CRITICAL TO CARE
WOMEN AND ANCILLARY WORK IN HEALTH CARE

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February 2006

The full report, including the Appendix, can also be downloaded on the following websites:

The National Coordinating Group on Health Care Reform and Women
(http://www.cewh-cesf.ca/healthreform/)

The National Network on Environments and Women's Health
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Acknowledgements

This paper is intended to provide a basis for discussion of women's ancillary work and of strategies for change. It is therefore a draft rather than a completed work. The members of the National Coordinating Group on Health Care Reform and Women have provided valuable feedback on an earlier draft. The National Network on Environments and Women's Health (NNEWH) provided assistance with editorial work, funding and distribution assistance. The content, however, remains the sole responsibility of the authors.

The National Coordinating Group on Health Care Reform and Women, and NNEWH are supported financially through a contribution agreement with the Bureau of Women's Health and Gender Analysis, Health Canada. The views expressed herein do not necessarily represent official policy of Health Canada, the National Coordinating Group on Health Care Reform and Women or the National Network on Environments and Women's Health.

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She has a care aide certificate from a college and she worked for years, providing palliative homecare. In recent years, this meant working through a series of private agencies. She came to know many of her patients well, often working extra, unpaid hours because they were so alone. She left the job for several reasons. Every time someone died she went through two losses: the loss of someone she had come to know well and the loss of a job. She found both highly stressful. The private agencies that employed her would often phone, leaving a message about the death and the funeral, but no condolences or other recognition of the relationship. They were managers without health care training who were primarily interested in the business. Frequently, there were no other assignments immediately available so she had to search out work with other agencies. One agency would send her to prospective wealthy clients, taking advantage of her certification as well as of her race. She was White and often these clients wanted a White care aide. Once the client was signed up, a different care aide was sent. The new one frequently had no formal training and was often from a racialized group. In the end, the job was too hard on her family, as well as on her. She quit to take another job.

Now she works as a unit aide in a hospital. The job involves a wide range of activities, from replacing refuse bags on patient tables and chatting to families, to cleaning shelves and responding to nurses' requests. She is casual, working weekends and replacing workers sick or vacationing during the week. She seldom knows her schedule in advance, often working seven or eight days in a row. She works at an amalgamated hospital which means she is at the bottom of the list in terms of both assignments and opportunities to switch to full-time work. At least the union makes sure she is on the list and has above minimum wages. The union also protected her from an abusive supervisor, handling her grievance and ensuring action. With children at home, the irregular schedule makes it difficult to juggle her family work demands with her paid work ones.

Another unit aide started working part-time in housekeeping at age sixteen, when she arrived in Canada from Trinidad. She has worked her way up to full-time work on

regular shifts now. Such promotions through the ranks are no longer possible because housekeeping is now contracted out. So are food services. As a result, women who have worked all their lives in the kitchen lost their jobs. The same thing happened in the laundry. In the process, the hospital lost the services of a woman who not only ensured the linen was clean but also that it was repaired. In each of these transitions, the workers first learned of the changes by rumour and then by notice of layoff. But the layoffs happened after one kitchen worker slipped on a spill in the hall and a laundry worker was stuck by a needle left in the linen.

A clerical worker is still employed by the hospital but staff has been cut back significantly at the same time as people are moved more quickly in and out of the hospital. Work has become faster, and there are fewer other workers available. As a result, she rarely takes breaks or has time off for lunch. She regularly has to learn new computer programmes, deal with anxious families and many people seeking admission who are both frail and unable to read or write either official language. A medical error resulted in a big investigation of her record keeping. Although she was absolved of blame, it has made her nervous about her work. Now her wrists are bothering her and she fears another outbreak like SARS. Few people seem to wash their hands when they come to the hospital now and it could start all over again.

The food services manager at the hospital works for a private firm that provides a range of facilities. She does not get paid what she would expect as a manager and has to answer to both the business that employs her and the hospital. She often has to take work home, without being paid overtime and on the weekend, making it hard on her young family and on her housework. While she would prefer to work for the hospital and make friends on the staff, everything else she tried was part-time. And with her family back in India and her husband unemployed, she has little choice about taking paid work

This is a composite picture, based on fragments of lives and research. It offers only a glimpse of the complex skills, conditions and relations involved in some ancillary jobs in health care.

INTRODUCTION

Who counts as a heath care worker? The question seems straightforward but the answer is far from simple.

Virtually everyone would agree that doctors and nurses are health care workers. However, even here there may be controversy. Do we include among our doctors those who practice chiropractics and homeopathy? Do we include nursing aides and orderlies when we talk about nurses? When it comes to other jobs created by the developments in technology and in the division of labour, there is even less consensus. Increasingly, many of these more controversial jobs are described as ancillary. The Romanow Report on the Future of Health Care in Canada, for example, makes a distinction between those who provide direct care and those who are engaged in ancillary services. While not offering a clear definition of ancillary services, the Report does describe them as services "such as food preparation, cleaning and maintenance". Clerical workers and laundry workers would also seem to fit in with this understanding of ancillary, given that these workers too do not provide 'direct' care. But the lines between the two kinds of work remain blurred. For instance, some of those who provide homemaking services do food preparation and cleaning but also may provide some direct care. At the same time, personal care providers who work in homes and hospitals do cleaning and food preparation, fitting them into both categories as well.

The question of where we draw the line between health care workers and non-health care workers is not just a matter of academic nicety, a debate without consequences for care. It is a central issue for policy development in health care because the definition reflects and reinforces practices that allow workers in health care to be divided into two camps, with each camp treated differently. One of the most obvious consequences is the contracting out of services defined as ancillary to firms that do work that is similarly defined in the non-health care sector. Defining these workers out of care can mean as well that too little attention is paid to their role in the success of interventions, in recovery, in sustaining health and in preventing illness or disability.

This paper argues that all those jobs described as ancillary are critical to care and that those with jobs defined as ancillary are health care workers. We start with the Romanow

Report's distinction between direct and non-direct, or ancillary, health care work. Here we include as ancillary workers not only the dietary, housekeeping and maintenance staff listed in the Romanow Report, but also the clerical, laundry, security and managerial staff working in health services who are seldom defined as providing direct care. We also include personal care providers and homemakers, who are sometimes understood as involved in direct care and sometimes defined as ancillary. Our intention is to be inclusive in ways that ensure all those involved in health services are considered when we look at care. The logic of our argument would lead us to use another term for these workers, but in order to relate our work to that of other discussions, we retain the term ancillary here.

The paper further argues that, with the exceptions of management, maintenance and security work, these jobs are mainly done by women. And it is the female-dominated jobs that are most frequently defined as ancillary. Such work is traditionally women's work, although it is sometimes also done by marginalized men. Associated as it is with all women's work in the home, the skills, effort, responsibilities and working conditions involved remain invisible and undervalued. This invisibility and undervaluing contributes to the process of defining this work out of care, equating it with hotel services, services that are also dismissed as requiring few skills and little effort or responsibility.

Finally, this paper argues that ancillary work, and the changes related to it that are underway, can be understood only within the context of global and national developments in governments and health services. The issues are not only Canadian ones, nor can they be addressed exclusively at the local level, nor simply in terms of health care.

These three arguments: namely, the contribution ancillary work makes to health care, the invisibility and undervaluing of this women's work, and the importance of the context in understanding influences on this work, are woven throughout the paper. It is a gendered analysis, one that takes not only the similarities among women but also differences among them into account. The objective is to establish a basis for a discussion of the implications for research, policy and other actions in relation to work done by thousands of women each day. Indeed, depending on where we draw the line, ancillary

workers may account for the majority of those who work in the health and social service sector.

These arguments are developed within the framework of a determinants of health approach. From this perspective, health is critically influenced by social and physical environments and by social and economic relations, structures and technologies, as well as by genetic makeup and health care services. Class, race and gender matter in health and care. Our approach differs from many versions of the increasingly popular social determinants of health approach in two significant ways. First, we emphasize the importance of these determinants *within* health care rather than seeing them mainly as variables influencing health outside health care. This is the case both for those needing care and for those involved in the provision of health care services. Although the health of everyone is shaped by their environments, relations and the structures in which they work and play, those who are ill, are under treatment or who are disabled are particularly vulnerable to unhealthy conditions. Equally important, the health of workers is shaped by their work environments. And what affects their health affects the health of those in their care. Second, we stress that these determinants are themselves shaped by global as well as national, regional, local and institutional forces in interconnected and often contradictory ways. This contrasts with those who treat the determinants more as independent variables.

The first section of the paper sets out the implications of applying a social determinants of health approach within health care services, seeking to reveal the ways in which ancillary work is critical to care. Our brief history of nursing work that follows is intended to demonstrate that ancillary work was once part of nursing and is still done by nurses if and when it is not done by others, precisely because it is so critical to care. In thinking about how the social determinants of health apply within care, it is important to recognize the features that make services in care different from other services such as those offered in hotels. Health care is a human right and a social relationship, provided to people who are at least in some ways dependent and vulnerable for variable lengths of time. There is often a significant knowledge and/or capacity gap between the health care workers and those seeking care, frequently leaving care recipients particularly vulnerable and with limited power. Health care needs are also usually unpredictable for both the

patients and providers, often generating high costs that are well beyond the means of most people. Health care requires the work of a coordinated team in and outside facilities, a team that includes those doing ancillary work. In short, the section sets out the characteristics of care that not only make it a unique service but also make ancillary services integral to care.

Based on statistical data compiled by Krista Scott-Dixon and presented in detail in the Appendix, the second section draws a portrait of the work and the workers. These data challenge some popular notions of ancillary workers while reinforcing others.

The third section of the paper examines the gendered nature of ancillary work. Our examination of the historical division of labour is designed to show that care and ancillary work have traditionally been done by women in and outside the household. One legacy of this division is the blurred boundaries between direct care and ancillary work, a blurring that indicates the integral relationship between the two kinds of labour. Another legacy is the invisibility and undervaluing of the skills, effort, responsibilities and conditions involved in doing the work. As women have entered the labour force in large numbers, they have made some significant gains through unions and professional organizations. Registered nurses in particular have been able to make many of their skills visible and valued, in part by shedding at least some of the tasks traditionally associated with women and the home. But the definition and valuing of skills remains a profoundly gendered process rather than a simple measurement of technical competence and a rewarding of objectively assessed effort and expertise. Here we set out some of the skills, effort and responsibilities involved in ancillary work, in an attempt to highlight both how gender has obscured them and the need for more research on the nature and conditions of this work.

This leads us to address the health hazards faced by the women who do ancillary work. Just as the skills are all too frequently rendered invisible by gender, so too are many of the hazards many women face in the relations and conditions of this work. Health care work has the highest rates of illness and injury of any occupational group, and part of the explanation for this pattern can be found in what Karen Messing calls "one-eyed science"; approaches to health that are gender-biased. Finally, we look at women's resistance to this invisibility and undervaluing, including the attempts to use

legislation and regulation. Rising female labour force participation rates, along with professionalization and unionization, have helped improve conditions in care work. In sum, this section sets out ancillary work as women's work, exploring the ways this female dominance contributes to the undervaluing and the hazards faced in the work, and the ways in which women have challenged these trends.

The fourth section looks at the context in which ancillary work is developing and changing in order to understand the forces that are shaping ancillary work in health care. Health care has become a global issue. One reason for this global interest is what is often presented as an alarming rise in health care expenditures. The solution offered is mainly better government management, usually understood as the adoption of practices taken from the for-profit sector and the shedding of government services, usually through contracting out to for-profit firms. Another reason is the opportunity for profit in an area traditionally without many investor-owned services. Both new public management and the shift to for-profit services are being promoted through international trade agreements and other pressures on national governments to open their health care to profit-seeking firms. And there is pressure as well to open borders to not only international services but to international workers as well. Ancillary services are particularly vulnerable to these pressures, given the assumed similarity to existing food and accommodation services in the for-profit, international sector and the notion that few skills are required. However, we argue that the evidence indicates that government health care expenditures are not out of control and that the most rapidly rising costs are those in the for-profit sectors, especially pharmaceuticals and technologies. This suggests that the model should not be the for-profit sector, even if we were to accept the notion that health care is a business like any other. Moreover, little can be saved by reducing expenditures on the lowest-paid workers, the ones who do ancillary work. Yet international pressure, along with considerable local support, is moving Canadian health care in this direction.

In a number of ways, health care reforms are a local version of international developments, albeit played out in a particular way. The Canadian public health care system was introduced in the wake of similar programmes in other countries, although it has certainly had its own unique features. We set out a brief history of the development of public care in order to show how the structure of the system makes it vulnerable to the

kinds of privatization underway. This privatization takes at least six forms. Some services have been contracted out to the private sector while some services have been duplicated by the for-profit sector. Responsibility for care payment has been shifted to the individual, as has the responsibility for care work and for staying healthy. Within the remaining public sector, for-profit managerial techniques have been adopted and public-private partnerships established, making the public sector harder to distinguish from for-profit firms. Together these processes make health care decision-making more a private than a public concern.

Ancillary workers have been the most vulnerable to several forms of privatization, with negative consequences for their pay, job security and conditions of work. Other health care reforms, such a regionalization, may promote or at least allow the privatization of ancillary services. Under regionalization, each local decision-making body is seeking to reduce costs in the most immediate form possible and the costs savings that come from contracting out to firms that pay less for ancillary work seems attractive. Privatization can also make team work more difficult, even as teams are being promoted in health care. And privatization is being undertaken without much research on the consequences for public health and care, in spite of the current emphasis on evidence-based decision-making. In summary, international pressures and local health care reforms are creating pressure to change the management and delivery of ancillary services in ways that are undermining both the stated purposes of many reforms and the conditions for the ancillary workers.

Finally, the paper looks at implications for policy research and other actions, stressing the issues for women as a group and for different groups of women. In order to recognize and value the contribution ancillary work makes to health care, we first need an active state that supports a public health care system based on non-profit delivery and dedicated to ensuring decent employment for the entire health care team. This means developing better mechanisms for accountability and better means for promoting equity. Second, we need better management. Such management should not only understand how the determinants of health apply within health care but should also be well-versed in the role gender and racialization play. This means ensuring employment security, along with decent conditions of work and for participation in work. Third, we need to promote

unionization and ensure that these unions are responsive to their various members, especially in ways that recognize their skills. Unions are the most effective measure to ensure better conditions and participation, but new measures are necessary to encourage their growth under changing work organization. Along with unions, we need better and better enforced labour standards in order to protect those who remain outside unions. Fourth, we need more, and better, research that is translated into practice. This means making gender and racialization central components in all research, research that begins by recognizing the critical part ancillary work plays in health care.

SECTION I - ANCILLARY TO WHAT?
A DETERMINANTS OF HEALTH APPROACH

The very term ancillary implies a particular understanding of health care. It invokes a notion of clearly defined activities with definite boundaries between work that is central and work that is peripheral or even non-health care. It fits best with a medical model of health care focused on scientifically-based treatment of body parts, with doctors the central authority. Diagnosis and cure are directed by a physician whose expertise and authority are based on a command of scientific research that established the causes and corrective treatments. Thus the physician is at the centre, directing the treatment that is understood as the purpose of health care. In such a model, health care workers are those who require formal, advanced training and who are mainly focused on interventions, treatment and cure, or on carrying out the directions of those who have such a focus. It is not surprising then that doctors and nurses are those who are the subjects in research on health care work, given that the dominance of allopathic medicine puts them at the centre of diagnosis and cure. An alternative model is a determinants of health one. This model leads to a much broader definition of both health care and health care workers, a definition which sees those termed ancillary as critical to care.

This section begins by setting out a determinants of health approach and the distinct features of health care work that separate it from other forms of paid labour. Then moving on to trace development in nursing work, we seek to show that work currently defined as ancillary was once part of nursing precisely because it is essential in care. Indeed, it is still required of nursing if it is not done by others because it is so critical to

care. The lines between direct and non-direct care work are difficult to draw because both are integral to care and because there is constant overlap in the work of a team that includes those defined as core and ancillary. A consistent application of a determinants of health approach leads to such a conclusion.

The Lalonde Report, produced under the direction of the then Canadian Minister of Health and Welfare (Canada, 1974), was one of the first public policy papers to set out what has become known as a determinants of health approach. From this perspective, health is also socially constructed rather than simply biologically determined or technically produced. According to the 1986 Ottawa Charter, a product of the First International Conference on Health Promotion, "Health is created where people live, love, work and play". The Ottawa Charter defined health promotion as "the process of enabling people to increase control over and to improve their health" (Canada 1986:1). Creating health means building healthy public policy; creating supportive work, home and community environments; strengthening community action; developing personal skills; and reorienting health services to be health promoting rather than simply treatment focused. The subsequent Adelaide Conference in 1988 defined health as a fundamental human right and stressed the importance of equity, identifying improvement of women's health as a priority not only because women suffer from inequality but also because they are critical in the daily promotion of health. Three years later, the Sundsvall Conference in 1991(World Health Organization) highlighted the spiritual, social, cultural, economic, political and ideological dimensions of environments.

A determinants of health approach is increasingly promoted in Canadian health care reforms. For example, in its October 2005 report, *Improving the Health of Young Canadians*, the Canadian Institute for Health Information begins by stating that: "the health and well-being of Canadians is linked to a number of factors, including health services; social, economic, cultural and physical environments; and interactions between individual biology and behaviour" (CIHI, 2005b:unpaginated). Health Canada recognizes twelve determinants: biological and genetic endowments; gender, income and social status; employment; education; physical and environments; social support networks; healthy child development; personal health practices and coping skills; and culture and health services.

And these Canadian organizations are not alone. The 2005 Organization for Economic Cooperation and Development's publication *Health at a Glance* considers health determinants, "reflecting growing policy interest in striking a better balance between spending on prevention and care" (OECD, 2005:i). Closer to home, the introduction to the Romanow Report (2002:xix) talks about the many presentations that "focused on the need to improve our understanding of the determinants of health," arguing for example that "the food we eat directly affects our health and our health care system".

In other words, a determinants of health approach tells us that health is critically influenced by social, economic and physical environments, by relations as well as by structures or technologies. Health is not only determined by genes and care, and not only about cuts and chemicals. Health is created everywhere. And it is created in classed, racialized and gendered ways.

Feminists throughout the world have emphasized the centrality of gender in the creation of health and care. Recognizing gender means recognizing the gendered consequences of subordinate relations and conditions. In these relations, women participate on unequal terms with men. The Fourth World Conference on Women (United Nations, 1995) agreed that "Women's health involves women's emotional, social, cultural, spiritual and physical well-being and is determined by the social, political and economic contexts of women's lives as well as by biology". A gendered approach thus means much more than analyzing data by sex. It means recognizing what women share socially as well as biologically. And it means understanding differences among women as well, differences related to their various social, cultural, physical and economic locations and abilities. The claim is not that gender is primary but rather that it always must be taken into account, considering ways it intersects with other factors.

Canadian women have been active participants in the global efforts to include gender in discussions of determinants of health. As the authors of *The Politics of Women's Health* put it, medicine has played "an active role in perpetuating some aspects of women's oppression while helping to reduce other dimensions" (Sherwin et al., 1998:3). Gender matters not only in how women are treated as patients in the health care system but also in how they are treated as workers. With women accounting for four out of five health care workers, gender is clearly a factor in care work. Here, too, Canadians have

contributed to a broad literature establishing the invisibility and under-valuing of women's health at work and women's health care work, both paid and unpaid (Armstrong *et al*., 2002; Grant *et al*., 2004). What Karen Messing (1998) calls one-eyed science has both used men as the standard in research and ignored the particular hazards in women's work. Armed with such research, women in Canada have been successful in having both sex and gender recognized as health determinants. Moreover, they have convinced the federal government to require all policy to have a gender analysis (Status of Women Canada, 1995; Women's Health Bureau, 2003).

Women in Canada have also highlighted the importance of racialization as a health determinant and as a factor in care work (Das Gupta, 1996; Guruge, Donner and Morrison, 2000). While racialization is not identified as a determinant of health, culture is one of the determinants in Health Canada's list. The absence of racialization could be understood as a failure to recognize the importance of racism as a factor. The federal and some provincial governments do have some policies on employment equity which acknowledge inequities resulting from racism. And the Charter of Rights and Freedoms can be understood to acknowledge racism. There is still, however, a long way to go before a determinants approach takes racism into account.

Although our approach here builds on the increasingly popular determinants of health literature, it differs from the most common applications in at least two important ways. First, instead of treating these determinants as largely independent variables, we understand them as interpenetrating ones. This means stressing the importance of these variables within health care, in terms of both patient and worker health. This not only implies a broader notion of health care work, and who counts as a health care worker, but also an emphasis on the particular characteristics of health care work. Our focus here is on paid health care work, but it should be noted that most health care work is unpaid and done primarily by women. This unpaid women's work has a significant impact on the value attached to women's paid work, an issue discussed further in the following sections.

The determinants of health take on a particular importance within health care. Social, physical and psychological environments are even more critical for those who are ill, frail or suffer from chronic conditions that make them particularly vulnerable. The importance

of these determinants is intensified within the health care workplace, reflecting the specific nature of health care work. Health care is about vulnerable individuals whose body parts cannot easily be divorced from their environments. Moreover, the environments for care are much more likely than other environments to constitute risks that are particularly dangerous to those requiring care. The environments for care are part of care, and can be as critical to health as clinical interventions. Indeed, they can influence whether such interventions succeed or fail. Research in British Columbia suggests that homemaking services may be even more important than nursing ones in maintaining care in the home and in preventing a move to facility care (Hollander and Tessaro, 2001). The influence of environments is in part why there is a term for illnesses that result from being treated in the system. Iatrogenesis refers to illness or death caused by health care.

Take food for example. The National Health Service in the United Kingdom describes health care food as "a token of exchange between hospital and patient, and it matters tremendously how it is made available to patients, how it is prepared and how it is served" (NHSEstates, 2003). While these aspects of food matter to us all, they have a particular importance when patients need to be tempted to eat. But food is more critical than this in care. Food not eaten, the wrong food eaten or food eaten at the wrong time in the wrong way can be especially dangerous to the ill, frail or disabled. So can food that is not correctly prepared. Yet the same Romanow report that identified food as a critical factor dismisses those who prepare and serve the food for the ill and disabled as non-health care workers. In her 1982 study of U.S. hospital workers, Patricia Cayo Sexton suggested that "Medicine's indifference to diet and nutrition is perhaps associated with both profits and prejudices". Profit features because it is more profitable to quickly treat or cure with pills and surgery than it is to do so through nutritional approaches and through making dietary workers integral to care; prejudice because this is traditional female work. "Since food diet, nutrition are the basic products of that historic female enterprise, they may be seen as essentially marginal to hospital operations, along with the dietary workers associated with them" (Sexton, 1982:38).

A similar point could be made about laundry and housekeeping work, where indifference may be compounded by the preponderance of immigrants and people from

racialized groups in such work. Because those needing care tend to be particularly vulnerable, they have special needs for clean physical environments and require special protections against the heightened risks posed by others who are ill. For example, research in the U.K. demonstrated that high cleaning standards play an integral role in controlling infection (Wilcox *et al*., 2005). Similarly, Canadian research has concluded that a reduction in resources assigned to housekeeping was an important factor in the spread of C. Difficile (Valiquette *et al*., 2004). Beds, bathrooms and toilets all pose health risks. Health care laundry that has not been appropriately handled can become life-threatening for patients (Orr *et al.,* 2002). Recent concern over patient safety and SARS has begun to shift attention to the determinants of health within hospitals (Healthcare Quarterly, October, 2005). However, very little research has been done on the safety of care in homes, communities and even long-term care institutions (Hassen, 2005:9).

Those who use the health care system also have particular needs in terms of social supports. When you are ill, facing surgery, struggling with a chronic illness or disability, the need for social support seems obvious. With hospitals and other facilities amalgamated in areas often far from friends and families and with most women in paid jobs, there is more pressure on paid providers to offer support. Doctors spend little time with patients, and increasingly this is the case for nurses as well. Ancillary workers are frequently the only people there to chat and respond to calls for help. For example, patients talk to those cleaning around their beds, and often influence that cleaning in the process. Cleaning staff "play an important role in handing people blankets and out-of-reach items, opening drink containers, getting personal items, notifying a nurse of problems and conversing with patients" (Cohen, 2001:8). Because health care is an interactive process, the people who need care are constantly defining new needs in ways that may pay little attention to the titles and credentials of workers. They want and need support now. By way of illustration, a clerical worker interviewed in an Ontario study told a story about a woman who had been informed she had cancer by a doctor and nurse who were immediately called away. "She had just been told and she broke down crying and the housekeeper that was cleaning up went over and she said, "Do you want a hug?" (Armstrong et al (1994:59).

Health care also requires interaction among those who provide care, because care itself must be integrated through the complementary skills of a range of providers. Health care necessarily involves a team that includes those who do surgery and those who make sure the surgery is clean; those who determine whether patients eat and those that help them eat; those who determine what records should be kept and those who keep them. Team members are interdependent in ways that mean distinctions between ancillary and direct care are blurred. The British House of Commons Health Select Committee (1999) warned that "The often spurious division of staff into clinical or non-clinical groups can create an institutional apartheid which might be detrimental to staff morale and to patients" (quoted in Sachdev, 2001:33).

A determinants of health approach also supports a focus on employment, working conditions, gender, culture and social support within jobs. In other words, it leads to a concern with the health of health care workers. As Jennifer Stone, Vice-President of CIHI explained, the "challenge, at a systemic level, is to keep health-care workers employed, satisfied, in good health, on the job, motivated and effective" (Conference Board of Canada, 2005:13). Nevertheless, most of the research on these issues has focused on the regulated professions, and especially on nurses (Canadian Nurses Association, 2004) and very little of it takes gender or culture into account. In one of the few studies that not only links patient safety and worker safety but also includes a range of providers in a variety of settings, Annalee Yassi and Tina Hancock (2005:32) conclude that "looking after the well-being of healthcare workers results in safer and better quality patient care". However, here too the focus is still on nursing staff, albeit a broadly defined nursing staff.

Ancillary workers often have part-time, temporary or casual work that means they often do not have sick pay or medical benefits (Armstrong and Laxer 2005). As a result, they frequently go to work sick, increasing the risk for both other workers and for those in care. New managerial practices and contracting out too frequently mean ancillary workers are unfamiliar with physical workplace and with the workers. This too can harm workers and those with care needs at risk.

A determinants of health approach may be the dominant discourse in policy circles but it is not in research and practice within health care. The role of ancillary workers in determining health within facilities and households is seldom considered, and reforms are

seldom assessed with the role of the determinants of health within care in mind. Health care differs from other work in significant ways, creating demands and expectations not found in other work. At the same time, the health of ancillary workers is often ignored, as is the role gender and race plays in their health. This paper seeks to address these gaps by considering ancillary workers as part of a health care team. While the logic of this approach would lead us to call them by some other name, we use ancillary because it is the term most commonly used in the policy and research literature.

The second way our approach to the determinants of health differs from the more standard version concerns the importance we attach to the ways these determinants are shaped by global as well as national, regional and local forces in interconnected and often contradictory ways. In spite of the emphasis on the social, most of the current determinants literature largely ignores power inequalities at various levels and the ways political economies influence health and care. The most popular determinants of health approaches provide no context for the social determinants of health (Poland *et.al*., 1998). And there is little explanation for changes over time or among groups, except for those explanations that look to individual practices or values. In an effort to identify some of the pressure leading to transformations in ancillary work, the final sections of this paper focus on the global context for health reforms and the ways these play out at the national level in Canada. However, the entire analysis presented here is understood within this context.

The Origins of Ancillary Work

Almost all the work currently done by ancillary workers was once done by nurses. And one of the first people to emphasize what we would now call the determinants of health within health care was Florence Nightingale, the woman often recognized as the founder of nursing training. Tracing the history through nursing allows us to see both the central role this work has played in care and the part it continues to play in determining health. If the work is not done by others, it is done by nurses precisely because it is so critical to care.

There are old and new debates about how the occupation nurse should be defined. Should it include, as Veronica Strong-Boag argues, the entire range of "women's

longstanding responsibility for maintaining family and community" (quoted in Bates, Dodd and Rousseau, 2005:8)? Or should 'nurse' be used as a more restricted term applied to those paid for caring work in the regulated nursing professions? The debate arises from the fact that women have, throughout recorded history, done care work and that care work has involved a wide range of activities, regardless of whether the work is paid and labeled as nursing and regardless of where it is done. The debate arises as well from the overlap both between paid and unpaid nursing work and between more restricted definitions of nursing tasks and those of domestic labour. Indeed, as Christina Bates, Dianne Dodd and Nicole Rousseau (2005:9) make clear in their introduction to *On All Frontiers. Four Centuries of Canadian Nursing,* nurse's struggle for professional recognition "had as its starting point a determination to banish the taint of domestic labour". It is a struggle that continues today, because domestic work remains central to care work, because domestic work is denigrated and because care work is not always easy to divide into discrete tasks that separate clinical from domestic tasks, direct from non-direct care.

Paid nursing work was primarily done in private homes until well into the twentieth century, although some nurses worked in hospitals and some may have worked in other kinds of residential care facilities. In French Canada, the first formal health care was initially provided mainly by nuns who trained each other and worked without pay (Coburn, 1987). Some midwives had trained in France's formal system and Aboriginal women continued their traditional practices (Benoit and Carroll, 2005). In English Canada, the public hospitals for the military were initially staffed by male nurses. But this practice of hiring men for nursing work was and is mainly the exception outside military and mental hospitals (McPherson, 1996:10). In response to epidemics of cholera, typhoid and smallpox that swept eastern Canada in the second quarter of the 19th century, hospitals recruited female lay nurses and paid them a wage (Coburn 1987:443). The label applied to a wide range of women who provided a wide range of services. Most were immigrants from servant classes and acquired their skills on the job. Their tasks included "cleaning and changing patients' clothes when they were admitted, monitoring symptoms until the doctor stepped in, restraining delirious patients, changing patients' soiled bedding and bedshirts, distributing medications and meals, and cleaning the patients and

the rooms" (Bates, Dodd and Rousseau, 2005:15). According to a Montreal doctor writing at the time, these nurses were "ill-educated", although he may have been talking about formal training and reflecting his own class position (Gibbon and Mathewson, quoted in Coburn, 1987:443). Other evidence suggests nurses had diverse levels of education and skills (Bates, Dodd and Rousseau, 2005:25). "Cleanliness was not a feature, either of the nurse, ward or the patient", in part because germ theory had not yet been propagated and in part because both the patients and the nurses had few resources (Gibbon and Mathewson, quoted in Coburn, 1987:443). Hospitals in general were often dangerous as a result; dangerous to both the providers and the patients, although Kathryn McPherson (2005) argues that there was a wide range of care that included high quality care.

Nurses helped change this in Canada by following Nightingale and others in establishing training schools for nursing that articulated the skills and duties of nurses. Nightingale emphasized "nurses' nurturing work, their management of sanitary conditions and their 'ability to make the hospital a home'' (McPherson, 2005:79). In the process, she and other reformers simultaneously enhanced the prestige of nursing and formalized training while firmly tying it to women's work. The combination of trained nurses, germ theory, cleaner environments, better funding, better techniques and richer patients all contributed to making the hospital a safer place for care.

At the beginning of the twentieth century, there were only two categories of women listed in the Census as working in health care: graduate nurses and students. According to George Torrance, hospitals even between the two world wars were characterized by very little division of labour. Graduate nurses supervised student nurses, "who not only provided most of the bedside care but also did many of the domestic chores as well". Some cooks, kitchen helpers and cleaners could be found but many of them, like the nurses, lived in the hospital residences. Wages were low for all these women, with little difference between general duty nurses and maids (Torrance, 1987:481). Nurses in private duty, who made up the majority of graduates, faced "pressure to blur the distinction between nursing and domestic work" (Keddy and Dodd, 2005:47).

All this started to change in the period after World War Two. Hospitals grew rapidly, prompted by new technologies and other developments such as antibiotics, by returning

soldiers need for care and by new approaches to health care, such as the medicalization of childbirth. Public financing of hospitals and then hospital insurance gave an enormous boost to hospital expansion. Work in public health and residential care also expanded along with the welfare state. The labour force grew enormously, and both managerial and labour strategies contributed to increasing specialization within health care work (Armstrong and Armstrong, 2003).

Until the 1960s, nursing students provided a significant proportion of the health care labour force. Nurses-in-training lived in residence and worked as apprentices in the hospital. Most were Canadian born and white, but usually women who did not have the resources to pay for their own education (Kirkwood, 2005). These unpaid apprentices "not only provided most of the bedside care but also did many of the domestic chores as well" (Torrance, 1987:481). But the changing demands of the increasingly technical nursing work, new ideas about both the organization of care and of education, and pressure from nurses' organizations combined to transform nursing education. Students left the residences and entered educational institutions, in the process leaving the nursing labour force until graduation and also leaving much of what we now call ancillary work to others. It is during this period as well that more foreign trained nurses were recruited in order to increase the supply and reduce the power of nurses created by shortages.

Meanwhile, as we shall see later in this paper, these formally educated nurses had been forming professional associations and unions that became increasingly successful in demanding decent wages and working conditions, as well as the right to leave some of those housekeeping tasks to others. Faced with rising labour costs and armed with new managerial strategies, health care organization introduced new occupational categories. The new division of labour developed gradually, but the trend was consistent, carving out pieces of nursing work to be done by those who had less formal training and less power. What we now call ancillary work emerged.

While the new division of labour is intended to define boundaries and leave nurses focused on the clinical aspects of care, the boundaries remain blurred. As one nurse interviewed by Riva Soucie (2005:57) for her thesis on nurses' learning explained: "We have fewer clerks too, so a third of my day is spent answering phones. If there's a cutback it always falls back on nurses. If a cleaner calls in sick, guess who's putting new

sheets on the burn stretcher? The only people that are there all the time are nurses". A nurse surveyed about conditions in long-term care wrote that

> Too much nursing time taken up doing work in dietary, passing juice, cleaning tables, passing snack cart. Nursing on evening shift in my facility get 3.5 hours per shift for nursing care. The rest is kitchen work, supper breaks, paper work. Tic sheets are four pages long and it takes 4-5 minutes per shift to do. When floor is in quarantine because of illness outbreak, no extra help is offered. My floor is working three staff for 48 people (Armstrong and Daly, 2004:20).

The boundaries remain porous not only because the nurses are there but also because the work must be done. It is critical to care.

Equally important, the boundaries among cleaners, dietary, clerical and other workers are not always clear either. Celia Davies (1995: 20) draws our attention to the "often unacknowledged therapeutic role that such workers play as they build close relations with patients and clients". So does Jerry White (1990: 70) in his study of Canadian hospitals. "The bond of caregiving work, loyalty to patients , and service orientation" united these workers in their opposition to changes that threatened their role in patient care, a point Robin Badgely (1975) had made more than a decade earlier.

The reason for this brief history rehearsal is not simply to emphasize the legacy of Nightingale or the significance of ideas about women's work. Both are clearly important in making nurses feel responsible and in holding them responsible for the entire range of care work. They are also important in establishing the value attached to the various aspects of nursing work, as is the historical division of labour itself. But this section is intended to make an additional and equally important point. Cooking, cleaning, feeding, recording and laundry are critical components of care work. They are integral to care. Although the work can be done by many different people, the work itself is part of a whole and requires intricate orchestration through teamwork. When such work is not done by others in a timely and efficient fashion, nurses must do it precisely because it is essential to care.

It is these other people, the ones now doing work previously done by nurses and still often done by them, whom we include as health care workers and focus on in this paper.

SECTION II – THE MISSING HEALTH CARE WORKERS

Who are these missing health care workers? Developing a portrait of ancillary workers is no simple task. The people we seek to capture in this section are often missing from the multitude of reports and statistics on health human resources. These health care workers cook and serve food, they clean and keep records, they bathe, feed and comfort, they do laundry, maintenance and security work. Some also hold managerial jobs. They work in hospitals and long-term care facilities, in homes and in offices, in courts and in governments. Most of those who do maintenance and security work are men while the overwhelming majority of those who cook and clean, provide home support, serve food and keep records are women. It is the female majority who are the focus of this paper, but it is also important to understand what jobs men do in care. Our determinants of health framework leads us to define the people who do this work as health care workers, distinguishing us from most other data analysts.

According to Statistics Canada, almost one in ten Canadians in the labour force is employed in health and social services. Almost one in five employed women works in this sector. Yet Statistics Canada's 2004 Labour Force Survey reports that only 54% of those employed in the health and social assistance sector are in health occupations.[i] Although they are employed by organizations defined as providing care, almost half of the employees are not counted as health care workers. The difference between those counted as working in health care and those counted as health care workers is explained in part by the difference in the two main ways Statistics Canada categorizes people in the labour force and in part by the assumptions buried within these categories.

One way is based on where people work, on what are called industrial categories. Health and social services is defined as an industry and it includes people employed in hospitals and long-term care facilities, as well as those who work in homes, in clinics, in courts and in government offices defined as providing health and social services. Until recently, all those employed in workplaces defined as providing health or social services would be counted in the industry. With the adoption of the North American Industrial Classification system, the industry is defined more in terms of the employer and less in terms of location. This has the effect of moving some people previously counted as working in health care into another industry if their work is contracted out to a for-profit

provider. For example, housekeeping services in a hospital that are contracted to a for-profit company may be counted as part of the food and accommodation industry rather than as part of health and social services. This new way of sorting the health care industry suggests that industrial categories are about more than simply another way of seeing the data. They reflect and reinforce new ways of organizing work that move some people out of health care, defining them as non-health care workers in doing so.

The second way Statistics Canada sorts people in the labour force is based on what people do, on occupational categories. Diane Galarneau (2004:16) explains that, for Statistics Canada, "Health care workers can be divided into three major categories: professional, technical personnel, and support personnel". Health professionals are those "primarily concerned with diagnosing and treating health problems in humans and animals and with providing related services such as pharmacy, nutrition, speech therapy, physiotherapy and occupational therapy" (Galarneau, 2004:17). Both registered nurses and licensed practical nurses are included in this professional group. Technical personnel are "primarily concerned with providing technical services to professionals" while support personnel are "primarily concerned with providing technical support to professionals" (Galarneau, 2004:17). This latter group includes assistants and aides, orderlies and patient service associates. These personal care workers are often included when they work in hospitals and excluded when they work in homes as home care workers. Thus there can be people working in the health services industry who do not do work defined as health care work.

The Statistics Canada occupational categories, like the industrial ones, are about more than simply technical groupings. This approach to health care occupations reflects a medical model focused on scientifically-based treatment of body parts, with doctors the central authority. It contrasts with, and limits, our determinants of health approach.

The other major source of data on health care workers, the Canadian Institute for Health Information, also relies on occupational data similarly defined. *Canada's Health Care Providers* (CIHI, 2005a and 2002) report data on nurses, doctors and some others, such as denturists and health record administrators/technicians. Its publication on *Health Personnel Trends in Canada* acknowledges that its focus "on only regulated health professions excludes unregulated health professions, and informal caregivers". But the

data on health occupations puts only 5% of the labour force in health occupations, leaving out approximately 5% counted by Statistics Canada as in the health and social service sector as well as all the unpaid providers, most of whom are women.

The categories used by the major statistical agencies as well as the assumptions buried within these categories limit the data available on ancillary work. So too does the lack of detail resulting from the small samples sizes that necessarily leave out some workers or lump them with others. For example, the data from Statistics Canada tell us nothing about the approximately 1000 people, most of whom are Aboriginal, who work as community health representatives (McCulla, 2004:14). Nevertheless, it is possible to highlight some of the most significant patterns in terms of the work and the workers. The following portraits are based primarily on an analysis of Statistics Canada occupational and industry data, prepared by Krista Scott Dixon and attached as the Appendix. They are as detailed as possible, in part because greater detail often reveals greater differences and larger inequalities. But they should be treated with some caution, because small numbers sometimes distort patterns. This is particularly the case when it comes to data on those identifying as visible minority.

Clerical Work

In health care, women work as medical and other kinds of secretaries, as court recorders and medical transcriptionists, as records and file managers, as receptionists and switchboard operators.

Not surprisingly, almost all of these clerical workers are women. Ninety-nine percent of the medical secretaries, 98% of court recorders and transcriptionists, 97% of receptionists and switchboard operators and 90% of the records managers and filing clerks in health care are women. However, men are more likely to be found as clerical supervisors. Although women are still the majority (84%) in this supervisory work, they make up only 74% of the clerical supervisors in residential care. It is interesting to note, however, that the men tend to have less formal education than the women. Three-quarters of the male clerical supervisors have high school education or less, while this is the case for less than a quarter of the women who supervise. Clearly their greater numbers do not reflect more formal credentials. Nearly half the women who do clerical work have a

community college diploma and another 10% have a university degree. In other words, the majority have post-secondary credentials. While 6% of women have less than high school, this is the case for 18% of the men in health care clerical work.

Clerical workers tend to be somewhat younger than the overall labour force and over-representative of visible minority groups. Most of the women are in their 30s or 40s. Unlike many other occupational categories, their numbers drop significantly after age 50. The male clerical workers are even younger, perhaps reflecting the growing lack of employment opportunities in male-dominated work. The proportion of immigrants who do this work is similar to the proportion of immigrants in the general population but those women self-defining as visible minority are over-represented among medical secretaries, records managers and filing clerks and under-represented in other health care clerical jobs. Males from visible minorities are over-represented in jobs working as receptionists and switchboard operators.

Clerical workers are more likely to have part-time work than women in the labour force overall. Only two-thirds of the receptionists and switchboard operators have full-time employment, while this is the case for just over 70% of the other clerical workers. The high proportion of male medical secretaries and receptionists working part-time may reflect their young age. They may take part-time as a supplement to school. In contrast, all the male supervisors are employed full-time. However, most of the male and female employees, part-time and full-time, have permanent employment. Indeed, they are more likely to have permanent jobs than is the case for the labour force as a whole.

When we first look at the earnings data on clerical work in health care, it looks relatively good for women. Medical secretaries in hospitals and court recorders average higher annual incomes than men, and so do records managers and file clerks, receptionists and switchboard operators in all workplaces. Only clerical supervisors and medical secretaries in ambulatory care face a wage gap that is higher than the labour force average between women and men. But we need to remember that there are few men in the jobs and most of them are young, unless they are supervisors. And when they are supervisors, they earn significantly more than their female counterparts. Moreover, the annual earnings of both men and women are low in these occupations. The average female annual income in 2002 was $25,100, while medical secretaries, records managers

and file clerks, along with receptionists, all earned less than this. Equally important, the men in these jobs earned significantly less than the male annual average. And these figures are for full-time employment. The many who are employed part-time earn even less.

Female-dominated clerical work is low paid everywhere. However, the wage gap is smaller for medical secretaries, records managers and filing clerks and receptionists in the health sector. Only supervisors and medical secretaries in ambulatory care fare worse than their counterparts in other industries. In terms of hourly wages, women doing clerical work in health care are paid almost a dollar more than other female clerical workers. Full-time workers in health care average 37 hours a week, while those employed part-time average between 20 hours for the public health sector and 17 in the private one.

In sum, clerical work is women's work, although men are significantly overrepresented as supervisors. It is more likely than other jobs in the labour force to be done by women identified as visible minority. Most of these women are fairly young, although the men are younger. The pay is better than in it is in other clerical work and the male-female wage gap is smaller. But pay is still low, especially given that the majority have post-secondary education.

Other Assisting Occupations in Health Care

Statistics Canada has a category that lumps together nurse aides, orderlies and patient service associates. All these occupations are defined as jobs that involve assisting nurses, hospital staff and doctors in providing basic patient care. Then there is an additional category for "other assisting occupations in support of health services" which Statistics Canada defines as jobs in which workers provide services and assistance to other health care providers. The boundaries amongst these groups are blurred not only by Statistics Canada but also in the practice of health care. Dental assistants are included in this large category as well. As a result, it is difficult to separate out those most frequently defined as ancillary from those who are not.

Aides, orderlies and patient service associates (PSA) can be found in all health care facilities, although they are most commonly employed in long-term care and home care. Their duties vary somewhat from jurisdiction to jurisdiction and from location to

location, but there are some common aspects to their work. Most provide personal care, although orderlies mainly transport patients, equipment and supplies. Wherever it is provided, personal care means bathing, toileting, shaving, grooming, as well as feeding and offering social support. These providers get people up in the morning and put them to bed a night; they walk them and talk to them. They remind them to take their medications and do colostomy care. In home care, they also shop, prepare meals, do banking, make phone calls, and clean their living spaces. The other assisting occupations work closely with other providers, and do a wide range of jobs requested by nurses and others defined as direct providers. Unit clerks, optical and pharmaceutical assistants and those who work at benches in medical labs are just some examples of the kinds of work included here. Dental assistants work by themselves cleaning teeth and taking x-rays. They also work alongside dentists, taking charge of the surgical tools and other equipment.

Men are most common as orderlies in hospitals, where pay and conditions are often better than they are in other organizations. The inclusion of orderlies helps explain why, in hospitals, men make up a quarter of the workforce in assisting occupations. In contrast, 90% of those employed in ambulatory services and residential facilities are women suggesting most of these are not orderlies. Many will be PSAs. Nine out of ten of those in other assisting occupations and nearly all of the dental assistants are also women. The majority of these workers are over 40, with most clustered around that age. The youngest group is the dental assistants, many of whom are under 40. Among the women, 57% have a college diploma while another 6% have university or some form of postgraduate accreditation. In contrast, nearly half the men have no post-secondary accreditation, although 13% have university. As is the case with clerical work, the women have more formal education than the men.

This kind of work is disproportionately done by immigrants and people from racialized groups. Compared to the labour force as a whole, women born outside of Canada are significantly over-represented while foreign-born males are under-represented. At the same time, the proportion of visible minorities is relatively higher compared with the overall labour force, especially for men. Both male and female Blacks and Filipinos are significantly over-represented in the aides, orderlies and patient service associate's category. Visible minority males are disproportionately found as dental

assistants and in the other assisting occupations in support of health services, where they account for one in four of the workers. Most of these men are Asian or south Asian in origin.

The work is also disproportionately part-time. Only 61% of the women who work as nurse aides, orderlies and patient services associates have full-time jobs, compared with 74% of women in the overall labour force. Men too have unusually high rates of part-time work. Twelve percent work on temporary contracts, about the same as the labour force as a whole. Just over two-thirds in the other assisting category have full-time jobs, with men here significantly more likely to have full-time work. Dental assistants are more likely to have full-time work, although nearly a third of the men have only part-time work.

Because such a significant proportion work part-time or part-year, the data on annual incomes tells only part of the picture. What the data do show is that women earn relatively low salaries, with annual wages for the female nurse aides, orderlies and personal service associates averaging from $24,972 in ambulatory care to$29,430 in hospitals. Nevertheless, they earn more relative to similar workers outside the health care system and the male/female wage gap is smaller for those employed in hospitals. While most work a 37 hour week, about 8% of women and 15% of the men work extra hours. What this suggests is both that the work is irregular and that the workers would like more hours of work if given the opportunity.

It is particularly frustrating to base the analysis here on Statistics Canada's category, given the lumping together of those usually defined as health care and those usually defined as ancillary. Greater detail might show particular patterns for personal service associates that distinguish this work from other jobs. From the data available, we can see that immigrants and those identified as visible minorities are significantly over-represented, although the patterns vary somewhat for women and men. Here, too, wages are low and part-time work is common, in spite of the fact that the majority have post-secondary education. But women still fare better relative to men and to women who do similarly defined work in other sectors.

Visiting Homemakers, Housekeepers and Related Occupations

Like the assisting occupations category, this one lumps together people in a range of jobs in ways that reflect in part the blurring of the lines between health care and household work. Those who provide home support services, such as shopping, cooking, cleaning and respite to families and individuals who are sick or disabled are here. So are those who keep house in embassies and other similar establishments. Foster parents too are included. The category, then, is broad. With over 80% counted as being in health and socials services industries, however, it seems likely that most are care workers. Indeed, half are in long-term care facilities or ambulatory health care services.

Again, it is no surprise that 90% of them are women. It is perhaps more surprising that most of them are relatively young, with the majority under 40. Perhaps most surprising is their formal certification. Nearly half have a trade or community college diploma. Another 11% of the women and 13% of the men have university or post-graduate education. The proportion that is immigrant is similar to the proportion in the population as a whole, but the women are much more likely than the men to be foreign born. While the proportion that self-identifies as visible minority is similar to the overall population, Blacks and Filipinos are over-represented in the case of both women and men.

Part-time work is high for both women and men in these jobs, with the rates for men three times as high. Temporary work is also more common than in the labour force as a whole. Full-time, full year workers similarly classified in other industries have significantly lower annual average incomes than the women who work in health and social services. Women in hospitals are the highest paid but the male-female wage gap is higher than it is in the ambulatory services. However, hourly wages are lower, on average, in health and social services. The difference both reflects and magnifies the high proportion of part-time work in the health and social service sector.

Unlike clerical and assisting work then, work in the home is not done disproportionately by immigrant and those identified as visible minorities even though a few groups are overrepresented. Like those other two occupations, however, it is disproportionately part-time and low paid. Nevertheless, once again the pay is still better in health care than it is outside it.

Cleaning/housekeeping, Laundry and Food Services

Health facilities and homes have to be cleaned, the laundry has to be done and people have to eat. This is, of course, work that is done in many service industries. However, health facilities are particularly dangerous places for both workers and patients because people are ill, frail or face surgeries that expose them to all kinds of risks from bacteria and other germs. These risks are in the air and ventilations systems, as we have learned from legionnaire's disease. They are carried on equipment, bathrooms, laundry and food trays. Most of those counted are doing these jobs in health care work in hospitals or long-term care, but it should be remembered that the "assisting occupations" and housekeepers described above do this work, usually in private homes.

Those who do food, laundry and housekeeping work, as well as those who supervise it, are mainly women. However, there are significant variations within these services. While women account for 85% of the food service supervisors and 72% of the supervisors in health care laundry facilities, they are only 38% of the cleaning supervisors. More detailed data reveals even more segregation. For example, women are just over half of those who supervise cleaning in hospitals but just over a quarter of those who supervise cleaning in long-term care. Because supervisory work usually goes to those with experience, it is not surprising to learn that most of the supervisors are over 45. However, significantly more of the male supervisors are in their 30s, suggesting gender also plays a role. This variation by gender cannot be explained by formal training. While 78% of the female supervisors have post-secondary certification, this is the case for 72% of the men. Again, we find a majority of people in occupations defined as unskilled bringing considerable formal credentials to their work.

It is not possible from Statistics Canada data to determine how representative these supervisors in health services are of the general population in relation to immigration and racialized groups. We know that, in terms of the labour force as a whole, male immigrants are over represented as supervisors in food, laundry and cleaning services and that this is the case for females in laundry services. Similar patterns emerge for those identified as visible minority. But we do not know what the patterns look like in health services.

Work in food, laundry and cleaning services tends to be precarious for supervisors, with large numbers employed part-time or in temporary positions. However, both the women and men who work as supervisors in health care are more likely than those with similar jobs in other sectors to have permanent positions and to work full-time. Moreover, both women and men have higher incomes as supervisors in health care and the wage gap is smaller in comparison to the overall labour force. For example, while women employed full-time as food service supervisors average $22,463 a year, those in hospitals average $39, 322, earning 87% of the male wage. Nevertheless, it is not all good news for women in health services. The male-female wage gap for cleaning and laundry supervisors is greater than the overall average, even though these women earn more than their counterparts outside health care.

According to Statistics Canada, there are three kinds of cleaners. The "light duty cleaners" clean lobbies, halls and rooms. The category lumps together those who work in hotels, motels and resorts with those who work in health care, in spite of the significant differences between health care and hotel service work. About one in five of those counted as light cleaners are employed in health and social services. Nearly three-quarters of them are women, although men make up a third of those doing light cleaning work in hospitals.

Specialized cleaners, the second category, are those who clean carpets, chimneys, ventilation systems and the like. They tend to be self-employed or to work for cleaning service companies. A majority counted as working in health care are men, but women are a slight majority in hospitals and do more of this work in long-term care. The third cleaning category, janitors, caretakers and building superintendents, is male dominated. Indeed, it almost looks like the difference between light cleaners and janitors is gender. More than 70% of those in health care are men, described as cleaning and maintaining the interior and exterior of a building. They are distinguished from light cleaners who "only clean" and do not do routine maintenance or outside work or what is described as "industrial cleaning."

Like light cleaners, laundry workers in health care are lumped with those employed in hotels and other, dissimilar organizations. They sort and prepare laundry for washing, operate machinery of varying sizes and handle the clean laundry for distribution. Even

though it is usually heavy work involving a great deal of lifting, four out of five laundry workers in health care are women. Men are most commonly found in hospitals, where the loads are heaviest, but they still make up less than a third of the workers. In long-term care, there are very few men doing laundry. There is as second category of laundry workers, those who iron, press or otherwise finish garments. These too are mostly women who work in hospitals.

In food services, there are cooks, food counter attendants, cashiers and kitchen helpers. Given the association of women with food preparation, that women make up more than four in five kitchen workers in health care seems obvious. Where health care differs significantly from other sectors is in the proportion of women who are cooks. While men are the majority of cooks in the labour force, women are nearly 80% of those in health care. Men are more common in hospitals, where they account for a third of the cooks and where they operate in huge kitchens. But in other health services, it is women who do most of the cooking. They are almost all the cashiers in health care as well.

Most of the women who do this work in health care are over age 35, although there are more in the younger age categories than is the case for other jobs in this sector. Male cooks in particular seem to be clustered on younger age groups. This is the only ancillary group where the men have more higher education than the women. Thirty seven percent of the men, compared to 31% of the women have university, college or trade certification, although a larger proportion of men than women had less than high school education. Male cashiers are particularly likely to have post-secondary education (83% compared to 36% of the women) and so are the male cooks (72% vs 35%). It not only seems likely that the young men working as cashiers and cooks more than account for the education difference but also that, in the rest of the jobs in this category, women have more formal education than the men.

Most of those employed in food services are Canadian born, with immigrants underrepresented in these jobs. It is not possible to calculate the distribution of visible minorities from the data available. We do know, however, that those men and women identified as visible minority are significantly overrepresented in light cleaning, laundry and food services in general, suggesting that this would be the case in health services as well.

In the labour force, these jobs tend to be disproportionately part-time especially for women. The cleaners, laundry and food services workers in health care are no exception, with only 62% of the women and 78% of the men employed full-time. Nevertheless, they still fare better than their counterparts outside health care in terms of full-time work. Cooks do significantly better in terms of full-time jobs, compared to those in other sectors. Nearly three-quarters of the women and over 80% of the men have full-time work compared to just over 60% in the workforce as a whole. Both women and men are also likely to have higher wages than those in other sales and service jobs. Women in health care average $1.90 more an hour and men $3.76. In food services, the advantage is even greater. This does mean that the wage gap is higher in health care, however.

Once again, the practice of lumping together workers from health with those in other sectors makes it difficult to develop a full portrait of these ancillary workers. Many of the patterns we can see are similar to those in other ancillary jobs, with few exceptions. As is the case in the occupations already described, the overwhelming majority are women. Indeed, women's share of the cooking jobs is greater here than it is in the labour force as a whole. Men, however, are disproportionately supervisors. Men are also more likely to be found in heavy cleaning, even though women do more than their share of the 'heavy' work. The only ancillary job where men are the majority is specialized cleaning.

In these jobs too, women on average have more formal education than the men. The exception is in food services, where the higher proportion of men with post-secondary education may be explained by the young men who cook and work as part-time cashiers. It is difficult to determine the proportion of immigrants and those identified as visible minorities. The data indicate over-representation among these jobs in the labour force and this suggests there would be over-representation in these health service jobs as well.

As with other ancillary jobs, the wages are low and part-time and temporary work is common. Nevertheless, the pay and the male-female wage gap is better than for similar jobs in the rest of the labour market. The exception is supervisors, where the male-female wage gap is greater than it is elsewhere.

Security Work

Security in hospitals is there to protect both buildings and people. Three quarters of those providing security are men, as is the case in the rest of the labour force. However, women make up over a third of those who do security work in long-term care facilities. Among the men employed in security work across industries, Blacks and South Asians are overrepresented compared to their presence in the labour force. Both men and women employed in the health sector are more likely to have full-time work compared to those who work elsewhere.

Managers

If we are to define health care workers as those who provide clinical or direct care, then those who manage in health care should be defined as ancillary. According to Statistics Canada, they are those responsible for planning, directing, controlling and evaluating services but not for delivering them. As is the case with other ancillary workers, the line between care and other work is hard to draw. Many managers in health care have traditionally emerged from the ranks, where they were involved in direct clinical care. However, increasingly managers come from other organizations or management training courses, often based on the assumption that health care should be run like a business.

Most of those classified as managers in health care work in hospitals, long-term care and ambulatory services, in that order. Women make up just over half of the senior managers, with their numbers particularly high in long-term care (59%) and social assistance (67%). Women are more common amongst those defined as lower level health care managers within institutions, where they account for 73% of the employed. Women are more likely to be managers in health care than in other sectors but, given that more than four out of five workers in care are women, they do not have a proportionate share of management jobs. Moreover, they are more likely to manage the smaller organizations and at lower levels. For example, 30% of the hospital managers are men, with women's share increasing as the size of the organization decreases.

Among senior managers, the women tend to be older than the men. This perhaps reflects different career paths, with women emerging from the ranks and men directly from management in other organizations. It may also reflect gender bias in promotion.

The pattern is less marked among middle managers, with only a slight preference for younger males.

Senior managers are more likely than middle managers to have university degrees rather than college diplomas, suggesting many middle managers emerge from clinical practice. The pattern may reflect the fact that most older nurses were educated in colleges or hospitals, rather than in universities, while all doctors would have university degrees. It is not surprising then that men in senior management are also more likely than women to have university degrees. However, more of the female senior managers have post-graduate or professional degrees. Among middle managers, women are more likely than men to have completed some form of post-secondary education. While 71% of female managers have such education, this is the case for only 58% of the men. In other words, the women in middle management have more formal higher education than the men while the reverse is the case in the senior management. At the same time, however, many of the women in the most senior position have higher accreditation than the men.

Compared to management positions in other sectors, those born outside Canada are somewhat more likely to hold senior management positions. However, immigrants are somewhat underrepresented in relation to their share of the overall labour force. Fourteen percent of senior managers and 16% of other managers are immigrants while those born outside of Canada make up almost 20% of the labour force as a whole. Visible minority men and women are less well represented in management positions. Visible minority women and men each make up only 3% of those in senior management. Visible minority women fare better than men in middle management, accounting for 5% of this occupation. But this is still a far cry from the 13% they represent in the labour force.

Managers in health care are more likely than other managers to hold full-time, permanent jobs, regardless of sex. Nevertheless, 15% of the women in senior management still only have part-time jobs while men are slightly more likely to have contract positions. Both sexes also do better in terms of pay on both a yearly and hourly basis, although the wage gap varies significantly by facility. Women working as managers in long-term care face a wage gap much larger than women face in the overall labour force and it should be remembered that this is where women are most likely to be found in senior management. For middle managers, the gap is largest in ambulatory care,

with those women working full-year, full-time paid just 56% as much as men. Women working as managers in government fare better compared to men, perhaps because of pay equity rules. Women and men in the public sector have shorter hours than in the private sector and, unlike the private sector, there is little difference between the hours women and men work.

Although women account for four out of five people employed in health and social services, their numbers decrease the higher the management position and the bigger the facility. Some of this disparity can be explained by the presence of physicians in senior management and the legacy of male dominance in that profession. However, the extent of the disparity suggests continuing discrimination. Immigrants fare better in health services management but this is not the case for those identified as visible minorities. And as is the case for other ancillary jobs, hours and pay are better for women managers, although this is not the case in long-term care.

The Composite Picture

These data tell only part of the story, mainly because there are only limited data available at this level of occupational detail. If we look at ancillary workers as a group, it is possible to reveal other patterns (Armstrong and Laxer, 2006). For example, one in ten ancillary workers has income that is below Statistics Canada's poverty line. The majority do not have benefits. Two-thirds do not have pensions, less than half have extended health or dental coverage. Comparisons between ancillary workers and those Romanow describes as direct providers reveal significant disparities, not only in relation to the incomes often justified in relation to education but also in relation to unionization and benefit coverage.

In sum, ancillary work is women's work. Some occupations that are female-dominated in the labour force are even more female-dominated in health care. Significant numbers of men are found in senior management, in supervisory ancillary work, in security and cleaning, although their share of these jobs is smaller than their share in the overall labour force. Ancillary work is low paid, often part-time and/or temporary. But women do better in health care than they do in similar job categories in the rest of the labour force. While similar jobs are low paid throughout the labour force, they are in general better paid in

health care. This is especially the case for men. The wage gap between women and men also tends to be smaller in health care, but this is not always the case. Moreover, these jobs are also more likely to be full-time and permanent, with more benefits and much higher rates of unionization when they are done in health care (Armstrong and Laxer, 2006). Most work as employees, with the exception of some managers, researchers, consultants, sonographers, dental technicians and medical transcriptionists, who tend to be self-employed. Self-employment is also more common amongst homemakers and housekeepers, where it is most likely to mean precarious work and pay.

Those who do jobs labeled ancillary in health care differ to some extent from those employed outside health and social services. Compared to the labour force as a whole, immigrants and those identified as visible minorities hold a higher proportion of ancillary jobs. Visible minorities are over-represented in most clerical jobs, other assisting occupations, food, laundry and cleaning work. They are, however, underrepresented as managers, especially in senior positions. Immigrants are over-represented in other assisting occupations, in food, laundry and cleaning jobs. Greater detail reveals greater differences both between women and men and among women. For example, women who work as visiting homemakers are more likely than men who do this work to be foreign born. While the number of people identifying as visible minorities in these homemaking jobs is similar to the proportion in the labour force, male and female Blacks and Filipinos have a larger share of jobs here than they do in the over labour force. The women tend to have more formal education and training than the men, except in the most senior management jobs and in the cooking jobs. Indeed, many women have much more formal education than the label of unskilled would suggest. The men who cook or who work as cashiers and clerks are younger than the women while most of the women who work in the laundry and kitchens are middle aged or over.

SECTION III - ANCILLARY WORK IS WOMEN'S WORK

A determinants of health framework leads to the definition of these ancillary jobs as health care jobs and of those who do the work as health care workers.

A gender analysis helps us understand how this work and these workers can be ascribed such low value. Combining a determinants of health and a gender approach helps us understand both the invisibility and the undervaluing of this traditional women's work.

We begin this section by exploring the nature of women caring work, with the intent of showing how the blurred boundaries between paid and unpaid care work as well as among kinds of care contribute to the low value attached to such work. In order to challenge this low value, we then move on to examine the skills, effort, responsibilities and conditions involved in this work. The discussion of conditions links the invisibility of women's work to the invisibility of the hazards they face in this work. But women have not simply accepted these definitions, conditions and valuing of their work. This section concludes with a brief analysis of women's resistance through unions, professional organizations and legislation.

Women's Care Work

Care work is women's work. This statement is about what women do, about what we say they do and about what we think they should do. In other words, it has material and ideological roots as well as discursive ones. The boundaries between male and female labour vary historically, and with class, physical location, racialization, immigration status and age among other social locations. Although the boundaries change, what persists is a division of labour between women and men. This division is not simply about difference but also about power and assigned worth. In general, women's work means less valued work, both in terms of prestige and pay. It also usually means fewer resources of the kind that provide the basis for having women's views prevail or at least have a significant influence.

Care work is perhaps the best example of what is meant by women's work. Throughout history, across social and physical locations, women provide the overwhelming majority of paid and unpaid care work. Feminist historians have demonstrated that there has been considerable variation in the extent to which women worked for pay in Canada over the last three hundred years, leaving some with little time to do work in their own households and others with no households or only minimal ones (Hamilton, 1978; Strong-Boag and Fellman, 1997). And they have demonstrated that

there has been considerable variation in the extent to which women could and did undertake caring work for their own household members and friends. But it is clear that when cooking, cleaning, laundry and basic personal care was provided, it was mainly provided by women.

It is also clear that, although there were significant variations in expectations about women's caring work, there was still considerable consensus that caring was women's work. The nineteenth century Nova Scotia Christian Minister obviously had a particular class of women in mind when he preached that 'when sickness seizes on the household and chiefly on the heads of households, how timeous and tender her influence then. She is the ministering angel, whose presence and sympathy extracts more than half the evil from the disease and mitigates and soothes where she cannot deliver" (Reverend Sedgewick 1856 in Cook and Mitchinson, 1976:25). But in order for such women to be ministering angels, other women were cleaning, cooking, doing laundry and handling much of the heavier aspects of care work. When such work in the home was paid, it was usually done by women who had recently immigrated (Strong-Boag and Fellman, 1997). But even with paid assistance, all but the very wealthiest women in Canada worked side by side with the women paid to help (Langton, 1950; Mitchell, 1981; Parr Traill, 1969).

Boundaries between unpaid domestic work and paid work were blurred within the household. So were the boundaries between care work and other forms of labour. Cleaning up after a sick husband, parent or child, washing their laundry and serving them food, organizing for their care and keeping their records were tasks difficult to sort definitively into care work or housework. Such tasks were difficult to sort in part because they were done by the same women in the same place or at least by most women some of the time. Boundaries were similarly blurred between care work in and outside the home, as women's labour force work was often very similar to the work they did in the home. In the labour force, the overwhelming majority of women also cooked, cleaned, did laundry, served food, nursed, taught and recorded (Ramkhalawansingh, 1974).

Attitudes about what women can and should do have changed significantly over the last three hundreds years. Most Canadians now agree when surveyed that men as well as women should do work in the home. However, a majority still think children will suffer if women are employed while their children are young and see caregiving as mainly

women's work (Zukewich Ghalam, 1997). Moreover, women continue to do most of the care work in the home, "both in terms of the likelihood of providing care and performing the most intensive tasks such as bathing, dressing and cooking" (Williams, 2004:10) Research by Decima (2002:1) reported that nearly 80% of family caregivers are women. Other data suggests men do more than 20% of seniors' care, in part because of the way this caregiving is counted. Statistics Canada includes in caregiving work inside activities such as housekeeping and personal care and outside activities such as house maintenance and transportation. In 2002, women were recorded as averaging 20 hours a week in housekeeping activities related to caregiving and nearly five hours providing personal care. Men, by contrast, average only six and a half hours doing inside house work and a little over an hour in personal caregiving. Most of men's contribution is outside the house, doing maintenance (5 hours) and transportation (3 hours) (Stobert and Cranswick, 2004:3). And even these data may underestimate the total time women spend in caregiving because the blurred boundaries make it difficult to separate out the amount and kinds of care work women do in the home. Women are more likely than men to see what they do in the home as simply part of being women rather than as care work to be reported. It is important to note, however, that Statistics Canada data suggests men do more care work because work dismissed as ancillary when it is paid is counted as caregiving when it is unpaid.

Similarly, women now work in virtually every job in the labour force and the majority of Canadians see this as appropriate (Zukewich Ghalam, 1997:15). However, most women remain heavily segregated into work associated with work in the home. One in five women in the labour force work in health and social services where they account for four out of five workers. In his research on hospital workers in Ontario, Jerry White (1990: 40) reports that many of those he interviewed commented on how similar their work was to what they did at home. Women interviewed about their work in long-term care commented on how they went home at night to start some of the same work again, although they also recognized that there were critical differences between their work at home and in health care (Armstrong and Jansen, 2003).

Boundaries between women's different kinds of care work have been blurred throughout history and they are blurred on a daily basis today. Indeed, as more paid and

unpaid care work moves into the home, the blurring has increased. One advantage of this blurring is that it reflects the integration of care work; the combination of the full range of care tasks. But there are also disadvantages. The blurring of boundaries makes it harder to see the work as skilled, as valued and as care. Ancillary work can suffer as a result.

Skills and Care

Our notions of skill play a significant role in the construction of ancillary work. The Nova Scotia Minister (in Cook and Mitchinson, 1976:21) who lectured on women's place made a strong plea for the education of women, arguing that that they required a curriculum that included " the sublime science of washology and its sister bakeology. There is darnology and scrubology. There is mendology, and cookology in its wide comprehensiveness and untellable utility, a science that the more profoundly it is studied it becomes the more palatable, and the more skillfully its principles are applied". While this may sound like a parody, it is clear from the rest of the speech that the Minister saw this work as similar to other work like biology that required a formal education. He went on to say that "knowledge of housekeeping…is essentially necessary" (quoted in Cook and Mitchinson, 1976:22). As dated as his views of women may seem, at least he recognized that such work involved skills. Contrast this to a recent Statistics Canada publication that, in talking about such the cooking, cleaning, laundry and personal care work, described them as "support occupations requiring few skills" (Galarneau, 2004:15).

Defining Skills

What do we mean by skills? Academic, policy makers and managers often talk about skills but seldom define with any precision what they mean by the term. Skills are frequently used as a justification for pay, prestige and power without any clear explanation of how they are understood or measured. As Attewell (1990:422) shows in his examination of the concept, skill is "a complex and ambiguous idea".

At a minimum, there is some agreement that skills refer to learned capacities. However, what constitutes learning and capacities remain a subject for debate. Most frequently, those learned in a formal setting and resulting in some form of accreditation are more visible and valued. Statistics Canada, for example, typically measures skills in

terms of credentials. According to a 2001 report, skill levels "reflects the level of education normally required in the labour market for a particular occupation" (Statistics Canada, 2001:6). Here, highly skilled means the job normally requires a university education and skilled means a college credential or an apprenticeship one while low skilled jobs require high school or less. Skill thus becomes equated with the education level set as a job requirement. It is about the job rather than the individual holding the job, although it may be the case that jobs held by those with university degrees become defined as requiring degrees - a process which equates the skill of the work with the skills of the worker.

This approach tells us only what signifies a skill rather than what skill is. It does not tell us what capacities people require to do the job. It also assumes that what is formally required in the job reflects what capacities are required and that these are acquired in formal education resulting in a credential. It thus ignores the learning acquired through other means, including what is learned informally on the job or in other places. Chefs are those in jobs that require chef certificates and chef's jobs require certificates.

Most commonly, then, formal certification becomes a proxy for skilled work and skilled people. However, skill may also be defined and measured more directly. Literacy skills, numeracy skills, computer skills, interpersonal skills, technical skills, clinical skills are just some of those aspects of work or workers that have been identified. But these too are open to interpretation and are not simple to assess. There is often disagreement about which of them are required in a job, about how they can be measured and about what level of capacity is required within each skill. What is required in the job is negotiated, as is the recognition of the skills this negotiation represents.

A review of the literature leads to the conclusion that skill is both a measurable capacity and a socially defined one. Whether it is recognized and measured, how it recognized and measured, and what value is attached to what is about a social process rather than about objective measurement. We cannot simply say a job is skilled or unskilled on the basis of credentials alone or on the basis of recognized skills. Rather, we have to examine the work and the social relations that surround it, including the power relations.

Gender Skills

What counts as skill is profoundly gendered. As Jane Gaskell (1991:142) explains, when we look at the skills of any job, "we come face to face with basic questions of value, of power, of women's place in the world. When people overlook women's skills, devalue them, give them low ratings, it is not a technical glitch, but a reflection of the status and power women have not had in the world". Gender plays a critical role in both the visibility and value of skills.

If we understand skills as learned capacities, then it is important to establish that the skills are learned. For women, many of the skills they have are assumed to be part of being female, to be natural rather than learned capacities (Steinberg and Haignere, 1987:163), in part because women begin learning them at a very early age. As Mary Corley and Hans Mauksch (1988:136) explain, a "set of characteristics which would otherwise earn applause and prestige, can be neutralized, if not trivialized, when identified with the presumed natural consequences of low status attributes". The very association with women may mean low status. The Ontario Pay Equity Tribunal, after listening to extensive expert testimony, concluded that "the sex of the job incumbent has been a factor contributing to the traditional placement of the job within the hierarchy of the workplace in both wages and status" (Ontario Pay Equity Hearings Tribunal 1991:7). As the quote from the Nova Scotia Minister indicates, there have been periods when the skills traditionally associated with women have been thought of as skills that have to be carefully taught. Veronica Strong-Boag (1985) has documented how domestic science emerged as discipline and a practice in homes in the first half of the twentieth century. But for the most part, the skills involved in cooking, cleaning, doing laundry and providing personal care are associated with women in ways that leave their acquisition obscured and degrade their value. Even clerical work tends to get lumped in with such natural characteristics. Indeed, we are increasingly sending care home to be done by women without providing any training and supports, based on the assumption they can do what any woman can do.

Where skills are learned and who teaches them is also critical to their recognition. And those who do ancillary work tend to primarily learn their skills either at home and/or on the job. In both cases, they usually learn them from other women also thought of as

unskilled. In neither case do they result in a piece of paper that testifies to their accomplishments. Indeed, the association of skills with the home itself tends both to obscure them and denigrate them, given that household work is much less valuable than labour market work in our society. Moreover, women often do similar work both in the labour force and in the home. The similarity in the skills employed contributes to their invisibility in both places.

Formal skills, learned in educational institutions, are much more likely to be recognized. Few places of higher learning teach cleaning and laundry skills, although there is such a programme for hospital cleaners in B.C. (Cohen, 2001). Both clerical and personal care skills are taught in post-secondary institutions but such female-dominated programmes themselves are assigned lower value than many male-dominated ones requiring the same length of training. Equally important, many employers do not require people to have these credentials in order to do the work and thus lower the value of the certification for those who have it. Moreover, large numbers of women with these skills tend to lower their value; in part because it is assumed they are only doing what any woman can do (Armstrong and Armstrong, 1983).

This leads to the issues of status and power raised by Gaskell. Skills' visibility and value are negotiated. Women have limited power in these negotiations. Skills in these jobs are assumed to require generic women's skills; so any women can be hired to do the job. Sonja Sinclair titled her book *I Presume You Can Type* (1969) as a way of emphasizing the assumption those women's innate skills extended to clerical work. In the case of cooking, cleaning, laundry and personal care work, the question is not even asked because the assumption is implicitly made. Women's power is limited by the segregation of the labour force itself that pits so many women against each other for this women's work. It is limited by their responsibilities or assumed responsibilities in the home. And it is limited by the males who still dominate decision-making in many arenas.

Caring is gendered work and work done by women is less likely to be seen as skilled or rewarded as skilled. This is particularly the case with those skills mainly learned at home by large numbers of women; the kinds of skills required in ancillary work.

Health Care Skills

At the same time as caring is assumed to require women's generic skills, many of the skills required in health care are assumed to be generic to service work. When managers and government started to talk about "hotel services" in hospitals, the claim was being made that the work and the skills involved in cooking, cleaning, laundry, feeding and clerical work in health care are generic. And neither required more than the skills any women had by virtue of her gender. Yet there is considerable evidence to suggest both that the work is skilled and that it is specific to care. The first sections argued that health care is a particular kind of work. Here we expand on the specific nature of health care work in order to expose the link between the specificity of health care work and the skills required.

Most importantly, it is about people who are ill, injured, disabled or frail. They are more vulnerable than the rest of the population, less able to help themselves and often emotionally fragile as well. Because it is about people in such states, "uncertainty is a feature of caring and flexibility of response is required" (Davies, 1995:19). Much is unpredictable in advance and irregularity is a constant. Irregularity requires workers who can respond to the irregularity, making judgments about what is to be done. When a patient's blood pressure suddenly drops, for example, and several nurses rush in to surround the bed, the dietary staff needs to stop putting down the tray and alter their work schedule.

In health care, personal contact is critical. This makes boundaries among tasks difficult to maintain. What should a cleaner do when a patient asks them to pick up their dropped glasses or simply wants a chat while the cleaner is the only one in the room, for example. Because care is about whole people with quite different needs and preferences and about active subjects, there are often significant differences from patient to patient. Those needing care seldom know who is assigned to what and simply wants care now.

Many of the hazards to patients and providers are specific to health care, and so are many of the ways of responding to them. The consequences of mistakes, of poor quality and of poor timing can literally be deadly. Concern over the spread of infections has highlighted a connected and significant difference between health care and other industries, leading to a growing awareness of the skills involved in the work (United

Kingdom, Comptroller and Auditor General, 2004). Research across the globe has demonstrated that a high standard of cleaning is central to ensuring a safe environment in health care (La Duca, 1987;Wilcox et.al. 2005). According to Health Canada, nosocomial infections, "which are acquired while in a health care setting or as a result of medical procedure, affect approximately 250,000 Canadians per year, with anywhere from 8,000 to 12,000 estimated deaths per year" (Health Canada, 2005:19). And these data do not take into account those who are receiving care in the home. The British Government now recognizes that "cleanliness is of paramount importance to patients and the public and has a role to play in the prevention and control of healthcare associated infections" (Davies, 2005:4). Cleaning in a hospital differs significantly from cleaning in hotel or office building. This means the skills required are different as well.

In her research with hospital cleaners, Karen Messing (1998) found that the skills, the complexity and the demands of work were often invisible to patients, other health care workers and managers. Indeed, the women doing the work were often invisible themselves, as keeping out of the way in a manner that made them hard to see was one of the job requirements. Cleaners are required to adapt "chemicals, methods and tools to different situations", reflecting the constantly changing environment in health care work (Messing, 1998:174). Both the equipment and patient belongings covered a broad range of configurations that did not match the computer description of the job (Messing, Chatigney and Courville, 1998:453). Moreover, workers have to take particular care to ensure they do not disrupt delicate equipment as they clean around it. Knocking over intravenous equipment could cause major havoc, for example. Their work is often interrupted by patients and providers, and they frequently have to respond to changes caused by emergencies or by the non-routine nature of much of health care work.

While cleaning in health care has received some research attention, it is hard to find research on those who do clerical, laundry and dietary work. Yet is it clear that each requires particular skills. In clerical work, records must be meticulously kept in ways that require considerable knowledge about health issues. Indeed, much of their work requires specialized knowledge and a specialized vocabulary related to health care organizations and health issues. Accuracy is particularly important because errors can have life and death consequences. Almost all of the work deals with confidential information. Much of

it also involves contact with people who are ill or distraught about those who are ill. It takes skills and effort to get accurate information and to get people to understand the information they need. Laundry workers in health care must carefully separate laundry, not in terms of colours and materials as we do at home, but rather in terms of diseases and patients. Laundry from isolation wards has to be washed in manually loaded machines and specially treated (Cohen, 2001:12). Food preparation too requires such knowledge, with special care taken to ensure foods meet the specific dietary needs of the ill, frail and disabled. Getting people to eat takes both skill and effort, especially when eating is painful or uncomfortable.

As a result of quite recent research, we do know more about some of the skills involved in the personal care work. Based on his experience working in a nursing home, Tim Diamond (1988: 48) found that personal care jobs were much more complex than a label of unskilled would imply. "The social relations involved in holding someone as they gasp for breath fearing that it might be their last, or cleaning someone, or laughing with them so as to keep them alive, feeding them or brushing their teeth, helping them to hold on to memories of the past while they try to maintain sanity in the present. They are unskilled and menial practices only if nursing assistants are presumed to be subordinates in the medical world". As Cynthia Cranford (2005:101) points out, personal care work is "intimate and intermittent," usually involving women and often involving women from racialized groups. All these factors contribute to their designation as unskilled.

Jane Aronson and Sheila Neysmith's (1996) research with home care workers reveals the wide variety of skills they employ in carrying out their personal care and housekeeping tasks. They have to listen, to talk and negotiate a plan with the person who needs care. They have to take individual preferences, attributes, abilities and health issues into account while keeping communications open. And they often teach clients how to cope. This complex process is "accomplished by means of observation, particular knowledge of the individual, a careful according of self-determination to the clients and a large degree of flexibility on the part of the home care workers" (Aronson and Neysmith, 1996:8). They have to juggle tasks and demands from patients as well as from employers, often changing their approach with each person and over time. In addition, they have to deal with family and friends, as well as with other paid providers.

While still often defined as unskilled, these providers are increasingly adding tasks that are recognized as skilled and even regulated in many provinces. According to the New Brunswick Advisory Council on the Status of Women (Smith, 2004:4), personal care providers are delegated basic nursing duties "such as catheter care, dressing changes and giving medications." And they are taking on more and more of these kinds of jobs, in part because they are the ones who are there when the need arises and in part because employers want more done by those who are paid less.

In sum, health care requires particular skills and ancillary workers bring skills to their jobs that are critical to care.

Regulation and Training

The notion of skill is central to the regulatory framework governing health care workers. For well over a century, multiple regulations have been developed to establish in law who can do what to whom in Canadian health care. Such regulations have a long history, reflecting the efforts of both providers and governments to control who could call themselves a practitioner and to establish standards as well as education and training requirements. Viewed by some as primarily a means to establish a monopoly and limit competition (Naylor, 1986; Johnson, 1972; Witz, 1992), such regulations have been defended by others as a means of ensuring quality care and protecting the interests of the public based on expert knowledge (Manitoba Law Reform Commission, 1994). In short, they are about who is defined as skilled.

"Regulation of occupations can be in the form of certification, licensure, or registration" (CIHI, 2002:24). Some providers, like doctors and dentists, are required to have a license to practice and these licenses are governed by a body composed primarily of those considered to be experts in the field. Only those with a license can legally do certain types of work or tasks. Initially, those required to have a license had a defined scope of practice that established what they had the right to do and how to do it. Increasingly, however, there has been a move towards a narrowing of the scope of practice to specific tasks considered high risk, some of which may be delegated to others (CIHI, 2002:24). In effect, some deregulation is happening across Canada and more workers are encouraged to do a range of tasks.

Certification allows those who have met the established requirements to use a title, such as massage therapist, although others may be able to do similar work without using the name. Some occupations require members to register and may require specific tests to grant registration. RNs are an obvious example. As of 2003, more than 30 health care professions were regulated in at least one jurisdiction, but the nature of the regulation varies significantly across Canada (CIHI, 2005a:14).

Licensing, certification and registration are primarily about formal education in post-secondary institutions but also usually involve some on-the job apprenticeship. Regulations in health care are thus about the individual. They recognize the skills acquired through the education system and acknowledge, through the applications of standards, the quality of those skills. What gets recognized and who gets to do the recognizing is a profoundly political process, albeit one presented as reflecting technical measurements. Patricia O'Reilly (2000) has documented some of the power struggles that were evident in recent struggles over the development of a new regulatory framework in Ontario. Some groups were successful in gaining recognition and other gained new rights. But many groups seeking legal status were excluded or marginalized, reflecting the political nature of the process.

Ancillary workers remain among the excluded and marginalized. Indeed, they do not even appear in O'Reilly's book or in other discussions of regulation. Ancillary workers are largely unregulated as individuals under provincial or territorial legislation. Some of the male-dominated work in trades and stationary engineering is regulated, and some provinces are moving to regulate training for security guards. But most of the female dominated ones are not regulated. There are post-secondary courses in health care clerical work, housekeeping and management and in personal care work. There are a number of private organizations offering training courses in these fields as well. However, there is significant variation in the extent to which these credentials are required for employment in health care and there is little if any legal regulation of this work in health care. Health and safety regulations may be the exception, with all jurisdictions requiring some training in this regard.

To say that there are no regulations applying to the individuals is not to say that ancillary workers have no training. Many have taken post-secondary courses specific to

their jobs and large numbers have formal education beyond high school (Scott-Dixon, Appendix). Many also have on-the-job training that does not lead to credentials but does increase their capacity to do the work (Armstrong and Daly, 2005). Almost all hospitals report providing some on-the-job training, although it is difficult to tell how much of this training is provided to ancillary workers. Long-term care facilities are less likely to provide such training and less than half of the ambulatory health care services report doing so (CIHI, 2005a:15). In other words, those services that employ a significant proportion of ancillary workers provide the least on the job training.

It is interesting to note that the World Health Organization (2005b) has recently published a report on *Preparing for a Healthcare Workforce for the 21st Century* that focuses on the skills needed to care for people with chronic conditions. The report argues that reforms in training are necessary, which "requires a fundamental change in perspective from the familiar approach," one that pays particular attention to a longitudinal perspective and prevention (WHO, 2005b:18). Five core competencies are listed: patient-centred care, partnering, quality improvement, information and communication technology and a public health perspective (WHO, 2005b:20). However, the report talks only about professionals. There is no discussion of the ancillary workers who play a critical role in public health and prevention, not to mention in the provision of long-term care.

So unlike the regulated professions, ancillary jobs lack the recognition, control and standards that go along with regulation. And the public lacks the protection regulation is said to bring. The lack of regulation suggests a lack of skill requirements, reinforcing the unvaluing of the work while failing to ensure that the workers have the skills required. Women in Canada receive less employer-supported training than men, in part because there is little recognition that skills are required and in part because many women have already acquired skills through informal means (Kapsalis, 1998). The failure to regulate and recognize the skills can only be understood through a lens that acknowledges the role gender, racialization, economics and power play.

Resistance

Moving Into The Labour Force

Many factors have contributed to changes in women's health care work. One of the most important has been the massive movement of women into paid work. As women entered the labour force in large numbers, they have increasingly resisted both their segregation into traditional women's jobs and the conditions in those jobs. While this movement is familiar to us all, it is worth briefly reviewing here because it sets the stage for the discussion of resistance within health care work that follows.

Although Canadian women's labour force participation rates dropped somewhat after the Second World War, they have been rising steadily since the 1950s. In 1951, just over 20 per cent of women were in the formal labour force (Armstrong and Armstrong, 1994:16). By 2005, three-quarters of women were counted as part of the paid workforce (Health Canada, 2005:30). Most of these women are married and a significant proportion have children, representing a dramatic shift from the pre-war workforce of single women who worked beside a few married ones who seldom had children (Statistics Canada, 2004).

As a result, women's labour force participation has become similar to that of men. Like men, women now remain in the paid workforce for most of their adult lives. The primary difference is that women are much more likely than men to work part-time. In 2003, 28 per cent of women, compared to 11 per cent of men, did part-time work (Statistics Canada, 2004:8). It should not be assumed, however, that this part-time work is a matter of choice for most women. Although 13 per cent of women took part-time work because they were caring for children and another 6 per cent did so because they had family or other personal responsibilities, 27 per cent said they took part-time only because they could not find full-time work (Statistics Canada, 2004:8). In other words, more women worked part-time because that was all the work they could find than did so in order to provide unpaid care and domestic work. And even when they give family responsibility as the reason for working part-time, we cannot assume this is a choice, especially given the lack of childcare and homecare. This is important to remember when we look at the large numbers of ancillary workers who have part-time jobs.

The data on reasons for working also helps us see why women take and stay in ancillary work, in spite of the poor pay and conditions. Women seek and take paid work for the same reasons as men. They need the money. Women's income is what kept the income of husband-wife families from falling before 1979. However, even with the majority of married women in the labour force, real family incomes have frequently failed to keep up with cost of living increases since 1979. Median family income declined between 1993 and 1994 while the number of low income families grew (*Perspectives on Labour and Income*, 2005:64). In an increasing number of cases, it was a wife's earnings that kept poverty at bay. According to Statistics Canada data, "The contribution of wives' earnings to dual-earner families ability to stay above the low-income cut-offs (LICOS) was overwhelming where the wife was the primary earner: 7% of such families fell below the LICOs in 1993, whereas almost half (45%) would have done so without her earnings."[ii]. Even in households with a man as primary earner, 9% would have fallen below the poverty line without women's pay (Statistics Canada, 1998). 1997 data show a continuing decline in family income, with more families in the bottom 30% of income earners. More recent data show inequality among households continues to increase. "While the poorest 10 per cent of families in most cities saw their income fall during the 1990s, those in the top 10 per cent saw increases of between 5 and 10 per cent" (Galloway, quoted in Jackson, 2005:27). The majority of dual-earner families have mortgages to pay and there are only small differences between dual earner and single earner households in terms of possessions such as dishwashers, freezers and microwave ovens (Statistics Canada, 1992). For the women without partners or without employed partners, the economic need is even more obvious.

This growing participation has been accompanied by continued segregation. Women still remain concentrated in teaching, nursing and other health occupations and in clerical and service work (Statistics Canada, 2004:8) And women still, on average, earn less than men. The combination of rising participation and continuing segregation was an important impetus for the growth of feminism. Women increasingly had little choice about working for pay but, in the process, they became increasingly aware of the inequalities in both pay and employment conditions. Feminists in and out of the labour force fought successfully for a range of legal and social protections.

They gained the right to stay in employment after marriage and after pregnancy, with maternity benefits provided for those who qualified under unemployment insurance. They won the right to equal pay for work of equal value in many jurisdictions and protection against sexual harassment. Birth control and divorce became easier to obtain and abortion is no longer illegal. The Charter of Rights and Freedoms includes provisions to protect women from discrimination from governments and human rights legislation is intended to ensure equality between women and men as well as among women. Labour standards legislation also helped ensure holidays, overtime pay, protection against unfair dismissal and minimum wages at the same rates for women and men. It should be noted, however, that such legislation is most likely to apply to those with full-time employment who are not self-employed. Moreover, new employment practices such as contracting out often remove workers from these protections (Cranford et al., 2005; Vosko, 2005).

It seems safe to say, then, that most women have responded to the growing demand for ancillary workers because they need the money. Of course, they may get other rewards from the work but this does not mean they have many choices about whether to take the employment. The women's movement worked hard to win legal and social protections for women that would improve their conditions of work. Many ancillary workers participated in these efforts and benefited from their success, as they did from their participation in unions.

Unions and Professions

Workers have been organizing to protect themselves and the public for well over a century. Health care is no exception, but the biggest growth happened in the post-war period. Indeed, professionalization and unionization after World War Two provide a major explanation for the better pay and smaller wage gap of ancillary workers compared to others with similar work in the private sector.

The men who worked as doctors also have a long history of organizing to ensure and protect their work (Naylor, 1986). Most of them were self-employed, and they used their organizations to establish shared practices and fees, to determine who could become a member and what they needed to know, to negotiate with those who paid or attempted to regulate them, and to develop collective benefits and services. They organized on the

basis of what they defined as professions, distinguishing themselves from unions. Like craft unions, they are united on the basis of their skills rather than their workplaces, as is the case with industrial unions. Unlike craft unions, however, professional organizations see themselves as united by particular intellectual disciplines that are taught in universities, based on theory and motivated by altruism. There is a great deal of debate both about what particular traits characterize a profession and about whether such characteristics are primarily the reason for their power or a justification for their power (Freidson, 1970; Johnson, 1972). And there are issues to be raised about the gendered nature of both professions and the analysis of professions (Armstrong, 1993; Witz, 1993). What is clear is that their success in requiring a university education and in controlling entry meant the professions were long dominated by white men with access to economic resources. And they used their power to influence the power of others within health care.

Women who worked for pay in health care took longer to organize, in part because they were women. Almost all of them were called nurses and they were outnumbered by doctors a century ago, although these official counts probably left out the many women who worked as lay nurses (Coburn, 1987). Most of these nurses worked in private homes, unless they were members of the religious orders that provided most of the institutional care. The combination of scattered workplaces, religious commitments and ideas about women's place made it difficult to organize. So did employer practices that often required women to leave paid work once they married. The Nightingale tradition also played a role. Nightingale schools were established in the late nineteenth century Canada and followed notions of female obedience and military order. As Judi Coburn has made clear, the nursing schools sought "the instilment of strict authoritarian values," a stance evident in the motto "chosen for the first school of nursing: 'I see and am silent'" (Coburn, 1987:447-448).

Nevertheless, nurses did start to organize. It is not surprising that nurses sought to follow the male lead and look for recognition as a profession. Not only were doctors the model in health care but doctors also had considerable power, authority and income, all of which was attributed to their professional status. Following the doctors' lead, the nursing graduates formed the Canadian National Association of Trained Nurses in 1908. This professional organization sought to encourage "mutual understanding and unity

among nurses in Canada" (Mussallem, 1988:401), elevate "the standards of education and promotion of a high standard of professional honor and establish a code of ethics" (Jensen, 1988:460). Like doctors, they struggled to ensure the legislative regulation of their profession. However, the first mandatory regulation was not introduced until 1953. And like the doctors, they worked to make a university education a requirement for recognition as a registered nurse. This too has taken much longer than it did for doctors and only recently have most provinces adopted policies that move in this direction. Not all nurses are happy with this development, in part because it follows the doctors' pattern rather than stressing the unique approach of nursing work and in part because it requires more economic resources, limiting entry by marginalized groups.

By the 1940s, the RNs were represented at the national level by the Canadian Nurses Association (CNA). Although the CNA supported collective bargaining for nurses, it insisted that it remain a professional organization and that there be no strikes. But a 1970 ruling in Saskatchewan argued that the provincial organization could not act as a union because it included nurse-managers on its board. From this point on, nurses' unions began to emerge and to act much more like other unions. Today, over 80% of employed nurses belong to unions.

Union organizing was facilitated by the federal funding of first hospital construction and then hospital care. Nurses were brought together in large workplaces where their shared time and experiences made organizing easier. The movement of nursing education out of hospitals also helped, because nurses were less subject to the daily discipline and cultural traditions of nursing at the same time as they were more exposed to the challenging critiques developing in post-secondary institutions. The women's movement helped as well, especially in terms of its successful demands to allow women to stay in their paid jobs after marriage and childbirth.

The combination of the growth in hospital size and the nurse unions' successes in demanding better pay and conditions contributed to the increasing fragmentation of nursing work. So did the development of technology and science, not only in medicine but also in management. More of the work previously done by nurses is now done by others. Some, like the therapists and technicians, defined themselves as professionals and organized on that basis. But most, like nursing assistants, personal care providers,

cleaners, dietary aides and launderers defined themselves as workers and started to organize their own unions. The biggest growth in female union membership took place between 1965 and 1975, and most of this growth was in the public sector and much of it was among ancillary workers (White, 1993:55). By the 1980s, data suggest that a majority of the ancillary workers belonged to unions. Although education and public administration has higher rates of unionization, health and social services remain among the most unionized sectors for women (Perspectives on Labour and Income, 2005:62).

Unionization gave women negotiated pay and working conditions, a legally binding contract, third party arbitration and some job security (White, 1993:62). As a result, wages improved significantly. Benefits such as vacations, pensions and extended health insurance were introduced and expanded. Hours of employment became regularized. The wage differential alone demonstrates the advantage women have with a union. In 2004, women without union coverage who were employed full-time averaged $21.13 an hour compared to $16.34 for non-union members. The difference was even greater for women working part time: $19.02 compared to $11.45 an hour (Perspectives on Labour and Income, 2005:67).

Unions also helped reduce the wage gap between women and men. In Manitoba, for example, the union local in the Winnipeg Health Sciences Centre won a pay equity settlement that not only increased the wages of laundry, dietary, nursing aides and housekeeping staff by sums ranging from $29 to $109 a month but also demonstrated to women and men the value of their work (White, 1980:103-106). In Ontario, five unions representing 100,000 women employed in nursing homes, shelters, home-care and other community agencies won a $414 million pay equity settlement which significantly raised wages for some of the lowest paid ancillary workers (Perry, 2003).

However, cutbacks in health care, reorganization and new managerial strategies have taken their toll. Many of the ancillary jobs have been contracted out with privatization. In the case of B.C., the union contracts were terminated by the government in the process (Cohen and Cohen, 2004). In some other jurisdictions, the collective agreements were simply not protected and new workers were not unionized. Between 2004 and 2005, the proportion of support staff in health care that were unionized declined from 56.3% to

53.6% and the proportion covered dropped from 57.75% to 54.95 in just that one year (Perspectives on Labour and Income, 2005:64).[iii]

Even those workers who have remained employed in the public sector and have remained union members have experienced a deterioration in their employment relations and conditions of work. The number of full-time, full-year nursing jobs declined. Wages and benefits have failed to keep up with inflation. Unions representing registered nurses have enjoyed some recent success in demanding better wages and conditions as well as a strategy to address future demands as a result of the perceived shortages. But other workers in health care have been less successful. This is especially the case in the areas where it is assumed any woman knows how to do the work and where visible minority and immigrant women are found in significant numbers.

In Calgary, regionalization led to privatization of laundry services in two major hospitals (Harder, 2003:134). The unionized laundry workers, most of whom were immigrants and earning low wages, initially agreed to pay cuts averaging 28 per cent as a means of saving their jobs. But when the Calgary Regional Health Authority contracted out the work to a for-profit firm, these workers lost their jobs. The Authority claimed it would save $2 million over five years and put priority on surgical services rather than on laundry services, pitting patients against providers.

Both the Canadian Union of Public Employees (CUPE) and the Alberta Union of Public Employees (AUPE) became involved, initially by advancing their own bid to operate a laundry in Calgary. When this was rejected and the firings announced, these unions and others supported the illegal walkout of laundry workers from the Bow Valley Centre. Public support was strong as a result of questions linked to politicians personally benefiting from the contracting out of the services, the overall cutbacks in health care financing and the unfair treatment of a particularly vulnerable workforce. “The rising level of public support for laundry workers and the growing sense of scandal led to a softening of the planned cuts” (Harder, 2003:136). The Authority promised not to contract out services for a year and to pay severance if later contracting out resulted in job loss.

In the end, Calgary did contract out the services to non-unionized employers and a significant number of the laundry workers took the retraining option offered by the

government. Lois Harder (2003:137) argues that the success was due in part to making visible the valuable service laundry workers provided, in part to social justice claims and in part to strategies linked to local issues. However, she links the ultimate failure to protect these laundry workers to the political and economic environment in Alberta as well as to the absence of a strong gender analysis and women's movement. She (Harder, 2003:137) concludes that in this environment "the possible range of legitimate political action is increasingly circumscribed."

While the majority of those defined as working in the health care sector are still covered by collective agreements, there is no guarantee that this will continue to be the case. Indeed, reforms seem to be designed to undermine union protection. The farther care moves away from hospitals and direct providers, the less likely union coverage. While three-quarters of those employed in large health care workplaces are unionized, only a minority are unionized in smaller ones (McMullem and Dubois, 2003:vii) Meanwhile, reforms are intended to shift care outside hospitals as much as possible.

Health and Safety

Health care work is dangerous to women's health. A gender analysis helps us understand both what the hazards are and why they have been largely ignored. The segregation of women into jobs defined as requiring little effort helps render many of the hazards invisible. So does the focus on male work and the tendency to use male-dominated work as the standard for safe practices.

The Canadian Institute for Health Information reports that health sector workers are over 50% more likely than other workers to miss work due to illness or injury (CIHI, 2002:87), with weekly absentee rates of 4.8% for all workers compared to 7.2% for health care workers. Moreover, health care workers are absent for longer periods of time, 11.8 days on average compared to 6.7 for all workers. In 2003, health care workers lost 10.7 days overall due to their own illness or injury. But support staff lost 13.6 days, while nurses lost 13.1 and childcare and home support workers lost 9.5 days (Perspectives on Labour and Income, 2004:Table 4). But even these high rates may understate the problem. In a survey of workers in Ontario long-term care facilities, 97% reported they had been ill or injured as a result of work at some time over the last five years, with over

half saying they had suffered illness or injury from work more than 11 times during that five year period. (Armstrong and Daly, 2004:28).

Not all illness or injury is reported, however, usually because it does not result in work absences. Under Canada's various labour codes, workers are not guaranteed payment while they are away sick. Thus workers with the lowest pay and without union protection are the most likely to work sick or injured. This is more likely the case for ancillary workers than for others in health care and especially the case for homecare workers. Moreover, women are less likely than men make to make claims for workplace injury under workers' compensation and even less likely to receive compensation when they do, in part because they have difficulty countering perceptions that their work is safe. They thus remain invisible in this injury data as well as uncompensated (Chung, Cole and Clarke, 2000; Lippel, 1995).

Given the much higher rate of illness and injury in this sector, it is logical to assume that it is the nature of health care work itself that causes the problem. And undoubtedly, there are aspects of work in care that create specific kinds of risks. Indeed, this is one of the factors that differentiate care work from other forms of labour. Part of the problem is also the aging labour force. With a majority over 40 doing the work, it is not surprising that injury rates go up especially given the nature of the work. However, the dangers inherent in health care work can be mitigated by strategies to protect workers. Similarly, the aging of the workforce can be countered with strategies to accommodate the workplace. But instead of addressing the health issues raised by these two factors, new methods for work organization are exacerbating them.

In spite of the high rates of illness and injury, and in spite of their high cost not only to employees but also to employers, there has been very little research done on the health hazards faced by the full range of health care workers, and even less done from a gender perspective. As early as 1977, Jeanne Mager Stellman exposed the health hazards women face in clerical and laundry work, in cleaning and in care work. She argued that women were hesitant to expose the hazards they faced, in part because they feared the consequences would be an assumption that they were too weak for the work and, this, in turn, could lead to job loss. At the same time, employers were blinded by assumptions about the safety of women's work and by their search for profit. Instead of addressing

health hazards, employers demanded evidence of direct causal links that were difficult if not impossible to establish, especially given assumptions about women's health and about the truth of scientific claims. Writing in 1998 (ix), the introduction to Karen Messing's book on women's occupational health, Stellman points out that "even the most straightforward measures are susceptible to inherent bias". The bias is what Messing (1998) calls one-eyed science, a science that either mainly assumes what applies to men applies to women, ignores women or bases research on stereotypes about women and their work. "Their differences from men can be emphasized or ignored by scientists, but the result of both procedures is the neglect of problems experienced by women workers" (Messing, 1998:xviii). In his more recent book on the gender dimensions of occupational health, Lauren Vogel makes a similar point about the bias in European occupational research (2003: 75). He explains that there has been investigation of nurses' workplace health issues, primarily because there is a significant recruitment problem. With fewer recruitment problems in ancillary work, however, there is less incentive to do research on the hazards they face.

In spite of this bias and of the limited nature of research on the health of ancillary workers, it is possible to draw on a range of international and national research to provide a partial picture of the hazards they face. The following sections explore some of these hazards, while identifying areas for additional research.

Infection and Respiratory Diseases

The greatest risk health care workers face, and perhaps the most obvious one that distinguishes their work, is the risk of infection and respiratory diseases (Ducki, 2004:217). Hepatitis B and AIDS, teratogenic viruses and tuberculosis are particularly dangerous hazards but not the only ones (Cesana *et.al.,* 1998). It is perhaps not surprising that those who provide personal care are at risk of infection or that women are more likely to get work-related infections than men, given women's dominance in health care work (European Agency for Safety and Health at Work, 2003:66). But the risk is not restricted to those providing personal care. "Support service staff, regardless of their specific work assignment, frequently come into contact with infected patients and contaminated surfaces" (Otero, 1997a:1). A U.S. study found tuberculosis infection was

significantly linked to occupation and that not only nurses but also housekeeping, laundry and security personnel were at high risk (Louther *et.al.,* 1997). Cleaners and dietary staff often have personal contact with patients on a daily basis, as do many clerical staff. And no people need be there for infection to spread. Beds, equipment and bathrooms are central locations for some of the most dangerous and difficult to control infections (Valiquette *et. al.,* 2004). Health care laundry that has not been appropriately handled can be a threat to those doing the work, with hepatitis A or B providing only one example (Borg and Portelli, 1999; Otero, 1997b; Wa, 1995). It is not only facilities that create such risks. Working in a variety of private households, with a variety of patients, can also expose providers to a range of infections and environmental hazards.

Although health care inevitably involves exposure to people with infections and with equipment or materials that carry diseases, the high infection rates are not inevitable. They can be controlled with good management and staff training that includes the entire health care workforce (WHO, 2002).

Lifting and Musculoskeletal Injuries

Back injuries have always been a problem in health care but their numbers are increasing as workers age, work intensifies and staff numbers are reduced. So are other forms of musculoskeletal injuries, such as problems with neck, shoulders, arms, elbows, knees (Shannon et al. 2001). "Limb disorders include a wide range of inflammatory and degenerative diseases and disorders that can affect tendons, ligaments, nerves, muscles, circulation and joint cartilage and result in pain and functional impairment" (European Agency for Safety at Work, 2003:41).

Many of these injuries come from lifting. And the problem is not simply that women often have limited upper arm strength. As a French study put it, the "loads to be handled in hospitals very often exceed men's as much as women's capacities"(Davezies, 2003:264). Fewer people are trying to lift sicker ones and often have no time or opportunity to get help from others or from a lift. Those who work alone in private homes are particularly likely to lift people alone, without mechanical aids or, too often, even training. According to a B.C. study, in one four year period in the late 1990s, nearly 40 percent of accepted WCB claims from home support workers were for over-exertion

injuries involving persons. “These claims amounted to 4.5 million dollars and more than 65,000 days lost” (Paris-Seeley, Heacock and Watzke, 2004:1). And that just calculates the costs to the employers. The average costs for hospitalization is highest for those with musculoskeletal and connective tissue injury and such injuries are among the top five in overall hospitals costs (CIHI, 2005c:46).

But the problem of back injuries and lifting is not restricted to those providing personal care. Fact sheets provided for dietary workers in Ontario make it clear that heavy lifting is one of the work hazards, as are long periods standing that can lead to back pain (HCHSA, 2004:1). Housekeepers also lift heavy machinery and garbage; laundry workers hoist heavy bags of soiled linen. A Scandinavian study of hospital kitchen and laundry workers found that workers “had various aches in the muscular-skeletal system, which they suspected were the consequences of prolonged standing and lifting of heavy objects” (Gunnarsdóttir and Björnsdóttir, 2003:70). Here too, lack of equipment, reduced workforces, little training and pressure to work at high speeds can increase the risks.

The good news is that some initiatives are helping to reduce these injuries while improving patient safety and clinical outcomes (Yassi and Hancock, 2005:34). Patient lifts installed in B.C. have reduced injury and increased patient satisfaction. Adaptive clothing has made dressing patients easier and training in handling stroke patients has helped improve care and limit worker risk. However, such strategies do little for those who lift non-patient loads. But there is every reason to believe that in laundries and kitchens, in cleaning and clerical work there are ways to organize work and workers in order to avoid such risks.

Chemicals, Needles and Cuts

The chemicals handled in health care are dangerous and varied. Those who provide personal care are exposed to chemicals in treatments and even in the breath of patients (Fuller and Bloom, 2005). Among the chemical hazards are antineoplastic and antiviral agents, sterilants and formaldyhyde (Cesana, 1998:23). Particular chemicals are required in cleaning to ensure that dangerous bugs are kept under control. Indeed, health care cleaners have three times the injury rate of other cleaners, often as a result of chemicals (Workers’ Compensation Board, quoted in Cohen, 2001:9). A California study reported

that home care workers found the hazards of common housekeeping tasks as important as those related to lifting (Stock, 2005). Cleaning chemicals are part of those household risks. Similarly, health care laundries use toxic substances to ensure that germs are destroyed, with chlorine bleach just one of many (Belkin, 1998). Indeed, there are chemicals used throughout the hospital that can pose a risk to anyone who works there.

Needles are another risk specific to health care. They carry all kinds of risks, not only for those who give them but also for those who clean up afterwards. Research reported in *Executive Housekeeping Today* (1991) found that housekeepers, not nurses, were at the highest risk of sharp-object injury. Laundry workers too find needles in the linen, and face injury as a result. Dietary workers face other kinds of risks in terms of punctures from knives, cuts from carts, and burns from hot dishes (Beaupré, 1991).

Here, too, it is possible to develop alternative approaches which would at least reduce the risk. Alternative chemicals are available, as are different approaches to cleaning. More time to dispose of needles can also help limit needle stick injuries. Better equipment, such as appropriate gloves, can protect workers.

Lack of Employment Security and Control

Along with contracting out and new managerial practices has come insecurity about employment. As we have seen, ancillary workers have high rates of part-time work and many are without union or benefit protection. All of these can contribute to concerns about security and have an impact on health. Equally important, those with ancillary jobs have never had much control over their work processes and lack of control can be hazardous to health (Karasek and Theorell, 1990). New work organization, along with for-profit managerial practices, has made it even less likely that these workers have control over their work or their pay.

A variety of studies have shown how lack of employment security can lead to stress-related health symptoms and damage to mental health (Hammerstrom, 1994; Lisle, 1994). Moreover, "stress can alter immune response and influence the onset and progression of physical illness" (Shields, 2004:9). And it is not only the workers who suffer. Research in India demonstrated that "accident frequency and severity rates were found to be significantly higher in temporary workers", leading to the conclusion that both

inexperience and insecurity contributed to greater injury and to accidents that have an impact on patients as well (Saha *et. al.,* 2005:375). Similarly, a survey of research on the expansion of precarious employment shows the significant health consequences of employment insecurity (Quinlan *et al.,* 2001).

Research initially done in the 1970s (Karasek, 1979) demonstrated that low levels of control over a job combined with high demand can lead to physical illness. Later research has confirmed this relationship (see Marmot et al. 1999) and showed that women face more of this "job strain" than men (Hall, 1989). The strain is a particular problem in jobs defined as unskilled, jobs like ancillary work. And the strain is increasing. Research on long-term care in Ontario and British Columbia, for example, reveals the increasing workloads that have been combined with more managerial control and less decision-making latitude for ancillary workers (Armstrong and Jansen, 2003). At the same time jobs have become more precarious for these workers, creating employment strain. Employment strain, like job strain, is about lack of control but in this case the question is control over hours of work, over pay and benefits and over when you are employed (Vosko, 2005). Again, take the example of Ontario. The Minister of Health and Long-term Care has made cuts to wages in ancillary work a major goal, arguing that "Just because it is a public health-care system doesn't mean…that we should expect to pay more to sweep the floor in a hospital" (Toronto Star, 2004:A1).

Job strain and employment strain are clearly women's issues. Women report more stress than men and those with the most stress are those with lower levels of income and formal education (Shields, 2004). In an Ontario study of women in female-dominated occupations, nearly half of the women indicated that stress was their major health issue resulting from work (Feldberg et.al. 1996). It is not surprising that women report more stress, given their segregation into the lowest paid work, their low pay and their other, unpaid work in the household and community. And their responsibility for unpaid care is rising just as their stress at work is increasing. It is also not surprising, given that women often have little control over their work in either sphere. Ancillary work is a prime example of stress creating relations. But in this case, the costs of the strain are borne by those needing care and by the system as a whole, as well as by the workers.

Here, too, there are some solutions at hand. Employment security, which would mean a guarantee of a job rather than of the particular job a woman currently occupies would allow employers some flexibility while providing workers with some stability. Several provinces once had such provisions, so this is hardly a radical or untried approach. More full-time jobs would also help and could save money in training and administration in the long-term. A national childcare and homecare programme would relieve some of the burden of unpaid work, giving women some control over their work in both spheres.

Workplace Organization

Employment strain and job strain are integrally related to work organization. Social scientists have long maintained that workplace relations, especially those related to the possibilities for social support and participation in decision-making have an important impact on health (Doyal, 1995).

The speed of change, combined with the speed up in work, has reduced both worker decision-making and the possibilities for making social connections at work. The President of the Canadian Safety Institute (Hassen, 2005:9) argues that "part of what has created compromises in patient safety is the fact that we are asking staff to master new technologies, processes, drugs, equipment, knowledge, etc. at an alarming rate, and asking them to be increasingly efficient and effective". But is it also the case that the same factors that threaten patient safety can threaten worker safety as well.

As researchers for the Canadian Policy Research Networks (Koehoorn et al., 2002:4) put it "restructuring typically had a short-term, bottom-line focus that did not consider the longer-term consequences for health human resources." As their report (2002:5) points out, "workload and other pressures, work schedules, job control, role stressors, and job insecurity" all influence employee health. But there has been little research linking these conditions to patient outcomes, especially in relation to ancillary work.

Like job strain and employment strain, new forms of work organization can have consequences for the mental health of staff in health care (Woodward et al., 1999). Health care workers suffer from mental stress caused by "work overload, pressure at work, lack of participation in decision-making, poor social support, unsupportive leadership, lack of communication/feedback, staff shortages or unpredictable staffing,

scheduling or long work hours and conflict between work and family demands" (Yassi and Hancock, 2005:35). Lack of full-time employment, casual and temporary work all increase the stress. So does constant switching among work areas, when workers have little control. Such stress helps explain why mental disorders are "the fastest growing cause of long-term disability" among health care workers. Stress can also have physiological consequences, including increased blood pressure and stress hormone response (Fox, Dwyer and Ganster, 1993; Theorell et al., 1993). Although most of the research identifying these causal factors in mental disorder has been done with nursing staff, there is no reason to believe that such factors do not contribute to ill health among ancillary workers.

What evidence we do have indicates the same health problems arise. Research on those working in private homes, for example, shows that the combination of multiple tasks that must be done in shorter time periods with poor equipment and in isolation from other workers takes a heavy toll (Bleau, 2003). The difficulties of completing the work are exacerbated by both demands from those who need the service and from the workers' desire to respond to their needs. This complexity is unique to health care, where responding to demands can mean the difference between health and illness.

Workers employed in Ontario long-term care facilities who were surveyed about conditions wrote about residents "not getting what they deserve" (Armstrong and Daly, 2004: 22), a problem that contributed to their stress, low morale and feelings of lack of support from management. Listen to a dietary worker:

> I work in the kitchen, it's a pretty busy place at most times. We have had a lot of cutbacks. People (are) losing their jobs after working for 22 years. I myself may lose mine after working for 19 years. Because of all these cutbacks we have to work sometimes doing the job of five people and we're tired and stress(ed) out because there is more work put on us than there should be. All of this makes it hard to enjoy our work. I remember the time when we enjoyed our job. Now you have hardly anytime to even go to say hello to residents (Armstrong and Daly, 2004:22).

They also wrote about the work-family conflicts created by inflexible and unpredictable schedules, a particular problem for women. One woman, asked if her paid work caused problems for her other responsibilities, offered a list: younger child at home, sick father,

dependent neighbour's spouse has recently passed away, working husband (Armstrong and Daly, 2004:16). Work and family commitments were frequently at odds, adding to their stress.

Work has too often been reorganized based solely on managerial theories rather than on consultation with those who do the work. Quebec cleaners interviewed by Messing (1998) complained of not being consulted by hospital administration, even when changes had important consequences for their work and even when their knowledge of the cleaning environment could help in the redesign. Their BC counterparts interviewed by Kahnamoui (2005) similarly complained that the work schedules and timing of tasks had not been based on any discussion with them about what was actually involved in the work. In both cases, the result was an underestimation of the work involved and significant stress on the cleaners.

Workplace organization can reflect workers' knowledge of what needs to be done and how it can be done. Such consultation can have the twin benefits of improving work organization and improving work relations. It can allow workers to develop social relations that create social supports for them in that work.

Workplace Violence, Sexual Harassment and Racism

Violence is common in health care. According to the International Labour Organization (2003:2), "Health sector personnel are particularly at risk of violence in their workplace. Violence finds its expression in physical assaults, homicide, verbal abuse, bullying/mobbing, sexual and racial harassment and psychological stress". An investigation of a U.S. health care organization found that both mental and physical violence increased with patient contact, regardless of job category (Findorff, 2004). A survey of Ontario long-term care workers indicated that all but a few had witnessed violence in their workplace. Almost three-quarters had violence directed towards them in the most recent three month period (Armstrong and Daly, 2004:29). The violence comes from patients, from families of patients and from other workers. Those who work alone in households face particular risks, often walking into violent relationships or even drug deals. Those who are employed by the homeowner may be particularly vulnerable, especially if they are immigrants without contacts in this country.

Women face more workplace violence than men. They are especially vulnerable to sexual harassment from employers, other workers, patients and families. Harassment is common, although often unreported because women fear they will not be believed or will lose their jobs. As Lesley Doyal (1995:168) points out, women who are harassed remain in a constant state of vigilance. The result can be "long term physical problems such as high blood pressure, ulcers or heart disease. In addition, mental health problems may well result from the need to deny fear, suppress anger and cope with the irrational guilt that many harassed women feel".

Racism creates similar problems. In her book on racism in nursing, Tania Das Gupta (1996) lists targeting, scapegoating, excessive monitoring, marginalization, infantilization, bias in work allocation, underemployment and denial of promotion among the manifestations of racism with health care. Although her focus is on nurses, there is every reason to believe that ancillary workers face racism as well. Indeed, given the fact that those identified as visible minority are overrepresented in ancillary work and that ancillary workers have less power than nurses, especially in terms of ease of replacement, it seems likely that racism is an even bigger problem for these workers.

Violence, harassment and racism are not new for women. However, education and training, job security, unions and effective compliant structures can help reduce the incidence. So can workplaces that promote social support. Supervisors too can make a difference. A U.S. study of a health acre organization found that increased supervisor support was associated with decreased violence.

Lack of Respect

In the research on Quebec cleaners (Messing, Chatigney and Courville, 1998:454), lack of respect was identified by both cleaners and supervisors as a major problem with health consequences. In identifying lack of respect, women are in some ways summarizing the health hazards they face as well as the invisibility of their skills, effort and responsibilities.

Respect would mean a recognition of skills and of the importance of training. It would be manifested in decent pay, benefits, schedules and working conditions, in safe equipment and chemicals, in adequate resources and time. It would be evident in

meaningful consultation and effective mechanisms for complaint. It would mean recognizing, and addressing the many hazards women face in health care work.

In sum, care work is traditional women's work. This material and ideological designation has influenced the development of nursing work and the value attached to ancillary work. Distinctions among various kinds of health care work are blurred by the female domination of the sector, as well as by the nature of the work itself. The overlap with household work helped keep the skills, effort, responsibilities and conditions invisible and undervalued. The specific characteristics of health care work lead to specific skills requirements. They also lead to specific health hazards in the work. But the rise in female participation rates contributed to the demands for more women's rights and for unionization, as well as for greater recognition of the skills involved in the work. Women in all health care jobs made significant gains until the late 1980s, when cutbacks and new managerial strategies combined to challenge these gains and their health. Ancillary workers are not protected by fear of shortages or by working in the public sector. Increasingly, they are not protected by unions either, as work is contracted out to non-union firms.

SECTION IV - THE GLOBAL CONTEXT

Reforms that have an impact on ancillary workers in care are not simply local. They are found throughout the world and need to be understood within this global context. Several factors have combined to make ancillary workers a target for change over the last couple of decades. In this section, we look at the international pressures and developments that are shaping ancillary work. In order to challenge both the definition of health care workers and the conditions of their work, it is necessary to understand these international forces at work.

Rising Health Care Expenditures

One such pressure is the growth in public sector spending on health care. For more than two decades, there has been a great deal of talk throughout the world about dramatic increases in health spending. Economist Åke Blomqvist, writing in 1994 (4), argued that health care had been singled out throughout the globe as "an area in need of productivity

improvement and better cost control" because of the rapid rise in the rate of expenditure growth. Among 29 OECD countries, between 1960 and 1998 the average annual rate of growth ranged from 2.2% in New Zealand to 7.5% in Spain (Anderson and Hussey, 2001:Exhibit 5). Between 1984 and 2004, health care spending in Canada "rose by almost $94 billion" (CIHI 2005c:17).

Undoubtedly, governments were spending more on care. However, the growth rate alone cannot explain the focus on productivity and cost. "In most countries the rate of increase in real health care spending was highest during the 1960s and generally has been declining since then, and the percentage of GDP spent on health care has been relatively stable since the early 1980s" (Anderson and Sotir, 2001:228). Canada's rate of growth in health spending during this period averaged 3.6%. In 2002, Canada stood eighth among 26 OECD countries in terms of public expenditure as a percentage of GDP, allocating 6.7% of GDP to health care. Expenditures alone cannot explain the focus on cost controls and productivity improvements in health care (OECD, 2002: Tables 10,11 and 12).

As Thomas Bodenheimer (1995: 29) explains, falling profits in the United States coincided with rising health care costs paid by employers in the 1970s. As a result, "individual health care consumers, business, and government gradually became concerned with the accelerating flow of dollars into the health care industry." Canadian business and individual Canadians were not as concerned about the rising costs, primarily because we have a publicly financed health care system for hospital and doctor care which means individuals and businesses do not bear the costs alone and that expenditures are lower. However, Canadian governments were facing pressure from rising health care costs combined with falling revenues resulting from falling profits as well as from tax reductions for corporations. Indeed, the tax reductions may have been a bigger factor. "Expenditures on social programs did not contribute significantly to the growth of government spending relative to GDP," according to two Canadian economists (Mimoto and Cross, 1991:1). Nevertheless, Canadians have become very familiar with arguments that health care budgets are no longer sustainable.

Health care workers account for a significant proportion of the costs in care. According to a former Director of Health Services Provision with the World Health Organization, health human resources consume between 60 and 80 per cent of health care

budgets (Conference Board of Canada, 2005:15). In cleaning, for example, staff costs account for up to 93% of total costs (Davies, 2005:4). And these costs rose with unionization in the sector beginning in the 1970s. Not surprisingly then, wages, salaries and benefits have been targets of reforms in health care.

However, it would be a mistake to see unreasonable demands from labour as a primary cause of cost increases. "Census data show that, on average, employment incomes for full-time workers in health occupations rose at about the rate of inflation between 1995 and 2000. That compares to almost a 6% after-inflation increase for all earners" (CIHI, 2005c:17). Moreover, there are huge disparities in incomes among health care workers (CIHI 2005c:16) and in their wage gains in recent years. Ancillary workers are the lowest paid of all those employed in this sector. Eliminating jobs or reducing wages for the lowest paid saves much less money than would doing the same for managers or physicians, although this has not prevented ancillary workers from being targets for change.

In Canada, much of the recent growth in health expenditures is attributable to expenditures on drugs. In 2004, $8.5 billion was spent by the public sector on prescription drugs (CIHI 2005c:61). Spending on retail drugs rose from 9% of total health spending in 1984 to 16% in 2004 (CIHI, 2005c:39). New technologies, especially information technologies, also accounted for a significant share of these new costs, although it is much more difficult to count their contribution to expenditure growth. Expenditures on drugs and information technologies are growing rapidly even though many of these technologies have not proven to improve patient care or to increase efficiency. According to an editorial in the *Journal of the American Medical Association* (Wears and Berg, 2005:1261), "roughly 75% of all large IT projects in health care fail" and the problems 'are not simply bits of bad programming or poor implementation." Similar points have been made about drug effectiveness.

In sum, the evidence does not support an argument either that health care costs are out of control or that health care labour costs are the major driving force. Even if both were the case, it would not make sense to target the ancillary workers who are the lowest paid of all workers. However, lack of evidence and logic have not prevented a focus on cost cutting that have meant major changes in ancillary work.

New Public Management

A second pressure for change comes from a new philosophy about the role and functioning of governments. Over the past two decades or so, there has been a major shift in approaches to government in Canada and throughout the industrialized world. Particularly influential in promoting this shift were the two US authors of a best-selling book entitled *Reinventing Government: How the Entrepreneurial Spirit Is Transforming the Public Sector* (Osborne and Gaebler, 1993). The central tenet of the reinventing government movement is that governments should where possible restrict themselves to "steering" and should leave "rowing" the ship of state to others, on the basis of competitively awarded contracts. In other words, they should focus on the development of innovative policies, leaving the delivery of programs to efficient agents in the market. Within government, there is a new managerialism. Market principles have been extended across the public sector as well as within public sector organizations (Exworthy and Halford, 1999). In others words, governments are to act like business, removing the notion of governments operating on the basis of a commitment to public service.

A complementary, if more systematic, approach to this marketization shift in government had been labelled New Public Management (Hood, 1991). New Public Management (NPM) insists on a sharp distinction between the policy-making roles of politicians and the policy implementation and routine management roles of public servants. The former are to set explicit goals, standards and performance measures, while the latter are to ensure that these objectives are realized in the most economical, efficient and effective manner possible. This is to entail not only the allocation of program delivery roles to successful competitors in the market, but also the adoption of private-sector practices within what remains of the public sector itself. The politicians are for example to rely increasingly on private sector management consultancy firms for policy development advice instead of on government policy analysts and senior public servants.

One assumption at work in NPM is that the private sector is more efficient and effective than the public sector in policy development as well as delivery. A second assumption is that those with careers inside the public sector cannot be counted upon to concentrate on the state's "core businesses", as they will instead endeavour to build up

their "empires." With NPM, the accountability and responsiveness of the state apparatus both to politicians and to citizens (increasingly thought of as clients, customers and consumers) is said to be enhanced.

There are several grounds for criticizing NPM, both in general and with specific reference to health care. From a range of theoretical and political positions, Savoie (1995), Shields and Evans (1998), and Johnson (2002, Chapter 11), among many others, have produced critiques of NPM in general. Here the focus is on NPM and health care. The most obvious criticism is that the impact of shifting the delivery of services to non-government agencies that compete with each other for short-term contracts falls most directly and negatively on the workers concerned. If costs are to be lowered, and if labour absorbs most of the costs, then NPM means less pay and worse working conditions. As Christopher Pollitt (1998:62, citing Kerr and Radford, 1994) puts it with reference to the UK practice:

> Considerable economies can usually be made by compulsory contract tendering of services such as building cleaning, catering, refuse collection and so on. These savings are made principally at the expense of the terms and conditions of the work force, but from the taxpayers' viewpoint they are real nonetheless.

The taxpayers' viewpoint claimed here is however problematic in health care, given that almost all taxpayers can anticipate needing health care and/or needing to provide some unpaid care to family and friends at some point in their lives. Overworked and low-paid health care workers who lack stable jobs are less likely to be in a position to provide sensitive, high-quality care to those taxpayers who become health care recipients. Eliminating perceived waste can mean eliminating important aspects of care. Consider the point made by Jane Aronson and Sheila Neysmith about some developments in home care abroad. "In schemes tried, for example, in the US, the UK, and Sweden, home care workers are assigned to clients on random or rotating bases so that time-consuming relationships cannot develop and tasks can be accomplished with assembly line efficiency" (Aronson and Neysmith, 1997:56, citing Chicin and Kantor, 1992; Qureshi and Walker, 1989; and Szebehely, 1995, respectively).

The NPM focus on efficiency and the elimination of waste, narrowly defined, translates into the offloading of care work from one agency to another, at the expense of

integrated services, and from the health care system in general to the privacy of the home, at the expense primarily of women, who have to pick up the care work, whatever their other responsibilities, interests and skills. The NPM focus on efficiency and the elimination of waste also paradoxically means that it tends to be inefficient even in narrow terms, lacking the surge capacity to deal with the waves of patients who show up at hospital emergency departments, much less to deal with major and virulent outbreaks of infections, such as avian flu or SARS.

The NPM emphasis on management (and thus hierarchical control) at the expense of both administration (and thus stability and fairness), and politics (and thus the centrality of values in shaping public services) is consistent with the language of "taxpayers" and indeed of "customers" and "consumers" as against that of "citizens" and "residents." Yet it was only as a result of popular, political pressure that Canada established medicare, its best-loved social programme. Its maintenance and improvement in the future will require that such pressure continue.

A final critique of NPM relevant here is that the separation of "steering" from "rowing" entails contracts between the state and private concerns. To the extent that these contracts contain what are successfully claimed to be trade secrets, they not only reduce transparency and public accountability, but they also blur the public/private distinction and make it more difficult to mobilize informed public opinion for medicare. This criticism applies with particular force to so-called public private partnerships or P3s, by which private consortia provide some combination of the design, financing, construction, operation and ownership of facilities such as hospitals that are ultimately paid for from the public purse. The public, however, is bound by rigid contractual provisions for 25 years or more. Under P3 arrangements, ancillary workers are particularly subject to becoming employed, if at all, by the private consortia rather than by the public sector. They may well lose their union protections and the pay, benefits and working conditions they have fought for years to achieve. Indeed, this may well be part of the motivation of those who advocate and implement the P3 mechanism.

Health Care Offers an Opportunity for Profit

Another pressure has come from the opportunities in health care created by its location primarily in the non-profit sector. This is particularly the case in the context of governments seeking to shed their operations and to promote business. Some aspects of health care, such as pharmaceuticals, have always been produced in part on a for-profit basis by investor-owned corporations. Until recently, however, investor-owned companies in health care services were virtually unknown. Indeed, there is still a great variety in ownership of health services and in "no country is the 'for-profit' firm dominant" (Cookson, Goddard and Gravelle, 2005:123). Health services thus offered, and continue to offer a new frontier for investment by for-profit firms.

Speaking of the emerging for-profit health maintenance organizations in the United States, Ellwood and others suggested that they "could stimulate a course of change in the health industry that would have some of the classical aspects of the industrial revolution – conversion to larger unit of production, substitution of capital for labor, vigorous competition, and profitability as the mandatory condition of survival" (quoted in Bodenheimer, 1995:26). All that is missing from this list is the fragmentation of work into identifiable tasks that allow the substitution of lower paid labour for higher paid labour.

Health education, health information and technologies, insurance coverage, supplies, equipment, laboratories and testing facilities, management, consulting and service delivery all offer opportunities for investment (WHO, 2005). These opportunities grew as governments withdrew from the field or failed to cover new developments. In some cases, governments paid the private sector for the work or the products, based on NPM assumptions that the for-profit sector is more efficient and effective than governments. By the 1990s, many for-profit firms had moved into the field, often with the assistance of governments. In *Bitter Medicine*, Jeanne Kassler (1994) documents the huge expansion and the enormous profit growth in the U.S. Colleen Fuller (1998) has done the same for Canada, showing that for-profit companies are growing here in strength and profits, albeit at a slower pace than in the U.S. And the expansion is still going on. "According to the president of the American Association of Health Plans, '450 million Latin Americans constitute a health-care market of $120 billion a year" (WHO, 2005:128).

However, as a number of economists (Mintzberg, 1989; Cookson, Goddard and Gravelle, 2005) have pointed out, the health care sector is not the same kind of market as other sectors. Disease is unpredictable both in terms of timing and of who gets sick for how long. Some illnesses can be very expensive, distorting the equilibrium of markets. Doctors and patients differ significantly in their access to necessary information, much more so than in the case of purchasing consumer goods. Moreover, demand is local in many cases and many areas of even the United States have populations too small to support competition in services (Himmelstein and Woolhandler,1994:231). And an unregulated health care provision can lead to low quality resulting in death or injury as well as significant inequalities in access to care.

As a result, in every country, supply, demand and delivery have been heavily regulated. Those countries shifting to more private investment have often had to introduce new regulations to address problems created by the conflicts between markets and care. In Ontario, for example, the government had to manage competition for homecare services rather than simply let the market operate. But even then, problems arose in terms of continuity of care, costs and quality. New regulations were introduced to limit the market even more in an attempt to address the particular characteristics of health care. In Manitoba, a private management firm failed in the attempt to achieve large savings by applying for-profit techniques to the hospital sector. The firm failed in part because the sector was already quite efficient and in part because it was hard to substitute capital for labour. The solution of reducing staff mainly meant a reduction in service. These regulations, along with the factors that gave rise to then, help account for the limited penetration of for-profit firms in some areas of care.

While differences between the health sector and other services are perhaps visible when it comes to life and death care provided by doctors and nurses, it is less obvious in the case of ancillary services. Indeed, much of ancillary work seems comparable to work done in the for-profit sector. It is increasingly described as hotel work in an effort to imply that the work is the same as work done in the for-profit sector (Cohen, 2001). Based on the assumption of such equivalencies and seeking opportunities for investments, large international organizations have pressured for both the privatization of these services and for international agreements that would allow them to provide them

anywhere in the world. Many companies that provide services to universities and hotels now cater to hospitals and nursing homes. Some have contracts with these facilities to do the work. Increasingly, public/private partnerships mean for-profit organizations build and manage the health care facility and provide all the services defined as ancillary while the public sector manager directs clinical care.

At the same time, technology is used to replace workers, speed up the work process and relocate the work. Clerical work provides an obvious example. As Ann Eyerman (2000:35) explains in her book on the globalization of clerical work, the "computer did not just replace our typewriter as the tool of our trade, it has transformed the structure of our work itself". It has also eliminated thousands of clerical jobs (De Wolfe and Associates, 2000) while moving others off-shore to countries such as Jamaica and India (Bueckert, 1993). Patients talk mainly to an answering machine when they call the hospital and may have their doctor's notes transcribed by someone living in another country. Some patients even check themselves into the doctor's office, inserting their health card into an automated machine and punching in their own information.

Food production too has been distanced from the local. In her book on the global production of food, Deborah Brandt (2004:14) argues that the "experiences of women in the food system offer a window on the restructuring of work in the new global economy". Health care is no exception. Many hospitals and other care facilities no longer have kitchens. Food may be made in another province or even across the border and merely reheated in the location where it is consumed. The work that remains at the facility level has become increasingly mechanized, often creating work on an assembly line (Gunnarsdóttir and Björnsdóttir, 2003). Similarly, laundry has been centralized into large corporate enterprises, with sheets and other materials often trundled far away for cleaning. In both food and laundry work, the process has been transformed by technologies that speed up production and do some of the heavy labour.

Technology has had less impact on cleaning, in part because cleaning has to be done at the local level. Spaces, as well as patients, make machines difficult to use. When machines have introduced to speed up the work, it is usually men who operate them (Messing, 1998). However, information technology has been used to estimate and control the amount of time each cleaning task takes (Armstrong et al, 1997; Messing, 1998), and

those programmes may be developed in another region or even another country without regard to the specific characteristics of the work or knowledge of the workers.

Health care services, then, offered an opportunity for profit just as other areas for investment were disappearing. Ancillary services seemed particularly appropriate for delivery by for-profit firms, based on their assumed similarity to service work in the private sector of the economy. Pressure from global corporations met with support from those promoting less government and from those seeking to reduce costs. While there is little research evidence to indicate that these organizations provided better or cheaper services, more of this work has moved into the for-profit sector and more is being moved every day. Research does indicate that food and accommodation services in the private sector are amongst those with the lowest jobs quality and lowest pay (Maxwell, 2002; Hughes, Lowe and Schellenberg, 2003:22), suggesting a grim future for those who have their jobs moved to the for-profit sector.

Global Markets and Workers

There is also pressure to pit workers against each other around the world, as a means of lowering labour costs in care. Workers, too, seek opportunities in other countries, especially in the face of global restructuring. There has long been a global market in workers but their numbers have increased with more emphasis on free trade and global markets. This is particularly the case with those recognized as health care workers. Health care professionals are in high demand in many areas, although their movement from east to west, south to north has been far from free.

Doctors have particularly strong professional organizations in the west, reflecting the long dominance of white men and reinforced by visible skills obviously acquired through formal training and by their control over admission to the profession (Witz, 1992). Nurses, too, have quite strong professional organizations and unions, skills acquired through formal training and protected by credentials as well as some control over admission. Both doctors and nurses in the west enjoy strong public support as well as high prestige. Both groups have used their power to limit entry from the foreign-educated. Nurses' power has been more limited, because doctors are in control and because they are women. While the currently perceived and certainly looming shortage of

health care professionals not only in Canada but throughout much of the world has strengthened nurses, doctors and nurses in the wealthy countries are being pressured to open the doors to more professionals from abroad.

By 2002, nearly a quarter of Canadian doctors were foreign trained while immigrants and non permanent residents make up just under 20% of the overall labour force. Those trained in the United Kingdom were most common (17% of all foreign trained), with another 11% from South Africa and 9% from India (Mullan, 2005: Tables 14 & Figure 5). In spite of these large numbers of foreign trained doctors, it should be recognized that medical associations have considerable power over admission to practice. It is difficult to get accurate data on the number of doctors living in Canada who have foreign credentials but are not practicing medicine because they have been refused admission to the profession. Some may be working at ancillary jobs in health care.

Compared to doctors, the foreign training of nurses is less consistently recorded, in part because entry is less carefully controlled. Although the criteria foreign-trained Registered Nurses must meet are somewhat less restrictive than those for doctors, there is a significantly smaller proportion who are foreign trained. Half of the 8% known to graduate outside Canada, are from the Philippines (29%) or the UK (21%), with another 7% from the US (CIHI, 2005d: Tables 14 & Figure 19). Given the large number of nurses compared to doctors, however, there are approximately as many foreign trained people working as doctors and RNs. Licensed Practical Nurses are even less likely to be foreigntrained. Less than 3% received their nursing education outside Canada. Like the RNs they were mainly trained in the UK, the Philippines or the US. Unlike the RNs, however, nearly 40% trained in the UK while only 17% came from the Philippines (CIHI, 2005e: Table 7& Figure 12). As is the case with doctors, we do not know how many nurses with foreign credentials are doing ancillary work. Research in British Columbia (Rivers, 2000) indicates that there are many nurses with foreign credentials who now work as personal support and home care workers, as cleaners, cooks and administrative staff. Another study in the same province found that the costs of language training, tests and upgrading, combined with wage loss during the process and family responsibilities, prevented foreign nurses from working as nurses. These nurses were from a wide variety of Asian, and eastern European countries, as well as from Central and South America.[iv]

While it is possible to develop a general picture of where doctors and nurses are trained, existing sources tell us nothing about where ancillary workers are trained. In contrast to doctors and nurses, ancillary workers are less likely to have collective representation that regulates entry. As we have seen, they are more likely to have skills acquired informally and assumed to be part of what any woman can do. Ancillary workers also have significantly less public visibility. As a result, there is no perceived shortage and no attempt to track where they acquired their skills. Nevertheless, it is clear that many come from other countries, with few of the kinds of controls there are for professionals (see Appendix). Many may also have training that goes well beyond what is explicitly required in ancillary work, and they may use this unrecognized training in their work.

In sum, there are global pressures to transform health care into a for-profit service. The pressures have been particularly strong in the case of ancillary work, which has been defined out of care and into the accommodation and food for-profit sector. The move has been supported by governments committed to a new philosophy and by the international movement of workers.

SECTION V - THE HEALTH POLICY CONTEXT

Health care reform in western countries has many similarities that go beyond the drive to make profit from the delivery of services and beyond concerns over costs as well as over shortages of providers. These common themes have to do with ideas about the principles for change. Privatization, teamwork, evidence-based decision-making, accountability, regionalization and an emphasis on public health have all been promoted in health care reforms in and outside Canada. This section reviews these common themes, seeking to show how many of their principles are contradicted by the practices in relation to ancillary workers.

Public Health Care

All reforms take place within the context of our complex public system and are limited by its structure and, some would contend, its popularity. In order to understand current

reforms and their impact on ancillary work, it is thus appropriate to rehearse the development and structure of public health care.

Under the *Canada Act*, health care is primarily a provincial/territorial responsibility. The federal government still screens immigrants, provides care to First Nations and Inuit peoples and the armed forces and regulates for drug and food safety, but most of the rest is left to the provinces and territories. Nevertheless, the federal government has used its ability to raise money through taxes as a way to influence public health care in Canada. This influence is most obviously evident in the *Canada Health Act* and related financial arrangements.

The federal government began the process of building a public system by offering, in 1948, to pay for half the cost of hospital construction. In the late 1950s, under the *Hospital Insurance and Diagnostic Services Act*, the federal government offered to pay for half the cost of specified services offered in hospitals if the provinces met certain criteria. A decade later, the federal government followed this successful strategy a third time with the *Medical Care Act*. The Act covered the services of allopathic doctors and some dentists working in hospitals. These two pieces of legislation were brought together in the 1984 *Canada Health Act (CHA)*. This short document set out clearly and simply the five principles that provinces must follow if they are to receive their money.

As mentioned above, *CHA* requires that all medically necessary services provided in hospitals and by doctors or nurses paid under the provincial/territorial plans must be universal, accessible, comprehensive and portable. Some aspects of extended care services are also covered. In addition, the government insurance plans must be administered by a non-profit, public agency. These principles are not defined in much detail. However, it is made clear that services must be provided under uniform terms and conditions and that a wide range of services are covered under the definition of hospitals, including all drugs and tests as well as all cleaning, food and laundry provided in them. The federal government, then, pays for services provided under provincial jurisdiction but does not deliver them. The provinces in turn mostly pay for services delivered by agencies that are not directly government-owned. Until recently, almost all of them were non-profit.

This approach to public care has a number of consequences that are relevant for the analysis of ancillary work. First, and most obviously, public health care services expanded enormously as they became more accessible to those who previously could not afford them. This expansion meant paid jobs in health care grew as well, especially for women. Second, services became more equally distributed not only among individuals but also across jurisdictions. Greater equity was, and is, particularly important to women and minority groups who need the system more but have fewer resources to use for payment. Many of these women do paid ancillary work. Third, although there was a more uniform approach, provinces and territories continued to have a great deal of leeway in determining what services are provided and how they are provided. As a result, there are considerable variations among jurisdictions in terms of such things as length of stay in hospital, number of doctors per capita and of ancillary workers. The regulation of these workers is also left to the provinces. Fourth, doctors' power grew along with the health care system in large measure because they determined what doctor or hospital care was medically necessary and thus covered by the public system. Clinical care and prevention based on medical perspectives dominated, rather than perspectives based on a determinants of health approach. Fifth, the emphasis was on doctor and hospital care because these were the services most clearly funded by the federal plan. This encouraged the development of large facilities, facilities which in turn had a high demand for ancillary workers. Other services, such as homecare and drugs provided outside hospitals, remained largely private responsibilities and ones that were often privately delivered, even though the *Canada Health Act* does mention extended health care services. Conditions for both patients and workers in these privately delivered services varied enormously. The extent to which these services were regulated also varied enormously. Sixth, many facilities remained as non-profit, non-government institutions, albeit ones considered as part of the public sector and heavily regulated as well as funded by the various governments.

Under this approach, federal health care costs were determined in large measure by what provinces and territories decided to spend. Costs continued to rise and so did federal concern about expenditures. These cost reflected in part the enormous expansion in the number of beds and thus in the number of health care workers. By the mid-seventies, the

federal government began moving away from their commitment to pay for half of the medically necessary care provided by doctors or hospitals. Limits were put on the total amounts to be contributed and the cash portion reduced. Part of this reduction was replaced by the federal government transferring some of its tax rights to the provinces and territories. In the mid-90s, the federal government collapsed all their contributions to health, social services and higher education into one package called the Canada Health and Social Transfer (CHST), and significantly reduced the overall amount it contributed. The CHST reduction was not simply about rising government debts, however. It was also about the increasingly dominant neo-liberal understanding of governments that defined both smaller states, for-profit management techniques and more personal responsibility as important in health as in other sectors.

The federal government thus reduced the amount of money available to provinces and territories at the same time as it made the federal contribution significantly more difficult to calculate. The changes in funding had an important impact on public care, although the impact was not immediately obvious. Perhaps most importantly, the lack of clarity about how much the federal government contributed to health care combined with reductions made it more difficult for the federal government to use its financial clout to enforce the five principles of the *Canada Health Act*. Provinces and territories increasingly challenged the federal government's right to a say in public care. Facing rising costs and falling federal contributions at the same time as they began embracing neo-liberal strategies, provincial and territorial governments turned to privatization as a means of reforming public care, as we shall see in the next section.

In recent years, the federal government has started to make up for some of the money lost to health care under the CHST, partly at least in response to public pressure. But it has not used this increase to enforce the principles of the *Canada Health Act* and most provinces and territories continue to resist any such move. The federal government has now moved to a Canada Health Transfer that identifies money going to health and has increased the funding, but there is still no evidence of enforcement. Meanwhile, the move towards privatization continues, especially in terms of for-profit delivery and methods of work organization (Armstrong and Armstrong, 2003; Gilmour, 2002).

It is important to remember, however, that some kinds of care have never been part of the public health system. The *Canada Health Act* explicitly covers only doctors and hospitals and some extended health care services. Provinces and territories have made some drugs and some home care, along with some dentistry, part of the public system. However, coverage for services other than doctors and hospitals has been much more uneven and tends to be the first to be shed by the public systems seeking to reduce costs. This is particularly the case with rehabilitation services at the moment.

So why is this history relevant for studying ancillary work? Perhaps most obviously, the expansion of public care meant many more paid jobs for women. It is also significant because this expansion in the public sector brought women together in ways that encouraged unionization and also encouraged the applications of human rights principles that are part of government commitments, as we shall see in a later section. The organizations delivering government services have been highly regulated by the state in ways that helped, for a period at least, to improve conditions of work. But this history is also meant to show that the complex system of what Canadians think of as public care makes categorization difficult and analysis confusing. In particular, the complexity makes it difficult to understand the impact of reforms that came in the wake of the new public management and of cutbacks in health care budgets. These reforms are changing the location, ownership and structure of care services in ways that have profound consequences for work and employment relations, as we shall see in the next section on privatization.

Privatization

Privatization is not a single, or simple, process. It is about much more than ownership and a simple distinction between public and private sectors. Indeed, the move to a new government philosophy and practices has blurred the lines between what is public and what is private in terms of not only ownership but also responsibility. This section explores various forms of privatization in order to make their impact on ancillary work more visible.

Canada's public health care system has, from the beginning, been characterized by a separation between purchaser and provider. The federal, provincial and territorial

governments mainly pay other individuals and organizations to deliver care. Before medicare, almost all the institutional care was provided by local governments or more commonly, by independent, non-profit organizations. The five principles of the *Canada Health Act* apply explicitly to doctors and hospitals but it is less clear that other services must conform to them and that delivery must be non-profit. This lack of clarity has important implications for privatization in its various forms.

Also from the beginning of medicare, there were pressures for reforms. As Malcolm Taylor (1987) put it, hospitals and doctors were handed a blank check when they were promised payment for care determined by them to be medically necessary. Governments quickly became concerned about controlling costs and this concern escalated in the 1990s. Those concerned about the medicalization of daily life, about the quality of care and about the authoritarian nature of health services called for reforms as well. Women's groups were particularly vocal in pushing for changes that would see fewer people in institutions, less power for doctors and more external evaluation of care procedures. By the 1990s, governments in Canada became increasingly disenchanted with public services and more enamoured with private ones.

These pressures were central in reforms of recent years, reforms characterized by privatization. Such privatization takes multiple forms (Armstrong, Armstrong and Connelly, 1997; Armstrong et al. 2001). One form is the shift in where care is provided. Less and less care is offered in the hospital, where the *Canada Health Act* principles clearly apply. More services are offered in facilities and homes where fees are usually charged or where individuals are required to pay for care, or provide it without pay.

This shift not only means a privatization of both costs and care work; it also means more of the paid work is done by those termed ancillary workers who often work alone. The farther care moves from hospitals, the more care work is unpaid as well. Because most of these ancillary workers are women, more of them take on this additional unpaid care work.

In addition to the privatization of costs and care work, governments have been contracting out services to for-profit concerns and entering into public-private partnerships that alter the nature and conditions of ancillary work. In order to initiate this process, they had to first define this work out of care. The discourse of 'hotel services'

both laid the ground work for, and reflected, the privatization of these services. In the process, the employment of these workers becomes a private concern, with their employment contract usually hidden from public view so profit-making companies can maintain confidentiality in order to compete. It is worth noting, however, that the *Canada Health Act* explicitly includes all such work in the detailed description of what is covered in hospitals, suggesting it is understood as central to health care rather than a 'hotel service'.

Even when these services remained part of non-profit organizations, there was significant pressure to follow the lead of for-profit management. In another form of privatization, governments moved to adopt for-profit business practices within their own organizations and to require such practices from others receiving their funding. Especially in the case of ancillary workers, considerable effort has been directed towards making work in health like work outside health. Those who work in kitchen, laundry, housekeeping, caregiving and clerical work in the for-profit sector are amongst the lowest paid and most precarious in terms of benefits, pensions, hours of work, union coverage and job security (Armstrong and Laxer, 2005). Privatization through the adoption of private sector practices means moving to such conditions within public institutions as well.

Research has begun to show the impact of the privatization of ancillary services through contracting out, public/private partnerships and the application of for-profit methods to this work. Carol Kushner (2005) looked at the contracting out of three services in Toronto hospitals: housekeeping; supplies and logistics; and food services. All three contracts were ended for several reasons. First, savings were short term and quite small, both because these services were already quite efficient and because the wages were already quite low. These are the lowest paid workers so you would have to fire three or four of them to make up for the wages of one nurse; seven or eight of them to equal the loss of one manager. Second, systems developed in the private sector were not easily adapted to the public one. Third, contracting added costs to administer the contracts, for severance and retraining, in capital developments such as renovating kitchen spaces and in staff morale. Kushner (2005:slide 11) concludes that there is "no scope for savings without serious compromises to quality". When housekeeping was returned to the public

sector, there was agreement that staff levels increased, the hospital was cleaner and the cleaning materials were less toxic, creating a healthier workplace. A joint hospital plan was developed through a non-profit organization to buy and store supplies and kitchens were reestablished in-house.

Privatization in its many forms thus has a significant impact on ancillary workers. Even when the work remains part of the public sector, managerial techniques taken from the for-profit are applied to their work in ways that both fail to recognize their contribution to health care and undermine their working conditions.

Integration and Team Work

Another common theme in health care reform is the emphasis on integration and team work. According to a report published by the Health Council of Canada (El-Jardali and Fooks, 2005:4), virtually all the organizations and governments they surveyed "recognize the importance of multidisciplinary teams" and call for "training on team-based care" (2005:5). The CIHI report on providers has chapters on "Teamwork in Health Care" and "Working in Health Care."

But the focus is primarily on doctors and nurses, although the others on the "Who's Who" list are also mentioned. Clinical providers are the only ones considered in the team, even though the work of the ancillary staff is critical both to care and to the work of that staff. Nurses and doctors cannot put someone in a bed that is not clean, for example, and they cannot leave a patient unfed.

Ancillary workers are not only left out of the teams described in the policy papers. In Karen Messing's (1998:172) educational session with cleaners, they "mentioned their invisibility in answer to the questions on their relations with coworkers" and the lack of consultation on their work. The contracting out services such as cleaning and laundry further separates these workers from each other, making team work difficult if not impossible. Research indicates it also separates out the services, making integration within the system equally difficult.

In England, a government report talks about the apartheid created by the contracting out of services. Steve Davies, in his British investigation of infection control and the contracting out of public services concluded that "The contract culture atomises functions

within a hospital and contributes to the breakdown of a team-based approach that unifies clinical and non-clinical staff, thereby damaging flexibility and overall effectiveness" (Davies, 2005:4). The result was a two-tier and even three-tier workforce among ancillary workers. The first two tiers were created by the workforce divided between those working under public sector conditions and those working under for-profit ones that are significantly worse. The third tier is made up of immigrant workers, hired under even more inferior conditions. Celia Davis (1995:26), also on the basis of British research, argues that "the new arrangements, by stressing market competition, lay bare the notion of hostility and warring, encourage it, celebrate it and aim to work with it rather than seeking to contain, hide or transcend it in some way."

In her study of contracted out cleaning work in a BC hospital, Kahnamoui (2005) found disruption of both services and teams, resulting in inefficient organizations and poor care. The log book where cleaning requests were written by clinical staff, and then read by the cleaning staff on the floor, has been replaced by a call centre at the corporation. Clinical staff reported waiting on the line for requests that had to go through the call centre, rather than directly to the cleaners. The call centre would then page the cleaner, who disrupts their work to respond to the call. Indeed, clinical staff could no longer directly ask cleaners to do work that needed to be done as a result of changes caused by the regular irregularity of health care. Calling the call centres took clinical staff away from their caring work. New staff was hired and those with years of experience and relationships on the floor dismissed. Tensions, rather than team work, were the result.

Separating ancillary from clinical work, in policy and in practice, conflicts with the emphasis on integration and team work. At the same time, it creates logistical problems and adds more work for the rest of the staff while making the support networks among workers more difficult to maintain.

Evidence-based Decision-making

Evidence-based decision-making is yet another central theme in health care reforms. The National Forum on Health (1997), a group appointed by the Prime Minister to advise on how to improve health and care, devoted an entire section of their report to evidence-

based decision-making. The section (National Forum on Health, 1997:3) begins by explaining that:

> The National Forum on Health believes that one of the key goals of the health sector in the 21st century should be the establishment of a culture of evidence-based decision-making. Decision-makers at all levels – health care providers, administrators, policy-makers, patients and the public – will use high-quality evidence to make informed choices about health and health care.

Research has become increasingly important with the call for evidence-based decision-making and there is a renewed emphasis on research that is interdisciplinary.

Yet there is very little research done on ancillary workers in Canada. It is difficult to find research on their work or on the workers. The multitude of documents on health care providers largely ignores them. There is little that either documents or analyzes their work in relation to patient care or to the health of the ancillary workers themselves. Statistics Canada makes it harder to track them, now that the industrial classification system no longer counts them as part of the health care sector if their employer is a for-profit firm.

The Romanow Report argues that ancillary work 'could be the domain of private providers" without offering any evidence to support this claim or even a clear definition of who the ancillary workers are. Indeed, there was no evidence provided by the Report even on how the division between ancillary and clinical work could be determined. Who is counted as a health care worker varies significantly, leaving considerable ambiguity and little means of assessing this recommendation and other policy on the basis of evidence.

Governments across Canada have been reorganizing the work without either much evidence that this is a safe and effective practice for patients and providers and without doing sufficient follow-up research to examine the impact on services, providers and patients. They have also been contracting out the work, based on a belief in the superior efficiency and effectiveness of the for-profit sector rather than on evidence.

Even when the research has been done, there is little evidence that the evidence drives the practices. There is a great deal of social science literature demonstrating the importance, for example, of social networks and control over the labour process in both

worker health and worker productivity. But the literature from these disciplines is seldom integrated in health care reform policies. The scan of views on health human resources prepared for the Health Council of Canada (El-Jardali and Fooks, 2005:7) points out that

> Despite robust evidence which suggests that improving working conditions in the short and long term is key to maximizing productivity and meeting growing service demands, stakeholders recognize that there has not been a lot of action in this regard.

This report (El-Jardali and Fooks, 2005:7) goes on to say that "much of the focus" has been on retaining nurses and physicians but little attention has been paid to other providers. While there is little indication that this report intends to extend the definition of providers beyond professionals, it is clear that issues linked to the quality of workplaces for ancillary workers is not on the agenda.

Emerging evidence suggests that separating out ancillary work for privatization is a mistake on all grounds. Most of this research has been done on cleaning services, perhaps because cleaning is more obviously connected to infection rates. A 2001 (Rampling et al, 2001:115) study conducted in the UK concluded that "In the long term, cost-cutting on cleaning services is neither cost effective nor common sense". When a UK survey of cleaning was first done in 2001, it reported that "20 out of 23 of the hospitals that have poor standards of cleanliness used contract cleaners" (Davies, 2005:18). He concludes that there is poor performance because most, and perhaps all, of the savings come from poorer conditions of employment (Davies, 2005:21), but little research has been done by policy makers on how these changing conditions impact on the health of the ancillary workers.

Recent research in British Columbia (Cohen and Cohen, 2004:4) shows that, in the wake of contracting out, the wages of ancillary workers "have been cut almost in half, and all these workers have no pension, long-term disability plan, parental leave or guaranteed hours of work". Wages for this mainly female labour force are now equivalent to those paid in 1968. Male dominated jobs fared better, creating a larger wage gap among ancillary workers. The unions in BC have charged the government under the Charter of Rights and Freedoms, claiming the action discriminates against women. The B.C. government did hire a consulting firm to conduct a 'quality audit' for facility

cleanliness, including the contracted cleaning services. The B.C. Nurses' Unions argued that the evidence from the audit was not reliable, given that both the health authority and the facility knew when the audit was to be conducted and that the auditing tool itself was inadequate (BC Nurses Union and the Health Services Association, 2004:49). Nevertheless, the audit reported that a quarter of the facilities did not meet their standards (Westech Systems, 2005). What this means in terms of the health of workers is not considered in the audit and it is not clear what action, if any, will result from this evidence.

In sum, evidence-based decision-making is much touted but little practiced when it comes to ancillary workers. The evidence that does exist suggests that ancillary work is critical to care and that cost cutting strategies can have long-term negative consequences for both patients and providers. So does contracting out. At the same time, research has focused on those who provide clinical care while reforms have proceeded without much evidence to support the strategies in relation to ancillary work or to assess the financial or health consequences for patients and workers.

Accountability

Calls for accountability are also at the heart of health care reforms. The Canadian Policy Research Networks, for example, have launched a seven-part series as a response to what they see as a demand from citizens. Citizens' forums and national reports have repeatedly identified accountability as a critical and priority issue.

Accountability seems to have a variety of meanings. According to the 2005 Ontario Budget (87), accountability "involves setting out expectations about the outcomes to be achieved; monitoring and reporting publicly on progress; using the information to improve performance; and working to achieve results and taking responsibility for them."

Accountability, however, tends to be understood as being about financial counting, managerial control and marketization within the public sector. Mark Exworthy and Susan Halford (1999) explain, in their book on the new managerialism in the public sector, that there is financial decentralization that divides public sector organizations internally into purchasers and providers who are expected to operate like businesses, with transparency defined in strictly market terms.

> The development of cost-centres allows abstract space inside organizations to become 'calculable' and therefore comparable: 'calculative technologies make it possible to render visible {the}activities of individuals, to calculate the extent to which they depart from the norm of performance and to accumulate such calculations in computers and files and to compare them. (Exworthy and Halford, quoting Miller, 1999:5)

This is what Ontario (2005:87) seems to mean as well, defining progress in terms of bottom-line financial results of hospitals, value-for-money audits and the like.

Accountability was a theme in federal/provincial/ territorial agreements on health care funding. Most recently, the way this notion of accountability was translated into practice was through a number of indicators that provinces and territories agreed to report on for their federal funding. The focus is on primary health care, catastrophic drug coverage and home care. According to the federal/provincial/territorial ministers' joint statement (2003:3), their reports "will inform Canadians on progress achieved and key outcomes. It will also inform Canadians on current programs and expenditures, providing a baseline against which new investments can be tracked, as well as service levels and outcomes". The indicators do move beyond money to focus on access, satisfaction and perceived overall quality. Leaving aside the fact that not all indicators were fully reported, the indicators fail to define quality and satisfaction in ways that allow either improvement in care or an assessment of ancillary work. Indeed, we have little idea from these indicators what contributes to either satisfaction or assessments of quality and no idea of what role ancillary works plays. Moreover, the hospitals that employ a majority of these workers are not covered by the indicators.

The problem is not only inadequate indicators. Accountability is made difficult by contracting out services and by public-private partnerships of the sort that are increasingly common for ancillary services. Lines of responsibility are blurred, making it difficult to determine who is responsible for what. Transparency is an issue because many aspects are held to be confidential in order to maintain necessary business secrets. There is no reporting we could find on the impact of reforms on the health of ancillary workers or on their work in health care delivery. There is little reporting on comparable costs or quality assessments of privatized ancillary work.

Ownership is integrally related to decision-making and accountability. Public facilities are responsible to governments and ultimately to citizens, creating at least the possibility for transparency and democratic control. Private organizations are responsible mainly to their members or their shareholders, making it possible to claim that much of the decision-making should be kept confidential and exclusive to those members of shareholders. When organizations need to make a profit over and above what they receive in funding, there is greater pressure to reduce costs. Given that by far the greatest expenditures in ancillary work are on labour costs, the pressure to reduce both the number of workers and their wages and benefits is greater.

Even if we understand accountability in narrowly accounting terms, the cost-benefit analysis of reforms in terms of ancillary workers is simply not done. Nor are there reports on the impact on their families, and the overall costs of this impact for the health system or the larger society.

Public Health

In the wake of SARS and threats of epidemics, public health has been identified as a priority area in health care. The World Health Organization (2005b:45) defines public health as "the science and art of preventing disease, prolonging life, and promoting health through the organized efforts of society". A public health perspective means "the health care workforce must be engaged in the full range of advocacy, disease prevention and health promotion activities relevant to the population served" (WHO, 2005b:45).

The public health movement of the nineteenth century focused on food, clothing, shelter and water. This was the period when regulations about the handling, preservation, preparation and inspection of food were introduced. Clothes made in infested tenements were recognized as contributors to diseases such as TB and union labels became a symbol of garments made in factories, rather than in households (Johnson and Johnson, 1982). Housing was identified not only as a problem for those getting clothes made there but also for those living there, as well as for those without homes. New regulations for tenements were introduced. Water and sewage systems were built and monitored. Records and recording also gained prominence as a health tool that allowed disease to be tracked and individuals to be treated (Jorland, Opinel and Weisz, 2005). A Royal

Commission on Capital and Labour investigated working conditions and wages, revealing both the discrimination against women and the role poor wages played in health. The knowledge gained about public health was applied in hospitals as well.

Nevertheless, very little of the discussion about public health focuses on the ancillary workers in facilities and households or on the role their work plays in preventing injury and illness. There is even less discussion about how their work injuries and illnesses can be prevented. In spite of the fact that the main strategies to prevent SARS involved ancillary work such as ensuring clean environments and accurate records, the focus remains on clinical aspects of care. And there is virtually no discussion of the health hazards faced in the household, even as more care is provided there.

Regionalization and Decentralization

All provinces, except Ontario, decentralized some decision-making in the 1990s. Regionalization of health authorities became the norm, and Ontario has recently moved in this direction as well. Provincial government retained the authority in setting standards, overall policies and budgets while regional organizations were held responsible for the management of services within their geographical areas (CIHI, 2005c:43).

On the one hand, regionalization brings some decision-making closer to those who need the services and allows programmes to be designed for local needs. It also creates the possibility of sharing services, such as laundry, across local facilities. On the other hand, regionalization means local authorities are left with the tough decisions about what to cut in response to provincial limitations on resources. Moreover, it is also up to these regional authorities to decide whether "to directly provide or contract out some services - such as meal services, laundry and cleaning for health care facilities - to for-profit companies" (Willson and Howard, 2002:221). Forced to find costs savings, many regions have looked to competitive bidding and the for-profit sector as a means of saving on labour. When Ontario regionalized home and long-term care services, it required competitive bidding and consideration of bids from for-profit firms.

While regionalization suggests not only local responses but also local impact, this is not necessarily the case under free trade agreements Canada has signed (Hankivsky and Morrow, 2004). When a local authority opens the market to for-profit provision, it may

be doing so for Canada according to international agreements such as the North American Free Trade Agreement (NAFTA). This could mean both that foreign corporations can bid on the contract and that it would be very difficult to return the service to the public sector if for-profit provision turns out to be a poor option.

Regionalization and decentralization thus has consequences for ancillary work. They may allow for the more effective organization of local services and their integration within the overall health care plan. But they may promote the separation of ancillary workers from other health care providers and encourage strategies that lead to deteriorating working conditions.

In sum, reforms in health care often ignore ancillary work, leaving them out of discussion linked to teams and integration, to evidence-based decision-making and accountability as well as pubic health. At the same time, ancillary work has been the focus of privatization strategies and defined out of care, even though a determinants of health approach would make them central to safe care. The contradiction can be linked to the failure to understand health care as different from other services and to the failure to understand that ancillary work is critical to care.

SECTION VI - CONCLUSIONS

This paper makes a simple argument. Those jobs described as ancillary play a critical role in health care and those who do this work are health care workers. Moreover, the health of these workers is integrally related to the effectiveness of care. The argument means applying a determinants of health framework within health care and recognizing that these determinants are interpenetrating rather than independent factors. A gender analysis helps us see how and why this works remains invisible and undervalued. Understanding ancillary work within the context of global developments reveals the forces contributing to the privatization of the work. Applying recent health policy priorities to ancillary work exposes the gaps in research and practice.

IMPLICATIONS FOR POLICY, RESEARCH AND OTHER ACTION

What, then, are the implications for action?

First, we need an active state.

On the basis of their research in long-term care, Jane Aronson and Sheila Neysmith (1997:61) argue that what is required to address the rights and responsibilities of both those who need care and those who do care work is an active state. This flies in the face of many global and national pressures but confirms the research on both health care and public health.

Active states, investing in public health systems, provide the most effective and efficient health care. Single, non-profit employers in health care services are in the best position to integrate ancillary and other care work in ways that promote health for both workers and those with care needs. The research overwhelmingly confirms the superiority of non-profit health services supported collectively through taxes and of employers in the public sector.

States are also in the position to legislate, monitor and regulate conditions for work and conditions for care. We need not only recognition of the skills, effort and responsibilities involved in ancillary work but also the establishment as well as the enforcement of standards for training, entry and conditions in this work.

However, it cannot simply be assumed that states always act in the best interest of us all or that states are always good employers. Indeed, although ancillary workers fare better in the public sector than they do in the for-profit one, they still too often face low pay, precarious employment and hazardous conditions. Neysmith and Aronson (1997:61) caution that "an active state would always be formulating policy among unequal participants with conflicting interests" and that such policy making is always a "huge challenge". In that challenge, the weakest frequently lose. The weakest are most often women and too frequently women identified as visible minority. New public management strategies mean that work is either contracted out to employers who lower pay and security or it stays in the public sector but has for-profit methods applied in ways that lead to deteriorating conditions for workers and care recipients. Keeping jobs in the broader public sector, in non-profit firms is a necessary but not sufficient condition for decent work and care.

We need better mechanisms to ensure that states and managers are accountable to both the public and to workers. This means greater transparency, which can only be attained if

health services remain in the public realm and the secrecy inherent to competitive contracts is avoided. It means more opportunity to influence health care decision-making, not just to receive more information on indicators chosen by governments. It also means recognizing and addressing the double or even triple workload women carry.

Second, we need better management.

Facing a shortage of nurses willing to take work as nurses, states and managers have started to look at the factors that keep people at jobs in health care. Although little attention has been paid to ancillary work or workers or to a gender analysis, many of the lessons from this nursing research can be applied to ancillary work. Other health care research is focused on sources for infections and errors in health care. A third area of research, in this case in the social science field, has examined the factors that contribute to healthy workplaces. It is time to bring all three together with a gender analysis in the management of ancillary work.

Managers should be trained not only in health care but also in the determinants of health related to both care and worker health. The two are centrally linked. According to the World Health Organization (2002), for example, infectious and bloodborne diseases are largely preventable with good management and staff training. Managing from the basis of such evidence means paying attention to the organization of work. "The design of jobs and how they are integrated into organizational systems provides the foundation for a high-quality workplace" (Koehoorn, 2002:8). Teams have been identified as essential to care work. In designing these workplaces, however, the focus has been on the medical and nursing staff. Good design, based on the evidence, would integrate ancillary work in these teams.

The evidence suggests as well that one of the best sources of information about workplaces is the people who do the work. Listening to workers, and acting on their advice, can improve both work relations and conditions for care. Ancillary workers account for as much as half of the health care labour force and they are often in a position to see what is happening on a daily basis in care, to see what may not be visible to others working in care. Their voices need to be there. As Phil Hassen (2005:9), President and CEO of the Canadian Patient Safety Institute explains, "Being able to report adverse

events without blame or retribution, to participate in addressing causes and to disseminate the lessons learned is part of the solution" to adverse events that cause injury and illness in health care.

Better management also means recognizing skills, teaching them in more formal ways and protecting these skills when work is reorganized. This requires resources, resources that can be understood as promoting health and preventing diseases for workers and care recipients. Particular attention should be paid to the skills and needs of those with disabilities and of older workers. Davezies (2003:273) argues that task shifting, which allows managers to adjust tasks to the particular skills and age of the worker can make it possible for older workers to fully contribute without injury. Such work shifting requires trust earned over longer term relationships and counters "managerial mobility policy which inevitably puts a greater focus on abstractly-defined work organization" (Davezies, 2003:274).

Equally important, states and managers need to promote employment security and decent conditions of work. High turnover creates high costs in terms of administration, continuity of care, training and workers' health. Based on their research with those who left work in homecare, Denton et al (2005:16) argue that the key to keeping workers is "good working conditions where employees have some predictability in their lives in terms of pay, hours of work and work scheduling". For these workers, such conditions not only provide the basics for survival but also indicate value we put on their work.

Good conditions are in turn related to good health. The high illness and injury rates in health care work come at a high price for the workers as well as for the system. They are the result of poor management, poor job design and poor working conditions, of precarious employment and lack of training, of no recognition, exclusion from teams and little control over work. The high rates can be addressed and reduced, with good management and state action playing a central role.

None of this will be possible if managers are not also educated about gender and about racism. As we have argued, the work force is profoundly gendered and raced. Without an understanding of the pervasive impact of gender and racism, managerial strategies are bound to fail, especially for women and visible minorities and especially in the long term.

Third, we need to promote unions.

The research is clear that all workers fare better with unions and this is especially the case for women (Jackson, 2005; White,1980, 1993). Unions not only help protect employment and conditions, they also give women the right to say no to unfair demands and to sexual harassment. Unions give women a voice and the capacity to enforce existing legislation, regulations and standards such as pay equity and anti-discrimination principles. Unions also allow management to deal with workers in a collective and consistent manner, promoting more stable work relations.

In recent years, government policy and managerial practices have been directed at reducing the role of unions. Workplace reorganization has meant that much of the existing legislation and regulations no longer apply. As a result, women are losing the protection provided in the past by unions and by labour standards. New legislation and regulations are required to address the gaps and to allow women to organize collectively to defend their rights. In the process of doing so, they can help protect those who need care as well by creating better conditions for care.

In promoting unions, it is equally important to develop strategies that take gender and racism into account. Unions have become increasingly conscious of the role they play and are making an effort to include such an analysis in their practices. Indeed, unions have played a central role in the adoption of anti-discrimination legislation and ensuring its application. Yet there is still a need to require a gender and racialization analysis. And as is the case with states, there is a need for measures to ensure unions are accountable not only to their membership but also to the public as well.

Fourth, we need more and better research.

Governments and researchers are promoting evidence-based decision-making. However, little research has been done in Canada on ancillary work. The research we have in Canada and from abroad often contradicts the direction of policy and practices. What we need then is more research that begins with a determinants of health approach within health care, recognizing the integral relationship among these determinants. This would mean making both gender and racialization critical components in research and in recommendations for action.

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[i] Calculated from The Labour Market in 2004 Perspectives on Labour and Income, 17(1): 54-68. Spring 2005, p.64.

[iii] There are variations in the number unionized because there are variations in the definition of ancillary.
[iv] This study is reported in a Proposal for the Development of a Pilot Project for Underemployed Foreign trained Nurses in the Lower Mainland from the Hospital Employees Union, Vancouver, May 2000.