OLD STRATEGIES, NEW GAME :
THE CHANGING HEALTH CARE SYSTEM AND ITS IMPACT ON CARE GIVERS IN LONG TERM CARE FACILITIES IN NOVA SCOTIA

by

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ABSTRACT

This thesis examines the pressures that are being placed on the health care system, focusing particularly on long term care facilities in Nova Scotia. As the title implies, this thesis explores how strategies developed in the private business sector are being implemented in the public health care system. It looks at what those strategies are, how they are being applied, who is affected by them, who gains from them, and why these strategies are being implemented now.

In order to answer these questions ideas and concepts are borrowed from three theorists: Max Weber, George Ritzer and Karl Marx. By combining different aspects of each of their works, we gain a better understanding of what is really going on behind the decisions being made surrounding long term care facilities.

Directly linked to the decision-making process are the effects that those decisions have. Ten women, all heath care employees, who have experienced the effects of private sector strategies which are infiltrating their work worlds were interviewed and their responses were described and compared in an exploratory fashion.

There is no simple solution offered to solve all the problems faced by the caregivers. However, a better understanding of what is going on in the health care system and a greater awareness of the struggles faced by those working within the system can only help to make us, and those with the decision-making power, better able to make decisions in the best interests of residents and caregivers.

CHAPTER ONE
INTRODUCTION

In recent years many Nova Scotians have begun to question the state of our health care system. If we were to turn on the television or open up the newspaper, somewhere we are bound to hear or read something about health care. Over the last few years many questions have been raised surrounding Canada's health care system, including: what is the future of health care in Canada? Is government spending too much or not enough? Recently we have begun to hear more and more stories of problems in our long term care facilities: problems of pay equity, poor working conditions, burn-out and strikes. All of this leads us to one question: what is going on with our health care system? The answer is shockingly simple. The Canadian health care system is increasingly being treated like a business, where profit and cost cutting measures are replacing quality care and provision[1].

In Canada it is the responsibility of governments at all three levels, federal, provincial and municipal, to ensure Canadians have access to good health care. It is with pride that Canadians discuss the universal health care system we have. However, that system is in jeopardy as governments at each level begin to focus more and more on cutting spending. (With the exception of the 1999 budget, which saw an increase in money transferred to the provinces for health care.) As cutting money becomes the central focus, governments have begun looking to the private sector for strategies that they believe are more efficient than the strategies currently being used by the public sector. As a result,

[1] "Quality care" attempts to meet all the needs of individuals, physical, mental and emotional. People are treated as people and not as body parts that need to be fixed.

strategies which are thought to work well in the private sector are being implemented in the health care sector in the name of efficiency and profit.

As we will see throughout this thesis, while the main goal of all non-profit long term care facilities is not to make money, the strategies they are adopting are based on a for-profit model. As a result, a reorganisation of this part of the health care system is occurring.

While the implications of these private sector strategies (which will be discussed in greater detail in Chapter Two) are not always obvious at first glance, and it is not until one spends some time working in a nursing home, for example, that the impact of government cuts and restructuring can be truly comprehended. By working in a nursing home one is given an opportunity to see first hand the working world of the staff. One can begin to see the challenges that workers face and the constraints under which they carry out their daily activities. However, it is not only the staff but the residents as well who are feeling the impact of the changing health care system.. Through observing the staff and residents it quickly becomes apparent that there is a need to dig deeper into the health care system. What is causing the changes to the health care system? How are those who are involved directly in the system being affected by those changes?

With these questions and observations in mind the purpose of this thesis is: *to explore the ways that the caregivers*[2] *working in long term care facilities in Nova Scotia perceive the impact of changes to the health care system on their working conditions and, in their opinion, on the quality of care that residents are receiving.*

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[2] Care givers refer to all staff involved in hands-on care to the resident including the Director of Nursing (DON), Registered Nurses (RN), Registered Nursing Assistants (RNA), Licensed Practical Nurse (LPN) and Personal Care Workers (PCW). (For a definition of each see the glossary)

Before going any further it is important to note that throughout this thesis many technical terms are used. In order to assist the reader with those terms a brief definition of each is given in the form of a footnote. As well, a Glossary has been included at the back of this thesis. One term that must be discussed in some detail is the use of the term *long term care*. In the province of Nova Scotia long term care has been the term used to describe care provided to the ageing population. "Long term care facility" is used interchangeably with nursing home, homes for the aged, special care facility, small options and residential facility. While there have been several attempts to develop a common language that is reflective of the care provided in these institutions, nothing has been solidified at this time and, as a result, terminology can become confusing (Nova Scotia Nurses Union, 1997:7). For the purpose of this research the term "long term care facility" will be used when discussing homes for the elderly. Because the research question deals with caregivers in facilities for the elderly, data were gathered from a variety of homes including nursing homes, a residential care facility, special care facilities and small option homes. In order to make things less confusing to the reader, only the term long term care facility will be used in this thesis.

As well, it is important to note that the elderly population is not entirely homogeneous. Socio-economic status or class, gender, age, culture and ethnicity are all important factors which influence needs for health care and other services (Bolaria, 1988:219). However, I believe it is fair to say that although these factors all influence and allow for diversity among the elderly, there are health problems and issues that all elderly people face which set them apart from other groups.

The second chapter of this thesis looks at the current health care system and what is going on in regards to the changes being implemented. As well, there is a discussion of the different strategies behind the changes and how these strategies are impacting on those involved in the health care sector. The chapter explores how old business strategies developed in the early 1900's are shaping the current organisation of long term care facilities in Canada and in particular those in Nova Scotia.

In the third chapter, an in-depth look at why the changes might be occurring is explored. Here, we look at concepts and ideas developed by Karl Marx, Max Weber, and George Ritzer and explore how their theories are being played out today. By applying the ideas and concepts developed by these men we can gather a better understanding not only of why changes are occurring in health care but the driving force behind the changes.

The fourth chapter deals with methodology and a discussion of what methods were chosen for this thesis and why. This chapter also includes the criteria used in gathering the information needed to answer the research question.

The fifth chapter provides the opportunity to hear from some of the caregivers working in and around Truro and Yarmouth, in order to see what they perceive are the important issues and challenges facing them today. Included in this chapter is a discussion of the perceived consequences these changes in heath care have had for residents. The discussion ends with a look at what nursing staff see as the future for long term care in Nova Scotia and what they would recommend in order to improve their lives and the lives of those they care for.

The final chapter looks at the critical themes that have emerged as a result of this research and how they support or allow us to question the theories discussed earlier in Chapter Three. Included in this chapter are lessons learned by the researcher during the undertaking of this research project. These lessons include those learned at a personal level, as well as conceptual and methodological lessons learned.

In an attempt to begin to make long term care come alive and to demonstrate the growing need for changes within the long term care system I leave you with the following scenario based on an actual situation. (The names and locations have, of course, been changed to protect the identity of the individuals.) This example was chosen from the many stories that were shared as it best illustrates some of the difficulties and issues caregivers are facing. Of the many examples caregivers gave, this one allows us to see not only the struggles faced by Nurse Williams, who is the caregiver, but also the impact of the changing health care system on Sadie, who is a resident in her care.

CASE STUDY

Nurse Williams has been employed in a long term care facility for twelve years. She is proud of her work but feels demoralised when speaking to nurses in acute care[3] who fail to acknowledge the importance of nursing in long term care facilities. Over the years she has seen many changes in the level of care required by the 65 residents that she supervises. Nurse Williams has outlined her responsibilities at the request of her administrator, who is performing an audit in an effort to identify increases in workload. The following duties are performed during her eight hour shift.

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[3] Acute care workers are nurses who work in hospitals with patients who have terminal illness.

- Supervision of eight Personal Care Workers who are responsible for the bathing, grooming, toileting and feeding of sixty-five residents.
- Administering medications (twice a shift to residents)
- Administering prescribed treatments to 12 residents
- Rounds with physicians
- Schedule meetings with families
- Charting and physician notifications of change in residents' behaviour.

Nurse Williams is particularly concerned with how quickly the general conditions of residents can change. She recounts the story of Sadie, an 86 year old retired school teacher who had been living in a seniors' complex. Having no immediate family, Sadie was admitted to the facility 3 years ago after her neighbours noticed changes in her appearance and behaviour. Sadie was diagnosed with Alzheimer Disease, a condition which led to decreased cognitive abilities and frequent night wandering. Last week, Jane a personal care worker, was struck in the forehead by Sadie while assisting her out of bed. Jane reported the incident to Nurse Williams who administered first aid to the lacerations on Jane's forehead and arranged transportation for her to the hospital to have her head sutured. Sadie's physician was immediately notified and an anti-psychotic medication was administered to Sadie. The prescribed drug now becomes a chemical restraint to Sadie, and to prevent further injury to staff or residents she is now confined to a geriatric chair with a lap belt.

Nurse Williams is concerned that Sadie's activities of daily living (bathing, grooming, mobility, eating and toileting) have been altered due to the use of restraints. Nurse Williams must now deal with the increased level of care required by Sadie. As well, without any additional staff support available, the quality of care is reduced for all other residents as well as for Sadie. Nurse Williams must now explain to the Director of Nursing

why there is an increase in skin impairments, such as rashes and bed sores on her unit. At the end of the day, Nurse Williams feels helpless and hopeless and wonders how best to meet the ever changing needs of the residents.

This scenario is only one of the many that help to demonstrate the current situation in which care givers find themselves. As we will see in Chapter Five, the scenario of Nurse Williams is not uncommon. However, first let us begin to understand what has led up to this type of situation.

CHAPTER TWO
UNDERSTANDING HEATH CARE

The purpose of this thesis is to explore the ways in which ten caregivers working in long term care facilities in Nova Scotia perceive the changes to the health care system as affecting their working conditions and the quality of care residents are receiving.

Before discussing current changes to the health care system it is important to highlight briefly how long term care institutions developed. This discussion is useful in order to understand the role industrialization and the economies have played in the developing and maintaining of long term care facilities. As well, it will help to create a picture of the changing treatment of the elderly in Canada.

The history of long term care

More Canadians today than in earlier years are living in long term care facilities. This change has come about as a result of several socio-historical changes in Canadian society. In the past, individuals did not live as long as they do today. In looking at the example of hunting and gathering societies, we find that on average the life expectancy from birth to death was about thirty-eight years. With the rise of agriculture-class based societies, life expectancy fell to thirty - to thirty-five years. Finally, in civilizations where slavery existed, life expectancy dropped even further, where people lived on average twenty to twenty-five years (Elder, 1984:25).

In industrialized countries such as Canada the human population has expanded and life expectancy has increased. Over the last twenty-five years life expectancy has risen from 69.7 years to 75.3 for men and from 76.8 to 81.3 years for women (Elder, 1984:25). However, it is important to note that in many low-income countries life expectancy is still as low as fifty years.

The increasing longevity of human life has been the result of new knowledge gained in the area of nutrition and in the advances in modern medicine and technology (Macionis, 1997:370). Canadians now have access to drugs and cures for many ailments, which in turn allows individuals to live longer. As well, a decline in the child and infant mortality rate[4] also contribute to the rise in life expectancy. Countries who have a low infant mortality rate have a high life expectancy. Moreover, gender also plays a role in the longevity of human life; women on average live five to seven years longer than men. In Canada, life expectancy has been steadily climbing since the early decades of this century. Advances in longevity as well as a decline in birthrates has caused an increase in Canada's elderly population. Tables 2.1 and 2.2 illustrate this increase in longevity.

In order to gain insight into why long term care facilities were developed, one must begin by looking at the various socio-historical changes that have taken place in Canada. By discovering how long term care facilities have come into being, a better understanding of how they have become what they are today can be reached.

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[4] infant mortality rate, refers to the number of deaths in the first years of life for each thousand live births in a given year.

Table 2.1
LIFE EXPECTANCY OF CANADIANS, 1920-1991

Males
EXPECTED REMAINING YEARS OF LIFE AT:

Year of birth	Birth	65 Years	75 Years	85 Years
1920-22	58.8	13.0	7.6	4.1
1930-32	60.0	13.0	7.6	4.1
1940-42	63.0	12.8	7.5	4.1
1950-52	66.4	13.3	7.9	4.3
1960-62	68.4	13.6	8.2	4.6
1970-72	69.4	13.8	8.5	5.0
1980-82	71.9	14.6	9.0	5.2
1989-91	73.9	15.4	9.4	5.2

Table 2.2

FEMALES
EXPECTED REMAINING YEARS OF LIFE AT:

Year of birth	Birth	65 Years	75 Years	85 Years
1920-22	60.6	13.6	8.0	4.3
1930-32	62.1	13.7	8.0	4.4
1940-42	66.3	14.1	8.2	4.1
1950-52	70.9	15.0	8.8	4.7
1960-62	74.3	16.1	9.5	5.0
1970-72	76.5	17.6	10.7	5.9
1980-82	79.1	18.9	11.9	6.6
1989-91	80.5	19.6	12.3	6.7

—

Source, Statistics Canada.

If we were to take a step back in history to societies that centered on agriculture we would find that the elderly were held in high regard and that age was most often with wisdom. Virtually all family needs were supplied by the members of the family. The family was the economic unit and the whole system of production centered on it. Within the family the elders were considered a productive and necessary part of fulfilling and meeting the needs of family members (Braverman, 1974:275). Older individuals were very active in family affairs as well as in the community.

During the eighteenth and nineteenth centuries in Canada things begun to change, Canada went from a society based on agriculture to one based on industry. With this change in economic production, the perspective and treatment of the elderly changed as well. The old were no longer valued for their wisdom; they lost their elite status and became viewed as one of society's burdens (Macionis, 1997:383). This decline in status was due to the idea that the elderly were no longer able to contribute to the production of goods in an industrially-based society.

Efficiency and productivity became the dominant goals of industrialized Canada. A youth orientation and preference developed and the elderly were phased out of the production process. The focus shifted and status was no longer associated with one's ability to produce many items for family use; instead it was achieved by one's ability to purchase many things (Braverman, 1974:277).

The elderly were seen as people who had passed the age of occupational competence. They were now, according to new cultural definitions of productivity, perceived as incapable of leading active, independent and productive lives. This new perception of the elderly resulted in a dramatic change in the treatment they would come to receive then and now.

Due to the changes in the mode of production in Canada, (moving from a society based on agriculture to one based on industry) institutional care for the elderly became an alternative to dealing with the elderly, who were now viewed as unproductive members. Today long term care facilities continue to be the focus of attention because they to a certain degree have come to replace the family as a means of caring for the elderly.

Long term care facilities also generate a lot of controversy because of the *industry* that has been created by them. Ultimately, long term care facilities are an industrial organization, and as such they are concerned with two variables, the input and the output. The input is the residents who come to live in the nursing home, and the output is the type of care they receive while they are there. What becomes established as a result of these two variables is a consumer-commodity relationship. Long term care facilities are service organizations whose target population is the elderly.

The type of care the facility provides for its residents and the type of working conditions the staff find themselves in is directly related to the type of long term care model the nursing home adopts.

Models of care

Two main models are adopted in the discussion of health care, the *social model* and the *medical model.* Long term care facilities in Nova Scotia are intended to operate under

the social model. In spite of this, many of the attributes from the medical model can be found within the long term care facilities throughout the province (Beanlands et al., 1994:9). In order to understand the implications for care delivery and the issues surrounding the present and future of health care delivery within the province, these two models of care must be explored.

In the social model the emphasis is placed on the facility as a home. It is not simply an institution which provides long term care to residents; rather the long term care facility is the residents' "home" (Conner, 1981:65). From this perspective physical care is seen as important, but the psychological and social well being of the resident is equally as important.

The social model also emphasises choice, increased control and rights similar to those found living in ones' own home. The care that is provided is ideally team based and uses a variety of resources such as social workers, nurses, recreational co-ordinators, community volunteers and family input (Beanlands et al., 1994:9).

The second model, and the one influencing many of the decisions surrounding the changing health care system, is the medical model. This model is based mainly on business values. Long term care facilities that adopt this model are mainly interested in running an efficient business. The medical model depicts residents as patients in need of long term, around the clock nursing care. The focus is on physical, organic problems, treatment and cure. The primary objective thus becomes meeting the physical needs of residents. Once physical needs become the central focus, patients can be broken down according to what body part is in need of fixing. This can further be broken down to the price it will cost to

fix each part. As we adopt this type of approach we are moving dangerously close to seeing patients in terms of cost only. Furthermore, once a price tag is attached, then we move into prioritising who and what is fixed first. Those in long term care are often left out in terms of priority. If we look at the recent 1999 budget, we find no mention of any funding federally or at the provincial level going into long term care. The funding instead is being put into technology and hospitals that have been given a higher priority. Because this type of model centres around for-profit business values, as we will see in Chapter Five, adopting this type of approach has serious consequences for caregivers and residents. Along with only treating physical needs the medical model also seriously limits choice for the individual as well as staff. Unlike the social model which emphasises team work the medical model emphasises delivery of care by one person, such as a nurse or doctor (Beanlands et al., 1994:9).

It is important to point out here that these two models are not mutually exclusive; one rarely exists in pure form. The general pattern, as we will see, is usually a combination of the two models. The extent to which each of the models is adopted is greatly influenced by the location of as well as the philosophy behind the delivery of care within different institutions. As we will see later on however, when the medical model is given more importance than the social model there are grave consequences not only for residents but also for staff. Tables, 2.3& 2.4 give a closer look at the two models as they pertain to institutions in general and to long term care facilities in particular.

Table 2.3

GENERAL CHARACTERISTIC OF THE SOCIAL MODEL AND MEDICAL MODEL OF CARE

SOCIAL MODEL	MEDICAL MODEL
Psychosocial services such as educational, creative, sensory awareness, religious activities provided by social workers, chaplains, recreationalists, community volunteers, and others	Organic/physical problems with physical methods, rehabilitation, and treatment using doctors, nurses and rehabilitation staff.
Psychosocial- capability orientation- finding solutions to problems which interfere with social functioning	Medical disease orientation
Psychiatric/behavioral characteristics	Physical, psychological and rehabilitative characteristics
Focus on social relationships and purpose/ meaning of life	Focus on institution
Focus on overall needs	Focus on limited needs (medical)
Care emphasis	Cure emphasis
Long term- chronicity	Short term- acute care
More community-based	Institution based
Medical problems are multiple and complex	Medical problems are one-dimensional
Team	Doctor-patient (key for decision making)

Table 2.4

CHARACTERISTICS OF INSTITUTIONAL CARE IN THE SOCIAL MODEL vs. THE MEDICAL MODEL

SOCIAL MODEL	MEDICAL MODEL
Primary social needs	Primary medical needs
More generalized care	More specialized care
Resident's overall needs primary	Professional service primary, patient need is limited to medical
Quality of life priorities	Technology and "cure" priorities
Focus on quality of life for quality assurance	Focus on medical care for quality assurance
Admission for social factors by self, family, doctors and others	Admission for physical and physiological factors by doctor
Negotiate for consent	Consent prescribed by legislation
Various organizational arrangements-simpler	Institutional organization arrangement- complex
Less expensive	More expensive
Accreditation standards- should be increased emphasis on quality of life, (e.g., resident councils)	Accreditation standards- evaluation by doctors, peer review and medical record audit, etc.

Adopted from Jesion, M.I., & Rudin, S.E., (1983).

Challenges to continuing care

The issues and challenges of continuing care can be categorised in three major categories. The first challenge being faced is based on "societal trends" (Beanlands et al., 1994:7). As many people are already aware, the demographic profile of Canadian society has been changing over the last ten years. As the population continues to age there is an ever increasing demand for services. It is estimated that by the turn of the century those aged sixty-five and over will constitute a significant proportion of the population.

As Table 2.5 indicates, 14% of the population will be over the age of sixty-five by the year 2011 and that will increase to about 22.7% by the year 2031 (Statistics Canada, 1993:110). If we look at the ageing population in Nova Scotia, we find that by the year 2011, 15.5 % of its population will be over sixty-five. (For a breakdown of each province and territory refer to Table 2.6.)

Connected to societal trends is the challenge of "socio-demographic change". Here it is argued that as a result of healthier lifestyles and a greater proportion of people retiring with pensions, people will be healthier as they age and their need for health care services will be compressed into the last few years of their life. Also included in this category are economic, environmental, technological and social challenges (Beanlands et al., 1994:8). One example of a social change may be the current trend towards more independent living among the elderly. For example, elderly people are being encouraged to remain in their homes as long as possible. As a result of this, when they arrive at the long term care facility

Table 2.5

GROWTH OF CANADA'S POPULATION AGED 65+, 1951-2031

Age group	1951 (%)	1971 (%)	1991 (%)	2011 (%)	2031 (%)
65+	7.8	8.1	11.6	14.6	22.7
65-69	3.1	2.9	3.9	4.5	6.4
70-74	2.2	2.1	3.0	3.3	5.8
75-79	1.3	1.5	2.3	2.6	4.5
80-84	0.7	0.9	1.4	2.0	3.2
85+	0.4	0.6	1.0	2.1	2.8

Note: Discrepancies among totals within each column are due to rounding in the original source.

Source, Statistics Canada

Table 2.6

POPULATION AGING (65+) IN CANADA, BY PROVINCES AND TERRITORIES, (ESTIMATED FOR 1951-1991 AND PROJECTED FOR 2011)

Provinces & Territories	1951 (%)	1971 (%)	1991 (%)	2011 (%)
Newfoundland	**6.5**	**6.2**	**9.7**	**15.1**
Prince Edward Island	**9.9**	**1.0**	**13.2**	**16.3**
Nova Scotia	***8.5***	***9.2***	***12.6***	***15.5***
New Brunswick	**7.6**	**8.6**	**12.2**	**16.0**
Quebec	**5.7**	**6.9**	**11.2**	**15.3**
Ontario	**8.7**	**8.4**	**11.7**	**14.3**
Manitoba	**8.4**	**9.6**	**13.4**	**14.3**
Saskatchewan	**8.1**	**10.2**	**14.2**	**14.5**
Alberta	**7.1**	**7.3**	**9.1**	**12.4**
British Columbia	**10.8**	**9.4**	**12.9**	**15.4**
Yukon	**5.1**	**2.8**	**4.0**	**9.6**
North West Territories	**2.7**	**2.2**	**2.8**	**6.6**
Canada	***7.8***	***8.1***	***11.6***	***14.6***

Source Statistics Canada

they are often much sicker than residents of the past and therefore require more care (Beanlands et al., 1994:9).

Another category that influences the delivery of long term care comes from challenges brought on by the other health care and social service sectors. These challenges include hospital transfers of medical and nursing functions, portability of services, and social policy changes such as education and training (Beanlands et al., 1994:9). Along with this category one would include government cutbacks which have led to deinstitutionalization and privatisation of health care. These two issues will be discussed in greater detail later in this thesis.

The third category which influences health care delivery is the challenge from within the continuing care sector. There are two main groups within this category: administration and service delivery. Services are generally administered by different divisions and ministries and there is a lack of integration among jurisdictions. Service delivery brings with it a set of challenges. Included in these are the need to develop quality assurance and better research and evaluation techniques. As well, there is an increased need for a number of adequately trained and qualified gerentologists and geriatricians. Furthermore, as communities become more multi-cultural and multilingual, more education for staff is necessary (Beanlands et al., 1994:9).

Overall it is estimated that 20-25% of the elderly will spend some time in an institution or long term care facility before they die (Tarman, 1988:244). In spite of the importance of institutional care for the elderly there is currently no uniform or coherent

policy in Canada that regulates the standard of accommodation, funding arrangements and quality standards of care. Institutional care, like many other aspects of the health care system, is left up to the provinces. Other than specifying particular conditions that have to be met in order to remain eligible for federal cost sharing arrangements, provinces make their own decisions regarding the organisation and funding of health care services (Tarman, 1988:245).

A national look

Before discussing the province of Nova Scotia, we will begin by looking at the changing health care system in a national context. After all, as mentioned above what occurs at the federal level affects what goes on at a provincial level. Canada's health care system has undergone many changes in the last ten years. Most of these changes are a result of government cutbacks at both the federal and provincial levels. As governments at both levels become more and more obsessed with eliminating the deficit and lowering the debt and with the restructuring of the economy, health care services suffer (Lexchin, 1994:10).

In the past the federal government was mainly involved in health care through its financial contribution to provincial health care services. The amount of money allotted to each province was tied directly to economic growth. However, as economic growth declined so did the amount of funding given to each province (Armstrong & Armstrong 1994:19). The exception to this trend was the 1999 budget, just recently announced. This budget saw an increase in the Canadian Health and Social Transfer (CHST) of $3.5 billion for health care per province. Along with that the federal government will give each province $2 billion dollars for the next two years and $2.5 billion for the three consecutive years to follow. In total,

provinces will receive $11.5 billion over five years. Despite this increase in funding it will still take 3 years to return to the 1995 levels of federal health care funding. (See Table 2.7 for a breakdown of the social transfers to provinces from 1990 to 2004.) However, even though we will eventually return to 1995 levels of funding, at the same time Canada will have seen an increase in its population by about 1.5 million people. As well, there will be 350,000 more elderly people requiring greater health care services than in 1995. Furthermore, as already mentioned earlier, even with the increased funding, little if any of that money has been promised to long term care . Again the issue of priorities arises, and again long term care is left out. In short, while the slashing of the health care budgets appears to have ended for the time being, the impact of this *increase* in funding remains to be seen. Because the 1999 budget was only recently announced, only time will tell how this increase in funding will influence the health care system. However, the impact of the 1995 budget cuts is visible and real (Simpson, 1999:A4).

By looking at the previous federal budgets we can see how much cost cutting has occurred and what justifications are being used to explain those cuts. The 1995 federal budget cut health care funding dramatically; as a result more financial responsibility for health was placed on each province. It has been suggested by federal leaders that health care costs account for 10% of the Gross Domestic Product (GDP)[5]. We are told that health care costs are out of control. However, if we take a closer look we discover that health care costs are not out of control. When Prime Minister Chretien and others talk about the proportion of the Gross National Product (GNP) spent on health care, they are not only talking about

[5] Gross Domestic Product (GDP) is a term used to describe the money value of all goods and services produced in a country in a set period of time, usually one year. It does not include unpaid services produced in the home which are not exchanged for money.

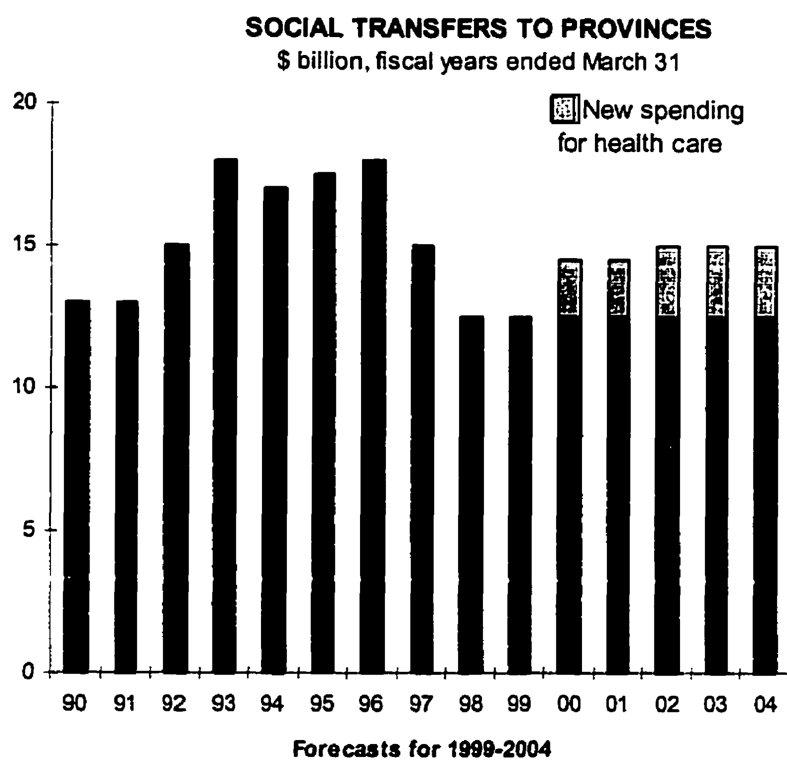
government expenditures or the cost of Medicare, but about all health care expenditures, both private and public (Armstrong & Armstrong, 1996:165).

By closely examining spending, we find that the costs of health care in Canada are not out of control. Health care spending accounted for by government money has been declining over the last three years. Contrary to what the Prime Minister's message implies, the proportion of the public budget spent on health care is not out of line with that of other countries (Armstrong & Armstrong, 1996:165). Table 2.8 demonstrates that there has been a decline in the public share of health care spending among G-7 countries, except for the United States.

In looking more closely at the percentage of GNP spent on health care for different countries we find that while health care expenditures were at 14.7% in Canada in 1989, they were at 15.3% in Australia, 15.1% in Finland and an outstanding 30.7% in Japan. Perhaps even more relevant is the amount spent by the US, which was 14.8% of the GNP. While the amount spent differs little between Canada and its neighbour, what is significantly different is the proportion of people serviced. The US public health care spending only covers the extremely poor and the military, while Canada has universal coverage. Even more alarming is that it is to the US system of health care that Canadian and European governments are looking as a model (Armstrong & Armstrong, 1996:166). While this system is not an attractive model from a social welfare perspective, it is very attractive from a private sector perspective.

> The USA is frequently used as a comparison country, particularly because of its leading economic position. Yet, the USA health system is markedly different from those in the EC (European Community) Countries. For example, most European countries showed a rising pattern of expenditures on health care (indicated by the percentage of GNP spent) during the 1970s and a flattening in the 1980s. In contrast the proportion of the GNP spending on health care in the USA in the 1980s continued to rise. The small proportion, around 40%, of health care expenditures that comes

TABLE 2.7



McIlroy, Anne (1999).

Table 2.8

Public Share in total health spending in the G-7, 1975-1992 (%)

G-7 Countries	1975	1980	1985	1990	1992
Canada	*76.4*	*74.7*	*74.7*	*73.1*	*72.2*
France	77.2	78.8	76.9	74.5	74.7
Germany	77.2	75.0	73.6	71.8	71.5
Italy	86.1	81.1	77.1	77.8	75.2
Japan	72.0	70.8	72.7	70.8	71.2
United Kingdom	91.1	89.6	86.3	84.4	84.4
United States, including tax exemptions for employer contributions	41.5 (49.5)	42.0 (50.2)	41.4 (49.4)	42.2 (50.2)	45.7 (53.7)

Source: Adopted from OECD

> from the public sector funds in the USA is in marked contrast to the European average of around 80% ... In financing health care, a system dominated by private medical practice, 35 million Americans - about one in six people - have no health insurance or protection against medical expenses. (McCarthy & Rees, 1992: 76)

To sum up, the government's argument that health care costs are out of control and out of line with other countries is false. Canadian public spending on health care has not significantly increased; what has increased is the amount of money spent by individuals.

According to Walker (in Lexchin, 1994:10), because Canadians hold the market in such high regard, health care policies have shifted from being based on the patient, or in this case the resident, to being based on cost-efficiency. The focus now is to concentrate first and foremost on reducing the size of the welfare state. The effect of these changes is that public policies being initiated across Canada is having a very negative impact on the quality of care patients are receiving. The same holds true for the working conditions of those who are providing the different health care services (Lexchin, 1994:11).

The Prime Minister's statements in dealing with health care reform have centred solely on cost cutting. Even with the new budget for 1999, health care and social transfers are still below those of the past. The problem with this type of approach is that it assumes that cost saving can occur by applying techniques like scientific management (which will be discussed later on) developed in the private sector to the public provision of health. As will become evident, it is exactly this line of thinking that is leading to a drop in quality care, increased work loads and inefficiency in the health care sector. The introduction of private sector strategies not only transforms patient care, but also has profound consequences for the

mainly female workers in the health care system (Armstrong et al., 1997:21). As we will see, this new organisation of the health care system is resulting in workers in long term care facilities (and other health care workers) facing an ever increasing work load, less control, more monitoring, reduced job satisfaction, deregulation and de-skilling, to mention only a few consequences (Armstrong et al. 1997:21)

While these strategies are being newly applied to health care services, they are strategies that have been used in the private for-profit service sectors for generations, dating back to the introduction of scientific management. However, the problem lies not only in the strategies that are bring applied, but also in how they are being applied and the consequences of dealing with people rather than objects.

Scientific management

Scientific management is not a new idea but has been in existence since Frederick W. Taylor (1911) developed several principles to make work more efficient. The ideas and principles shaped by Taylor have had and continue to have a huge impact on the work world throughout the twentieth century. Scientific management is an attempt to apply the methods of science to the increasingly complex problems of the control of labour in rapidly growing capitalist enterprises. It is impossible, according to Braverman (1974), to ever overestimate the importance of scientific management in shaping the labour process within the modern corporations and other institutions of modern society (Braverman, 1974:86). Scientific management in its simplest form can be said to be the science of the management of other's work under capitalist conditions (Braverman, 1974:86).

Taylor developed studies whereby he examined workers he regarded as already reasonably efficient and studied their work process in order to establish the most efficient means for performing tasks (Ritzer, 1996:24). Taylor developed his principles based on the notion of control. In doing so, he was seeking to answer the question of how best to control the labour power of others. One way to control labour power, according to Taylor's principles, was to develop time motion studies. The notion of this principle is quite simple: observe workers at their job and time each specific part of the job. Next, one must figure out ways to fragment the job into smaller tasks and then reduce the time it takes to perform each task. Work than is defined according to the amount of time it takes to do each task (Armstrong & Armstrong, 1996:116).

Along with time-motion studies Taylor also examined workers in order to establish a notion of the "one best way" to carry out the task. Once he discovered what he believed to be the one best way to perform certain tasks, he trained all workers to do the task the same way. This allowed for easy replacement of workers as jobs were simplified and could be taught quickly (Ritzer, 1996:4). Employers were now able to reduce the value of the worker by decreasing his/her training while at the same time enlarging his/her output. The result was that workers became less skilled and received less pay while employers' profits and control over their workers increased (Braverman, 1974:118).

With the introduction of scientific management, workers found themselves in a position whereby they were not only told what to do and how to do it, but also how much time it would take. Workers were no longer given the ability to think for themselves and all parts of their day were controlled by someone else.

Scientific management was adopted by employers because it gave them more control over the workers. As well, workers were said to be more efficient, more predictable and more profitable under this system. Although people no longer hear a great deal about scientific management, as we will see the ideas and principles developed by Taylor continue to shape the way that work is performed today. In the past many of these principles were adopted in relation to manual labour. However, today these strategies are being applied to the public and service sector because it is believed that the private sector, where these strategies have been in use for some time, is more efficient (Armstrong et al., 1997:23).

In many cases these strategies have just been given new names. In the case of health care the following terms have been adopted: Total Quality Management (TQM) or Continuous Quality Improvement (CQI), or even Patient Focused Care (PFC). Depending on the province, different terms are used, but the overall fundamental principles are the same. Like scientific management, these strategies all focus primarily on reducing costs, eliminating variation, and down sizing the work force (Armstrong & Armstrong, 1996: 132). Thus, as Trudy Richardson (1994) concluded in her research on PFC in the United States:

> There is no question that the advent of the generic health care workers ushers in an era of lesser-skilled, inadequately trained, inexperienced and lesser qualified health care providers. This entire process of throwing workers into a boiling pot, melting them down and recasting them into multi-skilled health care practitioners who are unlicensed and whose work is unregulated, means tens of millions of dollars in health care savings and an equivalent reduction in the quality and safety of patient care. (Richardson, 1994:29)

While those who work in the health care sector agree that there is considerable need to improve the health care system, they also recognise that the adoption of these private for profit strategies is not the answer. The price paid by staff and residents are far too high.

The impact on care givers

So how are these strategies being applied to the health care sector and what is the impact they are having? Before beginning this discussion it is important to state that all areas of the health care sector are being influenced upon by the implementation of these strategies. However, for the purpose of this discussion we will be concentrating on caregivers. Nurses form the single largest occupational group within the health care system; they account for approximately 38% of those who work in health care and medicine. There are nearly a quarter of a million registered nurses across Canada (approximately 9500 in the province of Nova Scotia). Of those, ninety-three per cent are involved in direct patient care (Armstrong & Armstrong, 1994 :39). Along with these nurses we also find a growing number of personal care workers and nursing assistants. It is currently estimated that there are 7500 long term care workers in Nova Scotia alone (Bueckert, Dennis, 1998:A2).

As management and government work to implement new strategies, nursing work is being redefined. One way this is occurring is that now, instead of being defined in terms of the care they are providing, nurses' work is defined in terms of tasks. By redefining nursing work in terms of tasks, management is able to adopt a variety of techniques to establish a *minimum time standard.* This time formula is not unlike that developed by Taylor, only now a computer system is used to determine the minimum number of care givers required to perform tasks as well as the amount of time each task should take (Armstrong & Armstrong, 1994:39).

The problem with adopting this strategy of time management is that one is no longer working with objects but with people. People are unpredictable and nursing is complex. Jo Flaherty, the Principal Nursing Officer for Health and Welfare Canada, provides this example to demonstrate the inadequacy of time formulas.

> According to some time formulas, bathing a patient is alleged to take six minutes. Well, I suggest even the holy ghost couldn't do it in six minutes unless you lifted the patient out, put him in a chair, hosed him down and let him drip dry, then put him back in. (Flaherty, 1990:79)

These new time formulas have been combined with a reduction in staff throughout the health care system. With fewer staff comes more work.

Multi-skilling is another concept that has been adopted by management to make health care work more efficient. More and more terms such as *multi-skilling*, *multi-functioning* and *multi-crafting* are being applied to nursing work (Robertson, 1992:29). Multi-skilling is the polite way of saying multi-tasking. However, instead of developing new skills, caregivers are finding that their work is being broken down into simplified tasks and that in fact what is occurring is de-skilling.

The idea behind multi-skilling is the same as the idea behind Taylor's notion of scientific management. First, management breaks each job down into detailed units of discrete tasks. Then the job is given a detailed definition so it can be easily reassigned to any worker. Next, the skill level required for each task is limited so it can be easily and quickly learned. Each job must be balanced in terms of time. Lastly, each worker, in this case each, caregiver must be encouraged and willing to do any job (Robertson, 1992:32). What is really occurring is increasing work intensity rather than skill development. Caregivers are now

being assigned more tasks than before. One example of this can be found in a study conducted by the Goldfarb Corporation. Goldfarb found that on average nurses now spend 30% of their day performing non-nursing duties. The duties they are now asked to perform under the heading of multi-skilling include such things as portering patients and changing beds (Goldfarb Corporation, 1988:52).

The second part of multi-skilling is directly linked to the first. If caregivers are trained to do non-nursing tasks fewer employees are needed. If nurses are now portering patients, there is no longer the need to hire orderlies. Nurses' work has now intensified and nurses have less time then ever to perform all of their given tasks (Armstrong & Armstrong, 1994:41). As well, if we continue to break down nursing tasks into simple and easily learned parts it is much easier to train people to perform them; this allows for easy replacement of workers. If tasks can be easily learned then less skill is needed to perform them and cheaper labour can be purchased. Thus, not only has the work load increased for caregivers and the number of employees dramatically decreased, the number of part-time workers has increased. The increase in part-time staff leads to more stress and more work for full-time staff. Often part-time staff are unfamiliar with the routine of the long term care facility and the residents who live there.

By employing workers on a part-time basis employers save money in two ways. First, employers often pay part-time staff fewer benefits and wages are lower. As well, part-time workers are only paid when they work and therefore employers can hire them on a demand basis. Moreover, people who work on a part-time basis can and usually do work harder than those employed for more hours (Armstrong & Armstrong, 1996:113).

The increase in part-time workers is also an advantage to management in that part-time workers are much easier to control. Most people who work part-time do so because it is all the work they can find. Nursing care is no exception and like all other forms of labour the number of people (in this case women) searching for work has increased. Between 1990-1991, in the Canadian work force, the number of women who were working part-time because that was all the work they could find increased by 80,000 (Statistics Canada, 1990).

While hiring part-time workers may be good strategy for management, it has consequences for full-time staff, for patients, and for those who can only find part-time work. According to Ellen Jeans, executive director of the Canadian Nurses Federation, many nurses are forced to work several part-time jobs in order to try to forge a career to support themselves and their families (Bueckert, 1998:A2). For full-time staff the problems arise in that many of the part-time staff do not receive enough training before being left on their own to carry out their tasks. For example, many full-time staff found that part-time staff often needed assistance with tasks such as bathing and toileting residents. Had the part-time staff received more training on these procedures they would not have needed the assistance of full-time staff. Lastly, as already mentioned, for residents an increase in part-time staff means that those involved in their daily care are often unfamiliar with the routines of the day as well as with the residents themselves.

Perhaps what is most disappointing of all for caregivers working in long term care facilities is the lack of any positive change within the industry. In Canada in the last ten years there have been several studies conducted that look at working conditions for staff and living conditions for residents in long term care facilities. In a study conducted in Alberta in 1988 by

the Christian Labour Association of Canada (CLAC), researchers concerned with and alarmed at the treatment of seniors living in long term care facilities conducted interviews with staff in order to try and make policy makers and the general public aware of what was going on in these settings (Christian Labour Association of Canada, 1988:5).

Included in their findings were the same issues as those discussed above: multi-tasking, under staffing and an increase in part-time workers. Perhaps the findings of CLAC can best be summarised in the following statement:

> Under staffing is the direct result of insufficient government funding and inadequate minimum staffing requirements. It also reflects the preoccupation of not a few private nursing homes with making money for their owners and shareholders, and the fact that care provisions for the elderly as well as wages and working conditions of staff members are secondary considerations. (Christian Labour Association of Canada, 1988:21)

The reason this study is important is that all the issues and concerns raised by caregivers in Alberta in 1988 are the same issues and concerns being raised by nurses and other caregivers across Canada in 1999. These problems have existed for over ten years and still nothing has changed. In fact as we will see in Chapter Five, for staff in Nova Scotia things have only worsened. Little change has occurred in the past ten years, even though research has shown there is a great need for change within long term care facilities.

While many of the problems in the health care system have continued to exist over the past ten years, one of the greatest challenges that only recently has appeared is the threat of privatisation.

Privatisation

With the introduction of private sector strategies in health care also comes the move towards privatisation, which has consequences not only for those who work in the health care

sector but also for those using the services. The focus on cost cutting and greater efficiency has brought about the conditions needed for privatisation. Canadian governments are adopting American for-profit practices in the public sector as a means of both improving and reducing costs. They are also shifting more of the responsibility for payments and provision of health care to individuals and for-profit companies. By doing this the government is moving dangerously close to creating a two-tiered system of health care. A good example of this can be found in the cutbacks to small option homes[6]. In the last five years the government has cut the funding it had previously given to people wanting to stay in small option homes in their communities. As a result, only those who are able to afford to pay their own way are able to stay in this type of facility. All those requiring assistance from the government must go to long term care facilities where funding is available. In the case of Nova Scotians, that means 75% of those entering long term care facilities are given little if any choice about the facility in which they will live out the remainder of their lives (Beanlands et al., 1994: 8).

As strategies like those discussed above are applied, Canadians' will spend more, not less, on health care. After all, it is in a private company's best interest to ensure profit as its main goal (Armstrong & Armstrong, 1996:188). As well, privatisation leads to inaccessibility and inequality. In a for-profit system more money comes from the individual and employers. As a result, the individual who is better able to pay for health care will receive more, as access becomes based on money (Armstrong & Armstrong, 1996:186).

[6] small option homes, refer to homes for the elderly that are limited to a maximum of five residents, and are currently not government regulated.

Lastly, privatisation has a great impact on workers. For-profit organisations increase their returns by increasing the number of unskilled workers and applying the private sector strategies, such as multi-skilling, time motion studies and increased part-time workers.

So, what does this all have to do with Nova Scotia? Before we look at the impact of the changing health care system on care givers in Nova Scotia we must first have an idea of what long term care facilities in this province are like.

Nova Scotia nursing homes

Like all other provinces, health care in Nova Scotia has been subjected to numerous changes over the past number of years. There have been a considerable number of bed reductions not only in hospitals but also in long term care facilities. Many acute care facilities have even been forced to close. While all health care services have undergone considerable cutbacks and changes, long term care facilities have faced perhaps the greatest burden of health care reform (Nova Scotia Nurses' Union, 1997:5). Table 2.9 gives us a break down of the number of homes for the elderly as well as the number of beds currently available in Nova Scotia.

All long term care facilities in the province are owned and operated by municipalities, municipal corporations, private non-profit societies, individuals or companies. In Nova Scotia, individuals are responsible for their own maintenance during their time in the facility. If the individual does not have sufficient resources to provide for his/her care, applications can be made to the municipality in order to acquire assistance. Therefore in every home we can find residents who pay all their maintenance costs, some who pay a portion of the costs and some who rely solely on the municipality to pay their costs.

Table 2.9

Long term care facilities in Nova Scotia

	NO. HOMES	NO. BEDS
Homes for the Aged	40	3616
Nursing Homes	27	2097
TOTAL	67	5713

Source: Nova Scotia Action Committee

TABLE 2.10

Publicly Supported and Private Paying Residents in Nova Scotia

	% of residents over 65 years	Publicly Supported (%)	Private Paying (%)
Homes for the Aged	96.4	71.4	28.6
Nursing Homes	90.0	80.5	19.5

Source: Department of Community Services

Nova Scotia is divided into 66 municipalities, and a single home may have residents from as many as 25 municipal units as well as private paying residents. Table 2.10 provides a breakdown between publicly supported and private paying residents in Homes for the Aged and Nursing Homes. As we discussed above, and as we can see from table 2.10 any move towards privatisation will have an incredible impact on residents and staff in Nova Scotia, as approximately 75% of the elderly require financial assistance.

So who is a typical resident? More often than not the population is a mix of the frail elderly, the mentally disabled, the mild to moderately mentally handicapped and the modestly physically disabled (Department of Community Services, 1992:11). However, in relation to the elderly population the profile of the typical resident has also changed over the last ten years. In a survey conducted by the Department of Community Services in 1992 it was found that the percentage of residents with behavioural problems and significant confusion has increased. As well, there has been a 15% increase in the overall number of residents who require Level II Care[7]. When it comes to physical capabilities it was found that the number of residents needing assistance to walk, or who are confined to a wheelchair and/or bed has also increased. This means that more and more residents are dependent on staff for partial or total assistance with mobility as well as with feeding and there is an ever increasing number of residents who are incontinent (Department of community Services, 1992: Sub. Committee 3p.13).

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[7] Level II care refers to the care required by a person with a relatively stabilized chronic disease or functional disability, whose condition is not likely to change in the near future and who requires the availability of personal care on a continuing 24 hour basis, with medical and professional nursing supervision.

The resident population has also increased at age upon admission to the nursing home. The average age at admission in 1985 is thought to have been 75, while in 1990 the average age was 79.6. With this increase in age comes a greater increase in needs. Staff need more training to deal with a wider variety of health issues. However, while there is currently an abundance of staff training opportunities in the province for long term care staff, there is no requirement that staff participate in training programs, either entry level courses or upgrading courses.

Currently in Nova Scotia the number of direct care staff assigned to a particular institution are determined using a formula calculation, and professional staff are added over and above this. In 1992 in homes for the aged, 14% of the direct care givers are registered nurses, 9% are licensed practical nurses or certified nursing assistants and 77% are care givers or personal care workers (Department of Community Services, 1992: Sub. Committee 3p.7).

A more in-depth look at who makes up the caregivers in long term care facilities in Nova Scotia and the challenges caregivers are facing is dealt with in Chapter Five as we explore the work world of ten caregivers. Before hearing from these women a more in-depth examination will be made of two critical questions. What is really going on in the health care sector? and, Why is it going on?

CHAPTER THREE
A THEORETICAL APPROACH

In order to answer the questions, what is going on in the health care system? and why is it going on? two different theories have been used in this thesis. The first theory is one that George Ritzer (1996) has borrowed from Max Weber (1968) and it is used to answer the question of what is going on in the health care sector. The second theory borrowed from Karl Marx answers the question of why is it going on.

It is with difficulty these two theories are brought together as they offer different and sometimes opposing approaches to explain how society works. Despite these differences, an attempt is made to bring several aspects of their works together. Through combining these perspectives, an attempt can be made to explain the current health care system. We will begin by discussing the question: What is going on in the health care sector?

Max Weber

In his work Weber demonstrates how the modern Western world produced what he terms *formal rationality* (Weber, 1968:809) This type of rationality refers to the search by people for the optimum means to an end. This means to an end is shaped by rules, regulations and large social structures (Ritzer, 1996:18). In this type of rationality individuals are not left on their own to find the best way to reach their objectives; instead, with the development of formal rationalisation people use rules to help them decide what to do. The "optimum means" for achieving their objective are said to have already been

discovered. Over time these means have been institutionalised in rules, regulations and structures (Ritzer, 1996:19).

According to Weber, formal rationality is comprised of four components which make up what he termed the *bureaucracy* (Weber, 1968:223). A bureaucracy is a large scale organisation comprised of a hierarchy of offices. In these offices people have certain responsibilities and act according to rules and regulations. The first component of the bureaucratic system is *efficiency*. For Weber the bureaucracy was the most efficient structure for dealing with large numbers of tasks and huge amounts of paper work. The second component is *calculability*, or the quantification of things. By reducing things to a quantifiable number of tasks, people could better gage their success at those tasks. The third component Weber examined was *predictability*. Because of the well entrenched rules and regulations found in bureaucracies they were and are highly predictable. This allows both the employee and employer to know how the other will respond to most situations. The last component is that of *control*. Bureaucracy emphasises control over people through the replacement of humans with non-human technologies (Weber, 1968:987). While Weber praised bureaucracy for its efficiency, he believed that it also had a negative effect on individuals in that bureaucracies made for de-humanising work places.

George Ritzer

In borrowing from Weber's theory of rationalisation, George Ritzer (1996) theorises that in society today we are moving beyond the existing structure of the bureaucracy into a model of rationalisation which he terms *McDonaldization*. According to Ritzer, it is this type of rationality that is structuring and shaping society today (Ritzer, 1996:1).

McDonaldization is " the process by which the principles of the fast food restaurant are coming to dominate more and more of American society as well as the rest of the world" (Ritzer, 1996:1).

Like Weber's bureaucracy, McDonaldization is comprised of the four components of *efficiency, predictability, calculability* and *control* (Ritzer, 1996:9). McDonaldization implies a search for maximum efficiency in increasingly numerous and diverse settings. According to Ritzer, efficiency means choosing the optimum means to a given end. Optimum here refers to the attempt to find and use the best possible means. In using a means and ends approach, efficiency can be applied to a wide variety of social settings including health care (Ritzer, 1996: 36).

In a McDonaldized society people rarely have to search for the best means to an end on their own. Rather, they rely on the optimum means that has already been established previously and institutionalised in whatever setting. For example, the best means may be part of a technology introduced into the organisations rules or regulations. This technology may be taught to the employee when they begin their employment with that organisation. Employees are not left on their own to try and discover the best means to an end (Ritzer, 1996:35).

Efficiency benefits the customer, manager and workers. Consumers can obtain what they need quickly, workers can perform their task more rapidly and easily, and managers gain because customers are served efficiently (Ritzer, 1996:36).

Ritzer argues that one of the many structures that has been influenced by rationalisation is modern medicine. Modern medicine has adopted the move towards

technical efficiency. An example of this move can be found in hospitals where technology serves to make the practice of medicine more efficient. Laser technology, for instance, has greatly increased the efficiency of eye operations (Ritzer, 1996:45).

The second component of McDonaldization is calculability. A McDonaldized society involves an emphasis on things that can be counted or quantified. In fact in many instances, people have even come to view quantity as a surrogate for quality (Ritzer, 1996:67). The emphasis on quantity relates both to the process and production as well as to the end results of the goods or services produced. Speed becomes the central focus when looking at production; in the case of the end result, the actual number of products produced or people served is what is important. However, this emphasis on quantity adversely affects the quality of both the process and the results. As well, employees have little if any chance of obtaining any personal meaning from their work (Ritzer, 1996:67).

In the health sector efforts are being made to quantify various aspects of the health care process. By limiting the amount of time given to each resident and maximising the number of residents seen in a day long term care facilities are able to reduce cost and increase profit. If care givers are able to look after more residents per shift, less workers are needed and owners save on wages.

The third component of McDonaldization is predictability. Rationalisation involves the increasing effort to ensure predictability from one time and place to another. A McDonaldized society emphasises such things as discipline, order, systematisation, routine, consistency and methodical operation. Most people prefer to know what to expect in most settings and at most times (Ritzer, 1996:77).

Predictability for workers means that tasks are made easier and can be performed effortlessly and mindlessly. Some workers prefer this, some do not. For managers and owners, predictability eases the management of both workers and consumers. Predictability also makes it easier to anticipate the need for materials, supplies, income and profit.

Bureaucracy is predictable in three ways. The first is through established offices which are set up so that people know from whom to take orders from. Secondly, the establishment of these offices ensures that employees know the tasks for which they are responsible. Thirdly, documentation of rules and regulations provide employees with boundaries in which to operate (Ritzer, 1996:99).

Historically medicine has been anything but predictable. However, according to Ritzer, a variety of forces are pushing medicine in the direction of greater standardisation. Various medical organisations, such as hospitals and long term care facilities, like all bureaucracies, are based on a series of rules, regulations and formalised controls which ensure standardisation. These standards lead physicians and caregivers to practice medicine more predictably. The situation now occurs in which the behaviour and treatment physicians or caregivers give to patients differs little from one patient or visit to the next.

The fourth characteristic of McDonaldization is control. Through increased control and the replacement of humans with non-human technology, an increase in control over both the employee and the consumer can be established (Ritzer, 1996:101). This replacement of human workers is motivated by a desire for greater control since humans are the source of uncertainty, and inefficiency and are unproductive within the rationalised

system. The goal of the organisation, in this case the nursing home, is to gain control over people gradually and progressively through the development of effective technology.

It is important to note here that technology refers not only to machines but also materials, skills, knowledge, rules, regulations, procedures and techniques. The main goal of non-human technology is control. Technology also leads in many instances to increased productivity, cheaper labour costs and greater inequality between workers and between management and workers (Ritzer, 1996:102).

As other rationalised systems move towards greater use of non-human technology, so does the medical field. An example of this is the growing importance of bureaucratic rules, control and the growth of modern medical machinery. In most cases the doctor with the black bag is gone. Now doctors act more as dispatchers sending patients on to the most appropriate machine or specialist. We are even beginning to see the emergence of computers which diagnose illness (Ritzer, 1996:103).

When discussing McDonaldization it is important to understand that all the basic dimensions of efficiency, predictability, calculability and control are intertwined. For example, the emphasis on things which can be counted make it easier to determine efficiency. As well, once quantified, processes and results become more predictable. Quantification is also linked to non-human technology which performs tasks in a given amount of time.

When looking at the process of McDonaldization it is easy to see both positive and negative aspects of rationalisation. The positive aspects are what Ritzer (again borrowing from Weber) defines as rational. The negative aspects of McDonaldization are what he

defines as *irrational.* Irrationality leads to inefficiency, unpredictability, incalculability and loss of control in the work place. Specifically, irrationality means that rational systems are unreasonable systems that deny human reason for people who work within them or those who are served by them (Ritzer, 1996:121).

Contrary to the promise of being more efficient, rational systems may end up being inefficient. As we will see in Chapter Five as the health care system moves towards a more rational system, inefficiencies begin to occur. For example, instead of increasing quality care for residents we find a decrease in the over all quality of care The ultimate irrationality of the medical world would be the unanticipated consequences of a decline in the quality of medical practices and a deterioration of the patient's health. With their focus on lowering costs and increasing profits, medical systems have reduced the quality of care for their patients. Ritzer argues that as the health care system continues to rationalise, health care professionals and their patients may need to learn how to control rational structures and institutions if there is to be any chance of rectifying the irrational consequences of McDonaldization (Ritzer, 1996:139).

While Ritzer's theory of McDonaldization may in fact give us some insight into what the changes to the health care system are based on, he does not discuss the driving force behind all the changes. This is where Karl Marx fits into the health care equation. He helps to answer the question: what is the driving force behind the changes to the health care system?

Karl Marx

For this thesis, we will be looking at the concepts of commodification, exploitation and surplus value in order to explain how the for-profit business model is influencing the restructuring of the health care system. According to Marx, in a capitalist society all social values are ultimately reduced to *commodities*. A commodity is defined as anything that is produced in order to be bought or sold in the marketplace for an exchange value (Marx, 1936:125). A commodity is something that contains the qualities necessary to fulfil or satisfy human needs. The specific need we are trying to fulfil does not matter, nor does it matter whether the commodity is satisfying our needs directly as a means of subsistence, or indirectly as a means of production (Marx, 1936:125)

According to Marx there are two facets of a commodity: its use value and its exchange value. The use value of a commodity is simply the properties of a given item that make it useful for the purpose of satisfying particular needs or wants (Hadden, 1997:59). As soon as a good is exchanged it acquires another feature unrelated to its use value, exchange value. The *exchange value* of a commodity is determined by the labour time *socially necessary* for its production. Marx argues that in any given society there is a more or less agreed upon socially necessary labour time. This necessary labour time is the amount of labour required to produce any use value under conditions of production normal for a given society and with the average degree of skill and intensity of labour prevalent in that society (Marx, 1936:129)

In a capitalist society the mode of production is based on exchange of commodities. The driving force behind capitalism is the need to increase the particular exchange value known as the capitalist's profit. In order to increase the exchange value the capitalist must attempt to raise the rate of exploitation in order to expand; furthermore, only by increasing the rate of accumulation or surplus value will the capitalist not be driven out of business by other capitalists. Therefore, in order to obtain surplus value the capitalist g.ves up some of his/her capital to the wage labourer in the form of wages. Labour thus itself becomes a commodity (Hadden, 1997:56). The wage labourer obtains a wage or means of subsistence from the capitalist in exchange for her/his labour power (Sacouman, 1999:49).

Wage labourers produce commodities for exchange on the market in return for subsistence, and the capitalist gets labour power. When a capitalist purchases labour power s/he does so by an agreement in which the worker agrees to work so many hours in exchange for a wage. However, what the capitalist is purchasing is not only labour, but labour power, which is the worker's ability to add value. That is to say, what the worker gets paid for is what it takes to reproduce the labour involved (Sacouman, 1999: 49). What is going on then, when the capitalist appears to be purchasing for example, eight hours of work in a given day? The worker produces the exchange value equivalent to his/her daily wage in say, four hours and produces new value for the capitalist in the remaining four hours. The value produced in the last four hours, when sold, accures to the capitalist in the form of surplus value, which is transformed into profit (Hadden, 1997:74).

Now the capitalist, anxious to further increase surplus value does so through exploitation. In the case of caregivers this exploitation occurs through the four components

of McDonaldization. Capitalists, to be capitalists, must exploit the working class and must always develop ways of raising the rate of exploitation (Sacouman, 1999:50).

The driving force behind the changes to the health care system thus becomes the need to commodify care in order to ensure an ongoing exchange whereby profit can be achieved through exploitation. A service such as a care provider is nothing more than the useful effect of a use-value, be it a commodity or be it labour (Marx, 1936:187). The worker, in this case the caregiver, produces a good, their ability to care, the capitalist or owner of the facility, purchases that good and sells it to the consumer, or resident, who requires the service. This creates the capitalist form of production in the field of services as we now have a commodity to be bought and sold on the market (Braverman, 1974:360).

It is important to point out here that services, like caregivers, only become important to the capitalist when they produced a profit. That is to say people have been performing tasks such as caring for the sick long before people were ever hired to do this. It was only when the service being provided could be exchanged for some monetary value that it became of interest to the capitalist (Braverman, 1974:362).

It was only when capitalists recognised that services could be profitable that they began to purchase labourers, or caregivers. Because capitalists, to be capitalists, need to increase profit, they must develop strategies which allow them to create as much surplus labour as possible. To do this capitalists raise the rate of exploitation through the four characteristics of McDonaldization discussed earlier. Once care becomes a commodity it has an exchange value, and it is that exchange value that capitalists are interested in maximising.

What is also important to point out here is that in terms of care giving the majority of workers are in fact women. Women make up roughly 80% of the health care work force, and one out of every ten women is employed by this sector. Therefore, any move towards the restructuring of health care, greatly affects a large percentage of women.(Armstrong, et.al, 1997:13). As such, the restructuring of the health care system must also be understood in terms of the search for-profit and the struggle over power and resources. The employer or owner is working to increase profits by introducing new technologies, by breaking jobs up into fragments that can be handled quickly by workers who require little training and who can be easily replaced, by making each employee work longer and harder, and by increasing control over the labour process. This need to increase profit has considerable implications for women (Armstrong, et. al, 1997:13).

Here it can also be argued that the restructuring of the health care system is occurring due to the fact that the majority of caregivers are women. Inequality in pay, availability of workers, a general undervaluing of "caring work," and the move towards only meeting physical need all help to create the conditions necessary for restructuring. Care is disappearing partly because it is less visible and hard to measure and partly because it is performed by women, and partly because it does not fit into a for-profit model (Armstrong, et.al, 1997:13)

As these principles of McDonaldization are put into practice and capitalists work to increase profits and maximise surplus labour, workers and residents suffer. Chapter five illustrated how McDonaldization and the adoption of for-profit practices are reshaping the work world of caregivers in Nova Scotia.

CHAPTER FOUR
METHODS

Choosing a method

In undertaking any research it is important to choose a method that will assist the researcher in answering the question being asked. For this reason it was important to choose a method that would allow insight into the staff's perspectives on the changing health care system. An exploration into how staff felt and understood their current working conditions and the experience of residents living in long term care facilities needed to be undertaken. To achieve this insight a qualitative approach was taken in this thesis. By using a qualitative approach the researcher is better able to develop a description, tentative explanation and understanding of the situation of caregivers (Rubin & Rubin, 1995: 2)

In trying to understand a complicated problem, such as the impact of the changing health care system, it was necessary to discuss the topic in-depth with those who had direct experience with and are affected by the changes (Rubin & Rubin, 1995:17). Therefore, in-depth interviews were chosen as the means to research how caregivers make sense of the world in which they work. As well, by using in-depth interviews the researcher is given the opportunity to help reconstruct events of which they were otherwise not a part. In-depth interviews give one the opportunity to look into the lives of others and to share in their world, to the degree that this is possible.

In-depth interviewing also allows those participating a chance to express what they see as the important elements in the changing health care system. By using in-depth interviews as the research tool the researcher is given the opportunity to see if their previous observations and understandings of the situation are the same or different from those of the people participating in the research. By conducting interviews the researcher can achieve a more accurate understanding of the staff's perspective. After all, understanding is best achieved by encouraging those participating in the research to describe their world in their terms as they understand it.

Ethical issues

Before beginning any type of research, considerable attention and thought must be given as to how the researcher will ensure confidentiality, privacy, and consent. In the case of this research project, extreme caution was taken to ensure that whatever information was gathered was kept confidential. That is to say, measures were taken to ensure that any information that could reveal a person's particular identity or their place of work was left out. All names were changed and each long term care facility where the research data was collected from was given a pseudonym.

All research participants were volunteers who received information about the research, including the nature and the purpose of the study, prior to volunteering to participate. All those who participated in the study were contacted twice. The first meeting was held to discuss the research and give respondents an opportunity to ask any questions. As well, it was used to make sure that those involved had a clear understanding of the

purpose of the research. The second meeting involved the actual interview. On both occasions participants were repeatedly reminded that they were in no way obligated to participate in the interviews and that they were free to withdraw at any time for any reason.

Before the interviews were conducted all participants were asked to sign a consent form. Included in the consent form was permission for the researcher to record the interview with the assurance that the tapes would be destroyed once the report was written up. (See Appendix A for the complete consent form). Participants were informed at the beginning of each interview that they were free to not respond to particular questions, and that they were free to terminate the interview at any time.

Choosing participants

In choosing caregivers with whom to conduct interviews a decision was made to choose people who had worked at a long term care facility for at least five years. This was important and necessary in that the research explores the effects of the changing health care system. It was therefore necessary to interview people who have been working in long term care long enough to be able to recognise what changes have taken place. Of those interviewed, five women were from Truro and the surrounding area, and five were from the Yarmouth area.

All the interviews were conducted using a semi-formal structure. That is to say, a question guide was used to stimulate conversation and to ensure all relevant topics and concerns were covered. However, the questions were used as a guide only and the interview was not solely limited to those questions. All those interviewed were encouraged to discuss any relevant topic. As a result of using the format of the semi-structured

interview, the interviews were more relaxed, less restrictive and less confining than a formal questionnaire or structured interview. This was important in that the goal of the interview was to achieve depth and breadth on the issues from each interviewee (See Appendix B for the interview guide).

Residents of the different long term care facilities were not interviewed. Instead, staff members were relied upon for information related to and concerning the quality of care that they perceived the residents were receiving. As well, the staff's perspective was used to explore any other effects the changing health care system may have had or may have on residents. Residents were not interviewed due to the difficulty of finding an adequate sample. Due to illness, dementia and other complications, most residents were unable to participate fully in interviews.

Choosing facilities

In choosing which institutions to contact a list of long term care facilities was obtained from two different hospitals in the province. In order to obtain these lists the Social Worker at each of the hospitals was contacted. One hospital was located in Truro, and the other in Yarmouth. These particular areas were chosen for several reasons. First, both were readily accessible to the researcher. Second, the two sites allowed for an exploration of whether or not there was a difference in the effects of the changing health care system according to where one lives in the province. It is important to note here that only those long term care facilities registered with the hospitals were on the list. As a result of that, the sample was limited to only those facilities.

Telephone calls were made to the different long term care facilities in order to set up a meeting to discuss the research project. In choosing which facilities to call, the researcher simply started at the top of each list. If a long term care facility declined any involvement the next facility on the list was contacted. This was repeated until the ten interviews were set up. Five interviews were done from each of the two lists, which resulted in interviews being conducted at two different sites within the province. As stated earlier, the long term care facilities contacted included a variety of different settings including, two small option homes, two nursing homes, two special care facilities and one residential facilities. In total seven different long term care facilities were represented. (For a definition of each type of facility refer to the glossary at the end of this thesis).

Of the seven facilities, each of the small option homes were private for-profit homes. The other five facilities were private non-profit homes. (For a definition of each refer to the Glossary at the end of this thesis). Yet, as we find in the analysis whether for-profit or non-profit all facilities have been affected by the changing health care system. As well, it is important to point out that none of the facilities represented in this research were unionised. Therefore the findings of this research are limited to non-unionised facilities.

Participant profiles

In choosing participants with whom to conduct interviews it was necessary to ensure that all types of caregivers were represented. Therefore upon contacting long term care facilities measures were taken to ensure that the registered nurses, directors of nursing, nursing assistants, and personal care workers were all represented. To ensure this, specific groups of workers were asked to participate in the study. For example, upon contacting the

long term care facility it was requested that a representative for the PCW, RN, DON, or NA participate in the study. Of those interviewed, two were directors of nursing, four were personal care workers, one was a licensed practical nurse, one registered nursing assistant and two were registered nurses. In all, participants had a combined work experience of sixty-six years in long term care facilities; the shortest had worked five years in nursing care and the longest having worked 20 years. Due to time constraints and financial constraints only ten interviews were conducted. As a result, the sample is limited to the experiences of these women.

All the ten caregivers interviewed were women. Women make up 79 % of the workers working in the health care industry across Canada with Nova Scotia is no exception (Statistics Canada, 1993, Table 1). Of the seven institutions represented none had a male caregiver on staff at the time of the interviews. However, four out of the seven facilities stated they had had male caregiver on staff at different times over the course of the last five years.

The different long term care facilities represented ranged in their capacity from five residents to eighty-six residents. The number of caregivers on staff ranged from three to seventy. On average for every one full time caregiver in each home there was three part-time workers. Out of the ten participants, six were considered full-time workers and four were part-time. However, those who were considered part-time often worked as many as forty hours a week, depending on the given situation of the facility

Each of the interviews were recorded with the shortest interview lasting thirty eight minutes and the longest interview an hour and a half. On average, interviews took about forty-five minutes.

Once the interviews were conducted, each one was transcribed verbatim. From there critical themes were pulled out in relation to working conditions, quality care, multi-tasking, cutbacks, wages, and staff morale. As well, each participant gave recommendations on what they believed would help to improve their current situation and these are presented in the analysis that follows. The next chapter explores the work world of ten care givers in long term care facilities in their words as they see it and understand it. As we will see in the next chapter, no matter how large or small the facility or what the number of staff employed all faced similar challenges and worked under similar constraints.

CHAPTER FIVE
DATA ANALYSIS

This chapter provides an in-depth look at the current issues facing caregivers. The order in which these issues are discussed is significant. The issues which came up again and again during the interviews are given priority over the issues which received less comment. The topics discussed cover the issues of quality care, multi-tasking, cutbacks, wages , staff morale, the mentally ill and the future of long term care. Wherever possible the exact words and responses of those interviewed were used. This was done in order to ensure that it is the caregivers' understanding of the current situation that is being presented and not the interviewer's understanding or interpretation.

Quality care

Quality care was the greatest concern for all those interviewed; and the umbrella under which all other issues could be subsumed. Quality care is seen to encompass all aspects of the long term care facility and is either directly or indirectly affected by any change that occurs, no matter how small or insignificant that change may appear to be. Again and again staff discussed the desire and necessity to provide quality care to the residents. When asked how the changing health care system has affected them, all of those interviewed responded that their declining ability to give good quality care to their residents was the greatest impact of the changing health care system. When asked to define what quality care was, most had a similar response, which included treating the resident (or patient) as a whole person, where one is working to meet not only the

residents physical needs but also their emotional and spiritual needs. One personal care worker had this to say:

> Quality care means making sure you are meeting the needs of each and every resident and that you meet those needs on an individual level. It means making sure residents are physically okay as well as emotionally okay. Quality care means making sure families are involved in patient care and most importantly quality care is care which is flexible to individuals.

Similar to her response was this one given by a director of nursing:

> Quality care is meeting all the physical, psychological and social needs of each individual which helps to enhance their well being.

While all caregivers recognized the importance of quality care and treating the individual as a person who had physical as well as emotional and spiritual needs, all felt that providing good quality care was difficult to achieve. All ten women felt that under the conditions they worked they were providing the best quality care they could, but that there was definite room for improvement. One RN put it this way:

> We all recognize the need for good all around personal care. However, it is physical care which is allotted the greatest amount of resources. Because it is much easier to see physical needs they are easier to treat, therefore the decisions that are being made on how many staff are needed and how much funding is allotted to each facility deal directly with physical needs. What is so critical here to know however, is that emotional, psychological and social needs are just as important. If a resident is depressed then they stop eating which leads to more physical problems etc.. Everything is interconnected and needs to be treated altogether.

What caregivers found the most frustrating was that those making all the decisions, in this case management and government, deemed only physical needs to be important. That there is an increased focus on physical needs in today's health care system should come as no surprise if we think back to the models of health care discussed

earlier. As we will hear, more and more facilities are adopting a medical approach which is making "quality care" that much harder to achieve. The focus is on running an efficient business where meeting those needs which are easily seen is what is important. Therefore residents are treated according to what body part is in need of being fixed, and not as an entire individual. While all of those interviewed expressed a desire to try to meet all of the residents' needs, all felt that under the current system this was impossible. One PCW made the following comment:

> .... because of all the time constraints in our job it is almost impossible to do anything but meet the physical needs of the resident. When you are responsible for 12 residents on your shift and each of those must be bathed, feed, changed, turned over, given medications, dressing changed, beds changed then they are fed again changed again and put to bed for an after noon nap you really don't have anytime to sit and chat. Even when you want to it is extremely hard to find time during the day just to sit and talk to a resident. Many of them are lonely and depression is a big problem but what can you do with out more staff?

Her thoughts were reiterated by an LPN who made the following observation:

> ... it used to be a few years ago that you actually had time to spend with each resident. After you finished meeting all the physical needs you could take a few minutes or longer to take them for a walk down the hall, or sit on their bed and ask how they are doing. But now you just don't see that. There use to be a lot more emphasis placed on the psychological welfare of the residents now that seems to be the last thing on the list. No one has anytime anymore you can barely look after all the physical needs.

A personal care worker shares this story to illustrate the growing decline in quality care for residents in her care:

> .... well perhaps the easiest way to see the effects of the changing health care system is in this example I ran into just the other day. I start my shift at seven in the morning. When I first get to work I start by waking up any of the residents who are still sleeping in order to start getting them bathed and dressed for breakfast. When I went into Mrytle's room to get her up I found that she was

already awake. She was lying in her bed crying. I went over and sat beside her bed and asked her what was wrong. She went on to say that she was extremely lonely and wished her family could visit more. I spent about ten or so minutes with her talking about her family and trying to comfort her. After ten minutes I knew I had to leave and wake up George so he would make breakfast. What is disturbing about all this is that those ten minutes I spent with Myrtle were not really spent listening to her. After she told me what was wrong, we started discussing it. But, at the same time as we were talking about it I was also washing her and getting her dressed which is distracting for her and me. But to take just ten minutes to sit and listen and not wash and dress her puts me twenty minutes behind and that means someone else doesn't make it on time to breakfast. You feel guilty. Here is a women who wants just a few minutes of your time. She is lonely and depressed but you can't even comfort her in a way that she deserves. It never use to be like that. We used to have time to spend with residents, now the only time we spend talking to them is when we're looking after their physical needs. There is no longer time and the residents suffer and you suffer. Some of these people have no one and staff are the only people they have to talk to and we don't even have any time to give them.

Cutbacks

When asked what would aid staff in being able to produce quality care, all of those interviewed felt that the issue of quality care was directly linked to the number of staff on duty, which in turn is linked to the amount of health care funding by the government. Over the last five or six years government has cut funding to long term care. As a result, the number of caregivers on staff has decreased in some instances, or the number of part-time staff has increased. This increase in part-time staff had a negative impact when it comes to providing good quality care, according to the caregivers interviewed. One RN had this to say:

... because the number of part-time staff has increased in a large facility like ours where you have seventy part-time and only twenty full-time coupled with over a hundred residents, it makes it hard for the residents to establish any form of relationship with the part-time staff. In many cases they may only see the resident once every couple of weeks because staff often work different wings. As well, staff do not get to know the residents that well either, so they don't always make good assessments. A bad day for one resident can look the same as a good day

for another resident. But if you don't know the type of behavior or personality of a resident you may asses them incorrectly. As a result of that, full-time staff are relied upon to make all the assessments which adds to their already demanding work load. As well, with an increase in part-time staff, staff members don't establish the same relationship with each other. Part-time staff often find themselves working with different people each shift and it takes a long time to adjust to each new person you work with as everyone has their own way of doing things. It is also hard because part-time staff are not always familiar with the routine of each facility so sometimes full-time staff get frustrated.

Her thoughts were echoed by this PCW, who is part-time:

> .. when you only work part-time it takes a long time to get to know the residents as well as the routine. It is also hard because you always feel like you're lost when you come back. You have to read a chart to find out what has been going on with the resident's life: are they the same as they were the last time you were there or worse? Are they on any new meds? There is a lot to know and it's hard to keep up.

While the increase in part-time staff causes problems for residents and caregivers, it has benefits in terms of profit and efficiency for business. According to one DON, by hiring more part-time staff as opposed to more full-time staff, nursing homes and other long term care facilities save money. Not only are part-time staff paid considerably less but employers do not have to pay them benefits. (It is important to note here however, in two of the facilities where interviews were done part-time staff are given benefits) As well, one DON went on to say that part-time staff are a benefit to the employer in that:

> ... part-time staff appear to have more patience with the residents and because they work a limited amount of hours they are not as tired or burned out as the full-time staff. So, from an employers' point of view the part-time employee brings a lot of benefits. This is great for the employer but like I said earlier not so great for the full-time staff or residents, So, it all comes down to what's important, staff and residents or saving money. Now it's all about saving money. Every year our budgets get smaller and the work load and demands of the residents increase.

An increase in part-time staff is only one of the effects of the changing health care system. Along with this change we are also seeing a change in the type of residents coming into the long term care facilities. All ten care givers interviewed felt that the changing type of resident created a need for an increase in the number of caregivers, not a decrease. In the last five years most residents entering long term care facilities do so requiring a higher level of care. But that increased demand is not matched by an increase in staff or in better training. One RN had this to say:

> ...over the last ten years we have seen a major change in the types of residents entering the nursing home. When I first started working here most of the residents were here because they had minor medical problems such as arthritis or slight dementia. Some were here as well just because they didn't want to live alone or had nowhere else to go. Now, however, things are quite different. When residents come to our facilities they do so at a much later stage in their illness. With home care and home support groups residents stay at home as long as possible and only come here as a last resort. Therefore, by the time they enter the nursing home they are seriously ill and require a lot more care.

Her thoughts were shared by this PCW:

> ...the resident today is much different from the resident of four or five years ago. Almost all of the residents we had before were level one. They only required a minimal amount of care basically assistance with bathing and a few daily activities. Now however, most of our residents are classified as a level two when they come in which means they require assistance with just about everything. However, the level of staff has not increased to meet the demands these residents bring with them. The other problem is that some facilities like ours are technically designed for level one residents, yet if you went through our facility you would find most residents here are a level two. Level one residents are all at home using home care or other services. Because of that we are forced to take on level two residents just to fill our beds and remain open. Yet truthfully we are not equipped to look after the level two resident as well as we should be, especially as the needs of each resident increase.

It is important to note that it is not only physical needs that have increased over the past five or so years. Eight out of the ten health care workers interviewed also noted an increase in the amount of emotional and psychological care now required by the residents. A DON had this to say:

> ....there has certainly been an increase in the numbers of residents who come in with dementia. We are seeing a large increase in Alzheimer's patients and this brings a new set of challenges because you now have wanderer's and some residents even become quite aggressive. Many are depressed and cry a lot. The biggest challenge for us is trying to deal with the emotional or psychological component of their dementia because, as I said before we really only have time for physical needs and even meeting those needs is quite difficult.

Her concerns were shared by this LPN who had this to say:

> .....many residents require more emotional support because they are more ill when they come and they often are in the later stages of dementia they need a more psychological approach in providing them care.

A PCW added these observations:

> ...the greatest change in the resident in the last few years has been in the level of care they require. Before most of the residents coming in were what we term level one or only requiring a little assistance now most are level two and require assistance for all aspects of their day, feeding, getting dressed going to the bathroom and some are even total care which means we do everything for them. So care is definitely heavier.

One LPN used the following story to illustrate the change in the type of resident currently entering the long term care facility:

> Thinking back to the type of residents we use to get and the type of residents we now get there is a considerable difference. When I first started working in nursing homes most of the residents were healthier, not only physically but also mentally. It was easier in the sense that more of your time was spent doing activities with the residents rather than so much time spent looking after them. We use to do all kindsof things. It wasn't unusual to take residents for walks or involve them in cooking and many liked to help with folding the laundry. In the afternoon we'd have time to play cards, whatever that person liked to do. Now however, most of the residents coming in require a lot of physical care. Most have some form of dementia and the things we used to do we can't do. First,

> most of the residents are too ill to be involved in activities and second, because they require more care there is less time to do the activities. Lastly, we don't have the staff we used to so there isn't the time to do anything but personal care such as bathing, feeding and giving out meds. It's really a shame because there are lots of things these people can still do.

Multi-tasking

Because more and more is required of caregivers during their shift, there is less time for any one-to-one relations with residents outside of meeting the daily physical requirements. All those interviewed discussed how their role within the long term care facility has changed and how they all have had an increase in the amount of work and the number of residents they are responsible for during their shift. This increase in responsibility was not limited to any one type of position. It did not matter if one was a PCW, RN, RNA, or DON, everyone's role changed. According to one PCW, her work load increased to include not only personal care but also laundry and light house cleaning. The changing portfolio of each caregiver is a result of the changing health care system. Caregivers are performing a wide variety of tasks which in the past they were not responsible for. One PCW had this to say:

> ... about three years ago the number of house keepers on staff was cut back from two to one. So, in order to keep up, PCWs were and are expected to help the house keeper on their shift. Now, we have even less time to spend with our residents. That means that now we are not only expected to do personal care but also to change the beds and help out with laundry and house keeping. This can include emptying garbage cans and tidying up the resident's room even changing beds. It doesn't sound like a big deal but when you can barely get the residents looked after on your shift adding more work makes it hard on us and the resident.

A similar response was given by an RNA interviewed who now finds that, like the PCW, her work load has increased with new jobs and responsibilities, yet she has no more hours in her shift to perform all these tasks.

> .. work is becoming more and more stressful. I use to like coming to work because the days always passed quickly because you had a lot to do. But, now I dread coming to work because no matter how hard I work I always leave my shift without having done the growing number of things I was supposed to do. Because our portfolios have grown to include not only personal care but also some housekeeping, and even record keeping I find no matter how fast I work there is no way I can accomplish all my responsibilities. I use to skip my breaks and cut my lunch short in hopes of finishing everything but even doing that didn't help. It is impossible to do everything. No one likes to leave work for the next staff coming in because they have as much to do as you do. We're always behind and we'll just never catch up.

The job portfolios for the RNs and the DONs have also increased. One RN had this to say:...

> I think perhaps the biggest change for me has been that now instead of doing patient care which I used to spend most of my day doing I now do a lot more record keeping and book work. The files we keep on each resident are much more complex now. And because residents now move from nursing home to nursing home (some are on waiting list in facilities in their home communities and are only in our nursing home temporarily until a bed comes up) we have to keep lengthy records for them to take with them. As well, I spend a good part of my day scheduling staff. We now have a lot more staff members to schedule as the number of part-time staff has increased. Now instead of having ten people to schedule in you have five full-time and, say, ten part time.

Another RN had similar thoughts:

> ... perhaps the biggest change for me has been that now instead of working with the other caregivers side by side I find a greater amount of my time is spent over seeing the other girls. I still give out the meds but then for the most part the rest of my day is spent keeping records and making sure the girls are doing their jobs and assisting them with those tasks they are unable to do. ...an example would be, dressing a particular wound or putting in catheters because our girls for the most part learn as they go. Now instead of working side by side with them, I act more as a teacher helping them learn how to do whatever is required so that in the future they can do it for themselves. In a busy day you don't have time to find an RN to help with every task so it's important they learn how to do these things.

It is not only that job portfolios have grown to encompass a wider list of functions and responsibilities which create problems for staff, but now caregivers find that the residents suffer as well. Again quality care is grossly affected by the changing and growing responsibilities assigned to staff. In the past most caregivers had more time to spend with residents, even if it was only a minute here and there to sit down and ask how someone's day was going. Now, caregivers have little, if any, time to spend doing anything but meeting physical needs. On average for those interviewed, 34% of their time was spent doing non-nursing tasks. This is consistent with the study mentioned earlier done by the Goldfarb Corporation, which found that roughly 30% of nurses' time is now spent doing non-nursing tasks. If we look at five years ago for those interviewed, we find on average only 10% of their time was spent on non-nursing tasks and that in the past, there were more employees. Nursing staff were not responsible for cooking, cleaning, feeding or portering.

While caregivers and staff suffer under increased work loads, again the employer benefits. Now the same amount of work is being done, but the employer only has to pay one person instead of two. By eliminating a housekeeper and adding her work load onto the caregivers, employers save money. Employers now get twice the work for half the pay. What is also important to recognize here is that in three out of the seven long term care facilities in this study, staff are required to complete all of their tasks before they are able to leave. Within these three facilities staff are not paid overtime, and in most cases caregivers on average work at least half an hour of unpaid work per shift. In only two of

the seven facilities are staff paid over time. In the case of the other two facilities, those tasks that caregivers are unable to fulfill are carried over onto the work load of those on the next shift.

For all staff, regardless of what title they hold, the amount of responsibility and list of tasks they must take on have grown considerably over the past five or so years. Yet, all research participants went on to note that while the work load has continued to increase as a result of more illness, fewer staff and greater time constraints, the number of hours in the day has not changed, nor has the amount of money each worker receives. As well, as we will see a little later, technology has not helped to reduce the amount of work for staff but in many instances has only added to their work.

As the level of care both physically and psychologically required by residents continues to increase, staff find they now have a lot more work and an increased strain on their time. Furthermore, because those entering long term care facilities are much more ill, physically and psychologically, caregivers need to have a broader knowledge and more training. However, all those interviewed stated that either courses and training were not available to them, or were too expensive or not mandatory, which makes meeting these challenges difficult.

One RN explained it this way:

> ...while there are some courses available it is hard for us because they are all located in Halifax which is a fair drive. But it isn't only the drive, there is no funding available to pay expenses which for our girls means if they want further training in say, Alzheimer's they have to pay their own way to Halifax, their three nights in a hotel, food and conference fees and most of them can't afford it.

A DON shared a similar response:

> Perhaps what is most surprising is that currently there is no requirement for staff to have particular courses. Take the PCW course it isn't mandatory that you hire only people who have this course. In fact most of our staff only have on the job training. In truth, a PCW course should be the minimal requirement. But, it isn't required and there is no funding right now so even if you want your staff to take the course they have to pay for it. Not only that, but as residents get sicker there are more residents that require particular skills to look after them. Some have catheters which need to be changed, some have sugar diabetes which require injections, some have swallowing problems. The list goes on but, instead of a better trained staff to deal with this sort of thing we are seeing on the job trained people performing skills they have no training for. This can cause problems. For example last week a catheter wasn't inserted properly and as a result the resident developed an irritation that could have been avoided.

Another RN went on to say this:

> What is getting more and more frustrating for me is the fact that those working in long term care now are doing things that in the past were only done by nurses, registered, trained nurses. For example it used to be only nurses could give insulin injections, insert catheters, give out medications and the list goes on. Now, however, the standards are changing and now it is getting so that less trained people such as LPNs and even those on the job trained individuals are being taught these skills, and not always well I might add. What is happening is that we are pushing out RN's. Less qualified and untrained people are doing things that we did in the past. By allowing this to occur we are jeopardizing the quality of care for residents, not to mention their health. You can not learn in one day what took us (RNs) to learn in three years. I know why they are doing it. Obviously, it is way cheaper to pay a casual personal care worker than it is an RN but it isn't right. I went through a lot of training and effort to get to be an RN and now they are trying to deregulate the standards so anyone can do what I do.

Wages

Only two of the ten caregivers interviewed had received a pay raise within the last six years. Three others have had no pay raise at all even with an increase in job responsibilities. The other five have had their wages frozen for the last six years. While

in some long term care facilities caregivers have taken pay rollbacks, that had not happened to any of those interviewed for this research. When asked if they felt they were paid fairly, a resounding "no" was given by everyone. One PCW put it this way:

> Since I started here I have been paid $6.50 per hour. After four years of hard work I'm still only making $6.50. Now I am responsible for more people and I have more things to do. The more you learn and do, the more they expect from you. Well let's put it this way: I was talking to a man the other day and he told me that the local garbage collector makes more money and has better benefits than I do. Yet, everyday I am responsible for the well being and lives of five people, who for the most part, are totally dependent on me and everything I do affects them. That's a lot of responsibility. But, it is not only that you are responsible for peoples' lives, we work hard. We never stop and we take a lot of abuse. We definitely deserve more money than we get.

Her thoughts were echoed by this RN:

> Wages are a topic that make everyone a little tense around here. Six years ago there was a wage freeze put into effect. So, for six years we have been working for the same pay. In that same time period the resident has come to require more care physically, emotionally and psychologically, therefore care giving has become much more complex and yet, with the increasing demands of meeting all the challenges brought on by the change in residents, we have also had to deal with staff cutbacks. So, while we work harder now, we get paid the same. There isn't anyone here that would tell you they are happy with their pay check or that they think they are paid fairly. Cutbacks are hurting us. Not only that but as you probably already know we are paid less here than RN's in hospitals and that makes us extremely angry and frustrated. We all have the same training and we all work hard so why should they be paid more because they work in a hospital? None of it makes sense.

Staff morale

When asked what other problems the caregivers encounter as a result of the changing health care system, seven out of the ten women felt that there had been a considerable drop in staff morale. One DON felt wages played a enormous part in staff morale:

> The wage freeze has really affected the overall morale of our staff. It isn't easy getting up everyday, going to work and knowing that you are paid less than your peers who work in hospitals. It makes you feel extremely inadequate and it leaves you with a feeling of belittlement.

One RN had this to say:

> well perhaps one of the biggest changes for me has been the decline in staff morale. In the past we had a lot more team work. Everyone pitched in and helped everyone else and no one seemed to mind when you asked for help. But now we all have so much to do that you don't have time to help anyone else. And before when our shift ended we use to sit around and have a coffee together chat and have a good time. Some would even visit with the residents for a little while. But now, most of us are too tired or we end up staying later than our shift anyway, not for coffee and chatting but just to finish our long list of things to do. I think for most people care giving is becoming work. I use to love to come to work and be able to help the residents and spend time with them but now you don't have any time to really get to know them, as a result of being so busy and now doing a lot of the work by yourself you don't really get to know the other staff members as well anymore either. It's hard to have good staff morale when you feel underpaid and unappreciated.

Similar thoughts were shared by this LPN:

> Overall staff morale isn't as high as it used to be. Most of us feel like work went from something that was fun where we actually made a difference in people's lives to something that is just work. You don't have much time to share with the residents. We use to be able to sit on their bed and ask them how they were doing. We use to know their families, now you don't have anytime and you really don't get to just sit and ask a resident how they are. For most of us that's the part of the job we loved forming bonds and relationships with the residents. Now there is just really no time and it isn't only hard on us it is also hard on the residents.

Throughout the interview several of the caregivers expressed how technology is now influencing their work day. While one would think technology would help improve working conditions, as we will see that is not always the case.

Technology

For some of the smaller homes, technology such as computers and medi-lifts have had little impact in that these homes do not have the funds necessary to purchase these items. For the larger facilities, technology has come to play a role in the work day. For example, now instead of files being hand written they are typed and entered into a computer. For some staff this has meant that they have had to learn how to use particular computer programs and develop computer skills. One RNA used this example to illustrate the impact of technology on her work day:

> At first I thought it would be great to have all our stuff done on computer, but it has turned out that it tends to make more work for some of us. First, doing records and updating files used to take a few minutes: open up the book, jot down a few notes and be on your way. Now you have to sit down at a computer, type in the information and if you can't type it takes twice as long. Then there is the problem of system failure, not to mention before if you wanted to know something about a particular resident you opened their file and it was easy to find. Now we all have to familiarize ourselves with a whole new system and half the time I spend twenty minutes clicking through trying to find something as simple as if a resident wears upper or lower dentures in case they are missing. Its crazy, maybe when they get the kinks out it won't be so bad but right now I find it just creates more work and more problems.

For some staff, the more equipment purchased by the owners of the home, the more work they are expected to do.

> We were all glad when administration finally purchased a medi-lift for us. It isn't easy lifting some of these residents in and out of bed or on and off the toilet and most residents require the assistance of two people, so we were glad when we were told a medi-lift was being purchased. However, we soon found out that now we were expected to get more work done because we had a machine to do all the lifting. Well, the machine didn't give us anymore time, you still had to get the straps around the resident and guide them in and out of bed. It took just as long using the machine as it did for two people to do the same task. The only advantage now was you could save your back. The other problem was that there was only one lift for 12 residents and you always found yourself waiting for

> the machine. Administration didn't see it that way though. They felt we should be able to do more, giving us time to get all our tasks done.

As mentioned earlier in Chapter Two, more and more time limits and formulas are being placed on tasks caregivers are asked to perform. Yet, when asked if there were particular time limits placed on each task, all the caregivers said "no". However, all went on to say that while there is no exact time each task should take, such as six minutes to bath a resident, there are time limits in the sense that you know dinner must be done by one o'clock or residents must be up by eight o'clock etc.. Working within these time constraints is difficult enough for these caregivers, let alone having exact minutes for each task. One PCW used the following example to illustrate how difficult working within time constraints can be.

> While there is no set time limit on feeding each resident per se there are time constraints in the sense that you have four residents to feed and an hour in which to do it. This might not seem too bad, but let's break it down. You have four residents and one hour, so you have roughly fifteen minutes to feed each one. Now if we think about how long it takes us to eat a meal that isn't much time. Remember as well that you feed yourself. Feeding someone else takes more time. Not only that, but figure in the person who has difficulty swallowing, or chewing. As well, we often choose our meals and therefore like what we are eating. These people don't have that luxury. Often you have to coax them along. As well, for some of these residents lunch time is also social time. It is one of the few time they have to see other residents and most like to talk. But you can't talk and eat and you only have fifteen minutes. These are just some of the things that place constraints on you. Everyday the situation is different depending on how the person you are feeding feels. I'll say it again fifteen minutes isn't much time. But, you have to get them fed because once lunch is over there is still lots to do before supper. It's hard.

This illustration brings up several important points that we discussed earlier. The first is the difficulties with time constraints and the second is that these are people we are dealing with. When time motion studies were applied in the past they were done so

according to objects not people. The problem with trying to place time limits on task involving people is that people are unpredictable. Furthermore, all aspects of care giving are complex, not every residents can be fed in ten minutes, or bathed in six minutes. Some residents have swallowing problems and some are unable to assist the caregiver in getting in or out of the bath. It is this complexity that needs to be looked at when placing time constraints on caregivers and cutting back on staff.

The mentally ill

One issue that did not seem to affect caregivers in long term care facilities to any great extent was the introduction of the mentally ill patient into long term care. With the move towards deinstitutionalization, more and more patients are being transferred from mental institutions to long term care facilities. The introduction of these new residents does not seem to be causing any new problems for the majority of those interviewed. Only five out of the seven facilities had residents who had been transferred from mental facilities into the nursing home; within those facilities only one caregiver expressed any real problem with this move. Most felt that the time they spend with the mentally ill resident is no greater than the time spent with the average resident. The difference, however, is in the type of care required. One DON put it this way:

> The mentally ill patient that comes to us whether they are mentally challenged, have dementia, or have post mental illness do not for the most part require any more care than the other residents. However, we do find that, unlike the elderly resident who needs assistance with physical care, these residents need assistance with psychological and emotional care.

The one person who expressed concern did so in regards to the lack of training her staff had in dealing with the type of behavior and psychological problems these residents bring with them. She gave the following example:

> It is one thing to deal with residents who have dementia. It is another thing to deal with someone who has a compulsive disorder or multi-personality. We do not receive training in these areas and if we are going to put the mentally ill into nursing homes we need to have some type of formalized training on dealing with psychological disorders. As of right now that I know of the only courses available deal with Alzheimer's and other age related dementia. These psychological problems are not the same as other mental illness. Training needs to be available if we are going to be taking these residents in not only for our sake but also for their sake.

With respect to benefits to the mentally ill person, caregivers felt that they benefited from their move and many improved in their behavior and social skills. With respect to the owners of the facilities, the benefit lies in keeping all their beds filled. As we will see, keeping beds filled is a growing problem.

As more and more services such as home care become available and more and more care facilities open up, the competition among facilities has been increasing. Of those interviewed, three expressed a concern for the growing competition that is arising among long term facilities. Because government has cut the funding given to each facility, it is becoming extremely important that all available beds in each facility are kept full. However, what is now occurring is competition among the services provided. Nursing homes now have to compete against home care and small option homes and vice versa. As a result of this, many facilities are forced to take on residents they are unequipped to handle, such as the mentally ill or the level two or three resident. However, with each bed that is not filled comes a direct impact on the budget of that facility. This

impact is then dealt with by cutbacks in staff, an increase in part-time staff, wage freezes or no wage increase, heavier work loads and a lowering of quality care. An RNA put it this way:

> In the past few years we have seen a definite decrease in the number of residents entering our facility. As I already mentioned more and more of the elderly are opting to use services such as home support. Because we are a level one facility a program like home support depletes our resources of eligible clientele. To fill our beds we often have to take level two residents. Because people stay at home until they are extremely ill and home support is no longer feasible, they enter the nursing home much more ill and often we are unequipped to deal with them. There has to be a better way to ensure licensed facilities can keep their beds full while at the same time providing the level of care they are equipped to provide. Competition is hurting everyone. As well, many people are providing services to the elderly who are not only untrained for but there is no standard or regulations set up to ensure the elderly person is being properly looked after.

So is it all bad? While all of these caregivers discussed the negative aspects of the changing health care system, all felt that the residents made their job worth while. One PCW had this to say:

> The residents are what make putting up with all the bad aspects of this job worth it. Most of the residents have been around for a long time and they have wonderful stories to tell. Most of them have done a lot of amazing things. They have seen a lot and done a lot and most importantly they know a lot.

Her thoughts were echoed by this RN:

> I enjoy the residents. Some of these residents have been here for four and five years. You really get to know them well and they become part of your life. They are happy to see you when you come in and you are happy to see them. At the end of your day it's nice to know that you helped someone or you made them laugh or smile. I always wanted to help people and working here gives me that opportunity.

So what are the solutions to these growing problems? While all those interviewed agree there is no one answer, all had suggestions which they believe will help to improve things for themselves as well as for the residents. However, all agree that it seems unlikely things will improve. It does not seem to matter how many studies are done and how much time is spent making those with the decision making power aware of the needs of the caregivers and residents, little movement towards resolving the current issues facing long term care occurs. Most feel that their working conditions and the quality of care for their residents will only continue to decline as the health care industry seeks to become a profit making business. However, despite this pessimistic out look, the following recommendations were made by those interviewed with regard to the future of long term care.

Recommendations

* There needs to be formal training for all those entering a position of caregiver. Courses in personal care should be mandatory and funding must be available for them.

* All facilities are understaffed and there needs to be a reworking of the funding formula in order for more staff to be hired.

* All long term care facilities should be regulated in order to ensure the safely and well being of all the elderly who enter them. Currently there is a considerable lack of standardization from one long term care facility to the next.

* All those seeking entrance into long term facilities should be eligible for funding from the government in order to ensure they are able to remain in their communities. Funding should not be given only to those entering government run facilities.

* There is considerable need for greater communication between those directly involved in personal care and those making health care policies.

* As residents' care requirements become more and more complex and the level of care required by each resident grows, there is a need for better training and more staff to deal with the growing needs.

* Wages and benefits for those working in long term care facilities must become consistent within the industry and equal to that of their colleagues in acute care.

* Policy makers and the general public must be educated in order to understand the importance of long term care facilities.

* There is a growing need to return to team work rather than a situation in which everyone is out for themselves. It is believed by doing this that staff will be happier and less isolated from one another.

* There is a need for improvement in staffing levels at all levels of care from; PCWs, to RNAs, to LPNs to RNs.

* Caregivers need a voice. All too often long term care gets pushed to the back burner and other health care issues take precedence. We need to deal with what is happening in long term care facilities now.

CHAPTER SIX
WHO WINS?

Drawing links

On the one hand, the argument presented in this thesis is quite simple. In the search for maximizing profit and in the name of efficiency, government and owners of long term care facilities are turning care into a business in which caregivers and residents are paying too high a price. By adopting an approach whereby practices that are currently being used in the private sector are adopted by the public sector, working conditions in health care are deteriorating. On the other hand, the situation is quite complex, because it is necessary that we understand the medical model of health care which is being adopted, and the impact of McDonaldization, which leads to the creation of an irrational health care system.

As our health care system continues to be reformed by applying practices taken from the for-profit sector, we are continuing to move towards a system of health care whereby what is important is what can be counted or quantified, what are deemed to be efficient practices, predictability and an increase in control. While these strategies appear to be quite rational in terms of providing greater profit and a more efficient work place for owners, they are in fact quite irrational in terms of providing quality care and acceptable working conditions for caregivers.

By looking at each of the components of McDonaldization we can see how they are rational in terms of management but irrational in terms of workers and residents. Efficiency for example, provides a work place whereby workers can perform their assigned tasks more easily and more rapidly, but as we heard from the caregivers in Chapter Five, the move towards efficiency has brought with it increased workloads, cutbacks in staff, multi-skilling, and de-skilling.

Predictability is beneficial to management in that workers know what is expected of them and the boundaries in which to operate. Again, as we heard from the caregivers, predictability also means that workers lose their ability to make judgment calls. As well, by trying to create a more predictable work place, the overall complexities of dealing with humans as opposed to objects is not taken into consideration.

For management and owners a move towards calculability is also beneficial. Quantification helps to maximize the number of residents a caregiver can look after, which increases profit and reduces cost. Now less caregivers are needed to look after the same number of residents. The problem with implementing this component is that now quantity becomes a surrogate for quality and residents suffer.

The last component is that of control. By increasing the amount of control management and owners have over their workers they are working towards reducing the amount of inefficiency, unpredictability and uncertainty in the workplace. However, for caregivers this increased control means that they have little if any control over their work world.

As we can see while each of these components are rational in terms of the goals of management and owners they are irrational in terms of the consequences they have for staff. The overall irrationality of implementing these straiegies is the lost of quality care residents receive. Furthermore, it has not been proven that these strategies from the for-profit sector are in fact more efficient. As we have heard from the women interviewed here, in terms of quality care these strategies are in fact inefficient. If these strategies continue to be used as the defining principles for the reorganization of the health care system, the social program that is so loved by Canadians will continue to deteriorate.

While there is no easy solution to the problems being presented here, it is important that in the process of structural reform we do not lose sight of the need for quality care. Strategies that are adopted for change must be based on an approach whereby humans are not treated as objects which can be counted and controlled. We must recognize that in providing care we are not working with simple but complex and changing situations; where efficiency is not based on profit but in providing quality care. The introduction of these new for-profit strategies must be stopped; at least, more studies must be done on the impact of these strategies. Only by exploring in-depth the impact of these strategies can we hope to find a better way to structure and meet the needs of the health care sector and those who work and use the services in that sector.

The goal of this research project was not to solve the increasing and growing problems faced by caregivers, but it was to help gain some understanding and insight into the challenges caregivers face and the forces behind these challenges. Although we only heard from ten out of thousands of women currently working in long term care facilities,

their stories and experiences can help us achieve a better understanding of the impact of the changing health care system.

Lessons learned

Like all research projects this one has limitations and many lessons were learned along the way. In terms of methods it is recognized that the small sample of women interviewed limits the amount of data that was available to be explored. As well, generalizations are limited to those women interviewed. However, it is important to recognize that the findings of this exploratory research project are supported by the literature reviewed. Because of time constraints and limited resources such as money and travel expenses, only ten women were interviewed. Had these constraints not existed, a larger sample could have been used.

In relation to time constraints and limited data, several concepts arose in this research which need to be explored in greater detail. If time and money had been available, the issues of competition and privatization would have been explored in much greater detail, as they have serious repercussions for all aspects of health care. As well, this research project was limited to interviewing caregivers only. More research needs to be done from the perspective of facilities' administrations and of families who place their family members in these long term care facilities.

If the researcher had had unlimited time and money, an exploration into what is happening within the long term health care sector in Alberta would also have been explored. Because research shows that many of the problems we face in Nova Scotia today were in fact what they faced in Alberta ten years ago, it would be of great interest

to see how Alberta dealt with these issues and to see if any progress was made in order to learn from their mistakes and possible achievements.

In terms of conceptual lessons it was extremely important to gain awareness and understanding of the many terms used in regards to long term care. As well, an understanding of the players involved in the game was important. Again, if constraints of time and money did not exist, the research project would have been expanded to include a wider perspective and a comparison between the goals of administration and of caregivers. A larger proportion of the interviews would have been dedicated to exploring the conflicting wants and needs of caregivers and administrators and the constraints under which both groups work.

In terms of personal lessons, this research has helped me to develop a better more in-depth understanding of those concepts and forces which are creating the need for the reorganizing of the health care sector. It has helped me to develop a new level of respect and admiration for those who work within the long term care facilities and who accomplish a great deal under a great many restraints. As well, it has helped to create in me an awareness of the importance of fighting for what we believe in. Let us all remember that these issues and challenges will likely affect us all, whether we work in the long term care facilities, have family members who live there, or end up there ourselves. We all have a collective responsibility to work to ensure that the long term care facilities of the past are not forgotten and replaced by the all consuming need and desire by a few for profit.

References

Armstrong, Pat and Hugh Armstrong (1994) "Health Care in Canada" in Joel Lexchin (ed). Take Care: Warning Signals for Canada's Health System. Toronto: Garamond Press, .

Armstrong, Pat and Hugh Armstrong (1996) Wasting Away: The Undermining of Canadian Health Care. Toronto: Oxford University Press,

Armstrong, Pat and Huge Armstrong, & Jacqueline Choiniere, & Eric Mykhalovskiy, & Jerry White. (1997) Medical Alert: New Work Organizations in Health Care. Toronto: Garamond Press.

Beanlands, Hope et al. (April, 1994) Long Term Care in Nova Scotia: A Vision for the Future of Continuing Care. Toronto: Community Services.

Bolaria, B. Singh (1988) Sociology of Health Care in Canada. Toronto: Harcourt Brace Jovanovich.

Braverman, Harry (1974) Labor and Monopoly Capital: the Degradation of Work in the Twentieth Century. New York: Monthly Review Press.

Bueckert, Dennis (1998) "Ottawa to Look at Crisis in Nursing, Rock Says". The Chronicle Herald. 16 June 1998:A2

Christian Labour Association of Canada (CLAC) (1988) Caring for Our Elderly: An Inquiry in to Working and Living Conditions in Alberta Nursing Homes. Alberta.

Conner, Patrick (1981) Long term Care Facilities and Organization Theory: Some Research Suggestions. Toronto: Academic Press.

Department of Community Services (1992) Report on the Long Term Care Review Committee. Nova Scotia: Department of Community Services.

Elder, Joe (1984) "Capitalism, Health and Illness" in John, McKinley (ed). Issues in the Political Economy of Health Care. New York: Tavistock Publications.

Flaherty, Joe (1990) "Testimony Before the Ontario Pay Equity Tribunal, Haldimand-Norfolk Case" in Joel Lexchin (ed). Take Care: Warning Signals for Canada's Health System. Toronto: Garamond Press.

Goldfarb Corporation (1988) The Nursing Shortage in Ontario (Report for the New Nurses Association. Toronto, March.

Hadden, Richard (1997) Sociological Theory: An Introduction to the Classical Traditions. Peterbrough, Ontario: Broadview Press.

Jesion, M.I., & Rudin, S.E. (1983) "Evaluation of the Social Model of Long Term Care." Health Management Forum. Summer, p.64-80.

Lexchin, Joel (1994) Take Care: Warning Signals for Canada's Health System. Toronto: Garamond Press.

Marx, Karl (1936) Capital : A Critique of Political Economy. New York: The Modern Library.

Macionis, John (1997) "Aging and the Elderly" in Macionis, John, Jane Nancarrow Clarke, Linda Gerber (eds). Sociology (2nd Edition). Ontario: Prentice Hall.

McIlroy, Anne (1999) "Provinces Can Get at Their Money Now" The Globe and Mail. 17 February 1999:A11

Noland, J. A. (1994) Focus on Canada- Profile of Canadian Seniors: Statistics Canada Ottawa: Cat. No. 96-312E, p.58

Nova Scotia Nurses Union (NSNU,1997) Current and Evolving Issues for Nurses and Residents in Homes for Special Care. Halifax: Nova Scotia Nurses Union.

Nova Scotia Action Committee (1994) "Long Term Care in Nova Scotia a Vision for the Future." Minister's Action Committee on Health System Reform, Blue Print Committee. p.21

OECD (1995) "Health Policy Study #7." Health Canada (Table 3).

Richardson, Trudy (1994) Patient Focused Care. Edmonton: United Nurses of Alberta.

Ritzer, George (1996) The McDonaldization of Society. London: Pine Forge.

Robertson, David (1992) "The Meaning of Multi-skilling" in Andre Beckerman, Julie Davis, Nancy Jackson (eds) Training for what? Labor perspectives on Skill Training. Toronto: Our School Ourselves Education Foundation.

Rubin, Herbert and Irene Rubin (1995) Qualitative Interviewing: The Art of Hearing Data. London: Sage Publications.

Sacouman, R. James (1999) Social Theory for a Change: Vital Issues in the Classics. Toronto: Irwin.

Simpson, Jeffery (1999) "11.5 billion injected for health." The Chronicle Hearald. 17 February 1999:A4

Statistics Canada (1990) Labor Force Annual Averages 1990. Ottawa: Ministry of Industry, Science and Technology.

Statistics Canada (1993) Population Aging and the Elderly. Ottawa: Census of Canada; Cat. No. 91-533E, p.110

Statistics Canada (1993) Population Aging and the Elderly. Ottawa: Census of Canada; Cat. No. 91-533E, p.48

Tarman, Vera (1988) "Institutional Care and Health Policy for the Elderly" in Singh, Bolaria (ed). Sociology of Health Care in Canada. Toronto: Harcourt Brace Jovanovich,

Taylor, Frederick (1911) The Principles of Scientific Management. New York: Norton.

Weber, Max (1968) Economy and Society, Volume 3. Totowa, NJ: Bradminster Press.

Appendix A

Letter to Participant(s)

I am conducting this research as part of the requirement for a Masters Degree in Sociology at Acadia University. The information will be incorporated into a thesis dealing with the strengths and weaknesses in care giving at long term care facilities throughout the province of Nova Scotia.

Participant's identities will not be used and all possible measures will be taken to ensure confidentiality of the respondents. If you are uncomfortable with this or any part of the procedure, you are free to withdraw from the study or refrain from answering any questions at anytime.

The interviews will be taped (with your consent) and then transcribed. The tapes will be destroyed after the completion of the thesis. The thesis will be available to the public after completion in the library at Acadia University, Wolfville Nova Scotia.

Again, you are in no way obligated to participate in this research project and may withdraw at anytime.

Thank-you for your cooperation.

Tracey Adams
Student Researcher
Acadia University
(902) 645-2567

Participant's Signature

Appendix B

INTERVIEW GUIDE

Background

How long have you worked at this long term care facility?

What is your current position?

Are you full/ part-time?

Is this the same position you started out with?

What type of training did you go through to obtain your job?

How many residents live here?

How many caregivers are on staff? Full-time? Part-time?

Can you describe a typical day here?

How is your day different now from four years ago?

What are some of the problems you encounter on your shift?

At any given time how many residents are you responsible for?

What would you describe as the positive/ negative aspects of your working day?

Quality care :

How much time would you estimate you spend with a resident during your shift?

How much of that time is spent meeting the resident's physical needs? emotional needs?

What does the term quality care mean to you?

Do you think your residents receive quality care?

What do you think would improve your ability to produce quality care?

How would you describe the level of care required by your residents?

How has the type of residents you work with changed over the last four years?

What types of resources and training are available to you in meeting the needs of the changing resident?

The Mentally ill:

Can you describe in your own words the difference between a mentally ill resident and the other residents?

What form of education did you receive before the mentally ill were placed in this facility?

What would you say are the positive and negative aspects of the movement of the mentally ill into long term facilities for the staff?, residents?, or the mentally ill?

Multi-tasking:

How has your job portfolio changed in the last four years?

Are there tasks you perform today that you were not responsible for in the past?

How much time would you estimate you spend on non-nursing tasks each shift?

Are there certain time limits attached to each task you perform? Example x minutes to feed or bath a resident.

What happens if you are unable to fulfill all your tasks on you shift?

How much time do you spend filling out records and reports per shift?

How has technology impacted on your day?

Cutbacks :

Do you usually work with the same staff members each shift?

How many caregivers work per shift? What proportion are DON, RN, LPN, CNA, NA, or PCW?

Has the number of staff per resident increased or decreased in the past four years?

Has there been an increase or decrease in the number of full/part-time staff working?

What type of training do part-time staff receive?

Wages:

How many hours a week do you work?

How often do you receive a pay raise?

At any time during your employment have you had to take a pay cutback?

Has your work load increased or decreased in the past five years?

Do you feel you are paid fairly for the work you do?

Staff Morale:

Can you describe your relationship with your other staff members? residents? administration?

How would you describe staff morale?

How has staff morale changed over the last four years?

Recommendations:

Given the changes to the health care system and knowing the constraints of cutbacks, what, if any, suggestions do you have on how to improve the health care system?

Glossary

Cross Training (Multi-Skilling):

Cross training means teaching differentially trained persons each other's jobs, either in part or as a whole. Multi-skilling is really just another name for cross training but implies that actual skills are being transferred, not just the mechanical kinds of "how to do" instructions.

DON:

The director of nursing is responsible for the day to day management of the long term care facility. They are responsible for the welfare of the residents, direction of personal maintenance of the physical plant, and the delivery of resident care services. As well, they are responsible for ensuring that all appropriate government acts and regulations are followed as well as standards, policies and accreditation. This person is usually a registered nurse with five or more years experience working in long term care.

Geriatrics:

A specialized branch of medicine that deals with the diseases of older persons and their therapy. The study of the aging process itself is called gerontology

GDP and GNP:

Gross Domestic Product and Gross National Product are terms used to describe the money value of all the goods and services produced in a country in a set period of time, usually one year. It does not include the unpaid services produced in the home which are not exchanged for money. The only difference between GDP and GNP stems from certain assumptions concerning who is a resident of a country and is of more interest to economists and statisticians than the casual observer.

Home for Special Care:

Any facilities licensed under the *Homes for Special Care Act and Regulations* and includes: Nursing Homes, Homes for the Aged, Adult Residential Centers, Regional Rehabilitation Centers, Residential Care Facilities, Group Homes and Developmental Residences.

Levels of Care:

Level 1 Care required by a person who is ambulant and/or independently mobile, and who primarily requires supervision and/or assistance with activities of daily living.

Level 2 Care required by a person with a relatively stabilized chronic disease or functional disability, whose condition is not likely to change in the near future and who requires the availability of personal care on a continuing twenty four hour basis, with medical and professional nursing supervision.

Level 3 Care required by a person who is chronically ill and/or has a functional disability, where the acute phase of illness is over, the vital processes stabilized, and where the potential for rehabilitation may be limited. This person requires a range of therapeutic services, medical management and skilled nursing care.

LPN:

A licensed practical nurse is someone who has taken a one year course which includes classroom work and practical training in a hospital. As well, a licensing examination must be passed and they are only to work under the supervision of a registered nurse.

Nursing Homes / Homes for the Aged:

These are facilities which provide level 1 and level 2 care. In most cases nursing homes are privately owned and operated while homes for the aged are operated by municipalities, municipal corporations and private non-profit societies.

Personal Care Worker:

This is the term coined to describe workers in the health care setting who have received very minimal, if any, formal job training but are given aspects of the trained health care worker's job to do. They are typically responsible for meeting the physical and social needs of residents. Minimal requirement usually is a willingness to take a PCW course, and any experience in working with the elderly is considered an asset.

Private Non-Profit Homes:

These are facilities operated by an organization incorporated under the Societies Act.

Private for Profit:

These are homes for Special Care which are owned and operated as a private enterprise.

RN:

Registered nurses have taken a four year course at a recognized university or within a hospital setting, which deals with technical skills, supported by a basic foundation in biological and behavioral sciences. Along with these courses a licensing examination must be taken.

Residential Facility:

These are facilities which provide care for elderly residents, people with special needs, and or youth. They are operated by municipalities, municipal corporations and private non-profit societies.

Small Option Homes:

These are facilities design to care for the elderly. They are not government funded and have a maximum capacity of five residents. Most small option homes are located in rural areas, in hopes that the elderly are able to remain in their community

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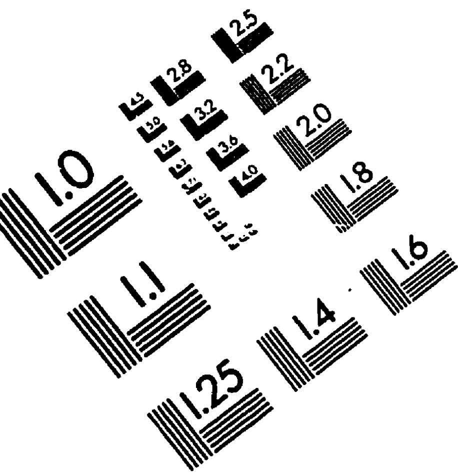
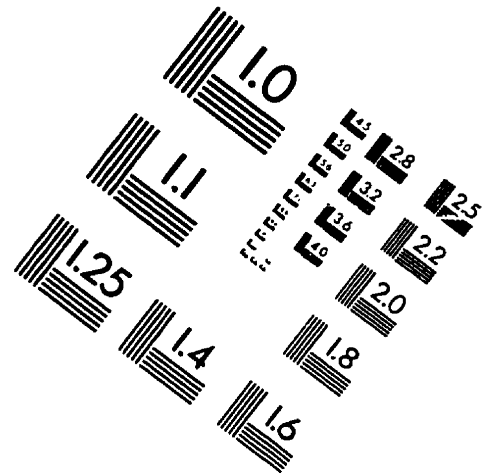
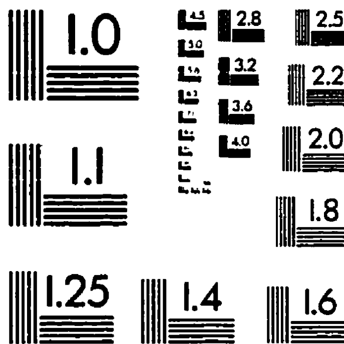
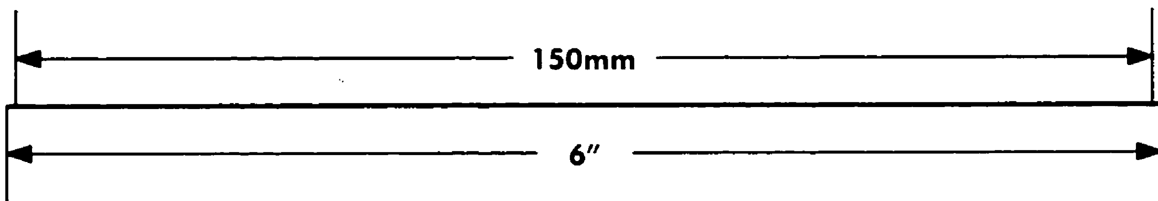

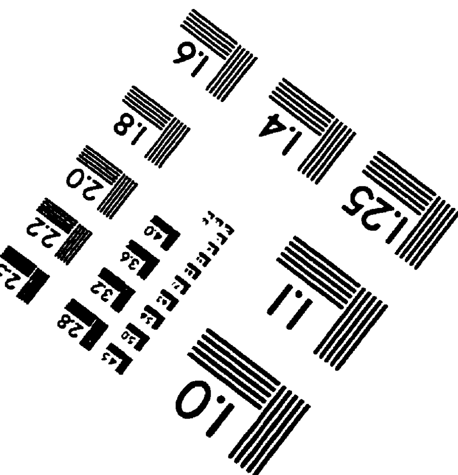
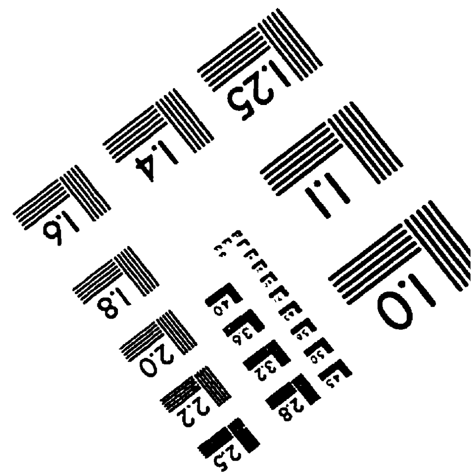

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