Social Science & Medicine 74 (2012) 390–398

Contents lists available at SciVerse ScienceDirect

Social Science & Medicine

journal homepage: www.elsevier.com/locate/socscimed

Structural violence in long-term, residential care for older people: Comparing Canada and Scandinavia

Albert Banerjee [a,*], Tamara Daly [b], Pat Armstrong [c], Marta Szebehely [d], Hugh Armstrong [e], Stirling Lafrance [f]

[a] *Re-imagining Long-term Residential Care, York University, 4700 Keele St, Toronto, Ontario M3J 1P3, Canada*
[b] *School of Health Policy & Management, York University, Toronto, Ontario, Canada*
[c] *Department of Sociology and Women's Studies, York University, Toronto, Ontario, Canada*
[d] *Department of Social Work, Stockholm University, Stockholm, Sweden*
[e] *School of Social Work, Carleton University, Ottawa, Ontario, Canada*
[f] *Social and Political Thought, York University, Toronto, Ontario, Canada*

ARTICLE INFO

Article history:
Available online 7 December 2011

Keywords:
Canada
Scandinavia
Long-term care
Nursing home
Violence
Assault
Elder-care
Work

ABSTRACT

Canadian frontline careworkers are six times more likely to experience daily physical violence than their Scandinavian counterparts. This paper draws on a comparative survey of residential careworkers serving older people across three Canadian provinces (Manitoba, Nova Scotia, Ontario) and four countries that follow a Scandinavian model of social care (Denmark, Finland, Norway, Sweden) conducted between 2005 and 2006. Ninety percent of Canadian frontline careworkers experienced physical violence from residents or their relatives and 43 percent reported physical violence on a daily basis. Canadian focus groups conducted in 2007 reveal violence was often normalized as an inevitable part of elder-care. We use the concept of "structural violence" (Galtung, 1969) to raise questions about the role that systemic and organizational factors play in setting the context for violence. Structural violence refers to indirect forms of violence that are built into social structures and that prevent people from meeting their basic needs or fulfilling their potential. We applied the concept to long-term residential care and found that the poor quality of the working conditions and inadequate levels of support experienced by Canadian careworkers constitute a form of structural violence. Working conditions are detrimental to careworker's physical and mental health, and prevent careworkers from providing the quality of care they are capable of providing and understand to be part of their job. These conditions may also contribute to the physical violence workers experience, and further investigation is warranted.

© 2011 Elsevier Ltd. All rights reserved.

Introduction

"Getting residents ready for the day – bathing, feeding all. There is not enough time in the day! 45 minutes to get 12 residents for breakfast!!! How do you think that works?"—Surveyed Canadian frontline careworker

This paper contributes to the research on violence experienced by frontline careworkers in residential care for older people. The majority of this research has been conducted in Anglophone countries and the US in particular. What has emerged is a relatively consistent portrait of a physically and verbally violent workplace (Pillemer & Moore, 1990; Shaw, 2004). Commonly documented forms of physical violence include: being hit, punched, pinched, poked, scratched, pushed or kicked. Having one's wrists twisted or hair pulled is also common. Research suggests such violence is frequent, though rarely reported (Robinson & Tappen, 2008). Violence has come to be "expected, tolerated, and accepted" as an inevitable part of elder-carework (Gates, Fitzwater, & Meyer, 1999).

Resident characteristics such as gender (Boyd, 1998), dementia (Cohen-Mansfield, Marx, & Werner, 1992) and pain (Malone, Thompson, & Goodwin, 1993) have been associated with resident-to-staff violence. The majority of incidents occur during direct care activities (e.g., bathing, dressing, feeding, toileting). Organizational conditions set the context for these activities and insufficient time, low autonomy and inadequate staffing have been associated with violence (Shaw, 2004). Agitated behaviours, for instance, increase markedly when residents with dementia are

* Corresponding author.
E-mail addresses: balbertb@yorku.ca (A. Banerjee), dalyt@yorku.ca (T. Daly), patarmst@yorku.ca (P. Armstrong), marta.szebehely@socarb.su.se (M. Szebehely), hugh_armstrong@carleton.ca (H. Armstrong).

0277-9536/$ – see front matter © 2011 Elsevier Ltd. All rights reserved.
doi:10.1016/j.socscimed.2011.10.037

uncomfortable or left alone (Cohen-Mansfield & Werner, 1995). Careworkers' low occupational status has also been linked to violence and victim-blaming, focusing on careworker "error" (Morgan et al., 2008).

This paper contributes to a research trajectory that recognises the systemic dimensions of violence. We introduce the concept of structural violence, and use it in two ways. First, we use structural violence as a frame to raise questions around whether and how social and organizational factors influence patterns of interpersonal violence (Farmer, 1997). Second, we use the concept of structural violence to analyse poor quality working conditions as a form of violence (Galtung, 1969).

Structural violence

The concept of structural violence was developed by Peace Studies scholar Johan Galtung (1969). The concept rests on a broad definition of violence, which extends beyond *direct* physical and psychological harm to include *indirect* actions. The concept draws attention to the role that institutions and social practices play in preventing people from meeting their basic needs or realizing their potential. Galtung distinguishes between personal forms of violence, like physical abuse, and structural violence, such as marginalization and exploitation. "Thus, when one husband beats his wife there is a clear case of personal violence, but when one million husbands keep one million wives in ignorance there is structural violence" (171). Following Galtung, we use structural violence to identify the heavy workloads, low levels of decision-making autonomy, low status, rigid work routines and insufficient relational care as forms of violence. Not only are these poor working conditions experienced as sources of suffering but they prevent careworkers from providing the kind of care they know they are capable of.

Our use of structural violence is further informed by the work of Paul Farmer (1997), who employs the concept to broaden the explanation of disease causation. Farmer observes that the risks for diseases, such as TB in rural Haiti, have been structured in advance, in large part, through the choices of human agents rather than the vagaries of microbes. Farmer uses the concept of structural violence to connect these human actions (and inactions) to their harmful consequences. He calls for research on structural violence that seeks to identify the interconnections between localized "suffering" and the "larger matrix of culture, history, and political economy" (272).

To explore the effects of culture, history, and political economy on residential care, we employed comparative surveys of careworkers from across three Canadian provinces (Manitoba, Nova Scotia, and Ontario) and careworkers in countries characterised by a Scandinavian model of social care (Rauch, 2007) – Denmark, Finland, Norway, and Sweden. Like Canada, these countries have a public health care system and large, ageing populations, so they offer a similar point of comparison. However, unlike Canada, Scandinavia has approached social care as a collective endeavour, viewing elder care as the responsibility of the State. Scandinavia has recognized the importance of State funded care for women's equity (Anttonen & Sipilä, 1996) and allocated greater resources to the sector (OECD, 2011:46–49), avoiding the level of commercialization found in Canada. To set the context for our analysis, we briefly describe long-term care in Canada and Scandinavia.

Long-term care in Canada

In Canada, "long-term care" denotes a continuum of services, including: homecare, retirement homes, assisted living, and residential care facilities – the latter are the focus of this study. Residential care facilities are distinguished by the higher care needs of residents and the availability of 24 h nursing. They are licenced and regulated by provincial governments.

Because long-term care is not presently an insured service under the *Canada Health Act* – the legislation that sets the national conditions for public care – there has been little federal oversight or funding and no national strategy (Banerjee, 2009). The development of long-term care thus reflects provincial and territorial differences, with no obligation on the part of governments to provide a standard range of services. Nevertheless, local struggles have led to the public funding of the medical component of care, though what counts as "medical" varies across jurisdictions. Nursing care is commonly covered but accommodations are treated as out-of-pocket expenses. Financial assistance for accommodation may be provided, though this is minimal and sometimes means-tested.

Residential care facilities vary widely across the country in ownership mix, profit status, size, and design (Berta, Laporte, Zarnett, Valdmanis, & Anderson, 2006). Facilities may be publicly owned and operated. They may be not-for-profit or charitable. Facilities may be private "mom and pop" operations or corporate chains. They range in size from four beds to more than 300 beds. Government facilities tend to be larger, housing residents with greater care needs. In general, Canadian facilities are large, averaging 96 beds (Statistics Canada, 2007).

Despite regional variation, there are trends towards privatization (CHA, 2009) and policy environments that discriminate against small facilities (Berta et al., 2006) and discourage innovation. Some jurisdictions have built special care units for residents with serious cognitive and behavioural impairment, providing higher staff-to-resident ratios and accommodating behavioural needs such as wandering. While these units are not common, studies suggest careworkers experience less violence (Morgan, Stewart, D'Arcy, Forbes, & Lawson, 2005).

Long-term care in Scandinavia

The Scandinavian model of social care, characteristic of Sweden, Norway, Denmark and Finland (Anttonen & Sipilä, 1996) offers a contrast to the Canadian model of care, conceptualizing social care as the responsibility of the State rather than the family. The municipality is the main provider of social care, offering an extensive range of services. Guided by the principal of universality, these services are not understood as a safety-net for those in need but provided for all classes of society. The Scandinavian approach to social care is summarized by Johansson and Anderson (2008: Table 1).

Table 1
Characteristics of the Scandinavian model of social care.

1. Greater state involvement than other countries
2. Heavy reliance on the public sector
3. Greater proportion of the labour force employed in the welfare sector
4. Co-ordinated national systems with over-all responsibility for pensions, sick-leave benefits, child care allowances and health services
5. Comprehensive social insurance systems which cover entire populations or subgroups
6. An advanced level of gender equality
7. Social insurance system free of class or occupational bias
8. General taxation
9. Great emphasis on providing services
10. Strong emphasis on full employment as a goal itself
11. A high level of trust between citizens and government
12. Strong popular support

Source: Johansson and Anderson (2008).

These cultural, political and economic differences set the context within which Scandinavian residential care has developed. However, this was not always the case and there are signs of change, as commercialization makes inroads. Until the 1950s, residential care was synonymous with "old-age homes" – institutions with low housing standards, limited access to care services and strict, authoritarian routines (Daatland, 1999). From the 1970s in Sweden, a decade later in Denmark and even later in Norway and Finland, new forms of adapted housing with access to care were introduced (Szebehely, 1999). While different concepts were and are still used – e.g., services houses, assisted dwellings and sheltered accommodations – facilities typically consist of apartments with normal housing standards (e.g., a single bedroom with kitchen and bathroom). The number of apartments in each facility varies (in Sweden on average 32) and support services are offered according to need. The 1980s saw the introduction of the group-home in Sweden, characterised by their small size (6–10 apartments sharing a kitchen and dining room), higher staffing ratios and home-like setting (Szebehely, 2009). In 1993, Denmark introduced the concept of "nursing flats" – two room apartments with private baths and kitchens, providing the same amount of nursing and care as traditional nursing homes (Daatland, 1999). Today, nursing flats have mostly replaced nursing homes. Compared to Denmark and Sweden, the larger, institutional-style home is more common in Norway and even more so in Finland. This difference is reflected in our data, providing further indication of the impact of policy choices on the experience of workers and the value of international comparative research in making these relations visible.

Presently, the Scandinavian age, gender and disability patterns in residential care approximate those in Canada. A small percentage of the national population live in facilities, though the proportion increases with age. In Sweden, for instance, 6.2 percent of those 65 years or older lived in facilities compared to 25 percent of those 85 years or older (NBHW, 2007:88). In Canada, the proportion is slightly less, with 4.7 percent of those 65 years or older living in facilities compared to 19 percent of those 85 or older (Statistics Canada, 2007:12). The majority of residents are over 80 years of age (71% Canada, 74% Denmark, 71% Finland, 76% Norway, 78% Sweden; (Nososco, 2009:160; Statistics Canada, 2007:54)). Across jurisdictions, the majority of residents are women, with the proportion of women increasing with age. While Scandinavia strives to have separate facilities for those with dementia, in practice this has not been achieved, and the reality is a mixed population, with large numbers of older people with dementia (Szebehely, 2009), as our data suggests.

The Scandinavian model of social care has strongly influenced the conceptualization, organization and delivery of residential care and provides a strong rationale for this comparative study between Scandinavian and Canadian contexts. While we would be remiss not to acknowledge the differences in residential care within Scandinavia (Trydegård & Thorslund, 2010), it is beyond the scope of this paper to provide an overview that is sensitive to the range of national and intra-national differences. Furthermore, as noted, there is substantial variability within Canada. While data are inevitably lost in aggregation, we believe this is more than made up for by the ability to raise questions and make comparisons relating to the broader context and the effects that differing histories and politics of care have on the experience of careworkers.

Data collection

We adopted a "context-sensitive" strategy to cross-national collaboration (Wrede et al., 2006). This approach does not assume similarities in the organization of health care across high-income countries but recognises differences in policy contexts and strives to understand their relationship to institutional organization and lived experience. We began with a questionnaire exploring the conditions of work from careworkers' perspectives.

The questionnaire developed from a series of qualitative studies of careworkers in Scandinavia. A preliminary version was piloted in focus groups with five to 10 careworkers in each country, as part of a larger project (*NORDCARE*). The questionnaire contained both qualitative and quantitative components addressing four themes: a) demographics; b) terms of employment; c) duties and working conditions; d) health, safety and violence. With ethical approval from the Regional Ethical Review Board in Stockholm, the questionnaire was mailed in 2005 to the homes of a random sample of 5000 unionized careworkers in home-based and facility-based care for older or disabled persons (Elstad & Vabø, 2008), drawing on addresses supplied by careworker unions (FOA in Denmark; JHL, SuPer and Tehy in Finland; Fagforbundet in Norway; Kommunal in Sweden). The overall response rate was 72 percent (Denmark 77%, Finland 72%, Norway 74%, and Sweden 67%). In this paper, we only use the responses from careworkers in facility-based care for older people.

The Canadian data were collected in collaboration with *NORDCARE*, using a questionnaire covering similar themes and numerous comparative questions. Ethical approval for the Canadian data collection was received from York University in Ontario. The Canadian survey sample and data collection was handled by the York Institute for Social Research (ISR). As it was not possible to obtain workers' home addresses, the sample was randomized at the level of institution and designed to be proportional by provincial population and facility ownership type. A total of 81 unionized long-term care facilities in Manitoba, Ontario and Nova Scotia were selected. Access to these institutions was facilitated by the five health-sector unions (CAW, CFNU, CUPE, NUPGE, SEIU). The unions identified a coordinating person within each facility, and the questionnaire was distributed in 2006. Due to this procedure, it was not possible to calculate response rates. A broad spectrum of workers ($n = 948$) from 71 of the 81 (88%) facilities participated. To ensure anonymity and independence, respondents mailed the questionnaire directly to the ISR.

The Canadian survey revealed heavy workloads and frequent violence. To explore these findings, we conducted focus groups in each of the Canadian provinces surveyed (two in Nova Scotia, two in Manitoba, and five in Ontario). No focus groups were conducted in Scandinavia. Canadian focus groups were organized by union contacts who advertised for participants but did not attend the sessions themselves. Each focus group had between three and eight participants, primarily female frontline careworkers and were held in each province between December 2006 and May 2007. Three facilitators were employed (one for each province). All had previous training and experience facilitating focus groups and had previously collaborated with the research team. Facilitators were briefed as to the goals of the study. Researchers were present at the Ontario sessions. Facilitators read a survey question, presented the descriptive statistical results, and participants were asked: "*does this reflect your experience?*" Questions focused on workload, staffing, autonomy and violence. Participants were asked follow-up questions on issues that emerged in previous sessions. The focus groups were recorded then transcribed verbatim. We undertook a thematic analysis of our qualitative data (Ryan & Bernard, 2000), comprised of focus group transcripts and open-ended survey. This involved a process of identifying data that were relevant to existing themes in the literature and identifying new themes by looking for patterns, attending to emphasis, emotions and unique or surprising remarks. The attribution of violence to systemic conditions was one theme that emerged, which differed from dyadic representations of violence in the research literature as a relationship between two

people. The importance of this theme prompted us to turn to the theoretical framework of structural violence as elaborated by Farmer (1997) and Galtung (1969) in order to extend our analysis. We returned to our data, attending to structural factors and subthemes specific to the conceptual framework of structural violence. In what follows, we distinguish focus groups data from qualitative survey data with an "FG."

Sample characteristics

While the survey covered all occupational categories, this paper reports on our analysis of frontline careworkers surveyed in Canada ($n = 415$) and Scandinavia ($n = 409$ in Denmark, 449 in Finland, 441 in Norway and 326 in Sweden). These careworkers perform similar duties, completing the majority of bodily carework. The Scandinavian careworkers, however, perform more relational carework and cleaning. Some differences in the organization of carework across jurisdictions posed challenges for comparative analysis.

The Canadian workforce is highly stratified, with the boundaries between occupational categories more pronounced (Armstrong et al., 2009). Labour is task oriented, with tasks allocated among job categories. Registered nurses (RNs) hold managerial roles, with licenced practical nurses (LPNs) and frontline careworkers providing direct care. LPNs perform more medically oriented, supervisory and administrative tasks; while frontline careworkers handle most bodily carework (e.g., bathing, toileting, dressing, feeding). Canadian frontline careworkers go by a variety of designations (e.g., personal support workers, health care aides, residential care aides).

There is much less stratification in Scandinavia, and the division of labour is not as pronounced. Scandinavian careworkers combine tasks given to Canadian housecleaners, dietary staff, frontline careworkers and LPNs. The distinction between occupational groups corresponding to LPNs and frontline careworkers is much less defined and regardless of occupational title, workers do almost the same tasks (Daly & Szebehely, 2011). To accommodate these differences, the data we present on Scandinavian frontline careworkers includes LPNs but the Canadian data does not.

There are also important differences in levels of "*health care related training.*" In Canada 76 percent of frontline careworkers surveyed hold "*a certificate from a college (completed in one year or less).*" In contrast, 83 percent of Scandinavian frontline careworkers have completed more than a year of training (Denmark 88%; Finland 88%; Norway 80%; Sweden 75%). We explore the relation of training to violence in Table 3).

There are also important similarities. This is a highly gendered workforce; over 90 percent of careworkers are women (95% Canada; 98% Denmark; 99% Finland; 98% Norway; 97% Sweden). This is also an ageing and experienced workforce. Over half (56%) the Canadian frontline careworkers surveyed were over 45 years of age. Scandinavians were slightly older, with 61 percent being 45+. Three fifths of Canadian frontline careworkers have worked in the sector for more than ten years with 29 percent having worked for 20+ years. Scandinavian careworkers were even more experienced; over two thirds had worked more than ten years, with 37 percent having worked 20+ years.

Results

Frequency and nature of violence experienced by Canadian frontline careworkers

We asked Canadian frontline careworkers "*How often are you subjected to physical violence by a resident or their relative?*" They indicated that physical violence was frequent, with 43 percent experiencing it on a daily basis and another 23 percent weekly (Table 2). Only 10 percent reported never experiencing physical violence. Focus group participants described violence as being an "*everyday occurrence*":

> *I've been punched in the face several times. I've been punched in the jaw several times. Getting hit. Having your wrists twisted….Pulling and shoving at you. I mean that's a day-to-day thing….Violence is an everyday occurrence.*[FG9]

Verbal violence was also common, with over one-third reporting being "*criticized or told off by a resident or their relative*" everyday (Table 2). This does not include sexist and racist remarks, which focus group participants reported "*happen all the time*"[FG8] and were "*very upsetting*"[FG8].

We asked careworkers how often they received "*unwanted sexual attention.*" Of the Canadian frontline careworkers surveyed, one-third said they experienced this on a daily or weekly basis. Unwanted sexual attention often occurred during bathing: "*Doing a bath on a male resident, he tries to push your head down to his penis*"[FG1]. Or, as another explained: "*You tell them to wash their private parts and they say 'No, you wash it. You're paid to do that'*"[FG1].

Focus group participants felt the survey findings underestimated the prevalence of unwanted sexual attention. They suggested this might be because some careworkers rationalize sexual violence. Similar tendencies to downplay physical violence were observed. "*I wouldn't classify it as violence. Basically like groping or if you happen to get them on a bad day when maybe their pain control isn't met through medication, they strike out at you*"[FG1].

Invisibility of violence

Studies of residential care in Canada indicate that most violence goes unreported (Goodridge, Johnston, & Thomson, 1996). Focus group participants cited excessive paperwork as prohibitive of reporting. "*When you are injured on the job to do WCB [Workers' Compensation Board] forms there's what? Eight pages*"[FG1]?

Careworkers reported being blamed for causing incidents. "*If you get hit it's 'What did you do?' It's always your fault*"[FG7]. This was attributed to their low occupational status. "*Yeah, it's your approach. But slap a manager, boy you're out within the hour*"[FG7]. Careworkers were also blamed for causing sexual violence, not an

Table 2
Frequency and nature of violence.

	More or less everyday (%)	Every week (%)	Monthly (%)	Less often (%)	Never (%)
Physical violence					
Denmark ($n = 398$)	5.0	10.3	7.0	43.0	34.7
Finland ($n = 447$)	8.1	11.6	10.5	46.5	23.3
Norway ($n = 438$)	6.8	10.7	7.5	45.2	29.7
Sweden ($n = 323$)	6.2	13.3	10.5	43.0	26.9
Canada ($n = 398$)	43.0	23.1	7.8	15.8	10.3
Being criticized or told off					
Denmark ($n = 399$)	8.0	14.0	11.0	48.9	18.0
Finland ($n = 447$)	5.8	10.7	12.8	54.8	15.9
Norway ($n = 436$)	9.6	16.3	7.3	52.1	14.7
Sweden ($n = 322$)	5.6	7.5	9.3	48.8	28.9
Canada ($n = 406$)	35.5	23.2	7.9	21.4	12.1
Unwanted sexual attention					
Denmark ($n = 403$)	1.5	2.2	2.0	31.5	62.8
Finland ($n = 444$)	0.5	2.9	3.6	33.6	59.5
Norway ($n = 437$)	0.2	2.3	2.1	31.4	64.1
Sweden ($n = 323$)	0.3	1.2	2.8	26.0	69.7
Canada($n = 399$)	14.3	15.8	7.5	31.8	30.6

χ^2 test: Physical violence $p < 0.001$; Being criticized or told off $p < 0.001$; Unwanted sexual attention $p < 0.001$.

Table 3
Frequency of physical violence by training level.

		Physical violence:				
		More or less everyday (%)	Weekly (%)	Monthly (%)	Less often (%)	Never (%)
None or less than six months of formal training	Canada ($n = 35$)	40.0	11.4	14.3	25.7	8.6
	Scandinavia ($n = 116$)	4.3	3.4	10.3	37.9	44.0
½–1 year of formal training	Canada ($n = 283$)	42.8	28.1	8.1	14.5	9.5
	Scandinavia ($n = 145$)	4.8	12.4	6.9	45.5	30.0
1 year+ of formal training	Canada ($n = 54$)	48.1	18.5	3.7	18.5	11.1
	Scandinavia ($n = 1330$)	6.9	12.0	9.0	45.3	26.7

In the Canadian case 1/2–1 year training corresponds to a 'health related college certificate completed in one year or less' while 1 year+ training corresponds to a 'health related diploma from college completed in more than 1 year' or (in a few cases) a 'health related university degree'.
χ^2 test: None or less than six months of formal training $p < 0.001$; ½–1 year of formal training $p < 0.001$; 1 year+ of formal training $p < 0.001$.

uncommon experience for women: *We had one [careworker] and when they went to management to complain, management told her that perhaps she shouldn't be so friendly with the male residents.*"[FG2].

Failure to report was also attributed to the normalization of violence. "*We normalize it. I think that's what happens*"[FG7]. "*We've been told it's part of our job*," said another careworker, "*that makes me mad*"[FG3]. Still another observed: "*We try not to [accept it], but management tells us: 'Well you're a big girl. You can't be… Nobody can bother you. Lighten up'.*"[FG3].

Violence experienced by Scandinavian frontline careworkers

Frontline careworkers in Scandinavia also reported violence from residents and family members. Seventy-one percent of all Scandinavian frontline careworkers were exposed to physical violence or threats of physical violence from residents (65% Denmark; 77% Finland; 70% Norway; 73% Sweden). The variation among countries was not dramatic (Table 2). It should be noted that the Scandinavian questionnaire likely over-estimates the frequency of physical violence, given that the question also includes "*threats*" of physical violence, whereas the Canadian one does not.

When the proportion of careworkers experiencing violence on a daily basis is compared, Canadian frontline careworkers report six times more physical violence (43.0% compared to 6.6%), four times more verbal violence (35.5%–7.4%), and twenty-three times more unwanted sexual attention than their Scandinavian counterparts (14.3%–0.6%). While we do not diminish the problem of violence in Scandinavia, these findings raise questions as to the reasons for such differences.

The comparatively lower rates of violence in Scandinavia are unlikely to be due to methods of data collection, since we asked careworkers nearly identical questions, with the exception of including "threats" of physical violence in the question put to Scandinavians. Similarly, the differences are not a result of the decision to exclude LPNs from the composition of Canadian frontline careworkers. Were we to aggregate Canadian LPNs in the category of frontline careworker as we did in Scandinavia, we would find that 38.2 percent of the frontline careworkers and LPNs experience violence on a daily basis (22% weekly; 9% monthly; 20% less often, and 10% never). Comparative differences remain large, with Canadian frontline careworkers and LPNs 5.7 times more likely to experience physical violence on a daily basis than their Scandinavian counterparts.

As noted, Scandinavian frontline careworkers have higher levels of formal training (83% of Scandinavian frontline careworkers have at least one year of formal training compared to 15% of Canadian frontline careworkers). Nevertheless, when we explore the exposure to physical violence by training, Scandinavian careworkers consistently experienced significantly less violence (Table 3).

While violence from residents is correlated with dementia, our results suggest that Scandinavians work with a slightly greater proportion of residents with dementia (48% of Scandinavian frontline careworkers reported that *most* or *all* of the residents they serve suffer from dementia, while 41% of Canadian frontline careworkers report that 60 percent of residents they cared for on their most recently completed shift suffered from dementia). Careworkers working with a higher proportion of residents with dementia and related diseases experience physical violence more frequently across jurisdictions, but the exposure to violence is lower in Scandinavia irrespective of the proportion of residents with dementia. Among those who report that the majority of their residents suffer from dementia, in Scandinavia 10 percent experience physical violence on a daily basis compared to 52 percent in Canada (Table 4).

Structural violence

The concept of structural violence highlights those social and institutional processes that systematically prevent people from fulfilling their basic needs or achieving their potential. Canadian careworkers reported that they were unable to deliver the quality

Table 4
Frequency of physical violence by proportion of residents with dementia.

		Physical violence:				
		More or less everyday (%)	Weekly (%)	Monthly (%)	Less often (%)	Never (%)
None or some residents have dementia	Canada ($n = 114$)	35.1	23.7	12.3	18.4	10.5
	Scandinavia ($n = 488$)	2.5	5.5	5.5	48.4	38.1
Around half of residents have dementia	Canada ($n = 58$)	43.1	19.0	15.5	17.2	5.2
	Scandinavia ($n = 317$)	5.7	12.9	9.1	47.3	24.9
Most or all residents have dementia	Canada ($n = 121$)	52.1	25.6	2.5	12.4	7.4
	Scandinavia ($n = 747$)	9.6	14.7	11.2	41.2	23.2

In the Canadian case 'None or some' corresponds to less than 40 percent of residents; 'Around half' corresponds to 40–60 percent and 'Most or all' corresponds to more than 60 percent.
χ^2 test: None or some residents have dementia $p < 0.001$; Around half of residents have dementia $p < 0.001$; Most or all residents have dementia $p < 0.001$.

of care they knew they were capable of given their current working conditions. These working conditions may therefore be explored as a form of structural violence. Indeed, workers' heavy workload, rigid work routines, low autonomy and low status were experienced as sources of physical and psychological distress. Focus group participants indicated that their working conditions contributed to conflict and violence. Careworkers noted, for instance, they were frequently required to rush intimate care activities, resulting in residents' agitation and violence. We therefore suggest that one possible explanation for the patterns of violence observed may be found in the differences in the organization of carework between Canada and Scandinavia and, more broadly, in the social, cultural, political and economic conditions that set the context for these. In what follows, we therefore explore differences between Canada and Scandinavia relating to aspects of work organization that careworkers raised as important both to the potential for violence and the provision of quality care.

Workload

Workload is a product of multiple interacting factors: the type of work, expected outcomes, the organization and distribution of labour, staffing levels, training and experience, resources and support. Canadian frontline careworkers reported heavy workloads that provided insufficient time to deliver quality care. While having "*too much to do*" was common across jurisdictions, it was particularly intense for Canadians, with 60 percent reporting this was the case "*all or most of the time*" compared to 40 percent of Scandinavians (Table 5). Canadians reported being continually "*rushed*," "*on a treadmill*," working "*like Speedy Gonzales shooting all over the place*"[FG9] or "*running around like a chicken with their head cut off*"[FG1].

We asked careworkers, "*how many residents do you care for when you work?*" On "*days, during the week*" Canadians were responsible for nearly twice as many residents (15) as their Scandinavian counterparts, although Finland was an outliner (6 Denmark; 15 Finland; 8 Norway, 9 Sweden; One-way ANOVA $p > 0.001$).

Canadian careworkers emphasised the importance of relational care that supported residents' social, emotional, psychological and spiritual needs. Our survey found the organization of carework in Scandinavia provided for greater relational caring (Armstrong et al., 2009: 61–66, 105–110). Inadequate relational care resulted in dehumanizing conditions, as one Canadian survey respondent explains: "*we do not work with machines, we work with humans and I find it very inhumane to have this many residents and only approx 10-15 mins to get them up or put them to bed each day.*" Careworkers reported having to choose between their own well-being and that of residents:

> *But to actually stop when they ask you to come over or, you know, just the most basic things that are just lacking now 'cause everyone is running. You know. You're kind of like yeah, yeah, just be quiet. I just want to go for my break. You know. You're just trying to get away at some point.*[FG1]

Canadian frontline careworkers insisted on the need for more staff. When asked for recommendations, Canadian frontline careworkers' primary request was increased staffing. Below is an excerpt of survey responses:

> *"More staff, an easier way to deal with physically violent res'." "Having more hands on care available…Everything is rush and rush." "A full crew of working people, everyday all day long….We are tired." "The staff to effectively and safely meet government standards." "NEED MORE STAFF."*

In addition in insufficient staffing, the practice of not replacing absent staff – "short-staffing" – was routine for Canadians, experienced daily by 44 percent of frontline careworkers (Table 6). In contrast, between 12 and 23 percent of Scandinavian careworkers reported "*short-staffing due to sickness, vacation or vacancies*" on a daily basis. The Canadian figures may underestimate the problem as we asked about short-staffing due to "*sickness or vacation.*" Participants clarified they also worked short-staffed because vacancies went unfilled. The problem for careworkers was clear: "*Never mind being sick or on vacation. Period. We're short-staffed*"[FG8]. Some linked short-staffing to resources: "*It's a cost saving measure for [management] if they don't replace the person*"[FG7].

Decision-making autonomy and horizontal communication

Low decision-making autonomy and insufficient opportunities for horizontal communication among co-workers were also identified by focus group participants as contributing to violence, inhibiting careworkers' capacity to tailor care to residents needs or share valuable information (e.g., about residents' changing physical/emotional states).

The survey found that levels of autonomy and horizontal communication in Canadian facilities were low. Only 24 percent of Canadian frontline careworkers said they could "*affect the planning of each day's work*," compared to 45 percent of Scandinavians ($p < 0.001$). And only 22 percent of Canadians said they had "*enough time to discuss difficulties in your work with colleagues*" all or most of the time, compared to 54 percent of their Scandinavian counterparts ($p < 0.001$).

Policies in relation to incontinence pads revealed in Canadian focus groups illustrate the structural limits on careworkers' autonomy. Participants noted that residents were put in "*diapers*" because of inadequate staffing. To contain costs, the diaper could not be changed until it reached a saturation point indicated by a thin blue line. This was the case even if the careworker judged they needed changing or the resident requested this change. Drawing attention to the links between structure and violence, one survey respondent observed:

Table 5
Workloads.

	There is too much to do			
	All or most of the time (%)	Sometimes (%)	Rarely (%)	Never (%)
Denmark ($n = 404$)	30.2	53.2	14.6	2.0
Finland ($n = 445$)	50.6	44.0	4.5	0.9
Norway ($n = 431$)	39.2	53.4	6.7	0.7
Sweden ($n = 325$)	40.0	50.5	8.9	0.6
Canada ($n = 411$)	60.3	36.0	2.9	0.7

χ^2 test $p < 0.001$.

Table 6
Working short-staffed.

	How often do you work short-staffed?				
	More or less everyday (%)	Weekly (%)	Monthly (%)	Less often (%)	Never (%)
Denmark($n = 402$)	23.1	31.1	21.9	18.2	5.7
Finland ($n = 442$)	12.4	26.9	31.4	26.2	2.9
Norway ($n = 426$)	13.6	32.4	18.5	31.2	4.2
Sweden ($n = 316$)	12.0	29.7	22.8	32.3	3.2
Canada ($n = 404$)	43.8	34.4	8.7	10.6	2.5

χ^2 test $p < 0.001$.

The residents - many of them have no family and they sit in a w/c [wheel chair] most of the day. They are sad and lonely. There are many things that could be done. But again not enough staff and no time. Would you like to be told – "no you can't go to the bathroom because your logo says no toileting. You have an Attend [diaper] on. Go in your pants and we will change you later"? With this to deal with the agitation level goes up!

Changing resident populations and training

Transformations in health and social care policy have increased the intensity and complexity of residential carework:

When I first started we would get residents that were in fairly good shape initially. Now we come to the fact that they want them kept at home longer. They're coming in 90-plus years old and total care… that just adds to the workload. So even though you may have a ratio of eight residents to one, you're still in actual fact probably doing 12 to one 'cause of the amount of care that you've got to do.FG7

Careworkers noted their training was inadequate to meet these changes:

We have all these other mental disorders. None of us have training for it. None of us! None of us had psych courses. I don't care if it's an LPN, a housekeeper. The only ones that may have some training are the RNs. We're not safe. The residents aren't safe… it's out of control. It's really out of control.[FG9]

Canadian frontline careworkers also had concerns around the implementation of training programs, noting that they were often required to attend during break time, a practice that fostered resentment and reduced attendance: "*We have in-services but they call them lunch-and-learns and they do them on our break time. And they provide us a sandwich and they think this is a great time*"[FG3]. Another explained: "*…you go in for like 10 minutes and you leave. Like you don't have time for the full half hour*"[FG4]. Participation rates for training programs may thus be inflated: "*They just don't care really if you go in for two minutes. Just sign that piece of paper…*"[FG4].

The experience and effects of structural violence

The concept of structural violence broadens the typology of workplace violence to include the low quality working conditions that careworkers experience as a form of violence. Working conditions are described by Canadian frontline careworkers with language fitting violence: "*stressful*," "*brutal*," "*out of control*," "*exhausting*," "*demoralizing*. These conditions take a physical and mental toll. Canadian frontline careworkers finish their shifts almost always "*physically tired*" (63%), "*mentally exhausted*" (40%) and suffering from "*back pain*" (36%). As one careworker described: "*by the time my day ends I'm like 'Oh my god let me out*'"[FG2]! One survey respondent expressed it this way:

I really wish there was more funding. I'm only 26 years old, I'm healthy and in good physical shape and I find myself to be tired and sore most days after work. I can't imagine how the older staff feels.

Many reported the consequences extend beyond work, a concern particularly salient for women who frequently go home to additional care duties. As one survey respondent described: "*My job takes over my life, due to being mentally, physically exhausted, sleep-eat-work, that's it. This kind of work in LTC drains you to no end.*"

Scandinavian rates of exhaustion were far lower. Indeed, Canadian frontline careworkers were twice as likely to end the day feeling physically exhausted, three times as likely to experience back pain, and four times as likely to be mentally exhausted as their Scandinavian counterparts (Table 7).

Structural violence has emotional consequences. Careworkers reported feeling "*mad*," "*stressed*," "*sad*," "*angry*," "*pissed-off*," and "*demoralized*." Forty-one percent of Canadian frontline careworkers reported feeling "*inadequate because residents are not receiving the care they should*" all or most of the time, compared to 26 percent of Scandinavians ($p < 0.001$). Focus group participants expressed "*frustration*" that they were unable to provide the care they knew they were capable of providing or that residents required – e.g., not being able to sit with residents when they were crying or not allowing residents to enjoy their meal or even chew their food. "*It's horrible when you're shoving [food] in there*"[FG3]. As another describes:

It really makes me feel personally bad when I know in my heart how somebody should be cared for, how you know that you would like to receive care yourself, how you believe that your family members should receive care. And when you are in that situation giving care to the residents and you know there's no way you can approach what you feel you should be doing, that is a very disappointing thing. You know you're letting the residents down and yourself down.[FG1]

Victims of structural violence typically suffer in silence (Farmer, 1997). Canadian frontline careworkers felt their voices were silenced and their working conditions were invisible. Careworkers suggested addressing this invisibility was key to improving the quality of work and care, as the following survey responses illustrate:

There should be a "law" that EVERY Member of Parliament should live in a nursing home for 90 days and be given care and meals just like it is now on a limited budget that "they" allow. I am 100% proof positive things would change over night after their 90 days sentence.
I feel the government should visit these facilities and actually see how hard we work and what it is like for a resident. They would see how the cutbacks have affected the time you get to spend with a resident.
Walk a mile in my shoes. You would really have an eye opener.

Table 7
Effects of structural violence.

	Almost always (%)	Often (%)	Sometimes (%)	Rarely (%)	Never (%)
Physically tired					
Denmark ($n = 408$)	26.0	35.5	27.9	9.1	1.5
Finland ($n = 448$)	32.8	42.4	19.2	5.4	0.2
Norway ($n = 440$)	29.5	39.8	25.2	5.5	0.0
Sweden ($n = 324$)	28.7	38.9	25.9	5.2	1.2
Canada($n = 402$)	62.9	23.6	11.2	1.7	0.5
With back pain					
Denmark ($n = 407$)	11.5	22.9	33.9	23.6	8.1
Finland ($n = 449$)	9.8	22.5	39.0	21.4	7.3
Norway ($n = 439$)	12.1	23.7	38.0	19.6	6.6
Sweden ($n = 322$)	15.2	23.3	38.2	17.7	5.6
Canada($n = 402$)	36.3	24.9	27.1	8.5	3.2
Mentally exhausted					
Denmark ($n = 408$)	8.3	22.3	42.6	21.6	5.1
Finland ($n = 449$)	11.6	31.4	38.8	15.8	2.4
Norway ($n = 439$)	8.0	28.5	45.3	13.4	4.8
Sweden ($n = 323$)	15.5	26.9	40.9	12.7	4.0
Canada($n = 402$)	43.5	25.9	22.4	5.5	2.7

χ^2 test: Physically tired $p < 0.001$; With back pain $p < 0.001$; Mentally exhausted $p < 0.001$.

Discussion

This study finds that Canadian frontline careworkers report higher rates of violence than their Scandinavian counterparts. Focus group participants perceived structural factors as playing a role in the conflict and violence they experienced (e.g., heavy workload, insufficient staff, rigid work routines, lack of decision-making autonomy and inadequate relational care). The differences examined in this paper between the organization of carework in Canada and Scandinavia support this structural explanation. Further investigation is warranted.

Our findings should be considered in light of the following limitations. First, violence is an everyday concept, not a technical term with a standardized definition (Howerton-Child & Mentes, 2010). Further, there exist multiple methods of assessing violence (Rippon, 2000). Our approach was to allow careworkers to define physical violence for themselves. While advantageous in capturing their experience, personal and cultural differences in the interpretation of violence may shape our findings and merit exploration. Second, because we did not have a list of home addresses for Canadian careworkers, we relied on union representatives to distribute the questionnaire within randomly selected facilities. This method of distribution may have generated a selection bias. However, our findings of frequent violence and low quality working conditions align with previous Canadian research (Armstrong & Daly, 2004; Boyd, 1998; Goodridge et al., 1996; Morgan et al., 2008). Finally, while the sector in both Canada and Scandinavia is highly unionized – with about eight in 10 workers belonging to a union – our results may not be representative of non-unionized environments.

This study has important implications for future research. Our findings reveal significant international variation in the organization of carework, suggesting the value of comparative research in identifying and exploring both the consequences and causes of these differences. Furthermore, while acknowledging that the relationship between working conditions and violence requires further research, we believe the lens of structural violence holds promise. It suggests important linkages between the conditions of work, quality of care and violence. While these concerns are often studied independently, they will benefit from more integrated inquiry. This strategy may also hold practical advantages, improving the quality of both work and care simultaneously.

The structural violence lens is not intended to negate the relevance of resident characteristics or interpersonal dynamics. Rather it posits that these need to be thought in relation to structures. Our data suggests, for instance, that training programs should take into account the difficulties of current working conditions and be delivered during work-time with careworkers replaced on the floor. Involving frontline careworkers in the development of training programs and more generally in formal processes that identify workplace challenges may be worth pursuing and could help address their marginalization.

This study contributes to a growing body of scholarship that raises questions around the health consequences of social injustice (e.g., Wilkinson & Pickett, 2010). Exploitation and marginalization are "archetypal" forms of structural violence, according to Galtung (1990). These would appear to define the conditions of work, as described by many Canadian frontline careworkers and some Scandinavians as well. Our study raises questions around the consequences of exploitation and marginalization, with respect to the well-being of workers and the prevalence of violence. We also note that the failure to adequately address ongoing risk, the normalization of violence and the blaming of victims is characteristic of violence against women. We therefore question why gender has typically been absent in analyses of health-sector violence.

We conclude by raising questions around the persistence of violence and poor quality working conditions in Canadian residential care. Comparisons to Scandinavia suggest that answering such questions will require investigating the effects of macro level social, political and economic choices on the conditions within facilities. More broadly, it will require addressing fundamental social justice issues relating to the value of care, the worth of carers and older persons more generally. This study suggests these are not solely ethical matters but structural, shaping the development of residential care facilities, the conditions within them as well as the experiences of those who live and work there.

Acknowledgements

The Scandinavian component of this project was funded by the Swedish Council for Working Life and Social Research. The Canadian component was financed by the Canadian Institutes of Health Research One Time Collaborative Research Grant - International Opportunity Program (OPC - 74350) and Pat Armstrong's CHSRF/CIHR Chair in Health Services and Nursing Research, and by the SSHRC MCRI Re-imagining Long-term Residential Care. The Canadian Union of Public Employees (CUPE), The Canadian Auto Workers (CAW), The National Union of Public and General Employees (NUPGE), the Service Employees International Union (SEIU) and the Canadian Federation of Nurses Unions (CFNU) partnered in the Canadian arm of the research. The Institute for Social Research at York University was responsible for the Canadian survey sample, distribution, collection and data entry. The data analysis and content of this paper, however, remain the sole responsibility of the authors. The authors are grateful for the feedback received from the anonymous reviewers.

References

Anttonen, A., & Sipilä, J. (1996). European social care services. *Journal of European Social Policy, 6*(2), 87–100.
Armstrong, P., Banerjee, A., Szebehely, M., Armstrong, H., Daly, T., & Lafrance, S. (2009). *They deserve better: The long-term care experience in Canada and Scandinavia*. Ottawa, ON: Canadian Center For Policy Alternatives.
Armstrong, P., & Daly, T. (2004). *There are not enough hands*. Toronto: CUPE.
Banerjee, A. (2009). Long-Term Care in Canada: An Overview. In P. Armstrong, M. Boscoe, B. Clow, K. Grant, M. Haworth-Brokman, B. Jackson, A. Pederson, M. Seeley, & J. Springer (Eds.), *A Place to Call Home: Long-term Care in Canada* (pp. 29–57). Halifax and Winnipeg: Fernwood Publishing.
Berta, W., Laporte, A., Zarnett, D., Valdmanis, V., & Anderson, G. (2006). A Pan-Canadian perspective on institutional long-term care. *Health Policy, 79*(2–3), 175–194.
Boyd, N. (1998). *Gently into the night: Aggression in long-term care*. Victoria: Worker's Compensation Board of British Columbia.
CHA. (2009). *New directions for facility-based long term care*. Ottawa, ON: Canadian Health Care Association (CHA).
Cohen-Mansfield, J., Marx, M., & Werner, P. (1992). Agitation in elderly persons. *International Psychogeriatrics, 4*, 221–240.
Cohen-Mansfield, J., & Werner, P. (1995). Environmental influences on agitation. *American Journal of Alzheimer's Care and Related Disorders and Research, 10*(1), 32–39.
Daatland, S. (1999). *Framtidens boformer for eldre*. [*Future housing for older people*]. Copenhagen: Nordic Council of Ministers.
Daly, T., & Szebehely, M. (2011). Unheard voices, unmapped terrain: care work in long-term residential care for older people in Canada and Sweden. *Int J Soc Welfare* 2011, doi: 10.1111/j.1468-2397.2011.00806.x.
Elstad, J. I., & Vabø, M. (2008). Job stress, sickness absence, and sickness presenteeism in Nordic elderly care. *Scandinavian Journal of Public Health, 36*(5), 467.
Farmer, P. (1997). Social scientists and the new tuberculosis. *Social Science & Medicine, 44*(3), 347–358.
Galtung, J. (1990). Cultural violence. *Journal of Peace Research, 27*(3), 291–305.
Galtung, J. (1969). Violence, peace, and peace research. *Journal of Peace Research, 6*(3), 167–191.
Gates, D., Fitzwater, E., & Meyer, U. (1999). Violence against caregivers in nursing homes: expected, tolerated, and accepted. *Journal of Gerontological Nursing, 25*(4), 12–22.

Goodridge, D. M., Johnston, P., & Thomson, M. (1996). Conflict and aggression as stressors in the work environment of nursing assistants. *Journal of Elder Abuse & Neglect, 8*(1), 49–67.

Howerton-Child, R. J., & Mentes, J. C. (2010). Violence against women: the phenomenon of workplace violence against nurses. *Issues of Mental Health Nursing, 31*, 89–95.

Johansson, S., & Anderson, K. (2008). *Diversity – A challenge to the Scandinavian care regime?* Forum on Public Policy. www.forumonpublicpolicy.com/archivespring08/johanesson.pdf.

Malone, M. L., Thompson, L., & Goodwin, J. S. (1993). Aggressive behaviors among the institutionalized elderly. *Journal of the American Geriatric Society, 41*, 853–856.

Morgan, D. G., Crossley, M. F., Stewart, N. J., D'Arcy, C., Forbes, D. A., Normand, S. A., et al. (2008). Taking the hit: focusing on caregiver "Error" masks organizational-level risk factors for nursing aide assault. *Qualitative Health Research, 18*(3), 334–346.

Morgan, D. G., Stewart, N. J., D'Arcy, C., Forbes, D., & Lawson, J. (2005). Work stress and physical assault of nursing aides in rural nursing homes with and without dementia special care units. *Journal of Psychiatric and Mental Health Nursing, 12*(3), 347–358.

NBHW. (2007). *Äldre - vård och omsorg 2006*. [*Care and Social Services for the Elderly in 2006*]. Stockholm: National Board of Health and Welfare (NBHW).

Nososco. (2009). *Social protection in the Nordic countries, 2008/2009*. Copenhagen: Nordic Social Statistical Committee. http://nososco-eng.nom-nos.dk/filer/publikationer/Social%20Protection%202010.pdf.

OECD. (2011). *Help wanted? Providing and paying for long-term care*. Paris: OECD Publishing.

Pillemer, K., & Moore, D. W. (1990). Highlights from a study of abuse of patients in nursing homes. *Journal of Elder Abuse & Neglect, 2*(1), 5–30.

Rauch, D. (2007). Is there really a Scandinavian social service model? *Acta Sociologica, 50*(3), 249–269.

Rippon, T. J. (2000). Aggression and violence in health care professions. *Journal of Advanced Nursing, 31*(2), 452–460.

Robinson, K., & Tappen, R. (2008). Policy recommendations on the prevention of violence in long-term care facilities. *Journal of Gerontological Nursing, 34*(3), 10–14.

Ryan, G. W., & Bernard, R. (2000). Data management and analysis. In N. Denzin, & Y. Lincoln (Eds.), *The handbook of qualitative research* (pp. 769–795). London: Sage.

Shaw, M. M. (2004). Aggression toward staff by nursing home residents. *Journal of Gerontological Nursing, October*, 43–54.

Statistics Canada. (2007). *Residential care facilities in Canada 2005/6*. Ottawa: Ministry of Industry.

Szebehely, M. (1999). *Caring for frail older persons in Scandinavia*. Paris: OECD.

Szebehely, M. (2009). Are there lessons to be learned from Sweden. In P. Armstrong, M. Boscoe, B. Clow, K. Grant, M. Haworth-Brokman, B. Jackson, A. Pederson, M. Seeley, & J. Springer (Eds.), *A Place to Call Home: Long-term Care in Canada*. Halifax and Winnipeg: Fernwood Publishing.

Trydegård, G.-B., & Thorslund, M. (2010). One uniform welfare state or a multitude of welfare municipalities? *Social Policy and Administration, 44*(4), 495–511.

Wilkinson, R., & Pickett, K. (2010). *The spirit level: Why equality is better for everyone*. New York: Bloomsbury Press.

Wrede, S., Benoit, C., Bourgeault, I. L., van Teijlingend, E. R., Sandall, J., & De Vries, R. G. (2006). Decentred comparative research: context sensitive analysis of maternal health care. *Social Science & Medicine, 63*(11), 2986–2997.