

THEORIZING PRECARIZATION AND RACIALIZATION AS SOCIAL DETERMINANTS  
OF HEALTH: A CASE STUDY INVESTIGATING WORK IN LONG-TERM RESIDENTIAL  
CARE

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## **Abstract**

This thesis uses anti-racist and feminist political economy of health perspectives that intersect with immigrant status, in order to analyze the findings from a single-case study investigating the social determinants of health and work precarization in a residential long-term care (“LTC”) facility in Toronto, Ontario. Throughout this dissertation, I use mixed methods case study to investigate social, political, and economic implications in the lives of health care workers. Observation, interview, and survey methods were utilized to investigate workers’ health in relation to the precarization of work. Specifically, I used the concept of precarization as a lens to track the ways in which work relations impact the other social determinants of health. The main areas of focus include the intersections of gender, work, and occupational health with race, immigrant status, and culture; the ways in which precarization affects employees in this specific health care sector; the implications of precarization in the health and wellbeing of workers and their families; the role of (un)paid care work and social support provided by family members; and the exercise of strength, resilience, resistance, agency, and coping strategies. Broadly, I will argue that precarization in LTC is an increasingly experienced phenomenon, and that various levels of precarization are experienced by particular workers who are women, racialized persons, and immigrants. This study contributes to our understanding of racialization as a social determinant of health, and analyzes the health impacts of workplace inequality through the lens of precarization. The study makes the case for closer attention to racism and precarity both on and as social determinants of health.



**Dedication**

This dissertation is dedicated to the vulnerable women, children, and men around the globe who are faced with numerous forms of social exclusion; those who experience daily struggles in both paid and unpaid work; and those who experience multiple forms of political and economic oppression.



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## Chapter 1: Introduction

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### *Overview of the Topic*

“I don’t have off days. [...] I work every weekend, every day. [...] 7 days a week.”  
(Participant 4, Nurse, Female, VM, F/T).

Research suggests that certain groups, such as racialized people and immigrants, often constitute a significant part of the precarious workforce. These groups experience high levels of contingent work arrangements and job insecurity, and their work arrangement is often part-time or temporary employment (Galabuzi, 2006; Standing, 2011; Das Gupta, 2015; Syed, 2015). These types of work arrangements have been associated with workload intensification, inadequate training, and poor participatory mechanisms needed for effective occupational health and safety (Aronson, 1999; Vosko, 2005; Lewchuk, Clarke, and De Wolff, 2011).

Although it is known that immigrants are one of the main groups who are a part of the precarious workforce and the precariat class (Standing, 2011; Das Gupta, 2015; Syed, 2015), experience persistent poverty (Ornstein, 1996; Ornstein, 2006; Hatfield, 2004), and constitute a large proportion of the working poor (Fleury, 2007), there is limited research devoted to understanding how precarization is connected to particular types of chronic health risks. There is also a need for further research that examines how certain groups are at risk of these health problems, such as racialized and immigrant workers in Canada (Syed, 2014). While precarious work is connected to temporary employment, agency work, (Vosko, 2000; Vosko, 2005), contract cultures, and adverse health and well-being (Syed, 2015; Das Gupta, 2015) through job demand, job control, and employment strain (Karasek, 1979; Karasek and Theorell, 1990; Lewchuk, De Wolff, King, and Polyani, 2005; Lewchuk, Clarke, and De Wolff, 2011), these studies are limited in their analyses for a number of reasons.

Presently there are studies which are guided by a positivist paradigm and are primarily



interested in describing and characterizing risk. For example, a study by Fleury (2007) models “the risk of having low family income taking into account specific personal, demographic, socioeconomic and family characteristics” (p. 49). Other studies have looked at the economic consequences of immigrant workers under-utilization of skills (Reitz, Curtis, and Elrick, 2012), the mental health impacts of immigrant resettlement and employment searches (Khoo and Renwick, 1998; Crooks et al., 2011), and the social consequences of discrimination in the labor market for racialized groups (Galabuzi, 2006; Das Gupta, 2002; Nestel, 2004). However, there are limited studies that focus on the understanding of chronic health risks among racialized or immigrant shift-workers; the connections between labor intensification, psychosocial factors, mental health issues, musculoskeletal disorders, and paid or unpaid gendered work (Syed and Ahmad, 2016); and the personal health practices or coping mechanisms among these groups, especially in highly urbanized and often expensive geographical settings. There is also the flip side to certain phenomena, such as the perception of underutilization of skills. While it may seem that certain groups of highly educated people are underemployed and are underutilizing their skills in brain-wasting jobs (Syed, 2015), the reality might be that the high level of skills they possess are indeed being extracted, utilized, and capitalized at lower costs, which benefits particular structures in the labor process (Gorman, 2018).

Research of the health care sector indicates that immigrant and racialized women have been found to work in high proportions as nurses (Das Gupta, 2002); midwives (Nestel, 2004); personal support workers; and care workers in ancillary roles or as support staff (Boyd, 1992; Armstrong, 2007; Daly, 2013). Studies involving care workers have identified many issues affecting them such as: the invisibility of work (Armstrong, Armstrong and Scott-Dixon, 2008); the invalidation of workers’ skills (Armstrong, 2013); job stress (Armstrong et al., 2009; Zaman,



2012); structural and physical violence (Armstrong et al., 2009; Banerjee 2010; Daly et al., 2011); precarity among ancillary staff (Armstrong and Laxer, 2005); work-related injuries and illness (Armstrong and Daly, 2004); presence of other health-limiting circumstances such as high workloads, labor intensification, task orientation, assembly-line style of work (Armstrong and Jansen, 2003; Daly and Szebehely, 2012); work hierarchies; and strict divisions of labor (Syed, Daly, Armstrong et al., 2016). All of these conditions seem to mimic those found in the literature about precarious work (Syed, 2015), and accordingly, there may be a need to draw upon a broader definition or criteria for precariousness and possibly identify instances of precarity/precarious work through the process of precarization. On the one hand, long term care (“LTC”) facilities are the homes and principal residences of elderly people who require assistance with their activities of daily living. On the other hand, as we shall see in the forthcoming chapters, LTC sites also present themselves as workplaces that have many of the above concerns for their workforce.

There is an increasing recognition that precarious work is a rapidly spreading reality for many people in Canada (Vosko, MacDonald, and Campbell, 2009; Lewchuk, Laflèche, Dyson, Goldring et al., 2013; Lewchuk, Laflèche, Procyk, Cook et al., 2015). As a result, there is a need to contribute to the knowledge of the expansion of precarious working conditions (or the precarization of work); as well as how these conditions are experienced and how they affect the social determinants of health (“SDoH”). This research should include places such as LTC sites, which are known to have precarity among ancillary staff (Armstrong and Laxer, 2005), and private companions (Daly and Armstrong, 2016). While the aforementioned research conducted in LTC homes is vital and important, there is a need for further work such as: investigating how precarization is experienced by focusing on the SDoH; especially among women, immigrants,



and racialized workers; and how precarization might be connected with particular types of chronic health risks, such as shift work and occupational cancers, for example.

There is also a need to address how chronic illness is experienced in the workplace, such as: examining sources of stress; workers' knowledge of shiftwork hazards; mental health hazards; physical hazards; coping mechanisms; and how such issues might be connected with precarization. This research should include marginalized groups who experience adverse working conditions, demonstrate how their health is affected, and investigate what are some of the coping mechanisms in order to decrease the burden of work-related illness and disability. Such studies might incorporate a self-report survey of personal health-related questions, but more importantly, they should assess the physical, mental, social, and psychosocial health outcomes of workers in a detailed, descriptive and qualitative manner.

### ***Research Objectives***

For this doctoral thesis, I have conducted a case study of workers in a single urban residential LTC facility in Toronto, Canada, employing a single-case study design (Yin, 2014; Creswell and Plano Clark, 2011). The purpose of this study is to contribute to knowledge of health and chronic illness among immigrants and racialized populations. This case study aims to make an original contribution to the occupational health literature by exploring adult racialized and migrant (ARMi) persons' social, political, and economic contexts. It is called the POWER study (Precarization Outcomes among Workers and Employment Resilience). I ask broad research questions about the physical, mental health, structural, and systemic factors that influence the lives of health care workers. I also ask how these factors are connected to precarization in their everyday lives and in their lived experiences. There is an emphasis on understanding structural and systemic risk factors of adverse health and wellbeing; forms of



violence and discrimination; examination of social and economic situations; post-migration experiences; experiences of settlement-related setbacks such as transfer of skills and credentials into the Canadian employment system; paid and unpaid gendered work experiences; the ways in which the work may be precarious; and forms of resistance, coping strategies and social support in response to their situations.

### ***Overarching Research Questions***

This study explores the meaning and ideas of precarization in the health care sector, specifically in LTC, and focuses on interpreting everyday paid and unpaid care work experiences in order to contribute to knowledge of health and chronic illness among women, immigrants, and racialized populations. The qualitative and quantitative components of this study have recruited n=42 and n=91 workers employed in a LTC facility, respectively. **The main thesis questions are as follows: How do racialized and immigrant workers experience work in residential LTC? What are the impacts of LTC work on the social determinants of health for racialized and immigrant workers? In what ways do LTC workers experience precarization, both at work and in the broader determinants of health? Are there gender differences?** The rationale for this study is to contribute to health knowledge, which may lead to policies or interventions that minimize the burdens of precarization and chronic illness in the Canadian workplace.

In researching this topic, I use a case of a LTC site in Toronto, Canada in order to explore work-precariousness and the occurrence of precarization. The concept of precarization, and its embeddedness within the broad area of occupational health and safety, serve as key points to understanding the political, economic, and social issues that can determine chronic illness among women, immigrants, and racialized workers. Through the intersectionality of feminist political



economy of health and anti-racism lenses, I unpack the ways in which precarization is experienced in everyday life for workers, and connect this with occupational health and safety research and policy. This single-case design analyzes a number of worker attributes and characteristics such as workers' job titles and roles, and it is organized through major themes, such as: workloads and break-taking; staffing levels; time; stress; physical aspects of work and injury; income challenges and management of budgets; housing; travel time and commuting; dual demands and care; social relations; and resistance and resilience. The data collection and analysis is grounded by theoretical frameworks from feminist political economy of health, anti-racism, and SDoH approaches. The methods that I used to conduct the analyses were qualitative thematic analysis of field notes and interview transcripts; and quantitative data analysis of the demographic questionnaire and exploratory survey data, which occurred with the assistance of Excel, and Statistical Package for the Social Science ("SPSS"). I argue that precarization is an increasingly normative experience because of the subtle ways in which it is injected into workers' personal lives and their work experiences, yet its impact is so profound that it supports evidence of chronic stress and illness among workers.

**The specific objectives of this project are to illuminate the complex visible and invisible work relations in LTC, how it could influence a broad number of the SDoH, and how they are connected with paid and unpaid care work. I explore the SDoH in relation to precarious work, and through the lens of precarization.** It might be the case that precarization is a subtle, but a broadly experienced phenomenon that has social and health consequences that cross multiple boundaries, disciplines, and occupations, meaning that different types of workers might experience it, whether or not they are nursing professionals, managers, or ancillary staff. Additionally, many different categories of workers could suffer its health and



social consequences. For instance, some questions I consider are as follows: do participants earn enough money for their needs? Did they believe they were underpaid for the work they did? Are budgets dependent upon or tied to wages? What happens when there is wage stagnation? What does this mean based on the high cost of living/dwelling in Toronto (particularly the high cost of housing and food)? Are wages reliable/adequate or unreliable/inadequate? An intersectionality approach might suggest that sex and disability status can make people vulnerable to low income and low wages. It might be the case that precarization is a hidden problem, which might affect front line care workers in invisible ways, which is why it could be perceived as a subtle problem. For instance, if these frontline care workers participated in unpaid, overtime work either from home or on the premises, then it might be one of the ways in which precarization is obscured. The other ways through which precarization is obscured, yet could affect a number of workers' SDoH, is through wage-related effects on food security, food quality, and food variability, as well as housing, living, and dwelling circumstances, among others.

If there is precarization of employment, then it could mean there is also parallel precarization in food security, in rent and housing, in health and social care for workers, and in their perceptions about chronic illness and occupational cancer prevention; in immigrant and racialized workers' accommodation and acculturation; in support systems; and in the social mobility of workers. Yet, these issues receive less public attention than lifestyle and behavioral factors such as diet and exercise interventions that are stated to influence worker's health and well-being. The project was designed to be one of re-situating, and re-focusing the inquiry back to the contexts and conditions in which people work; and how people's work fundamentally shapes their health, their livelihoods, and that of their families. I wanted to better understand the ways in which paid health care workers are vulnerable to precarization, what are the challenges



they face, what are their sources of social support, and how these employees exercise resilience and strength.

This research project was designed, interpreted, and guided by feminist political economy and anti-racist feminist scholarship using an intersectionality framework (Varcoe, Hankivsky, and Morrow, 2007; Hankivsky and Cormier, 2011). As we shall see in more detail in the next chapter, feminist political economy suggests that material and cultural discrimination against girls and women are the primary factors that influence their social conditions and health (Doyal, 1995; Armstrong and Armstrong, 2010). Anti-racism scholarship takes into consideration the social exclusion and discrimination often experienced by vulnerable groups based on racial status. Intersectionality refers to the simultaneous experiences of gender, class, race, sexual orientation, body size, or other social differences experienced by women (Varcoe, Hankivsky, and Morrow, 2007). Intersectionality recognizes the limitations of using single identity markers, such as gender, immigrant status, or Aboriginal status, and how these single identity markers on their own would lead to false classification of people that do not reflect their complex, lived realities (Hankivsky and Cormier, 2011). This study also holds a social constructivist worldview that is normative for specific types of mixed methods research (Creswell and Plano Clark, 2011), which has an assumption that individuals seek understanding of the world in which they live and work (Marshall and Rossman, 1995; Maxwell, 1996; Mertens, 1998; Creswell 1998; Creswell, 2003; Creswell and Plano Clark, 2011).

### ***Precarization as a Lens for Investigating the SDoH***

When we think about precarity, precarious work, and precarization, it may conjure up images of sweat shops in foreign lands, intensive working conditions, overworked employees, and daunting images of worksites such as those inspired by Upton Sinclair's (1906) book entitled



*Conditions of Meat Packing Plants.* The problems of precarity, precarious work, and precarization, however, are inherently contradictory. They are global, yet they are also present here in Canada; they are noticeable and apparent, yet they can also be obscured and subtle. Nonetheless, precarity, precarious work, and precarization have not achieved a heightened status to warrant crisis levels among governments and policymakers and in fact, these latter groups have normalized it. It was reported that when the Federal Finance Minister Bill Morneau was asked to comment about precarious work in October 2016, he suggested that Canadians should get used to it (Chartrand, 2016).

Precarity, precarious work, precariousness, precaritization, and precarization are concepts that might be a source of confusion because they are often used interchangeably (e.g. Holdcraft 2013; Schierup, Alund, and Likic-Brboric, 2015; Kasmir, 2018; Lain, Airey, Loretto et al., 2018), but in fact, they can be differentiated. For instance, precarity and precarious work, in their traditional meanings, are usually very specific to certain types of labor conditions. Precarity and precarious work are unequally distributed, and affect only certain workers who are marginalized, poor, and disenfranchised; whereas precariousness is a generalized human condition in which everyone is vulnerable (Butler, 2004; Kasmir, 2018). For example, stable unionized workers, such as high-paying, full-time autoworkers, can be vulnerable to precariousness if their plant is closed and layoffs are imminent (Kasmir, 2018). Kasmir (2018) further adds precaritization to this mix of terms, and claims that precaritization changes class relations, collective identities, and politics. Kasmir (2018, p. 1) states that together, these concepts refer to the lack of “stable work and steady incomes”.

In this dissertation, precarization and precaritization are understood as similar concepts that have some of the characteristics of precarity and precarious work, but there are some



nuances. Precarization, (or precaritization) can be thought of as a process, such as a continuum with different levels of precariousness (from low to high), and it can be applied to many categories and classes of workers.

Precarization has been understood as a global movement (Schierup, Alund, and Likic-Brboric, 2015). Like precarity and precarious work, precarization can be characterized by labor intensification (Standing, 2011). In addition, precarization seems to share similarities with proletarianization. Proletarianization is a Marxist concept that has a negative reputation (Wright and Singelmann, 1982). It sees work as becoming degraded, more routinized, with less autonomy (Wright and Singelmann, 1982), and with downward mobility of middle-class occupations, such as clerical workers, in terms of income, skill, prestige, power, or property, and irrespective of people's awareness that it involves them (Mills, 1956; Glenn and Feldberg, 1977). Over time, it results in an intensification of the labor process (Wright and Singelmann, 1982; Braverman, 1974), and it affects workers politically, economically, and psychologically (Glenn and Feldberg, 1977).

In this dissertation, precarization is understood broadly, and includes political, economic, social, and health domains. Precarization, as a process, would possibly involve labor intensification, and it would likely mean that workers experience adverse working conditions, which could also affect their SDoH in harmful ways. Precarity and precarious work, however, in their traditional meanings, do not usually apply to all workers, nor are they explicitly connected with the SDoH.

Precarity refers to a particular experience, or state of being. It is one of the key terms that has emerged in academic circles to reflect a global phenomenon related to workers' conditions of employment, their lives, and livelihood (Schierup, Alund, and Likic-Brboric, 2015). The



concept of precarity frequently highlights economic and existential experiences of uncertainty and risk; and it is both an ontological experience and labor condition (Nielsen and Rossiter, 2008). Precarity has been associated with: irregular, low-cost waged work, and micro-entrepreneurship (World Health Organization (“WHO”), 2007; Nielsen and Rossiter, 2008). It is often tied to migrants (Schierup, Alund, and Likic-Brboric, 2015).

Precarious employment is a parallel term that describes a multidimensional phenomenon that has the potential to devastate workers (Louie et al. 2006; WHO, 2007), and affect their health, as well as the health of their dependents and family members (Benach et al, 2000). The WHO (2007) defines it as the following:

“Precarious employment can be described as the lacking of the relations that support the standard employment relationship, making workers more vulnerable in jobs that are unstable, unprotected and increasingly unable to sustain individuals and families” (WHO, 2007, p. 56).

Precarious employment has traditionally referred to work that is part-time, temporary, casual, seasonal, short-term, self-employed, tele-work, shift-work, contract, or agency work (Polivka, 1996; Vosko, 2005; Vosko, MacDonald, and Campbell, 2009; Standing, 2011; Lewchuk, Clarke and De Wolff, 2011; Law Commission of Ontario (“LCO”), 2012). According to Holdcraft (2013, p. 42), “Precarious workers typically missed out on many benefits associated with full time, ongoing work with a single employer”. Kasmir (2018, p. 1) provides specific examples such as “garbage picking, performing day labor, selling petty commodities, and sourcing task-based ‘gigs’ through digital platforms” such as Uber and TaskRabbit. Precarious working conditions are associated with job dissatisfaction, fatigue, musculoskeletal pain such as backaches (Benavides, Benach, Diez-Roux, and Roman, 2000; Benach et al., 2004), as well as psycho-social aspects of job strain, such as lack of control and lack of participation in decision-making (Parker, Griffin, Sprigg, and Wall, 2002). Precarious working conditions have been blamed on broad events such as the over-production of university graduates; and neoliberalism



based on market competitiveness, which has resulted in labor market flexibility that transferred risks and insecurity onto workers and their families (Standing, 2011). Precarious employment relations have resulted in reductions in the proportion of unionized workers, especially since the 1980s (WHO, 2007), and has left workers vulnerable to income and job insecurity because of limited protections from labor laws, and union agreements (Benach and Muntaner, 2007). However, Breman (2013), and Kasmir (2018) challenge this timeline and suggest that precarious employment has existed for a relatively longer time.

Guy Standing's (2011) work contributes to the literature of precarity and precarious employment in which he suggests that an entire new global class, consisting of millions of people, is emerging. This developing class, which he terms the precariat, is volatile: the people belonging to it experience collective instability and "precariousness" (Standing, 2011, p.3). The precariat class is a heterogeneous group of people, ranging from temporary workers, to students and migrants, but it has not fully developed into a class because of its own internal tensions:

"The precariat is not a class-for-itself, partly because it is at war with itself. One group in it may blame another for its vulnerability and indignity. A temporary low-wage worker may be induced to see the 'welfare scrounger' as obtaining more, unfairly and at his or her expense. A long-term resident of a low-income urban area will easily be led to see incoming migrants as taking better jobs and leaping to head the queue for benefits. Tensions within the precariat are setting people against each other, preventing them from recognising that the social and economic structure is producing their common set of vulnerabilities. Many will be attracted by populist politicians and neo-fascist messages, a development already clearly visible across Europe, the United States and elsewhere" (Standing, 2011, p. 25).

Although the precariat class consists of individuals who experience contingent forms of labor, this is not to state that such a group of individuals is out of power or out of control over its circumstances. The precariat class exercises agency by using its votes or money that is in its possession to give itself voice and it forms a political platform to increase its influence in the world (Standing, 2011). For example, May Day, which was designated as May 1st, 2001 in Milan, Italy, consists of demonstrations and protests by young people, students, social activists, and trade unionists, all of whom demand basic worker rights, security, universal basic income,



and/or free migration (Standing, 2011; Kasmir, 2018). The history of May Day, however, can be traced earlier than 2001. May 1, 1886 marked a day of action in which half a million workers demonstrated protest through strikes in major cities in the United States, including Chicago, New York City, and Detroit (Foner, 1986; Kanowitz, 2008). The working class' demands, which sought improved working conditions, were not tolerated and the situation escalated to violence, and on May 4, police officers indiscriminately shot workers in Haymarket Square, Chicago (Kanowitz, 2008). Today workers continue to seek improved working conditions, express resistance, and exercise agency as in May Day, Battle of Seattle, and Occupy Movements (McNally, 2010; Robinson, 2006; Smith, 2012). Kasmir (2018) claims that the anti-precarity movement was also audible in the 2007/8 financial crisis, the 2011 Arab Spring, and anti-austerity uprisings.

Based on the foregoing review of the literature, one can see that the meaning of precarity or precarious work can be problematic, and there may be a need for an alternative definition. For instance, the meaning of precarity or precarious work might include work that not only has uncertain premises or development and lacks security or stability, but is also dangerous to workers, or threatens their health and safety (Syed, 2015). A review of empirical evidence from a number of studies further suggests that precarious staff tend to be over-worked, underemployed, under-paid, and these circumstances can perpetuate cycles of poverty, material deprivation, or helplessness, in which case there is a connection to the SDoH (ibid). Lain, Airey, Loretto et al., (2018, p.3) have proposed that "it is necessary to extend our focus beyond employment, and to consider other aspects of individuals' socio-economic circumstances". They fall short, however, of including SDoH. While these alternative meanings are useful, there might be disagreements about whether or not all workers have the potential of experiencing precarity



because of narrow and traditional meanings of precarity and precarious work. For example, a tenure-track professor might not consider him/her-self in a precarious position, even if this worker experiences work-related stress, work intensification, and atypical clusters of SDoH issues (e.g. housing problems, commuting long distances, and limited food selectivity) as well as ensuing from an organizational culture of new hiring practices and so forth<sup>1</sup>.

Within the Canadian context, precarization seems to be increasingly problematic for workers. Statistics indicate that one in four Canadians work in low paid jobs that have earnings less than two-thirds of the national median hourly wage (Jackson, 2005; OECD, 1996). Such low earnings lead to poverty; it affects 1.5 million Canadian families (Fleury and Fortin, 2006), and it can result in health inequities (Raphael, 2001; Raphael, 2007; Raphael, 2008; Raphael, 2010). Low income and poverty mean inadequacy in employment or working conditions, the latter of which are health determinants<sup>2</sup> (Public Health Agency of Canada, 2003; Mikkonen and Raphael, 2010). Furthermore, several studies have noted poor working conditions, due to low pay, racism, and precarious employment status, are harmful to people's lives and have adverse social and health consequences (Vosko, 2000; Vosko, 2005; Lewchuk, De Wolff, King, and Polyani, 2005; Galabuzi, 2006; Lewchuk, Clarke and De Wolff, 2011; Das Gupta, 2015). In response to these working conditions, there are currently movements for decent employment and

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<sup>1</sup> Perhaps precarization can be applied to all workers in relation to broader political-economic changes, and it can be thought of on a continuum, i.e. workers might experience variability ranging from low to high levels of precarization. Furthermore, when precarization is connected with the SDoH, such as with gender or race, it might offer new ways of understanding how workers are affected by highly intensive, stressful, and unhealthy working conditions and how they affect other determinants. Thus, while a tenure-track professor might not be experiencing precarity per se, he/she may be experiencing low levels of precarization.

<sup>2</sup> I will be referring to Social Determinants of Health (SDoH) by combining the Public Health Agency (PHAC) of Canada's (2003) DoH as well as Mikkonen and Raphael's (2010) and Raphael's (2004) SDoH. DoH are not the same as SDoH. For example, according to PHAC (2003), race is not a DoH. However, race is identified as a SDoH according to Mikkonen and Raphael (2010) and Raphael (2004). Instead, the PHAC uses the term culture. A possible explanation for this is that culture is a neutral term preferred by governments, but has a consequence of masking underlying issues of equity.



income, such as the \$15 and fair wages advocated by the Decent Work and Health Network (2017).

### ***Overview of the Contents of the Dissertation***

In chapter 2, I outline the theoretical frameworks and theoretical literature that I use for the dissertation: feminist political economy of health and anti-racism perspectives. There is a focus on the epistemological, ontological, and methodological assumptions that inform these lenses, and a discussion on the ways that gendered assumptions marginalize particular groups and classes of women into precarious and contingent work circumstances. Thereafter, I discuss racialized and immigrant people's experiences of adverse working conditions and I demonstrate how structural discrimination of (im)migrant and racialized persons has forced them into certain nonstandard and precarious forms of work. Using these perspectives, I connect the ways in which employment and working conditions shape workers' health and that of their families.

Chapter 3 presents the LTC context in Ontario and the literature describing working conditions in LTC. I discuss the nature of LTC work, details of what is involved in the work and I describe the job categories of the people who carry out the work. As the literature shows, this sector predominantly involves the work of women, and also involves work that is highly intensive and challenging. Moreover, the tasks carried out require a variety of special skill sets. These tasks are carried out by a broad set of workers, such as nurses, personal support workers or health care aides, recreation and activation workers, social workers, nurse practitioners, physiotherapists or occupational therapists, physicians, and chaplaincy staff among others.

In chapter 4, I outline the context of precarization, as currently understood in the literature as precarious work and precarity, and connect this to the occupational health literature as well as the SDoH. As the literature shows, the proliferation of precarious work has resulted from broad structural factors, policies and practices. These policies and practices include neo-



liberalization of labor at various levels such as: the global level, nationally, and regionally in Ontario. In this chapter, I highlight how precarious work often involves immigrants and racialized people who may often be experiencing under-employment. As the literature shows, under-employment often occurs due to patterns of settlement into highly urbanized geographic spaces, and what I have refer to as the process of “market migration”. Given such circumstances, I discuss the transnational process of globalization, how it involves the flow of people and the social process of acculturation as well as the flow of capital, and the economic process of international remittances that are sent abroad. In addition, I introduce the concept of resilience or agency that workers hold despite their vulnerable work circumstances.

Chapter 5 contains the mixed method strategy for the case study research design (Yin, 2014). I discuss the processes of site and participant selection as well as the approaches for data collection, coding, and interpretation. The site was selected based on feasibility of the project, richness of data, and geographical boundaries, with a focus on paid care workers in an urban residential LTC facility in Toronto, Ontario, Canada. More importantly, the site was selected based on relevance to the research question, and sought to explore the meaning and ideas of precarious employment in the health care sector, with a focus on interpreting everyday paid and unpaid care work experiences in order to contribute to knowledge of health and chronic illness among women, immigrants, and racialized populations. In other words, the study presents a case of how precarization is experienced by women; and by racialized and immigrant employees in an urban Canadian LTC setting. It explains the ways in which (and why) the work in LTC is precarious; how gender differences are experienced; and the health implications for these workers. I discuss the structure and my choice to use mixed methods research that involves a quantitative strand within a qualitative design. The qualitative component consists observations



and interviews; whereas the quantitative strand involves the use of an exploratory survey. I discuss the sources of evidence, processes of establishing rapport; recruitment, inclusion and exclusion criteria; data analysis procedures and data management; the mixing/merging strategy of qualitative and quantitative components; and data comparison, interpretation, and representation.

Drawing primarily on the analyses of interviews and the survey questionnaire with a broad range of health care workers, chapter 6 outlines the findings related to LTC work in the Greater Toronto Area (“GTA”), and how the work is intensive and stressful. For instance, I found that staffing problems were often cited as the source of concern and stress, which led to challenges with workload, time constraints, and inadequate support for staff. As I demonstrate in this chapter, staffing challenges are often blamed on deficiencies in financial resources and organizational budgets, but they are also integrated and connected to broader circumstances, which result from local, national, and global policies and practices. The data suggests that these practices that have emerged locally, across the province, and nationally are shifts in response to globalization and processes such as neoliberalism or market migration, in which workers can be exploited through the current manifestations in the labor-power exchange. For example, at the local, provincial, national and international levels, there is a notable pull away from collective mobility, collective social policies, and a push towards individualization, including emphasis on individualizing policies and practices that are one of the underlying sources of stress for workers and that these policies and practices also effect the health and safety of workers.

In chapter 7, I draw on the data collected through interviews with health care workers to explore how LTC workers serving urbanized residents have experienced precarization, and how they manage with the limited resources that they have. I examine how precarization presents



challenges to workers, such as income-related challenges, budgeting issues, and income deficiencies, as well as concerns about living, commuting, and travelling in expensive jurisdictions such as in Toronto or the GTA. The evidence in this chapter adds new insights, and provides real-life, concrete case examples while also substantiating findings from previous literature. In this chapter, the findings suggest that the barriers to achieving optimal health and safety among workers result from the different levels of income among workers, different educational backgrounds, socioeconomic status considerations, as well as the level of access to adequate resources, housing, commuting and transportation. In short, for LTC workers, their exposure to precarization and the variations in their self-report of health and wellbeing at the regional and community levels speak to the characteristics of the workers, and the obstacles in accessing social and health-sustaining resources. I suggest that the impediments in accessing social and health sustaining resources reflect different priorities, needs, and goals among the diverse group of workers. I connect these findings with the broader literature to suggest that at both the national and transnational levels, current research strategies, public health discourses, and workers' health, education, and outreach initiatives primarily focus on awareness, prescriptive procurement, lifestyle factors, exercise, and healthy eating practices as coping mechanisms for workers dealing with these issues rather than through prevention measures and policy interventions that take into account the SDoH.

Drawing on the literature of feminist political economy and critical social science scholarship, in chapter 8, I describe the interactions between paid and unpaid care work and care skills. These findings suggest that there are dual demands of care that has challenging effects on social life and social relations such as family and dependents, which remain particularly central for women, racialized workers, and immigrants. Yet, I also demonstrate how workers exercise



resistance, resilience, agency, and strength despite these experiences, and how they utilize services, resources, and support.

In chapter 9, I summarize this dissertation, and discuss how the findings fit with the existing literature, and elevate the concerns about precarization that are dispersed throughout the previous chapters. I raise questions about the politics of care work, and structural choices that are made under the current assumptions of neoliberalism that are often manifested in the social context as individualization; and in economic context as budgetary scarcity, restructuring, and austerity. In doing so, this chapter also raises areas for future research. For example, how are workers, particularly those who have reported severe fiscal challenges and budgetary constraints, able to send international remittances to family abroad – are they drawing on debt to meet their own budgetary deficits? There may also be a class context to this, such as sending remittances for investment in land and buildings. This concluding chapter draws on the findings that emerged from this dissertation and connects them to policy implications in order to develop recommendations for effective change. For instance, the idea to propose racism (particularly structural forms as opposed to only interpersonal racism) as a SDoH and appropriate policy interventions flowing from that will be recommended.



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**Chapter 2: Methodology**

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**I. Introduction**

In the previous chapter, I discussed how precarity, precarious employment, and precarization impact workers' lives and livelihoods. I also provided an overview about how precarious employment and precarization are rapidly spreading realities for many people in Canada. I highlighted the need for research to articulate how individuals manage their paid work within challenging contexts defined by power relations, racialization, and class differences.

In this chapter, I outline key studies of class, gender, and race that contribute to my study design. Section II identifies the main attributes of class theory. Section III explores feminist materialism as well as the contributions of feminist scholars who employ a critical political economy approach to health (e.g. Doyal, 1990; Doyal, 2000; Armstrong and Armstrong, 2010). Section IV presents intersectional approaches to the study of race, gender, and class including critical race approaches such as anti-racism theory, which explores oppression, social exclusion, and othering of immigrants and racialized persons. Section V describes the worldviews, epistemological, methodological, and ontological approaches taken up in this study. Finally, section VI provides a summary of the main points of discussion. While each of the above sections could be separate chapters in their own right, it would be out of the scope of this dissertation to present such descriptive depth and detail. Rather, the purpose of this chapter is to lay out for the reader the theoretical constructs and conceptual frameworks that are used in the current study.

My discussion will demonstrate how (and explain why) I have selected feminist materialist health scholarship that intersects with anti-racism theory as my choices of theoretical frameworks and approaches that inform this study. I used these theories to direct my approach



towards the subject area, to inform my inquiry (e.g. in the development of my research questions), and to guide my analysis and interpretation of the findings. There are several reasons for my selections of feminist political economy of health and anti-racism. First, they seem like appropriate choices given the research questions about precarity, and because the focus of the inquiry is about women, immigrants, and racialized persons. Secondly, I chose these theoretical approaches based on the ways in which research about these groups has been conducted, interpreted, analyzed, and critiqued in past queries; and also based on the practices and procedures that would help to gather rich, descriptive, and summarizable/quantifiable data that may help to close knowledge gaps in the literature. Consequently, this rationale led to the belief that these selections would be appropriate in guiding the research. I begin this discussion by articulating the materialist approach about class.

## **II. Class**

The concept of class is rooted in a materialist approach, such as political economy<sup>3</sup>. The forbearers of materialism and political economy are Karl Marx and Frederick Engels, whose world view was that power is produced or reproduced through organizations, interest groups, social structures, classes, and material conditions (Marx and Engels, 1964; Marx and Engels, 1969). The materialist/political economy approach suggests that there are essentially two<sup>4</sup> main groups with competing interests with respect to one another: the bourgeoisie or capitalist class,

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<sup>3</sup> “Political economists focus on the control of material resources and production through analysis of economic structures concerned with finance and commerce and control of human resources and people through analysis of political structures of the state (executive, judiciary, civil service, police, military, etc.). These structures are supported by the control of ideas and knowledge, which occurs through the dominant ideas of a society (e.g., its religion, mass media, education and science, etc.)” (Grabb (2007) as cited in Bryant, Raphael, and Rioux, (2010), p. 134).

<sup>4</sup> There can be more than two groups, depending on the class system. The Wright class system categorizes the working class as owners of skills/credentials, versus the bourgeoisie, small employers, and petty bourgeoisie classes who own capital, but may either: work themselves, hire people, or both (Bartley, 2004). Alternatively, the Erikson-Goldthorpe (E-G) classification schema stratifies the working class as professional, administrators, officials, proprietors, supervisors, and others who may be manually-employed, non-manually employed, or self-employed workers (Bartley, 2004)



and the proletariat or working class (Marx and Engels, 1964; Marx and Engels, 1969). While the first group often holds power, controls the flow of capital, rules over others, and earns profits, the other group or class must work, produce, and sell their labor power (Marx and Engels, 1964; Marx and Engels, 1969; Green and Thorogood, 2009). Yet, while people work, produce, and reproduce, they have human needs, and they require food, clothing, and shelter (Marx and Engels, 1964; Marx and Engels, 1969). Historically, these conflicting class relationships have been explained through property ownership and/or control (e.g. feudalism and slavery). Today, these class relationships are explained through capitalism, with various types of laborers who exchange their labor for wages (Marx and Engels, 1964; Marx and Engels, 1969), and a dominant class that controls and influences waged work. This conflict and control is unequal, with an elite, capitalist class that has exploited the working class through bonded, cheap, low-waged labor and precarious work (Williams, 1964; Genovese, 1967; Cohen, 1987; Cohen, 2008; Syed, 2015).

In the contemporary period, the struggle for power between the proletariat and capitalist classes is manifest in three types of political systems<sup>5</sup>. These political systems are social democratic models (e.g. Denmark, Norway, Finland, Sweden); conservative continental European models that have corporatist dictatorships, clientelist structures, or pillared polities (Italy, Spain, Portugal, France); and residual/liberal welfare states (e.g. USA, Canada, UK, Australia), also known as liberal or Anglo-Saxon nation-states (Esping-Andersen, 1990; Esping-Andersen, 1999). Esping-Andersen (1999) argues that there was a short period of time when there was a consensus between the proletariat and capitalist classes in these political systems during the post-World War period. During this time, low-skilled workers held secure jobs, they

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<sup>5</sup> Bamba (2011) highlights that there are additional welfare state typologies that include re-categorization of welfare states with alternative labels such as Bismarck, Non-Right Hegemony, Targeted, etc.



were well-paid, and their wages grew. There was also full employment growth, strong trade unions, various worker protections, and diminished pay inequalities. However, the golden age of consensus between the proletariat and capitalist class has long since finished, and it is now crisis-ridden due to welfare-state retrenchment and the rise of neoliberalism (Esping-Andersen, 1999).

Unfortunately, the change and deterioration from the golden age of consensus to one of crisis fit the assumptions of materialists, who suggest that social harmony does not exist between these two classes of people because they are often in conflict with one another (Armstrong and Armstrong, 2010). Rather, social disharmony is a typical and growing norm. Indeed, Raphael (2000) suggests that the situation is worsening, as poverty and economic inequality are increasing in Canada and across the globe, and these phenomena are marked with the rise of the political right. According to materialist scholarship, during such political shifts, people are not necessarily able to do things as they please, which might suggest that personal freedoms, and civil or political rights might also be compromised (Armstrong and Armstrong, 2010). Indeed, over-policing, mistreatment of minorities and immigrants, structural violence, and other forms of brutality are often criticisms under right-wing political regimes.

Materialist health scholarship recognizes the consequences of the conflict between the capitalist class and the working class. One of the assumptions (or observations) under the materialist approach is that economic relations determine and dictate other aspects of life, such as: culture, behaviors, norms, and attitudes. As a result, health scholars within the political economy school argue that the distribution of material conditions and income will determine health and wellness outcomes (Doyal and Pennell, 1979; Bambra, 2011). In other words, health equity and inequity have a class context (Townsend, Davidson, and Whitehead, 1986; Bartley, 2004). The class differences in morbidity and mortality mean that working class people die



sooner and suffer more ill health than middle class people (Doyal and Pennell, 1979). In Canada, research indicates that universal healthcare is more beneficial to the middle class than the poor and homeless because the latter cannot effectively access the system to the degree that the middle class does (Poland, Coburn, Robertson, and Eakin, 1998).

Materialists argue that health inequities are the worst for the working class who live in neoliberal regimes, such as Canada. Substandard working conditions are not accidental, and have been deployed by conservative capitalist (bourgeoisie) classes in order to exploit the working class. The rise of industrialization and proliferation of factories and factory workers further created opportunities for the bourgeoisie and capitalist classes to exploit workers with low-waged and precarious work, replacing a system of feudalism (Marx and Engels, 2010). Waged labor and an excess of workers seeking employment opportunities have led to a legacy of free market capitalism in the past 300 years and, more recently, the rise of market liberalism in the past 50 years (McLean and McMillan, 2003; Armstrong, 2013b; Syed, 2015).

Members of the working class can experience precarization of work, which could mean their work lacks security, stability, and is associated with temporariness, or powerlessness. When this happens, they are at risk of health problems because such working conditions induce stress and a cascade of related problems that affect the psycho-social aspects of the worker, and social relations within and outside of the workplace space. Another level of marginalization is contingent upon gender, which is discussed below.

### **III. Gender and Class**

Feminism is concerned with gender inequalities that arise from a system of patriarchy (Bourgeault, 2010a). Feminists argue that society is gendered in such a way that women and men have fundamentally different experiences and access to power and privilege (ibid).



Feminists have both criticized and expanded upon materialist approaches in representing and considering women's perspectives (ibid).

Feminist sociologists argue that the economic, social, and political issues for women arise as a result of social and political histories that are developed and written exclusively by men, and from the standpoint of men rather than women (Eisenstein, 1983; Smith, 1987; Smith, 1993; Bourgeault, 2010a). Feminist materialist scholarship extends the ideas of materialism by connecting market relations with domestic ones (Armstrong and Braedley, 2013). Feminist political economy frameworks also focus on equity for women (Krolokke and Sorensen, 2006). Scholars examine the economic needs of the family, the work of women in the home and in labor markets, and relations within workplaces. Feminist materialist scholarship also examines tensions related to women's paid and unpaid work, such as how production and reproduction affects women's lives (Armstrong, 2001). For instance, women's reproduction and unpaid caregiving roles could modulate the extent to which women participate in economic/paid economies, which can then affect their material conditions, social, political, health, and overall life circumstances. Context is considered vital, and there is a focus on the interactions between the micro, meso, and macro<sup>6</sup> levels (Daly, 2013).

Feminist perspectives have been influential in medical sociology, and in the sociology of women's health and illness (Bourgeault, 2010a). Feminist political economy approaches that are applied to health research have helped to explain the processes that make women vulnerable to health inequities at a variety of levels. The first has to do with the health care needs of women. For instance, women have different health needs than men and require diversity in health services (Doyal 1995; Armstrong and Armstrong, 2010). Yet, biomedical research and

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<sup>6</sup> Political economists recognize that meso-level SDoH are shaped by macro level structural determinants, such as: politics, the economy, the state, the organization of work, and the labor market (Bambra, 2011).



biomedicine are often applied to women in unfair ways that have health-compromising consequences for women. For example, women may experience pregnancy, birth, and different types of health issues during their aging and life course compared to men. However, health research and health care services often do not fit with women's needs (Armstrong, 2001). Furthermore, the Physician Health Study of coronary heart disease also excluded women from their trials, because coronary heart disease was thought of as a male problem, despite the fact that half a million women died of it each year in the USA (Doyal, 1995), and despite that women's risk of it and other chronic illness is influenced by a number of factors (Stampfer et al., 1985).

Feminist political economy approaches that are applied to health research have also helped to explain other ways in which health inequities are experienced by women that are separate from (or outside of the scope of) the health care system. For example, Armstrong and Armstrong (2010) argue that marriage or having children can prevent women from pursuing continuing education, and also from continuing their work, which can impact rates of poverty and health equity. Working women are also often susceptible to illness and absence from work due to family obligations. This phenomenon is often dubbed a double-burden (Armstrong and Laxer, 2005). For example, women tend to provide a majority of care in both public and private environment (Braedley, 2013). They also maintain the health and lives of those in their households, families, and communities through unwaged and low-waged invisible work (Braedley, 2013). This is especially true in the health care sector, which comprises of over 80% women as workers (Armstrong and Laxer, 2005). The double burden of paid work in the labor force combined with unpaid work in the home can make women more vulnerable to poorer health than men, and it can also cause stress and fatigue which have spiraling, health-compromising effects on their wellbeing (Department of Labour Women's Bureau, 1964; Lowe,



1989; Armstrong and Laxer, 2005; Armstrong and Armstrong, 2010; Braedley, 2013). Unfortunately, the double burden of women's work often remains invisible because women are expected to be responsible for social reproduction, yet paradoxically, this social reproduction overlaps both the public and private realms (Armstrong and Laxer, 2005).

Feminist materialists who are focused on analyses of health argue that women's health and wellbeing are directly affected by determinants of health, such as income and social status, because women are often paid lower wages than men (Doyal and Pennell, 1979; Doyal, 1995; Armstrong and Armstrong, 2010). Furthermore, another problem that affects women's health and wellbeing is that women are often sex segregated in the labor market. This means that women who participate in labor markets often do so as a reserve supply/army of labor in either daily, weekly, seasonally, or part-time basis to respond to demand and overproduction (Marx and Engels, 1964; Marx and Engels, 1969; Vosko, 2005; Marx and Engels, 2010).

Feminist materialists who are focused on analyses of health also argue that the health problems women experience are related to their discrimination and disadvantage while they carry out the gendered activities making up their daily lives (Doyal, 1995; 2000; Armstrong and Armstrong, 2010). Specifically, the dual demands of women's work in the home and the labor market have a direct effect on the way women participate in the workforce as well as on the sex segregation of women's work and women's wages (Armstrong and Armstrong, 2010). For example, if a job involves care work, it is most often performed by a woman, it is classified as unskilled, and, therefore, it is lower-paid than that of men in caregiving occupations (Armstrong, Armstrong, and Scott-Dixon, 2008; Armstrong, 2013b). These types of disparities in women's working conditions result in gender inequities in income and wealth, which make women



vulnerable to poverty (Doyal, 1995) and also vulnerable to health problems (Armstrong and Armstrong, 2010).

Research indicates that there are also ethical, moral and material implications of women's work, which also compromise their health and wellbeing, and this is based on particular stereotypes. For instance, in women's work in the health sector, and specifically within LTC, there is a perception that *good* women care for their families and others, either uncompensated or low-paid, and in doing so, they attain feminine moral worth (Braedley, 2013). As a result, while such types of women's work in the home or in the labor market are morally and ethically elevated in this regard, they can be detrimental to women's material conditions; because they are often invisible (Peterson, 2007), unpaid or underpaid, unregulated, un-supervised, undervalued; and they can be characterized by long hours, and can have dull, repetitive, and isolating working conditions that can perpetuate health inequities (Armstrong and Armstrong, 2010). The literature shows that care work, for example, might also be undeclared and undocumented (Williams, 2011). Furthermore, care workers frequently feel they are unseen, unheard, and accordingly, they are unhappy (Baines, Charlesworth, and Daly, 2016). Material conditions such as employment opportunities, wages, and scarcity of day-care also constrain women's roles and could confine them to work primarily in the home, even if ideas about women's place in the home changes (Armstrong and Armstrong, 2010).

Feminist health scholars challenge the assumption that maleness and femaleness starts and usually ends with sex differences in reproductive systems (Mead, 1950; Waldron 1986; Busfield, 1986). The biological differences between women and men go beyond the obvious ones related to reproductive systems, and also include genetic, hormonal, metabolic and other variations (Mead, 1950; Waldron, 1986; Busfield, 1986; United Nations, 1991; Doyal, 1995;



Doyal, 2000). Furthermore, while there are obvious differences between male and female patterns of sickness and health, with some health problems stemming from biological differences, these differences are more complex than pure biology (Doyal, 1995; Armstrong and Armstrong 2010). Most feminists reject biological determinism and biological models based on the understanding that there are differences among and between women beyond biology and which include class, culture and ethnicity (Doyal, 1995; Doyal, 2000; Armstrong and Armstrong, 2010).

One of the debates in feminist materialist scholarship is that certain forms of material conditions seem to be advantageous for women, but they might actually be disadvantageous. For example, part-time work has been advocated as a solution to the problem of balancing paid work and care responsibilities by allowing women (especially mothers) to balance their time in caregiving while also participating in paid work (Chalmers, Campbell, and Charlesworth, 2005). However, the material reality is that in part-time work, women are paid less; have little opportunities for training and career progression; have inequitable access to employment benefits; and often do not receive paid leave (Armstrong and Armstrong, 2010). The reasons for these inequities experienced by part-time women workers are due to various sex-stereotyping of women such as: having high absenteeism, being uncommitted to their work, being unproductive, inability to be career oriented, or wanting few responsibilities and pressures (Armstrong and Armstrong, 2010). Part-time work and part-time wages might also make women submissive and more dependent on men, often dubbed housewifization, because women's wages and power within the family are lower than that of men (Doyal, 1995; Armstrong and Armstrong, 2010). Thus, advocating part-time work or other one-size-fits-all approaches for women are not necessarily ideal practices.



Feminist political economy work is helpful in explaining the material differences in health by gender, and it went beyond gender in multiple ways, but it was initially limited in an anti-racism analysis and critique, the latter of which emerged only at the second and third waves of feminism (Krolokke and Sorensen, 2006). The particular concerns of women [and men] of color that were initially neglected began to change during the latter feminist social movements. It is now widely accepted that there are alternative and unique perspectives that can be offered when gender is analyzed in ways that intersect with class and race (Bourgeault, 2010a).

#### **IV. Race, Gender, and Class**

Political economy perspectives that have examined histories of slavery, colonialism, and indentured work indicate that non-standard and dangerous working conditions were a prevalent and normative work model under which capitalist classes exploited racialized and immigrant workers through indentured, enslaved or cheap wage labor (Williams, 1964; Genovese, 1967; Cohen, 1987; Cohen, 2008; Syed, 2015). In Toronto and the GTA, recent immigrants who are often racialized visible minorities tend to be employed in precarious, non-standard work with low pay, minimal employment protection, and no benefits (De Wolff, 2005; Syed, 2015). They also have had greater difficulties in obtaining full time permanent jobs than their predecessors because of arriving during times of recession (De Wolff, 2005).

Differences such as race, class, ability or disability, age, and other social identities lead to further marginalization, and men and women's lives are embedded in this reality (Ng, 1996; Dossa, 2009). For example, disabled people's experiences are not only limited to material abuses such as physical or emotional violence and poverty, but go beyond these experiences to include forms of social exclusion, oppression, objectification, and alienation (Gorman, 2007). Such experiences also include neo-racism and democratic racism (Galabuzi, 2006). Another



example of conflict is the competition between jobs taken up by low-waged temporary or seasonal migrant workers versus unemployed Canadian citizens who possess the same skills. These groups are pitted against each other while the capitalist class makes gains, exploiting either side. This is exactly the scenario that occurred in British Columbia, in which International Union of Operating Engineers and the Construction and Specialized Workers' Union asked the federal court Justice Douglas Campbell to grant an injunction to stop Chinese foreign workers from arriving in Canada (CBC, 2012a). The unions were concerned that foreign workers were recruited to work for HD Mining Ltd., while Canadian miners were not given a fair opportunity to work at the mine first (CBC, 2012b). Many of the above-noted perspectives have been inspired by critical race theorists.

Critical race theorists often focus on racialization, which is an active and ongoing process in which a dominant group identifies another group as having a race, often based on the latter group's physical characteristics, such as skin color (Dei, 1996; Biggs, 2004; Bourgeault, 2010a). Racialization frequently results in unequal and unfair treatment of particular groups of women and men (Dei, 1996; Bourgeault, 2010a), and it has social, economic, and political consequences (Galabuzi, 2006). For instance, many racialized men and women face racism, yet sometimes these claims of racism are considered to be biased, hypersensitive imaginings of people of color or anti-racist whites (Essed, 1991; Nestel, 2004). The reality of course, is that racism and racialization signify that race is not an imagined or natural distinction, but rather it is a socially and historically constructed category of difference (Nestel, 1996/1997; Bourgeault, 2010a).

Critical race theorists emphasize the identification of societal, political, economic, and legal structures that influence and distribute power unequally by race (Dua, 1999; Dua and Robertson, 1999). This theoretical approach focuses on vulnerable, marginalized, and racialized



groups based on their historical experiences of slavery, colonialism, post-colonialism, imperialism, cultural hegemony, and neo-colonialism (Green, 1995; Delgado and Stefancic, 2012, Syed, 2015). These marginalized individuals or groups frequently experience oppression, which is a social phenomenon that includes unjust acts or policies against a group because of their affiliation to that group (Bolaria and Li, 1985; Baines, 2012). Another social phenomenon is Othering (Said, 1978; Spivak, 1985; Weis, 1995; Said, 1995; Miller, 2008; Mountz, 2009). Othering refers to a process that aims to subordinate a group through social and political exclusion (Triandafyllidou, 2001), often through stereotyping. Othering was first coined as a systematic theoretical concept in Gayatri Spivak's (1985) work, although there are also contextual contributions to it in early post-colonial writing in which Said (1978) describes the construction of people from the so-called "Orient" by colonials as an exotic, subordinate, distant, and alien other (Jensen, 2011).

Immigrants and racialized persons can experience being "Othered" by being socially constructed as dependents, non-citizens, non-workers, and deemed to be Others in comparison to employed white male citizens (Das Gupta, 1996; Lawrence, 2004; Das Gupta, 2005; Kruger, Mulder and Korenic, 2004). "Their otherness is marked by the color of their skin, their 'strange' customs and languages, their immigration status, and their lack of citizenship rights." (Das Gupta, 2005, p. 320). They are further Othered on multiple fronts such as: coming from non-western countries, being poor, or being female (Bannerji, 2000; Sharma, 2001; Benhabib, 2004; Thobani, 2007; Sharma, 2006; Jiwani, 2006; Das Gupta, 2008; Das Gupta, 2009; Zaman, 2012).

In Canada, stereotyping and Othering usually involves narratives of positive traits attributed to the Canadian identity of the exalted subjects, and the negative traits attributed to the outsiders (Thobani, 2007). These outsiders are problematized and are responsible for creating a



crisis of immigration (Thobani, 2007). Othering of Muslims, for example, includes expressions of stereotypes, such as: hijab-clad women assumed to be shy, demure, oppressed, and without voice or agency (Zine, 2006), or even endangered (Razack, 2008). These Others are constituted as having strange religions and customs; smelly clothes and houses; being too noisy; having overt and gaudy costumes; and being forced into arranged marriages (Thobani, 2007). Such expressions can also become violent, such as the burning of crosses, Paki-bashing, and pulling off of Muslim women's headscarves (Thobani, 2007). Muslim men are constituted as being dangerous, while Muslim women are considered to be in danger (Razack, 2008). Women and children are stereotyped through the process of Othering, and constituted as weak victims. Bannerji (2000, p. 48) explains: "In the name of culture and [G]od, within the high walls of community and ethnicity, women and children could be dominated and acted against violently because the religions or culture and tradition of others supposedly sanctioned this oppression and brutality". Violence against racialized women and ethnic populations in Canada is thought to occur, quite mistakenly, because of their traditions, rather than because of structural issues (Bannerji, 2000), such as policies and actions legislated/mandated by the state, its institutions, and its actors.

There are many examples in the literature documenting who is oppressed, socially excluded, Othered, or marginalized in the labor market. Racism has made women of color and immigrant women particularly disadvantaged and subjugated, historically concentrated in manufacturing and low-paid service sector jobs (Glenn, 1992, Gabriel, 1999; James, Grant and Cranford, 2000; Das Gupta, 2002; Vosko, 2005). I have completed three studies of newcomers, various migrant communities, and visible minorities that document how they experience extensive health inequities (Syed, 2015) and acute as well as chronic illness (Syed, 2014; Syed,



2015). Other studies show how many immigrants and newcomers have experienced work related injuries, illness, and mortality (Liu and Norcliffe, 1996; Clark and Hofsess, 1998; Thurston and Vernhoef, 2003; Brown, 2006; Gilmore and LePetit, 2007; Premji, Messing, and Lippel, 2008; Smith, Chen, and Mustard, 2009; Smith and Mustard, 2009; Premji, Duguay, Messing, and Lippel, 2010; Liladrie, 2010). Certain groups, such as Filipino women, have experienced gendered labor migration, and often provide care work (Barber, 2000; Arat-Koc, 1997; Vosko, 2005; Sharma 2006), while being poorly compensated (Daly, 2013). Others have been recruited for seasonal agricultural work from Mexico and the Caribbean (Tucker, 2005; Sharma, 2006).

Anti-racism lenses and the other critical approaches mentioned above are useful when applied in health research for a number of reasons. For instance, incorporating these approaches can explain not only underlying causes of social exclusion and racialization, but also the potential (or resultant) health impacts of these processes. Anti-racism scholars have used critical political economy theory to argue that the state, and its political and economic structures play a vital role in ignoring and perpetuating racism and social exclusion (Thobani, 2007; Syed, 2015). Furthermore, Das Gupta (2005) argues that immigrants and people of color have experienced systematic racism that has been institutionalized by the Canadian state with its position to remain neutral in many policies and procedures. Additional research that incorporates critical health perspectives would be invaluable in advocating change.

One of the debates within anti-racist scholarship is whether there is overt racial discrimination against certain people, or whether it is disguised or embedded in class-based discrimination. This can be seen when Thobani (2007) observes that immigrants who were from the non-preferred races came from various classes such as farmers, peasants, merchants, small business owners, and entrepreneurs. Ong (1993) and Alund (2003) argue that transnational



capitalists, such as wealthy businessmen from mainland China and Hong Kong, who might invest in real estate ventures, are actively sought out and recruited by governments for their investments or entrepreneurial capital. Similarly, knowledge-based, highly skilled workers are actively sought out and recruited by governments for their expertise and technical capital. Those lacking such investments or skills are less welcome to Canada. Historically, while some wealthy Chinese and South Asian (“SA”) merchants and businessmen were allowed to bring family members and were exempted from paying the head-tax for their dependents, working class migrants were prohibited from bringing their families and paid head-taxes (Thobani, 2007; Bannerji, 2000). These scholars further suggest that it is only the investment and skills that are sought out, not the actual migrants themselves.

One of the limitations in anti-racism scholarship is that it often neglects to incorporate a critical health lens, which is important in understanding the end-results, harms, and consequences of racism and other forms of discrimination. While anti-racism theory is useful in examining the types of oppression and Othering experiences that lead to social inequalities and social exclusion, it does not explicitly concern itself with health equity.

An intersectionality approach offers some advantages in connecting anti-racism to health equity lenses. An intersectionality approach would allow us to connect and include multiple forms of marginalization with various SDoH, such as the notion of culture. Culture, for instance, is recognized as a DoH, and is also connected to employment and working conditions, the latter of which are additional health determinants through which racialized people frequently experience social inequalities and social exclusion. Intersectionality as a conceptual framework can extend the work of feminist approaches that are otherwise limited in the analysis of racism and other forms of discrimination. In other words, intersectionality frameworks may be



promising alternatives to a one-size-fits-all approach (Varcoe, Hankivsky, and Morrow, 2007; Hankivsky and Cormier, 2011).

Combining anti-racist and other critical research approaches with a framework of intersectionality can also help to inform a growing body of research about racialized immigrants, and the processes of resistance to acculturation. Extending these approaches to analyze class, gender, and race through an intersectionality conceptual framework may help explain some impacts of racialization on marginalized men and women's lives. In other words, an intersectional approach would help to demonstrate the complex nature of human interactions, experiences, and health consequences.

## **V. Worldviews, Epistemological, Methodological, and Ontological Approaches of this Dissertation**

I selected feminist materialist health scholarship that intersects with anti-racism theory as my epistemological and methodological choices that inform this study. I used these critical theories to inform and guide my inquiry as follows: in the development of my research questions, in my approach towards the subject, and also in my analysis and interpretation of the findings. There were many reasons for my choices of feminist political economy of health and anti-racism. First, they were perceived as adequate selections given the research questions, which focused on women, immigrants, and racialized persons, and asked: How do racialized and/or immigrant workers experience work in LTC? In what ways (and why) is work in LTC precarious? Are there gender differences? I also chose these theoretical approaches because they have been employed by a number of scholars who use qualitative and/or quantitative research methods, with a goal to eliminate knowledge gaps in the literature. Indeed, Guba and Lincoln (2005) list both qualitative and quantitative training in their paradigms of critical theories.



There are a number of epistemological, methodological, and ontological considerations in this project, which require elaboration. Epistemology refers to the study of knowledge (Varcoe, Hankivsky, and Morrow, 2007). Epistemology is associated with how the inquirer or researcher, who wishes to understand a particular subject, creates knowledge about these matters through research and other inquiries (Bryant, Raphael, and Rioux, 2010). Examples of epistemology include: the epistemology of positivism and feminist epistemology. The epistemology of positivism has its disciplinary roots in the natural sciences (Green and Thorogood, 2009). Positivists believe in *empiricism*, which is the idea that observation and measurement is the core of the scientific endeavor (Trochim, 2006). Positivism assumes and strives for objectivity, in which the researcher attempts to minimize or exclude political values, subjective impressions, and partial accounts that might bias their findings (Green and Thorogood, 2009). Feminist epistemology is a way of thinking that suggests that gender should influence the practice of acquiring knowledge and also the analysis of that knowledge (Anderson, 2017). Feminist epistemology identifies the ways in which the dominant conception, acquisition, and justification of knowledge systematically disadvantage women and other subordinated groups (Anderson, 2017).

Ontology refers to theories of being (Morrow, Hankivsky, and Varcoe, 2007). According to Guba and Lincoln (2005), the ontology of critical theories, such as gender (e.g. feminist political economy) and ethnic[ity] (e.g. anti-racism), is historical realism. In historical realism, reality is shaped by social, political, economic, cultural, ethnic, and gender values (ibid). Thus, the ontological approach for my study is historical realism.

Methodology is the theory and analysis that informs research (Varcoe, Hankivsky, and Morrow, 2007). Methodology often refers to the study of/ discourses about systematic,



theoretical analyses of the methods applied to a given field of study. In other words, methodology is focused on the specific ways, or the methods that are used to try to understand the world (Guba and Lincoln, 2005; Trochim, 2006). Bryant, Raphael, and Rioux (2010, p.126) state that “methodology is about the kinds of research tools that can be employed to acquire worthwhile knowledge about the world.” However, according to Morrow, Hankivsky, and Varcoe (2007), methodology is distinct from methods, the latter of which refers to the techniques or tools used to gather data. For instance, positivist methodology incorporates the use of the scientific method and emphasizes experimentation in an attempt to discern natural laws through direct manipulation and observation (Trochim, 2006). Positivist methodologies identify scientific findings through observable and often quantifiable evidence (Green and Thorogood, 2009). It is believed that the world and the universe are operated by laws of cause and effect that can be applied to the unique approach of the scientific method (Trochim, 2006). In other words, positivist methodologies often emphasize the use of surveys and other quantitative approaches for knowledge acquisition and generation.

Unlike a quantitative methodological emphasis in the school of positivism, research that uses critical theories has a methodological emphasis through a dialogic/dialectical approach (Guba and Lincoln, 2005). Researchers who would use critical theories would likely employ qualitative methods, which are inductive and without predetermined hypotheses<sup>7</sup> (Patton, 1990). They would likely ask different questions than positivists, and those questions would be addressed in alternative ways (Hoshmand, 1989; Ponterotto and Grieger, 1999; Reisetter, Yexley, Bonds et al., 2003). For example: the what, how, or why of phenomena are asked rather than

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<sup>7</sup> Here, I refer to null and alternative hypotheses used in statistical analysis, which is primarily a quantitative research method guided by the epistemology of positivism. See Agostino, Sullivan and Beiser (2006).



how many or how much (Green and Thorogood, 2009), and this provides insights into the dimensions of experience, and helps to add to the completeness of answers to the questions that are asked (McLeod, 2000; Reissetter, Yexley, Bonds, et al., 2003).

Scholars using a feminist political economy approach have grounded their studies in critiques of gender and class ideologies, with a methodological approach that conforms to the tradition of historical realism (Wilson 1983; Bryant, Raphael and Rioux, 2010). In other words, qualitative methods are often employed in gathering data, although quantitative methods have also been used to draw on statistics that have established the female-dominated care workforce, women's unequal position in the health-care field, and to reveal systemic discrimination against women (Armstrong, 2001; Armstrong and Laxer, 2005; Armstrong, Armstrong, and Scott-Dixon, 2008). Scholars recognize the importance of context and experiences, and seek a wide variety of sources for information and evidence (Armstrong, 2001). This context is local and familial, as well as global and capitalist (*ibid*). Accordingly, researchers' roles, propositions, actions, and end-goals might aim to emancipate, empower, and socially transform people's situations towards more equity and justice (Guba and Lincoln, 2005).

While feminist methodological research practices have endorsed qualitative methods, particular ones are encouraged more than others. For example, Smith (1987) supports interview methods as opposed to only using observational methods. The strength of interview methods is that it prevents objectifying the research subject as an Other (*ibid*), and gives them voice. Smith (1987) proposes going a step further beyond interview practice to preserve the subject and explore relations that are embedded in our everyday world.

Feminist materialist scholarship has also contributed a wealth of knowledge to the epistemological and methodological approaches in gathering social, economic, and health data.



For instance, “[m]aterialists contend that both bodies and ideas must be understood within the context of material conditions” (Armstrong and Armstrong, 2010, p. 171). Consequently, biology affects and is affected by social, economic, and political conditions. In other words, if one were to inquire as to whether or not biological factors/gene expression or social/economic/political conditions contribute to a person’s health and wellbeing, then materialists would contend that biology/gene expression is influenced by social, economic, and political conditions.

Feminist perspectives offer a number of epistemological and methodological critiques of mainstream health research, demonstrating the bias in how women are diagnosed, treated, and even studied. For example, the study and evidence used in the dominant research paradigms privilege quantitative methods, data, and numbers, such as: randomized control trials (RCTs), number of nurses per population, and number of Caesarean procedures per doctor (Armstrong, 2001). However, they can lead to certain biases. Indeed, RCTs have often been based on trials conducted on 70-kilogram adult males rather than females (Armstrong 2001). Furthermore, a study of coronary heart disease (“CHD”) entitled the *Physician Health Study* excluded women from their trials, because CHD was thought of as a male problem, despite the fact that women are also at risk of CHD and other chronic illness (Stampfer et al., 1985), and despite that half a million women die of CHD each year in the USA (Doyal, 1995).

Feminist epistemological perspectives also critique how knowledge that is gained may define how woman are perceived in society and how these perceptions can affect women’s paid and unpaid roles. For instance, culture, societal norms, and attitudes generate ideologies that define feminine and masculine work (Greenglass, 1973; Greenglass, 1982; Mackie, 1987). Ideas, ideologies, cultural norms, and attitudes about women get socially accepted over long periods of



time and manifest themselves as health inequities (Doyal 1995; Armstrong and Armstrong, 2010). As a result of the socialization process, internalization of biased ideas, and the social exclusion of women based on sexual stereotypes, women may become vulnerable to social problems. This vulnerability may worsen their health in a number of ways. For example, what is perceived as women's work includes comforting, cooking, feeding, bathing, toileting, record-keeping, cleaning, laundering, management and supervision, as well as other tasks (Armstrong and Laxer, 2005). Many of these tasks have been carried out traditionally in the home and other private spheres, making them invisible. The problem arises when meals have to be prepared on time, and when children are looked after on demand, which has an effect of restricting women's abilities to work outside the home, making them vulnerable to income inequalities and health inequities (Armstrong and Armstrong, 2010).

Based on the foregoing theoretical frameworks, approaches, and other considerations, I selected feminist materialist health scholarship that intersects with anti-racism theory to inform my study. For this dissertation, I ask how social class can link to grounded observable behaviors of people in everyday settings. Other examples would be: what is the relationship between employment and health, or are women's experiences in health care different from men's experiences.

## **VI. Summary**

In this chapter, I have outlined key studies of class, gender, and race that contributed to my study design. I identified the main attributes of class theory, and then I explored how feminist political economy work contributed to the critical political economy approach to health. I also presented intersectional approaches to the study of race, gender, and class using anti-racism theory in order to discuss and demonstrate the multiple ways in which health issues can be



compounded by social locations such as gender, class, race, and immigrant status. Finally, I described the epistemological and methodological rationale for this study.

In the next chapter, I will discuss the nature of LTC work in Ontario and build on the theory from this chapter by connecting it to working conditions in LTC. I will demonstrate that LTC work involves particular skills, and that particular groups predominantly carry out the work in this sector.



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**Chapter 3: Long-Term Care Context and the Literature**

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**I. Introduction**

In this chapter, I define the meaning of long term care (“LTC”). I also discuss some of the LTC context at the international level and the local level, the latter of which is focused mostly in Ontario. As indicated in the discussion, LTC refers to a network of health and social care services. It is also the arrangement of institutional forms of care. The social-care aspect of LTC involves social programs and services, such as income-supported housing. The health-care related aspect of LTC refers to nursing and medical care, therapeutic care, recreational care, and care that has to do with activities of daily living.

While recognizing the boundaries of institutionalized forms of care, the focus of this dissertation is on residential LTC in an urbanized region of Ontario. My research is focused on a residential care facility for seniors and the elderly, which I denote as Eastside Home. I have selected a variety of workers as key sources of information that may be representative of the occupational conditions within Canadian LTC facilities, and I have chosen to focus on precarization.

In the chapter’s next section, I discuss the international care work literature and draw upon the issues that are raised about this sector of employment. In section III, I describe the local contexts, including descriptions of LTC work in Ontario and the people who do the work. In Section IV, I discuss what is involved in LTC work, which includes visible and paid care, as well as invisible care, invisible skills, and invisible work. In section V, I outline the working conditions in LTC, which includes some background information about hierarchical workplace relations, market liberalism, neoliberalism, and precarization. Section VI describes previous research and analyses of LTC facilities, as well as a discussion about how my study contributes



to the existing literature and how it expands on the literature. Finally, Section VII summarizes the chapter's main points.

## **II. International Care Work Literature**

Both the international and Canadian literature suggest that the health and social care sector predominantly involves the work of women, immigrants, and racialized people, and that it requires a variety of special skill sets. Moreover, it also involves work that is intensive and challenging, and accordingly, a number of issues are raised. For instance, in the United States, research has identified and acknowledged enduring issues among care workers, such as high employee turnover rates ranging from 40% to 75%, with some rates as high as 400% to 500% (Pecarchik and Nelson, 1973; Kasteler, Ford, White and Carruth, 1979; Stryker, 1982; Halbur 1982; Halbur 1983; George 1983; Wagnild, 1988; Brennan and Moos, 1990; Banaszak-Holl and Hines, 1996; Cohen-Mansfield, 1997; Fitzpatrick, 2002; Harrington and Swan, 2003; Castle and Engberg, 2005; Castle, 2006). High turnover rates are associated with: low levels of unionization (Foner, 1994); high emotional demand at work, high levels of stress, emotional exhaustion, burnout (Kasteler, Ford, White, and Carruth, 1979; Cohen-Mansfield and Rosenthal, 1995; Banaszak-Holl and Hines, 1996), inadequate work organization, lack of role clarity, limited work autonomy, lack of participation in decision-making, understaffing, insufficient rewards, inadequate pay incentives, limited promotional opportunities, long hours of work, part-time work, corporate/for-profit ownership, and increased conflict – the latter of which is due to situations out of one's control (Cohen-Mansfield, 1997; Kasteler, Ford, White, and Carruth, 1979; Sigardson, 1982; Alexander, Weisman, and Chase, 1982; Mann and Jefferson, 1988; Karasek and Theorell, 1990; American Nurses' Association, 1991).

Unfortunately, high turnover rates can lead to other problems such as: decreased quality of care for recipients, impaired personal relationships between caregivers and residents,



increased organizational and management costs due to repetitive personnel training of newly hired individuals, increased work burden among the remaining staff, as well as decreased employee morale (Banaszak-Holl and Hines, 1996; Cohen-Mansfield, 1997; Castle and Engberg, 2005). Accordingly, research has focused on strategies for employee retention.

American research has further documented the ways in which LTC has been organized, the shifts in care work, as well as the attitudes towards care workers. For instance, Koren (2010) indicates that there was an entire culture-change movement that began in the early 1980s that focused on resident's rights, and resulted in legislation, such as the *Nursing Home Reform Act* of 1987. This legislation mandated individualized, person-centered care, and also required that each nursing home provide sufficient services for residents so that it enables them to attain and maintain their highest physical, mental, and psychosocial wellbeing (Koren, 2010). The work of Banaszak-Hall and Hines (1996) and others (e.g. Foner, 1987; Foner, 1994) focus on other issues. They indicate that there are widespread stereotypes that inaccurately constitute care work as low-tech and unskilled, and inaccurately portray care workers, who are often racialized women (e.g. Hispanics and Blacks, including Caribbean, Jamaican, and West Indian immigrants), as cold, condescending, insensitive, and harsh individuals.

European research indicates that migrant care workers have often provided care for older people in places such as in Italy, Spain, and the United Kingdom (Peterson, 2007; Degiuli, 2007; Williams, 2011; Williams, 2012; Shutes and Chiatti, 2012). They are often hired by families, or by providers of residential and home care services (Peterson, 2007; Degiuli, 2007; Williams, 2011; Shutes and Chiatti, 2012). In Sweden, survey data shows that residential care workers have experienced deteriorated working conditions in which the workloads are heavier than before, and job autonomy is now reduced (Szebehely, 2016; Szebehely, Stranz, and Strandell



2017). Swedish workers have also reported increased physical and psychological exhaustion (Szebehely, 2016; Szebehely, Stranz, and Strandell, 2017).

In Australia, researchers have identified and acknowledged issues among nursing home workers that also occur in other international contexts, such as: job [dis]satisfaction, worker stress, unpredictability, lack of time to complete tasks, and high turnover rates among staff (Brodaty, Draper, and Low, 2003). Sources of stress have also been documented, which are often broad, and include aggressive resident behaviors as well as organizational changes that may affect the work (Brodaty, Draper, and Low, 2003). Furthermore, research of migrant care workers indicates they are both providers and users of paid care services (Howe, 2009; Khoo, McDonald, and Hugo, 2009; Adamson, Cortis, Brennan, and Charlewsorth, 2017). In summary, migrant care workers in Australia serve as valuable sources of labor supply for aged care settings, but researchers have cautioned that adequate training pertaining to skills, cultural contexts, as well as working conditions are critical to ensure acceptable standards for migrant care workers, and the quality of services for care users (Adamson, Cortis, Brennan, and Charlewsorth, 2017).

All of these international contexts share many of the same, ubiquitous issues that are raised in the Canadian care work literature, including: a sharp rise in the demand of care due to dual-career household growth (i.e. a global increase in women's participation in the paid labor market), aging population demographics, decreasing fertility rates, concerns about working conditions for caregivers, stereotypes about care work and care workers, worker exploitation, and quality of care issues among recipients and consumers (Khoo, McDonald, and Hugo, 2009; Williams, 2010; Williams and Brennan, 2012; Adamson, Cortis, Brennan, and Charlewsorth, 2017). Canadian LTC is discussed in more detail below.

### **III. Long-Term Care in Ontario and in Canada**

The meaning of LTC can be quite broad in the Canadian context. LTC refers to a



network of health and social care services. The social care aspect involves social programs and services, such as income-supported housing. The health-care related aspects of LTC refers to nursing and medical care, therapeutic care, recreational care, and care that has to do with activities of daily living. Activities of daily living refer to everyday tasks that are carried out regularly, such as: walking, dressing, feeding, toileting, and taking a shower or bath (Vladeck, 2003; Banerjee, 2010; Canadian Institute for Health Information (CIHI), 2011). There are also instrumental activities of daily living, such as: shopping, housekeeping, and food preparation (CIHI, 2011; Personal Support Network of Ontario (“PSNO”), 2017a).

LTC is essentially the arrangement of institutional forms of care. This institutionalized form of care includes: home support and home care, as well as care in adult day centers, complex continuing care centers that are often attached to hospitals, retirement homes, assisted living facilities, and long-term residential care facilities (Banerjee, 2010; Ontario Ministry of Health and Long Term Care (OMHLTC), 2014a; OMHLTC, 2017). Home support and home care refer to the support and care of seniors with complex medical conditions who can often stay in their own homes if they receive particular kinds of support (OMHLTC, 2014a). Retirement homes are privately-owned, privately-paid accommodations for seniors who require little to no outside assistance, and typically do not need 24 hour nursing care (OMHLTC, 2014b). LTC facilities, on the other hand, refer to nursing homes, municipal homes for the aged, or charitable homes (OMHLTC, 2014c; OMHLTC, 2017a). LTC facilities are “[...] distinguished by the availability of 24 hour nursing care. They are also licensed and regulated by provincial governments” (Banerjee, 2010, p. 5). While recognizing these aforementioned boundaries of institutionalized forms of care, the focus of my dissertation is on the latter. The research presented in this dissertation is drawn from a residential LTC facility for seniors and the elderly.



Canadian LTC funding and service provision is complex. Canada's constitution, *The British North America Act* of 1867, does not explicitly state health and social care as matters of constitutional assignment and, in fact, the concept of health is missing in the delegation of federal or provincial legislative responsibility (Jackman, 2000; Braen, 2004). Instead, health and social care were thought to be concerns for religious and charitable organizations (Braen, 2004). However, the constitution does assign division of powers primarily through fiscal matters and spending as a federal power, and accordingly, provincial or territorial governments have taken jurisdiction over hospitals and local matters (Jackman, 2000).

In Canada, LTC is deemed an extended health service in the federal *Canada Health Act* of 1984, and it has often fallen outside the scope of the country's universal health insurance scheme (Alexander, 2002; Armstrong and Armstrong, 2010). Governments have increasingly relied upon LTC facilities for care that was previously provided in hospitals because they offered opportunities for governments to save money and resources while transferring the financial burden to people who pay for accommodation costs through out-of-pocket payments (Armstrong and Armstrong, 2006; Armstrong et al., 2009; McDonald, 2015). The federal government typically funds medical and health services that are provided by physicians, nurse practitioners, and nurses in LTC. These health services, however, are administered and delivered by the provinces and territories. Each province can have differing patterns and practices of service integration, design, size, ownership, and profit status (Pitters, 2002; Banerjee, 2009; Banerjee, 2010; Day, 2014; McDonald, 2015). For example, in Ontario, funding for non-health related services, such as accommodation, is paid privately or semi-privately, albeit subsidies may be available to those who qualify based on means testing<sup>8</sup> (OMHLTC, 2014a; McDonald, 2015;

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<sup>8</sup> Means testing refers to determining if income or assets meet a certain threshold after which an applicant would be approved or disapproved for public services. This type of decision making often occurs in neoliberal welfare states.



OMHLTC, 2017b). In Ontario, funding of LTC facilities covers only basic accommodation, so there is no funding for private or semi-private rooms (OMHLTC, 2017b). Ownership of LTC facilities can also vary. They may be publicly owned and operated, or they may be privately held. Furthermore, they may be not-for-profit and charitable, or they may be intended as a for-profit business venture (Pitters, 2002; Banerjee, 2010; McDonald, 2015).

### ***What is LTC Work?***

LTC work encompasses a wide range of services and sites for care, including home care, community-based services and care, supportive/assisted living, and facility-based care (OMHLTC, 2014a). The diversity in services and sites of care reflect the case mix of the elderly populations, who often have increasingly complex health needs, significant disabilities, and dementia rates estimated at 56.7% among residents in Canadian LTC homes (Aylward, Stolee, Keat, and Johncox, 2003; Canadian Study of Health and Aging Working Group, 1994). Furthermore, elderly residents are often frail, have multiple medical conditions, and have varying survival rates ranging from three months to 10 years, with an average of three years (Daly and Armstrong, 2016).

The health-related aspects of LTC work involve medical and nursing care. This care work can include: administration of medication and diabetic supplies, wound and skin care, flu vaccination, testing kits, medical equipment fixtures, dementia care, incontinence care, pain management, medical monitoring, and access to specialized allied health professionals and therapists, including physiotherapists, recreation therapists, etc. (OMHLTC, 2014a). The other aspects of LTC work involve assistance with activities of daily living, waking residents in the mornings, dressing them, lifting and transfers, meal preparation, feeding, bathing, grooming, toileting, getting them ready for bed each night, laundry, housekeeping, hospitality services,



social programming, and recreation (Armstrong, Armstrong and Scott-Dixon, 2008; Armstrong et al., 2009; Day, 2014; PSNO, 2017a).

### ***Who Performs LTC Work?***

The mix, title, and regulation of LTC workers vary across provincial and territorial jurisdictions. Many workers in urbanized communities are increasingly from racialized or immigrant populations (Alexander, 2002; Pitters, 2002; Maclean and Klein, 2002). This trend reflects the fact that historically, wealthy countries in the global North have sought out workers from countries of the global South as sources of cheap and flexible labor (Banerjee, 2010; Eckenwiler, 2012; Day, 2014; Syed, 2015). However, there is one common theme across all of Canada regardless of urbanization: women make up 80% of the workforce in the health sector (Armstrong and Laxer, 2005). Correspondingly, women also tend to do the overwhelming majority of work in LTC (Alexander, 2002; Pitters, 2002; Maclean and Klein, 2002; Banerjee, 2010; Day, 2014).

LTC work consists of a highly gendered labor force. This pattern of women's overrepresentation as workers in the health sector, and within LTC, reflects the gendered stereotypes and assumptions that set limits on women's roles, the latter of which I have mentioned in the previous chapter. For example, care within the family is considered to be primarily a private responsibility of women, which serves to reproduce and reinforce the notion that care work is a natural extension of women's roles (Day, 2014). These stereotypes and assumptions result in the placement of women in jobs that are so called light-duty work, such as the work that women occupy in LTC. In reality, care work is not light-duty work at all and it is both mentally and physically challenging (Armstrong and Armstrong, 2010).

Caregiving work is considered to be natural and therefore good for women, and it is morally and ethically elevated in this regard (Armstrong, Armstrong, and Scott-Dixon, 2008;



Armstrong et al., 2009; Armstrong, 2013b). However, the stereotyping and gendered assumptions about care workers (e.g. Williams, 2011) and care work, either in the home or in the labor market, can be detrimental to women's material position because it is devalued, underpaid, and defined as unskilled work (Banaszak-Hall and Hines, 1996; Armstrong, Armstrong, and Scott-Dixon, 2008; Armstrong et al., 2009; Armstrong, 2013b). The stereotypes and assumptions about care work and care workers are further problematic because they can lead to economic disparities in women's wages that perpetuate inequities in material conditions, making women vulnerable to poverty (Doyal, 1995) and health problems (Armstrong and Armstrong, 2010).

The people who do the work in LTC homes occupy various categories and titles, and they include: registered nurses ("RNs"), licensed/registered practical nurses ("RPNs"), nursing assistants, physiotherapists, occupational therapists, speech language pathologists, speech therapists, recreation therapists, personal support workers ("PSWs"), nursing aides, health care aides, dietary aides, cooks, counselors, chaplains, social workers, housekeepers, laundry staff, maintenance workers, security officers, clerical workers, care coordinators, office and administrative staff (Banerjee, 2010; Syed, Daly, Armstrong et al., 2016). Although all of the above types of workers are critical to care, the literature suggests that the majority of the direct care work in Ontario residential LTC is done by PSWs (Noelker, 2001; Armstrong and Daly, 2004; Armstrong, Armstrong, and Scott-Dixon, 2008; Banerjee, 2010; Day, 2014), so it is important to describe them here.

PSWs are commonly known as nursing assistants, nurses' aides, health care aides, and personal care aides. These occupational titles vary by region and facility because of PSWs' unregistered and unregulated status compared to other workers such as RNs and RPNs



(Armstrong, Armstrong, and Scott-Dixon, 2008; PSNO, 2017b). PSWs' work involves waking residents in the morning, washing, grooming and preparing them for meals, physically moving residents, feeding, toileting, bathing, and preparing residents for bed at night, as well as documentation of all of this work (Armstrong et al., 2009; PSNO 2017a; Syed, Daly, Armstrong et al., 2016). Research has shown that PSWs are perceived to have ancillary roles rather than being recognized as the backbone of LTC work (Armstrong, Armstrong, and Scott-Dixon, 2008; Armstrong, Banerjee, Szebehely et al., 2009). As a result, they are poorly compensated, receive few benefits, and often work in part-time, flex-time, or casual positions (Armstrong, Armstrong, and Scott-Dixon, 2008). PSWs are also perceived to be the lowest in the labor hierarchy, because they often have little input in organization and planning of formal care, although they do retain some limited control over how they work (Day, 2014). My research contributes to knowledge of the working conditions of PSWs and other care workers by examining social interactions and relations in order to analyze how working conditions align with care workers' health and wellbeing.

#### **IV. What is Involved in LTC Work?**

Long-term care work is challenging, labor intensive, and it can involve both structural and physical violence (Banerjee, 2010; Daly, Banerjee, Armstrong et al., 2011). Not surprisingly, research suggests that the effort inputted in LTC involves workarounds (Chadoin, Messing, Daly et al., 2016), as well as a lot of sacrifice (Baines, 2006). There are also visible and invisible aspects of care that is correspondingly paid and unpaid care (Baines, 2006). The reason for this dichotomy is complex and is explained below.

##### ***Visible and Paid Care***

The term 'visible care work' refers to the types of care work that are generally seen and counted by managers, organizations, structures, or governments. In a Canadian context, often



this visible care is oriented to include medical and nursing care (Banerjee, 2010; OMHLTC, 2014a; OMHLTC, 2017b), but less social care. Visible care would include physical checkups, pushing wheelchairs, lifting and transferring residents, administration of medications, activities of daily living, meal preparation, feeding, laundry, housekeeping, hospitality services, social programming, recreation, and access to specialized allied health professionals and therapists, including physiotherapists and recreation therapists. Visible care also includes the use of standardized tools for documentation and the coding of care encounters (Armstrong, Armstrong, and Scott-Dixon, 2008). It also includes activities that are quantified and measured, such as the number of sheets changed, baths given, and meals prepared or delivered (Baines, Evans, and Neysmith, 1992; Day, 2014; Armstrong, Daly, and Choiniere, 2016). The coding of care in Ontario and across Canada and the United States involves a program called RAI-MDS (Resident Assessment Instrument - Minimum Dataset), which is used to arrive at a LTC home's Case Mix Index ("CMI"), and is also critical in maintaining the LTC home's funding (Daly, 2013; Armstrong, Daly, and Choiniere, 2016). Unfortunately, such coding of care-work counts and renders visible the work that involves mostly physiological tasks. These are the tasks "[...] that can be counted, measured, and performed within a market-based contract" (Day, 2014, p. 40-41). Such coding and counting does not include invisible forms of care that are involved in care work, which is often social and emotional care, as discussed below.

### ***Invisible Care, Invisible Skills, and Invisible Work***

Research suggests that the providers of care (i.e. the carers) are required to perform tasks beyond the formal measurements and definitions involved in their occupational tasks (Baines, 2004; Armstrong, Armstrong, and Scott-Dixon, 2008). This care work is uncounted and invisible, yet it is work that must be done (Baines, 2004). Such invisible care work is a complicated matter for several reasons.



Firstly, the meaning of skills is complex, ambiguous, and not simple to assess (Armstrong, Armstrong, and Scott-Dixon, 2008). Skills are often defined to reflect the level of education required in the labor market (*ibid*). Such definitions would mean that high-skilled jobs would reflect university-level education, and low-skilled jobs reflect high school level education or less. However, these definitions ignore the learning and the experiences acquired from a job, or from other places (*ibid*). Indeed, LTC work is often essentialized as unskilled work (Banaszak-Hall and Hines, 1996), usually on the basis of educational credentials. The reality is that it involves the use of various skills, including: interpersonal skills, clinical skills, technical skills, literacy skills, numeracy skills, and computer skills (Armstrong, Armstrong, and Scott-Dixon, 2008).

Secondly, the value and visibility of care skills are connected to power, gender, and race. Skills that are carried out by particular groups are often stereotyped and essentialized. For instance, skills that are used in clerical and personal care occupations are assumed to be work in which women, [im]migrants, and racialized people use their inherent or generic skills (Armstrong, Armstrong, and Scott-Dixon, 2008; Williams, 2011). In addition to these assumptions and stereotypes, the context of the labor force, various structures, and political systems can also limit the power of women, [im]migrants, and racialized people who carry out LTC work, frequently pitting these groups against each other, and reinforcing the low wages paid to these workers.

Thirdly, in the health sector, care work involves a care relationship, as well as extensive interpersonal contact between providers and recipients of care (Banaszak-Holl and Hines, 1996). Care relationships are social relationships (Armstrong, Armstrong, and Scott-Dixon, 2008). As a result, both the carer and the patient (or resident) are emotionally involved (*ibid*). Such relationships cannot be easily measured or counted. Rather, they are things that are observed and



developed over time. For example, PSWs' work strategies not only involve empathy, but they must also tailor their tasks to the complex interactions they have with residents (Kontos et al., 2010a). Thus, care work requires emotional labor (Diamond, 1992; James, 1992; Hochschild, 1983; Hochschild, 1995). LTC work also requires hands-on bodywork and "[...] requires a great deal of skilled interpersonal labor to accomplish important care outcomes" (Day, 2014, p.34). Care work can further involve negative emotions as well as inequalities in care relationships, which oftentimes are ignored because of assumptions that emotions associated with care are always positive (Day, 2014). This assumption is challenged by Canadian research that suggests that care work can involve negative emotions, and structural or physical violence (Banerjee, 2010; Daly, Banerjee, Armstrong et al., 2011).

Fourthly, there are differences in power and knowledge between the carer and the persons seeking care (Armstrong, Armstrong, and Scott-Dixon, 2008), and these social factors are not easily measurable, nor do they necessarily get counted. For example, the people who are seeking care have various needs and demands. They can be vulnerable, dependent, ill, injured, disabled, frail, or emotionally fragile (ibid). LTC workers have to listen, discuss, and negotiate a plan with those seeking care by taking into account individual preferences, attributes, abilities, and health issues (Aronson and Neysmith, 1996; Armstrong, Armstrong, and Scott-Dixon, 2008). LTC workers must rely on their knowledge of how to maximize the comfort of care recipients, how to interpret residents' behaviors, while also minimizing concerns over the spread of infections (Armstrong, Armstrong, and Scott-Dixon, 2008). They receive sensitive information, personal stories, and details that are shared with them but without being sought, and they must deal with this psychological weight. Day (2014), p.12 demonstrates how certain care workers, such as PSWs, build and negotiate these social care relationships: they may seek out and apply



“[...] biographical information from residents and their family members” and also draw on their own personal experiences.

There are also organizational contexts as to how care is defined, and why some forms of care is counted and others rendered invisible or even treated as deviating from traditional care practices (James, 1992; Stone, 2000; Day, 2014). For example, employees in the caregiving sector may need to work differently from official organizational practices. Research indicates that PSWs work-around and depart from certain official rules and practices, and they make selective rule-breaking decisions in order to: maximize their work efficiency, improve upon the quality of care they are providing, and prioritize the care needs of residents (Bowers and Becker, 1992; Jervis, 2002). The work of Day (2010, p 10) speaks to this phenomenon: “For these frontline workers, the way that work was officially supposed to be done was understood as getting in the way of the care necessities they knew residents required”. Additional research demonstrates that care work involves work around strategies in order to meet the demands of the job (Dellefield, 2006; Kontos et al., 2010a; DeForge et al., 2011; Day, 2014; Chadoin, Messing, Daly et al., 2016).

The above-noted workplace strategies highlight the tension between the constraints involved in care work, the need to accomplish certain prioritized care tasks, and the risks involved (Armstrong and Daly, 2004; Lopez, 2006a; Lopez 2006b; Lopez 2007; Syed, Daly, Armstrong et al., 2016). For example, time constraints force workers to develop their own strategies of completing care and they often risk their own health and safety in this process (Lopez, 2006a; Lopez 2006b; Lopez 2007; Day, 2014; Syed, Daly, Armstrong et al., 2016). Unfortunately, many of these workers are misinterpreted as resisting and deviating from the rules and regulations of care (Kontos et al., 2010a). These workers are then essentialized as unwilling



to cooperate, or they are constituted as having personal failings (Kontos et al., 2010a). In addition to the structural limits enforced upon care workers' duties, some forms of organizational culture and management practices prohibit forms of care that mimic family-like relationships (Stone, 2000; Lopez, 2006a; Day, 2014).

Finally, it is important to note that sometimes there is a risk that care work remains unfinished because there is insufficient time to complete it, which has been documented by researchers (Armstrong and Daly, 2004). At other times, the care is either streamlined, or there is material sacrifice that is involved in care work, such as unpaid overtime work (Baines, 2006). Quite frequently, the sacrifices and streamlined care that is provided by LTC workers masks the reality that the working conditions in LTC are difficult. For instance, there are hierarchical work relations among and between various categories of workers, which can diminish team-oriented care and individualize it (Syed, Daly, Armstrong et al., 2016). There is also an added burden of high work effort combined with low wages. The evidence also suggests that there are racialized stereotypes in care work that operate in hierarchical ways (Williams, 2011; Syed, Daly, Armstrong et al., 2016), and there are numerous occupational health and safety hazards, precariousness, and labor exploitation (Williams, 2010; Williams, 2012), some of which are discussed below.

## **V. The Working Conditions in LTC**

LTC workers face numerous on-the-job hazards and constraints. For instance, Canadian research suggests that short-staffing/understaffing, and overwhelming workloads lead to feelings of inadequacy and exhaustion among employees (Banerjee, Daly, Armstrong et al., 2008). In addition to the risks to health and wellbeing associated with care work, LTC employees also face numerous risks to their health and safety on the job, including violence from residents (Armstrong and Daly, 2004; Banerjee, Daly, Armstrong et al., 2008, Banerjee, 2010; Morgan,



Crossley, Stewart et al., 2008; Daly, Banerjee, Armstrong et al., 2011) and health risks associated with increasing workloads due to care restructuring (Armstrong and Jansen, 2006). Workers also reported increased managerial surveillance, reduced work-autonomy (DeForge et al., 2011; Day, 2014), unwanted sexual attention, and racism on the job (England and Folbre, 1999; Duffy, 2005; Banerjee, Daly, Armstrong et al., 2008; Day, 2014).

### ***Hierarchical Workplace Relations***

Front-line Canadian LTC workers include a variety of occupations. Care work requires the collaborative effort of all of these multiple categories of workers who are often arranged in a team, and this team requires interaction and integration between and among the providers of care (Armstrong, Armstrong, and Scott-Dixon, 2008). However, research suggests that these teams are hierarchically arranged and function less as teams and more individually (Kontos et al., 2010a; Day, 2014; Syed, Daly, Armstrong, et al., 2016). Accordingly, it is imperative that these hierarchical relationships are analyzed in research practices rather than decontextualizing the experiences, interactions, and relations between and among workers. Furthermore, there may also be learning opportunities from these various perspectives and contexts that could otherwise be lost if there is a focus on only one set of workers. Finally, it is important to include the perspectives of a broad range of workers because the interactions and relations between individuals are embedded in social, economic, and political contexts that are an essential part of feminist epistemology that investigates social relations, and especially relations of ruling.

Care work is also downloaded along skill hierarchies, through gendered pathways (Hallgrimsdottir, Teghtsoonian, Brown et al., 2008; Day, 2014) and racialized pathways (Williams, 2011). For example, the work that has to do with physical tasks, manual labor, and the human body is accorded low status and poor remuneration, often falling on the shoulders of PSWs rather than registered nurses, physicians, and other health professionals (Diamond, 1992;



Twigg, 2000; Twigg, 2002; Gordon, 2006; Day, 2014). These hierarchies reflect the organization of care work under a market model, which seeks to control care labor through standardization, measurement, and documentation of care tasks while prioritizing and maximizing profits (Leduc-Browne, 2010; Daly, 2013).

### ***Market Liberalism and Neoliberalism***

The micro, meso, and macro levels of a political economy analysis shape care work (Williams, 2012). The micro level has to do with the day-to-day care relationships between workers, recipients, and employers. The meso level has to do with transnational institutions (such as businesses and organizations that are involved in health and social care) and networks through which care workers are connected (such as unions or labor networks) (ibid). Finally, the macro level has to do with the international and transnational space in which care workers and their families inhabit (Williams, 2012), such as the global context in which health and social care is often supplied by immigrant workers.

The working conditions in Ontario LTC are shaped by micro-level interactions of social actors within the context of the market-model, and also by the broad neoliberal ideologies and interests that subject care to the demands of individualization, profit-maximization, privatization, and cut-backs (Day, 2014). The neoliberal model of care is characterized by the application of market principles of supply and demand to the organization and function of care work (Daly and Lewis, 2000) and often under a guise of efficiency and elimination of wasteful resources (Daly, 2007; Armstrong and Armstrong, 2010). Under the neoliberal model of care, services in LTC facilities are often contracted out in order to control costs, and include the adoption of for-profit business-oriented managerial techniques (Daly, 2007; Armstrong, Armstrong, and Scott-Dixon, 2008; Seeley, 2012).



The neoliberal model of care narrowly conceptualizes care as quantifiable, physiological tasks that are counted, measured, and sold as if they are packaged products to consumers of care (Knijn, 2000). In order to maximize profits, this market model of care focuses on cost-cutting, and this has troubling implications for LTC workers (Day, 2014). As others have pointed out (e.g. Cohen-Mansfield, 1997), it begins with reduced staffing, and work that relies upon both the paid and unpaid labor of poorly remunerated and low-status care workers, who are from various social locations marked by gender, race and class (England and Folbre, 1999; Duffy, 2005), and immigrant status. The neoliberal mandate that has shifted care out of hospital settings and into LTC facilities has also resulted in increasingly complex care needs of residents (Armstrong and Armstrong, 2006; Armstrong et al., 2009). Both the resource-constraints under the market-model of care, and the rise in acuity of residents have translated to high workloads and workers' exposure to health and safety hazards (Armstrong and Jansen, 2003; Baines, 2006; Banerjee, Daly, Armstrong et al., 2008; Morgan, Crossley, Stewart et al., 2008; Day, 2014).

Researchers have identified that this neoliberal context results in a workplace struggle that materially coerces workers to perform unpaid care so that they retain their occupation, yet workers also feel a compulsion to work through moral principles of altruism (Baines, 2004). As a result, workers may self-identify themselves as being good and just when they provide care outside of their official contractual obligations (Baines, 2004; Day, 2014), but realistically they are exploited through such moral principles. Under such contextual norms, the working conditions of LTC workers include structural and personal violence, and precariousness (Armstrong and Laxer, 2005; Banerjee, 2010; Armstrong and Armstrong, 2010; Daly, Banerjee, Armstrong et al., 2011; Daly and Armstrong, 2016).

While Canadian studies recognize that many frontline care workers are women (Morgan,



Stewart, D'Arcy, et al., 2005; Banerjee, 2010), the reason behind such gendered work could be that men do not want to work in this sector because the wages are too low, and because it involves particular tasks, such as cleaning feces (Armstrong, Armstrong, and Scott-Dixon, 2008). Research further suggests that it is not women in general who carry out this sort of work, but rather [im]migrant and racialized women who do the dirty work (Anderson, 2000; Peterson, 2007). Many of these tasks parallel the descriptions of what Syed (2015) and others (Rodriguez, 2010; Standing, 2011) describe are the 4 Ds of precarious work: dirty, difficult, dangerous, or damned.

### ***Precarization***

Research demonstrates that the working conditions in LTC are often precarious, dangerous, and they put front line care workers at risk of injury or illness, including abuse and violence which often goes unreported (Mayhew and Chappell, 2002; Banerjee, 2010; Day, 2014). LTC workers experience precarization, and also precariousness in its traditional meaning i.e. because of job insecurity, combined with limited benefits and entitlements, irregular work, shift work, and low wages (Baines 2004; Banerjee, 2010; Daly and Armstrong, 2016). For example, in Ontario, while the minimum wage is presently \$11.60 per hour (Government of Ontario, 2017), wages for frontline care workers are only moderately better than this, ranging from \$12.50 per hour to approximately \$23 per hour (PSNO, 2017c). Government-set minimum wages are much lower than the maximum amount of \$23 per hour: the OMHLTC announced on April 30, 2014 that the minimum wage for publicly-funded PSWs would be set from \$14 per hour effective April 1, 2014 to \$16.50 per hour by April 2016 (PSNO, 2017c). These wages are only minimally higher than the general minimum wage, which was set to be \$15 per hour by 2019 (Government of Ontario, 2017), but this change has been blocked by the election of the conservative government and its leader Doug Ford (Crawley and Janus, 2018; Loriggio, 2018).



Other care workers, such as companions, have salaries ranging from \$10 to \$23 per hour (Daly and Armstrong, 2016).

## **VI. Discussion**

Previous research and analyses of LTC facilities has exposed the fact that these sites rely upon and reproduce the biomedical model of care that frames LTC provisions and care tasks through the notion that health is an absence of disease or disability (Armstrong and Banerjee, 2009; Armstrong and Armstrong, 2010; Day, 2014). This narrow definition focuses on an individual pathology, a decontextualized body, and an individualized plan of management, monitoring, and treatment without considering the social determinants of health (Reiser, 1995; Raphael, 2000; Cancian, 2000; Raphael, 2004; Armstrong and Banerjee, 2009; Armstrong and Armstrong, 2010). Through my doctoral dissertation, I hope to expand upon this research in regards to occupational health and safety of LTC workers and also to illuminate any risks to quality of care for residents. In particular, the focus is aimed at the SDoH that have every-day impacts on workers.

Despite the findings that the working conditions in LTC have been characterized as highly gendered and racialized, and the work is marked by violence and certain levels of precarization, there is limited understanding as to why or how workers continue to do what they do. There is also partial reflection upon the broad conditions that shape particular health and safety outcomes of workers e.g. with respect to the social determinants of health. With the above evidence related to the working conditions in LTC, this dissertation seeks to answer the following questions: How do racialized and immigrant workers experience work in residential LTC? In what ways (and why) is precarization occurring in LTC? Are there gender differences?

Although there is some research about precariousness in LTC for ancillary workers and for PSWs, in terms of precarization related to the SDoH for these care workers, the literature is



sparse. For instance, there is little information about broad determinants such as urban infrastructure, urban planning, and the built environment that includes things such as transportation and commute times. This doctoral dissertation builds upon existing studies in its attention to everyday aspects and processes, such as living/housing conditions, transportation, income adequacy, and budgeting. I also aim to examine broad structural processes of immigration and globalization, and how they may shape the working conditions in LTC.

Some evidence also suggests that there are limited ways in which workers, particularly the ones who are in the lowest workplace hierarchy, exercise resilience and agency. For instance, Day (2014, p.5) renders visible the care work of PSWs who prioritize certain tasks, adjust the tempo of their daily/nightly work, re-arrange their workload, devise work strategies, and make decisions about how to carry out the job requirements of care in a continual process of trying to “make it work”. The work of Lee-Treweek (1997) highlights that LTC workers show some control and resistance in their work by incorporating: selective compliance of prescribed tasks, and depersonalization strategies. Armstrong and Daly (2004) found that sometimes the care simply does not get done, with some tasks skipped in order to accomplish certain prioritized tasks. This evidence suggests that workers retain some measure of control over their daily work processes, although this control is severely constrained (Banerjee, Daly, Armstrong et al., 2008; Day, 2014). Baines (2011) and others (Baines and Daly, 2015) indicate that a number of resistance practices exist in the voluntary and non-profit social services sector. These include intra-workplace practices as well as civic/social engagement and activism outside of the workplace as follows: advocating for service recipients, even if workers were advised not to do so by their supervisors; encouraging service users to advocate for themselves even if it involved risk to self; bending rules for service users; organizing collective user groups outside of the



workplace; building coalitions with social movements or agencies; and using unions for social justice (Baines, 2011; Baines and Daly, 2015). Others have focused on women's agency in domestic work, such as actively seeking migration in order to improve the migrant's own family situation through remittances sent home, and using migration as a stepping stone for attaining education and qualifications for work (Williams, 2010). However, there is a limited understanding beyond social movement and civic engagement capacities about LTC workers' agency and whether or not (and how) LTC workers resist and cope with exploitation or abuse once their shifts end.

This study seeks to illuminate how coping strategies may unfold and whether or not there are spillover effects in the personal lives of LTC workers. By rendering these coping and resilience strategies and processes of workers visible, this dissertation begins from an assumption that care is the end result of how care workers must strategically organize both their working conditions and their personal lives in order to avoid occupational injury, illness, and disease to manage their multiple responsibilities within and outside of the workplace. By looking at the occupational health and safety of workers through the social determinants of health perspective, I seek to highlight the ways in which workers' total health and wellbeing is shaped by multiple determinants. I also seek to capture individual, collective, and collaborative strategies and processes of coping and resistance that enable people to work through these conditions.

Using a feminist political economy framework, my investigation of immigrant and racialized care workers' experiences utilizes multi-level analyses that are situated within nested areas: from the micro-level context and the social location of the worker, to the organization context (i.e. the occupational and environmental conditions in which the worker is situated), to



the macro or global level context (i.e. the broad processes of globalization and neoliberal restructuring).

A feminist political economy framework is concerned with connections between market relations and domestic relations (Armstrong and Braedley, 2013). It assumes that while social actors shape their social, economic, and political histories in local, national, and international arenas, people are not necessarily able to do things as they please (Armstrong and Armstrong 2001; Armstrong and Armstrong, 2010; Armstrong and Braedley, 2013). My project incorporates these assumptions, focuses on how working conditions shape the decision-making processes of care workers, and understands these working conditions as being shaped by micro, meso, and macro-level social, political, economic, and global processes.

Finally, perhaps the best place to start thinking about a global context for a case study of LTC is to consider an issue of global population movement and mobility. Current estimates indicate that there are 214 million international migrants (International Organization for Migration (“IOM”), 2013), of which Canada ranks in the seventh place among the top recipient countries who employ foreign-born caregivers of LTC (WHO, 2017). Indeed, as Day (2014) recognizes, the global patterns of migrant care labor are an under-researched aspect of the LTC work experience in Canada, although there is some literature about migrant workers’ contributions to elderly care (Howe, 2009; Khoo, McDonald, and Hugo, 2009; Williams, 2011; Williams, 2012; Adamson, Cortis, Brennan, and Charlewsorth, 2017) and other types of care work in international contexts (Williams, 2010). My project seeks to extend prior literature on what is known about migrant and racialized LTC workers, and their occupational health and safety conditions. Beginning from the notion that workers themselves are the best sources of evidence for understanding their work experiences, this dissertation draws on rigorous primary



interview data, survey facts, and observational information to understand the working conditions of racialized and immigrant care workers. The next chapter of this dissertation focuses on current knowledge and research of immigrant and racialized people's occupational health and its connection to precarization.

## **VII. Summary**

This chapter has discussed the LTC context internationally and in Ontario, as well as the literature describing the working conditions in LTC. I have provided a review about the nature of LTC work, including details of what is involved in the work, and I have provided descriptions of the people who carry out the work. As the literature indicates, this sector predominantly involves the work of women, racialized people and immigrants, and also involves work that is highly intensive and challenging. Moreover, the tasks carried out require a variety of special skill sets, some of which are rendered visible and others invisible. These tasks are carried out by broad categories of workers, such as nurses, personal support workers or health care aides, recreation and activation workers, social workers, nurse practitioners, physiotherapists or occupational therapists, physicians, and chaplaincy staff among others. I have also indicated some of the key gaps in the literature.

In the next chapter, I will outline a broader and detailed context of precarious work and precarization that is situated beyond the setting of LTC, and I connect this to the occupational health literature. I will also demonstrate the ways in which the process of precarization is connected to the SDoH, and to the work of immigrants, racialized people, and women.



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**Chapter 4: Precarization, Immigrant Work, and Occupational Health Literature**

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**I. Introduction**

Chapter one introduced the concepts of precarity, precarious work, precaritization, and precarization. In the current chapter, I expand on the process of precarization (or precaritization) and connect it to the occupational health literature.

In the second section of this chapter, I discuss the traditional meaning of precarious work and the theoretical assumptions behind a standard, normative model of work. The literature shows that in the contemporary period, precarious work reflects a continuation of an employment norm and legacy built under an assumption of a male breadwinner, female caregiver contract, which has specific consequences for both economic production and social reproduction.

The third section includes a theoretical discussion about the broad ways in which precarious work and the process of precarization may affect the health and safety of workers, and how these are connected with the social determinants of health (“SDoH”). While the various sociological perspectives about precarious work that are outlined in this section are important, these accounts are often distinct from ones that also include health perspectives, and on numerous occasions they neglect a SDoH approach to understanding health and illness. There is now a growing body of literature that provides an opportunity to make these connections. This literature review aims to bridge connections between the literature about precarious forms of work and SDoH and offers the concept of precarization as an alternative way to understand these experiences.

In the fourth section of this chapter, I present the literature about the proliferation of precarious labor. The work of critical political economists indicates that the spread of precarious labor (and precarization) has resulted from broad structural factors, policies, and practices.



These policies and practices include neo-liberalization of labor at various levels such as: the global level, nationally, and regionally. These perspectives indicate that conservative capitalism, neoliberalism, and new public management strategies are circumstances under which many workers are experiencing precarization and that these strategies mimic historical forms of labor exploitation.

In the fifth section of this chapter, I discuss immigration, market migration, and I highlight how precarious work involves not only the work of women, but also immigrants and racialized people, the latter of whom often experience “Othering”, racialization, and other forms of discrimination. I provide a detailed review of the literature that demonstrates the possible ways in which immigrant and racialized employees experience health consequences of precarization as a result of their working conditions. As the literature shows, many of the experiences of racialized and immigrant people in Canada and elsewhere involve globalization. These experiences are dynamic and complex because they involve the immigration and flow of people who may be immersed in social processes such as acculturation or cultural assimilation (Berry, 1997; Syed, 2012). They may also involve economic processes and the flow of capital in the form of international remittances. I also discuss the possible ways in which the literature of precarious work can be connected with the literature of double-workday stress and musculoskeletal conditions. Both of these things tend to be intensified among women, and especially immigrant or racialized women. In addition to these things, this section discusses the concept of resilience or agency that workers hold despite their vulnerable work circumstances.

In section six, I discuss the gaps in the literature and discuss how my dissertation seeks to expand upon and fill any knowledge gaps. By bringing all this literature together, I hope to identify how my research of immigrant and racialized female workers in LTC can provide an



opportunity to bridge knowledge gaps, and investigate any important points of contention. For instance, although there is some data about LTC workers' incomes, the gendered aspects of care work, and the working conditions in LTC, all of which I have described in chapter three, the literature is sparse in making the connections between income, race, immigrant status, and other SDoH, and the levels of precarization that are experienced by racialized and immigrant LTC workers. The literature is also sparse in explaining how these determinants affect LTC workers' total health and wellbeing.

While this chapter highlights how precarious work and precarization are frequently characterized by the work of immigrants and racialized people who may be experiencing underemployment, underutilization of skills or rather under-compensation, despite possessing a wide range of skills, this phenomenon is only sparsely documented in the migrant care work literature (e.g. Williams, 2010). Thus, it is a promising area of investigation. Finally, although there is some research about care workers' agency and resilience (e.g. Baines, 2011; Baines and Daly, 2015), the literature about this is limited to particular workplace strategies, social movements, and civic engagement. Accordingly, there is a need to gather additional data. Below, I begin the discussion with the traditional meaning of precarious work.

## **II. The Traditional Meaning and Context of Precarious Work**

This section discusses examples of precarious work from the literature. It also contains information about the general assumptions concerning the standard, normative model of work, and how these assumptions continue to unfold by manifesting themselves in gendered sectors of employment.

As I indicated already in chapter 1, precarious work is specific to less permanent forms of employment relationships. Precarious work is often associated with low remuneration; limited



or no job security, and often excludes severance pay, bonuses, health, dental, maternity or paternity benefits, and association with unions (Vosko 2005; Galabuzi, 2006).

It is estimated that approximately 25% of Canadian workers participate in these sorts of precarious, flexible, contingent, and non-permanent work circumstances (Lewchuk, Clarke, and De Wolff, 2011). Canadian studies echo the concerns raised by the World Health Organization (“WHO”) (2007): that the presence of non-standard and precarious work, compounded by decreased levels of social protection can lead to income inequalities (Vosko, 2005), occupational health problems, and poor health among workers (Lewchuk, Clarke and De Wolff, 2011).

In Canada, the normative model of standard, 9 a.m. to 5 p.m. employment, was originally built under assumptions of a family wage model, with a male-breadwinner, female caregiver contract in which women were often confined to the private, unpaid sphere (Connell, 1987; Vosko, 2005). One of the widespread assumptions under these models was that women were viewed to be in the workforce only temporarily, and they were never considered to be primary wage earners (Eichler 1997; Fraser, 1997; Vosko and Zukewich 2005, Lewchuk, Clarke, and De Wolff, 2011). As a result, women were excluded from early unemployment insurance policies (Porter, 1993; Vosko, 2005). Women with children were also excluded from the paid labor market and were made responsible for care-work and unpaid domestic labor (Lewchuk, Clarke, and De Wolff, 2011). Those women who did participate in the labor market worked in gendered and racialized occupations such as teaching, nursing, and domestic work (Porter, 1993; Vosko, 2005). In contrast to the assumptions about women, men who were viewed as being “wounded in war or at work” as a result of any injuries that they may have endured, were entitled to receive benefits such as rehabilitative care (Dossa, 2009, p. 19).



Today some of the gendered labor market practices that exist extensively in Canada are likely (and inappropriately) re-enforced by the same outdated assumptions of the family wage model consisting of a male-bread winner and female caregiver contract. The perpetuation of these assumptions has consequences for both economic production and social reproduction. For example, feminist political economists suggest that women continue to occupy unequal positions in the Canadian labor market (Armstrong and Armstrong, 2010; Duffy and Pupo, 1994; Luxton and Corman, 2001), and continue to be highly concentrated in certain work sectors while also being absent in other sectors. Industries such as the goods producing sector have few women employed compared to men (19% versus 45%, respectively) (Vosko, 2005). The reason for these disparities could be explained by the persistence of gender stereotypes about women such as that of biological determinism, and the myth that women are smaller or weaker than men that would confine them to certain occupations or sectors, as I have discussed in previous chapters of this dissertation. Equally important are the consequences that such circumstances have for women, and women's work.

The consequences of gendered labor market practices mean that many women are increasingly participating in precarious forms of work rather than stable, secure, and long term forms of full employment (Vosko, 2005). Dossa (2009) states that such employment can also affect the cultural, political, and social lives of women workers, with an increasing trend of feminizing poverty, especially among single women and the elderly in Canada. Although some forms of work, such as part time self-employment, are considered to be beneficial for women because they may "reduce job/family tension in the mid-life cycle" of women while women care for their dependents (Cranford and Vosko, 2005, p. 89), this understanding is problematic for two reasons. Firstly, it assumes and reinforces a paradigm that women are the rightful carers of



their dependents. Secondly, even if women are the primary caregivers in their families, part-time wages and self-employment might still be harmful for women because they may contribute to low retirement incomes among women, especially for the high proportion of female lone parents and elderly women living with incomes that are below the low-income cut-offs (Cranford and Vosko, 2005; Marshall, 2000; Statistics Canada, 2000).

The work of Wallius (1998) raises yet another problem: it indicates that women's participation in precarious forms of work undermines a nuclear family by virtue of the loss of long, stable earnings, and that this is problematic for social reproduction. In other words, women who are facing precarious labor market circumstances may face difficulties in their decisions to start families (Wallius 1998). As Lewchuk, Clarke and De Wolff (2011) demonstrate, precarious work places stress on women's relationship with their families and dependents, especially when there is unpredictability in work schedules. Their study demonstrates an example in which one precariously employed woman stated: "Someday I'd like to have kids", but this worker stated that in order to do so, she would require the security of stable employment so that after a maternity leave, she would be able to return to work and be secure in her employment (Lewchuk, Clarke and De Wolff, 2011, p. 201). Gendered work is adversely affected in these insecure markets, when women may wish to form marital unions or partnerships earlier than men, but delay having children for these reasons (Golsch, 2005).

The above social and economic problems stemming from precarious working conditions would raise questions about the occupational factors and work hazards from precarious work that could affect women's health and wellbeing. Indeed, such an approach is conducive to both feminist political economy and its intersectionality with health. The research of feminist scholars (Doyal, 1995; Messing, 1998; Linos and Kirch, 2008) demonstrates that paradoxically,



while women are stereotyped to be in less strenuous forms of work than men, they are in fact exposed to the physical strains of heavy labor, and they are increasingly exposed to hazardous chemicals, dusts, fumes, and other substances that can lead to infertility, cancer, and other health problems. Such issues have recently received high profile media attention in the case of pesticide exposure among airline attendants, many of whom are women, and it is raising concerns of the development of Parkinson's disease (Benms, 2013). As I mentioned in the previous chapter, LTC work can be precarious. Building upon this literature and by utilizing, in part, the feminist political economy approach to health, this dissertation seeks to illuminate in what ways LTC work can have various levels of precarization and simultaneously, it aims to describe the occupational health hazards that are reported by women.

Sexual harassment and violence are problems that women often face in the workplace. Evidence from Lewchuk, Clarke, and De Wolff (2011) demonstrates that these problems seem to be compounded for women who are employed in precarious forms of work. In one example, a female employee who worked six days a week at two separate occupations reported sexual harassment in both locations, in conjunction with heavy workloads, lack of benefits, lack of control over hours of work, and insecurity at both jobs (Lewchuk, Clarke, and De Wolff, 2011).

As I specified in chapter 3, LTC work involves forms of both structural and physical violence. Although the issue of violence is described by the Canadian Centre for Occupational Health and Safety ("CCOHS") in their section entitled Violence/Bullying (CCOHS, 2017), as well as the American National Institutes of Occupational Safety and Health ("NIOSH") (NIOSH, 2002; Bannerji, 2010), studies about sexual violence and harassment are significantly lacking by these research institutions, and they need to be clearly identified. As I write this dissertation, the issues of sexual harassment and sexual violence have received notable attention as high profile



cases have recently surfaced about workplace sexual harassment and violence in both Canada and the United States, which have been referenced and accompanied on social media with a hashtag as the ‘Me Too’ movement (i.e. #metoo). These cases include allegations against men employed in highly privileged positions, such as former NBC *Today Show* anchor Matt Lauer, producer and director Harvey Weinstein, and journalist and talk show host, Charlie Rose, among others (Kantor and Twohey, 2017; Gabler, Rutenberg, Grynbaum, and Abrams, 2017; Steel and Schmidt, 2017; Barker and Gabler, 2017). Canadian cases include sexual harassment allegations against the Soulpepper Theatre Company and one of its co-founders, Albert Schultz (Perkel and Deschamps, 2018), as well as allegations of harassment and bullying against Conservative senator Don Meredith (Press, 2015; Press, 2017).

### **III. Precarious Work, Precarization and Social Determinants of Health Issues**

This section describes the ways in which precarious working conditions and precarization are connected with the social determinants of health (“SDoH”). Specifically, employment and working conditions are linked to other health determinants such as education, literacy, income, and social status, among other things. Precarious forms of work also harm workers’ health and wellbeing through a variety of mechanisms. Drawing on this literature, I illuminate the importance of connecting precarious work and precarization with the SDoH.

In general, differences in working and living conditions can result in health inequalities, which should be reduced (Whitehead, 1990; Stronks, Mheen, Looman, and Mackenbach, 1996). Employment and working conditions are described as one of the SDoH (Public Health Agency of Canada (PHAC) 2003; WHO, 2008; Mikkonen and Raphael, 2010; Bryant, Raphael, and Rioux 2010), and are connected to many other determinants (Marmot, Friel, Bell et al., 2008; Lewchuk, Clarke, and De Wolff, 2011; WHO, 2008). Employment and working conditions are both structural, which means they are related to structures, institutions, and organizations (social,



political, economic, cultural); and material, meaning that they are connected to production, economic conditions, and wages/ compensation.

Employment can be linked to an individual's education and literacy, bringing with it income and social status, and the social and physical environments in which they live. For example, a strong educational background can improve good job prospects, which can also improve income and financial security (Lewchuk, Clarke, and De Wolff, 2011; Armstrong, Armstrong, and Scott-Dixon, 2008). Having a good, stable job may prevent circumstances of poverty, and can also improve social mobility. The type of job or the job status in which one is employed can also influence personal health in a number of ways. For example, King et al., (1992) show that workers who are employed in white-collar jobs (i.e. professional, managerial occupations) tend to have higher levels of education, higher income, and better health prospects than those workers employed in blue-collar jobs (i.e. skilled workers). These white-collar workers also had increased participation in physical activity than blue-collar workers or general laborers (King et al., 1992).

There are a variety of mechanisms through which employment and working conditions can have health consequences. Firstly, the type and extent of work hazards in a particular work environment can impact worker health. This includes chemical, mechanical, physical, ergonomic, biological, or psychosocial hazards (WHO, 2007). Secondly, good job prospects, together with a strong educational background can influence individual behaviors, such as personal health practices and coping skills. Thirdly, the social structure of employment, the power relationships at work, and the social or psychosocial aspects of the employment contract can determine health outcomes of workers (Lewchuk, Clarke, and De Wolff, 2011). For example, work could provide personal development and build social status, social relations, and



self-esteem (Lewchuk, Clarke, and De Wolff, 2011). An ideal workplace setting would be in a physically safe environment, have good social impact on workers, and be pleasant and enjoyable. One should be able to interact well with others and build positive relationships and bonds in such circumstances.

Studies show that there are certain aspects of employment that can have important consequences for personal health, which are: job security (i.e. degree of certainty of continuing work with minimal risk of job loss); control over working conditions; wages or income adequacy; pace of work; and regulatory protections (Rodgers, 1989; Picchio, 1998; Vosko and Zukewich, 2005). As we shall see in chapter 6, this dissertation contributes to a research trajectory that investigates some of these aspects, including: job-security, job-control, wages/ income-adequacy, and pace of work within LTC. It is expected that working conditions that are insufficient in these aspects of employment would be likely to induce stress responses in workers and would significantly threaten the health and wellbeing of workers. Decent employment conditions that would satisfy the various aspects of work would be least likely to pose stress for workers, and would possibly improve life circumstances. Jackson (2005) provides an example of the latter, and states that in the Danish society, there are high rates of good-quality employment with low levels of precarious and contingent work.

Research suggests that precarious, fragmented, and so-called flexible employment can be problematic to the health of workers through several mechanisms. Firstly, precarious work tends to be insecure and unstable, but it can also be associated with low income, which can lead to cycles of poverty (Vosko and Zukewich, 2005; WHO, 2007). Low income and poverty, in turn, can result in inequities in health (Raphael, 2001; Raphael, 2007). This is because precariously employed individuals often have temporary positions, and they may experience gaps in



employment. Low-waged, precarious labor, compounded with the lack of opportunity to save money, and lack of employment insurance eligibility, means that workers might rely on loans and credit cards for their day-to-day living expenses. This situation results in precarious workers going deeper into debt (Lewchuk, Clarke, and De Wolff, 2011). “Low wages make the possibility of layoffs, illness, and family crises very difficult to manage...” (Lewchuk, Clarke, and De Wolff, 2011, p. 165). In one example, a family of four with a vulnerable financial situation underwent an unexpected incident of an automobile accident that compromised their ability to cope (*ibid*). Low wages and living pay-cheque to pay-cheque were also reported by taxicab operators (Facey, 2010) and by temporary public sector workers who received \$9 to \$12.50 per hour in 2003, which was less than the average wages of \$16 to \$19 per hour that people received for similar work on fixed term contracts (Borowy, 2005). In the latter study, it was reported that workers did not think about a retirement plan, and had no opportunity for advancement in their occupation (Borowy, 2005).

Secondly, precarious work can be problematic for workers because they often lack collective bargaining, unionization, and the associated statutory benefits and entitlements that are otherwise found in standard employment (Vosko and Zukewich, 2005; WHO, 2007). Under precarious working conditions, workers might lack motivation or incentive to participate in collective organization and unionization, and to exercise rights embedded in workplace health and safety regulations (Lewchuk, Clarke, and De Wolff, 2011). These trends are troubling and have a health-equity impact because unionized workers are about two to three times more likely to be covered by medical, dental, and pension plans than non-unionized workers (Jackson, 2004; Lewchuk, Clarke, and De Wolff, 2011). Furthermore, under precarious conditions, extended



health or dental benefits would be only available by purchasing them privately (Vosko and Zukewich, 2005).

Precarious and flexible workers, such as self-employed individuals, might be further vulnerable to health problems in contrast to other types of workers because they might put their health and wellbeing on the back burner in their pursuit of making a decent living. For example, in one study, precarious workers reported that they ignored minor health problems because of a lack of money or benefits, despite knowing that these problems might one day become a larger health burden (Lewchuk, Clarke, and De Wolff, 2011). Furthermore, workers who are experiencing precarization and precarious conditions might also be pressured into harmful situations, such as receiving inadequate time off from work, or continuing work with a work-related morbidity, illness, or injury.

Precarious forms of work can have detrimental health implications because they tend to be associated with temporariness, powerlessness (Vosko and Zukewich, 2005; WHO, 2007), work-stress (Lewchuk, Clarke, and De Wolff, 2011), and have the potential to affect the social relations within and outside of the workplace (Benach, Benavides, Platt, Diez-Roux, and Muntaner, 2000; Artazcoz, Borrell, Benach, 2001; Prottas, and Thompson, 2006; WHO, 2007; Lewchuk, Clarke, and De Wolff, 2011). For example, Standing (2011) claims that in Ontario, temporary and seasonal workers often experience loss of power or control over their work because they waive their rights to choose their worksite and type of work, and sometimes they must pay fees to register with agencies in order to undertake employment opportunities, although it may be that they never have this option to begin with. Precarious and flexible work can also induce employment-related stress that begins even before the worker arrives at his or her workplace (Lewchuk, Clarke, and De Wolff, 2011). The health impacts are frequently



transferred to household members, creating additional stress, time pressure, and family or work imbalances, and partially explains the decline in fertility and birth rates found in advanced economic societies (Golsch, 2005; Crompton, 2006; Corman and Luxton, 2007; Lewchuk, Clarke, and De Wolff, 2011). In one example, a worker who reported precarious work-stress explained that it led to a lack of exercise and consumption of junk food that resulted in weight gain (Lewchuk, Clarke, and De Wolff, 2011).

Research demonstrates that precariously employed workers reported exhaustion, elevated blood pressure, musculoskeletal pain, migraines, lack of energy, frustration, and sleep disturbances (Lewchuk, Clarke, and De Wolff, 2011). Precarious, intermittent, and insecure forms of work have also been associated with psychological issues and poor mental health outcomes such as low self-esteem, dissatisfaction, as well as adverse social consequences that were fostered by harmful work relationships and working conditions (Sverke, Hellgren, and Naswall, 2002; Chirumbolo and Hellgren, 2003; Malenfant, LaRue and Vezina, 2007; Marmot, Friel, Bell et al., 2008).

Precarization and precarious work situations might impact personal health through particular psychosocial aspects, such as reducing levels of trust between and among workers, and by eroding social relations. Researchers at Simon Fraser University in Canada list the following 13 psychosocial factors that can modulate worker health: workload management, psychological support, organizational culture, clear leadership and expectations, civility and respect, psychological job fit, growth and development, recognition and reward, involvement and influence, engagement, balance, psychological protection and protection of physical safety (Samra, Gilbert, Shain, and Bilsker, 2012; CCOHS, 2015). In addition to these things, there are also factors that psychologically impact workers' health through responses to their work and



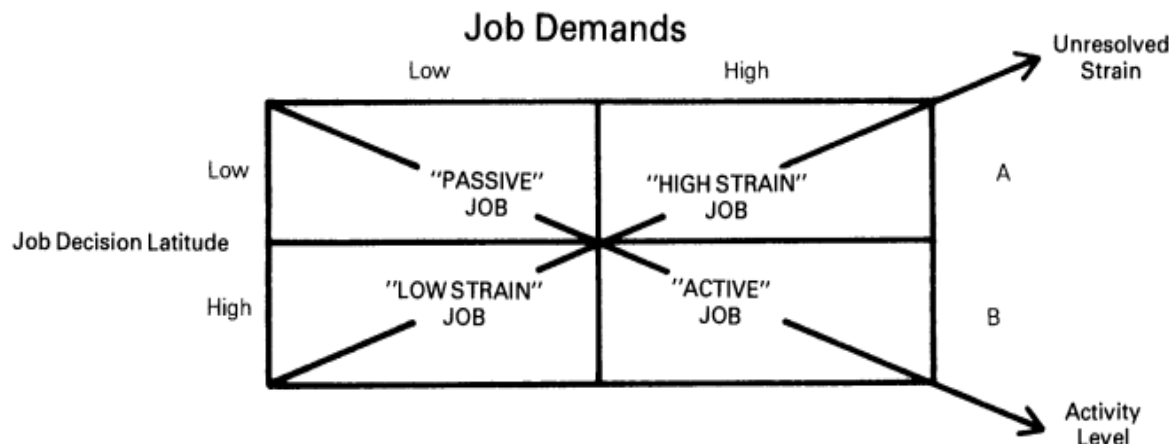
working conditions, such as: job demand, job control, social support, time pressure, degree of monotonous work, extent of social reciprocity (or effort-reward balance), autonomy, fairness, job security and social contact between co-workers and supervisors (Karasek, 1979; Karasek and Theorell, 1990; Bartley, 2004; Bambra, 2011; Samra, Gilbert, Shain, and Bilsker, 2012). The work of Lewchuk, De Wolff, King, and Polyani (2005) has extended upon the literature about job demand and control (Karasek, 1979; Karasek and Theorell, 1990), by applying it to precarious work circumstances, and the researchers found that precarious work undermines health through job strain, high demand, and low level of control (Lewchuk, De Wolff, King, and Polyani, 2005). Job-demand factors refer to work load, time pressures, work surges, work pace or rest breaks; while job-control factors refer to level of influence on work, level of participation in decisions, job satisfaction/dissatisfaction and level of social support (Karasek, 1979; Karasek and Theorell, 1990; Moen, Kelly, and Lam, 2013; CCOHS, 2014).

Originally, psychosocial factors were not included in studies of work and health. However, this has changed with the research of Karasek's (1979) and others (e.g. Theorell and Karasek, 1996; Karasek, Baker, Marxer et al., 1981; Karasek and Theorell, 1990). The significance of these findings means that particular workplace factors, such as job demand, employees' perceived control over their work, and job-strain, could modulate people's health and wellbeing. For instance, high demands (such as having to work hard or rapidly) combined with limited freedom to make job-related decisions result in job strain, and increase the risk of disease (particularly cardiovascular disease) (Theorell and Karasek, 1996; Karasek, Baker, Marxer et al., 1981; Karasek and Theorell, 1990). The original job strain model is shown below.



### Figure 4.1 - The Job Strain Model.

According to Karasek (1979, p. 288): “The labeled diagonals actually represent two interactions: situations where job demands and job decision latitude diverge (“A”), and situations where they are matched (“B”). The first situation, when demands are relatively greater than decision latitude, is of primary importance in predicting mental strain”.



According to Karasek (1979, p.287), job strain predicts symptoms of mental strain:

“The model postulates that psychological strain results not from a single aspect of the work environment, but from the joint effects of the demands of a work situation and the range of decision-making freedom (discretion) available to the worker facing those demands. These two aspects of the job situation represent, respectively, the instigators of action (work load demands, conflicts or other stressors which place the individual in a motivated or energized state of ‘stress’) and the constraints on the alternative resulting actions. The individual’s job decision latitude is the constraint which modulates the release or transformation of ‘stress’ (potential energy) into the energy of action. Thus, this is a stress-management model of strain which is environmentally based.” The term ‘stress’ refers to an internal state of the individual, but the research does not measure it directly. “[...] Instead, three related terms should be defined: The first term is an independent variable that measures stress sources (stressors), such as work load demands, present in the work environment. These are called ‘job demands.’ The second measures decision latitude and is called ‘job control’ or ‘discretion.’ The third is a derived composite measure that is called ‘job strain.’ Job strain occurs when job demands are high and job decision latitude is low. [...] Job demands (especially work load demands) probably express the overall output level of the firm, and job decision latitude is probably closely related to the firm’s authority structure and technology”.

The strength of the above model and the related findings is that workplace interventions that aim to improve productivity and efficiency would need to be assessed so that they are minimally burdensome for workers with respect to health and safety. However, a weakness of the above



model is that it was limited to only a few psychosocial factors. Furthermore, the studies that expanded upon this model were mostly focused on European men, and they were limited to predicting cardiovascular disease.

Taking into account numerous psychosocial factors, Syed and Ahmad (2016)'s literature review suggests that some of the health problems among immigrant and racialized women could be attributed to gendered and precarious forms of work. Syed and Ahmad (2016) suggest that, for these particular groups, worker health and wellbeing is affected by the high levels of stress and anxiety among workers, and that work-related stress not only plays a role in the development of physiological morbidities such as musculoskeletal disorders ("MSDs"), but that it might also have spillover effects on the personal lives of South Asian ("SA") women. The rationale for this hypothesis is that many studies have reported that particular psychosocial factors, such as high job demand, high workloads, and time pressures, can intensify an individual's vulnerability to MSDs (Linton and Kamwendo, 1989; Bongers deWinter, Kompier, and Hildebrandt, 1993; Bernard, Sauter, Fine, Peterson, and Hales, 1994; Koehoorn, 1999; Carayon, Smith, and Haims, 1999; Lundberg, 1999; CCOHS, 2014).

Research about precarious, insecure work environments raises a number of concerns about eroding social bonds and work relationships combined with individualized, isolated forms of work. A study by Sverke, Hellgren and Naswall (2002) shows that reductions in job security have been correlated with a lack of trust towards the work organization. Furthermore, there is also a concern that precarious work might erode social bonds that are otherwise present in permanent relationships and standard work arrangements. Researchers suggest that flexible and non-standard labor markets can leave workers with no commitment to a job, which can weaken the strength and bond between workers and their employers (Bauman, 2005; Lewchuk, Clarke,



and De Wolff, 2011). Lewchuk, Clarke, and De Wolff's (2011, p.173) study shows that employer employee lay-offs affect work relationships in the workplace, leaving staff with fewer work friends which can undermine a "sense of belonging". Precariously employed workers reported: isolation from work, over-working to maintain contracts, and hostility from co-workers who perceived them as threats and competition for the same waged work (ibid). Part-time workers also perceived themselves as being treated differently and being powerless compared to those in full permanent jobs (ibid). In addition to this, workers in temporary contract positions also reported extra effort and stress in their attempts to adjust to new and changing workplaces (ibid).

Precarious working conditions can also result in adverse social circumstances that can contribute to or exacerbate social exclusion. For example, researchers have reported that workers experienced social exclusion and social support deficits because of inadequate income that led to decreasing socialization or lack of commitment to social activities (Lewchuk, Clarke, and De Wolff, 2011). Friends became former or invisible friends because of the lack of time to maintain them, or because of the physical health burden of work precariousness and the resultant exhaustion from work (ibid). In addition, some workers excluded their friends from social circles when they knew about their dreadful financial situations because they did not want to burden them. One particular ethnic group of South Asians, reported that they were the least likely to receive social support from family and friends in these circumstances (Lewchuk, Clarke, and De Wolff, 2011).

Precarious, flexible, and substandard working conditions can induce fear, stress, and insecurity as well as lack of self-esteem and social worth. These reactions are due to the type of work being done (Standing, 2011). Workers have reported feeling insecure because of



“unexpected shift changes”, and the fear of being rejected from work opportunities because of scheduling conflicts (Lewchuk, Clarke, and De Wolff, 2011, p. 168). One female worker was afraid she would not be promoted to a full time permanent job because of her carpal tunnel syndrome, so she tried to conceal her musculoskeletal condition by removing and not wearing her medical brace (Lewchuk, Clarke, and De Wolff, 2011). Self-employed workers reported earnings uncertainty, isolation, lack of a safety-net, trouble sleeping, psychological issues (ibid), depression, anxiety (D’Souza et al., 2003) and experienced adverse mental health outcomes (Sverke, Hellgren, and Naswall, 2002; Chirumbolo and Hellgren, 2003). Precarious working conditions are associated with job dissatisfaction, fatigue, and musculoskeletal pain, such as backaches (Benavides, Benach, Diez-Roux, and Roman, 2000; Benach et al., 2004), as well as psycho-social aspects of job strain, such as lack of control and lack of participation in decision-making (Parker, Griffin, Sprigg, and Wall, 2002).

Precarious working conditions also tend to exacerbate health problems because of over-work and underpay. Research indicates that precarious workers report having worked long hours, made themselves available for emergency calls, carried out extra tasks unrelated to the job description, and inputted extra employment effort in comparison to non-precariously employed workers i.e. precarious employees worked much harder than non-precarious employees (Lewchuk, Clarke, and De Wolff, 2011). These workers also reported that they over-worked in multiple employment contracts in order to avoid insecure work situations, to make ends meet, to buffer unexpected job losses, and to provide a safety net for oneself i.e. they had more than one employer at the same time (ibid). The work of Baines, Charlesworth, Cunningham, and Dassinger (2012) indicates that the non-profit social services sector seems to share many of the characteristics found in precarious workplaces. The researchers found that this sector was



composed of two dichotomous clusters. The first one consisted of senior managers, which included many women, yet it resembled masculinized organization that exploited staff and required that they work long hours (ibid). The second cluster was feminized, consisted of staff who were self-sacrificing, alienated, and experienced workload issues such as an “endless” documentation “nightmare”, and meeting performance measurement targets that were required by the governing funding bodies (ibid, p. 366). The second cluster of workers also reported unpaid overtime work and working sick (ibid). Unfortunately, these types of work environments can take a toll on workers. For instance, the severe mental stress from extreme labor intensity combined with low wages among workers at Foxconn Corporation in China resulted in suicides and attempted suicides in 2010 (Standing, 2011). While Foxconn did eventually raise wages, Standing (2011) notes that their first response did not aim to improve working conditions nor raise wages. Rather, they reacted by surrounding the buildings with catch-nets for people who jumped, counseling for distressed workers, and encouraging workers to sign no-suicide pledge notes (Standing, 2011).

#### **IV. The Proliferation of Precarious Working Conditions, Precarization, and Worker Exploitation: Broad Structural Factors, Policies, and Practices**

This section begins by briefly summarizing historical materialist perspectives, inspired by the work of Marx and Engels, 1848; Marx and Engels, 2010, and expanding on this perspective with additional work which argues that conservative capitalism, neoliberalism, and new public management strategies exploit workers in ways that exacerbate historical forms of exploitation (Brodie, 1995; Western, 1995; Anderson, 2000; Hofrichter, 2003; McLean and McMillan, 2003; Vosko, 2005; Stasiulis and Bakan, 2005; Galabuzi, 2006; Armstrong and Armstrong, 2001; Marchington, Grimshaw, Ribery, and Willmott, 2005; Williams, 2010; Bourgeault, 2010a;



Bourgeault, 2010b; Lewchuk, Clarke, and De Wolff, 2011; Rose and Chaison, 2011; Standing, 2011; Armstrong, 2013b).

Many thinkers have used a critically-oriented political economy perspective to examine the histories of slavery, colonialism, and indentured work (Williams, 1964; Genovese, 1967; Cohen, 1987; Cohen, 2008). Their contributions have confirmed Karl Marx's and Frederick Engels' (1848) examination of feudalism and factory work, and indicate that indeed capitalist or bourgeoisie classes hold power and control over working conditions, and that these classes economically benefit from cheap forms of labor. They found that labor was often exploited through coercive, dangerous, or harmful working conditions. They argue that the rise of industrialization and the proliferation of factories and factory workers during the golden-age further created opportunities for the bourgeoisie and capitalist classes to exploit workers with low-waged and precarious work, replacing a system of feudalism.

There is an increased concern that the system of waged labor and an excess supply of workers seeking employment opportunities have created opportunities for the capitalist class to exploit, profiteer, and take advantage of the working class through free market capitalism in the past 300 years and, more recently, through the rise of market liberalism in the past 50 years (McLean and McMillan, 2003; Armstrong, 2013b). Today the current manifestation of worker exploitation continues through neoliberalization of government policies that are constructed through market models and new public management practices. Researchers argue that this has resulted in the proliferation of precarious and sub-standard working conditions (Vosko, 2005; Galabuzi, 2006; Lewchuk, Clarke, and De Wolff, 2011; Standing, 2011).

New public management practices and neoliberal strategies refer to central management structures that aim to control and reduce costs, reduce service duplications, or inappropriate use



of services, manage risk within an organization (Bourgeault, 2010b), and outsource labor in order to raise profitability (Marchington, Grimshaw, Ribery, and Willmott, 2005). These strategies and reforms are problematic for people in welfare states because they lead to privatization and individualization, which have detrimental social, economic, and health consequences for working class people. For example, Hofrichter (2003) notes that under neoliberal reforms, many employers seek to control organizational costs by reducing their full time workforce, relying on temporary or contract workers, and avoiding provisions of extended health benefits. New public management strategies and neoliberalization of the welfare state are also problematic for workers because they have resulted in social inequalities in the form of exclusion of citizenship and increased precariousness of work (Stasiulis and Bakan, 2005; Bourgeault, 2010a). Precarious and fragmented work has proliferated under these organizational changes through a market-oriented economic model, and this has included collaborations through public-private partnerships. Marchington, Grimshaw, Ribery, and Willmott (2005) suggest that these structural and organizational changes aim to maximize profits by outsourcing or contracting out cheapened forms of labor.

As a result of organizational changes that occur under neoliberalism and new public management strategies, many workers are increasingly losing control of their working conditions. Vosko (2005) suggests that the changes to the standardized and normative model of work and the rise of work precariousness mean that employees are experiencing more significant problems with social protection than ever before. An increasing body of health literature is drawing on this social context, which is leading to the realization that precarious working conditions and precarization may also have consequences for personal health. For example, precarious workers might be at risk of experiencing health inequities because of reductions in wages, and reductions



in regulatory protections that are otherwise offered from collective bargaining and unionization (Western, 1995; Hofrichter, 2003; Rose and Chaison, 2011; Syed, 2015). Structural changes under neoliberalism can also have direct consequences for health through stress pathways. For example, organizational changes, such as corporate downsizing, has been correlated with chronic stress and consequently such stress can modulate a cascade of adverse health outcomes for employees (Vahtera, Kivimaki, and Pentti, 1997; Kivimaki et al., 2001; Quinlan, Mahew, and Bohle, 2001; Ferrie et al., 2002; Sverke, Hellgren, and Naswall, 2002; Ferrie, Westerlund, Oxenstierna, and Theorell, 2007; Lewchuk, Clarke, and De Wolff, 2011).

Economic downturns and layoffs under neoliberal changes to the labor market have the potential to change household dynamics. The male breadwinner model assumed that a single income was sufficient for the household, but this is not necessarily true, and today it is near obsolete. While women from the proletariat class (i.e. working class) are required to work in today's paid economy, as they often worked even in past decades, middle class women now have to work to break even and in order to sustain the household (Hacker, 2006). This is because single incomes are frequently insufficient in the contemporary period. Furthermore, since the late 1970s and early 1980s, the labor market outcomes have worsened in high-income countries (Corak, 2013). There has been an erosion of standard employment relationships that were otherwise consolidated in the post-World War II period to protect workers against precariousness associated with the free market model (Vosko, McDonald, and Campbell, 2009). There has also been worsening inequality in certain welfare states, such as the USA, which have stifled inter-generational mobility (Corak, 2013):

“The cohort of American children raised since the 1980s, who will reach their prime working years in the coming decade, is likely to experience an average degree of intergenerational income mobility as low—if not lower—than previous cohorts who were raised in an era of less inequality. Inequality lowers mobility because it shapes opportunity. It heightens the income consequences of innate differences between individuals; it also changes opportunities, incentives, and institutions that form, develop, and transmit



characteristics and skills valued in the labor market; and it shifts the balance of power so that some groups are in a position to structure policies or otherwise support their children's achievement independent of talent" (Corak, 2013, p. 97).

Despite the increasing emergence of two-income households, working class families are not necessarily economically stable, and many economic deficiencies can exist. For example, in one study, a worker expressed frustration due to the inability to purchase a house, despite the fact that both he and his spouse had university degrees, and both were employed (Lewchuk, Clarke, and De Wolff, 2011). In the same study, researchers also found that a wife of a software engineer who did not work due to child rearing was now considering paid-work because her husband faced a looming layoff (*ibid*).

Differences such as race, class, ability or disability, age, and other social contexts lead to further marginalization, and men and women's lives are embedded in this reality (Ng, 1996). Immigrant and racialized women, for example, are further disadvantaged in their access to education and training, language courses, good jobs, and economic or social support from the state (Ng and Estable, 1987; Ng, 1988a; Ng, 1988b; Ng, 1993; Ng, 1994; Ng, 1996). The work of Ng (1988b) and others (e.g. Galabuzi, 2006; Thobani, 2007) also highlights that although some individuals are not quite immigrants, for instance they might be Canadian born, they are often referred to as 'immigrant' or treated as newcomers because of their visible minority status, and as a result, they experience social differences in discriminatory and inequitable ways compared to the dominant group.

Neoliberal policies frequently disadvantage women through the process of feminization of the labor market. Feminization of the labor market refers to the creation of certain precarious jobs that are occupied by women but paradoxically, as Vosko (2005) notes, such work is not necessarily liberating because it is often underpaid and undervalued. In the public sector, this means that clerical work has increased; yet the women who increasingly occupy such work are



seen as providing ‘indirect’ rather than direct public service (Borowy, 2005, p. 167). This means that women’s economic contributions in clerical and ‘indirect’ services are less valuable than men’s work, which means that they would be paid less since their services and work are considered to be indirect and therefore, insignificant.

Structural economic changes, such as privatization of services and state withdrawal from social spending, are problematic for households and families because they remove choice, and force health, childcare and elder care work to be performed as part of the unpaid work of women (Brodie, 1995; Armstrong and Armstrong, 2001; Lewchuk, Clarke, and De Wolff, 2011; Armstrong, 2013b). This process further cycles back and marginalizes women because unpaid care work within households shape occupational polarization, since women with dependents or parents who are seniors may seek flexible work to accommodate their schedules and unpaid care responsibilities (Walby, 2000; Cranford and Vosko, 2005).

Research suggests that structural changes to the labor market have consequences not only for women, but also other vulnerable groups whose labor is exploited. These groups include [im)migrants and racialized persons (Anderson, 2000). Today the current manifestation of worker exploitation includes ‘market migration’ of racialized persons (Syed, 2015), and a disproportionate proliferation of precarious and sub-standard working conditions among these groups (Vosko, 2005; Galabuzi, 2006; Lewchuk, Clarke, and De Wolff, 2011; Standing, 2011). Market migration refers to a theoretical concept describing the labor-market based recruitment of (im)migrants and racialized persons, yet these groups experience social inequalities and health inequities due to globalization and market liberalism that exploits and depreciates their labor (Syed, 2015). It is further explained below.



## **V. Immigration, Market Migration, and Work**

This section will discuss how precarization and precarious employment conditions fluctuate by social locations such as race and immigrant status. In particular, it will discuss the adverse work experiences of racialized and immigrant people in Canada, the processes leading these circumstances, and the health equity impacts on these groups.

Contingent and precarious work was the norm among immigrants in the late 19<sup>th</sup> and early 20<sup>th</sup> centuries in Canada (Vosko, 2005). Today, the situation seems to be similar to these earlier periods. Changes to the Canadian labor market following neoliberal restructuring of the 1970s have eroded standardized work, and have resulted in the spread of precarious employment among women, particularly immigrants, and people of color (Cranford and Vosko, 2005). A review of the literature indicates that migrants and racialized persons currently occupy some of the worst forms of work that is also low paid, and it is argued that this likely risks their health and safety (Syed, 2014; Syed, 2015).

Certain forms of precarious work continue to persist among historically disadvantaged groups (Vosko, 2005; Galabuzi, 2006). Men of color are more likely than white men to be in precarious, part time temporary and part time permanent forms of employment (Cranford and Vosko, 2005). Immigrants and workers of color are relegated to precarious forms of waged labor, such as part time permanent or temporary work (Duffy and Puppo, 1994; Arat-Koc, 1997; Vosko and Zukewich, 2005). The underlying problem may be discrimination. Immigrants and racialized persons experience significant levels of stereotyping and discrimination in the labor market, which make them vulnerable to poverty. Poverty and low income then cut into basic-need budgets, resulting in low-quality diets, imposing learning difficulties for the young, segregating them into low-income neighborhoods, which increase risks of school-dropout rates and contact with the criminal justice system, and increase social exclusion that prevent them



from participating fully in Canadian civic, political, and social life (Das Gupta, 2005; Galabuzi, 2006).

The various work experiences among vulnerable people in Canada can be understood in terms of the processes of Orientalism (Said, 1978), racialization (Galabuzi, 2006), or Othering (Weis, 1995; Miller, 2008; Mountz, 2009). It is argued that the racialization of the labor market and the surplus of precarious jobs taken up mostly by immigrants and racialized persons (Vosko, 2005; Galabuzi, 2006; Lewchuk, Clarke, and De Wolff, 2011; Standing, 2011) result from structural discrimination (Galabuzi, 2006).

There are many examples and indications of systemic and structural discrimination in the Canadian labor market. In Toronto, recent immigrants tend to be employed in precarious, non-standard work with low pay, minimal employment protection, and no benefits (De Wolff, 2005). They also have had greater difficulties in obtaining full-time permanent jobs than their predecessors because of arriving during times of recession (De Wolff, 2005). Differences like race, class, ability or disability, age, and other social contexts lead to further marginalization and men and women's lives are embedded in this reality (Ng, 1996; Dossa, 2009). For example, disabled people's experiences are not only limited to material abuses, such as physical or emotional violence and poverty, but also include forms of social exclusion, oppression, objectification, and alienation (Gorman, 2007). Such experiences also include neo-racism and democratic racism.

"Neo-racism" refers to the growing anti-immigrant discourses and policy actions of people in the North against migrants and racialized persons (Galabuzi, 2006, p. 9; Balibar, 1991). It also refers to the backlash against migration and displacement of people that has been unleashed by processes of globalization (Galabuzi, 2006). Neo-racism is dominated by a theme



of cultural difference, and holds a perspective that there are potential harms of abolishing borders, based on a view that there is incompatibility of social traditions and lifestyles (Galabuzi, 2006). “Democratic racism” means that there is a lack of commitment to the principles of equality and social justice, and there is a lack in action or social provisions for racialized minorities (Dossa, 2009, p. 70). It means that paradoxically, racist ideologies can co-exist with democratic principles that are articulated in Canadian society (Henry, Tator, Mattis, and Rees, 1995; Galabuzi, 2006).

The work of some Canadian scholars highlights particular problems for (im)migrant or racialized groups. Tucker (2005) suggests that in Canada, migrant workers from Mexico and the Caribbean face social exclusion in the communities in which they reside and are denied citizenship opportunities and lack the right to vote. Many of these people are employed in precarious work on age old prejudices that label them as inferior, that they could be exploited at low wages, or they are readily willing to work at wages and conditions below those of white workers (Das Gupta, 2005). These practices have disadvantaged immigrants and people of color. For instance, immigrants and members of ethnic and linguistic minority groups are more likely to work in jobs where there is a high risk of having a work-related health problem compared to non-immigrant groups (Premji, Duguay, Messing, and Lippel, 2010<sup>9</sup>), and they are more likely to experience injuries or illness, yet underreport it (Thurston and Verhoef, 2003<sup>10</sup>). Research of immigrant women working in the sportswear garment industry in Toronto conducted by Gannage (1999) found that the women were working in the sewing line, which was not commensurate

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<sup>9</sup> This study used Statistics Canada census data from 2001, Statistics Canada’s 2000 Survey of Employment, Payrolls and Hours (SEPH), and data from Quebec’s workers’ compensation board to test their hypothesis of whether or not immigrants and linguistic minorities were over-represented in high-risk occupations.

<sup>10</sup> In this study, researchers compared accident injury rate, lost-time injury rate, and factors predicting injuries between provincial samples and samples derived from ethno-cultural service agencies to assess the burden of occupational injury among immigrant populations in Alberta.



with their professional training received in their countries of origin, such as nursing. Others communicated that their spouses also held professional training, such as being a medical technician, but worked in the plastics factory in Canada. Domestic responsibilities also made it difficult for women to participate in work organizations, such as union meetings. As a result, participants communicated their stress and anxiety. Premji, Messing, and Lippel's (2008) study showed that language barriers experienced by immigrant workers can result in insufficient social interactions in the workplace as a whole, resulting in long-term psychological stress and strained work relations. Secondly, they found that there was extensive under-declaration of injuries, and illnesses. The reasons for this included lack of information, fear of retaliation, fear of being fired, or fear of the factory closing (ibid).

Canadian data indicates that immigrants are likely to be from the global South and work in occupations that are more physically demanding compared to immigrants from North America and Europe who are otherwise less likely to be employed in physically demanding occupations (Smith, Chen, and Mustard, 2009<sup>11</sup>). Studies have highlighted that there is a decline in immigrants' mental health because they are employed in jobs for which they are often over-qualified, yet unable to secure employment in matching their skills, experiences or expectations (Chen, Smith, and Mustard, 2010<sup>12</sup>). They have also highlighted that immigrants and newcomers to Canada are more likely to acquire acute work-related injuries than Canadian born individuals (Smith, Kosny, and Mustard 2009<sup>13</sup>; Smith and Mustard, 2009<sup>14</sup>). State actors have

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<sup>11</sup> Data was obtained from the Longitudinal Survey of Immigrants to Canada.

<sup>12</sup> This is one of the numerous studies utilizing survey methods that have been undertaken by the Institute for Work and Health ("IWH"), an arm's length agency under the Ontario Ministry of Labour.

<sup>13</sup> This study used data from Statistics Canada from the Survey of Labour and Income Dynamics in order to examine the factors associated with differences in access to income replacement benefits for workers experiencing a work-related injury or illness of 1-week or longer in the Canadian labor force.



enabled systemic forms of discrepancies and racism, and they are structurally reproduced. They are then institutionalized by the Canadian state as it remains neutral in its policies and procedures, and does little to resist such forms of racism (Das Gupta, 2005).

Researchers found widespread discrimination in the hiring process towards certain groups and racial minorities, who were only hired for temporary and contract positions and excluded from permanent positions (Lewchuk, Clarke, and De Wolff, 2011). This is consistent with other research that asserts that visible minorities tend to be the workers in precarious, low-income sectors (Galabuzi, 2004; Galabuzi, 2006). Age and disability compounded these problems. One worker reported how it is difficult to get a job when one is fifty years old (Lewchuk, Clarke, and De Wolff, 2011).

The work of Galabuzi (2004; 2006) and others demonstrates that racialized workers in Canada are consistently at a disadvantage because they earn less than their non-racialized counterparts, and are more likely to report: discrimination and harassment at work, high employment strain, high employment uncertainty and effort, and low levels of employment support (Lewchuk, Clarke, and De Wolff, 2011). Racialized workers are less likely to be unionized than white workers (Reitz and Verma, 2004), with one study from Toronto and the GTA citing rates as low as 14.9% unionization for racialized workers compared to 18.4% of white workers<sup>15</sup> (Lewchuk, Clarke, and De Wolff, 2011). White workers are clearly at an advantage, because permanent, standardized jobs in the labor market privilege white males as

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<sup>14</sup> This study used data from the 2003 and 2005 Canadian Community Health Surveys in order to examine the burden of work-related injuries among immigrants to Canada and compared this group to Canadian-born labor force participants.

<sup>15</sup> Although specific racialized sectors of employment, such as care work involving nurses, are highly unionized, this particular study from Toronto and the GTA includes various types of employees such as: homecare workers, university staff, service sector workers, and it includes random population-based surveys. The “phase one” pilot survey began in 2002, and “phase two” began in fall 2005 and winter 2006 (Lewchuk, Clarke, and De Wolff, 2011, p. 31).



managers, professionals, and workers in mass production sectors that have strong union representation (ibid). Researchers have also exposed widespread racism in seemingly innate organizations and institutions, such as Canadian academia (Ng, 1993; Ng, 1994). Many of these studies uncovered practices of under-hiring of racialized faculty in Canadian universities, which resulted in their under-representation, as well as adversely affecting racialized faculty's tenure and promotions (Samuel and Wane, 2005; Henry, Choi, and Kobayashi, 2012; Henry and Tator, 2012).

Work precariousness, especially through temporary employment agencies, has been found to be prevalent among recent immigrants to Canada when compared to Canadian born workers (Lewchuk, Clarke, and De Wolff, 2011). Those who are racialized immigrants may face disadvantages on multiple fronts, as they are under-employed, socially isolated, exposed to discrimination and racism in daily lives, and face barriers of language and access to services (Lee, Rodin, Devins and Weiss, 2001; Dossa, 2009; Syed, 2014).

Syed (2015) argues that precarious work circumstances among immigrants and racialized people are reflective of worker exploitation, which is a continuation of the historical legacies of slavery and indentured labor. These processes are now manifesting themselves under the reforms of neoliberalism in North American and European contexts. Syed (2015) calls the current manifestation of worker exploitation as 'market migration' of racialized persons and that it likely has health impacts (Syed, 2015). For example, neoliberalism, welfare state retrenchment, and claw-backs in social protections have led to the deregulation of work arrangements, which in turn, drives down wages, and increases levels of exploitation and vulnerability (Hofrichter, 2003; Tucker, 2003; Vosko, 2005; Galabuzi, 2006; Zaman, 2012). These situations are worsened when governments fail to adequately expand minimum wages, social policies, and social protections.



The above-noted situations often occur in North American and European contexts, but it is important to note the opposite trend has occurred to some extent in specific countries of the Asian Pacific, which suggests that countries are prioritizing health and social care given that aging populations and low fertility are global problems. The Japanese and South Korean governments introduced policies that started or expanded upon public childcare and elder care services (Peng, 2014; Peng, 2016; Peng, 2017) as opposed to implementing service cuts. This is surprising for South Korea given that it is an International Monetary Fund (“IMF”) rescue country (Peng, 2014). Both countries’ policy changes have also led to opportunistic strategies for creating jobs for women and the “younger elderly” (Peng, 2014, p. 400). As a result of these policy changes, Japan experienced worker shortages, and it ultimately led to the examination of its immigration policy in order to allow foreign workers to participate in the newly expanded care sector (Peng, 2016). However, there has been cultural resistance to immigration of workers from the Philippines and Indonesia to Japan, which is centered around ethno-racial hierarchies, and entrenched in mythical narratives of Japanese homogeneous nationalism, often stemming from cultural and religious beliefs, such as Japanese people’s divine lineage from a “Sun Goddess” (Peng, 2016, p. 290).

Unlike the issues of social expansion, job creation, and immigration flow in Japan, Korea, and Eastern Asia, researchers in North America and elsewhere are concerned with eroding social protections, the effects on worker’s social and life circumstances, and also about worker’s health and safety (Vosko, 2005; Galabuzi, 2006; Vosko, McDonald, and Campbell, 2009). These problems have worsened among the most vulnerable and marginalized groups, which are often women, immigrants, and racialized people.



Immigrant and racialized people's experiences of racism and discrimination can affect their health (and health equity) in a number of ways. First, racism and discrimination has an effect on health by impacting social determinants such as income, and divides poverty along racial lines (Galabuzi, 2006; Mikkonen and Raphael, 2010). In Canada, in 1999, racialized people earned 16.4% less than all other workers (Das Gupta, 2005). This worsened by 2005 for average employment income, in which racialized people earned 18.61% less than non-racialized workers (Block and Galabuzi, 2011). Further, poverty rates among racialized people were also higher at 35.6% compared to a general rate of 17.6% (Galabuzi 2001; Das Gupta, 2005; Galabuzi, 2006). Racialized families had poverty rates at 19.8% compared to 6.4% of non-racialized families (Block and Galabuzi, 2011). Racialized poverty can affect health by cutting into basic-need budgets and the necessities of life such as adequate nutrition, diet, and housing (Galabuzi, 2006). It can also affect the young by imposing learning difficulties, social and psychological pressure within the family, inability to participate fully in civic and social life in the community, inability to exercise democratic rights such as voting and advocacy, and it can increase mental health risks (Galabuzi, 2006).

Secondly, racism and discrimination in employment against particular groups can lead to long hours with low pay, that have indirect effects on health by impacting social determinants such as education, and thwarting social mobility that would have benefitted them through education and skills training post-migration (Lewchuk, Clarke, and De Wolff, 2011). Thirdly, racialized groups often face forms of discrimination that affect social patterns, such as: high levels of school-dropout rates, contact with the penal/criminal justice system, and segregation into low-income neighborhoods, which further deepens social marginalization (Galabuzi, 2006),



and can further spiral downward to affect a number of health-limiting factors (Mikkonen and Raphael, 2010).

In general, racialized peoples<sup>16</sup> and immigrants often have precarious work statuses, and they frequently experience discrimination in jobs, pay and promotions (Dion and Kawakami, 1996; Wilson, Landolt, Shakya, et al., 2011). Racialized immigrants also earn lower incomes compared to non-racialized and non-immigrant groups. Many immigrants switch to new and unfamiliar occupations, or work in areas that are repetitive and manual, such as garment work, which may unintentionally increase their risk of injuries (Gannage, 1999; Ng, 2009). Ng (2009, p. 194) suggests that the garment industry has experienced significant restructuring, in which “Vancouver is experiencing a boom” because of newcomers; however, there is also fragmentation of production, such as in Toronto, in which manufacturers reduced plant size and contract-out work to home-based workers or sweatshop operations.

### ***Underemployment among Immigrants***

Under-employment and under-utilization of skills occur when individuals are granted immigration based on high levels of education and skills, yet they are unable to find employment to match their skills. For example, a significant proportion of immigrants and racialized people in Canada have university degrees and professional qualifications (Statistics Canada, 2007; Gilmore and LePetit, 2007), but many are compelled to take precarious jobs due to systemic discrimination in the form of devaluation of previous education and professional experience, demand for Canadian experience, or accessibility issues to professional bridging or language training opportunities (Li, 2001; Chen, Smith, and Mustard 2010; Das Gupta, 2005; Galabuzi, 2006; Crooks et al., 2011; Syed, 2014). Such forms of discrimination also include differential

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<sup>16</sup> Some authors have used different terms, such as visible minority (“VM”). Racialized and VM are used interchangeably and have the same meaning.



treatment at the screening stages in interview processes, hiring, performance reviews, and promotions (Das Gupta, 2005; Galabuzi, 2006). It is often difficult to find work in the respective fields of racialized immigrants due to these various forms of discriminatory practices. As a result, these workers take up work in temporary agencies, factories, and warehouses, sell products or services on commission, work as security guards, drive taxicabs, or work as self-employed persons or farm workers (Das Gupta, 2005). One racialized worker interviewed in a study by Lewchuk, Clarke and De Wolff (2011) stated that Canada is supposedly tolerant, but because of these labor market experiences, she stated that “it isn’t...the expression is hogwash” (p. 115).

There are multiple commentaries about de-skilling and under-utilization of skills among immigrants and racialized persons. Dossa (2002) argues that racialized immigrants to Canada are described as experiencing descent from a person to a nobody. They experience deskilling and downward social mobility upon arrival to the host country (Li, 2001; Galabuzi, 2006; Chen, Smith and Mustard, 2010; Syed, 2014), which causes “...people’s worth and status to be diminished” (Dossa, 2009, p. 122). The work of Martins and Reid (2007) shows that South Asian (“SA”) participants in Toronto were frustrated by the lack of recognition of their educational qualifications acquired from their countries of origin to Canadian-equivalency. All participants in this study reported having a university level education, such as a Master of Philosophy degree and college teaching credentials, but were unable to find meaningful employment in Canada (ibid). This failure to secure work left participants feeling compelled to work in low-income occupations in factories or fast food franchises such as Tim Horton’s or McDonalds (ibid). Other researchers report a similar finding, confirming that their sample of highly skilled women in British Columbia held low paid occupational positions (Dyck and Dossa, 2007).



### ***Geography of Urbanization and Immigrant Settlement***

Statistics indicate that metropolitan areas of Toronto, Vancouver and Montreal along with adjacent municipalities are the most popular destinations for immigrants' settlement in Canada (Vezina and Houle, 2017) as well as settlement of their children (the second generation) (King, 2009; Statistics Canada, 2017). The GTA is also a popular destination for immigrant settlement. Data from the last two decades shows that many immigrants flock to these areas because of employment prospects (Schellenberg, 2004; Kosny, MacEachen, Lifshen et al., 2011; Syed, 2013; Syed, 2014). They also choose these areas because of affordable housing options that might be accessible to them, as well as cultural comfort found in ethnic enclaves and ethnic neighborhoods (Alba, 1999; Vezina and Houle, 2017).

### ***Acculturation***

Acculturation refers to immigrants' adaptation of the culture, norms, and values of the country to which they have immigrated, whereas assimilation refers to a process in which migrants are expected to conform to the current norms of the state (Syed, 2012). These processes often involve 'culture shedding', which is unlearning or undoing previous customs or traditions (Berry, 1997). The work of Galabuzi (2006) and others argue that immigrants and workers of color are often racialized through an assimilation policy that aims at maintaining a white society, which constructs categories of desirables and undesirables (Galabuzi, 2006), and drives these groups into corresponding occupations that are likewise desirable and undesirable. These critical perspectives suggest that racialized individuals are socially constructed as dependents, non-Canadians, non-citizens, non-workers, and are labeled as immigrant or foreigner in comparison to employed white male citizens (Bannerji, 2000; Sharma, 2001; Das Gupta, 2005; Sharma, 2006; Thobani, 2007). Immigrants and racialized persons are also "Othered" on multiple fronts such as: coming from a non-western country, being poor, being female, or being



disabled (Dossa, 2009). Dominant groups use these and additional differences, such as culture and religion, to distance themselves from minority groups to acquire or maintain privilege or power. The process of distancing thereby make the minority groups as the “other”, an outsider that is a pariah and one that is perceived to be dangerous (Galabuzi, 2006, p. 31).

The process of “Othering” of migrants is not an exclusive occurrence in Canada. In Germany, Arabs and Turks have experienced racialized discrimination, and politicians like Thilo Sarrazin exacerbated stereotypes by claiming that such groups were not willing or capable of assimilation (Standing, 2011). This is particularly disturbing, as involuntary or forced assimilation can also have adverse health consequences in itself (Syed, 2013). Similarly, Maghrebians, Blacks, and the Roma in France have experienced various forms of racism, with the former less likely to be called for job interviews compared to their native French, non-Maghrebian counterparts (Fanon, 1967; Standing, 2011). In the USA, American black men have a high incidence of unemployment, prison records, and below-average schooling, and in 2010 only 50% of adult blacks were employed compared to 59% of adult whites (Standing, 2011), which is likely to be attributed to old-age problematic conditions of anti-Black prejudice and racism (Firebaugh and Davis, 1988). Another example of racialization and differentiation is of the Canadian Muslim community, which is constructed by the dominant culture as a religious and racialized minority composed of predominantly SA, African, and Middle Eastern people, yet this community resists marginalization in its spatial settings (Razack, 2002). In the post-September 11 period, there has been an increase in racial profiling, backlash, and targeting of these racialized groups through national security concerns with undue attention from police and immigration officials, as well as the introduction of legislation that compromises the rights and liberties of these minorities (Galabuzi, 2006).



### ***International Remittances***

Economic migrants fill labor shortages for aging populations while contributing \$440 billion to the global economy in remittances between host and home countries (World Bank, 2011). Canada is one of the top ten destinations for migrants, and it is also one of the top source-countries of these remittances (World Bank, 2011). It is estimated that \$1.9 to \$2 billion are contributed to the Canadian economy annually from immigrants arriving under the Immigrant Investor Program alone (Ware, Fortin, and Paradis, 2010). Furthermore, \$3.4 million dollars in government revenues are collected from temporary and seasonal workers from Mexico and the Caribbean from employment insurance premiums and taxes (Brem, 2006). These statistics raise important questions and contradictions of work precariousness, such as: to what extent do workers send international remittances? What is the monetary value of annual remittances that each worker is able to send? How does precarization fit within this context? As indicated in the next chapter, I will justify my rationale for asking my participants particular questions about international remittances.

### ***Agency and Forms of Resistance***

The negative employment experiences of migrant and racialized workers might be used to limit or restrict border flow, based on misinterpretations that they are failed citizens and are unable to empower themselves. However, migrant workers retain some agency to influence the world in which they live. For instance, migrant workers have exercised agency through migration networks (Boyd, 1989; Massey et al., 1993) to sponsor friends, relatives, and community members (Banarjee, 1983; Shah and Menon, 1999; Percot and Rajan, 2007), providing information, housing, and financial assistance (Curran and Rivero-Fuentes, 2003). They have also prepared for work overseas by taking courses and examinations for accreditation



(Rodriguez, 2010), and have sought out improved living standards through demonstrations, such as May Day, Battle of Seattle, and Occupy Movements (McNally, 2010; Robinson, 2006; Smith, 2012; Standing, 2011). Research about care workers' agency and resilience has documented that workers often employ particular workplace strategies, as discussed earlier in chapter three.

### ***Occupational Health and Safety Concerns of Double Workdays***

Enduring racialized gender inequalities exist inside and outside the labor force (Das Gupta, 2005). Racialized migrant women tend to occupy some of the lowest sectors of the labor force (Ng, 1996; Dossa, 2009; Galabuzi, 2006). Government policies and employer practices continue to confine women of color to care work occupations such as child-care, nursing, caregiving, and to the service sectors as with retail work, which reflect the racialized sex and gender divisions of domestic labor (Glenn, 1992; Armstrong and Armstrong, 2001; Das Gupta, 2002; Cranford and Vosko, 2005; Vosko, 2005; Armstrong, Armstrong, and Scott-Dixon, 2008), and tasks associated with domestic, household labor and skills, such as ancillary and caregiving work in the health sector (Armstrong and Laxer, 2005; Cranford and Vosko, 2005; Armstrong, Armstrong, and Scott-Dixon, 2008; Armstrong, 2013b). They typically have low earnings, little benefits, few regulatory protections, and limited control over the labor process (Cranford and Vosko, 2005; Daly, 2013). Women of color are also the most likely to be in and out of jobs and have less than a year of work (Cranford and Vosko, 2005).

Racialized women often experience unique industrial and occupational segregation, and polarization (Glenn, 1992, Gabriel, 1999; James, Grant and Cranford, 2000; Das Gupta, 1996; Das Gupta, 2002; Cranford and Vosko, 2005; Galabuzi, 2006). The occupation-specific example of this is live-in domestic workers and care workers who are recruited from abroad (Arat-Koc, 1997; Vosko, 2005; Daly, 2013). These include Filipino long-term care workers, nannies,



domestic workers in Canada, some of whom work through the live-in caregiver program (LCP) through direct negotiations between the Canadian and Filipino states (Bakan and Stasiulis, 1997). These workers are in unrecognizable and unseen private spheres, and while their work is valuable, they are vulnerable because they are underpaid and overworked (Daly and Armstrong, 2016; Armstrong, Armstrong, and Scott-Dixon, 2008; Dossa, 2009). Although racialized and immigrant women enter Canada with desired human capital and skills, they are restricted in the type of work opportunities. Dossa (2009) confirms this with her description of Tamiza, who worked two jobs: one as a bank teller by day, and another as a babysitter by night.

Migrant racialized women frequently experience not only adverse working conditions, but also adverse health care experiences. Women are the least served by the health care system and immigrant women are marginalized further. For example, in one study, a female patient [Mehrun] who experienced breathing problems and muscle weakness was told that it was all in her head on two occasions by two different physicians and asked to change her attitude (Dossa, 2009). Racialized migrant women with disabilities are further vulnerable because they have less opportunity for education and work than men and are not considered “desirable” migrants (Dossa, 2009). Unlike her able-bodied counterparts, disabled women are perceived neither as waged workers nor as homemakers. They are socially constructed as dependents, which is a ground for exclusion from immigration (Dossa, 2009).

Double-workdays refer to the dual demands of paid and unpaid domestic responsibilities and are characterized by high job demands, high workloads and time pressures (Meintel, Labelle, Turcotte, and Kempineers, 1987). Messing (1998) recognizes that immigrant women are vulnerable to double-workday stress due to domestic (unpaid) and paid work responsibilities. Double-workday stress is particularly important as the high demands of paid and unpaid labor



pose a potential risk for onset of Musculoskeletal Disorders (“MSD”) (Karnaki, Polychronakis, Linos, and Kotsioni, 2008).

Syed and Ahmad (2016) highlight a number of Canadian studies that are relevant to the literature of double workdays. For example, Grewal, Bottorff, and Hilton (2005) demonstrate double-workday tensions among the SA women in their sample who communicated expectations to hold full-time employment and take on responsibility for most domestic chores in addition to traditional roles. Another study by Choudhry et al., (2002) also reported significant demands on SA women, including care for children, grandchildren and housework, which allowed for little personal time to focus on their own health. In this study, one participant reported that women were “martyrs” willing to do anything to provide for their families, and focused on others’ well-being rather than their own health (Choudhry et al., 2002). Spitzer et al., (2003) showed that SA and East Asian women’s caregiving roles are central to cultural identity and family survival, but these women experienced significant strain juggling demands of work and family, especially in low wage employment, and when social support systems were lost post-migration. High demands on SA and other racialized women could lead to fatigue, stress, anxiety and depression, the latter factors of which have been linked to MSDs (Lundberg, 1999; Kumar, 2001).

### ***Musculoskeletal Conditions***

Musculoskeletal disorders are defined as disorders affecting the muscles and joints, including back pain, repetitive strain injuries, spinal disorders, sprains, dislocations, and fractures. According to the World Health Organization’s (“WHO”) (2003) report, MSDs are among the dominant occupational health hazards affecting migrant workers. MSDs are one of the most prevalent and chronic health conditions in Canada, with 43% Canadians having reported having an MSD (Canadian Orthopedic Care Strategy Group (COCSG), 2010). MSDs also have a



detrimental cost to the Canadian economy, estimated at \$37 billion each year due to disease and injury (El-Gabalawy, 2014). These costs stem from hospital care, physician visits, rehabilitation and prescription drugs, but nearly 75% of the overall costs are indirect and due to absence from work, lost potential earnings and underperformance (El-Gabalawy, 2014; Coyte, Asche, Croxford, and Chan, 1998). According to Canada's provincial worker compensation boards, MSDs were the single largest category of lost-time injury claims and contributed to work-related absences due to injury or illness in Canada (Choi, Levitsky, Lloyd, and Stones, 1996; Polanyi, Cole, Beaton, et al., 1997).

Evidence shows that work-related MSDs such as tendonitis, carpal tunnel syndrome and other upper-extremity MSDs are more frequent among women than men (Ashbury, 1995; Karnaki, Polychronakis, Linos, and Kotsioni, 2008; Treaster, and Burr, 2004; Strazdins and Bammer, 2004; Messing, Stock, and Tissot, 2009). MSD prevalence has been reported to be higher among female employees than male employees in rubber manufacturing and assembly plants (Nordander, Ohlsson, Balogh, et al., 2008), sewing machine operations (Wang, et al., 2007) and newspaper offices (Polanyi Cole, Beaton, et al., 1997). Traditionally, the reason for women's vulnerability to MSDs has been predominately explained through a biological paradigm that assumes women are smaller in size and weaker than men. However, growing evidence suggests that women's vulnerability to MSDs is beyond simple biological differences between men and women (Doyal, 1995; Messing, 1998). Rather, these differences might actually be due to both the double burden of paid and unpaid domestic responsibilities that women experience and the feminization of certain forms of work. The risk of occupational injuries and MSDs seems to be compounded in many immigrants, especially immigrant women. One study by Premji, Messing,



and Lippel (2008) conducted in a garment factory in Montreal describes various health problems, including widespread musculoskeletal pain, among immigrant women.

Migration makes immigrants vulnerable to work-related accidents and illnesses because they are involved in increasingly precarious forms of work, such as part-time, seasonal, or casual work -- which refer to working less than full time hours ranging from 37 to 40 hours per week, working in particular seasons, or working on an on-call basis (Statistics Canada, 2008; COCSG, 2010; Cranford and Vosko, 2005; Syed, 2016). Among migrant women, these occupational problems are possibly exacerbated by the multiple burdens of paid work and unpaid domestic responsibilities coupled with deskilling and precariousness. While non-immigrant women may experience both paid and unpaid demands, Cranford and Vosko (2005) suggest that they are not exposed to the same precarious working conditions as are migrant women.

## **VI. Discussion**

Given the literature about double workdays, musculoskeletal disorders, international remittances, acculturation, agency, and resiliency among women, immigrants and racialized workers, a number of important research areas emerge. This dissertation seeks to illuminate how care workers, including those who are immigrants, experience precarization. It also raises tangential yet important questions including how the process of acculturation occurs at the level of the workplace, or how the process of workplace discrimination might be experienced. It will also investigate ways in which the flow of international remittances occurs and how resilience is exercised, despite the contradictions that racialized persons often face, particularly low remuneration and low status jobs, such as those found in LTC.

One of the gaps explored in this chapter is that although there is some literature citing racialized or immigrant people's negative experiences in the labor market, these experiences do not explicitly examine the health of these vulnerable groups. For example, Habiba Zaman's



(2012) research explores how a sample of racialized persons experience structural discrimination in their daily lives and at work, but there is no emphasis on how these experiences are connected to the SDoH and how they can impact personal health of these workers. Only recently have these connections and discussions of racism to health and well-being emerged (e.g. Das Gupta, 2015).

Another set of gaps in scholarly knowledge identified in this chapter are related to foci of research with racialized persons and migrants' occupational health experiences. Most studies have been carried out in the positivist tradition, with a focus on risk, exposure and presence or absence of acute work-related injuries (Smith and Mustard, 2009; Smith, Chen and Mustard, 2009; Smith, Kosny and Mustard, 2009; Chen, Smith and Mustard, 2010; Premji, Duguay, Messing and Lippel, 2010; Syed, 2014). These studies do not distinguish the diversity and variation between migrant and racialized populations, nor do they examine chronic health effects involved in the workplace (Syed, 2014). Therefore, there is a need to fill these gaps with qualitative research that examines the relationships between risk, exposure, and experience of occupation-related chronic illnesses among immigrants and racialized persons. This research should include the voices of marginalized groups who may experience adverse working conditions, and identify how their health is affected. Multiple methods are required to attend to these gaps, including self-report surveys as well as qualitative questions that explore the mental, social, and physiological health outcomes of workers in a detailed, descriptive, and qualitative manner. My project aims to fill these gaps and contribute knowledge to the aforementioned existing literature.

## **VII. Summary**

In this chapter, I have identified literature in which it is suggested that precarious and nonstandard working conditions are problematic for workers' social well-being, which can have



consequences for health because they are associated with determinants such as income, social status, personal health practices, and coping skills. Contingent and flexible working conditions can further impact health through dimensions of work such as: the degree of certainty of continuing work with minimal risk of job loss; control over working conditions, wages, and pace of work; and regulatory protection such as availability of benefits. As indicated earlier in chapter two, workers employed in nonstandard work are at risk of health problems. The social and health problems of precarization can be compounded by social locations such as gender, race, immigrant-status, and disability status. The increasingly precarious nature of the Canadian labor market and the erosion of standard working conditions have resulted in health and safety issues among these vulnerable workers. While there are some emerging connections between these things, little is known about how precarization affects SDoH among immigrants and racialized persons in LTC. Because of this reason, my dissertation aims to build on the theory and literature from the previous chapters and to fill knowledge gaps. The context about precarious work and precarization that was contained within this chapter, together with the previous two chapters, which were about the theoretical frameworks and the LTC context, lead into a discussion about the tools and methods that I utilize in order to conduct my study. In chapter five, I discuss the research design and data collection techniques that I employ in this study.



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## Chapter 5: Research Methods, Study Design, Data Collection Techniques

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### I. Introduction

The previous chapter identified studies of precarious work and the resultant occupational health and safety (“OHS”) concerns for women, immigrants, and racialized persons, highlighting feminist political economy, the social determinants of health, and anti-racism lenses. Precarious working conditions are problematic for workers’ health and wellbeing because they can adversely affect determinants such as income, social status, personal health practices, and coping skills, and they can adversely impact employee health through dimensions of work such as: wages, pace of work, and control over working conditions, among others (Organization for Economic Co-operation and Development (“OECD”), 1996; Vosko, 2000; Jackson, 2005; Vosko, 2005; Lewchuk, De Wolff, King, and Polyani, 2005; Louie et al., 2006; WHO, 2007; Benach and Muntaner, 2007; Lewchuk, Clarke, and De Wolff, 2011; Lewchuk, Laflèche, Dyson, Goldring et al., 2013; Lewchuk, Laflèche, Procyk, Cook et al., 2015).

This study examines whether and how precarity is experienced by racialized and immigrant people who work in an urban Canadian residential long-term care (“LTC”) facility; and how precarious work may have health implications for these workers. The main research questions are as follows:

- 1) In what ways and why is precarization occurring in LTC?
- 2) How do immigrants and/or racialized people experience work in LTC differently than their non-immigrant/ non-racialized counterparts?
- 3) Are their experiences gendered?
  - a) How do issues of gender, race, immigrant status, or culture modulate work-life balance and work-life experiences?
  - b) How do workers cope with precarization in LTC and in life circumstances?
  - c) How do workers manage problems that arise from precarization?
  - d) What downstream health effects do LTC workers identify with their labor (e.g. musculoskeletal pain or strain)?
  - e) How do workers manage their household budgets?



- f) What is the impact of workers remittances to their family in their home countries?

A single-case study design was selected to provide context for the “how” and “why” questions (Yin, 2014, p. 29) with regard to a residential LTC facility. Direct observations, interviews, and a survey were the primary data collection methods. The site was purposefully selected (Strauss, 1967; Patton, 1990b; Coyne, 1997) to reflect its diverse group of paid care workers in an urban LTC facility in Toronto, Ontario, Canada, and this selection was based on: prior networking, relevance to the research questions, feasibility of the project, richness of data, and location. Following this introduction, Section II outlines the case study design. The data sources and ethical considerations are included in Section III. Section IV provides the site context, while Section V discusses the qualitative and quantitative data collection methods. Section VI documents the participant sampling approach, sample size, as well as inclusion and exclusion criteria. The data analysis procedures including coding, and interpretation as well as data management are detailed in Section VII, while Section VIII describes the qualitative and quantitative samples as well as care workers’ demographic information. Section IX discusses study challenges and limitations, and section X provides a chapter summary.

## **II. Study Flow: Case Study Design**

According to Yin (2014), case study design consists of several steps. The first step of case study design requires the formulation of study questions, which are framed in specific ways: “Case study research is most likely to be appropriate for ‘how’ and ‘why’ questions, so your initial task is to clarify precisely the nature of your study questions in this regard” (Yin, 2014, p. 29). Accordingly, the questions for this project are: How do racialized and/or immigrant workers experience work differently than their counterparts in residential LTC? In what ways (and why) is work in LTC precarious? Are there gender differences?



The second step of case study design requires study propositions, which direct attention to something that should be examined within the scope of the study and that will enable researchers to move in the right direction. Yin (2014) further suggests that this focus should be on contemporary events over which a researcher has little or no control. However, Yin (2014) cautions that some studies do not have propositions. Instead, the topic is the subject of exploration, which makes the design exploratory. In exploratory studies, there is a statement of purpose and criteria for evaluating the exploration as successful or not (Yin, 2014). For this project, the contemporary event that is being investigated in which I have little or no control is precarization. There is also direct attention to at least two key areas of difference: race and gender. Therefore, this study is based on these propositions of difference by race and gender, and broader socio-political trends of precarization. It is not exploratory in the sense that it requires an evaluation; it is however, exploratory in the sense that the study seeks to learn “how” workers experience precarization and unequal relations at work.

The third step of case study design requires that the case be defined or bound (Yin, 2014). For example, in classic case studies, the focus is on an individual person as the case (Yin, 2014). Alternatively, a case can cover a firm or organization, such as the Korean firm Samsung (Yin, 2014), or a single community health center (Ferrari, Shakya, Ledwos, McKenzie et al., 2018). My case will be the organization, that is, the LTC facility.

The last step of a case study design requires the following: a) that the data is linked back to propositions; and b) that there is a criterion for interpreting the finding(s). This latter step requires identifying and addressing rival explanations in the findings (Yin, 2014). In my study, I will link back the findings to the study propositions, and I will evaluate any observable differences in race and gender. As the quantitative data is descriptive, rather than predictive, I



will not apply statistical tests. Rather, the numerical data generated from my survey and interview demographic questionnaire contribute to the observations and descriptions of race, gender, and precarity.

### ***Single-Case Design and Analysis***

According to Yin (2014), there are two major categories of case study research designs: single-case designs and multiple-case designs. My project consists of a single-case study of workers in a residential LTC facility. The focus is at the level of an organization, which is a single site; therefore, it will serve as a single-case design. This project's single-case design is grounded by an intersectional framework of feminist political economy of health and anti-racism along with attention to the social determinants of health, which enables a snapshot of worker attributes that can elucidate the social relations of the workplace. Therefore, this project includes the following characteristics for analysis: sex, race/visible minority ("VM") and/or immigrant status; the various job categories of workers; the roles (P/T and F/T) that each of the workers have; and the narratives of paid/ unpaid work, among others. While the workers, and their narratives or experiences, occur within the organization, they also occur within broader social, political, and economic contexts. The latter is reflected through the analysis of income and socioeconomic status, for example.

Case study designs can have various advantages and disadvantages. For example, one of the pitfalls of case study design is that the case study might focus on individual employees, however, if the data focus is only on individual employees, then the study will become an employee study and not an organizational study (Yin, 2014). In order to avoid this pitfall, I will bring the focus back to the organization. To assist with this process, I will refer to the site as Eastside Home, and, like Day (2014), I will bring the workers' experiences back to the focus of



this site. One advantage of case study research designs is that they are not completely “codified”; therefore, they can offer opportunities to make a study unique, and customized to the needs of the project (Yin, 2014, p. 28).

It may be reasonable to assume that Eastside Home is representative of a market-oriented system that makes up the local LTC structure in this urbanized region of Ontario, based on my prior experience from the *Invisible Women* Project. However, there are institutional differences. For instance, there may be various levels of privately hired companions, and this, in turn, may be reflective of the socioeconomic status, race, ethnicity, and neighborhood of the consumers of LTC. There are also differences between LTC homes based on their association with and proximity to a research and teaching hospital or acute care setting, leading to possible differences in access to care and expert resources.

### ***Case Study Design with a Mixed Methods Approach***

My project uses single-case design, and relies on qualitative interviews, observations, and a survey for quantified description. Because this case study used a combination of these sources of evidence in a single study, it is considered to be a mixed methods approach (Johnson and Onwuegbuzie, 2004, p. 17; Yin, 2014), the latter of which has higher rating for quality than case studies that rely “ [...] on only single sources of information” (Yin, 2014, p. 119).

Using a mixed methods approach enabled me to capture descriptive characteristics and detailed information about the site’s workforce, and such an approach is beneficial for occupational health and safety (“OHS”) research (IWH, 2011; IWH, 2015). Previously, Canadian OHS research was oriented through positivist paradigms that placed a higher emphasis



on quantitative methods, such as survey methods<sup>17</sup>. However, qualitative research has gained acceptance into academic circles as a credible form of research in its own right, especially in the social sciences, education, and health care, and it has helped to fill knowledge gaps (Rennie, 1999; Reisetter et al., 2003). Unfortunately mixed-methods research of migrant and racialized people's work experiences in Canada remains sporadic. To date, there are only a few studies examining: how community organizations improve health of racialized immigrant seniors (Koehn, Jarvis, Sandhra et al., 2008); the relationship between self-perceived mental health, social support availability, and urban center size among recent immigrants (Chadwick and Collins, 2015); differences in the sense of belonging to the local community between immigrants and Canadian-born persons (Kitchen, Williams, and Gallina, 2015); and healthcare-seeking behaviors of racialized immigrants (Wang and Kwak, 2015). Thus, this project also aims to fill these knowledge gaps.

### **III. Data Sources and Ethical Considerations**

As my research involves human participants, I completed a training module and obtained clearance certification from the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans, Core Course on Research Ethics (TCPS 2: CORE) on February 12, 2016. During the proposal drafting stage, I consulted my supervisor about potential sites, and was advised to network with key connections from potential sites, given that no data collection should occur. I established contact with a key stakeholder from my site on February 16, 2016 through LinkedIn, which is an employment-based social networking site. I was directed to contact the Chief Executive Officer ("CEO") of the site, which I did via email on March 21, 2016, and I was required to submit an executive summary for the site's internal ethics committee.

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<sup>17</sup> A survey method is not itself positivist, but it is a research method that is primarily driven by the epistemology of positivism, and it is considered to be one type of quantitative research method (See Creswell, 2003).



I maintained contact with the CEO by telephone and email, indicating that the executive summary and research proposal were in draft, and would need to be cleared by my committee, Department, and York University's Office of Research Ethics ("ORE").

In late August 2016, the proposal was approved by the committee and department, and submitted with the informed consent forms, the TCPS 2: CORE certification (**Appendix 5.01**), and executive summary (**Appendix 5.02**), to York University's ORE for approval. The ethics paperwork (i.e. informed consent forms) (**Appendix 5.03**) included a section explaining that the study participants would be provided with a token-incentive of a \$10 gift card for their interview participation; and a raffle would be drawn for a \$20 gift card from a group of individuals who had completed the survey (**Appendix 5.04**).

Certified ethics approval from York University was obtained on November 22, 2016, which included an approval period of up to 1 year (**Appendix 5.05**). That evening, I contacted the CEO of the site, and I submitted the executive summary for the site's internal ethics committee meeting. As described by the Nuremberg Code, I communicated elements describing the nature, duration, purpose, and methods of the research (Ghooi, 2011) in the executive summary. After the site's Professional Advisory Committee meeting ("PAC") and internal ethics approval on January 25, 2017, I attended the site on January 27, 2017. I continued fieldwork until April 2017. During the initial visit, which involved a tour of the premises, I met with the CEO. The Social Service Coordinator served as my guide and connected me with many workers and other participants. During this initial visit, recruitment flyers were posted at the site to facilitate recruitment, and were also distributed directly to potential participants (**Appendix 5.06**). The initial site visit enabled visualization of the geography and surroundings. For ethical reasons, the site remains anonymous.



#### **IV. Site Context: Geography**

I focused on an urban residential LTC facility in Toronto, Ontario, Canada. This jurisdiction is an immigrant-dense area (Schellenberg, 2004; Kosny, MacEachen, Lifshen, Smith et al., 2012) that has rich cultural backgrounds. This city is relatively large, diverse, and includes multiple suburban districts (e.g. North York, Scarborough, East York, and Etobicoke).

One of the features of this site's location, similar to other North American cities, is a presence of ethnic enclaves e.g. Greek village, Chinatown, and little Italy. I anticipated that the demographics would reflect the surrounding enclaves, and participants would report being born in a foreign country or have ancestral roots from particular regions of the world, such as the Caribbean, Southeast Asia, or South Asia. For ethical reasons, the specific ethnic population that resides in the region will not be disclosed; however, I will provide some information about it here.

The site of this research project is a not-for-profit nursing home with more than 150 beds, and it is connected to a larger seniors' apartment complex. Although workers are mostly hired directly, there are workers who are recruited from temporary employment agencies. Like other LTC facilities, particular services, such as dietary, meal preparation, and physiotherapy, are outsourced to companies.

The site is accessible by vehicle or by public transit, and is set amongst mixed residential and commercial buildings. Adjacent and nearby structures to the site include: several used automobile sales shops with lots occupied by automobiles, an ethnic community center, ethnic restaurants, meat and food markets, a flower shop, a barber shop, a church, and a mosque. There is no park or green space in the surrounding area. To the rear of the site there are detached brick, bungalow-style residential homes.



## **V. Data Collection Methods**

This section discusses the data collection techniques, the process in the field, the sources of evidence, the processes of site and participant selection, inclusion and exclusion criteria, as well as the strategies for coding, and interpretation.

I conducted a case study of workers that utilized evidence from direct observations, qualitative in-depth, semi-structured interviews, and a self-administered survey. The qualitative approaches that I used are often employed in ethnographies (Green and Thorogood, 2009). Previous research of Canadian LTC work includes ethnographies, albeit they were team-based rapid ethnographies (Daly, Armstrong and Lowndes, 2015; Daly, Struthers, Muller et al., 2016; Syed, Daly, Armstrong et al., 2016). An ethnography involves the study of people in their everyday lives (Emerson, Fretz, and Shaw, 1995). Ethnographies focus on questions such as: what is the culture of the group of people under investigation (Patton, 1990). The researcher attempts to capture and observe naturally occurring interactions (Green and Thorogood, 2009) and seeks immersion in the others' world to grasp the experience or phenomenon (Emerson, Fretz, and Shaw, 1995). While I did not conduct an ethnography (rapid or otherwise) per se, an important component of an ethnography is observation.

### ***Observations***

Observations include two types: participant observation or non-participant observation. I conducted non-participant observation. In non-participant observation, the researcher observes the field without involvement, and this may include analyzing audiotapes for instance (Green and Thorogood, 2009). Other examples might be shadowing staff for a shift, or sitting in a clinic reception area for brief periods (Green and Thorogood, 2009). It is also suggested that



observations should involve a framework and should be organized to ask questions of who is present, what activity or thing is happening, when, where, how, and why (Bogdewic, 1999).

One of the strengths of observational methods is that they provide data and descriptions about a particular phenomenon, and can include things, such as particular behaviors, and people's accounts of those phenomena (ibid). Observational methods might help to illustrate a truth about an event or process (Green and Thorogood, 2009). However, one of the weaknesses of observational methods is that they may be time-consuming, they may take: months to gain access to the field, months to years to gather data, and additional time for analysis (Green and Thorogood, 2009). Another weakness of observational methods is that for some types of research, observations might be inappropriate. For example, a researcher may be interested primarily in accounts or narratives, in which it is appropriate to use interview methods (ibid). Finally, another problem of field observations is that note-taking during observations might seem strange, and if the researcher writes the notes at the end of each observation period, it might not be possible to remember all the exchanges but rather only salient ones.

Building on previous experience drawn from the *Invisible Women* Project, I conducted observations of the site. The total observations amounted to approximately 131.75 hours. I observed between the hours of 7 am to 10 pm, although observations were extended to midnight when surveys were distributed to workers who started their shifts at 11pm. I also observed and interviewed individuals as early as 6:30 am. This meant that I was able to observe at least two scheduled shift changes that occurred at 7 am and 3 pm. Observations were conducted in secure (locked) and unlocked units/ wings at the site; in public spaces within the facility, and at the reception area. These spaces included: hallways and dining areas on the individual units, the recreation space of the atrium located on the ground floor, the employee break-room located at



the mezzanine level, and meeting rooms located in the basement-level.

Fieldnotes were generated during observations, when I was not formally interviewing participants, and often documented preliminary thoughts, assumptions, and the physical setting (**Appendix 5.07**). Fieldnotes are paraphrased words written from conversations, or an account of what the observer sees (Bogdewic, 1999). I used traditional pen and paper as well as a tablet computer, i.e. iPad, to document.

### ***Interviews***

The choice of individual, qualitative, semi-structured interviews over focus groups was based on several reasons. First, I felt that focus groups may not be optimal for the sake of confidentiality between workers. In focus groups, participants may not fully discuss their experiences, especially on sensitive topics. In contrast, one-on-one interviews might allow a focus on each individual's detailed story and would provide richness of each individual's context. Another concern about using focus groups was the potential harms of power and privilege dynamics that can exist among different categories of workers, which has been documented in previous studies of LTC (Syed, Daly, Armstrong et al., 2016). Furthermore, finding a day and time convenient to several people to join a focus group could have posed undue burden on participants due to their conflicting work hours, multiple forms of employment, and Toronto's lengthy commutes (Turcotte, 2011).

To establish familiarity with the topic of precarity, and to delve deep into the responses of my participants; semi-structured, open-ended, in-depth interviews were conducted so that detailed responses could be generated. A preliminary framework guided interviews (**Appendix 5.08**). The interviews were conducted with various individuals in the Eastside Home, including those who have special knowledge or status in relation to the study focus (Bogdewic, 1999). I



wanted to interview at least 2 to 3 workers that came from a variety of occupations such as nursing, personal support, dietary, recreation/activation staff, and administrative or non-clinical occupations, which I achieved. Initially, I had established a range of 20 to 30 participants to interview, as this is considered a reasonable range to achieve rigour in qualitative research (Baker and Edwards, n.d.). Nevertheless, I went beyond this range to ensure data saturation. In total, 42 face-to-face, in-depth, semi-structured interviews were conducted.

To establish trust and rapport with my participants, I remained in the field for observations for about a week prior to commencing interviews. Establishing trust and rapport between the researcher and participants is necessary in observational methods (Bogdewic, 1999), and interview methods (Fontana and Frey, 2005). A researcher might establish rapport by communicating their institutional affiliation or other information to the participants in order to establish trust, while also being reflexive and acknowledging their prior assumptions or ideas about the research. Bogdewic (1999) and Smith (1999) suggest that the researcher should be honest and state that he/she is in the setting that is being studied because he/she has limited understanding of it.

Interviews were conducted in the most convenient location for the participants, and often included a quiet multi-purpose office space within the facility. When the multi-purpose office was not available, alternative spaces were used such as: boardrooms, nursing stations, or private lounges that were located on the units, and were mutually convenient locations for both the interviewer and the interviewees. The interview process began with a brief introduction to the study, and review of the informed consent forms. After reviewing these forms, joint signatures were collected and the token incentives were distributed to the participants. Participants were then asked to fill out a short, demographic questionnaire (**Appendix 5.09**), which helped to



supplement the context for participants' responses, and helped to collect demographic information about the interviewees. Thereafter, interview interactions were digitally recorded using two Sony ICDPX440 recorders. The reason for utilizing two recorders was that one of the recorders served as a back-up recorder to minimize data loss.

According to Cowles (1988) and Flesch (1975), the length or duration of interviews should be flexible. Interviews should be long enough to allow participants to discuss their thoughts and feelings without strict time constraints (ibid). They should help to establish rapport, and should be long enough to allow time to deal with emotional reactions from potentially sensitive topics for which participants may be directed to support and resources (**Appendix 5.10**). I established an ideal range of 30 to 60 minutes per interview, but some interviews were as short as 15 minutes, which coincided with workers' break periods. Many of the initial interviews with key front-line staff reflected this duration and represented a research challenge. When more time was required, an additional follow up interview was scheduled if it was mutually convenient for the interviewer and interviewee. One of the drawbacks to this second interview was that the initial interview momentum was not always reproduced.

During the data collection process, interviews involved active listening, i.e. listening and being active in conversations. Participants were encouraged to elaborate on accounts of their experiences using probing to provide more details about their story for clarity and in order to "stay close to the lived experience" (Starks and Trinidad, 2007, p. 1375; Van Manen, 1990). During all interviews, audio recording equipment was used to record conversations and the audio-taped information was verbatim transcribed into interview transcripts using a professional transcription service.



## *Survey*

For the quantitative component, I conducted an exploratory, paper-based survey that included approximately 40 items (**Appendix 5.04**). The survey asked about related sensitive issues, such as income; occupational illness, injuries, and impairments; shift work; and how workers navigate systems of health and compensation. The survey included a section called “Country of Birth and Ethnicity”. Question 5 asked about country of birth and this information was interpreted as immigrant/non-immigrant status. For example, non-immigrant status was ascribed to those who reported being born in Canada. The survey did not ask about “race” explicitly because this may provoke anxiety among respondents. Instead, race was derived from the survey question 6 that asked about ancestral background with response options of European (white), SA, East Asian, Aboriginal, African, and so forth. For analysis, participant responses were grouped as “visible minority (VM)/racialized” and “non-visible minority/non-racialized”; the latter being European (white), and the former being all other responses. Those participants who selected more than one option were placed into “visible minority” if they did not select European (white) option in the survey. The survey also had an optional comment box on the last page for respondents to fill out “about how your work affects other aspects of your life, about why you chose to work in this field or about the health care field in general”.

Some of the survey questions were derived from existing surveys and some were developed ad hoc based on the literature review. For instance, the questions about personal income, household income, country of birth, employment/injury information, symptoms related to anatomical regions, weight, energy levels, and sleep were all derived from the work of Syed (2011). The remaining questions were derived from a variety of sources, such as the Canada Community Health Survey(s) (“CCHS”), Das Gupta (2009), and Banerjee (2010).



Paper based surveys have been used in prior research projects conducted in LTC (Banerjee, 2010; Daly, Banerjee, Armstrong, Armstrong, and Szebehely, 2011; Daly and Szebehely, 2012). One of the advantages of paper-based surveys might be direct interaction between participants and the researcher, which could help establish rapport and trust. Indeed, many participants who were approached in-person for survey participation expressed interest in the project. This direct approach made communication easier than alternative strategies such as internet or telephone; it gave the project direct visibility on the premises; and it may have helped to recruit further participants into the study. For instance, when participants saw that their colleagues were speaking to the researcher and accepting surveys directly, they were immediately drawn to the project, and also expressed interest in participating in the study.

## **VI. Participant Sampling and Inclusion/Exclusion Criteria**

### **Interviews**

#### ***Sample Size and Sampling***

The sample size for interviews generally depends on five things: the nature of the topic, the study design, the scope of the study, the quality of data, and the use of shadowed data, meaning that participants speak of their own and others' experiences (Morse, 2000; Morse, 2001; Starks and Trinidad, 2007). According to Patton (1990), qualitative inquiry can focus on relatively small samples, or even single cases ( $n = 1$ ). Most qualitative studies tend to have sample sizes that range ideally from 10 to 60 persons (Starks and Trinidad, 2007). My initial estimation for the sample size consisted of a range of 20-30 participants and it was expanded as explained earlier; the final sample size consisted of 42 in-depth interviews with participants.

I used a purposeful sampling strategy to recruit participants with employment experiences within the healthcare sector (Patton, 1990b; Starks and Trinidad, 2007). Purposeful



sampling refers to explicitly selecting interviewees who are likely to generate appropriate and useful data (Green and Thorogood, 2009). Purposeful sampling has the intention of selecting information-rich cases in which one can learn a great deal about issues of central importance to the purpose of the research that will illuminate the questions under study (Patton, 1990b). The latter technique has been implemented in previous LTC research as well (see Daly, Armstrong, and Lowndes, 2015; Daly, Struthers, Muller et al., 2016; Syed, Daly, Armstrong et al., 2016).

While this thesis focuses upon racialized persons or immigrants, and intersection of gender, sampling and recruitment for this study was broad and included non-racialized persons and men in order to compare and contrast experiences and include various social, economic, and political contexts. Sampling of racialized/non-racialized persons occurred in order to compare, contrast, and capture experiences to delineate any differences and similarities.

The recruitment methods were snowball techniques and direct purposeful recruitment by the principal investigator. Snowball techniques refer to recruitment in which existing study participants select further participants who are among their acquaintances (Biernacki and Waldorf, 1981); it has the advantage of recruiting persons involved in sensitive matters, and those who have shared experiences (*ibid*). For my study, snowballing was particularly relevant for sensitive experiences of discrimination and/or social exclusion.

Sample size saturation is theoretically achieved when side-by-side analyses of collected data reveal “nothing new” (Green and Thorogood, 2009, p. 119). Accordingly, sampling of participants with different experiences took place until the essence of the phenomenon and multiple dimensions of the social processes were thought to be fully explored (Silverman, 1985; Starks and Trinidad, 2007).



***Inclusion/ Exclusion Criteria and Recruitment***

For the qualitative component of this single-case study, I conducted interviews from a wide range (various categories) of workers (**Table 5.1**), followed by implementation of a short demographic questionnaire. As indicated earlier, 42 workers were recruited for this component, with a rationale to compare and contrast experiences of racialized persons to non-racialized persons. One of the aims of this project was to explore the experiences of gender and precarization/precaritization, with an interest in gathering a rich understanding of the psychosocial and mental health factors described in the occupational health literature (Bartley, 2004, Bamba, 2011; Canadian Centers for Occupational Health and Safety (“CCOHS”), 2015). Another goal was to connect structural and systemic barriers to health, and the social forces that shape these circumstances.

The inclusion/exclusion criteria were that individuals must work within the healthcare sector in ancillary, support, or direct services, the worker’s roles must be directly related to the residential LTC facility. The definition of work included both paid and unpaid work; and the latter was relevant because there were students and/or trainees working at the site. The definition of ancillary services is taken from previous work by Armstrong and Laxer (2005); and Armstrong, Armstrong, and Scott-Dixon (2008).

Recruitment flyers were posted at a display near a finger-print scanner, the latter of which served as an employee time-card, meaning that it was used by workers to input their work hours for the day. This strategic placement of the flyer would ensure that workers would see the recruitment flyers while arriving for their shifts or when leaving the premises at the end of their shifts. Recruitment flyers were also posted at nursing stations on each floor of the facility. Flyers were also distributed directly to participants by the principal investigator during direct



face-to-face interaction with workers. Those who agreed to participate were also provided with information to share with coworkers for snowball sampling. I continued to add individuals to the sample until I reached theoretical sample size saturation.

### ***Reflexivity***

Reflexivity is a principle that suggests “[...] that researchers should subject their own research to the same critical analysis that they deploy when studying their topic.” (Green and Thorogood, 2009, p. 23). Eakin, Robertson, Poland et al., (1996) suggest that reflexivity refers to the capacity to locate the research activity in the same social world as the phenomenon being studied. Sometimes it involves: methodological critiques; reflections on ethical dilemmas, feelings, or conflicts; points of clarification; or critiques of research concepts such as health, risk, participation, empowerment, control, responsibility, and dialogues of surveillance (Lupton, 1995; Bogdewic, 1999). I recognize that as a researcher who is attempting to understand others’ subjective experiences, my personal background may shape my interpretations of the research I am conducting. My perceptions, knowledge, and exposure to workplace health and safety literature may be shaped by my personal experiences in the field of public health. I bring knowledge of the Ontario workplace health and safety regulations; theories about racialization and precarization; and issues or barriers with respect to work-related injuries and illness. From a feminist epistemological standpoint, my positionality as a racialized woman and member of minoritized religious and cultural groups may also be beneficial in this study as an ‘insider’ (Griffith, 1998).



**Table 5.1 - Table of Interview Participants**

<b>Participant No.</b>	<b>Date</b>	<b>Job Title/Role</b>	<b>Visible Minority</b>	<b>Sex</b>	<b>F/T or P/T</b>
1	Thurs Feb 2, 2017	Trainee	Y	F	F/T
2	Thurs Feb 2, 2017	Allied Health	Y	F	F/T
3	Thurs Feb 2, 2017	Allied Health	Y	F	F/T
4	Fri Feb 3, 2017	Nurse	Y	F	F/T
5	Fri Feb 3, 2017	Manager	N	M	F/T
6	Fri Feb 3, 2017	Manager	Y	F	F/T
7	Fri Feb 3, 2017	Nurse	Y	F	P/T
8	Fri Feb 3, 2017	Support Staff	N	F	F/T
9	Mon Feb 6, 2017	Ancillary	N	F	P/T
10	Tues Feb 7, 2017	Nurse	N	F	F/T
11	Tues Feb 7, 2017	Trainee	Y	F	F/T
12	Tues Feb 7, 2017	Ancillary	Y	M	F/T
13	Tues Feb 7, 2017	Nurse	Y	F	F/T
14	Wed Feb 8, 2017	Allied Health	N	F	P/T
15	Wed Feb 8, 2017	Allied Health	Y	F	P/T
16	Wed Feb 8, 2017	PSW	Y	F	F/T
17	Wed Feb 8, 2017	Nurse	Y	F	F/T
18	Wed Feb 8, 2017	Trainee	Y	F	F/T
19	Thurs Feb 9, 2017	Allied Health	N	F	F/T
20	Thurs Feb 9, 2017	PSW	N	F	P/T
21	Fri Feb 10, 2017	Ancillary	N	F	F/T
22	Fri Feb 10, 2017	Support Staff	N	F	F/T
23	Fri Feb 10, 2017	Nurse	Y	M	F/T
24	Tues Feb 14, 2017	PSW	Y	F	P/T
25	Tues Feb 14, 2017	Allied Health	Y	M	F/T
26	Tues Feb 14, 2017	Support Staff	N	M	F/T
27	Tues Feb 14, 2017	Support Staff	Y	F	F/T
28	Wed Feb 15, 2017	Support Staff	Y	F	P/T
29	Fri Feb 17, 2017	Manager	N	F	F/T
30	Tues Feb 21, 2017	Nurse	Y	F	F/T
31	Tues Feb 21, 2017	PSW	Y	F	F/T
	Wed Feb 22, 2017	see above	see above	see above	see above
32	Wed Feb 22, 2017	Manager	Y	F	F/T
33	Thurs Feb 23, 2017	PSW	Y	F	F/T
34	Thurs Feb 23, 2017	PSW	Y	F	F/T
35	Fri Feb 24, 2017	Allied Health	Y	F	F/T
36	Fri Mar 3, 2017	PSW	Y	F	F/T
	Fri Mar 17, 2017	see above	see above	see above	see above
37	Fri Mar 3, 2017	Support Staff	N	F	F/T
38	Fri Mar 17, 2017	Nurse	Y	F	F/T
39	Fri Mar 21, 2017	Ancillary	Y	M	P/T
40	Tues Mar 28, 2017	Ancillary	Y	F	P/T
41	Sat Apr 1, 2017	Nurse	Y	F	P/T
42	Tues Apr 4, 2017	Ancillary	Y	M	F/T



## **Self-Administered Survey**

### ***Sample Size, Sampling, and Recruitment***

The size of samples in a quantitative survey design depends on the goal of the survey. If the results of the survey are to be generalized to a larger population (e.g. a province or country), then survey samples comprise of several hundred individuals who are randomly selected from the target population (Patton, 1990). If the goal of a survey is to advance understanding about a specific setting, then small samples would be sufficient as long as a decent response rate is obtained (e.g. 70% or more). Further, a sample size of 30 is also considered reasonable if the survey is “exploratory” in nature with the aim to obtain frequency counts; a sample of 30 also meets the assumption of a normal distribution (Norman and Streiner, 2000, p. 39).

For this study, a 40-item survey was distributed to workers. This length of survey was viewed as not burdensome for the potential participants in terms of their time and mental fatigue. The survey was executed independently from the interviews (i.e. there are no linked data to the interviews). The purpose of the exploratory survey was to collect data about mental health, shift work/occupational cancer, occupational illness, and demographic information, including data related to income, which may otherwise be personal and sensitive topics for discussion in interviews. For example, participants might not be comfortable in stating their salaries directly to someone in face-to-face interviews. Indeed in one instance during an interview, I perceived this sort of resistance from a male participant who reported that his spouse was making above average income; however, he did not want to disclose his spouse’s occupation nor specify a specific amount of remuneration. Another advantage of surveys over interviews might have to do with participant comfort. For example, participants may not be comfortable in stating their experiences of workplace bullying and discrimination in face-to-face interviews. In such cases,



it would be better to collect data through a survey. Indeed, Daly, Banerjee, Armstrong et al., (2011) and Das Gupta (2009) have used survey methods for these types of issues. Research from the Occupational Cancer Research Centre (“OCRC”) and the Institute for Work and Health (“IWH”) have also used survey methods in order to collect data about the perceptions of occupational cancers (Pahwa, Mustard, Aronson et al., 2012). Therefore, survey methods may be an optimal strategy to collect this type of information.

The inclusion/exclusion criteria for the self-administered, paper-based survey were the same as for the qualitative individual interviews. Furthermore, a purposeful sampling strategy was used similar to the interviews. While this study focuses on racialized persons and/or immigrants, and intersects with gender, survey sampling and recruitment was broad and included non-racialized persons and men in order to compare and contrast experiences, delineate any differences and similarities, and capture information reflective of employees’ social, economic, and political contexts. In total, 182 surveys were distributed to a total pool of 176 workers at the Eastside Home, of which 92 filled and returned; i.e. a response rate of 52%. One survey was excluded because the worker was not responsible for work that was related to any aspect of the LTC home. Accordingly, a final sample size consisting of 91 survey responses was achieved (**Table 5.2**). Some response categories were collapsed under a broader, larger category to meaningfully describe the sample, and because there were few responses (i.e. small numbers) as well. For example, the question about the job title (question 4) offered several response options including dietary aide, housekeeper, and maintenance worker, and these were collapsed as “ancillary work”. Likewise, job titles related to rehabilitative, pharmaceutical, and restorative care services were collapsed as “allied health”. Work hours were collapsed into part-time (up to 30 hours per week), full-time, (31 to 40 hours per week) and over-time (41+ hours per week).



This classification is approximately similar to those established by Statistics Canada (2016), although Statistics Canada (2016) does not distinguish between full-time and over-time work and simply codes over-time work as “full time”.

**Table 5.2 - Survey: Demographic Information (N=91)**

<b>Characteristics</b>		<b>Frequency</b>	<b>%</b>
Sex	Female	76	83.5%
	Male	14	15.4%
	No response/omitted	1	1.1%
Education	High school or less	13	14.3%
	Some college/post-secondary or more	77	84.6%
	No response/omitted	1	1.1%
Profession / Job Title	Personal support worker, health care aide, care aide	34	37.4%
	Nurse	19	20.9%
	Allied health	10	11.0%
	Ancillary	10	11.0%
	Administrative support, office staff, secretary, clerical	9	9.9%
	Manager, managerial role	5	5.5%
	Trainee	4	4.4%
Birth/ Immigration Status	Born in Canada	19	20.9%
	Born outside Canada i.e. Immigrant	66	72.5%
	No responses/omitted	6	6.6%
Race	Non-racialized	11	12.1%
	Racialized	78	85.7%
	No response/omitted	2	2.2%
Employment Status based on hours worked per week	Part-Time	34	37.4%
	Full-Time	40	44.0%
	Over-Time	15	16.5%
	No response/omitted	2	2.2%
Smoking Status	Smoker	7	7.7%
	Non-smoker	83	91.2%
	No response/omitted	1	1.1%
Alcohol Consumption	Yes	39	43.40%
	No	51	56.7%
	No response/omitted	1	1.1%
Self-Rated Physical Health Status	Poor to Fair	12	13.2%
	Good to Excellent	78	85.7%
	No response/omitted	1	1.1%
Self-Rated Mental Health Status	Poor to Fair	5	5.5%
	Good to Excellent	84	92.3%
	No response/omitted	2	2.2%



## VII. Data Analysis Procedures and Data Management

This study consists of a single-case design in which the LTC facility serves as the single-case, context, or boundary. The analysis, however, includes a number of things such as: the workers' job titles and roles; and is organized by major themes, such as: workload intensification; staffing problems; stress; income challenges, management of budgets; housing; travel time and commuting; dual demands and care; social relations; and resistance, resilience, and agency. The analysis is grounded by theoretical frameworks from feminist political economy of health, antiracism, and social determinants of health approaches.

Although qualitative and quantitative data collection was carried out concurrently, each data analysis step (qualitative and quantitative) was conducted individually/ separately (see details below) and then merged at the result synthesis stage.

### *Qualitative Coding, Thematic Analysis, and Rigour*

For the qualitative data analysis, I drew on “general social science knowledge” and located particular findings of my study within a broad context (Green and Thorogood, 2009, p. 196). Fieldnotes and interview transcripts were analyzed with thematic analysis for the dissertation using a coding system (Emerson, Fretz, and Shaw, 1995; Bogdewic, 1999; Boyatzis, 1998) with the aid of NVivo computer software program to organize and sort information. Coding of data involves identifying themes and subcategories, and can be a selective or an open process (Starks and Trinidad, 2007; Green and Thorogood, 2009; Dey, 1999; Strauss and Corbin, 1998; Creswell, 2003). Codes are listed in **Table 5.3**, which reflect both the literature and the themes that were addressed in the interviews that are a part of the propositions and research questions (**Table 5.3**).



**Table 5.3 – Interview List of Codes**Source: taken and modified from Daly, T. (2014), *Invisible Women Project*.

Code	Descriptor (if applicable)
Ageism	Stereotypes of age, prejudice
Age, ageing, elderly population	
Benefits	Related to unionization
Budget, costs of living or other expenses	
Bullying, discrimination	
Commute, transportation	
Coping strategy, coping aids	
Cost of living, money	
Culture	
Daily life, daily event, everyday event	
Day shift	
Dependent child, children, youth	
Dependent spouse, husband, wife	
Dependent relative(s)	
Disability, ability	
Environment, geography, climate	
Family, family planning	
Gender, gender stereotyping, gendered work, gender prejudice	
Goals	
Housing, rental	
Immigration, immigrant, migrant	
Intersection	Gender, race, class, disability, and/or immigrant status
Invisible	Invisible aspects of work, invisible worker, invisible issue
Management Model – not for profit	
Night shift	
Occupational Health and Safety (OHS)	Related to worker health and safety, ergonomics, musculoskeletal disorder, other issues, etc.
Occupational and Environmental	Related to the work environment
Paid work	
Political economy, neoliberalism	Market-centered, rates of pay
Precarization, precarious conditions, precarious work, precariousness, precarity	Uncertainty, e.g. extra employment to make ends meet
Problems	Any problem raised or identified by participant
Race, racialization, racism, prejudice, discrimination	Negative connotations or stereotypes of ethnicity, including different racial groups, between different ethnic groups
Recommendation	E.g. by staff, regarding organizational, work-related
Stigma, stereotyping	
Student	Status, level of training, or education
Support	Familial, social, organizational, co-worker, team
Temporary work, agency work	
Team work	Team building, working together



Time, time management	
Transportation	
Union	
Unpaid work	All domestic tasks and/or unpaid duties, unpaid time at work
Violence	Interpersonal or structural
Workload	Related to time, sufficiency

Accordingly, I coded the data and grouped codes into themes or categories. During the qualitative data coding, the codes and the meaning of the themes were revised and amended as necessary, because coding is an iterative process. The coding list was compiled with feminist political economy in mind, and reflects this with codes such as: gender, gender stereotyping, gendered work, and gender prejudice. For the analysis “style” of interview data, participants were given a voice and allowed to speak for themselves (Green and Thorogood, 2009, p. 197) through inclusion of their representative narratives. Audiotapes of each interview were transcribed verbatim by a transcription service that was referred by York University’s Institute for Social Research (“ISR”). Interview transcript data was read in its entirety to first obtain a general sense of the information collected and reflect on the overall meaning followed by coding as described above.

For analytic rigour, multiple strategies were used. Attention was paid to gather rich and detailed descriptions, as recommended by qualitative researchers (Denzin, 1989; Poland, 1992) so that a clear framework for further explication is available for any further interest in exploring the issues identified (Merriam, 1997). I asked participants for clarification on any points that were unclear. I attempted to be continually reflexive during all stages of the research process, and I reflected on ways in which my background, gender, culture, history and socioeconomic origin informed my data collection and analysis procedures. The data analysis involved constant comparison and contrast of data to identify core dimensions, typologies; and to test and elaborate on propositions on an on-going basis. Negative or discrepant information is presented along with



the other findings in this dissertation. Consultations with the dissertation committee members in order to discuss and consider alternative ideas and explanations, as well as review of the dissertation drafts by the committee has provided additional feedback on emerging themes and ideas.

### ***Survey Coding and Analysis***

Quantitative data analysis of the demographic questionnaire and self-administered survey data occurred with the assistance of Excel, and quantitative Statistical Package for Social Science (SPSS) software. Some of the data was collapsed into binomial categories where it was appropriate to do so. The rigor strategies for the survey and its interpretation included approaching and recruiting a diverse sample of workers at the LTC facility, answering any queries about the survey, accuracy checks in data entry, seeking support from the SCS, asking analytic questions, and discussing analysis plans and results with the thesis committee.

### ***Mixing/Merging of Results from Interviews and Survey***

The mixing and merging of qualitative and quantitative data occurred once each separate data analysis step was completed. In this case study, the interviews provided the core dataset and the survey offered supplementary data. Thus at the analysis stage, the survey results were examined to support, augment, or raise complexities within the findings from the interviews. I often used the secondary results from the quantitative strand to enhance the planning, understanding or explaining of the primary (i.e. qualitative) component. This means that the secondary data (the quantitative strand) either “support or augment the primary data” (Creswell and Plano Clark, 2011, p. 220).

A mixed methods design required that I address how the quantitative findings enhanced the understanding of the qualitative results, and how the data was merged. To do this, the results and findings were tabulated in the next chapters and appendices using side-by-side comparison



whenever it was possible to do so, as described by Creswell and Plano Clark (2011). The main subtopics/ themes are listed on the left side; bullet points from the face to face interview results that are related to that theme are listed in the middle column; and survey results related to a specific theme are listed in the right column. The generated results are deemed to have conceptual relevance (Green and Thorogood, 2009), meaning that the study findings have been brought back and connected with concepts and theories found throughout this dissertation.

### **VIII. Demographic Information**

I conducted 42 face-to-face, in-depth, semi-structured interviews with participants. In-depth interviews took place in person with individuals who reported that they had direct experience as: personal support worker or PSW (n=7), nurses (n=9), support staff (n=6), allied health professionals (n=7), ancillary workers (n=6), trainees (n=3), managers (n=4). In terms of sex, 83.3% (n=35/42) of interview participants were female and 16.7% (n=7/42) were male (**Table 5.1**). Data about immigrant status was not available for all participants. 71.4% (n=30/42) of participants were identified as visible minorities based on their ancestral background, and 28.6% (n=12/42) were Caucasian (**Table 5.1**). For employment status, 23.8% (n=10/42) worked part-time and 76.2% (n=32/42) worked full time (**Table 5.1**).

For the survey, a total of 92 surveys were collected from the site, but one was excluded because it did not meet the inclusion criterion, and some had incomplete responses to a few questions. Data was extractable from approximately 91 surveys. From the survey data, 83.5% were female (n=76/91) and 15.4% were male (n=14/91), with one omitted response (**Table 5.2**). 85.7% (n=78/91) were visible minorities (“VM”) (also denoted as racialized) based on their ancestral background, and 12.1% (n=11/91) were identified as Caucasian (also denoted as non-racialized or white). 72.5% (n=66/91) of respondents reported being born outside of Canada (i.e.



[im]migrant status) and 20.9% (n=19/91) were Canadian-born. This dissertation follows the tradition of Block and Galabuzi (2011), who use binary descriptors (racialized/non-racialized) in their report - unless otherwise noted.

The most common job title was reported as PSW, health care aide, or care aide (37.4%, n=34/91); followed by nurse (20.9%, n=19/91); allied health (10.9%, n=10/91); ancillary (10.9%, n=10/91); support staff (9.9%, n=9/91); manager, or worker in a managerial role (5.5%, n=5/91); and trainees (4.4%, n=4/91) (**Table 5.2**). In terms of work hours, 37.4% (n=34/91) of respondents worked part-time, up to 30 hours per week, while 44% (n=40/91) worked standard full time, between 31 to 40 hours per week, and 16.5% (n=15/91) worked over full time, i.e. 41 or more hours per week (**Table 5.2**).

A majority of the respondents had more than high school education (**Table 5.4**). Those who identified their level of education reported it as follows: 47.3% (n=43/91) had completed some college or university; 20.9% (n=19/91) had completed a bachelor's degree; 14.3% (n=13/91) had graduated from high school; 6.6% (n=6/91) had completed a master's degree; and so forth.

**Table 5.4 – Survey: Education**

Highest Level of Education	Frequency	%
Some College, University	43	47.3%
Bachelor's Degree	19	20.9%
High School	13	14.3%
Master's Degree	6	6.6%
Vocational, Skilled Trades School	4	4.4%
Professional Degree	4	4.4%
Advanced Degree, PhD	1	1.1%
No response/omitted	1	1.1%
Total	91	100.0%



Demographic information was further stratified, such as job categories by sex (**Table 5.5a** and **Appendix 5.11**).

**Table 5.5a – Survey: Job Categories by Sex**

<b>Total (n=91)</b>			<b>Female (n=76)</b>		<b>Male (n=14)</b>	
<b>Job Category</b>	<b>Frequency</b>	<b>%</b>	<b>Frequency</b>	<b>%</b>	<b>Frequency</b>	<b>%</b>
PSW*	34	37.4%	30	39.5%	3	21.4%
Nurse	19	20.9%	17	22.4%	2	14.3%
Allied Health	10	11.0%	8	10.5%	2	14.3%
Ancillary	10	11.0%	6	7.9%	4	28.6%
Support Staff	9	9.9%	7	9.2%	2	14.3%
Manager	5	5.5%	4	5.3%	1	7.1%
Trainee	4	4.4%	4	5.3%	0	0.0%
Total*	91	100.0%	76	100.0%	14	100.0%
*1 PSW respondent did not indicate sex						

Among all the female workers (n=76), 39.5% (n=30/76) worked as PSWs, 22.4% worked as nurses (n=17/76), 10.5% worked as allied health (n=8/76), among other job categories. Among all the male workers (n=14), 28.6% (n=4/14) worked in ancillary, and 21.4% (n=3/14) worked as PSWs, among other job categories.

Job categories were also stratified by VM/racialized status (**Table 5.5b** and **Appendix 5.12**). Among all the racialized workers (n=78), 41% (n=32/78) worked as PSWs, 23.1% (n=19/78) worked as nurses, and 10.3% (n=8/78) worked as allied health workers, among other job categories. Among all the non-racialized workers (n=11), 27.3% (n=3/11) worked as ancillary workers, while 18.2% worked as managers (n=2/11), allied health (n=2/11, 18.2%), support staff (n=2/11, 18.2%), among other job categories.



**Table 5.5b – Survey: Job Categories by Visible Minority (“VM”) Status**

Total (n=91)			VM (n=78)		non-VM (n=11)	
Job Category	Frequency	%	Frequency	%	Frequency	%
PSW*	34	37.4%	32	41.0%	1	9.1%
Nurse*	19	20.9%	18	23.1%	0	0.0%
Allied Health	10	11.0%	8	10.3%	2	18.2%
Ancillary Total	10	11.0%	7	9.0%	3	27.3%
Support staff	9	9.9%	7	9.0%	2	18.2%
Manager	5	5.5%	3	3.8%	2	18.2%
Trainee	4	4.4%	3	3.8%	1	9.1%
Total**	91	100.0%	78	100.0%	11	100.0%
*1 PSW and 1 nurse did not indicate ancestral background						

Observations indicated that high-level managerial positions were filled by racialized persons at approximately 50%. Although this proportion seems higher in survey responses, of which 60% managers (n=3/5) were VM, this discrepancy possibly arises because some managers did not participate in the survey.

Job categories were also stratified by immigrant status (**Table 5.5c** and **Appendix 5.13**). Among all the immigrant workers (n=66), 37.9% (n=25/66) worked as PSWs, 27.3% (n=18/66) worked as nurses, and 10.6% (n=7/66) worked as ancillary, among other job categories. Among all the non-immigrant workers (n=19), 26.3% (n=5/19) worked in allied health, and 21.1% (n=4/19) worked as PSWs, among other job categories.



**Table 5.5c – Survey: Job Categories by Immigration Status**

<b>Total (n=91)</b>			<b>Immigrant (n=66)</b>		<b>Non-Immigrant (n=19)</b>	
<b>Job Category</b>	<b>Frequency</b>	<b>%</b>	<b>Frequency</b>	<b>%</b>	<b>Frequency</b>	<b>%</b>
PSW*	34	37.4%	25	37.9%	4	21.1%
Nurse	19	20.9%	18	27.3%	1	5.3%
Allied Health	10	11.0%	5	7.6%	5	26.3%
Ancillary*	10	11.0%	7	10.6%	2	10.5%
Support staff	9	9.9%	6	9.1%	3	15.8%
Manager	5	5.5%	4	6.1%	1	5.3%
Trainee	4	4.4%	1	1.5%	3	15.8%
Total*	91	100.0%	66	100.0%	19	100.0%
*5 PSWs and 1 ancillary worker did not disclose immigrant status						

As indicated earlier, interview participants were mostly women (83%, n=35/42), and belonged to racialized groups (71%, n=30/42) (**Table 5.6** and **Table 5.1**). Of all the support staff who were interviewed (n=6), five were women, two were racialized, and four were non-racialized (i.e. white) (**Table 5.6**). Among the interviewed ancillary staff (n=6), three were women, four were racialized, and two were non-racialized. For allied health (n=7), six were women, five were racialized, and two were non-racialized. For nursing (n=9), eight were women and eight were racialized. For managerial positions (n=4), three were women and three were racialized. All PSWs who were interviewed (n=7) were women and six were racialized (n=6).







## **IX. Study Challenges and Limitations**

I recognize some of the challenges and limitations of my study. One challenge in this study involved recruiting potentially vulnerable persons who may be uncomfortable with the one-on-one interaction with the researcher due to ivory-tower perceptions about researchers. However, I attempted to minimize power and privilege dynamics by establishing rapport and reflexivity. Additional challenges were the length of timing of the interviews, and the availability of workers to participate in the study. Some workers were unavailable for interviews beyond their 15-minute break period, which resulted in some interviews having limited depth in the responses. To overcome this challenge, I requested additional follow up interviews. Another challenge is that with case study design, a single-case may warrant caution in transferring findings to other provinces or countries.

One of the dilemmas of using a mixed methods approach has to do with the quantitative component, and how it is connected to the epistemology of positivism. Positivism is often critiqued because it assumes that there is value-free or neutral inquiry that emphasizes separation of science from society (Green and Thorogood, 2009). However, this is unrealistic, and scientific research is in itself a social process, carried out by humans within specific social contexts, and therefore, research cannot be value-free or neutral (Green and Thorogood, 2009). Science is bound within society and social order (ibid). Positivism further assumes that evidence is deductive, and tests theories or hypotheses. However, these hypothesis and theories are not pre-existing, they are themselves produced from inductive processes (Green and Thorogood, 2009). Finally, positivism is also critiqued because sometimes the solutions or goals that are offered are unachievable or inappropriate (Green and Thorogood, 2009). For instance, the recommended research solutions and resultant interventions are based on tactics that appeal to



rationality for behavioral modification and how to make healthy choices (Poland, 1992). However, human behavior is shaped by a cultural world, which has different properties from the natural world (Silverman, 1985). Human beings are embedded in social contexts, are complex, unpredictable, and do not necessarily behave in natural science law-like ways that atoms, plants, or planets do (Green and Thorogood, 2009).

## **X. Summary**

This doctoral study is anticipated to extend knowledge of precarious working conditions among immigrants and/or racialized employees, and the social, economic, and political contexts of paid care workers through the use of a single-case study design of a Canadian LTC facility with analysis using interviews, observations, and self-administered survey methods for gathering evidence. While there is a wealth of knowledge about immigrant and racialized people's experiences of work, relatively little is known about how they experience precarization in their everyday living conditions and broad systems that govern their lives, their social interactions, and their social relations. The qualitative component and quantified description of this research project have been analyzed separately, and merged, to fit together information on: how precarization is experienced in LTC; differences in gender, class and ethnicity; knowledge of shift work hazards; and how these might affect social determinants of health and illness in the workplace, and how it may affect social relations.

In the next three chapters, I present my findings that were compiled from some of the most compelling evidence and narrative accounts. These findings were analyzed using an intersection of feminist political economy of health with antiracism lenses in which the qualitative findings have been organized by dominant themes and supplemented with quantitative data.



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**Chapter 6: Findings -- Intensive and Stressful LTC Work**


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“We know with long-term care, help is scarce. Resources are scarce. So we kind of try our best to maintain the standards.” (Participant 32, Manager, Female, VM, F/T).

## **I. Introduction**

Research indicates that there are a number of psychosocial characteristics of the work environment that can influence worker stress, health, and wellbeing, and can result in physiological symptoms of disease. These characteristics include job demand, job control, social support, time pressure, work surges, work pace, or rest breaks, (Karasek and Theorell, 1990; Bartley, 2004; Bambra, 2011; Lewchuk, Clarke, and DeWolff, 2011; Samra, Gilbert, Shain and Bilsker, 2012; CCOHS, 2014; CCOHS 2015; Syed and Ahmad, 2016). This chapter addresses some of these psychosocial characteristics; the findings are organized around a number of themes. Section II addresses workloads and break-taking while section III reviews staffing levels and workload intensity, and section IV, V, and VI explore time, stress, and physical aspects of the work and injury, respectively. Section VII discusses the findings and summarizes the chapter (**Appendix 6.1**). These themes suggest precaritized workplace characteristics are likely micro level effects that are influenced by meso and macro level policies and practices. For instance, market-oriented practices of health and LTC organizations increasingly rely on managing budgets and saving money through harmful fiscal measures, such as reduced hiring policies, freezing new recruitment/employment, which result in understaffing. These policies and practices occur in public service sectors when they are adopted by particular ideological groups, such as the Conservative government and its leader Premier Doug Ford, who has ordered hiring freezes, and cancelled numerous job openings in Ontario (Giovannetti, 2018).

Eastside Home, while publicly funded, represents a market-oriented institution. It is



embedded within a health care system that is shaped and constrained by intra-organizational structures, governments, and social and economic contexts. With this in mind, I draw on the data, including descriptions from my interviews with participants, to explore how paid and unpaid workers serving elderly residents manage with the resources that are available to them. The interviews reveal the importance of workloads, break-taking, and workers' health and safety outcomes, corroborating some of the survey analysis while also providing nuanced understanding of these concepts. The findings that emerged are discussed in detail below.

## **II. Workloads and Break-Taking**

Almost all of the 42 participants that were interviewed in Eastside Home reported that the workloads are heavy or excessive. Participants associated the heavy workloads with the facility being understaffed (section III), not having enough time (section IV), and with feelings of stress (section V).

In a survey response, a manager indicated she worked overtime every day, and the workload was too much:

“I love my job but to work overtime every day is too much. What about if we will implement the Franch [sic] model: work every day 9 hours and have 3 days off: Wednesday; Sat/Sunday?” (Respondent #003, Manager, Female, non-VM, F/T).

A nurse indicated in the survey that she experienced overloaded work due to excessive paperwork.

“Nursing is my passion and I love what I do as a nurse but due to overloaded work, it seems like I am not working as a nurse anymore – but admin – we have tons of paperwork to finish!” (Respondent #047, Nurse, Female, VM, F/T).

Another worker noted the need for help: “Work place work is very hard. We need all the help we could get (sic).” (Respondent #064, PSW, Female, VM, F/T).



Generally, front-line workers provide most of the direct care, such as feeding, clothing, or bathing residents. These front-line workers do not take work home because of the nature of personal work. These workers often reported that their high workload prevented them from taking breaks during work hours, and it required them to work extra hours in the facility. Managers also reported high workloads. However, because of the nature of their work, managers took their work home, and worked extra hours at home in order to complete the necessary tasks. While many workers reported missing their breaks, there were some exceptions to this, in which a few workers reported that they did not miss their breaks, despite reporting heavy workloads e.g. Participants 23 (Nurse, Male, VM, F/T), 24 (PSW, Female, VM, P/T), and 27 (Support Staff, Female, VM, F/T). Possible explanations for this might be work experience, tenure at the facility, age, work-relationships, and confidence, but this information was not collected. Others reported that they took some breaks during the workday, but never all the breaks to which they were entitled e.g. Participants 33 (PSW, Female, VM, F/T), 35 (Allied Health Worker, Female, VM, F/T), 37 (Support Staff, Female, non-VM, F/T), 40 (Ancillary Worker, Female, VM, P/T), and 41 (Nurse, Female, VM, P/T).

A nurse described the necessity of skipping or abbreviating breaks during the workday in order to manage the workload:

“[T]here’s not really any breaks in the day. If I’m eating lunch, it’s typically here at the desk unless I’m having a good day where things aren’t way too busy, then I try and go downstairs in the lunchroom, sometimes you’ll see me down there but I typically just go quickly and eat and then head off on my way. (Participant 10, Nurse, Female, non-VM, F/T)

The participant went on to state:

“I always feel so pressured to want to get out there and make sure that they have all their help, so I just quickly eat stuff and I go, because I don’t like to get behind on things.” (Participant 10, Nurse, Female, non-VM, F/T)



Another nurse described her workload, the necessity of skipping breaks, and the necessity of working unpaid hours in order to complete necessary tasks:

“ ‘Cause my floor is 28 residents, and every resident has a breakfast medication, lunch medication. And, 'cause you're spending hour and a half, two hours just giving out medication in the morning. And then lunch. And then do the treatment. So you don't. If-- in the beginning, I never had time to eat. Like, even for break you don't. You don't get time for break. 'Cause first, you go, you do your morning breakfast. After breakfast, there's meeting or like a bit of treatment. Then there's lunch. After lunch, then you have to document. Again, there's more wound and stuff, medications to give. So it's very busy.” (Participant 13, Nurse, Female, VM, F/T)

This healthcare worker relayed how her mother would tell her she should be able to eat at work because it does not take very long to do so, but the worker disagreed. She said she was too busy to eat. The worker indicated that she had to work over eight hours, and she was not paid for the extra work, which was between 30 minutes to an hour each day:

A: “My mom [...] So she's like, ‘you can get five seconds to eat.’ But no. You don't even get that five seconds to eat. It's too busy. And if you have, like, something extra happens, then you stay extra. [...] Plus eight hours. Yeah, eight hours, plus extra. So I had like some stuff going on, on my floor, so I have to stay.”

I: “Are you able to be paid for the extra work you do?”

A: “No. No, no.”

I: “Doesn't that concern you?”

A: “It does. I take -- 'cause I work for eight hours. They only pay for me for seven and a half. But sometime[s], I don't even get time for that half an hour break. Sometime[s], when I get time, I'm documenting and eating. Eating is like 30 seconds, but I'm still not getting paid for that other half an hour. And then, I'm staying half an hour early, like, late, sometime[s] an hour. And I'm not getting paid, no.” (Participant 13, Nurse, Female, VM, F/T)

Another nurse indicated that no one takes breaks. She said she was paid for 7.5 hours of work despite working 8, and that her lunch break was cut from her pay despite continuing to work at her computer and still remaining on the floor:

“We do all the wound care. We do all the creams for them [the residents]. Any treatments. So that's basically our whole shift is gone right there. So just to run around,



we never – none of us take breaks. None of us likes to leave the floor because we get scared if someone falls. The amount of paperwork just to write up an incident report is so much that people don't want to leave the floor. I eat while I type on my computer and then they complain that the work is not done. 7.5 we get docked that half an hour pay, but I don't even leave the floor.” (Participant 17, Nurse, Female, VM, F/T).

A support worker described the necessity of taking work home in order to complete necessary tasks:

A: “If I don't take work home I can't make deadlines, it's impossible. So, I take work home probably maybe, definitely once a week. Sometimes if it's a lot I have to take it home on the weekend.”

I: “Okay. How many hours do you estimate that you're putting in from home?”

A: “If I take it home, like, this week I had to take some work home and I was probably working on it for about two and a half to three hours. 'Cause I think I wrapped up at about 9:30, yeah so I would say about two and a half to three hours.” (Participant 22, Support Staff, Female, non-VM, F/T)

An allied health professional agreed with other participants that taking breaks was not feasible because of the workload:

A: “We don't get breaks. [laughs]”

I: “Tell me about that.”

A: “We work--we feed from 8:00 until 9:00. And then we have to cram all of our documentation into 45 minutes. And then we have programs from 10:00 to 10:30. And then back up. By the time we get all the residents back up, it's 11:30. And then we have time just about to do our attendance, which we have to track all of our activities and all the residents. So by then it's 12:00. So then we have to go back and feed again from 12:00 to 1:00.” (Participant 25, Allied Health Worker, Male, VM, F/T)

A manager described the necessity of working extra, unpaid hours at home:

A: “When you come home, nurses call you. You are on phone. So nobody care[s]. Like, before my vacation, I have a situation. I finish my shift, came at home, 7 o'clock. From seven until 11, I was dealing on phone, from somebody passed away, and finally said. So four hour[s], from seven to 11. I went to four hours, I'm working from home.”

I: “And that's unpaid? It's unpaid?”



- A: “Exactly. Okay. I'm not care about pay, but I do care about my time, I'm tired. I work from nine to six, and continue. Okay, so it's actually ongoing.” (Participant 29, Manager, Female, non-VM, F/T)

The same manager said earlier in the interview:

“It's what I'm saying. We never had day off and rest. We are [always] working.”  
(Participant 29, Manager, Female, non-VM, F/T)

Like that manager, another manager reported that it was nearly impossible to take eating breaks and that she felt faint and even though she tried to force herself to eat while on the unit, she was disrupted:

- I: “Okay. I see you’re very busy. Are you able to take your breaks? How long are your breaks?”

- A: “I never take a break. So if I want to have a snack, lunch, whenever. Like today I got my lunch maybe 2:30 and it’s like, eat and do something right? [...] Work at the same time because whatever time I take, I’m going to be pulled. So I kind of get accustomed to not taking breaks and if I want to eat like I have to. Because by 2 o’clock I felt I was going to pass out. So I said to them, ‘I need to eat something.’ And I was coming with a spoon. Something happened. I had to put my spoon down and go out to attend to something, because being here you still have to attend to things happening on the unit, right? If I hear something going on for a long time like a bell, or an alarm, I cannot just sit. I have to step out and see what’s going on.” (Participant 32, Manager, Female, VM, F/T)

An allied health professional described the heavy workload as the biggest challenge associated with the job:

- I: “Tell me about any challenges that you faced [...]. Tell me about challenges in the workplace.”

- A: “Well, the main challenge I would say is the workload. The workload, because it’s like you’re the only one, and you have to [do it]. If you don’t complete it today, you will be the same person who has to come back to do it the next day. So [my profession] it’s not like the nurses or the PSWs or the other workers: when you are absent or when you don’t finish, the next shift comes to take over. So when, a [title of allied health profession] is like, you have to do it. Today or tomorrow, it will be you again.”

The same participant stayed beyond paid work hours on a daily basis. This extra work was equivalent to approximately 5 to 7.5 hours of unpaid time each week, which is almost equivalent



to an entire extra shift per week. On a regular basis, this amount of unpaid work translates to significant remuneration owed to the worker:

I: “Some people told me that they actually stay beyond their hours, like, of work. Do you experience that, as well, or you try to leave when you need to?”

A: “For me, I experience it every day.”

I: “Tell me about that.”

A: “Yeah. So I finish work, I need to start documenting, but sometimes, especially when there is a shift changeover, we will have to go meet evening staff or have some assessment, which is much more important for the evening staff. Then, I get caught up in that. Then, most of the time, we have to stay longer, you know, stay back to finish that and go.”

I: “Okay. And how long do you, on average, stay back?”

A: “Most of the time it’s like one to one and a half hour.” (Participant 35, Allied Health Worker, Female, VM, F/T).

An ancillary care worker similarly reported that breaks were impossible because of the heavy workload, and that extra hours were needed to finish the work:

A: “I’ll tell you something. We have to start here – I fix food from 7:00 to 2:00. But if I’m [coming] 7 o’clock, I can’t take my break. I can’t take my break. I have to come 45 minutes [to] one hour early. I can’t take my break. I can’t. I can tell you something, I can’t tell [name of organization’s manager]. I can’t tell [them]. Everybody, we cannot take our break. All [the] people, they’re coming early here. We can’t take a break easily. You have to take a – we have a one hour break. We can’t take an hour break.” (Participant 39, Ancillary Worker, Male, VM, P/T).

The participants’ experiences in this study were characterized by heavy workloads without true opportunities for breaks; unpaid, overtime work; and labor that involved working from home. Unpaid, overtime work has been problematized in the literature with respect to the not-for-profit social services sector. In this sector, the work has been described as being a nightmare, with endless, self-sacrificing, alienated, and feminized forms of work (Baines, Charlesworth, Cunningham, and Dassinger, 2012). The LTC sector captures many of these



characteristics involving unpaid, self-sacrificing, and feminized labor. Further analysis, as we shall see, reveals precaritized working conditions.

While the participants in this study could potentially foresee that if they consistently worked through their lunch breaks on a daily basis, it might remain unpaid, there are legal and ethical issues involved in such unpaid work that must be addressed. Ontario labor laws stipulate that, “An employee must not work for more than five hours in a row without getting a 30-minute eating period free from work” (Ontario Ministry of Labour, (“OML”) 2018). Furthermore, the OML (2018) indicates: “Even if the employer pays for meal breaks, the employee must be free from work during the eating period.” Despite being so clearly stipulated by the government, this was not the case in Eastside Home, and workers were not ‘free’ in this sense.

High workloads and missed breaks are linked to other themes, such as staffing levels. In the next section, I present issues related to staffing levels and workload intensity.

### **III. Staffing Levels and Workload Intensity**

Inadequate staffing levels and limited personnel resources are known to be problematic in Canadian LTC homes (McGregor, Cohen, McGrail, et al., 2005; McGrail, McGregor, Cohen et al., 2007; Registered Nurses’ Association of Ontario (“RNAO”), 2007; Cammer, Morgan, Stewart et al., 2014; Syed, Daly, Armstrong et al., 2016). The reasons for inadequate staffing levels may be attributed to a number of factors. For instance, it could be due to organizational issues such as resource (re)allocation, employee burn-out, and high employee turnover rates (Kasteler, Ford, White and Carruth, 1979; Cohen-Mansfield and Rosenthal, 1995; Banaszak-Holl and Hines, 1996). Eight interviewees (20%) clearly expressed a desire to add more staff to the LTC facility.

A nurse summarized the staffing issue as the root cause of the heavy workload:



“[...] it’s such a heavy, heavy workload it almost feels like I’m [working] in the hospital in terms of the workload, and I find that it’s because of the staffing issue here.” (Participant 7, Nurse, Female, VM, P/T).

A trainee identified understaffing as a broad, systemic issue for healthcare:

“I think at the end of the day healthcare can always do with more help. We’re forever understaffed” (Participant 18, Trainee, Female, VM, F/T).

The problem of understaffing in this LTC home is often obscured with replacement workers from temporary employment agencies. For instance, if someone was absent from their shift, another worker who was recruited from an agency covered their shift. This agency worker looked just like any other worker. However, upon observing and probing workers, their agency-status and the problem of work-absences were revealed.

Many participants detailed the extent of understaffing problems when they were asked about changing anything in either their workplace or in their personal life. In fact, participants often expressed a wish to change human resources and staffing levels. One ancillary worker recommended adding staff to assist workers with particular tasks:

“Well, laundry would be -- 'cause laundry is what keeps us a bit behind. So if we had, like, an extra staff just to do laundry, that would be great. Because I can just focus [on cleaning] I could just focus on the rooms, not like going back and forth, back and forth, back and forth, and have the timing of the -- okay, this is 29 minutes past. Okay. I’ve got to do the laundry. So that would be great, an extra housekeeper just to do the laundry.” (Participant 21, Ancillary Worker, Female, Non-VM, F/T).

A nurse suggested what would be an ideal patient-to-staff ratio:

“[...] it’s kind of asking for the world, [it would be] more staff. I honestly hope that a four to one for staffing ratio for long-term care can be established. ... How do you expect someone to split their time for a seven and a half hours if they were to take their break, right, among how many residents? But if you have a four to one ratio, you can at least spend 7.5 divided by four. That’s a lot of time, right, like of really downtime. And we can personally make them feel very important and, you know, useful.” (Participant 23, Nurse, Male, VM, F/T)



An allied health professional asked for improved staffing levels in order to reduce work-related stress:

“[...] the only thing that I could really ask is just to have more staff, like, so we’re not so stressed out all the time.” (Participant 25, Allied Health Worker, Male, VM, F/T).

One support worker talked about how the organization was trying to get rid of some positions in order to save money, but there was push-back:

“...[W]hen I leave, the [support staff worker] comes. And then a [worker comes in] all day on the weekends. And then they were going to get rid of the during-the-week [position] because they got to save, like, millions of dollars in order to move [in] the next fifteen years. But there was a lot of pushback from families from what was supposed to start in February and I was told it’s not happening until further notice. So I think they’re going to try and find the money in other places, because I don’t think the families were comfortable with that at all. So I don’t think that that’s happening. If I had to guess, I would say no.” (Participant 26, Support Staff, Male, Non-VM, F/T).

Front line LTC workers needed ‘hands-on’ help according to one nurse who suggested that it could come from management:

“Hopefully our nurse managers are more helpful, more appreciative and more hands on to help the staff, because we’re front liners, you know.” (Participant 30, Nurse, Female, VM, F/T)

A manager stated that help is scarce in LTC and increasing staffing levels would be beneficial. Without “structure”, workers, such as nurses, are expected to do “anything and everything”. Once a worker does something out of their scope of practice, then they are ‘stuck’ with doing it in future. In nursing, there are many standards of practices and non-professional staff do not understand the responsibilities, which has led to misunderstandings and altercations. She indicated that if there were any mistakes, then nursing licenses as well as one’s job were at stake:

“I would say more structure to our position because our position is: you do anything and everything. If we have more structure to be responsible for certain things and not ‘whatever happens’. ‘Okay now you do this’, ‘[now] you do that because you’re the one that knows how to do it’ versus, ‘No, but I’m not responsible.’ ‘Oh but you know how to do it.’ Once you do it once, because you want to be a star, you’re going to be stuck with it. You know what I mean? So that’s the thing. Maybe structure better what we do and



getting more help. We know with long-term care, help is scarce. Resources are scarce. So we kind of try our best to maintain the standards. You have long-term care standards. You have College of Nurses' standards. There's so many things to kind of be abided and follow. Sometimes we kind of have misunderstanding or altercation with staff because of that, because they don't have the full understanding how responsible we should be in following those long-term care standards, College of Nurses. As nurses we have a license to keep. If you make a boo-boo then your license is on the stake. Then you will lose your job. You know what I mean? So it's not something easy to let go or mess up with, so you have to be very, very careful. Any conversation we have with family members, things happening, dealing with issues that arise, documentation. We have to be very, very careful making sure we're following the standards." (Participant 32, Manager, Female, VM, F/T)

Another nurse also recommended adding more front-line staff when asked what she would change:

"PSWs, nurses, so that everyone can feel less - I mean feel like they can get their job done and not be stressed about it and not having to rush through things, you know. It would flow through so nicely because residents would get so much care, you know. We would be on top of their medication, any illnesses, anything that happens, any changes, you know we would be able to address that right away." (Participant 41, Nurse, Female, VM, P/T)

Front-line carers and ancillary workers considered the facility to be chronically understaffed. Participants' often expressed that they wanted to solve the problem of staffing ratios that they deemed inadequate, with impacts on their "time", discussed in the next section.

#### **IV. Time**

Some of the challenges in LTC in Canadian provinces, such as in Saskatchewan, British Columbia, and in Ontario, are time constraints, the pace of work (Baines and Daly, 2015; Daly and Armstrong, 2016), and rushing care work (Hung and Chaudhury, 2011; Cammer, Morgan, Stewart et al., 2014; Baines and Daly, 2015; Syed, Daly, Armstrong et al., 2016). There is significant research about the issue of time. Cammer, Morgan, Stewart et al., (2014) see time as an intangible resource, which has implications on the quality of care work. Bourgeault (2010) also highlights the importance of time, such as taking the time to talk with and listen to older



persons, which is considered to be a quality of good carers and good care work. Furthermore, while research shows that residents appreciate timely care (Robichaud, Durand, Bedard et al., 2006), it can be problematic if the pace is too fast. Baines (2011) shows that the increased pace, intensity, and volume of work can undermine employees' capacity to work in tandem with their values. Hung and Chaudhury (2011) indicate that fast-paced processes limit the interaction between the staff and the resident, which results in no time to attend to the special needs of the resident. Accordingly, Baines and Daly (2015) indicate that dignity and sensitivity in care services are reduced in pressured, fast-paced, and leaned-out environments.

One PSW indicated in the survey that the job is very difficult with insufficient time because the ratio of PSW to residents is too high, which diminished her ability to socialize, connect, or communicate with residents:

“I choose [sic] this job because I wanted to help people. It is a very hard job, which a lot of people seems to think it's easy. Sometime I do cry cause I don't only get bad treatment from the residents but their family [too]. Most of the time I am on my feet from the moment I arrive at work to the time I clock out. The workload is 1 PSW to 14 Resident. 14 people for one PSW to take care of for 7 1/2 hr is not enough time and I don't take brakes [sic] because I provide good care for my residents and talk to them. We really don't have the time to communicate with them. Just imagine yourself being their age and don't have anyone to talk to” (Respondent #039, PSW, Female, VM, F/T).

Another PSW commented in the survey that she enjoyed this job, but also wished that she had more time to spend, talk, and not rush the residents:

“I choose this health care job because I love people and mostly elderly so I can take care of them. Just being in contact with the elderly brings joy to me when I talk and joke with them. I like to know that [I] am doing a good job and wish we had more time to spend and talk with our residents and don't rush some much [sic]. My joy is to work with the residents as long as I can and do my very best for them because I love them dearly and will put myself on hold for them. Please give us more time for them I asked.” (Respondent #102, PSW, Female, VM, F/T underlined emphasis original).



In interviews, almost all staff members indicated they did not have enough time to complete their work. One nurse offered more details about her workload and requirements around time management:

“They’re not asking me to do things that are ridiculous, it’s just that the amount of time that we have to do our top three tasks [i.e. medication, wound dressings, and documentation] that we always have to do, and that takes a lot of time. And then through that we get a lot of interruptions from the PSW, from like residents, this and that, and then they’re asking us to do this by the end of the day, or do this and this, and it’s just like, I can’t do it.” (Participant 7, Nurse, Female, VM, P/T).

One ancillary worker described her experience:

“There’s never enough time. They give you enough work for three people to do in eight hours and you only have six and a half to do it. [...] Some things just don’t get done every day. Some things they have to get done every second or third day because there’s just not enough time. If they give us enough time, if they gave us that extra hour, we’d probably still wouldn’t be able to finish all the jobs because then if we stay an extra hour, they’ll give you more hours, they’ll give you more to do. But no, we have to clean 25 rooms, dining room twice a day. All the hallways, the washrooms, plus the deep cleaning. The deep cleaning usually takes about an hour to do. So no, there’s not enough hours in a day. No, never. That’s the only thing I’m always worried that I’m going to get in trouble because I don’t finish my job but I just don’t have time. If they want me to stay and work, they don’t pay you. So I don’t stay.” (Participant 9, Ancillary Worker, Female, Non-VM, P/T)

Limited time means that some work is not completed, and other work is simply not done. Such deficits in time have been previously recognized as marked features of care work in Ontario’s LTC homes (Daly and Szebehely, 2012). In the section below, survey respondents reported how time constraints and time pressures were their top sources of stress.

## **V. Psychosocial Stress**

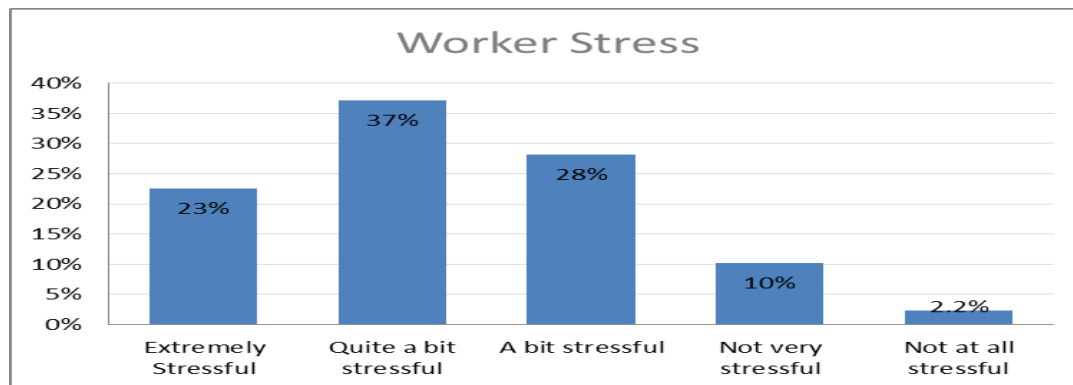
According to Selye (1950) and others (e.g. Gundersen, Mahatmya, Garasky, and Lohman, 2010; Kirschbaum, Pirke, and Hellhammer 1993; Singh, Petrides, Gold et al., 1999) stress is biological, psychosocial, and/or psychological: “In the biological sense stress is the interaction between damage and defence, just as in physics tension or pressure represents the interplay



between a force and the resistance offered to it.” (Selye, 1950, p. 1384). Psychosocial stress and psychological stress refer to “external events or conditions that threaten an individual’s wellbeing” (Gundersen, Mahatmya, Garasky, and Lohman, 2010, p. e54). Psychosocial and psychological stress is associated with social environments (Kirschbaum, Pirke, and Hellhammer 1993; Singh, Petrides, Gold et al., 1999), which would include workplaces.

Of the 91 survey respondents, 89 answered the question about stress. Of these respondents, 87.6% (78/89) reported at least some level of stress in their workday. 22.5% (20/89) reported that their work is extremely stressful, while 37.1% (33/89) found it quite a bit stressful (**Figure 6.1**). 28.1% (25/89) reported that the work was a bit stressful. Only 10.1% (9/89) reported that it was not very stressful, while 2.2% (2/89) reported that it was not at all stressful. Overall, a majority of respondents who responded (59.6%, 53/89) reported experiencing extreme or quite a bit of stress.

**Figure 6.1:** Reports of Stress Levels in Eastside Home (n= 89)



Respondents were asked to elaborate on what issues contributed most to their feelings of stress. Respondents could select all the listed stressors that applied to them. Out of 91 total survey responses to this question, the top five stressors were identified as time pressures i.e. not having enough time (74.7%, 68/91); the participant’s work situations (30.8%, 28/91); financial situations (27.5%, 25/91); personal or family responsibilities (18.7%, 17/91); and physical health



problems or conditions (15.4%, 14/91) (**Table 6.2a**). The fewest responses about stressors were attributed to personal or family's safety (1.1%, 1/91); discrimination (3.3%, 3/91); personal relationships (4.4%, 4/91); health of family members (5.5%, 5/91); housing (5.5%, 5/91); or too much workload or a picky boss (6.6%, 6/91).

Stress data was stratified by sex (**Table 6.2a** and **Appendix 6.2a**). 78.9% of women (60/76) selected time pressure/not enough time as a stressor compared to 50% of men (7/14) (**Table 6.2a**). Interestingly, 42.9% of men (6/14) selected financial situation as a source of stress compared to only 25% of women (19/76).

Stress data was also stratified by VM/racialized status, and the findings suggest disparities in terms of mental/physical health and discrimination (**Table 6.2b** and **Appendix 6.2b**). For example, among those who selected particular categories of stressors, such as “own emotional or mental health problem or condition”, 100% were racialized (n=8/8), none were non-racialized (**Appendix 6.2b**). Of those who selected “own physical health problem or condition”, 92.9% were racialized (n=13/14), and 7.1% were non-racialized (n=1/14) (**Appendix 6.2b**). Of those who selected “discrimination”, 100% were racialized (n=3/3), none were non-racialized (**Appendix 6.2b**).

One of the interesting findings is that, for those who selected particular stressors, they tended to be uniquely women (especially racialized women), such as stress due to: “health of family members” was selected by five racialized respondents and all five were women; and “personal or family's safety” was selected by a single racialized respondent and she was a woman (**Tables 6.2a and 6.2b, Appendix 6.2a and 6.2b**). Other stressors included: “Other...workload, picky boss” and it was selected by six racialized respondents and all six were women. The absences of non-VM and men as respondents for these variables reflect gendered



	Total (n=91)		Female (n=76)		Male (n=14)	
What Contributes Most to Feelings of Stress at Work / Outside of Work $\phi$	Frequency	%	Frequency	%	Frequency	%
Time pressures/not enough time*	68	74.7%	60	78.9%	7	50.0%
Own work situation*	28	30.8%	22	28.9%	5	35.7%
Financial situation	25	27.5%	19	25.0%	6	42.9%
Other personal or family responsibilities	17	18.7%	15	19.7%	2	14.3%
Own physical health problem or condition	14	15.4%	10	13.2%	4	28.6%
Caring for own children	13	14.3%	11	14.5%	2	14.3%
Employment status*	12	13.2%	6	7.9%	5	35.7%
Caring for others*	9	9.9%	5	6.6%	3	21.4%
Own emotional or mental health problem or condition	8	8.8%	6	7.9%	2	14.3%
School	7	7.7%	6	7.9%	1	7.1%
Other e.g. too much workload, picky boss	6	6.6%	6	7.9%	0	0.0%
Housing	5	5.5%	3	3.9%	2	14.3%
Health of family members	5	5.5%	5	6.6%	0	0.0%
Personal relationships	4	4.4%	3	3.9%	1	7.1%
Discrimination	3	3.3%	2	2.6%	1	7.1%
Personal or family's safety	1	1.1%	1	1.3%	0	0.0%

$\phi$  Respondents could select more than one response; \*1 respondent did not disclose their sex



**Table 6.2b – Survey Respondents: What Contributes Most to Feelings of Stress at Work / Outside of Work by VM Status**

	Total (n=91)		VM (n=78)		Non-VM (n=11)	
What Contributes Most to Feelings of Stress at Work / Outside of Work $\Phi$	Frequency	%	Frequency	%	Frequency	%
Time pressures/not enough time**	68	74.7%	56	71.8%	10	90.9%
Own work situation*	28	30.8%	24	30.8%	3	27.3%
Financial situation	25	27.5%	21	26.9%	4	36.4%
Other personal or family responsibilities	17	18.7%	16	20.5%	1	9.1%
Own physical health problem or condition	14	15.4%	13	16.7%	1	9.1%
Caring for own children	13	14.3%	11	14.1%	2	18.2%
Employment status	12	13.2%	11	14.1%	1	9.1%
Caring for others	9	9.9%	8	10.3%	1	9.1%
Own emotional or mental health problem or condition	8	8.8%	8	10.3%	0	0.0%
School	7	7.7%	5	6.4%	2	18.2%
Other e.g. too much workload, picky boss	6	6.6%	6	7.7%	0	0.0%
Housing	5	5.5%	4	5.1%	1	9.1%
Health of family members	5	5.5%	5	6.4%	0	0.0%
Personal relationships	4	4.4%	2	2.6%	2	18.2%
Discrimination	3	3.3%	3	3.8%	0	0.0%
Personal or family's safety	1	1.1%	1	1.3%	0	0.0%
$\Phi$ Respondents could select more than one response; *1 respondent did not disclose ancestral background						
**2 respondents did not disclose ancestral background						

Stress data was also stratified by job category, and may reflect socioeconomic status disparities between particular groups of workers (i.e. PSWs vs. other categories of workers in terms of financial situation and housing) (**Appendix 6.2c** and **Appendix 6.2d**). For example, “housing” was not a major source of stress (5.5%, 5/91). However, of those who selected “housing”, 60% (n=3/5) were PSWs; 20% (n=1/5) were allied health workers, and 20% (n=1/5)



were support staff. In other words, for workers with high socioeconomic status, such as managers and nurses, housing is not a source of stress.

Interview participants reported that they experienced stress in various ways during the performance of their duties in the LTC facility. One trainee commented about her experience of stress:

“[This] is a rewarding field but it can also be very stressful. I chose to work in this profession because I want to make a difference in other people’s lives as well as my own. My love for medicine has also pushed me to become a [job title]. My religion, fitness, and well-balanced diet are all the things that keep me going so that I can maintain a healthy body and mind”. (Respondent #027, Trainee, Female, VM, workload status unknown)

Almost all interview participants reported experiencing some level of stress associated with their work at this LTC facility, although one worker (Participant 22, Support Staff, Female, non-VM, F/T) reported that she only felt stress when she started working at her job, but no longer experienced it. This might be explained by a variety of factors, such as confidence, work experience, age, work-relationships, or tenure.

Some participants associated stress with excessive workloads, or with negative interactions with coworkers, superiors, and residents. When I asked about stress in the workplace, one nurse associated stress with supervisors’ negative behaviors, such as poor communication and imposing unrealistic expectations:

“I personally, I get stressed out sometimes, but once I’m home I kind of just drop it, drop everything at the door and don’t think about it until I come back to work the next day, or next time I’m here I just deal with it. I find that the work itself is stressful in the moment but once it’s done you feel relieved at the end of the day. It’s just that I think the managers or just management with this place puts a lot of stress on the workers mentally. I don’t know if it’s because the expectation that they have for us is ridiculous, and good communication method is not the best.” (Participant 7, Nurse, Female, VM, P/T)

An ancillary worker associated stress with both negative interactions with a supervisor as well as with a heavy workload:



“The only stress right here is...if there is something to be repair[ed], lots of job[s] to do. That's very stressful. It's more stressful than designing. It's more. Small [things], the boss will give you a shit if you don't finish the project. Yeah. Anyway. What to do?”  
(Participant 12, Ancillary Worker, Male, VM, F/T).

A nurse reported that mental stress had become sufficiently severe to cause her burnout; she attributed stress to an excessive workload and to negative interactions with co-workers and residents:

“Being here, I never really believed in burnout. When I was in school learning about nursing burnout I thought ‘What are these people talking about? I don’t understand it. This is stupid. I’d never get burned out.’ Oh my god, people never explained what it meant to be burned out. I am so burned out here. This place will mentally destroy you and I just want to get out of here. But I can’t because of the money. I’m only here because I need to make money. So, yeah, I’m like telling my [partner] ‘Please hurry up and get a job so I can quit.’ ”

The same nurse indicated later in the interview that she also felt depressed when she was questioned about how she felt at the end of her workday.

I: “[H]ow do you feel after a day’s work? You said you were extremely exhausted and you’re feeling burned out. Tell me about that.”

A: “I hate it here. Honestly I didn’t feel like that. Like I actually got last year, it was going – like I was kind of getting depressed...Then I started to realize that no matter what you do here, it’s not noticed. Like people still harass you for what you have to do. So being a [job title] nurse, like I told you I have my duties, plus we have care plans to do for everyone...Then we started to get residents with behaviours on this floor. You go to the management; you tell them ‘I have a behaviour.’ They tell you to deal with it. They don’t help you medicate; they don’t help you talk to the doctor.” (Participant 17, Nurse, Female, VM, F/T).

A support staff associated stress with negative interactions with managers and visitors:

I: “How do you feel after an evening's work, [or] a day, for that matter, on the weekends?”

A: “On the weekend I feel very exhausted when I work Saturday and Sunday 8:00 to 4:00. Number one, the chair is uncomfortable and number two is it's very busy on a Saturday and Sunday here. But that's part of the job. So it could be very stressful and there could be rude people, you know. Actually one rude person manipulated - was a bully to me and I told my manager and she never did nothing about it. She blamed me and told me how the person said I'm unkind and uncompassionate...And he was a bully. He wanted to - my name and to talk to the CEO and blah, blah, blah, and I said you don't need my name you



can just tell them who it is. So because I told him the rules, he wasn't happy, and he called the DOC and complained I'm unkind, uncompassionate. She called me in the office, 'the person reported you're unkind and uncompassionate.' I said I'm here five years, you know my personality. Am I ever unkind and uncompassionate? 'Well he says you need to be nice to him', and I said I know. I don't need to be nice to a bully who come and have no respect for me. I said actually I didn't realise that this place does not implement rules. The rules are there and management don't care about rules. You can do whatever you want." (Participant 28, Support Staff, Female, VM, P/T).

Finally, one PSW assessed how stress was associated with residents' aging and demands for

care, a combination that made the work more challenging:

"I can say before it was okay then now these people are getting old. It's getting so stressful. Very stressed. I'm so stressful [...] Well yeah, it's harder because they're [the residents are] getting old plus when you're dealing with some residents are very demanding. They want to take all your time for them and it's not possible." (Participant 34, PSW, Female, VM, F/T).

The ways in which the physical aspects of the job contributed to the intensity of the work, and to injury, are presented below.

## **VI. Physical Aspects of Work, and Injury**

Stress is associated with precarious work and musculoskeletal conditions. Musculoskeletal conditions are compounded in women due to the double burden of paid and unpaid responsibilities (Syed and Ahmad, 2016). Accordingly, this section describes the physical aspects of work, injury, and illness data that may reflect work-related stress. These findings are important because they represent the potential health-impacts of precarization.

### ***Significant Physical Symptoms***

Survey respondents were asked whether they currently have, or have previously experienced any significant physical symptoms of injury or illness to a significant degree in the last few years of work. They had to select from a list of anatomical regions (if it was applicable to them). The most common symptoms occurred in the back, the head/neck, the knees; particular



musculoskeletal sites such as the wrist due to carpal tunnel syndrome; and finally, the stomach. Surprisingly, no respondent selected “not applicable” (**Table 6.3a**).

Survey data about anatomical sites and symptoms was stratified by sex (**Table 6.3a** and **Appendix 6.3a**). Men reported symptoms of the back (64.3%, 9/14), head/neck (42.9%, 6/14), and knees (42.9%, 6/14) more than women for each of these sites i.e. back (52.6%, 40/76), head/neck (35.5%, 27/76) and knees (34.2%, 26/76) (**Table 6.3a**). Women reported more specific musculoskeletal symptoms such as carpal tunnel syndrome (22.4%, 17/76) compared to men (14.3%, 2/14). One of the interesting findings from this table is that those who selected “ears, nose, throat” (n=11), all were women (100%, 11/11) and there were no selections for these sites by men (**Appendix 6.3a**).

The data about anatomical sites and symptoms was also stratified by VM/ racialized status and interestingly, some anatomical sites were reported more by racialized workers than non-racialized workers (**Table 6.3b** and **Appendix 6.3b**). Racialized workers reported slightly more symptoms of the knees (37.2%, 29/78), chest/heart (11.5%, 9/78), intestinal/bowel (10.3%, 8/78) compared to non-racialized workers for the same sites i.e. knees (36.4%, 4/11), chest/heart (9.1%, 1/11), intestinal (9.1%, 1/11,) (**Table 6.3b**).

For those who selected musculoskeletal symptoms of the wrist/ carpal tunnel (n=19), all were racialized (100%, 19/19), and none were non-racialized (**Appendix 6.3b**). Of those who selected bladder (n=5), all were racialized (100%, 5/5), and none were non-racialized (**Appendix 6.3b**). Of those who selected “other sites or symptoms of the eyes, nerve pain, foot pain, or heel pain” (n=9), all were racialized (100%, 9/9), and none were non-racialized (**Appendix 6.3b**).



**Table 6.3b - Survey: Anatomical Sites of Significant Physical Symptoms Experienced by VM Status**

	Total (n=91)		VM (n=78)		Non-VM (n=11)	
Anatomical Region $\phi$	Frequency	%	Frequency	%	Frequency	%
Back*	50	54.9%	42	53.8%	7	63.6%
Head/Neck	33	36.3%	28	35.9%	5	45.5%
Knees	33	36.3%	29	37.2%	4	36.4%
Musculoskeletal e.g. wrist, carpal tunnel	19	20.9%	19	24.4%	0	0.0%
Stomach	14	15.4%	13	16.7%	1	9.1%
Ears, Nose, Throat*	11	12.1%	8	10.3%	2	18.2%
Chest/Heart	10	11.0%	9	11.5%	1	9.1%
Skin	10	11.0%	8	10.3%	2	18.2%
Intestinal/Bowel	9	9.9%	8	10.3%	1	9.1%
Other e.g. eyes, nerve pain, foot pain, or heel pain	9	9.9%	9	11.5%	0	0.0%
Bladder	5	5.5%	5	6.4%	0	0.0%

$\Phi$  Respondents could select more than one response; \*respondent did not disclose ancestral background



The data about anatomical sites and symptoms was also stratified by job category (**Appendix 6.3c** and **6.3d**), and this data suggests that, depending on the job category, workers had specific anatomical symptoms which may reflect their day-to-day work routines, and socioeconomic status. For example, among ancillary workers (n=10) the majority (80%, 8/10) reported symptoms of the back (**Appendix 6.3c**). Managers (n=5), however, reported symptoms of the back more frequently (60%, 3/5), possibly due to their extensive use of computers.

Survey respondents were asked additional questions related to physiological changes; for instance, if they experienced changes in the last few years in their weight, energy levels, or ability to sleep. They could select all items that applied, or select not applicable. Out of all survey respondents, 44% (40/91) reported changes in weight (**Table 6.4a**), 39.6% (36/91) reported changes in energy levels and 30.8% (28/91) reported changes in the ability to sleep.

Data on recent physiological changes was stratified by sex (**Table 6.4a** and **Appendix 6.4a**). Women consistently reported symptoms more than men (**Table 6.4a**). For example, 48.7% of women (37/76) reported weight changes compared to 14.3% of men (2/14). Also, 42.1% of women reported changes in energy levels (32/76) compared to 28.6% of men (4/14). Further, 31.6% of women reported changes in the ability to sleep (24/76) compared to 28.6% of men (4/14) (**Table 6.4a**).

The data about recent physiological changes was also stratified by racialized/VM status (**Table 6.4b** and **Appendix 6.4b**). Often racialized workers reported recent physiological changes compared to non-racialized workers. For example, 46.2% of racialized workers (36/78) reported weight changes compared to 36.4% of non-racialized workers (4/11). Racialized workers also reported changes in energy levels (41%, 32/78) slightly more than non-racialized



workers (36.4%, 4/11). However, non-racialized workers reported changes in the ability to sleep (45.5%, 5/11) more than racialized workers (29.5%, 23/78).

**Table 6.4a - Survey: Changes to Weight, Energy, or Sleep by Sex**

	Total (n=91)		Female (n=76)		Male (n=14)	
Recent Changes in Weight, Energy Levels, or Sleep $\Phi$	Frequency	%	Frequency	%	Frequency	%
Weight changes*	40	44.0%	37	48.7%	2	14.3%
Energy level changes	36	39.6%	32	42.1%	4	28.6%
Change in ability to sleep	28	30.8%	24	31.6%	4	28.6%
Not applicable	25	27.5%	21	27.6%	4	28.6%
$\Phi$ Respondents could select more than one response; *1 respondent did not disclose their sex						

**Table 6.4b - Survey: Changes to Weight, Energy, or Sleep by VM Status**

	Total (n=91)		VM (n=78)		Non-VM (n=11)	
Recent Changes in Weight, Energy Levels, or Sleep $\Phi$	Frequency	%	Frequency	%	Frequency	%
Weight changes	40	44.0%	36	46.2%	4	36.4%
Energy levels	36	39.6%	32	41.0%	4	36.4%
Ability to sleep	28	30.8%	23	29.5%	5	45.5%
Not applicable**	25	27.5%	21	26.9%	2	18.2%
$\Phi$ Respondents could select more than one response; *2 respondents did not disclose their ancestral background						

The data about recent changes in weight, energy levels, or ability to sleep were also stratified by job category (**Appendix 6.4c** and **Appendix 6.4d**).

While the survey did not ask whether or not the recent changes were worsening or improving, interview data revealed additional information about physiological status. For example, support staff described the effects of work-related stress on her physical health, which included symptoms of sleep disturbances, weight loss, gastrointestinal issues, and cardiovascular problems:

“[I]t's a stressful job. So, I don't sleep very well. I have - when I take work home I generally end up - I dream about work a lot, a lot. And I don't know, it's probably because I can't shut my mind down. It's hard to shut my - I just, I can't do it. I'm thinking



about what I have to get done...I was losing weight rapidly. I did not realize it was because of that situation. I thought there was something wrong with me. So, I did seek medical attention. I've been to a gastro doctor; I have heart palpitations so I have to see a cardiologist every two years. I'm monitored with a loop monitor for two weeks and there's no doubt in my mind that all of this is a result of the stress probably of the last five to six years.” (Participant 22, Support Staff, Female, non-VM, F/T)

Another participant reported sleep disturbances, among other problems:

I: “[...] you’re on your feet all day. Do you experience any pain, foot pain, back pain?”

A: “Pain, I don’t... End of the day, when I'm here, I don’t feel it; but when I go home, because we are on the computer also, I get wrist pain, sometimes back pain. Sleep disturbance is more, honestly. Yeah.” (Participant 35, Allied Health, Female, VM, F/T)

The data about recent changes in weight, energy levels, and/or ability to sleep are important because care workers are scheduled in rotating shift work, which may disrupt circadian rhythms and this might be exhibited in the physiological consequences that were reported above. In order to check this connection, participants were asked about shift work.

Respondents were asked to check off all applicable shifts they worked. Although morning shifts were the most frequent shifts worked by participants (51.6%, 47/91), participants also worked with nearly the same frequency in afternoon/evening shifts (49.5%, 45/91). The less-frequent selections were working in overnight shifts (17.6%, 16/91) and no shifts (7.7%, 7/91)) (**Table 6.5a**).

Shift work data was stratified by sex and indicates that men often reported work in particular shifts more than women (**Table 6.5a** and **Appendix 6.5a**). For example, 57.1% of men (8/14) reported working in the morning shift compared to 51.3% of women (39/76). Similarly, 57.1% of men (8/14) reported working in the afternoon shift compared to 47.4% of women (36/76). Finally, 28.6% of men (4/14) reported working in the overnight shift compared to 14.5% of women (11/76).



**Table 6.5a – Survey: Shift(s) Usually Worked by Sex**

	Total (n=91)		Female (n=76)		Male (n=14)	
Type of Work Schedule $\Phi$	Frequency	%	Frequency	%	Frequency	%
Morning shift	47	51.6%	39	51.3%	8	57.1%
Afternoon/ evening shift*	45	49.5%	36	47.4%	8	57.1%
Overnight shift*	16	17.6%	11	14.5%	4	28.6%
Not applicable – I do not work in shifts	7	7.7%	5	6.6%	2	14.3%
$\Phi$ Respondents could select more than one response *1 respondent did not disclose their sex						

Shift work data was also stratified by VM/ racialized status (**Table 6.5b** and **Appendix 6.5b**). This data suggests that racialized workers seem to be working in some of the most precaritized types of shift work compared to non-racialized workers. The most significant finding is that among overnight shift workers (n=16), all (100%, 16/16) were racialized and none were non-racialized (**Appendix 6.5b**). Likewise, among all racialized workers (n=78), nearly half (51.3%, 40/78) reported working in the afternoon shift compared to one-quarter of the non-racialized workers (27.3%, 3/11) (**Table 6.5b**).

Non-racialized workers often had the “good” shifts, or did not work in shifts at all compared to racialized workers. For instance, 72.7% (8/11) of non-racialized workers (reported working in the morning shift compared to 50% (39/78) of racialized workers (**Table 6.5b**). Further, 54.5% (6/11) of non-racialized workers reported not working in shifts at all, compared to 1.3% (1/78) for the racialized workers.



**Table 6.5b – Survey: Shift(s) Usually Worked by VM Status**

Type of Work Schedule $\Phi$	Total (n=91)		VM (n=78)		Non-VM (n=11)	
	Frequency	%	Frequency	%	Frequency	%
Morning shift	47	51.6%	39	50.0%	8	72.7%
Afternoon/ evening shift**	45	49.5%	40	51.3%	3	27.3%
Overnight shift	16	17.6%	16	20.5%	0	0.0%
Not applicable – I do not work in shifts	7	7.7%	1	1.3%	6	54.5%
$\Phi$ Respondents could select more than one response; *2 respondents did not disclose their ancestral background						

Shift work data was also stratified by immigrant status (**Table 6.5c** and **Appendix 6.5c**). The data suggests that immigrant workers, like racialized workers, seem to be working in some of the most precaritized types of shift work compared to non-immigrant workers. For example, among the respondents who reported doing overnight work (n=16), 81.3% (13/16) were immigrants<sup>18</sup>(**Appendix 6.5c**). 56.1% (37/66) of immigrant workers reported working in the afternoon/evening shift compared to 26.3% (5/19) of non-immigrant workers (**Table 6.5c**).

Canadian-born workers, (i.e. non-immigrants), like non-racialized workers, often had the “good shifts”. For example, 63.2% of non-immigrant workers (n=12 out of 19) reported working in the morning shift compared to 47% of immigrant workers (n=31 out of 66).

<sup>18</sup> 3 out of 16 respondents answered this question, but did not indicate their immigrant status.



**Table 6.5c – Survey: Shift(s) Usually Worked by Immigrant Status**

Type of Work Schedule $\Phi$	Total (n=91)		Immigrant (n=66)		Non-Immigrant (n=19)	
	Frequency	%	Frequency	%	Frequency	%
Morning shift****	47	51.6%	31	47.0%	12	63.2%
Afternoon/ evening shift***	45	49.5%	37	56.1%	5	26.3%
Overnight shift***	16	17.6%	13	19.7%	0	0.0%
Not applicable – I do not work in shifts*	7	7.7%	4	6.1%	2	10.5%
$\Phi$ Respondents could select more than one response; * 1 respondent did not disclose immigrant status						
*** 3 respondents did not disclose immigrant status						
**** 4 respondents did not disclose immigrant status						

Shift work data was also stratified by job category (**Appendix 6.5d and 6.5e**). This shift work data suggests that overnight shifts cannot be fully avoided for particular categories of workers because of the nature of the work. For example, support staff and managers worked in predominately “morning/day shifts” or no shift type work compared to nurses and PSWs, who predominately worked in “afternoon/evening shifts”. This could mean that there are potential disparities between different categories of workers with respect to the health risks of shift work and this may reflect more precaritized work status. Further research would need to be carried out in order to expand upon these findings, which might be beneficial in connecting these findings with biological risks that are contingent on circadian rhythms, such as the risks of breast cancer / prostate cancer.

### ***Physical Strain or Injury***

Interview data revealed that workers experienced various physical strains, injury or physical symptoms related to work and/or stress during the performance of their duties at the LTC facility. Physical strain, injuries, and other physical symptoms were associated with: being



seated throughout the workday or, alternatively, having to stand and walk throughout the workday; violent incidents from residents; repetitive motion; and lifting residents or equipment. An allied health professional described the physical strain of the job, which had resulted in a back injury. She also stated that prolonged work activities, over-time work, and aging will worsen to the point of ‘give up’ and ‘stop’:

“In [allied health], like when you're doing something, right, like over and over, it's a repetitive movement. So you get a strain, you get a sprain, whatever. Of like, what you're doing, the movement. And then from that, we don't realise that it's actually, like, impacting, right? Our body. The prolonged standing, the walking, the lifting, you never know, right? You would think that it's just not much or just not daily, but then over time, right, it culminates everything. As we age, then we're going to feel it because it's already there and everything, right? And then it's just a matter of time that it will give up on us. So, well, if I'm feeling that, I'll stop. I stop. [...] I feel here from the neck to here, my back.” (Participant 2, Allied Health Worker, Female, VM, F/T).

Another allied health professional experienced a wrist injury as a result of lifting a resident while working at a different LTC facility, although it was not clear if her employment at that site was held simultaneously while she was employed here at Eastside Home. It was severe enough to require medical attention and the involvement of the Workplace Safety and Insurance Board (“WSIB”), which is the provincial agency that compensates workers for work-related injuries. This experience demonstrates the physical nature that is involved in LTC work:

I: “[...] have you experienced any illness or injury while you worked because of work?”

A: “Yeah, lifting. Lifting. One time, I had an exercise with a resident -- not here, not here -- and then I lift the feet up, both feet. And it's so heavy, I didn't, you know, when you're working, you didn't think that if you lift it, you're going to be injured. So at the time I injured my wrist. [...] At the time, I went to the doctor and they gave me some WSIB and then that's it. I cannot work for one month.” (Participant 3, Allied Health Worker, Female, VM, F/T).

A manager at Eastside Home indicated that she had experienced urinary tract infections as a result of being unable to interrupt work to use the restroom:



I: “What are the hazards in your work that you do?”

A: “Hazards?”

I: “Yeah, any hazards that you think, like, either like computer overuse, like visual? The upper neck, can you tell me about what you think--”

A: “Yeah. you know, you're kind of seated so you have to kind of get up and walk, like, you know, every now and then. Good thing that the bathroom is a little further away, so we walk up, you know, I used to, you know, sometimes you get so busy that you don't even go to the bathroom. And then I used to have those, what do you call it? Urinary tract infection, and the doctor said you are not to do that.” (Participant 6, Manager, Female, VM, F/T).

This manager also developed chronic neck pain as a result of remaining seated in the same posture for too long at work for which surgery was recommended:

I: “Have you ever experienced being ill or injured in the workplace, like for example if you're on the computer a lot, did it ever strain your eyes [...]”

A: “Yeah, yeah. Actually, I have a neck pain, I don't know. In this, it's been there for a long time and [one decides] to kind of ignore it, but then it, you know, it sometimes even your posture, everything is affected by the pain. So I decided okay, I'm just going to go and get this dealt with, because you know, sometimes you don't even have time for appointments, because you know, if they want you to go for physio, they'll tell you to come three times a week. [...] I was to go for surgery, actually, but fortunately because it was a few months down the road, things kind of settled a bit so I didn't have to go for that.” (Participant 6, Manager, Female, VM, F/T).

A nurse reported swelling in the legs as a result of standing and walking all day at work and reported dangerous levels of fatigue that also had the potential to impair driving:

I: “And how do you feel after a day's work?”

A: “Tired.”

I: “Any other --.”

A: “Tired. Lower back pain sometimes when standing a lot and walking around a lot. My legs are usually swelling from standing up too much. Yeah, I just feel drained, it's like you can't go home without taking a nap, and some, especially if I work nightshifts...and you drive in the morning to go home and you're like passing out and it's very dangerous. So yeah, just tired.” (Participant 7, Nurse, Female, VM, P/T).



An ancillary worker also had experienced a back injury, apparently while lifting a bed at work:

I: “Are you on your feet all day?”

A: “No, I don't have any serious injury, but I can feel right now a pain in my left -- in my right side of my back [...]Sciakticah [sic].”

I: “Sciatica. Okay. Yes.”

A: “Nerve pain, I can feel it right here [...] By -- by --by lifting the bed -- you know, the bed, hospital [style] bed? It's too heavy, I think. This is the reason why I got this.”

I: “And did you get treatment for that or have you seen somebody?”

A: “Yeah. I went -- I went to the doctor's and they gave me a medications for that.”  
(Participant 12, Ancillary Worker, Male, VM, F/T)

A PSW reported a sprain associated with repetitive motion and continuous standing:

“Yeah[...]because this kind of job is a physical, you have to exert more physical [...]force and you're physical, right. So, sometimes I sprain my elbow I get pain in that, back pain and legs, because we're walking all the time, yeah.” (Participant 24, PSW, Female, VM, P/T)

A support staff worker reported that she experienced eye and back strain as a result of the sedentary nature of her occupation:

I: “And what about any experience of being [...] ill or injured at work, like sometimes you're walking around on your feet. Sometimes you're at a desk. So do you experience like eye strain or neck strain?”

A: “Oh yes, yes.”

I: “Tell me about that.”

A: “Neck is all the time, that's why I always go to my doctor, ask for prescription for a massage, because you know, I always feel pain in my shoulders, you know, and my eyes. Because having, you know, working in front of the computer for many, many years, right, the glares and stuff, so now I'm wearing glasses, [...], now I'm wearing glasses, right, because of that.” (Participant 27, Ancillary Worker, Female, VM, F/T)



Another worker reported back pain as a result of being seated all day at work and took Tylenol, because she was unable to afford a professional massage or chiropractic treatment and she reported that she paid for ointments and medical supplies out of pocket:

A: “My workstation, I would say the most difficult, what is not comfortable there is the chair. It's really uncomfortable. It hurts your back, it's way to the back like that. Like, you can't sit like that to be at the front desk. You're not in your lounging, you're not in your home. It's very uncomfortable sitting on the chair.”

I: “How do you manage, like when you get a sprain, for example, or had you managed pain and things like that, did you get a massage, do you go to a chiropractor, or do you just take [medicine]?”

A: “I can't afford that. I would love to, but I can't afford that, so maybe I'll take the Tylenol or I may put a heated pad or rub some sort of ointment for muscle pain or aches, like that's what I can do.”

I: “And everything's out of your pocket?”

A: “Yeah. Absolutely.” (Participant 28, Support Staff, Female, VM, P/T)

A manager said that there were three main pieces of equipment that led to chronic pain: the nurse's medication cart, a manual pill crusher, and chairs. All of these things raised ergonomic concerns for her:

I: “Can you think back and tell me about any health and safety issues that you've had...?”

A: “...as a nurse what I figure out, cart -- med cart, doesn't hit nurses' heights and it's actually affected. If you're tall or my height, that cart, where it's height, it's actually okay. But sometimes carts lower or higher and this is eight hours with meds, it's affected hand. And it's painful. So nursing homes doesn't pay attention that cart needs to be adjusted. And I can tell you in our home, I don't know if you're going to talk to nurses and they will realize, we have short nurses and we have tall nurses. But med cart the same size. Okay. So it's actually - they don't see that it hurts them now and they're tired, and it's affected shoulders and affected hands. Plus when I started to work here I actually requested to use electrical crusher because when I was a nurse we used manual, so could you believe to crush [for] 30 people three times. It's painful here and here. And when I was a [...] they started to use electrical, I order for all my nurse because they started to have a carpal syndromes and it was related to this. So when I started here, I asked [Name of Person] that we order for all of them and we have electrical crusher. So it's help. And what else? My cart is heavy. It's supposed to be more light, but it's heavy. To pull and push eight hours it's actually affected everything, okay. What else for safety. I don't know. Chair.



Not uh - chair needs to be comfortable, okay. So it's the same. Not every nursing station has a comfortable chair. This is important too.[...]" (Participant 29, Manager, Female, non-VM, F/T).

Another nurse experienced a sprain in the arm that required medical attention:

"I think I got a sprain once, a strain. I didn't realise it. I knew something happened but I was okay, but when I went home I couldn't move my arm. I came to work and oh my God I can't move my arm barely and I said let me go to the doctor, but they did take that easily, that was dealt with. I stayed home, I was fine, they paid me, no time, no questions asked, so my experience with that was good. Other staff, they get hurt but they leave disabled." (Participant 38, Nurse, Female, VM, F/T)

### ***Violence***

Violence occurred frequently and was reported ubiquitously. A nurse reported her experience of extreme violence as well as violence that she normalized at the workplace because of its "normal" and "minor" occurrence. On a secure unit, she required medical attention after a resident hit her in the stomach while she was pregnant:

I: "And what about working here in the different units? I know that resident safety is important, but what about staff safety?"

A: "[...] In the seventh floor there is. I mean so many times that we've gotten hit that it's - it's a small hit that you know, we don't really report, unless it's like a big thing, which happened to me when I was pregnant the first time. I was three months pregnant and somebody, a resident hit me in my tummy and that I had to report, you know. But on a normal basis we get scratched. We get punched, you know, we get hit a little bit. But, it's not like it's, it's something that I wanted to report. It's a minor things."

I: "[...] And when you reported it was anything done about it?"

A: "Oh yeah. Well I was - they compensated me for I think one or two days that I was off, because I had to go and get my ultrasound done and such." (Participant 30, Nurse, Female, VM, F/T)

A manager stated that she required medical attention as a result of an injury sustained while trying to support a resident who had almost fallen. Ironically, this worker was also pregnant when the injury was sustained:

A: "I personally had a work-related injury."



I: “Tell me about that.”

A: “I still suffer from that [...] I was transferring a resident with a PSW and he just failed. He just let go and wasn’t standing. He just was non-weight bearing all of a sudden. I don’t know what happened. So myself and the PSW had to kind of hold him and just, you know, bear all his weight, maximum weight and he was tall, to put him on the bed versus him falling on the floor and breaking something. From that I had severe injury to my lower back that I still suffer up ‘till now. At the time I couldn’t walk because it was extending to my leg.”

I: “Okay.”

A: “And I was off for a while and then I came back on modified duties. I was pregnant at the time as well so I went off on mat leave that same year and I came back and up until now I still suffer from my back because of that injury. I still go for treatments and I was at physiotherapy yesterday just because it got aggravated. Any extra stress or pressure on my back, it kind of aggravate that same area. [...] I was off for probably a month going for treatments and they had to be very careful. They couldn’t even do aggressive things because of pregnancy and then I came back on modified for maybe a couple of months and then I went on mat leave.” (Participant 32, Manager, Female, VM, F/T).

## **VII. Discussion**

An anti-racist feminist political economy analysis is important in analyzing the findings. This analysis helps to contextualize the workers’ location within Ontario’s health and LTC system, and indicates that these systems are experiencing a shift in the priorities, policies, and operations. When studying the broad health system and its context, these perspectives reveal that health and LTC services in large urban centers, such as in Toronto and the GTA, are centralized through particular organizational measures that tend to be governed, in part, by neo-liberal ideologies, or a market-orientation. In order to maximize profits, the market model of care focuses on limiting budgets and cost cutting, with troubling implications for LTC workers (Day, 2014). For example, a number of researchers (Daly, 2007; Armstrong, Armstrong and Scott-Dixon, 2008; Daly, 2012; Seeley, 2012) argue that under the neoliberal model of care, LTC facilities attempt to control costs by adopting for-profit business-oriented managerial techniques.



Such austerity measures begin by reducing the levels of staffing (England and Folbre, 1999; Duffy, 2005).

Eastside Home is a non-profit home embedded within Ontario's LTC system that is oriented towards market-oriented dominance (Daly, 2016). Market-oriented practices of Eastside Home, specifically reduced hiring practices, result in understaffing and workload intensification that can harm not only the health and safety of workers who are the providers of care, but also the services and supports that are available to the people who dwell and work in these communities. For instance, staffing, workload intensification, time, and stress are inherently bound. When there is insufficient staffing, there is often insufficient time to complete the work, and the work then becomes intensive, stressful, and harmful to people's health and wellbeing. As a result, staff might compensate for insufficient time and high workloads in harmful ways, such as skipping meal breaks and break-taking. When this happens too often, chronic stress and burnout can occur.

Previous research of LTC work shows that there are heavy workloads; staffing ratio challenges (Armstrong and Jansen, 2003; Daly and Szebehely, 2012; Syed, Daly, Armstrong et al., 2016); job stress (Armstrong et al., 2009; Zaman, 2012; Syed, Daly, Armstrong et al., 2016); de-skilling i.e. reductions about LTC workers' skills and abilities (Armstrong, 2013); precarity among ancillary staff (Armstrong and Laxer, 2005); and work-related injuries and illness (Armstrong and Daly, 2004). While some of the findings reported in this study are not new (e.g. staffing challenges, workloads, job stress), the connections to precarization, social determinants of health, and the presentation of the data in a stratified manner through sex, racialized status, and full time or part time employment statuses, are perhaps new. The findings further suggest that there is a growing pattern of precarization in LTC, which is not only reflected by market-



oriented practices in how economic work is valued, but also reflects growing imbalance between the proletariat and capitalist classes.

The findings highlight the challenge of heavy workloads in the category of job-demand factors (Karasek and Theorell, 1990; Moen, Kelly, and Lam, 2013; CCOHS, 2014), and are bound to health and wellbeing of workers. Understaffing results in workload intensification and high workloads that can harm the health and safety of care workers. When there is insufficient staffing, there is often insufficient time to complete the work, and the work then becomes intensive and stressful. As a result, staff might compensate for insufficient time and high workloads in harmful ways, such as skipping meal breaks and break-taking. When this happens too often, chronic stress and burnout can occur. Indeed a lot of workers reported injury, physical strain from the work, stress, sleeping disorders, and other problems.

While the existing LTC research raises concerns about under-funding and less time to care (e.g. Day 2014; Cammer, Morgan, Stewart et al., 2014; Syed, Daly, Armstrong et al., 2016), the findings in this chapter echoes not only the issues of less time to care but also significant concerns about the health and safety of LTC workers. Survey data about workloads, break-taking, and workers' health and safety outcomes, corroborated some of the qualitative findings.

Previous research suggests that understaffing and shift-vacancies occur not only because staff coverage is not available, but because they are actually implemented as cost-savings measures to have the same amount of work completed by fewer paid employees (Cammer, Morgan, Stewart et al., 2014). On the one hand, understaffing seems to be attributed to changes in the priorities of care policies, and the distribution of resources, but on the other hand, it is



attributed to the ways in which the labor-power exchange is organized, and the extent to which labor can be exploited.

The market model of care often relies upon both the paid and unpaid labor of poorly remunerated and low-status care workers, who are from various social locations marked by gender, race, and class (England and Folbre, 1999; Duffy, 2005). Poor remuneration, low status work, racialization, and gender are also all features of precariousness (Standing, 2011). One of the patterns that have emerged from the analysis that might allude to increasingly precarious working conditions in LTC has to do with budgetary scarcity. Budgetary scarcity – often discussed in the form of provincial funding -- is reflected in outcomes such as income inadequacy and understaffing, which in turn, seem to be affecting the working conditions in Eastside Home. This problem could be paralleled in the workers' own private lives.

Although poor remuneration was not explicitly asked in the survey, respondents cited financial situations as one of the most frequent sources of mental stress (**Tables 6.2a-6.2b, Appendices 6.2a-6.2d**). Interviewees further expressed problems related to income and budgeting (discussed further in chapter 7). For particular categories of workers, other social determinants of health (“SDoH”) issues, such as housing, were also selected as a source of stress. Given that employment, working and living conditions are SDoH and are inter-connected, these findings are significant.

While many of the examples demonstrate stress, they might also describe the effects of stress. For instance, psychosocial characteristics of work, such as job demand, time pressure, work surges, work pace, and rest breaks (which might be proxies of workload), as well as job control and social support, can influence worker stress, health, and wellbeing, and they can result in physiological symptoms of disease, as suggested in the beginning of this chapter. The



findings raise concerns about physical signs and symptoms related to LTC work, stress, and/or injuries or illness, including workplace violence from residents. The rationale for asking about physical signs and symptoms of injury, illness, violence, and/or work stress was to get a sense of the occupational health and safety issues in this organization. Interviewed participants reported that work-related stress affected physical health, which included a variety of symptoms such as: sleep disturbance, weight loss, gastrointestinal issues, and cardiovascular problems. Workers also reported a variety of injuries. This is not surprising, given the existing literature that indicates that 21.1% of direct care workers worked when sick more than 5 times over the past year despite reporting back injuries, sprains, needle pricks, flu, and stress (Armstrong, Armstrong, Banerjee et al., 2011). Standing (2011, p. 141) also recognizes that “the precariat will suffer from stress”.

Violence and abuse in LTC are often unreported (Mayhew & Chappell, 2002; Banerjee, 2010; Day, 2014). Violence is one of the problems that women often face in the workplace, which is compounded for women in precarious forms of work (Lewchuk, Clarke, & De Wolff, 2011). Canadian frontline care workers are six times more likely to experience daily physical violence than Nordic ones (Armstrong, Armstrong, Banerjee, et al., 2011). In one study, 43% experienced violence on a daily basis and another 23% weekly (Banerjee, Daly, Armstrong et al., 2012). It included punching, hitting, wrist-twisting, as well as verbal forms (ibid). Although limited, the evidence from the data supports the existing literature about structural and physical violence in LTC, and how it is institutionalized and normalized (Armstrong and Daly, 2004; Banerjee Daly, Armstrong, Armstrong, and Scott-Dixon, 2008; Morgan, Crossley, Stewart et al., 2008; Armstrong et al., 2009; Banerjee, 2010; Daly et al., 2011; Daly, Banerjee, Armstrong et al.,



2011; Banerjee, Daly, Armstrong et al., 2012). With respect to reporting, a nurse indicated that violence occurred so frequently, that it was not reported until it was extreme.

As described in chapter 4, stress is associated with musculoskeletal conditions and these conditions are compounded among women due to the double burden of paid and unpaid responsibilities. Survey data shows that musculoskeletal conditions are reported ubiquitously. It alludes to the Marxist notion that workers' bodies are disposable. Some of the data suggests that it is racialized/immigrant bodies that are disposable; as they often work in the riskiest shifts (such as overnight). The organizational structures might not be doing enough to provide workers with safe, healthy, and prosperous working conditions that foster social mobility. Indeed, this can be summarized by one worker who told me informally "once a PSW, always a PSW."

The findings described in this chapter also suggest that there is a growing pattern of precarization in LTC, which reflects market-oriented practices in how this economic work is valued, that may be emerging across the province, and it also reflects how there is a growing imbalance in the exchange of labor-for-wages. Many workers, often unwillingly, engaged in unpaid economic care work, and it was reported frequently in interviews. For instance, many workers remained at work well beyond their shifts in order to complete their work, while others took work home. They were not compensated for this extra time. Previous studies recognize unpaid care work is often completed by women and racialized people who are often from the working class (e.g. England and Folbre, 1999; Baines, 2004; Duffy, 2005; Baines, 2006; Armstrong and Armstrong, 2010).

Some workers reported doing work from their home. Others were on call. Workers should have the right to refuse unpaid call work; work carried out in the home during after-hours, which can result in stress and burnout (Nease, 2018). In addition, many staff worked through



their breaks and did not undertake a rest-period in order to manage their intense workloads, which is a form of workload intensification in LTC (e.g. Armstrong and Jansen, 2003; Daly and Szebehely, 2012). Meal breaks were often skipped, despite being required by provincial legislation. These conditions, at least to some extent, mimic sweatshops, indentured forms of labor, and some manufacturing conditions, which were historically carried out in racialized and gendered ways (Williams, 1964; Genovese, 1967; Cohen, 1987; Alund, 2003, Braziel and Mannur, 2003; Cohen, 2008). The work of Standing (2011, p. 119) recognizes the connections between precarization and intensification, with a section dedicated to “labour intensification”. Standing (2011, p. 115-116) indicates that we belong to a global market that operates continuously, non-stop, without breaking or relaxing:

“[T]he global economy has no respect for human physiology. The global market is 24/7 machine; it never sleeps or relaxes; it has no respect for your daylight and darkness, your night and day. [...] If a country, firm or individual does not adapt to the 24/7 time culture, there will be a price to pay.”

The evidence suggests that workers in Eastside Home are paying the price with their health and wellbeing with respect to issues of time, shift work, stress, break-taking, not being able to relax due to ‘sleep’ disturbances, and in many other aspects described in this chapter.

Organizational fiscal pressures leading to the possibility of eliminating some of the support staff positions was also reported as a problem in the interviews. Almost all of the support staff positions are undertaken by racialized women who work in multiple rotating shifts. In the case of Eastside Home, the elimination of this position is reported to be a cost-savings measure in order to save money in the budget and physically relocate the home. Although it has not been implemented because of pressures from the care clients/families, it is important because often the elimination/layoff of employees is a characteristic of neoliberal policies and practices (Syed, 2015), which often see workers as disposable. Furthermore, if these positions are indeed



eliminated, it would also mean that there would be significant social, economic, and health consequences for these vulnerable workers which would impact their SDoH.

An important part of the LTC work is about care relationships between providers of care and residents (Cammer, Morgan, Stewart et al., 2014); however, it is important to highlight the context that shapes care relationships. As the dissertation findings show, context, such as quality of care, is often obscured and it is necessary to step back and consider how basic resources, such as human resources, and everyday experiences are incorporated into care. If there is insufficient staffing, care quality may be compromised and may also be insufficient. Workers can benefit from adequate staffing levels because the latter are resources. Understaffing means there are human resource deficits. Just like other resources, adequate staffing levels are critical for high quality care to residents.

Adequate equipment and other resources are critical for providing high quality care to residents in LTC environments. Tangible resources (e.g. equipment, medicine, and supplies) vs. intangible resources (e.g. time or training) are distributed in limited supply in Canadian LTC environments (Stolee, Esbaugh, Aylward et al., 2005; Brazil, Bedard, Krueger et al., 2006; Armstrong, Armstrong, Banerjee et al, 2011; Cammer, Morgan, Stewart et al., 2014; Syed, Daly, Armstrong et al, 2016). For instance, Armstrong, Banerjee, Szebehely et al., (2009, p. 102) indicate that adult diapers were in such short supply, that workers reported that they had to “steal them”. While the lack of availability and poor state of repair of crucial equipment has been known to directly affect the quality of care, and could contribute to resident and staff injury (Cammer, Morgan, Stewart et al., 2014), equipment can be functional yet still pose problems for care. As indicated by one of the managers, ergonomic issues (e.g. lack of height adjustment of medication carts) and type of equipment (e.g. manual versus electrical crushers) can pose



hazards for workers. Both a support-worker and a manager highlighted how chairs were also a source of physical discomfort for workers.

Time is an intangible resource that is also deemed to be in short supply, and previously highlighted as a major issue in Canadian LTC (Cammer, Morgan, Stewart et al., 2014; Syed, Daly, Armstrong et al., 2016). Time constraints are often normalized by the fact that LTC facilities are chronically under-staffed (England and Folbre, 1999; Duffy, 2005). An ancillary worker notes how the sheer quantity of work requires three people but there is only a single person to do it.

As I have already indicated, the data analysis was informed through anti-racist feminist political economy lenses, which intersects issues of race and gender at the regional and community levels, and with broad policies and procedures. It has motivated questions to ask about who are the beneficiaries of these institutional arrangements, and what are the processes or contexts that are exposed with such an analysis, and what are the processes or contexts that are obscured. The evidence from my data reflects a discrepancy in health/social care objectives and the needs between the beneficiaries of paid/unpaid care work at the structural and organizational levels, and that of frontline care workers, who are the main producers of care and who experience their reality through material conflict. The current care structure is shifting towards profit-maximization, privatization, and cut-backs (Day, 2014). It alludes to a neoliberal model of care. It also alludes to precarization and deficits in social determinants of health, particularly working conditions.

The neoliberal model of care is characterized by application of market principles of supply and demand to the organization and function of care work (Daly and Lewis, 2000) and often carried out in the name of efficiency and elimination of wasteful resources (Daly, 2007;



Armstrong and Armstrong, 2010). The research evidence supports the existing and ongoing tension related to healthcare (and specifically LTC) understaffing versus managing budgets and saving money through particularly harmful fiscal measures, such as reduced hiring practices, and freezing new recruitment/employment. An overwhelming majority of participants expressed that if they could change their work situation, it would be by adding more staff to help with workloads. Unfortunately, the measures to reduce hiring have been recently implemented in the public service sector by the newly elected Premier Doug Ford.

With the above noted in mind, LTC organizations and structures should be concerned about particular points of contention and conflict, such as cost-saving measures that inform care (re)structuring, which have deleterious economic, social, and health consequences for vulnerable groups of workers (Armstrong and Jansen, 2006). Given that the organizations' quality of care and productivity are at stake, it is expected that the organizations and structures themselves would be a starting point to implement change.

### **VIII. Summary**

The key themes that I have highlighted in this chapter were: workloads and break-taking, staffing levels, time, stress, physical aspects of work, and injury. These major themes and the main points have been extracted and summarized in (**Appendix 6.1**). The evidence indicates that a lot of workers reported injury, physical strain from the work, stress, sleeping disorders, and other problems.

The findings from this chapter confirm some of the previous research of LTC work, such as: workload intensification, high workloads, staffing challenges, (Armstrong and Jansen, 2003; Daly and Szebehely, 2012; Syed, Daly, Armstrong et al., 2016), job stress (Armstrong et al., 2009; Zaman, 2012; Syed, Daly, Armstrong et al., 2016), categorization of LTC workers' jobs



(and particularly women's jobs) as "unskilled" (Armstrong, 2013, p. 102), precarity among ancillary staff (Armstrong and Laxer, 2005), and work-related injuries and illness (Armstrong and Daly, 2004). The research findings also highlight the deregulated nature of LTC work, the problems associated with working from home, and also about workloads, which belong to the category of job-demand factors (Karasek and Theorell, 1990; Moen, Kelly and Lam, 2013; CCOHS, 2014), and are bound to health and wellbeing of workers.

The findings echo some of the concerns that have been described in the previous literature (e.g. Day 2014; Cammer, Morgan, Stewart et al., 2014; Syed, Daly, Armstrong et al., 2016), that suggest there are scarcities in budgets, in time, and in the levels of staffing on the frontlines of Canadian LTC, and that this is normalized and institutionalized by organizational structures. Yet, as highlighted by Cammer, Morgan, Stewart et al., (2014), the problems of scarcity in budgets, staffing, and time constraints are generally deemed to be unacceptable in other service areas, such as on the frontlines of acute care settings.

The findings related to workload intensification, staffing levels, time constraints, and other problems suggest that Eastside Home has the features of precarious work circumstances, and that the work is carried out by mostly women and racialized workers. These work situations are informed by the organization's structure, cost-cutting measures, and discourses of scarcity in equipment, supplies and resources, all of which manifest in the everyday experiences and lived realities of care workers. The findings clearly indicate that there are discourses of scarcity in human/people resources as well as financial resources.

While there may not seem to be immediate incentives to alleviate the problems of worker stress and staff burnout, a few glaring ones exist, for instance, the Registered Nurses' Association of Ontario ("RNAO") (2007) advocates hiring additional staff. Given the evidence



provided in this chapter, and in the care literature, it would be imperative that employees are also retained once they are hired. This would be possible, in part, if the working conditions are improved, so that workers have the incentive to remain at work.

If these problems and situations are not alleviated, in the long run, they may become unmanageable. Furthermore, it is reasonable to expect that if the work environment in LTC does not resolve or improve, there might be adverse consequences not only for the recipients of care, but also for the organizations themselves in terms of lost productivity. Improving LTC in places such as Eastside Home would require a structural or organizational (re)assessment of the working conditions, so that it considers total worker health and wellbeing. It is important that workers are cared for, because they are themselves the producers of healthy and safe care for residents.

The findings from this chapter illuminate the complex and invisible aspects of precarity and begin to demonstrate new information about how precarity influences some of the SDoH, primarily employment and working conditions. For instance, the findings from this chapter illuminate how precarity is directly connected with paid and unpaid care work. The significance of these findings are that they highlight that precarity is not necessarily limited to certain sectors or occupations. Precarity, as experienced in the contexts of the participants, seems to be a subtle, but a broadly experienced phenomenon that has social and health consequences that crosses multiple boundaries, disciplines, and occupations.

Precarity in employment conditions means there is also parallel precarity in the health and social wellbeing of workers, and about chronic stress and illness; as evidently extracted from the lives of my participants. However, these issues receive less public attention than lifestyle



and behavioral factors such as diet and exercise interventions that are stated to influence worker's health and wellness.

In short, the evidence speaks to scarcities in organizational budgets, personnel resources, and time. This translates to deficiencies in the occupational health and safety-sustaining resources at the level of this organization that are not only connected to the wellbeing of workers who are the producers of care, but might also affect the health and safety of residents. The frontline care workers, who are often racialized, immigrant women, are the main producers of care, yet they experience material/class conflict with the beneficiaries of such labor at the various structural and organizational levels.

In the next chapter, I will discuss key findings that are related to: income challenges, budgeting, housing, travel to/from work, commuting times, and living in expensive municipalities such as Toronto and the GTA, and how these findings integrate with the broader literature.



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## **Chapter 7: Findings – Income Challenges, Deficits in Social Determinants of Health and Various Levels of Precarization Shape LTC Workers Health and Wellbeing**

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“We haven’t had any raise in the last five years. The last time they gave us a raise, it was only a bloody quarter, which was an embarrassment as far as I was concerned.”  
(Participant 9, Ancillary Worker, Female, Non-VM, P/T).

### **Introduction**

Chapter 6 highlighted different sources of employee stress based on race, sex/gender, and immigrant status. It also highlighted understaffing, workload intensification, time constraints, which shape workers’ break-taking, physiological symptoms, and the health and wellbeing of the LTC workers in the region of study. The analysis provided an organization-level example of the state of Ontario’s health and LTC system and explored: the priorities of the LTC organization, how the organization currently operates, and the micro-level effects on frontline staff. The data suggests certain things have priority over others in this organizational structure, such as cost savings, rather than adequate levels of frontline staffing. For example, Eastside Home has challenges with understaffing, among other things (e.g. time constraints), and as a result of this, frontline care workers reported workload intensification, significant levels of stress, limited break-taking, and other downstream effects. These working conditions allude to precarization and racialization in this facility, and in the long run, may result in chronic stress and burnout among frontline LTC workers.

This chapter describes the social determinants that shape workers’ health in Eastside Home, including worker’s incomes. I detail how personal finances are managed by different workers, and describe the budgetary challenges that many frontline care workers face. I also describe housing and dwelling accommodations, modes of transportation, and commute times. This analysis demonstrates varying levels of precarization that different types of workers experience, and how their social determinants of health (“SDoH”) are affected.



Section I of this chapter reports on income findings based on the survey and interview data. Section II presents housing and dwelling circumstances in Toronto and the GTA; describes how workers rely on sources of support for housing and living; and details choices related to groceries. Section III presents workers' issues about commutes. In Section IV, I discuss how a market model or neoliberal model of care creates precaritized conditions that result in income deficiencies and inequalities between various care workers, and I summarize the findings (**Appendix 7.1**).

While I recognize that the workers described in this chapter may experience various levels of marginalization and social exclusion based on their social locations – which is derived from an intersectional approach of feminist political economy of health with anti-racism theory – the analysis presented in this chapter only begins to reveal some of these findings. The length and depth of the analysis examines key issues and contextualizes the experiences, interactions, and relations between and among workers, which is an essential part of feminist epistemology that investigates social relations, and especially relations of ruling. However, it would be out of the scope of this chapter to discuss all of the issues. Rather, in the next chapter, I will discuss some of the remaining layers, such as scope and depth of private care, domestic care demands, and social life.

### **I. Managing Personal Finances, Income Challenges, and Budgets**

This section will present findings related to workers' income in relation to the cost of living in or near a major metropolitan city, which illuminates how some of the most precaritized participants are barely able to manage their personal finances. I begin with the data extracted from the survey responses. Thereafter, I will discuss the findings that are derived from the qualitative component of this project.



### ***Household Income***

The survey asked about household information, including the respondent's total household gross annual income in 2015 year-end. The reason that this year was chosen was because tax deadlines for the 2016 fiscal year had not occurred at the time of data collection. There were 11 income brackets to choose from. Of the total survey respondents (n=91), 88 answered this question, and three did not. Of those who responded to this question (n=88), 56.8% (50/88) reported household incomes between \$20,001 and \$60,000. The most common household income bracket was in the range of \$50,001-\$60,000 (17%, 15/88) (**Table 7.2a**). Few respondents had household incomes less than \$10,000 (2.3%, 2/88) or more than \$100,000 (9.1%, 8/88). Equal numbers of the participants reported household income brackets of \$20,001-\$30,000 (14.8%, 13/88) and \$30,001-\$40,000 (14.8%, 13/88), respectively, which was the next most common selection (**Table 7.2a**).

Household incomes were stratified by sex and indicates gender disparities (**Table 7.2a** and **Appendix 7.2a**). For example, two participants reported the lowest income bracket (less than \$10,000) and they were both women (**Appendix 7.2a**). More men (23.1%, 3/13) reported incomes of \$90,001 to \$100,000 compared to women (8.1%, 6/74) (**Table 7.2a**).

Household income data was also stratified by VM status, and suggests that racialized workers were at a disadvantage in certain household income brackets (**Table 7.2b** and **Appendix 7.2b**). For example, only 8% (6/75) of racialized workers reported household incomes of more than \$100,000 compared to 18.2% (2/11) of non-racialized workers (**Table 7.2b**). There were two participants who reported the lowest household incomes of less than \$10,000, and both were racialized (**Appendix 7.2b**). There were three participants who reported the next lowest household incomes of \$10,001 to \$20,000, all three were racialized.



**Table 7.2a - Survey: Household Annual Income by Sex**

[illegible]

**Table 7.2b - Survey: Household Annual Income by VM Status**

	Total (n=88)		VM (n=75)		Non-VM (n=11)	
Household Gross Annual Income for 2015	Frequency	%	Frequency	%	Frequency	%
Less than \$10,000	2	2.3%	2	2.7%	0	0.0%
\$10,001-\$20,000	3	3.4%	3	4.0%	0	0.0%
\$20,001-\$30,000	13	14.8%	9	12.0%	4	36.4%
\$30,001-\$40,000*	13	14.8%	11	14.7%	1	9.1%
\$40,001-\$50,000	9	10.2%	8	10.7%	1	9.1%
\$50,001-\$60,000	15	17.0%	14	18.7%	1	9.1%
\$60,001-\$70,000	7	8.0%	7	9.3%	0	0.0%
\$70,001-\$80,000*	4	4.5%	3	4.0%	0	0.0%
\$80,001-\$90,000	5	5.7%	4	5.3%	1	9.1%
\$90,001-\$100,000	9	10.2%	8	10.7%	1	9.1%
More than \$100,000	8	9.1%	6	8.0%	2	18.2%
Total**	88	100.0%	75	100.0%	11	100.0%
*1 respondent did not disclose ancestral background						
**A total of 2 respondents did not disclose ancestral background						



Household income data was also stratified by immigrant status (**Table 7.2c** and **Appendix 7.2c**). There were two participants who reported the lowest household income of less than \$10,000 and both were immigrant (**Appendix 7.2c**).

**Table 7.2c - Survey: Total Household Annual Income by Immigrant Status**

Household Gross Annual Income for 2015	Total (n=88)		Immigrant (n=63)		Non-Immigrant (n=19)	
	Frequency	%	Frequency	%	Frequency	%
Less than \$10,000	2	2.3%	2	3.2%	0	0.0%
\$10,001-\$20,000*	3	3.4%	1	1.6%	1	5.3%
\$20,001-\$30,000*	13	14.8%	7	11.1%	5	26.3%
\$30,001-\$40,000	13	14.8%	11	17.5%	2	10.5%
\$40,001-\$50,000**	9	10.2%	5	7.9%	2	10.5%
\$50,001-\$60,000	15	17.0%	12	19.0%	3	15.8%
\$60,001-\$70,000*	7	8.0%	6	9.5%	0	0.0%
\$70,001-\$80,000	4	4.5%	2	3.2%	2	10.5%
\$80,001-\$90,000	5	5.7%	4	6.3%	1	5.3%
\$90,001-\$100,000*	9	10.2%	6	9.5%	2	10.5%
More than \$100,000	8	9.1%	7	11.1%	1	5.3%
Total*****	88	100.0%	63	100.0%	19	100.0%
*1 respondent did not disclose immigrant status						
**2 respondents did not disclose immigrant status						
***** A total of 6 respondents did not disclose immigrant status						

Household income data was also stratified by job category and reflects a few socioeconomic status disparities between different categories of workers (**Appendix 7.2d** and **Appendix 7.2e**). For example, two respondents reported the lowest household income of less than \$10,000 and both were PSWs (**Appendix 7.2e**). None of these lowest income households were reported by managers, nurses, or other staff. Furthermore, none of the respondents from the highest household income brackets were PSWs.



### ***Individual Income***

Survey respondents were also asked to report their individual gross annual income for 2015. They were given 11 income brackets to choose from. Of the total survey respondents (n=91), 88 answered this question, and three did not. 75% (66/88) of respondents reported individual incomes between \$10,001 and \$60,000. Very few individuals earned less than \$10,000 (5.7%, 5/88), or more than \$100,000 (2.3%, 2/88). The most frequently selected individual income brackets were in the range of \$20,001 to \$30,000 (18.2%, 16/88) and \$30,000 to \$40,000 (18.2%, 16/88) (**Table 7.3a**).

Individual income data was stratified by sex, and suggest women's vulnerability to the lowest individual incomes (**Table 7.3a** and **Appendix 7.3a**). For example, five of the respondents reported the lowest individual income bracket of less than \$10,000 and all were women (**Appendix 7.3a**). Of those who reported the second lowest individual income bracket of \$10,001-\$20,000, 100% were women (10/10).

**Table 7.3a - Survey: Individual Annual Income by Sex**

Individual Gross Annual Income for 2015	Total (n=88)		Female (n=75)		Male (n=13)	
	Frequency	%	Frequency	%	Frequency	%
Less than \$10,000	5	5.7%	5	6.7%	0	0.0%
\$10,001-\$20,000	10	11.4%	10	13.3%	0	0.0%
\$20,001-\$30,000	16	18.2%	13	17.3%	3	23.1%
\$30,001-\$40,000	16	18.2%	13	17.3%	3	23.1%
\$40,001-\$50,000	13	14.8%	11	14.7%	2	15.4%
\$50,001-\$60,000	11	12.5%	10	13.3%	1	7.7%
\$60,001-\$70,000	5	5.7%	5	6.7%	0	0.0%
\$70,001-\$80,000	6	6.8%	4	5.3%	2	15.4%
\$80,001-\$90,000	2	2.3%	1	1.3%	1	7.7%
\$90,001-\$100,000	2	2.3%	2	2.7%	0	0.0%
More than \$100,000	2	2.3%	1	1.3%	1	7.7%
Total	88	100.0%	75	100.0%	13	100.0%



Individual income data was stratified by VM status and, like women's vulnerability to the lowest incomes, suggest racialized person's vulnerability to the lowest individual income brackets (**Table 7.3b** and **Appendix 7.3b**). For example, five of the respondents reported the lowest individual income bracket of less than \$10,000 and all were racialized workers (**Appendix 7.3b**). The most common individual income among racialized respondents was \$30,001 to \$40,000 (20%, 14/70) (**Table 7.3b**), which is not adequate for living in expensive areas such as Toronto and the GTA.

Interestingly, racialized workers also reported some of the highest individual income brackets; however, this information needs to be interpreted with caution. For example, two of respondents reported individual incomes of more than \$100,000 (n=2) and both were racialized (**Appendix 7.3b**). Similarly, two reported the second highest individual income bracket of \$90,001 to \$100,000 and both were racialized. During interviews, participants revealed additional information that might explain these unexpected results. For example, one racialized worker reported ownership of wealthy transnational businesses overseas. In addition to this sort of access to wealth, he also indicated that he worked at other LTC homes.

Individual income data was also stratified by immigrant status, and immigrants exhibited vulnerability, similar to women and racialized persons, to the lowest individual income brackets (**Table 7.3c** and **Appendix 7.3c**). For example, five of the respondents reported the lowest individual income bracket of less than \$10,000 and 80% (4/5) of them were immigrants (**Appendix 7.3c**). The most common income among all immigrant respondents (n=63) was \$30,001 to \$40,000 (22.2%, 14/63) (**Table 7.3c**), which is inadequate for living in expensive areas such as Toronto and the GTA.



	Total (n=88)		VM (n=70)		Non-VM (n=11)	
Gross Individual Annual Income for 2015	Frequency	%	Frequency	%	Frequency	%
Less than \$10,000	5	5.7%	5	7.1%	0	0.0%
\$10,001-\$20,000*****	10	11.4%	5	7.1%	0	0.0%
\$20,001-\$30,000*	16	18.2%	10	14.3%	5	45.5%
\$30,001-\$40,000	16	18.2%	14	20.0%	2	18.2%
\$40,001-\$50,000	13	14.8%	12	17.1%	0	0.0%
\$50,001-\$60,000	11	12.5%	10	14.3%	1	9.1%
\$60,001-\$70,000	5	5.7%	5	7.1%	0	0.0%
\$70,001-\$80,000	6	6.8%	4	5.7%	2	18.2%
\$80,001-\$90,000	2	2.3%	1	1.4%	1	9.1%
\$90,001-\$100,000	2	2.3%	2	2.9%	0	0.0%
More than \$100,000	2	2.3%	2	2.9%	0	0.0%
Total *****	88	100.0%	70	100.0%	11	100.0%
*1 respondent did not disclose ancestral background						
***** 5 respondents did not disclose ancestral background						
***** A total of 6 respondents did not disclose ancestral background						

	Total (n=88)		Immigrant (n=63)		Non-Immigrant (n=19)	
Gross Individual Annual Income for 2015	Frequency	%	Frequency	%	Frequency	%
Less than \$10,000	5	5.7%	4	6.3%	1	5.3%
\$10,001-\$20,000*	10	11.4%	8	12.7%	1	5.3%
\$20,001-\$30,000*	16	18.2%	6	9.5%	9	47.4%
\$30,001-\$40,000	16	18.2%	14	22.2%	2	10.5%
\$40,001-\$50,000***	13	14.8%	8	12.7%	2	10.5%
\$50,001-\$60,000	11	12.5%	9	14.3%	2	10.5%
\$60,001-\$70,000	5	5.7%	5	7.9%	0	0.0%
\$70,001-\$80,000*	6	6.8%	4	6.3%	1	5.3%
\$80,001-\$90,000	2	2.3%	2	3.2%	0	0.0%
\$90,001-\$100,000	2	2.3%	2	3.2%	0	0.0%
More than \$100,000	2	2.3%	1	1.6%	1	5.3%
Total *****	88	100.0%	63	100.0%	19	100.0%
*1 respondent did not disclose immigrant status						
***3 respondents did not disclose immigrant status						
***** A total of 6 respondents did not disclose immigrant status						



Individual income data was also stratified by job category, and suggests socioeconomic status disparities between different categories of workers (**Appendix 7.3d** and **Appendix 7.3e**). For example, of the five respondents who reported the lowest individual income bracket of less than \$10,000, two were PSWs, one was allied health worker, one was ancillary worker, and one was support staff (**Appendix 7.3e**). None of these lowest individual income brackets were reported by nurses or managers.

There was a subsequent follow-up question about whether the income from the previous question -- related to the respondents individual income -- was different from the respondent's normal income due to a maternity, paternity, sickness, or other leave. For instance, if there was a significant number of female workers away on maternity leave, this could affect their reported income (i.e. reduce it). Eight people from the study (n=91) did not answer the question and, therefore, they were excluded from the analysis. Of the 83 respondents who did answer this question, the majority answered no (84.3%, 70/83), and 15.7% answered yes (15.7%, 13/83) (**Table 7.4a** and **Appendix 7.4a**). Of those who responded yes, 76.9% were female (10/13), while 23.1% were male (3/13) (**Appendix 7.4a**).

**Table 7.4a – Survey: Income Fluctuations due to Maternity, Paternity, Sickness, or Other Leave**

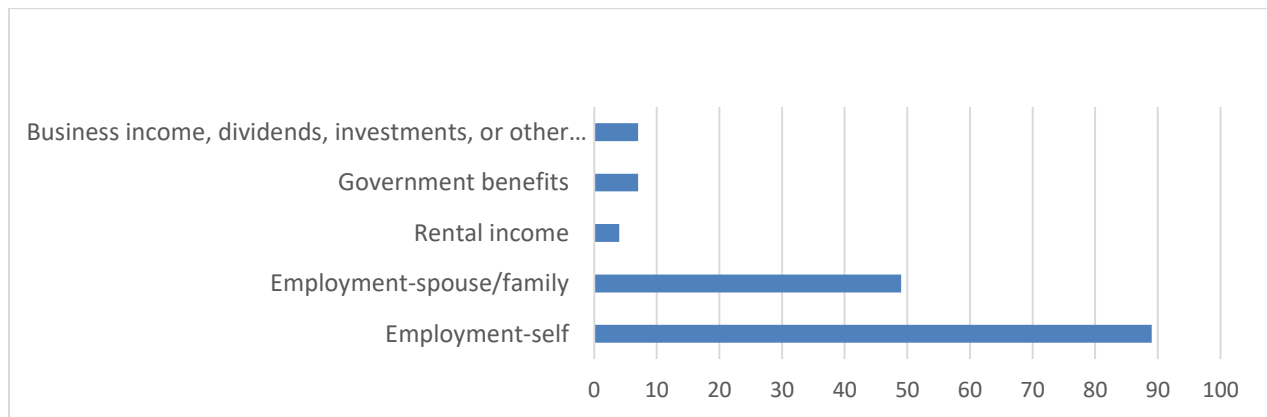
	Total (n=83)		Female (n=70)		Male (n=13)	
Income from parental/ sickness	Frequency	%	Frequency	%	Frequency	%
Yes	13	15.7%	10	14.3%	3	23.1%
No	70	84.3%	60	85.7%	10	76.9%
Total	83	100.0%	70	100.0%	13	100.0%

Survey respondents were also asked to indicate all sources of income. There were five options: employment-self; employment-spouse/family; rental income; government benefits; and business income, dividends, investments, or other income. They could select all that apply. 97.8%



(n=89/91) respondents reported income from their own employment (i.e. employment–self). A few respondents did not select this option, despite working in Eastside Home, which means they may have conflated employment–self with self-employment/entrepreneurship. Respondents relied on a variety of sources of income for their budgeting needs. 53.8% (49/91) respondents reported income from spouse/family; 4.4% (4/91) reported rental income; 7.7% (7/91) reported government benefits; and 7.7% (7/91) reported business income, dividends, investments, or other income (**Figure 7.5**).

**Figure 7.5 - Survey: Sources of Income among Respondents**



Frequency

Many of the interviewed participants reported that they did not earn enough money for their needs and that they believed they were under-paid for the work they did. These responses depended on sex, race, class, or socioeconomic status of participants -- the latter two of which are connected to job title, income, and/or education. Participants attributed household fiscal pressures to their wage stagnation and to the high cost of living in Toronto -- particularly the high cost of housing and food. When participants were asked if the work at Eastside Home paid well enough to meet the costs of living in Toronto, many replied that it was unreliable or



inadequate, and might be partially explained by job category or work status. For example, some ancillary workers were employed as part-time workers.

A nurse described the pay as inadequate for the workload:

I: “Tell me about your experience of the work and how well does it pay for the work that you do?”

A: “I don’t think we’re getting compensated for what we do for most of the time [...]”.  
(Participant 7, Nurse, Female, VM, P/T)

### ***Education and Job Titles as Socio Economic Status Indicators***

Participants were asked what was the highest level of education that they received. They were given eight options, but no one selected the option “elementary or middle school”. One person from the 91 respondents did not answer this question and is, therefore, not included in the analysis. 47.8% (43/90) of the respondents (said that their highest level of education was some college or university (**Table 7.6a**). The next most common answers were bachelor’s degree (21.1%, 19/90), followed by high school (14.4%, 13/90). In other words, workers in Eastside Home were well educated, with nearly half of the workers surveyed reported having some college or university-level education, and over one-third holding one or more university degrees. Education-related data was stratified by sex (**Table 7.6a** and **Appendix 7.6a**). 48.7% of women (37/76) indicated they had some college or university education compared to 38.5% of men (5/13) (**Table 7.6a**).

Education-related data was also stratified by VM/ racialized status (**Table 7.6b** and **Appendix 7.6b**). The most common level of education for racialized respondents was some college or university (41.1%, 37/77), which was slightly more than non-racialized respondents (36.4%, 4/11) (**Table 7.6b**).



**Table 7.6a- Survey: Highest Level of Education Completed by Sex**

Level of Education	Total (n=90)		Female (n=76)		Male (n=13)	
	Frequency	%	Frequency	%	Frequency	%
High School	13	14.4%	12	15.8%	1	7.7%
Some College, University*	43	47.8%	37	48.7%	5	38.5%
Vocational, Skilled Trades School	4	4.4%	3	3.9%	1	7.7%
Bachelors Degree	19	21.1%	16	21.1%	3	23.1%
Masters Degree	6	6.7%	4	5.3%	2	15.4%
Professional Degree	4	4.4%	3	3.9%	1	7.7%
Advanced Degree, PhD	1	1.1%	1	1.3%	0	0.0%
Total*	90	100.0%	76	100.0%	13	100.0%
*1 respondent did not disclose sex						

**Table 7.6b - Survey: Highest Level of Education Completed by VM Status**

Level of Education	Total (n=90)		VM (n=77)		Non-VM (n=11)	
	Frequency	%	Frequency	%	Frequency	%
High School	13	14.4%	11	14.3%	2	18.2%
Some College, University**	43	47.8%	37	48.1%	4	36.4%
Vocational, Skilled Trades School	4	4.4%	3	3.9%	1	9.1%
Bachelors Degree	19	21.1%	16	20.8%	3	27.3%
Masters Degree	6	6.7%	5	6.5%	1	9.1%
Professional Degree	4	4.4%	4	5.2%	0	0.0%
Advanced Degree, PhD	1	1.1%	1	1.3%	0	0.0%
Total**	90	100.0%	77	100.0%	11	100.0%
*2 respondents did not disclose ancestral background						

Education-related data was further stratified by immigrant status (**Table 7.6c** and **Appendix 7.6c**) and suggests that more immigrants had bachelors, masters, and PhD degrees compared to non-immigrants. For example, a single respondent who held an advanced degree, such as a PhD, was an immigrant (**Appendix 7.6c**). Six respondents had master's degrees and five of them were immigrants (**Table 7.6c**). 19 respondents had bachelor's degrees and 17 of them were immigrants compared to one non-immigrant<sup>19</sup>.

<sup>19</sup> One respondent did not indicate immigrant status.



**Table 7.6c - Survey: Highest Level of Education Completed by Immigrant Status**

	Total (n=90)		Immigrant (n=66)		Non-Immigrant (n=19)	
Level of Education	Frequency	%	Frequency	%	Frequency	%
High School	13	14.4%	11	16.7%	2	10.5%
Some College, University***	43	47.8%	27	40.9%	13	68.4%
Vocational, Skilled Trades School	4	4.4%	2	3.0%	2	10.5%
Bachelors Degree*	19	21.1%	17	25.8%	1	5.3%
Masters Degree*	6	6.7%	5	7.6%	0	0.0%
Professional Degree	4	4.4%	3	4.5%	1	5.3%
Advanced Degree, PhD	1	1.1%	1	1.5%	0	0.0%
Total*****	90	100.0%	66	100.0%	19	100.0%
*1 respondent did not disclose immigrant status						
*** 3 respondents did not disclose immigrant status						
***** A total of 5 respondents did not disclose immigrant status						

Education-related data was also stratified by job category (**Appendix 7.6d** and **Appendix 7.6e**). Next, I discuss social benefit access, labor organization, and working class strength.

### ***Social Benefit Access and Means-Testing***

A support staff worker indicated that she was vulnerable when previously unemployed, despite having a strong skill-set. This worker sought government-funded social benefit assistance. However, after means-testing, she was denied access because of the ownership of personal assets. This type of means-testing for determination of benefit eligibility is a common feature of neoliberal welfare states. This worker considered herself lucky that she had a good support system consisting of her family:

“Well the -- when I was like under employed or not employed I basically had to cash in everything I had. You don’t get assistance when you have any assets, so basically you cash in your life insurance, so I lived off it for three years, so. [...] All my retirement money went, everything went, for, like, you know, it costs money to live, you know, and



rent is very high, and food and -- and I'm lucky to have some support with my family."  
(Participant 8, Support Staff Worker, Female, Non-VM, F/T)

### ***Labor Organization and Working Class Strength***

One participant indicated that although there is always an increase in the cost of living (measured as the consumer price index or the rate of inflation), unionized workers did not receive a raise for a number of years:

I: "Do you think that the work pays well for what you do [...]?"

A: "No, it's not [...] the cost of living is getting higher. Since how many we didn't have even raise here [sic]"

I: "Really?"

A: "Yeah, last three years, because the budget, they don't have, they didn't get funding, I think. There is some, I don't know."

I: "Is that like, permitted? Aren't you unionised?"

A: "We are unionised, but they are still, they are fighting for that [i.e. a raise]." (Participant 4, Nurse, Female, VM, F/T).

An ancillary worker described the wages as being stagnant, and that workers only received a 25-cent raise during the last negotiations. She said this affected her in such a way that she was unable to afford things to meet the costs of living in Toronto. She cited an increase in shelter costs, for example, by \$15 to \$20 a month:

I: "[...] does [the job] pay enough especially for Toronto?"

A: "Well, we get \$19.43 an hour. I guess that's not bad [...]. We haven't had any raise in the last five years. The last time they gave us a raise, it was only a bloody quarter, which was an embarrassment as far as I was concerned. They still haven't settled the other contracts. I don't know. Everybody else seems to be getting nice pay raises but we don't get any [...]. That has an effect on my, on my overall, you know, because there's a lot of things that I can't afford now."

I: "Tell me about that."



- A: “Well, the cost of living goes up every year. You know, your rent goes up every year, 15, 20 dollars a month. My paycheque does not reflect that. You know, it’s not geared to the cost of living. What’s a quarter? You know. They gave the part-timers, you know, minimum wages. They gave them a fifty-cent raise. We got a quarter. Why do we get a quarter and they get fifty cents? You know. That doesn’t make sense. All the other government workers, they get a dollar more an hour, we don’t get that. You know. And they let us wait so long, we have to protest and march before they even think about talking. You know. They had these people in here from the union and they were trying to negotiate another contract and I said, ‘What? You’re going to negotiate a contract like the last one?’ He goes, ‘Yeah, yeah like the last one.’ ‘The last one you gave us a bloody quarter, what’s quarter? Minimum wage went up twice. That’s a dollar as far as my books are concerned and a quarter doesn’t match the minimum wage when it went up. I think that’s an embarrassment. I don’t think that we’re worthy of our jobs or anything.’ They didn’t say anything, they just said, ‘Well, I guess that’s not going to – you guys aren’t going to take a quarter.’ I said, ‘No, not this time. No way. You guys are idiots. Let me have a try with that. They’d never get away with it.’ You have to fight for them and these people seem like they’re all laid back and they don’t care. Well, maybe they’re just there to get the little paycheque there but they don’t care.” (Participant 9, Ancillary Worker, Female, Non-VM, P/T).

The same respondent offered thoughts about affording life in Toronto:

- A: “Well you have to cut things that you can’t afford. You don’t eat as much food as what you usually do. No entertainment because I can’t afford that. I’m just working to pay my bills. I have maybe a couple hundred dollars left afterwards for food, for a couple months for food. A couple dollars for food doesn’t go very far, not anymore because everything’s so expensive now.”
- I: “What about time for yourself? Are you able to take a vacation?”
- A: “If I’m sick, I have to borrow money because I don’t have enough money to pay my bills after that. I was off sick for a week and a half, I had the flu, really bad case of the flu too. You don’t get paid for that. You don’t get no sick pay, I’m not full-time. Only the full-time people get sick pay. Part-timers get no benefits and I’ve been on part-time now since the day I started. It’s only in the last year that I got full-time. But if [name of co-worker] comes back, I’m back to part-time and I’m back to fighting for my hours again, which I won’t be able to get.” (Participant 9, Ancillary Worker, Female, Non-VM, P/T).

The experiences of the workers above demonstrate several important points. Firstly, the responses demonstrate intra-class conflict between part-time and full time workers. Secondly, they demonstrate class conflict between the organized, unionized workers who are “fighting” for fair wages and sufficient paid working hours against the employer(s). According to the ancillary



worker, there has been no significant raise in the past five years. Other workers also corroborated this same sentiment and also indicated that the union was “fighting” for wages; one worker indicated that some of the union-related issues were in front of the courts. The class conflict between waged workers and employers, and intra-class conflicts between full time and part time workers, and unionized and non-unionized workers, are not surprising given that unions are perceived as weak in neoliberal states such as Canada and the USA.

The ancillary worker above also indicates that she is working to pay her bills, and there is little savings left over, which, if there is, it is only for basic necessities of life. She indicates that not only is a vacation impossible, but that costs for food are also challenging. When she was struck with illness, she did not receive sickness benefits. She states that only full-time workers receive sickness benefits, and because she is usually part-time, this benefit is inaccessible to her. Many workers corroborated this and it demonstrates precarization and challenges to SDoH with respect to income, food security, and health and wellness. Next, I discuss work-family financial support systems.

### ***Work-Family Financial Support Systems***

One worker (Participant 11, Trainee, Female, VM, F/T) indicated that her parents helped her. She communicated how she is fortunate that she never had student loan debt. Another participant (Participant 10, Nurse, Female, Non-VM, F/T) indicated that she felt fortunate that her husband had a good job. A manager stated that she had “sleepless nights” in order to finance higher education for her child:

“Actually, there is a huge demand on me financially because my son is in [...] school and he's doing the program, you know, out of Canada. So, actually with the US dollar, you know, value going up against the Canadian dollar and the fact that he goes, he has to do his electives in the US. So it's not only the fees but also the rent and he's -- so all of a sudden, it really spiked up like a third of the costs that I had budgeted for. So it, you know, I do think about that, you know? Because like. It, you know, it kind of went way



beyond the budget that I had estimated when he started, right? So I had planned some things, but fortunately, I had taken certain steps to plan for my retirement. [laughs] So, I know that as long as my son is in school, I won't be able to do that because I am the main earner. My husband is kind of semi-retired. He works part time. And he kind of teaches in a school. So he has some income but not a lot. So, I had taken steps -- so you know, I did certain things to, you know, draw on -- have money. Like, you know, like my house. Like, the mortgage and all of that I had to borrow in order to make ends meet. So, you know, I have had sleepless nights, you know, because in my entire experience, I've never seen money go the way it did in the last year or two. So it's like, you know, you're operating at this level and then suddenly you're expected to jump up and, you know. So, but you know, I would like to see him complete it and I feel that you know, I have to support him. So I'm just counting [on] that.” (Participant 6, Manager, Female, VM, F/T).

The respondent also mentioned her retirement plans:

“I was hoping to retire when I was about 55 or 56. But with this, having had -- I was hoping -- even with this, I was hoping by about 57. But...or right about now. Or last year. But you know, things happen, and then it just kind of pushes it back.” (Participant 6, Manager, Female, VM, F/T).

Clearly, the exchange with the manager above indicates that she is in a privileged position with respect to her finances. She was able to pay for her child's post-secondary education and she was able to think about and plan for early retirement, 10 years before the usual age of retirement, the latter of which is at 65. It is not uncommon for many people to retire later in life after the age of 65, depending on their socio-economic class.

### ***Salary Competitiveness and Adequacy for Costs of Living***

When an ancillary worker (Participant 12, Male, VM, F/T) was asked about his rate of pay, he described how his wage was inadequate to meet the cost of living. He indicated that his children worked and their money belonged to them but they assisted indirectly with food costs. He surmised that he could not really “support them with what they need”. In addition, he revealed that his spouse had a disability and she was unable to work so he held the responsibility to support the family.



One nurse described the pay as sufficient to meet the cost of living for her personal situation because she lived with family who paid for all her living, dwelling, and other expenses. However, she also stated that her salary was inadequate when taking into account the sheer quantity of the workload that was demanded of her:

I: “Tell me about your experience of the work and how well does it pay for the work that you do? Does it pay well [...]?”

A: “It pays well, but I think we should be getting more paid for the amount of work we do”. (Participant 13, Nurse, Female, VM, F/T)

Another nurse stated that the salary is not as ‘good as it could be’; it is enough to ‘survive’, but much lower than a physician’s salary, for example:

A: “I don’t think that the wage is as good as it could be [...] So I would say that it’s not the greatest but you can survive in, like I live in [GTA municipality] you can survive with what you make, but for the responsibility, I think that the wage should be more because you have a lot of responsibility here, solely responsible for the care of everybody and so its just – it’s almost as if you were to look at a physician and how much they have the same responsibility right, but the wages are not anywhere near each other.” (Participant 10, Nurse, Female, Non-VM, F/T).

When asked about the work and the adequacy of the pay, a support staff worker stated that while the salary was competitive, it did not meet the high cost of living, nor was the compensation sufficient for overtime workloads:

A: “I would say it's [...] It definitely could be better. Having said that, when I look at other job postings for [support staff role], they’re paid fairly low, the job postings I see range anywhere from \$40 to \$45,000. And I don’t make that, I make higher than that. So, I guess throughout, looking at [support staff] roles throughout, I guess I would be okay. But looking - when I look at the quantity of work that I am given is where I don’t feel that it matches. So, maybe in the big scope of just looking at a job title and a salary somebody would say that's a great salary. But when I look at the hours I put in and the work that I do from home, I would say that I would feel that I should be paid higher.” (Participant 22, Support Staff Worker, Female, Non-VM, F/T)

An allied health worker disagreed, stating the pay was adequate for the work but that it was inadequate to meet the cost of living. She stated that money was “tight”. She indicated that her



rent for a single room was \$800 alone, and in addition to this, she was still paying off her school-related debt:

A: “Oh my gosh. It's very expensive. I rent a room right now, so it's pretty expensive. We do get paid pretty well, actually, for [job title]. We get paid like 21. [...] Which, for most places, don't pay you that much. It's usually like 15, 16 [dollars per hour]. So we are lucky in that aspect, but it's still hard. Toronto's expensive. Like, just the room I'm paying is 800 alone, and then paying off school. And it's tight.” (Participant 14, Allied Health Worker, Female, Non-VM, P/T)

A support staff worker who had children described the cost of living as “challenging” and stated the need to postpone optional household purchases in order to meet basic expenses:

A: “Oh my, that's really challenging, you know, challenging. Because everything's, yeah, everything's going up and then pay stay the same, right [sic]. So, I just manage, you know, because I live what I have, if I can't afford anything, you know, even if I want to, I always say, even to my kids. Like, you know, if they want something, I'll check my budget and then I can tell them; oh can we do that or can I buy that in a few months' time, right. So, I make those arrangements with my kids and with my budget, you know, I just, you know, really budget.” (Participant 27, Support Staff Worker, Female, VM, F/T)

One support staff worker stated that the pay could always be better than it currently is, but other factors also mattered to her, such as the distance of the workplace from home and how she enjoyed her work and valued her colleagues:

A: “[...] the pay can always be better but I really like my job, I like the people here, I really like working here, so. And it's very close to my home [...]” (Participant 8, Support Staff Worker, Female, Non-VM, F/T)

While some workers emphasized rent, others described different living expenses. A PSW described the pay as inadequate for work that was very difficult and stressful, and also inadequate for the cost of living in Toronto. She stated that she had to “stretch whatever you are making” to meet the demands. She cited an example of how Toronto's land taxes were a source of financial stress, among other things. The same worker revealed that she worked only in this one LTC home, whereas many workers in Eastside Home were juggling multiple full-time jobs



to make ends meet. This may allude to the unreliability in the income and the precarious nature of the work:

- A: “It's hard, especially with your salary. But every day, something is going up and then you're trying to stretch whatever you are making to. I only do one job. I don't do two full-time jobs like some people. So it's difficult, but you do the best you could, right? That's all you could do [...] Your same things goes up every -- up in every flipping month, you swear to God [sic]. Land taxes, everything goes up. But like I said, the pay cheque stays basically the same. And if the pay cheque do go up, it might be 50 cents, 20 cents, and that doesn't really mesh with what everything else that's going up, so.” (Participant 16, PSW, Female, VM, F/T)

Another worker described utility costs such as hydroelectricity and high propane (gasoline) bills that fuelled her furnace in her home -- which she claimed was due to the government's recent implementation of a new carbon tax:

- A: “So yeah, the government is just raising stuff really crazy. Like heating and hydro, it's very expensive. And most places aren't giving you a substantial, and we're unionized, but yeah, everything is just getting very expensive. You have to really look outside of the city to get something that's more affordable.” (Participant 19, Allied Health, Female, Non-VM, F/T)

### ***Wage-Related Effects on Food Quality and Food Variability***

One PSW attributed the inadequacy of the pay to the stagnation of wages and described the effect of this inadequacy upon the quality and variability in the food she was able to serve to her family. In particular, she gave an example of how junk food, such as a bag of fries, is easier and cheaper to purchase than healthy food, such as salad:

- A: “[T]he cost of living has gone up, and we haven't gotten a raise in so many years. I don't even know. I just -- I don't even keep track. And it also makes a lot of people mad, because I started six years ago. They've worked here 20 years ago, and the pay is the same.” (Participant 20, PSW, Female, Non-VM, P/T)

The same participant went on to state:

- A: “The other day, my kids were like, “Oh, mom. Chicken again?” “Well, chicken's on sale right now. So yeah, that's what you're having.” And I just try and differ it up a little bit. But yeah, for sure. It's easier to buy a bag of fries than it is a whole salad. Salad's



expensive, but you do what you've got to do.” (Participant 20, PSW, Female, Non-VM, P/T)

A support staff worker also referred to the deleterious effect of inadequate pay on the food that could be served at home. She indicated that she used the assistance of technological tools to assist her with balancing her grocery budget:

A: “The cost of food has increased a lot. But I do probably what most people do, I buy what is cheaper that week. So, you know, if this time of year cauliflower seems to be more expensive then maybe I do a different vegetable, zucchini it is. You know, you just kind of, you try in balance. And then you see, you know, they have great tools now with like a flip app where you can look and see what items are on sale and you can price match and I'm a professional price matcher. But that's what I have to do to stay within the budget that I have aligned for myself.” (Participant 22, Support Staff Worker, Female, Non-VM, F/T).

The next sections discuss SDoH such as rent, housing, and dwelling accommodations that revealed information about living in Toronto and the GTA.

## **II. Housing and Dwelling Circumstances in Toronto and the GTA**

This section presents findings related to the circumstances of housing, living conditions, and navigating Toronto and the GTA.

### ***Housing Costs***

Recall from the chapter 6 that when participants were asked about sources of stress, they could select all possibilities that applied to their situation, including ‘housing’. Respondents reported that housing was least likely to be a source of stress, and had a frequency count of 5. The interviews revealed a number of themes. Some participants reported that they owned their own homes and made mortgage payments, while others paid rent. A few participants indicated that they lived with relatives who paid 100% of their housing expenses. Several participants described mortgage payments as a significant financial burden. For instance, a support staff worker stated that making monthly mortgage payments was a source of stress “that eats me up”:



A: “I own my own condo. So, yeah between mortgage and rental fees, that, yeah that eats me up and for some reason in the last six months I'd probably say even groceries. [...] So, yeah so I would say mortgage and maintenance fees probably consume the majority of my income.” (Participant 22, Support Staff Worker, Female, Non-VM, F/T).

Another participant, a nurse, stated that mortgage payments consumed the biggest part of his family's budget. He revealed that he and his family lived with his parents while they waited for the construction of his new home. He stated that housing prices were becoming too high and that he was fortunate to have parents and in-laws with whom he could live with until his home was fully constructed. The same participant revealed that housing prices increased so drastically in Toronto and the GTA, that he now considered living in areas that were previously non-ideal locations, more than 1 hour commute from work:

I: “Okay. What consumes the biggest part of your budget, is it housing, rental?”

A: “Mortgage, it's always that and finding a balance and how you - at the end of the day it's kind of like okay, I need some me time as well. That's mostly the challenge I'm finding but I get by [...] Yeah the 20% price hike, it's a new build... back in the day --This is not our first home, so that house that we're living in, back in the day it probably would have cost \$300,000 doubled, right [GTA municipality] -- seriously. Nobody even wants to go to [another GTA municipality] back in the days, [GTA municipality], anyway, right? [...] we're with my parents. [...] Yeah they don't want us to, you know, they're pretty much involved - we always like to consider their input, her mom and our parents who kind of collaborate and say ‘no, never, never rent. Come back, stay here for as long as you can, wait for the home to get finished, then you move out again’, so yeah” (Participant 23, Nurse, Male, VM, F/T)

The same worker went on to state:

“Yeah, we've been going places to see where we'd like to be. So, we're kind of like trial and error. We were at [second GTA municipality] at one point and then from [second GTA municipality] we were [third GTA municipality], we found it too far. We always wanted to be in the east and said you know what? Let's try [GTA municipality]. [...] We sell them, we go back to, if not my parent's home, her [my partner's] mom's place.” (Participant 23, Nurse, Male, VM, F/T).



Another nurse indicated that the high cost of living in Toronto had also pushed housing prices higher in the vicinity and in the GTA:

“...So it has extended over to where we live, it’s definitely the cost of living is astronomical, you’re going from – I had [dependents] also lives with us, so we’re a family of four and groceries can be expensive, especially if you want to eat healthy, right and in terms of housing, like funny enough that you say it, we have to sell our house, we’re selling our house to get a bigger house and the prices of houses have jumped by 35% in one year [...] before I got this job and I was in school, we were living on \$60 a week of groceries and living paycheck to paycheck, it was very stressful.” (Participant 10, Nurse, Female, Non-VM, F/T)

An allied health worker and ancillary worker concurred that the mortgage, utilities and groceries consumed the largest portion of their income.

“Oh, housing, for sure. Bills. Like, hydro, utility, all that sort of stuff, yeah. That’s, like, the major. [...] Any bills associated with owning a house, really, right? Like, property tax, all that stuff. It sure adds up, yeah.” (Participant 25, Allied Health Worker, Male, VM, F/T).

Another worker indicated that the biggest part of the household budget was reserved for the mortgage payment, and groceries. When prompted if there were daycare costs, the participant revealed that she no longer had that because her children were now older:

“Housing is one and the food, my gosh, like whenever I go to, every Saturday. Twice a week I go, because I cannot get everything every Saturday. I go to Wal-Mart every Saturday and then when I get home, you know, crap, I forgot this, I forgot this, this and that, right. So like, every week, and I have two kids, every week I will spend more than \$200, like \$250 every week. Yeah so, it’s really, you know, so in a month, how much is that, just for the food and yeah, so, housing and food. [...] Mortgage, yes, yes, and not just the mortgage, of course if something breaks then you need to, you know, fix it, you know, so.” (Participant 27, Support Staff Worker, Female, VM, F/T).

A support staff worker described the amount of her mortgage as \$1,500. Her mortgage was ‘not that large’ at 25% of her budget:

“[...] I’m trying to live or spend what I have now, not more than I have. I always pay my credit cards. I once only paid the interest because I forgot two or three days, so I’m hitting in my limit and I’m trying to do this. Of course, I have mortgage, it’s different, right. It’s like investment as well. [...] Not [that] large, the largest, okay, like \$1500. Maybe it’s kind of like 25%” (Participant 37, Support Staff Worker, Female, Non-VM, F/T).



Many workers reported needing the support of family to afford living expenses. One worker considered herself ‘super lucky’ because she was able to live with her parents:

“I’m super lucky. My parents lived in Toronto and I just live with them still. But I kind of thought about it [...]. But I was sort of thinking like people who are out of town or they live by themselves and they have to pay rent and food and stuff like that, like I don’t think – that’s just like such a big stress that I don’t have in my life, which I’m really grateful for. But like I have it pretty okay right now.” (Participant 11, Trainee, Female, VM, F/T)

An allied health worker believed that living in Toronto would have been too expensive without the support of family:

“Since I live with my family, it's so much -- but if I was -- it's so much better. But if I was living alone, definitely, I would have not been able to manage it. But since I live with my family and they provide a lot, so yeah.” (Participant 15, Allied Health Worker, Female, VM, P/T).

Another worker also lived with parents at no cost:

- A: “Background about me, I'm not quite sure if you're going to get into that, I still live with my parents. And I don't pay rent and they [...paid for schooling...], because OSAP was just not a thing. So I've been in the process of paying my parents back for tuition and I actually will be done with paying back everything by the end of this year, because I also used to work at Starbucks, David's Tea, just a slew of different part-time, transient work here and there, finding my niche. And then I found the research assistantship, and I really liked it. In terms of pay as living alone, very likely it's not that great. If I took on full-timeness with my part-time job and the wages there, I don't think it would be enough to live in the city, maybe outskirts and commute, but realistically it wouldn't be in the city at all.”
- I: “So this is something I'm guessing, is it like a cultural expectation that you're paying – sort of giving your parents the help that they sort of offered you, or is that something you're just doing out of the goodness of your heart?”
- A: “It’s a little mix of both. My parents come from a traditional background where they want to support me through everything, however at the same time with that they also have the expectation that once I am older and wiser and more successful, I will be giving the energy back.” (Participant 18, Trainee, Female, VM, F/T).

An allied health worker (Participant 15, Female, VM, P/T) believed that living in Toronto would have been too expensive without the support of family. Similarly, a support staff worker



indicated assistance from family and that her son contributed to the mortgage payments for her condominium. She stated that she considered selling it:

“It's difficult to be honest with you, but I'm thankful I have a good son that we live together and, you know, he has a good job and we make it together to manage our mortgage and live. [...] it's only me and one son live [together]. We have a condo and he contributes significantly, maybe half, and I contribute significantly a little more than half. He also is at university and he is good, so he's doing a good job as well as I. [...] He's working full time. He works as a computer analyst and full time and he goes to [educational institution] University too. [...] You know, the condo I would say the maintenance is big amount. That takes a lot of our money. Even today I was thinking, you know what, I need to sell this place.” (Participant 28, Support Staff Worker, Female, VM, P/T).

A nurse who lived with family described the burden of housing expenses, which were shared among family members. The monthly amount of the mortgage was low in this case:

“Oh for sure. I do. I do pay majority - not majority but part of the mortgage. I mean it's divided into myself, my dad and my two younger sisters. But it's still quite a lot. Because you know, living in a house with mortgage plus utilities alone cost about, I don't know, 600 or so a month, you're looking at internet, the water bill, the electricity, the heating. That's a lot. Yeah. So you're looking about more than \$600 a month and we also divide that as well. So yeah.” (Participant 30, Nurse, Female, VM, F/T)

### ***Rent***

Participants who paid rent were in financial situations very similar to those who made mortgage payments. Many participants who paid rent described their housing expenses as a significant financial burden:

“It's rising quite a lot I think. I would say the prices have definitely increased a lot, especially if you were to -- well, if I were to find a place in downtown Toronto but I don't plan to move there. In terms of midtown and a little bit uptown, midtown is okay if we look for like the older apartments or condos, but with the newer condos and stuff it's way too expensive for like the amount of space that they offer. Yeah.” (Participant 7, Nurse, Female, VM, P/T)

An allied health worker who rented a single room in a friend's home stated that her rent was helpful to the recipient's mortgage payment. She indicated that on her own, renting an apartment in Toronto would be unaffordable:



“But even to get an apartment, one bedroom, it's pretty high right now in Toronto, so I wouldn't be able to afford it on my own, either, so.” (Participant 14, Allied Health Worker, Female, Non-VM, P/T).

One nurse felt fortunate to rent from family, possibly because Ontario has strict tenant landlord policies in which eviction can be sought the day after a rental payment is due, and if it remains unpaid (Landlord and Tenant Board, 2015):

“In that way, I'm lucky. My mom lives downstairs. I live upstairs. We rent from her. [...] So if I don't have all of my finances at the beginning of the month, she'll let it slide for a week or two. And then, I just catch up.” (Participant 20, PSW, Female, Non-VM, P/T).

Another nurse reported that 70 to 80% of her budget went to housing and rental costs:

“Oh my God. Housing. I mean that's really expensive. I mean you're supposed to just only - spend, like, I don't know, 40 percent of your income with - 40 or 30 with housing, but no. Living in Toronto it's so expensive, 80 percent, 70 percent goes to housing, rent. And the rest are yours.” (Participant 30, Nurse, Female, VM, F/T)

### **III. Travel Time, Commutes, and Distance Travelled**

This section will discuss the data about travel time and commutes, which have been extracted from the in-depth, interviews.

For the 25 participants who gave a numerical estimate of their commuting time, the mean length of a one-way commute for all modes of transportation was 24.5 minutes ( $n=25$ ). Participants indicated that they commuted by car ( $n=16$ ), by public transit ( $n=3$ ), mixed transportation (e.g. automobile and public transit) ( $n=3$ ); and on foot ( $n=1$ ). Two participants did not disclose how they commuted. The mean one-way commuting time by car was 24.6 minutes. Commutes by car ranged in duration from five minutes ( $n=2$ ) to 60 minutes ( $n=2$ ), with a median commute time of 18.75 minutes. The mean one-way commuting time by public transit was 37.3 minutes, with a range from five minutes ( $n=1$ ) to 60 minutes ( $n=1$ ). The participant who commuted on foot reported that the walk took five minutes. Estimated one-way commute distance to Eastside Home was calculated using Map Data from Google ©2018 if participants



disclosed their route or intersection of origin. Nine participants disclosed this information. The mean one-way commute distance for these participants was 21.9km (**Table 7.7**).

**Table 7.7 Interviews: Travel and Commuting Times and Modes of Transportation**

Participant#	Mode of transportation	Estimated distance travelled (one way, kilometers)	Reported one way commute time (minutes)
5	Automobile	30	40 to 80 (midpoint 60)
7	Automobile	18	30
9	TTC - Bus	1.6	5
10	Automobile	45	41 to 50 (midpoint 45.5)
18	TTC	Undisclosed	45 to 50 (midpoint 47)
19	Automobile	Undisclosed – out of city	30
22	Automobile	Undisclosed	5
23	Automobile	Undisclosed	5
24	Automobile	Undisclosed	15
25	Automobile or TTC Bus	20.7	25 to 30 (midpoint 27.5)
26	TTC – subway + Bus	Undisclosed	60
27	Undisclosed	Undisclosed	10 to 15 (midpoint 12.5)
28	Automobile	Undisclosed	20 to 25 minutes (midpoint 22.5)
29	Automobile	43.7	30 to 90 (midpoint 60)
30	Automobile	6.4	10
31	Automobile/Bus	Undisclosed	15 to 20 (midpoint 17.5)
32	Walk	Undisclosed - nearby	5
33	Automobile	3.8	15
35	Automobile	Undisclosed	10 to 15 (midpoint 12.5)
37	Automobile/Bus	Undisclosed	10 to 15 (midpoint 12.5) drive 45 to 60 (midpoint 52.5)
38	Automobile	Undisclosed	30
39	Automobile	Undisclosed	10
40	Automobile	Undisclosed	8 to 10 (midpoint 9)
41	Automobile	28.4	30 to 40 (midpoint 35)
42	Undisclosed	Undisclosed	12



### *Carpooling and Car-Sharing*

One nurse indicated that she carpooled and picked up other staff on her way to work in order to help out the fellow workers:

“I can leave home at quarter after and I can get here – I don’t stop, I pick up a staff because you know, you’ve got to help out your fellow workers and then – no it takes me maybe half an hour [...] By car.” (Participant 38, Nurse, Female, VM, F/T)

A PSW indicated that her spouse would drive her to work each day, but was unable to pick her up because he worked in the evenings, and she did not wish to wait for him. She indicated that she needed to ‘get out of this place’. Accordingly, she used public transportation. When asked about the costs associated with a car, she indicated the following:

A: “I normally will take the bus and if my husband work --he works evening. It depend on the time [sic]. Sometimes he drops me off and then he goes [...] I don’t want to wait [...] I could wait [for him in the evenings] but I don’t want to wait because when I finish work, I need to get out of this place, so I go. I take the bus and I go home because I’ll get home a whole maybe hour, 45 minute before he comes.”

I: “Okay. By bus how long will it take?”

A: “Same 15-20. It depends on how it runs. [...] Max is half an hour.” (Participant 31, PSW, Female, VM, F/T).

Another PSW also indicated that her partner drives her to work, and that sometimes she commutes, the reason for the latter is because there is limited parking at Eastside Home. She indicated that her commuting time to her other place of employment, another LTC home, was very similar to this one:

A: “So, [...] my partner drive me here [sic]. Sometimes I commute, take the, because we don’t have the parking here, so.”

I: “Right. How long does it take you if you’re commuting?”

A: “15 minutes. [...] 10 to 15 minutes.”

I: “What about if your partner drops you off, how long does it [take], five minutes?”



A: “Eight minutes.”

I: “What about at your other home, does that take a while to [travel] or is it close by?”

A: “It’s the same thing.” (Participant 24, PSW, Female, VM, P/T)

One support staff worker indicated that she drove to work, which took her “about half an hour” and she described how she saved on fuel expenses:

A: “Yeah, I live outside the city so I commute.”

I: “How long does it take you?”

A: “About half an hour. [...] I drive. [...] My car is pretty good on gas and I also have a Costco membership so I usually get gas at Costco, and Costco’s gas is a lot cheaper than regular gas.” (Participant 22, Support Staff Worker, Female, Non-VM, F/T)

One nurse stated that she used the commute time of 45 minutes to reflect upon and think about her work during the day, which gave her an opportunity to release tension and stress:

“Yeah, [...] the long commute on the way home I try to release before I get home because you have a good 45 minutes right, to try think about it before I get there [...] I’m thinking about certain circumstances and it depends on the job, but you know, how is this patient doing or how is this person doing? [...] I always wonder if they’re okay or if there’s something more we can do for them, it’s just the type of person I am.” (Participant 10, Nurse, Female, non-VM, FT)

The findings indicate that a mix of automobile, public transit, and car-sharing/car-pooling were the modes of travel. Only one participant reported walking.

#### **IV. Discussion**

An anti-racist feminist political economy analysis is essential in illuminating the findings. It motivates inquiries that examine who are the beneficiaries of the institutional arrangements, and what are the processes or contexts that are exposed with such an analysis, and what are the processes or contexts that are obscured. This perspective reveals that the majority of front line care workers, who are racialized women, experience income-related problems that significantly constrain their living and dwelling conditions, which is particularly challenging in highly



urbanized places, such as Toronto and the GTA. For example, the most frequently selected individual income brackets were reported as \$20,000 to \$30,000 and \$30,000 to \$40,000 (18.2% each), which are well below the income levels needed for a person to survive and thrive in the GTA, which is \$46,186 to \$55,432 (Kumar, McKenzie, and Um, 2017). This finding suggests precarization of employment, and deficits in income, social and economic conditions, and health.

A number of researchers argue that female care workers' social and economic conditions may be attributed to a neoliberal or market model of care (Daly, 2007; Armstrong, Armstrong and Scott-Dixon, 2008; Seeley, 2012). According to this scholarship, under the neoliberal (or market-model) of care, LTC organizations often attempt to control costs by adopting for-profit, business-oriented managerial techniques that seek to maximize profits. This particular model of care focuses on cost-cutting, which has troubling implications for LTC workers (Day, 2014). Such austerity measures may reduce the levels of income for workers. In the case of Eastside Home, it was clear that sickness benefits were allocated to certain workers (e.g. full time staff) while being denied to others (e.g. part-time workers, agency workers). In addition to this, despite being unionized, workers indicated that wages were nearly stagnant and had not increased very much for a number of years.

Given that employment, working, and living conditions are SDoH, the evidence about costs of living, workloads, and stress, among other things, allude not only to health vulnerability but also precarization among many LTC workers. Many workers, despite being unionized, stated that the salary they received was insufficient for the costs of living and also for their workloads. Accordingly, these workers are vulnerable to significant social, economic, and health consequences. In chapter six, workers often reported high levels of stress, which reflects their



working conditions in this organization. They reported their financial situation as the third most frequent source of stress.

According to England and Folbre (1999) and Duffy (2005), one of the features of the market model of care is that it often relies upon both the paid and unpaid labor of poorly remunerated and low-status care workers, who are from various social locations marked by gender, race, and class. As I indicated in the previous chapter, my analysis revealed that the level of precarization in this organization is informed by the (un)paid labor of workers who are mostly women and racialized persons, who frequently reported working past their shifts and through their breaks, yet did not receive the appropriate remuneration.

An important part of the LTC work is about care and care relationships, which are often viewed as relationships or acts between providers of care and care recipients (Cammer, Morgan, Stewart et al., 2014). It is important to highlight the context that shapes these relationships. As my findings show, context is often obscured and it is necessary to step back and consider how basic resources and everyday experiences are incorporated into care. As I mentioned earlier, the evidence from my data reflects a discrepancy in health/social care objectives and the needs between the beneficiaries of care at the structural and organizational levels and that of frontline care workers, who are the main producers of care and who experience their reality through material conflict. Many workers are perceived as disposable, and they must make do with the little that they receive in remuneration.

### ***Summary***

In this chapter, I have presented key findings that emerged from the narratives of my participants that were drawn from the interview data and I discussed some of the results that were extracted from the exploratory survey. The key themes highlighted in this chapter were:



income, education, personal finances, and budgets; housing; and commutes. These major themes and the main points have been extracted and summarized in **Appendix 7.1**.

My findings suggest that precarization of work circumstances among women and racialized workers in Eastside Home are informed by class conflict between workers and the organizational structure, as well as intra-class conflicts. These conflicts are revealed by the unreliability/ inadequacy of wages, and the disparities in education and income between different statuses and categories of workers (e.g. between part-time or full time workers, PSWs or ancillary workers, nurses or managers). In other words, the inequalities that are experienced by specific frontline care workers tend to be dependent on factors such as job title and to some extent, level of education, both of which are socioeconomic class and status indicators.

There are several factors that can influence and contextualize LTC workers' health and well-being in Eastside Home, which is located in an urban environment. These factors are: gender, race, immigrant status, employment, income, education, living conditions, and other SDoH that shape the opportunities for a healthy life in urban and metropolitan regions. While participants reported individual salaries in the range of \$30,000 to \$50,000, significant income and wage discrepancies exist in terms of affordability for basic necessities of life, such as food and shelter. Some workers were restricted in choice among the options for healthy food.

The levels of stress reported from housing, income, and the issues of affordability seem to manifest in the everyday experiences and lived realities of care workers. Yet, there are also opportunities for intervention that could dampen the effects of wage stagnation, such as social housing, food stamps, and other social benefits that could supplement basic incomes. In the next chapter, I will discuss dual demands and care; the effects on social life and social relations, such as family and dependents; and coping, resistance, resilience, and agency.



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## **Chapter 8: Findings – (Un)paid Care Work, Domestic Demands, Social Life, and Coping**

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### **Introduction**

The findings in this chapter reveal the types of unpaid care work performed by staff of Eastside Home. Section I presents findings related to the care that is done for the family (e.g. spouse, relatives, dependent children, grandchildren, or in-laws) in the private realm. This unpaid care occurs in addition to the paid care work performed at Eastside Home. Hence, LTC workers have dual care demands. Section II describes the financial and other supports provided to extended family living in Canada and overseas, while Section III reports some of the negative consequences of the work for peoples' social life. Section IV discusses the ways in which workers cope, and exercise resistance, resilience, and agency. These strategies include: self-care, spirituality, recreation with family or friends, and solitary recreation. Section V discusses how the findings allude to precarization, how the study contributes to the existing care literature and SDoH literature, and how it expands on this literature. Section VI summarizes this chapter's findings (**Appendix 8.1**).

### **I. Dual Care Demands**

This section identifies how the participants manage the demands on them to care for family and friends. Participants' domestic care demands include support for spouses, children, and other family or relatives, such as: siblings, parents, and in-laws, who live with them, as well as the transnational family who live in the participants' countries of origin. The types of care that are provided for participants' family include financial support, physical care (e.g. bathing of children or dining care for parents with dementia), and housework.



### *Care for Children*

Of the 42 participants interviewed, 67% (n=28) are parents with children aged from 1 years to 40+ years (**Table 8.1**). This information tells us that care workers provide not only paid care at Eastside Home, but also have unpaid domestic obligations.

**Table 8.1 – Interviews: Number of Children Reported**

Participant#	No. of Children	Gender	Age (years)
2	1	Female	undisclosed
3	1	Male	4
4	1	Female	10
5	2	Male Male	4 8
6	2	Male Male	undisclosed
8	1	Male	40+
10	1	Male	11
12	2	Female Female	22 19
16	Multiple (2+)	Undisclosed	Adults
19	1	Female	2
20	4	Female	undisclosed
21	3	Female Female Female	undisclosed
23	1	Female	6
25	2	Female Male	Adult Adult
27	1	Male	undisclosed
28	2	Male Male	Adult Adult with 4 year old granddaughter
29	2	Female Female	Adult Adult
30	2	Undisclosed	3.5 1
31	2+	Undisclosed Daughter	Undisclosed Daughter has children (i.e. grandchildren)
32	4	Undisclosed Undisclosed Undisclosed Male	9



33	3	Undisclosed	Undisclosed
35	1	Male	Undisclosed
36	2	Male Female	Undisclosed Adult - Married
37	1	Female	Adult
38	1	Male	Undisclosed
39	2	Female Female	Adult Grade 10 Student
40	2	Male Male	Undisclosed
42	1	Male	Adult - University Student

One participant described how she was able to get assistance from her mother-in-law because she worked, but had previously done “everything” to care for her step-son:

“[...]But she [my mother-in-law] is a huge blessing in terms of helping clean and help take care of my stepson. So she’ll take him to school and pick him up from school and make his lunch and get him ready in the morning, which is very helpful. But before that, excuse me, it was me doing everything basically, so cooking, cleaning, laundry and managing everything with [name of child] and getting his lunch ready, so full duties at home and full duties at work, yes.” (Participant 10, Nurse, Female, Non-VM, F/T)

Another participant reported that his and his spouse’s decision to move to Canada was a result of care responsibilities of his son. This was despite the fact that both him and his wife were well off and well educated in their country of origin. Specifically, the reason to move to Canada was to alleviate the symptoms of his son’s health issue:

“[S]o both we had Masters in Economics. We have no impact and we have no problem but my son has the problem, he was sick. He has the bronchitis problem and everyday has a problem and then at last doctors test his allergy and got allergies to dust. In my home country there's a lot of dust and a very, very bad situation. So the doctors suggested, ‘If you go to any country that has no more dust your son gonna be sick less’; so take the decision and come and [it’s been] very good, after coming here my son is completely okay and he's now going to university.” (Participant 42, Ancillary Worker, Male, VM, F/T)

Many participants frequently referred to the resources involved in raising their children, including costs and investment of time. One worker (Participant 2, Allied Health, Female, VM, F/T) revealed that living with a child meant that more earnings were required as opposed to



being single with no dependents. Another worker (Participant 21, Ancillary Worker, Female, Non-VM, F/T) indicated that deferring bills from month to month was sometimes necessary in order to afford the expenses of a moderately sized household consisting of three daughters even though both she and her spouse worked. This worker highlighted that both spouses are the primary income-earners for this family of five. The trend of two primary income earners in a household is becoming more common, and one income is no longer sufficient in itself to sustain households among the working class. Some of the main, driving costs in families with children seem to be tuition, education, and other forms of financial support for children, as indicated below.

***Tuition, Education, and Financial Support for Children***

The parental responsibility to pay for children's tuition and education fees is normative in neoliberal regimes where there is little societal support, despite the age-old proverb that 'it takes a village to raise a child'. Recall from chapter 7 that one worker (Participant 6, Manager, Female, VM, F/T), indicated that she was responsible for her son's post-secondary education, while others indicated that their parents helped them with their educational costs (Participant 11, Trainee, Female, VM, F/T and Participant 18, Trainee, Female, VM, F/T).

Another worker (Participant 29, Manager, Female, Non-VM, F/T) described that she paid for the first undergraduate degrees for her children, but not for the second degree that each child pursued. She indicated that she was the main breadwinner of her household, and that she also supported her husband's family outside of Canada. The participant indicated the high cost of educating dependent adult children as beyond her means, and that her children had to take loans for their second set of university degrees:

I: "Are you the primary bread earner in your house?"



A: “Yes. Yes, I am, actually. [...] I did support my daughters with education to pay for one university [degree], so we pay one university around 40,000 cost [to] us. Second university [degrees] -- but second daughter - but second university [degrees] they pay themselves because I cannot pay for doctor med school 200,000. So she took a loan. Youngest with nurse practitioner, I pay for her [name of University tuition], but for her master's degree in nurse practitioner she took a loan, okay.” (Participant 29, Manager, Female, Non-VM, F/T)

Another worker (Participant 25, Allied Health, Male, VM, F/T) indicated that his daughter, who was still living with him and his spouse, just finished her post-secondary studies and started to work while his son was teaching in China. He indicated that both he and his spouse funded all of their children's education.

In addition to the examples above, another worker indicated that he was partially supporting an adult daughter after her university studies. His comments demonstrated how precarious her circumstances were and how he financially supported her, especially with the relatively high shelter costs. She was working at a wage of \$13 per hour, paying rent, and unable to find meaningful employment in her field after graduation:

“Okay. My oldest daughter, she's living in Toronto, from the first marriage, from my first marriage. She's living in Downtown. She's working in a company not in her field. But she did find a job in her field, you know. But she's picky. Like \$13 a month – like per hour. And she makes like \$1400, but she's paying around like 800, 900 for [...] For rent. And I'm giving to her, supporting her sometimes, like for cell phone. I pay for her cell phone. I give to her TTC card because she cannot – she's paying also, but she told me, ‘Dad, I don't save any money. I need to save money.’ And she finishes university. Imagine, she finishes university and she just found a job and she's working for \$13 per hour. It's meaning – [...] Not in her field. She's working in a store, like a store. [...] Retail store, yeah, \$13 per hour. [...] And she has to be pay OSAP and blah, blah. And sometimes I'm supporting her. Like last time she... quit one job and the stories wasn't – was good-- she treat bad. And she had like two – she worked for two weeks. I gave to her like 850 dollars. I made transfer to her by bank. Even the income tax, they can see everything, how it's going on. I gave to her \$850 to pay her tax – her rent, sorry, her rent. It's not easy.” (Participant 39, Ancillary Worker, Male, VM, P/T)



### *Daycare and Childcare Costs*

While tuition and education costs are recognized as parental responsibilities for older children, one worker indicated that basic things such as groceries were another set of costs. This worker reflected on this shift from childcare expenses and daycare expenses, to the costs of groceries as young children grew into teenagers and young adults. She also indicated that 10 years ago, childcare costs were “terrible” and she had to be thrifty in order to manage the costs:

“Oh my gosh that was [...] That was terrible, terrible, you know, because like I have to be really, really thrifty, you know, because like almost I’d say half of my pay, well not really, but you know, just goes to daycare. So, but then, when they’re little the cost of the food, you know, is also not that much compared to now that they’re teenagers, right. So, that compensates it, you know, okay, I spent less on food and then that goes to, you know, daycare. Now, no more daycare, but more on food. So, it’s like a balance, I don’t know if it’s balance or it’s just how it goes.” (Participant 27, Support Staff Worker, Female, VM, F/T).

Another worker said:

“My husband watches my daughter right now, so we save a lot of money, because daycare’s like a mortgage payment. [...] Daycare’s like over \$1,000 usually. So that’s like really expensive.” (Participant 19, Allied Health, Female, Non-VM, F/T)

Likewise, a nurse described the “juggle” of child care responsibilities:

“We had to juggle that. It was just basically determining who could go in later to work that day and who had to come home, so we would have to figure out whoever dropped him off, the other person would have to leave early and pick him up, so it’s part of juggling of who is going to do what, especially when you’re commuting, the biggest stress is trying to get them there when it opens and then deal with traffic and get to work on time and then leave work and try and get to the daycare on time right, so there was that added stress and then by the time you get home you’re all exhausted, then you have to make dinner, so that is the way things used to be but now we have a lot more help so it’s different, there’s not as much stress to like rush back and forth.” (Participant 10, Nurse, Female, Non-VM, F/T).

In the above example, the participant indicated that managing care responsibilities made her feel exhausted. Care work is indeed challenging. Its effects are described in more detail below.



*Care Work, Domestic Work, and Effects of Care on Personal Health and Wellbeing*

Many participants expressed the ways in which unpaid care work affected their health and wellbeing. A nurse found that fatigue from work made some of the chores associated with caring for two small children seem burdensome:

“Of course, I do have quite a bit of responsibility compared to before. Now not only that I need to take care of myself, I have to take care of little children, because they're still quite dependent. I have a three and a half and a one-year-old. So they still need to be fed in terms of I've got to make sure that there's food. Lucky that my parents are the ones cooking. My in-laws are the ones cooking as well. So I don't think about it, but I've got to prepare their food, I've got to prepare their snacks for the next day, prepare their lunch for the next day, give them bath before going to bed and you know, pretty much brush their teeth and such. So yeah, that's quite a bit. At the end of the day if I am really, really tired, I really still have no choice but to make sure I get them to eat. Give them a bath.”  
(Participant 30, Nurse, Female, VM, F/T)

A manager stated that she felt so exhausted after work that she did not have the energy to speak to her family. She indicated that her four children and parents needed her time:

I: “How do you feel after a day's work?”

A: “Exhausted. Yeah. Very exhausted mentally and physically. [...] I have to go home and I still have to manage the kids and feeding them, cooking, homework, taking them to appointments, you know, all of that. My only downtime is when I sleep. That's it. [...] Thankfully my parents come here for a certain period of time, so the cooking is now a blessing. So my mom cooks. I don't have to cook now but my kids are fussy eaters, especially my little one. He waits for me to go home, to get home to feed him basically.”

I: “How old is your youngest?”

A: “9 [...] But he's like a 2-year-old. He eats only with me and he's very, very fussy. I'm probably the only one, even he doesn't eat with his dad. I'm the only one who can convince him to have a good meal. So I try my best to go as early as I can and when I go there, my mom is like pulling her hair. ‘Oh your son did not eat. Why are you late? Blah, blah, blah.’ Yeah and then when my husband comes it's the same. So we barely connect and then I just have to sleep. It's like run, run, rush, rush, you know, four kids and parents and then everybody wants a piece of you when you go home right because they have so much to talk about and I'm so exhausted. Like I don't want to talk because I'm talking all



day. It's a bit hard but then I say to myself, 'You know what, I have to give them that time. It's not their fault.' ” (Participant 32, Manager, Female, VM, F/T)

Other participants also expressed how they found that unpaid care work required time, personal resources, and effort. When one worker (Participant 3, Allied Health, Female, VM, F/T) was asked about gaining new experience or skills, she indicated that having a child made it more challenging to reach career goals. Quite often it is women who provide paid care. Yet often women are also the ones balancing paid work with unpaid care responsibilities, while trying to achieve their own personal growth and development. The gendered component of care was an important part of people's experiences.

One PSW referred to the gendered expectations associated with childcare and housework, which she said was the “normal thing” to do:

- I: “What activities or responsibilities do you have in your home -- in your own home -- that you have to do?”
- A: “Well, normal thing [sic]. You have to cook, clean. Same thing, every woman [...] Every woman always have the hard work, right? You cook, you clean, you do grocery, take care of the kids -- which I don't have any kids anymore. They're big people now.” (Participant 16, PSW, Female, VM, F/T).

While the PSW above indicates that the work is hard, she suggests that they are normative, and that every woman has to do them. Like others, one worker noted that she was the primary breadwinner of her family, and often her spouse helped with domestic work:

- A: “Yeah. Like when I go home, you know, just spending time with my daughter, entertaining her, taking care of her, looking after her, getting dinner going and all that. Often when I get home we have to run out and do grocery shopping, run errands.”
- I: “Yeah. And may I ask how old your daughter is?”
- A: “She's 2.”
- I: “Okay. So you told me you're the main bread-earner, what about -- are you able to get help then from your spouse for example in doing things at home or?”



A: “Yeah, he’s really good, because he’s home with her so he’ll often get the dinner going and look after cleaning and washing the dishes and stuff.” (Participant 19, Allied Health, Female, Non-VM, F/T)

Several participants reported having husbands who either did not work outside the home or worked minimally but carried out care and household duties. For instance, one worker (Participant 4, Nurse, Female, VM, F/T) reported that her husband cared for their 10-year-old daughter while off work for health reasons. She is the primary breadwinner and holds the financial responsibilities and cleans the house, while her husband cares for their child and does cooking, with the exception of “traditional food”. Another participant reported that while her spouse did not assist with household organization, he did the grocery shopping, cooked, and “did not put things away”. She indicated that he provides minimal assistance with other housework because of the nature of traditional gender roles in the culture where he grew up:

“I’ve been married for what? 31 years. So I used to try and do everything because it doesn’t strike him that, you know, things to be put away or whatever, right? So, I used to just do whatever I could. So it was like I was doing two people’s things because for him, house is nice, he’s happy, but then he messes it all up, right? Because he doesn’t know how to put things away, or you know, when he cooks. So he’s too -- the kitchen used to be left in a mess. So I had to go and clean up. And one thing is now -- so I was new to this relationship too, so I didn’t feel that I needed to put him out, so I used to do it myself. [...] in the last maybe five years or so, I’ve been speaking out, you know? I mean, telling him that you know, he needs to clean up his own mess. And that I like to see the place the way -- so you know, there was some friction there because he wasn’t used to it because I’d allowed him to be the way he was for many years. And you know, I have two sons. My sons are not the most tidy people either. So, you know, I have had that stress, you know? Of trying to keep the home organised. I like to have a very nice home. And then if you have a nice home, you want to see it looking nice as well. So, my husband does cook but I found that because he leaves the kitchen in a mess, I’ve told him not to cook. I ask him to help me by cutting up stuff, so he cuts up the stuff and he leaves it for me. And then cooking is not very difficult, I just put it together. So he pretty much helps me, you know, like in preparation, food prep work [...] He does the groceries too, because I’m here at work, so he does the groceries. I give him a list and all of that. Sometimes he doesn’t remember, but with the phones it’s good, you can text the list and all of that, right? But, and I try to tell him to check the fridge but he doesn’t so anyway, I have to do all of that. He also...you know, generally the housework I do, like you know, the linens and all of that. So it is a lot because he never grew up doing housework chores like children here do because he grew up in Singapore. His mom was at home, so, you know, and I don’t know,



but he never -- it's not a priority. So that's how it is, you know?" (Participant 6, Manager, Female, VM, F/T )

The same participant went on to state that when her children were younger, the dynamics were more difficult because her husband did not support her. She indicated that she “had a bit of a hard time” training her children about organization, too but they “managed somehow”. One worker (Participant 12, Ancillary Worker, Male, VM, F/T) indicated he was the sole income-earner due to his wife living with disabilities and an upcoming surgery, and he did household activities such as washing dishes and cleaning the house.

## II. International Remittances and Financial Support for Extended Family Members

Survey respondents were asked about the portion of their income that was sent outside of Canada annually, if applicable, as international remittances. Almost half (48.9%, 43/88) of the survey respondents sent their income internationally (i.e. remittances to family or relatives), while 51.1% (45/88) of the respondents did not do it (**Table 8.2**). Of those who did send international remittances (n=43), 76.7% (33/43) sent over \$500 annually, and this was the most frequently selected quantity. The remainder (23.3%, 10/43) sent between \$0 and \$500. The survey did not ask the purpose of these remittances. While it is possible that these remittances may be financial support for extended family members, another possibility is investment (e.g. acquiring land, buildings, etc.)

**Table 8.2 - Survey: Income Sent Internationally Annually**

Amount	Frequency	%
\$0-\$100	3	3.4%
\$101-\$200	0	0.0%
\$201-\$300	1	1.1%
\$301-\$400	3	3.4%
\$401-\$500	3	3.4%
Over \$500	33	37.5%
Subtotal	43	48.9%
Not Applicable	45	51.1%
Total	88	100.0%



Interview data indicated that many participants reported financial contributions to relatives who are not children or spouses, such as parents, siblings, and in-laws living within and outside of Canada. One worker (Participant 2, Allied Health, Female, VM, F/T) said she occasionally sent money to relatives overseas as gifts, but she did not consider this to be a regular obligation or a burden because all of her siblings were located outside of the country of origin and everyone shared in the support. A manager, who provided financial assistance to her siblings, their families, and to in-laws, described her situation:

I: “Are you the primary bread earner in your house?”

A: “Yes. Yes, I am, actually. Plus I help my husband's family in [overseas country], which we constantly supported them and sent them money and unfortunately sent them more and more because his brother became sick -- cancer, last stage. So it means - it will cost us a lot of money and what I can say.” (Participant 29, Manager, Female, Non-VM, F/T)

The same worker also helped her mom and her brother's and husband's family:

“From first day I helped my mom. I need to send money to my mom, to my brother's family, and my husband's family. So we were supporting two families. So one salary was going out.” (Participant 29, Manager, Female, Non-VM, F/T)

One worker indicated that he had a sister in financial need overseas, but sometimes he was unable to help her:

“My sister in the Philippines. [...] This is the problem that I have right now, to see her. She's the only one I can't. [...] sometimes she is calling me and she needs the money, and I cannot afford to give -- send her money [...] Even a penny, I cannot send [...] It's very tough. It's very hard.” (Participant 12, Ancillary Worker, Male, VM, F/T).

Another worker indicated that prior to moving out of her family's home, she provided financial support to her sister who was studying in another Canadian city. Upon moving out, she described how she cared for her father after his surgery:

A: “Well before when I was staying with them, I was helping out. I was paying my sister's car [bills]. I've had to do two jobs and I did a lot of overtime here to make the money.



And now, because I've moved out, I'm with my fiancé, I tell him to work. Even though it's not enough I'm still looking for a second job because it's just expensive. Our rent itself is twelve forty. That's one paycheck of mine's already gone. Plus, I have a dog with me. Plus, like just our grocery and all that stuff, it's just ridiculous."

I: "[...] is your family ever requesting help [...]?"

A: "It's only been a month. So I have to wait for that call. But as soon as I moved out, every single day of the week 'Come shovel the snow because I kind of scared. Oh, can you come buy this? Can you come fix the TV? Can you take me to the doctor's?' Like it just started and I had to say no. Because I didn't have a car either because I had to like give my car to my fiancé. But now we finally got a second car, so that's me. Everything is me that pays the bills."

I: "There's no like male member of the family that would be shovelling the snow then?"

A: "No, because it's just my dad and me and my sister. And my sister lives in [name of Canadian city]. She's doing her veterinary in school there. So I was doing more the support of help. And my dad just had a surgery so he says 'Can you do all this stuff?' I'm like 'yeah'. So even then, they're old, right? You hear all these stories about people getting heart attacks when they shovel and stuff." (Participant 17, Nurse, Female, VM, F/T)

Another front-line care worker routinely sent money overseas:

"I send money home to my family. I grow up in a very close-knit family. My grandmother had three children and she raised all the children[s] children, so we all grow up in the same home. Now, my mother is the daughter of my grandma, so we came to Canada. The other stayed behind. But because of economic hardship, I used to support my grandmother and they were all living in the same [house], so you will send things to help my grandma. After my grandma pass on, I still continue to help them because they need the help and the other thing is that I intend to go back there to live, so I want to pay forward also 'cause when I get there who knows what life will dish out for you. So maybe my cousins' children might remember I used to help them because I pay for them to go to school, I help them with food, I help them with housing wherever I can. [...] Yeah, I lived on my own from 20, 21. But I - we grew up always helping each other, so it's like an obligation that you have to help the other ones that are not fortunate. You're fortunate to come out, so you share what you have. We always believe that you get blessed even more by sharing the little that you have." (Participant 31, PSW, Female, VM, F/T).

Another worker said she and her husband also routinely sent money to family back home:

I: "Okay. Tell me about what consumes the biggest part of your budget then?"

A: "[...] sending money for family back home [...] We have lots of families to support plus like the immediate family members plus extended family members that we have to help.



So we always have to send money and that takes up a portion plus the payment here like the bills, the mortgage, I have one now in university, as second one going in this year actually, 2017 September. Mama mia. So we kind of felt the stretch this year or last year, 2016 and we're kind of going to feel it more this year, so we're a bit on the stressed side when it comes to payment, but you know, we're thankful we're healthy. We can manage." (Participant 32, Manager, Female, VM, F/T)

She said her husband's relatives are overseas and are being supported by her husband, especially because without social support systems such as health care everything is paid privately, out of pocket:

"My husband's family, because he's basically the only one that supports, sends them money, and I'm the support for my parents. I have brothers that support them but we all kind of pitch in and help to make sure that their payments are. . .because my dad is retired. My mom never worked. He was a bank manager but back home there's no health support, like you have to pay for going to hospital, doctor visits, medications, all of that, and standards of living there is so expensive even though it's a tiny country." (Participant 32, Manager, Female, VM, F/T)

Another front-line care worker provided financial support for a widowed parent:

"Well right now it's only my mom because my dad passed away two years ago [...] But even then we still give them a little bit of money. Right now I'm giving \$50 a month for my mom and she appreciate." (Participant 34, PSW, Female, VM, F/T).

Another worker also sent money overseas to Asia when family members experienced an exceptional need:

"I have family back in [overseas country], but...I support them, but not on a regular basis. Yeah, not every month; but when a need arises, then I support them. Yeah [...] It's never like a pre-planned budget because whenever there's a need, then we provide. So we kind of adjust and cut down on our expenses, yeah." (Participant 35, Allied Health Worker, Female, VM, F/T)

Another worker (Participant 40, Ancillary Worker, Female, VM, P/T) sent money to a mother and sisters overseas on a monthly basis, but after ending a relationship and being reduced to one income, she was only able to contribute on "special occasions". Another ancillary health worker sent a substantial sum overseas to Asia every year:



“Basically not supporting but yearly I think \$13,000/\$12,000 has to be sent for festival [...] and recently my mom is sick, I gave them some money. They don’t need, everybody’s [...] I have to do this and you know, the festival we have a lot of relatives, my side and my wife’s side, so this is our culture, before the festival and before they eat we send everybody some money. So \$15,000/\$12,000 every year has to go.” (Participant 42, Ancillary Worker, Male, VM, F/T).

### ***Care Work for Family Requires Commitment***

In addition to financial support, participants performed care work for their family that required various forms of commitment. For instance, one manager had a mother in a nursing home and talked about how the care required a significant time commitment in personalized food preparation and cooking, and she indicated that it was a challenging few years:

“Yeah [my mom] she was in a nursing home and she needed a lot of care as well, so I used to go, you know, a few times a week to see her as well. And take care of her needs. We shared the responsibility as a family, but you know, sometimes you can’t just...you may have the things going on, but then her needs are also there, right? So it is, it was -- and then I was also not well, you know, and so it was, it was quite the challenging few years [...] She was in a nursing home for five years. So, and she had dementia so she wasn’t eating properly [...] they would try but they wouldn’t really go out of their way to feed her and make sure she eats, so we had to be there really to try and feed her. Sometimes it would take, you know, quite a while to get something into her. And then she would, you know, she would. . . she would find it really calming when we went. So, if that was going to make a difference in her day, especially before she went to bed. We just want her to make sure she was calm, you know? And she was able to sleep. We did have somebody who was with her as well. Like, a caregiver. [...] we just made the effort. I used to have to cook for her separately because she was not able to eat like, solid foods. So, she had to eat softened foods. And the pureed foods, she didn’t like it. So I had to like cook vegetables and stuff, like eggplant and you know, squash and things like that where she could easily swallow. [...] So that first used to be like on a Saturday morning, I used to have to do that as a separate job. And then after that I had to go and see her. So it would take a good portion of my day off, you know [...]” (Participant 6, Manager, Female, VM, F/T)

Guilt defined another worker’s care experience with her mother:

“I have an elderly mother who’s knocking on 80 and we’ve seen a decline in her cognition. So, she lives alone so I keep in touch with her a lot. She lives down the street. But I have siblings and we’re all very close with her so we all try but being the person - I stayed home the longest. My dad died when I was in my 20s and [...] [t]hat left my brother and my sister had already married by then. That left my brother and I. A year after my father died my brother moved out and it just left my mom and I. And I had a hard time, a lot of



guilt with wanting to leave and start my own life. So, I have only been on my own for the last three years. So, I have lived with her the longest so she is the most reliant on me.” (Participant 22, Support Staff Worker, Female, Non-VM, F/T)

The above example demonstrates how the participant wants to move on with her own social life, but care-giving guilt prevented them from pursuing this. As we shall see in the next section, it is quite common that LTC workers perceived problems with their social life and social relations.

### **III. Social Life and Social Relations**

#### ***Socializing and Barriers to Socialization***

This section presents the findings related to the social aspects of care-workers’ lives. None of the participants from Eastside Home indicated that work had a positive effect on their social life. Some participants often made an effort to protect and preserve their days off from work – e.g. the weekends – for social activities, either with friends or with their families:

“Oh, we make sure that every weekend we go out, you know. Every weekend. No absent of that, because that's the only time for the family, Saturday, Sunday. So I don't take any work on Saturday, Sunday.” (Participant 3, Allied Health, Female, VM, F/T).

Another worker, who held two jobs, reported that she had no time to socialize with friends. While she worked every day, she indicated she had a 3-week vacation and 9 days a year that she could book ‘day-offs’ to rest and to be with her children:

A: “[...] we have benefits here. We have 9 days a year.”

I: “Vacation?”

A: “No, no. Vacation I have 3 weeks. But I have day-offs. So all the day-offs, I have to rest. So I don't go anywhere. Or I spend [time] with my family. Usually half days I am at home anyway, no matter what. I have, I am with my kids. But, I work 7 days. Sometimes I take from -- I give my shift away.” (Participant 4, Nurse, Female, VM, F/T)

A PSW indicated that her work and family life are now balanced after both her and her husband stopped working two jobs, which was originally done in order to pay off her mortgage:



“Every other weekend my three sisters -- my one brother lives downtown. All five of us lives here in Scarborough. So there’s an occasion like Family Day, we are all together. We do potluck and summertime every weekend we do barbeque and plus we go summertime camping.” (Participant 34, PSW, Female, VM, F/T)

Many participants reported times when they would not socialize. One worker (Participant 13, Nurse, Female, VM, F/T) reported that she had no social life at the moment, but she also did not mind because she did not go out in winter because of the cold or at night because it would make her work more difficult during the day. Another worker who tried to keep up with relationships with friends found that work made it difficult:

“I try to make time to hang out with my friends. I would say maybe a couple a times a month. I -- it's really important just to keep up those relationships, but sometimes it's really hard with their schedule, my schedule. It's just life. That's the work life.” (Participant 14, Allied Health, Female, Non-VM, P/T)

A nurse reported that sometimes work and his dedication to his family left him with little time for his friends. He indicated he would have to sacrifice and “play big boy” i.e. a social role as a married man with a family, and forego social life with friends. Sometimes he would see what he missed out on through social media, and would get teased about it:

“I feel that I can use maybe a little bit of ‘me’ time. No, not for work, I said that, I think I already established that. Like, you know, whatever time I get for work, that's all 'cause parts of not being in a managerial. You swipe out, [and] you [only] worry about whatever needs to be done when you swipe in again. So, me time, why did I say ‘me’ time? There are times where you feel like your boys will call you up and now you have to play big boy now and say, ‘You know what? As much as I'd like to hang out, I enjoy my time with my family.’ And then you see a picture on Facebook, I was like ‘dang’. And then your partner will tease you about it: ‘you know you could have made time for that.’ ‘I chose to spend time with you guys and you're teasing me about it, dang, really?’ Things like that but it's not a big deal though, it's not.” (Participant 23, Nurse, Male, VM, F/T)

Like the above example, an ancillary worker said care for children took precedence over socializing:

“I used to have that, but I choose to having -- not having it now. 'Cause as my kids getting older, my kids need me more. So it's like I don't want to be like, nope, mom's going to go out. I'm not that kind of person. I always put my kids in first. So like, all my -



- like, I have friends here from work. And they're like, "Oh, let's go for coffee." And like, you know what? You know what? Or like even, another day, another day, 'cause I know I already have scheduled my kid [...]" (Participant 21, Ancillary Worker, Female, Non-VM, F/T)

A support staff worker talked about how work, school, and family left no time for friends:

"I don't really have, you know, lots of friends. It's because when I went back to school, I used to have friends, but then between family and work and school, right, so I have turned down many of their invitations, so they got fed up and then they just, you know, let me go. You know, but I mean it wasn't easy for me, because I was like, okay, this is my priority, I always have it and they think that; oh she's making excuses, she's making excuses, and this and that. So, I felt bad at that's how they feel, but and now they don't bother me anymore. So, I don't get invitations, I don't, well in a way there's, at least I get to spend time with my children, my family." (Participant 27, Support Staff Worker, Female, VM, F/T)

The above examples suggest that work pressures took a high toll on the lives of the participants, which meant they had to make certain social sacrifices. Although some responses might be perceived as prioritizing family care obligations over friends, some participants highlighted the importance of keeping up with friends, even though work schedules made this hard. Others expressed some resentment and remorse in their tone e.g. "*at least* I get to spend time with my children, my family" [emphasis added]. One PSW indicated how she and her husband had to work two jobs to pay off her mortgage and she could not afford more time with family. In the next section, I provide details about how participants coped with their work/life situations.

#### **IV. Coping, Resistance, Resilience, and Agency**

This section discusses the ways in which participants reported coping, resistance, and resilience strategies. The survey did not ask respondents about their level of participation in physical activity, and instead, this question was raised in the interviews. The rationale for this was that the meaning and extent of participation in physical activity could be revealed in more detail in interviews. The survey asked participants about smoking and alcohol consumption, which could be indicators of both personal health habits and coping mechanisms. The findings



are described below. Thereafter, I discuss other forms of resistance and resilience strategies that are extracted from the interview data.

### ***Smoking and Alcohol Consumption***

One of the survey questions asked participants if they smoke cigarettes daily, occasionally, or not at all. One person did not answer the question and was, therefore, excluded from the analysis. Of the respondents, 92.2% (83/90) indicated that they were non-smokers, responding with ‘not at all’. However, 5.6% (5/90) indicated ‘daily’ smoking, and 2.2% (2/90) indicated smoking ‘occasionally’ (**Table 8.3**).

**Table 8.3 - Survey: Smoking Status**

Smoking Status	Frequency	%
Daily	5	5.6%
Occasionally	2	2.2%
Not at all i.e. Non-Smoker	83	92.2%
Total	90	100.0%

The next question asked about alcohol consumption. Respondents were instructed to choose how often they drink alcoholic beverages over the past 12 months. There were seven choices to choose from, including an option to choose “not at all”. One person did not respond to the question and is excluded from the analysis. Of the 90 respondents, 56.7% (51/90) reported not consuming alcohol at all (**Table 8.4**). The most frequent consumption pattern was 2 to 3 times a month (14.4%, 13/90), followed by less than once a month (12.2%, 11/90). No-one reported consuming alcohol 4 to 6 times a week; however, one person reported consumption every day.



**Table 8.4 - Survey: Frequency of Alcohol Consumption**

Alcohol Consumption	Frequency	%
Less than once a month	11	12.2%
Once a month	7	7.8%
2 to 3 times a month	13	14.4%
Once a week	1	1.1%
2 to 3 times a week	6	6.7%
4 to 6 times a week	0	0.0%
Everyday	1	1.1%
Not at all	51	56.7%
Total	90	100.0%

Next, respondents were asked about the importance of cultural/ religious practices, spirituality, mindfulness, or meditation as a personal health practice or as coping strategies to deal with stress. The participants rated their response on a scale from ‘indifferent’ to ‘very important’, with the additional option of ‘not applicable’ (see **Table 8.5**). Two people did not answer this question and were excluded from the analysis. Of the respondents, 56.2% (50/89) rated these personal health practices as ‘very important’. 23.6% (21/89) rated them as ‘somewhat important’. On the other hand, 6.7% (6/89) said ‘not very important’, 4.5% (4/89) said they were ‘indifferent’, and 9.0% (8/89) said that these things were ‘not applicable’ to them.

**Table 8.5 - Survey: Cultural/Religious Importance**

Cultural / Religious Importance	Frequency	%
Very Important	50	56.2%
Somewhat Important	21	23.6%
Not Very Important	6	6.7%
Indifferent	4	4.5%
Not Applicable	9	9%
Total	89	100.0%



Next, respondents were asked about their religious affiliation. They were asked to choose from seven specific options, or alternatively they could choose “other”. Two people did not answer this question and were excluded from the analysis. The frequencies and percentages are displayed in **Table 8.6**. Of the 89 respondents, 65.2% (58/89) indicated that their religious affiliation was Christian. Other religious affiliations included: Muslim (11.2%, 10/89) and Atheist or no religious affiliation (11.2%, 10/89), among others.

**Table 8.6 - Survey: Religious Affiliations**

Religious Affiliation	Frequency	%
Christian	58	65.2%
Atheist or not religious affiliation	10	11.2%
Muslim	10	11.2%
Hindu	8	9.0%
Buddhist	2	2.2%
Sikh	1	1.1%
Jewish	0	0.0%
Other	0	0.0%
Total	89	100.0%

The data derived from the interviews suggests that participants’ resilience to precarity depends on four types of coping strategies as follows: self-care such as healthy eating and exercise (including walking, yoga, swimming, and going to the gym); spirituality (including mindfulness, meditation, solitary prayer, and communal worship); recreation (with family or friends), and; solitary recreation (including reading, listening to music, and watching television).

### ***Self-Care – Healthy Eating***

One worker said that she engaged in regular exercise and healthy eating habits, which she prioritized to the point where she shifted her life around these things:



“I’ve always been conditioned-- I guess to like – for exercise and stuff like that. Eating well, sleeping well. That to me is really important. So I make time for that. I sort of shifted my life with it though because now I go to bed super early and I wake up earlier so I get some school work done before I start here because I find it’s just easier for me to do rather than come home to do it because I’m tired.” (Participant 11, Trainee, Female, VM, F/T).

Another worker said that she had high blood pressure and she was borderline diabetic. Her doctor told her that her high blood pressure was likely from her stressful work whereas she attributed her diabetes to family history. She said in order to cope with work-related stress, she stopped taking her “work home”. She practiced healthy eating by growing some produce at home:

A: “High blood pressure and I think that was my doctor said it’s probably from the nerve from your job. That’s why I decided to separate my – no longer take my work home with me because I think that’s how I must have gotten it. But yeah, I have a high blood pressure. And I’m borderline diabetic but that runs in the family. Hopefully, I won’t get the disease but I probably will because most of the people in my family have gotten it.”

I: “Do you try to eat healthy?”

A: “Oh yeah, I grow my own. I make everything from scratch. I don’t buy any processed food at all because processed food has sugar and it has salt in it. They’re both real bad for you. They have apple ingredients and half of those, they just have funny names for them. But it’s still the same thing. It’s salt and sugar. They just have fancy names for them that’s all. Just call a spade a spade. You don’t have to have 60 trillion names for it. So there’s people who don’t understand what the hell you’re talking about unless you happen to be a professor or a scientist that know all about the stuff. And I’m skinny.” (Participant 9, Ancillary Worker, Female, Non-VM, P/T)

The participant went on to state that she relaxed herself by having a cup of tea, and as another health-conscious practice, she grew her own food:

A: “I usually just go home and just have a cup of tea and just sit down and think about nice things. The work that I have to do at home. I like to cook and I like to garden.”

I: “So you do that to keep yourself happy.”

A: “Oh yeah, every day I do my cooking. [Name of Family Member] says, ‘Where are you going?’ ‘I’m going to go enjoy myself.’ ‘Oh, you’re going to cook.’



I: “Oh, what about in the winter? If you’re not able to garden, what do you do if you’re not able to?”

A: “Oh, I grow all my fruits – all my vegetables all year long. And what I try to do is take the mint at the end of the year and sometimes they keep growing. Like I have my green peppers, my green pepper tree I brought in from outside. It’s still growing. I have a green thumb. I don’t know how I got this but the plants like to grow for me. I enjoy it.” (Participant 9, Ancillary Worker, Female, Non-VM, P/T)

Another participant stated that she tried to eat healthy, but she admitted that she also ate junk food sometimes:

“I am trying [to eat healthy] technically. I’m trying, because I can see, even me, I’ve never had any problem until 45, I ate anything I wanted, I did anything. But now, I need to watch, even me, so of course, but sometimes we’re just eating some junk as well.” (Participant 37, Support Staff Worker, Female, Non-VM, F/T)

Although the above participants indicated they ate somewhat health-consciously, one participant indicated she was unable to eat healthy exclusively because of the costs:

“I’ve tried to like eat like salad and like going to like the store to buy salad in a box. It’s like so expensive. So sometimes, it’s like, oh, I don’t have the money for that right now. So yeah, it’s expensive.” (Participant 15, Allied Health, Female, VM, P/T).

### ***Self-Care – Physical Activity***

Participants who were interviewed routinely reported engaging in physical activity as a form of self-care. For instance, one worker stated in the interview that she engaged in regular exercise as a social activity with her friends:

A: “So I work out with my friends like every three days.”

I: “In the gym?”

A: “Yeah, in the gym. We do like different [activities on different] days. So like Mondays, we would work on our stomach or something, and then Wednesday, our legs, and then -- and then, like, Friday, we just jog.” (Participant 15, Allied Health, Female, VM, P/T)



Another worker said she used walking, listening to music, and swimming as coping strategies to relax and destress herself, even in cold winter weather such as that in which the interview took place:

A: “I’m really into music. [...] I love music. I’m always listening to music -- when I walk to work, walk home. I swim, too. [...] It’s really relaxing.” [...] And I go for really long walks. Sometimes I’ll go for a walk for three hours if I need to just clear my mind. [...] I just find walking and listening to music is just a good way to clear your mind.”

I: “Okay. Even in the weather like --?”

A: “Yeah. Yeah. [...] I don’t mind. As long as I’m warm, I’m good.” (Participant 14, Allied Health, Female, Non-VM, P/T).

A PSW reported using exercise after waking up in the morning and before coming in to work:

I: “And you’re on your feet all day. Are you able to -- you’re -- I’m guessing you’re very tired. Are you able to do any [...] walking moderately or physical activity?”

A: “Well, what I do in the morning, I get up and I do exercise. I exercise for 45 minutes. [...] I do cardio. I have my exercise tapes, so -- and I do it three to four times a week. [...] When I go on my break, I try to walk the stairs. But that’s -- sometimes the feet tired, so I forget that.” (Participant 16, PSW, Female, VM, F/T).

One worker described regular exercise as his recreational activity which he pursued during the weekdays, and called it his form of entertainment:

“I mean, Monday to Friday I go to the gym. So, like, that’s [...] That’s entertainment to me, I guess. That makes it seem like I don’t do anything during the week but it’s, like, my own choosing, right? [...] Yeah, I weight train, Monday to Friday.” (Participant 26, Support Staff Worker, Male, Non-VM, F/T).

Another worker indicated that she engaged in regular, vigorous exercise to clear her mind:

“I’m just going. I like classes. You don’t need to think and you don’t have time to think because it’s the music loud. Everyone jumping and someone, you don’t even... That is why I love classes because you are in, that is, what, 45 minutes, one hour, you are not thinking about anything. If there’s no classes, then treadmills is the other one. Whenever you’re running or you, or just sometimes I’m just listening a book. On my phone, I have books and then I listen and then I’m not thinking about something else.” (Participant 37, Support Staff Worker, Female, Non-VM, F/T)



While the above participants engaged in physical activity, there were others who stated that they did not pursue it at all:

I: “Do you exercise?”

A: No, my metabolism is different like my sister, she’s twice the size of me. Her metabolism is different than me and she puts on the pounds. She’ll look at a cake and she’ll go like this. She always gets mad at me for that too. ‘Oh, you’re nothing.’ (Participant 9, Ancillary Worker, Female, Non-VM, P/T)

### ***Mindfulness, Meditation, and Spirituality***

Many workers reported that they used mindfulness, meditation, and spirituality as coping strategies. They consistently expressed that these practices were effective coping strategies because those practices allowed them to regain a sense of tranquility, calm, or centeredness after stressful events, and to achieve a tranquil state of mind before entering the workplace. Spiritual practices included participation in communal worship (e.g. church attendance), or individual prayer. One worker indicated that sometimes she used a dramatic method to regain her peace of mind:

“Sometimes when I get too stressed, I go in the wash room and scream. Well it relieves me.” (Participant 16, PSW, Female, VM, F/T).

Another worker took brief timeouts to practice mindful breathing when work became too stressful because she said she was becoming unhealthy and had chest pain:

“[B]efore in the past, I used to let it get to me. And I got sick of the stress. I had a lot of chest pains and I’m like, ‘No. I can’t not have stress get to me.’ When I close that door at 2 o’clock, I just have to let it go. And if I see something bothering me, I’ll just have to breathe and it’s like, it’s okay. Take my just two-minute break. I’ll just have a two minute. And it’s like, I think I’m going to do okay. So just move on. I have to -- just have to forget it. Because if you continue thinking about it, it’s not good.” (Participant 21, Ancillary Worker, Female, Non-VM, F/T)

Another worker also practiced mindful breathing to cope with stress:

I: “[S]o how do you deal with stress [...] what do you do exactly?”



A: “Well, I take deep breaths, breathing technique, you know, and then sometimes I need like fresh air or cold air on my face, you know. I don’t know, probably to brush it off, but and just to be quiet, you know, and eat.” (Participant 27, Support Staff Worker, Female, VM, F/T)

Mindfulness and meditation practices were sometimes ritualized:

“I love reading. And then, I have a little ceremony. When I know that I'm feeling stressed, I have a -- you know those candles, like [laughs] are they stress free or something, stress free candle. I have music. And I just lie down, just let loose of your body. Lie down, don't think of anything. It's a very good, like, yeah, meditation.” (Participant 2, Allied Health Worker, Female, VM, F/T).

A nurse used solitary contemplation to cope with stress:

“I don’t really meditate but I really just like to be on my own sometimes and just sit quietly in a room and not think about anything. I guess that’s my way of meditating, or just lay on the bed and just look at the ceiling, and just relax for like 10 minutes. Sometimes I fall asleep, sometimes I don’t. Yeah.” (Participant 7, Nurse, Female, VM, P/T)

While the above participants used non-spiritual forms of meditation and mindfulness as strategies of resilience, others indicated they actively used spiritual and religious forms of coping. An allied health worker, for example, said she used prayer as a coping strategy after negative interactions with people at work:

“We go to church every Sunday. [...] any prayers, yeah. It will help a lot. [...] Yeah, very helpful. Yeah, especially if you're so angry and you're so stressed with somebody, you just pray and then after a while you feel good. [...] Yeah. Because sometimes, you know, if you just get angry, you feel the, you know, it's not healthy. If you're -- especially if you're very nice and then somebody is, you know, freaking out like, wait, I'm being nice to you and then, yeah. So you just pray, you just pray for the person.” (Participant 3, Allied Health, Female, VM, F/T)

Another allied health worker said faith was really important to her and believed God could help in difficult times:

“I do pray. I go to church every Sunday. I'm Catholic. [...] Faith is really important. I believe God can get you through anything [...] even the hardest times.” (Participant 14, Allied Health, Female, Non-VM, P/T).



A PSW said she was religious and used prayer and hymns to cope with work-related stress:

“I go to church. I'm religious. [...] I'm not going to say I'm full-blown, but you know. [...] when you're stressed, sometimes you'll start singing a hymn. And before I come to work, I beg God to guide me through the shift and take me out here safely and bring me back -- you know, take me home” (Participant 16, PSW, Female, VM, F/T).

An ancillary worker prayed before she started her shift, and said that it made her feel great:

“I always pray when I come to work. And when I get to work, I'm going to thank God I came here safe and I -- when it's 2 o'clock, oh, thank you, God. It's over. Just go home. And there you go. [...] I feel relief. Like, stress free. Like, I feel like it's lightening your body. So I feel great.” (Participant 21, Ancillary Worker, Female, Non-VM, F/T)

A support staff worker said she used prayer to achieve a feeling of tranquility before going to work. She also stated that sometimes she would wake up from her sleep and start to think about her work, in which case, she would use prayer as a way to divert her thoughts:

“But for the most part I don't practice any form of yoga, meditation. I try to get myself centred every morning before I leave for work. I read a little prayer book. I read a portion of my bible. I have a little two, three minute prayer time, quiet time just before I come, take a deep breath. [...] It just calms me. [...] I just find it's a nice way to start my day. And some days I wake up late or I'm rushing and I don't get to do any of it and some days I can feel how that changes my day, I may be a little bit more irritable [...] at night [...] I can easily fall asleep sometimes but then I wake up and I'm thinking about work. Or you toss and turn a lot. So, I think I start praying but I'm not quite certain I ever finish the prayer, I think I fall asleep sometimes.” (Participant 22, Support Staff Worker, Female, Non-VM, F/T)

Another worker said she used prayer to deal with stress, prepare for work and attend church to recover from the stress of the workweek:

“I pray [...] we're very religious, you know, we're Catholic dominated people back home. So, I go to church every weekend, you know, with my children and, you know, even though I have so many frustrations here, you know, and then when I pray, it just releases everything, you know. So, for me it's, I get recharged, you know, emotionally and, you know, mentally so. Because I know I only have the weekend to recharge for five days, you know, for the next five days. So yeah, so I pray [...] every day while on my way here I pray while driving, it's like; Okay God, please guide me for my day today,



give me more strength, patience and, you know, to get by today, you know, and that really helps.” (Participant 27, Support Staff Worker, Female, VM, F/T)

Another worker described prayer and meditation as very important:

“I’m [religious affiliation], so it’s my cultural background and I like meditation and I like fasting, I like praying and mantras, repeated mantras, like really help me. [...] I feel - it’s a spiritual feeling. I do feel good because I’ve been practicing it from - as little as I know, so it’s something that bring peace to me and calm, tranquil, you know. It’s good for my soul and my mind.” (Participant 28, Support Staff Worker, Female, VM, P/T)

When asked about how one deals with stress, a manager indicated that she would have moments where she would just break down and cry. The participant also said she listened to music, prayed, and had the support of her family:

I: “Tell me about the level of stress and how you deal with it.”

A: “I think I cope. I try to cope. There’s moments when I just break down and cry. Crying for me is a good thing. [...] I pray. Prayer for me is a big thing. When I feel I’m too stressed, I pray. Praying helps a lot. Pray and music. [...] And family support. I mean my parents, very, very supportive. My husband, great support. Even my kids, you know, when they see me down, they kind of know and they kind of back off.” (Participant 32, Manager, Female, VM, F/T)

A nurse described worship as revivifying and compared it to that of a ‘drug’:

A: “Oh when I go to church, it’s like a really good [...] just to kind of get rid of all the external heaviness, it always kind of brings me back to centre [...] But going to church helps. [...] I’m on charge, I get to recharge, it’s like a rejuvenation [...] I sing when I’m really going – just got to sing it through, then I feel better, so church kind of recharges me, it kind of brings me back to what’s important and what’s love you know. It re-centers me back to reality, it’s like a drug [...] That’s my drug.” (Participant 38, Nurse, Female, VM, F/T)

Another nurse described prayer as a useful coping strategy for dealing with work-related stress:

I: “How do you deal with stress either in your job or family life?”

A: “Stress - I pray a lot. [...] So like if I’m worried about something and I would pray to God and you know please make this easy for me and stuff like that, and remove this problem from me, you know. So that’s one way. Another way is like I just - sometimes the stress is too - it’s very consuming, so I just - just unwind, just watch some TV, watch - you do something I like just for to get the time to pass you know.” (Participant 41, Nurse, Female, VM, P/T)



### *Drawing on Social Support from Family, Friends, and Others*

While participants used mindfulness and prayers as a way to cope, others indicated that they had very little time for those sorts of strategies, and instead drew upon social support and family and friends as a source of stress relief. For example, an allied health worker reported that time spent with a young son provided her stress-relief:

“My stress reliever's my son, you know. I make sure I spend time with him, because if I just, you know, if I went to the gym or go to the gym, you know the time is short that you're in, you should spend it with your son. You just read when he's, you know, he's playing, just read something that you know, self-help. That's it. My stress reliever's my son, you know. I make sure I spend time with him, because if I just, you know, if I went to the gym or go to the gym, you know the time is short that you're in, you should spend it with your son. You just read when he's, you know, he's playing, just read something that you know, self-help. That's it. (Participant 3, Allied Health, Female, VM, F/T)

A manager used conversations with friends and sisters as a coping strategy. She indicated that previously, her stress levels were so high, it affected her health and sleep patterns, to the point that she eventually resigned from her previous job. She revealed that she was personally against the use of medication because of their side-effects:

“Talking to my friends, you know, sometimes relieves the pressure. Talking and chatting. I have other sisters in other parts, not in Toronto, but you know, sometimes they visit and that kind of lightens the load a little bit. So you know, I know it's not always going to be like that, you know. So I just kind of manage. And I have had -- it was not recent, many years ago. Maybe, what? 15 years ago or thereabouts, I had a breakdown, actually. A stressful thing because I was trying to manage everything and I am a person who can't just let things be when I know they need attention. Need to take care of something needs to be taken care of, I can't just ignore it, I need to take care of it. So I have a high sense of responsibility. And so, it all got to me, you know? Eventually. And it affected me, and I think also the -- you give your best and when sometimes there's no recognition, I think that also kind of affects your stress levels, you know? Or value given. So, I knew I had to stop. Actually, I stopped working, I actually resigned from my [previous] job. [...] And I decided that I had to take care of my health because I had like, I couldn't go to sleep and you know, I had all of those things. So I kind of -- I don't believe in medication. Cause I know there are side effects” (Participant 6, Manager, Female, VM, F/T).



A nurse indicated that not only did she practice yoga at times, and draw upon on her faith, she also sought out social support, and coped by conversing with her pastor, her family and her friends:

“Usually if I have time, I usually go to yoga or I try something like that where exercise – sometimes you go off the track where you’re not doing it all of the time, then at that point it’s more of like a conversation where I talk with the people, my loved ones where we talk through things, like we always ask each other how our days were and if there were issues and we always do that at home, but otherwise then it would just be like my faith, so we’re Christian, so speaking to God about your concerns or your struggles or going to church and speaking to our pastor about currently what’s going on to seek guidance, I think would be our other avenue, but at this point any stresses I have here, I usually just work through with my family and just try to gain a different perspective. I also reach out to my friends that are also [job title], to try and gain a perspective on just come back to reality right, when you’re here alone sometimes things can become faded, so I try and seek social support like around me, or reach out further wherever I need to.” (Participant 10, Nurse, Female, Non-VM, F/T).

For one allied health worker, conversations with friends were helpful and relieved stress:

“I also -- talking just to like my closest friends, sometimes, have been the best help. They don't even have to say anything -- just listening sometimes, you just get it off. And then, you can forget about [it], right, once you say it.” (Participant 14, Allied Health Worker, Female, Non-VM, P/T).

A nurse indicated that she drew upon support by calling and speaking with friends and coworkers so that they did not feel isolated in their situations in which she would “vent” to manage the stress. She also indicated that they socialized with each other:

“I go on vacation. I just call up someone and I just vent. Or I vent to these people every day. Every day I see them I say this and this, and we walk in with that. Just to make it seem like we’re not alone. When you feel you’re not alone, it feels better. When you think it’s just you, you think ‘Okay, something’s going on.’ When all three of our PSWs – and we think we’re the same we’re like ‘Okay, this is good.’ And then you know we’ll buy food once in a while, like when it’s someone’s birthday I’ll get her flowers. Like we’ll do things for one another. I close the door, I’ll sit with my manager, we vent to each other. I listen to her venting and I realize mine is nothing compared to hers. So yeah, it’s just the feeling of not being alone.” (Participant 17, Nurse, Female, VM, F/T)

An allied health worker indicated she drew on support from her colleague:



“There's one [person] in my department -- we're really close. [We] started the same day, actually. [...] So we're pretty close. [...] We support each other all the time. We're always backing each other up. And whenever there's a problem with the management, too, we back each other up, which is good.” (Participant 14, Allied Health Worker, Female, Non-VM, P/T)

A trainee also spoke of “venting” to her boyfriend to alleviate stress because she did not have time for anything beyond this strategy:

“I don't...mentally speaking and stress speaking -- I don't think I take care of myself very well. I tend to vocalize my disdain for things and my opinions for positive and negative things. So if anything my boyfriend hears a lot about my stress and usually just venting is enough for me. I haven't tried to do anything beyond that mostly because I don't have the time to.” (Participant 18, Trainee, Female, VM, F/T).

Another worker had friends who worked in other LTC facilities, and they would meet and commiserate to de-stress. Other than this, the participant indicated that perhaps stress was a part of the way she worked and lived now, indicating the level of precarization she experienced:

“[...] venting -- a lot of my personal -- like my friends outside of work all work in long term care. So, probably 90% of them work in long term care and we just chat. You know, everybody has a best friend, you call your friend, you chat, you complain about the day. That's about it. You know, the odd time you get together and over dinner as you meet with friends and everybody has a chance to complain about their job or talk about the funny things that happened at the job, that's it. Other than that really it is just sometimes the best distress is just to sleep it away. And if I can get into bed and my head can get into a space where I can fall asleep, I always figure the next day's got to be better. It can't get any worse. And if it gets worse I just say that the next day's got to be better. It can't get any worse. We have to tell ourselves that. Or you know what? We'd be quitting every other day. So, it's just I don't know how I deal with it. Sometimes maybe it's just stress is routine which is really scary but when you're used to being in a stressful job I don't think you know any different. So, I may not have a tool, I think it's just the way I live my life now.” (Participant 22, Support Staff Worker, Female, Non-VM, F/T)

A different support staff worker said he would read a lot and talked with a close friend to “unwind”:

“I just -- I read a lot. [...] My roommate is a smart guy too, so we can have discussions about the world, or politics or stuff like that. [...] That's -- I guess that's how I unwind. [...] And then there's some guys that we hang out with on the weekends. Other than that, see the guys from back home every now and again.” (Participant 26, Support Staff Worker, Male, Non-VM, F/T).



A PSW indicated that she had a ritual in which she would go home after work, shower, pray, look at her iPad, go to bed, and then speak to her husband in the morning:

“Go home. I won't talk much with husband. Morning only, I talk to my husband. I open my iPad, look some series or music, reading or something like that; then I go to sleep. Morning only I get up and talk to my husband. After I go from here, I won't talk to anybody. Take shower, pray, then I go to the bed.” (Participant 36, PSW, Female, VM, F/T).

### ***Solitary Recreation***

Many interview participants reported that they used solitary recreation as a coping strategy and indicated that they engaged in five forms of solitary recreation, including: watching television, reading, listening to music, engaging in a hobby (e.g. participants engaged in photography, singing, or playing the piano), and traveling.

A nurse spoke of watching television as a way of relaxing after work:

I: “And how do you then, like, at the end of the day you said you want to soak off in hot water. What do you do then to relax and – ”

A: “As soon as I get home I just have to eat, watch my movies or watch my TV series for a little while and I'll be fine. I'm back to myself.” (Participant 30, Nurse, Female, VM, F/T).

A manager watched movies on the home television and watched YouTube videos to purge negative emotions:

“Sometimes I put a movie, like a drama movie that I want to cry or watch YouTube videos that I just break in tears. Always my kids watch me because when I'm seeing something and I start tearing, they just look at me, ‘Okay, she's going to cry now.’ They don't know the stress of my day. I like music. Sometimes I just pump it so loud in the car and it just give me this relief, you know?” (Participant 32, Manager, Female, VM, F/T)

An ancillary worker said: “[...] for mental repression I watch TV” (Participant 42, Ancillary Worker, Male, VM, F/T).

A PSW said she liked to listen to music and watch movies to de-stress:



I: “You said you listen to music. Is that cultural music or -”

A: “Yeah, yeah. I’m [cultural background]. You know, movie – we have the movies. I love to listen some music; same time, I have our religious song, too. That’s especially Friday.” (Participant 36, PSW, Female, VM, F/T).

A nurse took short vacations when work-related stress became intolerable:

A: “I go away when it gets too much, I’m off somewhere, I’m just like itching, I need to get away. When I’m stressed I start to be very irritable, I’m argumentative, I don’t want to hear what you have to say because I’m just – I had enough of you, doesn’t matter who it is, I’m just like God. I get tired, that’s when I get tired because I’m just like I’m done, I need a break and when that happens I know I need to go take time off or take a trip, I just need to get away because I’m boiling, you don’t want to boil in situations I just – I know my cue and I just do it.”

I: “You like to go particular places or do you go any --?”

A: “Niagara Falls or take a trip to the [overseas country] or just stay home, take a – for a couple days I just stay home, but I can tell when my stress level is not normal, it’s getting – I’m antsy and I’m bitchy and I’m – I don’t do as much of production as if I’m – no I don’t focus and I get mad at every little thing and I – they say and I said be because I’m just fed up – no because it’s bad, I just – I’m stressed.” (Participant 38, Nurse, Female, VM, F/T)

## V. Discussion

The findings presented throughout this chapter reveal that the majority of front line care workers, who are racialized workers, immigrants, and women, provide private care in their own lives while juggling the responsibilities of paid care. Paradoxically, the low status and low-remuneration of many frontline care workers from Eastside Home, which was discussed in detail in the previous chapter, do not reflect the realities of their production efforts and numerous skills, but rather stereotypes. For example, while women workers are sex-stereotyped as being good carers, they are negatively stereotyped as having high absenteeism, uncommitted to their work, unproductive, not career-oriented, or wanting few responsibilities and pressures (Armstrong and Armstrong, 2010). Yet, as we see from the evidence, these stereotypes are far from the workers’ realities. Most of the workers are deeply committed to paid care duties (e.g. they worked past



their shifts, and did not take breaks or rest periods), and yet, as shown by the new evidence in this chapter, they are also deeply committed to their private duties. Some of the participants have dependent children as young as 1 year old.

The findings also show that these LTC workers' wages are utilized in childcare, post-secondary education for their children or relatives, groceries, and housing for themselves and their families. Childcare expenses were described as "terrible" and like a "mortgage". Many workers wished to help their family, possibly through transnational kinship obligations (Singh, Robertson, and Cabral, 2012) but could not afford to do so. Many who had come to Canada as immigrants sent remittances internationally to family members.

The literature suggests that such remittances can be comprised of a number of things. For example, Singh, Robertson, and Cabral (2012) show that remittances can be community-based gifts such as money sent to religious institutions, money sent to villages of origin and clans for infrastructure projects or disaster relief; or they can be occasional amounts sent for emergencies triggered by crisis or illness; repayments of family debt; gift money for celebrations and life events; personal and family investments such as land and buildings; or regular amounts of money for a transnational family. Transnational family consists of members who are left behind in the countries of origin (Baldassar, Baldock, and Wilding, 2007). Although transnational families are separated by international borders, geographies, as well as distances, they are held together through bonds of collective unity, welfare, and family-hood (Bryceson and Vuorela, 2002). Transnational family experiences can involve rural to urban movement of working class (im)migrants from South Asia, East Asia, Southeast Asia, as well as South America and the Caribbean to North American and European cities (Georges, 1990; Grimes, 1998; Tacoli, 1999;



Mahler, 2001; Goldring, 2004; Ryan, 2004; Sana, 2005; Zelizer, 2005; Parrenas, 2006; Schmalzbauer, 2008; Singh, Robertson, and Cabral, 2012).

Although the findings do not provide in-depth accounts of the senders' perspectives, for LTC work, they are new and they establish a starting point for deeper examination of these issues in future research. For example, an amount of \$500 annually (which was the most frequent selection) might be established as a minimal threshold. Given that many participants report insufficient incomes, one could also investigate funding remittances through debt, which has been found in previous research (e.g. Singh, Robertson, and Cabral, 2012). Another area for research could be examining the relationships between remittances and how they are shaped by social relations and cultural values (*ibid*). Furthermore, one could also examine how remittances are sent (e.g. through networks of trusted agents) and when remittances stop (e.g. family reunification or death of the recipient) (*ibid*). There are also gendered perspectives that can be investigated, such as the perception that money is a medium to care /take care of families and sustain relationships in the home country, as well as gendered patterns among senders or recipients e.g. senders are often male (*ibid*).

Finally, the findings reveal important information about how participants rely on cultural/religious practices, spirituality, mindfulness, meditation, and personal health practices or coping strategies to deal with stress. The majority of respondents indicated they were non-smokers, and did not drink at all -- but those few who did smoke were born outside of Canada and were women. Those who reported drinking alcohol were also mostly women, were racialized, and were likely to be reported among PSWs. This latter finding is anticipated given that these groups made up the majority of the sample.



Many participants indicated that they routinely engaged in physical activity as a form of self-care, as well as mindfulness, meditation, and spirituality. Others indicated that they simply did not have the time for these things and relied upon social support from family or friends, or solitary recreation as a source of stress relief. These findings shed light on under-researched areas of how faith, social support, and other tools are used by workers to engage with coping, resistance and resilience, and are crucial for understanding SDoH and the conditions under which workers can access their preferred health/wellness practices. Understanding these particular cultural practices, resistance/resilience strategies, and how agency is expressed also point to possible directions in shifting the current framing of the [S]DoH field that may not be reflective of particular ethnic, religious, and cultural groups.

## **VI. Summary**

The evidence from this chapter demonstrates several important points that are summarized in **Appendix 8.1**. Firstly, it demonstrates the workers' dynamic responsibilities, and deep levels of involvement and commitment to their duties, despite the fact that their work (both unpaid and paid) is often labor-intensive, highly stressful, and often takes a toll on worker's health and wellbeing. Secondly, while the workers are remunerated for their care work in Eastside Home, the analysis reveals that many of the workers must rely upon their own resources for support in order to deal with the hazards stemming from their stressful, labor-intensive positions. Finally, the analysis indicates that workers are also drawing upon support from a variety of sources, including their co-workers.

This chapter also presents findings related to the dual demands of care, which include unpaid care for the family, such as for spouses, relatives, dependent children, or grandchildren. This care occurs in addition to the demands of paid care work performed in the nursing home. The data about the workers' social life and social relations reveal personal sacrifice, dynamic



responsibilities, and deep levels of commitment to care duties, both in the paid and unpaid work environments. The analysis further reveals particular behaviors (e.g. cigarette smoking, alcohol consumption), which occur in females and/or immigrants, respectively, and also reveals cultural/religious importance among respondents. The findings from this chapter also demonstrate the ways in which workers exercise resistance and resilience to their often precaritized circumstances and reveal their coping strategies. These strategies include: self-care, spirituality, recreation with family or friends, and solitary recreation.

This case study demonstrates and renders visible the variations in the levels of precarization among the workers at Eastside Home, and their immediate or transnational families. Given the level of care that LTC workers are required to do, and given that most workers in Eastside Home are unionized and in full time positions, it is interesting to see how much the topics of finances, financial support, education, paid childcare -- and topics that intersect with income, housing, food security, and other SDoH -- surface in the interviews and survey responses. For instance, interviews with some of the workers exposed not only underemployment (i.e. having qualifications and experiences that exceed their work e.g. Participant 42), but also vulnerability in SDoH issues such as food/shelter, education, finances, as well as services such as childcare. Depending on socioeconomic class, there is also the necessity of two-income households in order to meet the financial demands of raising children and supporting extended family.

The next chapter will contain the concluding remarks and will discuss how care work should involve acknowledging and addressing vulnerability to precarization. However, this concept can be challenging to unpack in a context where there is stigma and sex-stereotyping of workers, such as the essentializations that women are uncommitted to their work. This is



complicated by the fact that work-stress and workloads in the LTC sector can become overwhelming, and strategies to address these issues are often limited to behavioral modification rather than including a holistic approach, which considers income, employment, education (i.e. socioeconomic status), and other SDoH. In order to manage care and care work (in this case, the care work that occurs in the LTC facility), there needs to be commitment to total worker health and wellbeing, which involves the home, family, and community of the workers. Furthermore, given the diversity of care workers in this region, such approaches need to be culturally appropriate, and adequate supports must be provided to the workers. This means that not only do services and provisions need to exist, but they also need to be available, affordable, and accessible to the workers who require them. When such services and support systems are made available to workers, they can perform the work better, safely, with less of a personal toll on their health and wellbeing, and with better outcomes for the recipients of care.

In the following chapter, I discuss my conclusions as well as some policies to address these issues and implement and advocate recommendations for change. I will also discuss the importance of the findings from the earlier chapters, the ways in which the findings make contributions to the content, context and theory literature, and discuss what is needed and what should be done with the findings as a part of the concluding remarks.



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**Chapter 9: Conclusions – Theorizing Precarization and Racialization as Social Determinants of Health**

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**Introduction**

This dissertation uses an anti-racist feminist political economy framework to investigate precarization in an urban region of Toronto, Ontario. I conducted a single-case study of workers in a LTC home. The mixed methods research design included a qualitative component consisting of observations and in-depth, interviews. This approach was undertaken in order to draw upon multiple forms of data about the workers' occupational health, safety, and wellbeing to better understand the process of precarization. The analysis included the various job titles/categories of workers, the roles undertaken by each of the workers, and the narratives about the workers' experiences of paid and unpaid work, among other things.

The research presented within this dissertation confirmed some of the expectations about precarity and precarization, and also revealed some unanticipated findings. Firstly, it was anticipated that understaffing, high workloads, work intensification, time constraints, and work-related stress would be major themes and concerns for the workers, and that gender and race would be equity issues in terms of wage adequacy, food security, housing, working/living conditions, and health and wellness outcomes. These findings were highlighted in chapters 6, 7, and 8.

Secondly, it was also anticipated that the workers in Eastside Home who held some of the most economically vulnerable occupations, which were often reflected by their job titles, faced additional challenges in managing various demands. However, the extent to which the workers' personal histories, backgrounds and social relations would be uncovered in their narratives was not expected. Furthermore, the amount of international remittances was also surprising given some of the budgetary challenges that workers experienced in the local (and often expensive)



region of investigation. Gender inequities regarding urban and racialized women's health and wellness issues were anticipated and these were confirmed by the evidence, but it should be noted that these issues also affected racialized men at this site of study.

The LTC literature speaks volumes about the commodification of care work and the low-status, low-remuneration accorded to frontline workers who are often racialized men and women. There are also concerns about precarization among these workers, so observing how these processes intersect and operate was an interesting and under-researched area of investigation for this case study. While observing the practices of the commodification and sale of labor in the market (Esping-Andersen, 1990), it is also apparent that there is a parallel commodification and decommodification of women's paid and unpaid labor, respectively, that may be reflective of the local/provincial health sector.

Using the intersectionality of feminist political economy of health and anti-racism lenses, the process of precarization was unpacked in this dissertation by analyzing the experiences of individuals who worked in a LTC organization, which I referred to as Eastside Home. The experiences of these individuals were connected to research of occupational health, safety and wellbeing, social determinants of health ("SDoH"), and to policies and practices of LTC organizations, and other literature. Precarization is an increasingly normative experience because of the subtle ways in which it is injected into workers' personal lives and their work experiences, yet its impact is so profound that it supports evidence of chronic stress and illness among workers.

After exploring the critical literature about precarity and precarization, and LTC work; providing descriptions of the theoretical assumptions that framed this dissertation; and outlining the research methods; the remaining chapters of this dissertation were organized based on the



concepts that were revealed from the data. Some of the major concepts that were investigated were as follows: the manifestations of precarity and precarization in an urbanized and diverse area of Toronto; the gendered constructions of LTC work; the complexities of carrying out unpaid care work and domestic demands; immigrant and racialized persons' experiences of working in the health sector; the implications for health and wellness outcomes; and the interactions of space, race, and culture. The results of my research contribute to several key areas of scholarship and also provide data that can be used by a variety of stakeholders, including: policymakers, health care professionals, organizational change theorists, health researchers, community activists, and social scientists.

The precarization of employment means there is also parallel precarization in food security, in rent and housing, in health and social care for workers in education about chronic illness and occupational cancer prevention; and in immigrant and racialized workers' accommodation and acculturation; and in support systems for social mobility of workers as evidently extracted from the lives of my participants and yet, these issues receive less public attention than lifestyle and behavioral factors such as diet and exercise interventions that are stated to influence worker's health and wellbeing.

## **I. Contributions to the Precarization/Precarity/Precarious Work Literature**

This case study is grounded in the critical literature about work, health and wellbeing, with a focus on precarization, precarity, and precarious work. As indicated in the beginning of this dissertation, precarity is a term that reflects particular conditions of employment among vulnerable workers, and highlights economic and existential experiences of uncertainty and risk (Neilsen and Rossiter, 2008). Precarization, as a process, is understood broadly to include political, economic, social and health domains, and is characterized by labor intensification.



While precarity and precarious work, in their traditional meanings, are not usually applied to all workers, such as those working in full-time, unionized jobs with benefits, and who do not work through agencies, precarization can be applied to these workers. Precarization (or precaritization) can also be connected to the SDoH, and it can offer an alternative way to understand the continuum in which workers experience vulnerability in their living/working conditions.

The purpose of this study is to make an original contribution to the precarization/ precarity literature, and to contribute to knowledge of occupational health, safety, and chronic illness among women, immigrants, and racialized populations. There is an emphasis on understanding paid and unpaid gendered work experiences; examination of social and economic situations; examination of the ways in which the work may be precarious; structural and systemic risk factors of illness, disability, and discrimination; post-migration experiences; experiences of settlement-related setbacks such as transfer of skills and credentials into the Canadian employment system; and forms of resistance, coping strategies and social support in response to workers' situations. As a result, the findings and analyses offer several contributions to these aforementioned areas.

The topics of precarization/ precarity were introduced in chapter 1 and several gaps are identified from the literature. These gaps include: minimal amounts of mixed methods Canadian data; limited attention explicitly paid to the intersections of race and immigrant status with gender; minimal content about the roles of racialized/immigrant people's waged labor and unpaid care work; inadequate data about how precarization/ precarity function in everyday life and how it is connected with the SDoH; and minimal content about how these issues might be manifest in an urban geographical context. Given that precarization/ precarity are a rapidly spreading reality for many people in Canada, and that it is known to affect workers in the health



sector, there is growing recognition and need to contribute to the knowledge of how precarious conditions are experienced, especially among racialized and immigrant workers. There is also a need to investigate the connections between precarious work with particular types of chronic health risks, such as: shift work and occupational cancers; mental health hazards; physical hazards; examining workers' knowledge of these hazards; examining how chronic illness is experienced in the workplace; examining sources of stress; and exploring coping mechanisms. The research from this dissertation provides mixed methods Canadian data that speaks to each of these under-researched areas of work, health and wellbeing that operated at the level of a single-case study of workers at a LTC home.

This study explored the process of precarization with respect to employment and working conditions. It recruited workers from a specific area of the healthcare sector (i.e. those employed in LTC work), and focused on interpreting everyday paid and unpaid care work experiences in order to contribute to knowledge of health and chronic illness among women, immigrants, and racialized populations. The main thesis questions were as follows: How do racialized and immigrant workers experience work in residential LTC? In what ways (and why) is precarization occurring in LTC? Are there gender differences? The rationale for this study was to contribute to occupational health and safety literature, and care work scholarship so that it may lead to policies or interventions that minimize the burdens of precarization and chronic illness in the Canadian workplace.

## **II. Contributions to the LTC Literature**

This section discusses a number of contributions that are relevant to the LTC literature. These contributions are organized as follows: racialized and immigrant people working in LTC organizational structures, hierarchical work relations, weakened labor relations, workload



intensification, staffing challenges, time pressures, and stress. Although gender is mentioned here briefly, it is discussed in greater detail in the section about the contributions to feminist political economy of health literature.

***Racialized, Immigrant Labor in LTC Organizational Structures***

As indicated in the Canadian care work literature, a significant amount of care work is performed by racialized and immigrant people, especially in urbanized areas. The research presented in this dissertation supports this literature, and it also provides a reasonable quantitative estimate of the proportion of workers from these backgrounds. For example, the findings from the survey in chapters 5 and 6 indicated that a majority of the participants were immigrants; and were racialized. The findings from the interview data paralleled those of the survey.

Another contribution of this dissertation is that the evidence presented supports research that particular groups inadvertently participate in the ‘4Ds of precarity’. The 4Ds of precarity refer to work that is dirty, difficult, dangerous, or damned, and is often carried out by migrants and racialized people (Rodriguez, 2010; Standing 2011; Syed, 2015). Most other people are unwilling to do this type of work because of these aforementioned circumstances combined with low remuneration. For instance, Armstrong, Armstrong and Scott-Dixon (2008) recognize that care work pays very little and also involves socially undesirable responsibilities such as cleaning feces.

Research shows that racialized immigrant women tend to do the work in the lowest sectors of the health care labor force (Ng, 1996; Dossa, 2009; Galabuzi, 2006; Glenn, 1992; Armstrong and Armstrong, 2001; Das Gupta, 2002; Cranford and Vosko, 2005; Vosko, 2005; Armstrong, Armstrong, and Scott-Dixon, 2008). They are also often responsible for tasks



associated with domestic, household labor and skills, such as ancillary and caregiving work (Armstrong and Laxer, 2005; Cranford and Vosko, 2005; Armstrong, Armstrong, and Scott-Dixon, 2008; Armstrong, 2013b). In addition, they typically have low earnings, little benefits, few regulatory protections, and limited control over the labor process (Cranford and Vosko, 2005; Daly, 2013). Racialized women also often experience unique industrial segregation and occupational polarization as long-term care workers, nannies, domestic workers, and caregivers in Canada (Glenn, 1992, Arat-Koc, 1997; Bakan and Stasiulis, 1997; Gabriel, 1999; James, Grant, and Cranford, 2000; Das Gupta, 1996; Das Gupta, 2002; Cranford and Vosko, 2005; Galabuzi, 2006; Daly, 2013).

Evidently, it is often vulnerable groups such as racialized and immigrant men and women who tend to do the ‘dirty and dangerous work’ in LTC that many others are unwilling to do because of these characteristics as well as its low-status and low-remuneration. The findings from chapters 6 and 7 contribute to this literature and also speak to the health-compromising dangers that are exhibited in a precaritized workplace.

### ***Market Level Policies and the Neoliberal Model of Care***

Another important contribution of this dissertation is to the literature about the market-level policies and practices that are reflected in the working conditions of LTC organizations. These working conditions are described in more detail in the subsections below. While these market-level policies and practices have emerged locally, they are often also present across the province, nationally, and internationally. These policies and practices are shifts in response to globalization, neoliberalism, and market migration (Syed, 2015). Many workers are exploited in the labor-power exchange through these processes. Such labor exploitation continues as a



number of vulnerable workers from marginalized groups end up working in precarious occupations.

### ***Hierarchical Workplace Relations in LTC***

The findings support the existing scholarship indicating racialized and gendered hierarchical relations and inherent contradictions in LTC organizational structures. These hierarchical relations and contradictions exist when the job titles, status, and remuneration are not reflective of the workers' high-skill sets or experiences that are otherwise applied to the work on a daily/ nightly basis. Moreover, marginalization into particular front-line health-care occupations is maintained by structural processes that profit from the low-wages paid to the workers in these health and LTC organizations, and they unscrupulously benefit from the inequalities experienced by these workers. They frequently accord higher remuneration and higher status to non-racialized, non-immigrant, non-female, and elite workers, while the remainder of the workforce, as indicated by the evidence in this dissertation, often lives by a hand-to-mouth scenario. This was frequently reflected in the differences in basic socioeconomic status indicators and social mobility between racialized frontline workers and non-racialized management structure at Eastside Home. It was also confirmed in the discourses in chapter 7, for example, in the abilities of some workers to be able to pay for healthy food, take vacations, own homes, automobiles, and other assets, versus other workers barely being able to pay for shelter/living costs and barely having money left over to purchase groceries.

LTC workers are often arranged in a team, and this team requires interaction and integration between and among the providers of care (Armstrong, Armstrong and Scott-Dixon, 2008). However, in LTC organizations, the team is often hierarchically arranged, individual-oriented (Kontos et al., 2010a; Day, 2014; Syed, Daly Armstrong et al., 2016), and gendered (Hallgrimsdottir et al., 2008; Day, 2014). For example, the work that has to do with physical



tasks, manual labor and the human body is accorded low status and poor remuneration, often falling on the shoulders of PSWs rather than registered nurses, physicians, and other health professionals (Diamond, 1992; Twigg, 2000; Twigg, 2002; Gordon, 2006; Day, 2014). These hierarchies reflect the organization of care work under a market model, which seeks to control care labor through standardization, measurement, and documentation of care tasks while prioritizing and maximizing profits (Leduc-Browne, 2010; Daly, 2013).

### ***Weakened Labor Relations in LTC***

The research evidence that is discussed throughout this dissertation confirms the market-level policies and practices of care work, and demonstrates a notable weakening and pull away from collective mobility, collective social policies, and a push towards individualization, including emphasis on individualizing policies and practices that are one of the underlying sources of stress for workers. As noted in the findings in chapter 7, these policies and practices also affect the health, safety, and overall wellbeing of workers. This situation was powerfully demonstrated by one of the housekeepers who suggested that her overall wellbeing was affected by wage-stagnation that was directly associated with ineffective collective mobility, weak labor relations, and weak union negotiations with the employer.

The findings from this dissertation confirm some of the previous research of LTC work, such as: workload intensification; high workloads; staffing challenges; (Armstrong and Jansen, 2003; Daly and Szebehely, 2012; Syed, Daly, Armstrong et al., 2016), job stress (Armstrong et al., 2009; Zaman, 2012; Syed, Daly, Armstrong et al., 2016); categorization of LTC workers' jobs (and particularly women's jobs) as "unskilled" (Armstrong, 2013, p. 102); precarity among ancillary staff (Armstrong and Laxer, 2005); and work-related injuries and illness (Armstrong and Daly, 2004); some of which are described in detail below.



### ***Workload Intensification***

The research findings support a growing body of literature that questions the deregulated nature of LTC work, and the problems associated with intensive workloads in general. Workloads belong to the category of job-demand factors (Karasek and Theorell, 1990; Moen, Kelly, and Lam, 2013; CCOHS, 2014). The findings from chapter 7 demonstrated that there were significant job-demand issues at Eastside Home, with almost all participants reporting high workloads that prevented employees from taking basic meal breaks, and resulted in skipped rest-periods. High workloads and job-demands were also associated with staying back/ remaining at the site beyond the contracted work schedule, and yet there was no remuneration. One worker indicated that it was unacceptable that she was required to be available 24/7 on-call, and this worker, along with many others, also reported working up to several hours past the time that their shift ended, yet they were unpaid. The latter point highlights some of the problems of ‘working from home’, yet with no remuneration, but still required significant work effort, and was also unregulated.

### ***Staffing Challenges***

The research evidence supports the existing and ongoing tension related to healthcare (and specifically LTC) understaffing versus managing budgets and saving money through particularly harmful fiscal measures, such as reduced hiring practices, and freezing new recruitment/employment. These measures have been recently implemented in the public service sector in Ontario by Premier Doug Ford. An overwhelming majority of participants in chapter 6 expressed that if they could change their work situation, it would be by adding more staff to help with workloads. A housekeeper indicated that the expectation was that the work should be completed by a single employee, despite the fact that it demanded an effort of three people.



These working conditions in Ontario are shaped by a market-model and by broad neoliberal ideologies and interests that involve individualization, profit-maximization, privatization, and cut-backs (Day, 2014). The neoliberal model of care is characterized by the application of market principles of supply and demand to the organization and function of care work (Daly and Lewis, 2000) and often under a guise of efficiency and elimination of wasteful resources (Daly, 2007; Armstrong and Armstrong, 2010). Under the neoliberal model of care, services in LTC facilities are often contracted out in order to control costs, and includes the adoption of for-profit business-oriented managerial techniques (Daly, 2007; Armstrong, Armstrong, and Scott-Dixon, 2008; Seeley, 2012).

The neoliberal model of care narrowly conceptualizes care as quantifiable, physiological tasks that are counted, measured, and sold as if they are packaged products to consumers of care (Knijn, 2000). In order to maximize profits, this market model of care focuses on cost-cutting, which has troubling implications for LTC workers (Day, 2014). It results in reduced staffing, and work that relies upon both the paid and unpaid labor of poorly remunerated and low-status care workers, who are from various social locations marked by gender, race, and class (England and Folbre, 1999; Duffy, 2005). The resource-constraints under the market-model of care, and a rise in the acuity of residents have translated to high workloads and workers' exposure to health and safety hazards (Armstrong and Jansen, 2003; Baines, 2006; Banerjee, Daly, Armstrong et al., 2008; Morgan, Crossley, Stewart et al., 2008; Day, 2014).

### ***Time Pressures***

Time pressures belong to the category of job-demand factors (Karasek and Theorell, 1990; Moen, Kelly, and Lam, 2013; CCOHS, 2014). Time is also bound to issues of workloads and staffing levels (Bannerji, 2010). As highlighted by Bannerji (2010), LTC workers need time



to provide care, yet many experience significant impediments in achieving this. Care cannot and should not be rushed (ibid). The findings from chapter 7 support this existing research that problematizes rushed care, and demonstrates that workers struggle to balance time in LTC organizations. The findings from this study also contribute to the literature of psychosocial job-demand factors that can modulate workers' health and wellbeing. For instance, time pressures/ not having enough time were bound to high levels of stress and adverse health outcomes, as reported by the workers.

### ***Stress***

The findings about stress contribute to and support the existing literature suggesting that LTC work is highly stressful. This study demonstrated that an overwhelming majority of workers (87.6%, n=78 out of 89) reported at least some level of psychological or psychosocial stress from their work, as indicated in chapter 6.

One of the unique contributions about this study to the LTC literature is how workers attributed their work-related stress to physical strain and physical health symptoms. For example, interview respondents reported that work-related stress affected their physical health, which resulted in a variety of physiological symptoms such as: sleep disturbances, weight loss, gastrointestinal issues, and cardiovascular problems. Survey respondents indicated that the most common site of any physical symptoms or strain occurred in the back, followed by head/neck, and knees, and this was often exhibited in frontline care providers. The evidence from this project suggests that work-related stress is a consistent and chronic health hazard for many workers involved in frontline LTC work. These findings also confirm the hypothesis put forth by Syed and Ahmad (2016), suggesting that psychosocial factors in the workplace can modulate



the levels of stress and anxiety among racialized and immigrant women workers, and this may play a role in the development of physiological morbidities in these vulnerable groups.

### **III. Contributions to Feminist Political Economy of Health**

This section discusses the contributions related to feminist political economy of health. The discussion is organized with the following topics: care work and gender; paradoxes in care work ethics; social relations; challenges of double workdays and dual demands of care; double workday stress and its health implications, musculoskeletal disorders (MSDs); masculinities; and the male-breadwinner model. Although it is not always explicitly stated (due to space limitations), these findings are also relevant to the literature about racialized and immigrant women.

The research described in this dissertation was designed, interpreted, and guided by a feminist political economy of health framework, and it also intersected with anti-racism theory. Feminist political economy of health and anti-racism theory enabled the decision to select a single-case study design, and to analyze the process of precarization at macro, meso, and micro levels. These lenses facilitated the understanding of how gender and race are constructed, and how they intersect with immigrant status, and other levels of marginalization. The findings from this project confirm and extend the applications and approaches of feminist political economy of health and anti-racism theory to the research about precarity and precarization among racialized and immigrant women, the exploration of paid and unpaid household labor, care economies, and family structures.

#### ***Care Work and Gender***

The findings from this dissertation contribute to the existing knowledge about the gendered ways in which paid/unpaid care work is carried out. For example, women make up 80%



of the workforce in the health sector (Armstrong and Laxer, 2005). Correspondingly, women also tend to do the overwhelming majority of work in LTC (Alexander, 2002; Pitters, 2002; Maclean and Klein, 2002; Banerjee, 2010; Day, 2014). The findings from this study confirm this literature that states that care work is often performed by women, given that a majority of the interview participants and survey participants were female.

The research from this dissertation contributes to the feminist political economy of health scholarship by recognizing and making the gendered provisions and challenges of care work more visible. While Armstrong and Armstrong (2010) and Day (2014) recognize that care duties have often been referred to as the extension of women's natural duties and obligations; and have often been stereotyped as light-duty work, which unscrupulously justifies the invisibility, devaluing, and low-wages paid for this work (Armstrong, Armstrong, and Scott-Dixon, 2008; Armstrong et al., 2009; Armstrong, 2013b), the evidence from this dissertation provides more evidence to help challenge those stereotypes and assumptions. For instance, chapter 6 indicated how care work was both physically and psychologically intensive and stressful. Chapter 7 demonstrated the anatomical sites in which participants reported significant symptoms.

The findings also support the concerns found in the care work literature about the negative health effects that paid/unpaid care work has on the mental, physical, and social wellbeing of women. For example, almost all female participants that were interviewed had care responsibilities, as well as financial responsibilities, either for their children, for elderly parents, or extended family networks, both within and outside of Canada. Despite the fact that these women were very resilient, they encountered challenges in the management of their physical, emotional, and mental health, as well economic challenges that stemmed from their paid working conditions. Their stories also revealed that while they worked and provided paid/ unpaid care in



difficult, intensive and stressful working conditions, they also provided unpaid care, as well as financial and non-financial forms of support to their families and dependents. However, these forms of unpaid care responsibilities and fiscal demands are not necessarily sustainable or sufficient in the long-run. Given that these women are a part of an aging female workforce with aging dependents, the paid and unpaid care duties that are provided by these women may be significantly impacted over time if adequate support systems are not put in place.

The research from this dissertation also contributes to feminist political economy of health scholarship by addressing the changes and shifts in social, economic, and healthcare responsibilities. These responsibilities were once a part of collective social obligations during the golden age of welfare-states, but these are slowly being eroded, which transfers the social, economic, and health risks onto individuals and their families, into a veiled and private sphere. The evidence confirms the damaging consequences that broad, neo-liberal policy trends have on care providers and their families, and the implications for workers' health, safety, and wellbeing. The findings also expose the ways in which these neoliberal policy shifts conflict with the ideologies and realities of urbanized working class citizens.

### ***Paradoxes in Care Work Ethics - Ethical, Moral, and Material Implications for Women***

The research contributes to the literature about care work ethics by exposing contradictions in the perceptions and practices of care work. For instance, care work is often perceived through moral and ethical grounds of altruism (Braedley, 2013; Baines, 2004; Armstrong, Armstrong, and Scott-Dixon, 2008; Armstrong et al., 2009; Armstrong, 2013b). Care workers may even self-identify themselves as being good (Baines, 2004; Day, 2014) by upholding those moral connotations. Yet, a contradiction exists in this status when care workers are poorly remunerated or uncompensated. Paradoxically, such poor-remuneration/ lack of



compensation does not seem to raise moral and ethical questions when care work is stretched outside of workers' official contractual obligations, and causes stress and strain to these workers.

There is also a perception that *good* women care for their families and others, either uncompensated or low-paid, and in doing so, they attain feminine moral worth (Braedley, 2013). Caregiving work is also considered to be natural and therefore good for women, and it is morally and ethically elevated in this regard (Armstrong, Armstrong, and Scott-Dixon, 2008; Armstrong et al., 2009; Armstrong, 2013b). However, the stereotyping and gendered assumptions behind care work, either in the home or in the labor market, can be detrimental to women's material conditions because it is devalued, underpaid/ unpaid, and defined as unskilled work (Armstrong, Armstrong, and Scott-Dixon, 2008; Armstrong et al., 2009; Armstrong, 2013b). These stereotypes and assumptions about care work can also lead to economic disparities in women's wages that perpetuate inequities in material conditions, making women vulnerable to poverty (Doyal, 1995) and health problems (Armstrong and Armstrong, 2010).

Researchers have identified that a neoliberal context results in a workplace struggle that materially coerces workers to perform unpaid care so that they retain their occupation, yet workers also feel a compulsion to work through moral connotations of altruism (Baines, 2004). As a result, workers may self-identify themselves as being good and just when they provide care outside of their official contractual obligations (Baines, 2004; Day, 2014), but realistically they are exploited through such moral connotations. Under such contextual norms, the working conditions of LTC workers include structural and personal violence, and precariousness (Armstrong and Laxer, 2005; Banerjee, 2010; Armstrong and Armstrong, 2010; Daly, Banerjee, Armstrong et al., 2011). The contradictions in care work ethics demonstrate that the



organizational structures impose not only material power and privilege over women and racialized people, but also hold moral/ethical power and control over them.

### ***Social Relations***

The evidence from this case study contributes to feminist political economy of health scholarship that has to do with care relations and social relations, the latter of which are important in terms of social support networks, and may also be indicative of the scope and magnitude of precarization. For instance, insecure work environments often raise concerns about eroding social bonds and work relationships (Sverke, Hellgren, and Naswall, 2002). The findings in chapter 8 indicated that while some workers were able to maintain their social relations with families, this was seldom completed during the work week. In many instances, the employees reported that their work infringed upon their personal time and made it difficult to maintain social relations, such as friendships. For example, a nurse who held two jobs reported that she had no time to socialize with friends, likely because she worked each and every day. In another example, a PSW indicated that her work and family life were previously unbalanced because both her and her husband were working at two jobs; however, after each of them stopped doing this and remained in only one job, she reported that their lives were now more balanced than in their previous situations. Taken together, the evidence presented is supportive of the literature that indicates that precarious employment is harmful to people's lives because it has adverse social and health consequences (Vosko, 2000; Vosko, 2005; Lewchuk, De Wolff, King, and Polyani, 2005; Galabuzi, 2006; Lewchuk, Clarke, and De Wolff, 2011; Das Gupta, 2015).

### ***Challenges, Double Workdays, and Dual Care Demands***

The evidence confirms previous scholarship about care work being mentally and



physically challenging (Armstrong and Armstrong, 2010). The findings from this study also extend this work to suggest that care work is also *economically* challenging. For example, participants reported high and unaffordable costs related to their care duties, such as the costs of childcare. They also indicated that they often provided financial support for their children that extended into adolescence and adulthood. For instance, participants reported that they often paid for their children's undergraduate degrees and provided rent or other shelter costs. This evidence may be indicative of precarization among families.

In addition to the above contributions, the findings from this study also confirm the existing literature about women's double workdays. Double workdays refer to the dual demands of paid and unpaid domestic responsibilities that are characterized by high job demands, high workloads, and rigorous time pressures (Meintel, Labelle, Turcotte, and Kempineers, 1987). A report of the United Nations ("UN") (1994, p. 25) further suggests that the burden of care for children and the maintenance of the household should not be the sole responsibility of women, but rather should be a shared obligation:

“The full participation and partnership of both women and men is required in productive and reproductive life, including shared responsibilities for the care and nurturing of children and maintenance of the household. In all parts of the world, women are facing threats to their lives, health and well-being as a result of being overburdened with work and of their lack of power and influence.”

Unfortunately, the participants from this study reported that while they carried out their paid care work duties, which had depleted them of their time, energy, and mental and physical health; they also carried out a variety of domestic care tasks that were equally draining. For instance, in chapter 8, workers often reported the care of children that involved preparing meals, cleaning, and picking up/dropping off young children to daycare. In the long run, the quality and sustainability of women's work as well as the social, economic, and health conditions for these women and their families are at risk if adequate support systems are not put in place.



### ***Double Workday Stress and Its Health Implications***

The research evidence from this study demonstrates that care work is socially and economically challenging, and that it has financial, social, and health consequences for the providers of care. The findings from this research further confirm the hypothesis put forth by Messing (1998) and others (Grewal, Bottorff, and Hilton, 2005; Choudhry, Jandu, Mahal et al., 2002; Spitzer, Neufeld, Harrison et al., 2003), who recognize that women, especially immigrant and racialized women, are vulnerable to double-workday stress due to domestic (un)paid work responsibilities. Double-workday tensions result from the responsibilities and demands of holding full-time employment while taking on the responsibility for most domestic chores, caregiving duties, and traditional cultural roles (Grewal, Bottorff, and Hilton, 2005). Choudhry, Jandu, Mahal et al., (2002) reported that SA women experienced significant demands because they juggled care for their children, their grandchildren as well as housework, which allowed for little personal time to focus on their own health.

While Choudhry, Jandu, Mahal et al.'s (2002) study reports that the women in their study were “martyrs” willing to do anything to provide for their families, and focused on others’ well-being rather than their own health, the findings from this study have equally left the impression that women providing LTC work are ‘martyrs’ who often sacrifice themselves to provide both paid and unpaid care responsibilities, despite the fact that it is extremely stressful to do so. For example, the evidence in chapters 6 and 8 indicated that personal or family responsibilities were selected as the fourth most frequent sources of stress from the 16 possible contributors of stress that participants could choose from. Caring for one’s children was selected as the sixth most frequent source of stress. The findings from chapter 8 also indicate that exhaustion and fatigue were reported widely among participants, and in addition to this, having a child made it more



challenging to reach personal goals. Double-workday stress is particularly important because the high demands of paid and unpaid labor, combined with fatigue, stress, anxiety, and depression pose the risk for the onset of MSDs (Karnaki, Polychronakis, Linos, and Kotsioni, 2008; Lundberg, 1999; Kumar, 2001). This is explained in more detail below.

### ***Musculoskeletal Disorders (MSDs)***

As indicated in chapter 4, MSDs, also known as repetitive strain injuries (“RSIs”), are disorders affecting the muscles and joints, and they include back pain, spinal disorders, sprains, dislocations and fractures. MSD prevalence has been reported to be higher among female employees than male employees. The reason for women’s vulnerability to MSDs has been previously explained through a biological paradigm that assumes women are smaller in size and weaker than men. However, growing evidence suggests that women’s vulnerability to MSDs is beyond simple biological differences between men and women (Doyal, 1995; Messing, 1998). Rather, these differences might actually be due to the double burden of paid and unpaid domestic responsibilities that women experience. The risk of occupational injuries and MSDs seems to be compounded in many immigrants, especially immigrant women (Premji, Messing, and Lippel, 2008), which may be explained by the fact that they are often involved in multiple precarious work arrangements, that is exacerbated by the burden of domestic responsibilities coupled with deskilling (Statistics Canada, 2008; COCSG, 2010; Cranford and Vosko, 2005; Syed and Ahmad, 2016).

The findings from this study support the hypothesis that racialized and immigrant women’s double workday pressures could lead to an increased vulnerability to MSDs. Chapter 6 indicated that the most common physical symptoms occurred in the back, which included any pain and discomfort experienced by respondents. The next most common symptoms were



related to the head, neck, and knees. The head and neck region included symptoms of headaches, neck pain or sprain, and other discomfort; and for the knees, it included pain, sprain, discomfort, and locked knees.

### ***Masculinities***

The findings from this dissertation extend the feminist political economy literature about the social constructions of masculinity. They also provide some detail about men's roles in unpaid, domestic care duties and its effects on women's health and wellbeing. Masculinities refer to a field of study that resulted from women's activism against patriarchal systems of power, and suggest that men and masculinity place women and femininity in subordinate positions in society (Gardiner, 2002; Connell, 1995; MacKinnon, 1987). Traditional constructions of masculinity and care suggest that men produce while women reproduce; i.e. that men's contributions to the family are defined by their financial contributions while women's contributions to the family are defined by social reproduction and care work (Gardiner, 2002; MacKinnon, 1987). Such narrow constructions of men and women's roles dismiss the economic contributions of working women, fail to consider the mental, emotional, and relational work that is involved in care duties, and also pose challenges for working women, especially if they are the main providers of care in their families. My findings suggest that these traditional constructions of masculinity persisted in some household structures. For instance, one female participant indicated that traditional social expectations practiced in her husband's family may have made him less familiar with care work and doing various domestic duties because he was simply not expected to do them. As a result, she indicated she experienced significant challenges in the upbringing of her children when they were young because she carried out most of the gendered care responsibilities in her home.



The findings also contribute to the literature about masculinities in contradictory ways. For example, in chapter 8, many participants indicated that gendered roles were a normal occurrence, especially for childcare and housework. However, some female participants reported that they had assistance from male spouses and partners, which challenged traditional masculinities. Indeed, one participant, who was a male ancillary worker, indicated that his immigration to Canada from overseas was based on care responsibilities for his son. Another participant indicated that he provided many care duties for his spouse, who was disabled and scheduled for surgery. In contrast to these situations, a nurse's discussion of his familial obligations revealed some traditional masculinities. This participant stated that he sometimes regretted his work and his family obligations because it left him with little time for socializing with his friends, and he attributed these obligations and sacrifices as gendered expectations that he would need to 'play big boy' i.e. a social role as a responsible adult male.

Given that there are a number of men and women (especially immigrant and racialized groups) who provide care for partners, children, and relatives, both within and outside of Canada, their experiences and needs should be considered in the advancement of culturally appropriate policies and services to support these workers and care providers. Such service provisions would be an important step in ensuring equitable distribution of resources between men and women that may reduce the social and health impacts of paid and unpaid care work.

### ***Male Breadwinner Model***

The evidence in chapter 8 describes the complexities involved in the care for children, elderly parents, and other dependents, which include economic, social and health aspects. It also suggests that many of the workers' households were re-structured in order to provide the necessary care. This includes both financial restructuring and organizational re-structuring,



which is very different from the financial/organizational structuring of a male-breadwinner family model.

One of the unique contributions of this study is how it challenges the male breadwinner model and it supports evidence that women are increasingly equal (if not the main) breadwinners of their families. In chapter 8, I provided an example of a female manager, who indicated that she was not only the main breadwinner of her family, but she also supported her husband's family outside of Canada. A female nurse also indicated that her husband was not working and she was the main income earner in her family. These findings may be indicative of labor market modifications that have changed household dynamics, in which the male-only breadwinner model is near obsolete, and women are increasingly participating in the paid economy to sustain their households (Hacker, 2006), as working women have done in the past.

The findings also suggest that this restructuring is reflective of a shift of care responsibilities from a public domain towards a private one, including privatization of each of the components of care (i.e. social, health, and economic aspects). These shifts towards private, home-based care responsibilities, the erosion of welfare policies, and the lack of workplace support-systems reflect a broad trend towards reducing public health and social services, which paradoxically have an effect of increasing social inequalities and health inequities among citizens rather than producing healthy, economically productive workers and members of society. These shifts also reflect the gendered assumptions about the viability of unpaid health and social care duties and an increasing reliance on individual women for unpaid health and social care work rather than the provisions provided by the state.



### **III. Contributions to Anti-Racism/Critical Race and Immigrant Health Scholarship**

This section discusses the contributions of the project to the anti-racism/critical race and immigrant health scholarship. As indicated earlier in this chapter, one of the main contributions of this dissertation is to the literature about race, immigrant status, and occupational health, safety, and wellbeing. A majority of the survey participants were immigrants; and were racialized. The interviewees also reported a variety of ethnic backgrounds. Taken together, these statistics reflect a case example in which an overwhelming majority of LTC workers are racialized and immigrant workers in this urbanized region of Ontario. It also raises a number of important points and sheds light on various health issues, as noted below.

#### ***Race, Racism, Racialization, and Immigrant Status as Social Determinants of Health***

The evidence from this dissertation supports the literature about racialized and immigrant people's vulnerable health status, and the inequities that they experience. Race is recognized as a social determinant of health (Mikkonen and Raphael, 2010). Yet, neither race, racism, racialization, discrimination, nor immigrant status are recognized by the Public Health Agency of Canada's ("PHAC") (2003) determinants of health. There is a need to formally expand upon PHAC's determinants to include immigrant status, racism/racialization/discrimination and race as [social] determinants of health based on consistent research produced to date about these populations, and the supporting new evidence from this study.

#### ***Chronic Illness, Shiftwork, and Other Hazards***

The research findings from this dissertation contribute to the understanding of how precarious work is connected to chronic health risks and chronic illness in the workplace for racialized and immigrant workers. This is particularly relevant given that there are consistently high levels of stress and musculoskeletal conditions reported among the participants, as well as



evidence of chemical, physical, and circadian-rhythm hazards. For example, in chapter 7, the findings indicate that although morning shifts were the most frequent shifts worked by participants, they also worked with nearly the same frequency in afternoon/evening shifts. The less-frequent selections were working in overnight shifts and no shifts.

These shift patterns may be reflective of two things. Firstly, that overnight shifts cannot be fully avoided because of the nature of the work. Secondly, afternoon/evening shifts might be preferred choices and alternatives to working in high-risk overnight shifts. As a result, these patterns may be reflective of precautionary health measures that are undertaken by workers in order to minimize health hazards from shift-work. Further research would need to be carried out in order to expand upon these findings.

### ***Race, Space, and Urban Geography***

One of the major contributions of this dissertation is to the literature about race, space and urban geographies. While highly urbanized and often expensive geographical settings, such as Toronto and its peripheral municipalities, are the places of settlement and residence for racialized and immigrant people (Vezina and Houle, 2017; Statistics Canada, 2017) and their children (King, 2009), the evidence indicates that the geographic diversity and inclusion that are often celebrated in these areas ignore and deflect the harsh realities of socio-economic segregation. Data from the last two decades show that many immigrants flock to urbanized areas such as Toronto because of prospective employment (Schellenberg, 2004; Kosny, MacEachen, Lifshen et al., 2011; Syed, 2013; Syed, 2014), based on a perception of affordable housing options, as well as cultural comfort found in ethnic enclaves and ethnic neighborhoods (Alba, 1999; Vezina and Houle, 2017). However, the actual evidence revealed from this dissertation indicates severe problems involving socioeconomic status indicators, such as inadequate incomes



and unaffordable housing, among others. Urbanized communities, which are increasingly composed of racialized or immigrant populations (Alexander, 2002; Pitters, 2002; Maclean and Klein, 2002), also exhibit hyperinflation. They also have the worst commute times. My findings contribute unique and new knowledge about these racialized urban communities.

### ***Income Challenges***

The research findings from this dissertation contribute to the knowledge of immigrant and racialized workers' health status and the levels of precarity/ precarization they experience through the analysis of income and budgets. The levels of income one earns along with working conditions are among the health determinants<sup>20</sup> (Public Health Agency of Canada, 2003; Mikkonen and Raphael, 2010). Low income can lead to debt (Lewchuk, Clarke, and De Wolff, 2011) and cycles of poverty (Vosko and Zukewich, 2005; WHO, 2007). Low income and poverty, in turn, can result in inequities in health (Raphael, 2001; Raphael, 2007).

My discussion in chapter 7 highlights how workers frequently face budgetary challenges due to low wages, the latter of which is consistently acknowledged in the literature (Baines, 2004; Banerjee, 2010). For example, in Ontario, wages for frontline care workers range from \$12.50 per hour to approximately \$23 per hour (PSNO, 2017c). Government-set minimum wages are much lower than the maximum amount of \$23 per hour: the OMHLTC announced on April 30, 2014 that the minimum wage for publicly-funded PSWs would be set from \$14 per hour effective April 1, 2014 to \$16.50 per hour by April 2016 (PSNO, 2017c). In chapter 7, the most frequently selected individual income brackets were in the range of \$20,001 to \$30,000 (18.2%, 16/88) and \$30,000 to \$40,000 (18.2%, 16/88) (**Table 7.2a**). The most frequently selected household income bracket was \$50,001 to \$60,000 (17.0%, 15/88) among (**Table 7.3a**). Yet, all

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<sup>20</sup> As mentioned in chapter one, DoH and SDoH have different meanings in the literature.



of these income brackets are insufficient for economic survival. The individual income brackets fall well below the income levels needed for a *single* person to survive and thrive in the GTA at a range of \$46,186 and \$55,432 *after tax* (Kumar, McKenzie, and Um, 2017) (**Table 9.1**). These income trends are supportive of the Marxist, and critical race/antiracism literature indicating that wealthy countries in the global North have sought out workers from countries of the global South as sources of cheap and flexible labor (Banerjee, 2010; Eckenwiler, 2012; Day, 2014).

**Table 9.1** – Cost estimates of an individual living in the GTA. Taken from Kumar, McKenzie and Um (2017). Note that some values have been modified using midpoint calculations, as indicated. The estimated cost of thriving is listed in the report as a range between \$46,186 and \$55,432 after tax, for a single person age 25-40, which has a midpoint of \$50,809.

Line Item of Budget	Amount Required (CDN) per year
Food and Nutrition	\$ 3,605.00
Shelter	*18,075.50
Transportation	**4,407.00
Health Care	2,179.00
Physical Activity	562 .00
Social Participation	5,996.00
Personal Care & Hygiene	1,826.00
Professional Development	2,492.00
Savings & Debt	***12,278.00
Total	\$51,420.50
*Midpoint taken of the range of \$14,225 to \$21,926 per year.	
**Midpoint taken of the range of \$2,400 – \$6,414 per year	
*** Midpoint taken of the range of \$11,655 - \$12,901 per year	

### ***Wage-Related Effects on Food Security, Food Quality and Food Variability***

The findings from this dissertation support the literature that states that racialized and immigrant groups experience inadequate working and living conditions that are indicative of structural and systematic forms of inequalities that may result in health inequities (Syed, 2015). This was exemplified in a number of determinants of health, including diet and nutritional needs. For example, in chapter 7, I indicated that a PSW attributed wage-stagnation and inadequacy to



poor quality and variability in the food she was able to serve to her family. In addition to this, participants also cited other problems, such as high shelter costs, as indicated below.

### ***Housing and Dwelling Circumstances***

The research evidence supports the literature about the problems related to housing and dwelling circumstances in urbanized places. Although chapter 6 indicated that housing was least likely to be a source of stress for participants, and had a frequency count of 5, interview evidence in chapter 7 indicated that it was actually a source of stress for many participants, and in one case example, a participant stated that mortgage payments were a source of stress “that eats me up”. Taken together, the evidence suggests that workers must choose among the limited options for basic necessities of life related to shelter and food security given the material conflict between labor and the organizational structure at the particular site of investigation.

### ***Immigrant Status and Underemployment***

Although racialized and immigrant workers have settled in ethnically diverse neighborhoods that may be sources of settlement-related support, scholars have noted that structural and systematic forms of discrimination experienced by these marginalized groups have led to various social and economic consequences (Das Gupta, 2005; Galabuzi, 2006). Such consequences include underemployment and de-skilling. Underemployment and deskilling mean workers possess strong skill sets, abilities, and experiences, but their work may be deficient in prestige, power, and/ or remuneration, and it results in wage/ income disparities (ibid).

The findings support the literature about underemployment and deskilling which is often experienced by racialized and immigrant persons in Canada (Statistics Canada, 2007; Gilmore and LePetit, 2007). Underemployment is a form of precarious work. Underemployment refers to the pervasive experience of racialized/immigrant people’s participation in labor-intensive work



that does not match their skills, education, or experiences, and is often associated with low remuneration and low-morale or depression (Dean and Wilson, 2009), which Syed (2015) suggests is precarious. Being underemployed could mean that workers experience the 4Ds of precarity that were mentioned earlier in this chapter i.e. 4Ds of precarity refer to dangerous, damned, dirty, and difficult (Rodriguez, 2010; Standing 2011; Syed, 2015).

Underemployment, deskilling, and underutilization of skills are reported in Chapter 7 by a support staff worker. Another worker in Chapter 8 indicated that although she already had experience and training as an allied health worker in her country of origin, she was compelled to repeat her studies in Canada, and currently she was underemployed rather than being registered and practicing in her profession. A third worker, whose interview data on this topic is not explicitly presented throughout this dissertation, stated that he possessed a master's degree in economics, a doctoral degree, and was also a college professor in his country of origin, but rather than being able to work in his profession, he worked in Eastside Home as an ancillary worker. Another worker also reported that he was a successful businessman in his country of origin, but he now worked in multiple jobs in ancillary work.

The above evidence is supportive of research that indicates that a significant proportion of immigrants and racialized people in Canada, who often have university degrees and professional qualifications, are compelled to work in precaritized jobs. The research attributes such precarization of employment due to systemic discrimination in the form of devaluation of previous education and professional experience, demand for Canadian experience, or accessibility issues to professional bridging or language training opportunities (Li, 2001; Chen, Smith and Mustard, 2010; Das Gupta, 2005; Galabuzi, 2006; Crooks et al., 2011; Syed, 2014). As a result, these workers are compelled to work in low-income occupations (Martins and Reid,



2007; Dyck and Dossa, 2007) and take up work in temporary agencies, factories, and warehouses, sell products or services on commission, work as security guards, drive taxicabs, work as self-employed persons or farm workers (Das Gupta, 2005). This causes "...people's worth and status to be diminished" (Dossa, 2009, p. 122). In some cases, it has resulted in alienation from the image that Canada is a diverse, tolerant society (Lewchuk, Clarke, and De Wolff, 2011).

### ***International Remittances***

The findings from this dissertation contribute to the literature about international remittances. Canada is recognized as one of the top ten destinations for migrants, and it is also one of the top source-countries of these remittances (World Bank, 2011). Chapter 8 indicates that despite experiencing economic challenges, workers assisted families and relatives, and sent international remittances. Approximately half (n=43, 48.9%) of the survey respondents (n=88) indicated that they sent their income internationally, while 51.1% (n=45) indicated that this scenario was not applicable to them. Of those who did send remittances, a majority sent over \$500 annually (n=33, 37.5% of 88 respondents). These findings contribute to the literature about global economic activities that are generated between worker's current places of residence and other countries (World Bank, 2011), and also the literature about transnational families. These findings and statistics also pose a contradiction and raise important questions that could be directed for future research. For example, how do workers provide support given their precarious situations? One starting point for this type of research would be to ask if workers are taking on loans and debt in order to fulfill these commitments.

### ***Personal/Cultural Health Practices, and Coping Mechanisms***

This dissertation contributes to the knowledge of how racialized people and immigrants exercise agency, as discussed in earlier chapters. The evidence in this dissertation contributes



unique knowledge about agency, and describes particular personal health practices and coping mechanisms that may help to decrease the burden of work-related illness and disability. For instance, the evidence in chapter 8 indicated that a number of coping strategies that were employed, including: self-care, spirituality, recreation with family or friends, and solitary recreation. While it is known that culture is a DoH (Public Health Agency of Canada, 2003), there has been insufficient research about how racialized and immigrant people exercise agency and resilience with respect to cultural and faith-based practices, such as meditation, yoga, and prayer. The evidence from chapter 8 sheds light on the significance of these practices and how workers find them extremely useful.

#### **IV. Limitations of this Study**

A number of limitations exist in this study that warrant attention. Firstly, this project was conducted with a single-case (i.e. single site) of investigation. Although such an approach means that the findings may not always be representative of and generalizable to provincial and national data, a strength of focusing on one site means that certain issues can be investigated in a deeper way, with a closer look at context, which has been shown in previous studies (Diamond, 1992; Lopez, 2006a, Lopez, 2006b, Lopez, 2007; Day, 2014).

Secondly, another limitation of this study is that it relies on self-reporting measures of subjects. However, there is a possibility of bias if participants reported socially desirable responses (Foley, Manuel, and Vitolins, 2005; Podsakoff and Organ, 1986). A further challenge of this study is that provincial site inspections were carried out by the Ontario Ministry of Health and Long Term Care (OMHLTC) at Eastside Home. Although site inspections are a normal occurrence for LTC settings, there may be certain issues that arise. For instance, inspections that occur during researcher field visits could result in greater scrutiny of the researcher's presence at



the site and such a presence could be misinterpreted as spying on workers (Versperi, 1995; Day, 2014). In order to minimize both social desirability bias and the above-noted misinterpretations, survey participants and interviewees were assured of confidentiality and anonymity (Randall and Fernandes, 1991). Given the length and detail that was captured about work stress and precarity, it is likely that there was sufficient rapport, trust, and comfort built with participants.

Thirdly, although the survey is a useful tool for exploring various health questions, and was posed to both front line workers, and administrative/management-level employees, there are some limitations to its breadth. For example, VM status is often used as a politically neutral term; however, in this study, the results are interpreted through racialization, applying it as “racialized” status. Another example is that survey respondents indicated that the most common site of any physical symptoms or strain occurred in the back, followed by head/neck, and knees; and they also experienced physiological symptoms such as changes in weight, energy levels and sleep. While these and other symptoms are attributed to the experiences of work, they could also be complicated by an aging workforce, which also parallels the aging of residents and their increasingly complex care needs. As a result, further research would be needed to delineate these findings in greater detail.

Finally, although this case study research design conceptualizes, in part, a study of chronic conditions and chronic illness among workers, it is only conducted within a specific point in time (i.e. it was a cross-sectional study). An alternative strategy would be to approach these issues with a longitudinal study design. Longitudinal quantitative, qualitative, or mixed methods studies are considered to be beneficial for various health sector research (Galletta, Portoghese, Battistelli, and Leiter, 2012; Wong, Cummings, and Ducharme, 2013; Zaheer, 2017). However, it would be out of the scope of a doctoral dissertation to conduct a longitudinal design



and it would also be an expensive process, but it may be an option for future research.

## **V. Conclusion**

The project was designed to be one of re-situating, and re-focusing the inquiry back to the contexts and conditions in which people work; and how people's work fundamentally shapes their health, their livelihoods, and that of their families. I wanted to better understand the ways in which paid health care workers are vulnerable to precarization, what are some of the chronic conditions and illness in the workplace among these care workers, what are the challenges that they face, what are their sources of social support, and how do these employees exercise resilience and strength.

The barriers to achieving optimal health and safety among workers result from the different levels of income among workers, different educational backgrounds, socioeconomic status considerations, as well as level of access to adequate resources, housing, commuting and transportation. In short, for LTC workers, their exposure to precarization, and the variations in their health and wellbeing at the regional and community levels, speak to the characteristics of the workers, and the various impediments in accessing social and health-sustaining resources. I suggest that the barriers they face in accessing social and health sustaining resources reflect different priorities, needs, and goals at various structural levels. These structures include LTC organizations themselves, as well as broader structures that control funding decisions and resource allocation. I connect my findings to the literature and suggest that at the national and transnational levels, current research strategies, public health discourses, and workers' health, education and outreach initiatives primarily focus on awareness, prescriptive procurement, lifestyle/behavioral modification factors such as exercise and healthy eating practices as coping mechanisms for workers dealing with these issues. Instead, they should be focusing on prevention measures and policy interventions that take into account the SDoH.



***What is Needed and What Should be Done with the Findings***

The findings from this study reveal a variety of information about the physical, mental, social, and psychosocial health of workers in a detailed, descriptive and qualitative manner, as well as the social determinants that shape workers' health and wellbeing. These include the level of workers' individual and household incomes, as well as additional findings related to housing, dwelling accommodations, modes of travel, and commuting time. The findings also indicate the scope of which basic financial resources are negotiated, prioritized and experienced on the frontlines of LTC at Eastside Home, and how material circumstances that are shaped at the structural/organizational level have downstream effects on the workers who are providing the front-line care.

Care work should involve acknowledging and addressing vulnerability to precarity. However, this concept can be challenging to unpack in a context where there is stigma and sex-stereotyping of workers, such as the essentializations that women are uncommitted/unable to balance work with other demands. This is complicated by the fact that work-stress and workloads in the LTC sector can become overwhelming, and strategies to address these issues are often limited to lifestyle modification rather than including a holistic approach which considers socioeconomic status, income, and other SDoH.

In order to manage care and care work (in this case, the care work that occurs in a LTC facility), there needs to be a commitment to total worker health and wellbeing, which involves the home, family, and community of the workers. Furthermore, given the diversity of care workers in this region, such approaches need to be culturally appropriate, with adequate support that should be provided to the workers. This means that not only do services and provisions need to exist, but they also need to be available, affordable, and accessible to the workers who require



them. When such services and support systems are made available to workers, they can perform the work better, safely, with less of a personal toll on their health and wellbeing, and consequently, with better outcomes for the recipients of care.

### ***Implications and Recommendations for Future Research***

While this study indicates that health and wellness outcomes, social bonds, and social relations were affected by the working conditions, more work can be done. Given that Canadian immigration of people of color is increasing (Syed, 2014) from various parts of the world, my first recommendation would be to formally expand upon PHAC's determinants to include immigrant status and race as [social] DoH based on consistent research produced to date about these populations, and the supporting new evidence from this study.

Another recommendation would be to carry out further research that would investigate the relationship(s) between gender, race, and immigrant status on working conditions and health outcomes in racialized and immigrant communities. For instance, this could involve conducting health impact assessments of various workers who are involved in multiple forms of employment, and asking deeper questions about work-life balance. Additional questions could include the following: how are multiple workplace hazards and cultures connected with gendered and racialized health outcomes? Are there ways in which social care needs (i.e. social relations of individuals, families, and communities) can be solicited with greater capacity? For aging care workers, remaining in the workforce and continuing to receive remuneration could help prevent families experiencing precarity from falling into further poverty, however, what happens when people are working in multiple jobs? What types of policies and practices might be useful in addressing these challenges? How are workers, particularly those who have reported severe



fiscal challenges and budgetary constraints, able to send international remittances to family abroad– are they drawing on debt to meet their own budgetary deficits?

Researchers could inquire about how governments and workplaces can accommodate workers who are participating in multiple forms of employment, and also unpaid care work. For instance, often there are on-site childcare providers for young children in family-friendly workplaces. Could these policies be explored and introduced by employers in LTC homes? What about aging dependents? Are there any related benefits or resources that municipal, provincial, and/or federal governments can offer? A study by Sverke, Hellgren, and Naswall (2002) showed that reductions in job security are correlated with a lack of trust towards the work organization. Future studies of LTC workers might also hold promising data if the focus is re-shifted on social relations towards the work organization and management structures.

### ***Recommendations for Change and Policy Implications***

There are a number of recommendations for change. First, care workers require better psychosocial environments that foster work autonomy, flexibility, and inclusiveness. As previously suggested, care workers should have autonomy and flexibility in tailoring care needs to their residents' needs (Bannerji, 2010). They should also have the autonomy and ability to respond to risky work situations. In addition, care workers should have inclusiveness, voice, and respect in decisions that affect them. Their work requirements need to be made visible in order to fully appreciate the dignity, humanity, and complexity of relational care work (ibid). In addition to these things, labor policies such as protections from reprisals for refusing unsafe work should be implemented in order to protect workers' health, safety, and wellbeing, and these should not be merely theoretical approaches for safe work practices that are intended only to manage financial risks for organizations.



Workers' contractual obligations and time need to be acknowledged, supported and respected. This is important given that care workers have care responsibilities and care needs outside of the workplace, described in detail in chapter 8. Care workers' labor, wages, and contractual obligations should also reflect their efforts, as well as the importance of their meaningful and deeply rewarding work.

A third layer of change has to do with funding and service provision. The evidence suggests that there is ongoing tension related to healthcare and specifically LTC understaffing versus managing budgets and saving money. Issues of workload and staffing levels are bound to quality of care as well as safety, health, and wellbeing of both residents and staff. It is reasonable to expect that health care has a high demand and high level of need for help. Fiscal expenditures should reflect needs, and should not be reduced as merely cost-savings measures.

A fourth layer of change has to do with broad social policies and partnerships. The UN (1994, p. 25) recognizes that barriers to achieving women's healthy, prosperous households are found in inequalities in power relationships that occur at micro, meso, and macro levels of society:

“The power relations that impede women's attainment of healthy and fulfilling lives operate at many levels of society, from the most personal to the highly public.”

In order to improve workers' health and wellness, there is a need for broad social change that will result in better health equity. For example, engaging and partnering with governmental actors, grassroots/community activists, change champions, health care professionals, labor unions, and others could help foster collaboration and enable: educational initiatives, direct service delivery, and/or promote good social policies such as subsidized housing, transportation, and social services. These policies should be sensitive to sex, gender, race, immigrant status, and other social locations, and also deal with them as multiple intersecting social positions. Special



attention should also be paid to young people who enter the workforce so that they have opportunities for adequate work schedules, adequate living and working conditions, long-term social mobility that improves their future life prospects, and to prevent or reduce poverty.

A final layer of change consists of social settings. These settings consist of built environments, and they include various neighborhood level factors and resources that serve as key social determinants of health. It is often difficult to access resources in siloed spaces and racially segregated neighborhoods, which often lack services and supports for such groups. Therefore, targeting these social settings, neighborhoods, communities, and built environments could be a starting point for change. By recognizing and making the gendered and racialized provisions and challenges of care work more visible, the findings from this dissertation will enable policy makers, health care professional, social scientists, researchers, organizational change theorists, and other stakeholders to address these issues.



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## Appendices

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### Appendix 5.01 – TCPS 2: CORE Certification





## **Appendix 5.02 - Executive Summary**

This executive summary was requested by the chief executive officer (CEO) at the site of study. The executive summary was presented to the internal research ethics board at the proposed site, and a decision was made to allow the Principal Investigator to conduct research at the site. This summary was requested for January 26<sup>th</sup>, 2017 which was the date of an internal professional advisory committee meeting at the site. Enclosures with this summary included the recruitment flyer and consent form.

### **Introduction and Background:**

Employment and working conditions are one set of health determinants (Public Health Agency of Canada (PHAC) 2003; World Health Organization (WHO) 2008; Mikkonen and Raphael, 2010; Raphael, 2010), and are connected to many other determinants (Marmot, Friel, Bell et al., 2008; Lewchuk, Clarke, and De Wolff, 2011; WHO, 2008; Armstrong, Armstrong, and Scott-Dixon, 2008). Having a good, stable job prevents circumstances of poverty, and can also improve social mobility.

Many women and ethnic minorities work in particular sectors for employment, such as health and long term care, and are employed as nurses and caregivers, especially in highly urbanized areas such as Toronto, Canada. However, there is concern that Canadian health care work is becoming increasingly precarious.

### **Purpose of Study:**

This research is called the POWER study (Precarity Outcomes among Workers and Employment Resilience). The principal investigator (PI) of this project aims to capture the organization of work (such as which employees participate in the work) (i.e. part time/flex time, temporary), what (if any) work hazards are present, and if so who are these hazards relevant for (i.e. which category of workers). The research will aim to make an original contribution to the occupational health literature. The PI also aims to capture (if applicable) any experiences of work-related impairments and how workers (full time, part-time, casual, contract) navigate employment, social care, and health care systems and workers' compensation; as well as exercising resilience and strength. Because a lot of the work in long-term care is carried out by women and ethnic minorities who might be immigrants, their experiences as to how they entered their respective professions will also be examined, as well as: post-migration experiences, experiences of settlement-related setbacks such as transfer of skills and credentials into the Canadian employment system; paid and unpaid gendered work experiences, and how they might navigate the interface between work and social life.

As indicated in the recruitment flyer and consent forms, this study is about workers in long term care (LTC). There will be an emphasis on understanding structural and systemic risk factors of



wellbeing, the ways in which the work is precarious, and forms of resistance, resilience and strength.

Ethics and how the data will be used:

This project has undergone review by the research ethics board at York University, as indicated in our consent forms (attached). The interview documentation/recording of the participant(s) will not be associated with identifying information. Data will be collected through handwritten notes, audio tapes/digital audio device recorders, and iPad/pen and paper format. Only the researcher/principal investigator, dissertation committee, and a transcriptionist will have access to the transcript data from the interviews. Only the principal investigator and the committee will have access to other raw data. Transcripts, audiotapes, and raw survey data will be kept in a secure location with restricted access to the principal investigator and will be retained for a period of up to six years, after which they will be discarded.

Confidentiality will be provided to the fullest extent possible by law. Every effort will be made to ensure confidentiality. Identifying information that is obtained in connection with this study will not be connected with any of the study results. Workers will not be asked for their name. Workers' names will not be connected to the interview transcripts or survey in any way. The data that is collected from this study will be used to inform research on occupational health and fill knowledge gaps. The collected information will also be used to write a dissertation, which is a part of the requirement to complete a doctorate degree by the Principal Investigator.

If you have any questions with respect to the above, please contact the Principal Investigator:

Ms. Iffath Syed  
PhD Candidate  
Health, Nursing & Environmental Studies Building  
York University

Encl.



## Appendix 5.03 – Informed Consent Forms



### School of Health Policy and Management

York University

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#### **LETTER OF INFORMATION & PARTICIPANT CONSENT**

I am pleased to invite you to participate in the research study outlined below.

If you have any questions or concerns about the research, please feel free to contact the study's

#### **Researcher/Principal Investigator (PI):**

Ms. Iffath (Faith) Syed, MPH, PhD Candidate

**Study/Project Name:** Workers in Long-Term Care (LTC) – POWER Study

#### **Purpose of the Research:**

The purpose of this study is to capture the organization of work (such as which employees participate in the work (i.e. part time/flex time, temporary), what (if any) work hazards are present, and if so who are these hazards relevant for (i.e. which category of workers). The PI also aims to capture (if applicable) any experiences of work-related impairments and how workers (full time, part-time, casual, contract) navigate employment, social care, and health care systems.

This study is about paid workers in long term care (LTC) and will explore paid and unpaid work experiences, daily routines; how newcomer or immigrant workers have settled into their jobs in Canada; what are the skills and educational credentials workers possess and exercise in their jobs; the experiences, hazards, or types of work-related stress, injuries, and illness; the ability to manage, cope and access social support; how workers access systems of health and social care, and workers' compensation; as well as exercising resilience and strength.

#### **Procedures – what you will be asked to do in the research:**

If you volunteer to participate in this study, I will ask you to do the following things:

Participate in a one-on-one, in-depth personal interview and/or pilot survey. The interview will be audio recorded and will take approximately 30-60 minutes to complete. The pilot survey will take approximately 15-20 minutes to complete. Interviews will be conducted in the most convenient location for the study participant. This may include the participant's home, a quiet



public space, a small board room at the work organization, or other convenient and private location. Possible locations for meetings will take place in the Toronto or the Greater Toronto Area.

### **Risks and Discomforts:**

You may find that discussing and reflecting on your experiences of work, personal health, settlement, setbacks and returning to sensitive life events surrounding your experiences may result in some distress and/or frustration. We can direct you to a list of resources if you require and request assistance. The interview period will also demand a commitment of your time. We will hold interviews at a time that is mutually convenient.

### **Benefits of the research and benefits to you and/or to society:**

The research process will provide you with the opportunity to reflect on your own experiences and identify any issues or concerns surrounding your work, settlement or daily life routines. There are no known benefits to individuals. However, this research will aid in the understanding of the experiences and challenges of front-line care work in combination with unpaid family care; work and life balance; social support; social, health and settlement services.

### **Voluntary Participation:**

Your participation in the research is completely voluntary and you may choose to stop participating at any time. Your decision to stop participating in the research will not influence your status at work, your relationship with the researcher(s), or with York University, either now or in the future.

### **Withdrawal from the study:**

You may stop participating in the study at any time, for any reason, if you so decide. You may withdraw your consent at any time and discontinue participation without penalty. Your decision to stop participating, or to refuse to answer particular questions, will not affect your relationship with the researchers, York University, or any other group associated with this project. In the event that you withdraw from the study, all associated data collected will be immediately destroyed wherever possible. If you decide to stop participating, you will still be eligible to receive the promised pay for agreeing to be in the project. You are not waiving any legal claims, rights or remedies because of your participation in this research study.

### **Confidentiality:**

The interview documentation/recording of the participant will not be associated with identifying information. Data will be collected through handwritten notes, audio tapes/digital audio device recorders, and computer/pen and paper format for the pilot survey). Only the researcher/principal investigator, the dissertation committee, and a transcriptionist will have access to the transcript data from your interview. Only the principal investigator and committee



will have access to the survey results. Transcripts, audio tapes, and survey results will be kept in a secure location with restricted access to the principal investigator and committee, and will be retained for a period of up to six years, after which they will be discarded.

Confidentiality will be provided to the fullest extent possible by law. Every effort will be made to ensure confidentiality. Identifying information that is obtained in connection with this study will not be connected with any of the study results. You will not be asked for your name. Your name or identifying information will not be connected to your interview transcripts or survey in any way.

### **Questions about the research?**

If you have questions about the research in general or their role in the study that they should contact the researcher or their supervisor. The supervisor's name and telephone number and/or email address is provided below. The graduate program office may also be contacted and is provided below.

This research has been reviewed and approved by the Human Participants Review Sub-Committee, York University's Ethics Review Board and conforms to the standards of the Canadian Tri-Council Research Ethics guidelines. If you have any questions about this process, or about your rights as a participant in the study, you may contact the Senior Manager and Policy Advisor for the Office of Research Ethics.

### **Payment for Participation:**

All participants will receive an incentive of a \$10 gift card for completing the interview. In addition, a raffle for a \$20 gift card will be drawn at this site for those individuals who have completed the survey. For the raffle, the odds of winning are dependent on the total number of entries received. The total number of entries refers to the total number of surveys submitted to the Principal Investigator (PI). One survey questionnaire submission receives one entry into the raffle draw, with a maximum of one entry allowed per person. For example, if 80 total entries are received, the odds of winning are 1 in 80.

If you have questions regarding your rights as a research participant, contact:

Research Ethics Coordinator:  
Ms. Alison Collins-Mrakas  
Senior Manager & Policy Advisor  
Office of Research Ethics  
York University



Supervisor:

Dr. Tamara Daly, PhD

Associate Professor, CIHR Research Chair in Gender, Work and Health

York University

Principal Investigator:

Ms. Iffath (Faith) Syed, PhD Candidate

York University

Graduate Program Office:

Collette Murray, Graduate Program Assistant (Health Program)

York University

**Legal Rights and Signatures:**

I \_\_\_\_\_ (Name of Participant – please print) consent to participate in the workers in long term care (LTC) study. I have read the information provided for this study as described herein. I have understood the nature of this project and wish to participate. I am not waiving any of my legal rights by signing this form. My signature below indicates my consent. My question(s) have been answered to my satisfaction, and I agree to participate in this study. I have been given a copy of this form.

\_\_\_\_\_  
Signature of Participant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Principal Investigator

\_\_\_\_\_  
Date



### Appendix 5.04 – Survey

This survey is voluntary and is for research purposes only. Please aim to answer all questions, as there is important demographic information that will inform our research. Upon completion of this survey, please submit your envelope to the researcher directly, or mail the survey back to the address on the postage-stamped envelope provided. All information contained in this survey will be kept strictly confidential.

#### DEMOGRAPHIC INFORMATION

1. What is your gender?

- ☐ Female
- ☐ Male
- ☐ Gender neutral, non-binary (e.g. queer; LGBTQ community, etc.)

2. How many hours a week do you work for pay usually or normally (include all employers and organizations)?

- ☐ 0-10 paid hours per week
- ☐ 11-20 paid hours per week
- ☐ 21-30 paid hours per week
- ☐ 31-40 paid hours per week
- ☐ 41+ paid hours per week

3. For your paid work, do you work (check all that apply):

- ☐ through a single employer
- ☐ through multiple employers (including private family-employers)
- ☐ in standard employment (for example, 9am to 5pm workdays)
- ☐ permanently **with** benefits
- ☐ permanently **without** benefits
- ☐ non-permanently **with** benefits
- ☐ non-permanently **without** benefits
- ☐ in temporary employment (e.g. contract)
- ☐ casually or on-call
- ☐ through an agency or agencies
- ☐ none of the above

4. What is your job title?

- ☐ Personal support worker (PSW), health care aide (HCA), care aide
- ☐ Registered nurse (RN), registered practical nurse (RPN), nurse practitioner,
- ☐ Recreation therapist
- ☐ Housekeeper, maintenance worker
- ☐ Private companion, paid companion
- ☐ Religious leader, chaplaincy staff
- ☐ Administrative support, office staff, secretary, clerical
- ☐ Nutritionist, dietician
- ☐ Dietary aide
- ☐ Cook...

**this question continues on the next page**



- ☐ Occupational therapist
- ☐ Physical therapist
- ☐ Audiologist, speech language pathologist,
- ☐ Physician, medical doctor
- ☐ Massage therapist, acupuncturist, chiropractor
- ☐ Unit manager, managerial role
- ☐ Other (please specify): \_\_\_\_\_

### ***Country of Birth and Ethnicity***

5. Please check the following:

- ☐ Born in Canada
- ☐ Born outside Canada

6. Are you or is your ancestral background....(please check):

- ☐ European (white)
- ☐ South Asian (e.g. Indian, Bangladeshi, Pakistani, Sri Lankan, Nepali)
- ☐ East Asian (e.g. from China, Hong Kong)
- ☐ Aboriginal, Native Indian, or American Indian
- ☐ Caribbean
- ☐ Central Asian (e.g. Arab, Middle Eastern, Afghanistani, Iranian)
- ☐ Latin American
- ☐ Central American
- ☐ South American
- ☐ Pacific Islander
- ☐ British Isles
- ☐ Southeast Asian (e.g. Cambodian, Indonesian, Laotian, Vietnamese)
- ☐ African
- ☐ Australian or Oceania
- ☐ French Canadian or Francophone Canadian
- ☐ Mixed ethnicity (please specify): \_\_\_\_\_
- ☐ Other (please specify): \_\_\_\_\_

7. What is the highest level of education you received:

- ☐ elementary or middle school
- ☐ high school diploma
- ☐ some college or university training (e.g. two year associate's degree)
- ☐ vocational or skilled trades school
- ☐ university - bachelor's degree or undergraduate degree (e.g. B.A., B.Sc, B.N.)
- ☐ university – master's or graduate degree (e.g. M.A., M.S.W., M.P.H)
- ☐ university – professional degree (e.g. teacher's college, B.Ed, law, LLB. / J.D., medical, M.B.B.S., M.D.)
- ☐ university – advanced graduate or doctoral degree (e.g. Ph.D).

For the above question, please indicate if you received the highest level of education:

- ☐ within Canada
- ☐ outside Canada



8. How would you rate your current job to the **highest level of education**, skills or training you received (either in or outside of Canada):

- ☐ I work in a job that is **unrelated** my training, skills and level education
- ☐ I work in a job that is **somewhat below** my training, skills and level of education
- ☐ I work in a job that is **equal** to my training, skills and level of education
- ☐ I work in a job that is **somewhat relevant** to my training, skills and level of education
- ☐ I work in a job that is **very relevant** to my training, skills and level of education

## WORK HISTORY

9. Have you ever experienced bullying or discrimination in the workplace?

- ☐ Yes - once
- ☐ Yes - 2-5 times
- ☐ Yes - more than 5 times
- ☐ No

If yes to the above, think about the most recent experience. Do you feel this was this based on your ..... (check all that apply):

- ☐ Sex/gender
- ☐ Age
- ☐ Race, skin color, ethnicity, or ancestral background
- ☐ Immigrant status
- ☐ Ability/ disability
- ☐ Religion
- ☐ Other (please specify): \_\_\_\_\_

10. Did you ever experience a work-related injury or illness *within* your workplace?

- ☐ Yes - once
- ☐ Yes - 2-5 times
- ☐ Yes - more than 5 times
- ☐ No

11. Did you ever experience an injury or illness *outside* of your workplace that affected your ability to work?

- ☐ Yes - once
- ☐ Yes - 2-5 times
- ☐ Yes - more than 5 times
- ☐ No

**\*For questions 12 to 19 below, please think about the most recent injury/illness you experienced\***

12. When did you experience an injury or illness?

- ☐ Less than 6 months ago
- ☐ Between 6 months to 1 year ago
- ☐ Between 1 year to 1.5 year ago
- ☐ Between 1.5 to 2 years ago...

**this question continues on the next page**



- ☐ More than 2 years ago
- ☐ not applicable

13. How did the injury/illness occur?

- ☐ Exposed to or in contact with something *within* the workplace
- ☐ Exposed to or in contact with something *outside* of the workplace
- ☐ Contact with machinery or material being machined
- ☐ Injured while handling, lifting, or carrying an item (or a resident)
- ☐ Slip, trip, or fall
- ☐ I do not remember or do not know
- ☐ not applicable
- ☐ Other (please specify): \_\_\_\_\_

14. How long were you employed before you acquired this injury/illness?

- ☐ Less than 6 months
- ☐ Between 6 months to 1 year
- ☐ Between 1 year to 1.5 year
- ☐ Between 1.5 to 2 years
- ☐ More than 2 years
- ☐ not applicable

15. Did you report this injury or illness to someone?

- ☐ Yes
- ☐ No
- ☐ not applicable

16. Did you get medical attention for your work-related injury or illness?

- ☐ Yes
- ☐ No
- ☐ not applicable

17. If you got medical attention, did you apply for worker compensation or employment insurance (EI) sickness benefits?

- ☐ Yes
- ☐ No
- ☐ not applicable

18. Did you receive any benefits or compensation from the worker compensation board, government or from your employer?

- ☐ Yes
- ☐ No
- ☐ not applicable



19. If you currently work, do you have the same roles as prior to your injury or illness:

- ☐ Yes
- ☐ No
- ☐ not applicable

## **SHIFT WORK**

20. Which shift do you normally or usually work (check all that apply):

- ☐ Morning shift
- ☐ Afternoon/evening shift
- ☐ Overnight /night shift
- ☐ Not applicable – I do not work in shifts

21. Are you aware of the risks associated with shift work, such as risks to circadian/biological clock, hormonal changes, or occupational cancers?

- ☐ Yes
- ☐ No

22. Are you concerned about the outcomes associated with shift work, such as employee absenteeism and injuries?

- ☐ Yes
- ☐ No

23. Check if you have, or have had, any symptoms related to the following areas of your body to a significant degree in the last few years of work (check all that apply):

- ☐ Skin - rashes, hives, eczema, atopic dermatitis, contact dermatitis, or other skin condition
- ☐ Chest/Heart – irregular heartbeat, chest pain, cardiovascular problem
- ☐ Head/Neck – headaches, neck pain or sprain, discomfort
- ☐ Stomach - pain, digestive disorders, indigestion, acid reflux
- ☐ Back – pain, discomfort, including muscular pain
- ☐ Ears, Nose, Throat – infections, earaches, ringing in ears, sore throat
- ☐ Intestinal/Bowel – irritable bowel syndrome, constipation, diarrhea, bowel incontinence
- ☐ Bladder – infections, urinary incontinence, stones
- ☐ Musculoskeletal – pain, sprain, discomfort, carpal tunnel syndrome
- ☐ Knees – pain, sprain, discomfort, locked knees
- ☐ Other pain/discomfort (please specify): \_\_\_\_\_

24. Did you experience recent changes in the last few years of working in.....:

- ☐ Weight
- ☐ Energy levels
- ☐ Ability to sleep
- ☐ None of the above/not applicable



25. Are any of the above symptoms in questions 22 or 23 a result of your impairment, injury or illness:

- ☐ Yes
- ☐ No
- ☐ not applicable

## PERSONAL HEALTH

26. Would you say your health or safety is at risk because of your work?

- ☐ At great risk
- ☐ At considerable risk
- ☐ At some risk
- ☐ At very little risk or no risk
- ☐ I do not know

27. Would you say that most days at work were...?

- ☐ Extremely stressful
- ☐ Quite a bit stressful
- ☐ A bit stressful
- ☐ Not very stressful
- ☐ Not at all stressful

28. What contributes most to feelings of stress you may have (check all that apply)?

- ☐ Time pressures/ not enough time
- ☐ Own physical health problem or condition
- ☐ Own emotional or mental health problem or condition
- ☐ Financial situation (e.g. not enough money, costs of living, debt)
- ☐ Own work situation (hours of work, working conditions)
- ☐ Employment status (e.g. underemployment)
- ☐ Housing
- ☐ Caring for – own children
- ☐ Caring for –others
- ☐ Other personal or family responsibilities
- ☐ Personal relationships
- ☐ Discrimination
- ☐ Personal or family's safety
- ☐ Health of family members
- ☐ School
- ☐ Other (please specify): \_\_\_\_\_

29. In general, would you say your physical health is...

- ☐ Excellent
- ☐ Very good
- ☐ Good
- ☐ Fair
- ☐ Poor



30. In general, would you say your mental health is...

- ☐ Excellent
- ☐ Very good
- ☐ Good
- ☐ Fair
- ☐ Poor

## **HEALTH HABITS AND COPING MECHANISMS**

31. At the present time, do you smoke cigarettes daily, occasionally, or not at all?

- ☐ Daily
- ☐ Occasionally
- ☐ Not at all

32. During the past 12 months, how often do you drink alcoholic beverages?

- ☐ Less than once a month
- ☐ Once a month
- ☐ 2 to 3 times a month
- ☐ Once a week
- ☐ 2 to 3 times a week
- ☐ 4 to 6 times a week
- ☐ Everyday

33. How important are cultural / religious practices, spirituality, mindfulness or meditation to coping with stress or for personal health (cultural practices also include traditional healing such as Chinese, Unani, and homeopathic care):

- ☐ Very important
- ☐ Somewhat important
- ☐ Not very important
- ☐ Indifferent
- ☐ Not applicable

34. What is your religious affiliation?

- ☐ Christian (includes Protestant, Catholic, Mennonite, Restorationist/Mormon, Conservative, Orthodox)
  - ☐ Hindu
  - ☐ Muslim (includes Sunni, Shia, Ismaili, Ahmadiyya, Conservative, Orthodox)
  - ☐ Jewish (includes Reform, Conservative, Hasidic, Orthodox, Kabbalah)
  - ☐ Sikh
  - ☐ Buddhist
  - ☐ Atheist or no religious affiliation
  - ☐ Other? (please specify):
-



*Household Information*

35. What is your **total household** gross annual income before taxes for the 2015 year end (approximate):

- ☐ Less than \$10,000
- ☐ \$10,001 to 20,000
- ☐ \$20,001 to \$30,000
- ☐ \$30,001 to \$40,000
- ☐ \$40,001 to 50,000
- ☐ \$50,001 to \$60,000
- ☐ \$60,001 to \$70,000
- ☐ \$70,001 to 80,000
- ☐ \$80,001 to \$90,000
- ☐ \$90,001 to \$100,000
- ☐ Greater than \$100,000

36. What is your **individual** gross annual income before taxes for the 2015 year end (approximate):

- ☐ Less than \$10,000
- ☐ \$10,001 to 20,000
- ☐ \$20,001 to \$30,000
- ☐ \$30,001 to \$40,000
- ☐ \$40,001 to 50,000
- ☐ \$50,001 to \$60,000
- ☐ \$60,001 to \$70,000
- ☐ \$70,001 to 80,000
- ☐ \$80,001 to \$90,000
- ☐ \$90,001 to \$100,000
- ☐ Greater than \$100,000

37. Was your income from the above question different from your normal income due to a maternity, paternity, sickness, or other leave?

- ☐ Yes
- ☐ No

38. What are the sources of your income (check all that apply)?

- ☐ employment - self
- ☐ employment - spouse/family income
- ☐ rental income
- ☐ government benefits
- ☐ business income, dividends, investments or other income



39. Do you have any of the following dependents who live with you in the same household, for whom you are responsible for (check all that apply)?

- ☐ children
- ☐ parents
- ☐ in-laws...
- ☐ persons with disability
- ☐ grandchildren
- ☐ grandparents, elderly persons, or
- ☐ other relatives

40. Do you have dependents, relatives, or family that live outside of Canada and whom you (or a partner) assist financially? (e.g. send money back home)

- ☐ No
- ☐ Yes

If yes, how much do you send back home on average in a calendar year?

- ☐ \$0-100 a year
- ☐ \$101-200 a year
- ☐ \$201-300 a year
- ☐ \$301-400 a year
- ☐ \$401-500 a year
- ☐ \$500+ a year

***Please provide any comments in spaces below about how your work affects other aspects of your life, about why you chose to work in this field or about the health care field in general:***

***Thank you for taking the time to complete this survey. Your responses are important and highly appreciated. If you have any questions, or require assistance, resources, or support, please feel free to contact the Principal Investigator, Ms. Iffath (Faith) Syed. You may also contact the Project Supervisor: Dr. Tamara Daly.***

This survey has been taken and modified from the following sources: Syed (2011, unpublished data); the Canada Community Health Survey; Das Gupta (2009), and Bannerjee (2014). Many thanks to Mr. David Northrup of the York Institute for Social Research for his invaluable feedback and comments.



## Appendix 5.05 - Ethics Approval



OFFICE OF  
RESEARCH  
ETHICS (ORE)  
www.research.yorku.ca

Certificate #:	STU 2016 - 139
Approval Period:	11/22/16-11/22/17

### ETHICS APPROVAL

**To:** Iffath Syed  
Graduate Student of School of Health, Policy and Management,  
Faculty of Health

**From:** Alison M. Collins-Mrakas, Sr. Manager and Policy Advisor, Research Ethics  
(on behalf of Denise Henriques, Chair, Human Participants Review Committee)

**Date:** Tuesday, November 22, 2016

**Title:** Occupational health and Safety of Immigrants and Racialized Persons: A  
Case Study Investigating Precarity in Long-Term Residential Care

**Risk Level:** ☒ Minimal Risk ☐ More than Minimal Risk

**Level of Review:** ☒ Delegated Review ☐ Full Committee Review

I am writing to inform you that this research project, "Occupational health and Safety of Immigrants and Racialized Persons: A Case Study Investigating Precarity in Long-Term Residential Care" has received ethics review and approval by the Human Participants Review Sub-Committee, York University's Ethics Review Board and conforms to the standards of the Canadian Tri-Council Research Ethics guidelines.

Note that approval is granted for one year. Ongoing research – research that extends beyond one year – must be renewed prior to the expiry date.

Any changes to the approved protocol must be reviewed and approved through the amendment process by submission of an amendment application to the HPRC prior to its implementation.

Any adverse or unanticipated events in the research should be reported to the Office of Research ethics as soon as possible.

For further information on researcher responsibilities as it pertains to this approved research ethics protocol, please refer to the attached document, "RESEARCH ETHICS: PROCEDURES to ENSURE ONGOING COMPLIANCE".

Should you have any questions, please feel free to contact me.

Yours sincerely,

Alison M. Collins-Mrakas M.Sc., LL.M.  
Sr. Manager and Policy Advisor,  
Office of Research Ethics



## RESEARCH ETHICS: PROCEDURES to ENSURE ONGOING COMPLIANCE

Upon receipt of an ethics approval certificate, researchers are reminded that they are required to ensure that the following measures are undertaken so as to ensure on-going compliance with Senate and TCPS ethics guidelines:

1. **RENEWALS:** Research Ethics Approval certificates are subject to annual renewal. **It is the responsibility of researchers to ensure the timely submission of renewals.**
  - a. As a courtesy, researchers will be reminded by ORE, in advance of certificate expiry, that the certificate must be renewed. Please note, however, it is the expectation that researchers will submit a renewal application prior to the expiration of ethics certificate(s).
  - b. **Failure to renew an ethics approval certificate** (or to notify ORE that no further research involving human participants will be undertaken) **may result in suspension of research cost fund and access to research funds may be suspended/ withheld.**
2. **AMENDMENTS:** Amendments must be reviewed and approved **PRIOR** to undertaking/making the proposed amendments to an approved ethics protocol;
3. **END OF PROJECT:** ORE must be notified when a project is complete;
4. **ADVERSE EVENTS:** Adverse events must be reported to ORE as soon as possible;
5. **POST APPROVAL MONITORING:**
  - a. More than minimal risk research may be subject to post approval monitoring as per TCPS guidelines;
  - b. A spot sample of minimal risk research may similarly be subject to Post Approval Monitoring as per TCPS guidelines.

**FORMS:** As per the above, the following forms relating to on-going research ethics compliance are available on the Research website:

- a. Renewal
- b. Amendment
- c. End of Project
- d. Adverse Event



**Appendix 5.06 – Flyer****Workers in Long Term Care (LTC) – POWER Study**

**We want to hear from you!**

- **If you work in long term care**

**We would like to learn more about:**

- **Your experiences of work**
- **Your experience of work/family balance**
- **Whether or not you do shift work, agency work, are full time and/or part time worker?**

**What your participation means:**

**We will ask you to complete a short survey.**

We will interview you in person (at a time that you choose) in a secure and private place (example: boardroom).

**You will receive a gift incentive for participating in the interview**

**Please call or text Iffath (Faith) Syed or email**





## Appendix 5.07 – Samples of Fieldnotes and Dining Map

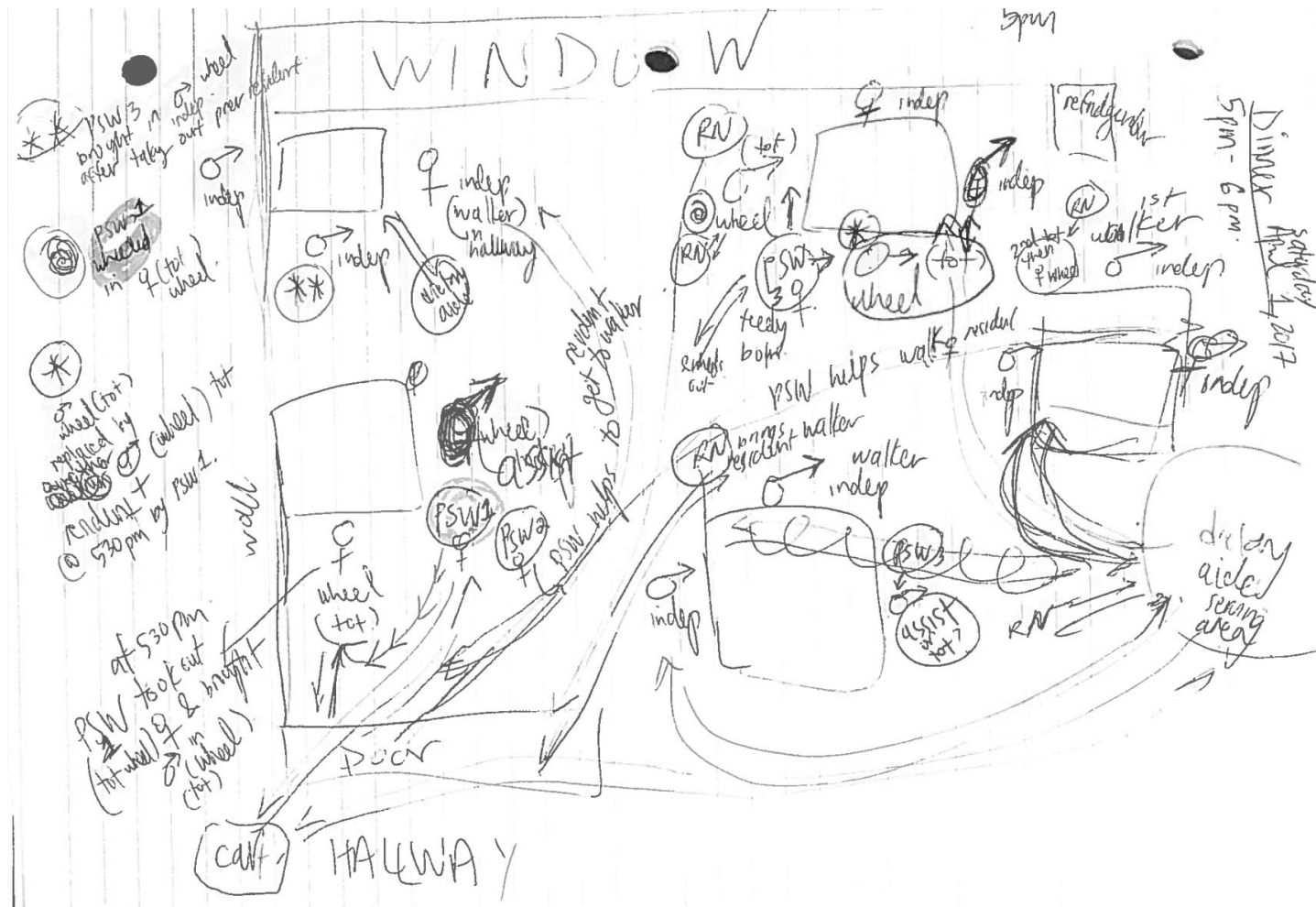
(Identifying information has been removed)

\* THURS FEB. 23, 2017 1:45 PM  
 \* 83.00 hr  
 + 4.00 hr  
 = 87.00 hr  
 \* I see [name] (PSW) at 2pm. She is ready for the interview – she is wearing red lipstick + black leather coat. Her hair is colored black I see white roots though at the side-burns. I overheard a very big argument in [name hidden]'s office between two women → [name] (PSW? Nurse?) plus another woman (family?) about her father (a resident on one of the unsecured floors). [name] said a big fat liar. The door slammed open and shut very hard several times. [name] (the manager) plus [name] (director) were talking to the two ladies.  
 \* It sounded like [name] (Director) would discipline [name] because she said/used those words "need to discipline".  
 \* I see one of the PSWs (from one of the secured floors) dressed in over-the-knee boots and black mini-dress with a lot of eye makeup.  
 \* I experience the fire drill → [name] asks me to follow her (ask the floor) and myself + other people sign into a fire drill sheet.  
 \* The Ministry ( ) is observing as well.

- Thursday February 23, 2017
- 1:45pm
- 83.00 hr+4.00 hr =87.00 hr
- I see [name] (PSW) at 2pm, she is ready for the interview – she is wearing red lipstick + black leather coat
- Her hair is colored black I see white roots though at the side-burns
- I overheard a very big argument in [name hidden]'s office between two women – [name] (PSW?/Nurse?) plus another woman (family?) about her father (a resident on one of the unsecured floors)
- [name] said he was a “big fat liar”
- The door slammed open and shut very hard several times
- [name] (the manager) plus [name] (director) were talking to the two ladies (i.e. worker and family)
- It sounded like [name] (director) would discipline [name] because she said/used those words “need to discipline”
- I see one of the PSWs (from one of the secured floors) dressed in over-the-knee boots and a black mini-dress with a lot of eye makeup
- I experience a fire drill – [name] asks me to follow her
- [name] (support staff) the two allied health workers, director, and myself with other people sign into a fire drill sheet.
- The Ministry [name] is observing as well



## Raw Fieldnote Sample (Dining Room Map)





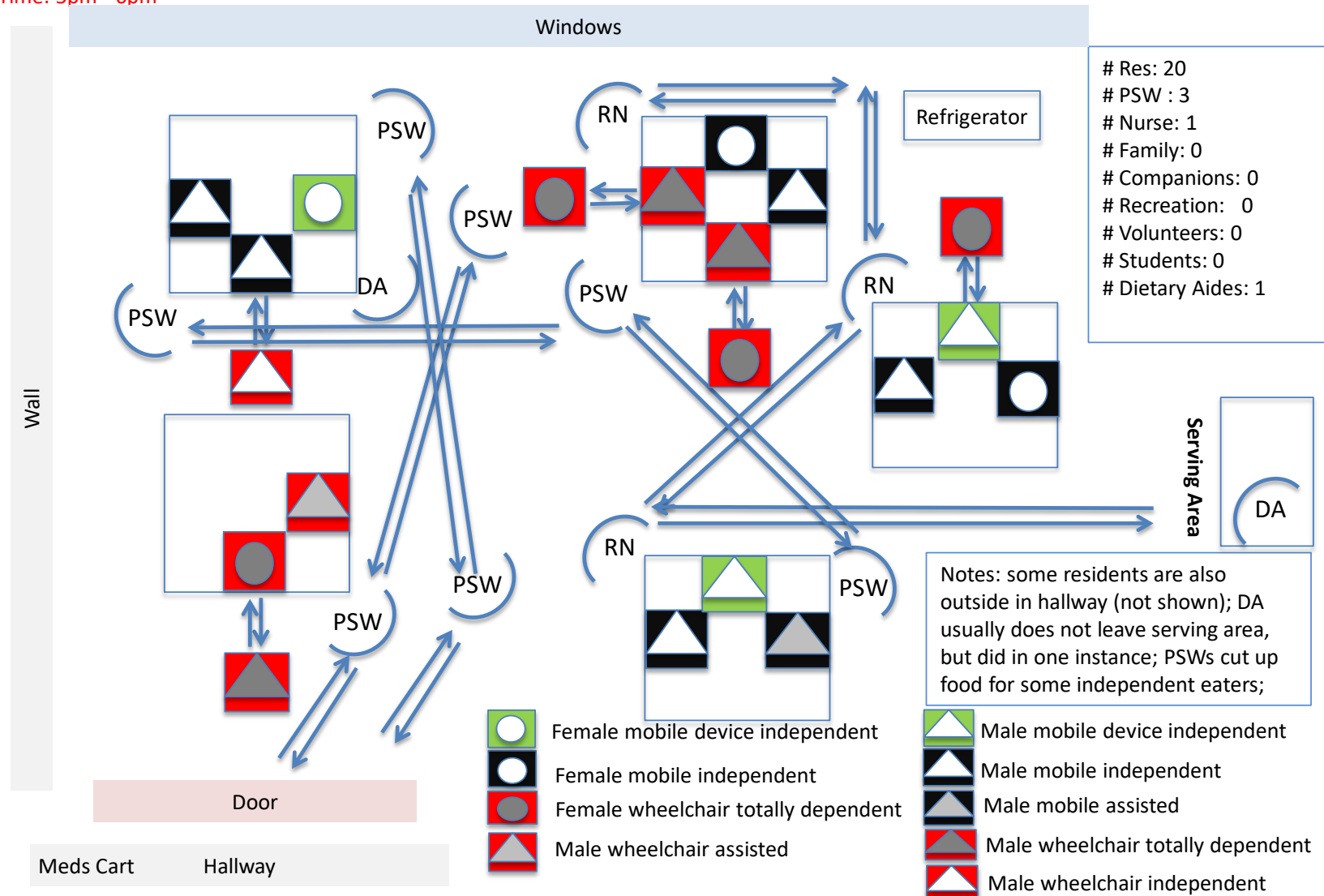
Meal: Dinner

Day: Saturday April 1, 2017

Time: 5pm - 6pm

## Eastside Home Dining Room Map

Observer: Iffath Syed

Mapping strategy taken and modified from *Invisible Women Project*



### **Appendix 5.08 – Interview Guideline and Framework**

This is a semi-structured, interview guide and protocol that includes: ice breaker questions, prompts and probes.

The following probing questions were used to converse with participants and elicit responses:

1. Please tell me about yourself. What do you do? What is your job title? Are you a full-time or part time worker? Do you prefer to work either full time or part time?

[These probing questions will encourage the individual to elaborate on their types of activities associated with work, place of employment, industry type, position, reason for employment. They will also encourage the interviewer to locate the work at the level of the individual (micro), the level of organization (meso) and the level of the national and global contexts (macro), and explore the structural limitations imposed on workers, how this influences decisions and decision-making in the workplace. Finally, in a broader way, it also helps to explore how the political economy (neoliberal policy context of Canada) influences their work, their behaviours, and their actions]

2. Tell me about your background. How did you start to work here?

[These probing questions will have the individual elaborate on processes of hiring, firing, training].

3. In what ways does your job match your education, skills or previous experience? Have you had opportunities while working in this job to gain new skills, training, education, and promotions?

[This probing question will seek to explore the workers' ability to sustain employment in their current field of interest and whether or not they have any future or current plans underway to pursue training or education in another field, and in a broader way, how the political economy (neoliberal policy context of Canada) influence their skills applicability and their work].

4. Tell me about your experience with your work? How well does it pay for the work that you do? How do you manage your budget while living in an expensive city like Toronto? How do you budget for your family or for sending money 'back home'?

[These probing questions seek to explore current employment compensation and adequacy relative to a real working wage, and how are budgeting needs are met in the context of living costs in one of Canada's most urbanized and expensive municipalities. For instance, how do employment and earnings affect workers' health and livelihood, and the lives of their families, e.g. personal goals, costs of daily living expenses, children's school goals, money sent 'back home'? How do employment and earnings affect personal relationships (e.g. spouses, children, relatives etc.? If the participant does not feel they receive adequate compensation they will be asked to elaborate.]



5. Where do you see yourself in a few years? What are your future plans?

[This question seeks to explore personal growth, development, future raises, and advancement in their field, as well as areas that they may be feeling any bias or discrimination.]

6. Prompt: What circumstances might block your future plans or career advancement?

- a. Probe: Sometimes a person might encounter problems at work, such as discrimination or bullying. How often does this sort of thing occur here? What kind of experience do you have either seeing or experiencing workplace discrimination or bullying?

[Under affirmative action policies, groups such as women, visible minorities, racialized persons, persons of color, and/or Aboriginals are protected because they might encounter various forms of discrimination or prejudice? Do workers acknowledge any experiences of structural and systemic discrimination? These probing questions will seek to: explore the structural limitations imposed on workers; how this influences decisions and decision-making in the workplace; and any experiences of structural and systemic discrimination. The responses to this question will be connected to theories of social forces, media conceptions and assimilatory mechanisms that shape these workers' experiences.]

7. Describe any experience you have had being ill or injured because of work. Example: such as lifting, or carrying something

[These questions seek to understand the occupational and environmental conditions of work, whether or not workers experience an acute or chronic illness in the workplace, or any other work-related impairments, and how workers navigate systems of workers' compensation and health care.]

- a. Did the injury require medical attention?
- b. Did you take a sick leave?

8. Prompt: Most jobs in the health sector can be unionized, although this is changing.
  - a. Is your job unionized, too? In what ways does the union impact you? In what ways does the union impact the work here?

9. What qualification or training in occupational health and safety do workers receive here? How did you feel about this training – is it adequate, or could it be modified? How so?

[These questions seeks to explore how workers navigate the structural system of employment and occupational health]



- a. Probe: In what ways does the Workplace Hazardous Materials Information System (WHMIS) affect work? Who provides training for WHMIS to workers? Is this training provided to all workers or particular groups who are exposed to particular hazards? What are some of the hazards in your work?
- b. How does this workplace organize the health and safety committee? Who is a part of it?
- c. Probe: How has the health and safety committee in the workplace, or the union raise or discuss the concerns of shift work? [Research suggests there is a strong correlation between shift work and occupational cancers, for example. What is being done to reduce exposure to shift work? Are certain workers (classes) more informed about these risks than others?].

10. How do you feel after a day's work?

[This question seeks to explore how workers navigate the structural system of employment and personal health]

11. What activities / responsibilities do you have in the home? Who do you share these activities / responsibilities with? Do you have trouble doing anything at home?

[This questions seeks to explore family roles and household daily activities]

12. How many individuals are in your family? How do you balance work life with home life and caring for your own family, such as dependents or elders?

[These questions seek to explore feminist political economy perspectives on dual demands of paid and unpaid work, and care responsibilities]

13. How do you get help when you need it – such as meeting certain people or going to certain places? What sort of help do you get?

[This question seeks to understand the mechanisms that are utilized for coping, such as social support, asking neighbors, family or friends for assistance, using community resources, and health-seeking behaviours that are sought in light of life circumstances, which may help to buffer the deleterious effects of substandard employment]

14. Prompt: this is a very dynamic and culturally diverse workplace, in what ways do you see that diversity in the workplace? How does everyone work together coming from so many diverse cultures? What are situations in which diversity or culture was a challenge in the workplace?

- a. Probe: for instance, recently there was a large debate about dress codes and banning niqabs and headscarves in public spaces, have you seen this sort of cultural topic ever raised at work?

[What are the social forces, media conceptions and assimilatory mechanisms that



shape these workers' experiences? Is there a clash of cultures?]

15. How do you deal with stress, either in your job or family life?

a. Probe: Do you meditate or pray, or practice mindfulness?

[This question aims to explore the coping mechanisms and health-seeking behaviours that are sought in light of life circumstances, which may help to buffer the deleterious effects of substandard employment].

Conclusion: Okay, so I think that should be all for now. Thank you so much for contributing your time to this research, I really appreciate it. Do you have any questions for me? Did you want to add any final thoughts or anything else as we finish?



**Appendix 5.09 – Short Demographic Questionnaire**

This demographic questionnaire is voluntary and all your responses will be kept strictly confidential and are used only for research purposes.

1. Are you ...?

- ☐ Female
- ☐ Male
- ☐ Non-binary (e.g. gender-neutral, queer, LGBTQ, etc.)

2. Are you either a ...?

- ☐ Full time worker
- ☐ Part time worker

3. Do you prefer to work either...?

- ☐ Full time
- ☐ Part time

4. Is your job ...(check all that apply)?

- ☐ Permanent
- ☐ Temporary
- ☐ Seasonal
- ☐ Casual
- ☐ On-Call
- ☐ Contract
- ☐ Through an Agency

5. Do you have a preference for...?

- ☐ Night shift
- ☐ Day shift
- ☐ Afternoon shift

6. Do you work in shifts...(check all that apply)?

- ☐ Night shift
- ☐ Day shift
- ☐ Afternoon shift
- ☐ Not applicable

7. Do you know about the health problems associated with shift work...?

- ☐ Yes
- ☐ No



### **Appendix 5.10 – Resources and Support**

If you experience any work-related injury or other illness, you are advised to seek medical assistance right away. Ontario law requires that an injury requiring medical attention be reported to the employer, and this responsibility may rest with your immediate supervisor. Please notify someone in your workplace if you experience a severe or serious injury that requires medical attention and you think it was acquired directly from work. If you feel uncomfortable reporting an injury to your employer or supervisor, you can choose to notify your union or union representative. Alternatively, you can contact the Ontario Ministry of Labour and/or the Workplace Safety and Insurance Board to speak to someone who can give you advice or information over the phone (Ontario Ministry of Labour (OML), 2009; Office of the Worker Adviser, 2013).

Some stress is normal but if you feel that you are experiencing any severe forms of stress which is affecting work and/or activities in your daily life, you are advised to contact your primary care physician. You may also consult resources found on the Canadian Centers for Occupational Health and Safety (CCOHS), health and safety specialists are available online or by phone between 8:30 am to 5pm EST.

If you feel that daily stress is interfering with your sleep, you may follow some sleep hygiene suggestions:

- Avoid caffeine, tobacco or alcohol - especially before bed time.
- Ask family members to be respectful if someone is sleeping. Family members can use headphones for the TV and radio if necessary.
- Most people sleep better when the room is cool. Consider using an air conditioner or fan in the summer months.
- Turn off the telephone ringer and answering machine speaker.
- Go to bed and get up at the same time every day. Make the room as dark and quiet as possible. Use heavy, dark curtains, blinds, or a sleeping eye mask. Soundproof the room where possible or use ear plugs. Use your bed primarily just for sleeping (e.g., do not watch television, read or do work in bed).
- If you are not sleepy, do not try to go to bed. Get up and read or do something quiet instead.
- Exercise regularly.



- Workplaces can help by providing environments that have good lighting, comfortable temperatures, and reasonable noise levels. Work tasks should provide a variety of interest and tasks should change throughout the shift.
- If extended hours/overtime is common, remember to consider the time required to commute home, meal preparation, eating, socializing with family, etc. Workplaces may wish to consider providing: on-site accommodations, prepared meals for workers, and facilities where employees can take a nap before they drive home.
- Eat at regular intervals and consume a balanced diet of fruits, vegetables, whole grains, healthy fats and protein.
- The Dietitians of Canada have made the following recommendations that are related to fatigue and sleep habits:
  - Establish Regular Eating Times - Our bodies need energy provided by food to be able to perform our daily activities. Having meals at regular times is important to function at our best. If you tend to skip meals or eat at irregular times, you may experience fatigue, food cravings or increased eating at the next meal. Aim to have at least three meals a day including a variety of foods from the four food groups of Canada's Food Guide.
  - Snack Ideas for Your Work Break(s) - Having snacks in between meals is a great way to keep us nourished and give us the energy we need to complete our work shifts. At breaks, opt for healthy snacks that include combinations from a variety of foods from the four food groups.
  - Check your caffeine intake - Excessive intake of caffeine can cause insomnia, headaches, irritability and nervousness. It is recommended that foods containing caffeine should not be consumed five hours before sleeping.
  - Snack for sleeping well - Going to bed with an empty stomach or immediately after a heavy meal can interfere with sleep. If you get home hungry, have a snack that is low in fat and easy to digest. A light snack before going to bed helps in getting a good restful sleep.

(Taken from CCOHS, 2012)



### Appendix 5.11 – Survey: Workers’ Job Categories by Sex

Total (n=91)			Female		Male	
Job Category	Frequency	%	Frequency	%+	Frequency	%+
PSW*	34	37.4%	30	88.20%	3	8.8%
Nurse	19	20.9%	17	89.50%	2	10.5%
Allied Health	10	11.0%	8	80.00%	2	20.0%
Ancillary	10	11.0%	6	60.00%	4	40.0%
Support Staff	9	9.9%	7	77.80%	2	22.2%
Manager	5	5.5%	4	80.00%	1	20.0%
Trainee	4	4.4%	4	100.00%	0	0.0%
Total*	91	100.0%	76	83.50%	14	15.4%
*1 respondent did not indicate sex						
+ % of frequency e.g. for PSW n=34						

Of all of the PSWs working in Eastside Home, 88.2% (n=30/34) were women and 8.8% (n=3/34) were men.



**Appendix 5.12 – Survey: Workers’ Job Categories by VM Status**

Total (n=91)			VM		non-VM	
Job Category	Frequency	%	Frequency	% +	Frequency	% +
PSW*	34	37.4%	32	94.1%	1	2.9%
Nurse*	19	20.9%	18	94.7%	0	0.0%
Allied Health	10	11.0%	8	80.0%	2	20.0%
Ancillary Total	10	11.0%	7	70.0%	3	30.0%
Support staff	9	9.9%	7	77.8%	2	22.2%
Manager	5	5.5%	3	60.0%	2	40.0%
Trainee	4	4.4%	3	75.0%	1	25.0%
Total*	91	100.0%	78	85.7%	11	12.1%
*1 respondent did not indicate ancestral background						
+ % of frequency e.g. for PSW n=34						

Of those who reported their job titles as PSW, 94.1% (n=32/34) were visible minorities and 2.9% (n=1/34) were non-visible minorities.



**Appendix 5.13 – Survey: Workers’ Job Categories by Immigrant Status**

Total (n=91)			Immigrant		Non-Immigrant	
Job Category	Frequency	%	Frequency	% +	Frequency	% +
PSW*****	34	37.40%	25	73.50%	4	11.80%
Nurse	19	20.90%	18	94.70%	1	5.30%
Allied Health	10	11.00%	5	50.00%	5	50.00%
Ancillary*	10	11.00%	7	70.00%	2	20.00%
Support staff	9	9.90%	6	66.70%	3	33.30%
Manager	5	5.50%	4	80.00%	1	20.00%
Trainee	4	4.40%	1	25.00%	3	75.00%
Total*****	91	100.00%	66	72.50%	19	20.90%
*5 PSWs and 1 ancillary worker did not disclose immigrant status						
+ % frequency e.g. for PSW n=34						

Of those who worked as PSWs (n=34), 73.5% (n=25) were immigrant and 11.8% were non-immigrant (n=4).



### Appendix 6.1: Chapter 6 Summary Table of Main Findings

This table summarizes the themes from chapter 6, which include: work intensification, staffing, limited personnel resources, time, psychosocial and psychological stress, and physical strain or physical symptoms of stress. The main themes are indicated in the left column, while the main points from the interviews are indicated in the central column and the corresponding points from the survey questionnaire (if applicable) are indicated in the right-hand column.

Theme	Main Points Extracted from Face-to-Face Interviews	Main Points Extracted from Survey
Work Intensification	<ul style="list-style-type: none"> <li>• Almost all participants reported high workloads</li> <li>• High workloads were associated with missing or skipping breaks</li> <li>• High workloads were associated with staying back/remaining at the site beyond the work schedule</li> <li>• High workloads were associated with unpaid economic work with no monetary compensation</li> </ul>	<ul style="list-style-type: none"> <li>• Participants' work situations were cited as the second most frequent sources of stress (the most frequent source of stress was "time pressures/ not enough time")</li> </ul>
Staffing Levels	<ul style="list-style-type: none"> <li>• There is ongoing tension related to healthcare and specifically LTC understaffing versus managing budgets and saving money</li> <li>• Health care almost always has a high demand and high level of need for help in terms of the required staffing</li> <li>• Many participants expressed that if they could change their work situation, it would be by adding more staff to help with workloads in order to reduce stress</li> </ul>	<ul style="list-style-type: none"> <li>• n/a – no survey questions directly correspond to the issue of staffing</li> </ul>
Time	<ul style="list-style-type: none"> <li>• LTC work requires significant management of time</li> <li>• Workers struggled to balance time</li> <li>• One worker indicated that their work could be completed by 3 people but the expectation was that it should be done by a single person within the allotted shift</li> <li>• Workers did not want to remain past their shift as it was unpaid economic work</li> </ul>	<ul style="list-style-type: none"> <li>• "Time pressures/not enough time" was selected as the most frequent factor that contributed to feelings of stress among survey respondents</li> </ul>
Stress	<ul style="list-style-type: none"> <li>• Most interview participants ubiquitously reported stress</li> </ul>	<ul style="list-style-type: none"> <li>• Most survey respondents reported at</li> </ul>



		<p>least some level of stress from their work</p> <ul style="list-style-type: none"> <li>• Most survey respondents ranked their work as extremely stressful and/or quite a bit stressful (these were the two highest-ranking categories of stress on the Likert scale)</li> </ul>
Physical Strain or Physical Symptoms of Work, Injury or Stress	<ul style="list-style-type: none"> <li>• Interview respondents reported that work-related stress affected physical health, which included a variety of symptoms such as: sleep disturbance, weight loss, gastrointestinal issues, and cardiovascular problems</li> </ul>	<ul style="list-style-type: none"> <li>• Survey respondents indicated that the most common site of any physical symptoms or strain occurred in the back, followed by head/neck, and knees.</li> </ul>



[illegible]



+% of frequency e.g. time pressure = 68
---



**Appendix 6.2c – Survey: What Contributes Most to Feelings of Stress at Work / Outside of Work by Job Category and Subgroup (continues on next page)**

[illegible]



**Appendix 6.2c – Survey: What Contributes Most to Feelings of Stress at Work / Outside of Work by Job Category and Subgroup (continued from previous page)**

[illegible]



**Appendix 6.2d – Survey: What Contributes Most to Feelings of Stress at Work / Outside of Work by Job Category (continues on next page)**

Total (n=91)			PSW		Nurse		Allied health	
What Contributes Most to Feelings of Stress at Work / Outside of WorkΦ	Frequency	%	Frequency	% +	Frequency	% +	Frequency	% +
Time pressures/ not enough time	68	74.7%	25	36.8%	17	25.0%	5	7.4%
Own work situation	28	30.8%	9	32.1%	7	25.0%	4	14.3%
Financial situation	25	27.5%	9	36.0%	3	12.0%	4	16.0%
Other personal or family responsibilities	17	18.7%	6	35.3%	4	23.5%	2	11.8%
Own physical health problem or condition	14	15.4%	3	21.4%	2	14.3%	1	7.1%
Caring for own children	13	14.3%	3	23.1%	2	15.4%	5	38.5%
Employment status	12	13.2%	1	8.3%	5	41.7%	2	16.7%
Caring for others	9	9.9%	2	22.2%	4	44.4%	1	11.1%
Own emotional or mental health problem or condition	8	8.8%	1	12.5%	1	12.5%	2	25.0%
School	7	7.7%	0	0.0%	1	14.3%	2	28.6%
Other e.g. too much workload, picky boss	6	6.6%	3	50.0%	2	33.3%	0	0.0%
Housing	5	5.5%	3	60.0%	0	0.0%	1	20.0%
Health of family members	5	5.5%	2	40.0%	0	0.0%	2	40.0%
Personal relationships	4	4.4%	1	25.0%	1	25.0%	1	25.0%
Discrimination	3	3.3%	1	33.3%	1	33.3%	0	0.0%
Personal or family's safety	1	1.1%	0	0.0%	1	100.0%	0	0.0%

Φ Respondents could select more than one response; + % of frequency count e.g. time pressure n= 68



**Appendix 6.2d – Survey: What Contributes Most to Feelings of Stress at Work / Outside of Work by Job Category (continued from previous page)**

Total (n=91)			Ancillary		Support Staff		Manager		Trainee	
What Contributes Most to Feelings of Stress at Work / Outside of WorkΦ	Frequency	%	Frequency	% +	Frequency	% +	Frequency	% +	Frequency	% +
Time pressures/ not enough time	68	74.7%	8	11.8%	5	7.4%	4	5.9%	4	5.9%
Own work situation	28	30.8%	4	14.3%	3	10.7%	1	3.6%	0	0.0%
Financial situation	25	27.5%	4	16.0%	2	8.0%	1	4.0%	2	8.0%
Other personal or family responsibilities	17	18.7%	1	5.9%	2	11.8%	1	5.9%	1	5.9%
Own physical health problem or condition	14	15.4%	4	28.6%	2	14.3%	1	7.1%	0	0.0%
Caring for own children	13	14.3%	1	7.7%	1	7.7%	1	7.7%	0	0.0%
Employment status	12	13.2%	4	33.3%	0	0.0%	0	0.0%	0	0.0%
Caring for others	9	9.9%	0	0.0%	1	11.1%	1	11.1%	0	0.0%
Own emotional or mental health problem or condition	8	8.8%	2	25.0%	1	12.5%	1	12.5%	0	0.0%
School	7	7.7%	0	0.0%	0	0.0%	1	14.3%	3	42.9%
Other e.g. too much workload, picky boss	6	6.6%	1	16.7%	0	0.0%	0	0.0%	0	0.0%
Housing	5	5.5%	0	0.0%	1	20.0%	0	0.0%	0	0.0%
Health of family members	5	5.5%	0	0.0%	1	20.0%	0	0.0%	0	0.0%
Personal relationships	4	4.4%	1	25.0%	0	0.0%	0	0.0%	0	0.0%
Discrimination	3	3.3%	1	33.3%	0	0.0%	0	0.0%	0	0.0%
Personal or family's safety	1	1.1%	0	0.0%	0	0.0%	0	0.0%	0	0.0%

Φ Respondents could select more than one response; + % of frequency count e.g. time pressure n= 68











Φ Respondents could select more than one response;\*respondent did not disclose VM status



**Appendix 6.3c – Survey: Anatomical Sites of Significant Physical Symptoms Experienced by Job Category and Subgroup**  
(continued from previous page)

	Total (n=91)		Ancillary (n=10)		Support Staff (n=9)		Manager (n=5)		Trainee (n=4)	
Anatomical RegionΦ	Frequency	%	Frequency	%	Frequency	%	Frequency	%	Frequency	%
Back	50	54.9%	8	80.0%	3	33.3%	3	60.0%	1	25.0%
Head/Neck	33	36.3%	4	40.0%	3	33.3%	3	60.0%	0	0.0%
Knees	33	36.3%	4	40.0%	3	33.3%	3	60.0%	0	0.0%
Musculoskeletal e.g. wrist, carpal tunnel	19	20.9%	1	10.0%	1	11.1%	0	0.0%	1	25.0%
Stomach	14	15.4%	0	0.0%	1	11.1%	0	0.0%	0	0.0%
Ears, Nose, Throat	11	12.1%	1	10.0%	0	0.0%	0	0.0%	0	0.0%
Chest/ Heart	10	11.0%	0	0.0%	1	11.1%	1	20.0%	0	0.0%
Skin	10	11.0%	2	20.0%	1	11.1%	0	0.0%	1	25.0%
Intestinal/ Bowel	9	9.9%	0	0.0%	1	11.1%	1	20.0%	0	0.0%
Other e.g. eyes, nerve pain, foot pain, or heel pain	9	9.9%	2	20.0%	1	11.1%	0	0.0%	0	0.0%
Bladder	5	5.5%	2	20.0%	1	11.1%	0	0.0%	0	0.0%

Φ Respondents could select more than one response;\*respondent did not disclose VM status



**Appendix 6.3d – Survey: Anatomical Sites of Significant Physical Symptoms Experienced by Job Category (continues on next page)**

[illegible]



**Appendix 6.3d – Survey: Anatomical Sites of Significant Physical Symptoms Experienced by Job Category (continued from previous page)**

	Total (n=91)		Ancillary		Support Staff		Manager		Trainee	
Anatomical RegionΦ	Frequency	%	Frequency	% +	Frequency	% +	Frequency	% +	Frequency	% +
Back	50	54.9%	8	16.0%	3	6.0%	3	6.0%	1	2.0%
Head/Neck	33	36.3%	4	12.1%	3	9.1%	3	9.1%	0	0.0%
Knees	33	36.3%	4	12.1%	3	9.1%	3	9.1%	0	0.0%
Musculoskeletal e.g. wrist, carpal tunnel	19	20.9%	1	5.3%	1	5.3%	0	0.0%	1	5.3%
Stomach	14	15.4%	0	0.0%	1	7.1%	0	0.0%	0	0.0%
Ears, Nose, Throat	11	12.1%	1	9.1%	0	0.0%	0	0.0%	0	0.0%
Chest/Heart	10	11.0%	0	0.0%	1	10.0%	1	10.0%	0	0.0%
Skin	10	11.0%	2	20.0%	1	10.0%	0	0.0%	1	10.0%
Intestinal/Bowel	9	9.9%	0	0.0%	1	11.1%	1	11.1%	0	0.0%
Other e.g. eyes, nerve pain, foot pain, or heel pain	9	9.9%	2	22.2%	1	11.1%	0	0.0%	0	0.0%
Bladder	5	5.5%	2	40.0%	1	20.0%	0	0.0%	0	0.0%
Φ Respondents could select more than one response; + % of frequency (e.g. back, n = 50)										

**Appendix 6.3c and 6.3d -** Workers selected various anatomical sites in which they experienced significant symptoms. For instance, of all ancillary workers surveyed, the most frequently selected anatomical site selected was the back (80%, n=8/10). Similarly, of all the PSWs surveyed, the most popular anatomical site selected was the back (52.9%, n=18/34). Of all the managers surveyed, the most frequently selected anatomical sites selected were the back (60%, n=3/5), the head/neck (60%, n=3/5), and knees (60%, n=3/5). Of all the allied health workers surveyed, the most frequently selected anatomical site was the head/neck (70% n=7/10).



### Appendix 6.4a – Survey: Changes to Weight, Energy Levels, or Sleep by Sex



	Total (n=91)		VM		Non-VM	
Recent Changes in Weight, Energy Levels, or SleepΦ	Frequency	%	Frequency	% +	Frequency	% +
Weight changes	40	44.0%	36	90.0%	4	10.0%
Energy levels	36	39.6%	32	88.9%	4	11.1%
Ability to sleep	28	30.8%	23	82.1%	5	17.9%
Not applicable**	25	27.5%	21	84.0%	2	8.0%
Φ Respondents could select more than one response ; *2 respondents did not disclose their ancestral background						
+ % of frequency count e.g. weight changes = 40						



	Total (n=91)		PSW (n=34)		Nurse (n=19)		Allied health (n=10)	
Recent Changes in Weight, Energy Levels, or Sleep $\Phi$	Frequency	%	Frequency	%	Frequency	%	Frequency	%
Weight changes	40	44.0%	13	38.2%	11	57.9%	5	50.0%
Energy levels	36	39.6%	13	38.2%	9	47.4%	5	50.0%
Ability to sleep	28	30.8%	7	20.6%	9	47.4%	4	40.0%
Not applicable	25	27.5%	11	32.4%	3	15.8%	2	20.0%
$\Phi$ Respondents could select more than one response; + % of frequency count (e.g. weight changes n= 40)								



**Appendix 6.4c – Survey: Changes to Weight, Energy Levels, or Sleep by Job Category and Subgroup (continued from previous page)**

	Total (n=91)		Ancillary (n=10)		Support Staff (n=9)		Manager (n=5)		Trainee (n=4)	
Recent Changes in Weight, Energy Levels, or Sleep $\Phi$	Frequency	%	Frequency	%	Frequency	%	Frequency	%	Frequency	%
Weight changes	40	44.0%	3	30.0%	6	66.7%	1	20.0%	1	25.0%
Energy levels	36	39.6%	4	40.0%	2	22.2%	3	60.0%	0	0.0%
Ability to sleep	28	30.8%	4	40.0%	2	22.2%	1	20.0%	1	25.0%
Not applicable	25	27.5%	3	30.0%	2	22.2%	2	40.0%	2	50.0%
$\Phi$ Respondents could select more than one response; + % of frequency count (e.g. weight changes n= 40)										

**Appendix 6.4c** – Approximately 67% of support staff (n=6 out of 9) reported recent changes in weight. 57.9% of nurses (n=11 out of 19) also reported recent changes in weight. 50% of allied health workers (n=5 out of 10) reported recent changes in weight. 50% of allied health workers (n=5 out of 10) reported recent changes in energy levels. 60% of managers (n=3 out of 5) reported recent changes in energy levels.



**Appendix 6.4d – Survey: Changes to Weight, Energy Levels, or Sleep by Job Category (continues on next page)**

	Total (n=91)		PSW		Nurse		Allied health	
Recent Changes in Weight, Energy Levels, or SleepΦ	Frequency	%	Frequency	% +	Frequency	% +	Frequency	% +
Weight changes	40	44.0%	13	32.5%	11	27.5%	5	12.5%
Energy levels	36	39.6%	13	36.1%	9	25.0%	5	13.9%
Ability to sleep	28	30.8%	7	25.0%	9	32.1%	4	14.3%
Not applicable	25	27.5%	11	44.0%	3	12.0%	2	8.0%
Φ Respondents could select more than one response; + % of frequency count (e.g. weight changes n= 40)								



**Appendix 6.4d – Survey: Changes to Weight, Energy Levels, or Sleep by Job Category (continued from previous page)**

	Total (n=91)		Ancillary		Support Staff		Manager		Trainee	
Recent Changes in Weight, Energy Levels, or SleepΦ	Frequency	%	Frequency	% +	Frequency	% +	Frequency	% +	Frequency	% +
Weight changes	40	44.0%	3	7.5%	6	15.0%	1	2.5%	1	2.5%
Energy levels	36	39.6%	4	11.1%	2	5.6%	3	8.3%	0	0.0%
Ability to sleep	28	30.8%	4	14.3%	2	7.1%	1	3.6%	1	3.6%
Not applicable	25	27.5%	3	12.0%	2	8.0%	2	8.0%	2	8.0%
Φ Respondents could select more than one response; + % of frequency count (e.g. weight changes n= 40)										



### Appendix 6.5a – Survey: Shift(s) Usually Worked by Sex

	Total (n=91)		Female		Male	
Type of Work ScheduleΦ	Frequency	%	Frequency	% +	Frequency	% +
Morning shift	47	51.6%	39	83.0%	8	17.0%
Afternoon/ evening shift*	45	49.5%	36	80.0%	8	17.8%
Overnight shift*	16	17.6%	11	68.8%	4	25.0%
Not applicable – I do not work in shifts	7	7.7%	5	71.4%	2	28.6%
Φ Respondents could select more than one response; *1 respondent did not disclose their sex						
+ % of frequency count e.g. morning shift = 47						



### Appendix 6.5b – Survey: Shift(s) Usually Worked by VM Status

	Total (n=91)		VM		Non-VM	
Type of Work ScheduleΦ	Frequency	%	Frequency	% +	Frequency	% +
Morning shift	47	51.6%	39	83.0%	8	17.0%
Afternoon/ evening shift**	45	49.5%	40	88.9%	3	6.7%
Overnight shift	16	17.6%	16	100.0%	0	0.0%
Not applicable – I do not work in shifts	7	7.7%	1	14.3%	6	85.7%
Φ Respondents could select more than one response; **2 respondents did not disclose their ancestral background						
+ % of frequency count e.g. morning shift = 47						



### Appendix 6.5c – Survey: Shift(s) Usually Worked by Immigrant Status

	Total (n=91)		Immigrant		Non-Immigrant	
Type of Work Schedule $\Phi$	Frequency	%	Frequency	% +	Frequency	% +
Morning shift****	47	51.6%	31	66.0%	12	25.5%
Afternoon/ evening shift***	45	49.5%	37	82.2%	5	11.1%
Overnight shift***	16	17.6%	13	81.3%	0	0.0%
Not applicable – I do not work in shifts*	7	7.7%	4	57.1%	2	28.6%
$\Phi$ Respondents could select more than one response; * respondents did not disclose immigrant status						
*** 3 respondents did not disclose immigrant status						
**** 4 respondent did not disclose immigrant status						
+ % of frequency count e.g. morning shift = 47						



**Appendix 6.5d – Survey: Shift(s) Usually Worked by Job Category and Subgroup (continues on next page)**

	Total (n=91)		PSW (n=34)		Nurse (n=19)		Allied health (n=10)	
Type of Work ScheduleΦ	Frequency	%	Frequency	%	Frequency	%	Frequency	%
Morning shift	47	51.6%	15	44.1%	9	47.4%	7	70%
Afternoon/ evening shift	45	49.5%	19	55.9%	13	68.4%	2	20%
Overnight shift	16	17.6%	9	26.5%	4	21.1%	0	0%
Not applicable – I do not work in shifts	7	7.7%	1	2.9%	0	0.0%	2	20%

Φ Respondents could select more than one response; + % of frequency count (e.g. morning shift = 47)







**Appendix 6.5e – Survey: Shift(s) Usually Worked by Job Category (continues on next page)**

	Total (n=91)		PSW		Nurse		Allied health	
Type of Work Schedule $\Phi$	Frequency	%	Frequency	% +	Frequency	% +	Frequency	% +
Morning shift	47	51.6%	15	31.9%	9	19.1%	7	14.9%
Afternoon/ evening shift	45	49.5%	19	42.2%	13	28.9%	2	4.4%
Overnight shift	16	17.6%	9	56.3%	4	25.0%	0	0.0%
Not applicable – I do not work in shifts	7	7.7%	1	14.3%	0	0.0%	2	28.6%
$\Phi$ Respondents could select more than one response; + % of frequency count (e.g. morning shift = 47)								

**Appendix 6.5d and 6.5e** - Frontline care workers often reported working afternoon/ evening shifts compared to other workers. For example, of the 34 PSWs sampled, 55.9% worked in afternoon/evening shifts (n=19), 44.1% (n=15) worked in morning shifts, and 26.5% (n=9) worked in overnight shifts. Of the 19 nurses sampled, 68.4% worked in afternoon/evening shifts (n=13), 47.4% (n=9) worked in morning shifts, and 21.1% (n=4) worked in evening shifts. Of the 10 allied health workers sampled, 70% (n=7) worked in the morning shift. Of the ancillary workers sampled (n=10), 70% (n=7) worked in afternoon/evening shifts. Of the support staff (n=9), 77.8% (n=7) worked in the morning shift. Of the managers sampled (n=5), 80% (n=4) indicated they did not work in shifts. Of the trainees sampled (n=4), 100% (n=4) indicated they worked in the morning shift.



**Appendix 6.5e – Survey: Shift(s) Usually Worked by Job Category (continued from previous page)**

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### Appendix 7.1: Chapter 7 Summary Table of Main Findings

This table summarizes the themes from chapter 7, which include: income, personal finances, and budgets; housing; and commute and travel time. The main themes are indicated in the left column, while the main points from the interviews are indicated in the central column and the corresponding points from the survey questionnaire (if applicable) are indicated in the right-hand column.

Theme	Main Points Extracted from Face-to-Face Interviews	Main Points Extracted from Survey
Income, Personal Finances, and Budgets	<ul style="list-style-type: none"> <li>Participants reported that their wages did not meet the costs of living in Toronto, many replied that it was unreliable or inadequate</li> </ul>	<ul style="list-style-type: none"> <li>The most frequent sources of income were “self” followed by spouse or family</li> <li>The most frequently report income bracket for household income was \$50,001 to 60,000</li> <li>The most frequently reported income bracket for individual income were \$20,001 to 30,000 and \$30,001 to 40,000</li> </ul>
Housing	<ul style="list-style-type: none"> <li>Several participants revealed that they made mortgage payments and described these payments as a significant financial burden</li> <li>Participants who paid rent were in financial situations very similar to those who made mortgage payments. Many participants who made rent payments described their housing expenses to be overwhelming.</li> </ul>	<ul style="list-style-type: none"> <li>According to the survey, housing was least likely to be a source of stress for participants, and had a frequency count of 5.</li> </ul>
Commute, Travel Time, Distance Travelled	<ul style="list-style-type: none"> <li>For the 25 participants who gave a numerical estimate of their commuting time, the mean length of a one-way commute for all modes of transportation was 24.5 minutes. The mean one-way commuting time by car was 24.6 minutes. The mean one-way commuting time by public transit was 37.3 minutes. The participant who commuted on foot reported</li> </ul>	<ul style="list-style-type: none"> <li>n/a</li> </ul>



	<p>that the walk took five minutes.</p> <ul style="list-style-type: none"><li>• Estimated one-way commute distance to Eastside Home was calculated using Map Data from Google ©2018 if participants disclosed their route or intersection of origin. Nine participants disclosed this information. The mean one-way commute distance for these participants was 21.9km.</li><li>• Several participants indicated that they carpooled to work, often a partner or spouse. One participant indicated that they picked up other staff on their way to work</li><li>• One participant indicated that she saved on gasoline because her vehicle was efficient and by purchasing it from a discounted retailer;</li></ul>	
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### Appendix 7.2b – Survey: Total Household Annual Income by VM Status

	Total (n=88)		VM		Non-VM	
Household Gross Annual Income for 2015	Frequency	%	Frequency	% +	Frequency	% +
Less than \$10,000	2	2.3%	2	100.0%	0	0.0%
\$10,001-\$20,000	3	3.4%	3	100.0%	0	0.0%
\$20,001-\$30,000	13	14.8%	9	69.2%	4	30.8%
\$30,001-\$40,000*	13	14.8%	11	84.6%	1	7.7%
\$40,001-\$50,000	9	10.2%	8	88.9%	1	11.1%
\$50,001-\$60,000	15	17.0%	14	93.3%	1	6.7%
\$60,001-\$70,000	7	8.0%	7	100.0%	0	0.0%
\$70,001-\$80,000*	4	4.5%	3	75.0%	0	0.0%
\$80,001-\$90,000	5	5.7%	4	80.0%	1	20.0%
\$90,001-\$100,000	9	10.2%	8	88.9%	1	11.1%
More than \$100,000	8	9.1%	6	75.0%	2	25.0%
Total**	88	100.0%	75	85.2%	11	12.5%
*1 respondent did not disclose ancestral background						
**A total of 2 respondents did not disclose ancestral background						
+ % of frequency count e.g. less than \$10,000, n = 2						



### Appendix 7.2c – Survey: Total Household Annual Income by Immigrant Status

	Total (n=88)		Immigrant		Non-Immigrant	
Household Gross Annual Income for 2015	Frequency	%	Frequency	% +	Frequency	% +
Less than \$10,000	2	2.3%	2	100.0%	0	0.0%
\$10,001-\$20,000*	3	3.4%	1	33.3%	1	33.3%
\$20,001-\$30,000*	13	14.8%	7	53.8%	5	38.5%
\$30,001-\$40,000	13	14.8%	11	84.6%	2	15.4%
\$40,001-\$50,000**	9	10.2%	5	55.6%	2	22.2%
\$50,001-\$60,000	15	17.0%	12	80.0%	3	20.0%
\$60,001-\$70,000*	7	8.0%	6	85.7%	0	0.0%
\$70,001-\$80,000	4	4.5%	2	50.0%	2	50.0%
\$80,001-\$90,000	5	5.7%	4	80.0%	1	20.0%
\$90,001-\$100,000*	9	10.2%	6	66.7%	2	22.2%
More than \$100,000	8	9.1%	7	87.5%	1	12.5%
Total*****	88	100.0%	63	71.6%	19	21.6%
*1 respondent did not disclose ancestral background						
**2 respondents did not disclose ancestral background						
***** A total of 6 respondents did not disclose ancestral background						
+ % of frequency count e.g. less than \$10,000, n = 2						



**Appendix 7.2d – Survey: Total Household Annual Income by Job Category and Subgroup (continues on next page)**

	Total (n=88)		PSW (n=33)		Nurse (n=18)		Allied health (n=9)	
Household Gross Annual Income for 2015	Frequency	%	Frequency	%	Frequency	%	Frequency	%
Less than \$10,000	2	2.3%	2	6.1%	0	0.0%	0	0.0%
\$10,001-\$20,000	3	3.4%	2	6.1%	0	0.0%	0	0.0%
\$20,001-\$30,000	13	14.8%	4	12.1%	1	5.6%	1	11.1%
\$30,001-\$40,000	13	14.8%	7	21.2%	2	11.1%	3	33.3%
\$40,001-\$50,000	9	10.2%	6	18.2%	0	0.0%	1	11.1%
\$50,001-\$60,000	15	17.0%	6	18.2%	3	16.7%	1	11.1%
\$60,001-\$70,000	7	8.0%	2	6.1%	1	5.6%	0	0.0%
\$70,001-\$80,000	4	4.5%	1	3.0%	2	11.1%	1	11.1%
\$80,001-\$90,000	5	5.7%	0	0.0%	2	11.1%	0	0.0%
\$90,001-\$100,000	9	10.2%	3	9.1%	4	22.2%	1	11.1%
More than \$100,000	8	9.1%	0	0.0%	3	16.7%	1	11.1%
Total	88	100.0%	33	100.0%	18	100.0%	9	100.0%



**Appendix 7.2d – Survey: Total Household Annual Income by Job Category and Subgroup (continued from previous page)**

	Total (n=88)		Ancillary (n=10)		Support Staff (n=9)		Manager (n=5)		Trainee (n=4)	
Household Gross Annual Income for 2015	Frequency	%	Frequency	%	Frequency	%	Frequency	%	Frequency	%
Less than \$10,000	2	2.3%	0	0.0%	0	0.0%	0	0%	0	0%
\$10,001-\$20,000	3	3.4%	0	0.0%	0	0.0%	0	0%	1	25%
\$20,001-\$30,000	13	14.8%	5	50.0%	1	11.1%	0	0%	1	25%
\$30,001-\$40,000	13	14.8%	1	10.0%	0	0.0%	0	0%	0	0%
\$40,001-\$50,000	9	10.2%	0	0.0%	2	22.2%	0	0%	0	0%
\$50,001-\$60,000	15	17.0%	1	10.0%	4	44.4%	0	0%	0	0%
\$60,001-\$70,000	7	8.0%	2	20.0%	1	11.1%	0	0%	1	25%
\$70,001-\$80,000	4	4.5%	0	0.0%	0	0.0%	0	0%	0	0%
\$80,001-\$90,000	5	5.7%	1	10.0%	0	0.0%	1	20%	1	25%
\$90,001-\$100,000	9	10.2%	0	0.0%	0	0.0%	1	20%	0	0%
More than \$100,000	8	9.1%	0	0.0%	1	11.1%	3	60%	0	0%
Total	88	100.0%	10	100.0%	9	100.0%	5	100%	4	100%



**Appendix 7.2e – Survey: Total Household Annual Income by Job Category (continues on next page)**

	Total (n=88)		PSW		Nurse		Allied health	
Household Gross Annual Income for 2015	Frequency	%	Frequency	% +	Frequency	% +	Frequency	% +
Less than \$10,000	2	2.3%	2	100.0%	0	0.0%	0	0.0%
\$10,001-\$20,000	3	3.4%	2	66.7%	0	0.0%	0	0.0%
\$20,001-\$30,000	13	14.8%	4	30.8%	1	7.7%	1	7.7%
\$30,001-\$40,000	13	14.8%	7	53.8%	2	15.4%	3	23.1%
\$40,001-\$50,000	9	10.2%	6	66.7%	0	0.0%	1	11.1%
\$50,001-\$60,000	15	17.0%	6	40.0%	3	20.0%	1	6.7%
\$60,001-\$70,000	7	8.0%	2	28.6%	1	14.3%	0	0.0%
\$70,001-\$80,000	4	4.5%	1	25.0%	2	50.0%	1	25.0%
\$80,001-\$90,000	5	5.7%	0	0.0%	2	40.0%	0	0.0%
\$90,001-\$100,000	9	10.2%	3	33.3%	4	44.4%	1	11.1%
More than \$100,000	8	9.1%	0	0.0%	3	37.5%	1	12.5%
Total	88	100.0%	33	37.5%	18	20.5%	9	10.2%
+ % of frequency count (e.g. less than \$10,000, n = 2)								



**Appendix 7.2e – Survey: Total Household Annual Income by Job Category (continued from previous page)**

[illegible]











### Appendix 7.3c - Survey: Individual Annual Income by Immigrant Status

	Total (n=88)		Immigrant		Non-Immigrant	
Individual Gross Annual Income for 2015	Frequency	%	Frequency	%+	Frequency	%+
Less than \$10,000	5	5.7%	4	80.0%	1	20.0%
\$10,001-\$20,000*	10	11.4%	8	80.0%	1	10.0%
\$20,001-\$30,000*	16	18.2%	6	37.5%	9	56.3%
\$30,001-\$40,000	16	18.2%	14	87.5%	2	12.5%
\$40,001-\$50,000***	13	14.8%	8	61.5%	2	15.4%
\$50,001-\$60,000	11	12.5%	9	81.8%	2	18.2%
\$60,001-\$70,000	5	5.7%	5	100.0%	0	0.0%
\$70,001-\$80,000*	6	6.8%	4	66.7%	1	16.7%
\$80,001-\$90,000	2	2.3%	2	100.0%	0	0.0%
\$90,001-\$100,000	2	2.3%	2	100.0%	0	0.0%
More than \$100,000	2	2.3%	1	50.0%	1	50.0%
Total *****	88	100.0%	63	71.6%	19	21.6%
*1 respondent did not disclose immigrant status						
***3 respondents did not disclose immigrant status						
***** 6 respondents did not disclose immigrant status						
+ % of frequency count e.g. less than \$10,000, n = 5						



**Appendix 7.3d – Survey: Individual Annual Income by Job Category and Subgroup (continues on next page)**

	Total (n=88)		PSW (n=33)		Nurse (n=18)		Allied health (n=9)	
Individual Gross Annual Income for 2015	Frequency	%	Frequency	%	Frequency	%	Frequency	%
Less than \$10,000	5	5.7%	2	6.3%	0	0.0%	1	10%
\$10,001-\$20,000	10	11.4%	3	9.4%	2	11.1%	1	10%
\$20,001-\$30,000	16	18.2%	6	18.8%	1	5.6%	1	10%
\$30,001-\$40,000	16	18.2%	8	25.0%	3	16.7%	4	40%
\$40,001-\$50,000	13	14.8%	7	21.9%	2	11.1%	1	10%
\$50,001-\$60,000	11	12.5%	2	6.3%	3	16.7%	1	10%
\$60,001-\$70,000	5	5.7%	1	3.1%	3	16.7%	0	0%
\$70,001-\$80,000	6	6.8%	2	6.3%	2	11.1%	0	0%
\$80,001-\$90,000	2	2.3%	1	3.1%	0	0.0%	0	0%
\$90,001-\$100,000	2	2.3%	0	0.0%	1	5.6%	0	0%
More than \$100,000	2	2.3%	0	0.0%	1	5.6%	1	10%
Total	88	100.0%	32	100.0%	18	100.0%	10	100%



**Appendix 7.3d – Survey: Individual Annual Income by Job Category and Subgroup (continued from previous page)**

	Total (n=88)		Ancillary (n=10)		Support Staff (n=9)		Manager (n=5)		Trainee (n=4)	
Individual Gross Annual Income for 2015	Frequency	%	Frequency	%	Frequency	%	Frequency	%	Frequency	%
Less than \$10,000	5	5.7%	1	10%	1	11.1%	0	0%	0	0%
\$10,001-\$20,000	10	11.4%	2	20%	1	11.1%	0	0%	1	25%
\$20,001-\$30,000	16	18.2%	4	40%	1	11.1%	0	0%	3	75%
\$30,001-\$40,000	16	18.2%	1	10%	0	0.0%	0	0%	0	0%
\$40,001-\$50,000	13	14.8%	1	10%	1	11.1%	1	20%	0	0%
\$50,001-\$60,000	11	12.5%	0	0%	5	55.6%	0	0%	0	0%
\$60,001-\$70,000	5	5.7%	0	0%	0	0.0%	1	20%	0	0%
\$70,001-\$80,000	6	6.8%	0	0%	0	0.0%	2	40%	0	0%
\$80,001-\$90,000	2	2.3%	1	10%	0	0.0%	0	0%	0	0%
\$90,001-\$100,000	2	2.3%	0	0%	0	0.0%	1	20%	0	0%
More than \$100,000	2	2.3%	0	0%	0	0.0%	0	0%	0	0%
Total	88	100.0%	10	100%	9	100.0%	5	100%	4	100%



**Appendix 7.3e – Survey: Individual Annual Income by Job Category (continues on next page)**

Individual Gross Annual Income for 2015	Total (n=88)		PSW		Nurse		Allied health	
	Frequency	%	Frequency	% +	Frequency	% +	Frequency	% +
Less than \$10,000	5	5.7%	2	40.0%	0	0.0%	1	20.0%
\$10,001-\$20,000	10	11.4%	3	30.0%	2	20.0%	1	10.0%
\$20,001-\$30,000	16	18.2%	6	37.5%	1	6.3%	1	6.3%
\$30,001-\$40,000	16	18.2%	8	50.0%	3	18.8%	4	25.0%
\$40,001-\$50,000	13	14.8%	7	53.8%	2	15.4%	1	7.7%
\$50,001-\$60,000	11	12.5%	2	18.2%	3	27.3%	1	9.1%
\$60,001-\$70,000	5	5.7%	1	20.0%	3	60.0%	0	0.0%
\$70,001-\$80,000	6	6.8%	2	33.3%	2	33.3%	0	0.0%
\$80,001-\$90,000	2	2.3%	1	50.0%	0	0.0%	0	0.0%
\$90,001-\$100,000	2	2.3%	0	0.0%	1	50.0%	0	0.0%
More than \$100,000	2	2.3%	0	0.0%	1	50.0%	1	50.0%
Total	88	100.0%	32	36.4%	18	20.5%	10	11.4%
+ % of frequency count (e.g. less than \$10,000, n = 2)								

**Appendix 7.3d - 7.3e** - The most common individual income among all PSWs (n=32) was \$30,001 to \$40,000 (n=8). The most common individual income among allied health (n=10) was also \$30,001 to \$40,000 (n=4, 40%). The most common individual income among ancillary workers (n=10) was \$20,001 to \$30,000 (n=4, 40%). Finally, the most common individual income among trainees (n=4) was also \$20,001 to \$30,000 (75%, n=3).



**Appendix 7.3e – Survey: Individual Annual Income by Job Category (continued from previous page)**

	Total (n=88)		Ancillary		Support Staff		Manager		Trainee	
Individual Gross Annual Income for 2015	Frequency	%	Frequency	% +	Frequency	% +	Frequency	% +	Frequency	% +
Less than \$10,000	5	5.7%	1	20.0%	1	20.0%	0	0.0%	0	0.0%
\$10,001-\$20,000	10	11.4%	2	20.0%	1	10.0%	0	0.0%	1	10.0%
\$20,001-\$30,000	16	18.2%	4	25.0%	1	6.3%	0	0.0%	3	18.8%
\$30,001-\$40,000	16	18.2%	1	6.3%	0	0.0%	0	0.0%	0	0.0%
\$40,001-\$50,000	13	14.8%	1	7.7%	1	7.7%	1	7.7%	0	0.0%
\$50,001-\$60,000	11	12.5%	0	0.0%	5	45.5%	0	0.0%	0	0.0%
\$60,001-\$70,000	5	5.7%	0	0.0%	0	0.0%	1	20.0%	0	0.0%
\$70,001-\$80,000	6	6.8%	0	0.0%	0	0.0%	2	33.3%	0	0.0%
\$80,001-\$90,000	2	2.3%	1	50.0%	0	0.0%	0	0.0%	0	0.0%
\$90,001-\$100,000	2	2.3%	0	0.0%	0	0.0%	1	50.0%	0	0.0%
More than \$100,000	2	2.3%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Total	88	100.0%	10	11.4%	9	10.2%	5	5.7%	4	4.5%
+ % of frequency count (e.g. less than \$10,000, n = 2)										



	Total (n=83)		Female		Male	
Income from parental/ sickness	Frequency	%	Frequency	% +	Frequency	%+
Yes	13	15.7%	10	76.9%	3	23.1%
No	70	84.3%	60	85.7%	10	14.3%
Total	83	100.0%	70	84.3%	13	15.7%
+ % of frequency count e.g. yes, n = 13						







### Appendix 7.6b – Survey: Highest Level of Education Completed by VM Status

	Total (n=90)		VM		Non-VM	
Level of Education	Frequency	%	Frequency	%+	Frequency	%+
High School	13	14.4%	11	84.6%	2	15.4%
Some College, University**	43	47.8%	37	86.0%	4	9.3%
Vocational, Skilled Trades School	4	4.4%	3	75.0%	1	25.0%
Bachelors Degree	19	21.1%	16	84.2%	3	15.8%
Masters Degree	6	6.7%	5	83.3%	1	16.7%
Professional Degree	4	4.4%	4	100.0%	0	0.0%
Advanced Degree, PhD	1	1.1%	1	100.0%	0	0.0%
Total**	90	100.0%	77	85.6%	11	12.2%
** 2 respondents did not disclose ancestral background						
+ % of frequency count e.g. high school, n = 13						



### Appendix 7.6c - Highest Level of Education Completed by Immigrant Status

	Total (n=90)		Immigrant		Non-Immigrant	
Level of Education	Frequency	%	Frequency	%+	Frequency	%+
High School	13	14.4%	11	84.6%	2	15.4%
Some College, University***	43	47.8%	27	62.8%	13	30.2%
Vocational, Skilled Trades School	4	4.4%	2	50.0%	2	50.0%
Bachelors Degree*	19	21.1%	17	89.5%	1	5.3%
Masters Degree*	6	6.7%	5	83.3%	0	0.0%
Professional Degree	4	4.4%	3	75.0%	1	25.0%
Advanced Degree, PhD	1	1.1%	1	100.0%	0	0.0%
Total*****	90	100.0%	66	73.3%	19	21.1%
*1 respondent did not disclose immigrant status						
*** 3 respondents did not disclose immigrant status						
***** A total of 5 respondents did not disclose immigrant status						
+ % of frequency count e.g. high school, n = 13						



**Appendix 7.6d – Survey: Highest Level of Education Completed by Job Category and Subgroup (continues on next page)**

	Total (n=90)		PSW (n=33)		Nurse (n=19)		Allied health (n=10)	
Level of Education	Frequency	%	Frequency	%	Frequency	%	Frequency	%
High School	13	14.4%	9	27.3%	0	0.0%	0	0%
Some College, University	43	47.8%	19	57.6%	10	52.6%	5	50%
Vocational, Skilled Trades School	4	4.4%	2	6.1%	1	5.3%	0	0%
Bachelors Degree	19	21.1%	3	9.1%	6	31.6%	3	30%
Masters Degree	6	6.7%	0	0.0%	1	5.3%	0	0%
Professional Degree	4	4.4%	0	0.0%	1	5.3%	2	20%
Advanced Degree, PhD	1	1.1%	0	0.0%	0	0.0%	0	0%
Total	90	100.0%	33	100.0%	19	100.0%	10	100%



**Appendix 7.6d – Survey: Highest Level of Education Completed by Job Category and Subgroup (continued from previous page)**

	Total (n=90)		Ancillary (n=10)		Support Staff (n=9)		Manager (n=5)		Trainee (n=4)	
Level of Education	Frequency	%	Frequency	%	Frequency	%	Frequency	%	Frequency	%
High School	13	14.4%	3	30%	1	11.1%	0	0%	0	0%
Some College, University	43	47.8%	0	0%	5	55.6%	1	20%	3	75%
Vocational, Skilled Trades School	4	4.4%	1	10%	0	0.0%	0	0%	0	0%
Bachelors Degree	19	21.1%	2	20%	2	22.2%	2	40%	1	25%
Masters Degree	6	6.7%	2	20%	1	11.1%	2	40%	0	0%
Professional Degree	4	4.4%	1	10%	0	0.0%	0	0%	0	0%
Advanced Degree, PhD	1	1.1%	1	10%	0	0.0%	0	0%	0	0%
Total	90	100.0%	10	100%	9	100.0%	5	100%	4	100%



**Appendix 7.6e – Survey: Highest Level of Education Completed by Job Category (continues on next page)**

Level of Education	Total (n=90)		PSW		Nurse		Allied health	
	Frequency	%	Frequency	% +	Frequency	% +	Frequency	% +
High School	13	14.4%	9	69.2%	0	0.0%	0	0.0%
Some College, University	43	47.8%	19	44.2%	10	23.3%	5	11.6%
Vocational, Skilled Trades School	4	4.4%	2	50.0%	1	25.0%	0	0.0%
Bachelors Degree	19	21.1%	3	15.8%	6	31.6%	3	15.8%
Masters Degree	6	6.7%	0	0.0%	1	16.7%	0	0.0%
Professional Degree	4	4.4%	0	0.0%	1	25.0%	2	50.0%
Advanced Degree, PhD	1	1.1%	0	0.0%	0	0.0%	0	0.0%
Total	90	100.0%	33	36.7%	19	21.1%	10	11.1%
+ % of frequency count (e.g. less than high school, n = 13)								

**Appendix 7.6d -7.6e** - The most common level of education selected among all PSWs (n=33) was some college or university (n=19, 57.6%). The most common level of education selected among all nurses (n=19) was some college or university (n=10, 52.6%). The most common level of education selected among all allied health workers (n=10) was some college or university (n=5, 50%). The most common level of education selected among all ancillary workers (n=10) was high school (n=3, 30%). The most common level of education among selected among all support staff (n=9) was some college or university (n=5, 55.6%). The most common levels of education selected among all managers were bachelor's degree (n=2, 40%) and master's degree (n=2, 40%). The most common level of education selected among all trainees (n=4) was some college or university (n=3, 75%). The respondent who selected an advanced degree such as a PhD (n=1), was an ancillary worker (100%, n=1).



**Appendix 7.6e – Survey: Highest Level of Education Completed by Job Category (continued from previous page)**

	Total (n=90)		Ancillary		Support Staff		Manager		Trainee	
Level of Education	Frequency	%	Frequency	% +	Frequency	% +	Frequency	% +	Frequency	% +
High School	13	14.4%	3	23.1%	1	7.7%	0	0.0%	0	0.0%
Some College, University	43	47.8%	0	0.0%	5	11.6%	1	2.3%	3	7.0%
Vocational, Skilled Trades School	4	4.4%	1	25.0%	0	0.0%	0	0.0%	0	0.0%
Bachelors Degree	19	21.1%	2	10.5%	2	10.5%	2	10.5%	1	5.3%
Masters Degree	6	6.7%	2	33.3%	1	16.7%	2	33.3%	0	0.0%
Professional Degree	4	4.4%	1	25.0%	0	0.0%	0	0.0%	0	0.0%
Advanced Degree, PhD	1	1.1%	1	100.0%	0	0.0%	0	0.0%	0	0.0%
Total	90	100.0%	10	11.1%	9	10.0%	5	5.6%	4	4.4%
+ % of frequency count (e.g. less than high school, n = 13)										



### Appendix 8.1: Chapter 8 Summary Table of Main Findings

This table summarizes the themes from chapter 8, which include: care for children, childcare costs, etc. The main themes are indicated in the left column, while the main points from the interviews are indicated in the central column and the corresponding points from the survey questionnaire (if applicable) are indicated in the right-hand column.

Theme	Main Points extracted from Face-to-Face Interviews	Main Points extracted from Survey
Care for Children	<ul style="list-style-type: none"> <li>Participants reported doing a variety of tasks in the care of children e.g. preparing meals, cleaning, picking up/dropping off young children to daycare</li> <li>One participant indicated that his immigration to Canada was based on care responsibilities for his son</li> </ul>	<ul style="list-style-type: none"> <li>Personal or family responsibilities were selected as the fourth most frequent sources of stress from the 16 possible contributors of stress that respondents could choose from</li> <li>Caring for one's children was selected as the sixth most frequent source of stress.</li> </ul>
Tuition, Education and Financial Support for Children	<ul style="list-style-type: none"> <li>Participants often paid for undergraduate degrees and one participant paid for her son's medical school tuition</li> </ul>	<ul style="list-style-type: none"> <li>n/a</li> </ul>
Childcare Costs	<ul style="list-style-type: none"> <li>Participants reported high and unaffordable costs of childcare</li> </ul>	<ul style="list-style-type: none"> <li>n/a</li> </ul>
Effects of Care on Personal Health and Wellbeing	<ul style="list-style-type: none"> <li>Exhaustion and fatigue was reported widely among participants</li> </ul>	<ul style="list-style-type: none"> <li>n/a</li> </ul>
The Effects of Caring for Others on Personal Goals and Personal Growth	<ul style="list-style-type: none"> <li>Having a child made it more challenging to reach personal goals</li> </ul>	<ul style="list-style-type: none"> <li>n/a</li> </ul>
Gender, Dependents and Care Experiences in the Private Sphere	<ul style="list-style-type: none"> <li>Sometimes gendered expectations were associated with childcare and housework, but participants also had assistance from male spouses and partners</li> </ul>	<ul style="list-style-type: none"> <li>n/a</li> </ul>



Financial Support to Other Dependents, Relatives or Family	<ul style="list-style-type: none"> <li>• Participants reported that they contributed to the support of relatives other than children or spouses, including parents, siblings, and in-laws.</li> <li>• Some participants were unable to provide even a “penny” of support because of financial constraints</li> </ul>	<ul style="list-style-type: none"> <li>• Most of the respondents said this was not applicable to them. Some of respondents indicated they sent over \$500 in remittances annually while the remainder sent between 0 and \$500</li> </ul>
Non-Financial Support to Other Dependents, Relatives or Family	<ul style="list-style-type: none"> <li>• Non-financial support included services-in-kind such as shoveling snow, taking elderly parents to the physician, etc.</li> </ul>	<ul style="list-style-type: none"> <li>• n/a</li> </ul>
Social Life and Social Relations - Barriers to Socialization	<ul style="list-style-type: none"> <li>• None of the participants from Eastside Home indicated that work had a positive effect on their social life.</li> <li>• Many participants who were interviewed indicated that they faced barriers to socialization. The reasons cited were: season/cold climate, lack of time, work duties, and childrearing</li> </ul>	<ul style="list-style-type: none"> <li>• n/a</li> </ul>
Coping, Resistance and Resilience Strategies	<ul style="list-style-type: none"> <li>• Participants engaged in a variety of forms of resistance and resilience, including various forms of self-care such as: healthy eating, exercise (including walking, yoga, swimming, and going to the gym), mindfulness or meditation practices; drawing on social</li> </ul>	<ul style="list-style-type: none"> <li>• The majority of the respondents indicated that they were non-smokers, responding with ‘not at all’, but indicated few indicated ‘daily’ smoking, and smoking ‘occasionally’</li> <li>• The majority of the respondents reported not consuming alcohol at all. The next most popular responses were 2-3 times</li> </ul>



	support - with family, friends and others, and solitary recreation	<p>a month and less than once a month.</p> <ul style="list-style-type: none"><li>• The majority of respondents rated personal health practices as 'very important', followed by 'somewhat important'. On the other hand, a few said 'not very important', 'indifferent', and/or 'not applicable' to them.</li><li>• The most common religious affiliation was Christian. Other religious affiliations included: Muslim and Atheist or no religious affiliation.</li></ul>
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### **Glossary of Abbreviations and Acronyms**

CBC – Canadian Broadcasting Corporation

CCHS – Canada Community Health Survey

CCOHS – Canadian Centers for Occupational Health and Safety

CCO – Cancer Care Ontario

CEO – Chief Executive Officer

CHD – Coronary Heart Disease

CIHI – Canadian Institute for Health Information

CIHR – Canadian Institutes of Health Research

CMI – Case Mix Index

COCSG – Canadian Orthopedic Care Strategy Group

CSHAWG – Canadian Study of Health and Aging Working Group

CUPE – Canadian Union of Public Employees

DoH – Determinants of Health

EI – Employment Insurance

F/T – Full Time

GTA – Greater Toronto Area

IMF – International Monetary Fund

IOM – International Organization for Migration

ISR – Institute for Social Research

IWH – Institute for Work and Health

LCO – Law Commission of Ontario

LTC – Long-Term Care

MSD – Musculo-Skeletal Disorder

OCRC – Occupational Cancer Research Centre

OECD – Organization for Economic Cooperation and Development



OHS – Occupational Health and Safety

OML – Ontario Ministry of Labour

OMHLTC – Ontario Ministry of Health and Long-Term Care

ORE – Office of Research Ethics

OSAP – Ontario Student Assistance Program

PAC – Professional Advisory Committee

PHAC – Public Health Agency of Canada

PSNO – Personal Support Network of Ontario

PSW – Personal Support Worker

P/T – Part Time

RCTs – Randomized Control Trials

RN – Registered Nurse

RNAO - Registered Nurses' Association of Ontario

RPN – Registered Practical Nurse

RSI – Repetitive Strain Injuries

RSI – Repetitive Strain Injury

SA - South Asian

SCS – Statistical Consulting Service

SDoH – Social Determinants of Health

SPSS – Statistical Package for the Social Sciences

TTC – Toronto Transit Commission

VM – Visible Minority

WHMIS – Workplace Hazardous Materials Information System

WHO – World Health Organization



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