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Voices from the 'Margins' of a Pandemic: Impact of a Lack of Employee Voice on Health and Safety for Community Support Workers During Covid-19

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Abstract

In the context of a community-based participatory project, we interviewed 84 community support workers to explore their experiences through the Covid-19 pandemic; participants highlighted significant workplace health and safety (WHS) concerns that either arose during, or were heightened due to, the pandemic working conditions. Participants detailed their efforts to activate employee voice mechanisms across the 'staircase of voice' (Wilkinson et al., 2010). However, despite significant efforts to employ these mechanisms, participants' messages were not received. This reinforces the importance of both workplace and societal conditions that support both the delivery and receiving of employee voice messages (Romney, 2021). Within the context of significant gendered regimes and poor societal perceptions of care work, the effectiveness of voice mechanisms was diminished, leading to significant erosion of WHS conditions.

Keywords: employee voice, workplace health and safety, care work, community support

Introduction

The relationship between the employee voice and workplace health and safety (WHS) has largely focused on the organisational level of employee voice to identify and mitigate WHS risks (Morrison, 2011, Quinlan et al., 2019). Often, this has focused on easily measured and mitigated physical hazards, which is mirrored in health and safety employment legislation. Consequently, a deeper engagement with the power dynamics that impact employee voice, and the role of the psychosocial work environment in workplace health and safety, are largely understudied.

Arguably, the Covid-19 pandemic has highlighted groups of workers that have previously been marginalised (Hodder & Martínez Lucio, 2021), with the focus on 'essential workers', moving

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beyond healthcare workers to include retail and supermarket workers and domestic and homecare workers. There is also evidence that the pandemic work context has exacerbated tensions in employee's' perceived neglect, and resulted in a negative impact on the meaningfulness that employees associate with work (Kong & Belkin, 2021). Indeed, while many workers became more 'visible' as essential workers, they were made vulnerable to greater risk, with many frontline healthcare workers exposed to severe illness and death from Covid-19, especially in the early days of the pandemic. As a moment in time that seemingly has changed employee-employer dynamics, it is a fruitful context in which explore employee voice, particularly within a group of previously marginalised workers.

This paper presents findings from a large-scale qualitative study on the experiences of the highly feminised workforce of home and community support workers during the Covid-19 pandemic, asking *"how has a lack of employee voice impacted on the health and safety of CSW and their clients during the covid19 pandemic?"* Given that these workers are precarious (Berry & Bell, 2017) during normal circumstances, the question remains how gender discrimination and a lack of voice were impacted during a crisis situation, as seen during the Covid-19 pandemic.

The remainder of the paper is structured as follows: a brief overview of the context of community support work; discussion of previous literature on employee voice, and the context of workplace health, safety and wellbeing within care work; and a description of the community-based participatory methodology and methods used in this research. Thematic findings are presented, before a discussion and implications for future research and policy are offered.

Employee Voice

Employee voice is employed in analyses across organisational psychology, organisation studies, employment relations and human resource management (Budd, 2014), with voice being defined as being the "articulation of individual dissatisfaction", "the expression of collective organisation", "contribution to management decision-making" or a "demonstration of mutuality and cooperative relations" (Dundon et al., 2014, p. 1152). Within employment relations, the notion of employee voice is used to describe the degree to which employees, both individually and collectively, are included in decision making, ranging from task-level to strategic decisions in the workplace (Wilkinson et al., 2014). At a task-level, employee voice is often used as a mechanism to achieve employee engagement, and consequent productivity and performance improvements (Barry & Wilkinson, 2016). Such initiatives are, therefore, focused on organisational outcomes, rather than individual worker outcomes and experiences (Donaghey et al., 2011; Josserand & Kaine, 2016). In contrast, collective voice mechanisms, such as unions and other collective organising efforts, are focused on improving work conditions and, therefore, employee outcomes (Ravenswood & Markey, 2018).

In this context, the staircase of voice (Wilkinson et al., 2010) is observable, with the implications across individual, organisational and sector levels of voice. In exploring these levels, the individual, organisational, national and international institutions that regulate employee voice become highlighted (Kaine, 2014).

It has also been suggested that silence be considered alongside observable voicing (Donaghey et al., 2011; Josserand & Kaine, 2016). A focus on silence may highlight areas where employee voice is ignored, and raises the issue of the hearing or receiving of voice. The importance of psychological safety to both the receiving of voice, and to the 'constructive voice delivery' has also been emphasised (Romney, 2021). From this view, voice mechanisms have to operate in an environment that facilitates employees being heard, and having their voice received, taken up and acted upon.

This nuanced view of the conditions to support voice reiterates the importance of gender regimes and voice, as the groups deemed as not having strong 'legitimate voices' in society are less likely to be received. Care work occupations, which encompass work that involves care processes, such as childcare, teaching, healthcare and domestic work, tend to be associated with feminised work, and with an increasing proportion of migrant workers. Gender regimes that undervalue care and support workers, their skill and experience mean that worker voice is absent from key decisions in funding and care models that have a direct impact on work conditions (Ravenswood & Harris, 2016; Ravenswood et al., 2018). Gender regimes are the same practices and norms that have long rendered care work as low status and low value work (England et al., 2002; Folbre & Nelson 2000; Palmer & Eveline 2012). Indeed, Ravenswood and Harris (2016) argue that gender and class intersect to confine care employees to be stereotyped as workers who are low-skilled, lacking in agency, and independence. However, Ravenswood and Markey (2018) claim that these same gender norms limit employee voice opportunities and outcomes for aged care employees. In other words, there may be some voice mechanisms at a workplace level related to WHS, but their focus, usability or the way in which they are followed up by managers is, in practice, limited.

Employee voice is the result of interaction between workplace, sector and national regulation (Marchington, 2015), and, therefore, occurs within a wider institutional, regulatory and organisational context (Kaine & Ravenswood, 2019). In a care work setting, this context is mediated by gender regimes (Ravenswood & Markey, 2018) which see care work as low status and low value (England et al., 2002; Folbre & Nelson, 2000; Palmer &Eveline, 2012), and/or intrinsically motivated (Ravenswood & Harris, 2016). Therefore, the voice of support workers is often excluded from decisions across the voice spectrum, from sector-wide funding models to organisational workload allocations.

WHS in community support work

The nature of the care work setting poses unique challenges for WHS. To date, research has focused more on identifying the frequency of injury incidences than on identifying hazards specific to the setting of the homecare setting (Macdonald et al., , 2017). Moreover, as the care takes place in a client's personal residence (an uncontrolled environment), it is difficult to provide the same standardisation of a clean and safe work environment as in a hospital or institutional environment (Amuwo et al., , 2013; Arlinghaus et al.,2013; Chalupka et al., 2008; Craven et al., , 2012; Lang et al., 2014).

In contrast to an institutional setting, WHS is impacted by the isolated nature of this work. Some argue that the perceived lower status of this care work, due to its location in private homes and isolation, has the effect of support workers (and others) tolerating hazards that would not be acceptable in a hospital environment (Markkanen et al., 2014). Hazards in a client's home are varied and may include cluttered or unstable walking areas through to violent neighbourhoods (Amuwo et al., 2013; Chalupka et al., 2008). Compounding this situation is the fact that most community support workers work alone with no immediate back up available.

This makes it difficult for a support worker to either avoid the WHS hazard or to leave their work and seek treatment in the case of injury or accident (Chalupka et al., 2008). The nature of home and community based care is necessarily mobile (Fitzpatrick & Neis, 2015), with community support workers required to travel from one client to another. This extra dimension to the work exposes workers to driving related hazards, timekeeping pressures as well as issues related to stress, fatigue and lack of time to follow WHS procedures correctly.

Although it has not always been a focus of WHS research or policy, the work environment – including workplace policy and culture – has a direct impact on WHS outcomes for community support workers. The effect of heavy workloads, rushed schedules, grief at the loss of a client, poor workplace relationships, lack of training and support can directly lead to poor decision making by employees (Andersen & Westgaard, 2015; Lang et al., 2014). It is also connected to poor mental health and physical issues, such as musculoskeletal disorders (Cloutier et al., 2008; Faucett et al., 2013).

Although WHS hazards and outcomes for community support workers have been noted, there is less research that explores how employee voice impacts the WHS of community support workers. This is despite many requirements in New Zealand, Australia and other countries to have worker participation in WHS in the workplace. Indeed, there is some suggestion that including support workers in all elements of WHS, including client care plans, can enhance the safety of both worker and client (Palesy, 2018; Palesy & Billett, 2017). In contrast, a lack of being heard leads to community support workers making unsafe decisions and avoiding reporting concerns or incidents (Dellve & Hallberg, 2008; Gong et al., 2009; Larsson et al., 2013).

Background: Carework & Covid in a New Zealand Context

Employee voice in New Zealand.

Farr et al. (2019) propose a model for how workers can have voice and authority in WHS decisions. This model includes structural, social, political and organisational levels of analysis. All of these levels interact around the power of the actors involved, i.e. workers, employers, society, and government. In the context of community support in New Zealand, the power of workers to be heard rather than silenced is potentially low. In terms of the regulatory environment, there is formal regulation to consider as well as the funding and indirect employment model of community care.

The New Zealand regulatory framework, specifically the Employment Relations Act (2000) is underpinned by a voluntarist approach to collectivism, which impacts the tendency towards a unitarist approach to the employment relationship (Geare et al., 2009).This approach tends to align to an individualised approach to engagement whereby the employee needs to engage directly with their employer, or find third-party advocacy (Dundon & Gollan, 2007).This individualised approach is mediated by the prevalence of small enterprises and organisations within the New Zealand context, where it has been found that the unitarist approach may result in moderate involvement in employment decisions for employees (Foster & Farr, 2016). Therefore, within a New Zealand context, individualised voice mechanisms are normalised. The Health and Safety in Employment Act (2015) does place more responsibility onto businesses to enable worker representatives. However, the employer can determine the form of participation and can also decline workers' requests for a health and safety committee in some circumstances, for example, if the business has 20 or fewer employees and is not a high-risk industry or the employer believes that their health and safety participation systems are adequate. Therefore, while the Act increases employer responsibility (direct and indirect) for WHS (Anderson et al., 2017), the inbuilt ability for employers to deny committees – a key form of representation – indicates some lack of political will for hard regulation (Farr et al., 2019). Additionally, the Accident Compensation Corporation employer schemes means that some employers in this sector operate under a "Partnership programme" where they are responsible for monitoring and reporting on any health and safety incidents raised by workers. This model assumes that workers are empowered to raise concerns within their workplace and, indeed, places an obligation on workers to do so (Worksafe, 2022). As has been noted previously, the care and support workforce has been silenced through the funding and regulation models that apply (Ravenswood & Kaine, 2015; Ravenswood & Markey, 2018). Furthermore, at an organisational level, managers tend to perceive workers in care and support roles to be less able, and less agentic (Ravenswood & Harris, 2016). In a context of individual approaches and only some willingness on the part of employers (Foster & Farr, 2016), this potentially reduces the ability of workers to have a voice that is both effective and addresses their WHS concerns (Ravenswood, 2011; 2013).

Community Support work in Aotearoa-New Zealand

In New Zealand, in a total of 70,000 plus care and support workers, approximately 15,000 are in home and community support. Within the New Zealand context, these workers are generally referred to as community support workers and provide care to a wide range of people in their homes, including older people who need support to live independently, people recovering from illness and accidents, people needing palliative care and people requiring disability support. They work for numerous community support providers who contract their service to multiple government agencies, including regional health authorities, Accident Compensation Corporation and the Ministry for Social Development.

The 2017 Pay Equity Settlement in New Zealand recognised that low wages and training opportunities for community support workers were created by historic gender discrimination. This systemic discrimination has resulted in the role and work of community support workers being regarded as low status. Little is understood about their skill and the work that they do, by those at multiple levels, including those at the policy making level. Existing gender inequalities are compounded by the lack of visibility of these workers and their work as they carry out their jobs, without backup, in people's private homes. This work context means they often have inadequate space and technology and work in unpredictable neighbourhoods and households. Furthermore, they have a complex range of clients with sometimes vastly different needs. As identified by Quinlan et al., (2015), the isolated, contractor-like roles of the agency workers in this sector leaves them in a vulnerable position where they are unlikely to seek help, even when at risk of physical, emotional or sexual harm. Indeed, the risk of harm from clients, clients' families or household members is not well managed or understood by managers or employers (Ravenswood et al., 2018).

Covid-19 Response and Community Support Work in New Zealand

Mirroring many other parts of the world, New Zealand's first case of Covid-19 was reported in late February, 2020. By late March, cases had been growing so quickly that the New Zealand government introduced a four-level alert system, with the country moving to the highest level of four on 24th March 2020. This level represented a complete lockdown alongside a stay-at-home order for all but those deemed ‘essential workers’. For the four weeks that followed, essential workers were required to carry documentation to verify their status, with police carrying out random checks of those travelling outside of their immediate home locations.

This approach was the beginning of the s Government’s ‘elimination strategy’, which aimed to keep Covid-19 out of New Zealand until effective vaccines were available, and the immunity of the population could be built up. This strategy was maintained until late 2022, when the levels of vaccination in the country reached over 90 per cent and it was no longer possible to prevent transmission of later ~~the~~ variants of the disease. In the intervening two years, New Zealand experienced multiple lockdowns due to breakout cases as well as complete border closure to all except returning citizens and permanent residents.

There is little data on how many healthcare workers were infected in the workplace in the early days of the pandemic. What is known is that 11 per cent of all total Covid-19 cases were healthcare workers, with more than 57 per cent having been infected at work. More Healthcare Assistants were infected than workers in other health occupations in New Zealand (Ministry of Health, 2020). While community support workers were classed as essential workers, it has been difficult to find information from the early days of the pandemic about whether they were allowed to undertake a full range of tasks, as officials focused on providing information to what were deemed ‘core’ health services. This focus also meant that, initially, community support workers were not provided personal protective equipment (PPE) (Mandow, 2020), as it was assumed their work was closer to domestic than acute in nature. Additionally, a general shortage of PPE saw the available stocks being directed towards core health services.

Research Design

Using a community-based participatory research (CBPR) methodology, we conducted in-depth semi-structured interviews with 87 participants and participant researchers to explore the experiences of community support workers during the Covid-19 pandemic in New Zealand. Participatory action research methodology was used because it generates contextual knowledge about specific communities’ needs (Aragn & Castillo-Burguete, 2015). Community-based participatory research emphasises the equity of community and academic partners to ensure mutual benefits and minimise the risks of the perpetuation of inequalities through the research process. This ensures that the voice of community partners is central to all phases of the research process (Nicolaidis & Raymaker, 2015). The partners in this project were two unions that represent the community support workforce in New Zealand – the Public Service Association (PSA) and E Tū.

The university researchers, E tū, and PSA worked collaboratively to identify the community need and project design as well as assisting in the recruiting of community support workers to take part in the research. The union partners recruited participants by approaching delegates and sharing research advertisements in member networks. Snowball sampling was also used, with some participants sharing the research with other support workers. To take part in the research, participants needed to self-identify as community support workers, and have experience working during the Covid-19 pandemic and consequent lockdowns.

A total of 87 participants were interviewed throughout 2021 for this project. Aligning with the CBPR approach, in the first phase, a group of 18 community support workers were initially recruited, interviewed using an in-depth semi-structured approach, and then trained as participant researchers (PR) by the university research team. In the second phase, the university researchers and participant researchers interviewed a further 69 participants. Of these 87 participants, two were not union members, with union membership information not known for a further 13.

Participants reflected the composition of the workforce in community support, although demographic information about this workforce is limited, HCHA (202) reports that women (93 per cent) of Pākehā descent (82 per cent) make up the majority of the home care support workforce; with 55 per cent of the workforce aged 55 years of age and over, and with very few under 30. Private providers oversee approximately 70 per cent of the work in home and community support (HCHA 2020). Most participants (51) were employed by for-profit organisations while 34 worked for not-for-profit care providers. The participants included 84 support workers, and three participants who worked in adjacent roles including coordinator, service manager, and community worker. While the research primarily focused on support workers in home and community care (58), there were also 18 participants in disability support services, and eight in organisations classified as other (generally offering both home and disability support).

Participant researchers were able to carry out as few or as many interviews as they preferred, with some choosing to recruit their own participants for interviews. In-person interviews were carried out where possible, however, with the rapidly changing pandemic situation and rural locations of some participants, most interviews were carried out via zoom and phone calls.

The interviews were semi-structured around two core issues: 1) what wellbeing meant to participants, and how wellbeing was linked to their work, and 2) how their experiences as community support workers through the Covid-19 pandemic impacted or enhanced their wellbeing. The interviews were sufficiently structured to allow the participant researchers to feel a sense of confidence in interviewing while ensuring all questions were open and not leading participants. Some participant researchers chose to follow this interview schedule while others had a more open conversation, guided only by the two themes above: understandings of wellbeing and experiences of wellbeing during Covid-19.

Data analysis followed Braun and Clarke’s (2006) six phases of familiarisation, coding, generation of initial themes, developing and reviewing themes, refining, defining and naming themes and writing up. Our analytical approach was both sequential and recursive (Braun & Clarke, 2006), with each phase building on the previous, but also earlier phases being revisited as later themes and patterns arose. We carried out the analysis in three sets: independent analysis of selected transcripts to agree on coding and theming; independent coding of the entire dataset, collective agreement within core research group on codes and formation of themes; and finally agreement on themes with the participant researchers and research partners.

Findings

Analysis of the full dataset resulted in a number of themes relating to poor WHS outcomes during the pandemic within a context of constrained employee voice. These increased pressures during the pandemic resulted in a number of negative WHS outcomes, including increased fatigue, increased risk of accidents, and exposure to violence. Each of these are discussed in turn.

Fatigue and Exhaustion

Many participants experienced significant fatigue and exhaustion throughout the pandemic and made specific reference to symptoms associated with burnout, such as apathy, difficulty sleeping, and heightened anxiety. Many others reported being *'tired'*, *'worn out'* or *'had it'*. For some participants, this fatigue came from additional tasks and measures required to protect their own health as well as that of their clients and families:

> *So you know, you work more than one shift, you've got to shower, get undressed in the garage, you know. Come in and shower, washing your clothes, disinfect and wash your clothes – before you touch a door handle. It was like you had got a bit of what's that disorder where you are – obsessive compulsive disorder. But you had to do that and you know, by the end of the day, if you did three shifts in a day, you were sort of exhausted from just keeping yourself safe and keeping your clients safe, just with keeping yourself clean and your clothing clean* (PR10).

While many participants described feeling exhausted, they also struggled to find space to take breaks. Participants described how, during this period, they felt pressured to work, even when they were unwell or on leave. This resulted in a feeling that there was no opportunity for rest or recovery. For example, one recalled:

> *And we're saying well, we're sick. You don't want us going near clients while we sick. We were obeying your rules. You're telling us to say home. Yet we've got your coordinators ringing us saying when are you coming back?* (P63).

Another participant who had a health condition that made them vulnerable to respiratory illnesses describes the reaction to taking breaks to protect their own health:

> *It's just really hard to have asthma at the moment... And they are like, quite rude and mean when I say I don't want to take on shifts or when I say that I'm feeling faint, and I can't work in this. They tell me that I still have to do it. I still have to, you know, just take a quick rest and keep on going. Yeah* (PR3).

Many participants described feeling ongoing pressure to take shifts on their rostered days off. For example, one noted *"Yeah, I am running on empty, and what I find stressful is when I suddenly get phone calls asking me to work on my days off"* (P61).

As a result of increased pressure to work, alongside additional infection control tasks carried out around and during work time, participants noted the erosion of their ability to achieve work-life balance. As one participant noted: *"So the problem is getting a work/life - the work life thing right. But during the lockdown, I was so busy I had no time to do anything on the farm. It all got neglected"* (P12).

Participants themselves linked this erosion of work-life balance to their wellbeing. Some also saw this as a sector-wide issue rather than one of individual working conditions:

> *The work life balance has to be and I guess I just haven't had a wellbeing. I'm quite burnt out because I just don't care about it terribly much at the moment. But there has to be a balance. And in this industry, there is no balance as far as I can see* (P23).

Increased Risk of Accidents

Some participants described suffering workplace injuries during this period. Workplace injuries within this sector are an ongoing issue (Ravenswood et al., 2021), participants described how the lack of resources and adequate flow of information was exacerbated during the pandemic, heightening this risk. The risks were often linked to a lack of adequate care plans, combined with unfamiliar carers not well matched with the care required, due to absences. For example, one participant noted:

> *I had a workplace injury. I've had the manager on record say the house, that it is a dangerous worksite. And I say well, why isn't this written in the notes and where is the care plan and she goes, 'what – no care plan? Where's the care plan?* (PR15).

Another participant described a situation where they were allocated to a client whose physical needs were such that they required hoists and lifting, which the support worker had not been provided or advised of: "It was a work accident, because I was placed within a home where there should have been hoists, and there should have been better matching of the carers. And I've ended up with two bulging discs in my spine" (PR18).

Other participants described how, even if they were injured, the pressure to work was such that they would avoid seeking proper medical attention rather than run the risk that their client may not receive the needed care: *"But still we kept on working. Because if we go for A&E and if they are going to put us off work for a week, we don't know who's going to cover – that will be so so, so hard"* (PR5).

Exposure to Violence

Participants also recalled times they were exposed to workplace violence. While it was acknowledged that this was always a risk when working across many different homes, often with complex needs, participants did describe how, during the pandemic, the stress on individuals impacted client behaviour and risk at times. For example, one participant recalled:

> *One woman actually assaulted me. And I went back and said to them that my family don't want me to work for her because my brother and that was here, and he would say you are not going to go and work with her again* (P67).

For some, the cancellation of clients' regular activities caused behaviour change, as highlighted in the following:

> *It was his behaviour changed because the things that would normally calm him down, like going out, going to McDonald's, something like that. That didn't happen because McDonald's wasn't open... I could see it coming about an hour before it happened. So, we were on the phone. I was safe. I was kept safe in a locked room. But that's not how you want to spend your work* (P50).

Other participants described how some clients became aggressive because of their concern around catching covid. One participant described:

> *So this lady and her daughter was at home this day, and she just ripped into me with the theory... [that] I was more likely to bring Covid into their house, than anybody*

> *also because of my age and she didn't want to see me again in the house. So that really upset me. I was really trembling, to be honest – a bit shaking* (P35).

In response to these poor WHS outcomes of exhaustion, fatigue, increased risk of accidents and exposure to workplace violence, participants did attempt to employ a range of voice mechanisms. The mechanisms described were across the individual, organisational and collective levels.

Individual-level mechanisms

At an individual level, participants described seeking information from specialised sources – because their employers did not provide sufficient guidance – which they, then, passed onto other support workers:

> *And I actually did reach out to an outside source at the hospital and asked for information. I said, look, this is just getting bizarre. As a union delegate, I'm getting people ringing me. I now need answers because, we've got some very irate and frustrated staff* (PR11).

Other participants wrote to both employers and local members of parliament in order to highlight concerns. As two participants describe: *"So anyway, I wrote to **, our local, New Zealand First MP, and he took the lead to caucus, and it got given to the Health Minister"* (P18). However, participants also recognised the limits of their individual efforts, encapsulated by the following: *"I don't know if they will listen to my voice"* (P60).

Organisational-level mechanisms

Some participants used organisational-level mechanisms to raise concerns. Some of these concerns were raised privately by the individual, such as: *"I actually wrote to my employer and complained about it"* (P36). Other participants described raising concerns in workplace meetings:

> *And we did have a meeting, not about Covid or anything and I thought I would go to one of our meetings over in [town name]. They just didn't even want to talk about it – the PPE situation. They just ignored me* (P1).

Efforts to employ voice mechanisms largely appeared to remain *unheard* or, if heard, did not result in actions on the part of the employer that validated these concerns. For example, one participant noted:

> *Yeah, we just basically got told to shut up and do it. It's on your roster to do it… So it must have got to some ears. I think it must have because I know there was a couple of other support workers complained about the same thing* (P36).

In addition to feeling unheard, participants also expressed concerns about the underlying messages in communications from both employers and at a governmental level, feeling these reinforced a perceived lack of value from employers and the government.

"there were several emails that came out. I think, remember thinking almost patronising in a way. As if – and treating us as if we were stupid" (P11).

Some participants felt that their employer should have been amplifying their voice, particularly given the WHS responsibilities within the context of a public health response:

> *I was disappointed that our employer would not take more of leadership there and just stepping up for us workers and saying, 'look, even if the government doesn't actually recommend or say we need to wear a mask, we think we should go on the safest side became the safe thing we can, because we do not really understand yet what that Covid is all about'* (P5).

For many, this lack of consideration of their needs resulted in participants taking their own precautions, feeling these were at odds with the direction they were given, but out of frustration for not being heard: *"But then there were times when you had to take the ball into your own hands and say f*ck what the government says… Bugger what [my employer] says. I'm taking my own safety precautions"* (P8).

Collective Mechanisms

Participants described employing union action and organising as a voice mechanism. In particular, participants felt that the lack of voice was most pronounced at the policy and central, Ministry of Health levels, given the otherwise regular and ongoing communication on many other pandemic-related issues, typified by the '1pm updates'[1]. Participants felt that attention and voice was given to a range of groups during this time, yet no attention paid to support workers;

> *…they're invisible almost especially to government. That was obvious with the director general last year. He acknowledged doctors and nurses but not the support workers in one of his first major television interviews – not interviews. But anyway, when he was on TV, and he completely missed out support workers and later on he started bringing them realising how important they were in the community* (P68).

Many participants felt that, as a workforce, their key voice was achieved through the unions, *"We've got delegates. We have a vocal voice"* (PR 15).

Participants highlighted how both the organising capacity and the access to decisionmakers and media played a role in how this mechanism was deployed. In one example, the union was both lobbying government ministers, and briefing the media prior to press conferences:

> *Yep. So level four, we were emailing all the Ministers on a daily basis to get PPE. We were talking to the media between 10 and 11 every day before the press -one o'clock –[the Director-General of Health] Ashley Bloomfield's press release – so that they could ask questions* (PR7).

Participants did perceive that this level of voice mechanism was heard to a degree, resulting in some improvements, particularly in relation to the provision of personal protective equipment (PPE). For example, one participant noted: *"that was partially our union putting pressure on as well because [union leader] was putting the pressure on pretty much daily,*

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[1] 1pm updates were regular, often daily breifings by the NZ government during the lockdown periods of the Covid-19 pandemic. These were screened on national television and streaming services.

because what was going back to the top brass was not what was happening on the ground" (PR15).

Concluding comments

Community support workers' WHS deteriorated within the context of a public health crisis due to increased workload and increased infection prevention needs. Additionally, they faced more aggressive and challenging behaviours from clients who were, themselves, experiencing the stress of the pandemic. In particular, the crisis made community support workers more vulnerable to poor WHS because their voice was silenced at multiple levels. For example, workers were reluctant to report incidents or risks because they thought no action would follow anyway (Dellve & Hallberg, 2008; Gong et al., 2009; Larsson et al., 2013). This was borne out through the regular experience of being unable to take leave or refusal to work additional hours.

Workers were not entirely silenced however, and actively sought out means to voice their WHS concerns. They did this individually and collectively, engaging at organisational and macro levels (Wilkinson, 2010). Given the circumstances of the pandemic, something that might otherwise have been an issue voiced at the organisational level, for example, PPE, became a WHS issue voiced collectively and at the policy/government level. This is perhaps due, in part, to the pandemic as well as funding circumstances whereby PPE was provided to public healthcare workers, and outsourced institutional care (such as general practices, rest homes) but was deemed unnecessary for home and community support. This indicates the extent to which WHS in healthcare is based on professional and institutional settings failing to account for a potentially more complex situation of care and support provided in clients' homes (Amuwo et al., 2013; Arlinghaus et al., 2013; Chalupka et al. 2008; Craven et al., 2012; Lang et al., 2014).

Despite the regular silencing of community support workers, a range of voice mechanisms were still employed across the individual, organisational and macro levels, demonstrating the 'staircase of voice' (Wilkinson, 2010). However, the mechanisms were not heard in an environment that followed up on community support workers' concerns, therefore, rendering their efforts ineffective. As Marchington (2015) notes, how effective voice is for workers depends not only on the workplace environment but also the macro environment, including employers (as associations, lobbyists) and government regulators. The macro environment, in this case, is complex: a crisis in which all those deemed essential workers were expected to accept some risk in order to continue in their work, which now had elements of service to society; a healthcare occupation that is not only outsourced from the public sector to largely profit-based care providers, but also out of sight as this work is conducted outside of the institutions associated with healthcare, and in clients' homes.

Finally, a highly feminised occupation, based in care work, that has long been undervalued and deemed as insignificant, unskilled work (England et al., 2002; Folbre & Nelson, 2000; Palmer & Eveline, 2012). In this case, our research exemplifies the way in which multiple macro factors, including regulation such as outsourcing (Quinlan et al., 2015; Kaine & Ravenswood, 2019) interact in a way that results in the silencing of otherwise agentic, capable workers. Not only does this result in national policy which ignores the nature of their work, but it reinforces the attitudes held by employers of this workforce being less capable, and of less value (Ravenswood & Harris, 2016). Although community support workers engaged in multiple individual and collective voice actions at multiple levels (Marchington, 2015; Wilkinson, 2010), this did not culminate in sufficient force to disrupt the systemic power inequality that negatively impacts community support workers' WHS. So, rather than highlighting WHS out of empathy when it impacts others (Heaphy et al., 2021), the negative impact of the pandemic on community support workers' WHS was systematically ignored, and their voice silenced.

Limitations of the Study

While a core part of the CBPR methodology, the co-design and partnership approach with unions in the study may have limited the range of participants who volunteered to take part. Although participation was open to any community support worker, it is acknowledged that the use of union communication channels made it more likely to recruit union members rather than non-union members. Additionally, data collection predominantly occurred during 2021 largely before the introduction of vaccine mandates. As such, the impact of vaccination mandates, which came into effect during 2021, on this workforce are not a core part of this dataset.

Implications for Future Research, Policy & Practice

The study holds implications for future research, alongside recommendations for policymakers and employers. This research highlights the importance of understanding the role of worker voice in WHS outcomes in the context of a dispersed and marginalised workforce, utilising the example of a specific workforce context. There is still much to be explored in terms of researching this link across other groups of workers, industries and even country contexts. There is also significant potential in investigating the impact of worker voice on specific aspects of WHS outcomes, for example, in the specific case of workplace violence.

This study also holds implications for policy and practice. For policy makers, this research highlights the opportunity for community support workers' voice to be implemented and become core to service provision models at multiple levels of the sector, from workplace health and safety, care plans, training and career development, to sector wide strategy and policy. At a sector- and employer level, this research demonstrates the importance of reducing the impact of exhaustion and burnout on community support workers through guidance, supervision and debriefing service provision to support workers and regular training on working through difficult situations. There is also a need to initiate mechanisms to include support workers in care plans for clients, enabling them to make recommendations when changes are made.

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