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The Age-Dependent Value of Life: State Responses to COVID-19 in Ontario's Long-Term Care Homes from March to December 2020

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Abstract

During the early waves of the COVID-19 pandemic, Canada saw high infection rates among its long-term care residents, leading to disproportionately high death rates from the virus amongst this population. The pattern of high death rates among long-term care residents persisted throughout the pandemic. Notably, the Canadian province of Ontario continually fared poorly, recording a total of 5,044 resident and 13 staff deaths by July 1, 2022 due to COVID-19. In the spring of 2020, the Ontario government called upon the Canadian Armed Forces to support some of the long-term care facilities with high rates of COVID-19 infections. The Armed Forces documented instances of residents dying in what they referred to as deplorable conditions. This article argues that the Ontario government failed to protect long-term care residents from COVID-19 and in so doing, marked their lives as expendable. By analyzing legislation and public documents, I identify how the state protected the interests of private corporations that own long-term care facilities and the neoliberal status quo in senior care, rather than vulnerable residents and the predominantly racialized women who staff these facilities. I propose that to uphold the long-term care system's neoliberal capitalist structure, the state constructed the lives of people living in long-term care facilities as dispensable through weaponizing discourses underpinned by currents of ageism, sexism, and racism, while constructing itself as "caring" for responding to an "inevitable" crisis. An analysis of state responses to the pandemic highlights flaws and can contribute to strategies that may prevent devastation in the future, implicating practices for how a society provides care to people in long-term care facilities.

Keywords: COVID-19, long-term care, seniors, Ontario, neoliberalism, Social Work Theory, Progressive Practice

Introduction

On March 11, 2020, the World Health Organization declared the new highly infectious coronavirus, 'COVID-19,' which had begun circulating in a few countries, a global pandemic. The virus led to large outbreaks and dire outcomes in senior care facilities around the globe. In Spain, seniors were found abandoned and dying in facilities by the military, and in Washington, USA, long-term care (LTC) facilities were hit hard early on (Mann, 2020). In Canada, LTC facilities provide 24-hour personal support and nursing care to residents, namely older people with life-limiting illnesses, complex care needs, and comorbidities.[1] On March 5, 2020, a staff member at

[1] Henceforth, I will use the term seniors to refer to such LTC residents.

Lynn Valley Care Centre in North Vancouver, British Columbia, tested positive for the virus. Three days later, on March 8, a resident of the centre became the first person in Canada to die of the virus (Comas-Herrera et al., 2020). That resident's death would mark the beginning of what would go on to be called Canada's "national shame" (Ambrose, 2020): the nation's preventable humanitarian crisis for seniors. As evidenced by the number of deaths and survivors' accounts (e.g., the Patient Ombudsman's report; Patient Ombudsman, 2020, or the *JTFC Observations* report; Canadian Armed Forces, 2020), I argue that Ontario's responses were particularly inadequate and failed to protect residents, families, and staff.

On March 17, 2020, Ontario went into a province-wide lockdown, closing all non-essential businesses and services. While Ontario prepared for an economic downturn, expected because of the lockdown (Gong et al., 2022), and worked to amass personal protective equipment (PPE) and ventilators for surges of hospital cases, LTC appeared forgotten. By the end of March 2020, LTC facilities had become the epicentre of the virus in the province. Despite warnings from other countries of what was to come, the Canadian state, and particularly Ontario, failed to establish sufficient protective measures for LTC facilities and the country saw the highest LTC death tolls among wealthy nations (Webster, 2020).

In Ontario, the COVID-19 pandemic exposed failures in ensuring high-quality care for seniors in LTC and exacerbated long-standing issues evident across Canada. That Ontario had one of the highest rates of COVID-19 in LTC since the pandemic was declared compared to other Organization for Economic Cooperation and Development (OECD) countries (Akhtar-Danesh et al., 2022), and seniors suffered in isolation and died in what many believe were degrading ways, underscored the urgent need to prepare LTC for ongoing and future public health emergencies. This article explores Ontario's responses to COVID-19 in LTC. I will examine how the state failed to prioritize LTC, how it perceives its role as a care provider, and discourses in government legislation exposed by the pandemic. Specifically, I will consider the kinds of interventions the state implemented because of COVID-19, including amendments made to Ontario's *Long-Term Care Homes Act* (LTCHA) (*Long-Term Care Homes Act*, 2007), COVID-19 emergency orders and policies, political speeches, and public documents. This paper is structured as follows: First, it describes LTC's structure in Ontario from intersectional (a term formally coined by critical race theorist Kimberle Crenshaw in 1989), feminist, and critical gerontological perspectives and discusses neoliberal, capitalist ideologies that govern the sector. Using an intersectional lens, it seeks to uncover how classism, racism, sexism, and patriarchy uphold one another in the context of LTC. It analyzes discourses hidden in policies and strategies implemented by the state to deal with the outbreak in LTC facilities, including commissions and military intervention, and discusses how the virus continued to spread and how the state's mishandling of LTC persisted. Finally, it considers the impact on residents, families, and staff of LTC facilities, and concludes with lessons from Ontario.

This article is based on the study I conducted from September 2020 to April 2021, as part of my Master of Social Work degree. This study is personally significant because of my work in LTC, where I witnessed macro structural issues such as legislated understaffing and poor infrastructure impact residents and staff on a micro level before and during the pandemic.

Theoretical and Methodological Frameworks

The study's theoretical framework draws upon critical social theory (CST), which is a synthesis of many theories. CST assumes that the fundamental nature of reality is layered with hidden, historically situated social structures (Neuman and Kreuger, 2003). Ontologically, CST assumes that the social world is filled with injustices, that individual experiences are directly related to external social contexts, and that reality is shaped by cultural and gender social norms and values. It locates social issues in historical contexts because systems of inequity are ingrained in society while the fundamental nature of reality is layered with deeper hidden structures (Neuman & Kreuger, 2003). Moreover, CST is aligned with this study, which seeks to locate state responses to COVID-19, in LTC, in social structures (e.g., ageism) represented by political discourse (talk and text; Van Dijk, 2015). Epistemologically, CST assumes that communities relegated to the margins are silenced and their knowledge is devalued. CST draws attention to and highlights their knowledge (Neuman & Kreuger, 2003).

The specific theories employed in the analysis are critical gerontology, feminism, and intersectionality supported by Black feminist theory. Critical gerontology is described in the context of resilience theories that focus on social relationships and cognitive resources: "Resilience within a critical ageing perspective needs to go beyond the individual to explore how different scales (or levels) of resilience make sense to the exploration of the lives of older people" (Wild et al., 2011, p. 149). Critical gerontology proports that older people thrive because of adverse experiences that build resilience. It examines their strengths rather than paints them as "deficient" for contracting a virus that was brought upon them.

Feminism holds the ontological assumption that androcentrism can be eliminated from knowledge production (Hesse-Biber et al., 2004). It is informative because issues in LTC are frequently women's issues, as they make up a high percentage residents and staff (Estabrooks et al., 2023; Walker et al., 2020). However, feminism is limited because it has historically ignored interlocking systems of oppression and is dominated by white women's perspectives (Hesse-Biber et al., 2004).

To address limitations with feminism, my study is underpinned by Ross' (2016) work, which examined intersecting systems of oppression and connected the history of white supremacy to the project of capitalism. To flourish, Ross asserted, the political and economic white supremacist system needs racism, classism, and heteropatriarchy, which are not mutually independent but rather maintain one another. This historical analysis is needed because it locates contemporary issues in history and helps explain poor outcomes in LTC. Ross discussed how patriarchy and sexism uphold racism and classism, which my study sought to uncover in the context of LTC. Classism is intertwined with sexism and racism because the private sector continues to grow in LTC and remains economically attached to governments, reproducing the property-owning capitalist class, while the sector is upheld by exploiting a racialized, feminized workforce. I argue that in Ontario, LTC is rooted in neoliberal capitalist business practices as it is feminized and racialized while senior care, primarily provided by women, is devalued. Women comprise the bulk of the workforce and most residents (Armstrong & Armstrong, 2020). It is worth noting that in Ontario, all LTC facilities are publicly funded through taxes and residents' fees; for-profit, privately owned LTC facilities draw their revenue from those funds and are thus incentivized to reduce expenses to maximize shareholder value (Ontario Health Coalition, 2022). Because of these realities, a racism and classism analysis are useful in understanding how racialized women are

exploited by the paradigm of substandard working conditions and low wages while shareholders reap profits (Lancaster, 2020).

Because, as Syed (2020) argues, feminism is historically rooted in the perspectives of white women, and care work in Canada is predominantly provided by immigrant and racialized workers, particularly Black and Filipino women, Black feminism is foundational to the study's analysis. Black feminist perspectives are essential in understanding the underpinnings of the state's responses to COVID-19 in LTC and political processes as Black women hold multiple identities marginalized by the state (Crenshaw, 1989). An intersectional framework (exploring the compounding effects of racism, classism, and sexism), supported by Black feminism, provides an understanding of how LTC workers' positionalities are experienced in the context of a patriarchal, racist, capitalist system that dominates Ontario's LTC sector. It also reveals how systems of oppression shaped the state's responses to COVID-19 in LTC, leaving the root causes of COVID-19 outbreaks and substandard conditions unaddressed and reproduced.

I am drawing on intersectional perspectives to question how race, sex, class, and age intertwine to inform the experiences of LTC workers and residents during the pandemic. Intersectionality is an expression of ideas that had been disseminated in Black feminist theory for decades (Crenshaw, 1989). By combining the experiences of class, race, and gender, intersectional and Black feminist thinkers describe how being a Black woman is a unique category of identity and informs the complex experiences of many frontline LTC staff.

The methodological framework of the study is built on Van Dijk's (2015) critical discourse analysis (CDA), which asserted that discourses are historical, cultural, and articulated through text and talk. Ontologically, CDA assumes that reality is constructed through discourses and that social structures are influenced by elites in power (Van Dijk, 1985). CDA allowed me to explore how discourses and ideologies of age, gender, class, and race operated in policy and underpinned the state's handling of the COVID-19 crisis.

CDA assumes that how topics are spoken about constitutes knowledge. Since hegemonic discourses suppress marginalized communities' perspectives, those perspectives are devalued and assumed to be subjugated knowledge (Van Dijk, 1985). CDA proposes that analyzing discourses exposes how they are articulated by dominant groups and employed to exercise power. Those in power typically include politicians who have control and influence over discourse.

Methods

To understand the Ontario state's responses to COVID-19 in LTC, I examined data including public documents, legislation, and political speeches during the period of March 2020, when the pandemic was first declared, to December 2020. I focused on the government's early responses to COVID-19 in LTC and additional responses as the pandemic wore on. I also examined outcomes of these responses for residents and staff. I used the data gathering method of archival research, searching online government websites and archives, and purposive sampling (a non-random technique for deciding on data that is most relevant to the research questions but avoiding biases; Dolores & Tongco, 2007) to uncover underlying and common themes in the data. The data is consistent with CDA's objective of analyzing politicians' discourses through text and talk.

I examined many public documents that recommend strategies to deal with COVID-19 in LTC and that describe the state's actions (such as deploying the military) including: the Canadian

Armed Forces (CAF) report on what they witnessed while deployed to LTC facilities experiencing explosive outbreaks of COVID-19 (Canadian Armed Forces, 2020), Ontario's Patient Ombudsman's report (Patient Ombudsman, 2020), and transcripts of the province's Commission into Long-Term Care including *Ministry Briefing on CAF* (Ontario's Long-Term Care Covid-19 Commission, 2020a) and *LTC Covid-19 Commission Meeting and Overview of the LTCHA* (Ontario's Long-Term Care Covid-19 Commission, 2020c). Relevant political speeches and briefings from Ontario's Premier Doug Ford and his ministers include: Fullerton's (Minister of LTC) *COVID-19: Ontario Premier Announces Measures for Long-Term Care Facilities* (CPAC, 2020b) and Premier Ford's *Ontario Launches COVID-19 Long-Term Care Commission* (CPAC, 2020a). I examined the *Visitor Restriction Policy* (COVID-19 Directive #3 for Long-Term Care Homes. Effective date: November 23, 2020) and the order *Education Sector* (O. Reg. 205/20), filed under the *Reopening Ontario (A Flexible Response to COVID-19) Act, 2020*) (*Reopening Ontario*, 2020, SO 2020, c. 17). I reviewed the orders *Work Deployment for Certain Healthcare Providers* (O. Reg. 74/20) and *Limiting Work to a Single Long-Term Care Home* (O. Reg. 146/20), both filed under the *Emergency Management and Civil Protection Act* (*Emergency Management Act*, RSO 1990, c. E.9). I also reviewed amendments made to the LTCHA and Premier Doug Ford's Progressive Conservative government's new *Supporting Ontario's Recovery and Municipal Elections Act, 2020* (Bill 218, *Supporting Ontario's Recovery Act*, 2020, SO 2020, c. 26).

I read these documents for the discourses that framed the state's portrayal of the pandemic in LTC and the state's interventions. Specifically, they speak to how the state perceives its role as a caregiver and how it envisions strategies within a privatized care model. Moreover, the public documents on military intervention highlight the discourse in the aftermath. Data speaks to how discourse and power influence policy, which in turn shaped conditions in LTC during COVID-19. By comparing these archived data, I noted threads of rhetoric. I excluded aspects of the Ombudsman's Report pertaining to hospitals as they did not relate to the research.

Analysis

The study is an analysis of the state's responses to COVID-19 in LTC informed by critical theories. The study employs a thematic approach for coding and analysis, and data is interrogated using questions posed by CDA and CST as proposed by Barbour (2008). Themes emerged from the data and I reviewed those that were repeated throughout the data to identify patterns in the discourse. I searched for deeper meanings of oppressive language and words and found three major themes emerging from the data: understaffing, the neoliberal model of care, and safety and protection. The theme of understaffing in politicians' discourse is understood by CDA and CST to be underpinned by deeper structures such as sexism and neoliberalism. I categorized codes such as infection prevention and control (IPAC), personal protective equipment (PPE), and privatization under the larger theme of the neoliberal model of care, discussed later in the article. A theme that frequently appeared in emergency orders was safety, which was categorized under the broader theme of protection. Moreover, themes revealed threads of rhetoric and identified patterns in the discourse. The relationship between codes is that their substandard practices (e.g., lack of PPE or improper IPAC practices) are required to uphold the privatized neoliberal system.

I also read data contrapuntally, as proposed by Edward Said in Bilgin's (2016) article. Contrapuntal analysis focuses on the "connectedness" of experiences, both in the past and present; it involves a normative history that is the dominant narrative and searching for underlying counter

stories. Raising contrapuntal awareness entails considering issues from different perspectives and recognizing many individual, independent story lines while appreciating the broader story. Experiences come with their own agendas, developments, internal formations, coherence, and external relationships, which interact with one another. I analyzed data in accordance with Bilgin's proposals to build awareness of the underlying discourses and subjugated knowledge of residents, staff, and families. In so doing, I also uncovered hidden state objectives that were manifested in practices residents, staff, and families thought were harmful. A thematic and contrapuntal interrogation of the data, underpinned by CST and CDA, allowed me to arrive at findings that revealed how the state views its role as a caregiver for aging populations and how it prioritizes LTC.

The Racialization and Feminization of LTC

LTC residents are primarily women over the age of 80 and often have life-limiting illnesses such as dementia (Walker et al., 2020). The staffing mix in LTC generally includes care aides and personal support workers (PSWs), nurses, doctors, and companions (hired privately by families). According to Estabrooks and colleagues (2023), Canada's LTC workers are typically older racialized women, with 35% born outside of Canada. Moreover, Armstrong and colleagues (2020) note, "More than 90% (of LTC workers) are women, up to 70% are over 40, about 60% speak English as a second language, and about half in urban centres are immigrants" (p. 14). The LTC workforce is highly racialized and feminized. LTC workers diagnosed with COVID-19 were likely to live in lower-income communities, with other essential workers, and with a higher household density (Estabrooks et al., 2023).

Moreover, PSWs and care aides are unregulated, provide 80-90% of care, and are paid low wages (minimum wage in Ontario, at the time the study was conducted). Because they were paid low wages, many staff were forced to work in multiple locations during the pandemic, to earn a living wage, contributing to the virus' spread. The undervaluation and marginalization of this workforce segment is demonstrated by their low wages as well as their exclusion from decision-making and participating in family care conferences even though they are the closest workforce to the residents (Armstrong et al., 2020). Their treatment by the sector points to defining characteristics of exploitative, capitalistic business practices that shape senior care in Ontario.

Neoliberalism in LTC downloads responsibility onto families while the state provides minimal support. Due to understaffing, many families hire private companions to care for their loved ones. Companions perform personal support and care aide-like roles as well as provide social engagement. Companions have no job security or benefits and are not protected by statutory programs (Daly et al., 2015). Structurally, they are excluded and not mentioned in LTC policy, leaving them in precarious positions working between formal employment and familial relations. The use of private companions adds to the racialization and feminization of care as most companions are female and racialized (Daly et al., 2015), and is characteristic of interlocking racism and sexism. Their exclusion from policy reflects deeper issues such as neoliberalism and privatization (Daly et al., 2015).

Ontario's LTC System: A Social Determinant of Health

In Ontario, nearly 80,000 residents live in 627 facilities. For-profit, private LTC facilities make up 57% of all facilities while 16% of facilities are publicly owned (Stall et al., 2020; Estabrooks et al., 2023). As evidenced by the Ontario government's interventions explored in the following sections, the state protects for-profit, private entities and values the economy over disrupting a system, leading to devastation in LTC. This article argues that LTC fared poorly because the sector exists at the intersections of racism, sexism, ableism, and classism, which are systems that mutually uphold each other and capitalism, and are necessary for the privatization of care.

Ontario lost 2,342 residents due to COVID-19 by December 6, 2020, while private LTC corporations paid out over $74 million in shareholder dividends during the first wave alone (Government of Ontario, 2021; Lancaster, 2020). Private LTC facilities are driven by shareholder profit. Armstrong and colleagues (2016) argued that to minimize expenses, private facilities cut staff and compensate by hiring unregulated care aides as opposed to registered and regulated staff. According to a report by the Registered Nurses Association of Ontario (2018), the only legislated staffing requirements in Ontario were ambiguous directions of care to meet residents' assessed needs and a minimum requirement of one registered nurse on duty at all times. There was no legislated minimum staffing ratio or requirements for how much care residents receive daily:

> Specific regulation in Ontario stipulates that one RN, who is both an employee of the LTC home and part of the home's nursing staff, must be on duty and present in the home at all times. This number is the same for all LTC homes despite varying sizes. The average number of residents in a nursing home in Ontario is 124. Thus the current staffing requirements translate to an average of just one RN for every 124 LTC residents. This is compounded for larger homes, which can legally employ one RN for upwards of 400 residents. (Registered Nurses Association of Ontario, 2018, p. 5)

Corporations tend to favour residents who do not require much care so that they can have less staff (Armstrong et al., 2016). As demonstrated by the pandemic, private corporations are accountable to shareholders first and foremost, which results in negative outcomes for residents and staff. By July 1, 2022, Ontario had lost 5,044 residents (NIA Long-Term Care Tracker, 2022). As discussed earlier in the article, major themes that appeared in the data include understaffing, the neoliberal model of care, and protection. These themes pre-date the pandemic and underlie social issues engrained in Ontario's LTC system, experienced on micro levels throughout the pandemic by residents, families, and staff, as noted by the Registered Nurses Association of Ontario (2018).

The State as a Protector for the Private Sector: Ontario's Neoliberal Model of Care

Armstrong and Armstrong (2020) provide a background to help contextualize the themes that emerged from the data, which inform my findings. They defined neoliberalism as a hegemonic ideology and a political and economic system of governance that advocates for the private market and for-profit industries to provide 'solutions' while individuals are seen as responsible for their own well-being. Neoliberal, capitalist orientations devalue seniors because they are viewed as not contributing economically. Provincial government after government did not want to pay for the ageing population's needs and played on ageist discourses. They promoted private LTC ownership and made it easy for the 'solution' of privatization to occur (Armstrong et al., 2020). Privatization

is seen as resolving the perceived strain seniors cause on the healthcare system. Racialized women workers who primarily staff for-profit LTC facilities are heavily exploited by the private sector (as noted above), which remains financially attached to governments.

Armstrong and colleagues (2015) examined the Ontario government's involvement in LTC and argued that privatization undermines old age security. Under neoliberalism, governments' faith is placed in markets, which view LTC as a commodity, and, in turn, drive privatization. The state employs discourses that demonize the "ageing population," claiming they will inevitably strain the healthcare system. These discourses are directed against seniors to promote privatization, as private corporations are seen as "solving" the stress seniors allegedly place on the system (Armstrong et al., 2015).

Armstrong and colleagues (2020) also noted that privatization has been actively supported by successive governments. In the 1990s, Ontario Premier Mike Harris' Conservative government introduced competitive bidding processes in LTC. These acted as a catalyst in the growth of corporate chains because small family-owned and municipal government-owned homes did not have sufficient capital and were driven out of business. Neoliberalism underpinned the state's involvement as it placed its faith in markets to deliver services.

Underlying neoliberalism and the push for privatization in LTC are ageism and the widely accepted devaluation of seniors. These elements were rampant during the COVID-19 pandemic. Fraser and colleagues (2020) assessed discourses that misrepresented and devalued seniors and concluded that the value of life was portrayed as dependent on age and is an underlying discourse leading to deplorable living conditions in LTC. Ageism is a defining characteristic of Western culture, as evidenced by the lack of preparation in LTC and by the view of seniors as burdens (Fraser et al., 2020).

The state's interventions, which I explore in the next section, highlight the relationship between privatization and neoliberalism: the state implements bills to protect the (for-profit) private sector and, in turn, the private sector protects the state's neoliberal agenda of relying on markets, providing minimal support, and promoting individual responsibility. The private sector decreases the costs of publicly provided services while neoliberalism encourages individuals to exercise choice (Teghtsoonian, 2009). This neoliberal model of care is prominent in the state's responses to COVID-19.

Neoliberalism in LTC is underpinned by and requires the maintenance of capitalism (Ross, 2016). Neoliberalism as an ideology and system is upheld through devaluing life and labour, and its survival is at the expense of staff and residents. By providing a safety net to the private sector and implementing inadequate policies, the capitalist, neoliberal set-up of LTC, which prioritizes the private sector at the expense of seniors and care workers, is maintained.

When care is put into the private sector, it becomes a for-profit business. In the process, the rights of residents and staff of LTC facilities to health and protection are diminished, as evidenced by the many facilities that experienced explosive outbreaks. This relegation of vulnerable seniors speaks to state-sanctioned age fragility. Once seniors arrive at a certain age, they are no longer considered full market participants. Economic issues merge with gender, age, and disability, in addition to the neoliberalization of LTC, to deem seniors' lives unworthy of protection (Macías, 2010).

Findings

Loopholes in Legislation and For-Profit Favouritism in Ontario's COVID-19 Responses, and Impacts on Residents, Families, and Staff

Living and working conditions in Ontario's LTC facilities were substandard prior to the pandemic. Daly and Szebehely (2012) compared working conditions in LTC facilities in Canada to Sweden and found the conditions in Canada to lack social connection, induce high stress levels, and foster heavy workloads. The reality faced by LTC residents every day due to understaffing, prominent in Canada, is further complicated by the inappropriate use of chemical and physical restraints. Walker and colleagues (2020) explored Ontario's LTCHA (Long-Term Care Homes Act, 2007) and noted that the constant use of restraints indicated low quality of care and that, historically, rates of physical restraint use were far higher in Canada than in other countries, including the United States.

Tufford and colleagues (2018) reviewed living conditions in LTC (internationally and in several Canadian provinces including Ontario) with a focus on locks and secure units utilized as "solutions" to the problem facing facilities when residents who have severe dementia pose a flight risk. They examined the social construction of risk mitigation, seen in facilities' installation of locks and restriction of residents' movement. This example is yet another cultural ageist manifestation that has become a living condition in LTC. Seniors are locked up because of the perception of risk and inadequate staffing to care for residents. Ageism manifests itself as understaffing and results in isolation, social exclusion, and loss of autonomy for seniors.

Another example of the inhumane treatment of residents is the "diaper policy" found across Canadian LTC facilities, as noted by Daly and colleagues (2011). Management of some LTC facilities created conditions where incontinence products were limited, and residents were not toileted regularly and left in soiled diapers. Some homes implemented policies stating diapers were not to be changed until they reached the saturation point, and staff were told to put used diapers back onto residents after baths due to time pressures, understaffing, and management's preoccupation with minimizing expenses. This scenario is a symptom of privatization, where profit is valued over the humane treatment of seniors (Daly et al., 2011). These conditions predate COVID-19 and represent structural issues that create racialized, gendered environments where precarious work is performed, as well as systems that marginalize seniors. Many pandemic reports and primary sources discussed below highlight the exacerbation of LTC's substandard living and working conditions.

As discussed above, I argue that the state prioritizes a neoliberal political agenda of maintaining the status quo over the well-being of LTC residents and staff. The state retains dominance through discourses of protection. My analysis of the data reveals relationships between privatization and safety and protection since they frequently emerge together while privatization appears to underlie the emergency orders.

Ontario's earliest pandemic "protections" for LTC consisted of emergency orders filed under the *Reopening Ontario (A Flexible Response to COVID-19) Act, 2020* (*Reopening Ontario*, 2020, SO 2020, c. 17) and *Emergency Management and Civil Protection Act* (*Emergency Management Act*, RSO 1990, c. E.9). Discourses of care, support, and protection are embedded in the titles of these orders. The language used in the orders explicitly portrays the state as caring, which dominates public discourse, while contrapuntally, it has the latent purpose of protecting Ontario's

economy. To deal with the crisis, Ontario's Conservative government ordered an independent Commission into LTC. The purpose of the Commission was to investigate the spread of COVID-19 within LTC facilities and examine how residents, families, and staff were impacted. It also examined the adequacy of measures established by the government to contain the virus' spread and provided guidance on how to better protect facilities from future outbreaks (Ontario's Long-Term Care Covid-19 Commission, 2020b). My analysis of the transcript of the Commission's report reveals loopholes in legislation favouring specific neoliberal privatized agendas, which led to devastation in homes.

After being deployed to five Ontario LTC facilities to respond to outbreaks and compensate for understaffing, the CAF submitted a report (CAF, 2020) to the province describing the conditions they witnessed. It included accounts of residents being neglected while crying for help, not being bathed for weeks, left in diapers, and with food in their mouths while they were sleeping; one nurse caring for over 200 residents and one PSW for 40 residents; the reuse of PPE; insect infestations; and food left out for days (CAF, 2020). The report recounted horrifying stories that depict the manifestations of the neoliberal model of care: substandard quality of care, poor infection prevention and control practices, and inadequate PPE. The report also revealed extreme understaffing leading to frequent falls by residents, staff not being provided with education, and examples of abuse and neglect. Ontario's Patient Ombudsman's report (Patient Ombudsman, 2020) outlined similar concerns. Many issues were attributed to the inhumanness of the state's visitor policy discussed below, as families could no longer enter homes to compensate for understaffing.

Most data spoke to the consequences of protective policies, especially the policy *COVID-19 visiting long-term care homes* (COVID-19 Directive #3. Effective date: December 26, 2020). The undertone of this policy attributes the spread of the virus to family and essential caregivers rather than inadequate state interventions. It did not protect residents from social isolation or its harsh impacts on mental health (COVID-19 Directive #3. Effective date: November 23, 2020; Hado & Feinburg, 2020). The state appears to consider caregivers "a type of essential visitor who is designated by the resident … and is visiting to provide direct care to the resident … (e.g. supporting feeding … personal hygiene, meaningful connection …)" (COVID-19 Directive #3. Effective date: November 23, 2020, p. 3). Supporting mental health is not mentioned in the policy as an essential duty of caregivers.

Since private corporations were given the freedom to implement individual versions of the visitor policy, "homes are responsible for establishing and implementing visiting practices that comply with Directive #3 and the Minister's Directive and align with the guidance in this policy" (COVID-19 Directive #3. Effective date: December 26, 2020, p. 2), I argue these corporations play a crucial role in achieving the hidden objectives of silencing seniors while constructing themselves as responsible, trustworthy, and compliant actors. *Directive #3 for LTCH under the LTCHA 2007* (COVID-19 Directive #3. Effective date: December 26, 2020) also favoured a neoliberal, individualized, and discretionary approach. As noted by Tufford and colleagues (2018), the nature of risk aversion is heavily biased, translating to unnecessary restrictions for LTC residents, for example, the immobilization of those who use wheelchairs or the use of antipsychotic drugs and chemical restraints. The impact of the visitor policy in relation to staffing contributed to the LTC system unravelling. The conditions for residents, which the CAF report described as deplorable, were caused by understaffing and were especially prominent with the absence of family caregivers, who had filled in staffing gaps prior to the implementation of the visitor policy (CAF, 2020).

Family members' unpaid labour allowed the mostly privatized LTC system to survive with minimal staffing (Hado & Feinburg, 2020). When family were no longer allowed to visit, the importance of their role was exposed.

Although neoliberal policies do not explicitly promote the disregard for LTC residents or endorse individualism, they do so implicitly. For example, policies in the LTCHA (Long-Term Care Homes Act, 2007) do not dictate staffing ratios, allowing facilities to determine their own staffing level. When private facilities understaff, they effectively download responsibilities onto families (Bilgin, 2016). This reality points to a pitfall in the state's COVID-19 responses. The state did not account for family caregivers' essential roles in compensating for understaffing caused by its own systems of neoliberalism and privatization. As a result, the state was left with the unmasking of a major staffing crisis. Since individuals and families are rendered responsible for their own care and could no longer be used to balance low ratios, LTC fell apart.

Despite their roles in preventing the system from collapsing, families are devalued by the state, as their labour, primarily performed by women, is not deemed essential. The CAF report (CAF, 2020) contains discourses that speak to the general devaluation of gendered care work while exposing the harmful impacts of LTC facilities that implemented their own versions of the visitor policy:

> It's heartbreaking to get a report about someone who is "agitated and difficult" and has been getting PRN narcotics or benzodiazepines to sedate them but when you talk to them they just said they're "scared and feel alone like they're in jail"— no agitation or sedation required. (p. 5)

In addition to providing bodily care, families served as sources of emotional support for residents. Before the pandemic, staff could not care for residents' mental health needs, since in Canada, medical models are valued over social care, for example, in contrast to Scandinavian countries (Daly et al., 2011). The pandemic also increased social isolation for residents of LTC facilities in Canada, resulting in more unnecessary forced drugging (Walker et al., 2020). This maltreatment implicates neoliberalism since, notwithstanding that there is insufficient staff to prevent forced drugging, it views care as an individual responsibility.

The state also maintained the status quo through discourses of support. For instance, *Education Sector* (O. Reg. 205/20),) allowed education workers (school staff) to "support" LTC operators in responding to outbreaks. As education workers have no specific training in LTC, from a contrapuntal analysis, this order reinforces the private sector's capitalistic objectives of a low-wage, unskilled labour market. Bringing education workers into LTC is a band-aid solution that maintains systemic issues upheld by successive governments (Armstrong et al., 2020).

The order *Work Deployment for Certain Healthcare Providers* (O. Reg. 74/20) was a protective measure that allowed staff to be redeployed as needed. The order *Limiting Work to a Single LTC Home* (O. Reg. 146/20) restricted staff to work at a single home. These directives are reactions to capitalist business practices that promote understaffing and force staff to take on jobs in multiple facilities to earn a livable wage (thereby potentially spreading COVD-19). I maintain that both orders were ineffective in that they allowed the private sector to continue exploiting staff and maintain the racist, sexist status quo in the senior care sector as these directives simply redistributed an already thin, racialized, and feminized workforce.

Women workers are disproportionally impacted by neoliberal capitalist practices and hidden discourses and objectives of maintaining a white supremacist hierarchy in society (Gee & Handford, 2012). Crenshaw (1989) noted the compounding effects of the double discrimination (sexism and racism) Black women experience, and these effects have been exacerbated by the state's responses to COVID-19 in LTC.

Although not explicitly stated, the Commission's briefing on the province's LTCHA suggests state-sanctioned precarity:

> [licensees must] limit the use of agency, temporary or casual staff to provide a stable and consistent workforce and improve continuity of care for the residents. That is in the statute. There are no regulations that correspond with that section. (Kristin Smith, in Ontario's Long-Term Care COVID-19 Commission, 2020a, p. 25)

My reading of this excerpt is that LTC facilities are required to have staffing strategies because employment is precarious. However, the state supports exploitation since there are no procedures to *regulate* those facilities in following the statute. In LTC, the state's historical macro racism (historical pattern of racism codified in laws) and sexism are reflected on micro levels. Moreover, as Ross (2016) points out in her analysis, racism and sexism are historically rooted systems of oppression needed to uphold the capitalist system. Here, CDA allows me to bridge the impact of macro level interactions with micro level interactions (legislated understaffing leading to high levels of stress for individual workers; Van Dijk, 2015).

Supporting Ontario's Recovery and Municipal Elections Act, 2020 (Bill 218, *Supporting Ontario's Recovery Act*, 2020, SO 2020, c. 26) was introduced in November, 2020, and is perhaps the most telling state response. This legislation protects anyone at risk of liability who acted "in good faith," effectively shielding negligent LTC corporations from lawsuits and accountability:

> Section 2 of the Act provides that no cause of action arises against any person as a direct or indirect result of an individual being or potentially being infected with or exposed to coronavirus (COVID-19) on or after March 17, 2020. (p. 2)

A contrapuntal and critical analysis of the discourses contained in Bill 218 exposes a hidden agenda: the state provides a layer of protection for negligent actors and is a protector of the private sector, which fulfils the neoliberal agenda of providing minimal support through a market-based approach (Armstrong & Armstrong, 2020).

Rather than disrupting the current LTC system, I propose that the state deployed band-aid approaches during COVID-19 that functioned to protect the status quo. Bill 218 provides a clear example of the state's deep investment in preserving the status quo. LTC's capitalist, neoliberal setup is maintained by providing a safety net to the private sector and implementing inadequate policies. The policy analysis reveals how COVID-19 provided a context whereby I came to understand the detrimental material effects of prioritizing the private sector and protecting the neoliberal status quo at the expense of seniors and care workers.

Apocalyptic Conditions in LTC: "A crisis decades in the making"

In a speech from a Ministry of Long Term Care briefing on April 15, 2020, Dr. Merrilee Fullerton framed the issues facing LTC during the pandemic as an unavoidable crisis, conveying that the government had done everything in its power to respond: "We have acted swiftly and decisively, despite our efforts this virus continues to spread and damage the lives of so many …"

(CPAC, 2020b, 5:16). While defending efforts and timing, the order limiting LTC work (O. Reg. 146/20) was announced one month after an outbreak at Pinecrest Nursing Home in Bobcaygeon, Ontario, during which almost half the residents died of COVID-19 (Government of Ontario, 2021). While Fullerton's speech portrays a caring state, it belies a narrative of seniors who were not afforded protection, as evidenced by the LTC death statistics. Since Fullerton presents outbreaks as natural and inevitable, she absolves the state and its "swift efforts" from any blame (CPAC, 2020b, 5:16).

Fullerton's speech also points to what I see as an insidious reality about the state's unwillingness to care for non-ideal citizens, namely elderly women with disabilities not deemed to be contributing economically along with their racialized caregivers: "We acted swiftly; this is a global situation across the world in terms of long-term care homes …" (CPAC, 2020b, 10:00). The discourses in Fullerton's speech represent who the state deems worthy of protection and attest to the widespread, global devaluation of seniors and their care (Fraser et al., 2020). The way politicians spoke about COVID-19 in LTC normalized the spread of COVID-19 within facilities. For example, Premier Ford commonly referred to COVID-19 in LTC as a "crisis decades in the making" (CPAC, 2020a, 2:45), which I argue is an illogical generalization to divert blame from systemic issues with privatization and the government's mishandling of the COVID-19 crisis, similar to how Fullerton naturalized outcomes in her speech from April 15, 2020 (CPAC, 2020b).

Moreover, to gain wide acceptance of the deplorable conditions in LTC, Conservative politicians played on Western cultural codes that devalue and demonize seniors. Language used by those politicians reflects rhetoric of a neoliberal state that is willing to sacrifice care for the sake of profit. In a political speech on July 29, 2020, Premier Ford acted as an apologist for the system and private sector when answering a reporter inquiring about massive outbreaks in private LTC homes:

> I just hate painting everyone with a broad brush. We've got the worst scenario that we're facing, we had about 22% homes, which is unacceptable, we had 80% that were clean as a whistle, and they were doing a good job, but the ones that we got the reports, they're being held accountable, it's very simple. (CPAC, 2020a, 22:33)

Rather than acknowledging the systemic problems caused by a neoliberal model of care and sustained by privatization, Ford manipulated discourse by individualizing homes as "bad actors" to be held accountable while constructing the private sector as "clean" and "good," effectively naturalizing neoliberal care as the only sustainable solution. Ford's speech is an example of how the state portrays LTC facilities run by private corporations as superior and advocates for the private sector while minimizing and presenting failures as individual rather than systemic issues.

My analysis of the data broadly noted manipulative rhetoric, advocating for the wide acceptance and normalization of the neoliberal model of care as the only ideal system. Moreover, politicians' discourses contained in the text and talk I examined as part of my study emphasize some topics at the expense of others. LTC facilities that experienced COVID-19 outbreaks were constructed as "a few bad actors," while the broader issue of a neoliberal privatized system was minimized or ignored.

The Expendability of Life and Depoliticizing of an Ongoing Crisis

Stall and colleagues (2020) studied LTC in Ontario between March–May 2020 and found that LTC facilities were underprepared for COVID-19 outbreaks. They investigated the factors that allowed the virus to spread and drew attention to the physical infrastructure of LTC facilities. Moreover, they noted that the 1972 Nursing Home Act was amended in 1988 to allow shared accommodations for only two people but that LTC facilities with the highest death rates during COVID-19 were private and followed improper design standards that had more than two residents per room. The Commission's transcripts (Ontario's Long-Term Care Covid-19 Commission, 2020a, 2020c) describe loopholes in legislation allowing for improper design standards:

> Long-Term Care Home Design Manuals apply only to homes built or redeveloped with Ministry funding … so the Design Manual does not apply to homes unless by way of a Development Agreement, and Development Agreement means we are paying for it … The older homes, they don't have to comply with the Design Manuals. I mean, you know, whatever, it is what it is. (Michael Orr, in Ontario's Long-Term Care Covid-19 Commission, 2020a, p. 59)

A contrapuntal examination reveals the state conforming to design standards fitting the privatized agenda of keeping facilities at high occupancy. Ontario's Patient Ombudsman report (Patient Ombudsman, 2020, p. 16) noted, "Many COVID-19 residents were in 4-bed rooms," exposing the state's ties to the private sector and cost-cutting measures that lead to a greater risk of exposure to the virus.

Moreover, in the Commission's briefing with the Ministry of LTC on the CAF, speakers from Ontario Health, an organization that oversees the administration of the province's healthcare system, referenced issues that LTC facilities experienced, including inadequate PPE and understaffing, which I argue were caused by neoliberal policies: "in terms of requiring homes to have X weeks of supply of PPE, that would not have been an existing requirement" (Brian Pollard, in Ontario's Long-Term Care Covid-19 Commission, 2020c, p. 32). This lack of oversight in regulating PPE to address outbreaks highlights an underlying narrative that contradicts discourses of care found in state interventions (policies, orders, and reports).

Many discourses held in the reports and briefings I examined contained historically situated racist undertones: "Many of the staff members who contacted [the] Patient Ombudsman were concerned about their access to appropriate PPE and the impact that [lack of access] would have on the people they cared for" (Patient Ombudsman, 2020, p. 21). Here, racism is evident as LTC staff are predominantly racialized women, who are not afforded appropriate PPE to protect against the virus. The discourses contained in care workers' voices in the Ombudsman's report allude to the historical devaluation of seniors and their caregivers, racialized women (Armstrong, 2020).

Discussion

To maximize profit, corporations that own LTC facilities in Ontario cut staff and supplies prior to the COVID-19 outbreak, leading to inadequate care and under-resourcing. The CAF report described a general culture of fear among staff who were afraid to access supplies for care and the impacts of under-resourcing for residents:

> [There was a] general culture of fear to use supplies because they cost money … Key supplies are often kept under lock and key, not accessible by those who need them for work … residents who routinely soil their bed despite incontinence products are not

> permitted to have an extra soaker pad or towel in bed to help protect sheets and blankets from soiling. (PSWs are afraid for their jobs on this issue.) (CAF, 2020, p. 4)

This excerpt illustrates how management created fearful environments for staff who feel unsafe in advocating for residents. This demonstration of fear parallels Daly and colleagues' (2011) finding of the "diaper policy" and staff fearing for their jobs if they took extra diapers and treated residents humanely. This mistreatment contains discourses of the expendability of life. To allow for and promote such treatment, the state dehumanizes residents and staff by viewing them through sexist, racist, ageist lenses.

I propose that privatization and the neoliberal system in which LTC operates in Ontario cannot be understood outside the context of insidious systems of oppression such as ageism, classism, heteropatriarchy, and racism. The data I analyzed demonstrates that the state views itself and acts as a protector of the private sector and is accountable to for-profit, private corporations rather than to the fragile seniors living in a system that makes them vulnerable. This role of protector was justified by the state because it constructed the lives of seniors and racialized women caregivers in LTC as disposable and influenced discourses to appear caring and to gain acceptance of the mistreatment (Macías, 2010; Van Dijk, 1985).

This study uncovered how deplorable conditions continued in LTC facilities in Ontario despite lessons from the first wave of COVID-19 and warnings from developments in other countries. The CAF report (CAF, 2020), the Commission into LTC (Ontario's Long-Term Care COVID-19 Commission, 2020), and the Ombudsman's report (Patient Ombudsman, 2020) all noted the horrific conditions brought onto seniors and their caregivers throughout the pandemic; however, these conditions do not exist in isolation during one public health crisis. I argue that LTC issues are historical and part of a broader neoliberal project. Through manipulating discourses and introducing reports such as the Commission's *Final Report* (Ontario's Long-Term Care COVID-19 Commission, 2020b), government officials have led the public to believe that most pandemic-related issues in LTC have been "resolved." In reality, as a result of state intervention, four years into the ongoing crisis, Ontario stands in the same place as it did during the first wave. Because policies were inadequate in protecting LTC and the CAF intervention was only temporary, thousands more residents died in deplorable conditions during successive waves of COVID-19.

When the "plague" entered Ontario's LTC facilities, the state implemented seemingly protective policies that had the latent purpose of protecting an ideological economic system: the neoliberal status quo in senior care. Despite multiple reports recording brutal conditions, the state has gotten away with committing and supporting deplorable acts. For neoliberal democracies to maintain power, they treat life as expendable through hegemonic discourses and implement policies that normalize dire conditions. In addition to influencing discourses that portray the neoliberal model of care as supreme, the state also implicitly declares that certain life is expendable, substantiated by the conditions discussed earlier and connected to the larger project of neoliberal capitalism (Ross, 2016). Responses to COVID-19 in LTC speak to the age-dependent value of life, and the devaluation of elderly disabled women and their racialized caregivers.

Crenshaw's (1989) critical race analysis of gendered violence explores how the process of racialization, classism, and other axes of power intertwine with gender to influence individuals' experiences. The devaluation of care workers and residents and maltreatment by the state during the pandemic occurred at these intersections. Crenshaw noted that white supremacy is a gendered phenomenon and examining Black women's experiences is crucial to understanding how women

become raced (Francis et al., 2016). Crenshaw also noted that structural intersectionality highlights how women of colour experience layered violence differently from white women, and their experiences are often unaccounted. Feminism, as a theoretical underpinning of my study, without intersectional, critical race, and Black feminist lenses would disregard the unique experiences of racialized and Black women who were forced into precarious work and were not afforded state protection from COVID-19 (Harris, 2020).

Macías (2010) discussed the philosopher Giorgio Agamben's work, which substantiates this finding. Agamben wrote about the expendability of non-ideal life and the spaces in which it occurs (in the context of LTC, the bodies of those who live in LTC facilities are deemed non-ideal and dispensable). He asserted that national belonging is negotiable and that life deemed "non-ideal" outside of the political community is "devoid of life" (Macías, 2010, p. 11). In the same vein, current liberal and neoliberal societies rely on marking certain bodies as dispensable. To maintain supremacy, they relegate some lives to spaces where they can be contained. Rights are suspended and marginalized populations are not perceived as citizens, which is made legal through state-enacted laws (Macías, 2010).

The relationship between neoliberalism, discourses of protection and privatization, and the construction of life as expendable requires that they are all needed to justify the current LTC system. The reports I examined, consequent to the onset of COVID-19, expose a privatized, neoliberal, capitalist system that caused immense suffering through a pattern of absence of care. The reports best captured the conditions residents suffered during COVID-19 outbreaks; at the same time, they allowed for the state to get away with conducting (independent) investigations but not taking action to implement concrete change. The reports revealed LTC as one way of upholding capitalism. LTC facilities experience the impact of historically situated discourses that are the result of interlocking systems of oppression required to uphold capitalism. The capitalist property-owning class relies on devaluing and othering the identities they deem disposable. As uncovered in the analysis, state interventions relied upon discourses of protection, support, and care.

CAF involvement and the Commission were designed to show major intervention but were really patchwork strategies. I propose that the Commission's *Final Report* (Ontario's Long-Term Care COVID-19 Commission, 2020b) was meant to mitigate the complications it discussed rather than shift policy or abolish for-profit care. As a result, Ontario continued to fare poorly because CAF intervention was only temporary and thousands more LTC residents died in deplorable conditions during successive waves. Long-standing issues leading to COVID-19's spread were seen as resolvable by the state through reports and the temporary deployment of CAF teams.

After the departure of the CAF, poor design standards, staffing issues, and deplorable living conditions remained but the government deemed them responded to. The state reifies its protection for the private sector, the neoliberal model of care, and devaluation of seniors' lives by eliminating LTC from public discourse, masked by reports and interventions. The issues noted by the CAF and discussed in the Commission transcripts cannot be permanently resolved by those interventions, especially since the state has chosen not to act on recommendations (Ontario's Long-Term Care COVID-19 Commission, 2020c). Discourses contained in implementing a Commission and deploying the CAF maintain social control because they deem LTC an area that should not be of public concern (Van Dijk, 1985).

Not the Conclusion: Toward Solidarity and Advocacy for a Better Tomorrow in LTC

This article's objective is to develop a thorough understanding of what happened in LTC during the first waves of the COVID-19 pandemic and why and how mistreatment occurred, and to tell the story of COVID-19 in LTC from the viewpoints of those who suffered the most. The data I analyzed, together with the numerous deaths among residents and staff, shows that the state did not prioritize LTC in its pandemic response plan. Instead, it prioritized a specific neoliberal agenda at the expense of seniors needing care. Epidemiological updates are included above, throughout my study, to demonstrate state inaction and consequently, as time went on, that conditions worsened, and deaths continued to pile up. The study uncovers how deplorable conditions were allowed to continue in LTC by tracing the courses of action the state took to distance itself from failing to protect the LTC sector against the virus.

My analysis demonstrates that the state views itself as a protector of the private sector and is accountable to private corporations rather than seniors. By constructing the lives in LTC as disposable and influencing discourses to appear caring, the state gained acceptance of its deplorable treatment of LTC residents. Many scholars (e.g., Armstrong, 2020) who have studied LTC note the common theme of substandard living and working conditions across Canadian and Ontarian LTC facilities.

Thousands of families across the province are missing loved ones, and the immense loss of life has been unimaginable and difficult to comprehend. I honour the memories of the lives lost to COVID-19 and state inaction. It should not have taken a pandemic that cost thousands of lives to address long-standing critical issues in LTC. Now, more than ever, it is urgent to take COVID-19's teachings and apply them to senior care. We must not wait for another public health emergency to act. LTC residents deserve better.

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