UNION EFFECTIVENESS AND THE COVID-19 PANDEMIC: A CASE STUDY OF ONTARIO LONG-TERM CARE UNIONS

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Abstract

The COVID-19 crisis in Ontario's long-term care (LTC) sector has brought unprecedented public attention to long-established systematic weaknesses in funding, staffing, and working conditions that have rendered both workers and residents highly vulnerable to infection. This study seeks to understand why unions have been unable to better protect long-term care workers from vulnerability to COVID-19 by exploring the effectiveness and limitations of unionization and assessing the challenges that unions have faced in safeguarding workers.

Eight union representatives amongst SEIU, CUPE, and OPSEU were selected as participants for hour-long semi-structured interviews. Interviews were thematically analyzed for challenges to union power as well as workplace attributes related to COVID protection. Twelve collective agreements were examined to assess the relative strength and weakness of clauses relating to health and safety, paid sick leave, disability benefits, wages, and job security in relation to part-time PSWs.

Collective agreements offered limited and varying degrees of protection to workers as unions faced constraints in bargaining within a largely privatized sector under the arbitration-based Hospital Labour Disputes Arbitration Act. The ubiquity of precarious, part-time PSW positions was identified as a major risk factor of COVID vulnerability. Unions also faced four challenges to their effectiveness: the structure of bargaining; challenges in member engagement; the neglect of long-term care and privatization of health-care; and labour relations with the Ford government. In addition to legislative reform concerning staffing and funding, this study suggests that unions engage in deeper forms of worker organizing to develop and exercise labour power beyond the legal confines of the strike-prohibiting HLDAA, as job action elsewhere by

feminized healthcare workers has been met with public support and contributed to changes in conditions of care and work.

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Table of Contents

No table of figures entries found.

Introduction

The COVID-19 crisis in Ontario's long-term care (LTC) sector has brought unprecedented public attention to long-established systematic weaknesses in funding, staffing, and working conditions that have rendered both workers and residents highly vulnerable to infection (Armstrong, Armstrong, and Bourgeault 2020). Across nursing homes, hospices, assisted living, and retirement homes, the sector has become an epicenter for outbreaks with almost 4000 resident and 13 staff deaths as of August 2021; to date, 15456 residents and 7278 staff have been infected with COVID-19 (OHC Long-Term Care Homes 2021).The sweeping pandemic has fueled pressures to reform the sector which has been subject to increasing corporatization across several provincial governments (Daly 2015). Privatization has been linked to problematic working conditions and a lower quality of care for residents while initial research suggests that for-profit homes, particularly under chain ownership, have higher rates of COVID infection and death in Ontario (Liu et al. 2020; Stall et al. 2020).

As a sector, long-term care has been underfunded and understaffed with a labour force that depends on low-paid and part-time personal support workers (PWS) (Baines and Armstrong, 2019; Cranford, 2005; Zagrodney and Saks, 2017). The workforce is mostly composed of women, including many racialized and immigrant workers, and these dynamics constrict the sector's labour power (Bourgeault et al. 2010; Cranford 2005). Multiple commentators in media argue that poor labour conditions in long-term care are directly implicated in the high rate of COVID-19 transmission and fatalities (Fudge 2020; Longhurst and Strauss 2020) while national media has connected cross-site COVID-19 transmission to PSWs who are often compelled to undertake multiple part-time jobs in order to earn a living (CBC News 2020).

Interestingly, direct care workers in Ontario's long-term care facilities have a relatively high union density of 71.3% according to the 2019 Labour Force Survey, with a reported 7.9% wage gap between unionized and non-unionized PSWs (2020). Several of Canada's largest unions represent workers in Ontario's long-term care sector and PSW unionization rates are much lower in home and community care settings. Despite the high level of union representation in long-term care facilities, COVID-19 has both revealed and worsened existing deficits in the sector's regulation and labour structure. Commentary from civil society (Ontario Health Coalition 2019), academic literature (Armstrong, Armstrong, and Bourgeault 2020; Brophy et al. 2021; Liu et al. 2020; Stall et al. 2020) and the 2021 Ontario Long-Term Care Commission all suggest that COVID-19 issues were driven by pre-existing systemic problems.

Unionization often provides worker protections by helping improve working conditions, the enforcement of health and safety guidelines, and fostering an overall culture of safety. Given the sector's high union density, this study seeks to understand why unions have been unable to better protect long-term care workers from vulnerability to COVID-19. The study explores the effectiveness and limitations of unionization by assessing the challenges that unions have faced in safeguarding workers throughout the pandemic.

First, a literature review surveys previous relevant research, followed by a brief contextual overview of PSWs in Ontario and a section on the project's methodology. The next section draws on key informant interviews to summarize collective bargaining for the unions involved in this study and identify workplace attributes that affected worker vulnerability. I then explore a sample of collective agreements to assess the strength of clauses relating to COVID protections. Following the collective agreement analysis, I examine the perceptions of union staff concerning challenges to union effectiveness and I then conclude with a discussion to synthesize

overall findings. Interview participants were from three prominent unions in the sector: CUPE, SEIU, and OPSEU. CUPE and SEIU are amongst the sector's largest in terms of PSW membership. The study focuses on part-time PSW conditions as they represent the largest worker demographic in the sector (Ministry of Long-Term Care 2020).

Literature Review

There is limited research on collective bargaining in long-term care and the topic is seldom addressed in research about the socio-political dimensions of care work or the changing nature of care work, none-the-less, these literatures provide important insights into contemporary PSW working conditions. Literature charts how neoliberal principles of efficiency and deregulation have shaped the evolution of long-term care in two broad ways: the privatization of LTC homes and the adoption of neoliberal management principles in facilities and governance. Previous research documents how privatization and the gendered construction of care work have together shaped PSW working conditions and labour relations in healthcare more broadly, while a handful of studies examine unionism in long-term care. The review provides context for the research inquiry at hand by engaging studies in feminist political economy, healthcare and aging policy, occupational health and safety, care work organization and unionism.

Privatization and the Withdrawal of the Welfare State in Long-Term Care

Scholars examining the evolution of long term care in Ontario study the role of neoliberalism, a model centered on purported market and competition-based efficiencies in for-profit care. Aronson and Neysmith (1997) explore how Ontario privatized care costs by withdrawing public funding, privatizing LTC homes, and relying on home and community care which typically involve family and unpaid care givers. Building upon the finding that the elderly

are positioned as "consumers exercising choice" rather than citizens with social security (Aronson and Neysmith 1997, 43), Armstrong et al. (2016) argue that eldercare security is jeopardized because of regulation that privileges the private sector and chain concentration, including subsidies, and a lack of quality employment which adversely affects care.

Previous studies show that the Ontario Ministry of Long-Term Care has been absent on the issues of staffing and minimum hours of care, while otherwise regulating facility licensing, reporting, and management in ways that favour corporate concentration (Armstrong, Armstrong, and MacLeod 2016; Banerjee and Armstrong 2015; Daly 2015; Harrington et al. 2017). Daly (2015) provides a robust, mixed-methods analysis of regulatory periods in Ontario LTC from the 1940's to 2013 and finds that for-profit ownership or management of beds grew by 80.3% between 1989 and 2013. Ontario now has a total of 626 LTC homes and the highest proportion of for-profit facilities in Canada, with 57% being run for-profit, 27% being non-profit, and 16% being publicly-owned (CIHI 2021). In contrast, the national average is 46% publicly owned and approximately 28% for-profit and 23% non-profit (ibid).

Profit maximization under chain ownership shifts care away from the public sector and into private and non-profit homes while impacting the conditions both care and work (Baines & Armstrong, 2019). Several scholars identify disparities in pay and work across types of ownership and management, and turnover caused by poor work conditions correlates with lower quality care. Hsu et al. (2016) completed a longitudinal study using the Statistics Canada *Residential Care Facilities Survey* and report that for-profit facilities in Ontario, especially those under chain ownership, have lower staffing levels and hours of direct care. Similar findings were reflected in Ontario with Berta et al. (2010), British-Columbia (McGregor et al. 2005), and across Canada (McGregor and Ronald 2011). Despite gaps in care, private facilities receive the

same level of resident care subsidization in Ontario as municipal and non-profit homes (Armstrong, Armstrong, and Bourgeault 2020; Hsu et al. 2016). Furthermore Canada holds lower bed to population ratios, declining bed availability, and high demand compared to other industrialized countries with marketized LTC (Harrington et al. 2017).

A Changed Organization of Work in Long-Term Care

In exploring the impacts of privatization on the organization and conditions of care work, several researchers posit that neoliberalism is incompatible with relational forms of care, a holistic approach that recognizes interdependence and reciprocity between workers, residents, family, and community. This stands in contrast to distilling work into medicalized, technical and delineated tasks with rigid divisions of labour (Baines and Armstrong 2019). Daly and Szebehely (2012) contend that Canadian long-term care workplaces are more task-oriented compared to Sweden, using survey data from unionized workers. Their study associates cost-cutting and resource constraints with increased task orientation and strict divisions of labour. Neoliberalism also implements forms of auditing that center individual worker behaviours while obscuring structural conditions of ownership, staffing, and funding (Banerjee and Armstrong 2015). Moreover, workplace emphasis on routine and pace of work can shift power away from direct care workers and toward management (Baines and Armstrong 2018) and feminized work can subsequently become de-skilled (Daly 2015).

Within occupational hierarchies, PSWs have lower status and represent the highest number of direct care workers, while LTC organization also falls along gendered and racialized lines. Combining interviews and ethnographic observation to explore workplace hierarchies and task-work, Syed et al. (2017) argue that the work of immigrants and racialized workers is particularly insulated from RNs. Additionally, PSWs hold less autonomy and job control than

other classifications, reflecting a limited ability to influence their workplace and participate in decision making (Braedley et al. 2018; Syed et al. 2017).

Direct care work also involves significant physical risks such as injury, violence, and harassment. Alamgir et al. (2007) ran a quantitative study in British Columbia and find that PSWs are particularly vulnerable to musculoskeletal injury as a result of performing transfers and lifts for residents. PSWs have a highest overall injury rate compared to RNs and LPNs regardless of care setting, while experiencing the most injuries in nursing homes. Banerjee et al. (2012) apply the concept of "structural violence" to LTC to center the systemic conditions that lead to work-related violence and identify poor working conditions and inadequate supports as key variables of concern.

Evidently, PSWs face an array of challenging working conditions that are determined by facility-level organization and sectoral attributes. Using critical approaches to ethnography and social theory, DeForge et al. (2011) explore how PSW knowledge is often marginalized from workplace planning under a "culture of compliance" (419) where relational aspects of care work are supressed. Braedley et al. (2018) echo the lack of control care workers are afforded and reveal intersectional impacts of high workloads, sexism, and racism on emotional and psychological health. Their comparative analysis argues that Ontario LTC (and Canada more widely) normalizes violence to a greater extent than other countries. Finally, through disability studies and a grounded theory approach, Kelly (2017) explores the co-existence of violence and worker abuse alongside caring relations with patients to suggest new directions in PSW education and work organization.

Labour Relations in Care Work

Scholarship on labour relations in care work mainly attends to nursing and hospitals though some studies include PSWs in long-term care facilities, community, and home care. Cohen and Cohen (2004) study how British-Columbian health care privatization has overridden collective agreement protections in job security allowing for contracting out, resulting in gender-based pay inequities and union concessions. In another British-Columbia study, Ponder et al. (2020) develop a wider political economy of the impacts of financialized long-term care where investment and real-estate interests have become intertwined with private care operations. In their case study funding cuts and contracting out for efficiencies create precarity and a "fracturing of the nursing home workplace" (808).

The specificities of care work stand in contrast to male-dominated and industrial sectors and research highlights the needs of care workers in relation to their unions and often calls for new orientations in union renewal. In relation, literature highlights the prominent "sense of vocation" (Armstrong 1993, 314) and "mission-driven" (McAlevey 2015, 329) orientation of nursing, care work, and social work more generally, referring to a deep commitment in relationship-based work and service (Briskin 2013). In one study of unionized workers in a non-profit home, unrecognized and unpaid labour is a common way of initiating more relational forms of care, suggesting that LTC unions need pathways to renumerate unpaid labour and to shape working conditions congruent with relational care (Baines and Armstrong 2019).

The nexus between workers and patients in care work is emphasized throughout research. However, studies reveal that PSWs experience conflict with clients too, shaped by low job status, the direct nature of their work across different care settings, and intersections of racialization and immigration status. One study of Toronto homecare workers and union representatives with CUPE and CAW shows that racialized workers are subject to expectations from white clients

that echo historical dynamics in domestic work (Birdsell Bauer and Cranford 2017). PSWs are also supportive of striking to improve working conditions and simultaneously hold concerns about patient welfare with job action (ibid). Another study of homecare PSWs with SEIU Local 1 in Toronto finds that workers approve of union politicization of funding but feel unions aren't accounting for client tensions (Cranford et al. 2018). These works suggest that unionism could become more responsive to the complexities of PSW worker-client relationships and improve anti-racist strategies in workplaces.

Nurses stand out amongst care workers in terms of higher job status, job quality, and labour power. While there are marked differences between nurses and PSWs, the existing literature on nursing labour relations offers some parallel consideration as a feminized workforce. According to Armstrong (1993) Canadian nurses used professional associations to develop vocational status, individual rights, and public policy influence while unionization influenced collective working conditions and equity concerns. Armstrong (1993) and Coulter (1993) posit that nursing professionalization adopts a hierarchical male professional model established by doctors and both authors suggest that health care transformation requires a more collective orientation.

The hierarchical organization of health care workers can silo nurses away from lower status workers and some elements of nursing power predicate upon such differentiation. However, multiple authors explore organizing cases where nursing power has improved has working conditions to the benefit of a broader range of workers (Armstrong 1993; Coulter 1993; McAlevey 2015). McAlevey (2015) states that nurses have more "individual skill-based power than any other type of unionizable worker" (319) in healthcare and presents American case studies of nurse-led wall-to-wall organizing that has led to gains. Nurses in the U.S. are also

more likely to join and support unions with strategies concerning patient care improvements, according to a Clark and Clark (2006) study which analyzes survey data, union negotiation priorities and strategies.

Scholars also explore the implications of job actions and wildcat strikes in nursing and healthcare. White (1990) accounts the 1981 CUPE hospital strike that took place in Ontario. The illegal 2-week action was a response to public sector cuts. As an early in-depth study of militant job action, White finds that women were willing to strike to improve care quality and working conditions. The study finds that female rank-and-file member priorities received limited support from CUPE leadership and the illegal job action amplified their union participation. In a work centered on the 1988 Alberta nursing wildcat strike, Coulter (1993) finds that "the solidarity of nurses and their union consciousness" (59) was developed through militant and illegal job action and union connections to the broader women's movement were fostered.

More recently, Camfield (2006) studies the 2004 British Columbia wildcat strike that involved over forty-thousand hospital and long-term care workers in opposition to neoliberal workforce re-structuring under Bill-29. The strike was comprised of mostly female and racialized workers and Camfield interviews key informants from the Hospital Employees Union (HEU) and CUPE. Camfield suggests the strike received public support and solidarity from other workers signifying a level of still existing labour militancy, public valuation of health care work, and a gendered sympathy for women workers. Camfield also suggests that the strike helped spur collective and popular opposition to neoliberalism.

Building upon understandings of public sector job action, Briskin (2013) analyzes a range of strategies in nursing work stoppages in Canada, the United States, and internationally. Their work identifies the "politicization of care" where job action is linked to patient well-being and

public support is often garnered. Such a framing connects care work and collective bargaining with wider socio-political structures. Women's militancy and agency as unionists and workers was exemplified through these job actions.

Existing literature explains how Ontario's long-term care sector became increasingly privatized under neoliberal regulation and now involves corporate chain concentration in ownership and management. The welfare state withdrew over several decades to the detriment of elder care security and sectoral funding levels. Corporatized logics have created a precarious workforce where worker monitoring, rigid task divisions, and assembly-line models of work are often implemented. Such workplace organization heightens health and safety risks and is furthermore incompatible with relational models of care. Through a handful of studies, previous research suggests that unionism in long-term care could better respond to PSWs needs by addressing tensions with clients alongside caring relations, anti-racist strategies, finding ways to renumerate relational work, and understanding simultaneous support and aversion for job action. Research also surveys historical strategies in developing labour power in nursing namely through professionalization, unionization, and wildcat strikes. Interestingly, studies reveal that illegal job action in nursing is often met with public support and sympathy when strikes are framed in terms of the public good, and these represent compelling examples of women's militancy.

The COVID-19 pandemic has provided unprecedented media, government, and scholarly attention to Ontario's long-term care sector and PSWs, and problems concerning working conditions and precarity in the workforce are well documented. However, the role of unions and collective bargaining remains underexplored and understanding union effectiveness may help inform ways forward in improving working conditions within the sector. Moreover, Ontario's

particularly high rate of LTC unionization and the magnitude of COVID's impact upon both workers and residents position the province as a worthwhile case study.

Ontario PSWs in the Context of Covid-19

PSWs represent the largest segment of Ontario's LTC workers and Block and Dhunna (2020, 7) found that amongst direct health care workers, 73% were PSWs, 16% were RNs and 11% were RPNs. The sector disproportionately relies on part-time work and in 2018, 41% of PSWs worked full-time, 48% worked part-time, 10.7% were casual and around half said they would prefer to work more hours according to a Ministry of Long-Term Care staffing study that was initiated in response to the pandemic (2020)**.** Across Canada, PSWs tend to hold both low-wage and insecure employment, and are among some of the lowest paid positions in health care (Zagrodney and Saks 2017). Almost 29% of PSWs in Ontario were found to have multiple jobs in a 2009 survey by Lum et al. (2010).

In Canada, over 90% of nurses and up to 90% of Personal Support Workers (PSWs) are women (The Canadian Women's Foundation et al., 2020, 4) and in 2009 survey of PSWs, 42% of respondents identified as racialized with the largest demographics being Black (17.5%), followed by Filipino (13.2%), Chinese (4%) and Latin American (2.8%) (Lum, Sladek, and Ying 2010, 5). The Ministry of Long-Term Care Staffing Study reported similar results in 2020. Several interview participants noted that racialized and immigrant worker demographics were most pronounced in the Greater Toronto Area compared to less urbanized regions of Ontario.

Methodology

To explore union effectiveness in protecting workers against COVID in long-term care facilities, eight union representatives amongst three prominent unions in the sector - CUPE,

OPSEU, and SEIU – were selected as participants for hour-long semi-structured interviews over Zoom (a video conference platform). CUPE and OPSEU had three participants each while SEIU had two interviewees. CUPE and SEIU are the sector's two largest unions though several others also represent workers in long-term care. Participants were key informants who offered high-level insight into the topics of unionization, collective bargaining, and working conditions from the workplace to sectoral level. Participant roles included staff and sector representatives who support collective bargaining processes and grievance procedures along with union research officers rather than elected officials. Three participants had worked as PSWs prior to or in addition to their role as union staff. Representatives were asked to identify workplace concerns preceding and during the pandemic, how collective bargaining has aimed to address those concerns, and to describe member engagement and labour relations in long-term care. Interview lengths ranged from 50-80 minutes and transcripts were analyzed inductively to identify themes across the interviews.

Interviews with union staff were thematically analyzed for challenges to union power as well as workplace attributes related to COVID protection and that could be addressed in bargaining. Clauses included the topics of health and safety, paid sick leave and disability benefits, wages, and job security, all in specific relation to part-time workers given the prominence of casualization in the sector. I then analyzed four recent collective agreements from each union (CUPE, OPSEU, and SEIU), to assess the strengths and weaknesses of relevant articles. The collective agreements represented workers at privately-owned facilities, municipal facilities, and not-profit facilities. Both CUPE and OPSEU had one municipal, one non-profit, and two private facility contracts while SEIU included three private homes and one non-profit contract. The collective agreement clauses were then assessed and a visual scale was applied to

convey the relative strength or weakness of existing article language. For comparability, the selected agreements represented bargaining units for PSWs and other support workers but excluded RNs, who are beyond the scope of this project. RNs typically hold separate agreements through ONA and are sometimes represented by other unions in Ontario.

The project scope focuses on long-term care facilities and nursing homes rather than hospital, home or community care settings which also involve direct care workers. Finally, a range of literature from academic and grey sources (such as policy and governmental reports, news articles, and union communication materials) were used to strengthen the project's analysis.

Collective Bargaining in Long-Term Care

LTC facilities are governed by provincial and territorial legislation, and these jurisdictions vary in terms of regulatory requirements and facility ownership composition. Ontario facilities fall under the *Long-Term Care Home Act (2007),* which was passed in 2010 and combined existing pieces of legislation that previously regulated care homes and charitable institutions in the province (Daly 2015). The act addresses a wide range of sectoral and facility requirements including facility licensing, funding, reporting and complaint mechanisms, as well as resident admissions and resident rights, amongst other areas (*Long-Term Care Homes Act, 2007, S.O. 2007*). While some aspects of facility workforce composition and skill mix are regulated, the act fails to address minimum standards in staffing and care, and this is considered a major weakness in regulation. Unions campaigns have subsequently focused on this area for legislative reform and similar priorities emerged from the 2021 Long-Term Care Commission.

The Ontario government and Ministry of Health's direct care envelope funds the wages, benefits, and associated supplies of nurses and PSWs in LTC facilities. Other funding envelopes include raw food, program and support services, and accommodation, and facilities also receive resident per diems amongst other supplementary and claims-based funds. For-profit facilities receive the same level of direct care funds as other facility types and channel their profit revenues toward shareholders instead of labour costs. Inadequate government funding has been consistently identified as a major factor in on-going staffing shortages and poor working conditions, both prior to and during the pandemic (Ontario Long-Term Care Commission 2021).

Collective bargaining in Ontario's LTC sector is regulated by a separate piece of legislation called the Hospital Labour Disputes Arbitration Act (HLDAA), which is a provincial law that prohibits long-term care and hospital workers from legally striking and prevents employers from lock outs. Following conciliation, arbitration is used as a dispute mechanism during bargaining impasses in the sector.

SEIU Healthcare Local 1 represents 60 000 frontline healthcare workers in Ontario in different healthcare settings including long-term care. They represent the largest number of PSWs in the province and strongly influence LTC bargaining by negotiating the largest central contract for nursing homes (SEIU Transcript Ontario LTC Commission 2020). Structured as a single large local with regional divisions, SEIU's sectoral importance is solidified via their Master Nursing Homes Agreement which covers 95 facilities through a formal and centralized bargaining process. According to SEIU's Head Researcher, the Master Nursing Homes Agreement has consistently settled at interest-arbitration over the past 10 years. SEIU's central long-term care bargaining committee includes a range of worker representation across geographic regions, facility ownership type and companies, full-time and part-time workers, and

direct care job classifications. The corporations of Extendicare, Chartwell, Revera, Rykka, and Sienna are bargained with through a centralized process. Interview participants from all three unions agreed that just as ONA's central agreements shapes the bargaining landscape for all Ontario RNs, the SEIU Master Agreement sets precedent for other direct care workers in long-term care.

CUPE Ontario, a public sector and nationally affiliated union, is the second largest in member representation with 35 000 LTC workers in Ontario (CUPE Transcript Ontario LTC Commission 2020). CUPE represents workers in 240 Ontario long-term care and retirement homes. The union prioritizes local level autonomy and elected representation while utilizing a formalized coordinated bargaining strategy in long-term care. A CUPE Representative explained that in some instances, the union centrally negotiates staple clauses, such as monetary benefits and grievance languages with multiple bargaining units under single employer. Remaining language is then negotiated under the purview of local tables. Unlike like SEIU, CUPE bargaining isn't strongly centralized, but it is coordinated and all local level proposals and potential agreements are vetted by sector representatives. The coordination is a response to the interest-arbitration process because each award affects prospects at other tables, which may also go to arbitration.

Last, OPSEU is a provincial public sector union representing workers in 15 facilities outside of the Greater Toronto Area; it is the smallest union included in this study in terms of numbers of members represented. In contrast to SEIU and CUPE, OPSEU tailors bargaining to each facility given its small number of workplaces and does not centrally bargain, though some municipal contracts cover more than one facility at once.

All three unions typically have wall-to-wall bargaining units representing a range of service classifications, including RNs in some cases. Each of the unions represents workers in public, for-profit and non-profit facilities. CUPE, SEIU, and OPSEU participated in the 2021 Ontario Long-Term Commission and have collaborated on advocacy campaigns including calls for a guaranteed 4-hour standard of care and demands to end for-profit care.

Attributes That Shape Worker and Vulnerability Protection

By drawing from reports, existing research, and key informant interviews, several work-related attributes were identified as influencing worker vulnerability or protection through the pandemic. Participants discussed workplace issues and associated collective agreement clauses that they felt were important to protecting workers including: health and safety; staffing levels; compensation; access to full-time work hours; contracting out and agency staff, and paid sick leave. Most participants suggested these areas would become heightened bargaining priorities given how their significance emerged with COVID-19.

Paid sick days were identified as a protective condition for workers to access leave without financial loss, along with paid quarantine leave, and disability benefits as workers faced serious illness with COVID. Participants also mentioned the importance of establishing a culture of safety between employers and unions to prioritize regular, reliable, and open communication without fear of reprisal. In this context, non-monetary language in Joint Health and Safety Committees (JHSC) and Labour Management Committees (LMC) could provide a useful communication forum between the employer and the union. For example, a SEIU representative explained that strong communication influenced access to personal protective equipment (PPE) as well as relevant, often-changing information surrounding COVID-19 that would also help keep workers more safe:

> …the places with strong health and safety committees have done a lot better during the pandemic. One location that I was covering … they have a strong health and safety committee now, right, and they're very militant. But at the start of the pandemic, they did not, and the employer actually just told them there was a respiratory outbreak without saying it was COVID. And at one point in time, 90% of our bargaining unit was COVID positive, quarantined in a hotel away from their families. So places with a strong health and safety committee and where the employer knew that they had to be open and upfront and honest, and that sort of thing, they had a better, a better chance of getting access to PPE, getting access to information and knowledge right, to help keep themselves safe.

Another participant who was a national union representative explained that engaged Joint Health and Safety Committees can provide "resilience" against COVID, encourage proactivity, and better cooperation from employers:

> They [Joint Health and Safety Committees] should be at the center and the core of every conversation around COVID that's happening now. Right? And if the Joint Health and Safety Committee is functioning and is effective, and is educated and knowledgeable prior to COVID, that is what's going to provide that resilience… it should be proactive, and that's why we look at COVID, as you know, there's opportunities for employers to be proactive as possible. You don't have to wait until COVID comes into your home, to start having a plan that will be put in place. You shouldn't have waited until the government forced you to come up with plans and communicate, you know, your PPE stocks and stuff like that. Conversation should have happened earlier on. And, in fact, when I look at the Joint Health and Safety Committees that are functioning quite well, in my long-term care

> homes, and where the employer actually sent me directly all of their inventory, what their plans were… Those are actually the homes that don't have – haven't had an outbreak.

The overarching characteristics of LTC work including precarity, high workloads, and low wages driven by privatization led to vulnerability during the pandemic in multiple ways. LTC facilities were commonly understaffed prior to the pandemic and in some cases staffing levels plunged as countless workers contracted COVID and fell ill, missed work due to health and safety concerns, and took care of sick family members (Armstrong et al. 2021; Brophy et al. 2021; Ontario Long-Term Care Commission 2021). Inadequate staffing and the nature of work under infectious disease and outbreak protocols (mandated by Public Health Ontario) also intensifies workloads. One study found that injury and violence against PSWs worsened during facility lockdowns as residents lost their access to routines and visitors (Brophy et al. 2021). Workers thus faced multiple coalescing pressures from COVID, which jeopardized their safety and worsened burnout.

To make ends meet with low wages, many PSWs become pressed to work multiple jobs in LTC. The sector's over-reliance on part-time, low paid positions and the ubiquity of PSWs working across facilities was another source of COVID transmission (Ontario Long-Term Care Commission 2021). This pattern was clearly identified in Ontario LTC facilities during the 2003 SARS outbreak as well (ibid). Temporary agency workers presented another risk as research suggests that facilities with a higher reliance on agencies had more severe outbreaks and higher rates of resident mortality, with one reason being inadequate infection protocol training (ibid).

The sector has an over-reliance on part-time and casual workers in part due to employers seeking to reduce benefits costs and maximize profit. SEIU's Head Researcher commented that

workers may be working full-time hours while remaining misclassified by employers as a way of reducing costs and avoiding benefit payments:

> What we've seen through COVID, was a large increase of part timers working basically full-time hours, but not experiencing any of the full-time benefits. Homes misclassified part-time workers all the time. It's just a way to get around paying them benefits. They'll work them the same amount of hours as a full timer, but keep them as part-time status.

As part of improved compensation measures, participants said that benefits-in-lieu were another priority item in bargaining where workers receive a percent or dollar value for hours worked in place of benefits. While this represents a potential improvement for part-time workers, in-lieu can still be cheaper for employers compared to full benefits and cannot replace fulsome health benefits, especially in a pandemic context (CUPE Transcript Ontario LTC Commission 2020). Moreover, in-lieu was originally intended to discourage part-time hiring in favour of more stable, full-time positions, but the sector nevertheless relies on part-timer workers (ibid).

Analysis of Collective Agreement Provisions

Collective agreement provisions that improved job quality in terms of wages, benefits, paid sick leaves, and facilitated union involvement in health and safety from PPE to workload were considered relevant to worker protection during the pandemic. Table 1 provides an assessment of the presence or absence, and strength of types of collective agreement clauses that key informants felt were most relevant during the pandemic. The examined clause types are: joint health and safety committees; employer rights concerning staffing; labour management committees; definition of part-time work; wages; job security; benefits; sick and quarantine

leave. The analysis focuses on part-time PSW conditions since these workers represent the largest share of employees in the sector and are more likely to be vulnerable to COVID.

In Table 1, relative clause strength was evaluated and coded using shades of grey; light grey indicated weak collective agreement language, medium grey indicates moderate language, and dark grey indicates stronger language. A blank or white cell reflects that the collective agreement did not include any relevant language to the clause. Strength assessment was based on whether clauses afforded the union more power to intervene against management rights or provided protection in terms of PPE, paid sick leave, and health benefits. For example, stronger health and safety language at SEIU Local 1 at Grace Villa directly references staffing and workload, PPE, and infectious disease training as issues to be discussed in JHSC, and meeting frequencies are quarterly or more if requested. Whereas weak language with OPSEU Local 262 at March of Dimes does not mention JHSC meeting frequency or issues relating to infectious disease and workload issues. Moderate language with SEIU Local 1 at Heritage Green includes a quarterly meeting frequency, JHSC input on infectious disease programs, but lacks workload references. The Table 1 assessment draws from complex articles; Appendix 1 provides article numbers for each provision to allow for full agreement text to be referred to for added details.

Table 1: Assessment of Relative Strength/Weakness in Collective Agreement Provisions (Refer to Appendix 1 for Article Numbers from Agreements)

		Collective Agreement Details												
		Facility Type	Municipal	Private	Not for Profit	Private	Private	Private	Municipal	Not for Profit	Private	Private	Not for Profit	Private
		Employer	Regional Municipality of Halton	Edgewater Gardens	March of Dimes Canada - Villa Verdi	Meaford Long Term Care	HCN-Revera Lessee	Regency Park Nursing Home	York Region	St Peter's Residence at Chedoke	Downsview LTC	Grace Villa	Heritage Green Nursing Home	Extendicare Canada Inc.
		Union	OPSEU Locals 261, 265, and 282	OPSEU Local 214	OPSEU Local 262	OSPEU 289	CUPE Local 5192	CUPE 3593	CUPE Local 905	CUPE 7780	SEIU Local 1	SEIU Local 1	SEIU Local 1	SEIU Local 1
		Location in Ontario	Region of Halton	Dunville	Hamilton	Meaford	Nepean	Windsor	York Region	Hamilton	North York	Hamilton	Hamilton	
		Agreement Dates	June 2019 to May 2022	January 2018 to December 2020	April 2018 to March 2021	December 2016 to November 2019	Expires December 2022	January 2019 to December 2020	2016 to 2019	February 2017 to February 2019	July 2019 to July 2022	September 2019 to September 2022	May 2019 to April 2021	September 2016 to 2019
Agreement Clauses and Sub-Topics	Health and Safety	Joint Health and Safety Committee												
		Personal Protective Equipment												
		Infectious Disease												
		Other												
	Employer Rights	Staffing and workforce												
	LMC	References to staffing/workload												
	Part Time	Part-Time Hours of Work												
	Job Security	Part-Time Seniority Hours Equivalent to One Year												
		Contracting Out												
		Full-Time to Part-Time Ratios, or Call-In Clause												

		Collective Agreement Details												
		Facility Type	Municipal	Private	Not for Profit	Private	Private	Private	Municipal	Not for Profit	Private	Private	Not for Profit	Private
		Employer	Regional Municipality of Halton	Edgewater Gardens	March of Dimes Canada - Villa Verdi	Meaford Long Term Care	HCN-Revera Lessee	Regency Park Nursing Home	York Region	St Peter's Residence at Chedoke	Downsview LTC	Grace Villa	Heritage Green Nursing Home	Extendicare Canada Inc.
		Union	OPSEU Locals 261, 265, and 282	OPSEU Local 214	OPSEU Local 262	OSPEU 289	CUPE Local 5192	CUPE 3593	CUPE Local 905	CUPE 7780	SEIU Local 1	SEIU Local 1	SEIU Local 1	SEIU Local 1
		Location in Ontario	Region of Halton	Dunville	Hamilton	Meaford	Nepean	Windsor	York Region	Hamilton	North York	Hamilton	Hamilton	
		Agreement Dates	June 2019 to May 2022	January 2018 to December 2020	April 2018 to March 2021	December 2016 to November 2019	Expires December 2022	January 2019 to December 2020	2016 to 2019	February 2017 to February 2019	July 2019 to July 2022	September 2019 to September 2022	May 2019 to April 2021	September 2016 to 2019
Agreement Clauses and Sub-Topics	Wages	PSW Starting Wage in 2018 or 2019												
	Benefits	Part-Time Pro-rated Benefits or Percent in Lieu												
		Benefits Continuance on Leave (Full-time and Part-Time)												
	Sick Leave	Sick Leave Credits at 100% of wages												
		Physician Certificate Requirement												
		Short Term Disability												
		Long Term Disability												
		Quarantine Leave												

Health and Safety Committees

Most contracts included general JHSC language that failed to articulate issues on infectious disease. Stronger language in all four SEIU contracts listed JHSC involvement with PPE and Infectious Disease Control, for example, requiring notification of residents with infectious disease and allowing JHSC input on training, education, and PPE. In contrast, the OPSEU and CUPE contracts had weaker clauses. Collective agreements for OPSEU Local 262 and CUPE Locals 5192 and 905 did not address prevalent safety concerns in the sector relating to workload, infectious disease, and did not articulate meeting frequencies (ex: once month or quarterly) either. In contrast, some articles under Health and Safety and Labour Management Committees explicitly mentioned staffing and workloads as issues to discuss. For example, CUPE 3593 and SEIU at Grace Villa call for meetings to receive and discuss CMI (case mix index) results, which are a quantitative methodology of assigning resources toward resident care, including staffing.

Staffing Levels and Workload

Amongst the collective agreements, all twelve management rights clauses referenced areas such as workforce direction, employee allocation, and staffing. These were evaluated as weak as they limited union abilities to protect workers by influencing staffing. No agreements completely prohibited contracting out, though seven out of twelve included moderate language that barred contracting if it leads to layoffs or reductions in the bargaining unit's work. The two weakest articles simply stated that contracting out shall be discussed by both parties and was found in OPSEU's contract with the Municipality of Halton, and another example was found with CUPE 905 (York) which requires notice and discussion between the parties. No language

existed in the two OPSEU contracts with Edgewater Gardens and Meaford, nor in CUPE 5192 with Revera – all of which are private homes.

In relation to workforce composition and full to part-time ratios, only the four SEIU contracts included stronger language stating that full-time positions cannot be split into part-time without agreement from the union. Strong language at SEIU at Downsview included a call-in clause to prioritize bargaining unit members for overtime work instead of contracting out, where possible. While SEIU language was stronger compared to CUPE and OPSEU (which didn't have any ratio language), it did not call for specific staffing levels. SEIU's Head Researcher offered context on staffing language that was unsuccessfully bargained:

> You know…we have, we do have language against like, shift splitting, so like taking a full-time position and switching, or splitting into two part-times. So that's one preventative measure. There's like, contracting out measures, but they're pretty weak, in my opinion, the contracting out, because these homes can still hire agency staff as long as it's not causing a layoff within the existing bargaining unit. So, yeah, no matter what, there's still a level of contracting out within nursing homes. I mean, we try to obtain that information from employers. Their representatives are very resistant to it. Yeah…but there's, I mean, there's no ratio within the homes. But I mean, we – you fight, right? That's, that's a hard thing to get into a contract would be…because no arbitrator is going to award it, you would need voluntary agreement from the employer, which doesn't happen. Yeah. So I mean, yeah. If you wanted to, you know, X percent that is full-time or X percent, that's part-time, you would, you'd have to get mutual agreement, which is next to impossible.

A range of part-time working conditions in terms of hours and benefits were set forth across the contracts. In weaker agreements, those who worked less than 37.5 hours weekly were still classified as part-time though this can approximate full-time hours. Stronger agreements defined part-time as those working less than 22.5 hours weekly. Part-time workers were generally excluded from fulsome health benefits and received less favorable provisions than those offered to full-time PSWs. Six out of twelve contracts included pro-rated benefits where part-time workers often paid higher premiums compared to full-time workers. Most of these were assessed as moderate provisions since they offered a limited form of benefits. Stronger language was found with CUPE 905 at York Region, where some benefits were offered in full with employer-paid premiums to part-time employees working above 52.5 hours bi-weekly. CUPE 5192 also had a stronger clause where part-time workers accessed full benefits but paid higher premiums. Only four contracts included benefits paid in-lieu, which several participants identified as a clause they wanted to prioritize in bargaining to help improve part-time compensation. The stronger articles at OPSEU 261, 265, and 282 (Region of Halton) and CUPE 7780 offered benefits in-lieu at 10% and 11% of earned wages, respectively. Moderate clauses were at $1.00 per hour with OPSEU 214 and up to $0.85 per hour at OPSEU 289, both representing workers at private facilities.

Wages

Part-time PSW starting wages were analyzed across the contracts for 2018 or 2019, the two years that were common across all agreements. CUPE's contract with York 905 had the highest wage at $26.72, likely influenced by their strength in comprehensively bargaining a large municipality with many job classifications. OPSEU locals 261, 265, and 282 contract with

Halton Municipality followed at $23.46 in 2019. One CUPE representative explained that municipal PSWs:

> "are the ones that are best paid. They have the highest proportion of full-time staff. And structurally speaking, in a lot of cases, they are actually part of larger municipal locals. And so there is more capacity, more funding available, all of those things".

Additionally, municipal facilities access municipal tax revenues, tend to re-invest within the workplace, and their wage rates may be influenced by comparison with other municipal employees such as EMTs. An OPSEU representative also spoke to the strengths of municipal home funding and its effect on workplaces:

> So the Ontario Health Coalition did a study and they compiled the data looking at the health outcomes and the death rates, across the different home types and municipal homes by far fared the best. Now municipal homes do have, you know, an extra layer of funding that is not accessible to the other home types. So having extra money, extra, you know, you know, staff who is more likely to be full-time, less transient, things to that effect, really added to better health outcomes….For-profit was by far the worst. I mean, there's exceptions to that, right, like Downsview Long-Term Care, I believe, is municipal, here in Toronto, and that was, you know, just a horrible, horrible s story of outbreak. You know, there's all the exceptions, but overall, I would say the desire to keep labour cheap as possible prior to the pandemic – so having a large pool of casual and part-times, who are transient in nature and going everywhere, really did make it difficult when COVID hit to shut the doors and try to keep things a little more under control. So I think that's a massive part of it. I also think – and I mean, this is a generalization, that municipal and non-profit homes are more inclined to meet on a

regular basis with joint health and safety committees as opposed to for-profit.

The spectrum of pay conditions in LTC was exemplified in the wage rates within the twelve contracts. Six agreements had wages between $20.26 and $20.75 including SEIU Local 1 with Extendicare (private), Grace Villa (private), Heritage Green (non-profit), CUPE 7780 (non-profit), OPSEU 214 (private) and OPSEU 289 (private). These wages were classified as moderate along with CUPE 3593 at Regency Park, a private facility with slightly lower wages of $19.48. The two lowest wages were found with OPSEU 262 in a non-profit facility at $16.88 and CUPE 5192's contract with private corporation Revera at $15.61. The average wage calculated across the twelve contracts was $20.55 and wage rate increases ranged from 1.25% to 2%.

Paid Sick Time and Quarantine Leave

Sick leave was examined alongside short and long-term disability benefits given the health implications and timelines of COVID-19. Two contracts, OPSEU at Edgewater Gardens and CUPE 8870 at St. Peter's did not reference any paid sick leave for part-time workers, while OPSEU at Meaford offered pay in-lieu. The nine other contracts in the analysis included pro-rated formulas for a small number of days that are insufficient in the context of COVID-19, which requires two weeks of isolation. However, a particularly strong contract from CUPE Local 905 had parity between full and part-time workers (based on hours worked) for a minimum of 5 paid days off. Benefits inequity was otherwise persistent between full-time workers and part-time workers usually could not access short or long-term disability benefits. However, the three contracts of CUPE Local 905, SEIU at Grace Villa and SEIU at Extendicare offered pro-rated disability leave for part-time workers. Most notably, CUPE Local 905 included a unique letter of understanding on quarantine pay where workers would receive time and half or double time pay for quarantining at home or work.

Existing sick time provisions were seen as insufficient in the context of COVID isolation and recovery times, with SEIU's Head Researcher saying:

> The lack of access to sick time and time away for folks who have to self-isolate is a huge Gap. So during the pandemic, sick leave has been a challenge. Some employers were making workers burn through their sick time, even though they had to mandatory, you know, isolate for 14 days. That's challenging, incredibly challenging for people.

Overall, collective agreement articles that could protect workers during COVID were relatively weak because clauses were limited in their ability to address pandemic-related health and safety, staffing levels and ratios, contracting out practices, paid sick and quarantine leave, and part-time working conditions. SEIU consistently had the very strong and moderately-strong clauses, as well as the lowest number of "missing" clauses out all three unions. SEIU was particularly strong in multiple facets of health and safety, from PPE and infectious disease to referencing staffing levels. CUPE had stronger language concerning part-time benefits in-lieu being offered at CUPE 5192, while CUPE 905 had strong benefits continuance language and the strongest sick leave clause amongst all contracts which included short and long-term disability for part-timers. OPSEU was the most consistently weak in terms of language, and no OPSEU clauses were evaluated as strongest. OPSEU's municipal contract covered more clause areas than its other home types, while the CUPE municipal contract with York had both broad coverage and strength. Non-profits with OPSEU and SEIU were a bit weaker than their private counter parts as well.

The COVID-19 pandemic tested collective agreements in unprecedented ways and as one CUPE Representative noted, "the way we structure contracts doesn't fit with this current reality". Gaps and inadequacies were made apparent, such as the need for improvements in sick leave,

quarantine leave, health benefits, the role of engaged health and safety committees, and guaranteed access to PPE. The influence profit motives was made apparent as well, with SEIU's Head Researcher citing examples difficulties in accessing PPE with private homes where in some cases workers were made to wear garbage bags instead of gowns and to re-use supplies.

Some participants explained how navigating the pandemic depended on pre-existing relationships and engagement levels prior to COVID. This could include an already active Joint Health and Safety Committee, accommodation histories during outbreaks outside of COVID, and the enforcement of agreements through the grievance process. Benefits such as life insurance for part-timers, paid leave to care for dependents, and benefits continuance on leave also emerged as newfound or further emphasized bargaining priorities in the context of a virus that threatens the lives of workers and their families.

In addition to recognizing difficulties that PSWs faced on the job, weaknesses in collective agreements, and changed bargaining priorities with the pandemic, participants shared insight into the broader challenges unions faced, as will be explored in the next section.

Challenges to Union Effectiveness

Participants identified several challenges that unions faced in developing and exercising power in workplaces and the LTC sector more widely. The challenges to union effectiveness fell into four themes: the structure of collective bargaining; challenges to member engagement; neglecting long-term care and privatizing health care; and governance and labour relations during the pandemic.

The Structure of Collective Bargaining

Long-term care workers in Ontario are covered by the Hospital Labour Disputes Arbitration Act (HLDAA) which sets forth an interest arbitration process for impasses at the bargaining table, which negotiations in long-term care regularly proceed to. The HLDAA prohibits strikes and employer lockouts, and unless otherwise agreed upon, arbitration awards typically last for 2 years. The HLDAA directs Boards of Arbitration to consider the following five factors and principles for comparability when determining awards: (1) the Employer's ability to pay in light of its fiscal situation, (2) the extent to which services may have to be reduced in light of the award, (3) the economic situation in Ontario and in the municipality where the home is located, (4) a comparison of the terms and conditions of employment and the nature of the work performed with other comparable employees and (5) the employer's ability to attract and retain qualified employees (HLDAA Section 9.1.1).

A principle of replicability intends for "arbitrators to arrive at a conclusion that is the same as what the parties would have arrived at, were they to engage in collective bargaining" as described by one CUPE Representative. As a result of comparability and replication, each arbitration award determines the possibilities and limitations of future awards across the sector. Consequently, union bargaining strategies are designed with this process in mind.

A CUPE Representative explained that arbitration presents difficulties for pattern bargaining since the 2-year award length prevents contract expiry alignment and each arbitration is quite labour intensive. As a result, working on multiple contract arbitrations at once would prove difficult. Bargaining in the sector was described as "coordinated" rather than formally patterned for the larger unions of CUPE and SEIU which represent more bargaining units and engage in a higher number of separate negotiation tables. As a union with a smaller number of

members in the sector, OPSEU's bargaining was more rooted in considerations per individual employer.

The Hospital Labour Disputes Arbitration Act shapes long-term care labour relations and limits labour power in distinct ways. Strikes are prohibited while arbitration remains a slow and conservative process. Pro-worker and sector-wide transformation would require a critical mass of individual arbitration awards to be won, which is an unfeasible prospect. Moreover, arbitration is a labour-intensive and legalized process that may lend itself to closed-door negotiations rather than rank-and-file driven negotiation. However, SEIU's Head Researcher mentioned a unique example of an unpreceded 100-member turnout to a arbitration hearing.

All the analyzed collective agreement provisions referenced staffing levels and workload to some degree in the context of labour management issues and three contracts referenced these issues in health and safety language. However, the provisions confer limited influence to unions and participants said that staffing and workload haven't been significantly rectified in bargaining. One SEIU Representative explained that the issues fall within permissive bargaining territory and that union proposals on staffing are lost at arbitration:

> I wouldn't say workload has been addressed through bargaining. It's, I mean, it's, we lose that one at arbitration regularly, right. The employer has the ability to determine the numbers and that sort of thing. Right. So unless we're into unsafe work territory, right, where people are given so much work that it's unsafe for them to, to do it that fast – we tend to be successful there. But I mean, we mostly lobby the government on that. Right, because we've tried numerous times and failed at dealing with it through arbitration and bargaining. So, we get into permissive bargaining territory when we start trying to bargain the baseline staffing levels on units, that kind of thing."

Another representative from CUPE similarly commented that short staffing was only reactively dealt with in grievances from a safety perspective, saying that "my locals file grievances every time they have to work short because someone is not going to be safe, right?"

Participants explained that because of arbitration comparability, awarded increases to items such as wage rates tend to be relatively limited and conservative. Non-monetary items are more easily agreed upon at the table and employers were said to purposefully defer monetary items to arbitration where only relatively marginal gains are possible. A national union representative described these constraints by saying "the thing is, is that the norm is such a low standard because of interest arbitration, that it's hard to push the envelope, and employers are very reluctant to be the trendsetter." While the SEIU Head Researcher commented on the difficulties of arbitrators seeking to balance both party interests:

> Arbitrators are not willing to award breakthrough items. So they're not going to tell a home that you need to have X amount of full-time workers, they just won't do it. They want to get rehired. Because all parties have to agree on an arbitrator. And this is a real thing within the system is that you can't appease too much to one side, or else, you know, you get blacklisted and it happens, it does happen quite frequently. So the arbitrator won't give either side a big change if the other one doesn't want it.

SEIU's Head Researcher furthermore described the system as "manipulatable" since employers are disincentivized to bargain at the table and attested that "leverage is a difficult one, when it comes to an interest arbitration system. Because there's no pressure on either party to get a deal because you have no risk of a work stoppage." Most participants acknowledged that by virtue of suppressing strikes through the HLDAA, labour power in the sector is distinctly limited as workers hold no legal avenue of withdrawing labour. Given the depth of problems within long-

term care, arbitration offers incremental changes and limits the ability of unions to make stronger and more necessary gains.

In contrast to most of the participants consistently speaking to the difficulties and limitations of arbitration, one OPSEU representative provided a more positive view of the process:

> we oftentimes are able to make wonderful gains at arbitration, we've been able to achieve some really great things for our members at our – without them having to incur the cost of a strike. So I wouldn't say that arbitration is a brutal second place to a strike. I would say that, you know, it's, it's a…it's another form of job action.

Despite this outlook, the overwhelming consensus was that arbitration represented more limitations than gains. The structure of labour relations in long-term care and bargaining under the HLDAA represents a challenge to union power since strikes are prohibited and unions are often led to arbitration with corporatized employers who are unwilling to negotiate substantial and monetary items. When arbitrated, salient issues of staffing and workload haven't been awarded in favour of unions and gains in areas such as wages are conservative in nature. Due to the limitations of arbitration in thus-far countering pervasive poor working conditions, participants unanimously called for government-led reform on employment in the areas of staffing standards, minimum hours of direct care, and eliminating privatized facilities. Sectoral policy was considered necessary to grapple with the scale and depth of the problems at hand.

Challenges to Member Organizing and Engagement

The composition of the long-term care workforce influences possibilities for member organizing and engagement. Many members face double or multifold burdens of work between unpaid domestic labour and waged work in the sector which can often involve more than one

part-time job to make ends meet. Participants explained how these conditions foster fatigue and burnout amongst membership which creates challenges to union engagement. Additional difficulties are presented since facilities run 24/7 and staff rosters fluctuate from day-to-day within and between facilities. These impeding circumstances exist along-side the interest-arbitration process and an inability to strike, which together suppress rank-and-file participation and certain pathways to exercising labour power.

The temporal and spatial structure of a precarious workforce was identified as a barrier to deeper organizing and engagement, which could potentially develop union power with worker involvement in various areas of workplace decision-making and accountability. Furthermore, an engaged union membership can help shift labour relations with employers, counterbalance staff-led, more bureaucratic forms of unionism, and develop worker consciousness.

One national union representative commented on the implications of worker burnout on union engagement:

> I think one of the major issues with organizing women in this workforce is that a lot of them have that compassion fatigue, and a lot of them are willing to take more than they should and … their energies are already spent fighting so many other barriers and issues, that when it comes to unionized issues, although we do fight to break down those barriers, they're exhausted by the time, I feel, that the local can get to them. Because they're working 2, 3, 4 jobs, you know, they're trying to stay afloat.

According to an OPSEU representative, the precarious workforce structure posed challenges to COVID-related protocol in preventing disease transmission:

> You know, there's all the exceptions, but overall, I would say the desire to keep labour cheap as possible prior to the pandemic – so having a large pool of casual and part-times,

> who are transient in nature and going everywhere, really did make it difficult when COVID hit to shut the doors and try to keep things a little more under control."

Participants also identified a range of power asymmetries that disproportionately affect racialized and immigrant women. Some employers created a fearful and exploitative environment that dissuaded member participation in their union, using discriminatory stereotypes such as implying that immigrants should simply be "thankful" to be in Canada rather than engaged in their union (national union representative). Other employers took advantage of language barriers to obfuscate communication and information, and exploited fears of losing access to more potentially stable work:

> sometimes them [immigrant workers] being taken advantage of, because some of them do have a language barrier. Right? So some of the communication methods that the employer may use, they may know that that person is not going to interpret it the way that they're delivering it, or they're not going to question it.
>
> – National union representative

In addition to commenting on employer tactics that exploit newcomer insecurities, some participants thought that immigrant workers held complex relationships with unions given differing labour relations in their country of origin. One OPSEU Representative noted that regional and provincial union leadership did not reflect the demographics of long-term care's membership, either. Participants recognized that unions themselves faced challenges in navigating workplaces with racial and ethnic segregation, where racialized workers are concentrated in lower-paying lower-status positions, such as PSWs and RPNs compared to RNs.

Unions responses to these barriers were to create more accessible campaigns and programs for members to engage with, such as signing petitions and writing letters to elected

offices. Worker outreach was deployed across different days and shift times, included translated information where possible, and virtual union meetings were considered a source of needed flexibility as well. Speaking to the double burden faced by women, an OPSEU representative described how their union tried to create accessible engagement actions:

> It's tricky, I mean, with the predominant group in the sector being women, it's hard. I mean, you know, the challenges of being, you know, either a mom or someone who takes on a great deal of, you know, household responsibilities in addition to work responsibilities, it's difficult to then ask those people again, to engage with their union in some form of action. That can be quite tricky. And then it shapes too how we try to engage these members. So we try to set up campaigns and programs that are relatively simple, don't require maybe a great deal of attendance.

A SEIU representative explained the particular importance of member involvement in the workplace. Their comments stood out amongst all participants to suggest action beyond a reliance on collective agreement mechanisms, some of which were legally supressed by the Ford government during the pandemic (a development that will be examined in an upcoming section):

> So they – as far as the exercising their…I mean, right now, direct action is the fastest way to get anything done in these homes, right. It's a little bit different when it's a non-COVID situation. People wind up, you know, they do that, the employer doubles down, imposes more discipline, that sort of thing. But right now, the employer needs them a lot more than they need their employer considering that training healthcare worker can find another job by tomorrow… if they're solid in the workplace, they're able to sort of get things in spite of the fact that collective agreement provisions are stripped [under the Ford government's Emergency Measures]. So I guess, in a nutshell, the groups that rely

> solely on collective agreement provisions and enforcement mechanisms in a collective agreement, like the grievance procedure, are at a disadvantage right now, whereas the workers who use that in conjunction with things like direct action are doing a lot better.

Participants openly recognized the difficulties of engaging a precarious feminized workforce and how employers used racialization and immigration status to thwart member engagement. Some discussed union representation and responsiveness to their member demographics as well. Most described relatively straightforward participation opportunities such as petitions, surveys, and membership meetings, apart from one SEIU representative who underscored the role and significant of direct action amongst workers.

Neglecting Long-Term Care and Privatizing Health Care

The COVID-19 pandemic brought unprecedented levels of awareness to long-term care along with bolstered public support to include the sector under the *Canada Health Act* and eliminate privatization. A September 2021 poll by NUPGE found that 71% of respondents supported ending for profit care and 81% support of funding increased in LTC (NUPGE 2021). Despite more current visibility, key informants suggested that systemic problems remained unaddressed prior to COVID because of pervasive negligence toward long-term care within health care.

Widespread public and political attention to the sector was frustrating to participants since workers, unions, residents, and advocates had all engaged in reform efforts years or even decades prior to the COVID-19 pandemic. Participants called attention to the pre-existing nature of overwork, understaffing, precarity, and poor working conditions which pandemic pressures then intersected with. Commenting on their participation in the 2020 Ministry of Long-Term Care Staffing Study, an OPSEU representative described their dissuasion:

> But you look around the room, and you have all these unions in the room. And they all said the same thing. Like, we were here 10 years ago. Right, pushing the government for more staff and more this and more full-time jobs. Like, why are we here again, like, you know what I mean, it just doesn't make sense, right?

Another OPSEU representative commented on union participation in the 2008 Sharkey Report, a McGuinty-government mandated investigation of LTC human resourcing in Ontario. The representative said:

> "the unions were part of that. And that, her – at the end of it, we, actually most of the unions if not all, left, because everything seemed to be getting put on the parking lot and nothing ever got resolved. The bottom line to that report was: here's the funding, let the employers deal with what they want to deal with. So you have your managers and your RNs, you have your big money people taking money out of the pot out of the nursing envelope, and then the frontline people get what's left."

Indeed, CUPE, SEIU, OPSEU, and CAW all withdrew from the Sharkey long-term process, citing doubt in its ability to rectify staffing, care standards, and administer LTC funding in ways that prioritize health care and proper working conditions over profits (CUPE Ontario 2009). The OPSEU representative's comment points to how LTC funding structures have continued to under-resource and under-support direct care workers. For example, with the sector's high level of corporatization for-profit homes divert funding they receive toward investor returns and dividends (Armstrong et al. 2021). A CUPE representative spoke to the siphoning of money toward shareholders:

> And I would be remiss to say that we're also like, on that kind of macro level…the removal of profit from the sector would go a tremendous way…the money that is

> provided in the nursing envelope is, is quite restricted. And so what – if employers have to use the money that they get from the government for nursing for that [direct care], and if they don't use it, they have to send it back. But for-profit providers can also take the money that they get in terms of fees from residents and some of the other envelopes that they get from government. And they can choose to invest that back into the workplace or they can choose to pay dividends to shareholders. They use it to pay dividends.

As eluded to by this respondent, links have been identified between corporate long-term care operators, their lobbyists, and Ontario governance over several different regimes. Former premier Mike Harris shaped the legislative architecture for LTC privatization and now holds a boardroom position with Chartwell, and Conservative premiers Bill Davis and Ernie Eves have held similar roles at for-profit companies (Helguero 2020; OHC Integrity Complaint 2020; Noorsumar 2020). The Ontario Health Coalition has investigated the revolving door between several Ford government officials and for-profit care, and the Coalition says civil society has been particularly ignored by the Ford administration (Helguero 2020).

With newfound attention directed at the sector, participants were concerned about misconceptions on the root causes of LTC problems and failures. One CUPE representative was bothered over the media's tendency to individualize problems and malign workers while obscuring the structural and political conditions that resulted in COVID outbreaks and deaths. Interviewees also suggested that long-term care had also been ignored because of the demographics of workers and residents. The workforce predominantly involves feminized, racialized, and immigrant workers, and such composition is particularly pronounced in southern Ontario and urban centres. Care work may be also undervalued because of gendered assumptions concerning "women's work". Resident demographics must be taken in account through the

lenses of systemic ableism and ageism as well. Most residents are elderly women with various forms of cognitive impairment and disability, though younger residents with disability are increasingly common. Commenting on the Canadian military's involvement in care homes during the pandemic and subsequent public scrutiny of the sector, a CUPE representative suggested that problems were long known but remained unaddressed in part due to gendered and racialized dynamics with workers:

> Women, primarily racialized women in scrubs have been saying this for decades it takes a few dudes in uniform coming in and saying it. All of a sudden, everyone pays attention…for far too long, it has been a thing that is out of sight and out of mind. And you know, I think a huge component of that is the gendered nature of care work.

LTC is excluded from the *Health Act* and doesn't receive federal funding or provincial health insurance coverage. (Armstrong et al. 2021). A narrow conception of health care allowed for LTC privatization and profit-interests to take priority over the conditions of care and work, while demand for beds continues to grow without needed funding increases (ibid). Corporatized services also supress labour costs and rely on a precarious workforce that is largely composed of racialized and immigrant women.

Several participants brought up the influence of privatization, government austerity, and inadequate health care funding as the structural conditions that prevented meaningful sectoral reform prior to COVID. A lack of political will on the government's part was clearly articulated. COVID-19 was generally viewed as a potential reckoning to begin remedying undeniable and now highly visible problems. However, some participants simultaneously expressed pessimism concerning the likelihood deeper transformation, such as the elimination of for-profit care, and

several interviewees expected the sector's staffing and retention crisis to continue to worsen given the arduous conditions workers have been subject to. LTC problems have grown and endured because of several intersecting factors: the sector's exclusion from the *Health Act*, health care defunding and privatization in Ontario, power relations that ignore the voices of racialized and immigrant workers, and close ties between industry and governance.

Governance and Labour Relations with the Ford Government

Prior to the pandemic, unions were already weakened in face of the HLDAA arbitration process and strike prohibition, a fractured workforce resulting from privatization and underfunding, and difficulties with member engagement. Ford government policies before COVID also shaped the difficult terrain workers and their unions have navigated. In 2018, Ford eliminated two guaranteed paid sick days that were provided to Ontario workers and placed in three unpaid days (Rushowy and Mojtehedzadeh 2018). In November 2019, Ford legislated public sector wage restraints with Bill-124 which caps wage increases to a maximum of 1% yearly total compensation including benefits. Bill-124 translates to real wage cuts and prevents workers from negotiating gains in sick days and additional benefit supports. In long-term care the legislation solely applies to non-profit homes and USW suggests this wage differential could worsen staffing inequalities between facility types (United Steel Workers 2020). Given the prominence of women in public sector work (Briskin 2013) the legislation furthermore represents a gendered attack on wages and both ONA and OPSEU have filed constitutional challenges to the bill (ONA, n.d.; OPSEU, 2020).

During the pandemic in November 2020, the Province established a recruitment program for "residential care aides" to enter the long-term care workforce from areas such as retail and hospitality, and education (Government of Ontario 2020). Participants disapproved of this

approach as it created a lower job classification outside of bargaining unit without requiring previous training or experience in care work and infectious disease protocol. The policy reflected a devaluation of long-term care work with blatant de-skilling and a failure to rectify funding (*CUPE Transcript Ontario LTC Commission*, 2020). Under on-going staffing pressures, care aides are likely to engage in direct care work even though their mandate is limited to "non-care" functions (Canadian Union of Public Employees 2020).

All participants expressed grave concern over governance and labour relations during the pandemic, an additional factor that jeopardized worker protections. In July 2020, the Ford government's *Bill-195: The Reopening Ontario Act* extended existing Emergency Orders based on monthly renewal. Orders from the *Emergency Management and Civil Protection Act* were originally set forth in March 2020 in response to the first COVID peak. The *Emergencies Act* and its temporal extension through Bill-195 allowed the government to continue to assign workers to essential services, set remuneration rates, and regulate the distribution of goods and services while overriding impeding collective agreement elements if deemed necessary (EA, ss. 8(1)(d), (e)).

Unions recognized the interference with collectively bargained rights as granting enormous latitude to employers to dismiss collective agreement provisions while limiting union abilities to grieve violations. Consequently, unionized workers could no longer count on the range of rights bargained for in their contracts, posing a significant challenge to union effectiveness. Participants explained that clauses such as shift scheduling, scheduled vacations, seniority-based layoffs, and by association grievance procedures were affected by the Orders. Unionized workers in long-term care were also subject to heightened staffing, assignment, and deployment measures controlled by employers. Accordingly, participants reported that members

were extremely dissuaded and confused over these changes which sowed doubt amongst some workers about the value of unionization. As one participant said, the Ford government showed "no respect for collective agreements" and all interviewees were concerned with the harmful precedent set by the policies.

Concerningly, the Ministry of Labour was consistently described as being shamefully inadequate during the pandemic. Participants denounced the Ministry's lack of in-person inspections (instead, using phone calls to assess working conditions), their nearly systematic refusal to uphold COVID-related claims of unsafe work, and an overall reluctance to enforce measures to protect workers. A national union representative described problems with the Ministry in relation to health and safety and its role in overturning work refusals:

> And I mean, they're not willing to really have an active and enforcement role on a good day, outside of COVID, let alone when COVID happened. And I think the proof was in the pudding when there was an article that came out to say that they haven't – there's been zero orders [work refusals] that have been issued from Ministry of Labour, …. I do think that though, their role should have been to enforce the law. And I think their role should have been to look at the Occupational Health and Safety Act, recognizing that it was not created and things weren't written with the perspective of being in a pandemic, where things are viewed virtual. I totally understand that. But I think that it's their role to take their language and adapt it to the circumstances now.

PSW retention problems worsened with COVID and a temporary pay bump of $3-4 was established for PSWs and direct care workers in October 2020 (Ministry of Long-Term Care 2020). However, this move by the Ford government was viewed as inadequate and divisive. Unions called for a permanent pay raise while some emphasized compensation parity for PSWs

across an array of workplaces beyond long-term care facilities (CUPE Ontario & OCHU, 2020). Participants explained that the pay bump criteria was vaguely defined and problematically implemented with delays in pay and confusion over who exactly qualified. An OPSEU representative conveyed the confusion experienced with government policies and unclear implementation earlier in the pandemic:

> And, you know, again, the government makes all these announcements. But you know, it's not till like, two months later that we know the finer details, right… So it's just, you know, it's the rollout of these initiatives too that just creates more confusion. Right. And it's like, members are calling us, "When the hell's it going on my pay?" It's like, you know what? It's not the union's initiative here, the union – you know, it's the government initiative. Right?

The pay difference created tensions between work classifications since a range of care workers within and across LTC settings remain over worked and underpaid. Some participants instead suggested that a widespread pay bump for both long-term care and healthcare would improve morale and staffing stability.

Overall, Ford government policies created difficulties for unions pre-ceding and during the pandemic by eroding sick days standards, capping public sector wage increases, and using measures to suppress collective agreements. Furthermore, the Ministry of Labour was largely unresponsive to on-the-ground workplace concerns while pandemic pay programs and staffing initiatives with new care aides left fundamental problems unaddressed.

Discussion

Ontario's LTC sector is highly corporatized with private logics implemented in the ownership and management of all types of LTC facilities. Neoliberalism and privatization has

changed the organization of LTC work and in this context, working conditions are shaped by gendered assumptions, limited labour power, and higher levels of precarity compared to other care work settings (Armstrong and Braedley 2013; Zagrodney and Saks 2017). For-profit homes are more likely to be insufficient in staffing and linked to higher COVID-19 resident deaths (McGregor and Harrington 2020) and in May 2020 the Ontario Health Coalition reported a COVID-19 death rate in for-profit homes of 9% compared to 5.25% in non-profit homes and 3.62% in public homes (*COVID-19 Death Rates*, 2020).

Union informants suggested that workplace-level protections involving health and safety committees, associated training and equipment, paid sick and quarantine leave would all be desirable safeguards against COVID. Collective agreements conferred certain protections, but unions had limited effectiveness in their ability to protect workers due to four significant and overarching challenges: the structure of collective bargaining, difficulties in member organizing and engagement, the neglect of long-term care and privatizing health care, and finally, governance and labour relations with the Ford government.

Though protections such as PPE provisions have an obvious and immediate relevance, informants described a holistic approach to establish a more stable and cohesive LTC workforce with improvements in pay, full-time hours of work, staffing, and benefits that also echo policy directions found in research. As bargaining is limited in its ability to address workplace issues that are deeply intertwined with sectoral deficiencies, participants called for legislative reforms to improve compensation and staffing, to eliminate for-profit care, and rectify inadequate funding in ways that echo policy directions found in research (Armstrong et al. 2021; Baines and Armstrong 2018).

Collective agreements in the sector did not provide strong protection for PSWs and the strength of clauses varied considerably by union and facility type. SEIU consistently included some of the strongest clauses, likely because of the union's sectoral influence through their Master Nursing Homes Agreement. This result suggests the power of centralized bargaining in larger unions. Some CUPE provisions were strong, especially in their municipal contract with York 905 while other CUPE articles were moderate in strength, and CUPE bargaining is coordinated but more decentralized than SEIU. OPSEU's contracts were consistently assessed as the weakest and they are a smaller, more atomized union in the sector.

While contracting out by employers in long-term care is likely to continue given the essential nature of care work and on-going staffing shortages, unions could leverage the safety implications of temporary staff who work in multiple facilities as added impetus to strengthen language against contracting. In response to the risk of COVID transmission across workplaces, the Ford government mandated a single-site work order in April 2020 three months after a similar policy was made in British-Columbia (O. Reg. 146/20). The order was aimed to mitigate the spread of COVID, but also increased financial pressures on workers and seldom included improved pay (Ontario Long-Term Care Commission 2021).

In health and safety, language calling for increased communication and accountability beyond the standards of the OHSA would prove useful. Gains could be made by requiring regular weekly meetings during an outbreak to coordinate the type of joint contingency planning concerning PPE that has been government mandated through the pandemic (Ministry of Health and Long-Term Care Directive 1 2020). Moreover, language could be strengthened by articulating the need for in-person infectious disease training, annual and updated training as disease information changes, and ensuring that training occurs on paid time.

Adequate PPE supply is another potential area to bargain for, though it would involve complexities with expiry dates and stock maintenance. Participants also explained that municipal homes tended to have better PPE provision and more cooperative JHSCs because of better resourcing and a stronger public sector mandate. Outbreak protocols add to already unmanageable workloads by raising resident case complexities and other stressors, but this scenario was not reflected in any of the agreements. Additionally, gaps in sick leave, isolation, and quarantine requirements could be rectified to ensure worker safety and financial stability to account for various circumstances of illness, potential exposure, and mitigating transmission.

Wages across the twelve collective agreement's reflected similar patterns confirmed in other studies, with municipal wages being the highest with CUPE Local 905 in York Region and OPSEU at the Region of Halton. Using information from the Ministry of Labour's Collective Agreement Database, the Ministry of Long-Term Care Staffing Study (2020) found average unionized PSWs wages to be $24.28 in municipal homes, $22.91 in hospitals, $20.78 in non-profit facilities, and $20.33 in for-profit homes. Wages are on average highest in municipally run homes and lowest in for-profit homes which involve stronger managerial efforts to supress labour costs (Armstrong and Braedley 2013).

In the sector's wider bargaining context, long-term care workers are subject to the same arbitration-based labour disputes law as hospital workers, the HLDAA, but the sector is excluded from universally insured health services that are covered by a hospital-focused 1984 Canada Health Act (Canadian Union of Public Employees 2009; Lewis 2020). Against a backdrop of low sectoral norms, participants explained that arbitration gains in the union's favour are often marginal while workforce issues are regularly awarded to the employer's favour. Moreover, the HLDAA prohibits strikes, which suppresses labour power by stifling the legal option to

collectively withdraw labour and current bargaining structures may exclude rank-and-file engagement compared to closed-door, "expert" led and legally specific processes.

Overall, key informants focused on arbitration, political and advocacy-based initiatives rather than ways to build labour power amongst membership. Serving as a voice for LTC workers at various scales of engagement and at the sectoral level, unions are involved in provincial organizing, lobbying, and campaigning with a similar orientation to Briskin's "politicization of care" (2013) that notably excludes job action. In these campaigns, conditions of care and work are clearly linked together along with funding and the role of LTC work in the public interest.

Though the Ford government has blatantly suppressed the upholding of collective agreements, no participants discussed the possibility of exercising labour power beyond the limitations of the no-strike HLDAA. Instead, participants discussed the challenges of a strike prohibition without broaching the prospect of illegal job actions or alternative legal regulation in labour relations. While union representatives may be less likely to discuss job action and wildcat strikes by virtue of their employment position, this represents a curious omission since the Ford government was viewed as no longer respecting collective bargaining processes. Key informants may also reflect a lack of consideration toward direct action and labour militancy and indicate limitations in living memory. After all, Albertan hospital and long-term care workers engaged in a wildcat strike in October 2020 during the pandemic. In 2013, thousands of homecare PSWs struck in Ontario to earn a $4.00 gain to their minimum wage, though this was a legal strike as they are not subject to the HLDAA (Cranford et al. 2018) and in Ontario, a major healthcare workers job action took place with CUPE in 1981.

Although case studies in nursing labour relations may not directly translate to PSWs, important considerations can be noted. Nurses developed higher pay and status compared through professionalization whereas PSWs in LTC have not professionalized. Wildcat strikes brought gains to nurses in terms of working and care conditions, and challenged traditionally male associations of militant action (Briskin 2013; Camfield 2006; Coulter 1993). These studies also reveal public support for illegal job actions by nurses and other healthcare workers, as they were framed to serve the public interest and heath care working conditions were valorized. Given the current focus on the sector, unions representing LTC workers could consider the possibility of PSW job action garnering similar and strong public support. Unions could explore deeper worker organizing that goes beyond campaign-based methods of politicizing working conditions. After all, limited change has been made through legalized pathways of labour relations and sectoral reform is unlikely to come from a government with continued close ties between industry and regulation.

Nursing is also a vocation that predominantly involves white women, in contrast to the racialized demographics of PSWs (in urban areas) who lack professionalized recognition by virtue of remaining an unregulated care occupation. Most participants discussed racialized workplace demographics and some comments suggested that immigrants were averse to union engagement due to experiences in their countries of origin. However, racialized and immigrant workers may be more likely to be assumed as being docile, lacking in agency, or lacking the potential to engage in militant action. As the Cranford et al. (2018) study on unionized homecare PSWs found, union renewal in LTC needs to involve anti-racism and respond to the specificities of PSWs, which differ from assumed archetypes of public sector health care workers. LTC

unions may need assess their own biases toward rank-and-file membership to then develop more effective ways of overcoming challenges in member organizing.

Overall, long-term care is at a crossroads where pre-existing systemic vulnerabilities have been brought to light and COVID-related hazards and difficulties will persist. This study revealed that collective bargaining confers limited and varying degrees of protection for workers against COVID and unions face significant challenges to their power. Unionization and labour relations merit further exploration as workforce reform will remain a key component of reshaping the LTC sector.

Finally, this study holds limitations by virtue of interviewing a small number of union staff as key informants (8 total) and the limited availability of collective agreement information for contracts that were in effect during the pandemic, after March 2020. Future research inquiries could incorporate interviews with rank-and-file LTC workers of various classifications to better understand their relationship with their union, their agency, and perspectives concerning labour relations as well as relational care. A comparative analysis between unions in Ontario and other provinces could prove useful, given the qualities of Ontario corporatized LTC sector and the Ford government's anti-union positions preceding and during the pandemic. Additional research could also explore the effects of arbitration on member engagement and organizing.

Works Cited

Alamgir H., Cvitkovich Y., Yu S., and Yassi A. 2007. "Work-Related Injury among Direct Care Occupations in British Columbia, Canada." *Occupational and Environmental Medicine* 64 (11): 769–75. https://doi.org/10.1136/oem.2006.031914.

Armstrong, Pat. 1993. "Profession, Unions, or What?: Learning From Nurses." In *Women Challenging Unions : Feminism, Democracy, and Militancy*, 304–21. University of Toronto Press.

Armstrong, Pat, Hugh Armstrong, and Ivy Bourgeault. 2020. "Privatization and COVID-19: A Deadly Combination for Nursing Homes." In *Vulnerable: The Law, Policy and Ethics of COVID-19*, edited by Collen M. Flood, Vanessa MacDonnell, Sophie Thériault, Sridar Venkatapuram, and Jane Philpott, 447–62. University of Ottawa Press.

Armstrong, Pat, Hugh Armstrong, Dan Buchanan, Tony Dean, Gail Donner, Arthur Donner, Sharon Sholzberg-Gray, Alex Himelfarb, and Steven Shrybman. 2021. "Investing in Care, Not Profit Recommendations to Transform Long-Term Care in Ontario." Canadian Centre for Policy Alternatives.

Armstrong, Pat, Hugh Armstrong, and Krystal Kehoe MacLeod. 2016. "The Threats of Privatization to Security in Long-Term Residential Care." *Ageing International* 41 (1): 99–116. https://doi.org/10.1007/s12126-015-9228-0.

Armstrong, Pat, and Susan Braedley, eds. 2013. "Introduction." In *Troubling Care: Critical Perspectives on Research and Practices*, by Pat Armstrong and Susan Braedley, 9–16. Toronto: Canadian Scholar's Press.

Aronson, Jane, and Sheila M Neysmith. 1997. "The Retreat of the State and Long-Term Care Provision: Implications for Frail Elderly People, Unpaid Family Carers and Paid Home Care Workers." *Studies in Political Economy* 53 (1): 37–66.

Baines, Donna, and Pat Armstrong. 2018. "Promising Practices in Long Term Care: Can Work Organisation Treat Both Residents and Providers with Dignity and Respect?" *Social Work & Policy Studies: Social Justice, Practice and Theory* 1 (001): 1–26.

———. 2019. "Non-Job Work/Unpaid Caring: Gendered Industrial Relations in Long-Term Care." *Gender, Work & Organization* 26 (7): 934–47. https://doi.org/10.1111/gwao.12293.

Banerjee, Albert, and Pat Armstrong. 2015. "Centering Care: Explaining Regulatory Tensions in Residential Care for Older Persons." *Studies in Political Economy* 95 (1): 7–28. https://doi.org/10.1080/19187033.2015.11674944.

Banerjee, Albert, Tamara Daly, Pat Armstrong, Marta Szebehely, Hugh Armstrong, and Stirling Lafrance. 2012. "Structural Violence in Long-Term, Residential Care for Older People: Comparing Canada and Scandinavia." *Social Science & Medicine* 74 (3): 390–98. https://doi.org/10.1016/j.socscimed.2011.10.037.

Berta, Whitney, Audrey Laporte, and Natasha Kachan. 2010. "Unpacking the Relationship between Operational Efficiency and Quality of Care in Ontario Long-Term Care Homes." *Canadian Journal on Aging / La Revue Canadienne Du Vieillissement* 29 (4): 543–56. https://doi.org/10.1017/S0714980810000553.

Birdsell Bauer, Louise, and Cynthia J. Cranford. 2017. "The Community Dimensions of Union Renewal: Racialized and Caring Relations in Personal Support Services." *Work, Employment and Society* 31 (2): 302–18.

Block, Sheila, and Simran Dhunna. 2020. “What Does It Cost to Care?” Canadian Centre for Policy Alternatives.

Bourgeault, Ivy Lynn, Jelena Atanackovic, Ahmed Rashid, and Rishma Parpia. 2010. “Relations between Immigrant Care Workers and Older Persons in Home and Long-Term Care.” *Canadian Journal on Aging / La Revue Canadienne Du Vieillissement* 29 (1): 109–18. https://doi.org/10.1017/S0714980809990407.

Braedley, Susan, and Meg Luxton. 2010. *Neoliberalism and Everyday Life*. Montreal, CANADA: McGill-Queen’s University Press. http://ebookcentral.proquest.com/lib/mcmu/detail.action?docID=3332176.

Braedley, Susan, Prince Owusu, Anna Przednowek, and Pat Armstrong. 2018. “We’re Told, ‘Suck It up’: Long-Term Care Workers’ Psychological Health and Safety.” *Ageing International* 43 (1): 91–109. https://doi.org/10.1007/s12126-017-9288-4.

Briskin, Linda. 2013. “In The Public Interest: Nurses on Strike.” In *Public Sector Unions in the Age of Austerity*, edited by Stephanie Ross and Larry Savage, 91–102. Labour in Canada 4. Canada: Fernwood Publishing.

Brophy, James T., Margaret M. Keith, Michael Hurley, and Jane E. McArthur. 2021. “Sacrificed: Ontario Healthcare Workers in the Time of COVID-19.” *New Solutions: A Journal of Environmental & Occupational Health Policy* 30 (4): 267–81.

Camfield, David. 2006. “Neoliberalism and Working-Class Resistance in British Columbia: The Hospital Employees’ Union Struggle, 2002-2004.” *Labour/Le Travail* 57: 9–41.

Canadian Union of Public Employees. 2009. “Residential Long-Term Care in Canada: Our Vision For Better Seniors’ Care.” Ottawa: Canadian Union of Public Employees. https://archive.cupe.ca/updir/CUPE-long-term-care-seniors-care-vision.pdf.

———. 2020. “Ontario Government’s Move towards Lower Classification of Workers Is Not Good for Long-Term Care Residents.” *CUPE.Ca* (blog). November 10, 2020. https://cupe.ca/ontario-governments-move-towards-lower-classification-workers-not-good-long-term-care-residents.

Clark, Paul F., and Darlene A. Clark. 2006. “Union Strategies for Improving Patient Care: The Key to Nurse Unionism.” *Labor Studies Journal* 31 (1): 1–19.

Cohen, Marcy, and Marjorie Griffin Cohen. 2004. “The Politics of Pay Equity in B.C.’s Health Care System: The Role of Government Multinational Corporations and Unions.” *Canadian Woman Studies* 23 (3–4): 72.

Coulter, Rebecca Priegert. 1993. “Alberta Nurses and the ‘Illegal’ Strike of 1988.” In *Women Challenging Unions : Feminism, Democracy, and Militancy*, 44–61. University of Toronto Press.

“COVID-19 Death Rates in Ontario Long-Term Care Homes Significantly Higher and Increasing in For-Profit Homes vs. Non-Profit and Publicly-Owned Homes: New Data Analysis.” 2020. Ontario Health Coalition. May 2020. https://www.ontariohealthcoalition.ca/index.php/death-rates-in-long-term-care-by-ownership-release/.

“COVID-19: Long-Term Care Homes.” 2021. Government of Ontario. August 16, 2021. https://covid-19.ontario.ca/data/long-term-care-homes.

Cranford, Cynthia, Angela Hick, and Louise Birdsell Bauer. 2018. “Lived Experiences of Social Unionism: Toronto Homecare Workers in the Late 2000s.” *Labor Studies Journal* 43 (1): 74–96.

Cranford, Cynthia J. 2005. "From Precarious Workers to Unionized Employees and Back Again? The Challenges of Organizing Personal-Care Workers in Ontario." In *Self-Employed Workers Organize: Law, Policy, and Unions*, edited by Cynthia J. Cranford, Eric Tucker, and Judy Fudge, 136–70. McGill-Queen's University Press.

CUPE Ontario. 2009. "Long-Term Care Process a Distraction: Unions Pull Out." March 30, 2009. https://cupe.on.ca/archivedoc770/.

CUPE Ontario, and Ontario Council of Hospital Unions. 2020. "CUPE Ontario and OCHU Say Wage Increase for Personal Support Workers Is Just the First Step." October 1, 2020. https://ochu.on.ca/2020/10/01/cupe-ontario-and-ochu-say-wage-increase-for-personal-support-workers-is-just-the-first-step/.

CUPE Transcript, October 8 2020 with Ontario's Long-Term Care COVID-19 Commission. 2020. http://www.ltccommission-commissionsld.ca/transcripts/pdf/CUPE_Transcript_October_08_2020.pdf.

Daly, Tamara. 2015. "Dancing The Two-Step in Ontario's Long-Term Care Sector: Deterrence Regulation = Consolidation." *Studies in Political Economy* 95 (1): 29–58. https://doi.org/10.1080/19187033.2015.11674945.

Daly, Tamara, and Marta Szebehely. 2012. "Unheard Voices, Unmapped Terrain: Care Work in Long-Term Residential Care for Older People in Canada and Sweden: Care Work in Long-Term Care: Canada and Sweden." *International Journal of Social Welfare* 21 (2): 139–48. https://doi.org/10.1111/j.1468-2397.2011.00806.x.

DeForge, Ryan, Paula van Wyk, Jodi Hall, and Alan Salmoni. 2011. "Afraid to Care; Unable to Care: A Critical Ethnography within a Long-Term Care Home." *Journal of Aging Studies* 25 (4): 415–26. https://doi.org/10.1016/j.jaging.2011.04.001.

Directive #1 for Health Care Providers and Health Care Entities –. 2020. https://www.health.gov.on.ca/en/pro/programs/publichealth/coronavirus/docs/directives/health_care_providers_HPPA.pdf.

Fudge, Judy. 2020. "Ontario's Long-Term Care Response Is Still Lacking." *Toronto Star*, April 2020. https://www.thestar.com/opinion/contributors/2020/04/16/ontarios-long-term-care-response-is-still-lacking.html.

Government of Ontario. 2020. "Province Launching Recruitment Program to Support Long-Term Care Sector." *News: Ontario* (blog). November 9, 2020. https://news.ontario.ca/en/release/59108/province-launching-recruitment-program-to-support-long-term-care-sector.

Harrington, Charlene, Frode F Jacobsen, Justin Panos, Allyson Pollock, Shailen Sutaria, and Marta Szebehely. 2017. "Marketization in Long-Term Care: A Cross-Country Comparison of Large For-Profit Nursing Home Chains." *Health Services Insights* 10 (January): 117863291771053. https://doi.org/10.1177/1178632917710533.

Helguero, Sam. 2020. "The 'revolving Door' between Ontario's PCs and the for-Profit Seniors Care Industry Worst Hit by Coronavirus." *The Post Millenial*, June 2020. https://thepostmillennial.com/the-revolving-door-between-ontario-pcs-and-companies-running-seniors-homes-hit-worst-by-covid-19.

Hsu, Amy T., Whitney Berta, Peter C. Coyte, and Audrey Laporte. 2016. "Staffing in Ontario's Long-Term Care Homes: Differences by Profit Status and Chain Ownership." *Canadian Journal on Aging / La Revue Canadienne Du Vieillissement* 35 (2): 175–89. https://doi.org/10.1017/S0714980816000192.

Kelly, Christine. 2017. "Care and Violence through the Lens of Personal Support Workers." *International Journal of Care and Caring* 1 (1): 97–113. https://doi.org/10.1332/239788217X14866305589260.

Lewis, Steven. 2020. "The Pandemic and the Politics of Long-Term Care in Canada." *Policy Options*, May 11, 2020. https://policyoptions.irpp.org/magazines/may-2020/the-pandemic-and-the-politics-of-long-term-care-in-canada/.

Liu, Michael, Colleen J. Maxwell, Pat Armstrong, Michael Schwandt, Andrea Moser, Margaret J. McGregor, Susan E. Bronskil, and Irfan A Dhalla. 2020. "COVID-19 in Long-Term Care Homes in Ontario and British Columbia." *CMAJ* 192 (47): 1540–46.

Longhurst, Andrew, and Kendra Strauss. 2020. "Time to End For-Profit in Seniors' Care." *Policynote: The Canadian Centre for Policy Alternatives*, April 2020. https://www.policynote.ca/seniors-care-profit/.

Long-Term Care Homes Act, 2007, S.O. 2007. 2010. https://www.ontario.ca/laws/statute/07l08.

"Long-Term Care Homes in Canada: How Many and Who Owns Them?" 2021. Canadian Institute for Health Information. 2021. https://www.cihi.ca/en/long-term-care-homes-in-canada-how-many-and-who-owns-them.

"Long-Term Care Staffing Study." 2020. Ministry of Long-Term Care: Long-Term Care Staffing Study Advisory Group.

Lum, Janet, Jennifer Sladek, and Alvin Ying. 2010. "Ontario Personal Support Workers in Home and Community Care: CRNCC/PSNO Survey Results." *Canadian Research Network for Care in the Community*, 1–36.

McAlevey, Jane. 2015. "Forging New Class Solidarities: Organizing Hospital Workers." In *Socialist Register: Transforming Classes*, edited by Leo Panitch and Greg Albo, 51:318–35. London: Merlin Press.

McGregor, Margaret J., Marcy Cohen, Kimberlyn McGrail, Anne Marie Broemeling, Reva N. Adler, Michael Schulzer, Lisa Ronald, Yuri Cvitkovich, and Mary Beck. 2005. "Staffing Levels in Not-for-Profit and for-Profit Long-Term Care Facilities: Does Type of Ownership Matter?" *CMAJ* 172 (5): 645–49.

McGregor, Margaret J., and Charlene Harrington. 2020. "COVID-19 and Long-Term Care Facilities: Does Ownership Matter?" *Canadian Medical Association Journal* 192 (33): E961. https://doi.org/10.1503/cmaj.201714.

McGregor, Margaret J., and Lisa A. Ronald. 2011. "Residential Long-Term Care for Canada's Seniors: Nonprofit, For-Profit or Does It Matter?" *IRPP Study* 14: 1.

National Union of Public and General Employees. 2021. "Poll: Replace for-Profit Long Term Care with Public System." *NUPGE* (blog). September 15, 2021. https://nupge.ca/content/poll-replace-profit-long-term-care-public-system.

Noorsumar, Zaid. 2020. "Party of Profits: Ontario Tories and the Profit Motive in Long-Term Care." *Rank and File*, April 1, 2020. https://www.rankandfile.ca/party-of-profits-ontario-tories-and-the-profit-motive-in-long-term-care/.

O. Reg. 146/20: LIMITING WORK TO A SINGLE LONG-TERM CARE HOME. n.d. https://www.ontario.ca/laws/regulation/200146.

Ontario Health Coalition. 2020. "INTEGRITY COMPLAINT: Health Coalition Requests Integrity Commissioner Investigate Political Donations & High-Level Personnel Links Between For-Profit LTC Industry and Ford Government Prior to Passage of Legal Liability Bill," November 2020. https://www.ontariohealthcoalition.ca/index.php/health-coalition-requests-integrity-commissioner-investigate-political-donations-high-level-

personnel-links-between-for-profit-ltc-industry-and-ford-government-prior-to-passage-of-legal-liability-bi/.

Ontario Long-Term Care Commission. 2021. "Ontario's Long-Term Care COVID-19 Commission: Final Report."

Ontario Nurses Association. n.d. "About Bill-124." https://www.ona.org/about-bill-124/.

OPSEU. 2020. "OPSEU Files Charter Challenge against Ford's 'Blatantly Unconstitutional' Wage-Cap Bill." *OPSEU* (blog). March 17, 2020. https://www.opseu.org/news/opseu-files-charter-challenge-against-fords-blatantly-unconstitutional-wage-cap-bill/103926/.

Ponder, C. S., Andrew Longhurst, and Margaret McGregor. 2020. "Contracting-out Care: The Socio-Spatial Politics of Nursing Home Care at the Intersection of British Columbia's Labor, Land, and Capital Markets." *ENVIRONMENT AND PLANNING C-POLITICS AND SPACE* 39 (4): 800–817. https://doi.org/10.1177/2399654420960489.

Rushowy, Kristin, and Sara Mojtehedzadeh. 2018. "Ontario Moves to Hold Minimum Wage at $14 and End Paid Sick Days." *Toronto Star*, October 23, 2018, sec. Provincial Politics. https://www.thestar.com/politics/provincial/2018/10/23/ontario-moves-to-hold-minimum-wage-at-14-and-end-paid-sick-days.html.

SEIU Transcript, October 15, 2020 from Ontario's Long-Term Care COVID-19 Comission. 2020. http://www.ltccommission-commissionsld.ca/transcripts/pdf/SEIU_Transcript_October_15_2020.pdf.

Stall, Nathan M., Aaron Jones, Kevin A. Brown, Paula A. Rochon, and Andrew P. Costa. 2020. "For-Profit Long-Term Care Homes and the Risk of COVID-19 Outbreaks and Resident Deaths." *CMAJ* 192 (33): 946–55.

Syed, I, Tamara Daly, Pat Armstrong, R Lowndes, M Chadoin, and V Naidoo. 2017. "How Do Work Hierarchies and Strict Divisions of Labour Impact Care Workers' Experiences of Health and Safety? Case Studies of Long Term Care in Toronto." *Journal of Nursing Home Research Sciences* 2: 1–17.

The Canadian Women's Foundation, Canadian Centre for Policy Alternatives, Ontario Nonprofit Network, and Fay Faraday. 2020. "Resetting Normal Report 2: Women, Decent Work, and Canada's Fractured Care Economy." Canadian Women's Foundation.

United Steel Workers (USW). 2020. "Grant Exemption to Bill 124 or Risk Seniors in Long-Term Care: Steelworkers." June 26, 2020. https://www.usw.ca/news/media-centre/releases/2020/grant-exemption-to-bill-124-or-risk-seniors-in-long-term-care-steelworkers.

White, Jerry Patrick. 1990. *Hospital Strike: Women, Unions, and Public Sector Conflict.* Toronto: Thompson Educational Pub.

Zagrodney, Katherine, and Mike Saks. 2017. "Personal Support Workers in Canada: The New Precariat?" *Healthcare Policy | Politiques de Santé* 13 (2): 31–39. https://doi.org/10.12927/hcpol.2017.25324.

Appendix 1 – Collective Agreement Article Numbers

		Collective Agreement Details											
		Facility Type	Municipal	Private	Not for Profit	Private	Private	Private	Municipal	Not for Profit	Private	Private	Not for Profit	Private
		Employer	Regional Municipality of Halton	Edgewater Gardens	March of Dimes Canada - Villa Verdi	Meaford Long Term Care	HCN-Revera Lessee	Regency Park Nursing Home	York Region	St Peter's Residence at Chedoke	Downsview LTC	Grace Villa	Heritage Green Nursing Home	Extendicare Canada Inc.
		Union	OPSEU Locals 261, 265, and 282	OPSEU Local 214	OPSEU Local 262	OSPEU 289	CUPE Local 5192	CUPE 3593	CUPE Local 905	CUPE 7780	SEIU Local 1	SEIU Local 1	SEIU Local 1	SEIU Local 1
		Location in Ontario	Region of Halton	Dunville	Hamilton	Meaford	Nepean	Windsor	York Region	Hamilton	North York	Hamilton	Hamilton	
		Agreement Dates	June 2019 to May 2022	January 2018 to December 2020	April 2018 to March 2021	December 2016 to November 2019	Expires December 2022	January 2019 to December 2020	2016 to 2019	February 2017 to February 2019	July 2019 to July 2022	Sept 2019 to Sept 2022	May 2019 to April 2021	September 2016 to 2019
Agreement Clauses and Sub-Topics	**Wages**	PSW Starting Wage in 2018 or 2019	Schedule B	Schedule A	Schedule A	Schedule A	Schedule A	Schedule A	Schedule 1 - LTC	Schedule A	Schedule A	Schedule A	Schedule A	Schedule A
	Benefits	Part-Time Pro-rated Benefits or Percent in Lieu	19.04	22.04		19.03	Appendix A	18.01	25.5	20.1.7.	28.01	22.07		22.13
		Benefits Continuance on Leave (Full-time and Part-Time)	19.1	16	16	19C		18.04	21.8		11.04D and 16	9.01D		9.01D
	Sick Leave	Sick Leave Credits at 100% of wages	19.06	21.01	23	19.02	18.02	18.05	20	18.1	22.01	24	41.01	24.02
		Physician Certificate Requirement	19.07	21.04	23		18.03	18.07	20.12 and 20.13	18.2	22	24		24.05
		Short Term Disability	Appendix A	21.02, 21.03, and 22.01	Schedule B,C	19.02			25.6			24	41	24C
		Long Term Disability	19.01		Schedule B,C	19.02			28.1	20.1.5.			41	
		Quarantine Leave							LOI					