Hélène David, Esther Cloutier et Élise Ledoux

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“Precariousness, work organization and occupational health: the case of nurses providing home care services in Québec.”

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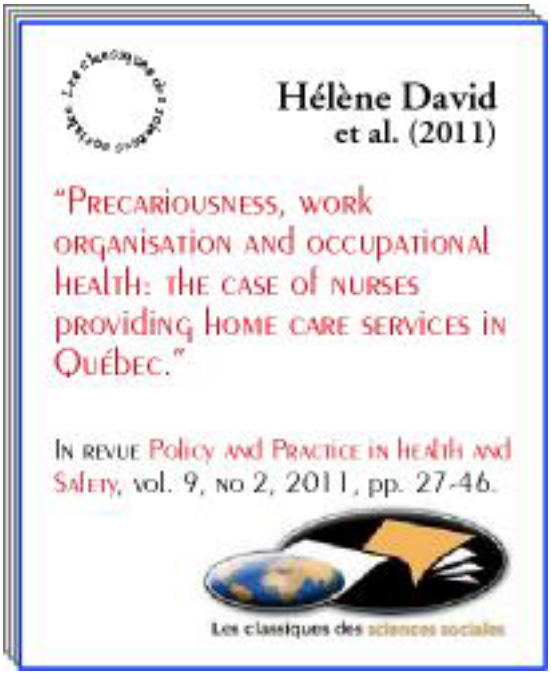

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Summary

Hélène David, Esther Cloutier et Élise Ledoux

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Introduction

Several convergent case studies have brought to light the numerous effects of precarious work on the health of nurses who provide home-care service in the public sector. Our study allowed us to document the specific role that employment and work organization played in supporting the self-protection strategies that nurses developed. To this end, we explored the employment status, employment and work conditions, career paths, and general occupational health of both permanent nurses and precarious-status nurses, the latter working as either casual employees in the public system or for private agencies. With regard to work organization, it would seem that the presence of a large proportion of precariously employed nurses changed the task distribution and workload, which in turn affected the work conditions of permanent nurses and, consequently their general occupational health. [1]

[1] The expression “general occupational health” comprises all the aspects of the nurses’ occupational health that could be taken into account. It includes occupational safety. The acronym "OHS" corresponds to the term "occupational health and safety both in its legal and social meanings.

1. Context

This first section of this article discusses different aspects of the difficult work situation of nurses in the Province of Québec, Canada. The poor state of their occupational health and safety (OHS) and the risks to which they were exposed represented one important aspect. The changes in the public health system and the additional constraints that they imposed on nurses also contributed to the situation. In this context, precarious work, which has been increasing considerably among nurses, has become a major issue which has affected their health and their ability to continue working.

There are many poorly-understood aspects of OHS in service sector jobs, which are often held by women [1]. The present study focused on those related to nurses’ work. Methodological questions played an important role in our research because we were convinced that different inquiry tools were needed from those used in industrial work and male dominated occupations.

We must also consider the fact that the healthcare sector in Québec has been undergoing profound changes for more than a decade. The demand for healthcare and services has been increasing significantly while, at the same time, the government has been imposing considerable budget restrictions. To meet the growing demand in the absence of a sufficient number of workers, managers have attempted to change their fundamental approach to administration, in particular by modifying certain aspects of the nurses’ employment status and work organization. These changes include employing precarious personnel with fixed term contracts or subcontracting them through private agencies.

Our research took place in the homecare departments (HCDs) of Québec’s local public health centres (LPHCs), which are front-line, government-funded establishments. Since all of their funding comes from the Ministry of Health and Social Services, the managers of these HCDs are obliged to find ways to reduce operating costs or access to their services. They must develop new control strategies so as not to go over the allocated budgets without directly refusing any pa-

tient requests for home care. Hiring precarious personnel makes it possible to complete some of the work usually conducted by permanent nurses – of which there are an insufficient number – by other nurses who are not accorded this status.

At the heart of these conflicting choices are the various elements of work organization which affect both individual and collective behaviour. Precarious work, for instance, has proven to be a major issue. Indeed, the number of hours worked by precarious nurses (casual or private agency) represented between 28.4% and 50.5% of the total hours worked by all nurses (permanent, casual and private agency) depending on the HCD studied [2, 3, 4, 5] [2].

The concept of precarious work, which is now well documented, can refer to a large variety of situations [6, 7, 8]. Research exploring the relationship between precarious work and OHS is rarer and as yet incomplete [9, 10, 11, 12, 13 14, 15 16, 17].

2. Methodology, key concepts & case descriptors

2.1 An in-depth multidisciplinary approach employing embedded case studies

The complexity of the two main study subjects, namely the relation between precariousness and OHS, and the organizational determinants of the protective strategies developed by nurses, made it necessary to employ multiple embedded case studies. This type of research makes it possible to describe the how and why of a phenomenon that cannot be extracted from its real-world context. It is characterized by the identification of a large number of variables, recourse to multiple factual data sources, the need to crosscheck these sources through trian-

[2] In the following pages, all the data come, unless indicated otherwise, from case studies by the research team directed by E. Cloutier.

gulation, and the evolution of its analytical framework as the research progresses from one case study to another [18].

The people composing the research team had skills in anthropology, demographics, work psychodynamics, sociology, ergonomics and statistics that were very useful in collecting and interpreting data from wide ranging sources. Our multidisciplinary research involved the ergonomic observation of the nurses' work activities, individual and collective interviews, a questionnaire on musculoskeletal pain and psychological health (with risk indicators for musculoskeletal disorders (MSD) and occupational burnout) [3], as well as administrative documents and statistical data for the previous three years (2005-2007).

Four case studies, which presented different organizational characteristics, were conducted in succession in the HCDs of urban and semi-urban LPHCs. The re-iterative nature of the research influenced the choice of each successive case. The cases were chosen based on theoretical criteria that allowed them to be compared, and on consultations with researchers and practitioners in the health network using criteria such as the department's latitude, the organization of the programs, the types of meetings for the healthcare teams, the implementation of OHS, and organizational and financial support for the HCD from the LPHC management. The analysis units that were embedded in the study of the four LPHC homecare departments comprised job status, work organization, the nurses' protective strategies, and the OHS problems affecting them.

Case studies were also conducted in two private nursing care agencies (PNCAs). These were the two largest PNCAs of those with which the most OHS efficient LPHC [4] had contracts [5]. Each agency had a

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[3] Based on two validated instruments: the *NORDIC* questionnaire [19, 20], which was adapted by the Institut de recherche en santé et en sécurité du travail (IRSST), a government-funded research institute on OHS in Québec, and the validated French version [21] of the *Maslach Burnout Inventory* [22]whose goal is to determine if people are at risk of occupational burnout.

[4] Which had the most pro-active prevention organization.

[5] The nursing market in Québec is expanding rapidly. Some 40 private agencies employing nurses are now noted in the official statistics (Le Registre des entreprises du Québec). Others however are listed in another category, that of

dispatcher who received service requests and distributed work assignments to the personnel. To be hired, nurses had to belong to the nurses' professional corporation and have at least one year's experience, although preference was given to more experienced nurses. The private agencies had more than just the LPHC home care departments as clients. They also had other LPHC departments, various private companies such as retirement homes, and insurance companies who wanted their clients to have a medical examination. PNCA 1 employed and placed other personnel in addition to nurses; however, it only worked with one establishment, the above-mentioned LPHC. PNCA 2 only employed nurses but had several institutional clients in the public and private health-care system. The following data refers only to the work that they did for the homecare departments.

The six aspects analyzed in the two private agency studies were: the labour market for nurses in Québec, the nursing labour force working for these two PNCAs, the employment and work organization there, the work activity of the agency nurses, the sharing of responsibilities between the PNCAs and the LPHC homecare departments, and the internal management of OHS in the PNCAs.

employment agencies, which effectively makes them impossible to find for our purposes [23].

2.2 Definitions of employment and work organization, precariousness, protective work strategies, and overall occupational health

The main concepts used in this article are defined below so as to facilitate our understanding of the relationships between these concepts.

Employment and work organization

Because the homecare department (HCD) is only one department among many in a local public health centre (LPHC), its organization of employment and work follows in large part from that of the LPHC. For the purposes of this study, only the characteristics of the HCDs relevant to work organization were examined.

In keeping with Bélanger et al. [24], we consider that "*work organization refers to how jobs are defined and configured*." The dimensions that were considered in the observation of the four HCDs were: the geographic area served, the organization of the nurses' routes, the work schedules, the division of work, the relationship between professional groups, the existence or non-existence of multidisciplinary teams, work meetings (regular/ad hoc, unidisciplinary/multidisciplinary, technical, training, support or information), the existence of a work group [6], information transmission, and training.

For the two private nursing care agencies (PNCAs), information on employment and work organization was obtained through interviews with managers and the examination of institutional data. Employment and work organization involved: the PNCAs' business strategy, de-

6 According to Vézina [25], the social aspects of work are expressed through the work group, which thereby contributes to identity construction. The work group is characterized by "*a common language, project, practices, rules, and work organization*".

velopment plan, recruitment and training of nursing personnel, employment and work conditions for hired nurses (availability, schedules, case types, choices), organizational and professional support, and internal OHS management.

The relationships between the agencies and the client institution were documented with similar data sources. The information comprised: past recourse by the HCD to the private agencies, type of agreement between the two parties, receipt and processing of requests for home care by the agencies, induction and instructions provided for agency nurses by the HCD, workload given to agency nurses, types of cases and responsibilities attributed to agency nurses, and agency and HCD managers’ responsibilities with regard to nurses.

Precariouness

As shown in Table 1, there are several specific criteria that define the employment status of the three categories of nurses who work for the HCDs.

Table 1: Employment status of the nurses in the four Local Public Health Centers Home Care Departments

Nurses' employment status	Categorization	Employer	Regulations for employment and work conditions	Pay	Employee benefits[a]	Compliance with occupational health and safety (OHS) legal requirements[b]
Permanent*c Regular (PN)	Continuity Open-ended contract (OEC) Regular weekly schedule	Local Public Health Center (LPHC)	Master collective agreement[d] for the health and social services sector	According to the master collective agreement	According to the master collective agreement: Public holidays and annual vacations, salary insurance (disability leave), pension plan	Compliance with OHS legal requirements
Casual*c Temporary (CN)	Precariousness Fixed-term contract (FTC) On-call work	Local Public Health Center (LPHC)	Master collective agreement	According to the master collective agreement	According to the master collective agreement: Public holidays and annual vacations, salary insurance (disability leave), pension plan	Compliance with OHS legal requirements
Employed by private agencies (AN)	Precariousness Fixed-term contract (FTC) On-call work	Private nursing care agency (PNCA) contracting firm	Individual contracts An Act Respecting Labour Standards[e]	Based on the market + extra pay in lieu of benefits	In most cases: - no public holidays or annual vacations - no salary insurance (disability leave) - no pension plan	Minimal compliance with OHS legal requirements OHS disregarded and/or subcontracted

a- Bernier et al. [26] state that for precarious workers: "*It often becomes difficult to determine whether people in non standard jobs will have access to protection plans. The growing number of these jobs brings about sometimes considerable disparities in how people executing similar tasks in the same company are treated*."
b- According to An Act Respecting Occupational Health and Safety, L. R. Q. c.S-2.1 (AOHS). Québec's workers' compensation board (QWCB) is responsible for its implementation.
c- Synonymous terms. For greater clarity only one of these terms (*permanent* and *casual*) will be used for each work status in the article.
d- Agreement reached between the State-employer and several unions that represent different categories of personnel employed by public health institutions.
e- This law (An Act Respecting Labour Standards, R.S.Q., c. N-1.1), comprises the minimal employment standards that apply to all employees. The Labour standards commission of Québec (Commission des normes du travail du Québec) is responsible for its implementation.

Permanent nurses (PN) held regular jobs, so called because they were associated with a position that was financed on a reoccurring basis and protected by several provisions in the collective agreement. Most permanent nurses worked full time and often did overtime. In addition to visits to patients' homes, these nurses spent close to half of their time administering cases, including opening and closing the files of their own patients and of those being treated by precarious nurses. This position likewise comprised tasks such as organizing daily routes, administration, and conducting training and information activities, most often concerning new developments in treatment. Other work elements included communication with other health practitioners – such as doctors – and other institutions – such as hospitals.

Casual nurses (CN) who were employed by the LPHC homecare departments did not have regular positions, being offered only fixed-term contracts (FTC). Their status was thus precarious. They could only work as replacements or supernumeraries. These casual nurses could perform long-term replacements and thus benefited from the formal work conditions of permanent nurses. They could also fill occasional short term vacancies or respond to extra work that could not be handled by the regular staff. They could work full or part time or even be asked to work overtime. Their employment and work conditions fell under the master (national) collective agreement of Québec's health sector.

The nurses working for the private agencies were subcontracted out to meet the demands of their PNCAs' clients, namely the various health centres [7]. The nurses employed by PNCAs usually had no formal employment contract, not even a personal one. They informed the agency, normally on a quarterly basis, of the days and hours they were available; the agency called them when needed. They did not necessarily work all the hours for which they had declared themselves available. The hourly wages of the agency nurses were slightly higher than those of permanent nurses in the public health system. However, they were only paid for the time worked (almost exclusively in pa-

[7] A nurse who held several jobs at the same time could be a permanent part-time employee with one health institution and have fixed-term contracts (FTCs) in other public health institutions or private agencies. She would then have a precarious status. In our study however, only her status in the institution under study was taken into account.

tients' homes) and their years of experience were not completely taken into account. The slightly higher hourly pay (in comparison to public sector salaries) was supposed to financially compensate for the various benefits they did not receive. Their employment and work conditions were regulated only by the Québec Act Respecting Labour Standards and not by the master collective agreement covering nurses employed by the public health institutions. They had no access to the employee benefits of the public sector, which would have been equivalent to approximately one third of their salary [27].

Protective work strategies

A detailed analysis of the work activity revealed that in all of the case studies the nurses employed by the HCD developed protective strategies that were intended to preserve their physical and psychological health by reducing the physical, cognitive, and affective workload. These strategies, which were identified during the observation of the four HCDs under study, were divided into nine categories: using specific equipment, adopting certain postures, managing work time, reorganizing tasks, providing information to patients, reviewing their practices, contesting decisions and making collective demands, turning to the workgroup, and setting limits.

The protective strategies of the agency nurses were identified by observing their work activity and conducting interviews. This analysis revealed that the choice to work for a PNCA, despite the precarious status and its consequences, was linked to the possibility of choosing one's availability, schedules, programs, practices, patients, and types of service. This, in turn, allowed for greater flexibility in terms of individual situations related to one's career path or private life. They also mentioned that their versatility and skills were recognized.

This choice can be considered a protective defensive strategy on the part of agency nurses [8]. However, even though it allowed them to

[8] According to work psychodynamics, initially developed by Christophe Dejours, people develop defensive strategies at work to ward off suffering and to keep on working despite their suffering. The most efficient and least damaging strategies for one's psychological balance are collective, which, by defini-

reduce the overall workload, it comprised some considerable disadvantages. These included financial insecurity, lack of salary insurance (disability leave), lack of knowledge about the various environments where they were sent to work, and difficulties in creating relations with the permanent personnel. This protective defensive strategy likewise prevented the agency nurses from having recourse to most of the positive strategies to which HCD nurses could turn.

General occupational health

As many dimensions as possible were retained so as to have a realistic, overall understanding of the nurses' occupational health and safety. There were several reasons for which this could not be done just by examining official workers' compensation statistics. Work-related mental health problems were, for example, more difficult to detect. Temporary assignments after accidents or anticipated risks were recorded separately and were not accounted for in official frequency rates. Several other aspects of the data collection methods might also have considerably modified the official OHS statistics on injury frequencies and length of absence. These involved the under-reporting of accidents and OHS management that could arise either from negligence or from the fact that reporting was sometimes entrusted to subcontracting organizations far removed from the workplace. The fact that unionized nurses often chose to seek their salary insurance (provided for in the master collective agreement) rather than compensation by the Québec Workers Compensation Board (QWCB) [9] also had an impact. On the other hand, agency nurses' occupational injuries were the legal responsibility of their employer, the

tion, require the presence of a group. Individual defensive strategies are more damaging and are neither created nor supported collectively. The most common strategies among teachers in primary and secondary schools, according to M.-C. Carpentier–Roy [28], involved remaining silent about one's fears and anxieties, taking as much sick leave as possible, investing in other areas of life than work, and adapting, which was the most common of individual defensive strategies and which had such insidious affects as paralysis and individualism.

9 The Québec Workers Compensation Board (QWCB) is the English translation of la Commission de la santé et de la sécurité du travail du Québec.

PNCA, rather than the HCD even though the accident happened in a house to which they had been sent by the HCD. This would seem to have contributed to a lack of vigilance and under-reporting of the agency nurses' accidents by the PCNAs.

The following indicators, which complemented each other, were chosen to sketch a better general portrait of nurses' occupational health. They comprised: the official registers of nurses' occupational injuries kept by each institution [10] whether or not they were submitted to the QWCB; the official register of the nurses' temporary assignments kept by each institution; the records for salary insurance requests to which permanent nurses had access when they had OHS problems (as did, in certain circumstances, casual nurses working for an HCD); the nurses' answers to health questions during face-to-face interviews; the nurses' written responses to a questionnaire on physical pain and certain psychological health dimensions.

3. Work organization and employment status of nurses in LPHC homecare departments

Though the effects of precariousness are considerable, they are also difficult to determine. The issues that are examined in this section therefore concern the work activity of nurses in HCDs, looked at from several angles in order to identify its distinct components.

[10] Both the LPHCs and PNCAs.

3.1 Precariousness as an LPHC management tool and its effect on nurses’ health risks

A very broad portrait of nurses’ employment status, of recourse to agency nurses, and of the latter’s OHS can be drawn using a few characteristics of the LPHC homecare departments. In the four LPHCs, the proportion of hours worked by casual nurses relative to permanent nurses varied from 23% to 48%. As for agency nurses with respect to both groups of LPHC nurses, the proportion varied from 0% to 22%. [11] Of the four LPHC homecare departments, the HCD that hired the fewest casual nurses was also the one that made the greatest use of agency nurses.

One example illustrates how certain specific factors can be the cause of health problems. We noted that, in these four HCDs, the one that presented the highest frequency rate for nurses’ injuries compensated by the QWCB was also the one that employed the highest proportion of precarious nurses (casual and agency). However, the HCD that employed the lowest proportion of casual nurses nonetheless had an inferior performance with respect to the mean length of absence from work. Its intensive use of agency nurses might be at the root of this poor performance, as will be discussed further under the "excellence paradox".

Several other organizational factors might also contribute to this agency’s poor performance. Its nurses were faced with a very high, chronically excessive work load, as the department was unsuccessful in filling vacant positions. They were also subjected to increased constraints in their management of schedules and responsibilities due to the association with external units, the private agencies. This HCD made the greatest use of agency nurses but also employed the most organizational measures to make this procedure more efficient. It also had the highest disability leave for psychological disorders; further-

[11] 100% is equal to the number of hours worked by nurses employed by the homecare departments (regular and casual).

more, all the disability leave paid by the nurses' salary insurance was associated with psychological disorders.

The mean length of disability leave for the nurses employed by another HCD, which also used many precarious nurses but which chose to hire them itself as casual nurses, was much shorter than that of the above HCD which employed many more agency nurses.

Other qualitative data shed light on the organizational factors that possibly affected more personal data, such as the relationship between a nurse's employment status, her ability to turn to protective strategies, and her health problems. These same data likewise suggested that different types of precariousness might have had different consequences for health protection strategies such as going on leave as for health in itself, as will be shown below.

A report by Goudswaard et al. [15] sheds light on some aspects of precarious work. These researchers considered that employment status influenced work conditions, which in turn affected OHS. They distinguished two scenarios concerning OHS risks that ensued from precariousness. The first scenario is called "intensive precariousness." It occurs in an establishment where, even though there is no formal difference between work conditions and the nature of tasks, a gap grows between regular workers (OEC) and casual workers (FTC) in terms of remuneration, job security, schedule choices, access to training, and career possibilities. Casual workers point out they are assigned the most inconvenient schedules, are paid less, and have little possibility of being promoted. In the second scenario, called "extensive precariousness," exposure to risk is shipped outside of a firm or institution to contractual workers, subcontractors, and placement agency workers who carry out the most monotonous, dirty, or dangerous tasks in relatively deficient ergonomic conditions.

We found certain but not all of the elements of these two scenarios in the HCDs under study. Extensive precariousness was more common among agency nurses, to whom the HCDs subcontracted part of the work. Intensive precariousness, on the other hand, was more common among casual nurses, employed by the HCDs and who had fixed-term contracts. It turned out that certain aspects of work organization allowed (or did not allow) workers to develop their experience, empirical knowledge of their field and tasks, and protective work

strategies. It was not always clear whether this resulted in one or the other type of precariousness as defined by Goudswaard et al.

3.2. Precariousness and permanent nurses' strategies to control their workload

The data collected in the four HCDs from seven regular and four casual nurses (observed and interviewed) underscored a particular aspect of the relationship between, on the one hand, the nurses' employment and work organization, and, on the other, the risks to their general health. These data helped in understanding the paradox created by some of their protective work strategies. These strategies were intended to preserve their physical and psychological health by reducing the physical, cognitive, and affective workload. However, in a context where it was impossible to increase the proportion of permanent nurses, it then became necessary to turn to precarious nurses for tasks involving the direct care of patients. This, in turn, increased the volume of other kinds of tasks conducted by permanent nurses, such as administrating cases and files.

Route management is a good example. It consisted in setting up a weekly visiting schedule for each of the nurses, who are responsible for existing and newly assigned patients. Route management, which was one of the permanent nurses' tasks at the HCD [12], turned out to be one of the most time-consuming tasks. They devoted, on average, more than 15% of their work time in the HCD to this task, since every nurse had to change routes frequently because of the different changes and requests that came up. Furthermore, because of budget restrictions and changes in the way the health system is run, permanent nurses often had to make major changes that had consequences for their colleagues. Route management was particularly demanding on Fridays or on the day before public holidays because of the large number of patients who were being sent home by the hospitals and had to be im-

[12] Work at the HCD took up 42% of their time on average. Most of the rest of their time was spent going to patients' homes and caring for them [29].

mediately cared for by the HCDs in keeping with the hospitals' instructions.

So as to complete their tasks and balance their route from one day to the next, permanent nurses turned to individual strategies – such as occasionally postponing blood sampling or a patient's care – or to collective strategies. Among the latter, there was redistribution of tasks to colleagues from the same sector, to evening and weekend nurses, to precarious nurses (both casual and agency), and the practice of temporarily delegating tasks to other types of homecare workers. The need to make sure that choices did not reduce services or overload a colleague was one of the considerable difficulties that ensued from these modifications. These choices represented major irritants for the nurses that made them feel they had lost control.

Even though turning to precarious nurses was unavoidable in the short term, the coordination that was required between regular and precarious nurses, such as the need to pass on information, monitor tasks, added to the workload. Integrating precariously employed nurses reduced the permanent nurses' temporal latitude, which made it more difficult and even impossible for them to use some of their established strategies.

When they delegated their clinical tasks to precarious personnel, permanent nurses had to nonetheless make sure the tasks were being properly carried out and collect the information after the visit so as to keep files up to date and ensure follow-up. Our observations revealed that permanent nurses did not deal solely with the seven or eight files of the patients they personally saw each day, but rather with a total of 13 or 14, since they were also in charge of the patients seen by precarious nurses. The fact that precarious nurses, especially agency nurses, often had no idea about the work day that awaited them when they arrived at the HCD, and therefore needed to be given instructions, also added to the permanent nurses' workload. To accomplish all these tasks, several permanent nurses put in extra hours that they did not declare and chose to do certain tasks requiring concentration during their official lunchtime so as not to be interrupted. Some permanent nurses chose to no longer work full time. All of these defensive strategies came with a personal cost.

Despite their short- and medium-term efficiency in reducing the nurses’ daily workload, the route management strategies had several long-term inconveniences. In particular, they made the relationship between permanent nurses and their patients less stable and brought about a loss of information about patients and their follow-up. These management strategies affected not only the quality of the user service but also the workload. The permanent nurses often had to make up for the shortcomings of a work organization that attempted to reduce all work time to “productive” time, which added to their own workload and wasted their time. These tasks required, on average, more than one extra hour per day [13] beyond the official workday. The agency nurses were thus not the only personnel affected. There were also considerably negative consequences for the work and time organization of the permanent nurses in charge of these cases [14].

However, whereas the full-time permanent nurses could extend their workload over a longer period by putting off till later certain less urgent visits or tasks, precarious replacement personnel could only do so over the much shorter period of their assignment. This combination of personnel with different statuses had negative repercussions on the workload of both regular and precarious nurses, thereby increasing their risk of OHS problems. Generally speaking, these difficulties were greater for those with a precarious status who had less knowledge of the environments to which they were assigned than did permanent nurses.

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13 The permanent nurses’ official workday was six and a quarter hours, to which they added one and a quarter hours.

14 The work of nurses in charge of cases took place at the LPHCs in the afternoon after their morning home visits. The nurses followed up on the files of patients they were responsible for and organized all the details concerning healthcare, hygiene, and accommodation.

3.3 The importance of occupational experience and case knowledge

One of the main results of our study was that occupational experience was found to be beneficial for OHS in all of the nurse categories, since it favoured the acquisition of protective strategies that helped to reduce postural constraints. Moreover, experienced nurses developed the ability to carry out early detection of health problems, plan care, and teach by verbally interacting with patients while giving them care. Occupational experience thus made it possible to reduce the length of the visit.

Our results likewise showed that the nurses' knowledge of each case was a necessary element in their OHS protection. Several mechanisms enhanced this knowledge, in particular exchanges between colleagues and various types of meetings (professional, multidisciplinary, clinical, training). However, the number of these meetings varied according to the HCD, and precarious nurses were rarely invited.

Nurses also had to have some latitude to be able to develop protective strategies and use them. The conditions for acquiring occupational experience and case knowledge were not the same for each nurse, given that this acquisition was not directly related to the length of time the nurses had been working. In most cases, precarious nurses were given short-term and/or temporary replacement tasks. Even though they provided the same care to the same patients as did permanent nurses they did not, however, see the same patients on a regular basis and conduct the associated follow-up; they did not therefore acquire an equivalent experience and knowledge of the cases.

Because of this lack of stability in their tasks and environment, the agency nurses had to draw upon previously acquired knowledge in order to carry out their work activity in varying contexts. The experience they constructed on a daily basis went beyond a simple transfer from one situation to another, since it involved thinking about their nursing practice. They developed various kinds of strategies to make

up for the shortcomings in their work environments and thereby protect their health and safety by anticipating and preventing incidents. These strategies were aimed at saving time (e.g., by doing two tasks simultaneously such as a nursing task and early detection of health problems), reducing the cognitive and physical load (e.g., by using postures that lessen constraints), and improving service quality, efficiency, and patient security (e.g., by improving communication with patients) [5].

When we made a general comparison between the agency and permanent nurses, we saw that the agency nurses drew upon experiences and strategies that were identical to those of the permanent nurses when providing care, but that they also had to add on other strategies. Whereas nurses employed by HCDs tried to maintain a stable group of patients so as to benefit from the protective effect of their case knowledge (e.g., by collectively deciding that they should be regularly assigned the same patients), the agency nurses’ work context kept them from developing this level of experience. They stated that it was their knowledge and experience of the work environments that replaced their case knowledge.

3.4 Aspects of work organization and OHS in the HCDs

The nurses employed by the HCDs [15] were exposed to a wide range and degree of risks. The frequency rate of their OHS problems was 35.9%; the QWCB however only compensated 9.6%. Those nurses who were covered by the master collective agreement used salary insurance more often than the other nurses. The average annual duration of their work leave was quite high, at more than three months per person.

[15] Agency nurses not included.

In the HCDs under study, the data for these different sources of compensation on an annual basis [16] indicated that a third of the HCD nurses were on work leave for OHS problems, a proportion that was three times greater than the leave paid by the Québec's workers compensation board to all nurses. For a group of 100 nurses, this would be equivalent to 11 nurses on leave every day due to OHS problems. These rates are 10 times higher than the daily work leave rates compensated by the QWCB to all nurses. It was likewise established that half of the claims made to the QWCB dealt with musculoskeletal disorders (MSD), whereas salary insurance primarily covered work-related, psychological health problems. The long-term leave of nurses (employed by the HCDs) due to musculoskeletal and psychological disorders represented more than half of all the long-term leave paid for by salary insurance; they were likewise more numerous than the occupational injuries compensated by the QWCB. The annual average length for work leave covered by the QWCB was 21.3 days whereas that figure rose to 91.8 days when insurance covered the salary. The answers to the psychological health questionnaire indicated moreover that 54% of the HCD nurses who answered considered that they did not find personal accomplishment in their work and 29% considered that they suffered from pronounced emotional exhaustion.

These figures unequivocally show that the health risks for the HCD employed nurses (agency nurses not included) were very high, independent of their regular or casual status.

[16] To arrive at a complete portrait, the level of risk for OHS problems was calculated by taking into account indicators associated with: a) injuries compensated by the QWCB; b) temporary assignments, according to QWCB legislation; c) disability leave of three or more days, potentially related to work (only MSD and mental health symptoms were retained) with salary insurance. This is necessarily an underestimation.

3.5 The "excellence" paradox

The HCD that had the most organizational components for supporting the nurses' work activity made it easier for them to employ protective work strategies. Not surprisingly, this HCD also had the best OHS performance, particularly with regard to the contemporary result indicators created for our study [17]. So as to reduce the inconveniences ensuing from the lack of nurses and recourse to private agencies, the nursing management team established several organizational measures, such as an organized and continuous relationship with a single private nursing care agency, which was treated as a partner. Of the four HCDs observed, this was the one that turned most often to a PNCA and that applied the most organizational measures to make this relationship more efficient.

However, this HCD also had the longest average disability leave among the nurses it employed [18]. These surprisingly long disability leaves (146 days/year as compared to 32, 48, 76 days/year respectively for the other home care departments) perhaps reveal the limitations of too much precariousness which, at a certain point, created a disorganization effect that could not be countered. These figures also point to the excellence paradox that was so detrimental to the HCD nurses. They were torn between the institutions' quest for ideal performance and their own search for personal well-being at work that would allow them to keep working [30].

Two external factors which exerted a strong internal influence on this HCD must be taken into account to understand this apparent con-

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17 The frequency rate of occupational injuries, the average length of disability leave, and the daily disability leave rate describe the past. Questionnaire answers were employed to characterize psychological health and the prevalence of musculoskeletal pain at the time of the study. The preventive organizational measures were intended to reduce future risk.

18 As this LPHC did not use temporary assignments and did not have a history of contesting compensation demands, this might have resulted in higher statistics for disability leave and injury compensation.

tradiction. The first factor, which affected all the HCDs, came from policies and practices of the Ministry of Health and Social Services. One example among many: the Ministry had set up a computerized statistical form on the amount of care and services given by each department. Each employee had to fill it out on a daily basis, since the Ministry attributed its credits for the following year based on this data. The list of tasks that had been given a numerical code did not cover all the activities that nurses conducted. Moreover, the average duration of each activity was ascribed a standard value that did not always correspond to its real duration.

The HCDs therefore only received funds for part of the work conducted in their department. This ministerial procedure penalized those HCDs which were most actively looking for solutions to their organizational problems. For example, one HCD under discussion here attempted to create a clerk position to provide overworked nurses with logistical support. However, it was not able to have the position financed by the government because the tasks attributed to the clerk were not considered to be nursing tasks, although they were in fact performed by the nurses in the absence of a clerk.

The second factor was specific to this HCD confronted with the "excellence paradox" [19]. This HCD belonged to a suburban health network that had a high population density and that took to heart its independence from the metropolis. It established this independence through a thorough process of dialogue with the other members of its regional healthcare system and through closer ties with the private sector. It created, among other things, mechanisms for detecting and preventing disabilities and health deterioration among the older population. This resulted in a higher demand for care and services which were often accompanied by standardized measures that had been de-

[19] As explained by Aubert and de Gaulejac [31]: "*more than ever now, people are being encouraged to develop and pursue an image of themselves that conforms to outside standards of excellence and success, to the detriment of their real personality.*" The high cost of success leads to "*the sickness of "idealness," which generally affects people who cherish an ideal and who put a great deal of effort into attaining this ideal […]. The need to work energetically, remain vigilant, achieve excellence, strive for greater success and personal accomplishment, and always try harder is at the basis of this phenomenon."*

veloped elsewhere. Though the commitment of the regional healthcare system to improving clients’ health was positive for the target populations, it increased the demands on this HCD without increasing funding sufficiently.

In the face of considerable pressure and regional support involving highly standardized procedures and time allotted per procedure this HCD, confronted with the excellence paradox, systematically put in an exceptional effort to create an efficient and supportive organization. However, the very high volume of hours (50.5%) [20] worked by precarious nurses (28.1% for casual and 22.4% for agency nurses) not only seemed to undercut the beneficial effects of these organizational innovations but also seemed to impose a heavy health cost on the nurses employed by this HCD.

4. Private nursing care agencies (PNCAs)

Examining the situation of private agencies and their nursing personnel added a complementary perspective to that of the LPHC homecare departments discussed above. The main points of one nurse’s career path are looked at here, as they shed light on the importance that PNCA nurses attributed to their health and the strategies they developed when subcontracting so as to protect themselves and be able to keep working. The differences between PNCA nurses’ work and that of HCD nurses is then considered. Finally, given that agency nurses tasks were not determined by their employer, the complexity of OHS management is analyzed.

[20]- The volume of hours worked by the nurses employed by the HCD (regular and casual) represented 100%.

4.1 Career path and health history of a private agency nurse: a longitudinal view

The data drawn from interviews and questionnaires on the career paths and health histories of eight nurses from the two PNCAs showed how their past employment and work conditions influenced the nurses' decisions to work for a private agency. The details of one nurse's career path and the events that led her to make a costly compromise in choosing precarious employment with a PNCA are described.

This nurse had been practicing her trade for some 30 years. After beginning in the public sector, she joined the private sector 14 years ago. She had been working for the same PNCA for five years. Her health history was marked by several events that she linked to her career path. She stated that the recurrent tension and pain in her cervical region started in the first 16 years when she was working as a permanent nurse in a large public sector hospital. She likewise noted that she had received very little recognition for her abilities, and, furthermore, that the work atmosphere had worsened over time. Given her work values, this situation became an increasing source of conflict, eventually leading her to look for another workplace in an agency.

After a year and a half in palliative care, she held a clinical-administrative job for five years so that she could be closer to her children. Even though her static position at the computer caused her neck pain to become worse, she said that it was the loss of this job after five years that she found especially upsetting.

She went on to conduct paramedical examinations for three years; however, her private employer's financial difficulties convinced her to go to work for a private agency. No longer wishing to work in HCDs, she chose the vaccination and blood sample section of an LPHC as her work environment. Shortly after being hired by the agency, this nurse had a work accident that she did not declare to the QWCB. She attributed it to a poorly set up workstation and considerable workload and time constraints. This accident reactivated her neck pain, and she was

forced to consult specialists. The diagnosis was arthritis and a herniated disc in her neck. The accident left her with numbness in the left index finger and short-term fatigue associated with poor posture when working. She maintained however that she did not have persistent health problems. She had not stopped working since joining the agency and affirmed that she had never taken disability leave since being hired. She enjoyed her work, in particular the contact with the patients. Her career path was quite rich in terms of experience, health history, work hours, and development of protective strategies. A quick look at her experience indicated the wide-ranging abilities she had acquired.

In short, this nurse had chosen to change employers and job status due to her desire to achieve work-family balance and because of previous work conditions that she felt were directly linked to her health problems. She had developed an individual defensive strategy.

4.2 Private agency nurses working for HCDs

The data indicated that several elements affected the agency nurses’ work in the HCDs and distinguished it from that of nurses employed by the home care departments. The agency nurses had less time per visit than did the permanent nurses, making one more visit per day on average, that is seven and a half visits as compared to six and a half. They also met with greater constraints in these visits, as Seifert and Messing [32] have shown for nurses in an acute-care hospital. A lack of precision in the execution conditions and tasks to be carried out were a source of stress and increased mental workload for agency nurses. Other than requesting nurses and sending them as required, the relationship between the PNCAs and their clients, the HCDs, was often nonexistent. This is all the more striking given that support from the HCD and agency with respect to difficult situations would seem to be even more necessary and critical for agency nurses than for those employed by the health care departments. The agency nurses rarely had access to training and information sessions organized for the regular personnel even though the quickly changing

homecare context made these sessions all the more necessary. The lack of contact with work groups seemed to negatively impact their OHS in several ways, such as a lack of recognition, no access to collective strategies, no sharing of protective strategies, no sharing of information, and so on.

Two specific aspects of the agency nurses' integration into the HCDs seemed to contribute to an increased OHS risk: the shorter duration in which they could employ their strategies for controlling their workload, and the conditions for acquiring experience. In both cases, continuity in client demands made it possible for full-time nurses, but not precarious nurses, to acquire knowledge of the work environment and organizational culture, which influenced the development of protective work strategies.

As noted by Gouswaard et al. [15] and Rebitzer [10], the deficient conditions for integrating precarious workers into companies keep these workers from developing work methods that would help them to preserve their OHS. Prevention requires an understanding of the work to be done, the workplace and its risks, the personnel, and the equipment. Precarious workers, however, often do not have the time to become familiar with these elements. Nevertheless some nurses thought there were advantages and considered that their irregular relationships with patients allowed them to keep a protective distance.

The context was such that agency nurses were not nearly as able as permanent nurses to put the full range of their protective strategies to use. Precarious nurses were thus at greater risk of OHS problems than were the HCDs' permanent nurses. That being said, in the home care departments where the proportion of precarious nurses was the highest, the frequency rate for occupational injuries and health problems tended to be higher for all the nurses working in or with these departments, irrespective of employment status.

4.3 OHS in private agencies

Despite the fact that, as employers, the agencies were legally responsible in case of accidents, OHS management was minimal in the two agencies we studied and seemed to be limited to the payment of premiums to the QWCB and the reporting of injuries; this led us to suppose that there may have been under-reporting. The owners of the two agencies said that they were in charge of workers’ compensation issues and that the premiums were paid. However, these managers’ statements revealed grey zones and vaguely defined responsibilities. They frequently (but erroneously) alluded to providing a safe work environment for the agency nurses as the responsibility of the client, for example.

Our analysis of the documents made available to us revealed that there were no formal documents concerning OHS management in these agencies. Only the procedure for initial integration of new employees mentioned measures inspired by OHS law. We were told that these new recruits were informed of the precautions to be taken, the use of individual protection equipment, accident reports, and the transportation of blood samples. OHS training seemed to be deficient with regard to technical training for care and monitoring tools. The agency nurses were not that well informed and generally did not remember the procedures for reporting a work accident. Only the procedure in a case where someone pricks herself with a needle was well known, given that it is highly standardized throughout the health system and requires a mandatory declaration because of the risk of HIV or hepatitis.

Even though one of these two agencies provided technical training to its nurses, negotiated agreements when necessary with the HCDs for instruction and training for the nurses, and occasionally requested that certain detrimental work conditions be modified, these initiatives did not seem to be enough to reduce the numerous health risks for its personnel. The data indicated that the agency nurses considered their health risks to be both numerous and considerable. In their opinion,

the risks comprised physical and temporal constraints associated with workload and the layout of homes, the violence and mental health issues of patients, and injections. Depending on the body part, 1/3 to 3/4 of the nurses stated they had musculoskeletal disorders (MSDs) in the neck, arm, or shoulder region; a large majority of these nurses stated their pain was work-related. Moreover, psychological health indicators revealed that more agency nurses than HCD nurses declared that they did not find personal accomplishment in their work (76.9% versus 54.2%) and were at greater risk of depersonalization (17.2% versus 6.1%). The agency nurses however were much less likely to say they suffered from emotional exhaustion (13.3 % versus 29.4 %). The interviews of agency nurses and the recounting of their career paths confirmed that there was under reporting of injuries.

There was no trace of OHS-related disability leave over the last few years in the two private agencies studied here. Of the few incidents reported, not one gave rise to QWCB compensation or salary insurance payments. There was an extreme contrast in terms of OHS declarations between the PNCAs' "perfect" official registers and those, less perfect, of the HCDs, in particular with regard to the extremely high OHS risks of the nurses from the latter. This very large difference in OHS declarations was all the more striking given that the PNCA nurses declared physical and psychological health problems that were quite similar to those of their HCD colleagues. These observations are in keeping with the conclusions of Thébaud-Mony et al. [14], who stated that work contracts are increasingly taking the form of a service delivery, that is of a supplier-to-client relationship in which "*all room for negotiation between those who give the work and those who execute it disappears regarding work conditions, schedules, hygiene, and safety*." Doniol-Shaw et al. [33] likewise concluded that the responsibility-based relationship between clients and workers is being diluted as subcontracting becomes increasingly common. They note that clients not only contract out the intensification of work and the subsequent risks, but they also delegate the management of compensation since they no longer have to worry about prevention.

Given the advantages that some agency nurses found in their employment situation, this type of employment remains attractive. The individual relationship of agency nurses with their "chosen" precarious status was thus complex, contradictory, and ambivalent. One of

the major consequences of this type of employment was that agency nurses personally took responsibility for the consequences of their work-related health problems and their individual protection strategies. Since these strategies were at the workers’ expense, they were thus defensive. One nurse stated it clearly when she affirmed that her agency’s flexible management of shift availability allowed her to be unavailable when she felt too tired or was in pain. This was a double externalization of OHS costs: from the LPHCs to the PNCAs, and from the PNCAs to their personnel. These strategies likewise encourage the State’s withdrawal, since compensation costs are hidden and therefore cannot serve as indicators for possible prevention measures.

5. Conclusion

During the course of these case studies, the in-depth examination of employment and work organization and of the nurses’ work activity allowed us to bring several protective work strategies to light. These strategies were an important part of their real work activity, allowing them to maintain their physical and psychological health and to keep on working by reducing their physical, cognitive, and affective work load. The nurses employed these protective work strategies differently depending on whether the employment and work organization provided support or not. Employment and work organization provided support when the accumulation of work time led to the acquisition of concrete experience and knowledge of the people being cared for and of the work environment. This gave nurses the latitude they needed to put protective work strategies into motion, such as adopting certain postures, re-organizing certain tasks, giving information to patients, and setting limits.

Employing protective work strategies did not solely depend on the employment and work organization of the HCD where the nurses were working. It also depended on that of the PNCA and on its relationship with the HCD, this relationship influencing whether or not agency nurses could use their strategies.

Furthermore, examining the work activity of both regular and precarious nurses shed light on the relationship between, on the one hand, employment and work organization and, on the other, protective work strategies. The role of these organizational factors helped us to understand how the rise in precariousness in a workplace amplified the general work-related health problems of all nurses and not just those with a precarious status. Employment and work organization and protective work strategies thus proved to play an important role in the process through which overall work health and precariousness were associated.

Our methodology, which employed organizational case studies rather than large sample-size statistical studies, did more than just focus on the differences between people based solely on their regular or precarious status. Rather, our approach also shed light on several organizational factors that interacted synergistically and thereby reinforced or weakened their effect on the nurses’ overall health. These observations showed that it was possible, through appropriate organizational choices, to set up measures likely to reduce health risks even when precariousness was not completely eliminated. Nonetheless, several of these organizational choices would require changes to the Ministry of Health’s policies for frontline-care, which is clearly underfinanced. Sufficient financing would make it possible, on the one hand, to create more permanent positions and, on the other, to provide adequate care and services. Indeed, regular assignments and a stable work environment would require stable work positions. Though a certain flexibility is needed in healthcare services, it must be a minimal component rather than being used, as is currently the case, to replace work organization and employment status stability, that is, permanent positions and regular jobs. If this is to be accomplished, it will be necessary both to properly understand the situation’s systemic nature and to avoid undoing the positive impact of one measure through inertia or other measures creating the opposite effect, such as, for example, unduly increasing the proportion of precarious employees [21].

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ABSTRACT

Several convergent case studies have brought to light the numerous effects of precarious work on the health of nurses who provide home-care service in the public sector. Our results not only allowed us to document the employment status of nurses with precarious jobs (those working as either casual employees in the public-system or as subcontractors for private agencies), but also their career path, employment and work conditions, and occupational health. With regard to work organization, it would seem that the presence of a large proportion of precarious nurses changed the task distribution and workload, which in turn affected the work conditions of permanent nurses and, consequently, their overall occupational health.

KEY WORDS

Career paths, case studies, nurses, employment and work organization, occupational health and safety, precariousness, work strategies.

Fin du texte