Rural Long-term Care Work, Gender, and Restructuring*

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RÉSUMÉ
La restructuration – l'introduction de changements qui modifient la façon dont les soins de santé sont délivrés pour optimiser l'éfficacité à moindre coût – s'ajoutant à la ruralité et aux idéologies et pratiques sexistes des milieux ruraux produit des établissements de soins longue durée dont les environnements ne sont pas sans conséquences particulières pour leur personnel féminin et pour les résidents et les communautés qu'ils desservent.
Cette étude avait pour but d'évaluer dans quelle mesure la ruralité affecte la mise en place de la classification des patients dans les foyers de soins longue durée en Ontario. La méthodologie de l'étude comprenait des entretiens et des groupes de travail avec du personnel de soins longue durée directement en contact avec les patients, des administrateurs et des informateurs clés en première ligne. Les conclusions de l'étude ont montré que l'offre des soins de santé de longue durée en milieu rural a lieu lorsqu'un environnement de travail restructuré rejoint les idéologies et pratiques qui prennent des caractéristiques particulières lorsque celles-ci ont été developpées et soutenues dans un contexte rural. Ces facteurs determinent le marché du travail et les conditions de travail des femmes en milieu rural. Nous défendons que ceci produit une expérience rurale unique pour le personnel des soins longue durée, et nous concluons que ceux qui mettent en place les systèmes de classification doivent prendre en compte les facteurs contextuels tout autant que les exigences pratiques et financières.

ABSTRACT
Restructuring – the introduction of changes that alter the way health care is delivered for maximum efficiency and least cost – layered with rurality and with rural gender ideologies and practices, results in rural long-term care settings that have particular consequences for the women working in them, and for the residents and communities that they serve. This research investigated how rurality affects the implementation of patient classification in Ontario long-term care homes. Methods involved interviews and focus groups with front-line long-term care workers, administrators, and key participants. The findings revealed that rural long-term care delivery takes place when a restructured work environment intersects with gender ideologies and practices that take on particular characteristics when developed and sustained in a rural context. These factors shape the labor market and working conditions for rural women. We argue that this produces a uniquely rural experience for long-term care workers and conclude that those implementing classification systems must consider contextual factors as well as practical and financial exigencies.

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In this article, we consider the consequences – for care as well as for employed caregivers – of a failure to consider certain contextual issues when standardized measurement tools are introduced into a rural, long-term care (LTC), institutional environment. The contextual issues, specifically, involve gender, health care restructuring, and rurality. A key element in health care restructuring is patient classification, a funding accountability system that administrators use to slot LTC and nursing home residents into a limited number of "levels of care". Administrators classify patients by reviewing documentation about health status and applying that information to a standardized measurement tool with fixed parameters for those elements required to meet care needs (Canadian Nurses Association, 2004). Classification, in turn, connects the minute-by-minute work of care to the government funding made available to individual institutions. Although small pockets of money are available to nursing homes through other sources, institutions in Canada depend primarily on government funding derived through patient classifications. Classification systems have already been subject to the critique that they do not recognize the unique characteristics of the individual resident, the community, and the institution function (Canadian Nurses Association, 2004; Christian Labour Association of Canada, 2002). It has also been suggested that patient classification systems reduce human care needs to a number, ignoring the needs of women as patients, as well as the skills of women as providers in assessing and meeting those needs (Armstrong et al., 2002). Even Ministry officials have acknowledged complaints about the process and the need for a more sensitive model (Smith, 2004).

Our study of the documentation activities associated with classifying residents into levels of care need in rural LTC homes revealed that the process of patient classification can fail to meet patient care needs. With its focus on rural long-term care, this study has pushed that critique further to investigate how contextual issues – such as those associated with gender, health care restructuring, and rurality – can contribute to the problems related to patient classification systems. Our research revealed that the delivery of rural long-term care takes place where a restructured work environment intersects with gender ideologies and practices that have been developed and sustained in a rural context. It is this particular context that produces an important, uniquely rural experience for both residents and those engaged in LTC work. Since in its current forms in practice the LTC patient classification system ignores this unique context in which both worker and resident reside, it is open to misuse and inaccuracies that ultimately bring into question its reliability and effectiveness as an appropriate measurement tool.

In North America, women are the majority of "front line" providers of formal and informal long-term, chronic care to older adults. As the Standing Senate Committee on Agriculture and Forestry (2006) has suggested, it is also likely that women, due to gender-specific mortality rates, make up a significant majority of the nearly one-quarter of all Canadians over age 65 who live in a rural region. As the population ages, older rural women will be drawing disproportionately on the services of long-term and chronic-care providers in their communities, and the providers will likewise be an aging, predominantly female workforce. LTC policy and practice thus affect not only those women who are employed in that particular sector, but ripple out to affect the quality of life of the predominantly female population in need of care. Despite this circumstance, gender analyses are rare in health care and health labor force policy development. Gender is particularly absent as a lens through which to assess the impact of policy on older rural women.

Undoubtedly, in Canada some of the issues that affect rural nursing home care workers apply also to their urban counterparts, including the failure of patient classification systems to generate appropriate institutional funding (Armstrong & Armstrong, 1999). All nursing home workers cope with the impact of classification systems on their work. However, in rural communities, workers contend with additional challenges related to geographic location and demographic change, such as the effects of weather and youth out-migration (Skinner et al., 2008). As relatively recent assessment tools, classification systems reflect broader shifts that include a preoccupation with metrics, for example, associated with the present phase of health care restructuring taking place across Canada, and indeed throughout the western world. This restructuring attempts to impose "efficiency" through what has been termed "tick box care" (Lakhani, 2009). By "tick box care", Lakhani was referring to methods of defining care through predetermined templates that preclude conditions or circumstances outside the categories. Patient classification, according to the Canadian Nurses Association (2004), is when economic efficiency is given precedence over human needs. This is evidenced by patient classification systems requiring caregivers to respond to patients' needs through the standardized timing of care activities, such as feeding or dressing, and stripping those tasks of critical human interactions that are so crucial to effective caregiving.

Although the literature addresses some issues pertaining to work in rural LTC homes, the convergence of factors that lead women into low-paying jobs in rural nursing homes has not been examined. Similarly, the ways in which changes and continuities in rural communities affect workers in this sector as they deal with

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changes in health care systems remain unexplored. However, our research has shown how rural LTC links restructuring, gender, work, and rural community in specific, but often unnoticed, ways. The focus of this article is on how these factors operate together – how they intersect to create a particular work and care environment. In our approach, we followed feminist scholars who have insisted that to understand women's condition, it is necessary to attend not simply to the various forms of identity (gender, race, class, etc.) that affect women's lives, but also to reveal the ways that these identities interact and build on each other, compounding the effects on women's lived experiences. The idea of *intersectionality* has been taken up by feminist scholars in very different contexts, as Crenshaw (1991) has noted, building on the idea that people ordinarily live multiple and layered identities (e.g., woman *and* working class *and* black). The proposition is that this layering results in substantively distinct experiences that are important to bring into focus.

Our argument in this article, then, is that the restructuring of Canada's health care system associated with patient classification processes is experienced in a distinctive way by female nursing-home workers providing front-line long-term care in rural settings. Restructuring, layered with rurality and with rural gender ideologies (longstanding ideas that women are the caretakers of home and family that effectively restrict them to the domestic sphere) and practices, results in long-term-care settings that have particular consequences for the women working in them, and for the residents and communities that they serve.

This article explores some of the layers of contextual factors examined in our research study that together constitute rural long-term care. Following a presentation of the research design, we discuss health care restructuring and, in particular, the introduction of classification systems. We then discuss the restructuring of rural communities, including a description of how it has affected rural health care. Finally, we add a gender analysis as a major factor that complicates, but also helps us to understand, the process of health care restructuring in rural communities.

Research Design

Our research relied primarily on data obtained for Ontario in a two-year study, the objective of which was to investigate the impact of patient classification systems on the work of front-line workers in rural LTC and nursing homes in Ontario and Manitoba.[1] Our initial investigations in this study indicated a complex set of interrelated structures, actors, and processes in which a key and consistent finding was that front-line workers must engage with an overwhelming number of documents in the course of their work. To understand precisely how classification systems affect front-line nursing home workers, we learned how the forms and texts used in accountability structures in LTC homes operate to organize the work carried out there.

Ethical approval was obtained from the Research Ethics Board of the University of Guelph. During the tenure of the research project between 2003 and 2005, we undertook interviews with front-line LTC workers and nursing home administrators in private and public facilities. These included health care aides (HCAs) and personal support workers (PSWs) (n = 24) as well as registered nurses (RNs) and registered practical nurses (RPNs) (n = 8 in total). Fifty-three key participant interviews were also conducted with representatives of unions, seniors' organizations, health care agencies, private home operators, and consultants. We spoke with 34 key provincial and federal government workers including those employed by the Ministry of Health and Long-term Care in Ontario as official classifiers and Community Care Access case workers. Face-to-face interviews with front-line workers took place privately on-site (without administrators present) with one or two workers at a time. Interviews were approximately one to two hours long, were audiotaped, and later were transcribed into text for analysis. Using a form of institutional ethnography (Campbell & Manicom, 1995), our participants spoke from their particular positions in the work process of long-term care, allowing us gradually to piece together a picture of how the patient classification process is coordinated. This picture took the form of a "map" (further explained in Leach, Hallman, Joseph, Martin, & Marcotte, 2006).

Institutional ethnography is a method of inquiry that was first developed by feminist scholar Dorothy Smith (Smith 1990). In her work on the social organization of knowledge, Smith saw that women were being misrepresented by the forms of knowledge that researchers claimed portrayed their conditions (Campbell & Gregor, 2008). Smith's concept of "institution" refers to a form of ruling that takes place through institutional discourses and technologies that force people's actions to become coordinated by institutional practice. This exercise of power can be seen in the organizational texts and text-mediated practices such as form-filling and documentation practices that are particularly prevalent in long-term care (Campbell & Gregor, 2008). making institutional ethnography a very relevant method of inquiry for our research.

The institutional ethnography inquiry always begins through an exploration of the everyday lives of a group of people, and is conducted from the viewpoint of people whose experiences are being ruled. In its application to

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health care research, Sinding (2010) has suggested that the strength of institutional ethnography's

> … detailed descriptions of the everyday, often mundane tasks involved in getting and providing care and treatment also reveal how access is more readily gained, and needs are more routinely addressed, for some patients than for others—knowledge that can allow us to trace the production of health care disparities. (p. 1657)

Thus, institutional ethnography offers researchers a way to look at the everyday world of rural LTC work and to "map" out how things happen the way they do in rural LTC facilities (Campbell & Gregor, 2008).

To gain an understanding of documentation's effect on women's working conditions in rural LTC, we asked rural LTC workers to take us through a step-by-step explanation of the work they do from the moment when a new resident arrives at the rural nursing home until the end of a normal shift. This research process yielded a rich body of information about patient classification, front-line work, and rural long-term care. As well as capturing how the process is intended to work, this method allowed contradictions and points of tension to emerge as workers shared their frustrations when relating how the process did not always work as intended. As we learned about the system in rural LTC homes, we learned also from the study participants where the system does not work, where "bottlenecks" or congestion occurs, and where and how this impacts residents and rural working women in their personal lives. Patient classification systems incorporate the actions of many people whose day-to-day work involves continually feeding information into the facility's system. The information we acquired from the range of people involved in the classification process for rural LTC patients formed the basis for the arguments made here.[2]

Health Care Restructuring and Patient Classification Systems

Governmental restructuring has caused health care settings in rural and urban areas to be reorganized, and provides the context within which LTC work environments are changing. In many provinces, private corporations are moving aggressively into the business of delivering long-term care. In Ontario, approximately 60 per cent of nursing homes are privately owned (Rachlis, 2007). When combined with changing demographics, this trend makes the Canadian nursing home sector ripe for investment, and rural communities provide attractive incentives: inexpensive land and labor, a pleasant environment, and an aging population (Ontario Health Coalition, 2002). As profit-taking becomes an increasingly common aspect of LTC delivery in Canada, it puts management under pressure to reduce costs (Rachlis, 2007).

In 1999, over 240,000 people were living in Canadian nursing homes (National Advisory Council on Aging, 1999). Residents are predominantly women whose average age at admission is 80 years. The care work undertaken in long-term care is considered to require less skill and to hold less status than nursing work in hospital settings. This is evidenced not only by the lower wages paid to LTC workers compared to their counterparts in hospitals, but also by the lower requirements for professional qualification of those who provide direct care to the home's residents (Szebehely & Daly, 2009). Although HCAs and PSWs are assuming more of the responsibilities that once were carried out by RNs to care for residents, HCAs and PSWs have been denied government regulation and association on several occasions (Ministry of Health and Long Term Care, 2006). These factors have serious implications for staffing and, consequently, for care in LTC facilities.

The lesser status of LTC work is also spelled out in fundamental health care legislation. Under the Canada Health Act, long-term care is exempt from the definition of "medically necessary" insurable health coverage. Yet increasingly, services provided to residents are, in fact, medically necessary. The most prevalent LTC diagnosis is dementia, but other diseases and disabilities are common.[3] Activities of daily living are difficult for most residents, who also need pharmacological and other treatments administered. Health care restructuring in Ontario has resulted in the early discharge of chronically ill elderly patients from hospitals into the community, with the assumption that families can provide such care (Armstrong et al., 2002; Shore, 2007). Moreover, the closure of psychiatric institutions has placed enormous pressure on LTC resources. These shifts mean that patients with more chronic conditions must go into a nursing home prematurely because they or their families cannot cope in the absence of support (National Advisory Council on Aging, 2006). Also, as a result of rural depopulation, residents may have no family living in the area or, because rural women need to work increasingly outside the home, they may not be available to provide care. In this way, government policy has (however unintentionally) caused the care of elderly people with acute medical needs to be transferred from hospitals to LTC homes.

The categories of care associated with the Alberta classification system, which is the basis of the Ontario patient classification system, provide information to assess residents' resource requirements (Christian Labour Association of Canada, 2002). In Ontario, levels of care range from A (least intensive) to G (most intensive). Most residents fall within the high end of the

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resource-intensive categories, suggesting a significant demand for nursing services and hands-on care (Ministry of Health and Long-Term Care, 2008). Yet, our research revealed that this care is often sacrificed for the required activities associated with charting, documenting, and accounting.

Front-line workers spend significant time completing forms that pertain to the health status and safety of the residents in their charge. They document information from the work of other health care providers such as physicians, who sometimes ask front-line workers to enter notes for them. As well, workers are often charged with documentation that safeguards the liability of the nursing home, such as collecting data on water quality at frequent intervals during the day. Most of these forms feed into the creation of a "care plan", the key document that outlines the activities needed to care for a specific resident. Care plans are reviewed and updated as the resident's condition changes and are fed into quarterly and annual reports for each resident, prepared by RNs or nursing home administrators. It is these reports that contribute to the formula which calculates the dollars the home will receive from the government, which in turn determines the number and type of staff engaged in care.

The classification measurement instruments used by hospitals and gatekeeper agencies, such as those established specifically to provide and administer home care, are often different from those used in nursing homes. This leads to difficulties in interpretation and results in duplication or omission when assessments must be made, again by busy facility staff. This also creates opportunities for errors and inaccuracies from the moment the resident first arrives at the nursing home. Front-line workers have also suggested that the classification outcome itself may not be valid, for a number of possible reasons. Some homes were reported to "document for dollars" – that is, to record what could be a very occasional event as something routine in order to maximize funding. As well, and perhaps most importantly, overworked staff told us they often did not have time to chart accurately. Information might be recorded much later in the day, or even later in the week. As several of our respondents stated, the classification process is just "check, check, check, check" and "… not accurate at all".

Despite all the time spent by direct-care providers on documentation, provincial classifiers relied primarily on the summary documents created by RNs and administrators, and rarely sought the advice of those who actually provided hands-on care to residents every day. In almost all cases, the classifier worked with nursing home administrators, or with the charge RN or director of nurses, to translate the care plan into the level-of-care categories. In this way, the context of the relationship between individual nursing home worker and the individual resident was lost. One respondent, for example, noted that her workplace had endured a period of prolonged construction, resulting in an increase in difficult "behaviors" that required extra nursing care when residents were disturbed by the noise of hammers and drills. Because patient classification disregards issues like this, the extra time and effort required to manage these behaviors was not accounted for, forcing care providers to compensate by sacrificing other important aspects of care.

Another catch in the process is that the current funding system does not provide automatic adjustments to ensure that staffing levels increase with resident needs. The result is overworked LTC staff, stretched to provide sometimes even the minimum time and resources needed for providing optimal care (Canadian Auto Workers, 2004).

Restructuring and Rurality

We found that the classification demands of health care restructuring in rural LTC facilities add to the strains imposed by existing rural-specific conditions. The context of rurality, as we will explain, alters the way in which LTC work is both experienced and provided. Sumner (2002) argued that in rural communities, neoliberal restructuring has taken the form of "public sector reform, tariff reductions, changes in tax structure, [and] cutbacks to rural services". Ontario rural communities continue to reel under the impact of the commercialization of agriculture and decline of the family farm, and the shift away from labor-intensive manufacturing industries (Winson & Leach, 2002). The service sector is now the largest employer in rural communities, but unlike urban centers, few high-wage service sector jobs have been created. Rather, rural job creation tends to be in the lower-wage service areas such as tourism (Statistics Canada, 2005). Rural communities must also deal with the government's shifting of responsibilities to schools, hospitals, and public service offices, which have themselves been consolidated in larger regional centers because of cutbacks. As the state redefines its role and responsibilities, pressure increases on rural community associations and families to look after themselves, often in the absence of adequate resources to do so (Armstrong et al., 2002).

Our research indicates, too, that rural nursing homes have access to fewer resources than their urban counterparts. Specialized medical and ancillary services are usually available only at a distance; thus, nursing staff may take on responsibilities that in cities would belong to physicians (Crosato & Leipert, 2006; Penz & Stewart, 2008). The additional responsibilities carry added

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stress and are not remunerated. Emergency services may take longer to arrive because of distance, weather conditions, or the consequences of funding cuts, so nursing staff learn not to rely on specialized assistance. Staff may not arrive for scheduled shifts when roads are closed, so that those about to end their shifts must stay on, often working two or even three back-to-back shifts. As two LTC workers observed:

> *Maybe the ambulance isn't going to be there in two minutes, or firemen or police. …. We're more isolated and [conditions can be] weather related. We are really at a disadvantage in the rural setting because we don't have the availability of quick response services in blizzard-like conditions. We just don't have the facilities that city people do. If our car is stuck in the ditch, we haven't got a bus to take and that kind of stuff. We have a long laneway in our facility. We've had times when ambulances have been stuck in our laneway or ice storms, … where you don't have the availability of quick response or a snow plough to help out.*
>
> – Registered practical nurse

> *If you live in the smaller city, you can walk in the blizzard, but if the roads are closed rurally, some people end up doing 2 or 3 shifts of overtime because people can't get in.*
>
> – Health care aide

The absence of resources that urban homes take for granted has consequences for how classification systems operate, and those consequences often have a negative impact on rural LTC homes. Patient classification systems are moving towards reliance on full computerization, with the expectation that computer stations will be located in individual residents' rooms. We found rural nursing homes to have, at most, only one or two personal computers, operated by people with little training. These were often located in the director's office and had dial-up Internet access, either because more sophisticated networks were expensive, or because broadband infrastructure was lacking. Problems with software training and computer support, and the privacy aspects of sharing patients' documentation through on-line technologies, were concerns we heard from study participants as well as from front-line workers.

Another factor in rural LTC care is rural geography, which contributes to training issues for LTC workers, with implications for staffing. Training deficits limit the skills available in rural homes and decrease the standard of care and capacity of nurses to deal with residents. Yet technological changes and rising care needs mean that as more technically advanced medical equipment is required in order to treat residents, training becomes critical.

Rural LTC homes cater to local rural residents who want to stay in their communities, yet with the out-migration of younger people from rural communities, it is common for the rural elderly to be without relatives nearby. It has been suggested that seniors in some rural communities enter nursing homes earlier than the national average because of a lack of community or social/family support nearby (Joseph, Leach, & Turner, 2007). However, on a positive note, nurses reported that in close-knit rural communities, people visiting their own relatives often took the time to visit with others they knew from the community. Overall, nurses felt residents received a very personalized form of care in the homes.

> *There is not the same sense of "coming from community" in Metro Toronto. … You don't get the same sense in small communities in rural Ontario. Work is seen as part of the work of community … caring for other members of community … maybe people you've grown up with.*
>
> – Union representative

Front-line workers are quite likely to have known residents for many years before they became residents. The workers may have been taught by residents, served by them, and socialized with them. This familiarity becomes especially important if residents' family members live far away.

In a rural context where nurses must routinely fill in for missing specialist services and residents are personally connected, accurate classification-related documentation is likely to be a lower priority.

The Importance of Gender

Understanding what is happening in long-term care in rural communities requires not simply attention to processes of restructuring and to the conditions that rurality shapes for health care, it also requires attention to the specificity of gender relations in rural areas. A growing literature argues that women's roles in rural Canadian communities remain more deeply entrenched in traditional expectations and are less affected by shifts in ideas about gender and women's roles in urban centers (Carbert, 1995; Leach, 1999; 2011). This is not to deny that women are bringing about change for women and girls in their communities, but it recognizes that engrained ideas affect women's ability to participate in their communities in certain ways. These ideas form the backdrop against which women perform the institutionalized work of care. Jobs in care work, teaching, and serving – all associated with and extending women's "natural" abilities for caring for others – have long represented acceptable work for women. There is thus a convenient "fit" in rural communities in Canada between the expansion

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of the nursing home sector and traditional work roles for women (Leach, 1999). In our study, we found gender important in two related ways: we found that it shaped LTC work itself, and it shaped women's activities outside the workplace.

Since providing physical care to others is traditionally associated with women in the domestic sphere, many of the demands of care work are undervalued and rendered invisible (Armstrong & Jansen, 2004).Additionally, like many jobs in recent years, part-time and casual work are common in the health care sector (O'Brien-Pallas et al., 2003). These trends result in unresolved workload and work satisfaction issues. For example, nursing staff have little time to complete tasks and standards are often unmet (Armstrong & Daly, 2004; CUPE, 2002). Many caregivers are not satisfied with the level of care they are able to provide, and, in particular, they are frustrated by the amount of clerical and other non-nursing activities, such as those associated with classification, that take them away from patient care (Thomson, Dunleavy, & Bruce, 2002). As a result, nurses are increasingly called on to order supplies, find staff replacements, and assume other tasks that under-utilize their training.

Despite the apparent intent of classification systems, staffing levels in LTC have not kept up with the increasingly high levels of care required by residents. One health care aide in our study listed half a dozen tasks she aimed to complete *before* her shift formally began each day. Aides told us that they felt pressure and distress because they were unable to meet needs for meaningful activity, including extended one-to-one contact and support for rehabilitation so residents could be empowered to participate in their own care.

Workload issues in rural LTC homes are compounded by gendered norms and expectations shaped by rurality that operate in the broader community. Many women, for example, return home from nursing jobs to farm responsibilities and domestic chores. One respondent noted that "a lot of people who work in the facilities are farm people … [they are] wives who are nurses who have married into a farming family". This has important implications for nursing staff and the expectations of their roles in rural communities. In rural life, personal and professional boundaries are often blurred. Rural nurses in Alberta, for example, have reported that they were always on duty, getting called at home in the evening, and being asked for advice at community functions or when shopping (Skillen, Heather, & Young, 2002). The impact of overwork and stress in a rural nursing home may also affect workers' lives at home and in the community. Armstrong and Jansen (2004) described a situation where a woman had been accosted at her church to account for the care provided at the home where she worked. This woman was telephoned at home frequently to serve as a counselor for neighbors seeking information about nearby nursing homes.

Given the persistent debt crisis in family farming in Canada, off-farm income is increasingly critical (Roppel, Desmarais, & Martz, 2006). Skillen et al. (2002), for example, reported that nurses contribute income to pay farm bills and contribute time to caregiving in their extended family, assisting their neighbors, and cooking for hired farm help: "I have to be a mother, I have to be a wife, I have to be a farm labourer … and then to do the nurse thing as well" (p. 15). Moreover, these women also complained about the vast amount of paperwork that they had to do, for farming and for nursing.

Women who do not leave rural areas to seek post-secondary education find themselves ill-equipped for more demanding jobs (Corbett, 2007). As a consequence of these trends of supply and demand, women in rural communities looking for work frequently find it in the LTC homes located there (Leach, 1999). For well-qualified women, long-term care may provide some of the best jobs in town for women. As one administrator remarked:

> *We pay our staff very well. Our RNs are at hospital parity. And when you take a look in and around this particular geographic area …where else can a woman get a job and make as much money?*
>
> – Administrator

For less-qualified workers, however, the expansion of the LTC sector has contributed to the expansion of precarious work options through the proliferation of part-time and casual positions without job security or even week-to-week predictability. Juggling part-time positions at different homes, sometimes in different communities, puts pressure on workers as they negotiate multiple management styles and dozens of residents, not to mention that driving long distances after one long shift at one care home to begin another shift at another care home can be dangerous. Together these practices make women's work lives unstable, with serious consequences for their capacity to function in other parts of their lives. Worryingly, women often internalize the contradictions in the system, rationalizing constraints on their work options in terms of personal "choices" when they are not really choices at all:

> *I started off part-time and now actually I am part-time by choice. There was a couple of full-time opportunities that came up but one was laundry and one was straight evenings … and if I worked straight evenings I would never see my husband, so I opted not to go for that one.*
>
> – Health care aide

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A further issue is the retention of nursing staff, which is even more significant for nursing homes. Retirement losses will have a more serious impact than any other factor on the LTC sector in Canada in the near future,[4] and rural areas will find it difficult to compete with urban centers for scarce human resources (Pong & Russell, 2003). Moreover, the LTC workforce is an aging one. Local labor market dynamics – that is, who is available and for what jobs – shape the availability of workers for long-term care in rural and urban contexts. In rural areas, a major factor is the relentless out-migration of young people in search of further education and/or wider employment options, with the consequence that rural nursing homes have difficulty recruiting workers, at all educational levels. An Ontario government ministry classifier recognized the problem:

> *I know people that worked in homes for 30 years and they're still there. Sometimes it's hard to convince some people about where you need nurses, but there just isn't anybody around in the rural area. And most definitely up north is an issue, a huge issue up there. Not too many want to go live up there.*
>
> – Ministry classifier

Restructuring Rural Long-term Care: 'I shall go from working here to living here'

We might consider the ways that employers derive benefit from the collective wisdom embodied by this aging LTC workforce, which is effectively held captive due to fewer options – education, employment, transportation – than men enjoy (Fuller & O'Leary, 2008; Leach, 1999). It could be argued that older women's knowledge and skills have in fact permitted health care restructuring in this sector to be implemented so smoothly. One front-line worker explained that older women can handle the speedup of work demanded by restructuring, but she had observed that younger staff seemed unable to work hard and talk to residents at the same time:

> *The new staff comes in and finds it very overwhelming, where older staff have done it so long … I think the fact is that residents, until you get to know them, it's so easy to fall into a conversation and stop working. Rather than working and talking, they stop and talk, or the resident really plays on them or something. …. What would maybe take me fifteen minutes or twenty minutes to do, it may take them half an hour, forty-five minutes to do the same thing.*
>
> – Health care aide

This woman also noted that older workers take less sick time than part-time and younger workers. This suggests a tension between the care that older workers feel residents need (and that they empathize with as they age themselves), and the realities of a rural labor market where agency workers cannot be pulled in at a moment's notice.

> *I've not felt good, but I've come in because I know what it's like working short ….not so much that we work short, … but if you're not there, well, "where were you?" They become very dependent on you and you hate to not be there for them, and they're vocal [about it].*
>
> – Health care aide

Yet an older workforce also brings limitations. Classification systems tacitly assume a mix of physical capacity in the nursing workforce. In an older nursing population, workers may be less able to do physically demanding tasks because of a lifetime of repetitive strain and injury.

> *We have two full-time nurses off right now; I don't think they are ever coming back. … Yes, all the rest of us are going to physio when we come in. We have to line up like cattle, it's insane.*
>
> – Registered practical nurse

The recruitment of LTC workers in rural communities is primarily from a labor pool that is significantly different from its urban counterparts in terms of age and skill level. It is the pool of aging women workers in rural areas that provides the kind of flexible workforce that in urban areas of Canada is found within the population of new immigrant women. This is in part a result of more general societal shifts in terms of women's work, but more specifically it relates to the ways that restructured health care policy has changed women's care work options. Overall, the increasing reliance on part-time and casual workers, which allows the flexibility of not committing to full-time or permanent staff wages, reflects the consequences of a funding strategy that relies on classification systems to determine staffing levels.

Conclusion

Our research has illuminated the conditions in rural nursing homes in which patient classification systems are being introduced without concern for those particular conditions. With current staffing levels and resources, the increased documentation associated with classification interferes with care provision that is itself constrained, or at the very least shaped, by the realities of rural life. In 2003, the Deputy Minister of Health reported the Ministry's intent to collect information in better ways, not only to improve individualized care plans, but to "… reduce nursing time spent on documenting and to increase time spent on providing care …"

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(Legislative Assembly of Ontario, 2003). Our research indicates that this intent has yet to be realized.

In the rural context, the exigencies of classification systems play out alongside location-related factors that are much less significant in urban areas, revealing some of the ways that classification systems are designed with urban geography and urban social relations in mind. The social aspects of rural life are not well accommodated by classification systems that fail to recognize social interactions which are not simply care related, but that contain elements of longstanding gendered rural community relationships as well. Classification systems are premised on assumptions that care workers will have basic levels of skills in the most up-to-date methods and technologies of care, and increasingly in the use of information technologies. In a rural context, these may be absent due to problems of access to training and infrastructure deficits. Furthermore, gender ideologies may deter women from pursuing new skills, and with an increasingly older workforce the desire to learn new skills for a low-wage job may be absent.

Geographic distance, identified as a major issue for rural women more generally, exacerbates tight staffing situations and makes those who work in rural LTC homes either more self-reliant in terms of specialized skills and forms of care, or simply resigned to "making do" in their absence. Difficulties finding staff and volunteers and lack of resources to support long-term care in areas such as emergency services, medical specialists, and technological support add to workers' stress. This is the context in which restructuring intersects with gender and rurality, factors overlooked by patient classification processes in long-term care.

We have argued that the expansion of LTC facilities in rural communities has built on existing ideas about gender and work, at the same time providing women with what appear to be flexible work options, because part-time work permits workers to handle domestic, and sometimes farm, tasks also. Overall, the shape of the labor market in the rural context – who is available to work, prevailing wage rates, training challenges, and the aging workforce – affects the availability of labor for long-term care, which has a specific impact on staffing in rural nursing homes. Given the predominance of women as caregivers, these factors play out on the gendered terrain we have outlined.

Canadian rural communities are struggling to find ways to sustain themselves, to establish a stable economic base that will generate jobs and taxes and services that contribute to the community itself, rather than relying on profit-taking or political agendas formed in places far away. We consider that LTC homes can – and do – make a positive contribution to the sustainability of rural communities. They are quite literally well positioned to do so in that they are dispersed across the rural landscape, providing a valued and critical service and a source of employment in small communities throughout Canada. They generate jobs, services, and taxes, and through those they have the capacity to contribute to the communities in which they operate. The relationship between long-term care and rural sustainability is bidirectional. If nursing homes disappear because they can no longer afford to operate, rural communities will suffer. Conversely, if communities decline, LTC homes in these areas are in jeopardy. We conclude that as it is presently organized, the system of patient classification used to determine funding for LTC homes has detrimental consequences for front-line workers in rural LTC homes, as well as for residents in those homes. This suggests the need for policy changes to improve the lives and working environments of women employed in rural LTC homes, as well as the quality of life of the elderly women and men who live there. To be able to contribute in a more active way to rural community sustainability, the patient classification system must be better able to account for local, contextual factors, to be able to improve the operation of facility-based long-term care in a rural context. Such changes will ameliorate the situation, improve the quality of care for rural seniors, and make LTC homes the positive force for community sustainability that they can be.

Notes

1 The research project addressed rural long-term care (LTC) in Ontario and Manitoba. These two jurisdictions used different patient classification systems and had significant aging populations. In Ontario, all but one of the LTC homes were located in the southern part of the province in communities with populations of less than 10,000 and located more than one hour's driving time from a major urban center. In Ontario, long-term care in rural (and urban) areas is increasingly provided through privately owned and operated corporate homes. In Manitoba, privatization is occurring at a far slower pace with most rural LTC homes continuing to be run as public homes.

2 In earlier work (Leach et al., 2006), we showed how classification systems comprise coordinated sets of activities carried out by care workers and which are organized by both visible texts (forms and charts) and invisible texts (best-practice guidelines, union contracts, codes of practice).

3 According to Pricewaterhouse Coopers (2001) – commissioned by the Ministry of Health and Long Term Care to do an evidence-based study of staffing levels needed in Ontario LTC facilities – given the increase of residents with cognitive decline, 44.2 per cent of residents could not locate their room, 64.4 per cent had communication difficulties, and 64 per cent had some form of dementia. Most residents also had varying degrees of incontinence.

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4 In 2001, between 36 per cent and 49 per cent of RNs working in long-term care were aged 50 or older (O'Brien-Pallas et al., 2003).

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