Structural Violence in Long-Term Residential Care

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Drawing on survey responses from 948 personal support workers providing care in long-term residential facilities in three Canadian provinces, and from 1574 responses to a comparable survey in four Nordic European countries, we document the levels of violence found particularly in Canada. Almost half of the Canadian workers, about 95% of whom are women, experience violence on a daily or almost daily basis. This is over six times the rate experienced among similar workers in the Nordic countries. Canadian participants reported constant and ongoing physical, verbal and sexual violence. These workers are usually expected to tolerate this abuse as part of the job. Moreover, as is often the case with women’s working conditions, it is under-reported, invisible and seldom addressed. The comparison with Nordic Europe demonstrates that the violence is not inevitable. We discuss several of its sources, and avenues of recourse identified through gender-based analysis of the Canadian and Nordic data and follow-up interviews. Insufficient staffing levels constitute a primary cause that prevents over-burdened workers from providing adequate care.

Health care work is dangerous. Our quantitative and qualitative findings indicate the extent and impacts of rising illness and injury rates, as well as violence, experienced by direct care workers in long-term residential care homes in Canada and Nordic Europe. We argue the need to see beyond individual workplaces and workers in order to better

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understand and reduce these dangers, framing the problem as structural violence.

Our analysis was prompted by a discussion of incontinence pads, or what are more commonly called adult diapers, that emerged in a group interview. In response to our question on tasks left undone, the following exchange took place. We report it here in full because this discussion was so central to our analysis.

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

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

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

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

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

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

We have to steal them. [laughter]

Seriously. You want to take care of your residents properly. If they’re wet, you want to change them. If I’ve got a baby sitting in front of me, that baby I feel dampness, we’re likely to change them. With our elderly we say: at 75 per cent, we change them.
It's absolutely true what they're saying 'cause we have the same... There's not the nursing staff to toilet every hour like they want and what they need. We do the best we can do in the time that we're given...and the products that we're given to do it with.

It's not that we feel good about it either. (Armstrong et al., 2009:102).

This discussion of diapers prompted us to ask to what extent can the very high illness and injury rates in health care be understood as the inevitable result of care work and to what extent can they be understood as indicators of structural violence? The term structural violence is most commonly attributed to Johan Galtung (1964; 1969), who used the term to talk about the systemic ways that institutions and structures serve to prevent people from reaching their potential or from fulfilling their basic needs. More recently, Wilkinson and Pickett (2010: 134-37) used the term to label the positive connection between inequality and violent crime rates. We use it here to think about the ways developments at the global, national, regional and local scales are preventing care workers from providing the kind of care they see as necessary and as part of their job.

Methods

This paper draws on primary data collected for a study comparing working conditions in Canadian and Scandinavian long-term care facilities. The study involved qualitative and quantitative methods.

The quantitative data come from a 2006 survey of workers in unionized long-term care workplaces in three Canadian provinces and four Nordic countries. The questionnaire used in all countries was basically the same but the methods of distribution differed.

In the Canadian survey, the Institute for Social Research (ISR) at York University was responsible for the sample design and distribution. The sample was based at the level of the organization, and designed to be proportional by provincial population and by nursing home

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2 For ease of reference, in this article we refer to Nordic countries in lieu of listing each time the four countries (Denmark, Finland, Norway and Sweden) that were included. Similarly, we refer to Canada and Canadians, rather than listing the three provinces of Manitoba, Nova Scotia and Ontario. Further, when interpreting our findings, one should bear in mind that in the Canadian context surveys were sent to unionized facilities only and in Nordic Europe to unionized workers. These results are therefore not representative of non-unionized facilities or non-unionized workers, but the vast majority are unionized in all the jurisdictions under consideration. Further discussion of the survey findings can be found in “They Deserve Better” The Long-term Care Experience in Canada and Scandinavia (Armstrong et al., 2009).
ownership type. A total of 81 unionized long-term care facilities in the provinces of Manitoba, Ontario and Nova Scotia were selected. Five major health care unions provided contacts at each facility to aid the ISR in the distribution of the survey. A union representative at each workplace was asked to distribute the survey to the staff at the facility. To ensure anonymity and independence in answers, the completed questionnaires were mailed back by respondents. Workers from 71 (87.6%) of the 81 workplaces selected participated. A total of 948 surveys were returned. Although the survey covered five groups of workers, the focus here is on direct care workers, those personal support workers (PSWs; n=415) and licensed practical nurses (LPNs; n=139) who provide the majority of hands-on care and who are most comparable across jurisdictions. As is the case in Nordic Europe, this is a highly unionized sector so relying on unionized workplaces is appropriate. The majority of those surveyed, like the majority of workers, is over age 45 and most have at least 10 years experience working in the field.

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

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

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3 These include the Canadian Auto Workers (CAW), the Canadian Federation of Nurses Unions (CFNU), the Canadian Union of Public Employees (CUPE), National Union of Public and General Employees (NUPGE) and the Service Employees International Union (SEIU).
Our qualitative data come from two Canadian sources. One is the comments written in the margins on the questionnaires. In addition to filling in the spaces explicitly left for comments, respondents frequently clarified and expanded in the margins on their answers, offered critiques of our questions or addressed areas not raised in the questionnaire. These responses have all been typed into our data base and sorted as part of the analysis provided here.

Our second qualitative source is nine focus groups conducted in the three Canadian provinces in order to validate the survey results and provide workers with an opportunity to discuss our findings and offer additional comments, insights and elaborations. If anything, the focus group respondents were more negative about the conditions they faced at work, and the consequent impacts on residents, than were the individuals who completed the questionnaire. The focus groups were organized by our union contacts, who advertised for participants but did not attend the interviews themselves. Our interviewers asked participants to assess our initial findings from the survey, following a semi-structured interview schedule. All sessions were transcribed and entered into our data base.

FINDINGS

Among full-time workers, absences from work due to illness and disability are highest for health care workers, whether measured by industry (health care and social assistance) or by occupation (health). Between 1999 and 2009, the incidence of absences increased in this industry from 6.7% to 8.3% of days annually, and in this occupation from 6.7% to 8.7% (Statistics Canada, 2010: Tables 4-21 and 5-7). Within the broad occupational category in 2009, support staff experienced the highest rate at 9.8%, followed by nurses at 9.2% (Statistics Canada, 2010: Table 3-1). European data also indicate that health services workers have the highest absences due to illness and injury.

In spite of these high numbers, our survey respondents suggest that these data significantly understate the number of health care workers who are injured or ill each year as a result of their work. According to our respondents, it is common for workers to go to work while they are sick or injured. This “presenteeism” is not unusual in any of the countries included in our study, a practice that leads to absence rates that hide the actual levels of workplace illness and injury. Nevertheless, there are some differences among countries in terms of the

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4 The concept of “presenteeism” appears now to be quite widely used in Nordic Europe. See for example Elstad & Vabø (2008).
extent to which those providing direct care go to work when they are ill. As Figure 1 shows, just over one in ten Finnish workers say they have gone to work ill more than five times in the past year, compared to one in five Canadian workers. At the same time, the Canadian workers' reports of days missed at work due to illness and injury are consistent with Statistics Canada data, suggesting these workers are not exaggerating their claims.

![Figure 1: Direct care workers who have worked when sick more than 5 times over the past year, comparing countries](image)

It is clear from Figure 2 that the number of work-related injuries or illnesses is high. More than half the Canadians injured their backs in the survey year, and more than a quarter did so more than once in the year. More than a third experienced sprains during the same period, with almost one in five saying this was the case more than once. Needle pricks are less common, but both flu and stress pose major health hazards.
Figure 2: Number of work related injuries or illnesses sustained over the past year, Canadian direct care workers

As we can see from Figure 3, there are significant differences among countries. Back pain provides the telling example. While a third of Canadian workers report back pain “almost always”, this is the case for only one in ten Finnish workers. The proportion of Canadian workers reporting this kind of back pain was twice as high as the proportion of Swedish workers.

Figure 3: Proportion of direct care workers that “almost always” finish the day with back pain, comparing countries
Although we do not have comparable data from the Nordic countries on the stress question, stress differences can be deduced from the reports of feeling physically exhausted. Figure 4 compares the number of direct care workers who “almost always” feel physically exhausted at the end of their shift. Once again, the proportion of Canadian reporting such exhaustion is twice the proportion of those from Sweden. There are only small variations among the Nordic countries but the fact that here Finnish workers have the highest proportion in contrast with the lower rates of back pain (Figure 3) suggests that real differences among countries are being captured.

The differences among countries are even larger when we look at reports of violence. Indeed, Figure 5 reveals some startling differences. Compared to workers in the Nordic countries, Canadian workers are almost six times as likely to report they experience violence more or less every day from a resident or a family member. While more than a third of Canadian workers experience violence this frequently, the average among Nordic countries is under seven per cent. Our data also show that, while nearly three quarters of Nordic workers say they experience violence less than once a month, less than a third of Canadian direct care workers say this is the case. And the data probably understate the levels of violence experienced in Canada compared to the Nordic countries, given that the Canadian questionnaire asked only about physical violence while the Nordic countries asked about both violence and threats of violence.
Figure 5: Proportion of direct care workers experiencing violence “more or less every day” by a resident or family members, comparing countries

These data represent only some of the health problems experienced by the workers in our study. Together they indicate not only that the rates of illness and injury are higher than officially recorded in all countries included in this study, but also that there are significant variations among countries in terms of the illnesses and injuries sustained by workers.

Explanations

These high rates of illness and injury have not gone unnoticed. However, they are often understood in terms of the attributes of the individual worker or the person needing care. This includes gender, most frequently seen as an individual characteristic. Some research also looks to the workplace, although this too is frequently seen as a product of the necessary nature of the work or of union protections that allow workers to leave work when they choose.

According to Statistics Canada (2010:54), “Several factors have contributed [to the rising trend in work absences]: notably, an aging workforce, the growing share of women in the workforce (especially those with young children), high worker stress, and more generous sick- and family-related leave benefits”. Similarly, a 2004 report for International Monetary Fund on work absences in Europe (Bonato and Lusinyan, 2004) attributed the higher rates of absences due to illness and injury in the health sector to the high number of women and employment in the public sector. A Norwegian study (Ericksen, Tambs
& Knardahl, 2006) looked to role conflicts and violent patients as factors, while other studies have looked to leadership and particular working conditions.

We did locate one recent review of literature on violence against nurses with the promising title of “Violence Against Women” (Howerton Child & Mentes, 2010). Gender appears only spottily in their discussion, however, and primarily in individual terms.

While undoubtedly the individual characteristics of residents and workers as well as the characteristics of particular workplaces and leaders make a difference, the international trend towards increasing rates of illness and injury, combined with significant differences among jurisdictions, suggest that it is necessary not only to link these factors but also to place them in the context of larger organizational and structural processes. The notion of structural violence allows us to do that and to look to the systemic ways that institutions and structures serve to prevent people from reaching their potential or from fulfilling their basic needs.

Herein lies the link to diapers. The workers in the group interview are talking about how they are prevented from providing for the basic needs of the residents. In our interviews, when the workers raised the diaper issues they also talked about how residents were often violent in relation to diapers both because the diapers too often meant a loss of dignity and because the severe limits placed on the number of diapers used meant residents spent long hours in sodden pads. As one worker said, “I might hit out too if you left me in that”. And the problem is not limited to diapers, at least according to the Canadian respondents. These workers reported leaving a host of tasks undone on a regular basis. Indeed, as Table I indicates, they said that only feeding is rarely left undone, while foot care is often left undone and this is even the case with the turning that is so essential to skin health.

### Table I: Physical care left undone

<table>
<thead>
<tr>
<th>Task</th>
<th>Often</th>
<th>Sometimes</th>
<th>Occasionally</th>
<th>Never</th>
<th>Not sure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feeding</td>
<td>0.0</td>
<td>3.2</td>
<td>9.2</td>
<td>85.5</td>
<td>2.0</td>
</tr>
<tr>
<td>Bed changing</td>
<td>2.0</td>
<td>8.1</td>
<td>25.7</td>
<td>60.4</td>
<td>3.8</td>
</tr>
<tr>
<td>Changing clothes</td>
<td>2.5</td>
<td>10.0</td>
<td>26.4</td>
<td>57.3</td>
<td>3.8</td>
</tr>
<tr>
<td>Turning</td>
<td>4.7</td>
<td>13.1</td>
<td>28.5</td>
<td>49.2</td>
<td>4.5</td>
</tr>
<tr>
<td>Toileting</td>
<td>6.0</td>
<td>13.5</td>
<td>31.0</td>
<td>46.6</td>
<td>2.9</td>
</tr>
<tr>
<td>Bathing</td>
<td>3.9</td>
<td>14.8</td>
<td>34.4</td>
<td>41.4</td>
<td>5.5</td>
</tr>
<tr>
<td>Tooth brushing</td>
<td>13.7</td>
<td>22.7</td>
<td>33.9</td>
<td>24.8</td>
<td>4.9</td>
</tr>
<tr>
<td>Foot care</td>
<td>22.2</td>
<td>25.6</td>
<td>26.6</td>
<td>15.0</td>
<td>10.6</td>
</tr>
</tbody>
</table>
It is not only the essential physical tasks that are left undone, it is the social ones as well (Table II). Less than half say they can provide emotional support often or sometimes. Indeed, these workers say that the social tasks are the first to be eliminated, although they are the most rewarding for both residents and workers.

**Table II: Social Care Left Undone**

<table>
<thead>
<tr>
<th>Task</th>
<th>Often</th>
<th>Sometimes</th>
<th>Occasionally</th>
<th>Never</th>
<th>Not sure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Keeping in touch with residents’ family members</td>
<td>6.7</td>
<td>16.0</td>
<td>33.0</td>
<td>28.6</td>
<td>15.7</td>
</tr>
<tr>
<td>Emotional support</td>
<td>19.2</td>
<td>23.6</td>
<td>30.5</td>
<td>23.3</td>
<td>3.4</td>
</tr>
<tr>
<td>Training</td>
<td>13.0</td>
<td>23.9</td>
<td>30.2</td>
<td>19.3</td>
<td>13.5</td>
</tr>
<tr>
<td>Chatting</td>
<td>33.6</td>
<td>21.8</td>
<td>24.4</td>
<td>17.9</td>
<td>2.2</td>
</tr>
<tr>
<td>Walking/exercise</td>
<td>19.8</td>
<td>24.4</td>
<td>33.0</td>
<td>15.8</td>
<td>7.0</td>
</tr>
<tr>
<td>Taking residents’ out socially</td>
<td>33.9</td>
<td>12.7</td>
<td>17.1</td>
<td>10.1</td>
<td>26.2</td>
</tr>
</tbody>
</table>

Although we do not have comparable data for the Nordic countries on tasks left undone, we do have responses to the question on feeling inadequate as a result of not having enough time and training to provide appropriate care (Table III). Two-fifths of Canadian workers say they feel inadequate all or most of the time and nearly half say this is sometimes the case. Although inadequacy is not uncommon in Nordic countries, the proportion feeling inadequate all or most of the time is half as great in Denmark, compared to Canada, and even lower in Norway. This suggests that feelings of inadequacy cannot be understood simply as an inevitable product of the work. These workers have skills they are prevented from using and needs they are prevented from addressing with those skills. As a result, they feel like they are harming not only the residents but also their own health. Commenting on the effect of no time to care, one PSW reported, “And actually I’ve literally been in tears watching some of these girls when they go home and they’re in tears”.

As another PSW put it:

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

Table III: Feelings of Inadequacy, Comparing Countries

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

These data paint a picture of structural violence and the variations among countries suggest that more than individual characteristics of workers, residents and workplaces are factors in the high and rising rates of illness and injuries. Although more study is required to identify the processes that contribute to these rates, our research combined with the work of others provides enough evidence to indicate the importance both of locating work within the context of larger social processes and organizations and of linking factors together.

We begin with gender, understood as a social relation that varies across countries rather than as an individual characteristic or variable. Gender is a central organizing feature of long-term care and is profoundly implicated in the structuring and valuing of this work across jurisdictions. In all the countries included in our survey, women are the overwhelming majority of the workers and residents. What Connell (2006) calls a gender regime shapes the work and care in such facilities. Both the inadequate resources allocated to long-term residential care and the low value attached to the work done there has to be understood as related to the low value attached to women’s work, especially to the kinds of work such as feeding, bathing, diaper changing, toileting, cleaning, walking, and chatting that make up the bulk of the tasks in long-term facilities (Benoit & Hallgrimsdottir, 2008).

Long associated with women’s domestic responsibilities, this work is largely defined as unskilled, something women do by instinct rather than as a result of learning (Armstrong, Armstrong and Scott-Dixon, 2008). At the same time, the elderly women who make up the majority of residents are also not highly valued. While age means a loss of status and power for the majority of both men and women, women
are particularly devalued as they age and are especially unlikely, as a result of their lower pensions and lifetime earnings, to have the resources that would allow them to purchase alternatives or to have other basis of power.

As Elwér, Aléx and Hammarström (2010:9) conclude in their elder care research in Sweden, a gender perspective “must acknowledge that workplaces are affected by their context in society, which is gendered at all levels”. Gender is reflected in the diaper discussion, with women on the one hand allowed little decision-making power and on the other resisting these restrictions by hiding diapers so they can both respond to resident needs and feel better about their work. They respond to the needs of residents in part because this is expected of them as women and as employees and in part because it is providing for this care which gives them the satisfaction of doing good women’s work. Andersen’s (2009) review of the literature on residential care aides work showed that caring relationships are, along with relationships with colleagues and families, critical in keeping women working in residential care.

Gender regimes set the stage for this commitment. Women not only feel more responsible but are also held more responsible for the care deficit created by the combination of the increasing proportion of residents with major health issues and staff reductions (Baines, 2004). Our respondents wrote into the margins of the questionnaire to emphasize the extra hours they put in, coming in early, leaving late and skipping breaks, as they are expected to do and feel internal pressure to do. One example speaks for many:

“There is not enough time to effectively complete my work, so my breaks are cut short and/or leave work late. I can no longer sit and chat with a resident/family member or find myself saying “I’ll be with you as soon as I can”. I find this appalling. Residents are human beings and they should be treated as such.”

It is difficult to understand this overwork or its health consequences without reference to gender. Nevertheless, such an analysis is not common. For example, Andersen’s (2009:6) thorough survey of the literature shows the “concern regarding lack of financial compensation and rewards, which shape general job satisfaction (frequency effect size 38.0%), supervisory styles that are generally hierarchical, demeaning and dismissive (frequency effect 37.3%) and violence and aggression in the workplace which pose serious threats to the personal safety of the aide (frequency effect size 36.6%)”. She also reported that the women providing care are motivated by a belief that they are needed and that the job is important, factors that keep them
working even when they feel their work is not valued. Yet no gender perspective is identified in the literature summarized to help understand the low value attached to the work or the relations in the workplace.

Differences in gender regimes may also help explain differences among countries. For example, our research suggests that there are significant differences among countries in the extent to which direct care workers have a say over planning their days and the monitoring by staff. It may well be the case that differences in valuing women's work can help us understand why two-thirds of Danish workers can affect the planning of their day and so can nearly half the Swedish workers while this is the case for only a quarter of the Canadian workers (Figure 6). Our research does not allow us to answer the question but it is one worth exploring.

Figure 6: Direct care workers who can affect the planning of each day’s work “all or most of the time,” comparing countries

Although gender regimes help us understand the low pay and overwork, they cannot alone provide the explanation for deteriorating conditions in long-term residential care, especially given that this has long been women’s work and long involved mainly elderly women. Other aspects of the context need to be identified and linked to the gender regimes. And the context for long-term residential care has been changing significantly. In the wake of World War Two, Canada and the Nordic countries began to decommodify services such as health care, defining them as public goods rather than as commercial ones (Esping-Andersen, 1990). Services for the elderly, who constitute the overwhelming majority of those in long-term residential care, were not a priority in Canada but were part of the universal welfare model in Nordic Europe with publicly financed and delivered services offered to all. An aging in place model has been part of the Nordic approach since
the 1950s, with nursing homes also available as part of the public system. Canada was slower to develop public financing and delivery of residential care, but the overall movement was in this direction with variations by provincial jurisdiction.

However, major ideological and practical shifts began in the 1970s. Partly based on arguments that welfare state social supports are no longer sustainable given rising debts and deficits, and aging populations, all governments have faced growing pressure from international corporations and from international bodies such as the World Trade Organization to adopt managerial practices taken from the private sector, to reduce services and to hand over whole sections or parts of public services to the private, for-profit sector. Competition was to provide a win/win result; lowering costs while improving quality. Increasingly, health services in general and long-term residential care in particular were identified as sources of profit and as a commercial service rather than a public good.

In Canada, this has led to a rapid growth in the corporate ownership of facilities, usually with large amounts of public funding. Variations among provinces remain. The province of Ontario now has a majority of its publicly financed beds in for-profit facilities while in Manitoba only a quarter of the beds are in for-profit facilities. Overall, more than two in five residential care beds in Canada are now owned by for-profit companies. By contrast, the overwhelming majority of facilities in the Nordic countries are publicly run, although the number of for-profit owners is growing and there are variations among the Nordic countries as well.

In addition, there is significant support in high-income countries for deinstitutionalization. Care in the home is understood as preferred by those with care needs and as cheaper for governments, although there is evidence that some of the elderly may prefer facility care and a lot of evidence that care at home is cheaper because the costs are borne mainly by women through unpaid labour. In any case, those who enter residential facilities in Canada now have much greater physical and mental health care needs compared to the past. Although these developments are common to the countries in our study, a higher proportion of the elderly live in long-term residences in Nordic Europe, those with dementia are often placed in separate facilities and it has not been the practice, as it is more frequently in Canada, to put younger people who have been deinstitutionalized with high care needs into facilities previously reserved for the elderly.

Especially in Canadian facilities, the population is changing in other ways. It is increasingly mixed in terms of those from racialized and cultural groups. At the same time, more of those working in residential care are women who are immigrants and/or racialized women. The
structural violence does not come from the changing population in residential care but rather from the failure to provide adequate training for staff to deal with these changes and the failure to provide adequate staffing levels to deal with greater the needs that accompany them. Those seeking profit in particular seek to save money by reducing their main expense; that is, staff. As McGregor, Cohen and McPhail (2005:468) reported, “Our findings suggest that, with the same funding from government, not-for-profit facilities decided to allocate more of their resources to staffing than did for-profit facilities.” Canada, with the highest proportion of for-profit ownership, also has the highest proportion of workers who report having too much to do (Table IV).

**Table IV: Having too much to do, comparing countries**

<table>
<thead>
<tr>
<th></th>
<th>All or most of the time (%)</th>
<th>Sometimes (%)</th>
<th>Rarely (%)</th>
<th>Never (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denmark</td>
<td>30.2</td>
<td>53.2</td>
<td>14.6</td>
<td>2.0</td>
</tr>
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<tr>
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</table>

By inserting comments into the questionnaires, the Canadian PSWs were emphasizing the ways low staffing levels prevented them from providing the kind of care residents required, as the following quotes indicate:

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

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

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

But it was not only for-profit facilities that have cut back on staff in an effort to reduce expenditures, increase control over the workers
and apply for-profit practices to this sector. As we can see from Table IV, in all countries a significant number of workers said they had too much to do. However, only a few of the Swedish care workers indicated that they wanted more time for personal care, and those who did often mentioned grooming rather than “basic body work”. For example, they wrote in “put rollers in their hair, fix their nails - A lot of small things that you never have time for”.

Low staffing levels mean workers have no time to care. As women, they try desperately to fill the care deficit and, in the process, they threaten their own health. We can add to the structures and processes that constitute structural violence the lack of control over their hours and work, the close supervision and the physical facilities that make their work dangerous to do, or at least to do in the ways they see as necessary. Providing care is demanding work. But it can also be rewarding work if women have the resources and support they need to do the work they know is necessary. And residents are much less likely to be violent if they receive the care they need, and are treated with dignity and respect.

CONCLUSIONS

There is a growing body of work documenting the rising illness and injury rates, including growing levels of violence, within long-term care facilities. Our research adds to this literature but seeks to go beyond it in arguing that we have to understand these rising rates in terms of structural violence. Such an approach draws out attention to the systemic ways that institutions and structures serve to prevent people from reaching their potential or from fulfilling their basic needs. Gender is one of those institutions, and a critical one in revealing how the work is undervalued and controlled. But we must also understand long-term care within the context of neo-liberal restructuring that has shifted away from care as a public good to treating it as a commercial one and away from public services to for-profit ownership and managerial practices. Individual characteristics of workers and residents, as well as leadership practices and the nature of the work, are undoubtedly factors in the rates of injury and illness. Nevertheless, our international comparisons suggest we need to go beyond the individual workplace and workers to the larger structures not only to understand the health consequences but also to prevent them.
REFERENCES


