

THE PAINS OF PRIVATIZATION

How Contracting Out Hurts Health Support
Workers, Their Families, and Health Care



by Jane Stinson,
Nancy Pollak and
Marcy Cohen

APRIL 2005



CCPA
CANADIAN CENTRE
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BC Office

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A companion piece to this paper, *The Hidden Costs of Health Care Wage Cuts in BC* by Marc Lee and Marcy Cohen, looks at the personal, family and organizational impacts of wage cuts in the health care sector.

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Summary and Key Findings

Since 2003, British Columbia has witnessed the most sweeping privatization of health support services in Canadian history. To date, 8,500 public sector jobs have been eliminated and the work contracted out. Pay rates for the affected positions have been cut by more than 40 per cent. The newly privatized jobs in BC hospitals and nursing homes are substandard in all respects: low pay, meagre benefits, heavy workloads, poor training, and no job security. The clock has been turned back on a sector that formerly offered good compensation, decent working conditions, and respectful teamwork.

The workers who perform these cleaning and food service jobs are usually women with children; many are immigrants of colour who also support family members abroad. They are a vulnerable group with few employment choices. The corporations who employ these workers are foreign owned and are global giants in their field.

This study investigates the experiences of 24 of these workers using qualitative, interview-based methods. The workers are employed in housekeeping and food service jobs in the Greater Vancouver area and represent the demographics of the workforce.

This study raises pointed questions about privatization: What does a society give up – and take on – when cleaning, laundry, food, and security services in health care facilities are outsourced to transnational corporations? What are the implications for the individual workers and their families? Are there hidden costs for patients, workers, and communities? If so, what are these costs, and where and how are they likely to surface?

The study concludes that conditions of work for these privatized workers are unacceptably harsh. In most cases, income from the job leaves families living below the poverty line. Contracting out not only endangers the health of these workers, but the well-being of their families and the patients they serve. Detailed findings are outlined below.

Economic and Ethnic Status

- Most of the workers interviewed were immigrant women born in the Philippines, India, and other countries of the south. The majority of them have post-secondary educational credentials that would qualify them for better-paying jobs but for systemic barriers that limit employment opportunities for internationally educated professionals. Many are over 45 years old and are concerned that their job offers no pension. A higher-than-average percentage are single parents compared with the BC workforce.
- A privatized health support job in BC is virtually synonymous with poverty. All but one of our study participants have serious income problems; more than three-quarters have incomes below Statistics Canada 2003 Low-income Cut-off (LICO). Single parents are automatically condemned to poverty by privatized wage rates. For example, a 47-year-old Indian-born woman, the sole support for her two daughters, earns \$1,426 per month at her hospital cleaning job. Her family is approximately 44 per cent below the 2003 LICO of \$30,744 per year.
- Housing is a critical issue for many: some have trouble paying their rent, others are coping only because they live in subsidized housing. Several workers live with their extended family to keep costs down. Many are unsure how they will survive in the short and long term. They talk about living hand-to-mouth, looking for additional work, or hoping for more hours.
- Over 40 per cent of participants have at least one other job to help make ends meet. Over half are sending money overseas to their children, siblings, parents, grandparents, nieces or nephews. They are determined to honour these family commitments, though they can ill afford to do so.

Working Conditions

- Almost all participants describe their workload as hectic, exhausting, and stressful. They deal with unpredictable assignments, frequent interruptions from remote call centres, and routine under-staffing when the company fails to replace absent employees. They often feel too rushed to work safely and take shortcuts that put them at risk for needlestick and other occupational injuries.
- Hours of work are problematic. Half of participants work between 20 and 37.5 hours a week, a twilight zone between full and part-time employment. Half are dissatisfied that the company does not offer them more hours: they need the money and resent being cut back by several minutes or hours a week, with no parallel reduction in workload.
- Relations with company supervisors are often strained. Many participants view their supervisors as unsympathetic, ill-informed, powerless, and unlikely to help with problem-solving. Many supervisors assign tasks without detailed explanations and cannot be relied on to provide training. Although relations with nurses and other facility staff are usually quite positive, privatization has introduced elements of distrust and isolation. Privatized workers are exposed to frustrations about corporate service quality; at least one company forbids direct communication with nurses and other staff, and disallows coffee breaks in the same room.

- The relationship between workers and patients/residents is sharply diminished under privatization. Three fifths of participants want more time for patients/residents, yet excessive workload eliminates time for contact and, in some facilities, the company prohibits talking with patients. The net effect is patients/residents with less human contact than before, and workers with few opportunities to express their caring nature.

Impacts on Workers' Health, Well-being, and Family Life

- Exhaustion, pain, illness, and injury are commonplace, with over four fifths of participants reporting that their physical health is adversely affected by the job. Their discomfort goes beyond a reasonable level of after-work fatigue. Soft-tissue pain, numbness, headaches, and other ailments were cited. Over 60 per cent of participants got sick or injured on the job (though three-quarters had been on the job less than nine months); almost half of them took time off due to these injuries. Others, however, were reluctant to stay home for fear of being dismissed. With no job security and substandard sick time – two days over six months, and no accumulation of unused days – it is not surprising that people come to work unwell.
- Their emotional and spiritual well-being is in decline. Three-quarters of participants describe feelings that range from depression to anxiety, powerlessness, frustration, and anger about their circumstances. Workload is the biggest cause of emotional distress; disrespectful treatment from supervisors is another key source. Among workers who are former in-house employees of their facility, many are dispirited by the severe drop in pay and benefits, loss of rights, separation from coworkers, and increased workload. The most common response to all these feelings was to bottle them up.
- The combination of heavy workload, insecurity, emotional stress, and inadequate income has repercussions for family life. Participants describe having little time for children and grandchildren, and being short-tempered or depleted at home. Several put a stop to their own or their children's educational plans due to financial problems. The majority are cutting back on fitness and recreation for their family; a quarter have dropped vacation plans. Almost all participants say their social and community connections have shrunk: low spirits and lack of money have placed friends and neighbours out of reach. Overall, the picture is one of challenged families, shrinking social participation, and involuntary exclusion from community.

This study concludes that conditions of work for these privatized workers are unacceptably harsh. In most cases, income from the job leaves families living below the poverty line. Contracting out not only endangers the health of these workers, but the well-being of their families and the patients they serve.

Consequences

- Unsatisfactory working conditions, poor remuneration, and no job security do not invite loyalty to the job. Over half the participants in this study are dissatisfied with their job, and just under half intend to leave within six months. In contrast, support workers in BC's non-privatized facilities demonstrate a high degree of job loyalty: 11.6 years on the job, on average. Privatization is a recipe for high staff turnover.

- At the same time, the corporations that create these sweatshop conditions are right to believe that an unhappy service worker is easy to replace. Social and economic conditions in Canada create a pool of workers, mainly female and often immigrants of colour, who have no choice but to accept wages and conditions that overtax their bodies and disrupt their families. That these factors are known to produce low morale and high turnover may not concern the corporations, but they should concern our health authorities.
- The factors that create overworked, unsupported, underpaid, and transient cleaning staff are also associated with cleanliness problems. This study is consistent with numerous others that link privatization to declining hygiene in health care facilities. Indeed, our participants expressed many concerns about the quality of service they are able to provide. Three-quarters do not believe their company employs enough staff to deliver good quality service. Many are dissatisfied with the on-the-job training they receive. (Unlike hospital house-keeping departments, private companies do not require new hires to have a Building Service Worker or equivalent college certificate.) Our participants described cleaners who are unaware of how to properly clean the rooms of patients with antibiotic resistant infections (i.e. MRSA, VRE). The exploitative and insecure nature of the work appears to be an obstacle to developing skills and competency.
- From a business perspective, high returns on investment in the service sector are predicated on low labour and supply costs. From a health care perspective, good quality services are predicated on well-trained and well-supported staff. The testimony of privatized workers gives a powerful clue as to the priority in BC today. Corporations are accountable to their shareholders, not to workers, patients, and local communities. The entrenched insecurity that workers experience is not an unintended by-product of privatization, but rather is directly tied to corporate goals of labour flexibility and low costs, in pursuit of the bottom line.
- Over time the financial costs of privatization will emerge. The costs of deteriorating standards of cleanliness in health care facilities are one dimension. Social services costs relating to the children and elderly parents of privatized workers are another. Staff injuries and illnesses are the most direct expense. Health support services are already the most absence-prone sub-sector in the Canadian workforce. From the evidence of this study, lower safety standards and decreased worker well-being are the unplanned offshoots of contracting out.

THE PROBLEMS IDENTIFIED IN THIS REPORT cannot continue unchecked. The government policy of contracting out health care support services is jeopardizing the health and well-being of workers, their families, and patients and residents in BC facilities.

The unspoken reality that allows for the degradation of these jobs is twofold: 1) service work is 'women's work,' and 2) many service workers are immigrants of colour. Privatization exacerbates the poverty trend among recent immigrants and immigrants of colour in Canada, in which relatively high levels of education are rewarded with low wages and insecurity. Governments have a responsibility to implement policies that reduce poverty and discrimination among working people, not policies that increase wage disparities and social exclusion while reinforcing historical patterns of sexual and racial exploitation.

Cheapening the role of support service workers is unwise. These workers deserve decent pay and working conditions. As a society we would do well to acknowledge the worth of the housekeepers, cooks, laundry workers, clerks, and security workers in our health care system.

Introduction

Since 2003, British Columbia has been the scene of the most sweeping privatization of public health support services in Canadian history. This study examines the impact of this contracting out on the lives of health support workers. It is an in-depth investigation into the conditions of privatized jobs and how the well-being of workers and their families are affected by these conditions. Our aim was to construct a human portrait of this untested and far-reaching change and to consider some of the broad social implications of outsourcing in BC hospitals and long term care (LTC) facilities.

Contracting out is often cited as a means for governments to do taxpayers a big favour: to reduce public costs by reducing the public payroll. The accuracy of this claim must be questioned, and this study asks some very pointed questions. What does a society give up – and take on – when cleaning, laundry, food, and security services in hospitals and nursing homes are outsourced to transnational corporations? On whose backs are savings, if any, achieved? Are there hidden costs for patients, workers, and communities? If so, what are these costs, and where and how are they likely to surface?

Privatization is life altering for both the person who loses the job (a relatively well-paid public sector job) and the person who assumes the job (a much less favourable position in a private company). In BC the persons caught in both ends of the privatization tangle are predominantly female, working class, and from racialized communities. Throughout Canada women are the vast majority of health care support service workers. In southwestern BC a sizeable percentage of these workers are women of colour from immigrant and non-immigrant backgrounds. Contracting out raises important questions about exploitation on the basis of sex, race, and immigration status. Although governments and employers may try to frame privatization as a straightforward business decision, it is, among many other things, a social justice issue.

The Background: Breaking Contracts, Making Contracts

The contracting-out wave that began in October 2003 was a result of the province's decision to downgrade health support jobs, ostensibly to bring wages and employment conditions in line with the hospitality sector.¹ The government was also looking for avenues to reduce public spending in the face of falling revenues due to costly tax cuts.

In January 2002, the province passed legislation that unilaterally removed job security and no contracting-out clauses from the collective agreements of thousands of health support workers. The *Health and Social Services Delivery Act* (Bill 29) was designed to free employers from their obligations to health care unions, primarily the Hospital Employees' Union (HEU), and thus pave the way for contracting out. Spurred by government cuts to their operating budgets, several regional health authorities and LTC facilities chose to lay off their in-house support staff and enter into outsourcing arrangements. The beneficiaries of these actions were the largest transnationals in the field today: Aramark, Compass, and Sodexo, based in the U.S., Britain, and France respectively.

Between October 2003 and July 2004, housekeeping services in all 32 hospitals in the Lower Mainland and southern Vancouver Island were privatized (see Table 1). Many of the same hospitals and some LTC facilities also contracted out their dietary, security, and laundry services during this period. (Not all regional health authorities or health care employers in BC chose the privatization route: the Interior and Northern health authorities did not privatize support services; the northern end of Vancouver Island was also left in-house.) By March 2004, approximately 6,500 housekeeping, food, laundry, and security workers affiliated with the HEU and the BC Government and Service Employees' Union had lost their jobs; another 2,000 were gone by July 2004.

This wholesale dismantling of in-house health support services has no Canadian parallel. The closest match is Alberta, where two of Calgary's four hospitals privatized their housekeeping services; however, Calgary chose to introduce changes over an extended period. In BC the rate and pace of change were stunning: 8,500 health care support jobs vanished from the public sector in under a year.

Health authority	Facility	Total number of facilities
Fraser	Burnaby Hospital, Chilliwack Hospital, Delta Hospital, Eagle Ridge Hospital & Health Centre, Fraser Canyon Hospital, Langley Memorial Hospital, Mission Memorial Hospital, MSA General Hospital, Peace Arch Hospital, Ridge Meadows Hospital & Health Care Centre, Royal Columbian Hospital, Surrey Memorial Hospital	12
Provincial	BC Cancer Agency, Children's & Women's Health Centre	2
Vancouver Coastal	Lions Gate Hospital, Mount St. Joseph's, Powell River General, Richmond Hospital, Squamish General, St. Mary's (Sechelt), St. Paul's Hospital, Vancouver Hospital, Vancouver Hospital (UBC Pavilion)	9
Vancouver Island	Cowichan District Hospital, Gorge Road Hospital, Lady Minto/Gulf Islands Hospital, Ladysmith & District General Hospital, Nanaimo Regional General Hospital, Queen Alexandra Centre for Children's Health, Royal Jubilee Hospital, Saanich Peninsula Hospital, Victoria General Hospital	9
Total facilities		32

In the United States, privatization of housekeeping services has been modest in comparison and geographically dispersed. A 2003 survey found that only 6.8 per cent of surveyed hospitals had contracted out their cleaning services, down from 27.4 per cent in 1999.² In Great Britain, where competitive tendering for support services was mandatory between 1983 and 2001, the private market controlled only 29 per cent of housekeeping, 13 per cent of food services, and 7 per cent of laundry services in 2003.³ Since then, many of these privatized services have been brought back in house. British Columbia's headlong rush into contracting out is not only unprecedented but out of step with jurisdictions that attempted and then reversed their privatization experiments.

"Voluntary Recognition Agreements:" No Choice for Workers

Prior to hiring any workers, the three corporations went looking for a union ally. Their intention was to make a pre-emptive move against the HEU, should it seek to organize the privatized facilities. A partner was found in Local 1-3567 of the Industrial, Wood and Allied Workers (IWA). The parties signed "voluntary recognition agreements," which set down the terms and condition of employment before the new workforce was in place.⁴ Armed with the partnership agreements, the companies recruited staff at regional job fairs. Individuals were interviewed by company officials and then sent to an IWA Local 1-3567 information session in an adjoining room, where they were expected to sign a union card before being hired. The majority of the new hires were not from among the recently laid off HEU workers.

Losing Ground on all Fronts

Not surprisingly, these blatantly *involuntary* partnership agreements between Local 1-3567 and the companies had a number of negative features. The agreements run for six years, unlike the typical labour contract of two to three years' duration. The 2003 Aramark/IWA Local 1-3567 agreement for health care started a housekeeping aide at \$9.50/hr, rising to \$11.21/hr after six years.⁵ The median wage for housekeeping aides across the three IWA Local 1-3567 agreements with Aramark, Compass, and Sodexo was \$10.25/hr.⁶ In comparison, the wage for the same job under the HEU's Health Support Subsector collective agreement was \$18.32/hr – 79 per cent higher than the privatized rate.

Contracting out effectively wiped out more than 30 years of pay-equity gains for British Columbian women in health housekeeping jobs.⁷ Further, the province went from being a national leader in pay rates for health support services to being the lowest in the country, significantly lower than the Canadian average. In 2003, a privatized cleaner in a BC hospital was earning 26 per cent less than the national average union wage for the job.⁸ This decline in income is especially punishing in light of the high cost of living in Vancouver, where housing costs are steeper than anywhere else in the country.⁹

ENTRENCHED INSECURITY: Benefits in the IWA Local 1-3567 agreements were also sharply reduced in comparison with the original facilities agreement. Outright losses included the elimination of pension, long-term disability, and parental leave provisions. Vacation, sick time, medical, and dental benefits were pared back.¹⁰ Sick leave under the HEU contract was 1.5 days per month for regular full-time employees, accumulating up to 156 days. Under the Aramark/IWA Local 1-3567 agreement, sick leave was two days per six-month period, with no accumulation. Similarly, premiums for medical, dental, and drug coverage, fully paid by the employer under the HEU contract, were cut back to minimal dental and extended care coverage in the IWA Local 1-3567 agreements, with the worker paying 30 per cent of premiums.¹¹

BC went from being a national leader in pay rates for health support services to being the lowest in the country. This is especially punishing in Vancouver, where housing costs are steeper than anywhere else in Canada.

Part-time workers were the biggest losers. Employees working fewer than 20 hours a week had no benefits, unlike under the HEU contract, which extended pro-rated coverage to part-timers.

Finally, the language in the IWA Local 13567 agreements eliminated scheduling based on seniority, guaranteed hours of work, input into worksite transfers, and job security. Again, the HEU contract had favourable language on all these matters (excepting job security, which was terminated under Bill 29).

The outcome of these bargain-basement agreements is a badly paid, poorly protected, and highly insecure workforce. In 2005, a full-time cleaner working for Aramark will earn \$400.13 a week, or about \$20,800 a year. If she were to fall sick and stay home for more than two days in a six-month period, her paycheque would be docked. If her child were to need braces, she would pay the full amount out of her own pocket. If her manager were to transfer her to another facility – perhaps far from a bus route – she would face a tough choice: transfer or quit.

The HEU challenged the IWA Local 1-3567 agreements as a violation of workers' right to choose their own trade union, at the BC Labour Relations Board (LRB), and in May 2004 the first of these agreements was ruled invalid.¹² The HEU also launched member-to-member organizing drives in each worksite as soon as the new workforce was in place. The drives have been highly successful. By June 2004, when the interviews for this research were being conducted, HEU had filed applications for certification in the three health regions in the Lower Mainland. There were, however, a number of sites where HEU's applications for certification were still pending at the LRB and there were no negotiations between HEU and the contractors.

As a consequence, during the period of this study the IWA Local 1-3567 contracts were the *de facto* terms and conditions of employment. The personal and societal consequences of working under such precarious conditions are the subject of this report.

Outright losses included the elimination of pension, long-term disability, and parental leave provisions. Vacation, sick time, medical, and dental benefits were pared back.

Study Objectives and Methods

The primary objective of this study was to gain an intimate understanding of how a privatized job actually looks and feels in workers' lives. We also wanted to give public voice to the experiences of support service workers, mainly women and visible minority immigrants, whose daily contributions to Canada's health care system are largely invisible and often misrepresented as inessential. To do so, we investigated many dimensions of our participants' lives, from their physical health and emotional well-being, to their family relationships and community involvement. Four major questions were posed:

1. Health and well-being of workers: How do the working and employment conditions of privatized jobs affect the health and well-being of workers? Questions were asked regarding workload; job strain (issues of demand, control, and support); training; job security; number of work hours; scheduling; relationships with supervisors and co-workers; and compensation such as wages, benefits, and sick time.
2. Family, social, and community life: How do working conditions and wages affect the home and community life of workers and their families?
3. Sex, ethnicity, and immigrant status: What, if any, is the relationship between privatization and workers' sex, ethnicity, and immigrant status?
4. Quality of service and care: How does the privatized work environment affect workers' ability to provide good quality service?

This is a qualitative, interview-based study that uses a purposive, non-random and illustrative 'typical

case' sampling strategy. Our 24 participants were employees of Aramark, Compass, and Sodexo, performing housekeeping and food service jobs in various health facilities in the Greater Vancouver region. They were selected to reflect the demographics that characterize this privatized workforce regarding age, ethnicity, sex, and family status; thus they were mainly female immigrants, middle-aged and with dependents. We also chose a mix of newcomers to health care and former in-house workers (and former HEU members), to compare the responses of the two groups. Our aim was to determine whether workers with prior experience had noticed differences in employment conditions, training, quality of care, and other factors before and after contracting out. We were also curious whether attitudes and expectations about the job would vary between new and seasoned workers.

Our primary research instrument was a face-to-face interview of about two hours' duration, using a structured survey with both closed-ended (pre-coded) and open-ended questions (see Appendix 2). Interviews were taped by a researcher between June and August 2004, usually at the worker's home or a setting of his or her choice. The tapes were transcribed and the responses transferred to tables for statistical and qualitative analyses.

To find a suitable pool of subjects, we asked HEU organizers to solicit candidates at worksites where the union was conducting organizing drives. The individuals who expressed interest were among the majority who signed with the HEU; although they were not necessarily union activists, they were willing to speak about their working conditions under condition of anonymity.

	Other health support service workers^a	Privatized workers (24)
Female	83%	79% (19)
Workers under 45	41%	50% (12)
More than one job in health care	6%	21% (5)
Another job not in health care	3%	21% (5)
Total with more than one job	9%	42% (10)
Financially support children/adults outside home ^b	17%	67% (16)
Dependant children ^b	46%	67% (16)
Dependant adult ^b	28%	58% (14)
Total with dependants ^b	65%	88% (21)
Single parents	10%	25% (6)
Identify as visible minority	37%	75% (18)
Language other than English as first language	36%	(not available)
Born outside Canada	43%	88% (21)

^a Based on Hospital Employees' Union "Member profile survey" (2002).
^b Includes children and adults living abroad to whom contract workers send support money.

Profile of Participants

The majority of our 24 participants were immigrants (88 per cent, 21/24) and female (79 per cent, 19/24). The percentage of females parallels the gender composition of the HEU workforce in 2002, though our sample is more predominantly immigrant and visible minority (see Table 2).¹³ Similarly, our sample is somewhat younger than the HEU population: 50 per cent of our participants were under 45 years old. The majority (88 per cent, 21/24) were supporting family members, either children, adults, or family overseas. Among the immigrants, most were supporting their immediate family in Canada and their extended family overseas.

In most cases our participants were the primary “wage earner” in their household. A third of the women were married, another third were divorced. On average, our female participants tended to have lower family incomes (below \$2,000/month) than our five male participants. For the minority of women living with a partner, their spouse generally worked full time and sometimes at more than one job. It was unusual, however, for the spouse to have employment benefits or a pension plan.

The majority of our participants (71 per cent, 15/21) were people of colour, all but one of whom was an immigrant. Almost half were from the Philippines, almost a quarter from India. Other participants had emigrated from the United Kingdom, Central America, the South Pacific, Asia, and Russia. For the majority, English was not their first language.

About half of our participants arrived in Canada before 1991. Other studies that analyze income and earnings for immigrants based on their time in Canada have shown that more established immigrants (pre-1991) tend to improve their income over time.¹⁴ We found a similar pattern within our sample: established immigrants (pre-1991) had higher family incomes than newer immigrants.¹⁵ The majority of newer immigrants were 45 years old or less, while the reverse was true for established immigrants.

The majority of our participants had post-secondary education; 71 per cent (15/24) of the immigrants had university- or college-level education, fairly evenly divided between early and more recent immigrants. Three immigrant workers had graduate degrees. The immigrants tended to be more highly educated than the few Canadian-born individuals in the study.

Ten of our 24 participants (42 per cent) were former in-house health care workers and former HEU members.

A stark picture emerges of these workers’ personal circumstances. They have heavy family responsibilities (both in Canada and abroad) and limited employment options. Most of them are vulnerable by virtue of being women and immigrants from Asia. The majority are mothers, and a sizeable percentage are single parents who work more than one job. All these factors help to explain why they may have felt compelled to take a job that offers so little by way of wages, security, and respect.

THE WORK: Almost three-quarters of our participants worked in hospitals (17/24), the other quarter in long term care facilities (6/24). Most participants (20/24) worked in a variety of housekeeping jobs, the rest in food services (see Table 3).

The women housekeepers were usually assigned to clean resident rooms, beds, and common areas such as hallways, dining areas, and offices. Their duties included disinfecting isolation rooms, which meant exposure to antibiotic-resistant organisms such as MRSA (methicillin resistant *Staphylococcus aureus*), *Clostridium difficile* (*C. difficile*), and VRE (vancomycin resistant *enterococcus*). Others had more specialized duties such as cleaning and disinfecting the surgery lab, using heavy machinery to strip and varnish floors, or shampooing carpets. Other cleaning assignments included working in palliative care rooms and doing terminal cleaning of discharged or deceased patients’ rooms. One participant was a housekeeping supervisor who organized the cleaning schedule, trained workers, and operated the floor machines. Another was a lead-hand housekeeper who “did everything” in a multilevel LTC facility.

All five men worked in hospitals as housekeepers. One man worked as a waste runner (picking up garbage throughout the hospital), another did heavy cleaning (handling large garbage containers, mattresses, equipment and supplies, and machine floor cleaning); another was on call to clean up spills (toxic, blood, urine) and to collect sharps (needles), blood from operating rooms, and bio-hazardous waste; and the fourth man cleaned the emergency department.

Among the food service workers, three were dietary aides. Their duties included working in the dining area of an LTC facility, setting tables, ferrying food up from the kitchen, serving from a steam cart, returning dirty dishes, cleaning tables and chairs after meals, and mopping the floor. A production line worker in a hospital did general help to prepare sandwiches and salads for the hospital's food shop and for outside catering. Another woman worked as a cashier and server in a retail food outlet in a hospital.

Structure of This Report

The remainder of this report is divided into five major sections. The first four discuss the key findings from the interviews and related research: 1) working and employment conditions; 2) impacts on workers' health and well-being; 3) impacts on family, social, and community life, and 4) impacts on BC's health care system. The final section examines the wider implications of privatization, including public accountability and social justice issues.

Table 3: Employment Characteristics of Participants	
Type of facility	
Hospital	71% (17)
Long Term Care	25% (6)
Both	4% (1)
Contract company	
Aramark	46% (11)
Compass	29% (7)
Sodexo	25% (6)
Occupation	
Housekeeping	83% (20)
Food Service	17% (4)
Duration of current employment	
Less than 6 months	29% (7)
6 to 9 months	46% (11)
10 to 12 months	25% (6)
Lost former in-house health care job to contracting out	
Yes	42% (10)
No	58% (14)
Duration of employment before losing job to contracting out	
Less than 6 years	33% (3)
6 to 9 years	44% (4)
11 to 15 years	22% (2)
No response	(1)

Working and Employment Conditions

Workload: Intense, Exhausting, and Hazardous

Health care facilities are demanding workplaces. Even in the best of circumstances, cleaners and food service workers are lifting, bending, reaching, carrying, and exerting themselves in a constant stream of physical tasks. Clearly, a reasonable pace of work, regular breaks, and support to work safely would be essential to avoid pain and injury.

Yet many participants in this study described their work as demanding to the point of exhaustion. The majority (92 per cent, 22/24) rated the physical demands of the job as very high, and all agreed that their work required a lot of physical effort; 83 per cent (20/24) were adamant on this point. Most reported not having enough time to get their assignments done; many were unable to finish tasks without skipping breaks or lunch. Supervisors pushed them to work faster, often because the company had failed to replace an employee who called in sick. Frequent turnover also contributed to heavier workloads, with staff being expected to orient, train, and assist new workers.

Key points about workload:

- 100 per cent of participants felt their job was very hectic
- 92 per cent (22/24) rated the job's physical demands as high or very high
- 79 per cent (19/24) felt too rushed to work safely; 33 per cent (8/24) felt this at all times
- 50 per cent (12/24) said excessive workload was the prime cause of job stress

Many people complained of physically heavy, irregular, and unpredictable workloads. Being at the mercy of pagers and call centres was a particular source of stress. (Under privatization, cleaners are often assigned tasks via off-site call centres.) Housekeepers were notified to immediately clean a room after a patient discharge or to attend to another part of the hospital, yet were expected to also fulfil their regular

duties. One hospital worker had no set routine and was simply assigned task after task by the call centre. All participants felt their job was hectic, with 79 per cent (19/24) saying it was extremely so.

Key causes of work overload:

- variable and unpredictable work assignments
- frequent requests from call centres and pagers, on top of scheduled duties
- high staff turnover that necessitated training and assisting new workers
- an onerous regular workload

Training and assisting new workers was another cause of work intensification. A dietary worker in an LTC facility described usually feeling “like a chicken without its head. Always juggling things. Watching [new] co-workers to ensure safe practices.” High turnover meant the demand for training was constant, and the new hires needed a lot of guidance due to inadequacies in the corporate training program.

Several workers were able to get their job done only by sacrificing their breaks. “For the last couple of months I haven’t taken the last 15-minute break,” said a dietary worker. A cleaner said “if I take my 30-minute lunch break, I will never finish the job. I either stay longer or rush to get it done.”

Fear of being fired created pressure to finish the assigned tasks, regardless of the load. A housekeeping supervisor observed that “if the work is not done, you’ll be fired because of complaints from hospital staff.”

Pressure from supervisors was another source of workload stress. An experienced health care worker described how her supervisor was “always at your back, watching you, you can’t relax; it boiled me.” Another was equally blunt: “The contractor pushes us to do too much. It’s abusive.”

More women than men rated the physical demands of their job at the highest possible level. They were also more likely to say they had insufficient time to get their work done and felt they had too much work. This difference may be due to the fact that the men had jobs with set routines and some autonomy – waste handlers, for example, who moved from floor to floor – and were not subject to the same pressures regarding short staffing and being pulled off one task to do another. Notably, no-one – male or female – agreed that their workload was about right.

Many participants in this study described their work as demanding to the point of exhaustion. Most reported not having enough time to get their assignments done; many were unable to finish tasks without skipping breaks or lunch.

Staffing Levels: Not Enough Workers to Get the Job Done

Official staffing levels are one thing. How many people actually work on a shift is another. Our research shows that short staffing – fewer workers than regularly scheduled – was a commonplace occurrence for our participants. Working shorthanded has many negative consequences: intensified workload, higher stress, greater risk of injury, and a potential drop in service quality. At the same time, the company benefits by saving money on a smaller payroll.

Key points about staffing levels:

- 75 per cent (18/24) of participants had worked short staffed in the previous month
- 38 per cent (9/24) said they always worked short staffed
- 75 per cent (18/24) believed the contractor didn’t have sufficient staff to provide good quality service

Short staffing usually happens when the contractor fails to replace a worker who calls in sick or quits. Some workers reported that people regularly called in sick, and management expected the others to just pick up the extra work. One housekeeper believed the contractor “didn’t hire enough people to replace those who call in sick.” A male waste runner said short staffing used to occur every weekend at his hospital but was getting better: “The supervisors kept quitting from stress.”

Short staffing often meant being too rushed to work in a safety-conscious manner. “At training I was told there would be two people,” said a housekeeper. “Now, there’s just one. I’m worried I could be injured at night and no-one would know. It happened elsewhere.”

Short staffing often meant being too rushed to work in a safety-conscious manner. “At training I was told there would be two people,” said a housekeeper. “Now, there’s just one. I’m worried I could be injured at night and no-one would know. It happened elsewhere.”

A former supervisor thought the company made a conscious, cost-saving decision not to employ enough staff on weekends. Short staffing was allowed, she said, “because there was no WCB, no authorities in place, therefore the company can force people to work improperly. They used on-call workers. They used anyone including people not trained to work in the emergency department or operating rooms.”

Short staffing due to sickness didn’t happen everywhere. “People are scared to call in sick,” said a cleaner. “If you’re sick, you must provide a doctor’s note.” Yet in another facility, some workers were believed to phone in sick as a protest against schedule changes by the contractor. “It’s so bad, people don’t want to go in,” said a dietary worker.

Contract workers weren’t the only ones who felt the burden of understaffing. A cleaner in an LTC facility noted that nurses and patients complained a lot when sick workers were not replaced.

Income and Benefits: Inadequate Pay, Insecure Lives

Not surprisingly, privatized jobs that offer low wages did not provide adequate income for our participants. The shortfall between effort and reward was dramatic. Only one worker reported that her income was somewhat adequate; she was a supervisor who earned \$15.00/hr. All others reported serious income problems with real consequences to themselves and their families.

Key points about income and benefits:

- 96 per cent (23/24) of participants said the job’s income was inadequate for their family needs; 83 per cent (20/24) said very inadequate
- 78 per cent (18/23) had incomes below the LICO poverty line
- 42 per cent (10/24) had at least one other paid job, to help make ends meet

Workers were harried by the inadequate wages, irrespective of whether they had dependents. Many were unsure how they would survive in the short and long term. They talked about living hand-to-mouth, looking for additional work, or hoping for more hours. “I can’t live off \$10 an hour,” said a young, single food service worker. “I’m lucky to be still at home. I live paycheque to paycheque.” Many workers were aware that they were undervalued, which heightened their stress at work. “It’s not much, only \$10.50 an hour for working so hard,” said a 52-year-old Filipina worker who cleaned a hospital on the night shift. Some former in-house workers found themselves in general financial peril due to being laid off, unemployed, and hired back at much lower pay and benefits – often for doing the same job.

It is almost impossible for a housekeeping aide or dietary worker in a privatized health support job in British Columbia to achieve earnings above Canada’s Low-Income Cut-off (LICO) standard, unless

they are a full-time employee with no dependents.¹⁶ Table 4 offers evidence of how precarious their financial circumstances are: 78 per cent (18/23) of our participants fell below the 2003 poverty line. In British Columbia, a privatized health support job is virtually synonymous with poverty.

All single parents had wages below the low income cut-off. For example, a 47-year-old Indian-born woman, the sole support for her two daughters, earned \$1,426/month at her hospital cleaning job. Her family was approximately 44 per cent, or \$13,632 a year, below the 2003 LICO.

Housing was a critical issue for many workers. Some had trouble paying their rent. A divorced woman in her 50s said she was okay financially but only because she lived in subsidized cooperative housing. A male cleaner supporting three young children lived in public housing. Another cleaner had sold her home. Another woman described how her family had moved to a one-bedroom apartment after she and her husband lost their health care jobs. They slept with a curtain between their son's bed and their own, a situation she found very difficult.

Several workers were living with their extended family to keep housing costs down. A 22-year-old dietary worker, living in her parent's home, was paying only half the requested rent in order to afford her car and cell phone. A 46-year-old cleaner bluntly said she'd be out on the street if her home weren't family owned.

Importance of Benefits

Benefits are almost as important as hourly wages to workers, and several of our participants volunteered comments about their frustration with the contractors' paucity of benefits. And yet the fact that the contractors offered *any* benefits at all was attractive to several workers, which underscores their significance. Only three participants (13 per cent) had health benefits under a spouse's plan. One cleaner chose

Table 4: Privatized Workers Below 2003 Poverty Line (LICO) by Family Size and Type

Family size	2003 poverty line (LICO)	Total % and no. below LICO	Single- parent families below LICO	Two- parent families below LICO	Single, separated, or married no kids below LICO
1	\$19,795	57% (4/7) ^a	-	-	57% (4/7)
2	\$24,745	100% (3/3)	100% (2/2)	100% (1/1)	-
3	\$30,744	75% (3/4)	100% (2/2)	50% (1/2)	-
4	\$37,253	100% (6/6)	100% (1/1)	100% (5/5)	-
5	\$41,642	50% (1/2)	-	50% (1/2)	-
6	\$46,031	100% (1/1)	-	100% (1/1)	-
Total		78% (18/23)*	100% (5/5)	82% (9/11)	57% (4/7)

^a Excludes one worker who was no longer employed by the company. Note: The LICO is calculated by Statistics Canada for various family sizes. The LICOs cited here are for families residing in a major city.

to work for his company precisely because some benefits were available; he was irritated to have seen none so far. Another cleaner with the same company said the employer had lied about the level of benefits at her hiring.

A food service worker with another company viewed her extended health benefits (at 70 per cent coverage by the employer) as the only good thing about her company. Yet another worker with the same contractor, a single mom with two kids, had not bothered to sign up because the benefit plan was so poor. She had been an HEU member and knew a good plan, and this was not, in her view, a good one.

Several workers volunteered their concern about the lack of a pension plan. A Filipina woman in her 50s was conscious of having no family nearby to support her in old age. “Your wages are flat. You worry about the next day, worry about being older,” she said. The low level of sick days was another concern (two days every six months, with no accumulation of unused days). A cashier in a hospital was well aware that the sick leave provisions in the HEU contract had been superior.

The Need for Another Job(s)

The inadequacy of income was demonstrated by the fact that almost half (10/24) of our participants had at least one other job; four among them had more than one. Proportionally more men than women were likely to have another job.

Both full-time and part-time workers held multiple jobs in equal proportion, which suggests the difficulty of making ends meet even with a full work week. But former in-house workers, who lost their jobs to contracting out, were twice as likely to have other jobs than workers new to health care.

Number of Work Hours: Dissatisfaction is the Norm

Half of our participants were dissatisfied with the number of work hours offered by the company. Their dissatisfaction had a single source: they wanted and needed more hours to survive economically. Many dealt with the shortfall by taking a second or third job elsewhere. Even a few workers with full-time employment (37.5 hrs/wk) expressed the need for more hours (see Table 5).

Table 5: Hours of Work/Number of Jobs	
Hours of Work	
Full time – 37.5 hours/wk	33% (8/24)
Over 20, less than 37.5 hours/wk	50% (12/24)
20 hours/wk and less	17% (4/24)
Number of Jobs	
One job	54% (13/24)
One other job	25% (6/24)
More than one other job	17% (4/24)
Unemployed	4% (1/24)

Key points about number of work hours:

- 50 per cent (12/24) of participants were dissatisfied with their hours and wanted more
- 50 per cent (12/24) worked between 20 and 37.5 hrs/wk – a twilight zone between full and part-time employment
- 33 per cent (8/24) had full-time hours (37.5 hrs/wk)
- 29 per cent (7/24) were just shy of full time (36.25 hrs/wk), which they resented

Our participants had work hours ranging from 7.5 hrs/wk (one shift) to 37.5 hrs/wk (full time). The full-time norm in British Columbia's health care sector is a 37.5-hour week. Many workers saddled with the reduced 36.25-hour week had fully expected to work standard hours, and were angry and upset they were not. They needed every extra dollar, given the very low wages. The shrunken work week – 75 minutes short – represented a broken promise, which contributed to their disillusionment with the job. Some workers saw the reduced week as nickel-and-diming employees while the company lined its own pockets.

In some cases, workers started at one level and saw their hours whittled back. A male cleaner described his experience:

When I was hired I was told it would be an eight-hour shift. After that I go to work and was told my hours are 7.5 a day... Then they cut five minutes again. Now they're at 7 hours 25 minutes a day. With 600 employees, [the company] is saving five minutes each – calculate how much that is. Everyone says it's okay. It's not okay!

Reduced vacation entitlement was another consequence of reduced working hours (days off are calculated by hours worked, not weeks). One worker was very upset to discover the impact on his vacation time – and holiday plans – of working less than the full-time hours he had been promised. “It takes a lot longer to get the proper amount of time off,” he said. Despite talking to the company about getting extra time, “they would not budge.”

Many workers saddled with the reduced 36.25-hour week had fully expected to work standard hours, and were angry and upset they were not. They needed every extra dollar, given the very low wages.

Work Schedule: Making it Work, Despite Little Choice

Health care staff are often required to be available to work shifts around the clock, seven days a week. Having some choice about one's schedule is important to avoid conflicts with family responsibilities, especially for the mothers who make up the majority of these service workers.

Key points about scheduling:

- 64 per cent (14/22) of participants had no choice or input into their work schedule
- 52 per cent (12/23) had a schedule that caused problems with family responsibilities

A very small number of our participants had some input or flexibility when it came to choosing a shift or rearranging their schedule. Former in-house workers were more likely to say they had no say about their timetable than were new health care workers. This difference likely reflects the greater influence that experienced staff had enjoyed through the HEU collective agreement, which recognized bidding rights on shifts based on seniority.

Workers were unhappy about their schedules for a variety of reasons: family obligations; lack of public transit on weekends; and unpredictable hours that made it hard to attend church meetings or have a social life. One cleaner believed her supervisor was guilty of favouritism, giving preferred shifts to preferred

workers. Three women had waited months for a regular Saturday off or for both weekend days, so they could spend time with their children or elderly parents. A male housekeeper refused to work weekends because he wanted to take his son to hockey practice; he demanded that the company live up to the shifts he had indicated on his job application, which excluded weekends. He was aware of the risk of getting fired; his supervisor as much as threatened him when he refused the weekend shift and then harassed him for weeks afterwards.

Working Relations: Not Always an Easy Road

Good working relations among co-workers can make the difference between a bearable and unbearable job, especially in a high-pressure environment like a hospital. When jobs are privatized, the notion of “co-worker” changes radically. Cleaners who were once hospital employees now work for a private company; they no longer attend a common staff meeting or partake of shared organizational values, culture, and benefits; they may no longer eat together in the same lunch room.

We wanted to determine how co-worker support was affected by privatization and so examined three relationships: with company supervisors, with other company employees, and with facility staff such as Registered Nurses (RNs) and care aides. Responses varied according to the relationship, but general questioning gave rise to a picture of less-than-harmonious working conditions.

Key points about work relationships:

- 63 per cent (15/24) of participants faced conflicting demands from other staff
- 58 per cent (14/24) felt exposed to hostility or conflict from other staff

Supervisors: A Troubled Link Between Company and Worker

Supervisors play a significant role in either helping or impeding workers’ ability to do their job. Their support may be moral or practical. But a supervisor can also make things worse by pressing workers to work faster or by failing to provide assistance. Indeed, the interactional style of a supervisor, such as their capacity for fairness and collaboration, is known to affect the blood pressure of their staff,¹⁷ and support (or lack thereof) from supervisors is associated with neck and shoulder pain.¹⁸

Key points about the relationship with supervisors:

- 61 per cent (14/23) of participants did not find their supervisor helpful
- 74 per cent (17/23) said their supervisor did not deal with work problems
- 42 per cent (10/24) said their supervisor was a major source of workplace stress
- 39 per cent (9/23) never felt appreciation or respect from their supervisor

Very positive comments were made about some supervisors, but this was the exception. Almost half of our participants (42 per cent, 10/24) viewed their supervisor as unsympathetic and a major source of stress. Feeling pushed to work faster and being unfairly scrutinized were frequent complaints. “The supervisor won’t listen to why the job is not done,” said an experienced hospital cleaner. “We have difficult situations and unreasonable deadlines. They don’t understand the difficulties of [this] dirty and dangerous job.”

A common concern was that supervisors seemed poorly informed, even untrained, regarding the work. Some supervisors appeared to be “over their heads”; others were virtually invisible because they never left the office, only used pagers, never checked up on the worker, or provided direction by merely handing

out a list of things to do. Not only were supervisors unhelpful, they sometimes needed help themselves. A male cleaner described a situation in his hospital:

One day the supervisor asked me for help doing MRSA [antibiotic-resistant organism] in the Intensive Care Unit... She was upset because she didn't know how to do it. I thought the supervisor would know how to do everything. She left crying, stressed out by the pager constantly ringing. What kind of supervisor is that?

Most workers did not think their supervisor was willing to listen to problems with the work assignment. Worse, a clear majority of participants did not think their supervisor would take steps to deal with problems. Workers noticed that, even among supervisors who tried to act, their relative lack of power was apparent: supervisors would blame higher management or company policy.

There was a high turnover rate among supervisors. Over half our participants (54 per cent, 13/24) had seen a change in supervision since starting the job, which for the majority was at most nine months earlier. A male waste runner had six supervisors in his 10 months of contract work; a female cleaner had four changes in three months. A few workers believed that supervisors quit because they couldn't take the pressure themselves.

COMPARING THE OLD AND THE NEW: Former in-house workers were asked to compare their previous experience of supervision with their current experience. All but one said the company's supervision was worse, citing less cooperation and hands-on assistance. One cleaner explained that her old supervisor "could always be reached with any question or problem. They provided more training and had a reminder training session after three months... They cared about us and understood our injuries." Some workers sorely missed their former supervisor; one said:

I loved my old supervisor... We used to be like a family. Not afraid, no stress, nothing. At work now I'm scared inside all the time, very nervous and scared.... When my [old] supervisor called me to do discharges and other things, he always said 'please can you do this?' The way they talk in a family. But now it's changed. They just call us like we are slaves.

A common concern was that supervisors seemed poorly informed, even untrained, regarding the work. Some supervisors appeared to be "over their heads."

Co-workers: Good Relations – and Friction Too

In contrast to their relationships with supervisors, most participants felt appreciated and respected by co-workers with the same contractor. Former in-house workers were less enthusiastic: just half shared this view. But in general, workers felt good about their co-workers, saying they helped and supported each other, worked side-by-side, acted like a team, and were friendly.

Key point about relationships with immediate co-workers:

- 71 per cent (17/24) of participants felt appreciated and respected by their co-workers

There were acts of solidarity in the face of difficult working conditions. "Others appreciate when I speak out for them," said a woman cleaner. "We have rights.... I don't care if they lay me off. I have to stand for my rights. Some just take it." A male Filipino relief cleaner was concerned that a male supervisor was discriminating against female Filipina cleaners, and spoke to him on their behalf (to no avail).

Those who felt a lack of respect and appreciation from co-workers talked about distrust, competitiveness, back-stabbing, and gossip. There was also talk about cliques drawn along ethnic lines. For at least one former employee, working at her old facility, this ethnic split was a new and distressing feature caused by the stress of privatization.

Fractured Relations with Facility Staff

A mixed picture emerged regarding the relationship between contract workers and in-house staff (nurses, care aides, and others). On the one hand, the majority of our participants felt appreciation and respect for their work; all the men reported a positive experience here. Nurses would show gratitude in different ways, such as praising a good job, joking together, or sharing food.

Key points relating to relationships with nurses and other facility staff:

- 71 per cent (n. 17) of participants felt appreciated and respected by other staff; 46 per cent (n. 11) felt this strongly
- 38 per cent (9/24) felt isolated from nurses; 25 per cent (6/24) felt very isolated

At the same time, concerns about privatization were affecting the relationship. Some workers felt the nurses appreciated their work but were unhappy with the overall quality of housekeeping. “Nurses empathize that we have too much work,” said a cleaner, “but still get frustrated if the work is not done properly.”

A lead-hand housekeeper described how the company forbade direct communication with nurses and other staff, and physically segregated workers by disallowing coffee breaks in the same room. Another cleaner said “the manager is always transferring you to different departments because they don’t want you to be nice or close to them.”

Many workers reported getting a rocky welcome when they arrived as the newly privatized workforce. “They hated us when we first came because they knew the past workers,” reported one worker. A former employee who returned as a contract worker described how it was “odd at first for myself and them but we talked. We both got used to it. The pain was there. I was kind of a traitor. ‘Why did I go there?’ But I explained to them that I don’t have a choice.”

A female, immigrant housekeeper, new to health care, had been deeply hurt by ill-treatment by nursing staff:

We’re not part of the team. They think we are ignorant, no education... [They] hurt you as a person because they don’t like the changes. Said it was your fault this happened. If you didn’t apply for the job, the government would see the problem. They felt housekeeping was better before. After five months someone finally responded to my hello.

Policies of contractors exacerbated the fractured relations. A lead-hand housekeeper described how the company forbade direct communication with nurses and other staff, and physically segregated workers by disallowing coffee breaks in the same room. Another cleaner said “the manager is always transferring you to different departments because they don’t want you to be nice or close to them.”

Role confusion was also evident. A housekeeper talked about her conflict with care aides regarding a toilet blocked by a diaper. The Registered Nurse asked the housekeeper to deal with the matter and the woman refused, saying it was the care aide’s job. She phoned her manager, who confirmed her perception: she was responsible for disinfection *after* the aide dealt with the diaper. The RN’s response was that nobody knows their job anymore.

Compared with other participants, female former in-house workers felt very isolated from other staff. They described previous work relationships as being much more supportive, and they missed their friends. Other staff “looked at you differently now.” Another worker described the workplace as “way different. Before there was more unity. Now there is a bar and a gap. It is awkward. [We all] try but the reality is there. What happened is still there.”

Impacts on Workers' Health and Well-Being

Workers in health facilities are far from immune to health problems. Indeed, these jobs rank among the most risky of all occupations in Canada. A labour force survey by Statistics Canada in 1998 found that health care support workers had almost double the national average of days lost due to injury or illness: 11.3 days lost per year, compared with 6.6 days.¹⁹ Even in light of this occupational vulnerability, the incidence of illness, injury, and stress among our participants was disturbing.

Key points relating to health and well-being:

- 83 per cent (20/24) of participants said their job negatively affected their physical health: exhaustion, pain, illness, and injury were the norm
- 75 per cent (18/24) said their job negatively affected their emotional or spiritual well-being: frustration, anxiety, depression, feelings of powerlessness, and conflict were common
- Job dissatisfaction was widespread and far above the provincial average

Most participants (62 per cent, 15/24) rated their general health as being good to excellent (though women frequently had a less positive view). But further questioning revealed that very few people were free from pain, fatigue, and emotional distress as a direct result of their employment conditions, and many had experienced injury or sickness.

The Canadian Community Health Survey of Statistics Canada (CCHS) offers a comparison between our participants' self-reported health status and that of BC workers in general (see Appendix 1 for a description of CCHS data). The comparison revealed a startling difference (see Table 6). Our participants were over five times more likely than other working British Columbians to rate their health as less than good: 21 per cent compared with 6 per cent rated fair; 17 per cent compared with 1 per cent rated poor. At the other end of the spectrum, only one worker (4 per cent) in this study rated their health as excellent, in contrast to 26 per cent of British Columbians in the community health survey. The roots of this discrepancy can be found in the testimony of the workers.

Exhaustion and Pain: The Toll of a Heavy, Rushed Workload

Almost all workers described their job as physically exhausting and pain-inducing, though more new health care workers reported adverse impacts on their health than did former in-house workers. The exhaustion went beyond a reasonable level of after-work fatigue. "Every day, because of the workload, I feel like I'm going downhill," said a lead-hand housekeeper. "I'm just so tired." She couldn't see herself working to age 50 – the job was just too heavy. A 40-year-old single mother with two jobs said, "I'm flat down when I go home to bed." Even a 22-year-old dietary worker described being too tired to do anything after work. Others remarked that they felt prematurely aged or could barely walk after work some days.

Aches, discomfort, and pain were commonplace. The frequency of severe pain was striking given the relatively brief time in these privatized jobs. No participant had worked more than a year for the contractor; 46 per cent (11/24) had been employed six to nine months, and 29 per cent (7/24) had worked less than six months. Despite the short exposure, individual workers reported:

- sore muscles, knees, feet, legs, arms, wrists, and shoulders
- numbness in feet from walking many hours
- pain in legs and hips
- regular migraine headaches
- stiff neck and shoulders from heavy mopping
- sharp pains in fingers from handling mops
- major pain in back; arms sometimes numb from lifting heavy linens and garbage bins
- joint pain and tendonitis in both upper arms from lifting
- tendonitis in shoulder, neck, and back from lifting heavy bus pans
- pulled muscles in back and constant pain in shoulder and neck, from lifting in kitchen

Table 6: Self-Reported Health Comparison

Health status	All BC employees*	Participants
Excellent	26%	4%
Very good	41%	33%
Good	26%	25%
Fair	6%	21%
Poor	1%	17%

*Source: Statistics Canada, Canadian Community Health Survey (CCHS) Cycle1.2 (2002). See Appendix 1 for details.

On-the-Job Injury and Illness

Not surprisingly, work-related illness and injury were common among these workers, as was a sense that they and their co-workers ran a high risk of getting hurt or sick on the job. For example, a food service worker reported that four of her colleagues had received stitches for kitchen injuries in the 10 months they had worked for the contractor. People new to health care were almost twice as likely to report getting sick or injured than were former in-house workers. This difference may be due to better training and greater familiarity with safety procedures that former workers had received in their old jobs.

Key point relating to illness and injury:

- 63 per cent (15/24) of participants got sick or injured on the job
- 47 per cent (9/19) took time off as a result
- 40 per cent (6/15) avoided taking sick time even when ill or in pain because they feared contractor retaliation or couldn't afford the wage loss

Individual workers reported injuries and illnesses such as:

- back injury, dizziness, and headaches from constant beeping of pager
- sore back and knees, several colds including a five-day illness through which she worked
- swollen hands, sore shoulders and wrists
- cuts from using a knife when a can opener was broken
- repetitive strain injury in right upper back
- twisted thumb with mop; hurt knees from tripping over vacuum cord
- burnt hand from coffee grounds
- flu, colds, infection, vertigo
- constant pain in upper arms
- flu, upper body pain
- hospitalized with retching after chemical reaction to clean mop head
- high blood pressure from being followed by supervisor

Not surprisingly, work-related illness and injury were common among these workers, as was a sense that they and their co-workers ran a high risk of getting hurt or sick on the job. People new to health care were almost twice as likely to report getting sick or injured.

These disorders created obvious hardship and limitations for the workers. Over three-quarters of those with an injury or illness (including stress reactions) said the problem had affected their personal and family life. Ailments such as back, muscle, and joint pain restricted the overall mobility of some. One cleaner was hampered by a back injury for almost three months, yet received no physiotherapy and no assistance from the Workers' Compensation Board.

The misfortunes also took a toll on the workplace. Almost half of the sick or injured people took time off work, the majority of them women. The time off ranged from a day to deal with exhaustion or to see a doctor about an injury, to three weeks after slipping on a floor (with dizziness for months afterward). One worker, who had been absence-free during the two years of her former health care job, admitted to taking a couple of weeks off because of extreme unhappiness at work.

The Risky Business of Taking Care of Yourself

Despite these absences, the majority of our participants said they were reluctant to take time off for health problems. Just under half of our participants said they would call in sick only if they were incapable of working. Some reported to work despite poor health. One housekeeper worked with the flu because her contractor was very short of staff; another ignored an injured knee and, after three months, was in considerable pain.

Their reasons suggest a corporate strategy of discouraging paid sick time by pitting the worker's physical well-being against their economic survival. Many workers said their employer had a strict requirement to provide a physician's note if they called in sick, even for one day. The deterrent is obvious: getting an appointment on short notice is not easy, some physicians charge money for notes, and sick people

often don't feel like getting out of bed to see a doctor. A lead-hand housekeeper spoke proudly about challenging the company's policy of requiring a note after one day's illness. As a result, a note is necessary only after an absence of two days or longer.

Workers were aware that repeated absences could be grounds for dismissal. "Nobody wants to call in sick because they're afraid," said a cleaner and former in-house worker. "Now if you're sick two times and go home, that's it. You're fired."

The majority of our participants said they were reluctant to take time off for health problems. Just under half of our participants said they would call in sick only if they were incapable of working. Some reported to work despite poor health.

Sacrificing Safety for Speed

Our participants were clear about the prime cause of their injuries and debilitation: excessive workload at an excessive pace. A hospital cleaner said she did too much rushing with heavy loads of laundry in over-stuffed bags. A male cleaner described being behind schedule – working 30 minutes over shift – and getting injured as he raced along. A housekeeping supervisor, outraged by the company's insistence on sacrificing safety for speed, had complained to both the Workers' Compensation Board and the Labour Relations Board about safety violations. She believed the workers in her nursing home were being forced to work in hurried and incorrect ways, without personal protection.

Fear of injury and disease were common. A male housekeeper explained the risk of exposure to contaminants when rushing:

You're hurrying and don't check your glove and you have hole in it. We should change gloves after everything we touch. We're cleaning blood, feces, etc. We're at risk a lot of times. We use thin latex gloves. They break so easily.

Another cleaner knew that taking shortcuts to get the work done was dangerous: gathering used needles in haste only increased his risk of a needle stick and a life-threatening illness such as hepatitis or HIV.

Former in-house workers were divided on whether their risks had increased with privatization, with six out of 10 believing the risks had grown

Emotional Distress: The Toll of Exploitation and Disrespect

Three-quarters of our participants (18/24) reported that their emotional or spiritual well-being was adversely affected by their job. Some workers who claimed to be emotionally unaffected used coping strategies such as defiance and avoidance. A lead-hand housekeeper said she would simply not allow the job to get to her: “Nobody touches that part of me.... It’s just my physical health that’s affected.” A hospital cleaner in his mid-50s, who worked another full-time job as a school janitor, described pretending things weren’t as bad as they were:

Don’t want to think about it. Forget about your work from your other job. Just do your job, never open your mouth. Concentrate on something else.

Another cleaner kept going by reminding herself, “I can find another job elsewhere.”

Distress manifested as depression, anger, upset, and frustration. Former in-house workers were saddened and traumatized by the combination of many blows: severe drop in pay and benefits, loss of rights (seniority, job security, etc.), separation from old friends, and increased workload. A cleaner described having felt strong and healthy prior to privatization. Now she felt like doing nothing, not even housework; at home she cried a lot and felt crazy. A food service worker in a nursing home felt depressed “because I’m back where I used to be but without my fellow co-workers and with less money and the same work.”

Emotional stress was also caused by disrespectful treatment from supervisors and nurses. A new cleaner felt like quitting after being repeatedly menaced by his supervisor, who “used threats and orders, but never ‘please.’” Another woman, reluctant to admit to being emotionally or spiritually affected by the job, nevertheless felt a steady assault on her dignity at work:

For them, we are dumb slaves. They can do everything they want with us. You feel like a slave. It’s stress.

Being silent was the most common response to workplace stress reported by our participants. A woman cleaner said stress made her “get quieter. Don’t want to talk to anybody. Thinking of how to resolve problems. Sometimes cry, explode inside. I disagree but listen and don’t say anything.” A male housekeeper described a similar reaction: “I feel angry but try not to show it because I’m scared for my supervisor to know. I can’t lose this job.” A hospital cleaner talked about feeling powerless to express her anger and frustration at work, which only made things worse.

Anger and frustration were the response of a quarter of our participants. “I get very irritable and bitchy because I’m tired,” said a dietary worker, “and frustrated because I can’t get it all done.” Another woman said she was crankier at work and at home than before. A 55-year-old Filipina cleaner, on medication for high blood pressure, said she often felt as though she would “burst and blow up.” Several workers said the stress made them feel either nervous, worried, headachy, weak, absent-minded, or intolerant of being around people.

Not surprisingly, workplace stress and the associated negative feeling were a direct line to low morale. “You become angry. Then you get into ‘who cares?’” said a former in-house worker. “Nobody else does, why should I? Your morale goes down the tubes. The morale was awesome before.”

Impacts on Family, Social, and Community Life

Most Canadians in the paid workforce face the challenge of juggling work and home responsibilities, with working women carrying the heaviest duty towards children, elderly parents, and other dependent adults. The juggling act of our participants was exceptionally demanding. Many had commitments to family beyond their immediate household, and their attempts to fulfil their economic, emotional, and social duties were often undermined by their low wages and difficult employment conditions. As a result, workers were dealing with uncertainty, sadness, and loss as they struggled to meet personal obligations.

Key points about impacts on family, social, and community life:

- 54 per cent (13/24) of participants faced difficulties in supporting their extended family
- 63 per cent (15/24) had cut back on fitness and recreation
- 29 per cent (7/24) had put educational plans on hold
- 88 per cent (21/24) said the job interfered with their social and community life

One reason for these hardships is the simple fact that these employees are among the working poor (see Table 4). Substandard wages, inadequate hours of work, nonexistent benefits, and job insecurity translated into deprivations for their families: a falling standard of living, with little money for tuition, recreation, lessons, or holidays. The need to supplement income with a second or third job created obstacles to spending time with children, spouses, parents, and friends.

Another factor is the demographics of this workforce. Our participants, especially the immigrants, were often supporting their own children as well as a niece, uncle, sister, or parent. Their dependents either resided with them or lived overseas, often in impoverished circumstances. Tables 7a and 7b show the extent of the personal and financial responsibilities shouldered by these workers. A quarter were single mothers, the majority of whom also sent money to family overseas. Indeed, 71 per cent (n. 17) of all participants were supporting extended family either at home, in Canada, or abroad, while 54 per cent (13/24) were sending money to relatives in other countries. This financial help was maintained even though incomes had dropped below the LICO poverty line. The needs of kin did not decrease with the reduced wages of a privatized job.

Finally, the heavy workload and unsupportive climate at some health care facilities left workers feeling exhausted and dispirited. Coming home in a depleted state was harmful to their sense of self and to their families.

Table 7a: Forms of Family Support by Family Type – Supporting Children at Home

Children at home	Single-parent families	Two-parent families	Total
One child at home	2/5	2/8	31% (4/13)
Two children at home	2/5	6/8	62% (8/13)
Three children at home	1/5	2/8	23% (3/13)
Total supporting children at home	5 ^a	8	54% (13/24)

^a Excludes one single parent supporting her children abroad, not at home.

Table 7b: Forms of Family Support by Family Type – Supporting Adults and Extended Family

Dependants	With children		Without children	Total
	Single parent families	Two-parent families	Single, married separated, etc	
Supporting adults at home	0	2/8	0	8% (2/24)
Supporting adults nearby	0	0	2/10	8% (2/24)
Supporting family abroad	4/6	5/8	4/10	54% (13/24)
Total	67% (4/6)	88% (7/8)	60% (6/10)	71% (17/24)

Little Time and Energy for Family

Almost every parent with a dependent child or children talked about lacking time and energy for their family. “My husband usually cooks and takes the kids to the park because I’m so tired,” said a hospital cleaner. “Sometimes my husband is supportive, sometimes he complains.” Another cleaner described how she soldiered on at home even when exhausted or ill: “I do what a mother has to do. I cook for them when tired. Go camping even if tired.”

A father who worked two full-time jobs to make up for lost income saw himself as “an absent person from the home” and said his children complained about not seeing enough of him. A grandmother, living in a suite in her son’s home, told her grandchildren that she was “working to get toys” to help them understand her need to be left alone. A relief cleaner, the main caregiver for her 93-year-old father, had no predictable days off. She was often unable to take him to church and other community activities; cuts to provincial home care services did not help their situation. A single woman was frustrated that she had no flexibility in her work schedule to help her mother recover from surgery.

Many of our participants felt supported by their immediate families as they balanced the demands of work and home. At the same time, the strain at home was evident. A male cleaner spoke of three marriage breakdowns among his co-workers, caused by financial woes, in his 11 months at the contract job. A lead-hand housekeeper talked about her husband’s unhappiness when she came home angry.

When I’m at home, I don’t really feel like saying I’m tired or whatever. I just keep quiet. I just try to be sociable with my husband and my son, but the last few months I’ve been jumpy at home.

She worked full time because her husband had lost his higher-paying in-house job; he too was working as a privatized cleaner.

A single mother recognized that she was taking out her work frustrations on her two kids but felt too tired and stressed to cope differently. Another single mom was in worse shape. After losing her in-house cleaning position, she became depressed; now she was constantly fighting with her two kids and extended family.

Privation: Sacrifices for Family at Home and Abroad

Emotional strain, overwhelming schedules, and fatigue were only part of the trouble. Some felt intense pressure to continue sending money overseas, despite their own drop in income. A single mother, having lost a well-paying dietary job, was still supporting her niece at nursing college in the Philippines. She had no idea how she would cover the upcoming semester, though she worked at two jobs. A 55-year-old cleaner, also from the Philippines, had sent money home to pay for various nieces’ schooling. Another cleaner, a mother of two, help to support four families overseas. She explained how she and her husband did it:

We send the same amount of money now, even with a lower income. We need more jobs to make up the difference. Even then, it’s still not enough money for them. They don’t understand the situation here.

Several workers had reduced the amount they were sending outside the country. Another former in-house worker, a refugee, had been unable to bring her children to Canada as planned due to the loss of income. They would eventually come, but she feared being unable to afford a larger food bill and apartment.

Seven workers described how their own or their children’s educational plans had been put on hold due to financial constraints. A hospital cleaner said she could no longer help her 18-year-old nephew

with tuition. A father, working two full-time jobs, worried about “scraping up” the money for his youngest child in university. A single mother feared that, with the loss of her relatively well-paid health care job, she was also losing her children:

My kids can't go to school anymore. I can't afford to send them. They don't understand. Even my kids are depressed. They're yelling at me, I'm yelling at them. It's like a crazy house. I feel sorry for my youngest girl. She wanted to do college but now she can't.... I can't educate my girls.

Another former in-house worker and single parent had a 15-year-old son who had been attending a private religious school, which she could no longer afford. Her son was unhappy about the prospect of changing schools; he suffered from severe anxiety and his counsellor advised against the move. As it was, the mother could no longer provide him with a bus pass or cell phone (to keep in touch), and he had quit the school band because they could no longer afford the rental instrument.

The majority of our participants (63 per cent, 15/24) had been forced to cut back on recreation and fitness for themselves and their children, such as going to the gym or community centre. A quarter had eliminated their holiday and camping plans. “Holidays are out of the question,” said a 53-year-old cleaner. “The budget is limited.”

In Withdrawal: Cutting out Friends and Community

Almost all our participants (88 per cent, 21/24) said their job had a negative effect on relationships with their friends and community. A single mother said she missed going to parties, visiting friends, and participating in her church, but was so tired on her day off she could only manage grocery shopping. A married woman said she no longer had time to volunteer at her son’s school. A single man in his 40s had taught music to youth groups but gave it up after getting the contract job; he had two jobs and no time left over.

Some workers declined social invitations simply because they felt so bad. A new hospital cleaner explained: “Why should I visit friends when I’m angry? I’m not good company. So I don’t go out. I feel exhausted, and I don’t feel good about myself.”

Another cleaner, working at three jobs to make up for lost income, was too tired for friends. She was also reluctant to visit people because her family couldn’t afford to reciprocate the offer. In the past they would go for picnics with another family, but “now I pray it will rain so they won’t call.” She wasn’t alone in avoiding socializing for financial reasons. A man in his 50s talked about how he and his wife were having difficulties going to weddings in their Fijian community due to the expense of gifts. A 55-year-old cleaner, who usually attended the North American convention of Igorot (the indigenous people of the Philippines), had cancelled her 2004 trip for lack of money. A father with three young children said he never visited friends anymore because he and his wife had only one day off in common, on a weekday.

A single man said he was cut off from his social circle due to long work hours, but also could no longer afford the activities. He had lost friends and was depressed by the lack of company. Ill treatment at work didn’t help his morale: “makes you feel like a lesser person, like maybe I don’t deserve to be treated well, maybe I am a second-class citizen. You don’t obviously think that, but it has an effect.”

Another cleaner, working at three jobs to make up for lost income, was too tired for friends. She was also reluctant to visit people because her family couldn’t afford to reciprocate the offer. She wasn’t alone in avoiding socializing for financial reasons.

Impacts on the Health Care System

Support staff are part of the bedrock of a health care facility. They ensure the cleanliness of rooms, furnishings, and equipment that are vital to infection control; they prepare and deliver meals; they dispose of garbage and bio-hazardous materials; and they do the laundry for patients and staff. Some support workers, notably cleaners and food servers, have daily contact with patients and residents. Their work is both basic and essential.

It follows that the working and employment conditions of these workers have implications for the health care system. When support staff are obstructed in their ability to provide good quality service in regard to hygiene, nutrition, and infection control, patients may suffer, and nurses and other health professionals may find their efforts undermined. Obstructions come in many forms under privatization: administrative segregation, substandard employment conditions that result in high staff turnover, cost-cutting measures, and poor training and inadequate supervision.

Our investigation uncovered several areas in which the privatization of support jobs appears to threaten service quality. Training standards, contact with patients and residents, job stability, and quality control practices have all diminished with the shift to contracting out.

Training and Staff Development: Cracks Below the Surface

Before privatization, support staff at hospitals and LTC facilities in British Columbia were usually hired on the basis of minimum educational credentials or prior work experience. For example, a hospital house-keeping department would require new hires to have a Building Service Worker or equivalent college certificate; dietary workers were expected to have an Institutional Aide Certificate or equivalent.²⁰ This baseline level of knowledge would be supplemented on the job by in-services, staff meetings, training sessions with supervisors and other personnel, daily supervision, and peer reminders. The net effect was a workforce with a common set of skills that was continuously reinforced and upgraded.

Private contractors do not appear to require formal credentials in their hiring criteria; rather, they provide their own training and orientation. All but one of our participants went through a company program, which typically lasted three days. Overall, both new and former in-house workers were critical of the training they received, whether in initial sessions or in their ongoing status as company employees.

Key points about training and staff development

- 39 per cent (9/24) of participants performed work for which they were not trained
- 67 per cent (16/24) were expected to train inexperienced co-workers
- 54 per cent (13/24) did not receive explanations about their assigned tasks
- Nine out of 10 former in-house workers believed the company's training was inferior to their previous training

None of our participants were impressed by the quality of training offered by their contractors. The formal content was not necessarily the problem. For example, one contractor trained cleaners over a three-day period in the use of equipment and mops, disinfection and sterilization methods, and in identifying hazardous materials in accordance with provincial requirements for WHMIS and MSDS sheets.²¹ The instruction, however, was mainly videos and talking heads, with only a single day for hands-on practice. Even then, one of our participants, an emergency department cleaner with prior training in cross-contamination, believed too much time was spent on bed-making and not enough on sterilization. The company's sterilization video was so boring, he said, trainees had dozed off. At work later on, he saw co-workers ignoring proper procedures for cleaning rooms infected by methicillin resistant *staphylococcus aureus* (MRSA).

An emergency department cleaner with prior training in cross-contamination, believed too much time was spent on bed-making and not enough on sterilization. He later saw co-workers ignoring proper procedures for cleaning rooms infected by methicillin resistant *staphylococcus aureus* (MRSA).

Another former cleaner was dismissive of the minimal training she and others had received: "The contractors don't care how we use chemicals. They don't know how to clean. People I work with are uneducated. I opened clean linen and it was full of hair. Six or seven sheets a day like that. Nobody listens to us. It's frustrating."

An experienced food service worker had similar concerns: "They showed a video and called it orientation or training. It introduced me to the company but had nothing to do with serving the residents or what to do with the residents." A cleaner was equally blunt: "They showed us, they didn't train us." The poor training showed. Several cleaners observed their inexperienced co-workers cleaning toilets and other surfaces with the same rag, a highly unsanitary practice.

Nine of 10 former in-house workers described the company's training as worse than their previous facility's offerings. In the past, they had benefited from a regular monitoring of their development as

staff persons. A cleaner in an LTC facility described how her former facility “had given you actual training, then they gave you someone to shadow. It was very hands-on and straightforward. The company was just show-and-tell.”

Over a third (9/24) of our participants, new and experienced alike, reported doing work for which they were not trained. One man transported bio-hazardous materials for a month before being trained, despite telling his supervisor he was unfamiliar with the task. Another man never received training in handling dangerous materials and frequently observed other untrained workers disposing of bio-hazardous waste in a questionable manner.

Companies expected their workers to train new staff – a common occurrence, given the high rate of turnover – with little regard for workload issues or the soundness of the training. Two-thirds of our participants had been called upon to play a training role. All but one of the former in-house workers were routinely used for this purpose. A hospital cleaner who lost her job to privatization and returned as a contract worker described her experience:

As the only person who had worked there before, I was familiar with the building, where things were. I trained every new hire for six months, a new person every month, in addition to my regular routine. It was so much I couldn't finish my regular work.

Workers were also concerned by a lack of follow-up and explanations. Over half our participants (54 per cent, 13/24) had been given tasks without a detailed explanation (e.g. why a particular cleaning technique was necessary). A seasoned cleaner believed the dearth of instructions was at least partially due to the supervisors' own inexperience: “They don't have a clue. We tell them [what is what].”

Supervisors should play a central role in training and reinforcing good work practices. Prior to contracting out, in-house supervisors in hospitals were expected to communicate updated information (about infection outbreaks, cleaning supplies, etc.) and monitor the skill level of frontline staff. In housekeeping departments, the supervisor is the conduit between infection control personnel and cleaners, and would arrange and provide in-services to staff on a regular basis.²² Yet almost half our participants (11/24) didn't feel that they could discuss training matters with their supervisor. Others were frustrated by ineffectual responses. One worker summed up the situation: “You can speak your mind but their hands are tied. The budget is so tight. Supervisors are limited in time and money. It won't change anything.”

Over a third (9/24) of our participants, new and experienced alike, reported doing work for which they were not trained.

Cutting the Human Link Between Workers and Patients/Residents

Interaction between support workers and patients/residents is recognized as an ingredient in good quality care. Studies have documented the significance of daily contact between cleaners and patients within the busy, oftentimes impersonal atmosphere of a hospital.²³ Although not involved in hands-on care, cleaners and food service workers play a role in observing patients and alerting nurses when necessary. Within acute care facilities they can contribute to patients' recovery by providing social interaction; within LTC facilities they can be a source of comfort.²⁴

This aspect of the support worker's role is sharply diminished by contracting out. The change occurs for indirect reasons (e.g. excessive workloads that eliminate time for interaction) and direct ones (e.g. a company ban that prohibits talking with patients). The net effect is losses for both parties: patients with

fewer human exchanges than before, and workers with fewer opportunities to express their caring nature, one of the job's few graces.

Key points about patient/resident contact:

- 33 per cent (8/24) of participants never have time to talk with patients/residents
- 63 per cent (15/24) of participants want more time for interactions
- Most former in-house workers report having less time for contact than before

Even among participants who reported having time for interactions, the contact was fleeting. A hospital cleaner squeezed in moments during her break or "if there's only one patient in the room." Another cleaner knew it was "not my job to do it, but I have a minute for them, to comfort them.... Sometimes no-one answers when they ring the bell." The few participants (3/24) who always had time for patients did so by cleaning and talking simultaneously. "I really enjoy [patients]," said one woman. "But gotta keep cleaning, the clock is ticking."

Prohibited Contact, Inhibited Contact

A former in-house cleaner described how she was advised by her manager to avoid interactions with patients because it would "take too much time." Some hospital staff were instructed to respond to patients with a "yes or no" only and to never share information because it would "lead to more conversation." Another experienced cleaner, employed by the same company at an LTC facility, was given the same direction. "They have no-contact rules but we try not to follow them," she said. "We feel awful because the residents know us. They call to us."

The corporate approach was in stark contrast to the values of the facilities themselves, a discrepancy noted by a former in-house worker:

[The facility] told us to keep an eye on the residents, to help them when they're in danger. With Aramark, it's 'don't touch them, no drinks, don't deal with them directly.' We're told this in orientation.

Another worker echoed a similar philosophy at her old workplace: "Management was happy if we had a relationship with residents. We would exchange cards, celebrate birthdays."

A dietary worker in an LTC facility spoke poignantly about the value of talking with residents, based on her former experience: "It makes us both happy and feel more relaxed, more like a family atmosphere;" she was now too rushed for meaningful contact.

DOWNGRADING THE ROLE: Interestingly, nine of 10 former in-house workers said they had at least some time for patients, compared with only 29 per cent (4/14) of new workers. Yet experienced workers were also much more dissatisfied with their current level of contact: 90 per cent (9/10) wanted more time for patients, compared with 43 per cent (6/14) of new workers.

These figures present a disturbing picture. New workers, unaccustomed to patient contact and discouraged from it by workload and company directives, can neither find time for interactions nor do they want (or miss) them. The job description of these support workers is being socially re-engineered: by inhibiting and/or prohibiting connections between workers and the vulnerable people they serve, the expectation and desire for such contact is being lost.

Job Dissatisfaction: The Erosion of Continuity and Experience

Staff retention and continuity are valued in health care settings. These are complex workplaces with sick and elderly people, and the need for teamwork, trust, and familiarity with protocols cannot be overstated. Cleaners and food service workers may not have the most prestigious positions in a facility, but their work is directly related to the well-being of patients and staff alike.²⁵ An experienced worker has more knowledge to contribute than a greenhorn.

Support workers covered by the Hospital Employees' Union contract have relatively good terms of employment, and they demonstrate this fact by loyalty to their jobs. For example, cleaners in HEU are a mature and stable lot: 45 years old and 11.6 years on the job, on average.²⁶ Support workers covered by the partnership agreements between Local 1-3567 (IWA) and the private corporations are in much different shape. Their employment terms are not only dramatically less favourable than those of HEU workers, they fall below BC's standards for unionized hotel cleaners and are the lowest paid health services support workers in the country.²⁷ Not surprisingly, attachment to the job may be in short supply among these workers.

We detected a contradictory picture regarding our participants' beliefs about their role, their sense of belonging to the health care team, and their job satisfaction. On the one hand, the majority believed their work was worthwhile and felt good about being team members. On the other hand, no one expressed strong satisfaction with their job. Indeed, the majority (14/24) were dissatisfied. Most damning, only a little more than a third (9/24) intended to stay in the position. Our participants were caught in a paradox: they had a positive sense of personal accomplishment but a negative sense of job satisfaction.

Key points about job satisfaction and retention:

- 83 per cent (20/24) of participants felt they had little job security
- 58 per cent (14/24) of participants were dissatisfied with their job; 29 per cent (7/24) were very dissatisfied
- 42 per cent (10/24) intended to leave the job within six months; another 13 per cent (3/24) were undecided
- 96 per cent (23/24) believed they did worthwhile things at work

Table 8: Job Satisfaction

Job satisfaction level	All BC employees*	Participants
Very satisfied	44%	0%
Somewhat satisfied	44%	42%
Not too satisfied	9%	29%
Not at all satisfied	3%	29%
Total	100%	100%

*Source: Statistics Canada, Canadian Community Health Survey (CCHS) Cycle1.2 (2002). See Appendix 1 for details.

Job pride, conscientiousness, empathy, and responsibility were evident among new and experienced workers alike. All but one worker agreed that they contributed valuable things at work. Several referred to pride at doing a hard job properly, stopping the spread of germs and disease, and helping and cheering up patients. One worker understood her role at the nursing home in this way: “I talk to the residents, sing to them when I’m cleaning. It feels like I’m transferring the care I would have given my mother.”

Similarly, the majority of our participants (83 per cent, 20/24) felt good about being part of a health care team. Although their status within the team was not without complications and conflict, they had a positive view of their role. As a 58-year-old food service worker in an LTC facility said: “I don’t think people realize the value of what health care workers do, all of us. They don’t understand that our work is to make the residents’ lives better.”

Yet this strong sense of purpose did not translate into commitment to the company. Over half our participants (58 per cent, 14/24), new and former workers alike, expressed dissatisfaction with their job. Women were more likely than men to say they were not at all satisfied.

When these workers are compared with other British Columbians, via the Canadian Community Health Survey (CCHS), the depth of their unhappiness comes into focus (Table 8). The CCHS reported that almost half of BC workers in 2002 were very satisfied with their job. None of our participants felt this way. Indeed, workers in this study were 10 times more likely than other British Columbians to be wholly dissatisfied with their job: 29 per cent compared with 3 per cent.

This dissatisfaction gave rise to an inevitable result: instability. Few of our participants intended to stay in their job for the next six months. Only nine people (38 per cent) had definite plans to remain, while 10 (42 per cent) planned to leave, and the remainder either didn’t respond or were undecided. Two people who intended to stay were prepared to leave if a better job presented itself. Former in-house workers were twice as likely to want to quit than were new workers, a trend that signals a draining of know-how from the sector.

All told, the picture is of a frustrated and demoralized workforce: not necessarily resistant to the role, but highly discouraged by the conditions.

Workers in this study were 10 times more likely than other British Columbians to be wholly dissatisfied with their job: 29 per cent compared with 3 per cent.

Service Quality: The Downward Pull of Staffing Levels and Cost Cutting

Reducing labour costs is the prime means by which private contractors can maximize their profits in labour-intensive departments such as housekeeping and, to a lesser extent, food services. Contractors may also lower their costs by reducing the quantity and quality of supplies. Although this research did not focus on privatization’s impact on service quality, many of our participants expressed concerns that service had declined. In particular, they believed that staffing levels were too low and staff replacement practices too haphazard to ensure a consistently high quality of housekeeping.

Key point about service quality:

- 75 per cent (18/24) of participants did not think contractors were employing enough staff to provide good quality service

Many cleaners were very concerned that inadequate staffing levels were exposing patients and workers alike to serious risks. At a basic level, staff shortages made it difficult for workers to clean properly and

avoid complaints about a “dirty” facility. On a more critical level, staff shortages meant that isolation rooms, operating rooms, trauma units, and emergency departments were not necessarily receiving the specialized and careful treatment they warranted.

“[The company] can do better but they don’t,” said a lead-hand housekeeper. “Two people are needed to clean isolation rooms properly. They only have one. And the staff aren’t trained properly and don’t have proper equipment to clean isolation safely.” A housekeeping supervisor described her efforts to clean a trauma unit with insufficient staff and improper equipment. The unit was heavily used, very dirty, and in need of immediate attention. Her insistence that it be cleaned properly, and the delay in finding staff to do so, led to an altercation with a nurse and her subsequent firing.

Another housekeeper gave a succinct account of how staff shortages created hazards at his hospital:

First, there are not enough people so workers are spread too thin. As a result they rush and make mistakes. Second, the staff gets tired, especially if doing back-to-back shifts when people don’t show up for work. When staff is exhausted, mistakes really multiply and the personal injury rate goes up, and so does the workers’ risk of contracting a disease. And patients are not in a sterile environment.

Pinching Pennies, Reducing Quality

Several participants raised concerns about the quality and quantity of supplies used for cleaning and nutrition. In particular, a few were alarmed and angered by their contractors’ insistence that they use only one pair of disposable gloves per shift. The gloves were flimsy and would break after extended use, exposing the workers to hazardous body fluids and wastes. Moreover, using the same gloves all day had the potential of spread pathogens throughout the facility, especially if isolation rooms were being cleaned. Concerned workers have refused to follow the contractors’ rules, to protect themselves and patients.

A lead-hand housekeeper was told by her contractor to re-use and disinfect the same pair of gloves during the shift, a practice she defied and encouraged her co-workers to defy as well: “It’s for my safety and the residents’ safety. [The company is] just cheap. But we don’t listen to them. I said no.”

The supervisor of housekeeping at another facility, working for a different contractor, was also outraged when the general manager ordered a single pair of gloves per shift:

I considered this impossible because some of us deal with bio-hazardous waste and should not use the same gloves for cleaning a washroom as for cleaning a nursing station. My way was to steal gloves from the nursing station, if possible.... And most of the workers are doing the same. The company knows [we do this] but they don’t care. They save money.

A former in-house worker was appalled by her company’s shortcuts in food service. The district manager had instructed dietary servers to use a single sanitizer bucket all day long to wipe down dining room tables, chairs, and carts. She believed the company was managing the facility as though it were a hotel, not a home for extended care residents who spill a lot of food when they eat: “They don’t understand that these old people have trouble eating and make a big mess. The bucket gets disgusting, full of ‘floaters.’” The manager had also attempted to cut costs by replacing big paper napkins with smaller ones, but the plan had backfired: food servers were now using *many* small napkins to handle the mess.

But her greatest concern related to the food itself. Residents of LTC facilities often have difficulty swallowing, and their meals must be specially prepared to accommodate this and other eating problems. She observed that the company’s purees were often too runny and the potatoes too lumpy. Even more alarming, she had heard that the manager was planning to eliminate Carnation Instant Milk and soy milk from the menu as a cost-cutting measure (the former was provided for extra calories, the latter for lactose intolerance). The worker was very distressed that residents’ nutritional needs would suffer for the sake of saving money.

Unmasking the Consequences: A Troubled Future

Canada's health care system is engulfed in persistent turmoil. The parts of the system that work well are usually overlooked; the areas that are faltering are subjected to periodic, intense scrutiny; and the occasional outrage is seized by the media and then forgotten.

Chronic turmoil encourages a crisis mentality, which offers a wedge to ideological interests. The notion that medicare is starved for funds becomes an argument for cutting costs and pouring all available dollars into direct patient care. Cleaners, food service workers, laundry workers, and security guards are dismissed as "ancillary." These low-status workers are no longer viewed as essential to health *care*, unlike nurses and physicians. Cooking, housekeeping, and laundering – traditionally women's work – cannot possibly require much skill or be very important. Cleaning a hospital or nursing home is equated with cleaning a hotel or convention centre, ignoring the scientific evidence and common sense that says otherwise.²⁸ In an age that routinely denigrates public servants and glorifies the marketplace, a move to convert public services into for-profit deliverables seems normal, even smart. Privatization becomes legitimized by default, without any examination of its real-life effects.

Unjust: Re-inventing the Sweatshop, 21st Century Style

The picture that emerges from our examination is clear. The workers who perform privatized health support service jobs are unsupported, poorly trained, overworked, and insufficiently rewarded. Although they take pride in their role and are committed to service, they feel disrespected and exploited. Exploitation comes in the form of substandard working conditions, excessive workloads, and low compensation compared to other Canadian workers.

Most of these workers are immigrant women of colour born in the Philippines, India, and other countries of the south. For many, their first language is other than English. The majority are mothers. Compared with both the HEU membership and BC employees in general, a higher-than-average percentage are single parents.²⁹ As immigrants, they are often supporting relatives both at home and overseas – the Euro-Canadian stereotype of a nuclear family does not apply here. Many have educational credentials that would qualify them for higher-status and better-paying jobs but for the systemic barriers that discriminate against internationally educated professionals in the Canadian labour market. Most are over 45 years old and quite aware that their job offers no pension. Their limited employment options and substantial family obligations make them captive to these privatized jobs, albeit captives with escape on their minds. Their loyalty to the job is weak, and their physical and emotional health is suffering.

One reason escape may not be possible is the high rate of unemployment among Canadian immigrants. Recent immigrants (under seven years in the country) between the ages of 25 and 54 with a university

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degree experience unemployment at least triple the rate for Canadian-born individuals.³⁰ Immigrant women are more likely to be unemployed than immigrant men, and much more likely than Canadian-born women. In 2001, the unemployment rate for immigrant women aged 25 to 54 was approximately four times that of Canadian-born women in the same age group – 10.5 compared to 2.7 per cent. The equivalent rate for immigrant men was 7.4 per cent compared with 2.3 per cent for Canadian-born men.³¹

Unemployment is not the only pitfall for immigrants. Studies have revealed the growing gaps in income and earnings between immigrants and non-immigrants in this country.³² A recent survey by Statistics Canada looked at the vulnerability of immigrants to being stuck in a low-income bracket.³³ The study concluded that recent immigrants were at greater risk of experiencing low income than other Canadians, with visible minority immigrants having the most serious exposure to low income regardless of how long they lived in Canada. The Statistics Canada report attributed these patterns of poverty to so-called human capital deficits, i.e. the individual immigrant's lack of English or French

language skills, low educational credentials, or rejection of foreign credentials by regulatory bodies and employers. Racial discrimination in hiring was cited as another possible factor.

What the Statistics Canada analysis did not consider were the employment conditions under which visible minority immigrant workers are expected to work. Our study shows that a deliberate government policy – the privatization of health support services in British Columbia – can lead to substandard employment conditions and poverty for visible minority immigrant workers. The privatized workers in this study, who spoke English and often were better-educated than their Canadian-born colleagues, are at the mercy of institutionalized racism and sexism: denied jobs commensurate with their skills, at risk for high unemployment, and then offered up for exploitation to large corporations. A Filipina woman in our study, a single mother who had lost her in-house job, expressed the truth of her circumstances:

If I don't do this [job], I won't be able to raise my son and give him encouragement to move on to a good life.... I just keep telling myself, 'I have to do this, have to do this, have to do this.' It's very hard, but I can cry. That's the only way to dispense my emotion.... I just keep telling myself in the mirror, 'You have no choice, no choice, no choice.'

Rather than finding a more hopeful life in Canada, these women and men find themselves trapped. Privatization has pushed them below the poverty line, robbing them of energy, time for family and community, and a sense of well being.

The corporations that create these sweatshop conditions are right to believe that an unhappy service worker is easy to replace. Social and economic conditions in Canada have created a pool of workers, mainly female and often immigrants of colour, who have no choice but to accept wages and conditions that overtax their bodies and disrupt their families. That these factors are known to produce low morale and high turnover in health care facilities³⁴ may not be a concern to the company, but they should be a serious concern to the public. Social injustice is just one layer of the scene that is unfolding in BC's privatized health care facilities.

Unintended: Hidden Costs Today, Even Costlier Tomorrow

The danger that privatization poses to workers is relatively easy to grasp. But this study detected other risks too, chiefly the pressure on workers' families. The strains of heavy, insecure, and low-wage employment were directly felt within the home. The need for an additional job(s) and the exhaustion at the end of a hard day's work meant the erosion of family time. Living below the poverty line resulted in deprivation: less money for necessities; cutbacks to recreation and lessons; declining mental health; and perhaps worst of all, constricted educational opportunities. Lack of time, money, and energy caused many people to withdraw from their social circles and community life.

The effects of privatization reach deeply into personal lives, draining the resilience of families and extracting human potential from society. Overall, the picture is one of challenged families, shrinking social participation, and involuntary exclusion from community. Although perhaps hidden from the larger community today, these stresses will eventually surface.

Similarly, the *financial* costs of privatization will become apparent. The economic threat of deteriorating cleanliness in our health care facilities is one dimension. Social services costs relating to the children and elderly parents of privatized workers are another. Staff injuries and illnesses are the most direct expense. Health support services are already the most absence-prone sub-sector in the Canadian workforce. From the evidence of this study, lower safety standards and decreased worker well-being are the unplanned offshoots of contracting out, and the price will be paid by individuals and health care system alike.

Unsustainable: Degrading the Workforce, Degrading the Service

Contracting out has far-reaching consequences in a workplace. On a simple level, routines and personal relationships are uprooted. On a deeper level, lines of communication and coordination, structures of authority and responsibility, and notions of identity and teamwork are radically disturbed.

A 2004 environmental scan of a Vancouver hospital, prompted by staff concerns about deteriorating cleanliness and infection control, found that an entire web of quality assurance practices had collapsed with the privatization of housekeeping services.³⁵ The study also revealed how fractured staff relations, due to contracting out, contributed to the decline of safe working practices. Deficiencies in cleanliness were easy to document: blood-stained curtains, dirty floors, uncollected garbage, and empty soap dispensers were common throughout the facility. But some digging was required to determine the structural causes. One recurring theme was misgivings about the contractor's ability "to deliver knowledgeable, responsive, and stable cleaning services."³⁶ The study found that the hospital's privatized cleaners were isolated from infection control personnel; locked into inflexible work routines; unable or afraid to respond to staff

requests; discouraged from taking initiative; and cut off from patients. Their turnover appeared to be high, and continuity of service was spotty. The report summarized the negative consequences of this high turnover:

a stream of inexperienced workers; little familiarity with job routines or special circumstances; no growth of the confidence and expertise that leads to problem-solving and taking initiative; and no chance to establish relationships and build trust. The continuity of . . . housekeeping service has deteriorated, and the result can be found in unsatisfactory service and tense relationships.³⁷

In short, privatization appeared to hamper the development of skills and competency, and to actually *disengage* workers from their workplace. We found similar dynamics among the participants of this study.

“Employee engagement” is recognized as a key ingredient in organizations that perform effectively. The Auditor General of British Columbia examined this factor in a 2003 study of the province’s public service. Engaged employees, he wrote, are “intellectually and emotionally involved in the work and organization. Engaged employees . . . demonstrate an intense desire to remain a part of their organization.”³⁸ Evidently, workers in privatized health support jobs are not among the province’s engaged employees.

The Auditor General outlined the attributes of a healthy job in another report that focused specifically on the health care workforce:³⁹

- demands fit the resources of the person
- a high level of basic predictability
- good social support
- meaningful work
- high level of influence at work
- balance between efforts and rewards

Remarkably, Sodexo, Aramark, and Compass appear to actively violate every one of these points. In our study, workers reported

- excessive workloads
- unpredictable job routines (pagers, call centre requests)
- little support from supervisors and managers
- disconnection from patients (a meaningful part of the work)
- no consultation
- onerous demands coupled with low wages and meagre benefits

The province’s health care system is threatened by this troubled work environment. Employee satisfaction is a bellwether of an organization’s success in fulfilling its mandate. In his 2003 report, the Auditor General of BC described the chain reaction that starts with employees’ positive sense of work-life balance and leads to job loyalty, improved client relations, and profitability.⁴⁰ Although this corporate paradigm is not strictly applicable to the health care sector, the Auditor General identified its general relevance to public services. Front-line workers are the human face of an organization, whether they are tellers in a bank, sales clerks in a department store, or cleaners in a hospital room. When they feel valued, supported, and committed to their jobs, they are better able to deliver sound services. The powerful association between organizational effectiveness and satisfied workers was expressed by the Auditor General in this way:

If the health authorities are to fulfil government’s expectations of ‘putting patients first,’ they must ensure that the work environment supports health care workers in their efforts to provide the best patient care possible. Such support includes protecting workers from undue stress and risks.⁴¹ (emphasis added)

Aramark, Compass, and Sodexo's dual obligation is to provide shareholders with profits on the one hand and health authorities with services on the other. A built-in tension exists between these two obligations. High returns on investment in the service sector are predicated on low labour and supply costs – efficiencies in the most businesslike sense of the word. Good quality services are predicated on well-trained and well-supported staff. The testimony of privatized health care workers in BC gives a powerful clue as to which obligation is dominant.

These corporations are accountable to their shareholders, not to workers, patients, and local communities. The entrenched insecurity that workers experience is not an unintended by-product of privatization, but rather is directly tied to corporate goals of labour flexibility and low costs. In BC's health support service sector, jobs with standard (and desirable) employment conditions have been downgraded to non-standard jobs with little to recommend themselves. The loss will be felt by more than the workers.

Unaware? Making a Well-documented Wrong Turn

Privatization of health support jobs may be relatively new to British Columbia, but it isn't new elsewhere. The United Kingdom has had long exposure to contracting out. As mentioned earlier in this report, Compulsory Competitive Tendering for health support services was the law between 1983 and 2001. Public confidence in the cleanliness of the UK's hospitals declined dramatically during this period. Surveys of patients uncovered a widespread belief that "standards of cleanliness had dropped in recent years. Many blamed this on the introduction of Compulsory Competitive Tendering."⁴² In the meantime, alarm over the soaring incidence of hospital-acquired infections prompted the UK's National Health Service (NHS) to develop national standards for hospital cleanliness and a multidimensional action plan to reduce infection rates. In 2001, the competitive tendering stipulation was dropped.

The latest development in Great Britain's experiment with contracting out was a national directive in September 2004 that required for-profit contractors to pay their cleaners the same wages and benefits as in-house cleaners. The Department of Health recognized that privatization had incited a race-to-the-bottom price war among service providers, including in-house housekeeping departments, which were forced to compete against corporate bidders. The result was predictable: "the net effect of this was that [housekeeping] budgets and therefore standards were vulnerable to being driven down ... until, in some cases, they reached unacceptable levels."⁴³ A 2004 report from the Patient Environment Action Teams found that the "incidence of poor cleaning was twice as common among privatised contracts than it is with in-house services."⁴⁴

The NHS action plan against nosocomial (hospital-acquired) infections adopted a system-wide approach to the problem. The role of skilled, well-supported cleaners was repeatedly hammered home.⁴⁵ The UK is now restoring housekeeping as an integral part of health care after almost two decades of disengagement – and deterioration – under contracting out.

The lessons from other jurisdictions are well documented. Health care services are not reducible to ordinary market commodities. The much-vaunted efficiencies of for-profit companies are not necessarily compatible with a sector that relies on sophisticated teamwork, continuous reinforcement of skills, and public confidence.⁴⁶ Yet our study suggests that health authorities and BC's provincial government have ignored the hard truths learned elsewhere.

The entrenched insecurity that workers experience is not an unintended by-product of privatization, but rather is directly tied to corporate goals of labour flexibility and low costs.

Undeceived: The Public is Watching, the Workers are Aware

The privatization of health support services in BC has had its share of media attention. There was a brief flurry in 2002 when the provincial Liberals used Bill 29 to tear up the contract of the Hospital Employees' Union, after explicitly promising not to do so in the election campaign. However, the actual laying off of thousands of BC health support service workers was treated as a non-issue. This fact alone was extraordinary, given the haste with which BC facilities were privatized and the scale on which staff were laid off. A massive social experiment was underway in the province, yet people seemed to pay little attention.

By 2004, the public had grasped that things were amiss. A Greater Vancouver hospital was in the hot seat after a spate of hospital-acquired infections among maternity patients.⁴⁷ The health authority was

In many parts of BC, media reports have appeared about unclean hospitals, shabby nursing homes, and families distressed by hospital-acquired infections. Health authorities continue to issue assurances about the success of privatized housekeeping and dietary services, but there is a marked and growing dissonance between public perceptions and official pronouncements.

forced into a speedy review of the hospital's emergency and infection control processes, declared them acceptable, and hoped the story would drop from sight. But the story will not go away. In many parts of BC, media reports have appeared about unclean hospitals, shabby nursing homes, and families distressed by hospital-acquired infections. Health authorities continue to issue assurances about the success of privatized housekeeping and dietary services, but there is a marked and growing dissonance between public perceptions and official pronouncements.

Workers have also raised their voices. Dissatisfaction led the overwhelming majority of privatized workers to end their involuntary relationship with the IWA-Local 1-3567 in favour of joining the Hospital Employees' Union. Nurses and other health care professionals are also disturbed about deteriorating standards in the wake of privatization. The 2004 case study of the Vancouver hospital plagued by housekeeping problems was a collaboration of the BC Nurses' Union, the Health Sciences Association, and the Hospital Employees' Union.⁴⁸

Unacceptable: The Need to Reverse an Ill-Conceived Policy

The problems identified in this report cannot continue unchecked. The government policy of contracting out health care support services is jeopardizing the health and well-being of workers, their families, and patients in BC hospitals and nursing homes. The public is waking up to the immediate risks. Over time, more serious damage to the health care system, social services, and communities will become evident.

Privatization exacerbates the poverty trend among recent immigrants and immigrants of colour in Canada, in which relatively high levels of education are rewarded with low wages and insecurity. Governments have a responsibility to implement policies that reduce poverty and discrimination among working people, not policies that increase wage disparities and social exclusion while reinforcing historical patterns of sexual and racial exploitation.

As a society we would do well to acknowledge the worth of the housekeepers, cooks, laundry workers, clerks, and security personnel in our health care system. The analogy to a home is obvious. If the fundamental need for secure surroundings, healthy food, and cleanliness is unmet, a family is unlikely to thrive. How much more true is this for people who are elderly and sick, and for the hardworking staff who provide them with care?

Appendix 1: Canadian Community Health Survey (CCHS) of Statistics Canada

The self-reported health (Table 6) and job satisfaction (Table 8) of our participants were compared with indicators for employees in British Columbia based on Statistics Canada's Canadian Community Health Survey (CCHS) Cycle 1.2 Mental Health and Well-Being (2002) Public Use Microdata file, which contains anonymized data collected in the year 2002. All computations on these microdata were prepared by Sylvain Schetagne and Jane Stinson, and responsibility for the use and interpretation of these data is entirely theirs.

The CCHS survey includes 36,984 respondents aged 15 or over, residing in households in each province. It is estimated to cover approximately 98 per cent of the population aged 15 or older in the 10 provinces due to the selection of respondents through probability sampling. Excluded from the survey are residents of the three territories, persons living on Indian Reserves or Crown lands, clientele of institutions, full-time members of the Canadian Armed Forces, and residents of certain remote regions.

The comparative data in our Tables 6 and 8 are from the CCHS Cycle 1.2 Mental Health and Well-Being (2002), for employees aged 15–64 in British Columbia who worked the week before the survey. Weighted data were used. The smallest region for which health data are provided is the province of British Columbia, so we were unable to make a precise comparison of our participants with health care employees in the same geographic region (Greater Vancouver). Although not as close a match as we would like, the working population of BC is an appropriate reference group to assess the experience of the privatized workers in our sample.

Appendix 2: Interview schedule

A complete schedule of interview questions used in this study is available on our website or upon request. Download this 13-page PDF from www.policyalternatives.ca, or call the BC Office at (604) 801-5121.

Notes

- ¹ The BC Liberal government embraced the idea that cleaning, food, laundry, and security services do not differ significantly between hotels and hospitals. The view that ancillary services in the hospitality and health care sectors are essentially the same was advanced by the right-wing Fraser Institute in a 1995 paper, which critiqued the relatively decent wages of health support workers in BC. The government's dismembering of the HEU contract was justified as a means of shifting dollars from "non-essential services" to direct patient care.
- ² Hospitals and Health Network, Contract Management Survey, October 1999, p. 48; and October 2003, p. 56.
- ³ Unison, *Bargaining Support, NHS Market Structure*, bsg@unison.co.uk, April 2003, p. 1.
- ⁴ Voluntary recognition agreements are most common in "the building trades and in forestry work, where work is short-term and specific trade unions have long established records in protecting workers rights in these industries. In these limited cases setting up a 'voluntary recognition agreement' between the employer and the trade union before the work actually begins protects workers from having to build a union from the beginning each time a new short-term job begins. In fact, it guarantees them the wages and benefits already standard in the sector. But this is a very different circumstance from the work in hospitals, where voluntary recognition agreements are undercutting wages in an established sector and where an on-going work relationship with a different union already exists." Marjorie Cohen and Marcy Cohen, "A return to wage discrimination: Pay equity losses through the privatization of health care." Vancouver: Canadian Centre for Policy Alternatives – BC Office, April 2004. p.18.
- ⁵ Compass Group Canada (Health Services) Ltd. et al. and Industrial, Wood and Allied Workers of Canada Local 1-3567, Partnership Agreement, October 2003, Appendix A.
- ⁶ Cohen and Cohen, p.18.
- ⁷ Ibid, p. 4.
- ⁸ Cohen and Cohen, pp. 15-16. The purchasing power under these agreements is equivalent to what it was for HEU housekeepers 30 to 35 years ago.
- ⁹ Cohen and Cohen, p. 13.
- ¹⁰ Aramark – Local 1-3567(IWA), Partnership Agreement, July 17, 2003.
- ¹¹ Ibid.
- ¹² British Columbia Labour Relations Board. BCLRB No. B 173.2004. Aramark Canada Facility Services Ltd. and Hospital Employees' Union and Industrial, Wood and Allied Workers of Canada Local No. 1-3567. May 20, 2004.
- ¹³ The data on the Hospital Employees' Union membership in Table 2 come from the "HEU Member Profile Survey" conducted in 2002 by the McIntyre and Mustel Group.
- ¹⁴ Palameta, Boris. "Low income among immigrants and visible minorities." *Perspectives* (Statistics Canada – Catalogue 75-001-XPE); Summer 2004: 32-37.
- ¹⁵ Sixty per cent (n. 6) of our participants who immigrated before 1991 were in the "\$2,000/month and more" income bracket compared with 36 per cent (n. 4) of those immigrating after 1991.
- ¹⁶ In 2004 the median wage for housekeeping aides under the IWA agreements is \$10.25/hour, or \$384.37/week at full-time hours. This works out to \$19,987.50 per annum. The 2003 LICO for a single-person household is \$19,795; for a two-person household, \$24,745.

- ¹⁷ Wager, N., G. Fieldman, and T. Hussey. "The effect on ambulatory blood pressure of working under favourably and unfavourably perceived supervisors." *Occupational and Environmental Medicine* 2003; 60:468-74.
- ¹⁸ Ahlberg-Huten, Gunnel et al. "Social support, job strain and musculoskeletal pain among female health care personnel." *Scandinavian Journal of Work, Environment and Health* 1995:21:435-9.
- ¹⁹ Akyeampong, Ernest B. "Missing work in 1998 – industry differences." *Perspectives* (Statistics Canada) Autumn 1999; p. 33.
- ²⁰ Cohen, Marjorie. "Do comparisons between hospital support workers and hospitality workers make sense?" Vancouver: Hospital Employees' Union, 2001. p. 6.
- ²¹ WHMIS stands for Workplace Hazardous Materials Information System. MSDS stands for Material Safety Data Sheets. Both relate to the identifying, labelling, and handling of hazardous materials in the workplace.
- ²² "Falling standards, rising risks: Issues in hospital cleanliness with contracting out" is a 2004 case study of a BC hospital with privatized cleaners; it offers a detailed description of the role of housekeeping supervisors. British Columbia Nurses' Union, Hospital Employees' Union, Health Services Association, 2004.
- ²³ For example, see Marjorie Cohen, "Do comparisons between hospital support workers and hospitality workers make sense?" Vancouver: Hospital Employees' Union, 2001; Karen Messing et al., "'Light' and 'heavy' work in the housekeeping service of a hospital." *Applied Ergonomics* 1998, 29: 451-459; and Karen Brodtkin Sacks, *Caring by the Hour: Women, Work and Organization at Duke Medical Center*. University of Illinois Press, 1988.
- ²⁴ Armstrong, Pat and Irene Jansen. "Burned out and tired: The impact of restructuring and work organization on workers in long term care." National Networks on Environments in Women's Health. Ottawa: Canadian Union of Public Employees, 2004.
- ²⁵ Cohen, Marjorie. "Do comparisons between hospital support workers and hospitality workers make sense?" Vancouver: Hospital Employees' Union, 2001.
- ²⁶ Hospital Employees' Union. "HEU Member Profile Survey." Vancouver: McIntyre and Mustel, 2002.
- ²⁷ Cohen, Marjorie, and Marcy Cohen. "A return to wage discrimination: Pay equity losses through the privatization of health care." Vancouver: Canadian Centre for Policy Alternative, April 2004.
- ²⁸ A thorough examination of this issue is found in Marjorie Cohen's in-depth study, "Do comparisons between hospital support workers and hospitality workers make sense?" Vancouver: Hospital Employees' Union, 2001.
- ²⁹ Based on comparisons with the 2002 HEU membership survey and the 2002 Canadian Community Health Survey (CCHS).
- ³⁰ Galarneau, Diane and Rene Morissette. "Immigrants: Settling for less?" *Perspectives on Labour and Income*. Statistics Canada, 2004. Catalogue no. 75-001-XPE. Ottawa: 7-18.
- ³¹ *Ibid.*
- ³² Frenette, Marc and Rene Morissette. "Will they converge? Earnings of immigrants and Canadian-born workers over the last two decades." Analytical Studies Branch research paper no. 215. Statistics Canada, 2003. Catalogue no. F0019MIE2003215. Ottawa. Pico, Garnet and Feng Hou. "The rise in low-income among the elderly." Analytical Studies Branch research paper no. 198. Statistics Canada, 2003. Catalogue no. 11F0019MIE, Ottawa.
- ³³ Palameta, Boris. "Low income among immigrants and visible minorities." *Perspectives* (Statistics Canada – Catalogue 75-001-XPE); Summer 2004: 32-37.

- ³⁴ Auditor General of Scotland. "A clean bill of health? A review of domestic services in Scottish hospitals." Audit Scotland, April 2000. www.audit-scotland.gov.uk
- ³⁵ BCNU, HEU, HSA. "Falling standards, rising risks: Issues in hospital cleanliness with contracting out." Vancouver: British Columbia Nurses' Union, Hospital Employees' Union, Health Services Association, 2004.
- ³⁶ Ibid, p. 53.
- ³⁷ Ibid, p. 40.
- ³⁸ Auditor General of British Columbia. "Building a strong work environment in British Columbia's public service: A key to delivering quality service (2002/2003 Report 1)." Victoria: Office of the Auditor General of BC, 2003. p. 2.
- ³⁹ Auditor General of British Columbia. "In sickness and in health: healthy workplaces for British Columbia's health care workers." Victoria: Office of the Auditor General of BC, June 2004. p. 20. The report drew on ideas in a 2001 report by the Canadian Health Services Research Foundation, entitled "Commitment and care: The benefits of a healthy workplace for nurses, their patients and the system."
- ⁴⁰ Auditor General of British Columbia. "Building a strong work environment in British Columbia's public service: A key to delivering quality service (2002/2003 Report 1)." Victoria: Office of the Auditor General of BC, 2003. p. 63.
- ⁴¹ Auditor General of British Columbia. "In sickness and in health: healthy workplaces for British Columbia's health care workers." Victoria: Office of the Auditor General of BC, June 2004. p. 2.
- ⁴² Department of Health (UK). "National standards of cleanliness for the NHS." London: Department of Health, April 2001.
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- ⁴⁴ Cited in a report by the U.K. trade union central, Unison: "Cleaner's voices: Interviews with hospital cleaning staff," pp. 4-5.
- ⁴⁵ "Improving patient care by reducing the risk of hospital-acquired infection: A progress report." Report by the Comptroller and Auditor General, National Audit Office, HC 876 Session 2003-2004: 14 July 2004. p. 7.
- ⁴⁶ Dr. Michael Rachlis dissects the mythology that health care services are normal market goods in "The hidden costs of privatization: An international comparison of Community and Continuing Care," in *Without Foundation: How medicare is undermined by gaps and privatization in Community and Continuing Care*. Vancouver: Canadian Centre for Policy Alternatives – BC Office et al., 2000.
- ⁴⁷ In 2004 several women who had caesarian sections at Surrey Memorial Hospital came down with serious infections.
- ⁴⁸ BCNU, HEU, HSA. "Falling standards, rising risks: Issues in hospital cleanliness with contracting out." Vancouver: British Columbia Nurses' Union, Hospital Employees' Union, Health Services Association, 2004. The report focussed on the emergency department of St. Paul's Hospital.

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The Economic Security Project is a major research initiative of the CCPA's BC Office and Simon Fraser University, in partnership with 24 community organizations and four BC universities.

The project examines how recent provincial policy changes affect the economic well-being of vulnerable people in BC, such as those who rely on social assistance, low-wage earners, recent immigrants, youth and others. It also develops and promotes policy solutions that improve economic security.

The project is funded primarily by a grant from the Social Sciences and Humanities Research Council of Canada (SSHRC) through its Community-University Research Alliance Program.

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