BARE CARE:

WORKING WITHIN/REWORKING RESTRUCTURED LONG-TERM CARE

by

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Abstract

In the past nearly two decades in British Columbia (B.C.), Canada, the provincial government has restructured its responsibility for elder care, ceded to the private and financial sector an ever more prominent role, and opened up investment potentials for global capital. With this as context, I investigate the political economic developments and priorities, as well as everyday and uneven geographies of long-term care sector restructuring. Through comparative ethnographic case studies in a for-profit and a non-profit care facility in Vancouver, B.C., I explore how restructuring shapes the everyday conditions, practices, and relations of work and care.

Drawing on workers' experiences and perspectives, I generate a nuanced and intimate account of care work reorganization and labour process change. Understanding labour as embodied, I look at how workers' bodies and subjectivities are enrolled into and affected by restructuring. I find that restructured care work entails dehumanization and is premised on the expendability of workers' bodies, and emotional and mental energies. But it also contradictorily requires, cultivates, and draws on workers' emotional labour to ensure quality care under deteriorating conditions. I look at how the embodied impacts of restructuring, including work intensification, injuries, and burnout, erode workers' quality of life, future security, and even their family relations. I also explore the potentials and limitations of institutional and worker strategies that are employed to manage, buffer, or exploit restructured care settings.

Disrupting dominant conceptions of restructuring as rigid and uniform, these case studies show that restructuring processes and outcomes are not only flexible and particular, but are mediated by a constellation of actors, motivations, relationships, and practices. They also reveal

that very different levels of care and quality of work, as well as distinct forms of privatization, emerge from the same restructured residential care system. Overwhelmingly, state and capital's neglect of the basic requirements for quality care and work results in deficits that are borne by frontline caregivers as well as those who must survive within this regime of care. At the same time, the work these caregivers do to fill the gaps in care ultimately aligns with and enables state and capital interests.

Lay Summary

Over the past nearly two decades, long-term care in British Columbia (B.C.), Canada, has been neglected, underfunded, and privatized. I look at the past, current, and future priorities and developments in the long-term care sector in B.C. and the Vancouver Coastal Health Authority (VCH). I undertake ethnographic case studies in a for-profit and a non-profit care facility in Vancouver, B.C. to understand how the restructuring of the sector shapes everyday work and care. Workers' experiences reveal the changes and challenges in care work overtime, and the impacts to their bodies, families, and future security. I also explore a variety of organizational and worker strategies that are used to manage restructured care settings. What these case studies highlight is that restructuring processes and outcomes are not only flexible and particular, but that they create very different levels of care and quality of work, with often negative consequences for workers and residents.

Preface

This thesis, including design, field work, analysis, and presentation, is the original, unpublished work of the author. It was approved by the University of British Columbia's Behavioral Research Ethics Board, certificate number H17-01372.

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List of Abbreviations

British Columbia (B.C.)

BC Care Providers Association (BCCPA)

Health Care Assistant (HCA)

Health Employers Association of BC (HEABC)

Hospital Employees' Union (HEU)

Gracious Care Centre (GC)

Licensed Practical Nurse (LPN)

Mountain View (MV)

New Democratic Party (NDP)

Public-private Partnership (P3)

Registered Nurse (RN)

Resident Assessment Instrument - Minimum Data Set (RAI-MDS)

Request for Proposal (RFP)

Special care unit (SCU)

Vancouver Coastal Health Authority (VCH)

Workers' Compensation Board (WCB)

Acknowledgements

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Dedication

For my grandparents, Helen and Harold Boettcher, who lived the end of their years in long-term residential care and offered much inspiration along the way. For all those who strive towards creating and sustaining a world that supports caring well for oneself and one another.

Chapter 1: Introduction

1.1   The Personal is Political

Like many feminist geographers, whose research emerges from and is situated in relation to their lived experience, my research interest stemmed from my family's experiences in long-term residential care. My mother, sister, and I were heavily involved in the life and care of both of my grandparents, even after they entered residential care. My grandparents had two very different experiences there. My grandfather lucked out in the lottery placement of care and ended up a facility that was built on the premise of a home-like environment, and had a reputation for providing quality care. The facility had a stable core of care staff, and the intimacy of this home-like space fostered relations between staff, residents, and families. In contrast to common conceptions of institutional care, my grandfather not only was provided with good care, but in his ten years there, he flourished and grew as a result of meaningful relationships built with long-term care staff, and active involvement in quality of life programs (music and art therapy, and spiritual care). His caregivers intimately knew and were attentive to his needs, likes and dislikes, hobbies and personality quirks. They would take the time to play a coveted game of cards with him, and knowing he loved curling, two care staff took him to watch the curling bonspiel on their day off. The staff not only cared about him but also cared about our family, especially my grandmother who visited almost daily.

Yet in his time there, there were particular instances that revealed how policy changes and sectoral constraints altered the relations and conditions in the facility. With broader cutbacks and budgetary pressures, the facility was facing the threat of cuts to programs and services, and

staffs' wages. Rather than rely on stable funding, the organization had to increasingly appeal to private donations and volunteers to maintain programs and services. In one case, when the art therapy program was cut back, the art therapist stayed on in a volunteer capacity to maintain the program one day a week. I became interested in better understanding the commitments and efforts of individual workers to ensure quality care in a deficit care system.

My grandmother's experience further honed my interest in interrogating the systemic constraints that underwrite the organization and provision of care. It took a long time, a lot of persistence, and extreme circumstances to get my grandmother into residential care. After my grandfather's death, my grandmother's dementia rapidly advanced to the point that she needed a higher level of care. Yet we faced immense hurdles to accessing additional care because she already lived in an assisted living facility, and had the help of my mother and home care workers who would come to help her up in the morning and to bed at night. Her wandering the streets, getting into strangers' cars, or calling the police on what she believed to be a murderous daughter was not enough for her to secure a place in residential care. It was when she lashed out violently during a visit with my mother and sister, posing a threat to herself and others, that the health authority deemed her eligible for care.

In contrast to my grandfather, my grandmother ended up in a locked, overcrowded, and understaffed special care unit of an old and decrepit care facility. Because of understaffing, residents were placed in the lounge for easy monitoring. Here they sat in a circle staring at one another or sleeping, while restless residents wandered the halls and into rooms. Most were in a far more advanced state of dementia than my grandmother. Being confused and upset by this unsettling and unfamiliar space, she confined herself to her room and wept much of the day. While staff were caring, they were overworked, and hardly present. With few staff and limited

time, workers were typically occupied with residents who had the highest care needs, effectively neglecting my grandmother. This environment lead to my grandmother's decline and my mother's frantic move to get my grandmother transferred to the facility where her husband, my grandfather, lived, and where she knew the staff and had connections to. A handful of months later she was transferred and lived out her final months in ease.

1.2   Methodology

My research investigates the everyday contexts of long-term care sector restructuring in Vancouver, British Columbia (B.C.), Canada. I explore three key aspects of restructuring: the political economy of long-term care restructuring; care work reorganization and its embodied effects; and, institutional and worker strategies employed to manage restructured care settings. I believe that the everyday world of care work, and the changes it is undergoing, can provide fascinating insights into how economies and societies operate. My research is guided by theoretical frameworks from feminist political economy and labour geography, and geographies of care and social reproduction (Armstrong et al., 2009; Armstrong & Braedley, 2013; McDowell, 2009, 2015; England, 2010; Katz, Marston & Mitchell, 2012; Meehan & Strauss, 2015; Pratt, 2004, 2012). While long-term residential care restructuring in B.C. has been pursued through devolution, austerity, privatization, and financialization[1], I seek to better understand the

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[1] Recent research has explored the processes and effects of restructuring in long-term residential care across Canada (Armstrong, Armstrong & Scott-Dixon, 2008; Armstrong & Braedley, 2013; Armstrong et al., 2009). Relevant studies include those that focus on devolution and austerity (Cohen, 2012; Cohen, Murphy, Nutland & Ostry, 2005; Cohen, Tate & Baumbush, 2009; Longhurst, 2017) and privatization, financialization, corporatization, and contracting out (Armstrong, Armstrong & MacLeod, 2016; Harrington et al., 2017; Stinson, Pollak & Cohen, 2005).

particularities and tendencies in the dynamics of restructuring. I wed theoretical and empirical insights on care sector restructuring, and changes to the organization of work and provision of care (Armstrong & Armstrong, 2009; Baines, 2004; Banerjee, Armstrong, Daly, Armstrong & Braedley, 2015; Cohen, 2011; McDowell, 2009) to those that attend to embodiment and identity, affect and emotional labour, the body and materiality, difference and devaluation (Bolton, 2010; Ducey, 2010; England & Dyck, 2011; Lanoix, 2013; Salzinger, 2003; Twigg, Wolkowitz, Cohen & Netteton, 2011; Wolkowitz, 2006; Wolkowitz & Warhurst, 2010). Following Armstrong and colleagues, I understand care as a relationship rather than simply a service, such that the conditions of work and the conditions of care are co-constituted (Armstrong et al., 2009).

Critical attention to the ways in which intimate scales and subject positions articulate with broader webs of power, knowledge, and oppression open up alternative narratives and novel ways of analyzing and understanding restructuring. I seek to garner specificity and broader connection, and "hunt for the global forces that quietly undergird personal experience and exchange" (Pratt & Rosner, 2012, 2). Just as other feminist analysts have unsettled distinctions between production and reproduction, public and private, home and work, care and coercion, economy and society, global and intimate, I strive to show they ways in which they enmesh, shift, and blur (Katz, Marston & Mitchell, 2015; Pratt & Rosner, 2012). My research is a situated geography, or grounded account, of care sector restructuring. In this regard, restructuring is not an abstract, uniform, and autonomous process but highly contingent and uneven. It operates through a variety of social actors, practices, relations, and institutions, with differing impacts and implications for various groups involved. This research thus aligns with the work of feminist scholars who challenge dominant and decontextualized conceptions of capitalism, neoliberalism, globalization, and financialization (Nagar et al., 2002; Pollard, 2012). It also answers the call to

pay greater attention to the body and embodiment in workplace and labour geographies (McDowell, 2015; McMorran, 2012). Crucially, it draws, builds on, and I hope will inform the literature and debates around the nature of and contestations over care sector restructuring and care work reorganization[2] by attending to regional and local particularities (B.C. and Vancouver), intimate scales, and embodied accounts.

My research undertakes two comparative ethnographic case studies in a non-profit and a for-profit long-term residential care facility.[3] This includes over 450 hours of participant observation and 39 in-depth semi-structured interviews with frontline workers, management, and family members. An analysis of grey literature and policy documents highlights past, current, and future priorities and developments in the long-term care sector in B.C. and Vancouver Coastal Health Authority (VCH). The aim of these case studies is to connect everyday experiences, social relations, and material conditions within facilities to broader social, political, economic, and historical forces (Burawoy, 1998; Griffith & Smith, 2014; Smith, 2005).

Ethnography entails sustained engagement, involvement, and immersion in everyday life and work in these two care facilities. It provides for rich, deep, contextualized, and nuanced descriptions, interpretations, and explanations of the phenomenon under study. Ethnography aptly accounts for the embodied, experiential, relational, and sensory dimensions of both care work and fieldwork (McMorran, 2012; Pink, 2012). Comparative case studies allow me to tease

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[2] In particular, I have garnered countless critical insights from publications emerging from the Reimaging Long-Term Residential Care project, led by Pat Armstrong out of York University. Much of this work focuses on approaches to care, work organization, and issues of financing and ownership. See a list of publications here: http://reltc.apps01.yorku.ca/publications

[3] Long-term residential care is defined as the provision of accommodation, supervision, care, and support for persons unable to function independently due to complex medical, physical, or cognitive care needs. In colloquial terms it is better known as a nursing or care home.

apart place-based tendencies and particularities of restructuring processes and outcomes. I am interested in how distinct logics, motivations, and relationships shape uneven geographies of restructuring in non-profit and for-profit sites. These place-based ethnographic case studies are not representative of the entire long-term care sector in B.C. Yet they illuminate broader temporal changes to the sector and care work, and yield surprising and specific findings about restructuring. The comparison offers hypotheses and hunches that could be further explored in a more expansive study.

I initially reached out to fifteen non-profit and for-profit care home administrators, and the two facilities that eventually became the focus of my research were both a good fit for the research, and interested and able to take me on as researcher. It was sheer luck that the two facilities happened to be a for-profit and non-profit, which allowed for a comparative analysis. For both facilities, I completed an internal ethics review in addition to the standard ethics review of my academic institution. I initially assumed that a facility that let a researcher in would have "nothing to hide", and likely offer higher quality work and care, and have positive management-worker relations. I quickly learned that this was too simple a picture, and there were a myriad of adverse developments occurring, particularly in one of the facilities, prior to and during my time there. I am grateful that both institutions trusted that I would represent the challenges under which they operate fairly, and granted me such open access to their facilities.

Fieldwork spanned ten months from August 2017 to May 2018. I spent an average equivalent of two full days a week in the facilities. While the bulk of my time was spent there between 9am and 6pm, I also spent time in the facilities from 7am until 11pm to see differences in shifts and routines. I went around the facility with a notepad and pen in my pocket, and would jot brief notes that I expanded on as soon as I was able to. Out of a commitment to conduct the

research in an involved and reciprocal manner, and avoid being the distanced, detached observer, I decided to pursue participant observation through a volunteer position in the recreation department. Overtime, however, my formal volunteer role was transposed to just "hanging out", helping out, and observing care home life outside of the confines of the recreation department. I became a fixture of facility life and work (Foner, 1994). I helped staff with activities and events, served tea and coffee at mealtimes, portered residents around the facility and spent one-on-one time with them, and sat and chatted with families in common spaces or staff in the staff room and on the floor. This allowed me to engage with and observe the daily activities and people in the facilities on a more intimate level. It provided a grounded understanding of how restructuring plays out in the relationships, practices, and conditions of work and care. It also afforded the opportunity to better get to know and develop relationships with those who work, live, and visit the facilities. Overall, staff responded positively to my choice of research methods. They felt that, as the frontline of care, their experiences and concerns should be integral to research and policy decisions related to improving care and work. They liked that I was able to see the everyday demands and challenges of their work, up close and over time.

For reasons of privacy and informed consent, participant observation was limited primarily to the common spaces (lounges, dining areas, hallways, activity rooms, staff rooms, etc.) unless I was otherwise invited (into a resident's room, manager's office, nurses' station, etc.). I did not enter the private spaces of residents' rooms to observe the most intimate contexts of care unfold. It was the everyday informal conversations and experiences generated around the staff room table and on the facility floors that generated some of the richest data. While I did not include residents in formal interviews because of challenges with informed consent and meaningful participation, particularly for those with cognitive impairments, their perspectives

and stories are included through everyday interactions and informal conversations. Participant observation was a reflexive practice of honing attention, watching interactions, navigating relationships, and reflecting on one's perceptions, thoughts, and reactions.

Even while I volunteered in both facilities, I was integrated into work and life to varying degrees in each site. At Gracious Care Centre (GC), the non-profit facility, the management always made space and time for me. They were open to me sitting in on a variety of meetings, shared key documents with me, and provided answers to my questions. I was asked multiple times to offer feedback on any improvements to care, or to voice any concerns I had. At Mountain View (MV), the for profit facility, while I worked closely with one manager who offered much of her time and insight, management were more harried, and I often felt like I was in the way or an extra burden. When I expressed interest in obtaining key documents, or being involved in meetings, I was never offered the opportunity. My requests for follow-up questions were sometimes not answered or displaced. I am unsure if this was due a lack of transparency or because management were simply so busy that my requests were a low priority.

I am highly conscious of the work-related pressures that managers and frontline staff face, and I attempted to respect people's right to privacy and non-interference. I was attentive to the potential demands my research or position placed on them. In the staff room, for instance, I became attuned to the feeling the space and workers imbued. Knowing break times help tired workers rest and recuperate from their heavy workloads, I was careful not to encroach on their space and ask too much. I learned to pick up on cues about their receptivity and engagement, and adjusted how I responded to them in those spaces. There were countless times I put the research project on hold or aside to sit with workers in silence or to engage on other topics. Throughout the research I explicitly positioned my personal experiences, and the motivations and political

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commitments that underpinned my research. I allied with frontline staff, empathized with their situation, and offered to be a resource or lend a hand when I could. This helped to build trust and understanding, yet also required reflexivity over uneven and limited exchanges (Wolf, 1996). The research also required reflexivity about power and vulnerability in the research process, especially when working with dependent seniors and marginalized workers. It necessitated continual attention to the positionality of myself and research participants, in terms of age, race, ethnicity, class, and gender, and how that shapes our differential experiences and relationships to not only the research but the broader social world. I was also continually negotiating residents demands for time, and the drive to obtain data in the time-limited confines of academic research. I also constantly navigated boundaries with residents including managing disappointment when lengths of time passed between visits, being their advocate, and doing "extras" for them, such as obtaining information and attending community events with them.

The in-depth semi-structured interviews with frontline workers, management, and families identified key themes and issues from their perspectives and experiences. I include the full ambit of workers in long-term care because they are all integral to the delivery of care. Reflecting the long-term care workforce, I interviewed predominately care aides, but also nurses and allied health workers (mostly recreation staff), support service workers (cleaning and dietary staff), and companions. The family members I interviewed were those who were highly involved in facility life or their loved one's care. Management included administrators and managers of care, recreation, or support service departments. For confidentiality reasons, I lump the variety of allied health and support service workers into one category (simply, allied health and support services), and management and administration into one category (simply, management).

I wanted to situate myself in the facilities, and develop relationships with the people that live, work, and visit there before I pursued interviews. The relationships I built were shaped, to a large extent, by the spaces which I had access to, and frequented most. For instance, I spent far more time in the main common spaces and in the recreation department, and less time in the separated special care units (SCU). The most effective way I communicated my research was interpersonally. In one facility, where staff were fragmented by different break times in separate staff rooms, and because of a rotating work schedule, I held two pizza lunches to share my research with staff. At the other facility, standard break shifts and times in a common staff room served as the avenue to share research information.

Interviews with workers typically were off-site, unless they requested it be done at the facility for reasons of convenience, such as on their breaks or before work. Interviews with family members and management tended to be at the facility for ease. Interviews lasted approximately one to one-and-a-half hours. There were a handful in the range of two or three hours. My interview schedule was iterative and evolved in response to prior comments or observation, as well as to people's particular position. The semi-structured format attended to general themes, yet honed in on experiences, and delved deeper into novel and interesting responses. While I did not intend to conduct a focus group, the two pizza lunches served that purpose when disgruntled workers turned it into a space to share their collective concerns.

While the particularity of experiences rendered confidentiality sometimes difficult, I used pseudonyms for the facilities and research participants, and broad occupational classifications (e.g. care worker instead of nurse or care aide). I also delinked the occupation from the narrative if appropriate. Confidentiality was also a challenge given that a handful of staff worked in both facilities. I was told a couple of times that there were workers at MV who wanted to speak with

me, yet were fearful of employer retaliation. In this regard, I was highly attentive to the contexts in which workers shared sensitive information with me (e.g. (un)safe spaces and times, who was on shift), and to any potential harmful outcomes.

Many workers also expressed barriers to interview participation, including having very little time because of work and family demands, or some were simply too exhausted by the end of the day. Although I had aims of a more collaborative research process, I realized that time commitments, and a lack of resources and interest made it largely unfeasible in terms of workers capacities and in the short span of a graduate research project. Even with this goal, it is ultimately my specifically positioned self and the dictates of academia that direct the research design and process, data interpretation and representation, and knowledge production and dissemination (Wolf, 1996). Who and what I chose to listen to or record, or what questions I asked or not, shapes what knowledge is produced. The end research product is a partial story of situated knowledges (Haraway, 1988; Rose, 1997).

Given concerns over barriers to participation, and out of a commitment to fairly pay workers for their contribution and time, an honorarium of $25 an hour was provided to workers who participated in a formal interview. I did not to pay management and families, unless there would be an explicit barrier to participation, as these almost always took place on paid work time or subsequent to visits at the care facility. Workers who expressed interest in or responded positively to requests for interviews tended to be those I developed closer relationships with. They tended to have long-term experience, and they were passionate about their work, or worried about its current and future state. At MV, they were outspoken worker advocates, or discontent with the downward degradation of their work and workplace. There were some workers who felt the interviews were a cathartic release, others who became frustrated and upset bringing up

work-related challenges. While this may yield more extreme worker responses, it is tempered by the inclusion of family and managers' perspectives, and my own experiences and observations.

Moreover, beneficial outcomes of the research may not materialize the way that workers expect they will. Some workers were hopeful that I could bring forward their experiences and perspectives to politicians and policy-makers in more powerful positions. Others, who thought that my research could lead to improvements in the sector, or affect change in the workplace. I attempted not to mislead about my lack of capacity and power, even as I will share the research results through a variety of channels including facility management, workers, advocates, and the general public, with the aim of contributing to advocacy ends.

1.3   Care Facility Sites, Spaces, Staff, and Schedules

At Mountain View (MV) and Gracious Care Centre (GC) – the atmosphere, feeling, and spaces of each – are strikingly different. Both are publicly subsidized facilities. MV is part of a large for-profit chain care home operator with facilities in many provinces across Canada. GC is a faith-based non-profit single operator facility. MV has a more institutional and depersonalized feeling. Entering the front door, the first thing a visitor encounters is a glassed-in receptionist desk, and glass-fronted management offices with closed blinds and often half-closed doors. A large dining room, newly created activity room, and a common area with couches and chairs are to one side of the main floor. Unless it is mealtime, or there is a large monthly facility event, the main floor tends to not be used by residents and families. Even while the décor is aesthetically pleasing and the common areas are embellished with handmade decorations made by the recreation department, the space feels bare and is quiet. Upstairs, memory boxes are set on the

wall outside residents' rooms to house personal trinkets and photos, but the rooms inside have minimal personal touches. The elevator posts notices about resident satisfaction surveys, or appeals to residents not to keep herbal remedies in their room as management will be by to check. When it is mealtime, however, the common spaces on the main floor come alive. During this time, there are many family members, friends, and companions that visit, help feed, or bring food in for their loved one. Two ethnically segregated groups of residents and families gather together before and after mealtimes: one Chinese, the other Italian. They occupy the space with their sociality, chatting and checking in with each other. Compared to GC, where residents almost always eat together, those that need additional assistance with feeding stay on their floor and there is at least one care staff there to help.

There are evident spatial divisions in the facility. Because a code is needed to move around the floors, residents tend to stay on their own floor, and are set out around the common lounge, in their typical places. Overlooking the lounge is a glassed-in nurses' station. Management is almost always in their office rather than interacting with family, residents, and staff on the floor. While management eats together in the little used activity room, frontline staff have their own small, separated staff rooms (one for care staff, one for support service staff). In the care staff room, there are no dishes, cutlery, or dish soap. Instead staff bring their own supplies from home. The ceiling was also in disrepair, some furniture broken, and the couch ended up ridden with mice. Organized family involvement in the facility is low. Officially there are Family Council meetings, yet they rarely happen because of low interest.

In comparison, GC is known to provide exemplary care, and is "called to serve" and carry out the healing Ministry of Jesus Christ. GC provides holistic, compassionate care in a multicultural, homelike environment. When a visitor enters the facility they are immediately met

with a bulletin board of facility events, and the common areas downstairs are often occupied in activity. Aside from a dining room and lounge, there is also a chapel, large and stocked recreation department, and resident kitchen where families can use the appliances and make a meal. At mealtimes, the end of the lounge is occupied by a core group of family members, who sit together and help feed their loved ones. The space of GC pervades a home-like and comfortable feeling. Many residents' rooms are decorated with their own furnishings and pictures (one resident's room is chock full of hoarded goods) to provide a sense of familiarity and comfort. To this end, residents are able to lock the door to their room, even if staff can get into it if they need to. Staff wear plain clothing, or floral or printed scrubs to make care less hospital-like. Each new resident has their picture posted in the elevator so everyone knows who they are. In the elevator and around common spaces are residents' artwork and motivational quotes. Both make the facility feel less institutional and fosters a sense of community.

Management and staff are warm and friendly, and stop by residents and their family members in the hallways or common areas to take a moment to check in and chat. The spaces and relations at GC create what many family members call "a place of caring". There is an affective atmosphere that makes GC stand out from other facilities. A tight-knit group of family members, who are also on the Family Council, act as electrons that draw in and connect other family members and residents. Pets and children (including staffs') are often running around the care home. A large number of families, friends, and community members attend larger facility events such as the summer social and holiday feast. For the events, the rooms are festively decorated, and special treats are served. These events bring together an array of people and generations, and all involved are genuinely having fun. There is often dancing and singing, and the space pervades life and energy. GC is often busy and abuzz, and residents are often engaged

and active. Daily and monthly activities includes bowling, bingo, bus trips, and numerous special activities per month like birthday teas, performers, community choirs, and an annual talent show.

There is a beautiful, thoughtful, and celebratory way that death is dealt with at GC. There is also much support provided to families and staff to deal with loss and bereavement. Before a resident passes away, an announcement is made through the facility. Staff, family, and friends are invited to gather around the bedside to share thoughts and fond memories together. This contrasts with my one encounter of institutional dealings with death at MV. At MV, residents who pass away have their picture and name printed onto a poster board displayed in the reception area. One time, I was shocked to see the picture of a man who had just passed away with seemingly little notice. Later that day the picture and name were replaced on the poster board. I am told there was a mix-up, and they accidentally posted a notice of passing for a resident who was, in fact, still alive. Luckily, a staff person noticed it early enough in the morning before many family members arrived. At GC, there is also a profound respect for all life, and a deeply felt humanity that is expressed in the relations and practices of care. During morning liturgy, the spiritual care leader does a peace ritual where she engages in eye contact, touch, and tells each resident "peace be with you". "Mission integration" has the unique goal of integrating the organizational mission into everyday practice. Mission integration is about inclusive decision-making, spiritual and professional growth, and creating a place of work and care that exudes hope, joy, respect, love, meaning, and motivation. While residents and staff may be of any or no faith, management leans towards following the Christian faith.

The organization of care at both facilities is similar. Care aides get residents up and ready for the day between 7:30-9am, and back to bed between 6 and 8:30pm. Mealtimes tend to take a half hour to an hour at 9am and 5pm. Because both facilities have only two elevators, it is a

traffic jam of wheelchairs to and from mealtimes and activities on the main floor. The quiet

times for frontline staff are typically between 2-3pm and after 9pm. While the nurse tends to the

medication cart, or is on the computer doing documentation work, care aides are almost always

on the move, going back and forth down the halls, and into and out of rooms. Weekends are

noticeably quieter and more relaxed as no management are around.

The care workforce is aging, highly gendered and racialized, and from immigrant

backgrounds. Staff average fifty years of age, and many are retiring, or will soon retire (BC Care

Providers Association (BCCPA), 2018). Overwhelmingly, long-term care is a gendered space,

and restructuring is also profoundly gendered. Those who live and work in residential care are

predominately women. Two-thirds of residents are women, as they tend to have more illness and

disability, live longer, and have less access to income to pay for care (Armstrong & Banerjee,

2009). Women comprise 90% of care and support service workers in the sector (Cohen, 2009),

and family members who provide unpaid care work for their loved one are resoundingly women.

At MV, the vast majority of care and support service staff are Filipino. In both facilities, this is

the case especially for new and incoming staff. Many came to Canada under the Live-in

Caregiver Program, but have nursing backgrounds in their home country. At GC, the long-term

care staff are largely South Asian and Filipino. In both facilities, there is a smaller number of

care staff from China as well as Southeast Asian, Central and South American, and African

countries. Only a handful of care, nursing, or allied health staff are men. At MV compared to

GC, there are more male care and support service staff. At GC, just less than half of the

management team are men. Management at MV is dominated by white women, while at GC

management is whiter than frontline staff but more than half are racialized. At GC, a large

number of workers have been there since the day the facility opened about 25 years ago, or are

very long-term. Many have moved from lower status support service and care aide positions to nursing or management positions. The permanent staff at MV, too, are relatively stable, and many of them have also been there long-term. MV has around 100 residents, while GC has around 75. MV has a very large proportion of Chinese Mandarin or Cantonese speaking residents. This makes communication a challenge for staff. GC residents have a wider array of nationalities and ethnicities, but there is a larger Caucasian-European presence than at MV. There is also a substantial Chinese population. Because of the large resident turnover, the number of Chinese residents increases each year in both facilities.

There are around 50-60 and 60-80 regular staff at GC and MV respectively, excluding a large pool of casual staff. Directed by the health authority's medical model of care, which fragments whole persons into discrete parts, different departments in each facility attend to different aspects of care provision. Health care assistants (HCAs, or simply care aides) perform largely body or personal care, such as bathing, toileting, and feeding. Licensed practical nurses (LPNs) and registered nurses (RNs) provide largely clinical care, such as medication management, resident assessments and documentation, as well as care aide supervision. Allied health and spiritual care ensure residents' social, emotional, cognitive, physical, and spiritual care needs. And support services workers ensure the conditions for resident health and wellness through the provision of food and hygienic living conditions The bulk of facility staff are either care staff (nurses and care aides) or support service workers (cleaning, dietary, and laundry staff). And care aides, by far, comprise the largest portion of the long-term care workforce. While the care and nursing aide hours are similar at both facilities, the number of allied health care hours (which include recreation and physiotherapy) is quite a bit higher at GC than MV. At both facilities, there are approximately an equal number of residents on the floors (25-30). Each

shift, there is one LPN on every floor, except that one floor has a RN instead. On the day shift, each care aide cares for an average of 8 residents. With the new increase in funding for care aide hours across the province, this moved down from 8.5 residents. On the evening shift, care aides care for an average of 10 or 11 residents. On night shift, there is one care aide to care for 25-30 residents. Care aides work in teams on the same floor with the same residents. At GC, they rotate from one side of the floor to the other every week to ensure fair workload distribution.

1.4   Thesis Structure

I examine the restructuring of care in these two facilities in the following three chapters. Chapter One traces and unpacks past, current, and future priorities and developments in the long-term residential care sector in B.C. and VCH. It overviews local and broader interconnections in enmeshed processes of devolution, austerity, privatization, and financialization using a critical policy and feminist political economy framework. Chapter Two opens with a brief sketch of the literature on the reorganization of care work, as well as body work, emotional labour, and gendered bodies and subjectivities. The remainder of the chapter attends to an empirical study of labour process change from workers' frontline experiences and perspectives. I look at how particular bodies, affects, and capacities are enrolled in restructuring processes in uneven ways and with adverse effects. Chapter Three examines the different institutional strategies created and deployed to exploit or buffer restructured care settings in a for-profit and a non-profit facility. I assess the uneven geographies of restructuring by attending to the constellation of strategies, actors, motivations, and relationships involved.

Chapter 2: The Restructuring of B.C.'s Long-term Residential Care Sector

In this chapter, I employ a feminist political economy and critical policy lens to trace and unpack past, current, and future priorities and developments in long-term residential care policy, funding, and provision. This overview focuses on B.C.-based contexts, particularly the Vancouver Coastal Heath Authority (VCH), while connecting local developments to broader social, political, and economic forces and trends. This chapter looks primarily at the changes in the long-term care sector implemented by the B.C. Liberal government between 2001 and 2017, and their impacts today. It utilizes grey literature and policy documents, news and business reports, snippets of field work data, and academic literature to interrogate the following questions: What are the processes and dynamics of residential care restructuring in B.C. and VCH? How are neoliberalization and the historical devaluation of social reproduction enrolled in restructuring processes? To what extent, and in what ways, are market-oriented models of care and economic rationalization integrated into residential care funding and delivery? What is the scope of privatization and contracting out in the sector? How have the private sector, and corporate and financial firms, shaped developments in residential care? And how do the dynamics and impacts of financialization compare and differ to those of privatization?

2.1   Social Reproduction, Care, and Neoliberalization

Care is a fundamental human necessity. All people require care, and the demands and needs of giving or receiving care fluctuate throughout the life course. Despite this, as Silvia Federici (2012) argues, eldercare in capitalist societies is in a state of crisis because of the

devaluation of reproductive work, and the largely racialized, gendered, immigrant care workforce that performs "non-productive" work on "unproductive" frail, disabled, elderly bodies. There is also tension in that, under worker-oriented and social investment welfare policies, unpaid care is considered to have no inherent worth and is construed as a burden because it impedes household labour market participation (Fraser, 1997; McDowell, 2001). Because care work entails work on bodies, and contains elements of touch and emotion, it is naturalized as women's work, further contributing to its devaluation (Dyer, McDowell & Batnitzky, 2008; Wolkowitz & Warhurst, 2010). Additionally, as Pat Armstrong tells it, long-term care is characterized as "…the place of last resort, and where we send people to die. So this structures the way we think, and our main idea has been how to keep people out of these facilities, rather than to see them as an integral part of a continuum of care" (in Silversides, 2011, 31). In this light, long-term residential care invokes socially distancing imaginaries of not only institutionalization but also death, disease, disability, decline, and dirty work (Jervis, 2001, Lawton, 1998). These axes of devaluation and marginalization shape how we think about and invest in care and care work, and by extension, residential care has been rendered socially and politically invisible, deprioritized, and neglected. It is argued that this is why deep austerity and rampant privatization are perpetuated with little public contestation (Seeley, 2012)

The devaluation of care has historical roots in the marginalization of social reproduction, of which care is one vital aspect. Social reproduction, or the socially necessary daily and generational reproduction of people and collective social life, in western societies has been relegated to the private sphere and as the natural domain of women's unpaid labour (Green & Lawson, 2011; Laslett & Brenner, 2989; Luxton & Bezanson, 2006). This has effectively obscured its intimate connection to wider society and economic production, and undervalued this

work. To this day, paid work in the care and service sectors are highly feminized, devalued, and under-paid (Duffy, 2005). Social reproduction has traditionally been provided primarily outside of the marketplace, in the domestic sphere, or later through state and capital sponsored social welfare systems. But in the current era of neoliberal financial capitalism, state and capital have largely withdrawn from ensuring collective conditions for social reproduction (Fraser, 2016). In effect, this has (re)privatized the responsibility and cost for social reproduction to the household, marketplace, and voluntary sector with gendered, racialized, and classed implications (Bezanson, 2006; England, 2010; Katz, Marston & Mitchell, 2012).

The devaluation of social reproduction and care is evident in the B.C. Liberal government's approach to long-term care, which from 2001-2017 pushed forward and entrenched an agenda of austerity and privatization that is ongoing even today. This agenda reflects the broader trend in the neoliberalization of health and social care sectors that has occurred to varying degrees and with diverse outcomes in advanced capitalist countries, including Canada (England & Ward, 2007). The neoliberalization of B.C.'s long-term care sector is evident in restructuring processes that concurrently scale back the welfare state, and roll out privatization (Peck, 2001). In this context, the role of states is increasingly to facilitate investment and economic growth in the interests of global capital while eroding the power of labour and sidelining social welfare concerns (Bakker, 2000) This implications of this are that "[t]he changing sociospatial contexts of subjects involved in life's work are shaped and constrained by the state in contemporary capitalist society, perhaps even more than ever before" (Katz, Marston, & Mitchell, 2012, 15). The rise of individualism and market-oriented ideologies erode collectivism and enable the insertion of private markets and capital into more spheres of everyday life, including care (Bakker, 2000, 2007). At the same time, patterns of demographic

and labour market change, including population aging and dual income-earning households, increase the demand for care (Bezanson, 2006; Luxton & Bezanson, 2006). And a globalized market in care workers reshapes the international reproductive division of labour and the supply and demand of care work (Dyer, McDowell & Batnitzky, 2008; Kofman & Raghuram, 2015).

2.2   Devolution and Austerity

Across Canada and in B.C., long-term care funding and provision is increasingly viewed through an economic lens where "reductionist assumptions" (Banerjee et al., 2015) and financial logics and valuations prevail (Chiapello, 2015). This has enabled restructuring processes that narrowly define collective responsibility and restrict entitlement for care. Furthermore, long-term care in Canada falls outside of universal entitlements to health care services under the Canada Health Act (Banerjee, 2009; Day, 2013). This results in a patchwork of long-term care service provision, funding and staffing structures, and regulations across the provinces and territories, and their regions (Armstrong et al., 2009). It also increases the role of private markets for care-related services (Armstrong & Banerjee, 2009). Increasingly, publicly funded long-term care is reorganized through New Public Management tenets that emphasize market-oriented and managerialist practices of competitive tendering, cost-effectiveness financing, and efficient, performance-based delivery (Armstrong et al., 2009; Armstrong, Armstrong & MacLeod, 2016; Baines, Cunningham & Fraser, 2011; Day, 2013). Yet critics argue that these developments are contradictory to quality conditions of work and care, and neglect the complex relational and resource-intensive nature of care (Baines, 2015; Banerjee et al., 2015; Seeley, 2012).

In 2011, more than a quarter million people lived in long-term residential care in Canada (Armstrong & Braedley, 2013). In 2017, in B.C. this represented 4% of the senior population (Office of the Seniors Advocate (OSA), 2017b). Outsourcing service provision from the public to the non-profit, charitable, and for-profit sectors is a key characteristic of the neoliberalization of health and social care (Baines, Cunningham & Fraser, 2011; Day, 2013). While 95% of residential care facilities in B.C. are publicly subsidized, it is provided through a complex mix of for-profit, non-profit (including charitable and religious affiliates), as well as public operators (McGregor et al., 2011). In 2015-6, the five health authorities in B.C. spent $1.8 billion, or 12% of health care expenditures, on residential care services (Bellringer, 2017). In publicly subsidized facilities, residents pay up to 80% of their after tax income on the cost of accommodation and hospitality services, with a monthly maximum of $3,279 in 2018 (Plecas, 2017). This compares to the median monthly cost of $6,000 for a private pay bed (SunLife Financial, 2017).

Since 2002, the number of long-term care beds in B.C. has not kept pace with the needs of an aging population (Longhurst, 2017). As a result, residential care is increasingly difficult to access, and has a long waitlist. Numerous reports from the B.C. office of the Canadian Centre for Policy Alternatives (CCPA) reveal a continual downward trend in access to care (Cohen, 2012; Cohen et al., 2005; Cohen, Tate & Baumbush, 2009; Longhurst, 2017). Between 2001 and 2016, for persons 75 and over, access to residential care and assisted living spaces declined by 20%, while access to home support declined 30% (Longhurst, 2017). Under the B.C. Liberal's 2002 Continuing Care Renewal Plan, care provision transitioned from institutions (hospitals and residential care facilities) to private homes and less supportive forms of seniors' housing. This plan promised to improve seniors' care by building 5000 new long-term care beds. But closer analysis reveals that this "increase" entailed the closure of over 2500 non-profit long-term care

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beds between 2002-4, and their replacement in largely private, for-profit assisted living or supportive living units (Hospital Employees' Union (HEU), 2009).

Concurrently, changes in admission criteria since 2002 tightened eligibility for residential care, restricting access. While care provision shifted to the home, home support and care hours were cut back. Inadequate supports mean that seniors in need of a higher level of care have to rely on private payment for care services, or the unpaid care labour of (mostly female) family and friends. Those without family or access to income become sicker and more frail, and at risk of accidents and injuries. Hospitalization is often the consequence. It is also the precursor to seniors being able to obtain a higher level of care provision. Yet lengthy waitlists for residential care means that seniors are often cared for in the hospital longer than is necessary, or they are sent back home without adequate supports to wait for a bed to open up. Overwhelmingly, the crisis response to care needs ends up costing substantially more than if preventative supports and less intensive forms of care were in place. This not only wastes resources but creates unnecessary stress and suffering for seniors and their families (Cohen, 2012).

Tightened eligibility has led to a dramatic change in the resident population over time. Twenty to thirty years ago, those in residential care were more-or-less cognitively capacitated and mobile, and had minimal care needs. While residents' care needs increased over time, they accelerated about a decade ago. Increased longevity and a model of care based on "aging in place" and "keeping seniors at home" mean that people entering residential care are older and frailer, and have more complex care needs. As one manager at MV shares, these were once people "who ten to fifteen years ago you would have found sitting in hospital beds." Residents now frequently have moderate to severe cognitive impairment (often dementia-related), mental health and behavioural challenges, physical dependence, and multiple disabilities or medical

conditions. Because of this, most need substantial or total assistance with their Activities of Daily Living (grooming, dressing, washing, eating, toileting, etc.) (Kary, 2107; Plecas, 2017). The average resident age is 85 years, and 59% of residents are over 85 (OSA, 2018).

Residential care is now informally characterized as dementia and palliative care. Sixty-three percent of residents have a diagnosis of dementia. "Palliating in place" is a key goal, and end-of-life care is a common feature in long-term care (Cohen, Tate & Baumbusch, 2009; OSA, 2018). The current average resident length of stay is less than one year and three months (OSA, 2017a), and care home managers claim that over one-quarter of the resident population passes away each year. In one of my facility field sites, seven residents passed away in a very short span of time, equating to a loss of almost 10% of the entire resident population. With people now entering residential care in such an advanced state of cognitive and functional decline, their transition into care is more difficult, and they have a harder time engaging with, and settling into their surroundings. Furthermore, a faster resident turnover has implications for workers' emotional wellness, as well as building long-term relationships and knowledge of residents.

Compared to the acute sector, funding, equipment, and supplies in long-term care are wanting. As the complexity of the resident population continues to rise, care facilities have not seen a corresponding increase in funding, staffing, and training to adequately meet these needs (Cohen, Tate & Baumbush, 2009; Kary, 2017). Moreover, a recent CCPA report shows austerity trends in seniors' care in B.C. Between 2002-2012, per capita expenditures for residential care for seniors over 65 dropped by more than 60%, placing B.C. "dead last by a huge margin" amongst the provinces (Lee, 2015). Austerity measures in social and health care is the result of devolved responsibility and shrinking funding transfers from federal to provincial, regional, and municipal levels. It is also the result of regressive provincial tax cuts that led to a loss of $3.4

billion in public revenue from 2001 to 2010 (Longhurst, 2017). As a result of underfunding, the

2017 Seniors Advocate report shows that 85% of B.C.'s publicly subsidized residential care

facilities fail to meet the government's minimum staffing guidelines of 3.36 hours of direct care

per resident per day (BCGEU, 2018). Comparing public to privately owned and operated

contractor facilities (both for-profit and non-profit), 33% versus the respective 4% meet or

exceed minimum staffing level guidelines. Beyond underfunding, this signals a lack of funding

parity between facility ownership type[4] (Kary, 2017; OSA, 2018).

To offset a legacy of Liberal government austerity, the B.C. New Democratic Party

(NDP) last year announced an investment of $548 million over three years in seniors' care. Much

of this funding is earmarked for additional care aide hours in residential care to bring facilities up

to an average of 3.0 care and nursing hours per resident each day. This combined with allied

health (recreation, occupational, and physical therapy, etc.) hours will reach the goal of 3.36

direct care hours. While this is a much-needed investment, some advocates believe this is still

bare bones. Given the current level of nursing and care hours in facilities, this translates to only

an average increase of 22 minutes of care per day (Culbert, 2018). This also compares to other

countries, like Sweden, who have invested in 5.2 hours of direct care and have double the

number of facility care staff compared to the Canadian average (Armstrong et al., 2009). Many

feel three hours is not enough considering the extent of resident care needs. The classification of

direct care hours, too, has been critiqued as an overstatement (Armstrong et al., 2009). This is

because LPN and RN hours are included in the 3.0 hours of direct care, yet they tend not to

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[4] In sum, this is because the health authorities expect contracted facilities to put forth some of the costs
associated with long-term care operations. This is further explained in chapter three at the start of the
section on GC's fundraising strategies.

provide hands-on care but rather documentation and medication management (Givetash, 2017).

Additionally, advocates point out this investment disproportionately advantages for-profit

facilities as they typically have the lowest care aide hours. There is also concern that increasing

funding without subsequent accountability measures could see investments funneled into profits

rather than staffing. For example, there is currently no way to track if facilities are replacing their

additional care aide hours when staff call in sick or are on vacation (Culbert, 2018).

Sectoral underfunding has created deficits in care home operating budgets, posing risks to

debt and facility closures (Cohen, Tate & Baumbush, 2009). In this context, unionized wages and

benefits are made "unsustainable". Facilities face pressure to rein in costs by reducing staffing

levels, and contracting out care and support services to remain viable (HEU, 2009). To reduce

labour and benefit costs, casual and part-time work is endemic across the sector (over 40% of the

workforce) (Armstrong et al., 2009). Many workers piece together multiple jobs, making it

difficult to juggle work demands and home life (Armstrong et al., 2009). There has also been a

downward trend in wages and benefits across the sector over time, with workers in private

facilities and contracted out departments typically hardest hit. The Hospital Employees' Union

(HEU) reveals there is typically a 20% loss in what a care aide would earn in a public versus

private care facility (Givetash, 2017).

The vast majority of long-term care facilities in B.C. are unionized, which is associated

with better wages, benefits, job security, and work conditions compared to non-unionized

workers (Armstrong et al., 2009). Most long-term care workers fall under the Health Employers

Association of BC's (HEABC) master agreement that sets standard wages and benefits for over

230 publicly-funded health care employers across B.C. Yet operators, typically for-profits, can

exempt themselves from HEABC processes or contract out the work to circumvent these set

wages and benefits. Even under the master agreement, workers' wages and benefits have been eroded. In response to a 2004 job action initiated by HEU members over the threat of contracting out, the B.C. Liberal's implemented back-to-work legislation to end the protest, and issued an "unprecedented" 15% pay cut for health care workers (Armstrong & Hume, 2004). While this pay cut occurred nearly 15 years ago, workers state it is only now that they are getting back to the wage they were previously at.

The provincial government and health authorities have staffing level and skill mix guidelines. This outlines a particular ratio of registered nurses (RNs), licensed practical nurses (LPNs), and health care assistants (HCAs) depending on the shift and facility size. In the mid 2000s, to reduce labour costs, reclassification occurred and work was downloaded from higher to lower paid and skilled workers, while the work was also becoming more complex (Seeley, 2012). RNs began to be replaced with LPNs, and LPNs were reskilled to do nearly the same scope of work of RNs. This includes medically complex care tasks such as inserting feeding tubes, dressing wounds, giving out medications and intermuscular injections, and undertaking medical assessments. HCAs' scope of work, too, has extended into wider arenas. HCAs provide palliative care, do some documentation, and some dispense medications. To save costs by shifting more work from LPNs to HCAs, employers often require HCAs to have a Certificate of Medication Administration. Workers generally bear the costs of training. This poses barriers to certification for those who cannot afford it, typically newer immigrants in poorer paying care work. While the responsibilities and skills of HCAs and LPNs widen, their wages and much of their training have not correspondingly increased. Subsequent to problems that sprung up from reclassification, cutbacks, and contracting out, the B.C. Liberals implemented the BC Care Aide

and Community Health Worker Registry. This increasing credentialization individualizes responsibility and puts the onus on workers to ensure quality care under deteriorating conditions.

2.3   Privatization

Privatization has become the solution to state deprioritization of care, and is encouraged through legal, policy, and regulatory changes. Privatization has gained traction through discourses of unsustainable health care costs amidst a "grey tsunami" of population aging, fiscal crisis, and debt reduction. It is also bolstered by the neoliberal notion that privatization creates more competition, choice, and efficiency. At the same time, this also legitimizes cuts to public expenditures and a reduced role for the state (Armstrong & Armstrong, 2009; Armstrong, Armstrong & MacLeod, 2016; Armstrong & Braedley, 2013). In the current political economic climate, economic growth and business interests have sidelined social welfare concerns and collective public interests (Aronson & Neysmith, 1997; Cohen & Cohen, 2006; Day, 2013). Consequently, HEU's secretary-business manager Jennifer Whiteside notes, "'there's been a shift in the last 10 years that has really tipped the scale in favour of the private sector without any kind of debate publicly about how it is we want to be delivering care to seniors.'" (in Abassi, 2016).

Sectoral underfunding would logically repel private investments. Yet privatization has been encouraged by facility assets and development potentials, and the ability to change subsidized beds into higher paying private pay beds. Privatization is bolstered by a lack of enforceable staffing and quality care standards, poor government oversight, and the unrestricted ability to contract out work and drive down wages and benefits (HEU, 2009; Longhurst, 2017). In Canada, in 2014, for-profits accounted for 37% of publicly funded residential care facilities,

placing it somewhere in the middle of Norway (6%) and the United States (US) (70%). The top for-profit care operators in Canada acquired rates of profit from 9% to 28%, with the latter figure being far greater than in for-profit operations in the US, United Kingdom (UK), Sweden, and Norway (which averaged around 10%) (Harrington et al., 2017). In B.C., long-term care is delivered in almost equal parts by non-profit, public, and for-profit operators. Yet there is a rising trend of public funding going to for-profit care home operators and service providers.

Between 2001 and 2016, the number of beds in for-profit facilities increased by 42% at the same time as they decreased by 11% in non-profit and public facilities (Longhurst, 2017). Privatization in residential care has been facilitated by New Public Management policy changes in the late 1990s and in 2001 that ended direct capital funding grants for non-profit operators. Over 90% of the net residential bed closures between 2001 and 2005 occurred in non-profit facilities. This is, in part, because they cannot access sufficient capital to support necessary renovations, and most end up being replaced by newly built for-profit facilities (Cohen et al., 2005). In one recent example, one large private, for-profit facility will be built to replace two older public facilities on B.C.'s Sunshine Coast. This decision was made despite a lack of community consultation by the health authority, and ample community opposition to the private provision of care. In the transition from public to private operations, there is concern that 200 facility staff are at risk of either losing their jobs or facing a $5 an hour cut to their wages (Garvey, 2016; HEU, 2017). At the same time, request-for-proposal (RFP) bids for new publicly-funded residential care facilities and beds were established on a competitive basis. These changes favour large private operators because of their ability to lower bids and leverage capital in the context of high land and building costs.

The "government expects a public-private partnership [P3] approach to be used to develop new capacity for residential care beds" (Plecas, 2017). While not technically a P3, the recently announced Pearson Dogwood Redevelopment Project is premised on a unique public-private hybrid. In this development project, VCH sold off almost the entirety of its 25 acres of Pearson Dogwood Lands to major real estate development company Onni Group. Onni Group will develop the land into a mixed-use community with commercial, retail, park, and health care space, as well as market rate and supported housing units, worth an estimated $2 billion. VCH claims all income generated from the sale of this public asset will be re-invested into health care (O'Brien, 2016; O'Connor, 2015), yet this claim is difficult to substantiate. Onni will rebuild or replace two of VCH's residential care facilities. The George Pearson Centre, which houses 114 residents with complex medical and physical conditions, will be closed and its residents integrated into market housing in independent living or group home units with supports.

The corporatization of residential care has been entrenched with the end to direct capital funding grants and the establishment of competitive RFPs. Private care home owners and operators increasingly consist of large chain corporations, sometimes associated with major financial firms. There has been a simultaneous decrease of small family-run, or single operator facilities (BCCPA, 2016; Cohen, Tate & Baumbush, 2009; HEU, 2009; Longhurst, 2017; Kary, 2017; McGregor et al., 2006). This mirrors developments in residential care across Canada, where in 2014, the top five chains owned 24% of beds and 19% of care facilities (Harrington et al., 2017). Corporate consolidation is also evident in VCH's recent Residential Care Rejuvenation plan. This entails the largest residential care bed development in 50 years, worth $40 million over 10 years. Out of a total of 943 beds (with only 225 of these being new beds),

for-profit chain operators won six out of eight bids to build or extend care facilities to house these beds (HEU, 2016b).

For-profit chain companies reconfigure the scale and spaces of care because of their tendency to build and remodel facilities in large institutional style (Burns et al., 2016). While this allows them to maximize economies of scale, it impacts residents' quality of life. Large care facilities tend to feel less home-like, and often there are fewer common spaces for residents, families, and friends to interact. Similarly, Amy Horton (2017) found that financialized care chains create care facilities in a hotel-like fashion, with aesthetically pleasing yet often underused or inappropriate spaces. Their focus on the visual surface of facilities comes at the expense of investment in new equipment, additional staffing, or training. And in B.C., for-profit chain facilities typically have a larger number of residents than non-profit facilities, with many housing 200 residents or more (OSA, 2017).

The private sector operates under the narrative that they can innovate and improve care services while increasing efficiency and reducing costs. While they provide a much needed influx of funds to the care sector, this is only needed because of government disinvestment. Moreover, their actions are directed under the imperatives of profit maximization, which is inversely linked to quality conditions of work and care. HEU's Jennifer Whiteside argues that the profit motive "'…puts subsidized home units and care home beds at risk whenever private, for-profit companies believe they can increase profits by marketing these services privately – or cash in on rising real estate prices'" (in Stueck, 2017). The transfer to or expansion of private pay beds is one profit-generating tactic (Harrington et al., 2017). For-profit operators typically have higher numbers of private pay beds because they are able to charge substantially more for

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them. Private pay beds also align with health authority interests because it transfers financial responsibility for care to the resident.

A case in point is Retirement Concepts' recent Terraces Assisted Living debacle. In this private, for-profit operated facility, twenty seniors in publicly subsidized units were given eviction notices to make way for higher paying private pay units. Terraces claims that they terminated their contract with VCH for these subsidized beds because public funding has not kept up with inflation and facility costs. But there is the underlying motive that private pay units start at $4,600 a month, while subsidized units are limited to charging residents 70% of their income. Critics argue this allows Retirement Concepts to cash in on inflated real estate values in the metro Vancouver area, where more people are expected to sell off their homes to pay the high cost of private care. After much public shaming the eviction notices were extended for two years to give residents the opportunity to find alternative housing and care (Lazaruk, 2017; Stueck, 2017). However, finding other arrangements is no easy feat, and eviction and resettlement creates worry, stress, and health risks for seniors.

What this situation reveals, is a new regime of financialized welfare. On one hand, individuals are charged with taking on the responsibilities, costs, and risks associated with the private purchasing of care services. On the other hand, financial strategies, including property assets and mortgages, allow individuals to save, borrow, and invest for their care needs (Langley 2008; Roberts, 2013). Financialized welfare is also evident in VCH's Residential Care Rejuvenation plan. In Vancouver and North Vancouver, approximately one-quarter of newly built or revamped residential care beds will be private pay (Vancouver Coastal Health, 2017). This move hinges on the notion of financialized subjects willing and able to extract cash out of their million-dollar home, and invest in private pay care. Yet private payment for care creates an

inequitable two-tier system where access is mediated by ability to pay. This poses particular

problems for older women, who are more likely to need care but are disadvantaged by income,

pension entitlements, and retirement benefits (Seeley, 2012). As private payment circumvents

lengthy publicly subsidized waitlists for residential care, people in desperate situations may opt

to pay privately for a bed in order to access care sooner. Once they have accessed, or depleted

their finances on, private pay care, they can switch to the waitlist for a subsidized bed, albeit with

the secure position of being in the care system.

  While the government encourages private actors to enter or increase their market share in

seniors' care, there are a myriad of accountability and transparency issues associated with private

for-profit operations. Increased sectoral reliance on private operators to provide a large number

of publicly subsidized care beds creates an imbalance of power where operators gain substantial

leverage and are able to negotiate care bed prices with health authorities on terms that best suit

them. As seen at Terraces, the operator can threaten to terminate their contracts otherwise. Given

this dependence, health authorities are also constrained in their ability to end contracts and find

alternatives for residents and staff in facilities that have quality of care or work issues

(Harrington et al., 2017). While huge sums of public money fund private businesses and large

corporations, and subsidize their profit-making endeavours, there are no requirements for them to

share the contracts they are awarded or publicly report on their finances and revenues. There is

also little government oversight of contracted facility operations and finances. One union official

shared that from information obtained from the health authority on auditing practices in the

residential care sector, only once did it appear that substantial auditing was undertaken. This took

place as a result of the neglectful death of a resident, and other instances of abuse at Beacon Hill

Villa, a facility also owned by Retirement Concepts (Sandborn, 2007). To obtain information on

the value of subcontracted support services contracts in hospitals and long-term care facilities, HEU is forced to file costly FOI requests (HEU, 2007). This poses challenges for the public to understand how decisions over the delivery of care is made, or to compare the quality of work and care across different care facilities. This has implications for families looking for best care options.

2.4   Contracting Out

Contracting out in long-term residential care is the practice of a facility operator employing a third-party private, for-profit company to deliver a service such as laundry, food, cleaning, or care rather than having it delivered in-house. Contracting out not only enables short-term savings, but also shifts responsibility for service provision and staff management from the facility operator to an external operator. It allows facility operators to evade obligations for working conditions and workers' rights and entitlements, and also externalize risks and liabilities (Zuberi, 2011a). Subcontractors hold contracts for delimited sums of money and timeframes, preventing operators from going over-budget on service provision. Because they also need to ensure profits on limited-sum contracts, subcontractor companies are associated with worse wages, benefits, and work conditions.

Contracting out is promoted through the Liberal government's 2002 Health and Social Services Delivery Act (Bill 29) and the 2003 Health Sector Partnership Agreement Act (Bill 94). These developments signaled the intensification and entrenchment of the neoliberalization of health and social care services in B.C. This was "the most sweeping privatization…in Canadian history" (Stinson, Pollak & Cohen, 2005, 5). It drastically restructured health support service

delivery in residential care facilities and hospitals. Bill 29 and 94 are anti-union legislation that have driven down labour costs and bolstered capital accumulation by eroding employment rights and protections, work terms and conditions, and wages and benefits in health and social care sectors (Armstrong & Armstrong, 2009). They opened a new market for care and support services, and a handful of for-profit service providers emerged in their wake.

The B.C. Liberals pursuit of contracting out in health care was legitimized by discourses of unsustainable costs and representations of health care support service work (cleaning, dietary, and laundry services) as overcompensated unskilled work. Containing health care costs was premised on relocating support work in health care from "vital" to "non-essential", and drove down the wages and work conditions of support workers (Cohen, 2001). Yet this obscured the training and skill involved in working in high risk health care settings, and masked the centrality of this work to quality patient care (Zuberi, 2011b). Such degradation was enabled because it affected a marginalized workforce comprised of older, racialized, and immigrant women with limited labour market options and opportunities (Cohen & Cohen, 2006).

Bill 29 removed "key job security, pay equity and contracting-out provisions" in the collective agreements of residential care and hospital support service, maintenance, and security workers (Longhurst, 2017, 13). It also allowed service contracts to be terminated and re-tendered with only 60 days' notice. Contracting out fragmented the sectoral bargaining process, because workers who still have union representation have to bargain with their individual employers instead of as part of the HEABC. In this position, unions are weakened and lose leverage to advance workers' rights and work conditions. Multinational corporations Aramark, Sodexo, Acciona, and Compass are the beneficiaries of Bill 29, to the detriment of over 9,000 workers who lost their jobs (HEU, 2008). Laid off support service workers who were rehired by these

corporate contractors had their wages cut nearly in half and their benefits slashed (Cohen &

Cohen, 2006; Stinson, Pollak & Cohen, 2005). The money saved was funneled to into corporate

profit, where these four companies posted profits that totaled over three billion dollars in 2013

(HEU, 2013). This deliberate policy choice created needless quality of care concerns, including

hygiene issues, infection outbreaks, and patient deaths (Cohen & Cohen, 2006). These

developments drew on and entrenched segmented labor markets, and came at the expense of

workers' lives and livelihoods.

In 2003, the Health Sector Partnership Agreement Act (Bill 94) followed Bill 29. Bill 94

enabled the contracting out care, nursing, and recreation therapy work in private, for-profit and

non-profit contracted facilities. It also eliminated successorship rights for unionized workers.

This means if a facility is sold, or a subcontractor transfers or terminates its contract, union

representation and collective agreements are void. Staff are then laid off and re-hired by a new

operator or subcontractor, and a different contract, keeping wages and benefits low. "Contract-

flipping" has become a rampant practice because each iteration of contracting out allows for the

termination of union successorship rights, dismantles collective agreements, and continually

depresses workers' wages, benefits, and work conditions (Cohen & Cohen, 2006; HEU, 2009).

To this end, a handful of for-profit facilities have contracted out their departments numerous

times, amplifying job insecurity. Contracting out creates vast variation in wages, benefits,

entitlements, hours, job security, work conditions, and unionization. This has resulted in a tier-

ranking of subcontractor companies depending on their treatment of workers.

Privatization and capital accumulation have crept into public and non-profit facilities in

covert and complicated ways. Contracting out has become widespread within B.C.'s long-term

care sector, particularly on Vancouver Island and the Lower Mainland (HEU, 2016a; HEU,

2015). While contracting out has been pursued primarily in for-profit facilities for profit-making

ends, it has also become a tactic to manage sectoral austerity in public and non-profit facilities.

By 2009, across B.C., HEU found that care was contracted out in thirty-nine, or 14% of care

facilities. Dietary, laundry and/or cleaning services were contracted out in 107 or 37% of care

facilities (2009). The Senior Advocate's directory of residential care facilities in B.C. shows that

under VCH, 50% of for-profit facilities, 26% of non-profit facilities, and 63% of public facilities

have contracted out food services (OSA, 2017a). While the public and non-profit rates may seem

shocking, Sodexo was awarded the food services contract for VCH and Providence facilities

(Providence owns and operates five of the seven non-profit facilities that contract out food

services). Yet evaluating which facilities have contracted out care or support services is a major

challenge. There is no monitoring or required reporting of contracting out aside from the Seniors

Advocate's directory, and this only reports whether or not food services are provided by an

outside contractor. There are also no regulations that require facility operators to communicate or

consult with workers or residents and their families when they make operational changes, such as

contracting out, that impact the quality of care (Abassi, 2016).

Distinct principles are assumed to underwrite operations in for-profit, non-profit, and

public institutions. In for-profit operations, the aim is to maximize profit for the benefit of

investors and shareholders. This means privatization and contracting out privilege the generation

of short-term, high-value returns, which often undermines the interests of workers, residents, and

their families. Whereas in non-profit and public operations, revenues are typically reinvested into

the facility and service provision to the benefit of residents and workers (Ronald, McGregor,

Harrington, Pollock & Lexchin, 2016). While the B.C. government enables privatization,

research routinely shows that private, for-profit care facilities and contracted out services provide

inferior quality conditions of work and care. These findings are consistent across a variety of contexts and countries including the US, UK, and Australia (Ronald et al., 2016; McGregor et al., 2006; McGregor, Cohen & McGrail, 2005).

In a meta-analysis of 82 studies which compared the quality of care in for-profit versus non-profit care homes internationally, 40 studies found statistically significant results of higher quality care indicators in non-profits. This included more and higher quality staffing, and lower prevalence of pressure ulcers for residents. In contrast, only three studies favoured for-profits, while 39 studies were statistically inconclusive (Comondore et al., 2009). For-profits are linked to higher staff turnover and discontinuity of care, more quality violations, and workplace injuries (Cohen, 2009; Harrington et al., 2012; Longhurst, 2017; Ronald et al., 2016; Silversides, 2011). Another B.C.-based study (McGregor et al., 2005) found that non-profits, compared to for-profits, had an average increase of 34 minutes of direct care. Another B.C.-based study found a significantly higher number of nursing hours per resident per day in publicly operated facilities (McGregor et al., 2010). Higher levels of care and nursing staff, more likely in non-profit and public facilities, are associated with "reduced resident time in bed, improved feeding assistance, incontinence care, exercise and repositioning" (Ronald et al., 2016, 3). In contrast, understaffing is linked to higher rates of incontinence, falls, and aggression among residents (Seeley, 2012). Moreover, for-profit facilities are associated with poorer resident health outcomes and higher hospital admission rates, including for pneumonia, anemia, and dehydration (McGregor et al., 2006). Because for-profits send residents to the hospital more often and for less severe circumstances compared to other facility types, it can be posited that they externalize high care costs. As a consequence, taxpayers often end up paying more for for-profit care when both direct and indirect costs are accounted for.

It is important to note that these are tendencies, and that the association between privatization and quality of care is neither uniform nor straightforward. Some non-profit and public facilities, especially in rationed funding contexts, may operate under the similar market logics of cost reduction and efficiency that erode quality care and work. However, as a generalization, studies that compare ownership type typically find better quality care indicators and outcomes in non-profit and particularly public facilities, and for-profit facilities typically show the worst of all alternatives (Ronald et al., 2016).

2.5   Financialization

Many scholars today see the dominant mode of capital accumulation as financialization, where value is accrued through primarily financial markets and means (French, Leyshon & Wainwright, 2011; Harvey, 2010). Financialization also signifies the growing prominence and power of financial institutions, logics, values, calculations, and technologies in both political economies and everyday social life (Hall, 2012). Financial firms and ventures, small and large, local, national, and international are involved in the financing, building, owning, and managing of long-term residential care in Canada. These include Real Estate Investment Trusts (REITs), private equity ventures, and pension funds.

Like privatization, financialization is encouraged as governments renege their responsibility for care provision. Financial sector involvement grows under increasing market opportunities and rising demand for care, and to cash in on growing waitlists, a lack of competition, and stable public funding. As Amy Horton notes, it is crucial to tease apart the differences and similarities of the dynamics, practices, and outcomes of financialization and

privatization. The key distinction here is how value is extracted and realized (2017).

Privatization ensures profit maximization in large part by intensifying labour productivity, and cutting labour costs. In contrast, financialization is driven and sustained by high return potentials based on financial engineering and high risk activities.

For financial firms involved in long-term care, money is funnelled into complex corporate structures and tax loopholes; acquisitions are enabled through tax deductible, low interest debt financing; facilities are bought and sold as property assets in high-growth real estate markets; and sale-and-release-back arrangements separate the ownership of property assets from care operations to inflate and extract high rent and debt payments from operators (Burns et al., 2016; Harrington et al., 2017; Horton, 2017). High risk and high return financial activities should not be applied to fundamental welfare services such as seniors' care (Burns et al., 2016). Financial firms are "adept at taking money out (cash extraction) and prone to recurrent crisis" because they habitually buy and sell facility assets using "debt leveraged buyouts" (Burns et al., 2016, 3). This inflates facility prices and indebts the chain because revenue cannot cover the cost of financing. To maximize returns, facility ownership changes are frequent, and acquisitions and mergers are pursued to increase market share (Harrington et al., 2017).

Financial firms, many foreign-based, own a large portion of assisted living, independent living, memory (dementia) care, and residential care facilities across Canada. In one example, in 2013, Health Care REIT Inc., now Welltower REIT, one of the largest US-based REITs, became joint venture investment partners with Revera Inc. Revera is Canada's second largest provider of seniors' care, with more than $29 billion in assets and 500 properties in high growth real estate markets in Canada, the UK, and the US (Harrington et al., 2017; Revera Key Facts, n.d.). Major acquisitions of other facility chains were enabled through Welltower's strategic leveraging of

capital. Welltower is now the second largest owner of seniors' retirement and care facilities in Canada with 113 properties. They own 100% of Health Lease REIT as well as 75% of Revera, 100% Sunrise Senior Services, and 50% of Chartwell's facilities (Baena, 2014).

Investing in health care REITs is deemed to be a relatively safe, stable, and productive investment in uncertain, stagnant, and volatile economies (Lerner, 2017; Persinos, 2016). This is also because, in advanced capitalist countries, seniors' care services are fundamental to how societies and economies operate. Global investors flood Canadian seniors' care markets, with the effect of increasing prices relative to profits. At the same time, the rate of return for investors "remains significantly higher" in seniors' housing than "high-end apartments", and as "REITs drive for growth, they buy regardless" (Korstrom, 2016). PwC and Urban Land Institute's report (2018) on Canada's real estate trends score seniors housing an "Expected Best Bet for 2018". A scan of Welltower's annual corporate report (2016) as well as online information on health care REITs illuminates the ample interest that financial firms have in investing in the "growth potential" of a "silver economy". A fragmented seniors' care sector possesses plenty of potential for acquisitions and growth, especially as health care is devolved to lower cost settings and in high growth markets. Investors can capitalize on the combination of increased longevity, consumption-orientation, and buying power of today's older adults. A rise in incurable dementia-related diseases can be construed as a tremendous opportunity to create and market innovative services, products, and accommodations, including memory care (Persinos, 2016; Welltower, 2016). Investment portfolios are transformed to diversify assets and risks. This means shifting to profitable private pay models, and investing in independent or assisted living housing while divesting from publicly funded, tightly regulated residential care (Harrington et al., 2017).

Longhurst points out that the B.C. government has "enabled a model in which public funding subsidizes the real estate acquisitions of private investors" (2017, 13). The buying and selling of care home assets to exploit inflated real estate prices is evident in the 2017 sale of B.C.'s Retirement Concepts, where CEO Azim Jamal cashed in for $1 billion. In this hotly contested case, Anbang Insurance Group Co. Ltd., a $360-billion-dollar Chinese investment firm bought out 21 Retirement Concepts' seniors' care homes (Willcocks, 2018). Retirement Concepts is the largest and highest-paid private provider of residential care and assisted-living services in B.C. They control 10% of contracted care beds, and collected almost $97 million in public funding in 2016-7. There are over 2,500 workers, 1,900 residential care residents, and 750 assisted living residents in these facilities (HEU, 2018; Hunter, 2017).

Despite significant concerns, including Anbang's unsustainable global spending spree, its ambiguous ownership structure and association with the Chinese state, and a myriad of issues related to foreign ownership, the federal and provincial governments quickly approved the sale (Butler, 2017; HEU, 2018; McGregor & Ronald, 2017; Willcocks, 2018). This decision was made with little concern to the costs, benefits, and risks to those who live and work in the facilities, or to Canada and Canadians as a whole. Anbang's investments span asset management, finance, and leasing (Wells, 2017). In 2015, they bought the four Bentall towers in downtown Vancouver. The purchase of Retirement Concepts is their first foray into seniors' care. To critics, this purchase reveals an underlying motive: It is not about a commitment to seniors' care, but "a recent trend that has emerged…with Chinese private equity firm buying up seniors' care facilities and health care assets in an attempt to move large sums of capital abroad and out of the Chinese market" (Butler, 2017). One union advocate shares that after having done a land value assessment on the purchased facilities, her estimate found the actual land values to be worth

around about a quarter of the $1 billion sale price, and is confused over the mechanisms that underwrite this extreme inflation of facility property values.

It was expected that Anbang would follow the sale-and-lease-back arrangement with the properties being leased back to Retirement Concepts, who would continue to operate the care facilities (Butler, 2017; Sinclair & Trew, 2017). Yet this risky arrangement is what led to the 2011 bankruptcy of the UK's Southern Cross care facility chain (Horton, 2017). Retirement Concepts claims it will continue to manage the day-to-day operations and that no change will be made to staffing and quality of care. Yet the lack of provincially enforceable standards and poor regulatory mechanisms cannot guarantee this (Sinclair & Trew, 2017). Furthermore, there are regulatory and accountability issues associated with foreign ownership because trade agreements (like the Foreign Investment Promotion and Protection Agreement) become entangled with B.C.'s care sector. In this regard, investor rights clauses pose major barriers to making improvements to care provision and work conditions. This is because they can be construed as a loss of revenue and investment value, which are challengeable under some trade agreements (Sinclair & Trew, 2017).

Recent developments in the Anbang sale reveal an uncertain future. In the Chinese state's latest anti-corruption blitz, Anbang's chairman Wu Xiaohui was sentenced to eighteen years in prison for economic crimes, including $10 billion in fraud and embezzlement (Bloomberg News, 2018). In February 2018, a Chinese government regulator took control of Anbang's assets, including Retirement Concepts facilities, giving itself two years to manage its assets and reign in debt. It is highly uncertain what will happen to work and care in these facilities. There is widespread concern that operational cuts, contracting out, or divestment of company assets will be strategies undertaken to deal with the debt (HEU, 2018). Recent reports reveal that Chinese

government regulators are currently reviewing and initiating divestments of Anbang's overseas

assets worth $10 billion in order to manage debt and bring capital back to China (Chatterjee &

Zhu, 2018). While no action plan has been initiated as of yet to deal with this issue, unions and

advocates are urging the province to adopt one. They would like to see the government assess the

case for publicly purchasing these facilities, place a moratorium on contracting out, and expand

oversight mechanisms to ensure the quality and continuity of care and work (HEU, 2018).

Financial instability, crisis, and collapse are not anomalous outcomes but rather structural

dynamics of financial markets and tactics. This is largely a result of tendencies towards

excessive debts and interest payments, frequent acquisitions and liquidations, and inflated asset

prices that leaves "care operators and landlords with huge liabilities that have crippled the sector

for years" (Horton, 2017, 111). As Harrington et al. show, "where financial risks are limited,

there is an incentive for…risk-taking" (2017, 20). A high risk combination of sale-and-lease-

back arrangements, rapid debt-financed growth, falling occupancy rates, and reductions in public

funding contributed to the collapse of the Southern Cross care facility chain. Five years before

this, Southern Cross was owned by a giant global private equity firm, Blackstone, which rapidly

expanded its care facility portfolio before selling them off at an inflated price. Blackstone

extracted a profit of £600 million through this and other forms of financial engineering. Yet the

sale combined with a variety of aforementioned factors, left the facility operations in a weak and

unstable state. The bankruptcy affected 750 facilities, 37,000 residents, and 41,000 workers. It

led to widespread quality of care and work concerns, and left taxpayers and individual investors

to pay the price, while Blackstone was cleared of responsibility (Burns et al., 2016; Ford, 2011).

Frequent ownership changes enable each seller to make a profit from a debt-financed

buyer, which burdens the care operator with more debt, even as asset valuations fall. Horton

highlights how in 2005, Four Seasons "was sold to investors for £1.4 billion, which was 14 times the company's earnings" (2017, 111). "When it was acquired by new owners seven years later, the company's value had fallen by more than 40 per cent; Terra Firma paid only 8 times the company's earnings" (Horton, 2017, 111). Yet, by 2008, Four Seasons' debt load reached £1.5 billion (Horton, 2017). Debt-based acquisitions led to near imminent financial collapse, and the chain's earnings dropped substantially. This compelled debt deferment and sale, closure, or transformation to private pay arrangements of fifty of its facilities (Horton, 2017; Plimmer, 2016). In another case, private equity owned HC-One was created from the collapse of Southern Cross and is now the UK's largest seniors' care home chain with 369 care facilities. In a climate of rising real estate returns and investor interest, and to release cash to pay off debt, HC-One is currently selling off the entirety of their care facilities for £1 billion (Horton, 2017). Care UK, the largest private provider of publicly contracted services in the UK is "£250 million in debt and is paying around £24 million each year in financing costs", rendering it on the brink of "'being near or in default'" (Horton, 2017, 113). In the US, HCR ManorCare recently filed for bankruptcy with over $455.8 million in unpaid and deferred rent owed to its REIT landlord Quality Care Properties Inc. Similar to Southern Cross, this bankruptcy was the result of rising rent payments, funding cuts, and low occupancy rates. While ManorCare's profits fell and could not pay its rent, its former CEO was paid out a $116.6 million settlement for owed compensation (Church, 2018).

In this context, the implications of financialization, are enmeshed with, yet distinct from privatization and austerity. Financialization also has particular consequences for long-term care workers and residents. Many scholars see the source of value in financialized operations shift from labour to finance, where labour becomes marginal. Yet Horton (2017) argues that given the

labour intensive nature of the care sector, labour still holds a key position in accumulation processes. In this sense, financialized care facilities also tend to drive down workers' wages, degrade work conditions, and amplify job insecurity but there are higher risk financial tactics underpinning this, such as frequent facility sales and operational restructuring (Horton, 2017). Facilities that are sold or go bankrupt also create fear, insecurity, and stress for residents and workers. This also reveals the myth of the dominant idea that changes in ownership have no effect on the quality of work and care in facilities because ownership is separate from operations.

2.6   Privatizing Profits and Socializing Risks

In the context of financialized, for-profit, publicly-subsidized care, Burns et al. point out "the privatisation of gains and socialisation of losses" (2016, 3). And Horton highlights how "the state has become a crucial source of value for financial actors" (2017, 41). This is because the risks, losses, and liabilities associated with financial investment in critical welfare infrastructure are transferred from financial actors to taxpayers, workers, residents, and their families. Financial actors are able to extract profit in risky ways yet are absolved of responsibility for such practices. Indebtedness, bankruptcy, and closure of care facilities results in either state intervention or bailout, or divestment of facility assets, often purchased by another (often financial) firm.

Crisis prone developments associated with austerity, privatization, and financialization, including the Anbang debacle, provide ample evidence that the provincial and federal Liberal governments' policy priorities are not only unsustainable but cause significant risk and harm. In a striking juxtaposition, the federal government announced in May 2018 that it will buy out Kinder Morgan's Trans Mountain pipeline. They want to ensure that this fossil fuel infrastructure

– "an investment into Canada's future" – will be built, even at the minimum cost of $4.5 billion to taxpayers (Morneau in Harris, 2018). Comparing with this buy out to the selling off of vital seniors' care services highlights not only government's vested interest but also what counts as a national interest and economic priority. In both the Kinder Morgan and Anbang case, the federal government justified its purchase or sale to preserve or create jobs, expand or enhance infrastructure and public services, and secure or reassure foreign investors (Harris, 2018). Yet analysts resoundingly claim that these government rationales and decisions make no economic sense (Link, 2018). In reality, the risks and costs disproportionately outweigh any benefits, and there is no guarantee of investment in sustainable, good paying jobs or improvements to service provision (Chase & Hunter, 2017; Wells, 2017).

These developments reflect Katz's (2001) argument about the contradictory and uneven geographies of state (dis)investment and (under)development, and how this speaks volumes about processes of valuation, and of futures envisioned and materially produced. In the case of seniors' care, the state has shed its responsibility, ceded to the private and financial sector an ever more prominent role, and opened up investment potentials for global capital. Despite long-term care being an essential publicly funded welfare service, public accountability, transparency, and control over service provision has been eroded. The risks and costs associated with austerity, privatization, and financialization have been shifted to taxpayers, workers, residents, and their families while the private and financial sector have made ample gains.

Chapter 3: Embodied Labour and Care Work Reorganization

This chapter looks at how restructuring reorganizes the everyday conditions of work, and the practices and relationships of care in a for-profit and a non-profit care facility. I look at frontline workers' experiences of change at work, and in the labour process, and how these relate to sectoral and workplace restructuring. In this chapter I ask: How is restructuring embodied and lived out in frontline work? In what ways is restructuring effected through and effecting of care workers' bodies, and mental and emotional energies and capacities? Relatedly, how does it impact residents' quality of care, and workers' view of their work and themselves as workers? How are workers able to work within and rework constrained care settings? How do the embodied impacts of restructuring seep beyond the "boundaries" of work and into workers' home and family life? Lastly, how does it impact their quality of life and social reproduction?

3.1   The Labour Process and Workers' Bodies, Subjectivities, and Affects

Given that long-term care is heavily labour intensive, labour is a key target of cost-reducing, efficiency-yielding, and profit-generating restructuring processes (Armstrong & Armstrong, 2009). While labour costs have been reduced through cuts to wages, benefits, and staffing levels (see Mountain View's (MV) strategies, chapter three), I focus here on the care labour process in the context of sectoral restructuring. In particular, I look at the similarities and particularities, as well as the embodied dimensions, of labour process rationalization and intensification in a for-profit and non-profit facility. Under the predominant neoliberalized model of care, dimensions of care are decoupled, and unmeasurable social and affective relations of

care are marginalized. Complex processes and relations of care are reorganized and transformed into clinical, routinized, time-limited, quantifiable, outcome-oriented care tasks. At the same time, understaffing and under-resourcing make it so that care workers are constrained to provide even the basic bodily aspects of care, such as toileting, bathing, and feeding (Armstrong et al., 2009; Seeley, 2012).

Care workers' experiential knowledge and autonomy to provide responsive and holistic care are undermined (Banerjee, Armstrong, Daly, Armstrong & Braedley, 2015). Workers are overburdened and overworked, and care provision is sped-up and rationalized akin to assembly-line processes under the scientific management of Taylorism (Armstrong & Banerjee, 2009; Baines, 2004a, 2015; Banerjee et al., 2015; Diamond, 1992; Lanoix, 2011). At the same time, residents with increasingly complex care needs require comprehensive and attentive care delivered by workers with adequate time and resources to care well (Armstrong & Banerjee, 2009; Banerjee, 2009; Silversides, 2011). As work conditions erode, and the quality of care suffers, workers are subject to high rates of workplace violence, injuries, and burnout (Banerjee et al., 2012). What these contexts make clear is that restructuring processes underlying the reorganization of work and delivery of care are premised on assumptions of the disembodied subject. Restructuring is enacted without considering the embodied consequences to those who live and work in residential care.

What this chapter also works to uncover is the ways in which the corporeal, mental, and emotional are co-constitutive of care work. It also looks at how they are manifest under the pressures of labour rationalization and intensification, even if they are seldom or narrowly considered in policy decisions. Scholarly work on care tends to dichotomously conceptualize care work as either unpaid, informal familial caregiving that emphasizes the affective and

relational components or as commodified, paid care work that focuses on the physical and laborious components and overlooks emotional and social contexts (Folbre & Nelson, 2000). This is far too simple a picture. The concept of body work, or work that "takes the body as its immediate site of labour", is utilized by critical feminist scholars to hone in on the corporeal and embodied dimensions of care work (Wolkowitz, 2006, 147). This literature increasingly pays attention to the articulation of emotional labour and materiality in work on and with sentient and responsive bodies (England & Dyck, 2011; McDowell, 2009; Twigg, 2000; Twigg et al., 2011; Wolkowitz, 2006).

In care work, emotional labour is salient in terms of negotiating contexts of intimate touch, dealing with transgressive bodies, and hiding negative feelings. Even physical care routines involve much emotional labour, relationships of trust, and embodied knowledge. In a restructured long-term care sector, it also is crucial to diffusing tension and ensuring adequate care in the face of rationalized service delivery, bureaucratic institutional organization, and the differing demands of managers, residents, and their families (McDowell, 2009). While emotional labour is vital to the smooth provision of care, it is an invisible aspect of work, neither acknowledged as a skill nor accounted for in job role or remuneration (Bolton, 2010; McDowell, 2009). Under new regimes of accumulation, "[w]hat are the new technologies of power and knowledge that are being brought to bear on laboring bodies?" (Katz, Marston, & Mitchell, 2012, 14). How do workers enact, expand, and entrench restructuring through everyday work practices? What is the productive potential of affect and emotional labour in restructured care work? And how are workers' gendered subjectivities invoked and drawn on to ensure quality care in restructured care settings? I pursue and seek to answer these questions in this and the following chapters.

Looking at how affect gets produced and deployed in ways that align with pro-market health care reform, Ariel Ducey asks "how can people be motivated to care – about their jobs, their patients, their employers – when all objective indicators suggest there is little care for them?" (2010, 29). She finds that biopolitical techniques, in this case, soft-skills training programs for hospital staff, draw on, nurture, and reshape workers' identities and dispositions in ways that cushion the adverse impacts to patient care. It is productive modes of "affective modulation", in contrast to overt forms of discipline, control, or repression, that deploy power and reproduce injustice in the service of state and capital (Ducey, 2010, 26). Salzinger's (2003) work, *Genders in Production*, illuminates femininity as a produced and productive force central to global production processes. Her account denaturalizes the essentialist idea that femininity is an innate trait of women that is drawn on, used up, and exploited by capital. Femininity is generated through a myriad of employer and workplace practices, expectations, and discourses that devalue and position women as docile, exploitable, and cheap workers. For her, femininity is "a structure of meaning" that organizes production, recruitment and labour control practices, and shapes workers' identities (Salzinger, 2003, 15). As Adkins and Lury (1999) and Acker (1990) argue, workers identities are key resources for capital by helping to create and maintain divisions of labour, labour market segmentation, and workplace control.

Embodiment is crucial to better understand the co-constitution of workers' bodies and subjectivities. Feminist theorists conceptualize embodiment as the socio-cultural and political-economic relations of power that mark, signify, or manifest through and on bodies. It is also a corporeal mode of being-in-the-world. Social reproduction and feminist labour geography scholars highlights how valuations and assumptions associated with embodied social attributes, such as gender, race, class, nationality, and immigrant status, differentially divide and relegate

particular bodies into "appropriate" work in care and social reproductive sectors (Ferguson, 2008; McDowell, Batnitzky & Dyer, 2007). Attending to care as an embodied practice, Lanoix (2013) draws on personal experience to articulate care as "…an embodied response that comes from a bodily encounter with another being" and which co-comprises material, relational, affective, communicative, attentive, and responsive dimensions (Lanoix, 2013, 95).

As previously outlined, overworked bodies and workplace violence and injury are routine in restructured care work. This is what Banerjee et al. (2012) have termed "structural violence" in the organization of Canada's long-term care system. In this context, I am interested in whose bodies, lives, and livelihoods are cared for and whose are neglected or depleted as a result of restructuring processes. In this sense, how is workers' "life instrumentalized" (Huang & Li, 2012, 227) in the service of capital, state, or employer? Both Michelle Yates (2011) and Melissa Wright (2006) theorize that ever-increasing drives for capitalist accumulation rapidly use up, dispose of, and render workers as waste in the form of unemployment, injury, or disability. This fits in with Sylvia Federici's seminal work *Caliban and the Witch* (2004) that interrogates how women's bodies are reconceptualized, co-opted, and made productive by state and capitalist agendas. She explores how, in the transformation to capitalist work relations, the body was reduced to an orderly, controllable, industrious proletariat work-machine. In this context, "not only is work the condition and motive of existence of the body, but the need is felt to transform all bodily powers into work powers" (140). Yet can workers be rendered merely labouring bodies to be exploited and expended at the same time as their emotions and feelings are vital to the reproduction of a restructured care system?

3.2   Care Work: Rationalized, Intensified, and Decontextualized

Care sector restructuring is put into practice through everyday workplace practices (England, 2010). Workers narratives illuminate a steady degradation in the conditions of care work, and rising demands of care provision. Every worker with a handful of years of experience relays that residents now coming into residential care have very complex and heavy care needs, and this requires a lot of time and attention. This change in the resident population is paired with systemic workload issues that makes their work very challenging. But this was not always the case. Long-term staff share memories of what work and care used to look like. Even as little as ten years' prior, they recall that most residents were semi-independent, their care needs were minimal, and they could go on day trips alone or with company. Because residents' needs were not as complex, and workloads not as heavy, resident care was very different. Staff had more time to engage with residents on a social and emotional level. Previously, staff at Gracious Care Centre (GC), the non-profit facility, would do fun activities with residents. They recalled tea parties and pajama parties with music and dancing. They often took mobile residents outdoors to get fresh air, go on walks, and picnic in the park. Ten years' prior, staff were also equipped to provide more one-on-one care for residents at the end of their life, or with high-needs behaviours. Aruna and Maryam, two long-term care staff at GC, offer an interesting glimpse of the changes to their work overtime:

> Aruna: A long time ago we used to do activities with the residents. We used to sing songs, we used to play cards….We used to spend a lot of quality time with the resident.
>
> Maryam: You [would] hold their hand, and sit with them, and listen to them….It is very important to listen to them.

Maryam: Yeah, I listen to them, and what they have to say. But that time is no more. We cannot sit with them and listen to them.

Aruna: She *(referring to Maryam)* used to go up and do manicure, and do the nails, and listen to the residents. I remember Maryam, she used to spend a lot of time doing that.

Maryam: I want to keep them clean, you know, just like my mom. Make them feel good.

Aruna: But there is no time now, it's too short. We don't have time to do any extra things we want to do for them.

In the current context of systemic underfunding and understaffing, and residents increasing care needs, more of workers' time is taken up providing basic care and performing essential work tasks. Heightened documentation demands to ensure government accountability also mean more time is taken away from frontline care, compounding the problem. Residents with physical impairments need mechanical lifts to help get them up and down onto their bed, wheelchair, toilet, or bath. Residents with cognitive impairments or behavioural issues need more direction and assistance from staff. Both require more staff and more time to provide care. Nurses' workloads are also increasing because of having to assess and manage medically complex care, and specially crush, administer, and monitor complicated medication regimes. Even support services workers' workload is affected. For kitchen staff, this entails specialized dietary requirements including food prepared to the needs of people with particular health concerns such as diabetes. Residents are at higher risk of choking so there is more work to puree and mince food, and thicken beverages. For laundry workers, residents soil more laundry and linens. The accelerated rate of resident turnover means it takes more time for all types of workers to get to know the needs and preferences of newer residents. For allied health workers, like Sofia, the "dramatic change" in the resident population, including more dementia and more wheelchairs, "means that there is more work, because the residents need more help":

For something as simple as walking to the dining room, you need more people only for that 'cause it takes longer. Trying to get everybody into bed, and to take everybody back up, trying to have everybody attend programs. Previously, you just have to have a good calendar and position it in a strategic point in the facility, and residents will choose what do they want to do today. Now you have to go resident by resident, not only a reminder by telling them, but portering them to the program of their choice, or whatever it is *(staff now spend a good 20-30 minutes gathering residents to attend group activities)* ….There has also been a decline in the cognitive abilities. That means that you are constantly trying to motivate and find ways to still run interesting programs. What do they like to do? But you need to motivate them so they are able to do what they have done all their lives. It's a way of keeping up, figuring out how to run things.

In the context of understaffing, the assistance needed to meet residents' high needs contrasts with staffs' capacity to provide that help. There are a myriad of pertinent examples that highlight this, but the following two stand out. As I help residents to their rooms from lunch, I see 100-year old Mary, who is hearing and sight impaired. She is confused, wheeling herself around the common area of her floor in a tizzy. She claims that the nurse went away without giving her her medications, and she was not able to get her attention because the nurse was busy rushing back and forth down the halls, attending to other matters. Having to depend on others for her life essentials is immensely frustrating, especially when they are constantly occupied. She feels "helpless and stupid" to the point that she "wants to burst into tears" because the nurse was short with her rather than communicative and reassuring.

In another striking example, it is evening time and there are a handful of residents and care aides waiting for the elevator to take them up to start getting ready for bed. The elevator arrives and fills up, and Lili, who has advanced dementia, is left there alone. Another elevator arrives and two staff, who are now off-shift, hurry into the elevator. When Lili calls out to them for help, one of the workers, sounding rushed, tells her she cannot help because she does not know her room number. She instead tells Lili to wait there for a care aide to come get her, but

then looks at me exasperated, and mutters under her breath "but they don't come". As the elevator closes and Lili is left there, she becomes increasingly confused and upset. I come beside her and tell her I will help her to her room. As we arrive on her floor, it is a typical scene of post-dinner rush. Residents congregate around the elevator. They are dropped off from the dining room and wait for staff to take them to their room. Care staff are busy moving up and down the halls, and in and out of rooms, getting residents ready for bed one at a time. When we get to her room, Lili recognizes where she is and looks relieved. When I ask if there is anything she needs, she hugs me tightly and thanks me for helping her.

Given widespread understaffing and heavy workloads, a mismatch between tasks and time characterizes the organization of care. Care and support workers describe their work as bare bones, having no time, feeling pressured, and rushing or running around. Morning care routines and mealtimes are when workers are most constrained to care for a large number of residents in a short span of time. Care workers' comments on the morning care rush include:

> Simran [GC]: "You should see us in the morning, it's so busy from 7 to 9am. We often don't have time to go to the bathroom or get a drink."

> Valeria [MV]: "…you're running like chickens to do your job and be able to provide at least the essentials for them, but that is it."

> Anaya [GC]: "I have to run around to get people ready, that is the only way I can do it."

A typical scene of morning care in both facilities highlights how care staff work under tightly timed schedules that map tasks and regulate bodies in space and time. Most care staff start work at 7am, but there is a morning report before they start resident care. This means they are not on the floor until 7:15am or later, and they have to have residents down to the dining area between 8:30am and 9am. Tasks and departments are highly reliant on one another, and if they

are not down in time, they will impact the work of dietary and cleaning staff. For care, the staff-to-resident ratio translates into each care worker providing care for eight or nine residents. This means that staff are allocated approximately ten minutes per resident for their morning care routine. A group of care aides at MV reflect on how it makes them feel to rush through morning care. Current conditions make it so residents get little choice in how their care is provided and what their day looks like:

> Camila: I go into a residents' room, who is still sleeping, and I feel so bad! They're just laying there, sleeping. They look so peaceful. They just want to sleep, but you have to get them up and ready. If I don't do this, it will affect the rest of the morning schedule.

Jerome adds that "no one wants to be rushed like that, not even us". That "even I need five or ten minutes to get up after the alarm goes off. Imagine waking up right away and being rushed to get ready for the day? They're old and tired. They don't want that." Reyna ruminates "...they are not robot, they are old. No matter how hurry you want to, you can't. Especially most of them have a lot of pain. Pain here, pain there." Because of this, she has to be attentive and careful even while she is forced to rush care.

A large proportion of residents need assistance to eat, yet understaffing and tightly timed and interdependent schedules render mealtimes rushed and organized in an assembly-line fashion. Food must be prepped and ready; residents brought down; food served; residents fed; dishes cleared; dining room cleaned; and residents brought back up, toileted, and put into bed. To ensure smoothened operations, staff focus on the task at hand and scramble to get their work done in time rather than spend time to sit, chat, and connect with residents. During mealtimes, a handful of care staff are on their break, and remaining care aides are charged with more residents to feed. One care aide often rotates between feeding two, three, or four residents together at one

table. When residents sit apart, they are fed in succession, and some wait twenty to thirty minutes for their turn, as their meal goes cold. Because workers have much to do in so little time, the practice of feeding reveals skillful technique, attentive negotiation, and embodied knowledge. One morning at GC, as care staff are occupied in other tasks, I assist two residents who need full assistance to eat. Even under a nurse's guidance, I struggle to feed them. I become frustrated trying to navigate pureed food into their semi-closed mouths, and I end up putting more food onto their chins than into their mouths. Fifteen minutes later, after making little progress, another care aide takes over. She mixes their meals into particular consistencies, moves her body around their wheelchairs, and places her arm around them for ease. She is now in a better position to assist them to intake food, and she empties their plates in no time.

Because care staff are overworked, high-demand residents are often seen as additional burdens they have little time or patience to deal with. During my time at GC, one floor was renowned for having a particularly difficult mix of residents who had either advanced dementia or mental health-related behavioral challenges. Overtime, workers were mentally, physically, and emotionally worn out because of the mix of heavy workloads and residents' incessant demands. It got to the point that, in the words of one care worker, "I can't take it anymore, I'm only human." Workers are charged to care for residents who would ceaselessly repeat themselves, follow them around, or wander into other residents' rooms. Many of these residents either lost their ability to speak English, or did not speak it in the first place, creating communication barriers, additional confusion for residents, and higher demands on workers. Care staff spend a lot time monitoring wandering residents, making sure they are safe, and preventing potential upsets between residents. Nighttime is when residents with dementia become restless and wander, posing a particular challenge for the sole care aide on night shift who tends to nearly

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thirty residents. Aruna, who often works night shift, describes how exhausting this shift can be. The previous night, she was on her feet all night, running back and forth, because one man was continuous wandering and another notoriously demanding lady was unable to sleep and continually pressing her call bell for assistance.

An additional demand is Vancouver Coastal Health Authority's (VCH) failure to account for the actual time and staffing it takes to provide safe, quality care in their funding and staffing models. I am told by a nurse that this comes about, in part, because the standardized resident assessment system (RAI-MDS 2.0) does not capture all the socially necessary work that goes into providing care. Frustrated workers share how, instead of increasing staffing and resources, VCH provides educational workshops to enhance workers' skills and strategies as an individualized solution for systemic workplace issues, including resident aggression. Fung, a care worker at GC shares how this training appeals to staff to take their time with residents and ensure a comforting environment when providing care tasks such as baths. To this, Fung scoffs that there is no consideration that workers are extremely limited and pressured in the time they can spend with residents given current staffing levels and care schedules. She pointed out that no amount of calming music or soothing voices, as proposed in training, would offset this. In this context, the allocated 20 minutes to get a resident into and out of the tub, and washed and dried, is rushed rather than relaxing. This is especially the case when it takes two, three, or more staff to help one resident into their bath, as is often the case for residents with dementia who resist care or lash out at workers.

Another example of a laudable yet unrealistic goal is the CLEAR program, which MV is enrolled in. The goal of the program is to reduce the inappropriate use of antipsychotic medications in B.C.'s residential care system. Medication management has become the standard

way to deal with challenging behaviours associated with dementia and depression in residential care. As the Seniors Advocate reports, 34% of people living in residential care are prescribed antipsychotics, yet only 4% are diagnosed with a psychiatric disorder. Similarly, while only 24% are diagnosed with depression, 47% are prescribed antidepressants (OSA, 2015). To address this issue, CLEAR seeks to replace the inappropriate use of medications by providing for residents' holistic needs. While the program offers training around person-centred care, MV care staff feel there also needs to be an increase in staffing, recreation programs, and physical activities to engage residents. This is because given the current staffing, time, and resources constraints, the program places additional demands on them and they are challenged to put goals into action.

Widespread sectoral underfunding undermines VCH's goal for person-centred care. Health authority funding models prioritize physical and clinical over social, emotional, and spiritual dimensions of care, which is further entrenched by the narrow biomedical emphasis on seniors' care (Armstrong & Banerjee, 2009; Day, 2013). Joy, an allied health worker, illuminates the impoverished nature of funding models that neglect the myriad facets of residents' humanity and identity. People are not only physical bodies, she notes, but they have emotional, psychological, spiritual, and social needs, which, in turn, affect their overall health and wellness. Sofia, another allied health worker, ponders what is valued in funding models. She asks, "[b]ecause their bottoms are cleaned and they're fed…that's life, that's enough?" Sofia feels there is an increasing recognition and valuation of programs that support a more expansive concept of care, including recreation and music therapy. Yet in a deficit long-term care system, there is a simultaneous drive to reduce costs and implement cheaper alternatives. This means that these important components of care are underfunded and under-capacitated. Sofia believes the system is "not going to cut salaries from doctors or nurses, you're not going to cut the nurse

position….They can cut recreation 'cause your loved one is taking the pills, is clean, has eaten." Joy speaks to the logics of visibility that shape funding priorities. Take spiritual care for example, "it's very hard to measure…so many people thought it's not important". This is the reason why she believes spiritual care is unfunded in residential care.

VCH's funding model suggests how funding should be allocated. They recommend 0.36 hours of care, or the equivalent of 22 minutes of care, be provided by a mix of allied health staff, which may include an occupational therapist, physiotherapist, recreational therapist, social worker, and dietician. A recreation department in a facility with 100 residents is only funded 0.8 of a full time position, or four days out of the week. Because of funding constraints and a lack of standards, physio, occupational, music, and recreation therapy are not consistent in care facilities. They are most often provided at paltry levels, fundraised for, or paid out of pocket. For instance, MV reported providing just above 10 minutes of allied health care per resident per day, while GC reported over 30 minutes. The Seniors Advocate found that in B.C.'s residential care system, only 12% of residents received physiotherapy, 9% received occupational therapy, and 22% received recreation therapy in the week before they were surveyed (OSA, 2015).

While funding is extremely limited, there is a great need for these programs because they improve mental and physical health, and can prevent and delay dementia-related illnesses. Without programs to engage residents, make them feel good, and alleviate the boredom from "just sitting around", they will decline faster. Leah, an allied health worker at GC, is highly aware of the benefits. After successive rounds of physiotherapy and offering continual encouragement, she has witnessed wheelchair-bound residents regain their capacity to walk with a walker. Similarly, staff and family members talk about the special influence that music has on many residents. Because music activates a part of the brain that is different than judgement or

cognition, people with dementia are able to connect to it. GC's music therapist uses music, rhythm, and dance to find what "makes them come alive". And residents are engaged: "…for that one hour they were clapping, they were laughing, and they were dancing".

3.3   Dehumanization: Machine Work, Robot Workers, Assembly Line Care

Casual conversations and interviews with frontline workers about the conditions of work and care are peppered with the word human. Their stories of work similarly invoke descriptions and metaphors of machine work, robot workers, and assembly-line care. These words signify a sense of profound dehumanization in the organization of care work, which neither regards nor treats workers or residents in human terms, as embodied subjects with holistic needs. The care system's privileging of efficiencies and profits reduces workers to a cost to cut and a labouring body to work harder. It simultaneously reduces residents to a bed to fill, an object of care, and a biological body to attend to in narrow terms. Workers feel they are not able to treat residents as human when they are forced to rush and manipulate them in ways that render their compliance to bare and basic care. In this regard, one care worker exclaims, "you can't rush them, they're not robots!" Workers would like to take their time and provide more and better care, but this is not realistic under current conditions. Workers, too, feel dehumanized in a context of understaffing, where they are subject to intensified workloads that expend their corporeal, mental, and emotional energies and capacities.

Rushed care also limits residents' choices, desires, and participation in their care because of the extra time it entails. Anaya, a care worker at GC, reflects with sadness that it is simply not feasible given current constraints. Instead, "we take this ability from them, and once we take it

away, they end up losing the ability for good". She struggles with this: "We don't want to take away their independence. They've already lost so much coming into care." In the context of low staff-to-resident ratios, Maryam, a care worker at GC, shares what it is like for residents to wait around for evening care when one care staff is charged to care for over a dozen residents:

> So they start getting sleepy in the hallway, in the lounge area, they're half sleeping. Because we are busy with the residents. So how hard it is, sleepy people, bringing in their rooms and giving them care. We keep saying, 'open your eyes'….They start slipping down from their wheelchairs. They've been sitting in their wheelchair so long….How hard for them, for their back….They're so sleepy, because they're so weak, they want to go to bed. It's like if we got sick, we want to go to bed, right? They are a hundred or 95 years old, right. They want to be in the bed, and they're sitting a long time in the chair, waiting for us…[that is also] why are they frustrated. Because they're tired. They want to lie down. They need our hand to care. Maybe somebody's [incontinence] brief is wet, maybe somebody poop in their pants. Who will sit in the chair?

Two situations at MV starkly highlight the dehumanization of residents that result from bare care settings. In one case, a lady that did not speak English flagged me down to get my attention. Clearly uncomfortable in her wheelchair, she smelled as if she had soiled herself. When I alerted a care aide of this, she matter-of-factly told me she would get to her later, during her toileting time, as she was busy with something else. In another case, during a music therapy session, I am beckoned over by a large man reclined in a wheelchair. He tells me he has to urinate. I flag down a care aide to help him, but she replies "he goes in his briefs, he's wearing diapers". I am mortified to tell him he cannot be helped to the toilet, and that he should go in his pants instead. Because there are not enough staff to respond to spontaneous bodily needs, toileting is scheduled, and provided in assembly-line fashion. Reyna, a care worker at MV, jokes that when families demand that their loved one be put immediately on the toilet, staff have to tell families that "they're number three in line for the toilet". While this may look like resident neglect or disregard to family members, it is the outcome of systemic issues of understaffing and

workload intensification that render workers unable to meet residents needs as they arise. Unfortunately, this is not easily visible to family members, and often ends up creating tension and conflict between them and workers, rather than generating the solidarity and support needed to collectively place demands on the facility management and health authority for more staffing.

Residents, too, share their experiences of bare and rushed care: Their call bells go unanswered, or they have no one to chat with about their day. One physically dependent resident at GC is insistent that there is "no way" staff spend three hours a day with her providing care, as outlined in VCH funding models. Rather her time with care staff is only for a handful of minutes in the morning and again in the evening when they help her with physical care tasks, and that is it. Some residents are restless spending their time sitting around and waiting because staff get them up too early for care or to mealtimes in order to manage the contradiction of too little time and too many tasks. Staff do not have the time to listen to and reassure sad, anxious, or depressed residents, or keep the company of ill or palliating residents. In the case of Bill, one lucid resident at MV, "one time, I was left on the toilet for three and a half hours. I kept pressing the buzzer, but no one came." He claims, "they never come". He feels that it takes hours after he buzzes his call bell before they get to him. He says, "I keep track now. It's getting worse. I wait longer and longer." Luigi, who is dependent on MV's staff to get him to and from activities and appointments complains staff are never able to get him to where he needs to be on time, and sometimes he is wholly forgotten about. When they do get him ready for the day, he is rushed through the process. They tell him, "'hurry, put your foot in, put your foot in, hurry, hurry, hurry!' Rush, rush, rush. When they rush me like this, I get nervous and confused."

Understaffing and heavy workloads erode the quality of care. In MV in particular, there are many instances of residents' breath stinking, their clothes being soiled, or generally looking unkempt, or smelling unclean. Balbir, a care worker, corroborates this:

> Now the problem in this facility I work right now [MV], is the staff and the hours, they cut back to us. The proper care is not even enough; we are short of time. We are short of time, because we have to rush….And then after that, it's funny, some of them are not properly oral care, like you can smell the resident. Once you see the resident, how filthy the sometimes, how dirty sometimes. Not properly cared.

Joan describes her brother's difficult transition into care at MV, where he felt "there is nothing to do, there is nowhere to go, no one to talk to". And this makes for long and lonely days. In his initial weeks there, he substantially declined. While his doctor and facility staff labeled it as disease progression, Joan felt it was in large part an outcome of the bare care environment, and rather a symptom of poor quality care.

Similarly, if there were enough staff, communication between staff, residents, and families would be better, and this would contribute to a higher quality of care. Nenita, a care worker at MV, feels that being understaffed means little time to talk with and listen to residents and their families to understand their needs, wants, and concerns. Instead of being able to get to the root of an issue, care staff are compelled to choose the quickest, easiest method on hand, often doling out more medication or calling the doctor. Valeria, a care worker at MV, wishes there were more staff to be able "to talk to them [residents], to interact with them. Because right now we hardly interact with them. So they are left alone sitting all day…unless there is some activities or family that comes to visit." She connects dehumanization not only to underfunding, but also to the profit logic that extracts value from care and neglects care relationships. She argues, "this is not assembly-line care, we work with humans and have relationships with them".

For workers, bare care environments strip away workplace autonomy and erode the relational nature of the work. In this regard, workers feel reduced to robots. Clara, a care worker at MV, is frustrated about this: "we've been working, running our routine like a robot". Referring to her heavy workload she pleas, "we are only humans, even machines break down!" She points out that workers are not caring for machines, or working in automated settings. To provide good care, workers have to be able to make autonomous decisions that respond to individual needs, arising issues, and unpredictable bodily rhythms. "We cannot just follow the program, right. Exactly five o'clock: eat. You cannot be late!" To carry out work that is "safe and proper", workers need to be flexible and attentive.

The machine metaphor comes up most often in workers' experiences of contracted out work. Loysa, a casual nurse at GC, shares her experience at a private facility with a shockingly low staff-to-resident ratio. As a nurse, she had 60 residents to look after. She had so much work to do in so little time, she not only routinely worked through her breaks to get her scheduled work done, but was challenged to respond to any issues that arose. This could include circumstances as serious as medication monitoring, health complications, or a resident fall. She was even told by management not to talk to the residents, because "if you start a conversation with them, they won't stop, and you don't have the time". She laments, "I am put under so much pressure, and there is no extra time, but I can't just leave them. I have to help them and see what is going on. I can't just walk away." As her narrative reveals, there is no recognition of the contingent nature of working on and with vulnerable humans. Residents do not respond like predictable, efficient machines implicit in the allocation of staffing and scheduling of work tasks.

Gian, a support service worker at GC, shares that at her previous job with a subcontractor company, the workload was that of two or three positions. To save money, they expect staff to

squeeze in more work in less time. They do this by cutting back hours and keeping the workload

the same, or adding tasks on to an already overloaded workday. She further explains:

> And your break time, they don't care! They give you so much work…it's like, when I go there the first week, so, I set a time for my break, right. So, I go and sit down in the staff room, and then in about ten minutes the staff said, 'hey how come you're still here?' I said, 'I'm taking my break.' *(Staff replied in a surprised voice)*: 'You're taking your break? I think you better go finish your work!' What they say is you can't finish your work [otherwise]. So I said, 'oh okay, I'll go.' And that's it: ten minutes….[if I] take my break I will be late…to finish. And [working] overtime, they're not going to pay you. So they give you so much work. It's your choice: do you want to finish or not? But you know, you have so much, so much, you have to finish it. If not, you can go faster. You'll work faster, push. That's why I, after a year and a half, you're already, your body, everything is like a machine keep going, you have to go….It just keeps going, keeps going. There's no time for you to slow down. No break, no slowing down….I was like oh my God, there is work like that, I didn't know how bad it could be.

Under assembly-line care, frontline workers routinely reflect on feeling bad or guilty that

they are unable to provide what they see as good care, or assisting residents to do things they

like. Maryam and Aruna highlight how the structural features of their work subjectively play out:

> Maryam: It's like whatever you're [the resident] trying to say, we have no time to listen to you, you know.

> Aruna: And they become more anxious, panicking, stressed. I feel sorry for them too, but, it's our system, they make us work like that.

> Maryam: Sometimes we have to say, 'okay, right now I don't have time to sit and talk, but later we will sit and talk.' But then later we don't have time either.

> Aruna: We lie!

> Maryam: How can you promise that? Break their heart.

> Aruna: It breaks our heart. We have to lie to them.

Aruna describes this further:

> Our workload is more heavy than before. And then we feel sorry for the resident because they don't have that kind of [one-on-one] care. The last days of their life, they don't have

the quality to spend with somebody. And sometimes they are alone by themselves, nobody is with them. Sometimes if they have family there, the family comes. If they don't have family, who can do it? Even if we want to do it, we don't have time.

Aruna concludes, "what's going to happen, later, when we get old? Because the [healthcare] system is cutting more hours, more hours, more hours." And Maryam adds, "sometimes I think when they cut back…they think it's piece work. It's not piece work. They're human beings." Balbir, a care worker at MV, similarly ruminates, "they're human beings too" but the way we treat them is like "the way we treat animals". "So, sometimes I feel sad, because I said to myself, 'my goodness, someday I will be one of this, and I don't want to be one of this, if possible.'" Valeria, a care worker at MV, echoes this in her comment that "it's really hard for residents nowadays" to be in care facilities. "Even though families come to visit them, they need more, they deserve more….it's the end of their life, it should be more enjoyable. It's not just someone who will bring business." She feels disenchanted with the current system of care:

> If I had a family member that needed to go there [into a care facility], I wouldn't allow it. Because they don't have a really good quality of life. No time for them. All they need is someone to talk to them, or someone to, I don't know, do something nice for them, have a nice hairdo one day. To do something different, and that will make their day. If you only spend time with them, they will have a happier life.

3.4   Structural Violence, Mental and Emotional Labour, and Burnout

Health, safety, and wellness issues, including injuries and violence, are key concerns and critical priorities for workers at both MV and GC. These issues are linked to structural contexts including understaffing, under-resourcing, workload intensification, and an increasingly complex resident population. This also has implications for residents. Balbir, a care worker at MV, pointed out how staffing levels on her floor were cut back to the point that there is simply not

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enough staff to monitor residents and provide safe care. This has contributed to an increase in resident falls, injuries, and hospitalization, sometimes with devastating damage.

I learned this firsthand at MV when I was helping a resident to her room after dinner, and she wanted to lay down in bed. As care staff were occupied bringing residents back up from dinner or helping them to finish their meal, I ring her call bell so staff are notified that she needs assistance, but they can come when they are able to do so. When I left, care staff did not come quick enough. The lady struggled to get out of her chair on her own, it ended up tipping over, and she fell out and bumped her head. A care aide informed me this lady had been agitated all day and is at risk of falls. I should have kept her in the common area so staff could keep an eye on her. Very concerned about the potential repercussions of a fall for this tiny, frail woman, I rush to her room. She is sprawled on the floor, conscious, but the side of her head already had a giant goose-egg. There was a nurse holding an ice pack to her head, and four care staff attending to her, taken away from their other duties. Later reflecting on the situation, I realize no one communicated these essential things to me (that this lady was in an agitated state, was a fall risk, and that I should have placed her in the common area). But this is not a fault of the staff. If care staff were less overwhelmed, they would have more time to communicate and be quicker to respond to residents. Later, I go to visit this lady to see if she is okay. She is so tiny lying in bed. Her icepack keeps sliding off of her forehead so I stay for a while and hold it in place. It saddens me that there are too few staff to be able to spare time to sit with her and make sure she is okay.

The risk of injuries in the current organization of care impacts not only residents, but increasingly frontline workers. Workplace violence is an increasingly common experience for residential care workers. While resident aggression is often portrayed in a medicalized light, as the result of challenging resident behaviours, often associated with dementia, it is also an

outcome of under-met care needs and the poor conditions residents live under (Diamond, 1992). When workers rush residents through care it can exacerbate residents' confusion, frustration, and agitation to the point where they lash out at workers. Resident aggression is the second leading cause of workplace injuries for B.C. care aides (BCCPA, 2018). For workers in residential care, violence constituted 16% of all workplace injuries in the past five years (SafeCare BC, 2017). It is frontline care staff who provide intimate care, and in particular casual staff with less relational knowledge of residents, who are subject to resident aggression more than any other worker in long-term care. But even while companions provide intimate care, they face far less violence from their clients because they are able to provide slower, more attentive, one-on-one care.

While workplace violence is commonplace, workers feel, relative to programs to enhance resident's safety and prevent resident abuse, that the safety of workers is neglected by the health care system, and at MV, by management as well. As Clara, a care worker at MV, puts it, "resident safety, yes; but worker safety, no….It has been a fight every day. We don't ask for much. This is basic safety." She sees this neglect enabled by the marginalized social positioning of the majority of frontline care workers: "We carry it on our shoulders. We are foreign people, we have no complaints, we are new to Canada. We don't mind to do the hard jobs, but we're not taken care of." Workers point out while they now receive VCH mandated workplace violence training, facilities are not equipped with additional staff and resources to prevent violence from occurring in the first place, or protect themselves when it does emerge. Additionally, VCH's increasing educational and reporting requirements, which seek to mitigate and document workplace violence, place additional time demands on staff. Workers providing care for an aggressive resident need enough staff to be able to work as a team, and ensure care is not rushed. Given a lack of workplace protections, staff take situations into their own hands by being vigilant

in the face of potential violence, and walking away from aggressive residents when it is safe to do so.

During one dinner break, I ask a group of care staff whether or not incidents of violence are reported and addressed. They laugh and reply that if they reported it each time, they would have to fill out reports four inches thick each day. Getting hit, slapped, grabbed, scratched, kicked, bit, or spat on are routine aspects of their work. As such, they do not report it unless it is a more serious incident. Their responses highlight, given the demands of reporting and little extra time in a workday, how commonplace workplace violence is overwhelmingly brushed off, normalized, under-reported, and underestimated (Foner, 1994). This is the case even though it has significant adverse impact on the psychological health and material safety of care workers.

Other prevalent health and safety concerns include repetitive musculoskeletal strains and injuries such as carpal tunnel syndrome, arthritis, and chronic back, neck, shoulder, and arm pain. This is the result of overwork and overexertion due to understaffing, and rushed and heavy workloads It is also the effect of care tasks that require lifting and bending, as well as pushing, pulling, and maneuvering heavy wheelchairs, bodies, and equipment. It is especially risky when understaffing means one worker completes tasks that require two or more staff for safety reasons. It weighs especially hard on an aging workforce that is already worn out from the work. Stress, anxiety, exhaustion, and related illnesses are also common under challenging work conditions. While common throughout the long-term care sector, injuries and other adverse work-related health outcomes are heightened in contracted out work (Zuberi, 2011a, 2011b; Cohen & Cohen, 2006). MV, a for-profit facility, stands out because it has a high number of workers with injuries, or chronic health ailments, and on Workers' Compensation (WCB) or short and long-term disability benefits. Many workers at MV explicitly point out the rising rates

of injuries among themselves, and link this to the increasingly heavy workload. At GC, in contrast to MV, strong extended benefits go a long way to ease the impact of workload intensification and treat the stress and strain of overworked bodies.

WorkSafeBC data between 2012 and 2016 shows that B.C.'s care aides, more than any other occupational category, such as construction workers and police officers, are subject to more time-loss workplace injuries. The vast majority of claims were by women (89%), and in residential care (61%) (Griffin, 2017). Overall, care aides rate of injury is approximately four times the B.C. average. WorkSafeBC claim costs in 2017 for the long-term care sector reached nearly $13 million (BCCPA, 2018). Across the sector, workplace injury is implicated in rising costs associated with overtime hours, sick days, and short and long-term disability. Unaddressed systemic violence also perpetuates recruitment and retention issues in the sector (BCCPA, 2018). There are ramifying financial, corporeal, and psychological consequences for workers, including taking time off to recuperate (without entitlements to a full income); not being able to pursue full-time or overtime work, or work an additional job; and early retirement. A handful of workers face difficulties trying to prove chronic pain, stress-related, or mental health issues, which leave no visible sign on the body, in order to access WCB or disability entitlements. Injuries and ailments also have long-term impacts and leave lasting traces. Valeria, a care worker at MV, has had a bad back pain for many years. By the end of the workday her back agonizes, and nothing makes it better. She describes how this impacts her work and home life: "…sometimes when I work day shift I come home and I can't even make dinner. That's how bad it is." Sometimes she is in so much pain that "…by two hours working it's been enough, or by lunchtime, it's like 'oh I need to go home'".

Many workers could not imagine how, under such challenging conditions, they would persist working until retirement age. There were a couple of staff who either left or were seriously contemplating leaving care work for another job that was easier on the body. Yet some experienced obstacles due to their age, narrow skill set, and lack of experience outside of care work. Retiring early is also contingent on pension entitlements and financial stability. Retirement in a sector characterized by job insecurity is a major challenge because many workers work casual for many years, or end up losing their pensions if they are contracted out. Workers at GC, compared to MV, have not been contracted out, and long-term workers have access to relatively good pensions. This is financial security for workers in residential care, however, is not common. Many older workers at GC speak frequently and eagerly about retiring earlier than they anticipated because they do not know how much longer they can hold on doing this work. In contrast, workers at MV would like to retire early, but face financial barriers to do so. For Gian, a support services worker, her aspirations to work one job into retirement were short-lived because of the severe bodily impacts of contracted out work, including her hands turning claw-like from overwork: "I thought I could work there until I retire, then after half a year I thought maybe ten years. My retirement is getting less and less." She laughs, "I think at one and a half years, I say no more, I can't take it anymore!"

Apart from injuries and physical violence, verbal and emotional abuse are equally as common, and sexual harassment does happen (Seeley, 2012). Workers face racial slurs and discriminatory treatment from some residents. Workers at MV describe how they are treated like "a dog" or "slave" by demanding residents and their families. In Clara's words "…they call you, 'come to serve me.' After that, you are a piece of nothing….They say go back to your country!" One lunch time at MV, the conversation of a group of care staff turns to the topic of sexual

harassment in the workplace. They share anecdotes of bathing excited male residents, or having

their breasts or buttocks grabbed by one of the notoriously lewd residents. One young worker

had a resident call out that she had "nice boobies", and that she should come by later and keep

him company in bed. She was humiliated because he did this in a public area of the care home,

and in front of his family, who just laughed about it. She felt even more frustrated when it was

brushed off by management and left unaddressed because it was blamed on his dementia.

Although often invisible, difficult to measure, and typically not included as markers of

occupational health and safety, mental and emotional stress, exhaustion, and unwellness are

common for care workers (BCCPA, 2018). "Doing more with less", or providing care in austere

and intensified contexts, drains workers of their bodily, mental, and emotional energies and

capacities. This is amplified through a lack of workplace support to effectively deal with these

contexts. The demands and pressures of the work are inscribed on the worn out faces and bodies

of frontline staff. Sofia, an allied health worker at GC, describes how the mental and emotional

demands of the job are, in part, a result of the change in resident population:

> …mentally there are days that after 5pm, I am done. I am exhausted. Mentally, it's draining. Part of it could be because of the workload. Part of it, I believe, a bigger part I believe, is because of the population that we serve. The elderly that we serve in most of our facilities, due to their decline, cognitive decline, dementia and strokes and other things, they lose motivation and initiation skills. So many times, it's the recreation staff…who brings your energy, you're pulling everybody back. Even if it's a small social, we are the ones creating the interactions. They don't anymore, they lose the initiative. So at the end of the day, some days, it's draining.

Nenita, a care worker at MV, sets up a real-life scenario of the myriad demands,

including part-time work, heavy workloads, and family duties, that can lead to burnout:

> …you come from another facility, you work there for four hours with the demented people, and here you go, you're done at 3pm. You have a 4pm [shift] at another facility. You're running, driving, dealing with the traffic. Then you have four hours there too, and

you have residents to get them up, to get them ready for supper, to clean them for bedtime. And here is your family calling you, 'mom what's for dinner? Mom, I'm sick.' Where were you there? They call that burnout. And, why this poor lady or care staff, why did you do that [work two jobs]? Because, financial issues. Do you know why? Because she only has four hours at MV. She needed to find another four hours….Because of the budgeting, two hours here, four hours here, these people, they are grabbing all the jobs, to support their family, right. And you come home, and your son or daughter, they're sleeping, and the next day here you go, you jump again to your job. But if you had 7.5 hours with the good benefits in this situation, living in Vancouver, with the taxes, housing problem, you have to follow the standard of living, how could you survive?

Additionally, some workers feel they put the needs of the residents above their own, or have difficulty asserting workplace boundaries with residents. Karen, a manager at MV, recounts her time on the frontline. Because there are immense challenges to provide quality care and programming given systemic deficits, workers may feel committed to go above and beyond, exhausting themselves in the process. As Karen relays: "you always want to be the best and give to the resident, but it's not possible". This makes it hard, "especially when your new…and you're full of excitement and vim and vigor". As a result, "there's a pretty high burnout rate", which she herself experienced at least twice in her twenty-odd years in long-term care.

There are particular psychological and emotional health impacts associated with the heightened demands of working in a special care unit (SCU). SCU workers speak about their limited life span in the SCU, and the likelihood of facing burnout if they remain there too long. Maryam who worked in GC's SCU for many years, talks about the emotional labour involved. She describes being contained in a locked unit with the same residents with very high needs day-in and day-out. She was eventually taken off the unit and placed somewhere else because she was emotionally overwhelmed and "used to cry all the time". At MV, casual staff will rarely take an on-call shift in the SCU because the work is so challenging. Balbir, a SCU veteran, reveals this is "because they easily get burned out. Because if they work there for just a week, you get

burned out. And I can see their facial expression and attitude, they start being mean to the residents." In contrast to sensationalized and decontextualized media accounts and public portrayals of elder abuse in care homes, it is rather exhaustion, overwork, and burnout that push workers to lose patience and sometimes take it out on the residents.

Resident deaths also lead to grief and stress for many workers, especially when long-term relationships are involved. Working with residents who are ill, declining, and dying, and helping their families cope can create "compassion fatigue". As Valeria, a care worker at MV, tells it,

> …when you lose them, it's a very, very emotional time to heal from all that because, like I said, we are not only providing the care, we are also human beings that care a lot for them and it is hard to lose them too, right.

Many care staff develop close and meaningful relationships with the residents they know and care for. As May, a manager at GC, shares, "when they go, a piece of you goes with them too". Maryam articulates how the residents she cares for affect and change her:

> You start loving them – you're with them more than eight hours [a day]. They're part of our life now. That's what I was saying, I learned so much from my residents. I was kind of brought up here. I came from a different country, and I learned so much from them. You start loving them….they've already affected us inside. How about if someone is dying in your hand, and you have the dead person and you're going home? That person was there ten years with you, and you think you're not affected? You're affected.

Emotional management is crucial for workers who intimately encounter death. Anaya, a care worker at GC, shares the necessity of developing a thicker skin, because when a resident passes away, "it used to really affect me. I look at things differently now through my experience, I've learned with age. I had a mentality shift. I don't want to see them suffer. You get hardened."

For many workers, their work and the residents they care for are often on their mind outside of working hours. For Vicky, an allied health worker at GC,

I think as caregivers of any sort we think about our residents a lot, and when we're not working, thinking of ways we can help them, and brainstorming ways that their lives could be better, could have a better quality of life.

Bringing work home is also the result of workers' embodying the stress, anxiety, and exhaustion of heavy workloads. Tricia, a care worker at MV, has the "bad habit" of being unable to maintain boundaries between her work and home life. Rather than being able to relax at the end of the workday, her work colonizes her mind, and she mentally prepares and plans for the next day at work. She is also worn out from a heavy workload and finds it difficult to find the time or energy to eat well, spend time with her family and partner, and maintain her religious practices. She ponders, "what will happen to me? I will get sick and then there will be nobody to do the work." Jenny, a support service worker at MV has a similar experience:

I've had different people tell me…'leave it there where it belongs.' Because that place, it will eat you alive. It'll devour you. It's true, if you let it. It will take everything you have. You know, even though I keep telling myself, just leave it there, don't think about it. Just don't bring it home with you. But I've still got this habit where I take it home with me. I'm dwelling on it…

Work intensification, which depletes workers of their mental, emotional, and bodily capacities and energies, has implications for how they engage with their families. This is especially the case for workers that juggle a myriad of work-related and domestic demands, and when they have young children or elder parents to care for. Maryam articulates that "when we go home we don't want to talk to anybody, you know. Because we get so much pressure from work and we're tired, and pain in the body, of course our family gets affected." Nenita, a care worker at MV, echoes that "you don't have time to [spend with] your family. Your burned out. You are not in the mood to talk with feelings with your family." Workers are exhausted from work and have no energy to go out with their partners and families. Valeria feels "it is only work, work,

work. I cannot enjoy anything else, because it's my limitations not only financially but also physically." When they get home, many workers need to turn off, tune out, rest up, and recharge from the workday before they can spend time with their family. When workers are tired and on edge, additional family demands may be met with impatience and frustration.

3.5   Workers' Strategies of Control and Care

To manage the contradictory demands of relational care work and restructured bare care settings, workers actively develop, enact, and negotiate everyday informal coping and resistance strategies. Their strategies of care and control include shortcuts to manage heavy workloads, fostering worker cooperation and support, and moving beyond bare care by asserting expansive practices of care.

To manage intensified workloads and tight timelines, workers are compelled to create shortcuts in the provision of care. This is the case even if the quality of care suffers in the end. Because workers have only about ten minutes per resident during morning care routines to provide all the necessities, including toileting, grooming, and dressing, they are stretched and pressured to provide even bare and basic care. Shortcuts allow the work to be done faster or more efficiently. They include rotating which residents' care needs are prioritized that day, and leaving some care undone until later that day or the following day. They may speed through tasks such as washing bodies, combing hair, and brushing teeth (also see Armstrong et al., 2009). Many workers mentally prepare the next steps of the care routine, or for their next resident. Staff may also alternate which residents get up or not in a day, or keep them for lengthy periods in tilt-back

wheelchairs because of the time it takes to transfer them in and out. They corroborate this is happening in other facilities they work in as well. In the words of Balbir, a care worker at MV:

> Yeah, we have to do rush, rush, rush all the time. That's the problem. But rushing all the time that is where you get injured yourself or the resident. Especially when you are using the lift. Then ten, fifteen, to twenty minutes is not even enough to spend on one resident….[And] how many residents you get up? Maybe a resident may stay in bed for a while because you cannot get them up because you don't have enough time.

Reliance on adult incontinence pads (diapers) has been widely criticized as an undignified tactic used in care facilities to deal with toileting needs amidst widespread understaffing. To further save costs, management may ration incontinence pads (Armstrong, Armstrong & Daly, 2012). Or, as one casual care worker at MV shares, to save time, staff in another facility she works in use wash cloths inside the incontinence pads to soak up urine. This makes it so staff do not have to go through the laborious process of changing the pad as often. Joan, a disgruntled family member at MV, tells me care staff have put two incontinence briefs on her brother. This makes it quicker and easier for staff to clean him up if he soils himself. Workers simply take the top one off, and do not need the two people that would be required to change the pad. Yet, for her brother, this was uncomfortably bulky and impeded him from using the washroom. It also posed a safety hazard as he had trouble walking around.

A two-person assist is the term for care practices which require two workers to complete them safely, such as when using a lift to hoist or transfer a resident with mobility issues. With understaffing, the practical policy of the two-person assist turns into an unrealistic practice. Care workers at MV and GC typically opt to do a two-person assist alone because there are too few staff and they do not have the time it takes to wait for another worker to arrive. It also takes that worker away from completing their own tasks. Another similar organizational procedure that

care workers circumvent in their attempts to provide more care in less time, is the requirement to be present while dependent residents use the toilet. While residents take ten or fifteen minutes or more on the toilet, workers clearly will not get through their workload if they wait around. They would rather multitask while they wait, and check-in on the resident at intervals. As one worker shares, she jimmy-rigs linens together to keep resident safe and secure when she leaves to do other work. Workers are ambivalent about resorting to these trade-offs, even though they use this time to manage their workloads and provide extra care under the current constraints. A major conflict for workers is that by undertaking these practices, they risk injury to themselves or the resident, and may not be covered by WCB due to negligence. These fraught strategies parallel Lopez (2007) and Foner's (1994) findings that informal workplace rule-breaking is used to offset workload pressures and provide better care.

Workers cope with heavy workloads, quality care issues, resident violence, and emotionally laden contexts by "letting it go". This is a skill many of them have honed over time. For Maryam, when a resident gets upset or lashes out, "you learn to let it go. You can't let it bother you, otherwise it will get to you." "I let it go in order to do the work and be there for the person. I don't hang onto it and let it affect my work." Ashley, a manager at GC, describes,

> The staff are so caring, they take it to heart. They just want the best for the resident. I told them, 'it's okay, you do the best you can. Your job is to keep them safe'….When I started this job, I worked hard to make sure everything is done right, and on time. You can get obsessive-compulsive about it. But if you do that you're going to get burned out. You've got to let it go. If you're dedicated, it can be hard on you to leave a job undone. But it's the system they are working in, not the worker.

Positive relationships between workers buffer the adverse effects of restructured care settings, and workers make a conscious effort to foster cooperation, support, and sociality in the workplace. Tricia, for instance, a care worker at MV, often spends her break time helping to

offset other care workers' heavy workloads by feeding residents at lunch and dinner. Workers share a key reason they stay working in their job or at the facility long-term, even amidst degrading conditions, is because of friendly and supportive relations between staff. A handful of care staff mentioned taking a pay cut or travelling longer distances to remain at GC or MV for precisely these reasons. Positive staff relations prevent staff turnover. This in turn, generates the long-term knowledge and skills necessary to make heavy workloads manageable and provide quality care. It also saves facilities on the costs of continually training and orientating new workers. In under-resourced and understaffed settings, teamwork, effective communication, trust, and long-term staff relationships are imperative to perform better care work. A support service worker at MV reveals, "you have to be very organized. I help other staff get their work done. If one is behind, everyone is behind. I help them get the job done on time. Number one is about teamwork." This is especially the case for casuals who have not yet acquired the experience, skills, and strategies needed to get a heavy workload done in short timeframes, or to provide care or diffuse difficult situations by attending to residents' particular needs and preferences. When a new casual is on shift and unable to keep up with the heavy workload, long-term staff often help out with their tasks. They "won't make it" through the workload otherwise.

Many workers go so far as to say they truly love their jobs, the residents they care for, and staff they work with. Some felt their workplace is like a second home and family. In both facilities, there are frequent displays of worker's long-term connection and appreciation for one another. Birthday parties, baby showers, potlucks, and dance parties were held at and outside of work. At MV, Althea recounts that one unanticipated outcome of contracting out was that workers' relationships were solidified as they bonded over hardships:

It had a big effect on people at the time. It's a really [big] crisis….It was very stressful, but we talk with each other all the time, what are we going to do. It's a big cut for our wages, but then again, we made it. That's how we really built the relationships between staff because of what we went through.

Similarly, another care worker at MV claims that amidst much worker discontent with the management and union, "a lot of people you talk to would say if it wasn't for the other people I was working with, I wouldn't work here anymore". Strong staff relationships and community building is key for staff to collectively deal with workplace issues. In particular, workers at MV take turns cooking and bringing meals to share with each other on their breaks. They use break time to banter, raise workplace concerns, share support, and take the load off a heavy day of work. At MV, it is also workers who look out for one another given the lack of respect and regard they feel from the corporate head office and management. A low budget for staff appreciation events meant that workers had to pay $35 a head to attend their own Christmas party. This high cost posed a barrier for many of the lowest-paid staff to attend. To offset the cost of the ticket and to generate money for small gifts or prizes at the party, a group of care workers took it upon themselves to donate money and fundraise on their own time. Workers also pool and distribute money to help sick or disabled co-workers when they need to take extra time off or obtain therapy, particularly when they are not covered by benefits.

In underfunded care settings, and under impoverished practices of care, workers face immense challenges to treat residents as human beings, and be treated as human themselves. Workers and residents are not simply labouring or warehoused biological bodies devoid of full humanity. They have relational, emotional, and social needs and desires, which they express through strategies that aim to rework and re-humanize the practices of care. These strategies

entail "going slow" to counter rushed care, expanding practices to meet residents' holistic needs, and reasserting relational care by "going the extra mile".

In contrast to, or to make up for shortcuts in care, some workers make the conscious decision to "go slow" (see also Foner, 1994, 64, 146). Marilou, a care worker at MV, describes how during evening shift, she takes her time to provide good care, and makes sure not to rush her residents. While other workers finish their main tasks around 8:30pm, she often works until 10pm, completing any morning care tasks left undone. "Going slow" ensures that residents' dignity is upheld, and also gives residents the extra attention needed to look and feel well cared for. By "going slow", she also reduces the risk of violence, injury, and strain on the job. This is especially important because as a casual worker she does not have access to benefits like short-term disability. But being able to deliver slow care under work overload hinges on workers' skills and knowledge of residents' needs, wants, and behaviours, which develop through long-term work experiences and care relationships. Similar to "going slow", a casual allied health worker at MV subverts impoverished targets that allocate ten minutes for one-on-one "social interventions" with residents by lengthening the time she spends with them. Rather than strictly follow the activity schedule or focus on numbers of residents reached, she privileges quality over quantity interactions with residents, and is flexible with programming to better respond to their needs. This is evident when she takes intentional time out of her busy workload to be attentive to and calm a frustrated resident when no other care staff are around to intervene. She later reflects, "she needed time. I needed to take her into her room and talk with her. I needed to listen. I had to forget the schedule, that was secondary."

To counter the bare provision of care and reassert relational care, many care staff routinely "go above and beyond" the regimented scope of their tasks and role, and provide "little

extras" for residents. This is particularly the case for residents without family and with little financial means. Care workers find meaning in and express pride at being able to do good care work, including making residents look and feel good, by providing little extras. Little extras include cutting, dying, and styling residents' hair, or manicuring their nails. Staff may come in early or on their days off to host special events that bring joy to residents. Marisol, a care worker at MV, volunteered her time on a day off to help organize a karaoke event and bring in her karaoke machine. This was important to her because it meant a lot to one resident in particular, and to keep things lively for residents, you have to "go outside the box and break up the routine".

Staff often bring in special items for residents, such as their favorite foods and treats. This may be cake for a residents' birthday, or a plate of potluck food for a resident who misses home cooked meals. When residents need clothing and other goods, there are some workers who go out of their way to gather old clothing from deceased residents, donate their own items from home, or go shopping for residents on their own time. Anaya, a care worker at GC, shares how staff take turns to check-in with residents and pick up what they need or want when they are next at the store. Simran, who has worked at GC long-term, often volunteers her time to go clothes shopping for one resident she is particularly close to. She likes doing these things, in part, because she sympathizes with the resident, especially because he has no family.

Anaya echoes that many workers do this extra work to better residents' lives, to help out, and because they best know the needs of their residents. While these forms of unpaid labour are routinely performed, Anaya shares that workers do not want to be recognized or even remunerated for it, as "it's for the resident, not for us". Althea, a care worker at MV, puts herself in residents' shoes and ruminates over the challenges of getting old and not having money or family to rely on to support oneself. One companion believes that the unpaid "extras" she

provides for her clients will eventually be reciprocated: "Sometimes it's not always about money….I believe in good karma, so when we get old somebody will take care of us too." But workers' talk of coming to the assistance of residents without either family or money reveals more subtle tones of compulsion. There are simply no other means or no one else to do the work. There are also few resources to support and compensate them to do this necessary work. In this regard, Vicky, an allied health worker at GC, claims you have to be passionate about your work. People do not do this work for the money, she argued, but because they are caring. Through this, they gain inherent rewards rather than remuneration for the unpaid labour and "little extras" they provide. Yet management may implicitly appeal to or explicitly ask accommodating staff to undertake this extra work. While "going the extra mile" is crucial to ensure quality care, it is largely invisible, goes unacknowledged, or is taken for granted by managers, corporate head offices, and government funders.

Similar to Vicky's sentiment, in response to my question about what keeps workers motivated to do this challenging work, many of them expressed something about "loving the job". They do not do this work for the money, they do it because they love the work, or their "heart is there", otherwise "you won't last". For one support service worker, "the work is very hard, but if you love your job, it becomes okay, you can manage, you can do it. It is about your mentality." For many workers, the residents are their "number one", and they find the care, and interactions with them highly rewarding. Some do the work because they want to help vulnerable people and make a difference in their lives. Others care well to reflect how they treat their own family, or want to be treated when they get old. Under myriad demands, loving the work helps restore workers' energies and keep workers' morale up. It also underwrites a deficit care system.

3.6   Implications of Rationalization for Worker and Resident Wellbeing

Restructuring and rationalization processes are implemented with insufficient consideration of the lived impacts and embodied ramifications to both workers and residents. They are abstracted from the realities of care work on the ground. Intensified workloads and regimented care tasks and schedules constrain workers' ability to provide attentive, responsive, and holistic care. Workers struggle to provide even basic physical care needs let alone the contingent, social, emotional, and relational aspects of care. For a rationalized labour process to be carried out, the care relationship becomes dictated by the time-clock (Cohen, 2011; Lanoix, 2013) and care workers' and residents' bodies and behaviours are rendered compliant and controllable. Subjective holistic beings and unpredictable bodily rhythms must be transformed into predictable, divisible, and manageable objects to be worked on through standard, measurable, and discrete care tasks (Twigg et al., 2011). In this context, residents lose their independence, choice, and dignity. Normal human requirements and desires are deprioritized and residents are forced to deal with situations that would in other circumstances be intolerable. This includes being left on the toilet or in incontinence pads so that care workers can juggle other tasks. Yet, care work is labour intensive and relatively inflexible to scheduling. In one regard, bodily functions cannot wait or be contained within efficient timeslots, and multiple bodies cannot be worked on at once. This highlights the need for a stable and relatively high ratio of care workers to residents. While this should place limits on cuts to staff levels and care hours (Cohen, 2011; Twigg et al., 2011), systemic deficits are supported and perpetuated by workers' unpaid labour and additional care.

Overwhelmingly, the costs and consequences of restructuring are borne by and come at the expense of the largely gendered, racialized, immigrant care workforce. This has implications for the quality of life of workers as well as those they care for. Frontline workers' embodiment of restructuring processes is reflected in their experiences of overwork, violence, injury, chronic pain, stress, exhaustion, and burnout. These contexts seep beyond the porous "boundaries" of work to impact their own social reproduction and family relations. Expanding on the mechanisms and outcomes of restructuring, this chapter sheds light on the ways in which a rationalized organization of care and intensified care labour process are premised on the dehumanization, exploitation, and expendability of particular bodies, and corporeal, mental, and emotional capacities and energies. Yet it also contradictorily requires, cultivates, and draws on workers' caring commitments and emotional labour to ensure quality care under deteriorating conditions.

There are both gains and limitations associated with worker strategies to gain control and assert meaningful care. Their strategies illuminate contradictory elements of resistance and self-exploitation, care and coercion, empowerment and compulsion (Baines & Broek, 2017). On one hand, in the context of bare care settings, workers' strategies of expansive and relational care make immediate, tangible improvements to quality of work and care. They are able to make gains, however small and fraught, when systemic issues remain unaddressed or improvements are slow to materialize. On the other hand, they are unsustainable and uncertain. Their strategies represent individualized forms of charity rather than broader advocacy or systems change. While their tactics help offset a deficit care system, it also contributes to its reproduction, and thus aligns with state, capital, and managerial interests. It is workers' commitments to those they care for, and willingness to extend themselves, for instance, that act as a buffer against the negative

impacts of restructuring. Yet drawing on workers' feelings and affects to secure commitment may be seen as a form of affective domination. There are also bodily, health, mental, emotional, and financial costs for those who overextend themselves to fill the gaps in care (Baines, 2016). Routinized unpaid overtime and going above and beyond, for instance, clearly comes at the expense of workers stretched thin or drained from a myriad of demands at work. Given taxing work conditions, some workers are politicized about and delimit the emotional labour and unpaid labour they provide.

Care workers often view themselves foremost as carers rather than workers. Given the drastic change in residents' care needs, for instance, some workers feel it is important to provide emotional and social support to residents, even if it is through unpaid labour. In this regard, strategies associated with emotional labour may draw on workers' caring identities and derive meaning, satisfaction, and reward. It also enables a sense of effectiveness and integrity in the work (Baines, 2004a; 2015). Workers' caring commitment is often naturalized, by themselves, managers, and others, as a function of personality or gender, cultural, or national traits (Adkins & Lury, 1999). Yet this effectively elides and entrenches gendered and racialized ideologies, divisions of labour, and relations of power that structure expectations over whose responsibility it is to fill the gaps in care (Dyer, McDowell & Batnitzky, 2010; Huang, Yeoh & Toyota, 2012). Particular groups, such as women and migrant workers, are viewed as having an inherent, endless, and elastic ability to give or self-sacrifice under any condition (Baines, 2016). Yet this masks the constraining or conducive political economic forces, including labour markets and immigration regimes, that relegate and immobilize racialized immigrant women to the bottom tier of social reproduction work (Dyer, McDowell & Batnitzky, 2010; Pratt, 2003; Strauss, 2015). Unpaid care work may not only be bolstered through feelings of obligation but out of

avoidance of management surveillance and discipline, and to secure their jobs (Baines, 2004).

Caring commitment motivates, in part, not only entry into care work but also remaining in it under eroding conditions of work and wages (Baines, 2016). For many workers, care work is not just work. It entails caring about vulnerable persons who they have connections with and attachments to. This means workers may rework rather than resist difficult work conditions. And they may face challenges bounding the unpaid work and emotional labour they perform if it will be detrimental to those they care for. As such, workers' coping and resistance strategies tend to privilege caring for others or reasserting meaning into care practice even if it comes at their expense. This intentional trade-off is what Donna Baines (2016) calls compromise resistance.

Similarly, workers often drew on family ideals and tropes, where providing care for residents is akin to "taking care of a grandparent", or "being part of a family". This is especially the case when workers spend lots of time and build relationships with residents. It helps to foster workers' patience, compassion, and sense of duty. It also entrenches heteronormative patriarchy and is premised on gender, race, and class inequities. Workers also mobilize surrogate familial roles. When residents have no family, workers sometimes feel compelled to replace the work that their own daughters, mothers, sisters, and wives would otherwise do. For instance, during a memorial service at GC, a handful of deceased residents had few family and friends present. It was staff who worked closely with these residents that came up to the podium to speak heartwarming words of remembrance and share endearing anecdotes. This resonates with the work of Lisa Dodson and Rebekah Zincavage (2007), and Tsung-yi Michelle Huang and Chi-she Li (2012), where family ideologies and metaphors are drawn on by care workers to bring meaning and value to their role, or to alleviate the hardships and demands of their work. Yet they point out this may also be exploited by employers, in the service of state and capital, to bolster

good care in deficit contexts. Dodson and Zincavage (2007) also found that the family trope is unevenly deployed, for instance, in management's neglect of workers needs for a family-supporting wage, or bereavement support in the face of resident deaths.

Workers reveal how long-term, positive workplace and care relationships are vital to quality work and care. Yet this is typically undermined by the degradation and contracting out of care work, which is correlated with high rates of worker turnover and the discontinuity of care (Zuberi, 2011b). So why is it that, at both GC and MV, many workers remain working long-term under such challenging conditions? They put up with poor work conditions, in part, because they truly care about and even love their work, their co-workers, and the residents they care for. This is also bolstered by strong and supportive relationships workers draw on in both facilities to manage workplace constraints and concerns. Yet this signifies, again, that the burden falls to workers to manage eroded care work. And without broader forms of support and systemic improvements, their efforts will be fraught and unsustainable, and relationships of care lost.

Chapter 4: Institutional Strategies to Manage a Restructured Care Sector

To better understand the mechanisms and outcomes of restructuring in particular care facilities, in this chapter, I look at the institutional strategies deployed to manage sectoral austerity and operational deficits, or take advantage of restructured policy and regulatory environments conducive to profit-making. Relatedly, I attend to their impacts on the material conditions of work and care. Throughout this chapter I ask: What are the common or unique ways in which restructuring touches down in particular care facility sites? What are the strategies used to buffer or facilitate restructuring processes? How is this mediated by distinct logics and place-based dynamics in a for-profit versus non-profit facility? Which groups are tasked to manage, subsidize, and support constrained and under-resourced care settings? What are the impacts and implications for different groups involved in care? How are relationships and commitments, affect and emotion, difference and devaluation enrolled in and affected by such strategies?

4.1   Case Study 1: Mountain View

Long-term care facilities are grossly underfunded, yet the imperative in private, for-profit facilities is profit maximization. Considering these two seemingly contradictory and incompatible forces, how is Mountain View (MV) able to be profitable? While strategies of profit-making in for-profit facilities include using care facilities as financial assets, conversion to private pay models, and cost-cutting, the focus of this chapter is on the latter. This chapter investigates a variety of tactics, largely dictated by a corporate head office and rolled out by

facility management, that manage restrictive budgets and capitalize on amenable policy and regulatory environments. This includes contracting out support services and frontline care; cutting labour costs by reducing staffing levels, hours, and wages, and intensifying workloads; skimping on staff education and facility maintenance budgets; financial manipulation and keeping a close eye on accounting and auditing; and, lastly, meeting workplace concerns through practices of denial and deception. These strategies that exploit restructured care settings come at the expense of workers, with adverse implications for quality of work and care.

4.1.1   Contracting Out and Contract Flipping

In the last twenty-odd years, MV has been sold four times. The last sale happened about a year ago. In its current form, its ownership is separate from its facility operations, and these are undertaken by different companies. These companies are both financial firms with large stakes in the real estate market. In order to manage the contradictory mix of facility underfunding and profit-making imperatives, labour costs, which comprise the greatest cost in long-term care, are the main target of cost-cutting. Contracting out is a key strategy employed by facilities to cut costs. Reflecting the trend in long-term care, contracting out has been pursued in MV as well as the chain's other facilities. Subsequent to MV's first sale to a larger for-profit business nearly twenty years ago, frontline care and support staff were contracted out. Employment relations were first moved out-of-house to external subcontractor companies (the support services and care departments were contracted out to different subcontractors). They were then brought back "in-house" under a subsidiary company spawned out of, but legally separate from, the corporate owner, to pursue further costs savings. Complex contracted out arrangements and corporate

structures mean that money can more easily be funneled into difficult to track channels, profits skimmed from care provision, and risks and responsibilities averted. Subsidiary companies also enable their parent company to pursue additional profits by "captur[ing] a full range of long-term care business to reduce market competition and improve corporate stability" (Harrington et al., 2017, 20).

Although contracting out has adverse implications for work and service provision, workers were given no input into or warning of decisions to contract out. When workers received termination notices, they had the "choice" between looking for a new job in a sector undergoing extensive contracting out, or keeping their job, albeit with drastically reduced wages and benefits. Althea, a long-term care worker at MV, paints a bleak picture of workplace tension and management deception and coercion surrounding the initial context of contracting out. Before being contracted out, workers at MV were unionized by the Hospital Employees' Union (HEU), a union with widespread membership in B.C.'s health and social care sector, and a typically positive reputation amongst workers. In the mid-2000s, because of internal conflict over workers' satisfaction with the level of union representation and support, in combination with pressure from the management that if staff did not decertify, their work was at risk of being contracted out, staff decided to decertify from HEU. Workers were convinced that this move, which aligned with management's interests, would protect their jobs and given them more leverage to make workplace gains. Staff were stunned when, following decertification, management took measures to first cut back workers' wages, and then contract out the work anyways.

Post-contracting out, workers initially were not unionized. It was when they were brought back "in-house" under the subsidiary company of the larger corporation that they were told they

could unionize under a weaker corporate-sponsored union or remain non-unionized. While being unionized has advantages over not being unionized, workers point out the union was not chosen by them but rather "brought in by the bosses". Because of this, workers were and are distrustful of and disappointed by the union, which they feel is absent, unsupportive, and privileges managements interests. A lack of union support and threats of further contracting out have dampen workers' ability to voice concerns, address injustices, and make gains in the workplace. Adding insult to injury, when the B.C. Supreme Court ordered a $75 million settlement in 2008 for compensation and re-training for unionized health care workers contracted out as a result of Bill 29, workers at MV were further disadvantaged as the decertification excluded them from accessing it (HEU, 2008).

Contracting out highlights contradictory logics and complicated outcomes. From the perspective of management, the practice of rehiring laid off workers treats them as expendable at the same time as it recognizes that long-term relations and experience are vital to the work. For workers, they were aware that contracting out leads to poorer work conditions, wages, and benefits, yet the majority were resigned to reapply to remain in their position because finding a better job was uncertain and risky in a sector characterized by rampant contracting out. In the words of one worker: "many places only hire [at] $16 an hour. We would rather keep what we got." Even if they found a job for $22 an hour, it likely would be casual. A new job means starting again from zero, with no seniority. In a workforce composed of primarily older immigrant women, many were aware of the labour market constraints on their mobility and opportunities, and decided to stay at MV. Althea sums up workers' constrained choice to stay:

> I guess at the time everybody just want[s] to survive, have something to live on day by day...Because we need the money, we know it's less money, but where are we going to go? Who's going to hire us right away?

Steady income and access to benefits trumped concerns over reductions in pay. This was a priority for the majority of workers who financially provided for a family in Canada and sometimes abroad, and "have mortgages, credit cards to pay off, car payments, university payments for our children". Many workers were worried over leaving positive worker relations behind and the challenges of integrating into a new workplace and work team. For Fernando, a key reason he remained in support services at MV was because "the workers in the facility are like a second family". Working at MV long-term, Nenita similarly feels that "this is my family for how many years?...you again don't want to build another family from another job". Those that did leave MV in larger numbers were workers close to retirement age, who would simply cut a loss and retire early, as well as support service workers because the drop to near minimum wage was not viable. Fernando points out that when these support service workers left, the vast majority of new hires were recent Filipino immigrants.

4.1.2   Cutting Labour Costs: Eroding Wages, Benefits, and Staffing Levels

Because of contracting out, workers at MV are excluded from the HEABC master agreement that negotiates collective agreements for over 230 publicly-funded health care employers in B.C. This means that MV workers' collective agreement is negotiated on an individual facility basis, weakening the union and workers' ability to make substantial gains. Consequently, there is a substantial gap in the wages and benefits of MV workers compared to workers under the master agreement. When care and support work was initially contracted out, wages were reduced by about one-quarter to one-third. Care aide wages went from around $23 an hour plus excellent benefits under the master agreement to a total of $22 an hour including

wages and benefits under their newly negotiated contract (approximately $18 an hour in wages

plus $4 an hour in benefits). Comparing the master agreement to their individual collective

agreement, care aides' wages are $5 less an hour in the latter. When shift differentials, such as

wage top-ups for working nights and weekends, are included, the wage drops by about $7 an

hour. Similar wage losses occurred for all other worker categories. An allied health worker took

a $7 an hour pay cut to obtain full-time work at MV rather than remain casual in another facility.

Support service workers' wages were rolled back to poverty-level rates, which in 2018 equal

only a couple dollars more than the current hourly minimum wage. Numerous workers, like

Jenny, express their chagrin at receiving "mere pennies" for an annual raise:

> And of course the management, well they think ten cents a year is sufficient enough! Yeah, that's what we were told one time. Because one of the support staff asked the general manager when we just got a ten cent a year raise. He's like 'what are we supposed to do with ten cents a year?' 'Well,' she said, 'that's quite sufficient.' I thought, WHAT! You can't even buy a postage stamp for that *(laughs).* That's coo-coo. I couldn't see them living on it. Yeah, it's like hullo? What planet are, what century are they in?

In the last round of bargaining, incensed workers highlight corporate's petty tactics of drawing

out negotiations, which led to several months where staff worked without wage increases. In an

urban context of skyrocketing costs of living, workers' wages have not caught up to what they

were about 15 years ago, before contracting out. Valeria, a care worker, notes, "we still stay at

the same salary, same benefits, everything still kept us the same as when we were privatized".

The combination of part-time hours and poor wages for support service workers means

their paycheques are paltry. Thirty hours of work equals around $700 after tax and union dues

for two weeks of living expenses. Fernando matter-of-factly shares how as a result, his family

had to sell their home and move in with their in-laws. He continues to struggle to support his

family, and both he and his wife had to take on additional jobs. Ray, a single support worker, too

struggles paycheque to paycheque. He laments that workers "shouldn't have to work two or three jobs to make ends meet. After I pay my rent and bills, what money is leftover for food for two weeks?" He finds it stressful that "the cost of living keeps going up. Every time I'm in the supermarket, the price of something else has gone up." He empathically reflects on the lives of his other co-workers, many who support a family, and run to and from another job before or after their shift at MV, caught in an endless cycle of trying to make gains while working bottom-end precarious jobs.

In fact, working two or three jobs is standard for support workers and care aides at MV. Fernando works every day of the week to make ends meet. He works as a cleaner early in the morning, then comes to MV for the afternoon shift, and spends his "days off" doing independent contract work. In between work, he spends much of his time on public transit commuting to and from his various workplaces in the Vancouver area and home in a distant suburb. Working one job until midnight, and starting another one early the next morning is exhausting, and it affects his work and home life. While a few other workers are interested in additional work or income, some face structural barriers because of their older age or limited education. Other workers find they are too physically and mentally exhausted by the end of the day to be able to take on another job. For care staff, rotating schedules prevent them from obtaining a second steady job. And this has the effect of securing their time and energy as workers dedicated solely to MV.

In addition to wages, what were once strong benefits were eroded. The 2009 contract negotiation led to original and new workers receiving drastically different benefits packages. The agreement was that original workers could keep their relatively good benefits package, while the benefits package for new workers was substantially reduced. In disregard of new workers' current and future security and wellness, pension plans were eliminated, vacation time went from

20 to 15 days, and extended health, prescription drug, and dental benefits cover only 60-70% of

the cost (compared to 80-100% for original workers). Sick days for all care staff – critical in

health care settings – were reduced from eighteen to five days a year, and, as a result, working

while sick is commonplace. Angel and Nenita complain, "we have only five sick days a year and

we work in health care, so we are prone to get sick all the time, and injured. So, it's really hard.

We have to work even when we are injured." At the same time, they cannot afford to "even miss

one day because then you will be short on rent". This is echoed by Camila, that "money is

coming not too much, okay. It doesn't matter, I have a headache or whatever, I come. Only if I'm

really, really, very sick, I stay home….I'm coming because I need the money." In a subsequent

contract negotiation, workers gained short-term disability benefits, but because they cover only

60-70% of their income, the benefits are not financially supportive enough for staff to rely on,

without worry, in times of illness or injury. Camila experienced precisely this when she used her

disability benefits on two separate occasions for quite severe health issues. Being on leave

without adequate financial support caused her stress and aggravated her poor health. In the end,

she came off disability leave early, before she was fully recovered, because the benefits were not

enough to live off of. Valeria relays a similar experience:

> Well my problem was my back, my hip, and my knee because of too much walking,
> going up and down. My pain got really bad to a point I couldn't walk. I was off for a
> couple months, so I went on disability but unfortunately disability only pay like, uh, 8-10
> weeks so I had to go back to work because they didn't pay me for even three months,
> which I wanted, I really needed it. So I needed to go back to work. That is, right now, it is
> a struggle for me because you know, I didn't really take care of my problem enough….It's
> hard to be off as much as you need, cause my bills were getting piled up….Everything is
> just money coming out and it's not even enough to pay bills. Yeah. So, I came back to
> work but, yeah, it's a struggle….my back wasn't too bad but right now it's getting back to
> [where] I was before. The pain is more, and pain medication is not even helping

4.1.3   Workload Intensification and Unpaid Overtime

The work has been reorganized to lower costs and pursue profits. In addition to wage and benefit losses, staffing and hours were cut back, and workers face heavier workloads. Care aides lost 18 minutes of work each shift, and some full-time care, support, and clerical positions were cut back to part-time. This allowed management to accrue savings over time and through reduced benefit packages. Because of cutbacks, during "non-peak" times of the day, such as 1:30-3:00pm and after 9:30pm, care staff are left alone or with more residents to tend to, posing a health and safety risk to both workers and residents. Workers in all departments consistently talk about the intensification of work as hours and staffing are cut, and work tasks and responsibilities are added to remaining positions. Part-time staff feel their workload is that of a full-time position, or one position is allocated the work of two or more positions.

As Valeria frustratingly claims, "this is their practice, and no one lasts – they go on sick leave". In the case of the payroll clerk, when overwork and stress pushed her to take a leave of absence, corporate replaced her with someone without necessary training or knowledge but, workers suspected, at a lower pay scale. As a result, scheduling and payroll issues abound, including errors with pay, vacation, and benefits. Frustrated staff, who often budget from paycheque to paycheque, spent their break time or stayed after work to sort out the mess. And the replacement often stayed late or came in on weekends to deal with work overload. Similarly, positions on leave or vacation may not be filled. Rather, other workers are stretched thin to cover these tasks in addition to their own. While their workload and responsibilities rise, their remuneration does not. When one frontline worker was asked to cover the work of her superior, who went on extended vacation, in addition to her own workload, her request for additional pay

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was denied by corporate. They used the rigidity of union collective agreements as a scapegoat to preclude paying a higher wage, even though these additional work responsibilities clearly breached the same bounds they were so vigilant to maintain. The incongruence of wages and work responsibilities is further enabled through the exploitation of workers' enthusiasm and commitment to the work, or timidness to refuse or pushback. It is also justified by the notion that workers are gaining good experience, and that is reward enough.

Burdensome workloads mean that some tasks are left undone or corners are cut to get the work done in time. Because there is no housekeeper to cover half of one floor until the afternoon, care staff on duty tend to spills and messes, and garbage, including soiled incontinence pads, piles up and poses an occupational health and safety concern for residents and staff. While management appeals to care staff to take on this extra work, there is no time for them to do it. Cutbacks in the support service department further constrains care aides in helping to feed residents, as they now help the dietary staff serve food and drinks. In the evenings, at night, and on the weekends, the RN takes on a host of additional responsibilities. She is in charge not only of overseeing resident care on her floor, but managing care provision in the entire facility. She also monitors who comes in and out of the facility, directs incoming phone calls, deals with families as well as staffing issues such as sick calls or injuries, and manages emergency and maintenance issues that arise. Because she "runs around" the facility dealing with so many, often unexpected, demands, her regular tasks rarely get done in time.

Workers consistently link facility renovations to workload intensification. When one floor was renovated to add ten new rooms, staffing levels did not increase. For six years, staff cared for 37 instead of 27 residents, violating VCH's staffing guidelines. One care worker shares her disappointment that VCH allocates only an average of 3.26 minutes per resident for staff to

complete each care task. This highly restrictive and impoverished calculation is generated

through nurse assessments of residents' care needs, which then determines the budget for care

hours the facility receives from VCH. She believes this low number is the result of nurses not

having enough time and education to do accurate assessments and proper documentation. This is

also compounded by an inadequate assessment system that does not account for many necessary

aspects of care. While MV had one nurse dedicated to doing resident assessments, post-

contracting out, the position was lost and the task was added to other nurses' heavy workloads.

To further ensure efficiency and extract value, strict plans and schedules must be adhered

to. This places additional demands on facility management to document and assemble data, and

audit in tandem with head office financial analysts, monthly financial, program, and staffing

reports. Tightly timed departmental tasks also require that managers closely surveil workers to

ensure tasks are completed on time. Ray, a harried support service worker, is often rushing

around the facility trying to complete his tasks. He describes his work "like a mad house" with a

"continuous" workload that "goes on forever". He concludes the effect it has on him:

> Let's just put it in a nutshell…a lot of times, I hate to tell you this, but I dread going to
> work. Because it's so, because there is such a heavy workload…. It's not an enjoyable
> place to work and of course you've got a lot to do, and you've got to hurry, hurry,
> hurry…it just overwhelms me at times. Of course I stay there, it's more or less economics
> right. I mean, where else am I going to get a job?

Similarly, the recreation department takes on a large number of programs given they only

employ one activity aide and a recreation manager who divides her time between delivering

frontline programs, resident assessment and documentation, and activity planning. Karen, a

manager, describes how the recreation department is desperately trying to obtain the budget for

an additional part-time position because when their previous part-time person left, the remaining

staff stepped in to continue to provide the same amount of programs presumably on a temporary

basis. But because targets were met with less staff, and residents are not complaining, the pleas

for additional funding for staffing are deprioritized:

> I've been told many times, that part of the problem is – and it's a good problem to have – that most people are happy here, the residents are satisfied, the family members aren't complaining, so why would they give us more money if everything's going on nicely? And we do an enormous amount of programs for how we're [staffed]. So sadly, if I was doing a worse job with the department, then I would get them [more staff]. But I can't very well take those programs away.

In contrast to the ideas and agenda of the corporate head office, the results of a recent

resident and family satisfaction survey show low scores for recreation therapy. A subsequent

action plan also identified a lack of staffing and resources as barriers to achieve better quality

programs. Without being afforded additional support, it is a wonder how goals for

improvements, laid out in the action plan, will be made. What this implicitly signals is that

corporate expects frontline staff to step up and fill the gap. Yet the request for a part-time

position is not frivolous. The current heavy workload expends workers' capacities, sometimes

draining them to the point that, for one casual activity aide, "by the end of the day I want to cry".

Quality programs, she points out, require energy, effort, engagement, and time, but she often

feels unable to provide this. When she is worn out, there are negative impacts on the residents,

yet she continues to get no help or support with programming.

In all departments, there are not enough hours to complete heavy workloads, and workers

routinely provide unpaid overtime, working through breaks, coming in early, and staying late.

While this is required to ensure basic care, it goes unacknowledged by management. It is

unaddressed in staffing allocations and workers' remuneration. Working overtime is often the

result of dealing with unpredictable bodily needs and the unanticipated time demands of falls,

illnesses, and doctor calls. Many staff work through their break in whole or part, because there are no other staff to relieve them of resident care. Camila shares a typical scenario:

> Like Mariella, sometimes she wants to go to the bathroom, and you say 'I have to go to eat mama, my break.' And she is staring *(giving puppy eyes)* and she cries. So you have to! If you don't put her on the toilet in the moment, you will have to do more work because she made a mess.

Camila and Reyna speak about the disjuncture between management expectations, the nature of the work, and understaffing. While Camila officially starts work at 7:18am, she comes in at 7am in order to get her work done. Even though she has been asking management for many years now that she get paid for this work, because it is necessary, they continue to pay her from 7:18am.

Similarly, one support service worker officially starts at 6am, but comes in between 5-5:30am each day, without pay, so she can get through a heavy workload. As long as it keeps the pressure from management at bay, she does not mind doing this extra work. But for workers who are not able to come in early, they cannot finish their work on time and are worried that it makes them look like they are not pulling their weight. A frustrated worker exclaims that, "people want to quit. Four people quit already! They are sick and tired." The unsustainable workload has been an ongoing agenda item at the labour management meeting for a very long time. A couple of workers have also brought up the workload issue multiple times over the years with different managers, but nothing changes. One of them shares with me, as she takes her break while completing her work tasks, that even after this, "they knew the work is already too much but instead, when they changed around the positions, they added another task to mine!"

While the issue remains unresolved, workers say it cannot wait: "Our bodies are not that strong" and "we are getting older". While management claims that staff are not supposed to provide unpaid overtime, Reyna, a care worker, claims they are "deaf" to workers concerns and

"they will just tell you, 'you need to take your break'". But another worker laments, "we can't

because, if we take a break, the work won't get done and it will be put onto the next shift". She

jests at management, "maybe we should let the laundry pile up? Let's let it pile up and see what

it looks like!" Then they have to do something about it. Nenita questions the workers who

continue to provide this unpaid overtime: "Are you happy to do it?" "How about your back, how

about your financial, is it okay? How about your family? You left them for four hours for free!

It's not right!" She relays, in an exasperated tone, non-reciprocal workplace practices of staff

giving and management taking:

> The funny thing, I came one time at 7:10am, and they deduct my [wages] ten minutes.
> It's ridiculous. When I have a [resident] fall, and I have a doctor rounds, and the LPN
> doesn't know what is going on on the floor, I stay….It's 3:10pm, I'm not saying I got ten
> minutes overtime to the RN or the manager.

Compared to GC, the management team at MV is about one-half the size, even though

MV is one-quarter larger in terms of the number of residents. While management rolls out head

office policy and procedure with seemingly little question or challenge, managers are also

impacted by workload intensification. They are unceasingly busy, and "can never seem to get the

work done". An interview with Donna, a manager, offered an interesting glimpse into the

everyday chaos created as a result of cutbacks and work overload. As the receptionists' hours

were reduced from full-time to part-time, the management team takes over her roles in the

afternoon. This includes assisting incoming and outgoing visitors and screening calls to the

facility. During our interview, we were continually disrupted by the phone ringing and front door

buzzing, as visitors and workmen came in and out of the facility and her office. Donna became

visibly annoyed and distracted, and her thoughts trailed off or were forgotten entirely. When I

apologized for the bad timing, and asked if we should reschedule, she muttered under her breath,

clearly agitated, "it's always like this". This was a vital turning point where I realized

management are not only facilitators of corporate's profit-seeking measures, but are also targets

of it.

4.1.4   Cost-cutting Measures: Food, Programs, Education, and Maintenance

Mealtimes are a highlight of many people's day, particularly for residents in long-term

care. Yet under imperatives of cost-cutting mealtimes are reduced to a rushed, medicalized, task-

based activity (Lowndes, Armstrong & Daly, 2015). At MV, resident complaints commonly

revolve around unappetizing and poor quality food. A survey of the dining room after a meal

illustrates widespread dissatisfaction: Some plates will be barely touched and most are only half-

eaten. One evening I sit with Anna and Don at their table, and a dietary worker serves them grim,

plastic looking hamburgers and a tart filled with canned fruit. Anna eats only half the hamburger

and no coleslaw, stating "I'm not hungry, you don't do anything here." She subsists off the

deserts rather than the main meals. I turn to the table behind us and ask the men how their dinner

was. Robbie cracks a joke, "it's better than nothing". Luigi tells me he does not mean to

complain, but he is getting tired of the selection of chicken or fish, chicken or fish, in different

iterations. The funny thing, he says, is the meat is indistinguishable – you often don't know what

you are eating. He believes the food is not fresh or healthy, and often foregoes the meal

altogether. This dissatisfaction is the result of food budget cuts that saw previously scratch-made

quality meals reduced to the purchasing of premade, mass-produced, frozen food. This move also

saves on preparation time and labour costs. Clara sums up the impact on the dietary workers:

"All they got to do now is bake it, steam it, boil it." Yet poor quality food lacking in nutrients has

adverse implications for residents' quality of life and overall health and wellness. Interestingly, while many residents have a hard time eating facility food, they greatly enjoy home cooked or restaurant food that their family members bring them.

Because there are limits to the reduction of frontline care work, life-enhancing activities and services are also the targets of cutbacks. Recreation programs are executed low-budget, and supplies for activities are wanting. One activity aide, with the help of a recreation manager, is stretched thin to provide social, emotional, and physical programs and activities for over one hundred residents. As a result, there is a lack of capacity to engage resident's diverse interests and abilities. Activities are typically organized for limited spans of time on each floor to reduce the time it takes to get residents to and from activities, and to lessen the number of residents the activity aide tends to. Under HEU, MV had a physiotherapist, occupational therapist, and a social worker, who contributed to quality of life programs. But post-contracting out these positions and associated programs were cut back, and an exercise room was lost in the renovations. Joan, a cynical family member, feels this is particularly hard on residents in the special care unit (SCU). She calls these residents "the Forgotten People" as they are rarely able to leave the unit and participate in larger facility life because "they can't spare the staff to take them up or downstairs. You won't believe the amount of times I've come up and he's [her brother] been sitting in his wheelchair staring at a blank wall, getting no stimulation."

There is also little budget for equipment upkeep and repair, and much of it is in poor condition. Mattresses are old and worn, imprinted with the ghostly shape of bed-ridden bodies. Mechanical lifts and wheelchairs are not maintained, and items like alarm guards and call bells do not function well or at all, with implications for staff and resident safety. While the facility does not want to pay the high price of a facility alarm system that would prevent residents with

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dementia from exiting the facility, there are not enough staff to adequately monitor wandering residents. When a resident escapes, Clara, a care worker, feels that it is staff who get blamed. Because the sole maintenance person is overworked, care staff feel compelled to fix plugged pipes and drains because "it's not fair to my resident that they cannot go to the toilet, because it's already been three days and it hasn't been fixed". While programs and maintenance are cutback, costs are shifted to the resident and their family. The tendency in for-profit care facilities, as is the case at MV, is to charge residents higher and additional fees for items, such as recreation activities, equipment, cable TV, and private rooms, which are typically included in non-profit and public care homes. One incensed family member claims "they charge for everything in this care home, they charge for every breath". She was billed hundreds of dollars more in fees per month compared to the non-profit facility her husband was previously at, even though both facilities are publicly subsidized.

Skimping on educational and professional development opportunities, too, saves the facility money, yet has implications for staff and resident relations and safety. Adequate education is especially important when providing care for people with dementia. Staff point out that dementia-related training, such the Gentle Persuasive Approach, would be helpful for all staff to learn more effective ways to deal with challenging behaviours. This is because staff lacking education may deal with confused or agitated residents in inappropriate ways, which ends up making the situation worse. Support staff are also routinely excluded from developing such important knowledge and skills, even though all departments work together in the provision of care. A licensing inspection last year found that many workers were not up to date on required education. To remedy this, the educational components were dumped on workers at once so they could catch up, disregarding the overwhelming workload increase. Workers also express a need

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and desire for team-building workshops across departments "…so that staff can bond, staff can know each other…so it's like we're on one team". Angel points out the paradox that teamwork is integral to the organization's mission, yet management claims there is no budget to foster this. This is even the case when managers "are always telling to the staff, that 'oh, they don't have enough skill.' But if you put them into team building, they develop their own skills."

At the same time, staff recount the deteriorating quality of education they receive. Education used to entail all staff and were often half or full-day sessions provided externally by VCH. But because staff complained about not being paid to attend mandatory educational workshops that fell outside their work hours, management moved to a model of in-service education. Now education is provided in brief 15-20 minute sessions or printed booklets with multiple choice tests, which staff are expected to do on their own time or at work. When education is done at work, management pulls two workers at a time from each floor to take the training and test, which leaves only one care aide and nurse to attend to almost 30 residents, posing a safety issue for residents and workers. Working through educational materials at work takes time away from care and poses distractions. As Nenita relays, "call bell rings, someone is on the floor, someone made a mess, someone needs to do the toilet, and you can't do what you're doing – you're trying to understand what is the meaning of the education". For mandatory education that is externally provided, management is highly selective about which staff can attend. Because it is often only one or a couple staff that get to attend, they are tasked with supporting the entire facility and rest of the staff with the skills and knowledge to support contexts such as palliative and wound care. While facilities receive an annual education grant, staff point out it is not going to quality education, and wonder where the money goes instead.

4.1.5 "It's the Budget" or Practices of Deception, Disregard, and Denial

Filing Workers' Compensation Board (WCB) claims, protecting workers from workplace violence, and following union rules when filling staff vacancies take a lot of time, which management does not have. Because it is a time-consuming process, management used to circumvent the union seniority list when shifts needed to be filled by directly calling in hard-working staff who would likely oblige. Yet dedicated advocate staff put a stop to this by calling management out on this practice. In a sector where casual work is prevalent and workers vie to build up their hours for seniority to apply for permanent positions, such practices are highly unfair and prevent some staff from accumulating much needed hours. Workers also feel that management prioritizes the interests of families and complies with their demands, even when workers are not able to ensure them. In contrast, some family members feel unsupported by management, and excluded from their loved ones' care. As Joan angrily recounts, neither management nor staff communicated significant issues to her, including when her brother had a serious fall that went unreported. While Joan felt kept in the dark, fraught relations between staff and management may have prevented workers from reporting out of fear of disciplinary action or losing their job.

In another situation, poor support from management impedes workers from filing WCB injury claims, and it is advocate staff instead who come to the assistance of scared and injured staff. One advocate staff relays that workers with English as a second language are particularly uneasy about filling out the lengthy and complicated paperwork "because they don't understand what's on the paper". When these workers try to get help from management their calls are ignored, and advocate staff lend a hand with the paperwork or offer advice on how to proceed.

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To prevent WCB claims in the first place, one manager threatened staff that if they get hurt, it is on them to complete the forms. In this adverse environment, workers sometimes forgo their claims "because they don't want stress and no one is helping them", or "it's too much work". While lowering the number of WCB claims frees up more time for management, and also lowers operators' insurance rate fee (Zuberi, 2011a), a lack of support to access WCB is alarming because injured staff have few other means to access compensation.

High rates of injury and violence are also prevalent concerns amongst workers, which goes unaddressed by management. Clara, a care worker, shares that her main concern is that there are no protections offered to workers who face workplace violence. Reports of violent incidents are made but there is no action taken from management. Workers also feel unsupported to deal with bereavement resulting from the deaths of residents, which is especially difficult when they lose someone they are attached to, the death is unexpected, or multiple deaths occur in close succession. There is no counselling or support program to help workers cope with the grief and trauma of dealing with death. Rather than meaningful address of systemic workplace concerns, staff are provided Band-Aid solutions, such as a session of laughter yoga or a ten-minute massage, to counteract overwork, stress, and grief. But workers joke that they do not have the energy to laugh, or that only a handful of staff got a massage because "if you are number 11, I'm sorry, no more budget".

Workers frequently mention that their ongoing concerns related to understaffing and heavy workloads are met with management's response that there is currently no budget. As such, no action is taken, and staff are told to wait for the next budget. Exhausted and exasperated, Valeria illuminates how staffs' incapacity to provide adequate care goes unaddressed by management: "Now there is more aggression, extended care, dementia, but no extra care staff

even though it was promised." "The company keeps saying it's the budget, but it's really their greed. They make money off of us – the workers and residents." Tricia also pinpoints the lack of resolve to the fact that corporate "has a heart for business" not the people that work or live there. All staff hear is that there is no budget, and the same issues persist. Yet workers also highlight the arbitrariness of management inaction to deal with understaffing. They claim that additional staff were brought in during licensing and accreditation inspections to make workloads appear more manageable.

Workers are disenchanted. As Valeria ruminates, "I regret staying here for so long. It depresses me." It has been so many years, and nothing changes. Balbir is similarly frustrated "…that management doesn't help us, they need to support us", and wonders "how come they don't fight for it [more hours and staffing]? They're the management. This is about improving the care of residents. We need to be supported so we can give proper care." Angel cynically jokes that at the labour management meetings "we just go for the donuts and cookies now, they don't listen to us, nothing changes". Instead, management displaces blame and responsibility for budget deficits to government underfunding, "washing their hands clean" of profiteering practices that play a substantial role in budget allocations. Rather than management using their position of influence to advocate to the corporate head office or health authority for additional funding, overburdened staff are called on to develop solutions without any change to the constraining conditions they labour under. Donna, a manager, is aware that the "workload is always an issue" but appeals to staff to not be so "hard on themselves", and "work smarter". She concludes, "I don't have all the answers and I go back to them and say I'm looking for solutions because I am really wanting them to take some ownership of this."

Workers, like Angel, challenge management claims and locate budget deficits in the profit-making activities of their multi-million-dollar corporate owner: "It's not a Vancouver Coastal problem, who give us the budget. It's the company that receives the money." To that Nenita replies, "I'm not blaming them, but please don't be greedy. They should take their portion enough, but they should be giving it with the employees and the poor residents who need it…" Staff are concerned that public funding is being funneled from care into complex corporate structures. This is a difficult claim to substantiate, but they do know that last year, VCH gave the facility extra funding to increase their care aide hours and put a mandatory LPN position on the night shift. While MV increased their short-shift care aide positions by an extra hour, no LPN position was created. This was going on for three months before a licensing inspector found the facility to have no mandatory LPN on night shift. At the same time that MV was found out and forced to create the LPN position, the care aide hours were cut back. While care workers point out the coincidental timing, management claimed it was because there was no longer a budget for the care aide hours. But staff are not convinced that government funding dried up mid-fiscal year and point out that the extra care aide hours were maintained in other facilities. Workers caution, "where does the money go?" They highlight that it is not simply how much funding the care facility receives, but where the funding goes that is important: to frontline care or profit.

4.2 Case Study 2: Gracious Care Centre

Gracious Care Centre (GC) is a non-profit care facility that offers a striking contrast to MV. It extends conceptions and practices of care in ways that counter the economic rationalization of restructured publicly funded care provision, and dominant practices of

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contracting out and cost-cutting. To put expansive conceptions of care into practice on the frontline, management and staff at GC do a lot of extra work through fundraising, juggling funding and staffing allocations, taking on personal responsibility for cost-containment, and fostering caring commitments and communities. In contrast to MV, these strategies buffer restructured care settings, and are not meted out against workers, but rather are actively enrolled and enacted by them to fill the gaps in care.

4.2.1   Fundraising for Quality of Life Programs, and Juggling Funding and Staffing

The management and Board of Directors at GC do a substantial amount of fundraising. They host fundraiser events, write grants, and solicit personal donations to support quality of life programming. This includes physiotherapy, music therapy and musical entertainment, bus trips, and a large and active recreation and spiritual care program, all of which are either underfunded or not funded at all by the health authority. Necessary equipment, too, such as ceiling or standing lifts, shower chairs, and specialized mattresses, are also underfunded and obtained through fundraising. Out of operation costs that total $6.6 million, GC is currently funded at 92%, up from a historical low of 87%. GC may get further caught in a budgetary bind and management sometimes "scrambl[es] to find money" because unexpected expenses arise, and the health authority does not fully cover maintenance, capital costs, or sick time and other replacement costs. Even while deficits reach $30-40,000 each year, GC is able to manage it because contracted facilities (like GC) work with a rolling budget, allowing deficits to be passed from one year to the next without ever really being resolved. As a result, GC is always playing "catch-

up" with its finances, and every year the deficit must be offset through additional fundraising in order to prevent cuts to programs.

Contracted facilities, like GC, are subject to greater funding shortfalls than publicly operated facilities (Kary, 2017). This is because the health authority expects non-profit societies to come to the table with costs, and to fundraise and mobilize volunteers. To fill the funding shortfall, and to ensure additional quality of life programs and activities, the Board, management, and staff at GC have a goal to fundraise $190,000 a year. A couple of large fundraising events are undertaken each year including theatre nights and food fairs, raising tens of thousands of dollars. One manager is also tasked with writing multiple grants each year, and a large portion of fundraised money comes from a $80,000 Community Gaming Grant. While they have luckily received it each year they applied for it, it is not guaranteed. While fundraising is typically the ambit of management, this year they hired their first consultant to advise them on legacy giving. Susan, a manager, excitedly shares that the aim is to increase family, friends, and community members' awareness that they "can leave us things in your will, and you can leave us [life] policies", and "if you have stocks and shares and bonds…you can leave that to us". There will be "lots of opportunity for people to donate to us. They just don't know that [yet]".

Families are a significant source of donations, and some confided that they donated what they could – up to thousands of dollars each year – to contribute to quality of life programming and to offset their family members' portion of underfunded recreation costs. The bus used for weekly outings was a donation from the family of a deceased resident worth $100,000. GC's Family Council also contributes immensely to fundraising by hosting events such as an annual holiday craft and bake sale, which doubles as a community event. The Family Council fundraised for palliative care carts stocked with goods and toiletries to support family members

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through their loved ones' palliative process. Overall, fundraising contributes to an extensive array of activities which attend to residents' differential spiritual, emotional, cognitive, physical, and musical capacities and needs.

The management and Board at GC are ethically committed to not contract out care or support work because of the adverse implications to work and care conditions, and workplace relationships, including "union issues up the yin-yang", "staff squabbles", and "inter-departmental conflicts". Instead, management fills funding shortfalls and departmental deficits by getting creative in how they allocate government funding, juggle staffing, and share tasks across departments. Experience and knowledge of frontline health care work, and how different departments affect one another is crucial to determine better budget allocations. The recreation department is a case in point. While the health authority does fund recreation therapy hours, in a facility with less than 100 residents, the funding is only enough to hire one activity aide for four days a week, which would equal a paltry daily average of fifteen minutes of recreation per resident. But GC recognizes the importance of a strong recreation department, and that it takes the pressure off overburdened care staff. As Susan relays, to maintain recreation programs every day of the week, funding is shuffled around from other department budgets:

> I believe that if recreation is strong…they will meet a very large percentage of our residents' needs. Never mind the care. They will meet those needs, whether they're psychological, emotional, whatever it might be. For me, having a firm and strong recreation team, and not just 0.8 full-time hours [one worker four days a week, as per VCH funding models]. But having enough bodies, so we're covered seven days a week, and there's somebody in the building to do things with our residents, we can alleviate a lot of the boredom. And it is, it's the boredom, and the helplessness, and the loneliness that our residents actually feel. If we have somebody, like spiritual care staff…that can step in and fill that gap, because, at 2.6 hours of direct resident care [as per the VCH funding model], our care aides and our nurses do not have the capability and time to do that….So that's why I put such a focus on recreation. I honestly believe that recreation and spiritual care should be incorporated into direct care, because what they do might not be clinical care, but it is still care. And that just drives me crazy that somehow the health

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authority – not so much the health authority – it's the Ministry of Health, doesn't seem to understand that concept….I find it ironic because you look at the mission, vision, and values statements and what does it say? Holistic care! And I laugh because they don't really understand the true concept of what that means.

In another case, to relieve the rush of morning care routines, labour hours were moved from the kitchen to care department, because they "can manage, but the care can't". In doing so, they created an additional care position on the condition that this position help kitchen staff serve meals and clear the dishes at meal times.

To alleviate heavy workloads and meet demands during peak times, tasks are not only formally reallocated but also informally shared by workers across different departments. During my first day at the facility, two managers proudly point out that the cook is in the dining room helping to serve lunch because they are short-staffed. He moves from table to table, serving food, and chatting with residents. Workload demands also shift depending on residents' changing needs and capacities. While care staff used to help recreation with their work by portering people up and down to activities, Vicky relays how, given residents' increasing care needs and care staffs' exhaustion, recreation staff now help care staff by "serving tea and coffee, or helping them with feeding, just to give them a break". Countering the task-orientation of mealtimes, Vicky enjoys doing the tea and coffee because she can make it "more light and make it feel like I'm a restaurant person, like a lady serving tea and coffee. Make it a little more interactive and fun. Less institutional." Recreation has also shifted the intent of some of their programs. Small gatherings of residents during mealtime used to be for the social element, but now it is done to help out kitchen and care staff so they have less residents to serve and feed.

4.2.2   Taking on Personal Responsibility to Manage Funding Shortfalls

Both staff and management routinely take on personal responsibility for managing budget

deficits and containing costs, with the ultimate aim to smooth departmental operations and keep

contracting out at bay. Practices of personal responsibility include completing work tasks outside

of work time, going above and beyond in their work, and self-surveilling work practices, such as

being careful and conscientious about costs and waste. These practices are more steadfastly

enrolled by workers who have experienced contracting out. A couple of times, especially when a

large number of staff were on sick leave, I heard workers who have experienced contracting out

voice concerns and caution staff about the budgetary consequences of over-taking sick time and

overspending on overtime hours. This self-discipline generates immense savings for the facility

at a cost to workers. Susan responds to my curiosity about how the facility has been able to work

around funding shortfalls and prevent contracting out by highlighting the productive, cost-saving

nature of workers' attentiveness and commitment:

> It's such a difficult thing to define in a way. But I think if you can instill in the staff pride
> of the work they do and the place they work in, it makes a big difference, because staff
> then go the extra mile, and staff will also take better care of things….Also, I think that all
> of us are very conscious of the money that we spend. All of us. Like May keeps our food
> cost at roughly $6 per resident per day. $6.25 or whatever it might be….let me give you
> an example: so May won't buy everything from Sysco, which is our supplier. On her way
> to work, May will stop at Superstore and she will pick up say cucumbers, or lettuce, or
> whatever, because at Sysco, if she sees the price and says 'oh, I won't spend that,'
> because you're going to charge me $12, I can buy that at Superstore for $5. Then I'll go to
> Superstore and we'll buy them at Superstore. All of us do those kind of things….All of us
> are really cautious and careful.

May substantiates this: As long as "Susan and I are here, I can guarantee you there's no

contracting out", because "I will not go over my cost, my food budget. I'm constantly looking at

my food cost." May is able to minimize food costs, while maintaining food quality, through meticulous attention to food cost and waste. While they are funded $7.20, and the average funded food costs is $8.00 per resident per day in B.C. (OSA, 2018), May keeps their costs down to around $6.00. She does this by maintaining relationships with suppliers, acquiring free goods, assessing what residents like to eat, and getting creative with leftovers – turning "seafood Newburg on Friday night….[into] seafood chowder on Saturday lunch". Having personal connections with suppliers means she is able to elicit donations of food stuffs – congee soup base, tins of cabbage rolls, or chicken pot pies – often in the sum of hundreds of dollars. She knows her suppliers well, and if she is short on product and low on money, she will call them up and request, "I can't afford it, can you send me a case over for sample?" The money she saves in food purchasing is reallocated to recreation. Similarly, she often does not pay the list price for goods, but rather bargains for them. She exclaims, "ask Susan, she hears me on the phone. It's constant! I'm not paying $5 something for that!" She does this work, because in the end, "it's for the residents".

Susan relays how, in a highly insecure long-term care sector, management and staff work hard to adhere to tight budgets, and this is acknowledged by the management's decision not to contract out the work:

> [Support services] really go the extra mile to keep their costs really, really low. My attitude is, if I were to do that [contract out], I would be saying to them that what you've done in trying so hard to do, it's insignificant. I would never do that because they really work hard to keep our cost down. Our food waste is between 2-5%. If you consider that the health authority is 47%! The problem with them is they have got Sodexo. All their food is by contracted out people. I don't know if you've been in the hospital, but…it's disgusting, disgusting!…Their people don't eat the food because it looks so dreadful, so there's so much waste. 47% is just beyond shameful. And we are sitting at 2-5%....And part of that is, because between May, the staff, the dietitian, they stay on top of what's working well....So they're just trying to accommodate the residents likes, and dislikes, and needs. So it does, it makes a huge difference. And I think, for me, I have not yet seen

the need to contract out….And obviously, contracted-out care aides, that would be the last thing I would do, because the care aides are the ones that have the closest relationship with the resident. And, no, I would not ever do that. Not while I'm here. I will resign first.

Because of ubiquitous fundraising efforts, staff are very much aware of the issue of sectoral underfunding. This not only dampens complaints about workloads, but also prompts some staff to donate to the facility. May shares that staff may buy a ticket for a fundraiser event, or might give "$100 there for the donation, but they don't want anybody to know". She sees their generosity as something that is encouraged from "the top", through an organizational culture that emphasizes going above and beyond. Because management is like that, staff tend to follow suit. In order to minimize costs and subsidize programs, staff and managers routinely donate goods from home or "volunteer" their time to pick up necessary items for programs or residents. Vicky, an allied health worker, for instance, bought some art and craft supplies when she was out shopping because they were running low and needed it for an activity. She positions this as "just part of the job", but also acknowledges that taking time away from the residents and programming to do things like purchasing is frowned upon by management.

4.2.3   Fostering Caring Communities and Commitments

In my inquiries into what made GC a different facility from the rest, the most common response from staff and family members included something like "it comes from the top down". I came to realize this signified that management models acts and behaviours of leadership, teamwork, respect, and care for all, which is instilled in the organizational culture and taken up by frontline staff. As one manager articulates, the frontline staff need to see "…us working

together, they see us helping each other, being there for each other, stepping up to the plate when we have events, when we have functions, whatever". The management is "not in our offices hiding away, we are a part of the process". In effect, this "cascades down to our frontline staff", because "they look at that and they say if they're doing that…then we can do that too". Staff and families view this positively. Sofia, an allied health worker, speaks about the reciprocal sharing of work and helping out when needed:

> I have worked at two places, and I have seen big differences between one and the other. And I don't know exactly why. I think part of it has to do with the administration. The philosophy of the organization, the philosophy of administration, and how that gets implemented by the administration team….and eventually it trickles down. One of the big differences I have seen here is that departments work cooperatively….here, all the departments work together. And the dietitian staff, they come and say 'can you help us set up for this?' Well, 'yes of course.' And they will help me when it's me by myself when my staff is sick, and I say 'please can you help me bring residents because we have an entertainer.' That doesn't happen everywhere, not even close.

Vicky, an allied health worker, "think[s] it's the top down approach and the bottom up approach with the camaraderie, with staff. So we have a strong community, and we're almost like family in a sense." She has worked at GC for years and "…noticed that from the first day, and working other places, it's not the same". It boils down to the fact that "people are just respected here", management "make an effort to not be in their office, to be out interacting with the staff and residents", and "everybody looks out for each other". Even "the families feel it. There's a lot of gratitude from families." Similar to Vicky, other staff expand beyond the "top down" theme to express that good work cannot be performed without the will, dedication, support, and positive relations of staff themselves. One care worker shares how staff "talk and share what is going on and how we are feeling, and we learn from each other". She points out that because GC has not pursued contracting out, which erodes wages and benefits, and most staff are long-term and in

secure full-time positions rather than working in two or more casual or part-time jobs, they are committed and can give more to their work and the facility.

To achieve cooperation and teamwork on the floor, management enact a flexible and "soft", rather than "hard" organizational hierarchy. In this arrangement, management are refreshingly "hands-on", departmental roles blend, and it is expected for staff to take on tasks where needed. In the context of increasing resident care needs without a relative increase in staffing, management lends a hand to assist care and kitchen staff by portering residents to the dining room, helping to serve and clear plates, or feeding residents to ensure heavy workloads and tight timelines are managed. Leading by example is key because, as May reveals, "I don't want them to say, well, why are you asking me to do this when you don't even do it?"

It is also expected, given the type of work, that staff display appropriate attention and care towards the residents. May is not afraid to tell her staff if you cannot do that for the resident, "I don't think you should be here…apply for housekeeping, hideaway, clean a room, you don't have to deal with the resident. But if you're not willing to have the patience with the resident, this is not your job." Similarly, one allied health worker describes how management creates the space and work culture for staff "to be joyful and respectful and supporting residents". A high standard of care is the norm, and "it shows up when somebody isn't doing that, in a place like this". Indeed, the bounds of care extend beyond official and funded work roles and responsibilities. Impelled by tenets of Christian service to help the vulnerable in need, some management take on additional informal care and advocacy work. This includes providing hot lunches and transport, and attending doctors' appointments with residents of their nearby independent seniors housing complex. Another manager shares that she provides around five hours of unpaid overtime each week because her paid hours, which are fundraised for, are not enough to do what she feels is a

good job. While this allows her to ensure quality interactions with residents and families, she also feels better about her work.

Susan describes how a high standard of care, integral to organizational culture, is ensured through management expectations, hiring and evaluation practices, and the traits of persons drawn to this type of work:

> I think, firstly, I do think people who are working in this industry are born, they're not made….generally people come into this work, they are generally caring people anyways. Added to which…our whole philosophy is, I believe quite different, and when we interview – and that's from the management level all the way down to the maintenance person – it's made very clear to the people that we interview, that in our organization, two things: We believe…that this is the residents home, and *we work in their homes*. And there has to be that respect for the fact that there is their home….The second one, of course is, and it says so in all our job descriptions, in the end, it says 'and other duties as assigned'. And we make very clear when we give the job description to the staff member, or the potential staff member, that that's exactly that it means. It means that you will do whatever is necessary to make the residents life a better life. And that means working with your colleagues, that means cleaning up if it needs to be done, that means the administrator pushing a wheelchair because it needs to be done. And it's made very clear right from the get-go – that is our expectation, and if you don't want to work as a team, which means we all carry each other's burdens, this is not the place for you. It's not.

She adds that those who do not fit in either decide to leave on their own, or peer pressure pushes them in line.

There is a focus on creating communities of care, and fostering the caring commitments and capacities of not only management and staff, but families, companions, volunteers, and others involved in care. This has the effect of relocating care from an individual and private to a collective practice. Families and friends involved in the care of their loved one get to know and care about other residents too. GC fosters caring communities in a myriad of ways. They host events, such as special dinners, concerts, memorials, and afternoon teas, which bring a broader community into the facility. They have a variety of community connections including a large and

dedicated Board, an associated charitable group, and an extensive volunteer labour pool. They create a friendly, appreciative, and supportive space, which fosters others' inclusion in facility life and care provision. In this environment, strong connections are forged, and it is quite common to see family and friends of deceased residents, or previous staff continue to drop by to visit, or help out around the facility. As May says, "they don't have to, but they all do". Tom, an allied health worker, feels "blessed to be part of such a loving and caring team", which he dubs a "family" "because that word really describes the feeling I get when I am here". The difference is "the staff don't only 'care for' the residents, they 'care about' them".

Yet all the work that goes into maintaining an organizational culture of care is elided in the "natural" and "easy" way that staff go about their work. Meilei, a family member, invokes this as a "spirit of care", where staff view and provide resident care in expansive and holistic terms. They extend themselves for the residents. She reflects that even while staff face many work-related demands, they love their work, and make it look like "it's not extra work to do", like "they have the secret ingredient". And "even down to the maintenance guy, when residents ask him for things, he assists, he listens. There are no confines that 'this is my role.'" This is unique: "Visiting other places, you see that there's something extra here." This "spirit of care" is what some managers and staff feel is the reason that some residents enter the facility with only months to live, but end up living many more years. The quality of care and relationships, and engaging environment provides meaning for residents, which they argue, improves their condition and extends their lives.

Management works in partnership with, supports, and encourages a strong and vibrant Family Council. At GC, the Family Council is a tight-knit group of committed family members and is a space to share information, concerns, and experiences related to institutional care.

Importantly, they provide mutual support and assistance for family members and friends coping with their loved one's transition into care, and during difficult times of illness, death, and bereavement. For Jeanne, a newer Family Council member, it is nice to know you are not alone when you are going through the hard and stressful transition period. Now that her mother is settled into the facility, she reaches out to and supports new residents and family members. The Family Council creates a community of care that promotes high quality care for all the residents living at GC. Meilei reflects on the Family Council's connection and care for not just their loved one, but all residents in the facility, and particularly those whose family members are not active in their lives. She will "hug, kiss", and chat with residents who "just need someone to understand them". Family Council is there to "give a hand" and "take care of each other" beyond what staff are able to do given their heavy workloads. This was evident when Iris, a long-term resident, was sick and bedridden, and a handful of family members brought her flowers and baked goodies to cheer her up. Meilei feels that "the residents are a part of us, and we are a part of them". When a resident passes away, "we are affected, even if we don't know them that well". These often-present family members also create a lively and fun atmosphere, as they gather at a communal table to feed their loved ones, banter and converse, and exchange support.

In restructured care settings where staff are overworked, staff and family relationships tend to be strained or distant, and there is little support to include family members in care. In contrast, Darlene, a family member, relays how her involvement is made a priority at GC, and her choices are respected:

> I feel like they know that we are important to Lacey. And having us here is a good deal for their patient….We are part of it when we want to be, and they're so respectful when we are not. Everything we do they are grateful for, and they never criticize us, which is pretty amazing.

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In a supportive and trustful environment where things are well taken care of, Meilei describes how this invites families "to be more involved, to take part, to grow with it in the human sense. You're not worried, you see things and trust them." Even with family involvement, staff never lessen their attention to and care for residents.

4.2.4   Workplace Support, Appreciation, and Advocacy

GC's organizational culture and management practices recognize the conditions of work and care are intimately tied, and are responsive to the rights and needs of all persons involved in care, particularly and distinctively frontline staff. This has the effect of cushioning the constraints and pressures of sectoral restructuring and fosters dedication, teamwork, and care in the workplace. Management is knowledgeable of and involved in frontline work, which allows them to understand the demands of the job, be supportive and proactive in resolving issues when they arise, and actively strive to better work and care conditions. In Susan's position, "how can I sit here in my office and say to my staff this is what I expect of you, if I actually don't know the road that they're walking. But I do know, cause I'm there…" and "I'm talking to staff, talking to residents' family members about things that are going on." Positive relationships and good communication between management and frontline staff are essential for quality care. Otherwise, "the person who suffers at the end of the day is the resident and the family, and then staff, and then up the ladder". Care staff are the "eyes and ears" of care provision. They possess intimate, frontline knowledge of the residents they work with, their health and functional status, and changes to it. At GC, care staff are integral to informing care plans and decision-making, which is not common practice in most facilities (McGregor et al., 2011). There are multiple arenas,

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including care conferences, interdepartmental meetings, open forums, and management open door policies where frontline workers voice workplace concerns and inform care provision. While workers are given autonomy in their work, they, in turn, are empowered in, and take ownership of their work, and trust is built between staff and management. Also distinct, is that staff are provided support, through counselling sessions and prayer circles, to help them cope with hardships, such as death, that emerge in their work or home life.

Frontline staff are not only included in important forums, but their ideas are listened to and their concerns acted on. Staff routinely suggest that this is what makes GC a different and good place to work. One care worker compares GC with two other facilities she casually works in. In the latter two, the management stays in their office, and she does not even know who they are. Because of this, when an issue arises, she is not comfortable to go to them. At GC, in contrast, she feels free to go to management with an issue. She knows they will listen to her, that they are fair, and will not take sides. During an evening break, Helen, a long-term care worker, beams at me as we discuss what makes GC different. She tells me that so many staff have stayed at GC long-term because it is so good, and even the casuals want more hours. While cutbacks and heavy workloads affect all facilities, the difference at GC is "…you can work easier, you come to work happier". This is "because we have support from the management, they listen to our ideas, we talk to the management, so and so need to change, we need to do some adjustments, they will listen to us" and "try to figure out how to work on the problem".

Another care worker compares her workload at GC to another non-profit facility she works at. She claims that even though she has more residents to care for at GC (nine versus six residents), she feels that the workload is less because of the support provided by management and co-workers. In her words, GC "is a nice place, environment is nice, staff is nice,

management is nice - they are really good people. They listen to you; they care about you."
Anaya describes how managers' support, care, and appreciation for staff translates to recognition
of their hard work and staff feeling less stressed on the job. This, in turn, allows them to provide
better care. The management respects staff, residents, and family members equally, and draws a
clear line on unacceptable treatment for all parties. Susan relays, "I will not allow our residents,
or families, to talk badly to our staff. I simply will not put up with it. And I'm very clear about
that." "I've told that to some family and some residents and they get the message quite quickly."
At the same time, if "the staff treats a family member badly, I'm right there, saying this is not
on". While work demands are high, when management listens to, supports, and responds to
staffs' concerns, staff, in turn, are committed to the facility, and are more willing to go above and
beyond at work.

While GC tends to take in more challenging residents, they simultaneously advocate for
the staff and residents, and have declined residents that are not a good fit, or when staff are
unable to meet their care needs. To determine this, management looks at staffs' workload and
ability to provide necessary care: "Are our staff overworked, exhausted? Can they manage
another challenging resident?" Given a mix of understaffing and changes to the incoming
resident population, GC must sometimes limit access to care in order to ensure safe, quality care
and work for current residents and staff. In particular, because care staff are at their maximum
capacity to assist residents during mealtimes, GC now must decline entry to persons that need
total assistance with feeding. Special consideration may be given to families that are able to
assist their loved one to eat. Deficit care contexts constrain facilities' capacity to meet high care
needs. While the aim is safety for both staff and residents, this paradoxically privileges persons

with lesser care needs and support to access care, and impedes access to persons with higher care needs and without support.

In another instance, Susan explains how she draws on relationships with health authority officials to advocate for additional staff and negotiate more funding:

> We look at the health authority and licensing as our partners in care. They're not the enemy. They're not our antagonist at all. They are partners in care. We should treat them with respect and consideration and courtesy. So you will very rarely see us having conflict with them. I sit on the leadership committee because of that, because I think we need to have our voices heard….These are funders, these are the people that dictate what we can and can't do….And that's why, like last year when I went and approached them. I said 'you know guys, we really, really need more money. We need more funding. I need at least the equivalent of at least one full-time position in my evening staff.' I did a total breakdown of the [staff] routine….And I literally did that – what did you do from 3:30pm until you went home, minute-by-minute, hour-by-hour, including your breaks, etcetera. By the time you got to the end of doing that you want to put your head down on the desk and weep because you'll be exhausted going home, and because it is exhausting reading it. And I did that based on the staff feedback on the routines….I have an aging workforce at an average age of 47 in our facility right now. People are becoming older, becoming more prone to injury, more tired, and all the rest of it. I said, 'look at our present population. So many years ago we had 21 wheelchairs we now have 49 or whatever it was at the time. With all that, we have only got 17 ceiling lifts, but I have 50 something people in wheelchairs.' So here we are, look at that physical work involved….So I walk them through this entire thing and I said, 'you know, I come to you and say I really need this money. This is not frivolous; this is not fluff money. I need this money to maintain my staffs' health. To maintain my residents' safety. Please would you consider it?' Well, literally within not even two months, we got the funding for one full-time position.

In order to make gains, they also make concessions with the health authority. For example, when they are able to do so, they may take in challenging residents that other facilities will not. In the words of Susan, it is about "pushing back where we stand firm for certain things, but also being flexible with them too".

Susan was also in the process of setting up a meeting with health authority officials to explain the immense difficulties they faced with a previous resident they were being pressured to take back in. Susan shares that they do not want this resident back because she placed so many

unfair demands on the care staff. There was one time when she rang her call bell seventy times in twelve hours, with the result of overwhelming, stressing, and tiring out the care staff. Susan will not put the staff through that hardship again. She is determined that they will "absolutely not have her back here", and half-seriously jokes that if she shows up at the door, they will lock her out. In a similar vein, management also lobbied the health authority and nurses' union to increase LPNs pay to "what their work is worth" "because they were so underpaid" for their scope of responsibilities. Respect and advocacy for staffs' needs, in turn, bolsters staffs' workplace commitment, and managers are aware that "it's those things that count at the end of the day. And that's how you get loyalty." This approach prevents a divisive "us and them" environment, dissipates potential conflict, and establishes positive management-labour relations.

4.3   Downloading the Care Deficit to Companions, Volunteers, and Family

In both facilities, as is commonplace across the sector, the care deficit is downloaded to and filled by companions, volunteers, family members, and friends (Armstrong & Braedley, 2013). These groups provide not only much of the social and emotional care work, but increasing the physical care tasks too. Companions are a common fixture in care facilities. They comprise a rising proportion of the long-term care workforce, even while there are few studies that focus on these workers (Armstrong & Braedley, 2013). Companions are about equal in number at both GC and MV. Even though they are privately paid by residents with financial means, and contracted as workers external to the facility, they perform vital, often extra care work alongside facility care staff (Daly, Armstrong & Lowndes, 2015). Private pay companion programs are even integrated in some facilities as a supplement to bare publicly funded care. While their work

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is crucial to resident care, most or all of the companions I got to know have neither stable hours of work, financial security, nor access to benefits and entitlements, including sick time and vacation. GC does set standards for companions, including the condition that they are personally insured under WCB. These companions are all Filipina. Most previously worked as live-in caregivers, and a couple had gone through Health Care Assistant training. Some initially worked through an agency, making near minimum wage. But after a couple years of employment and making connections in facilities and with families, most are now self-employed and gain clients through word-of-mouth.

Companions primarily provide one-on-one care, support, and companionship. Lyn, a companion at GC, has time with her clients "…to talk to them, and yeah, hold hands and say, 'oh yeah, how have you been doing?'" because, "of course, the care aides don't have much time….they have to work fast". Companions may take their clients out for walks, lunches, or to run errands. The emotional and social care they provide improves residents' engagement and reduces loneliness and depression. This is how Benilda, a companion at GC, describes of her work with Thomas:

> He tells me he wants to go to bed. I tell him no, no, no, not now. Let's go out! We do something, we went to the sunroom. We spend time. I ask him more questions….Those kind of things makes him, I think...[feel] included, or more, his cognitive comes back too. I don't know exactly really, but at least he got some memory to share. Cause again, care staff, they don't have time to ask those kind of questions….I wish the care staff would have more time to sit and listen to them, right. But that's not the reality, right….Instead of getting depressed, you want to, you want them to be involved in some part of their life right, cause they can feel depressed because they don't have anybody to share that.

Companions' work lightens the load of overburdened facility staff. They often do aspects of basic care that staff do not have time to do, such as providing more than one bath per week; immediately changing an incontinence pad when needed; cutting fingernails or shaving facial

hair; or, taking the time required to encourage or assist a resident to finish their meal. They may do little extras for residents such as styling their hair nicely or manicuring their nails. In contrast to overworked facility care staff, companions are able to be attentive and responsive to the feelings, needs, and desires of their client, and offer them choice and flexibility:

> Benilda [companion at GC]: I just do the sponge bath and things like that, if she doesn't feel like doing [a shower]. Or, if you want to go out, it's a nice day today, we can go out. If she doesn't feel like it, we can just go sit there, and just have some fresh air. And if you feel like going for a walk later then we can go. Or, if you want to go in, I give her some options about what you would like.

Companions, working in close proximity with their clients and other residents, act as an extra pair of eyes and hands to alert and help staff when a resident falls, is aggressive, or soils their incontinence pad. Because staff are not always around and attentive, companions often monitor, redirect, or occupy wandering, confused, or lonely residents. As Lyn describes, "when they're busy, and everybody's acting up", staff are "always grateful" to have her help. Being able to provide one-on-one care and interaction also helps to settle and engage residents. Companions support residents to be involved in the activities and life of the care home. This is particularly the case for residents living in locked SCUs, where they are not able to participate in programs off their unit unless accompanied. Even when companions are with a client, they often take time to chat with and help other residents. At MV, one resident, Wei, will not eat without assistance. Because it often takes so long for staff to get around to helping her, she sits there staring at her plate and her tablemate worries that she is not eating. Wei does not have her own companion, but often the companion of another resident will help her once she finishes feeding her client. Even though the facility rule is that they cannot help feed residents because it is a liability if the resident chokes, she risks feeding Wei because "what can I do? She wouldn't eat otherwise." In

another situation at MV, Divina, a full-time companion to Emma, creates fun and comfort for other residents on Emma's floor by chatting and joking around with them. When the music therapist plays each Monday, she livens up the space by singing and dancing along. One afternoon, I drop by Emma's room to say hello and find Emma tucked into bed and dozing as Divina repositions Emma's roommate so that she lays more comfortably in bed. At the same time, they chat in Cantonese, which Divina picked up when she worked in Hong Kong as a caregiver. While much of the care that companions provide is invisible and unremunerated, it is vital to residents' quality of life and crucial to support facility staff.

Volunteers are similarly an integral component of care. While volunteers have always been involved in care facility life, in the context of underfunding and cutbacks, programs such as spiritual care, recreation, and art and music therapy now increasingly rely on volunteers to replace previously paid workers and even whole departments. Volunteers provide one-on-one social interaction, and their work frees up time for staff to attend to other needs and tasks. Volunteers often comprise a large part of the workforce, save the facility a lot of money, and contribute immensely to residents' quality of life. Largely due to its religious affiliation, GC has an extensive base of over forty volunteers in recreation and spiritual care. These volunteers assist with activities such as bingo and bowling, bartend during pub time, and porter residents to and from morning liturgy. Spiritual care also has five specially certified palliative care volunteers. Many volunteers are highly dedicated and provide long-term service of ten or fifteen years or more. Comparatively, MV has far fewer volunteers, even while there are a committed few that provide vital services such as mass, bible study, and pet therapy. The difference in volunteer numbers at MV compared to GC is likely due to a lack of management capacity to effectively

engage volunteers. Or, one candid family member thought it could stem from potential volunteers' aversion to bolstering MV's corporate profit through their free labour.

Family involvement is critical to the provision of care, and it is typically much appreciated and supported in facilities, unless it is an overly demanding or critical type. Research has explored how even with a loved ones' entry into residential care, high levels of care continue to be provided by families (Keefe & Fancey, 2000; Lanoix, 2010). In both facilities, many residents have family and friends often visit, sometimes every day or multiple times a week. To some dedicated family members, staff jokingly ask them, "when are you getting on the payroll?" Meilei, now retired, comes every day to GC to feed her mother Ming Yue. Because Ming Yue's disease is progressing, she is not able to swallow well and it takes a long time to feed her. Meilei painstakingly cuts her food into tiny morsels and slowly spoons it, bit by bit, into Ming Yue's mouth. It is a tedious process that takes negotiation, prompting, and the patience of a saint. Unlike care staff, Meilei is able to take the time needed to feed her mother well. She also takes a bit of the burden off care staff who have to feed multiple people in one sitting.

Involved family members create a sense of community, which is encouraged or thwarted by the spaces and broader relations in the care home. Their visits bring cheer, comfort, and support not only to their loved one, but to other residents as well. At GC, the sister of one resident comes in once a week to gather a small group of Chinese residents to play mahjong, a coveted activity given it is the only Chinese-specific one in the care home. At MV, there are a handful of highly committed Chinese families that rotate visitations in half or full-day shifts, so that their loved one is never alone and lonely. Families not only provide in-person care, but many also purchase extra care-related services out of pocket to improve the quality of life for their loved one. Rose's husband privately pays for physiotherapy and massage services out of their

dwindling savings. While this has done immense work to rehabilitate her post-stroke body, it is either not publicly funded, or only minimally so. In Jacob's case, his family cannot afford private physiotherapy so he relies on his wife to help him to and from the exercise room and onto the machines, as staff do not have time for this.

Since her mother's transition to GC, Jeanne comes every day to visit, even if the amount of time she spends there has decreased over time. She comes in the early evening to share dinner with her mother, Delia, in the family kitchen. She feels it is best for Delia to be away from the rush and hubbub of clanging dishes and loud voices in the main dining room, which she finds irritates and agitates her. Having cared for Delia at home for years, Jeanne is the expert in Delia's health and care. She helps staff by monitoring Delia's illness, managing her medications, and communicating any changes in health status to staff. After dinner, Jeanne sets out Delia's clothing for the following day. She started doing this after she found Delia unacceptably wearing four shirts, two pairs of pants, and multiple socks. She also likes to dress Delia up because she enjoys looking good. Before she helps Delia to bed at night, she takes her for an evening shower. To Jeanne, one allocated bath per week is insufficient. And because Delia always liked to have an evening shower, it has a settling effect on her. Now that Delia is at GC rather than being cared for at home 24/7, Jeanne feels her contribution to Delia's care is a win-win situation. Staff get additional time with other residents as they have one less person to care for in the evenings, and Jeanne gets mornings off and the evenings to spend time with her mother.

While some family members are involved out of their own volition and enjoy being a part of the care and community, others are there out of necessity, a sense of responsibility, or guilt. At both facilities, there are a handful of family members consistently present during meals times to help with feeding. Yet at MV there are more family, friends, and companions that help offset the

workload of care staff, compared to GC where more nurses, allied health staff, and managers step in to do this work. Previously mentioned, at GC, high needs residents may only be able access care if they have family to provide for their extra care needs. Similarly, Janet, a family member at MV, shares that her husband needs help to eat, but on the days she cannot make it into the facility, his food will sit there, getting cold, because the care staff do not have time to feed him right away. She also often has to step in to do her husband's personal hygiene work as staff are rushed and do it haphazardly. Joan similarly feels the need to come in almost every day to do simple things, like play music on the iPod or TV, so her brother can enjoy what he loves. While this contributes to his quality of life, staff do not have the time to do it. She feels he gets little stimulation in the facility, and that he is merely existing, and certainly not thriving. Her eyes well up as she looks at me. Conflicted, she asks "should I be doing more?" She pauses before she replies, a sad and bitter tone, "but, I don't want to do more. I just don't want him to be short-changed."

4.4   Implications of Institutional Strategies for Work and Care Conditions

In contrast to typical conceptions of neoliberalized restructuring as rigid and uniform, the case studies of GC and MV reveal that restructuring processes and outcomes are not only flexible and alterable, but are mediated by a constellation of strategies and contingent on the actors, motivations, and relationships involved. It is essential to account for the organizational culture and context in which care is organized and delivered (Foner, 1994; James, 1992). Undoubtedly, very different levels of care and quality of work, as well as distinct forms of privatization, emerge from the same public funding models and restructured residential care

system. At MV, this includes more explicit and severe forms of privatization that are meted out against workers at their expense. And at GC this includes individualized forms of privatization that are often actively enrolled and enacted by workers to fill the gaps in care. While unpaid labour is routinized and institutionalized into the organization of care in both facilities there are different logics and mechanism at work. Where unpaid overtime at MV more often ensures workers get through heavy workloads, at GC, it typically emerges as a function of organizational culture, and management and staff practices of going above and beyond to ensure quality care.

In the case of MV, the drive for profit-making skims and squeezes profit out of a meager set up. The adverse impacts of strategies of contracting out and cost-cutting, which manage and exploit restructured care settings, are borne by frontline workers, as well as residents and their family members, with major implications for quality of work and care. It is clear that whatever is gained in terms of short-term savings does not outweigh the damage done to staff morale and care relationships, and intensified labour-management conflict. Overwhelmingly, cuts to staffing levels and wage end up in overwork, unpaid overtime, and discontentment amongst workers. This then translates into work-related stress, exhaustion, burnout, and injury, and erodes the quality of care provision.

Going beyond simplistic, dichotomous accounts of good or bad employers, it is crucial to note that much of workers' work-related hardships stem from the additional pressures and lack of support from the corporate head office and facility management. Workers, for instance, feel they are treated as expendable and exploitable and that their hard work and efforts go unappreciated. They also feel that directives from the corporate head office come from a distance. They are disembedded from facility realities, staff capacities, and the embodied impacts on the ground. In this regard, management and corporate emerge as an additional layer of oppression on top of the

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threats and degradation associated with cutbacks and contracting out. Throughout the fieldwork, I was aware of poor relationships between workers and management, yet I was surprised at the extent to which it materialized when I analyzed the field notes and interview data. Clearly, workers' concerns need to be acknowledged and addressed, and the management can do far more to challenge or mitigate the demands of corporate head office, and advocate for the staff and residents. But it is also important to consider that the management, too, are in a difficult position. They are placed in the middle and subject to pressure from both the corporate head office and frontline staff. They are tasked with implementing practices and procedures that cut costs and ensure profits, and subsequently managing their consequences.

Crucially, care and support staff are the foundation and frontline of the long-term care system. When they are not supported or treated fairly, or their relational skills and knowledge disregarded, workplace operations falter and quality of care deteriorates, ironically undermining corporate profits. While management and corporate ignore deep-rooted issues and continue with business as usual, family and staff recognize that for a facility to run well, and to achieve high quality care, staff must be supported, workplace concerns addressed, and care relations based on cooperation rather than division and conflict. Staff that are treated well, in turn, treat residents well. As one allied health worker notes, "if the staff is not supported…or felt appreciated, there is going to be a schism somewhere between doing your job at the basic, and going the extra mile". This echoes Nancy Folbre and Julie Nelson's (2000) insight that positive relationships, intrinsic rewards, and fair compensation, either consolatory or monetary, not only foster high quality care, but also achieve workplace productivities. As noted, these contexts are at play in GC far more than at MV. This also aligns with Sharon Bolton's (2009) argument that the

demands, forms, and outcomes of emotional labour are distinct under the imperatives of capitalist accumulation, even under the common context of restructuring.

At GC, the emphasis on fundraising and voluntarism, practices of personal responsibility and charity, as well as going the extra mile constitute individualized forms of privatization that subsidize a deficit care system. These individualized forms of privatization are shaped by different logics, and have distinct processes and outcomes than forms of privatization that are premised on shifting public services to the private sector and under a for-profit model. While person-centred models of care can have the unintended effect of neglecting the needs of workers, GC works hard to respect and support the interests and concerns of all persons involved in care, particularly and distinctively for workers. While many of the strategies GC employs are promising, they are also complicated and fraught. There are both radical potentials as well as limits. While there is a genuine and expansive ethic and practice of care, many strategies oscillate between elements of choice and compulsion, empowerment and constraint. Strategies that strengthen caring commitments and communities make significant, tangible improvements to quality of care and work, and foster social relations of reciprocity and collective care. On the one hand, management and workers may identify with a caring commitment, and feel good going the extra mile to ensure higher quality care. On the other hand, given under-resourced settings and heavy workloads, extending oneself to provide adequate care or juggling additional tasks, even to help a co-worker out, can also be construed as additional demands that frustrate, exhaust, and expend workers' emotional, mental, and physical capacities.

Moreover, workplace practices and affects shape and reproduce particular worker identities in order to garner control, compliance, and care (Acker, 1990; Adkins & Lury, 1999; Ducey, 2010). Organizational culture and management practices that foster caring commitments

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and going above and beyond to fill the gaps in care, even with good intentions, may take for granted, capitalize on, invoke, and bolster inequitable gendered, racialized, and classed power dynamics that underpin care workforces and care worker subjectivities. Furthermore, bleak prospects in a restructured long-term care sector help position GC as a very good workplace. Rampant contracting out and widespread insecurity act as omnipresent threats that hamper complaints, discipline workers, and foster practices of self-surveillance and going above and beyond. Ultimately, such practices enable the facility to remain viable without cost-cutting and contracting out, and staff remain working in relatively secure conditions.

Compared to MV, workers' exhaustion and frustration does not stem from management and corporate but rather from systemic developments in long-term care, largely an increasingly challenging resident demographic combined with understaffing and under-resourcing. The glaring difference between management in both facilities, is that at GC they make the time and have the commitment to support, assist, and advocate for workers. Far more than I anticipated, positive workplace relations, an active and proactive management, and a well-integrated community of care emerged as crucial defenses to adverse restructuring processes and ensure higher quality care. Yet the future is uncertain. Reliance on fundraising endeavours as standard operating procedure, and individualized efforts to step up and subsidize deficit care settings are fragmented, insecure, and unsustainable strategies. There is no guarantee to the continuity of either in the wake of personnel, organizational, or political economic changes. In one case at GC, when a donor failed to provide the funds for the music therapy program, which they donated to annually over the last decade, management and staff were left scrambling to find money, and spent time they did not have pursuing additional fundraising. In another case, the current management and Board are committed to not contract out the work, but once they retire or leave

it is up to new management and staff to make bare bones budgets work or face the threat of contracting out. As one candid support worker asks May, "'this is my thirteenth care home [I worked in], I have been privatized everyone. Are we going to privatize if you're not here to control the budget?'" And May replies, "I can't guarantee that. I can only guarantee you that I can do what I can while I'm here with Susan."

Lastly, while the labour of companions, volunteers, and family members is vital to the provision of care, their involvement is uneven and uncertain even as it is heavily relied on. For instance, not all residents, particularly women and the most elderly and vulnerable, have the financial means to hire a private companion. Not all facilities are capacitated to engage and coordinate volunteers, and not all family members have the time or will to provide extra care. While the presence of family and friends contribute greatly to facility life, the vast majority of those regularly involved were, not shockingly, older women, many of whom are retired and without children to care for. Their disproportionate involvement reflects and reinscribes a patriarchal division of labour that relegates women as providers of care, comfort, and companionship. And their ability to "freely" provide this care is typically through their release from the capitalist realm of production. There are also a myriad of financial, emotional, and corporeal stresses and strains involved in individualized efforts of family and friends to fill gaps in care, particularly when there are few resources and supports available. For women who are employed or caring for a household or dependents, a double or triple duty of work and care emerges when responsibility for long-term care is shifted back to the familial sphere. As these women tend to be older they, too, may have their own health issues, or tend to another family members' health issues. Such contexts pose obstacles to be involved in care on one's own terms, and raise equity issues when involvement emerges through constraint or coercion. Forms and

costs of care provision that once were or should be integral to publicly funded long-term care are increasingly displaced to and provided by not only families, but also precariously situated volunteers and companions, again raising equity issues (Daly, Armstrong & Lowndes, 2015).

Overwhelming, the myriad of strategies employed in facilities and across the sector support and subsidize a deficit system, fill the gaps in care, and keep facilities afloat. While such strategies are crucial for working in and reworking restructured care settings, they give the false impression that things are running smoothly. More importantly, they may mask and fail to challenge the structural forces that underpin deficits, and thus depoliticize and diffuse pressure for much needed systemic transformation (Baines, 2016).

Chapter 5: Uncertain Futures, Different Futures

I have outlined how the state has devolved responsibility for care, and encouraged for-profit privatization and financialization at a cost and risk to workers, residents, and taxpayers (Chapter One). I then evaluated restructuring from the perspective of care work reorganization, labour process change, occupational health and safety, and workers' strategies of care and control (Chapter Two). In Chapter Three, I explore the differential ways restructuring touches down and is managed in a for-profit and non-profit facility. I look at the myriad of actors, motivations, and relations involved, and the material impacts on work and care.

What these chapters overwhelmingly reveal is that work terms and conditions have been greatly eroded over at least the last fifteen years so as to impair the ability of care workers to provide safe, responsive, and quality care. Workers narratives recount that work in the long-term care sector has shifted from being decently-paid and secure to poorly-paid and highly insecure. Experiencing the frontline effects, workers are disenchanted by, as well as passionately opposed to, government neglect over care provision. They feel the government "only cares about money", or "the bottom line", and that the hard work and relationships involved in care are neither recognized nor supported. They have moral concerns that good care cannot emerge from a for profit model, and believe that profit maximization has a dehumanizing effect. They note that it capitalizes on vulnerable peoples' care needs and labour market inequities. As Valeria sees it, "government allow[s] business companies to get rich and richer and we are getting poorer and poorer".

Workers who have experienced contracting out are highly politicized and know the oppressive forces that shape their work. Although Bill 29 and 94 were enacted over fifteen years

ago, they remain alive in peoples' memory and embodied experience. Workers locate blame squarely on the Liberal government for "destroying" health and social care work. An environment of widespread degradation and insecurity creates a sense of hopelessness and cynicism. There is a lot of fear and uncertainty about what the future holds. Even workers at GC are worried over what will happen to their jobs when the management and Board members change. But fear is particularly rife at MV because of a recent ownership change and the fact that workers' collective agreement expires soon. In the face of continual loss, they wait "in limbo" for the decisions of the corporate head office, and "go day by day". Yet because the sector is characterized by extensive contracting out, workers feel that they cannot change jobs to better their position. Moreover, a relatively good benefits package compels original staff at MV, in contrast to new staff, to remain in their jobs amidst deteriorating conditions.

Long-term care policy decisions, and the organization of care, are disembedded and disembodied from everyday realities of life and work in facilities. There is widespread sentiment among workers and some management that inadequate or harmful policies, which affect their work and care, are made by people who have no experience or involvement in long-term care. They feel that policy makers should consult with frontline workers, step into their job for a day, or visit facilities to witness the day-to-day operations and work conditions. There is a contradiction between restructuring and rationalization processes and the requirements of good work and care. As noted, the current organization of care does not account for the contingent, relational, social, and emotional nature of care. A key issue for workers is that inadequate staff levels and heavy workloads leave them no time for basic and safe care, let alone attentive and holistic care (Armstrong et al., 2009). Care practices, which entail trust, intimacy, and responsiveness are incompatible with market-oriented imperatives of efficiency, cost reduction,

and profit maximization (Rämö & Skålén, 2006). Care work cannot be subsumed to economic rationalization without severely compromising its quality, and leading to insecure, exploitative, and dehumanizing conditions of work and life (Cohen, 2011).

Overwhelmingly, state and capital's neglect of the basic requirements for quality care work results in care deficits that are borne by caregivers at the frontlines. At the same time that care workers face constraints and hardship in restructured care work, they are not totally subordinated to and undermined by them. Care workers instead find innovative ways to reassert relational and meaningful care, just as they find strategies to protect themselves and cope with work overload. Workers draw on gendered identities of care, deploy emotional labour, and embody and diffuse systemic pressures by going above and beyond, and filling gaps in care. Yet this work aligns with state and capital interests as it allows them to continue to renege their responsibility for care. As feminist scholars have argued, everyday practices of care and commitment have profound economic significance. They are vital to capitalist accumulation and enable the state to withdraw from ensuring the conditions for social reproduction (Dyer, McDowell, & Batnitzky, 2008; Katz, Marston & Mitchell, 2012; Nagar et al., 2002; Pratt, 2012).

Sue Ferguson and David McNally argue that the dynamics of contemporary capitalist accumulation are premised on the "continual pressure to deny the (costly) humanity of real people, to deny the 'excess' needs thrown up by socially embodied human life and to impose 'bare life' instead." (2011, 17). This insight can also be applied to contexts of state austerity. Restructuring relies on and expends care workers' bodily, emotional, and mental capacities and life forces to ensure care for others. It is crucially dependent on the unpaid labour of workers, as well as families and volunteers (Armstrong et al., 2009; Day, 2013; Seeley, 2012). It hinges on gendered, racialized, and classed inequities and has uneven outcomes. Workers are overworked,

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stretched thin, and wasted in the process. What workers earn is not even enough to meet their own social reproduction needs. They struggle financially, work two or more jobs, and have no time for themselves or their family. In the context of continuing cutbacks, poor wages, intensifying workloads, and adverse impacts to their health and wellness, many workers wonder what will happen to them as they age. They are concerned for their own future, and having to rely on bare publicly funded care. Reflecting the unsustainable conditions that impede new generations from entering or staying in long-term care work, one worn out care worker muses "who will care for us when we are old and our bodies are worn from this work?"

While there are different strategies employed in a for-profit and non-profit care facility, the literature (Armstrong, Armstrong & MacLeod, 2016; Stinson, Pollak & Cohen, 2005; Zuberi, 2011a, 2011b) shows that those that emerge from MV are prevalent in facilities with contracted out care and support services. The logic of private, for-profit operators is by definition profit maximization, even if it has particular and contingent manifestations and outcomes in different facilities. The involvement of financial firms, for instance, is an additional layer to privatization which will yield different results because of higher risk, higher return financial practices. It is also crucial to consider that these deficit care contexts and strategies emerge specifically from austere public funding as well as an ideological commitment to privatization. The impact of privatization may be cushioned in private pay settings, where residents simply pay more for better care. As well, in GC, the strategies employed are highly specific to its particular non-profit, charitable, and faith-based associations and management-driven objectives and aims. Furthermore, because public facilities have higher funding and staffing levels than contracted facilities, the impacts of restructuring may be cushioned and the institutional strategies to deal with them will be different. This illuminates how restructuring contributes to a two-tiered and

wildly inconsistent system where good care is only accessed by those with the money to buy it or those lucky enough to land in high-quality facilities. In this regard, further research could be done to tease apart the particular manifestations of restructuring in different care homes types, and how this contributes to an uneven and inequitable geography of care provision.

The state of work and care conditions illuminates the value and priority placed on long-term care. Resulting hardship and suffering are the result of deliberate policy decisions, even if this is obscured from the public imaginary. The crisis in care is created through a complex mix of devolution, austerity, privatization, and financialization. It results from for-profit imperatives and high return corporate and financial tactics that skim and squeeze money out of already deficit care operations (Burns et al., 2016). While there are calls to increase funding for long-term care, echoing Diana Burns and colleagues, and frontline workers in for-profit care, "the issue is not simply how much money goes into adult care but where the money goes" (Burns et al., 2016, 2). There are also calls by advocates that contracted out work should be brought back in-house to redress the adverse outcomes to work and care that result from contracting out. Yet this fails to consider how "in-house" subsidiary companies employ practices akin to subcontractors. Attention to the similarities and specificities of the mechanisms of, and work outcomes in subcontracted versus subsidiary companies would be a fruitful avenue for future research to explore. These insights are pertinent given the BC NDP this year committed $548 million in seniors' care but there is little government oversight in terms of facility operations and finances. In this regard, the extent and power of private, corporate, and financial actors, and their tactics, in seniors' residential care must be seriously questioned, problematized, and put an end to.

In the context of a highly insecure, degraded, demanding, and undervalued work, workers in long-term care point out that there are very few people entering this type of work and there is

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a high rate of turnover in most facilities. There are simply too few gains and too many costs associated with this work. Angel, a care worker at MV, claims that new workers come, but after they go through training and realize the heavy workload, they leave. A worker at GC speaks about her work in another facility in a contracted out department: "The workload keeps getting worse and worse, and so many people are quitting. They're always looking for staff because no one wants to work there." The predominance of casual and part-time positions, low pay, and heavy workload compels workers to look elsewhere for work.

Recruitment and retention issues are endemic in long-term care and create short staffing concerns in most facilities. The NDP's recent investment in care aide hours in B.C., requires 1,500 full-time equivalent care aide positions to be filled, which will rise to 2,849 in the next three years (BC Ministry of Health in BCCPA, 2018). In B.C., the seniors care sector is expected to be the fastest growing industry. Statistics Canada estimates there will be double the number of seniors over the age of 80 between 2011 and 2036, and WorkBC estimates 18,650 care aide positions will be created, three-quarters of which will be in seniors' care facilities, and home and community care (BCCPA, 2018). At the same time, care workers point out few people are willing to do this work. Given recruitment and retention issues, both MV and GC have been challenged to fill new positions and workers reveal they often continue to work short-staffed because there are not enough staff available to cover sick and vacation time, especially when most workers have two or three often casual jobs to juggle.

Even while care provision shifts to the home, there is and will always be a need for residential care, particularly as the population ages, because it offers a high level of support and care that cannot be found elsewhere. Yet necessary improvements to care, including fair wages and benefits, and supportive work conditions, cannot be made unless those in positions of power

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take real account and redress of the systemic issue in residential care. Improving the quality of care means paying attention to sectoral and workplace conditions. But this is often little considered. For instance, a recent report by the BC Care Providers Association, which represents over 300 non-government seniors' care organizations (both for-profit and non-profit), obfuscates the key forces at play in the retention and recruitment crisis and helps to maintain the status quo. There is no mention of sector-wide job and income insecurity, poor work conditions, and heavy workloads that stem from rampant privatization and deep austerity. Rather the blame for worker shortages is displaced, in one part, to "a lack of awareness of the quality job opportunities and rewarding careers that await future care workers" (BCCPA, 2018, 11). They outline how jobs in the seniors' care sector are secure, and the wages and benefits are competitive, but disregard how they deteriorate in contracted out work. They use early childhood educators to compare wages, yet they are one of the lowest paid care workers, earning an average of $16 an hour in B.C.

As we have seen, the current conceptualization and organization of residential care is unsustainable and unjust. Scholars of feminist care ethics point out that giving and receiving good care is vital to human and societal well-being, and must be supported. They ask what is needed to "maintain, continue, and repair our 'world' so that we can live in it as well as possible?" (Fisher & Tronto, 1990, 40). This entails new ways of thinking about how we can thrive in our everyday lives, individually and collectively. How can we revalue and enact care outside of capitalist profit-making imperatives, and economic and financial logics that privilege efficiency and cost-reduction? To counter conceptions of elder care as a burden or drain on the state and society (Lanoix, 2006), we must reconfigure capitalist social and economic relations that render this work, caregivers, and the elderly unproductive and undervalued. For this to

occur, there must be a cultural shift in how care is (re)valued, (re)thought, and (re)organized. For Joan Tronto (1998, 16),

> One of the central tasks for people interested in care is to change the overall public value associated with care. When our public values and priorities reflect the role
> that care actually plays in our lives, our world will be organized quite differently.

What has happened to our political and cultural imagination where care is conceptualized and provided in such narrow, impoverished terms, that such a low quality of life has become normalized and often condoned? How is it that residential care is deemed the last and worst option, or a "non-choice" (Armstrong et al., 2009)? How can we allow workers to be overworked into exhaustion, disability, early retirement, and without future security? How is it that one-third of care staff in Canada report they have no time to talk with residents (Armstrong et al., 2009)? Can we not think of more expansive, life-fostering models for care, where thriving trumps merely surviving? (Lanoix, 2006). How can we pay attention to the needs, desires, and aspirations of all persons involved in care? (Baines & Armstrong, 2018). Can an ethics and practice of care be premised on concern for reciprocal relationships, caring towards others, and a more even distribution of human vulnerability and precariousness? (Murphy, 2011). Can we remodel facilities as small-scale communities integrated into and integral to wider communities? Perhaps this could be a place where residents want to end their days, workers are supported and rewarded, and families and community members want to be involved. These are important questions given an aging population, and large and growing elder care sector. Elder care is not a marginal activity, even if it is typically treated as such. It occupies a prominent position in, and ensures the reproduction of, the economies of advanced capitalist countries.

The state of long-term care is not inevitable or natural. It is rather a political and policy choice, and can be challenged and changed. Frontline workers have the experience and expertise, and intimately know what is needed to improve the conditions of their work and care (Armstrong et al., 2009; Diamond, 1992). When workers are asked what they would like to see change in their work, their responses are not frivolous or unfair. Mainly, they want respect, recognition, support, job security, fair remuneration, and a manageable workload. For care workers, a key priority is more staffing to ensure safe, dignified, and quality work and care. Even one additional worker makes a difference. And extra pair of hands means more time to feed and toilet residents, and foster their independence in care provision (McGregor et al., 2005). Workers do not want to keep rushing through care. They want to spend time with residents and be able to attend to their individual needs. Workers' desires align with residents' perspectives on quality care, which emphasizes relationships, companionship, comfort, and support (Aronson & Neysmith, 1997).

Care workers highlight that care has implications not only for identity but also politics. As Katz, Marston and Mitchell (2012, 19) argue,

> If it is through these practices that capitalism and other relations of domination and exploitation, together with their mobile subjects, are produced, maintained, and remade, then they hold the possibility for altering, undermining, and undoing these relations—for making new subjects.

At MV, because of the hard work and persistent pressure of dedicated advocate staff, workplace gains have been made, however slight. They have been able to push back against management's breach of union seniority lists and unpaid attendance at educational workshops. Because of workers' incessant pleas to management to consider the laundry department's workload and increase staffing hours, management just announced that the laundry department will be under

review. One frontline worker has also been tasked to advise the recently hired support service manager about making necessary improvements.

To further challenge neoliberalized models of care, and reinvent new ones, care needs to be reconceptualized and reorganized as highly skilled, and socially and economically valued work. It must be moved from an individual or private to collective responsibility and practice. Silvia Federici calls for the politicization of elder care that "places [it] on the agenda of social justice movements" (2012, 236). In this regard, elder care is uniquely situated to resist restructuring and rationalization processes as it holds potential to build a wider, more inclusive platform to affect change. It can mobilize not only inter-workplace relations of support and resistance, but also connect to struggles and solidarities across other care facilities, care sector sites, and social reproductive arenas (Fraser, 2016). As conditions of work are conditions of care, effective resistance must bring together workers, residents and their families, as well as broader communities. As Kim England (2017) notes, domestic worker advocacy organizations draw on an ethics of care, highlighting personal connections and interdependence in broader relations of care, to make their campaigns visible and forge broader solidarities. In this sense, it is important to connect worker issues with caring issues in order to challenge the underlying forces that impede and erode quality conditions of work and care.

Inspiration can be gleaned from Bentham and colleagues (2013) *Manifesto for the Foundational Economy*. Their work seeks to recentre the economy around the local production of goods and services that support everyday life and wellbeing, such as health and social care, education, and food production. Yet they point out that while these sectors employ a massive proportion of the workforce (40% in the UK), and are growing, they are uniformly characterized by insecure, undervalued, low-wage work. The move to a foundational economy entails a shift

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away from dominant and decontextualized calculations of lowest costs and highest profits, which masks indirect and externalized costs, and overrides long-term and future benefits. For them, a rethinking and refocusing of the economic around tenets of social value, social obligation, and reciprocal social relations is crucial to ensure just, secure, and sustainable economies. These same principles, I believe, hold a critical place and expansive potential for regenerating a model for long-term care provision based on interdependency, responsiveness, respect, and equity.

Bibliography

Abassi, D. (2016, October 4). Seniors at Nanaimo facility face uncertain future as debate rages
over care model. *Nanaimo News Now.* Retrieved from:
http://nanaimonewsnow.com/article/511362/seniors-nanaimo-facility-face-uncertain-
future-debate-rages-over-care-model

Acker, J. (1990). Hierarchies, Jobs, Bodies: A Theory of Gendered Organizations. *Gender and
Society*, *4*(2), 139-158. doi:10.1177/089124390004002002

Adkins, L. & Lury, C. (1999). The labour of identity: Performing identities, performing
economies. *Economy and Society, 28*(4), 598-614. doi:10.1080/03085149900000020

Armstrong, P. & Armstrong, H. (2009). Precarious Employment in the Health-Care Sector. In
L. Vosko, M. MacDonald, & I. Campbell (Eds.), *Gender and the Contours of Precarious
Employment.* (pp. 256-70). New York: Routledge Press.

Armstrong, P., Armstrong, H. & Daly, T. (2012). The thin blue line: Long term care as an
indicator of equity in welfare states. *Canadian Women's Studies*, *29*(3), 49-60.

Armstrong, P., Armstrong, H., & MacLeod, K. K. (2016). The threats of privatization to
security in long-term residential care. *Ageing International, 41*(1), 99-116.
doi:10.1007/s12126-015-9228-0.

154

Armstrong, P., Armstrong, H. & Scott-Dixon, K. (2008). *Critical to Care: The Invisible Women in Health Services*. Toronto: University of Toronto Press.

Armstrong, P. & Banerjee, A. (2009). Challenging Questions: Designing Long-Term Residential Care with Women in Mind. In P. Armstrong, M. Boscoe & B. Clow (Eds.), *A Place to Call Home: Long Term Care in Canada*. (pp. 10-27). Winnipeg, MB: Fernwood Publishing.

Armstrong, P., Banerjee, A., Szebehely, M., Armstrong, H., Daly, T. & Lafrance, S. (2009). *They Deserve Better: The Long-term Care Experience in Canada and Scandanavia*. Ottawa, ON: Canadian Centre for Policy Alternatives.

Armstrong, P. & Braedley, S. (2013). Introduction, In Armstrong, P., & Braedley, S. (Eds.), *Troubling care: Critical perspectives on research and practices,* (pp. 9-14). Toronto: Canadian Scholars' Press Inc.

Armstrong, J. & Hume, M. (2004, April 29). Back-to-work legislation imposes 15% pay cut on health-care staff. *The Globe and Mail.* Retrieved from: https://www.theglobeandmail.com/news/national/back-to-work-legislation-imposes-15-pay-cut-on-health-care-staff/article18281516/

Aronson, J. & Neysmith, S. (1997). Retreat of the state and long-term care provision: Implications for frail elderly people, unpaid family carers and paid home care workers. *Studies in Political Economy, 53,* 37-77.

Baena, T. (2014, September 30). *Industry Trends – New Entrants to the Senior Living Market.* Vancouver, BC: British Columbia Seniors Living Association Conference Presentation. Retrieved from: http://www.bcsla.ca/wp-content/uploads/2014/01/Tony-Baena-Industry-Trends.pdf

Baines, D. (2004). Caring for nothing: Work organization and unwaged labour in social services. *Work, Employment & Society, 18*(2), 267-295. doi:10.1177/09500172004042770

Baines, D. (2006). Forum: Quantitative Indicators "whose needs are being served?" quantitative metrics and the reshaping of social services. *Studies in Political Economy*, *77*(1), 195–209. https://doi.org/10.1080/19187033.2006.11675118

Baines, D. (2015). Neoliberalism and the convergence of nonprofit care work in Canada. *Competition & Change, 19*(3), 194-209. doi:10.1177/1024529415580258

Baines, D. (2016). Moral projects and compromise resistance: resisting uncaring in nonprofit care work. *Studies in Political Economy*, *97*(2), 124–142. https://doi.org/10.1080/07078552.2016.1208793

Baines, D. & Armstrong, P. (2018). Promising Practices in Long Term Care: Can Work

    Organization Treat both Residents and Providers with Dignity and Respect? *Social Work*

    and Policy Studies: Social Justice, Practice and Theory, 1(1), 1-26.

Baines, D. & Broek, D. (2017). *Coercive Care: Control and Coercion in the Restructured Care*

    Workplace. British Journal of Social Work, 47, 125-142. doi:10.1093/bjsw/bcw013

Baines, D., Cunningham, I., & Fraser, H. (2011). Constrained by managerialism: Caring as

    participation in the voluntary social services. *Economic and Industrial Democracy*, *32*(2),

    329–352. https://doi.org/10.1177/0143831X10377808

Bakker, I. (2000). Restructuring Discourse and its Gendered Underpinnings: Towards a Macro-

    analytical Framework. In T. Cohn, S. McBride, & J. Wiseman (Eds.), *Power in the global*

    Era: Grounding globalization (pp. 24-38). New York; Ipswich: Palgrave Macmillan.

Bakker, I. (2007). Social Reproduction and the Constitution of a Gendered Political

    Economy, *New Political Economy*, *12*(4), 541-556. doi: 10.1080/13563460701661561.

Banerjee, A. (2009). Long-Term Care in Canada: An Overview. In P. Armstrong, M. Boscoe and

    B. Clow (Eds.), *A Place to Call Home: Long Term Care in Canada.* (pp. 29-56).

    Winnipeg, MB: Fernwood Publishing.

Banerjee, A., Armstrong, P., Daly, T., Armstrong, H. & Braedley, S. (2015).

"Careworkers don't have a voice:" Epistemological violence in residential care

for older people. *Journal of Aging Studies*, 33, 28-36. doi:10.1016/j.jaging.2015.02.005

Banerjee, A., Daly, T., Armstrong, P., Szebehely, M., Armstrong, H. & Lafrance, S. (2012).

Structural violence in long-term, residential care for older people: Comparing Canada and

Scandinavia. *Social Science & Medicine,* 74(3), 390-398.

BC Care Providers Association (BCCPA). (2016). *Part 1: Sustainability and Innovation:*

Exploring Options for Improving BC's Containing Care Sector. White Paper on Funding

and Innovation. Burnaby, BC. Retrieved from: http://bccare.ca/wp-

content/uploads/BCCPA_part_1_HR-May-2016-UD.pdf

BCCPA. (2018, June). *Situation Critical: A Made-In-BC Plan*

to Address the Seniors Care Labour Shortage. Burnaby, BC: BCCPA. Retrieved from:

http://bccare.ca/wp-content/uploads/2018/06/Situation-Critical-June-2018.pdf

BCGEU. (2018, February 02). Province's seniors are still not receiving minimum care hours.

BCGEU News. Retrieved from:

https://www.bcgeu.ca/province_s_seniors_are_still_not_receiving_minimum_care_hours

Bellringer, C. (March 2017). *Health Funding Explained 2*. Victoria, BC: Auditor General.

    Retrieved from:

    http://www.bcauditor.com/sites/default/files/publications/reports/FINAL_HFE2_2.pdf

Bentham, J., Bowman, A., de la Cuesta, M., Engelen, E., Erturk, I., Folkman, P.,…Williams, K.

    (2013, November). *Manifesto for a foundational economy.* Centre for Research on Socio-

    Cultural Change Working Paper No. 131. Manchester, UK. Retrieved from:

    http://hummedia.manchester.ac.uk/institutes/cresc/workingpapers/wp131.pdf

Bezanson, K. (2006). *Gender, the state, and social reproduction: Household insecurity in neo-*

    liberal times. Buffalo; Toronto: University of Toronto Press. doi:10.3138/j.ctt2tv3j4.

Bloomberg News. (2018, May 10). Anbang's former chairman Wu sentenced to 18 years in jail

    for $10-billion fraud. *Financial Post.* Retrieved from:

    http://business.financialpost.com/investing/anbangs-wu-sentenced-to-18-years-in-jail-for-

    10-billion-fraud

Bolton, S. (2009). Getting to the heart of the emotional labour process: a reply to Brook. *Work,*

    Employment & Society, *23*(3), 549-560. doi:10.1177/0950017009337069

Bolton, S. (2010). Old Ambiguities and New Developments: Exploring the Emotional

    Labour Process. In Thompson, P., and Smith, C. (Eds), *Working life: Renewing labour*

    process analysis. (pp. 205-218). New York; Houndmills, Basingstoke, Hampshire:

    Palgrave Macmillan.

Burawoy, M. (1998). The Extended Case Method, *Sociological Theory, 16* (1), 4-30.

Burns, D., Cowie, L., Earle, J., Folkman, P., Froud, J., Hyde, P.,…Williams, K. (2016). *Where*

    Does the Money Go? Financialised chains and the crisis in residential care. Manchester,

    UK: Centre for Research on Socio-Cultural Change Public Interest Report. Retrieved

    from:

    http://hummedia.manchester.ac.uk/institutes/cresc/research/WDTMG%20FINAL%20-

    01-3-2016.pdf

Butler, M. (2017, February 22). *Liberal approval of billion dollar sale of B.C. retirement-home*

    chain 'doesn't pass the smell test'. Ottawa, ON: The Council of Canadians. Retrieved

    from: https://secure.canadians.org/ea-

    action/action?ea.client.id=1899&ea.campaign.id=37815

Canadian Centre for Policy Alternatives. (2015, November). *Privatization Nation: The Canada-*

    wide Failure of Privatization, Outsourcing, and Public-Private Partnerships. Regina,

    SK: Canadian Centre for Policy Alternatives. Retrieved from:

    http://www.cupelocal2.com/pdf/privitization-nation.pdf

Chase, S. & Hunter, J. (2017, February 23). Chinese conglomerate Anbang defends takeover of

    B.C. retirement-home chain. *The Globe and Mail.* Retrieved from:

    https://www.theglobeandmail.com/news/politics/chinese-conglomerate-anbang-defends-

    takeover-of-bc-retirement-home-chain/article34126274/

Chatterjee, S. & Zhu, J. (2018, July 19). Exclusive: China's Anbang prepares to sell overseas

    properties worth $10 billion – sources. *Reuters Business News.* Retrieved from:

    https://www.reuters.com/article/us-anbang-group-divestment-property-excl/exclusive-

    chinas-anbang-prepares-to-sell-overseas-properties-worth-10-billion-sources-

    idUSKBN1K917X

Chiapello, E. (2015). Financialisation of valuation. *Human Studies, 38*(1), 13-35.

    doi:http://dx.doi.org/10.1007/s10746-014-9337-x

Church, S. (2018, March 5). Bankrupt HCR ManorCare to Give Ex-CEO $116.6 Million in

    Pay Deal. *Bloomberg News.* Retrieved from:

    https://www.bloomberg.com/news/articles/2018-03-05/bankrupt-hcr-manorcare-to-pay-

    ex-ceo-116-6-million-in-pay-deal

Cohen, M. (2001, October). *Do comparisons between hospital support workers and hospitality*

    workers make sense? Burnaby, BC: Hospital Employees' Union. Retrieved from:

    http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.558.6927&rep=rep1&type=pdf

Cohen, M. (2009). What matters to women working in long-term care: a union perspective. In P.

Armstrong, M. Boscoe and B. Clow (Eds.), *A Place to Call Home: Long Term Care in

Canada* (pp. 97-103). Winnipeg, MB: Fernwood Publishing.

Cohen, M. (2012, July). *Caring for BC's Aging Population Improving Health Care for All.*

Vancouver, BC: BC Health Coalition and Canadian Centre for Policy Alternatives BC

Office. Retrieved from:

https://www.policyalternatives.ca/sites/default/files/uploads/publications/BC%20Office/2

012/07/CCPABC-Caring-BC-Aging-Pop.pdf

Cohen, R. L. (2011). Time, Space and Touch at Work: Body Work and Labour Process

(Re)organization. In J. Twigg, C. Wolkowitz, R.L. Cohen and S. Netteton (Eds.), *Body

work in Health and Social Care: Critical Themes, New Agendas.* (pp. 19-35). Malden,

MA; Chichester, West Sussex, U.K: Wiley-Blackwell.

Cohen, M. & Cohen, M. (2006). Privatization: A strategy for Eliminating Pay Equity

in Health Care. In M. Luxton & K. Bezanson (Eds.), *Social reproduction: Feminist

political economy challenges neo-liberalism* (pp. 117-144). Montreal: McGill-Queen's

University Press.

Cohen, M., Murphy, J., Nutland, K. & Ostry, A. (2005). *Continuing care renewal or retreat?: BC residential and home health care restructuring 2001-2004*. Vancouver, BC: Canadian Centre for Policy Alternatives. Retrieved from: http://policyalternatives.ca/sites/default/files/uploads/publications/BC_Office_Pubs/bc_2005/continuing_care.pdf

Cohen, M., Tate, J. & Baumbush, J. (2009). *An uncertain future for seniors – BC's restructuring of home and community health care, 2001–2008.* Vancouver, BC: Canadian Centre for Policy Alternatives. Retrieved from: http://www.policyalternatives.ca/publications/reports/uncertain-future-seniors

Comondore V.R., Devereaux P.J., Zhou Q., Stone S.B., Busse J.W., Ravindran N.C.,….Guyatt, G. (2009). Quality of care in for-profit and not-for-profit nursing homes: systematic review and meta-analysis. *British Medical Journal (BMJ)*; 339(b2732). doi: 10.1136/bmj.b2732

Culbert, L. (2018, February 24). Staffing is so low in some B.C. care homes that seniors can't shower or go to the toilet when they want. *Vancouver Sun.* Retrieved from: https://vancouversun.com/health/seniors/staffing-is-so-low-in-some-b-c-care-homes-that-seniors-cant-shower-or-go-to-the-toilet-when-they-want

Daly, T., Armstrong, P., & Lowndes, R. (2015). Liminality in Ontario's long-term care

    facilities: Private companions' care work in the space 'betwixt and between.'

    Competition & Change, 19(3), pp 246–263.

Day, S. (2013). The Implications of Conceptualizing Care. In P. Armstrong & S. Braedley

    (Eds.), *Troubling care: Critical perspectives on research and practices* (pp. 21-31).

    Toronto, ON: Canadian Scholars' Press Inc.

Diamond, T. 1992. *Making Gray Gold: Narratives of Nursing Home Care*. University of

    Chicago Press, Chicago.

Dodson, L. & Zincavage, R. M. (2007). "It's like a family": Caring labor, exploitation, and racein

    nursing homes. *Gender and Society*, *21*(6), 905-928. doi:10.1177/0891243207309899

Ducey, A. (2010). Technologies of Affective Labor: From Objects to Affect. In E. Boris & R.S.

    Parreñas (Eds.), *Intimate Labors: Cultures, Technologies, and the Politics of Care* (pp.

    18-32). Redwood City, CA: Stanford University Press.

Duffy, M. (2005). Reproducing labor inequalities – challenges for feminists conceptualizing care

    at the intersections of gender, race, and class. *Gender and Society,* 19, 66–82.

Dyer, S., McDowell, L. & Batnitzky, A. (2008) Emotional Labour/Body Work: The Caring

    Labours of Migrants in the UK's National Health Service. *Geoforum,* 39, 2030–2038.

    doi:10.1016/j.geoforum.2008.08.005

Dyer, S., McDowell, L. & Batnitzky, A. (2010). The Impact of Migration on the Gendering of

    Service Work: The Case of a West London Hotel. *Gender, Work & Organization, 17*(6),

    635-657. doi:10.1111/j.1468-0432.2009.00480.x

Eckford, S. (2016, August 18). Trellis preparing to finalize land deal, file applications for

    Silverstone centre. *Coast Reporter*. Retrieved from:

    http://www.coastreporter.net/news/local-news/trellis-preparing-to-finalize-land-deal-file-

    applications-for-silverstone-centre-1.2325657

England, K. (2010). Home, work and the shifting geographies of care. *Ethics, Place &*

    Environment, 13(2), 131-150. doi:10.1080/13668791003778826

England, K. (2017). Home, domestic work and the state: The spatial politics of domestic

    workers' activism. *Critical Social Policy, 37*(3), 367-385.

    doi:10.1177/0261018317695688

England, K. and Dyck, I. (2011). Managing the Body Work of Home Care. *Sociology of Health*

    & Illness, 33(2), 206-219. doi:10.1111/j.1467-9566.2010.01331.x.

England, K. & Ward, K. (2007). Introduction: Reading Neoliberalization. In K. England & K. Ward (Eds.), *Neoliberalization: Networks, States, Peoples* (pp. 1-22). Blackwell, London.

Federici, S. (2004). *Caliban and the witch.* New York: Autonomedia.

Federici, S. (2012). On Elder Care. *The Commoner,* 15, 235-261. Retrieved from: http://www.commoner.org.uk/wp-content/uploads/2012/02/10-federici.pdf

Ferguson S. & McNally, D. (2011). *Precarious Migrants: Gender, race and the social reproduction of a global working class.* Retrieved from: http://davidmcnally.org/wp-content/uploads/2011/01/Ferguson_McNally.pdf

Fisher, B. and Tronto, J. (1990). Toward a Feminist Theory of Caring. In E. Abel & M. Nelson (Eds.), *Circles of care: Work and identity in women's lives* (pp. 36-54). Albany, N.Y: State University of New York Press.

Folbre, N. & Nelson, J.A. (2000). For love or money – or both? *Journal of Economic Perspectives,* 14, 123–140.

Foner, N. (1994). *The caregiving dilemma: Work in an American nursing home*. Berkeley: University of California Press.

Ford, G. (2011, July 11). How Blackstone made its £600m from Southern Cross. *Capital Ravings*. Retrieved from: http://capitalravings.blogspot.co.uk/2011/07/how-blackstone-made-its-600m-from.html.

Fraser, N. (1997). *Justice interruptus: Critical reflections on the "postsocialist" condition*. New York: Routledge.

Fraser, N. (2016). Contradictions of Capital and Care, *New Left Review*, 100, 99-117. Retrieved from: https://newleftreview.org/II/100/nancy-fraser-contradictions-of-capital-and-care.

French, S., Leyshon, A. & Wainwright, T. (2011). Financializing space, spacing financialization. *Progress in Human Geography, 35*(6), 798-819. http://dx.doi.org.ezproxy.library.ubc.ca/10.1177/0309132510396749

Garvey, S. (2016, September 30). Sunshine Coast residents angered by public-to-private long-term care switch. *CBC News*. Retrieved from: http://www.cbc.ca/news/canada/british-columbia/sechelt-privatizing-care-1.3786182

Gibson, P. (2016, May 24). Guardian: Government orders review of seniors' care staffing. *Health Employees Union News Blog*. Retrieved from: http://www.heu.org/news-media/news-blog/publications/government-orders-review-seniors-care-staffing.

Givetash, L. (2017, February 15). Chronic Care Home Understaffing Hurting BC's Seniors, Say

  Advocates. *The Tyee.* Retrieved from: https://thetyee.ca/News/2017/02/15/BC-Care-

  Home-Understaffing/

Green, M. & Lawson, V. (2011). Recentring care: interrogating the commodification of

  care. *Social & Cultural Geography, 12*(6), 639-654. doi: 10.1080/14649365.2011.601262

Griffin, K. (2017, October 3). Health care assistants experience highest number of workplace

  injuries in B.C. *Vancouver Sun.* Retrieved from: https://vancouversun.com/news/local-

  news/health-care-assistants-experience-highest-rate-of-workplace-injuries-in-b-c

Griffith, A. I. & Smith, D. E. (2014). *Under new public management: Institutional ethnographies*

  of changing front-line work. Toronto: University of Toronto Press.

  doi:10.3138/j.ctt7zwbzq

Hall, S. (2012). Geographies of money and finance II: Financialization and financial

  subjects. *Progress in Human Geography, 36*(3), 403-411.

  http://dx.doi.org.ezproxy.library.ubc.ca/10.1177/0309132511403889

Haraway, D. (1988). Situated Knowledges: The Science Question in Feminism and the Privilege

  of Partial Perspective. *Feminist Studies, 14*(3), 575-599. doi:10.2307/3178066

Harrington, C., Jacobsen, F., Panos, J., Pollock, A., Sutaria, S. & Szebehely, M. (2017).

    Marketization in Long-Term Care: A Cross-Country Comparison of Large For-Profit

    Nursing Home Chains. *Health Services Insights*, 10, 1–23.

Harrington, C., Olney, B., Carrillo, H. & Kang, T. (2012). Nurse staffing and deficiencies in the

    largest for-profit nursing home chains and chains owned by private equity companies.

    Health Services Research, 47, 106–28. doi: 10.1111/j.1475-6773.2011.01311.x

Harris, K. (2018, May 29). Liberals to buy Trans Mountain pipeline for \$4.5B to ensure

    expansion is built. *CBC News.* Retrieved from: https://www.cbc.ca/news/politics/liberals-

    trans-mountain-pipeline-kinder-morgan-1.4681911

Harvey, D (2010) *The Enigma of Capital.* London: Profile.

Hospital Employees' Union (HEU). (2018, March 2). Province urged to adopt action plan to

    protect care as Chinese government regulator takes control of Retirement Concepts. *HEU*

    Newsletter. Retrieved from: https://www.heu.org/news-

    media/newsletters/publications/province-urged-adopt-action-plan-protect-care-chinese-

    government-regulator-takes

HEU. (2017, May 3). Liberal candidate uses false facts to cover up impact of care home

    privatization in election ad. *HEU News Release.* Retrieved from:

    http://www.heu.org/news-media/news-releases/liberal-candidate-uses-false-facts-cover-

    impact-care-home-privatization

HEU. (2016a, April 4). Stop the sale of seniors' care in Nanaimo, says HEU.

    HEU News Release. Retrieved from: http://www.heu.org/news-media/news-releases/stop-

    sale-seniors-care-nanaimo-says-heu.

HEU. (2016b, June 3). Health authority's privatization of care puts jobs and

    services to seniors at risk. *Health Employees Union News Blog*. Retrieved from:

    http://www.heu.org/news-media/news-blog/publications/health-authority%E2%80%99s-

    privatization-care-puts-jobs-and-services-seniors-risk.

HEU. (2015, March 2). Layoff notices issued to nearly 1,200 Lower

    Mainland health care workers. *HEU News Release.* Retrieved from:

    http://www.heu.org/news-media/news-releases/layoff-notices-issued-nearly-1200-lower-

    mainland-health-care-workers.

HEU. (2013, October 4). Island and Lower Mainland health support workers deliver over 98 per

    cent strike mandate. *HEU News Release.* Retrieved from: https://www.heu.org/news-

    media/news-releases/island-and-lower-mainland-health-support-workers-deliver-over-98-

    cent

HEU. (2009). *Quality of Care in B.C.'s residential care facilities: A submission to the Office of the B.C. Ombudsman on Seniors' Care.* Burnaby, BC: HEU. Retrieved from: http://www.heu.org/sites/default/files/uploads/2010%20seniors/HEU%20submission%20 to%20Ombudsperson.pdf

HEU. (2008, February 22). HEU members approve Bill 29 settlement, *HEU News Release.* Retrieved from: https://www.heu.org/news-media/news-releases/heu-members-approve-bill-29-settlement

HEU. (2007, October 25). Victoria's failure to disclose documents serious roadblock in Bill 29 talks – HEU. *HEU News Release*. Retrieved from: http://www.heu.org/news-media/news-releases/victoria%E2%80%99s-failure-disclose-documents-serious-roadblock-bill-29-talks-%E2%80%93-heu

Horton, A. (2017). *Financialisation of Care: Investment and organising in the UK and US* (Doctoral dissertation). Queen Mary, University of London, London, UK. Retrieved from: http://qmro.qmul.ac.uk/xmlui/handle/123456789/31797

Huang, T. M. & Li, C. (2012). In G. Pratt & V. Rosner (Eds.), *The global and the intimate: Feminism in our time* (pp. 211-231). New York: Columbia University Press.

Huang, S., Yeoh, B. S. A., & Toyota, M. (2012). Caring for the Elderly: The Embodied Labour of Migrant Care Workers in Singapore. *Global Networks, 12*(2), 195-215. doi:10.1111/j.1471-0374.2012.00347.x

Hunter, J. (2018, March 13). B.C. reviewing sale of retirement home operator to Anbang Insurance. *The Globe and Mail.* Retrieved from: https://www.theglobeandmail.com/canada/british-columbia/article-bc-reviewing-sale-of-retirement-home-operator-to-anbang-insurance/

James, N. (1992). Care = organisation + physical labour + emotional labour. *Sociology of Health and Illness, 14*(4), 488-509. doi:10.1111/1467-9566.ep10493127.

Jervis, L. L. (2001). The Pollution of Incontinence and the Dirty Work of Caregiving in a U.S. Nursing Home. *Medical Anthropology Quarterly,* 15(1), 84-99. doi:10.1525/maq.2001.15.1.84

Kary, M. (2017). *Strengthening Seniors Care: Supporting Paper.* Burnaby, BC: BCCPA. Retrieved from: https://cnpea.ca/images/bccpa_roadmap_full_jan2017.pdf

Katz, C. (2001). Vagabond capitalism and the necessity of social reproduction. *Antipode, 33,* 709-28.

Katz, C., Marston, S. & Mitchell, K. (2012). Life's Work: An Introduction, Review and Critique. In K. Mitchell, C. Katz & S. Marston (Eds.), *Life's work: Geographies of social reproduction* (pp. 1-26). Hoboken: Wiley-Blackwell.

Keefe, J. & Fancey, P. (2000). The care continues: responsibility for elderly relatives before and after admission to a long term care facility, *Family Relations, 49*(3), 235–244.

Kofman, E. & Raghuram, P. (2015). *Gendered migrations and global social reproduction.* Houndmills, Basingstoke, Hampshire; New York, NY: Palgrave Macmillan.

Korstrom, G. (2016, April 3) Major acquisitions drive consolidation in fragmented seniors' care sector. *Business in Vancouver*. Retrieved from: https://www.biv.com/article/2016/4/major-acquisitions-drive-consolidation-fragmented-/

Langley P. (2008). *The Everyday Life of Global Finance: Saving and Borrowing in Anglo-America*. Oxford: Oxford University Press.

Lanoix, M. (2006). The Problem with High Maintenance Bodies. In A. Beaulieu & D. Gabbard (Eds.), *Michel Foucault and Power Today* (pp. 93-106), Lanham, Maryland: Lexington Books.

Lanoix, M. (2010). Triangulating care. *International Journal of Feminist Approaches to Bioethics, 3*(1), 138-157

Lanoix, M. (2011). Assembly-line care: Ancillary care work in post-Fordist economies, *Work*, 40, 41–50 DOI 10.3233/WOR-2011-1205

Lanoix, M. (2013). Caring for money: Communicative and strategic action in ancillary care. *International Journal of Feminist Approaches to Bioethics, 6*(2), 94-117. doi:10.2979/intjfemappbio.6.2.94

Laslett, B. & Brenner, J. (1989). Gender and social reproduction: Historical perspectives. *Annual Review of Sociology, 15*(1), 381-404. doi:10.1146/annurev.so.15.080189.002121

Lawton, J. (1998). Contemporary Hospice care: The Sequestration of the Unbounded Body and 'Dirty Dying'. *Sociology of Health and Illness, 20*(2), 121-143. doi:10.1111/1467-9566.00094

Laxer, K., Jacobsen, F. F., Lloyd, L., Goldmann, M., Day, S., Choiniere, J. A. & Rosenau, P. V. (2016). Comparing Nursing Home Assistive Personnel in Five Countries. *Ageing International*, *41*(1), 62–78. https://doi.org/10.1007/s12126-015-9226-2

Lazaruk, S. (2017, March 30). Vancouver retirement-home residents facing eviction receive reprieve. *The Vancouver Sun.* Retrieved from: http://vancouversun.com/business/local-business/vancouver-retirement-home-residents-facing-eviction-receive-reprieve

Lee, M. (2015, October 30). *Spotlight on health care austerity: seniors' residential care.*

    Vancouver, BC: Canadian Centre for Policy Alternatives BC Office. Retrieved from:

    http://www.policynote.ca/spotlight-on-health-care-austerity-seniors-residential-care/.

Lerner, M. (2017, September 21). Health Care REITs Thrive as Americans Age. *REIT Magazine.*

    Retrieved from: https://www.reit.com/news/reit-magazine/september-october-

    2017/health-care-reits-thrive-americans-age

Link, B. (2018, March 29). Kinder Morgan Through the Eyes of the Tyee. *The Tyee.* Retrieved

    from: https://thetyee.ca/Analysis/2018/05/29/Kinder-Morgan-Eyes-Tyee/

Longhurst, A. (2017, March). *Privatization and Declining Access to BC Seniors' Care: An*

    Urgent Call for Policy Change. Vancouver, BC: Canadian Centre for Policy Alternatives

    BC Office. Retrieved from:

    https://www.policyalternatives.ca/sites/default/files/uploads/publications/BC%20Office/2

    017/03/access_to_seniors_care_report_170327%20FINAL.pdf

Lopez, S. H. (2007). Efficiency and the fix revisited: Informal relations and mock routinization

    in a nonprofit nursing home. *Qualitative Sociology, 30*(3), 225-247. doi:10.1007/s11133-

    007-9062-0

Lowndes, R., Armstrong, P. & Daly, T. (2015). The Meaning of "Dining": The Social

  Organization of Food in Long-term Care. *Food Studies Interdisciplinary Journal, 4*(1),

  19-34. doi:10.1177/0733464815574094

Luxton, M. and Bezanson, K. (2006). Introduction: Social Reproduction and Feminist Political

  Economy. In M. Luxton and K. Bezanson (Eds.), *Social reproduction: Feminist political*

  economy challenges neo-liberalism (pp. 3-10). Montreal: McGill-Queen's University

  Press.

McDowell, L. (2001). Father and ford revisited: Gender, class and employment change in the

  new millennium. *Transactions of the Institute of British Geographers, 26*(4), 448-464.

  doi:10.1111/1475-5661.00034

McDowell, L. (2009). *Working Bodies: Interactive Service Employment and Workplace*

  Identities. London: Wiley-Blackwell.

McDowell, L. (2015). The lives of others: body work, the production of difference, and labor

  geographies. *Economic Geography, 91*(1), 1-23.

McDowell, L., Batnitzky, A. & Dyer, S. (2007). Division, segmentation, and interpellation: The

  embodied labors of migrant workers in a greater london hotel. *Economic*

  Geography, 83(1), 1-25. doi:10.1111/j.1944-8287.2007.tb00331.x

McGregor, M. J., Baumbusch, J., Abu-Laban, R. B., McGrail, K. M., Andrusiek, D.,…Ronald, L. (2011). A Survey of Nursing Home Organizational Characteristics Associated with Potentially Avoidable Hospital Transfers and Care Quality in One Large British Columbia Health Region. *Canadian Journal on Aging*, *30*(4), 551–561. https://doi.org/http://dx.doi.org.ezproxy.library.ubc.ca/10.1017/S071498081100047X

McGregor, M. J., Cohen, M., McGrail, K., Broemeling, A. M., Adler, R. N., Schulzer, M.,… Beck, M. (2005). Staffing levels in not-for-profit and for-profit long-term care facilities: does type of ownership matter? *CMAJ: Canadian Medical Association Journal, 172*(5), 645–649. https://doi.org/10.1503/cmaj.1040131

McGregor, M. and Ronald, L. (2017, February 22). Don't let seniors' care become a private equity money maker. *The Star.* Retrieved from: https://www.thestar.com/opinion/commentary/2017/02/22/dont-let-seniors-care-become-a-private-equity-money-maker.html

McGregor, M. J., Tate, R. B., McGrail, K. M., Ronald, L. A., Broemeling, A.-M. & Cohen, M. (2006). Care Outcomes in Long-Term Care Facilities in British Columbia, Canada: Does Ownership Matter? *Medical Care, 44*(10), 929-935

McGregor, M. J., Tate, R. B., Ronald, L. A., McGrail, K. M., Cox, M. B., Berta, W. & Broemeling, A.-M. (2010). Trends in long-term care staffing by facility ownership in British Columbia, 1996 to 2006. *Health Reports*, *21*(4), 27–33.

McMorran, C. (2012). Practising workplace geographies: Embodied labour as method in human geography. *Area, 44*(4), 489-495. doi:10.1111/j.1475-4762.2012.01101.x.

Meehan, K. & Strauss, K. (2015). Introduction: New Frontiers in Life's Work. In K. Meehan & K. Strauss (Eds.), *Precarious Worlds: Contested Geographies of Social Reproduction* (pp. 1-24). Athens, GA: University of Georgia Press.

Murphy, A. (2011). Corporeal vulnerability and the new humanism. *Hypatia, 26*(3), 575-590. doi:10.1111/j.1527-2001.2011.01202.x

Nagar, R., Lawson, V., McDowell, L. & Hanson, S. (2002). Locating globalization: Feminist (re)readings of the subjects and spaces of globalization. *Economic Geography, 78*(3), 257-284. doi:10.1111/j.1944-8287.2002.tb00187.x

O'Brien, F. (2016, March 28). Pearson Dogwood development deal set to transform Vancouver's Cambie Corridor. *Vancouver Courier.* Retrieved from: https://www.vancourier.com/news/pearson-dogwood-development-deal-set-to-transform-vancouver-s-cambie-corridor-1.2218370

O'Connor, N. (2015, February 19). Onni buys Pearson-Dogwood lands. *Vancouver Courier.* http://www.vancourier.com/news/onni-buys-pearson-dogwood-lands-1.1768988

Office of the Seniors Advocate (OSA). (2015, April). *Placement, Drugs and Therapy…We Can Do Better.* Victoria, BC: Office of the Seniors Advocate. Retrieved from:

https://www.seniorsadvocatebc.ca/app/uploads/sites/4/2015/09/PlacementReport.pdf

OSA. (2017a). *British Columbia Residential Care Facilities Quick Facts Directory.* Victoria, BC: Office of the Seniors Advocate. Retrieved from:

https://www.seniorsadvocatebc.ca/app/uploads/sites/4/2017/01/Residential-Care-Quick-Facts-Directory-2017.pdf

OSA. (2017b). *Monitoring Seniors' Services 2017.* Victoria, BC: Office of the Seniors Advocate. Retrieved from:

http://www.seniorsadvocatebc.ca/app/uploads/sites/4/2017/12/MonitoringReport2017.pdf

OSA. (2018). *British Columbia Residential Care Facilities Quick Facts Directory Summary*. Victoria, BC: Office of the Seniors Advocate. Retrieved from:

http://www.seniorsadvocatebc.ca/app/uploads/sites/4/2018/01/QuickFacts2018-Summary.pdf

Peck, J. (2001). Neoliberalizing states: Thin policies/hard outcomes. *Progress in Human Geography, 25*(3), 445-455. doi:10.1191/030913201680191772

Persinos, J. (2016, March 22). 7 High-Yielding Health Care REITs as Safe Havens in a Terror-

    Stricken Market. *The Street.* Retrieved from:

    https://www.thestreet.com/story/13503839/1/7-high-yielding-health-care-reits-as-safe-

    havens-in-a-terror-stricken-market.html

Pink, S. (2012). Re-Sensing Participatory Observation: Sensory Emplaced Learning. In S. Pink

    (Ed.), *Doing Sensory Ethnography* (pp. 63- 80)*,* London; Thousand Oaks, CA: Sage

    Publications.

Plecas, D. (2017, March). *Residential Care Staffing Review.* Victoria, BC: Ministry of Health.

    Retrieved from: http://www.health.gov.bc.ca/library/publications/year/2017/residential-

    care-staffing-review.pdf

Plimmer, G. (2016, April 27). Four Seasons in crisis talks as earnings slide 39%. *Financial*

    Times. Retrieved from: https://www.ft.com/content/bfbfaff4-0c5b-11e6-b0f1-

    61f222853ff3

Pollard, J. (2012). Gendering capital: Financial crisis, financialization and (an agenda for)

    economic geography. *Progress in Human Geography*, *37*(3), 403–423. doi:

    10.1177/0309132512462270

Pratt, G. (2003). Valuing Childcare: Troubles in Suburbia. *Antipode,* 35, 581-602.

    doi:10.1111/1467-8330.00340

Pratt, G. (2004). *Working feminism.* Edinburgh: Edinburgh University Press.

Pratt, G. (2012). *Families apart: Migrant mothers and the conflicts of labor and love.*
Minneapolis: University of Minnesota Press. doi:10.5749/j.ctttt5jj

Pratt, G. & Rosner, V. (2012). Introduction: The Global and the Intimate. In G. Pratt & V.
Rosner (Eds.), *The Global and the Intimate: Feminism in Our Time* (pp. 1-27). New
York, NY: Columbia University Press.

PwC & the Urban Land Institute. (2018). *Emerging Trends in Real Estate: United States and
Canada 2018.* PricewaterhouseCoopers. Washington, D.C.: PwC and the Urban Land
Institute. Retrieved from: https://www.pwc.com/us/en/asset-management/real-
estate/assets/pwc-emerging-trends-in-real-estate-2018.pdf

Rämö, H., and Skålén, P. (2006). Time and space in new public management reform: The case
of geriatric care. *International Journal of Public Sector Management, 19*(5), 513-525.
doi:10.1108/09513550610677807.

Revera Key Facts. (n.d.). Mississauga, ON: *Revera Inc*. Retrieved from:
ttps://www.reveraliving.com/about-revera/about-us/docs/revera-fact-sheet

Roberts, A. (2013). Financing Social Reproduction: The Gendered Relations of Debt and

    Mortgage Finance in Twenty-first-century America, *New Political Economy, 18*(1), 21-

    42, doi: 10.1080/13563467.2012.662951

Ronald, L. A., McGregor, M. J., Harrington, C., Pollock, A. & Lexchin, J. (2016). Observational

    evidence of for-profit delivery and inferior nursing home care: When is there enough

    evidence for policy change? *PLoS Medicine, 13*(4), e1001995.

    doi:10.1371/journal.pmed.1001995

Rose, G. (1997) Situating knowledges: positionality, reflexivities and other tactics, *Progress in*

    Human Geography, 21, 305-20.

SafeCare BC (2017). *Violence Prevention.* Burnaby, BC: SafeCare BC. Retrieved from:

    http://safecarebc.ca/initiatives/violenceprevention/

Salzinger, L. (2003). *Genders in production: Making workers in Mexico's global factories.*

    Berkeley: University of California Press.

Sandborn, T. (2007, October 12). Big Senior Home Chain Has Thick File of Complaints. *The*

    Tyee. Retrieved from: https://thetyee.ca/News/2007/10/12/BeaconHillVilla/

Seeley, M. (2012). Women, Aging, and Residential Long-term Care. In P. Armstrong,

      B. Clow, K. Grant, M. Haworth-Brockman, B. Jackson, A. Pederson and M. Seeley

      (Eds.), *Thinking Women and Health Care Reform in Canada* (pp. 107-127). Toronto:

      Women's Press.

Shapiro, E. & Seeley, M. (2009). Less Money, More People: Implications of Policy

      Changes in Long-Term Care. In P. Armstrong, M. Boscoe, & B. Clow (Eds.), *A Place to*

      Call Home: Long Term Care in Canada. (pp. 58-65). Winnipeg, MB: Fernwood

      Publishing.

Shore, R. (2016, September 17). Sechelt community angered by plan to replace local care homes

      with bigger, privately run facility. *Vancouver Sun.* Retrieved from:

      http://vancouversun.com/news/local-news/sechelt-community-angered-by-plan-to-

      replace-local-care-homes-with-bigger-privately-run-facility

Silversides, A. (2011). *Long-Term Care in Canada: Status Quo No Option.*

      Ottawa, ON: Canadian Federation of Nurses Unions. Retrieved from:

      https://nursesunions.ca/report-study/long-term-care-in-canada-status-quo-no-option.

Sinclair, S. & Trew, S. (2017, February 27). Trade Deal Ups Risks in Chinese Firm's Takeover

      of Seniors' Care Giant: FIPA means province could be blocked from improving care

      standards for residents. *The Tyee.* Retrieved from:

      https://thetyee.ca/Opinion/2017/02/27/Chinese-Firm-Takeover-Seniors-Care-Giant/

Smith, D. E. (2005). *Institutional ethnography: A sociology for people*. Lanham, MD: AltaMira Press.

Sodexo. (2017). *Fiscal 2017 Registration Document*. Retrieved from: http://www.sodexo.com/files/live/sites/sdxcom-global/files/PDF/Finance/Sodexo-Registration-Document-FY17.pdf

Stinson, J., Pollak, N. & Cohen, M. (2005). The Pains of Privatization: How Contracting Out Hurts Health Support Workers, Their Families, and Health Care. Vancouver, BC: Canadian Centre for Policy Alternatives. Retrieved from: https://www.policyalternatives.ca/publications/reports/pains-privatization

Strauss, K. (2015). Social reproduction and migrant domestic labour in Canada and the UK: Towards a multi-dimensional concept of subordination, In C. G. Lewis, H. Skrivankova, K. and L. Waite (Eds.), *Vulnerability, exploitation and migrants: Insecure work in a globalised economy* (pp. 59-71). London: Palgrave.

Stueck, W. (2017, March 27). Critics raise concerns over privatization of B.C. seniors' care. *The Globe and Mail*. Retrieved from: https://www.theglobeandmail.com/news/british-columbia/critics-raise-concerns-over-privatization-of-bc-seniors-care/article34441520/

SunLife Financial. (2017). *Long Term Care in British Columbia.* Retrieved from:

    https://www.sunnet.sunlife.com/files/advisor/english/PDF/Completereport-LTC-Costs-

    BC.pdf

Tronto, J. C. (1998). An ethic of care. *Generations, 22*(3), 15-20.

Twigg, J. (2000). Carework as a Form of Bodywork. *Ageing and Society, 20*(4), 389-411.

    doi:10.1017/S0144686X99007801.

Twigg, J., Wolkowitz, C., Cohen, R.L. & Netteton., S. (2011). Conceptualising Body Work in

    Health and Social Care. *Sociology of Health and Illness, 33*(2), 171-188.

    doi:10.1111/j.1467-9566.2010.01323.x

Vancouver Coastal Health. (2017, July). *Residential Care Rejuvenation*. Vancouver Coastal

    Health: About Us. Vancouver, BC: Vancouver Coastal Health. Retrieved from:

    http://www.vch.ca/about-us/development-projects/residential-care-rejuvenation

Wells, J. (2017, Feb. 25), Anbang's B.C. acquisition raises questions about Ottawa's approach to

    foreign takeovers: Wells. *The Star.* Retrieved from:

    https://www.thestar.com/business/2017/02/25/anbangs-bc-acquisition-raises-questions-

    about-ottawas-approach-to-foreign-takeovers-wells.html

Welltower. (2016, November). *The Aging Population: Driving Health Care Real Estate*
    Investments. Welltower Corporate Presentation. Toledo, Ohio: Welltower. Retrieved
    from: http://www.welltower.com/wp-
    content/uploads/2016/11/3Q16_Corporate_Presentation_v2_11-02-16.pdf

Willcocks, P. (2018, February 26). How the Chinese Government Took Control of BC Seniors
    Homes. *The Tyee.* Retrieved from: https://thetyee.ca/Opinion/2018/02/26/Chinese-
    Government-Control-BC-Senior-Homes/

Wolf, D. (1996). Situating Feminist Dilemmas in Fieldwork, in D. Wolf (Ed), *Feminist*
    Dilemmas in Fieldwork (pp. 1-55)*.* Boulder: Westview Press.

Wolkowitz, C. (2006). *Bodies at Work*. Thousand Oaks, Calif; London, England: Sage.

Wolkowitz, C. & Warhurst, C. (2010). Embodying Labour. In Thompson, P., & Smith,
    C. (Eds), *Working Life: Renewing Labour Process Analysis* (pp. 223-239). New York;
    Houndmills, Basingstoke, Hampshire: Palgrave Macmillan.

Wright, M. (2006). *Disposable women and other myths of global capitalism.* New York:
    Routledge.

Yates, M. (2011). The Human-As-Waste, the labor theory of value and disposability in

contemporary capitalism. *Antipode, 43*(5), 1679-1695. doi:10.1111/j.1467-
8330.2011.00900.x

Zuberi, D. (2011a). Contracting out hospital support jobs: The effects of poverty wages,
excessive workload, and job insecurity on work and family life. *American Behavioral
Scientist, 55*(7), 920-940. 10.1177/0002764211407835

Zuberi, D. (2011b). The Deleterious consequences of Privatization and Outsourcing for Hospital
Support Work: The Experiences of Contracted-Out Hospital Cleaners and Dietary Aids in
Vancouver, Canada. *Social Science & Medicine,* 72, 907-911.
doi:10.1016/j.socscimed.2010.12.024

Appendices

Appendix A Interview Schedule for Frontline Staff

1. How long have you worked at [X] for?
2. What brought you to this work and what has kept you here long-term?
3. Tell me about your work. What do your work tasks and workload look like on a typical day?
   a. What have been some key changes in your work and workload since you started?
   b. What are the staffing levels like? Is it enough to provide good quality care?
   c. Have staff positions, hours, wages been reduced at all?
4. What are some key challenges you face in your work?
   a. Are you able to provide the quality of care you want to? How do you feel about this?
   b. Do you have enough time to get your work done? Is working unpaid overtime common in your work?
5. Is your work physically or emotionally demanding?
6. Have you experienced health issues, injury, or violence related to your work?
7. Does your work impact your home life?
8. Do you feel you have control over, or can give input into the way care is provided?
9. Do you feel supported and respected in your work?
10. If an issue comes up is it heard and addressed?
11. What is needed to ensure high quality work and care?
12. If there was one thing you wish you had more time to do what would it be?
13. Is there anything else you would like to mention that I did not ask?

Appendix B Interview Schedule for Managers

1) Tell me about your position. What does your work look like on a typical day?
2) What is the model of care followed here?
3) How does the organization develop goals and make decisions over its activities and provision of care?
4) What is different about this facility than most? What is it that works so well here?
5) Have there been any major changes at [X] since you started here?
6) What are the key challenges the facility faces?
   a. Is the current level of funding and staffing enough to provide quality care?
   b. How do you manage the funding shortfall?
7) Have you had to implement any cost-saving measures? What are these? How has this impacted care?
8) What is needed to ensure high quality work and care?
9) Do you have any thoughts about the future of long-term care?
10) Is there anything else you would like to mention that I did not ask?

Appendix C Interview Schedule for Family Members

1) What was caring for [X] like before you came to [X]?
   a. What were some of the key factors that determined the move here?
2) How often do you come to the facility to visit? What does your typical visit look like?
3) Did you face any barriers to accessing care?
4) What was the transition into the facility like?
   a. Is [X] now settled? Are you happy with the outcome here?
5) How involved are you in [X] care? In what ways?
6) Do you feel welcome and included here? Are you involved in any activities in the home?
7) Do you pay out of pocket for any additional services?
8) Have you had any issues here? Have they been addressed?
9) What does good quality care look like to you?
   a. Are there any changes you would like to see made?