

Unheard voices, unmapped terrain: comparative welfare research and paid care for older people in Sweden and Canada

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I. Introduction

Feminist scholars have stressed the importance of examining the state's role in financing, organizing, delivering and administering care in the welfare state since the 1980s (e.g. Wærness 1984; Orloff 1993; Jenson 1997). Foregrounding gender in its analyses one stream of welfare state research focuses at the macro level relationship between women's labour market participation and the coverage of care services for children or elderly people (e.g. Daly & Lewis 2000; Anttonen et al. 2003). Also situated at a broader level, those coming from an ethic of care perspective view care as a central element of a functioning society (e.g. Tronto and Fisher 1990; Sevenhuijsen 2003). A related stream analyses the welfare state's contribution to meet the risks and strains related to caring for society's most dependent. For instance, Kittay et al (2005) argue that our social policy is built around notion's of a fictitious independent, unembodied person, not dependent on others save for exceptional circumstances. In addition, given the dominance of women in care work, we either need to figure out how to remove the gender gap or mitigate the caregiving burden that women face (ibid).

From a micro level, the rich literature on care work stresses how care is much more than practical work. Expressions like 'labour of love' and 'caring for and caring about' point to the significance of relations and emotions in care work, but stress also that care involves physical and often arduous hands-on work (e.g. Graham 1983, Ungerson 1983).

Care work involves care for the body, what Twigg (2000) refers to as body work; social care for the mind and spirit; and care for the environment, including cleaning and maintenance. When we refer to care work we mean the health and social care services required by people in residential or home care settings, provided by paid workers, though not all of the work is paid for, and it is provided with varying levels of professional training, from nurses to support workers. These services are primarily aimed at older people and those of any age with physical or cognitive disabilities.

Care work – paid as well as unpaid – has been characterised as a combination of intellectual, emotional and manual labour (James 1992) or in Leira's (1994) words: loving, thinking and doing. Overviews and theoretical considerations on care work, have been developed by Leira & Saraceno (2002); England (2005) and Fine (2007). The care work literature goes some distance in addressing concrete practices constituting the care relationship – what Dyck et al (2005) refer to as the “micro-politics of care negotiation” – by examining paid (Aronson & Neysmith 1996; Armstrong et al 2008) and unpaid care work (Wiles 2002). This work sheds important light onto an area often neglected. Comparative work is the exception (e.g Cameron & Moss 2007; Armstrong et al 2009), since most of the literature's examples and case studies tend to be locally- or regionally-based, giving us little sense of what conditions are like in different international contexts.

What remains absent from most *comparative* policy-oriented research is the articulation of care worker's working conditions and the encounter between the care worker and the user of the services done in a way that

links it to the broader social, political and economic context. It is, as Michael Burawoy and colleagues (2000) describes, about “link[ing] micro-practices and macro-structures.”

This lack of attention renders the paid care workers who actually carry out the care services hardly visible. It also means that comparative work in the area of long-term care is relatively unmapped terrain. Therefore, while paid care work obviously is under pressure for transformation due to shifting steering principles and economic resources, the content and the strains of the daily work have been neglected in comparative research. Thus very little is known about whether there are national (or welfare regime specific) differences in the employment conditions and the workdays of care workers. This knowledge gap is problematic because it tends to render invisible a large, women-dominated sector of the workforce. Long-term facility care is also a relatively understudied area. Existing at the nexus between health and social care, they care for society’s most vulnerable and are most often the final home of the vast majority of its residents. In many respects long-term care facilities and the care workers operate at the bottom of the funnel of health and social care policy.

The aim of this paper is to broaden the agenda of comparative welfare state research by contributing care work research that links concrete practices within a gendered political economy of health perspective (Armstrong, et al 2001; Andrew et al 2003). We focus our attention on the relations between care workers and residents embedded in the everyday realities of care work, in the context of the highly gendered context of long-term care for older people in Canada and Sweden.

This paper describes some of the similarities and differences in the conditions of care work and analyses how the changing organisation of eldercare services affects the everyday life of facility based care workers for elderly people in Canada and Canada carried. It aims to contribute to debates about how care and dependency are situated in the welfare state. We argue that an on-the-ground analysis of the relations between long-term care workers and residents reveals how each society cares for its most vulnerable and is thus symbolic of how care is valued by each society. Good working conditions – care for the worker – are the precursor to good care for residents (Armstrong & Daly 2004), so an analysis of relations between care workers and residents, this micro-politics of care, is more broadly illustrative of how the welfare state deals with issues of dependency.

II. Method

Two research teams worked in tandem on this comparative study of long-term care in Scandinavia (Sweden, Denmark, Finland and Norway) and Canada (Ontario, Nova Scotia and Manitoba).¹ A largely identical survey was distributed in respective jurisdiction to workers in long-term care in 2005 by a Scandinavian team and in 2006 by a Canadian team. The survey instrument included open and closed questions exploring employment qualifications, patterns, and workload, and also asked more detailed questions about working conditions, health and safety, work and family life issues, and the acuity of the residents’ needs (for further information about the studies, see Armstrong et al 2009).

This paper uses the responses from 557 unionized care workers in residential care for older people in Canada, of whom 142 are *Assistant Nurses* (licensed or registered practical nurses) and 415 are *Care Aides* (personal support workers, health care aides or nurse's aides) and of 203 *Assistant Nurses* (undersköterska) and 89 *Care Aides* (vårdbiträde); in total 292 unionized care workers in residential care for older people in Sweden.

A note about terminology. Collectively referred to as care workers in this paper, we have further categorized workers according to licensure but not necessarily by function since, as the paper discusses, inter-country and intra-country variation exists. Care Aides (CA) generally have less training in terms of duration, while Assistant Nurses (AN) have trained for a longer period of time. In Canada, professionalized workers are Licenced or Registered. When we choose to call this group *assistant nurses*, without any prefix indicating regulation, it is simply an adaptation to the Swedish case where a Swedish *undersköterska* is not more regulated than a *vårdbiträde*. Our own research, and a review of the international literature shows that there are many titles given to the less skilled occupational group, what we term as *care aides*: auxiliaries, personal support workers, resident attendants, nursing aides, nursing home aides, resident care aides or nursing assistants. The fact that there are so many titles, even within the same country, corresponds with the lack of professionalization associated with this work.

Long-term care is largely a unionized work environment at all of the study sites, with about eight in ten workers belonging to one. Our research reflects responses of unionized workers who typically have more job security and wage protections than their non-unionized counter-parts. The majority of the jobs are low pay, low autonomy work, what Karasek and Theorell (1990) referred to as a high demand, low control and low support environment.

III. Care in Context

In this section we present our survey, which documents how residential care workers (assistant nurses and care aides) experience their work. We first describe the facilities and care workers, then turn to analyse working conditions including the division of labour, and demands, workload and other negative experiences.

a. The Facilities

Both Canada and Sweden are rich countries and both countries spend a larger share of their GDP on residential care than the OECD average: 2.07 per cent in Sweden and 1.06 per cent in Canada compared to 0.88 per cent on average in the OECD countries (OECD 2005:26). These proportions must however be related to the proportion of older persons in different countries. Sweden has the world's oldest population: 5 per cent are 80 years and older compared to 3 per cent in Canada (OECD 2005:101). In relation to the proportion of older persons in the population Sweden still stands out as more generous than Canada but the difference between the two countries is smaller than it first appears (Szebehely 2009).

In both Canada and Sweden, the ownership patterns of the nursing homes include publicly-owned, private charitably-owned and private-commercially-owned. However, in Canada almost half of residents live in facilities

run by for-profit companies, about one-quarter in not-for-profit facilities and another quarter in facilities run by the government sector (Statistics Canada 2007). In Sweden, the vast majority of publicly financed eldercare services is publicly delivered, but an increasing proportion (15 per cent in 2008) of the residents live in privately-owned facilities (NBHW 2009).

The average residential care facility in Sweden has 32 residents (NBHW 2007a) and almost all older people in residential care have their own private room or small apartment, usually with a private bathroom (>95 %) and cooking facilities (75 %). Only one per cent of the elderly in residential care live in a shared room (NBHW 2009). An average residential care facility is much larger in Canada: 96 places; 70 per cent of the residents in Canadian residential care live in facilities with more than 100 beds (Statistics Canada 2007, p 11 and 18). There is often less privacy in a Canadian facility and the size and design of the facilities make a Canadian residential care facility often more hospital-like than home-like (Gnaedinger 2003; Armstrong & Bannerjee 2009).

Between the different jurisdictions studied, the resident populations are similar in the sense that women are the vast majority of residents and residents typically have more than one health and/or disabling condition, and the populations exhibit nearly identical rates of Alzheimer's and dementia.

b. The Care Workers

Care labour, in both its paid and unpaid forms, and when it is needed by someone unable to care for themselves is, according to Kittay et al (2005), more accurately called dependency care/work. Like other areas of paid care work, such as home care, work in residential long-term care homes is often viewed through the lens of tasks, lacking an important connection to the affective dimensions of the work (Aronson & Neysmith 1996). Others refer to this as relational caring.

Who are the care workers? With women comprising more than ninety per cent of the direct-care staff, the workforce is heavily woman-dominated. In Canada, federal data delineates between workers providing 'direct care', such as nurses, physiotherapists and occupational therapists, and personal support workers (care aides), and those providing general services, such as administration, dietary, housekeeping, laundry plant operations, maintenance and security.

According to the Canadian survey presented in this paper, the residential care workforce consists of 15 per cent Registered Nurses (RN), 15 per cent Assistant Nurses (AN), forty-four per cent Care Aides (CA), 18 per cent support workers and 8 per cent other occupational groups. The composition of the Swedish residential care workforce is quite different. According to a large survey from eight Swedish municipalities from 2003 (Gustafsson & Szebehely 2005) slightly less than 6 per cent were RN, just over half (54%) were AN, more than one-third (33%) were CA, 3 per cent managers or physio- or occupational therapists, 3 per cent were support workers (mainly janitors, housekeeping and kitchen staff) and another 3 per cent could not be categorised (Gustafsson & Szebehely, unpublished data).

The composition of the care workforce is similar in the sense that a large part of the actual work in residential care facilities is carried out by direct care workers: assistant nurses and care aides. This is particularly the case in Sweden, which has a much lower proportion of registered nurses in the residential care workforce and also a lower proportion of support workers..²

The staffing level is probably the single most important context factor for the care workers' working conditions as well as for the quality of care (for a systematic review see Murphy 2006; see also Eaton 2000; Harrington et al 2000). The staff to resident ratio in Sweden (according to NBHW 2001 p. 34) has been estimated to 5.2 hours for direct care staff (RN, AN and CA) per resident and day, and 5.6 hours when also managers, physio- and occupational therapists are included. No information is available on support workers. Statistics Canada (2007, table 10) reports a Canadian average of 4.7 *total staff* hours per resident-day (including 'direct care' and 'general services', i.e. administration and support staff).³ Statistics Canada does not specify hours worked by 'direct care' staff. This is instead reported in a study by McGregor et al (2005:647) from the Canadian province British Columbia, which reports that the total staffing hours vary between 3.5 and 4.4 hours per resident and day, depending on type of facility (lower or higher care needs), while the number of hours worked by 'direct care' staff (RN, AN and CA) vary between 2.5 and 3.2 hours per resident-day.⁴

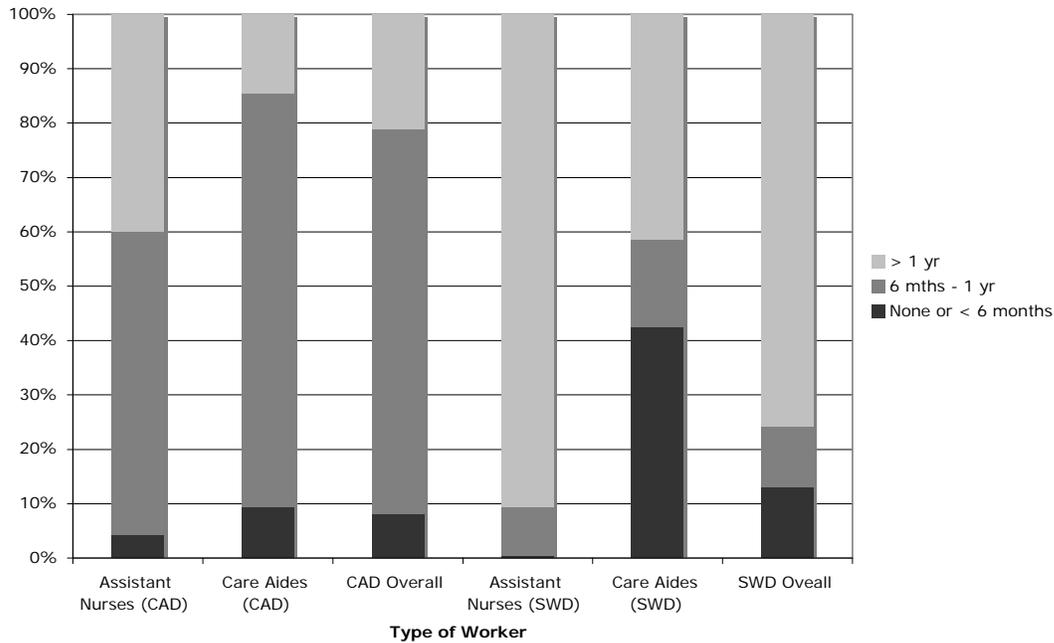
These comparisons must be treated with caution because of the different roles support staff play in each jurisdiction. However, Swedish residential care clearly seems to have the highest staffing levels, especially when we compare the hours worked by 'direct care' staff. This 'ranking' is fairly consistent with the OECD figures on spending on residential care reported above, with Sweden spending more on residential care per elderly in the population. However, probably due to the higher proportion RNs in Canada (and the higher wages paid to RNs compared to other care workers), the difference in staffing level between the countries seems to exceed the difference in spending.

To sum up, there are both similarities and differences in the policy context of residential care: the workforce is almost entirely female and the majority of the residents are also women, very old and with substantial care needs. The resources, the composition of the workforce and the size of the facilities differ quite markedly. Sweden spends more money and has a higher staff to resident ratio. The care workers are mainly publicly employed, and are usually working in fairly small facilities where almost all residents have private rooms. The facilities in Canada are bigger than in Sweden and more residents live in shared rooms. The public sector has a more limited role as employer of the care workers in Canada than in Sweden, though both countries have a mixture of for-profit, not-for-profit and municipal ownership.

c. Staffing Intensity, Tenure and Training

Registered Nurse staffing intensity is lower in Sweden than in Canada, suggesting a lower level of professionalisation amongst Swedish residential care workers. Interestingly Chart 1 depicts how more of the Swedish care workforce spends a longer time training to be a care worker.⁵

Chart 1: Residential Care Workers in Canada and Sweden by Years of Formal Training



As depicted in Chart 1, just over three-quarters (76%) of Swedish care workers have at least one year of formal training compared to less than one-quarter (21%) of Canadians.⁶ This is a partial reflection of the fact that care aides (CA) are the majority (75%) of the Canadian care workers in the study while the majority (70%) of the Swedish care workers are assistant nurses (AN). A larger proportion of the AN in Sweden (91%) than in Canada (40%) have at least one year of formal training. Canadian aides typically hold less than one year of training, since most hold college diplomas, so few (15%) have more than one year of training. But, amongst care aides in Sweden there is an even split between those with very little and more than one year of training: over four in ten (41%) have completed at least one year of schooling; and over four in ten (43%) have little or no training. Fewer than one in ten in Canada (9%) have such little training.

Most care workers in Canada and Sweden have significant job experience: almost two-thirds of the Canadian and slightly more of the Swedish workers have worked in this capacity for 10 years or more. Only a few care workers have neither experience nor formal training, suggesting that many have acquired qualifications and become skilled at their jobs through experience rather than through formal education (cf. Armstrong & Daly 2004).

When we focus on all care workers (AN and CA), the training tenure is longer in Sweden. In addition there is a much higher proportion of assistant nurses in Sweden. But as mentioned earlier, the much lower proportion of RN as well as of other types of support workers such as dietary and laundry workers in the Swedish care workforce, also seems to indicate fairly different skill mixes and divisions of labour between the two countries.

This suggests different taken-for-granted notions about ‘appropriate’ providers of care and the division of care work.

d. Casualization of Care Work

Care work has been *casualized*, as a large proportion of the care workers we surveyed in Sweden (65%) and Canada (41%) work part-time. In both countries part-time work is much more common among care workers than it is amongst the female workforce overall (Statistics Sweden 2006; Statistics Canada 2004, p. 8).

This casualization appears to be involuntary, since in the two countries a significant proportion work shorter hours than are preferred. For instance, 16 per cent of the Swedish and 22 per cent of Canadian care workers want to work more hours. Holding more than one job is also an indication of the involuntary nature of part-time work. The fact that a larger proportion of the care workers in Canada than in Sweden regard themselves as involuntary part-timers, is reflected also in the proportion of the workforce holding more than one job. Fewer than one in ten in Sweden (7%) do, while more than double that report multiple job holding in Canada (17%).

e. Division of Care Work

One of the important differences to emerge from the data is that there are country-specific differences in occupational divisions of care work in residential care.

Table 1. Care Workers’ Ordinary Work Tasks in Canada and Sweden

% reporting doing the following ordinary work tasks at least monthly	All Care workers		Canada		Sweden	
	Canada (n=557)	Sweden (n= 292)	Assistant nurses (n=142)	Care aides (n=415)	Assistant nurses (n=203)	Care aides (n=89)
Clean resident’s room/apartment	53.4	82.2	39.5	58.0	80.5	86.4
Serve food	86.4	86.6	73.0	90.6	86.4	87.2
Help with personal hygiene	95.3	100.0	81.4	99.8	100.0	100.0
Sit down for a coffee and a chat with a resident	46.6	64.4	46.5	46.7	65.3	62.4
Follow a resident on an errand outside facility	7.3	36.3	2.4	8.9	36.1	36.8
Administrative tasks	47.7	82.5	86.2	34.5	90.4	63.4
Contact with other health care providers	18.5	41.5	60.2	4.3	42.1	40.2
Hand out pills from a dispenser	23.3	91.3	86.5	3.1	91.0	92.0
Give an injection	19.2	38.8	74.2	1.3	43.6	27.6
% reporting that 5> tasks listed above are part of their ordinary work	26.8	81.7	67.9	13.5	84.2	76.1

Figures marked in bold indicate a statistically significant difference (p<0.05).

Body work (Twigg 2000), including help with dressing, bathing, toileting or changing incontinence products; and *servicing food* are part of most care workers’ workdays, irrespective of country or occupational category. But

when it comes to most other tasks Swedish and Canadian care workers have different workdays. For instance, Swedish care aides more often do delegated *'professional' tasks* such as giving injections or handing out medicine. They also more frequently contact other providers in the health care system or do administrative tasks. They are engaged more often in *relational aspects of work* such as having a cup of coffee and a chat with a resident or *following a resident on an errand* outside the facility. Even cleaning is more common among Swedish care aides than among their Canadian counterparts.⁷ One quarter of the Swedish care workers also cook meals for the residents (not reported in table 1; the question was not asked in the Canadian survey).

Swedish care workers (both AN and CA) carry out a variety of tasks including cleaning, cooking, laundry but also recreation and other 'social activities', that in the Canadian context to a large extent are carried out by CA in conjunction with other occupational groups such as dietary and activation workers and professional therapists.

What differs markedly between the two countries is who does what. With one exception (having a cup of coffee with a resident), there is a substantial difference between the AN and the CA workdays in Canada: the 'professional' tasks (administration, injections, handing out pills and having contact with the health care system) are far more common among the ANs, while household tasks (like cleaning and serving food) and body work (help with personal hygiene) are more commonly CA duties. In Sweden the two groups of care workers seem to have much more similar workdays: there is only a significant difference between AN and CA when it comes to administration and giving injections, which are more common among AN – but the difference is far smaller than in Canada.

If we divide the Swedish care workers by length of formal training instead of by occupational group, there seems to be little difference among the Swedish care workers.⁸ Unlike in Canada where the division of labour between Assistant Nurses and Aides is more pronounced, owing in part to the regulation of certain care acts, Swedish care workers all seem to engage in most of the care acts independent of their occupational position or educational background.

In terms of tasks, the workday seems to be the least varied for Canadian care aides: while between 68 and 84 per cent of the Canadian and Swedish ANs and the Swedish CAs regularly do at least five of the nine tasks reported in table 2, this is the case only for 14 per cent of the Canadian CAs.

The survey's asked workers open-ended questions, which allowed space to comment on different aspects of work in their own words.⁹

On the one hand, some jobs in Canadian long-term care are becoming very task-specific. Workers report having a "bath girl" who comes in to help get caught up on the twice weekly mandated bath, or the "diaper girl" responsible for doling out supplies including incontinence products. In this way the work is becoming more Taylorist and assembly line. Residents are processed through their bath, one after the other, or allowed a pre-allocated number of diapers, after which Care Aides must negotiate for more, making the resident's case – they were sick or had an accident.

At the same time, there is evidence that the Care Aide role is expanding through the downloading and offloading of tasks workers associate with other jobs: one-third of Canadian care workers responses to the open-ended question ‘*Are there tasks that you have to do that you think you should not have to do?*’ reflect a concern over the division of labour between Registered Nurse, Assistant Nurse, Care Aide and other support workers, such as Dietary and Cleaning staff. Respondents argued that maintenance staff should take care of garbage, housekeeping should do the cleaning, dietary staff should serve food and take care of dishes, and laundry staff should put away linen. A few mentioned that others should do more qualified nursing tasks. Examples of responses from the *Canadian care workers*:

Making and changing beds. Should be done by housekeeping, not a nursing task. (CA)

I am a Health care aide, not a dietary aide. I should assist residents to eat, not dish out meals. (CA)

Putting clothes away. I think laundry should do this job. (CA)

Clean fridges, wash chairs in dining area, should be kitchen’s and housecleaning’s job, not health care aides. (CA)

Serving - dietary should do meals and we should only help feed. (AN)

Application of treatment creams – RN or RPN (registered practical nurse) should do this in their job. (CA)

There is evidence that the scope of Canadian care aide’s role is expanding, troubling older, established divisions of labour:

(...) putting away residents’ personal clothing was once a laundry task. We also put away linens - laundry once did this too. Dietary used to clear tables and give out juices at snack time. Housekeeping used to clean, now they only pretend to clean - we have to clean fecal matter and blood - their job description doesn't permit cleaning of bodily fluids! (CA)

Few Swedish care workers discussed division of labour issues. However, they indicated a preference to not do cleaning much more frequently than their Canadian colleagues. “*Cleaning*” was mentioned by more than half of Swedish AN and CA who answered the question and only by one out of ten Canadian care workers.¹⁰ Unlike in Canada in Sweden housekeeping staff are generally not employed in residential care meaning that the cleaning of common areas and residents’ rooms are care workers’ tasks. While many of the Swedish care workers wanted to do less cleaning overall, others more specifically argued that they wanted to do less cleaning of the common spaces, but seemed to be more willing to do the cleaning of the residents’ private rooms. “*Laundry and cleaning common areas, e.g. day room and corridors*” (CA). Other housekeeping chores were mentioned less often, although some mentioned that they did not want to do laundry and a few that they did not want to cook. If an argument was used, it was usually that they wanted to spend more time with the residents, but some AN also mentioned that they wanted to do more “nursing tasks”: “*The cleaning takes too much time from nursing and care.*” (CA)

Among the Canadian care workers, *servicing food* was most frequently mentioned as a task they did not want to do (mentioned by one-quarter of Canadian care workers who responded to the question). Quite often, the Canadian care workers used a hygiene argument when they argued why they did not want to serve food:

Serving the meals and cleaning off the tables. Looking after residents personal hygiene needs and then serving food isn't hygienic! (AN)

Handling food. Not very sanitary after handling urine and faeces. Then you have to serve meals. (CA)

Serving their plates of food especially after us done residents care and toileting. We should not be giving their lunch and supper plates and feel that our uniforms carry germs. (CA)

Swedish care worker's did not mention not wanting to serve food, nor did they use this kind of sanitary argument in relation to any other task. Obviously they did not regard the combination of 'dirty' and 'clean' tasks to be a problem in the same way as did many of their Canadian colleagues. Since in the Swedish context there is not another occupational group around to share the work with, they usually expect to switch between personal care and housekeeping tasks (such as cleaning, laundry and sometimes also cooking) during a workday. There is an expectation that the residents and the care workers prepare the meals and do other household activities together as part of the official Swedish residential care ideology, especially in smaller units for demented elderly (Malmberg & Zarit 1993). While this relationship is certainly not always the case, it is not unusual either.

Interestingly enough, recently the Swedish National Board of Health and Welfare published recommendations in this area. The Board opens the document by noting that some residential care facilities have misinterpreted the EU-regulations regarding food handling. The Board therefore now informs the residential care sector that residents still are allowed to spend time in the kitchen and to participate in cooking. The Board stresses that the staff needs to be trained about the risks in handling food, but the underlying message is that normal caution is enough: both staff and residents should wash their hands, use an apron and not deal with food if they have any infectious disease (NBHW 2007b).

Compared to Canada, the smaller size of the Swedish facilities, as well as the different division of labour and a different ideology (residential care regarded as social care rather than health care), probably affect not only the workday of the care workers, but also the way the workers perceive their work tasks.

f. Demands, workload and other negative aspects of work

Previous research has shown that being a care worker in residential care is demanding. The workload is generally reported to be very high, the work both physically and mentally challenging, and the care workers are more exposed to fatigue, pain and work related injuries than many other occupational groups. Research from different international contexts present a similar picture in this respect (Chappell & Novak 1992, Armstrong & Jansen 2000, Ross et al 2002a, Trydegård 2005).

Table 2. *Workload and negative experiences of work. Residential care workers in Canada and Sweden*

	Care workers		Canada		Sweden	
	Canada	Sweden	Assistant nurses	Care aides	Assistant nurses	Care aides
Number of residents helped per workday weekday (average)	19.9	8.8	32.7	15.2	8.8	8.8
Carry, lift or pull heavy loads or persons (%) ⁱ	77.4	66.3	59.2	83.3	69.5	59.1
Too much to do (%) ⁱⁱ	57.8	40.9	50.4	60.3	42.9	36.4
Work short staffed due to sickness, vacation or vacancy (%) ⁱ	48.3	12.2	55.2	46.0	12.0	12.8
Experience physical violence from a resident or resident's family (%) ⁱ	38.2	5.8	24.6	43.0	5.9	5.7
Can affect the planning of each day's work (%) ⁱⁱ	24.1	48.1	24.8	23.8	48.3	47.7
Feel physically tired after a working day (%) ⁱⁱⁱ	60.4	27.8	53.2	62.9	28.6	26.1
Feel mentally exhausted after a working day (%) ⁱⁱⁱ	43.0	14.5	41.4	43.5	15.8	11.4

Figures marked in bold indicate a statistically significant difference ($p < 0.05$).

ⁱ More or less every day. Other response alternatives: Every week, Every month, Less often, Never.

ⁱⁱ All or most of the time. Other response alternatives: Sometimes, Rarely, Never.

ⁱⁱⁱ Almost always. Other response alternatives: Often, Sometimes, Rarely, Never.

However, when comparing workload and demands between Canada and Sweden, there seems to be substantial differences (Table 2). Allowing that the majority of care workers in both countries carry out physically heavy tasks every day, what really is striking is the difference between the two countries. The Canadian care workers seem to have much more demanding working conditions: they give help to far more residents per day, and they work short staffed, have too much to do and experience violence from residents much more often than their Swedish colleagues.¹¹

There is clear evidence that lack of autonomy – a combination of high demands and low control in daily work – is a particularly unhealthy combination (Karasek & Theorell, 1990), and the Canadian care workers are worse off than their Swedish colleagues in terms of autonomy: far fewer of them can affect the planning of their daily work. Not surprisingly then, the Canadian care workers more frequently feel physically and mentally exhausted after completing their workday.

When contrasting two groups we risk concluding that the group experiencing better conditions are problem-free. It is therefore important to emphasise that Swedish residential care workers have more physically demanding work, experience high rates of backpain, of fatigue and of work related illnesses/injuries compared with the Swedish workforce in general (Bäckman 2001; Gustafsson & Szebehely 2009).

The different division of care work between AN and CA in the two countries is reflected by the fact that there is hardly any difference in how the two categories of care workers in Sweden experience their work, while

the Canadian CA have more demanding working conditions than the AN. The more equal sharing of the tasks in Sweden thus seem to even out some of the negative consequences of the workload, borne by the two groups of care workers. However, the main conclusion from table 2 is that both groups of Canadian care workers are worse off than their Swedish colleagues.

The higher average number of residents cared for by each Canadian AN (33 residents) compared to each CA (15 residents) reflects the division of labour since AN are responsible for handing out medicine to residents in the unit (ward, floor or similar) requiring them. The higher average numbers of residents helped per day in Canada compared to Sweden reflect both the larger size of the facilities and units and the lower overall staffing levels in Canada.

Having a too heavy workload and lacking time to properly care or being time-squeezed were reported in many comments to the open-ended questions. *Workload* was mentioned as a reason by six out of ten *Canadian care workers* when we asked about reasons for considering quitting the job: “*Too much work not enough time. Too much stress.*” (AN) “*So much work to do in so little time. Too many residents to look after, I feel I am doing a lousy job ...*” (CA) “*Very hard work because working short lots of time. Getting 31 res[idents] up with 2 PSW (personal support workers) is not easy. And to get them up and washed at a decent time for breakfast.*” (CA) “*When my shift is through, I go home and unfortunately I have nothing left to give to my own family, I’m too tired, stressed!*” (CA)

In response to the same question, Swedish workers also indicate that their workload is heavy. Almost half responded with comments indicating that they worried about negative impacts on their own health: “*Workload, stress, increased demands from the employer to do more in the same time as previously. Understaffed.*” (AN); “*Don’t think I will manage the workload with heavy lifting, dressing etc. Have been on long-term sick leave.*” (AN) “*It is too mentally demanding. Heavy lifting. The municipality is closing down [units], giving us more and more tasks so work becomes too physically arduous.*” (CA); “*I will not be able to manage the speed and workload, neither physically nor mentally.*” (CA)

Many care workers in both countries stressed that they did not have enough time for the *relational aspects of work*, as they wanted more time to talk and listen to the residents:

More time to listen to residents concerns about how they feel. (Canadian AN)

Sitting and chatting to our residents, listening to their concerns/ fears and also to their stories/ history of their life. (Canadian CA)

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

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

Besides these shared themes in the care workers' comments on what they wanted more time for, there were also some striking differences. More than half of the *Canadian care aides* expressed a wish for more time for *personal care* – the daily tasks that form the base of their working days. The comments reflected the workload and severe time constraints, but also the routinised and task-based organisation of work. Many argued that they felt bad about rushing the residents and wanted time to talk and listen while doing personal care, others stressed their own workload, and many mentioned both:

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

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

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

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

In contrast, only a few of the Swedish care workers mentioned that they wanted more time for personal care, and those who did often mentioned grooming rather than 'basic body work': 'Put rollers in their hair. Fix their nails. A lot of small things that you never have time for.' (Swedish AN).

The *Swedish care workers* instead stressed that they wanted more time to take the residents *out from the facility* for a short walk or to engage in recreation or rehabilitation (this was mentioned by more than 60 per cent of the respondents, often in combination with time to talk and listen):

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

To go out for a walk, shop or for a cup of coffee. To socialise / talk more.' (CA)

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

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

Time to 'go out' was hardly at all mentioned by the Canadian care workers, and only a few mentioned that they wanted more time to participate in recreation with the residents. The difference in the responses seems to reflect the different level of workload in the two countries: the Canadian care workers most often seemed to not even think about doing more than the bare essentials. But the different response pattern probably also reflects the different division of labour and the more health care oriented focus in the Canadian setting – social activities like

going for a walk or taking a resident out for a coffee is rarely a task for the Canadian care workers, and they did not seem to think that it could be otherwise.

Care workers in Canada more often than in Sweden mentioned that they felt bad about the way the residents were treated, and argued that older people *deserve better care*:

... God help our seniors. We need more funding so we can let these people live with grace and dignity... (CA)

... Our job does not just include washing and dressing but should also include time to spend talking or socializing with our residents. They deserve better. (CA)

... You have a list of residents to care for and you better manage your time well or you won't have time to do what has to be done, let alone do any extras for them. These people are old and move very slowly and you're trying to rush them to the bathroom to get their care done, it's not fair that their last years on this earth has to be this way. ... (CA)

... Some days, when you are short staffed (which seems like everyday), it is very stressful because the residents are very demanding and don't understand that you are short staffed and that you run behind more. Which they shouldn't have to understand. But a lot of the time I see a different person in myself and it is not very nice :(and I dislike the person it makes me be on these stressful days. ... (AN)

There was also another theme in the comments mentioned by the Canadian care workers that was hardly at all mentioned by their Swedish colleagues: Many Canadian care workers expressed a serious critique of residential care, or at least a strong advice to prospective residents and their families to be really careful when choosing a facility. Others mentioned that the family should be more engaged in order to compensate for understaffing. One out of four Canadian respondents mentioned these kinds of comments to the question on most important changes needed in eldercare, compared to hardly any of the Swedish respondents. Some *Canadian* examples:

Stay at home if you can. (AN)

Get your family to look after you. There have been too many staffing cuts to get the care that you deserve and are paying for. (CA)

Find a way to get private help because LTC centres are not what you think they are. (CA)

Don't go to a nursing home, you don't get the proper level of care you deserve although management makes it sound that you get good care. You don't. (CA)

I hope I never need to be in this type of setting. (CA)

Die early, so you don't need it. (CA)

These quite heartbreaking comments are much more common among care workers in Ontario than in Nova Scotia or Manitoba. Ontario is the province with the largest facilities and lowest staffing ratios,¹² and the

relationship between staffing, facility size and workload becomes clear when we contrast the Ontario care workers to the care workers in the other two provinces. An Ontario care aide helps nearly eighteen (17.5) residents per day on average, compared to just over eleven (11.1) in the other two provinces taken together. Of the Ontario care aides more than two-thirds (68%) report that “*all or most of the time*” they have too much to do compared to less than half (46%) of workers in Nova Scotia and Manitoba. The comparison within Canada supports the interpretation of the relation between resources, workload and the care workers’ assessments of the quality of care they are able to give.

IV. Conclusions

Not only has mainstream comparative research often missed the significance of examining care services for people and their family and friend networks, but also researchers’ predominant focus on financing rather than on service delivery, organization and administration obscures several substantive changes that are occurring. Previous care research has shown how important relational caring is, that the care provided is adapted to the needs of both care worker and recipient meeting the individual situation and changing needs. This micro-politics of care negotiation is dependent upon linking practices at the micro level to meso and macro level contexts. To make that possible there needs to be enough *time* for the encounters and *continuity* in the relationship between the care worker and the resident, as well as a *limited number of residents* for each worker to relate to. But the care worker must also have sufficient *freedom of action* in her daily work to be able to adapt the help provided to the changing and different situations of the care recipients she meets during the day. Her decision latitude can be affected by lack of time, but also by a hierarchical organisation with pre-determined occupational tasks and detailed regulations.

If recipients are not satisfied with the care they receive, it is hard for the worker to be satisfied with her work. Thus to be pressed for time or not being able to control one’s workday imply negative working conditions for a care worker (as for other workers). But if a care worker is not able to provide ‘good enough’ care (cf. Meagher 2006) because of lack of time or autonomy at work, this is also a problem for the recipients, and it will in turn amplify the negative working conditions for the worker. Not being able to provide care according to own one’s standards of ‘decent care’ is strongly related to mental exhaustion (Gustafsson & Szebehely 2005) and the inability to provide quality care has been shown to be a primary reason for residential care workers for leaving their jobs (Bowers et al 2003).

To be able to provide ‘good enough’ care and to be recognised accordingly – a right or an utopia?

Many care workers in both countries express a wish to provide good care, but resources, scale and the way work is organised can hamper these intentions, in particular in the Canadian case. In the words of McMurdo & Witham (2007, p. 914): “Good people working in poor environments with poor systems of care will inevitably produce poor quality of care.” If “good people” are hindered from providing good care, it is a problem for old people living in residential care facilities as well as for the care workers. But it is also a problem for the families of

frail older people who may find themselves forced to leave a loved one in a facility they see as far from ideal or to take on a caring task that may be overwhelming. As Guberman (2004) has pointed out, the choice between residential care and family care can be a non-choice if institutions are not socially acceptable alternatives.

Thus there are many good reasons for policy oriented welfare researchers to take a closer look at the everyday life in residential care, and analyse the consequences of different models of care for all the parties involved: the elderly themselves, their families and the care workers. The staff is clearly central here. If care workers with high ideals can be recruited and are willing to stay, and if the organisation of the services leaves enough space for the care workers to provide good quality care, only then can residential care be a welfare resource for all three parties involved. Like Kittay argues, we are not independent, autonomous and unembodied beings, we need to depend on others. We need care. And, it is not realistic in the long run to expect that care workers will continue to accept the working conditions, health risks and low pay associated with the low priority care work if afforded. And it is certainly not defensible from a social justice perspective to hope that the reward they get from the relations with the residents will compensate for low pay, exhaustion and health problems caused by scarce resources and un-caring organisational principles. As Nancy Folbre has argued, the emotional bonds between care workers and care recipients that are endemic to good care make it possible to pay lower wages and still recruit and keep care workers – the ‘prisoner of love’ dilemma (Folbre 2001, see also England 2005). The care workers in this study, especially in the Canadian case, make a strong argument that frail older people deserve better care than they themselves are able to provide within the current framework. The policy challenge is to make good care possible.

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² According to the regular statistics, which does not differentiate between home based and residential based care or between care for older and disabled people, 5% of the Swedish care workforce are registered nurses. This is a lower proportion than in any of the other Nordic countries; Finland, where 18% are RNs, is closest to Canada in this respect (Edebalk 2004).

³ In both countries 'staff hours' refers to working hours, and it should be noted that this is very different from the time actually spent with residents.

⁴ The figure on total staffing hours reported by Statistics Canada (2007) is 3.7 for British Columbia.

⁵ If not otherwise stated, in the following, all figures on the Swedish and Canadian care workers are from the Swedish-Canadian survey presented in section II.

⁶ The proportion of Swedish care workers with no or only short formal training in the present study (13%) is lower than has been reported in other sources: according the latest statistics 22% of the care workers in residential care lack basic formal training (NBHW 2007a, p. 61).

⁷ The difference between the countries is probably larger than it appears from table 1. In the Canadian survey the respondents were asked how often they would do 'cleaning (including room, bathroom, common areas)', while the Swedish respondents were asked how often they would 'clean a resident's room/apartment (e.g. vacuum or swab the floor)'. It is possible that fewer Canadian workers would have reported doing cleaning if the same question would have been used in the two countries.

⁸ Among Swedish care workers with no or very short formal training, 32% give injections and 73% carry out administrative tasks compared with 42% and 85%, respectively, among care workers with 1 year formal training or more. These differences between the educational groups are not statistically significant.

⁹ In the Swedish-Canadian survey the following questions were asked: 'If you believe you will continue with your job, please tell us what's keeping you?', 'If you have considered quitting your job, please tell us why?', 'Are there tasks that you have to do that you think you should not have to do?', 'Are there any tasks you should have more time for?' and 'What changes regarding long-term care would you recommend?'. 95% of the Canadian and 98% of the Swedish respondents have answered at least one of these questions; usually several.

¹⁰ The comments from the Canadian care workers most often mentioned specific cleaning tasks, such as wheel chairs, bedpans or the cleaning of clogged toilets, rather than cleaning in general. It should be noted that despite the many negative comments on cleaning, especially among the Swedish care workers, cleaning (or other housekeeping tasks) were hardly ever mentioned as a reason for considering quitting (neither in Canada nor in Sweden).

¹¹ A Canadian report, based on the same survey, relates the particularly high exposure to violence among Canadian care aides to inadequate resources and training: 'Rushing care tasks, working understaffed, not having time to develop relationships with residents, and managing cognitively impaired elderly, without adequate training all contribute to the violence experienced by care workers.' (Banerjee et al 2008, p. 4). The authors conclude: 'Comparisons with Nordic countries demonstrate that the levels of violence we find in Canada are far from inevitable.'

¹² Statistics Canada (2007, table 10) reports 3.8 total staff hours per resident-day in Ontario compared to 5.7 in Nova Scotia and 5.2 in Manitoba.