take on additional shifts, though over one-quarter still do.

Taking on additional shifts is a means for many to approximate a full-time work-week and cobble together a viable income. However, in other cases taking on additional shifts is involuntary and the employers' way of coping with the inadequate staffing that plagues the sector. As one LPN noted:

> *I find there always seems to be a shortage of nurses/staff and management puts a lot of pressure on you to work extra shifts, even when you don't want to and will change your shift to 12 hrs instead of 8 without warning.*

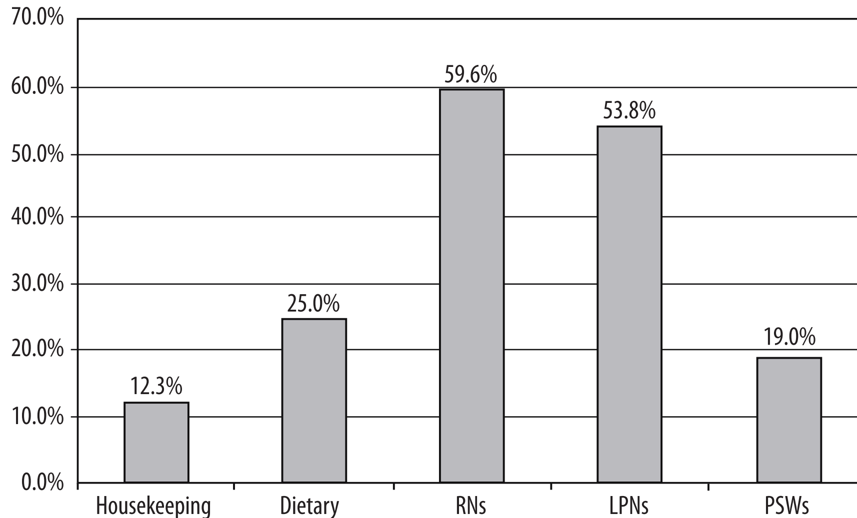
Besides working additional shifts, one-quarter of long-term care staff worked additional hours in the two weeks preceding the survey. Working additional hours was most common for RNs and LPNs, although most workers did extra hours. When asked if they were compensated for working these additional hours, either financially or through time in lieu, 16 per cent of the workers said they were not compensated, while 9 per cent received only partial compensation for their additional work. RNs were the least likely to be compensated, suggesting the problem of unpaid labour is worse for them:

> *"We DO need to be paid for the hours we DO work. We arrive 30 minutes early and leave 30 minutes late to get the work done."* RN

> *"We often stay overtime to complete but are refused to be paid by management. Often work short but expected to do same workload."* RN

Working through breaks was also a commonly reported problem, and one that is again exacerbated for RNs and LPNs. As Figure 10 indicates, a majority of RNs and LPNs report missing at least half of their scheduled breaks. This seems to be less of a problem for PSWs, but nearly one in five say they miss at least half their breaks.

Figure 10: Missing half or more scheduled breaks



In the majority of cases, the need to work through breaks was explained by staff as a response to inadequate staffing levels. However, in some cases workers told us that management requires that they take their breaks. Such well-intended policy measures may be counterproductive in a context of inadequate staffing. They do not address the main problem of understaffing and thereby make an impossible day more so. Such secondary solutions also further reduce the quality of care provided. As one nurse explains:

> *My facility has recently cut RPN hours and we now have 5.5 hours to complete our work. That only gives me 5.5 hours to do 2 med passes, all treatments, all documentation, assistance with ADL's, BDL's and CCL's for 60 residents. Management wants us to still take our breaks, so it is actually 4 hours and 45 minutes. This is not enough time to effectively compete my work, so my breaks get cut short and/or I leave work late. I can no longer sit and chat with a resident/family member or find myself saying 'I'll be with you as soon as I can.' I find this appalling. Residents are human beings and should be treated as such!*

We do not have precisely comparative data for the Scandinavian countries because the question is somewhat differently worded. In that survey, workers were asked how often they skip or shorten a lunch break. Nearly two-fifths of the Scandinavian care workers report they do so at least every week, with 16 per cent of them skipping a break almost every day. Missing their mandated break is obviously also a problem in Scandinavia as well, although not as great a problem as it is in Canada.

Conclusions

Staffing and workloads, then, are the major issues for all workers in long-term care. Indeed, over half of the Canadian staff worried a great deal about staffing levels and about workloads that are too heavy. However, the data from Scandinavia indicate there is nothing inevitable about these staffing levels or workloads. Not only are there more staff regularly assigned, but more staff are also actually there in Nordic countries. Workers in these countries are significantly less likely to work short. They are also less likely than their Canadian counterparts to say they have too much to do and to say they have too much meaningless paperwork that adds to their workloads. Even though the proportion that is elderly is higher in Scandinavia than it is in Canada, these countries are able to provide more care staff per resident. Clearly there are alternatives to the current care levels here.

Chapter 4
Working Conditions

In one sense, the main working condition is the number of staff available on any shift. Without adequate staff appropriately prepared for the work, it is hard to provide care. But effective staffing levels, while essential, are not a sufficient condition for decent care or decent work. Indeed, reaching optimum staffing levels or even determining them may depend on a range of working conditions that promote or inhibit job satisfaction, worker morale, and employees' physical or mental health, and thus the care they are able to provide. In this chapter, we explore some of these conditions.

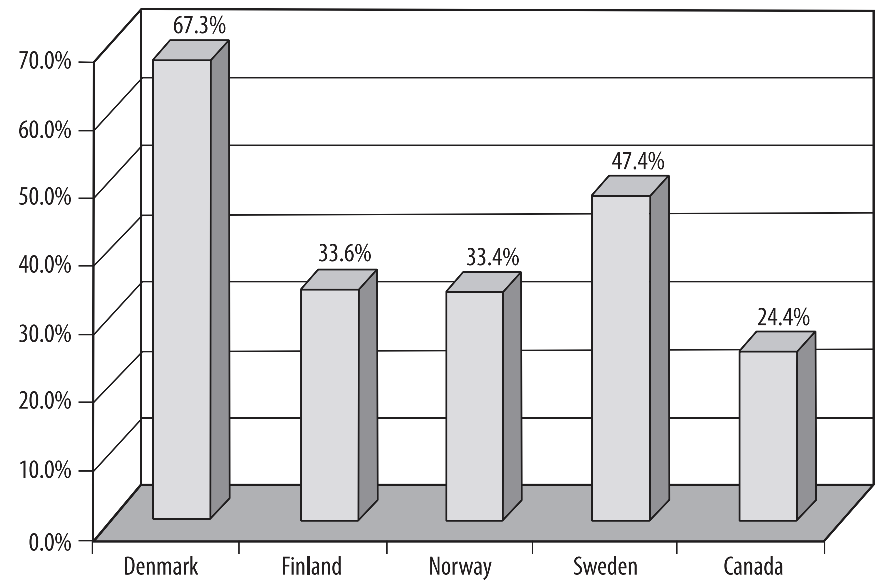
We begin with the extent to which workers have control over their work, based on the research that tells us that such control has an impact on workers' health and the quality of their work. Those trusted to do their work and given some autonomy in doing it, work more efficiently and effectively. [67] We then turn to more traditional indicators of working conditions, namely, working hours and scheduling, pay and benefits. Hours, pay and benefits do more than set the conditions of work. They also indicate the value attached to the work. Indeed, the relatively low value placed on long-term care is reflected here. The physical facilities and conditions within the workplace are at least as important to workers as they are to residents, and serve to structure the way care can be provided, and at what risk. This is why we look at this issue next. And finally, in the last section of this chapter, we turn to the physical and emotional demands of the job, demands which are also shaped by other conditions of work.

Autonomy, Consultation and Choice

Study after study has shown that organizational culture is critical to developing decent working conditions and that it is important for employees to have some say in their jobs and some influence over their work[68] This can be particularly important in health care, where it is the care providers who are in daily contact with the residents and who thus know a great deal about the residents' individual needs. Moreover, greater flexibility in responding to demands can help workers cope with the heavy workloads.

However, the Canadian workers in our study report that the administration does not understand the daily realities of care work. Nor do they feel that care-givers have a say in the organization of their own work. Yet the comparative responses from the Scandinavian countries suggest it is possible to allow workers to share in decision-making. While only a quarter of the Canadian workers said they could affect the planning of their day always or most of the time, this was the case for 45 per cent of those in Nordic countries. Within Nordic countries, two-thirds of those in Denmark said they had this kind of influence. Clearly, employers can opt to allow workers choices and to have their say in meaningful ways, but this is not an option taken by many Canadian employers.

Figure 11: Direct care workers who can affect the planning of each day's work "all or most of the time," comparing countries



Our Canadian respondents seem to have given up on influencing planning and work organization. One Canadian PSW with over 10 years of experience refused to offer any recommendations on improving care, saying "No. There is no point, PSWs don't have a voice." Yet many believed that, if their voices were heard – if their skills, experience and expertise were taken into account – when designing long-term care policy, we would see great improvements in both working conditions and quality of resident care. The two quotes below represent comments by many:

> *"Management and government make all kinds of rules and regulations and they do not even know what we (health care aide/PSWs) do. The people with*

authority need to work on the floor and along with us to really understand our workload and frustrations. Then maybe they would really listen to us and ask us for our input for better resident care and less burnt-out staff." PSW

"The health care field is steadily getting worse because no one asks the people who would know what would work - i.e., the people who work daily with these residents. Dept. of Health makes decisions – from people who sit behind a desk, as management – most of us have zero input and have to bear the brunt of their ridiculous 'solutions'." LPN

At the level of facility administration, workers report that they are not encouraged to express opinions or voice criticism. Rather, the opposite is true. Workers told us there were often repercussions for voicing criticism or suggesting how facility work routines could be improved. There were significant differences among staff members, with dietary staff and housekeeping staff most likely to feel their opinions and criticisms were not wanted. But a significant proportion of RNs and PSWs also felt this way.

Choice, autonomy and consultation are based on trust. Asked if they feel like their supervisor does not trust the staff, over a quarter of the Canadian direct care workers strongly agreed and another third agreed somewhat with the statement (Table 8).

Table 8: Supervisors don't trust staff; too much monitoring and control, comparing countries and direct care workers

	Strongly) agree (%)	Somewhat agree (%)	Somewhat disagree (%)	Strongly disagree (%)
Denmark	11.8	16.8	34.8	36.6
Finland	5.6	22.8	32.2	39.4
Norway	6.5	17.2	27.8	48.5
Sweden	8.1	29.1	31.3	31.6
Scandinavia	7.9	21.0	31.5	39.6
Canada	**27.4**	**33.4**	**21.7**	**17.9**

In sharp contrast, only 8 per cent of the Nordic staff strongly agreed with this statement. While over 70 per cent of the Nordic participants disagreed, only 40 per cent of the Canadian staff did.

Trust is also reflected in sharing information. Without sufficient information on residents, on care routines, and on health reforms, workers have difficulty exercising any autonomy they do have. Here, too, there are sharp contrasts with the Nordic respondents.

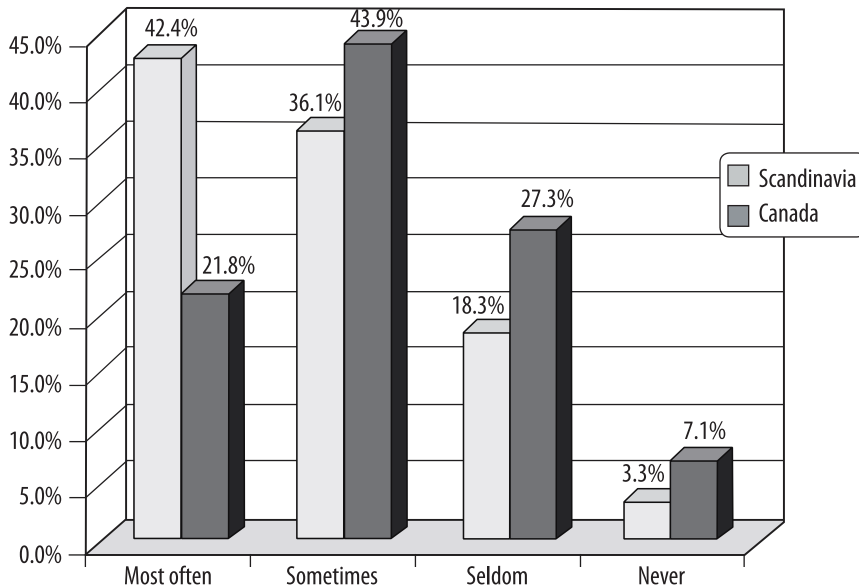
More than 40 per cent of the Nordic workers said they frequently have sufficient information from their supervisors on workplace change, but this was the case for only 26 per cent of the Canadian workers (Table 9).

Table 9: Direct care workers receive sufficient information from supervisors about workplace changes, comparing countries

	Most often (%)	Sometimes (%)	Seldom (%)	Never (%)
Denmark	37.3	42.5	18.5	1.7
Finland	47.8	29.1	21.7	1.3
Norway	43.2	36.1	19.3	1.4
Sweden	39.8	35.1	22.0	3.1
Scandinavia	42.3	35.6	20.3	1.8
Canada	**25.9**	**50.5**	**21.6**	**3.0**

Similar differences appeared when workers were asked about support from supervisors (Figure 12). More than a third of the Canadian direct care workers said they seldom or never had such support, compared to less than a quarter of the Nordic respondents.

Figure 12: Direct care workers receive support from supervisors, comparing Canada and Scandinavia



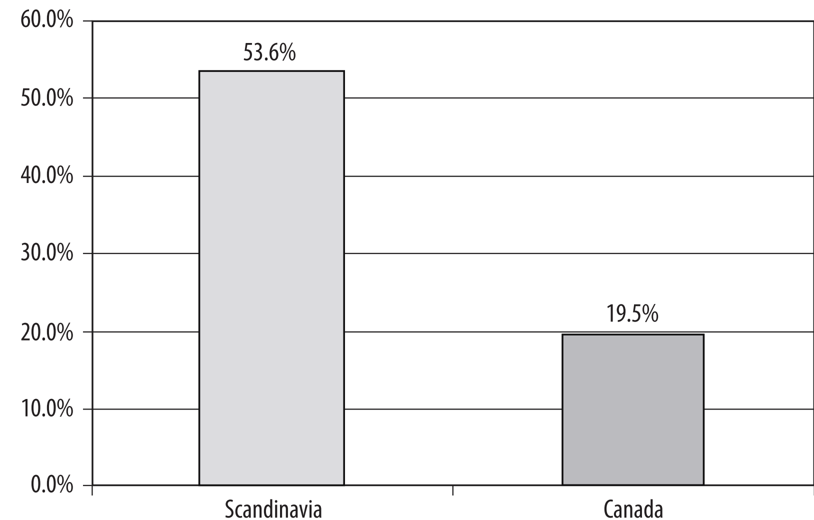
The differences were much smaller, though, when it came to their work being appreciated by their closest supervisor. In both Nordic and Canadian surveys, a majority reported believing they were appreciated by their closest supervisor. Such support can be significant for morale, especially when the closest supervisor is the one likely to have the most contact.

However, the Canadian respondents wrote many more negative comments about management in general. They also expressed stronger negative feelings and much more often wrote that not being treated with respect was a reason for considering quitting. One PSW, for example, wrote that "Management thinks nothing but profit and making workplace look beautiful. Don't feel any appreciation for all my loyal years of service." Another wrote that "We are treated badly. No respect. Belittled." LPNs made similar comments: "Change in my shift schedule with no regard for years service; Management treat staff like dirt."

Appreciation can also come from other workers. Indeed, this support may be critical in the daily pressures of care, given that co-workers rather than supervisors are more likely to be there on a regular basis. It is encouraging, then, to find that, in both Canada and the Nordic countries, a majority felt supported by colleagues. However, there were major differences in the time available to discuss difficulties at work with colleagues.

Figure 13 indicates the stark difference between Canadian and Nordic workers. Nordic workers were more than twice as likely as the Canadians to say they have enough time to share concerns with colleagues all or most of the time. Over a quarter of the Canadians said this was rarely or never the case, compared to just 8 per cent of the Nordic respondents. Time to share difficulties can be empowering for workers. It can also allow them to develop strategies to address their concerns -- strategies that work for residents as well as for the workers. The comparable data for the Nordic countries indicate it is clearly possible to organize work in a way that allows this time, while the Canadian data suggest we do not do so here.

Figure13: Proportion of direct care workers who have enough time to discuss difficulties with colleagues "all or most of the time" in Canada and Scandinavia



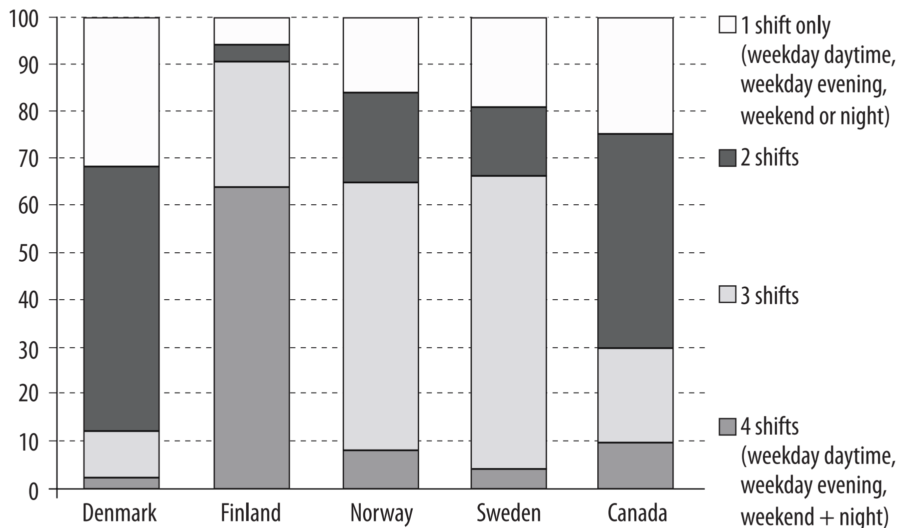
Hours and Benefits

Long-term care facilities operate 24 hours a day, so it is not surprising that many of those employed in long-term care work shifts. Our survey found that there was no typical work week in the long-term care setting. The most commonly worked shifts included working days and weekends. However,

over a third of the workforce usually work evenings or nights, excluding housekeepers and dietary workers who generally do not work nights.

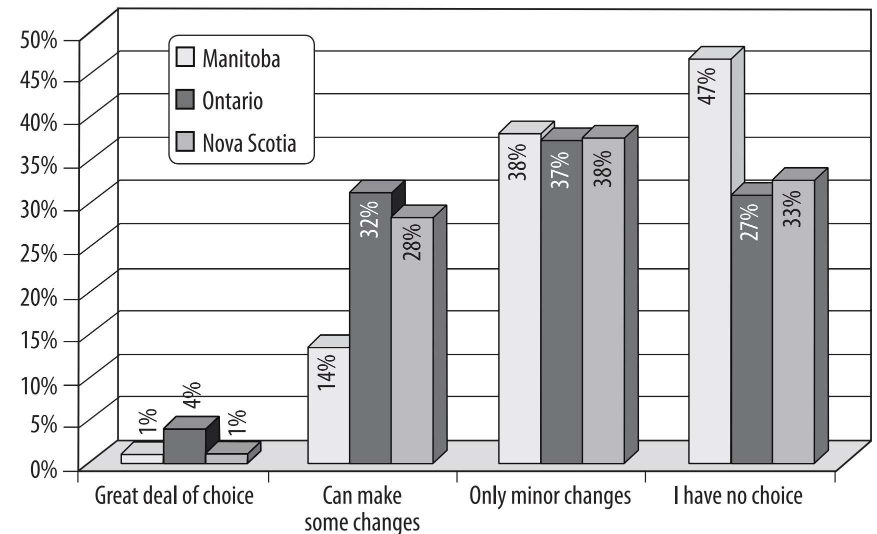
As Figure 14 indicates, the shift pattern is complicated and varied. Canadian and Danish direct care workers are the most likely to have only one or two shifts (day, evenings, nights or weekends only, or a combination of two of these), while Swedish and Norwegian care workers usually work a combination of three shifts. The unfortunate Finnish care workers usually work all times of the day and the week. These varied patterns suggest that there are national routines that do not necessarily reflect the nature of care work and that there are taken-for-granted ways of organizing care work in each country that do not consider care workers' unpaid work and social relations outside their paid jobs.

Figure 14: Shift combinations, comparing countries



The irregularity of shifts is problematic for both workers and residents, making it difficult to plan or know who will be there. The irregularity in shift scheduling is made worse by the fact that care workers have little say about when they work. Nearly a third of our Canadian respondents say they have little choice about their schedule, and over a third say they can only make minor changes (Figure 15). It is interesting to note, however, the differences among Canadian provinces in terms of scheduling choices, which suggest that it is possible to give workers more say in their schedules. While close to half of the Manitoba respondents report they have no choice, this is the case for only a third of those from Nova Scotia.

Figure 15: Choice in shift scheduling



The majority of workers in Canadian residential care facilities are unionized, which helps explain why their pay and benefits are better that those of roughly comparable workers outside health care who are not unionized.[69] However, long-term care workers are paid less compared to their more equivalent counterparts in the hospital sector. These lower wages reflect gendered assumptions about the skill involved in the work and about the care needs of the residential population.[51] They also reflect the limited power of the residents and of a labour force dominated by women, many of whom are from racialized and/or immigrant communities. Yet a study carried out nearly a quarter of a century ago, when care needs in these facilities were not quite so complicated as they are today, showed that the needs of residents and the demands of the work are as heavy in long-term care as they are in hospitals.[70]

Reflecting the fact that almost all the workers surveyed were union members, we found a high degree of permanency in employment (Table 10). The overwhelming majority had permanent positions, with almost two-thirds receiving benefits. Dietary staff were the least likely to have permanent jobs with benefits, followed by PSWs. But permanency is not always easy

to achieve. One PSW wrote on her survey, "Sadly it takes years to get a permanent position so your life is given over to taking whatever shift you can get. You become exhausted working back to back shifts, then getting no shifts at all."

Table 10: Permanancy in employment, Canada

	Permanent w/benefits (%)	Permanent w/o benefits (%)	Temporary (%)	Casual (%)	Other (%)
Housekeeping	73.0	13.0	1.0	5.0	8.0
Dietary	53.4	30.1	5.5	2.7	8.2
RNs	70.7	20.7	0.7	2.9	5.0
Nurses	70.2	14.9	3.5	7.8	3.5
PSWs	61.3	23.5	4.2	6.9	4.2
Canada	**65.0**	**21.0**	**3.2**	**5.8**	**5.0**

However, the proportion of workers with permanent positions is significantly higher in the Nordic countries overall (Table 11), although the Finnish rates are closer to those in Canada. If the survey had included non-unionised workers, the proportion having non-permanent positions would be higher in Scandinavia and in Canada. For instance, in Sweden, according to a large survey, 72 per cent of elder care workers have permanent positions, 9 per cent are in temporary positions, and 19 per cent are employed by the hour.[71]

Table 11: Permanency in employment, Scandinavia

	Permanent (%)	Temporary (%)	Hourly (%)	Other (%)
Denmark	96.7	3.3	0.3	0.8
Finland	75.7	19.1	0.7	4.5
Norway	94.0	4.3	1.2	0.5
Sweden	87.4	4.1	7.9	0.6
Scandinavia	**88.0**	**8.1**	**2.2**	**1.7**

Permanency does not necessarily mean full-time work, nor does unionization necessarily mean benefits. In our survey, many of the permanent positions in Canada are in fact part-time positions. Two out of five were employed part-time and one in five of those with permanent jobs did not have benefits.

As one personal support worker explained: "I understand now why there are no full-time jobs in this field. Employers want only part-time or casual workers, because for them it's cheap. They don't have to pay benefits."

Part-time work is particularly common among dietary aides and cleaners, but is prevalent in all long-term care occupational categories. Workers in our Nordic survey were almost equally divided into part-time and full-time staff, but with large differences between the countries, as Figure 16 shows.

Figure 16: Full and part-time employment for direct care workers, comparing countries

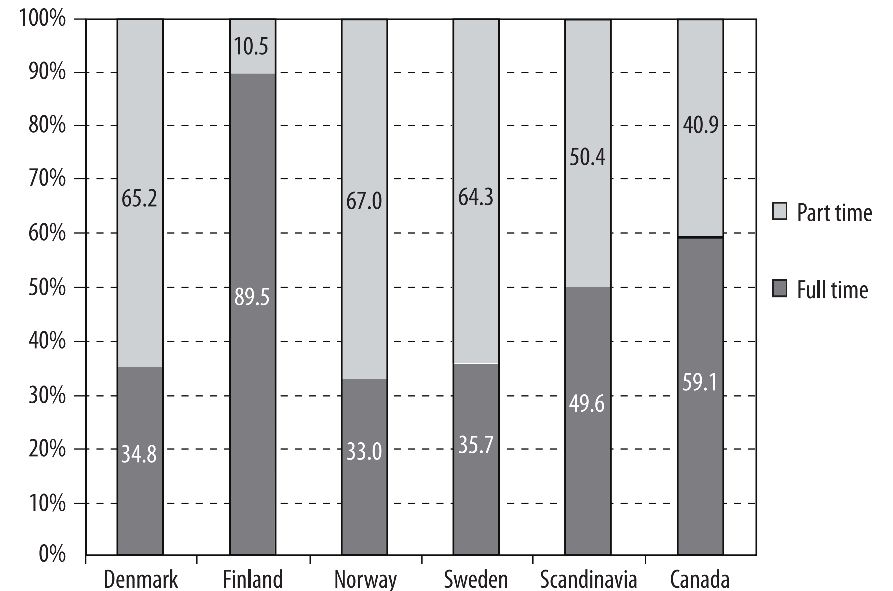
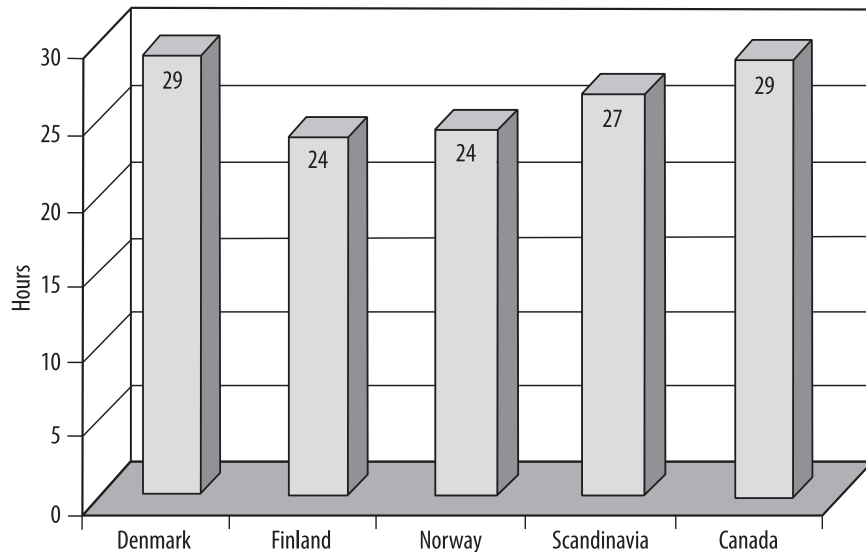


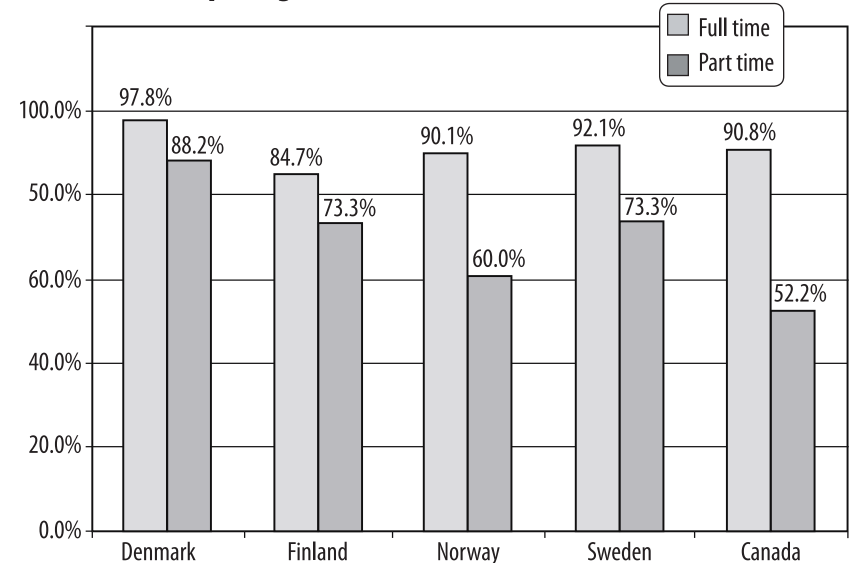
Figure 17, which presents the average weekly hours for part-time workers, indicates that many of these employees are putting in close to full-time hours of work, although the average hides considerable variability among workers and even for the same worker over time. However, the average number of hours worked by part-timers in the Nordic countries is somewhat lower, with Denmark closest to the Canadian average.

Figure 17: Average weekly hours for part-time direct care workers, comparing countries



Although the proportion working part-time and the average hours are fairly similar in Canada and the Nordic countries, there is a sharp contrast in terms of the numbers who choose part-time employment. In Canada, much more of this part-time work is involuntary, with 48 per cent of those working part-time saying they want to work more hours compared to 26 per cent in the Nordic countries. Not surprisingly, as Figure 18 shows, Canadian part-time workers are most likely to be dissatisfied with their hours. It is interesting to note that Denmark has been more successful than other countries in organizing the care work in a way that results in such a small number doing involuntary part-time work. As a result, Danish part-time workers are more likely to be satisfied with their hours. In Norway, involuntary part-time work is a much more common problem.

Figure 18: Direct care workers satisfied with hours, comparing countries



Such involuntary part-time work results in workers having to cobble together multiple shifts and multiple jobs to make ends meet. This is most often the case in Canada, but similar complaints are also heard among the Scandinavian care workers, especially the Norwegian ones. As one Canadian worker wrote in:

> *Get an end to all these short part-time employments so that everybody could have a salary they could live off of. And so that more men could make a living in this field and so that no one should have to combine 2-3 jobs and take on extra hours to make ends meet.*

A Canadian dietary worker explained: "I work at two nursing homes part-time to get full-time hours." It happens to RNs, too: "Many employees juggle two or three part-time jobs just to get by – with no loyalty shown anywhere." A PSW summed up the situation by writing: "Stop with the system part-time/full-time how it is now! It is a ridiculous system and workers don't feel loyal to an organization."

The part-time/full-time "system," as the worker quoted above called it, also creates a sense of inequality and divisiveness among staff. One RN expressed the sentiment this way: "The rest of us who can only obtain 'part-time'

employment are used as mops to clean up what is left over after the full-timers have finished using up time and benefits." Despite the stress, strain, and animosity created by the failure to provide full-time employment, the reliance on part-time workers would appear to be a strategic means of containing costs by avoiding having to pay for benefits.

The problem, as our Nordic comparisons indicate, is not working part-time nor is it working shifts, but how work is organized and who decides. Canadian workers lack autonomy when it comes to choosing their shifts and deciding whether they will work full or part-time. Without such autonomy it is difficult for these workers, most of whom are women, to organize work to meet their own needs and those of their families at home. Caring for their families is made more challenging by last-minute schedule changes that are required to ensure there is at least some coverage for residents in understaffed facilities.

As we explore more fully later, workers' disempowerment was reported as a source of extreme stress, leading to burn-out, intense resentment, and an overall sense of disloyalty to both their facility and to the health care field in general.

Pay

In addition to the problems of involuntary part-time and the failure to pay part-time workers benefits, many long-term care workers believed they were underpaid. As one PSW with over 25 years of experience put it, "The pay is not very good for the amount of work we have to do and the risks we have to take." An RN put the issue succinctly: "I find it difficult to understand why I make less money than a welder or plumber." Indeed, because of the heavy workload and low pay, some noted that they were getting out of the field. As another PSW explained: "I am taking a course outside of here to get a new job. I don't want to do this for the rest of my life. It's too hard on the body. I have been here for 4 years and we don't make enough to stay."

Another commonly expressed concern was the fact that long-term care positions and equivalent hospital positions were differentially remunerated, with workers telling us that the long-term care positions were less well compensated. For many, this was just one more example of how long-term care work was disrespected and the elderly neglected. As one LPN put it, "We always get lower wages than hospitals...I feel like a lower class LPN."

For others, the relatively low pay fostered a desire to leave long-term care for better-paid jobs. In the words of an RN: "I recently have chosen full-time at the hospital, only because I need benefits. I will remain casual in LTC but had to do what was best for me and my children."

It is not easy to get Canadian data on wage comparisons between hospitals and long-term care facilities. However, Figure 19 provides some indications of salary differences for LPNs.[72] Hospital-employed LPNs are clearly the highest paid. Nursing homes would fall in both the non-profit and other organization categories in this table. The table indicates that not only are LPNs wages lower in the nonprofit homes, but that they are even lower in the other organizations, namely, for-profit facilities. The same source provides data on wages for PSWs, without showing whether they work in hospitals or residential care facilities, perhaps because so few work in hospitals. What these data do show is that in 2008 PSWs in for-profit facilities were paid $13.83 an hour, on average, compared to $14.88 in non-profit ones.

Clearly these wage differences are not about the nature of the job. The low wage rates reflect the search for profit. They also reflect, especially for PSWs, the attitude toward the work and the women who do this work. Describing the predominance of women in health care work, an article in a Statistics Canada publication baldly stated, it was "particularly evident in support occupations requiring few skills."[73] This assumption of few skills simultaneously denies the complexity of the tasks involved in this care work and the experience these workers bring to their jobs, and helps excuse their low wages.

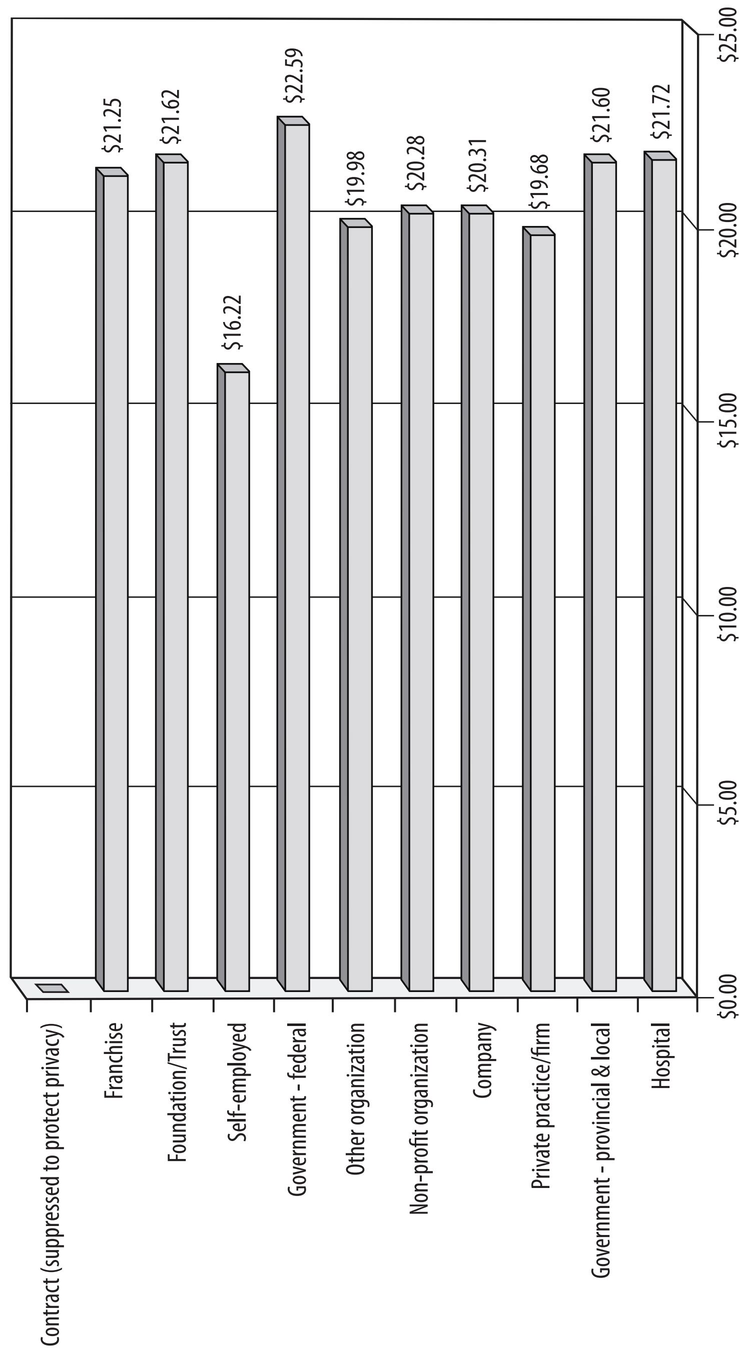


Figure 19: LPN median hourly rate by employer type (Canada)

Source: Payscale, 2008, *Median Hourly Rate by Employer Type - Job: Licensed Practical Nurse (LPN)*. www.payscale.com

In addition to the problem of low wages and wages that are lower relative to hospital workers, our respondents also reported having to pay for some forms of training. While most workers reported that their employers provided them with some of the training they needed, the majority of the direct care staff said the employers did not pay for all the training required. Overall, less than a third said all their training was paid for by their employers. Paying for training out of already low salaries means even less money to take home at the end of the day.

In addition to paying for some of their training, workers also lose money by putting in unpaid overtime. A third of the nurses say they are not paid or given time in lieu for their overtime, and this is the case for 17 per cent of the other nursing staff as well.

In the Nordic countries, care workers are not expected to take training courses in their free hours. However, a higher proportion of the Nordic than the Canadian care workers report that their employers do not provide them with the training they need.

Perhaps surprisingly, unpaid overtime is as frequent in Scandinavia as it is in Canada. This involuntary volunteer work is a product of the gap between the residents' care needs and the workers' desires to provide good care on the one hand and insufficient staffing levels on the other, even in Scandinavian facilities. As one worker summed it up: "More pay for the work we do. The way it is now, you work for nothing several hours a week because you never can take your lunch break." (LPN [equivalent] Sweden)

Around the world, the wages for care work are lower than for other occupations with similar length of formal training. This is true also for Scandinavian care workers, and complaints about low pay are not uncommon among the survey respondents. The workers in all the countries included in our survey mention low pay as a problem in itself. A low wage, often in combination with involuntary part-time employment, makes it difficult to make ends meet. But often low pay is also understood as a lack of recognition for their work. Writing into the survey, a provider explained: "Higher salaries so we feel more appreciated. More appreciation from those high up!" (LPN [equivalent], Sweden)

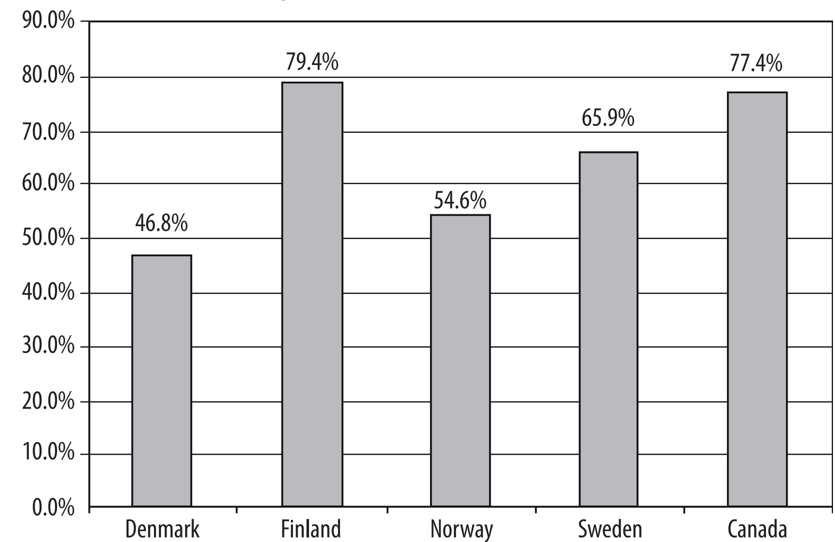
Physical and Mental Demands

Work in these facilities requires staff to put out a great deal of physical and emotional effort. Some of the effort is a necessary part of the job, although it can be made easier by appropriate training, adequate resources and sufficient social support. But some of the effort is primarily the result of the way the work is organized, as our comparative data indicate.

The work in long-term care has become more physically demanding, especially as residents enter facilities with more complex needs and as more are confined to beds or wheel-chairs. Old people can be heavy to move and may even be resistant to help, increasing the strain on the worker. With more men in long term care, the physical demands also change because men are often heavier and stronger, making their resistance more problematic. The problem is so frequent the workers even have a term for the behaviour. "You know you have a resistant resident. You still have to bath them, you still have to toilet them, you still have to take them from somebody's room if they're in somebody else's room. And we're the ones that have to do it, you know. There's ones that swing out at you or kick or whatever".

Although work in residential care is assigned primarily to women who are frequently defined as weaker than men, it is clear from our surveys that heavy lifting is certainly an everyday experience for most direct care workers. All those in direct care lift, but most of the heavy lifting is done by PSWs in residential facilities. As Figure 20 shows, PSWs in Canada and the Nordic countries all report that lifting heavy bodies is a major feature of their everyday work. Asked about health issues, the first thing mentioned in focus groups is lifting: "it's the constant... you're actually working against the way your body is built to do the lifting and stuff to be able to move people around" Except for Denmark, the majority in all jurisdictions report they carry, lift, or pull heavy things or people every day.

Figure 20: Direct care work requires heavy lifting "everyday," comparing countries



However, as Figure 20 indicates, the Denmark exception suggests there are some alternatives. Less than half the Danish workers, compared to nearly 80 per cent in Finland, say they do heavy lifting every day. These comparative data indicate that the heavy lifting is not always a necessary part of the job. Equipment can help. Although mechanical lifts often do the job, some patients don't fit into them and some lifts don't fit into the rooms where lifting must be done, at least according to our focus group participants. The number of other workers around to assist also makes a difference. As we heard in our focus groups, "You don't always have enough staff to be able to deal with those residents. Instead of having two or three in the room or two or four now you're down to one."

Even though Canadians are more likely than their Nordic counterparts to report heavy lifting every day, they are less likely to say they do so in awkward positions. Indeed, this is one of the few places in the survey where workers in Nordic countries seem to have more problems than those in Canada. While we are not sure what explains these differences, it does indicate that we are not simply capturing differences in willingness to complain in different countries and that this is an area worth exploring further.

Running around all day, working at an intensive pace, adds to the physical demands of lifting, bending, and pulling. Most of these workers spend their entire day on their feet and much of it is spent running from resident to resident or place to place.

The work is also mentally demanding. The residents in long-term care are usually there at the end of their lives. Workers get to know, and love, their residents:

> *You get very personal with residents. You're there all the time. You hear their problems or you hear about their life, you know. It's like an extended family almost. You're there every day, every day with the same residents, eh? You get emotionally attached to them and when they die it's hard.*

And usually , it is these workers who are there when the resident dies.

> *I mean there's a lot of times that people are dying alone. And no matter how much we want to, we become their only family. We're with them every day all day and they're at the place in their life where they're dying and we become the only thing that's left for them and we don't even... I can tell you that there's staff that will physically come back to work to sit with people on their off time off because somebody is going to die alone and they don't want that.*

Death is a daily, emotionally demanding aspect of their job, an aspect which is made harder by workers feeling that they did not have enough time to chat with or comfort the resident and by the lack of time available to support their colleagues in their grief.

Death is a necessary part of the job, but the lack of support and time for comfort is not. Asked about emotional demands, one focus group participant responded:

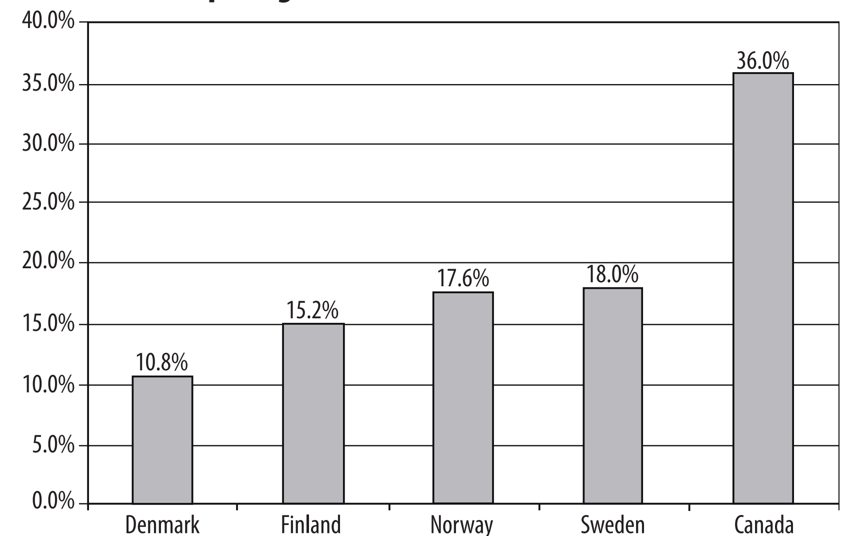
> *You talked about the emotional part. There's a lot of times when somebody just needs somebody to sit there and hold their hand or give them a hug or whatever, and we don't have time to do that. And then I leave my job feeling like I didn't provide that person with what they needed from me that day. And I can't. I mean I just physically cannot.*

Similarly, dealing the individual needs and complaints from those who are in pain and daily discomfort is also a demanding and necessary part of the job. So is responding to their families and friends. But it is made worse, these workers say, by the lack of time to respond to calls or to even treat residents

with dignity and respect. Residents become even more demanding, adding to the emotional strain.

The emotional demands of the work are also made worse for workers worried about job changes that will make their work more difficult. All countries have been reforming their health care systems and this is particularly the case in Canada. These reforms show up in the mental demands on workers, with Canadians twice as likely as their Nordic counterparts to worry about changes. As Figure 21 shows, Canadians direct care workers are more than three times as likely as their Danish counterparts to worry about such changes. Change can be for the better, but if it is not designed with workers and residents in mind, it can add to the mental demands on both.

Figure 21: Direct care workers who "often" worry about changes that will make their work more difficult, comparing countries



The Physical Environment

The physical space and the equipment available set the stage for how work is carried out as well as establishing the living space for residents. It also influences how visitors are able to interact with residents and workers. We therefore asked respondents to assess their physical facilities as places for work and for living.

The Canadian respondents were most concerned about the bathrooms, with over 40 per cent saying they did not meet the needs of residents very well or at all well (Table 12). Bathrooms are critical to the care that workers provide, and it is where much of their work is done. Bathrooms are also the most dangerous areas for both residents and workers. It is disturbing, then, to see so many say the bathrooms do not fit the care needs.

Table 12: The quality of long-term care facility design

Characteristic	Proportion (%) of staff saying facilities meet current residents' needs			
	Very Well	Fairly Well	Not very well	Not well at all
Hallways	46.2	41.6	7.7	4.2
Lifts	36.9	47.9	10.6	2.6
Elevators	33.3	38.1	9.8	4.0
Dining room	32.7	41.0	17.6	8.5
Private rooms	32.7	42.9	12.6	9.7
Locked units	26.7	25.8	7.9	8.6
Family meeting areas	25.7	42.7	16.9	10.3
Stairs	25.6	27.4	7.5	7.8
Recreation facilities	25.0	39.1	21.9	10.8
Outdoor spaces	22.3	36.3	19.4	14.0
Bathrooms	24.5	32.1	24.4	18.3
Medical equipment	18.5	52.5	21.8	7.2
Ventilation	14.5	30.5	26.6	25.0
Smoking areas	11.0	16.7	8.6	8.6

Not all facilities have the same features and thus percentages do not add up to 100. Of note: 55.3 per cent of staff do not work in facilities with smoking areas, stairs (31.8%), locked units (31.0%), elevators (14.8%), and outdoor spaces (8.1%).

Recreation and smoking areas were also seen by many as a problem. A third said the recreation areas were not adequate and 30 per cent said this was the case for outdoor spaces. Part of the problem focus group participants say, is that the spaces available were not developed with the current

residents in mind. Explaining why she thought the outdoor recreation space was inadequate, a focus group participant said:

> *it was designed for people that could walk around and weren't elderly. So anybody in a wheelchair, the sidewalks are not wide enough and there's no railing on them and it was designed to be a country resort area is what the administrator at the time wanted so it's totally inadequate for anybody elderly. The cement patio, you could put a couple of wheelchairs. At the very most it would hold two, and that's if you open the door, put the wheelchair out, close the door, move the chair in front of the door. It's just, it's a sham, it's a waste of money. Total waste of money*

More than a quarter did not think that meeting rooms met resident needs very well. They were much less concerned about the smoking areas, however.

These are the spaces for living and the workers' evaluation of them as poor suggests the low priority given to life-enhancing activities in many facilities. They also reflect the failure to keep up with the needs of a changing resident population.

Dining areas were evaluated somewhat more highly. A third said the dining areas met resident needs very well, while another 41 per cent said they did so fairly well. This is encouraging, given the importance of food and companionship in eating for residents. Indeed, in Canada dining is often the highlight of the day for residents and a time of intense work for care providers. However, focus group participants were often less than enthusiastic about the dining spaces. For example, one PSW said "they're not big enough for all the wheelchairs.... We've got most of the residents in wheelchairs and just don't have enough room for them."

What the Canadian survey reveals is that long-term care facilities are not meeting the residents' needs very well, according to the workers who provide care in them. The picture they draw is one of facilities that are adequate at best – and certainly far from impressive as homes. According to these workers, a considerable proportion of staff work in facilities which are not designed to meet residents' current needs well. One worker summed up the problem by saying that "I think they were designed when residents were all a lot of level one, two, three, a mixture. And now that the residents are getting more and more into higher levels, we don't have adequate space for them" And they were designed when there were fewer residents as well. For example, "It was designed for 30 residents and now we have 44. They

didn't address the issue of the dining area or the recreation or the chapel area when they added the extra 14 residents."

Ventilation is particularly problematic, with a majority surveyed saying ventilation is not meeting residents' needs well. Heating and cooling systems are especially important to those who are old and in poor health, given that their systems do not adjust readily to temperature and their bodies are more susceptible to illness as a result. Similarly, air ventilation is critical, as the experience with legionnaires' disease has made clear. Medical equipment and supplies and family meeting areas, while identified by only a minority as an issue, are still a problem in a quarter of the homes.

While we found that the majority of workers have access to a good staff room and lounge, one in five do not have access to places where they can take a break from the heavy demands of their work (Table 13). We also found significant differences among job categories, with one-third of RNs telling us they do not have access to a good staff room or lounge. This was also the case for over a quarter of both the housekeepers and nurses surveyed. Given the high emotional demands of the job, a space away from residents is particularly important for those involved in direct care.

Table 13: Access to a good staff room or lounge

Have access to a good staff room		
	Yes (%)	No (%)
Housekeeping	74.0	26.0
Dietary	88.6	11.4
RNs	66.9	33.1
LPNs	74.3	25.7
PSWs	85.6	14.4
Canada	**79.6**	**20.4**

Unfortunately, these numbers cannot create a full picture of the design problems in long-term care facilities. But they show that a large proportion of workers must care for residents in facilities that do not support the needs of workers or of residents well. Because these workers are there and spend the most time with residents, they are in a good position to advise on the kinds of design changes required to provide dignified work and living spaces.

Conclusions

Work in long-term care is hard. It is physically and emotionally demanding. Part of the problem results from the needs of the residents. But our comparative research suggests that the work need not be so difficult and demanding. It is possible to allow workers more autonomy and choice. It is possible to consult them more and involve them more in decision-making. It is possible to make the physical and social environment more amenable to care. And it is possible to recognize the skills and effort involved by paying wages equivalent to those who provide care in hospitals, hiring them for full-time jobs, scheduling work in ways that are more responsive to workers' needs, and paying benefits.

Chapter 5
Consequences for Care

The initial chapters in this book provide a description of long-term care facilities and of the working conditions within them. The responses from the Scandinavian countries indicate that other conditions are possible, even with a higher proportion of the population that is elderly. But the major question these data raise is "So what?" In this chapter, we begin to answer this question by looking at what we learned from workers about what it means for residents.

The following chapter turns to what it means for workers, but we start with residents because, in most cases, the workers' comments reflected a great deal of concern about the inadequate levels and kinds of care received by residents. As we indicated in the introduction, conditions of work are, after all, conditions of care. Workers expressed a great deal of concern – if not grief – over the challenges they face in trying to provide compassionate, dignified care. As one PSW with over 20 years experience poignantly expressed it, "Seniors have no golden years in LTC, just grey days." Where we have comparable data, we draw comparisons with the Scandinavian countries in order to help us see the consequences of different working conditions for residents and for those who provide care.

No Time for Essential Tasks

The sacrifices that must be made to handle excessive work-loads become visible in workers' responses to the question about what tasks were left undone (Table 14). In spite of the work pace they keep, the overtime and extra hours they put in, workers cannot do all the jobs that need to be done to provide decent and respectful care.

We see that this is the case for many tasks that we could all agree are essential to staying alive. Food, of course, is critical. The work that is most likely to get done is feeding, with a significant majority saying patients rarely go without being fed. It is still upsetting that more than one in ten say this happens occasionally or sometimes. It is important to note that more than one overview of research indicates that malnutrition is a common problem in nursing homes.[74-76] Research carried out in New Brunswick concluded that 70 per cent of the residents were at risk and linked this risk to the organization of work.[74] The major source of this risk is clear. A California study concluded that nursing staff levels played a major role in food intake among residents.[77]

Table 14: Physical care left undone

Task	Proportion of workers saying tasks left undone (%)				
	Often	Sometimes	Occasionally	Never	Not sure
Feeding	0.0	3.2	9.2	85.5	2.0
Bed changing	2.0	8.1	25.7	60.4	3.8
Changing clothes	2.5	10.0	26.4	57.3	3.8
Turning	4.7	13.1	28.5	49.2	4.5
Toileting	6.0	13.5	31.0	46.6	2.9
Bathing	3.9	14.8	34.4	41.4	5.5
Tooth brushing	13.7	22.7	33.9	24.8	4.9
Foot care	22.2	25.6	26.6	15.0	10.6

Our interviews, and the comments that were added to the survey, indicate that simply stating that feeding gets done does not mean that enough time is allowed to encourage people to eat or to digest their food, let alone enjoy it. It is clear that rather than eating being an occasion for exchange and enjoyment, it often becomes a task workers must complete quickly, frequently having to feed more than one person at a time. As one personal support worker put it: "It would be nice to see the personal touch return to care instead of treating [them] like numbers due to time..." The issue is not only one of nutrition and personal food preferences, but also one of the failure to allow workers time to use what is often the main event in the day as a time for sharing, other social interaction, and care.

While respondents say they can at least make sure that most people get some food, the same cannot be said about getting people to the toilet. Indeed, as one PSW succinctly put it, toileting " routines have gone down toilet. There's no time for them. So now instead of preventative, you're always doing everything after the fact." Less than half report that toileting never goes undone. It is worth noting, however, that Ontario respondents were much more likely than those in the other two provinces to say toileting was frequently left undone, with 48 per cent saying that this was the case. When toileting is left undone, workers leave residents for longer periods of time in adult incontinence products, increasing the risks of

infections and perhaps leading to increased resident violence against workers, as residents react against the discomfort and the indignity.

This is where our focus groups were particularly exercised and maintained that less and less toileting is actually done. Listen to this discussion among workers:

As far as toileting goes, I think that as workers we feel we're doing the best of our ability to do it. I don't know about anybody else, but do you know that in the last year or so they have really, really pushed the use of incontinent products and that is wrong because what I'm seeing, and I mean I've worked in the facility for 27 years so I've seen the changes from using, you know, cloth material as diapers to, you know, disposable diapers to Depends that they've got now. And what they're using now they're limiting us to how many Depends that we can put on these residents...

Yeah, we're not allowed to change these residents unless they're 75 per cent.

Don't get us wrong 'cause we're not saying that they're being toileted on a regular basis 'cause that's so not what's happening. We're caring for them the best we can but they're sitting in diapers that are saturated 'cause they say that they hold all this liquid in that product and they don't.

Yeah, and they're limiting us. And I'm telling you, they're monitoring it... They have diaper police.

There's only so many that are sent to each unit. It's one per shift. It's unbelievable.

And management will go round and they will look in all the closets and all the drawers and they will pull all the hidden stuff out. I mean the girls hide it all over.

We have to steal them. [laughter]

Seriously. You want to take care of your residents properly. If they're wet, you want to change them. If I've got a baby sitting in front of me, that baby I feel dampness, we're likely to change them. With our elderly we say: at 75 per cent, we change them.

It's absolutely true what they're saying 'cause we have the same... There's not the nursing staff to toilet every hour like they want and what they need. We do the best we can do in the time that we're given...and the products that we're given to do it with.

It's not that we feel good about it either.

Sparked in part by our research, a subsequent survey of Ontario workers confirmed what we were told in our interviews.[78] While there is significant variation among facilities, workers are increasingly told not to change diapers until they reach the blue line that indicates the saturation point. In addition, workers say many homes limit the total number of diapers and lock up the diapers to ensure the quota is maintained. In our Nova Scotia interviews, workers from two different homes said they are required to sign the date, time, and their initials on the diaper before they put it on the resident. The rest of the workers in the room shook their heads when these two women told us about the policy, suggesting that such a policy is not universal but is worrisome nonetheless. At the same time, more and more residents become dependent on diapers because workers do not have enough time to respond to residents' calls for assistance or to do the kind of exercises that can help prevent incontinence.

Time to bathe is also an issue, according to these workers. The overuse of diapers makes a lack of bathing even more important. Everyone needs a regular bath in order to prevent infection and to feel comfortable and dignified. People who sit in diapers have a greater need of regular bathing, which is why provinces require a daily bath for those who are incontinent. But less than half of our respondents report that residents never go without the required bathing, with 20 per cent saying it is sometimes or often the case that bathing is skipped for the day. Equally important, workers commented in the interviews on the short time allowed for bathing and the uncomfortable spaces in which they provided baths, often resulting in further indignity for the resident.

Beds and clothes do seem to get changed more regularly, but without clean bodies the appearance of cleanliness may offer little by way of comfort and dignity to residents. And given that these respondents say that only a quarter never go without their teeth brushed, the comfort provided by clean clothes and beds may be limited for some.

With a growing number of residents confined to their beds, more and more need to be turned, which involves shifting their position on a regular basis to avoid problems such as pressure ulcers. Yet only half of our respondents said that turning is almost always done, while over a quarter said it was occasionally left undone. Foot care is also often left undone, according to

nearly a quarter of the workforce, with only 15 per cent saying it is always done. However, there was significant variation among provinces in terms of the number saying foot care is always done, suggesting it is possible to include such care. Foot care may seem like a luxury, one we associate with a spa and indulgence. Yet foot care can be critical to health, especially for the elderly who are diabetic, because inadequate foot care can result in wounds that do not heal, leading to infection and ultimately a choice between amputation or death. Perhaps as important, it affords a moment for positive physical contact and conversation between residents and their care providers, as well as providing sound preventative care.

When the essential tasks go undone, it is often the result of a disruption in the system. As a focus group participant explained,

> *When you have dying residents or flu that hits your facility that's all extra work and you have no extra staff to help out. You know, you've got to do this and then you have to hurry up and do the rest that aren't squawking or don't need as much care. And there's just not enough time and you just don't know what to do first or last or leave out.*

But such disruptions are regular occurrences in long term care, ones that are made worse by low staffing levels that can mean essential task go undone.

No Time for the Environment

The first tasks we think about as essential in long-term care are those related to bodily functions like eating and eliminating, bathing and tooth brushing. Clearly these are essential not only to staying alive but also to feeling alive. The physical space can be just as important for both. Research shows that clean environments are a major factor in preventing illness and injury, while unclean ones can spread infection and increase costs. And infection rates are rising, especially as more people are sent to long-term care facilities after surgery.[79] Although a majority say this never or only occasionally happens, it is worrisome then that 18 per cent say that the cleaning of rooms, bathrooms and common spaces are sometimes or even often left undone.

Table 15: Structural care left undone

Task	Proportion of workers saying tasks left undone (%)				
	Often	Sometimes	Occasionally	Never	Not sure
Cleaning common spaces	4.7	13.2	27.6	37.2	17.2
Cleaning room/ bathroom	6.8	12.9	29.8	36.6	14.0
Recording	8.7	18.0	34.4	34.6	4.3
Building maintenance	9.6	14.3	27.2	26.1	22.8

Similarly, over half report that building maintenance is never or only occasionally left undone. But over 20 per cent say that this often or sometimes happens. Inadequate maintenance in a facility is more problematic than it would be in most homes. A broken elevator left unfixed, for example, can mean major problems in delivering people to dining rooms or food to other floors for the many residents confined to wheel-chairs.

No Time to Care

Both these workers, and the research on the topic, indicate that health care requires much more than dealing with physical needs.[80-84] Treating people with dignity and respect, and keeping them in the best possible health, involves social relations.[85,86] Long-term care workers understand "care" to involve not just helping residents with basic bodily functions, but also attending to their social and emotional needs.[87,88] These are key aspects of respecting the humanity of the residents they care for, aspects research indicates are critical to quality care.

Here, too, workers say this social care is too often left undone. Some workers do report that they have time for at least a brief conversation For example, a focus group participant responded that "If a resident wants to talk up at our home and we're going by and they say 'Come here', we never ignore them. We go. We talk to them. I mean we can't spend a long time with them but we will talk to them, and you know, we do it or just sit and talk to them". As Table 16 indicates, however, a third say they often do not have time to chat

to patients or to take them out of their confined physical spaces. Less than a quarter say the essential emotional support required by these residents is never left undone, and the same is the case for chatting. The task least likely to be left undone is talking with relatives, but this is not a daily task in any case, so may well be easier to accomplish.

Table 16: Social care left undone

Task	Proportion of workers saying tasks left undone (%)				
	Often	Sometimes	Occasionally	Never	Not sure
Keeping in touch with residents' family	6.7	16.0	33.0	28.6	15.7
Emotional support	19.2	23.6	30.5	23.3	3.4
Training	13.0	23.9	30.2	19.3	13.5
Chatting	33.6	21.8	24.4	17.9	2.2
Walking/exercise	19.8	24.4	33.0	15.8	7.0
Taking residents' out socially	33.9	12.7	17.1	10.1	26.2

As one PSW put it:

> *"I love my work with my residents – especially Alzheimer residents. Unfortunately, as things stand now, our work-load is such that we do not have the time to give quality care or spend much needed time with our residents. Our job does not just include washing and dressing, but should also include time to spend talking or socializing with our residents.* ***They deserve better****."*

While we do not have comparable Nordic data on many of these specific care practices, we do have data on those that relate to providing social and emotional support. Take the example of having time for coffee or some similar activity with a resident. A chat and a coffee is part of everyday work for most care workers in Denmark, Norway and Sweden. It is much less so for care workers in Finland and Canada. Indeed, a majority of Canadian respondents said they rarely had time to sit and have coffee, and this was the case for two-thirds of those in Finland. Time for coffee and a chat does happen regularly for some Canadian workers, indicating it is not the nature

of care work or Canadian culture that is the barrier. In a Nova Scotian home, for example, a worker told us that they were always required to have a pot of coffee "on" in case someone wanted to have a "cuppa." But this does not seem to be the experience of most care workers in Canada.

Table 17: Direct care workers sitting for coffee, comparing countries

	Several times a day (%)	Daily (%)	Weekly (%)	Monthly (%)	Rarely or never (%)
Denmark	17.6	51.9	10.7	3.1	16.6
Finland	4.1	15.5	6.7	6.2	67.5
Norway	14.0	45.9	15.0	4.0	21.1
Sweden	14.3	37.8	9.2	5.4	33.3
Scandinavia	12.3	37.4	10.4	4.7	35.2
Canada	**14.3**	**15.5**	**10.7**	**6.2**	**53.4**

No Time to Walk, Talk and Exercise

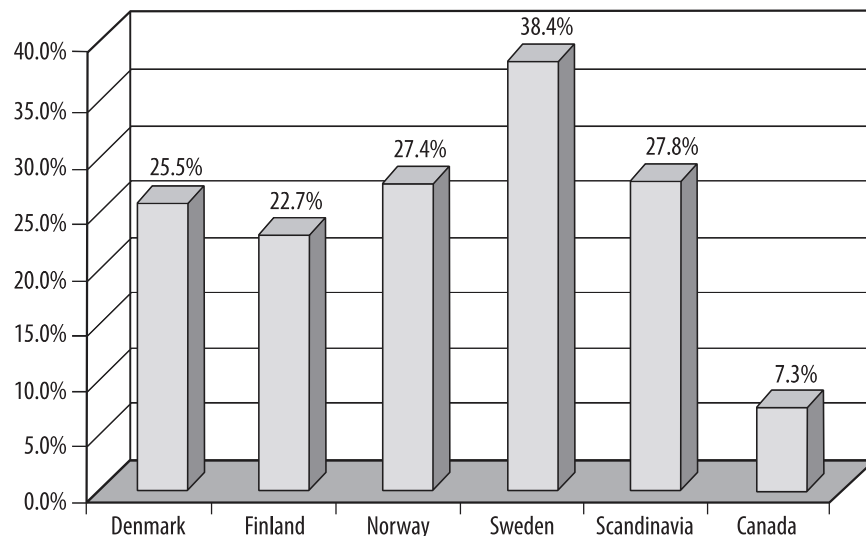
Walking with a resident accomplishes two goals: exercise and social support. Here is one place where the Canadian survey respondents indicated they had more time to care than their Nordic counterparts did (Table 18). While only 17 per cent of the Nordic respondents said they accompanied residents for a walk once or several times a day, this was the case for almost half of the Canadian respondents. It may be that Canadian respondents understood a walk as being about taking someone to meals or the bathroom while Nordic workers read "a walk" as a leisure activity.

Table 18: Direct care workers accompanying residents on a walk, comparing countries

	Several times a day (%)	Daily (%)	Weekly (%)	Monthly (%)	Rarely or never (%)
Denmark	3.8	12.6	21.5	14.5	47.6
Finland	5.5	17.7	16.3	14.4	46.0
Norway	1.5	10.6	13.5	11.1	63.4
Sweden	2.0	11.8	20.7	11.5	53.9
Scandinavia	3.3	13.3	17.7	11.5	53.9
Canada	33.1	17.5	10.0	4.6	34.8

This different understanding of the question is suggested by the fact that Nordic workers were much more likely than their Canadian counterparts to say they accompanied a resident on an errand outside their home (Figure 22). Only 7 per cent of the Canadian care workers reported that following a resident on an errand outside the facility was part of their work, compared to 28 per cent of their Nordic counterparts.

Figure 22: Direct care workers accompanying residents on an errand outside of the facility at least monthly, comparing countries



Talking with families is also an important aspect of care. When asked about keeping in touch with families as a task left undone, a quarter of the Canadian respondents said this was often or sometimes left undone, implying that it is usually done. The response to the question on how often there was contact with a resident's family was more positive, with a majority saying they had contact once a day. It may be that contact is understood as different from keeping in touch. Nevertheless, the responses together suggest that communicating with families has some priority in residential care.

Assembly Line Care

Providing social and emotional care is also essential to preserving the dignity of residents who have often undergone serious losses. As one LPN explained:

> *All too often people forget that a resident has been put into a nursing home and therefore has been stripped of everything they have accomplished in life. Their money, home, personal belongings, ability to make their own decisions and so forth. The only thing they have left is their dignity. Too often that is taken too.*

Under current working conditions, these workers say – in particular given the levels of understaffing and the resulting excessive workloads – such dignified, humanistic care is nearly impossible to provide. Rather, current working conditions instrumentalize "care" such that it too often becomes a task-oriented function to be done in the shortest possible time. Worse still, this dehumanizes the residents, transforming them into factory-like products or boxes to check off on a task list. As one LPN noted, "We are so hurried and residents feel like a number on a list of things to do." This negatively affects both workers and residents. Rather than caring for residents, residents are pushed through an "assembly line." Speaking for residents, long-term care workers have the following to say:

> *"I am a compassionate health worker who believes that we should work for the residents, but all too often they work for us on our tight schedule."* LPN

> *"I wish that things were geared more towards the residents and their needs. Treated as they deserve, instead of rushing and so pushed through daily routines like an assembly line."* PSW

> *"I fear that our care is in danger of becoming 'assembly line nursing' due to government demands, lack of government funding, lack of time to care properly for our residents"* PSW

This assembly line feeling is made worse by the increasing use of part-time employment contracts. As indicated earlier, over 40 per cent of the Canadian survey workforce has only part-time work. Continuity of care is sacrificed for residents who are faced with ever-changing caregivers; an issue of particular relevance for those who are cognitively impaired and who benefit from both continuity and familiarity. It cannot be assumed that those working part-time have more energy to give to their job, given that most take on extra hours and multiple jobs in order to survive. There is added stress for workers who constantly have to deal with new work environments, activities and co-workers. There is also additional stress for the full-time staff, who often have to teach the frequently changing part-time employees. And stressed workers have less time or energy to provide quality care. Furthermore, the reality of part-time and casual workers moving from facility to facility and unit to unit increases the likelihood of the spread of infectious diseases, an issue of particular concern for the more frail and vulnerable residents.

Although part-time work is often understood as a result of women choosing to enter the labour force on a part-time basis so they can deal with their other job at home, most of the part-time employees in this survey would prefer full-time employment. It is employers who are choosing part-time work. However, replacing full-time positions with part-time ones has implications for what care means and how it is delivered. Indeed, many Canadian reports the need to move to more full-time staff, with a 70 per cent full-time complement suggested as a desirable level.[89,90]

Conclusions

The working conditions described in the earlier chapters have consequences for care. The Canadian workers say they have no time for those tasks widely recognized as essential for survival, let alone for the ones like social support, or the exercise, and the chatting that these workers see as necessary to health. The physical space seems less neglected, but there are problems here as well. In contrast, the Nordic respondents do say they have more time for social care, demonstrating that it is possible to structure the work differently. At the same time, the Nordic workers also see room for improvement. They too want more time to care.

Chapter 6
Consequences for Workers

Conditions for residents in long-term care have been the subject of several recent media exposés. The CBC's 2007 series on nursing homes, for example, focused on assaults on residents.[91] But there has been little attention paid to the consequences for workers of inadequate care, lack of respect, and poor working conditions. In this chapter we turn to those questions, beginning with the feeling of being inadequate that such conditions engender. Workers report losing sleep over their concern and taking these worries home in other ways, indicating just some of the effects on their health.

Feeling Inadequate All the Time

As a result of the tasks left undone, long-term care workers reported frequently feeling inadequate because residents were not receiving the care they require. Equally important, workers feel that the residents are not receiving the care they deserve. In short, as the PSW put it, "They deserve better."

Feelings of inadequacy are widespread among the workers in our survey. Over a third of the Canadian workers said they felt inadequate all or most of the time, while another half said they sometimes felt inadequate. Only 17 per cent reported that they never or rarely felt inadequate. The sense of inadequacy was somewhat higher among direct care providers than among those working in dietary or housekeeping, though for the most part it seems to be a general sentiment. Four out of ten PSWs and one-third of RNs and LPNs reported feeling inadequate all or most of the time.

While workers in Nordic countries also report feeling inadequate, the problem is not as widespread there. A quarter of all the Scandinavians surveyed said they felt this way most of the time compared to close to 40 per cent in Canada. The numbers were even lower in Norway and Denmark. Clearly, feeling adequate most of the time is not a necessary condition for workers in long-term care.

Table 19: Feelings of inadequacy among direct care workers, comparing countries

	All or most of the time (%)	Sometimes (%)	Rarely (%)	Never (%)
Denmark	20.0	55.3	21.7	3.0
Finland	33.0	52.5	13.0	1.6
Norway	18.5	69.9	10.2	1.4
Sweden	32.2	57.3	9.3	1.2
Scandinavia	25.7	58.8	13.7	1.8
Canada	**39.2**	**47.1**	**8.8**	**4.8**

Feeling inadequate in relation to the needs of the residents is strongly correlated to feelings of mental fatigue. According to a large Swedish survey, mental fatigue is three times more common among care workers who often feel inadequate because they cannot provide the help the care recipients need than it is among care workers who feel inadequate less often.[71]

Just as it is important for residents to have social interaction and support from workers, it is also important for workers to have social support from other workers. The job is emotionally draining, physically demanding, and frequently heart-wrenching when residents die. This makes social support particularly important for the workers. Yet only a quarter say such support is never absent, with less than a quarter saying the support is often there. The time pressure on workers shows up in this lack of social support, and the lack of social support shows up in their health.

For some the result is frustration, burnout and tears. "And actually I've literally been in tears watching some of these girls when they go home and they're in tears".

Losing Sleep

What's more, many workers leave work so preoccupied that they are unable to sleep. More than two out of five Canadians sometimes or often lose sleep because of their work, and 17 per cent told us this happens all or most of the time. Losing sleep because of work was particularly serious for RNs and direct caregivers in general.

The concerns that keep them awake when they should be sleeping reflect the inadequate staffing and the related excessive workloads that prevent them from caring well for residents. The Nordic data make it clear that such stress is not a necessary result of the work in long-term care. When we add together the first two columns in Table 20, we see that only 15 per cent of Nordic workers say they think about work so much that it keeps them awake.

Table 20: How often do direct care workers think about work such that it keeps them awake, comparing countries

	Almost always (%)	Sometimes (%)	Rarely (%)	Never (%)
Denmark	3.5	12.1	25.2	23.5
Finland	5.3	14.3	32.3	13.4
Norway	2.7	13.4	31.6	17.0
Sweden	5.6	11.4	30.6	19.8
Scandinavia	4.2	12.9	30.0	18.2
Canada	**17.0**	**19.8**	**27.8**	**13.5**

As one Canadian LPN put it: "I am, however, often physically and mentally exhausted after a shift. Also, I often feel frustrated knowing that, because of time constraints and workload, I frequently leave work knowing that I haven't done a good job. I don't even have five minutes to talk with somebody who's lonely and just needs to talk." She goes home to toss and turn, worrying about the work left undone.

Taking it Home

This feeling of inadequacy spills over into care workers' homes. As another PSW put it: "I go home after most busy evening shifts feeling exhausted and discouraged because I was only able to do the minimum because I ran out of time." The exhaustion makes it hard to take up work and social commitments outside their paid jobs. This is particularly a problem for the women who make up the majority of these care providers and who also do the majority of work in the home.

When asked whether their working hours fit with their family and social commitments, one-quarter said they fit very well, whereas just over half told us their working hours only fit fairly well with their other commitments. At the same time, one-fifth of the respondents told us their hours do not fit well with their family or other social commitments outside the long-term care facilities. Overall, as is clear from Table 21, there was little difference between Canadian and Nordic respondents in terms of the numbers reporting their shifts fit very well. The biggest difference is in the number saying the shifts do not fit very well. More Canadians say this is the case. Here, however, Denmark, not Canada, is the outlier, with almost half of Danish workers reporting that their shifts fit very well with their other commitments.

Table 21: Shifts fit with direct care workers' other commitments, comparing countries

	Very well (%)	Fairly well (%)	Not very well (%)	Not well at all (%)
Denmark	49.0	42.6	6.9	1.5
Finland	11.1	52.0	33.0	3.8
Norway	13.5	57.4	23.4	5.7
Sweden	14.4	52.1	26.8	6.7
Scandinavia	22.1	51.1	22.6	4.3
Canada	**23.3**	**55.6**	**16.9**	**4.3**

Not surprisingly, those working more regular shifts found it easier to balance these commitments. For instance, two out of five of the direct care workers assigned day shifts during the week reported that they were able to fit in family and social commitments very well. Similar patterns appear for the Nordic respondents. By contrast, only 16 per cent of the Canadian direct care workers who had combination shifts (day/evening/and weekends) found they could fit these commitments in with their work very well. And this was the case for an even smaller number of Nordic workers. Night shifts created more difficulties for Canadians than for their Nordic counterparts, but only 11 per cent of those Canadians working the night shift combined with another shift could balance family and social commitments very well with their working hours.

Table 22: Shift type that fit "very well" with direct care workers' other commitments, comparing countries

	Scandinavia (%)	Canada (%)
Weekdays, day only	44.6	42.0
Weekdays, evening only	39.4	32.1
Nights only	44.0	30.2
Evening and weekend	30.8	14.9
Weekday, day & weekend	46.0	37.4
Day, evening and weekend	11.8	15.9
Night and other	9.3	11.0
Other	23.3	0.0

As we would expect, the worst working shifts in relation to family and social commitments are those which combine many different shifts. The worst situation is having two shifts combining day-evening, weekdays/weekends, and especially if night shifts are also included, which we have noted is most common among Finnish care workers. Working nights only is much better, presumably because it allows workers to develop a stable plan in relation to their families. From a policy perspective, this raises important questions. Residents need help 24/7, but this does not necessarily mean that the same person has to do all kinds of shifts.

Even more disruptive than irregular shift combinations were the excessive work-loads long-term care workers routinely face on the job. These extreme work-loads exhaust workers, and leave little if anything for themselves or their loved ones. This was the case for workers from every occupational category in long-term care. As one PSW put it, "When I'm stressed out, my family feels the brunt of it – I complain, I'm tired, a lot of demands – get told what to do all day. I do not want to have demands on me when I get home."

A housekeeper explained that, "Yes, the work-load wears you out, sometimes I am so tired after work I have no energy to do anything. Even on days off you're tired." An LPN summed up the situation for many by saying, "I have no other life because I'm too exhausted. Our health care system is

burning out all of our health care workers." Indeed, taking their exhaustion home was a common theme:

> *I think for me personally I find that there's so many demands on me during the course of my day, not only my normal routine but anything else that comes up in a day or if somebody dies or if somebody is very sick, all of that plus family plus things that need to be done plus the added paper work and also because I'm union president if there's something going on with that, by the time my day ends I'm like 'Oh my god let me out.' You know, I'm just exhausted. I can't even function enough at home to... you know, like I need clearing head time.*

The problem is not exclusive to women, however. On the survey, a housekeeper reported that he has no energy left for anything else: "I am so worn out at the end of each work day. I go home and sleep instead of being able to do things with my son and wife."

Because unpaid care in the home and household work in general is still primarily women's work and because most of this labour force is female, it is not surprising that many of these women do another job at home. Indeed, nearly three out of five of those within the long-term care workforce have children living with them. This care work limits their ability to work and earn a living, especially in the absence of either employer or government supports. For instance, nearly one-quarter of the Canadian workers with children told us they would work more hours if better or less expensive child care were available.

In addition to caring for children, 29 per cent of the Canadian and 39 per cent of the Scandinavian care workers provide regular assistance to family members or friends with long-term disabilities and illnesses. Most of them do so for a disabled or ill parent, but many provide help to a disabled spouse or a child, and it is not uncommon to provide regular help to more than one relative. Fortunately, most are not alone in caring for these individuals. However, more than one in four of the Canadian care workers do not have any assistance in doing this work, and 12 per cent told us that their employment or working hours were affected by such informal care work.

Even though a higher proportion of the Scandinavian care workers also provide care outside their paid employment, the number of hours spent on caring for family members is lower and the Nordic care workers are less often left alone in these caring responsibilities. This is especially the case

in Denmark, the country with the most generous coverage of home-based elder care services in the world. Almost half of the Danish care workers who provide help to a relative share the caring with (another) professional care worker. Thus it is not surprising that only 5 per cent of the Danish care workers who provide informal help report that their employment or working hours have been affected, compared to 15 per cent in Sweden, where there have been substantial cuts in the formal care services in recent years.

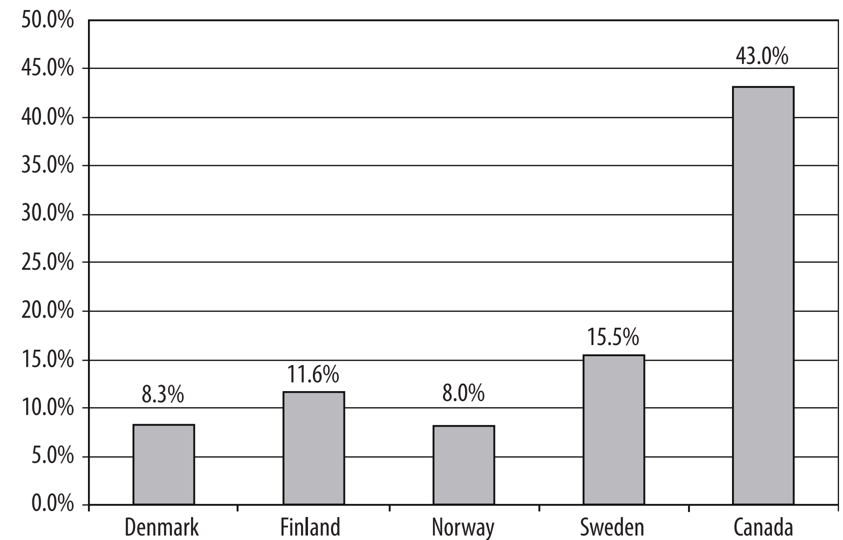
In short, the consequences of working conditions in long-term care do not stop at the door of the facilities or with the worker. Writing into the margins of her survey, one RN summed up the problem: "Staffing not being increased to compensate for the extra work-load, and my family ends up bearing the brunt of it. I do enjoy working with residents and my co-workers, but wish I had more time to give the residents while at work." Another worker wrote that she is "always tired, mentally stressed," which leads her to "take frustration out on husband" while another reported that "I seem to use up all my patience at work. Sometimes, being a single mother, I find myself short-tempered at home."

Taking it Out on the Body

Caring in an understaffed and under-resourced environment stretches workers to the limit. The Canadian long-term care workers report leaving work both physically and mentally exhausted. Two-thirds of the staff often or almost always finish their work day mentally exhausted. There is little difference among workers, with the exception of dietary staff, who are less likely to leave work mentally exhausted. Nonetheless, even for them over one-third reported finishing their day mentally exhausted.

Contrast this with the Nordic countries (Figure 23). Close to four times as many Canadian respondents said they almost always went home mentally exhausted. Clearly the toll is much greater on the Canadian workforce in long-term care. However, when we add the often to the almost-always answers, we see that more than a third of the Scandinavians also suffer from mental exhaustion. But Canada remains significantly worse on this measure, as well. Nearly two-thirds of the Canadians say they go home often or almost always mentally exhausted. These differences between Canada and the Nordic countries indicate that the work can be organized differently to reduce the stress at the same time as they suggest much more needs to be done in all countries to reduce the mental exhaustion of these workers.

Figure 23: Proportion of direct care workers who finish the day "almost always" feeling mentally exhausted, comparing countries



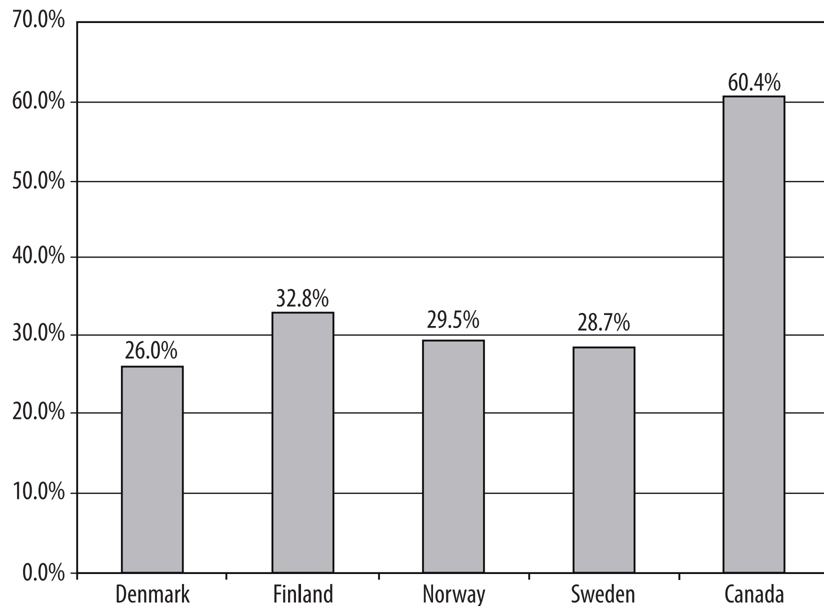
Staff in Canadian long-term care facilities are even more likely to leave work physically exhausted. The overwhelming majority of workers reported often or almost always finishing work physically tired. There was little difference found between occupational categories, though once again dietary workers are somewhat less likely to finish their day physically exhausted. The physical exhaustion is not surprising, given the workload and the work pace that respondents describe. As the following RN explains:

> *I am truly "exhausted" (physically, mentally, and emotionally) after a few consecutive shifts at my place of work, which gives me less energy on my days off to enjoy family time. I chose nursing almost 32 years ago when RNs were in abundance and nursing was actual hands-on direct care. Now I am buried in paperwork, compliance and MOH [ministry of health] regulations. My shifts are now a marathon med. pass pushing a heavy med. cart in an awkward position on a carpeted hallway and trying to make time for treatments, appointments, meetings, in-services and assisting other staff. The real enjoyment has disappeared from this noble profession.*

What is perhaps surprising, though, is the difference between Canada and the Nordic countries. Almost twice as many Canadian direct care workers

say they go home physically tired after a working day. Certainly the Nordic respondents report being tired, as Figure 24 shows. But the differences in the responses once again indicate that the work need not be as exhausting as it is in Canada and that there is room for improvement everywhere.

Figure 24: Proportion of direct care workers who "almost always" finish the day physically exhausted, comparing countries



This problem of physical exhaustion not only cuts across occupational categories. It cuts across age categories as well. As one PSW laments: "I really wish there was more funding. I'm only 26 years old, I'm healthy and in good physical shape, and I find myself to be tired and sore most days after work. I can't imagine how the older staff feels." The older staff report feeling consumed by their work or "beaten down," according to a recent CBC report.[91] In our study, one PSW close to retirement explained: "My job takes over my life, due to being mentally, physically exhausted. Sleep-eat-work. That's it. This kind of work in LTC drains you to no end."

Others expressed similar sentiments. A housekeeper, for example, wrote in that:

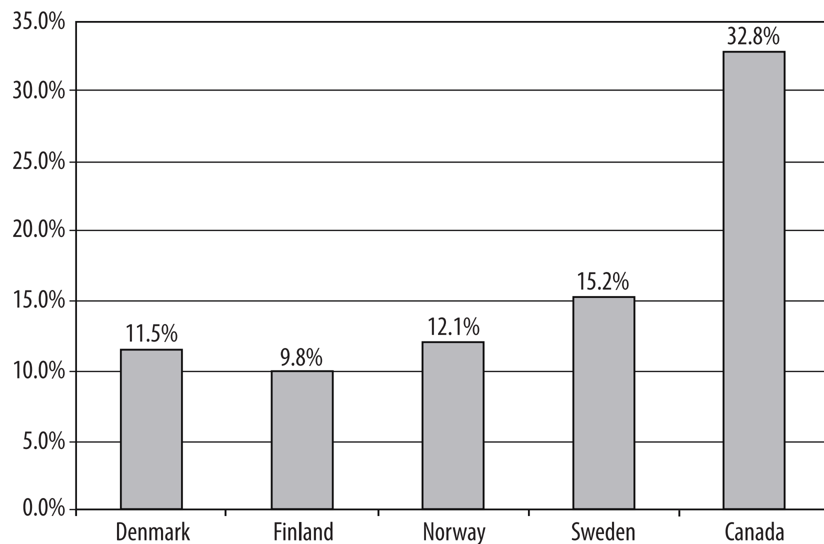
> *As I get older I have concerns about my physical shape – e.g. my hands show signs of arthritis. I work in laundry, I have foot and knee pain and do have to be careful as to shoes (orthotics, etc) more than I did when younger and did not work on my feet all day.*

Back Pain

In addition to mental and physical exhaustion, working under current conditions takes a severe toll on workers' backs. Back pain is alarmingly frequent. Almost all staff have experienced back pain at the end of their day, though this is somewhat more common for PSWs. During the focus group discussions, one staff member described the effects of back pain as follows: "I can assure you by the time I'm finished within just an hour and a half I have to lie down 'cause I can no longer walk and I can no longer sit or stand because my back is completely gone."

Back pain may seem inevitable, given the nature of the work. Regardless of job category, heavy lifting was a daily experience for three-quarters of workers. Working in awkward positions was less common, but nonetheless experienced by over one-third of the staff more or less every day. However, the Nordic data indicate back pain is not as inevitable as it seems. Overall, only 12 per cent report almost always having back pain, compared to 33 per cent of the Canadians. As Figure 25 shows, there are differences among Nordic countries, suggesting different strategies at work at the country level. But the rates in these countries are all significantly lower than the Canadian ones. Even when we include those who say they often experience pains in their back, there are significant differences. While 54 per cent of Canadian direct care workers report always or often having such pain, this is the case for 35 per cent of the Scandinavians.

Figure 25: Proportion of direct care workers that "almost always" finish the day with back pain, comparing countries



Canadian long-term care workers consistently report current levels of understaffing are key contributors to exhaustion and burn-out. These, in turn, can lead to back injury. Both heavy lifting and working in awkward positions can be alleviated by better facility design, proper lifting equipment, and having enough staff so that workers do not have to work alone as they so often do, at least according to those in our survey.

Injury and Illness

Given the current working conditions in Canadian long-term care facilities and the high illness rates, we should not be surprised that the majority of the workforce felt their health and safety was at risk. Indeed, research from the United States shows a clear relationship between low nursing staff ratios and high injury rates.[92] Similar research in British Columbia found that "workload is an important determinant of injuries and increased staffing levels correlate with decreased injuries", although the authors point out that other organizational, physical space and equipment issues also matter.[93]

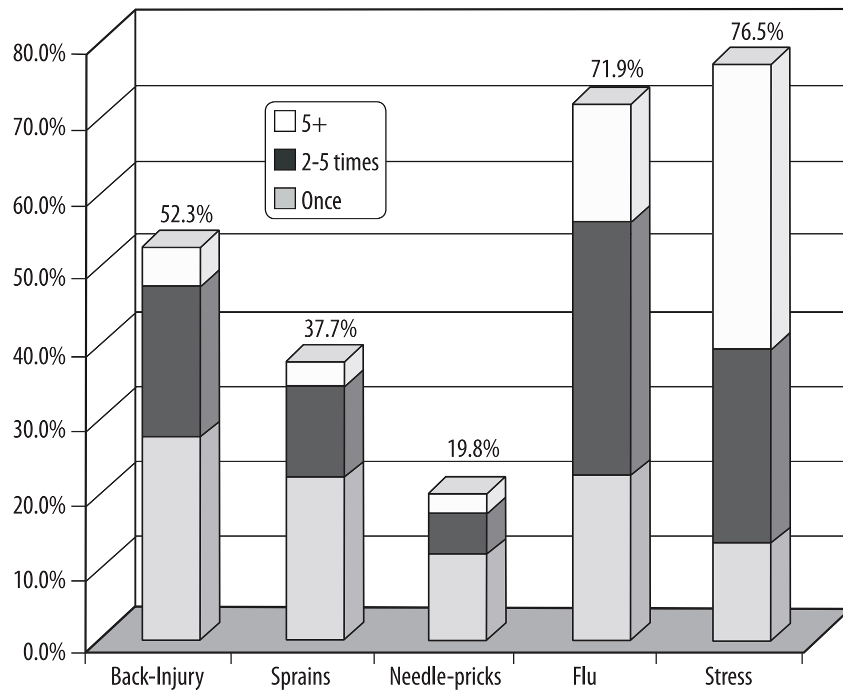
Only a quarter of the Canadian respondents felt there was little or no risk from their work. As for the rest, two out of five said they felt at risk some of the time, while nearly a third felt considerable or great risk. Direct care workers experienced more risk than housekeeping and dietary staff, though workers in all these jobs seemed to think that they risked their health and safety at work.

The sense of risk is appropriate, given that workers are often injured when working in Canadian long-term care facilities. "Research on the Canadian workforce has consistently indicated that health care workers have a greater risk of workplace injuries and more mental health problems than any other occupational group."[94] And data from Statistics Canada indicate that it is the support staff in health services who have the highest incidence of absences due to illness or disability.[95]

Not surprisingly, given the loads they regularly lift, back injury is the biggest problem. Lifting people is hard under any circumstances, but when they are old, ill, and perhaps resistant, it can be very difficult. Over half the workers have suffered a back injury as a result of their work. A startling 5 per cent say they have injured their backs more than five times on the job, and just over a quarter have experienced back injury once. As Figure 26 shows, workers also commonly report experiencing sprains as a result of their work, with 15 per cent reporting this kind of injury more than once. Needle pricks are common among nurses, and are even experienced by those not responsible for giving injections.

Physical injury is not the only threat to workers' health. They routinely fall ill as a result of their work, and many suffer from stress (Figure 26). Nearly three-quarters of the Canadian long-term care workers report being sick with the flu as a result of their job, although many still go to work. For more than a third, this is a repeated occurrence. For more than three-quarters, stress is common. Much of this is due to current working conditions – in particular understaffing and under-resourcing. As one RN commented on the survey: "I have always enjoyed what I do, but with increased demands and staff shortages the position has been very stressful. I come home exhausted mentally and physically and wonder if I have actually helped anyone and what I have missed or forgotten."

Figure 26: Number of work related injuries or illnesses sustained over the past year, Canadian direct care workers



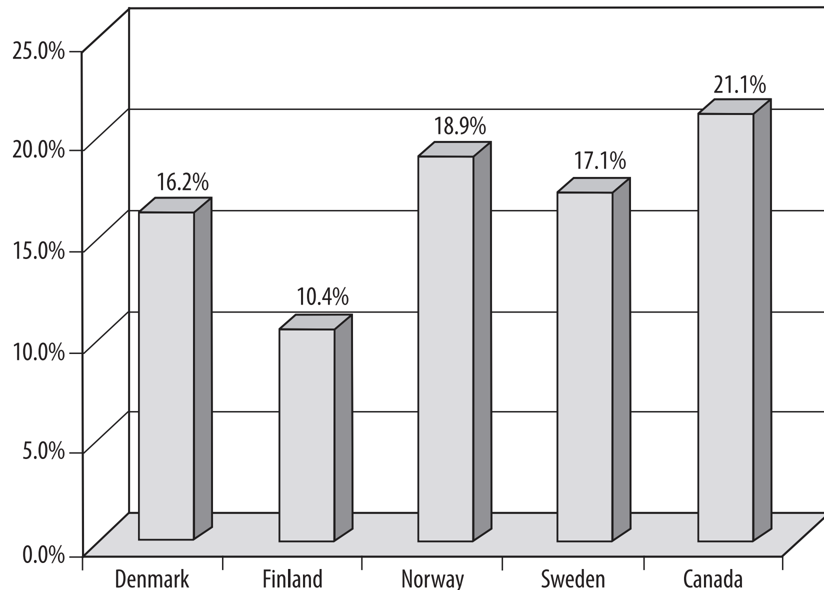
In addition to the stress caused by working conditions, there is the emotional stress which comes from caring for vulnerable residents and especially those who are dying. As one PSW describes: "We become very attached. When they hurt, we hurt. When they die, a piece of us dies. I cry in the night for the loved ones that are dying and are gone. I can't explain the stress that we endure." Another put it this way: "This job is very difficult. To be at this place and see every day, sorrow, depression, pain, crying, see the sad eyes, hands, sickness..."

Risk often means both workers and employers suffer. We asked staff about the number of days of work lost to illness or injury over the past year. One in ten reported losing more than 11 days. A similar proportion of staff lost between six to 10 days due to illness or injury. And one-fifth of the staff lost up to five days of work due to illness or injury over the past year. These reports are consistent with Statistics Canada data which show that an average of 12.3 days are lost per worker per year in health care, the highest of any industry.[95]

In spite of all these threats to their health, more than half the staff members report they did not lose any days of work. This figure needs to be interpreted with caution, as we have been repeatedly told in interviews that, due to understaffing and working short, the long-term care workers show up to work even when they are sick and injured. Well over a third said they have done so two to five times in the last year, and those most likely to do so are those involved in direct care. Not only does this negatively affect their own health, but it also poses serious health risks to the residents. And these residents are often already in such a fragile state that their immune systems offer little protection against germs or viruses carried by care providers. Weakened by injury, workers may also make mistakes or have even more difficulty lifting residents. That nearly 20 per cent of workers have worked sick more than five times over the past year indicates that ill-health is extremely common among the long-term care workforce. It cause for concern. Not only for residents and workers but for employers and taxpayers as well.

Canadians are not alone in showing up for work when they are ill or injured, but they are the most likely to do so. Here we do have comparative Nordic data. Figure 27 compares those who have worked sick more than five times in the last year, indicating the high numbers in all four countries who do so. The data show that Scandinavians also go to work even when they are sick or injured. However, they are somewhat less likely to do so than their Canadian counterparts

Figure 27: Direct care workers who have worked when sick more than 5 times over the past year, comparing countries



The phenomenon is talked about as "presenteeism" in Europe, a term designed to serve as a contrast to absenteeism.[96] Workers show up for work when they are sick or injured for many reasons, as we found in our focus groups. They feel a commitment to residents, and this is particularly important if they think employers will not hire additional staff to replace them while they are away. Some work because they have no sick leave left or because, as part-time employees, they have no right to such leave and need the money. The differences among countries may be explained by the fact that Nordic employers are more likely to replace absent workers, leaving workers more freedom to care for themselves when they are ill or injured. This conclusion is supported by an article based on the Nordic survey showing that demands at work are strongly correlated to the level of sickness presenteeism, even more than to sickness absence, suggesting that the workers become sick from high job stress.[96] But if the staffing levels are too low or the demands too high, the workers feel forced to go to work even when they are sick, because otherwise both their co-workers and the care recipients would suffer.

Indeed, the Canadian respondents made it clear why they thought the illness and injury rates are so high: "We are run off our feet to get our work done. Therefore, we've had an increase of work-related injuries, more off sick with stress." But our comparative data indicate that injury and illness rates need not be so high, and both money and quality can be saved by different organizational practices. Research in Sweden and Norway, for example, shows reduced illness and injury with shorter workdays that maintain full-time salaries.[38]

Workplace Violence and Unwanted Sexual Attention

There is a considerable body of literature on elder abuse, although the literature does suggest that such abuse is significantly more likely in private homes than it is in facilities.[97] Abuse against the elderly in nursing homes most frequently takes the form of neglect, rather than of direct assault from care providers, although there are growing concerns in Canada about resident-to-resident assault.[98] Violence directed towards staff by residents has received much less attention, however.

The studies that are available show that long-term care workers frequently experience violence from residents and even from family members.[99,100] The violence is both verbal and physical. The verbal violence experienced by care workers often includes threats, screaming, cursing, racial insults, and demeaning remarks. The physical violence experienced by care workers includes being slapped or hit with an object. It frequently involves being pinched, bitten, having one's hair pulled, being poked or spit on. Having one's wrists painfully twisted is also very common. Sexual harassment has also been noted, although this form of violence has received far less attention in the literature.

Our research investigated violence against workers, and our findings are deeply troubling.[101] Indeed, the levels of violence in Canadian long-term care facilities are shocking, especially when compared to the Nordic countries. Indeed, violence is far too common an experience for all workers in long-term care. Not surprisingly, perhaps, Canadian personal support workers report the highest level of violence, in part because they provide most of the direct care, and violence is most likely when personal care is provided (Table 23). But we found that almost all of the personal support workers, LPNs and RNs in our survey indicated that they had experienced some form of physical violence from residents and their family members while at work. Nine out of ten said

this was the case. Given that housekeeping and dietary staff are less likely to engage in direct care activities with residents, it is not surprising that they are much less likely to have experienced physical violence on the job. Yet, even here, nearly half of dietary staff and 43 per cent of housekeepers tell us they have experienced some form of violence at work.

Table 23: Abuse directed against PSWs by residents or family members

Type \ Frequency	More or less every day (%)	Every Week (%)	Monthly (%)	Less often (%)	Never (%)
Physical violence	43.0	23.1	7.8	15.8	10.3
Unwanted sexual attention	14.3	15.8	7.5	31.8	30.6
Racist comments	6.1	5.6	3.8	23.0	61.5

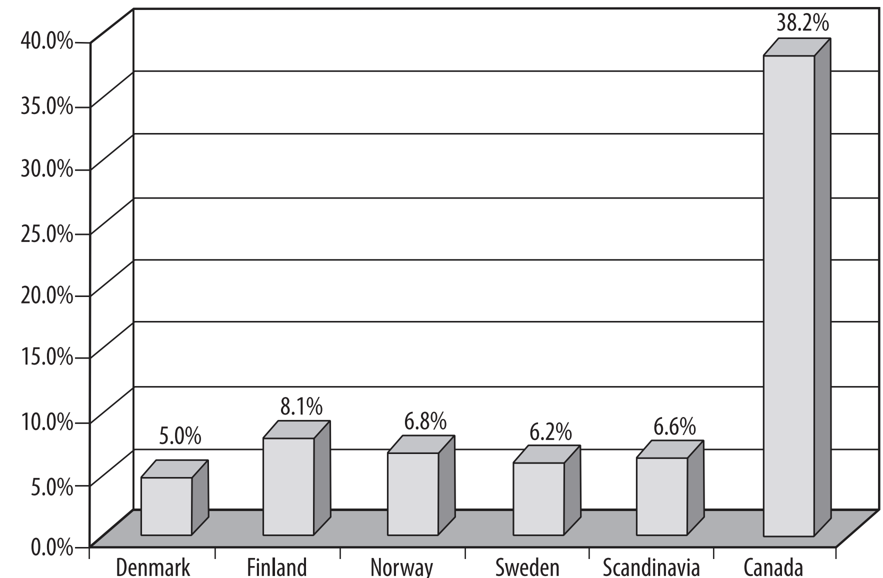
The physical violence is both common and frequent. More than two out of five PSWs reported that physical violence occurred more or less every day. For LPNs and RNs, the daily experience of violence was somewhat less common. Nevertheless, a quarter of the LPNs and 17 per cent of RNs reported experiencing violence on a daily basis.

Verbal abuse is also extremely common, although, as is the case with physical violence, it is more common for direct caregivers than for housekeepers or dietary staff. One-third of PSWs and LPNs told us they experience verbal abuse virtually every day, while all workers reported that such abuse is a regular occurrence. These numbers likely underestimate the problem of verbal abuse because we inquired about how often they were "being told off" by residents or their families. This therefore excludes other forms of verbal abuse, such as sexist comments or persistent yelling. Most importantly, we did not specifically include racial slurs, which focus group participants noted was all too common.

Workplace violence in long-term care is frequent. But it is preventable. Our international comparisons of direct care providers clearly demonstrate that such violence need not be part of the job. When comparing the levels of violence experienced by Canadian LPNs and PSWs who provide the bulk

of the direct care with those experienced by workers in Denmark, Finland, Norway and Sweden, some startling differences emerge (Figure 28). Levels of violence in Canadian long-term care workplaces are extreme when compared with the situation in the Nordic countries.

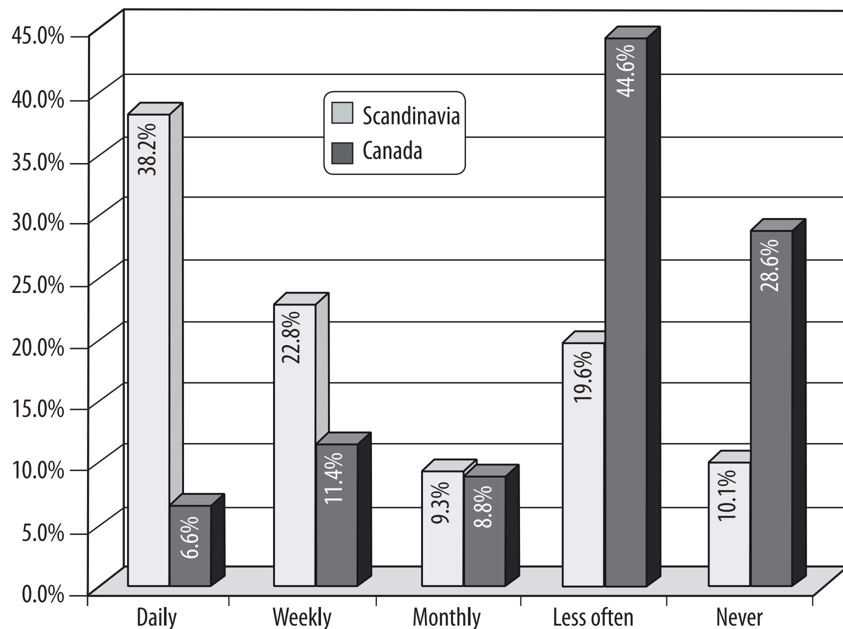
Figure 28: Proportion of direct care workers experiencing violence "more or less every day" by a resident or family members, comparing countries*



*Note that the Nordic questionnaire likely overestimates the level of violence as it asks about violence and threats of violence. The Canadian questionnaire asks about physical violence.

In terms of physical violence, Canadian direct care workers are well over six times more likely to experience daily violence than workers in Nordic countries. To put it another way, in Canada, well over one-third of direct care workers experience violence on a daily basis. The average among the Nordic countries is below 7 per cent. Similarly, while nearly three-quarters of Nordic workers say they experience violence less than once a month, less than one-third of Canadian direct care workers say this is the case (Figure 29).

Figure 29: Frequency of violence experienced by direct care workers, comparing Canada and Scandinavia



And we have reason to believe the differences may be even higher. The Canadian questionnaire asked only about physical violence. The Nordic questionnaire was worded to ask about violence and threats of violence. This means that the actual violence experienced by Canadian staff far outstrips both the actual and threatened violence in Nordic countries. For example, focus group participants pointed out that "There is a lot of emotional and mental abuse that comes through from family members putting down the staff feeling that they're not doing enough. They're not caring for their family members."

Workers link the violence they experience with current working conditions. In particular, having too much to do, too little time, and limited autonomy place direct care workers in a bind: they must enter into a situation they know is potentially dangerous, and rush daily care activities, or suffer the consequences of not completing their work.[100] They also note the dangers of rushing direct care activities. These activities – where most of the violence occurs – often involve intimate acts and the sharing of personal space. If such care is rushed, or worse if it is forced – for instance, when residents are required to get up, get dressed, or bathe before they are ready – this may

leave residents feeling threatened, fearful or overwhelmed, and prone to retaliate violently. The situation is made worse by the lack of time to comfort, console or chat, or even talk a resident into a calmer state.

Residents, they say, are often lashing out against the inadequate resources and staff time. The treatment of incontinence, our focus group participants said, offers a particularly telling example. Recall the exchange reported above about the use of diapers and the restrictions on how many can be used. 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, they drew attention to a technological innovation that may serve cost-conscious employers in the short run, but certainly does not serve incontinent residents nor those caring for them. In these new diapers, "There's a line at the top. Once that line changes colour, they're 75 per cent." The technology, not the worker or the resident decides.

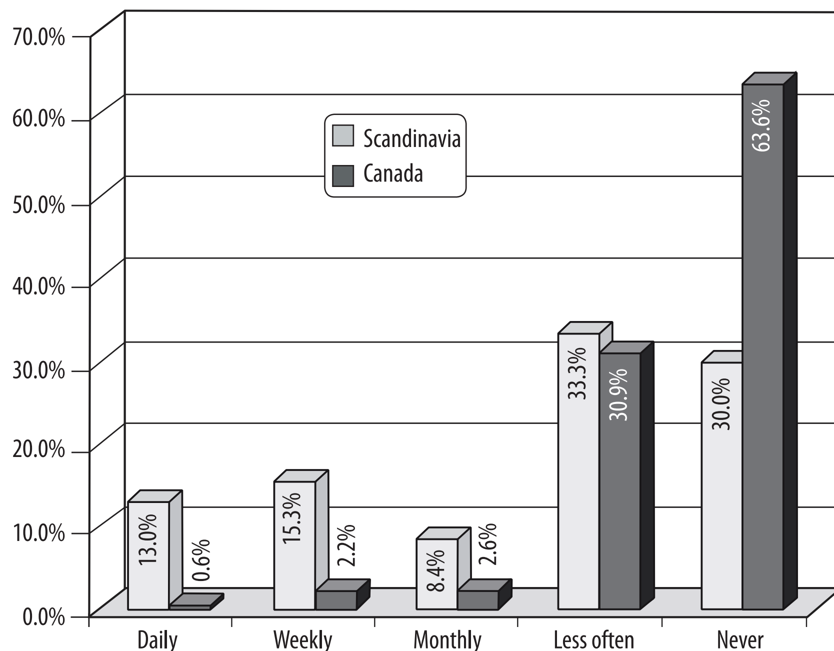
Workers cannot respond to residents' needs, but instead must go by the blue-line indicator on the diaper. When workers get close to the resident to change the diapers, they are often the victims of the anger residents feel about the discomfort and indignity they have suffered. Workers feel the response as a kind of double violence. They are being actually attacked and, at the same time, feel their own dignity as workers has been assaulted because they cannot use their judgement to do what they see as right for the resident. It is a form of structural violence they feel as a result of the working conditions.

While sexual attention may not seem to be an obvious form of violence, it is nevertheless often experienced as a form of assault. Like other forms of violence, unwanted sexual attention was also commonly experienced by the direct care providers in our survey. Again PSWs led the way, followed by LPNs and RNs. Unwanted sexual attention was not as frequent as other forms of violence, but 30 per cent of PSWs said they experienced unwanted sexual attention on a daily or weekly basis. Describing a "typical" incident of sexual violence, one direct care worker noted: "Doing a bath on a male resident, he tries to push your head down to his penis." Or, as another one put it: "You tell them to wash their private parts and they say 'No, you wash it. You're paid to do that'." "Or somebody grabbing your breast, grabbing your bum while you're doing care. You know, that kind of stuff."

Here, too, our Nordic data suggest that such unwanted sexual attention is not a necessary part of the job or a necessary response from the residents.

Rather, as is often the case with other forms of violence, it may be a way that residents take out their frustration with inadequate care on workers. As Figure 30 shows, more than twice as many Nordic respondents say they never experience unwanted sexual attention, and virtually none of the Nordic respondents say this happens on a daily basis. Clearly, unwanted sexual attention is experienced in Scandinavian facilities, but it is relatively infrequent compared to Canada, suggesting once again that there are factors in the work and workplace that make it more or less likely that such assaults will happen.

Figure 30: Frequency direct care workers experience unwanted sexual attention, comparing Canada and Scandinavia



There is another form of violence that is even less often studied in long-term care facilities, namely, racism. On the whole, 12 per cent of the Canadian respondents said they encounter racist comments on a daily or weekly basis. This figure likely underestimates the level of workplace racism for a number of reasons. First, we looked at responses for the entire population in the study and did not compare rural and urban facilities. It is likely that racialized groups, who comprise a higher proportion of the personal support staff in large urban centers, experience higher rates of racism than do others reported in this study. Second, the questionnaire was available only in English, and workers were required to fill them out alone. This prevented the aid of interpreters, so workers with language barriers are likely to be underrepresented. Thirdly, we asked if they experienced racist comments and not if they had witnessed racist comments or if they saw themselves as members of racialized groups, which might have influenced the outcome. Nonetheless, that more than one in ten reported racist comments on a daily or weekly basis is disturbing. In our focus group discussions, some care workers commented that they personally experienced or overheard racism "all the time" at work.

In sum, our study makes is abundantly clear that violence is a constant and ongoing part of the job for direct caregivers. As one PSW put it, "I am subject to aggressive (physical and verbal) abuse from residents and their family members almost every shift." Another succinctly responded to the violence question by writing: "It's physical. It's moral. It's sexual. It's verbal... I've had broken ribs. I've been sexually assaulted in a shower room. Had my clothes torn off."

Our study also indicates that this violence is not captured by official data or reports. Research suggests that the vast majority of violence in long-term care goes unreported.[100,102] Studies indicate that official reports are generally completed only if medical attention is required.[99] For the most part, either nothing is said, or a comment might be made to a nurse. Such comments, however, are unlikely to result in a formal, written report. For instance, in a study of a large Winnipeg long-term care facility, Donna Goodridge and her colleagues estimated that less than one per cent (0.27 per cent) of violent incidents were reported.[100]

A number of explanations have been suggested for the lack of documentation, including the burden of additional paperwork, the lack of management follow-up, a culture of blame, fear of confrontation with management, the desire to avoid conflict with residents, and the myth that violence is just part of the job.[99,103,104] It may also relate to sexism – specifically, the invisibility and normalization of violence against women

According to our respondents, caregivers work under conditions that not only foster violence but also render it invisible. Most violent incidents go unreported. Workers are afraid to report violent incidents, fearing that they will be blamed. Or they simply don't have the time to do so. Alarmingly,

workers inform us that they are expected to take such abuse as "just part of the job".

Participants in our focus groups cited paperwork and fear of being blamed by their superiors as reasons for their silence around workplace violence. "When you are injured on the job, to do WCB forms there's what?, eight pages?" Another said it somewhat differently:

> *There's so much paperwork involved in filling out an occurrence report or an incident report, and when you do that then the nurse looks at you: "Explain the situation." She looks at you as if to say, "Well, that's your fault."*

Being blamed for incidents of violence was not only common, but also revealed a demoralizing and unsupportive work environment. The sense of futility is palpable in the following remark: "If you get hit, it's 'What did you do?' It's always your fault." This experience was voiced by yet another: "Yeah, it's your approach. But slap a manager, boy, you're out within the hour." Workers report being blamed even for sexual violence: "We had one [such incident against a care worker] and when she went to management to complain, management told her that perhaps she shouldn't be so friendly with the male residents."

Most disconcerting was our finding that violence has become routine and that caregivers are expected to tolerate it: "We've been told it's part of our job," said one care worker. Another observed, "We try not to [accept it], but management says, 'Well, you're a big girl. Don't let it bother you...Lighten up'."

What our findings make clear is that, although there is a definite need to improve the documentation of violent incidents, we cannot expect staff to participate in reporting procedures until the culture of blame is addressed. Indeed, our study finds trust between management and staff lacking throughout. For instance, six out of ten personal support workers we surveyed told us their supervisors don't trust the staff and that there was too much monitoring and control. And over one-third told us that they "rarely or never" got support from their closest supervisor. Under these conditions, it is understandable why violence is unreported. Violence remains invisible to the public. And for care workers, it goes unaddressed.

Conclusions

The low staff levels, the hectic work pace, the physically and emotionally demanding work, the low level of control and unequal pay take a toll on workers' bodies and in their homes. Too many feel inadequate and lose sleep at night as a result. They are physically and mentally exhausted, injured and ill. They face violence, racism, and unwanted sexual attention on a regular basis. Although there are similar problems in Scandinavian facilities, workers report much lower levels of violence, fatigue and pain. Clearly, these are not necessary outcomes of providing care. They can, and should, be addressed.

Chapter 7
Thinking Back, Looking Ahead

Long-term care, according to the Canadian workers in our research, fails to treat either residents or care providers with dignity and respect. The single most important factor in this failure is the inadequate staffing levels. There are simply not enough people there to provide quality care. The official data on staffing levels indicate that Canada does not meet the standards for the number of direct care providers established by experts as necessary for adequate care. Moreover, the official numbers often hide the fact that workers are not replaced when they are ill or on vacation, or when a vacancy occurs.

Many of the other problems these workers identify stem from this single issue of staffing. Residents, for example, often become violent towards care providers because they are frustrated beyond endurance with the lack of care. They sit in soiled diapers for hours because there are no workers available to answer their call. They are rushed through dinner because there are too many who need to be fed. Or they miss their bath because there are not enough staff the get everyone adequately bathed. And they sit in their rooms without exercise or conversation because the workers have no time to chat, to explain, or provide social support.

Workers become injured because they rush to provide services. Or they come to work when they are injured or sick because they know that otherwise there will be no one there to provide care. They work unpaid hours to make up for the care deficit. They go home physically exhausted because they looked after far too many residents, or they go home emotionally drained because they could not provide the care they knew should have been provided but couldn't be in spite of their best efforts. These health issues spill out onto their families, making it difficult to cope with the unpaid domestic work these mainly female providers face once they leave paid work. Workers experience overload and stress, products of structural violence.

Although of late, more money has gone into long-term residential care in Canada, this new money has not gone primarily to hiring more staff relative to the number of residents. Especially in Ontario, funding priorities have been directed towards increasing the size of the long-term care sector, either through building more institutions or renovating older ones.[105] This concern with the availability of "beds," important as it is, hides quality of care issues that deeply affect the residents occupying these beds and the workers who care for them.

The results of this research clearly indicate that there is a need to direct policy attention and financial resources towards quality of care issues by addressing the staffing levels that are so integral to the provision of quality care. Staff working in long-term care report that whatever additional funding has been allocated to the long-term care sector, it is being felt on the floor, neither by the workers nor by the residents. "Funding never seems to go directly to hands-on care," according to one PSW with over 20 years of experience in the field, prompting her to wonder "if the Ministry really understands what goes on in nursing homes. It's easy to mandate, but how do we implement without proper staff?"

A number of the workers we surveyed also told us that the manner by which care needs are determined is inadequate and fails to provide an accurate assessment of what is required to offer proper care. According to one Registered Nurse: "The Ministry's classification system for funding in long-term care is for the birds. They classify residents once a year, for annual funding. They don't get a true picture of how heavy some of the residents are throughout the year." Another expressed the same sentiment differently:

> *"I feel that the way health care funding is granted in the long-term sector should be changed. If funding goes down due to poor documentation, then how is it going to get better with reductions in staffing which result in even less time for documentation, therefore funding will go down again. I feel that funding should reflect the number of residents, medications etc., not what is written in a care plan."* LPN

But staffing levels are far from the only issue. Work organization and lack of autonomy are also critical factors. Although it is necessary to provide 24-hour care, it is not necessary to schedule so many irregular shifts that prevent both continuity of care for the residents and a reasonable home life for the workers. It is not necessary to deny workers any choice in scheduling. It is not necessary to hire so many workers on a part-time basis, limiting continuity of care for residents and secure employment for staff. Nor is it necessary to prevent workers from making their own decisions about how to respond to residents' needs in ways that both allow workers to use their knowledge and allow residents to have their individual needs met.

Lack of choice and autonomy is in turn related to the failure to involve workers in decision-making or to consult them on changes. Workers are the experts on daily needs in long-term care because they are there. Yet they

are rarely asked about work organization or resident needs. Indeed, the problems with accurately assessing care needs – and therefore providing sufficient funding for direct care – would seem to stem from a more general disjunction (an abyss, according to staff) between what goes on "on the floor" and administration at the level of both governmental policy-making and facility management. More than one worker suggested that Ministry staff should come spend a day on the floor, or, better yet, a day as a resident, to see what actually happens in terms of care. Employers, too, need to listen to workers and allow them more choice in their shift schedules, as well as in their scheduling of tasks throughout the day.

Workers fail to report the violence, racism, and sexual harassment they face, in part because they feel their complaints will not be heard or, worse, that they will be blamed for the problem. This is particularly an issue for women, who too often assume the blame when residents act up or who are not believed when they do complain. The excessive bureaucracy required to report such complaints, or to report workplace injuries of other sorts, also prevents workers from recording the problems they face. And it serves to hide the actual numbers of workplace injuries. Indeed, these workers already face far too much paperwork that limits their time for care, and reporting injuries seems like just another addition to their workload -- an addition that often feels equally useless. Instead of real consultation or actual monitoring, accountability takes the form of increasing numbers of forms to fill out, few of which, these workers say, reflect what happens in daily practices.

Physical space is also an issue for both residents and providers. Buildings are too often not designed to meet the care needs of current residents. Nor are they designed to provide adequate space for workers to do their jobs. Equally important, many are not maintained to standards that promote the health of either workers or residents. We need to think of the needs of current residents and providers in developing long-term care, and to provide funds to ensure adequate standards of maintaining facilities to promote rather than undermine health.

The workers in these long-term care facilities are low-paid relative to their counterparts in the hospital sector and to the skills as well as the experience involved in their work. They are not often provided with the pay and support for the training required as the complexity in resident care rises. This low pay and the limits on training reflect, at least in part, the value

attached to this female-dominated work and is related as well to the high number of immigrant and racialized women employed in this sector. Equally important, the low pay and limited training are related to the low value attached to the residents, most of whom are elderly women without significant financial resources. The low pay, and the low benefits, both reflect and reinforce the limited power of the women who care and the women with care needs.

Even though the Canadian approach to long-term care in terms of organization and physical structures is increasingly medically-based, the work organization remains primarily one of custodial care. Neither approach seems appropriate for the population today, and should be replaced with a social care model that emphasizes supportive care based on meeting the goals of assuring dignity and respect for both worker and resident. Only by shifting the paradigm can governments achieve a commitment to these goals.

Better pay and benefits, as well as more full-time work would also help keep workers on the job and doing the work in a way that allowed continuity of care for the residents, an especially important issue for the growing numbers with dementia. More pay and time for training and for breaks would also help, but neither addresses the fundamental problem of too few people to provide care, the failure to involve workers in decision-making, or to grant them the right to decide about aspects of care in ways that would allow them to provide compassionate social care.

Too often the current conditions in long-term care are represented as inevitable in light of the growing number of those with care needs and of the nature of residential care. Many of these conditions have become so entrenched that workers see no option other than leaving. As an LPN put it, "The work I do is mentally draining...So much so that I strongly believe anyone working in a nursing home should be given early retirement and benefits and extra compensation for all the abuse one suffers over the years."

Alternative approaches to care are frequently represented as unsustainable in the face of the growing number of elderly, or impossible, given the diagnosis of residents. But our research reveals significant variations among provinces that challenge this notion of inevitability. The data from the Nordic countries provide a greater challenge to ideas about the impossibility of

alternatives. Even with significantly more dependent elderly, those countries are able to provide higher staffing levels and more time for social support, as well as more choice and autonomy for workers and residents. As a result, workers face less violence and lower injury rates. And they enjoy better health as they provide better quality care.

This is not to suggest that things are perfect in the Scandinavian countries for either residents or workers. Workers there are not without complaints and there is certainly room for improvement, especially in areas like pay and recognition. It is rather to suggest that there are choices to be made, choices that can improve conditions for workers and residents. To do so means recognizing that the conditions of work are the conditions for care.

Finally, it is important to recognize the joy these workers feel in providing care and the commitment they have to their work. They stay because they love the residents and because they feel they make a difference in their lives. They hide diapers and secretly recycle clothes; they buy residents shampoo and attend their funerals. It is a relationship with rewards for both residents and providers. As one focus group participant put it, it is like having grandparents. "They know what's going on in our lives just as much as we know. We're like the outside extension for them to the rest of the world, you know." What these workers want is to provide dignified care, which means having dignified conditions for work.

In planning for an alternative approach to long-term residential care, it is worth taking seriously a question posed to us by a Registered Nurse with over 25 years of experience in this field. Recognizing long-term care as an issue that should concern every one of us, she asks: "Is this what we all have to look forward to?" What this study shows, and in particular our Nordic comparisons, is that we can do better. They – we - deserve better.

Appendix A
Method

This report draws on four sources of data to provide a portrait of working conditions in Canadian long-term care facilities.

First, it draws on a survey of workers in unionized long-term care workplaces in three Canadian provinces and four Nordic countries. The questionnaire used in all countries was basically the same but the methods of distribution differed.

In the Canadian survey, the Institute for Social Research (ISR) at York University was responsible for the sample design and distribution. The sample was based at the level of the organization, and designed to be proportional by provincial population and by nursing home ownership type. A total of 81 unionized long-term care facilities in Manitoba, Ontario and Nova Scotia were selected. Five major health care unions (CAW, CFNU, CUPE, NUPGE, SEIU) provided contacts at each facility to aid the ISR in the distribution of the survey. A union representative at each workplace was asked to distribute the survey to the staff at the facility but the completed questionnaires were mailed back by respondents to ensure anonymity and independence in answers. The survey was conducted between January and August 2006. Workers from 71 (87.6%) of the 81 workplaces selected participated. A total of 948 surveys were returned. The returned surveys represent five major job categories: housekeepers (n=101), dietary aides (n=73), personal support workers (n=415), LPNs (n=139), and RNs (n=141).

The Scandinavian data were collected as part of a larger study, *NORDCARE: The everyday realities of care workers in the Nordic welfare states*.[106] In 2005 a questionnaire was mailed to a random sample of altogether 5000 unionized direct care workers in home-based as well as residential-based care for older or disabled persons in Denmark, Finland, Norway and Sweden. The overall response rate was 72 per cent (Denmark 77, Finland 72, Norway 74 and Sweden 67). The comparisons in this book are based on the responses from 1,625 care workers in Scandinavian residential care for older people: 409 in Denmark, 449 in Finland, 441 in Norway and 326 in Sweden.

The survey was sent to the workers at their home addresses provided to the researchers by the unions for care workers in the four countries (FOA in Denmark; KAT, SUPER and TEHY in Finland; Fagforbundet in Norway; and Kommunal in Sweden). This was regarded as the most reliable way to get national, representative samples of care workers. In Scandinavia around 80 per cent of the care workers are unionized, and the survey may thus be regarded as representative for a significant proportion of the care workforce in Scandinavia. However, the respondents differ from the entire group of Nordic care workers in that they are somewhat older, have longer work experience and more often have permanent positions

Whenever we report comparisons between countries based on the survey, we compare direct care workers (that is the Canadian PSWs and LPNs combined and the equivalents to these occupational groups in the Nordic countries).

Our second source of data is from the comments written in on the questionnaires. In addition to filling in the spaces explicitly left for comments, respondents frequently clarified and expanded in the margins on their answers, offered critiques of our questions or addressed areas not raised in the questionnaire. These responses have all been typed into our data base and sorted as part of the analysis provided here.

Third, nine focus groups were conducted in the three Canadian provinces in order to validate the survey results and provide workers with an opportunity to discuss our findings and offer additional comments, insights and elaborations. These discussions were conducted between December 2006 and May 2007 in each of the three provinces surveyed (Manitoba, Ontario, and Nova Scotia). The focus groups were organized by our union contacts, who advertised for participants but who did not attend the interviews themselves. Our interviewers asked participants to assess our initial findings from the survey, following a semi-structured interview schedule. All sessions were transcribed and entered into our data base.

Fourth, we draw on data and research from a variety of sources to expand on our analysis, including research conducted in Canada and abroad as well as data from a variety of statistical agencies.

For ease of reference, in this report we refer to Nordic or Scandinavian countries and Scandinavians in lieu of listing the countries each time. Similarly, we refer to Canada and Canadians, rather than listing the three provinces. Further, when interpreting our findings, one should bear in mind that in the Canadian context surveys were sent to unionized facilities only and in Scandinavia to unionized workers. These results are therefore not representative of non-unionized facilities or non-unionized workers.

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