

Women, Migration and Care Work: Filipino Health Care Aides
in Canada

By

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Abstract

Personal care homes have become increasingly dependent on the employment of immigrant care workers. This qualitative study explored the high concentration of Filipino health care aides in personal care homes from their own perspectives, as well as that of policy stakeholders. In depth interviews were conducted with seven Filipino health care aides working in personal care homes in Winnipeg, Manitoba. Semi-structured interviews with policy stakeholders examined the policy context of the health care aide labour force.

The study identified several factors that influenced the migration and employment of Filipino health care aides including: poverty and unemployment, migrant social networks, barriers in the labour market and financial incentives. The lack of regulations for health care aides sustained the flow of immigrant labour and enabled the expansion of social networks. Although their employment decisions were primarily based on financial need, health care aides valued their work and viewed themselves as critical care providers.

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CHAPTER ONE

Introduction and Study Objectives

As Canada's population ages, the demand for qualified caregivers continues to rise. Personal care homes have become increasingly dependent on the employment of immigrant care workers to carry out their essential functions, tasks which Canadian born workers are often reluctant to perform (See Appendix 1). Traditionally, registered nurses and licensed practical nurses "have been the primary providers of patient care" (Pyper, 2004: 6). Since the 1980s, however, the composition of the health care workforce has shifted. The number of health care aides increased substantially, while the proportion of licensed practical nurses declined (See Appendix 2). Immigrant women are significantly overrepresented among health care aides who provide the bulk of care work in Canada's personal care homes (See Appendices 1, 2 and 4).

More than any other ethnic group, Filipino women are overrepresented as health care aides¹ in the Canadian health care system (Statistics Canada, 2008). Though Filipinos constitute only 1.2 percent of the Canadian workforce, they make up 5.6 percent of the health care aide labour force (Statistics Canada, 2008). In Winnipeg, Manitoba, almost half (45 percent) of all health care aides were born abroad and 20 percent of health care aides are Canadians of Filipino origin (Statistics Canada, 2008) (See Appendices 1 and 4).

¹ This figure is based on Statistics Canada National Occupation Classification System category D312 - Nurse Aides, Orderlies or Patient Services Associates. In Manitoba, these workers are usually referred to as health care aides, although there is no standard term. This category does not include health care aides employed in home care, they fall under G811 - Visiting Homemakers, Housekeepers and Related Occupations. As a result, this figure does not capture the entire health care aide population.

As the fastest growing sector of the nursing workforce (Pyper, 2004), health care aides play a critical role in Canada's health care system, particularly in long-term care. These workers, however, are also embedded within the global movement of women. Filipino health aides are connected to the world's largest organized labour-exporting program; approximately 10 million Filipino migrants work in 197 countries around the world (POEA, 2008). More than half of these migrants are women (POEA, 2008). The migration of Filipino women has been described as "the widest flow of contemporary migration in the world today" (Parrenas, 2008:4). Yet the labour market participation of Filipino women is relatively narrow, with millions of Filipino women concentrated in the care sectors of high income countries (Parrenas, 2008). Ehrenreich and Hochschild (2002) term this process "the globalization of women's work", whereby caring labour in high income countries is increasingly performed by migrant women who work in private homes, hospitals, personal care homes, and child-care centres (Ehrenreich and Hochschild, 2002). Research in this field focuses on nurses (Ball, 2004; Bourgeault and Wrede, 2008; Choy, 2003; Stasiulis and Bakan, 2005) and domestic workers (Ehrenreich and Hochschild, 2002; Bakan and Stasiulis 1995; Lindio-McGovern, 2003; Parrenas, 2001; Pratt, 1999). Comparatively few studies have investigated migration and health care aides (Armstrong et al., 2008; 2006; Bourgeault et al., 2009; Brown and Braun, 2008; Cangiano et al., 2009; Onuki, 2009).

This study addressed this gap in the literature by examining the migration and employment of Filipino health care aides in Winnipeg, Manitoba. A qualitative study was undertaken to explore the high concentration of Filipino health care aides from the perspectives of health care aides and health policy stakeholders. The study sought to identify the factors that contribute to the occupational segmentation of Filipino health care aides as well as the context of

their migration and employment in personal care homes in Winnipeg, Manitoba. Life history interviews with health care aides provided an in-depth examination of their migration and employment experiences. Semi-structured interviews with health policy stakeholders examined the policy context of long-term care in order to identify policies and practices that impact the composition of the health care aide workforce.

Objectives

The overall goal of the study was to examine the intersections between female migration from the Philippines and the health care aide labour force in Winnipeg, Manitoba. To achieve this goal, the study identified three objectives:

1. To examine the migration and employment histories of Filipino health care aides
2. To examine the work experiences of Filipino health care aides
3. To examine the policy context of long-term care in Manitoba

In-depth life-history interviews with Filipino health care aides examined the social, historical and economic contexts that shaped their migration, their reasons for working in personal care homes and their experiences of employment in these facilities. Semi-structured interviews with managers and administrators investigated the policy context of long-term care in Manitoba.

Thesis Organization

This thesis is organized into six chapters including this introductory chapter.

Chapter 2 provides a review of the literature on three subjects: migration and the Philippine state, the Filipino community in Manitoba, and personal care homes in Canada and Manitoba. This chapter is intended to provide contextual information pertaining to the migration and employment of Filipino health care aides.

Chapter 3 provides a review of literature on three theoretical approaches to migration and employment. The first perspective is a macro-level approach, arguing that global inequalities direct migrant women from low-income countries into the care sectors of high-income countries. The second perspective focuses at the meso-level of the gendered and racialized division of labour in long-term care. The third perspective looks at the role of social networks in the perpetuation of migration flows and the social organization of labour.

Chapter 4 presents the research design and methods used to conduct this study. The study site, participant population, recruitment techniques, interview process and data analysis are described. The life-history method is presented and discussed.

Chapter 5 presents the results of the study. The chapter is organized into two sections. Section I focuses on the migration and employment of health care aides and presents the themes that emerged from the study. Section II looks at personal care home work and compares the experiences of health care aides with the perspectives of health policy stakeholders. This section situates health care aides' employment experiences within the long-term care policy context.

Chapter 6 presents the discussion of the study findings and conclusion. The discussion is divided into four sections. Section I examines the migration and employment histories of Filipino health care aides. Section II discusses the impact of the policy context on the composition of the personal care home workforce. Section III analyzes the results of the study using the three theoretical perspectives reviewed in Chapter 3. Section IV outlines the policy recommendations based on the results of the study. This chapter ends with a discussion of the study's limitations and final conclusions.

CHAPTER TWO

Literature Review

This review of the literature will examine migration from the Philippines, the Filipino community in Manitoba as well as the organization and administration of personal care homes in Canada and Manitoba. The literature on health care aides including their job description, training, work experience and occupational health and safety will also be presented. This chapter is intended to situate Filipino health care aides within the context of the global migration of Filipino workers, Filipino migration to Manitoba, as well as the personal care home labour force.

Philippine Migrant Workers and State Policy

Filipino women are among the most peripatetic people in the world. Every day, more than three thousand overseas contract workers leave the Philippines in search of work abroad (POEA, 2008). In 2007, over one million Filipino workers left the archipelago to work overseas (POEA, 2008). These workers joined nearly 10 million Filipino migrants who work in 197 countries around the world (POEA, 2008). Ranked first in organized labour-exporting countries, the Philippines supplies the “global labour market with a diversified pool of migrant workers ranging from computer engineers to domestic helpers” (Siracusa and Acacio, 2004: 332). Almost a quarter of the total labour force, or one in every ten Filipinos, works abroad (Agunias and Ruiz, 2007). More than half of these migrants are women (POEA, 2008). In 2007, remittances from migrant workers totaled over US \$17 billion, representing 13 percent of the country’s Gross Domestic Product (GDP) (World Bank, 2007). The Philippines ranks fourth among top remittance receiving countries, following India, China and Mexico (World Bank,

2007). With the devaluation of the peso and an enormous foreign debt (US \$52 billion), the state relies on the money sent home to stabilize the economy and service external debts.

Underdevelopment propels the migration of millions of Filipinos each year. Widespread poverty and unemployment force workers to search for employment abroad. In 2006, the number of Filipinos living below the poverty line reached a record 27.6 million people (Bello, 2008). Between 2003 and 2006, the proportion of Filipinos living below the poverty line climbed from 30.4 percent to 32.0 percent (Bello, 2008). The Philippines has one of the highest levels of income inequality in Asia, with the richest and poorest 20 percent of the population earning 55 percent and 4 percent of the Gross National Income (GNI) respectively (ABD, 2008).

While the Philippines' tradition of labour migration traces back to U.S. imperialism at the turn of the 20th century (Choy, 2003), it was not until the 1970s that the Philippine government institutionalized labour export. When rising oil prices increased demand for contract migrant labour to the Middle East, President Ferdinand Marcos, "saw an opportunity to export young men left unemployed by the stagnant economy and established a system to regulate and encourage labour outflows" (O'Neil, 2004: 1). On May 1, 1974, Presidential Decree No. 442 was signed into law, formalizing state promotion and regulation of labour export. The order established a bureaucracy to recruit, manage and place migrant workers abroad and the state has actively promoted labour migration ever since. With the introduction of structural adjustment programs in the 1980s, the Marcos administration began to re-orient the Philippine economy toward export-led development. Labour export has become a critical feature of an otherwise narrow export industry, constituting 23 percent of export earnings between 2001 and 2006 (Agunias and Ruiz, 2007: 3).

Beginning in the 1980s, a shift in the international demand for migrant labour drastically altered the gender composition of this mobile workforce. The relative decline in the demand for construction and production workers and the expansion of the global market for service workers augmented “the proportional exodus of female migrant labour” (Bakan and Stasiulis, 2005: 56). Since the mid 1990s, the majority of Filipino emigrants have been women. Many migrant mothers provide income for their families at the expense of family separation. Feminization of the migrant labour force raises critical questions about the social costs associated with labour export policy².

The World Bank and the International Monetary Fund (IMF) insist that developing countries implement policies that promote migration and maximize remittance flows (Stasiulis and Bakan, 2005). According to the World Bank, “migration is an integral part of development in both developed and developing countries” (World Bank, 2008). In the midst of the global economic recession, the World Bank is encouraging the Philippines, along with other developing countries, to offer bonds to overseas workers to finance development (World Bank, 2008). The Philippine experience casts doubt on whether this strategy advanced by the World Bank and the IMF will be successful in promoting development. For over thirty years, the Philippine government has vigorously pursued labour emigration to procure foreign exchange, but their developmental record is one of the worst in Asia. In the short term, remittances may have helped them to cover their debt obligations, but they have not produced balanced economic development.

² In 2006, domestic workers comprised the largest group of overseas Filipino workers, accounting for 29.7 percent of all new hires registered with the Philippine Overseas Employment Association (POEA) (POEA, 2008). Domestic workers are disproportionately subject to poor wages and dangerous working conditions, especially in Asia and the Middle East.

The Filipino Community in Manitoba

The Philippines is the number one source country for immigrants to Manitoba. In 2007, 3,279 Filipinos arrived in Manitoba, constituting 30 percent of all immigrants to the province (Manitoba Labour and Immigration, 2008). Canadians of Filipino origin make up the largest immigrant group in Manitoba, and Manitoba has the highest proportion of Filipinos of all Canadian provinces and territories (3 percent). In 2008, the government of Manitoba signed a memorandum of understanding with the Department of Labour and Employment of the Republic of the Philippines (DOLE). The memorandum established a relationship of “cooperation and shared priorities” between Manitoba and the Philippines which include expediting the approval of selected individuals for migration and employment in Manitoba. The document sets out a framework for coordinating labour migration. Manitoba regularly provides the DOLE with a list of qualified employers and the DOLE updates Manitoba’s Department of Labour and Immigration with a list of authorized recruitment agencies. Under the agreement, Manitoba Labour and Immigration partnered with 4 Regional Health Authorities to recruit over 100 nurses from the Philippines to work in rural personal care homes in 2010.

Established in 1998, Manitoba’s Provincial Nominee Program is designed to attract new arrivals to the province. The program allows potential migrants to apply directly to the province for permanent residency. It has resulted in a dramatic increase in immigration to the province, with the largest group of immigrants coming from the Philippines (approximately 30 percent). The program fast-tracks qualified immigrants who can “demonstrate employability and potential to settle successfully” (Manitoba Labour and Immigration, 2008). Individuals applying under the family support stream of the Provincial Nominee Program must meet minimum age, education and work requirements in addition to having a relative willing to support their

settlement. Minimum requirements include at least one year of post-secondary education and attainment of a diploma or certificate, at least two years of full time work experience within the last five years and demonstrated English or French proficiency. The family support stream constitutes the largest group of immigrants, making it faster for families to bring their relatives to Canada. The definition of relative is broader than the federal immigration system, encompassing cousins, aunts, uncles, nephews and nieces.

The history of Filipinos in Manitoba dates back to the 1950s, when the first recorded Filipino immigrants arrived. This wave of Filipino migrants was made up of nurses and doctors who came to Canada via the United States. Following the Second World War, the Philippines became a major source country of nurse migrants. In the 1950s, nurses from the Philippines were issued temporary visas to work in the United States under the Exchange Visitors Program (Choy, 2003). Some of these nurses crossed the border to Canada when their visas expired (Stasiulis and Bakan, 2005). In 1967, the liberalization of Canadian immigration policy allowed Filipino nurses to immigrate to Canada as independent immigrants (Stasiulis and Bakan, 2005). That same year, direct recruitment of Filipino nurses began and over 110 Filipino nurses arrived in Manitoba between 1967 and 1968 (Dalayoan et al., 2008).

Coinciding with the recruitment of Filipino nurses, the garment industry in Winnipeg began to recruit workers from the Philippines. The first group of Filipino garment workers arrived in Winnipeg on October 1, 1968. By the end of the year, 114 workers, mostly single women, were recruited to work in Winnipeg's clothing factories. Over the next decade, thousands more Filipino men and women migrated to work in Winnipeg. Many sponsored their friends and family members, securing them employment in Winnipeg's garment factories. A significant

portion of these migrant workers came via the Netherlands where Filipino workers were recruited to work in garment factories throughout the 1960s (Dalayoan et al., 2008).

In the early 1990s, Winnipeg's garment industry suffered significant job losses (Bloskie, 2005). Though the industry recovered for the duration of the decade, the new millennium saw the loss of over half of all garment manufacturing jobs to offshore factories (Cash, 2007). In 2007, Western Glove Works dismissed their last 100 production workers and Peter Nygard closed his garment factory, terminating the employment of the remaining 230 garment workers, most of whom were immigrant women (Cash, 2007; Kusch, 2009). With the collapse of the domestic garment industry many Filipino women have taken employment as health care aides, home care workers and child care workers (Kusch, 2009; Pratt, 2009). While several scholars suggest this trend is on the rise across Canada (Nestle, 2006; Pratt, 2009; Stasiulis and Bakan, 2005), there is no available research quantifying this phenomenon.

Personal Care Homes

Personal care homes provide basic services, supportive care and 24 hour professional nursing care to residents who are unable to live independently. Over 200,000 residents live in 2,216 personal care homes across Canada (Statistics Canada, 2011). As Canada's population ages, the number of older adults living in personal care homes is increasing and residents are older, sicker and require higher levels of care than ever before (Armstrong and Daly, 2004; MNU, 2006). Resident acuity is due, in part, to the aging population and the changing population health of older adults. The Canadian Study of Health and Aging conducted in 1991, estimated that 252,600 seniors in Canada suffered from dementia (Canadian Study of Health and Aging Working Group, 1994). By 2008, that number nearly doubled to 480,618 representing 1.5

percent of the Canadian population, according to a study commissioned by the Alzheimer Society of Canada (Alzheimer Society, 2010). The study: “Rising Tide: The Impact of Dementia on Canadian Society” (2010) predicts the prevalence of dementia will increase to 2.8 percent of the population by 2038 or 1,125,184 Canadians. As dementia rates increase, governments have focused their efforts on developing community-based programs to keep seniors living at home or in their community as long as possible. The expansion of alternative care arrangements such as home care, assisted living and supportive housing facilities means that older adults who enter personal care homes have increasingly complex medical and behavioral conditions.

A study conducted by the Canadian Institute of Health Information (CIHI) profiled the population health of over 50,000 residents living in long-term care facilities across Canada between 2008 and 2009 (CIHI, 2010). The study found that the majority of long-term care residents had a documented diagnosis of Alzheimer’s Disease or a related dementia (57 percent). Over ninety percent of seniors living in residential care facilities had moderate to severe cognitive impairment, which may suggest that a portion of the population has an undiagnosed type of dementia. Approximately 80 percent of residents required extensive assistance or were totally dependent on staff for activities of daily living and over 85 percent of residents were incontinent. Seventy percent of residents were prescribed psychotropic medications, 30 percent had possible depression and 60 percent exhibited “challenging behaviors” including physical violence and resistance to care (CIHI, 2010). One quarter of residents exhibited wandering and thirty three percent had experienced a fall during the last 180 days. In addition to their cognitive and functional problems, a high proportion of residents had multiple medical conditions. Eighteen percent had diabetes, 17.7 percent had suffered a stroke and 8.4 percent were diagnosed with cancer. These data suggest that residents in personal care homes suffer from a range of

medical conditions, functional limitations and behavioral disorders that require complex medical and supportive care.

Although residents of personal care homes require complex medical care and continuous supervision, long-term residential care is not covered under the *Canada Health Act (CHA)*. Whereas “medically necessary services” are defined as core services under the CHA, “extended health-care services” are not. As a result, long-term care is not fully insured in any provincial or territorial jurisdiction. With no national standards, provinces and territories vary significantly in terms of administration, financing, quality and access to long-term residential care (Berta et al., 2006). There is regional variation in terms of the mix of private and public funding, the cost to residents, minimum allowances, staffing ratios, and personal care home standards (Berta et al., 2006). This had led to inequalities in access to residential care, the quality of care provided and the working conditions for long-term care employees.

Personal Care Homes in Manitoba

Manitoba has 126 personal care homes housing 9,832 beds. In addition, approximately 1000 seniors are on waitlists for personal care home placement (OAG, 2009). Manitoba’s personal care homes include a mix of for-profit and not-for profit homes as well as devolved personal care homes owned and operated by Regional Health Authorities (RHAs). In 2008, there were 68 RHA owned personal care homes, 40 not for-profits, and 18 for-profits (OAG, 2009).

The Department of Health is responsible for system design, funding, regulating, licensing and developing provincial personal care home policies, while Manitoba’s eleven Regional Health Authorities (RHAs) are responsible for program development and delivery (Berta et al., 2006). Provincial funding for personal care homes is administered by the RHAs and personal care homes also collect fees from residents. Residents pay a set fee based on income ranging from

\$10,841 to \$25,441 annually in 2008 (OAG, 2009). In 2008, personal care homes in Manitoba received government operating funding totaling \$290 million and approximately \$142 million of residential fees (OAG, 2009). The cost per resident, per year is approximately \$43,000, with residents paying approximately one third of the total cost (OAG, 2009).

The Winnipeg Regional Health Authority (WRHA) uses a per diem funding model based on the cost per bed per day for all not for-profit personal care homes in the region and to fund all for-profit personal care homes in Manitoba (OAG, 2009). Operational funding is based on per diem rates calculated according to residents' levels of care. There is one rate for level one and two beds and another rate for level three and four beds (OAG 2009). Although for-profit and not for-profit personal care homes receive the same rates, the bed levels used to calculate the funding for not-for profit homes have been frozen since 2001, whereas for-profit bed levels are updated annually (OAG, 2009). As a result, not for-profit personal care homes are potentially underfunded compared to for-profit homes (OAG, 2009). Unlike non-profit care homes, for-profit care homes are not required to submit audited financial statements to the WRHA, so it remains unclear how they generate profit.

Health Care Aides

Health care aides provide the bulk of care work in personal care homes. Over 100,000 health care aides work in residential care facilities across Canada (Statistics Canada 2007; 2008). They represent the largest portion of nursing staff in residential care facilities and the largest group of workers in personal care homes overall (Pyper, 2004; Statistics Canada, 2008). Since the 1980s, the number of low-wage and less-educated health care aides employed in Canada's health care system has increased, while the proportion of LPNs has fallen. Between 1980 and 2003, employment nearly doubled for health care aides, while the number of LPNs decreased by

nearly 40 percent and the number of RNs remained relatively stable (Pyper, 2004). Although the boundaries of care work are often blurred, personal care home workers are organized hierarchically, with RNs acting as managers and clinical care providers, LPNs performing a mix of clinical and supportive care, and health care aides providing the bulk of personal and supportive care (Morgan et al., 2002). This work includes dressing, feeding, bathing, grooming, toileting, lifting, meal preparation and cleaning.

Unlike professional nurses, health care aides are an unregulated workforce. They are not subject to an external regulatory organization, so they are only accountable to their employers³. Due to provincial variation and regionalization, there is no inter-provincial agreement on terminology or definitions. Job titles vary among facilities and between provinces. For example, those who work as health care aides in personal care homes hold a variety of other job titles including: nurse aide, personal support worker, nursing attendant, patient care aide, health care assistant, orderly, personal care attendant, nursing home attendant, etc.

Education and Training

There are no national standards governing the educational requirements of health care aides. It is up to provinces and territories to regulate the training of health care aides and there is

³ In 2006, Ontario's Health Professions Regulatory Advisory Council (HPRAC) submitted a report to Ontario's Minister of Health of Long-term care examining whether personal support workers should be considered a regulated health profession. The report entitled, *A Report to the Minister of Health and Long-Term Care on Regulatory Issues and Matters Respecting Personal Support Workers (2006)*, concluded that personal support workers do not qualify for regulation under the *Regulated Health Professions Act*. In 2010, British Columbia established the British Columbia Care Aide and Community Health Worker Registry. All health care assistants in British Columbia who have graduated from a health care assistant training program must register. In addition to maintaining a database of registered health care assistants, the registry allows employers to identify health care assistants who have committed serious violations. (See <http://www.cachwr.bc.ca/> for more information).

significant variation across jurisdictions. Several provinces have training programs for health aides (Health Canada, 1999). British Columbia's programs requires 22 weeks at a community college program; Saskatchewan's training programs requires a pre-employment program and a two year on the job program; Ontario's training programs require Personal Support Worker training from a community college; and Quebec's educational programs require 960 hours of training from a community college (Health Canada, 1999). In Manitoba, health care aides are required to obtain a health care aide certificate, but there are no regulations governing these training programs. As a result, health care aide certification programs within Manitoba vary in terms of length, curriculum graduation requirements and tuition.

Staffing Levels

The low staffing levels in Canada's personal care homes have been linked to negative health outcomes, resident to staff violence, workplace injury, staff burnout and low morale. Negative health outcomes associated with low-staffing levels have been well documented in the literature (Armstrong et al., 2008; Banerjee et al., 2008; Doupe, 2006; Harrington et al., 2000). A study conducted by the Manitoba Centre for Health Policy (Doupe, 2006) found that lower staffing levels in Manitoba's personal care homes were associated with increased prevalence of pressure ulcers. The Health Care Financing Administration (HCFA) report to the United States Congress found that low staffing ratios in nursing homes were associated with reduced quality of care measured in terms of health outcomes (urinary tract infections, sepsis, electrolyte imbalance, pressure ulcers, skin trauma and weight loss). In order to address concerns raised by Congress, the study aimed to determine whether minimum staff to resident ratios should be established. The project included an analysis of the relationship between staff ratios and resident health outcomes in over 5000 nursing homes as well as a time-motion study of nurse

aide care tasks. The study found that nurse aide ratios below 2.0 care hours per resident day significantly reduced quality of care across all measures, and estimated that nursing homes require a minimum of 2.8 to 3.2 nurse aide hours per resident day (depending on the case-mix) to provide quality care (HCFA, 2001). Despite the evidence, provincial governments across Canada have been reluctant to increase staffing levels to meet the minimum standards deemed necessary to provide quality care (Armstrong et al, 2009). In Manitoba, health care aide ratios in personal care homes range from 2.19 to 2.56 care hours per resident day (OAG, 2009). According to the findings of the HCFA (2001), these staffing levels are below the minimum ratio required to provide safe, quality care.

Occupational Health and Safety

Care work is dangerous work. Workers in personal care homes are exposed to a variety of health hazards including contagious and infectious diseases and musculoskeletal injury (Armstrong et al., 2008; CCOHS, 2008; Morgan et al., 2002). Staff members are at risk of exposure to blood-borne diseases such as Hepatitis B and AIDS as well as air-borne diseases including viruses and tuberculosis (Armstrong et al., 2008). There is also risk of exposure to drug resistant organisms such as multi-drug resistant tuberculosis (MDR-TB) and methicillin-resistant staphylococcus aureus (MRSA) (CCOHS, 2008). Adverse health effects are also associated with long time exposure to chemicals used for cleaning and sterilizing (CCOHS, 2008). Not only are nursing staff at risk for contracting these diseases, but so are support staff including housekeeping and laundry and food services personnel (Armstrong et al., 2008). These workers often have personal contact with infected patients and contaminated surfaces (Armstrong et al., 2008).

Personal care homes are ranked among the top 10 industries for musculoskeletal problems, the most common cause of worker absence and injury (MNU, 2006). Care work can be physically demanding leading to overexertion and injury. Health care aides are particularly vulnerable to musculoskeletal injury. Their work involves heavy lifting and many injure their backs, necks, shoulders and knees (Armstrong et al., 2008). Work absences are used to measure occupational well-being (Pyper, 2004). Nursing staff have high absence rates compared to the rest of the Canadian labour force. Compared to regulated nurses, however, health care aides are more likely to be absent from work and lose more days of work to illness and disability (Pyper, 2004).

Workplace Violence

Lifting and physical exertion are not the only causes of injury among staff in personal care homes; nursing staff are subject to high rates of violence at work. Banerjee et al. (2008) found that “violence is a constant and ongoing part of working in Canadian [long-term care] facilities” (Banerjee et al., 2008: iv). Health care aides are often pushed, shoved, hit, yelled at and bitten. Verbal abuse often includes threats, screaming, cursing, racial insults and sexual harassment (Banerjee et al., 2008: 4). According to their study, 89.7 percent of personal support workers had experienced some form of physical violence while at work. Nearly half (43.0 percent) of personal support workers encountered violence on a daily basis. The report focused on violence against personal support workers, but violence impacts other nursing staff as well; 16.8 percent of registered nurses and 24.6 percent of LPNs experienced violence on a daily basis (Banerjee et al., 2008: 4).

Studies have shown that poor working conditions contribute to the high levels of violence experienced by personal care home workers (Banerjee et al., 2008; Levin et al., 2003; Novak and

Chappell, 1994). Most violence occurs during daily activities, which “often involve intimate acts and the sharing of personal space” (Banerjee et al., 2008:10). When care workers are overworked and understaffed, have limited autonomy and are pressed for time, they often have to rush daily care activities. Rushing or forcing residents to get up, get dressed, bathe or eat puts staff at risk for violent reactions. The lack of autonomy created by poor working conditions impedes workers’ ability to accommodate residents’ needs, making them increasingly prone to workplace violence.

Stress and Burnout

Nursing staff in personal care homes report high rates of job stress (Morgan et al., 2002; Novak and Chappell, 1994; Pyper, 2004). Stress impacts the physical and psychological wellbeing of staff and is associated with reduced quality of care (Morgan et al., 2004; Pyper, 2004). Negative outcomes associated with prolonged occupational stress include coronary heart disease, impaired performance, decreased productivity, increased absenteeism and burnout (Morgan et al., 2002). Burnout refers to “a condition of emotional exhaustion, depersonalization, and reduced personal accomplishment” associated with caregiving stress. A study of nurse aides in rural personal care homes identified workload as a major contributor to job stress (Morgan et al., 2002). Nurse aides were less likely than nurses to have enough time to complete their work, and had a lower perception of control. Caring for residents with dementia can be particularly stressful. Chappell and Novak (1994) found that stress among nursing assistants was related to residents’ characteristics, such as severe cognitive impairment and uncooperative behavior. As the number of residents with dementia and multiple medical conditions continues to rise, it is likely that occupational stress and burnout will increase.

Despite their growing presence in the Canadian nursing workforce, and the increasing complexity of residents' care needs, health care aides remain an unregulated workforce. Poor working conditions increase the risk of occupational illness and injury as well as stress and burnout. Low staffing levels force health care aides to ration out care, placing them at increased risk for violent reactions from residents. The levels of stress and autonomy that health care aides experience at work impact the quality of care they can provide, highlighting the connection between the working conditions of health care aides and the quality of life of the residents they care for.

CHAPTER THREE

Theoretical Perspectives

Due to the complexity and diversity of human migration, contemporary analyses of migration draw on multiple theoretical perspectives and analytic levels. This chapter presents three theoretical perspectives that offer complementary explanations for the high concentration of Filipino health care aides working in long-term care. The first perspective is a macro-level approach, arguing that contemporary female migration patterns are shaped by global structures of inequality that direct migrant women from low-income countries into the care sectors of high-income countries. The second perspective focuses at the meso-level of the gendered and racialized division of labour in long-term care, contending that the demand for immigrant health care aides is a structural feature of Canada's health care labour force. The third perspective looks at the role of social networks in the perpetuation and expansion of migration flows. Migrant social networks refer to a set of social ties linking migrants and non migrants in origin and destination communities "through the bonds of kinship, friendship, and shared community origin" (Massey, 1988). This micro-level approach focuses on informal organization among immigrants arguing that well developed migrant social networks lead to occupational segmentation.

Women, International Migration and Care Work

Filipino women working as health care aides in Canada's hospitals and personal care homes are part of a global migrant workforce of women. In 2005, 191 million people, representing 3 percent of the world's population lived outside of their country of birth (UN, 2006). Until the 1980s, men made up the majority of international migrants. Today,

approximately half of the world's migrants are women (UN, 2006). The relative decline in the demand for construction and production workers and the expansion of the global market for service workers augmented "the proportional exodus of female migrant labour" (Bakan and Stasiulis, 2005: 56). This pattern of female migration is part of a global process termed the "feminization of migration" (Ehrenreich and Hochschild, 2002).

Traditional accounts of migration assume that migrants move for individual economic gain. This perspective views migrants as rational economic actors whose decisions "are shaped between the 'push' of economic difficulties in the country of origin and the 'pull' of new work opportunities in the country of destination" (Bauer and Thompson, 2004: 335). Feminist scholars have challenged this view of migration because it overlooks non-economic reasons for migration, focuses on individuals, rather than families or households and regards women primarily as dependent migrants (Bauer and Thompson, 2004; Houstoun et al., 2004; Raijman et al., 2003). Contesting conventional theories of migration, Raijman et al. (2003) state: "contrary to the widely accepted assumption that migration is a rational strategy to maximize family income and minimize risks associated with a variety of market failures...we argue that international migration, especially for women, is a strategy abounding with dilemmas that defy instrumental rationales and assumptions" (Raijman et al., 2003: 731). For example, millions migrant mothers provide income for their families, but often at the expense of family separation and lack of direct involvement in their children's upbringing. Women may leave behind their families with the hope of supporting their migration in the future. As such, women's migration may be instrumental for family migration. Though women migrate for financial reasons, as immigrants they often face downward social mobility (Bauer and Thompson, 2004; Raijman et al., 2003). Reports of abuse, human rights violations and even death raise concern about the

vulnerable position of female migrant workers (Agunias and Ruiz, 2007; Ball, 2004). Some migrate for non-economic reasons: in the Philippines, where divorce is illegal, migration may be the only alternative to an unsatisfactory marriage.

As part of their effort to rethink migration theory, feminist researchers have devoted attention to the growing international migration of care workers. Every year, millions of women from developing countries migrate to work in the care sectors of wealthy countries. Ehrenreich and Hochschild (2002) term this process “the globalization of women’s work”, whereby care work in high income countries is increasingly performed by migrant women. There are historical precedents for the globalization of women’s work. What is unique today is the “sheer number of female migrants and the very long distances they travel” (Ehrenreich and Hochschild, 2002: 5). The proponents of this theory argue that international migration patterns are responding to a “crisis of care” in the world’s developed nations (Parrenas, 2002).

As the world’s population ages, attention has shifted from child care and domestic service to the provision of elder care (Anderson, 2007). In high income countries, caring for the young and old is increasingly performed by migrant women working in private homes, hospitals, personal care homes, and child-care centres (Ehrenreich and Hochschild, 2002). Nestel (2006), writing of the feminization of international migration, argues, “This focus [on domestic workers] now needs to be widened so that we can account for the ways in which the same dynamics have operated within other sectors, including the health care labour force.” (Nestel, 2006: 19). Similar to the situation in a large number of households, personal care homes have become increasingly dependent on the employment of immigrant care workers. As a result, female migration patterns are not only linked to changes in the gendered division of labour in households, but also the structure and demand for care work in Canada’s personal care homes.

Scholars in the field of migration and care work are primarily focused on macro-analytic theories of migration and social reproduction (Isaken et al., 2008), referred to as “global care chains” or the “international division of reproductive labour”. These approaches views care work as a global commodity, allocated to migrant women from developing countries (Ehrenreich and Hochschild, 2002). First proposed by Hochschild (2000), the concept of “global care chain” has attracted considerable attention in the field of women and migration (Hochschild, 2000; Isaken et al., 2008; Sarvasy and Longo, 2004; Yeates, 2004; 2005). The initial concept is based on the work of Parrenas (2001,2005), who asserts that the international migration of women has created a “care deficit” in sending-countries such as the Philippines because thousands of migrant mothers leave their children and parents in the care of others. This conceptual model connects women’s participation in the paid labour market and rising demand for migrant child care and domestic workers through symbolic chains of women around the globe.

The concept of an international division of reproductive labour draws on Marxist theory of the division of labour, feminist theory and globalization theory (Parrenas, 2001; 2005; Misra et al., 2006; Onuki, 2009; Young, 2001). Proponents of this theoretical perspective argue that migrations of care workers are embedded in the global political economy (Parrenas, 2001; Misra et al., 2006; Onuki, 2009). Structural adjustment programs and neoliberal policies have created global inequalities that shape the international flow of care workers (Misra et al., 2006; Onuki, 2009; Yeates, 2005; Young, 2001). At the same time, neoliberal policies in developed countries create the demand for migrant caregivers because of women’s increased participation in the paid workforce and the privatization of child care (Isaken et al., 2008; Misra et al., 2006; Young, 2001). The result is an international division of ‘care’ labour that is organized along the lines of gender, race, class and citizenship.

The theoretical work on globalization and care work highlights the sheer magnitude of this international phenomenon and draws attention to otherwise overlooked workers. It suggests that relations of social reproduction are not only gendered, but increasingly embedded in global structures of power and uneven development. This perspective connects the prevalence of Filipino health care aides in Canada to poverty and underdevelopment in the Philippines. On the other hand, the inclusion of health care aides and nursing homes into macro theories of global migration and care work (Brown and Braun, 2008; Ehrenreich and Hochschild, 2000; Stasiulis and Bakan, 2005) raises questions about categorization of “care work”.

Care work is a broad concept with multiple meanings. Generally, it refers to a “range of tasks and activities to promote the personal health and welfare of people who cannot, or who are not inclined to, perform those activities themselves” (Yeates, 2004). In the literature on women and migration, the term care work encompasses an array of occupations traditionally associated with women’s work, including nurses (Ball, 2004; Bourgeault and Wrede, 2008; Choy, 2003; Stasiulis and Bakan, 2005); health care aides (Armstrong et al., 2008; 2006; Brown and Braun, 2008; Cangiano et al., 2009; Onuki, 2009); domestic workers and nannies (Enrenreich and Hochschild, 2002; Bakan and Stasiulis 1995; Lindio-McGovern, 2003; Parrenas, 2001;2005;2008; Pratt, 1999); and even sex trade workers (Enrenreich and Hochschild, 2002). These occupations are gendered and often filled by migrant women from developing countries. There are, however, important distinctions between these occupations. The connection between sex-trade work and care work (Ehrenreich and Hochschild, 2002) is particularly controversial. Lumping all “care” workers together may create a unified theory, but it masks critical distinctions between these occupations. There are significant differences between personal care home workers and child care providers or domestic workers. As Canada’s population ages, the

social, supportive and health needs of personal care home residents have shifted dramatically: residents have escalating rates of dementia, immobility, frailty, co-morbidities and complex behavioral issues. Health care aides are not simply performing domestic labour within the health care system; they are front line workers delivering a range of supportive and personal care to residents with increasingly complex health problems.

Furthermore, their migration entry channels are different. While nurses and domestic workers may be recruited through international agencies, health care aides are not. In many countries, nurses qualify as skilled workers and are often classified as “in demand”. Other occupations such as domestic workers and health care aides are considered “low skilled” or “unskilled” and may fall under different immigration categories. Sex-trade workers and domestic workers may migrate through illegal channels, including human trafficking.

If migration patterns are shaped by the demand for care workers in receiving countries (Choy, 2003; Parrenas, 2008; Nestel, 2006), then what factors affect the demand for Filipino health care aides in Canada? Unlike domestic workers, health care aides working in personal care homes are caring for institutionalized residents with complex health problems, so women’s participation in the paid labour force is a less compelling explanation for their growing numbers. To examine the demand for Filipino health care aides in Canada, the following section reviews the literature on health care labour, gender, migration and race.

Gender, Race and Health Care Work

The uncertain place of health care aides within the literature on globalization and care work reflects the tensions inherent in the concept of caring labour. On one hand, the term “care” is associated with women’s unpaid, reproductive work in the home. On the other hand, it is used to refer to health care labour, particularly in the field of nursing. Unlike women’s unpaid work

in the home, health care work is generally understood as a skilled occupation. Health care aides appear to fall somewhere in between, performing a mix of domestic and supportive care within health care and household settings.

In their book, *Critical to Care: The Invisible Women in Health Services*, Armstrong et al. (2008) explore this dichotomy by analyzing the interplay of gender and race in the division of health care work. According to the authors, work performed by health care aides is invisible and undervalued because it is traditionally women's work. Female-dominated jobs are most frequently defined as ancillary through their association with women's domestic duties. Though critical to the provision of care, these occupations are classified as separate and subordinate to health care work. Long-term residential care is not covered under the *Canada Health Act* (CHA). Whereas "medically necessary services" are defined as core services under the CHA, "extended health-care services" are not. As a result, long-term care falls under provincial and territorial jurisdiction. With no national standards, provinces and territories vary significantly in terms of administration, financing, quality and access to long-term residential care.

Conceptually, the dichotomy between medically necessary services and extended health services marginalizes the more supportive aspects of care, positioning them at the periphery of health care. In practical terms, this had led to inequalities in access to residential care, the quality of care provided, and the working conditions for long-term care employees.

Like Armstrong et al. (2008), other feminist scholars argue that the gender division of labour in the health care system reflects the traditional division of labour between men and women (Butter et al., 1987; McPherson, 1996). According to this perspective, women are responsible for domestic-oriented tasks such as cleaning, caring and support, while men perform the more prestigious, intellectual, curative work. Although this approach highlights some

important distinctions between men and women in the health care system, if fails to take into account other dimensions of social identity such as race, class and country of origin. To counter this omission, Nestel (2006) contends that the health care labour force does not resemble the “traditional family”, but rather, “the newly constituted bourgeois family in which migrant and immigrant women of colour perform the fundamental caring duties, allowing the (white, middle class) woman of the family to pursue more prestigious, lucrative, and autonomous forms of work” (Nestel, 2006: 21). Overlooking race or immigration status means failing to take into account how “women are positioned as both dominant and subordinate in relation to one another” (Nestel, 2006, 17). In the female-dominated field of nursing, it is not merely gender, but the interplay of gender, race and country of origin that defines the work and skills of Filipino health care aides.

Historically, nursing in Canada has been racially and culturally exclusive (Calliste, 1993; McPherson, 1993; Stasiulis and Bakan, 2005: 107). Following the Second World War, racial and cultural restrictions were eliminated from nursing education, allowing Black, Asian and First Nations nurses to enter the profession. In the late 1960s, the liberalization of immigration policy facilitated the entry of migrant women of colour, resulting in an increasingly diverse nursing labour force.

Despite the diverse makeup of Canadian nurses, evidence suggests that racial segmentation is a feature of nursing in Canada and the United States (Armstrong et al., 2006, 2008; Ball, 2004; Calliste, 1993; Nestel, 2006; Stasiulis and Bakan, 2005). The distribution of immigrant women and women of colour within the nursing workforce reflects hierarchies within the profession. According to Nestel (2006), the majority of highly skilled nursing is performed by white registered nurses, while immigrant women of colour are overrepresented among lower

skilled nursing staff, including licensed practical nurses, health care aides and home care workers (Nestel, 2006). Racial biases have been found in recruitment and hiring, promotions, supervision, work assignment and disciplinary practices (Calliste, 1993; Stasiulis and Bakan, 2005). Immigrant nurses are often employed in inferior positions with poor working conditions that Canadian born nurses will not fill. The high concentration of immigrant women and women of colour working as health care aides, and their lack of representation in managerial positions in nursing (Nestel, 2006; Stasiulis and Bakan, 2005), suggests structural inequalities pervading Canada's health care labour force.

The racialized hierarchies evident in nursing today stem from the transformation of nursing education and the organization of the profession. Until the 1960s, nurses were responsible for the domestic and caregiving tasks that are now performed by lower ranking health care aides. In fact, virtually, "all of the work currently done by ancillary workers was once done by nurses" (Armstrong et al., 2006: 16). At the turn of the twentieth century, there were only two categories of women working in health care: graduate nurses and students (Armstrong et al., 2006). Student nurses provided bedside care and domestic chores. Following World War II, Canada's hospitals expanded rapidly, fueled by new technologies and the introduction of public financing for hospital insurance. Canadian nurses formed professional associations and unions (McPherson, 1996) demanding better wages and working conditions, "as well as the right to leave some of those housekeeping tasks to others" (Armstrong et al., 2006:19). With a growing labour force and rising labour costs, new occupational categories emerged distinguishing between the skilled and clinical aspects of nursing and the domestic work required in the provision of health care. With registered nurses taking on more complex, clinical tasks, "subsidiary personnel such as ward aides, practical nurses, and nursing assistants

were introduced to take responsibility for the many less technological aspects of patient care that [registered nurses] had previously performed” (McPherson, 1996: 6).

Following the model of physicians, nurses have struggled to secure professional control through university requirements. In 1982, the Canadian Nurses Association adopted the “Entry to Practice” position (Nestel, 2006: 20). This policy stipulated that the preferred credential of nurses entering practice is a four-year bachelor of nursing degree. The formation of an elite, university educated nursing workforce, “constructs a defining border between the working-class aspects of nursing labour and its more scientific and intellectual ones” (Nestel, 2006: 20).

The movement to professionalize nursing in Canada led to the creation of a nursing hierarchy that ultimately differentiated health care workers along lines of gender, race, and country of origin. The new order of nursing distinguishes between “those with university training, and those whose education is acquired in more accessible and less prestigious institutions like community colleges; between labour in which traditional female caring skills are the major component and labour that is more medical and managerial” (Nestel, 2006: 20).

Massey et al. (1993) argue that high concentration of immigrants within a particular occupation does not simply reflect the social status accorded to the work, rather, it alters it. Jobs with high numbers of immigrants are labeled “immigrant jobs” leading to stigmatization. Native born workers are reluctant to fill these positions, increasing the demand for foreign-born workers. Whereas feminist scholars (Armstrong et al., 2008; Nestel, 2006) emphasize the connection between job characteristics and the social status of women who occupy these positions; Massey et al. (1993) argue that high concentrations of foreign-born workers will lower the social status of a job, regardless of its characteristics. Because health care aide work has

historically been associated with women's work, relegated to the bottom of the nursing labour hierarchy, it is likely that the characteristics of the work impact the prestige attributed to the job. On the other hand, Massey's theory of social labeling suggests that this process is dynamic, and the growing proportion of immigrant women working as health care aides alters the social status accorded to the occupation thereby increasing the demand for immigrant health care aides.

Values attached to workers' skills are not neutral. Rather, they are shaped by social context and the historical struggle between workers and employers and among workers to control labour markets (Gaskel, 1993). Time spent in training is often used to determine the level of skill involved in work, but it is not an objective measure. The absence of regulations for health care aide certification and relatively short training period may reflect the low value placed on their work, and by extension, the marginal position of the women who perform it. As Gaskel comments, "When we overlook women's skills, devalue them, give them low ratings, it is not a technical glitch, but a reflection of the status and power women have not had in this world" (Gaskel, 1993: 204). According to Cangiano et al. (2009), the 'low skill' categorization is problematic, reflecting the short training programs and predominance of immigrant women in the work force. The study found that 'soft skills' such as communication and respect were critical to the provision of care. Although these skills are often overlooked, recipients of care, families, managers and nursing assistants valued caring skills.

The status of health care aides is not only linked to their ranking in the health care labour hierarchy, it is also connected to the patients they care for. Health care aides constitute the largest workforce in personal care homes, providing personal and supportive care to residents that are increasingly sick and disabled. As front line workers, the care that they provide directly impacts the quality of life of long-term care residents (Morgan et al., 2002). In addition to

providing basic care, health care aides constitute the “key component” of the social environment, playing a central role in the daily lives of residents (Morgan et al., 2002). These areas of work, however, are often viewed as separate and subordinate to medical care. Health care aides working in long-term care facilities make less money than their acute care counterparts and they are also more likely to be women, visible minorities and immigrants (Statistics Canada, 2008). The stigma attached to dementia sufferers and the disabled is transferred to the workers who care for them (Walsh and O’Shea, 2009). This, in turn, impacts the quality of care residents can receive.

The relatively low status of long-term care is also evident in the makeup of the nurse workforce. In Canada, foreign-born nurses are more likely to work in long-term care than native-born nurses (Fujisawa and Colombo, 2009). In 2009, the Manitoba government recruited over 100 nurses from the Philippines to work in rural personal care homes throughout the province, indicating that Canadian-born nurses are reluctant to fill long-term care positions. Thus the status of health care aides is not only linked to their position within the nursing workforce, but to the status of long-term care and the residents who depend on it.

The literature on immigrant women within the health care labour force looks at the development of gendered and racialized hierarchies within the field of nursing, highlighting the relationship between occupational hierarchies and social categories such as gender, race and country of origin. According to this theoretical framework, the high concentration of immigrant health care aides is inextricably linked to the low status accorded to this occupation. By emphasizing the interplay of social identities, including gender, ethnicity and country of origin, this theoretical perspective demonstrates the structural inequalities pervading Canada’s health care labour force. It goes beyond feminist critiques that lump women together into one category,

demonstrating inequalities between women. This approach is particularly well suited to analyses of nursing work, as the profession is female-dominated.

On the other hand, this perspective does not address immigrant women's reasons for pursuing work in long-term care, nor does it account for the high concentrations of women from specific ethnic backgrounds to the exclusion of others: the predominance of Filipino health care aides relative to other ethnic groups remains unaccounted for. In fact, the literature tends to use categories such as race and immigrant interchangeably, while research suggests that these two factors have very different implications in the labour market (Waldinger and Lichter, 2003).

Migrant Social Networks

Finally, the third theoretical perspective – social network theory – offers a “micro-social” approach, focused on the informal social processes structuring the supply of migrant labour. This orientation differs from economic or structural theories because it gives precedence to the social context within which migrants make decisions and seek employment (Portes, 2007). According to network theory, bonds of kinship, friendship and shared community of origin create migrant social networks that facilitate future migration and link immigrants with job opportunities in destination countries (Massey, 1988). Each act of migration creates a set of social ties, increasing the likelihood of subsequent migration by reducing the costs and risks associated with migration (Massey et al., 1993: 448). Once migration reaches a “critical threshold”, migrant networks will perpetuate the flow of new immigrants: “The expansion of networks reduces the costs and risks of movement, which causes the probability of migration to rise, which causes additional movement, which further expands the networks, and so on” (Massey et al., 1993: 449). Unlike other theoretical perspectives that attempt to explain the

origins of migration, network theory focuses on the social structures that “sustain migration over time” (Portes, 1989:612). Moving disrupts social relations, but it also leads to the creation of new social networks that convey information about job markets to new immigrants seeking employment. Networks provide a source of social capital that migrants utilize to acquire foreign employment (Massey et al., 1993). According to this perspective, labour migration occurs within the context of social relations, whereby migrants “draw upon obligations implicit in relationships such as kinship and friendship to gain access to employment and assistance at the point of destination” (Massey et al., 1993: 449). Once networks are well developed, migration flows tend to expand. This theory views migration as a dynamic social process, with each act of migration altering the context of future migration (Massey et al., 1993).

As migrant networks expand, the theory posits, the pool of potential migrants in the source country will expand from close kin to community members, to people from different regions and varying socio-economic backgrounds. In the destination area, migration networks can lead to a very different phenomenon: occupational segmentation. In addition to linking people, social networks connect “immigrants and the institutions that sustain them” (Waldinger and Lichter, 2003: 3). The social networks that span immigrant communities can stream immigrants into occupational niches, predominantly low-status jobs that native-born workers are reluctant to fill. Because migrants tend to follow their family, friends and fellow citizens, they make use of these social connections when searching for a job. These social ties convey information about the job market, providing social supports and job referrals that ultimately impact the organization of labour.

Not only immigrants utilize social networks; employers use them too. Waldinger and Lichter’s (2003) study of immigrant labour segmentation in the United States analyzed the

interaction between social networks and bureaucracy in the workplace. According to the authors, employers use informal social networks among their employees to bring forward new recruits, particularly when the job does not require formal training. When employees refer applicants they reduce the cost and risks associated with hiring, in part because they have a stake in the performance of the new recruit, especially if it is a family member. Managers often assess applicants based on the characteristics of the employee recommending them, because they “believe that good employees produce good referrals” (Waldinger and Lichter, 2003: 105). This process allows employers to avoid costly recruitment strategies, and they do not have to increase wages to attract native born workers. There are potential consequences to this strategy, however. Ethnic groups with strong familial bonds can gain power in the workforce, leading to tension or conflict with management or other minority groups. When ethnic groups become too strong, management can view them as burden, and they may establish bureaucratic procedures and formal hiring processes to limit the power of social networks in the workforce (Waldinger and Lichter, 2003).

Waldinger and Lichter (2003) found that the job requirements for entry-level hospital workers were higher than other industries, even among jobs with no formal training requirements. The demands of health care jobs, which often involve interacting with health care professionals and patients, require linguistic and interpersonal skills. Hospital management emphasized the importance of speaking English and expressed concern over the linguistic diversity of their employees. For example, one hospital manager explained: “We’re really trying to promote and encourage people to speak English . . . if there’s an emergency situation, you know, these instructions are more often than not given in English.” (Waldinger and Lichter, 2003: 75). Another manager commented: “If they talk Tagalog or Chinese, say, on the job, we

will not tolerate it long. This is an English-speaking facility” (75). Job requirements, such as English fluency, limit the scope of social networks in the work place, because they disadvantage immigrants and formalize the hiring process. Language requirements are often necessary in hospitals given the nature of the work, so the constraints they place on social networks may be an unintended consequence. Nevertheless, workers who lacked fluency in English were present in the hospital workforce, especially in low-status positions that involve limited interaction with patients or health care providers. The combination of referral based hiring and the demand for skilled employees results in a tension between the expansive tendency of social networks and the formal requirements that bound them (Waldinger and Lichter, 2003).

Recent empirical research on immigrant caregivers in the UK, Ireland and Canada supports the hypothesis that migrant health care aides use informal networks to secure employment (Bourgeault et al., 2009, Cangiano et al., 2009; Walsh and O’Shea, 2009). In each country, informal social networks played a significant role in the recruitment of immigrant care workers. According to the studies, migrant social networks act as pathways linking migrants to employment opportunities in long-term care. Bourgeault et al. (2009) study of immigrant care workers in Canada found that recruitment agencies do not play a significant role in the migration or employment of immigrant health care aides. Rather, informal networks and word of mouth direct immigrants to seek work in long-term care. Many migrants discovered employment opportunities through family and friends already working in the long-term care sector. Employers also utilize informal social networks, relying on referrals and word of mouth to recruit new employees (Bourgeault et al., 2009; Walsh and O’Shea, 2009). For example, an employer interviewed in Walsh and O’Shea’s (2009) study of migrant care workers in Ireland, commented: “Word of mouth seems to get around. We’ll say we have a migrant worker here,

he'd tell someone back home...so we're getting CVs and applications all the time from abroad.” (74).

Similarly, research on Philippine migration suggests that social networks expand labour migration flows from the Philippines. While the Philippine state has long promoted labour-export through government institutions, scholars argue that migration has become entrenched in the social fabric of the Philippines, often referred to as a “culture of migration” (Asis, 2006; Choy, 2003; Parrenas, 2001). The magnitude of human migration flowing from the Philippines alters the context in which future migrants leave. Migration has become a social ideal, albeit fraught with controversy (Choy, 2003; Parrenas, 2001). With over 10 million migrants working on foreign shores, millions of Filipinos have connections to family members in almost 200 countries around the globe. While poverty and unemployment, as well as state policies that encourage emigration, propel the migration of over a million Filipinos every year, social network theory suggests that the transnational connections among Filipinos will perpetuate and expand the flow of future migrants: “Even without government involvement, labour migration from the Philippines will likely persist thanks to social networks, social capital, and social remittances that have flourished. Filipino society has become migration – savvy, having developed the ability to respond and to adjust to the changing demands of the global labour market.” (Asis, 2006). If this is the case, it suggests a continuing pattern of Filipinos securing foreign employment through social networks.

Manitoba's immigration policies may also promote the expansion of migrant social networks. According to Massey et al. (1993), immigration policies that promote family reunification increase the strength and scope of migrant social networks: “They reinforce migrant networks by giving members of kin networks special rights of entry” (450). Manitoba's

Provincial Nominee Program is specifically designed to promote migration through community and family connections, and it represents the largest source of Philippine immigrants to Manitoba (Manitoba Labour and Immigration, 2008).

With the exception of family reunification programs, social network theory largely ignores immigration policies and political and economic conditions. By focusing on micro-level social relations, this perspective does not account for the public policies and transnational inequalities that structure migration patterns and occupational segmentation. The theory of social networks and occupational segmentation highlights the organizational power of informal social ties, but it does not take into account the barriers immigrants face in the labour market, or the conditions that propel them to emigrate in the first place. Network theory is based on the concept of progressive accumulation of social ties; it is intrinsically oriented toward the future. As such, it is largely a-historical, unable to account for the root causes of human migration. On the other hand, it offers a dynamic theory of migration and the social organization of labour that does not contradict other explanations. In fact, the constraints of the theory make it compatible with other explanations: it is not a grand theory of human migration. As Portes (2007) puts it: “Regardless of the various perspectives on the origins of labour migration, all contemporary scholarship converges on the concept of social networks as a key factor sustaining it over time” (77). The strength of this perspective comes from its successful application in a number of empirical studies (Curran et al., 2005; Davis et al., 2002; Massey and Zenteno, 1999; Waldinger and Lichter, 2003) as much as its ability to complement other theoretical and analytical approaches.

This chapter reviewed multiple theoretical perspectives that offer complementary explanations for the high concentrations of Filipino health care aides working in personal care

homes. While the theories approach their subject through different analytical lenses, they are not necessarily contradictory. Massey et al. (1993) assert that the complexity of contemporary migration “requires a sophisticated theory that incorporates a variety of perspectives, levels and assumptions” (1993, 432). The three complementary perspectives presented in this chapter provide insight into the prevalence of Filipino health care aides from different analytical levels: the global processes facilitating this movement, the structural demand for immigrant health care aides within Canada’s long-term care work force, and the social networks linking immigrants to occupational niches.

CHAPTER FOUR

Methodology

This chapter presents the research design and methods used to conduct this study. The research process is described, including the overall research design, the sampling strategy, recruitment, data collection and analysis. The strengths and limitations of the life history method for research involving women and migration is also examined. The chapter concludes with a discussion of recruitment challenges as well as ethical considerations.

Research design

This is a qualitative study of the migration and work experiences of Filipino health care aides in the Philippines and Winnipeg, Manitoba. The research includes interviews with Filipino health care aides, health policy stakeholders and key informants from the Philippine community in Winnipeg. The core of the research project consists of in-depth interviews with Filipino health care aides working in personal care homes in Winnipeg, Manitoba. Using a life-history approach, these interviews explored their decisions to migrate, their settlement experiences in Winnipeg and their work experiences as health care aides. To supplement this data, semi-structured interviews were conducted with health policy stakeholders to examine the policy context in long-term care. In addition, semi-structured interviews were conducted with key informants from the Philippine community to obtain a broader understanding of the Philippine community in Manitoba. Participants were recruited using a purposive sampling approach. This sampling strategy involves selecting cases that will enable in depth understanding of the central

research questions (Patton, 2002: 230). The different purposive sampling approaches used to recruit health policy stakeholders, health care aides and key informants will be discussed below.

Study Site

The study was conducted in Winnipeg, Manitoba. According to Statistics Canada 2006 census data, almost half (45 percent) of all health aides working in Winnipeg were born abroad and 20.1 percent of health care aides are Canadians of Filipino origin (Statistics Canada, 2008). The large Filipino population and substantial health care sector make Winnipeg an ideal location for a study of Filipino health care aides. Health care aides were recruited from multiple personal care homes, rather than a single site. This ensured that the study sample would include health care aides working in different types of personal care homes (publicly run, non-profit and for-profit).

Long-Term Care Policy Stakeholders

Interviews

Seven interviews were conducted with policy stakeholders including two long-term care administrators, two managers of personal care homes, one union representative, and two representatives from the Department of Labour and Immigration. Semi-structured interviews were conducted in person or over the phone, depending on the preference of the participant. Each interview lasted between 30 and 45 minutes, was recorded and subsequently transcribed. Field notes were taken during the interview.

Interviews with health policy stakeholders were designed to obtain information about the policy context in long-term care. Participants were asked broad, open-ended questions about

changes to long-term care policy and the major challenges faced by personal care homes. Health policy stakeholders were also asked specific questions about working conditions in personal care homes, the long-term care workforce and the employment of immigrant health care aides (Please see Appendix 7).

A single thirty minute semi-structured interview was also conducted in person with two representatives from the Department of Labour and Immigration to obtain background information about Manitoba's immigration program and the recruitment of health care workers from the Philippines. The participants requested to be interviewed together. Representatives were asked questions about the Provincial Nominee Program, current trends in immigration to the province, and the international recruitment of health care workers.

Recruitment

Interviews with managers and administrator took place between June 2009 and July 2010. A purposive sampling approach was used to select health policy stakeholders. This strategy involved identifying the stakeholders involved in administering and managing the health care aide labour force and contacting them directly to request in an interview. Potential volunteers were identified through websites for personal care homes and government bodies. The union representative and one of the long-term care managers were identified during interviews with health policy stakeholders. Potential volunteers were contacted by email or telephone and asked to participate in an interview. One administrator was interviewed over the phone, while the other participants were interviewed in person.

Representatives from the Department of Labour and Immigration were identified through the Department. The Department provided contact information for a potential volunteer. After

emailing the potential participant information about the study, she suggested meeting with a different representative and forwarded the email to the potential volunteer. The staff member agreed to participate and invited an additional representative from the Provincial Nominee Program. The two representatives were interviewed at the same time.

In total, eight long-term care policy stakeholders were contacted for an interview and seven agreed to participate. One did not respond to requests for an interview. All of the seven participants who agreed to participate completed an interview.

Key Informants from the Philippine Community

Recruitment

Given the lack of literature on Philippine migration to Winnipeg, additional interviews were conducted with three individuals from the Philippine community who were active in community organizations. Key informants were recruited using a snow-ball sampling technique. Potential participants were identified through the websites of community organizations as well as through word of mouth. Potential participants were contacted by email or telephone and asked to participate in an interview.

Participants

The purpose of these interviews was to obtain background information for the research project and to establish contact with community members to facilitate the recruitment process. While this data was not included in the analysis of health care aides' experiences, this research informed the development of interview guides for health care aides as well as the sampling strategy. In addition to providing contextual information, key informants from the Philippine

community acted as consultants for the recruitment of health care aides and referred the principal investigator to potential participants.

Interviews

Members from the Philippine community provided insight into the historical and cultural context of the Philippine community in Winnipeg and the migration of health care aides. Semi-structured interviews were conducted with three key informants. The interviews lasted between 30 minutes and 1 hour, were recorded and subsequently transcribed. Community informants were asked broad questions about migration from the Philippines to Winnipeg, including questions about the Philippines, the history of the Philippine community in Winnipeg, challenges faced by recent arrivals and resources available for new immigrants. They were also asked questions about Filipino health care workers and Filipino health care aides. Depending on their area of expertise, each key informant was probed about additional aspects of the Philippine community.

Health Care Aides

Recruitment

Recruitment of health care aides took place over a period of one year, from June 2009 to July 2010. In total, seven health care aides participated in interviews. Prior to commencement of the study, it was determined that recruitment would take place through advertisements posted at a Filipino community centre. At the beginning of the study, however, key informants were consulted for advice on recruitment of health care aides. It was suggested that word of mouth would be the most effective recruitment strategy, so it was decided that health care aides would

be recruited using the snowball sampling technique. Snowball sampling refers to type of purposive sampling that yields a study sample through “chain referrals” (Biernacki and Waldorf, 1981: 141). It is often used to recruit populations that are vulnerable, difficult to access, or have “low social visibility” (Biernacki and Waldorf, 1981).

The first four health care aides were recruited using snowball sampling technique. An informant from the Philippine community provided contact information for 5 health care aides working in personal care homes. Each potential participant gave permission for their contact information to be passed on. Three of the potential volunteers agreed to participate in the study. Two declined to participate because they didn't have time, citing they had multiple jobs and young children. One of the health care aides provided contact information for another health care aide who agreed to participate in the study.

While snowball sampling provided the first four health care aides, it did not yield any further health care aides because participants were concerned about the workload of their fellow employees and felt they would not have the time to participate in an interview. Although these women were part of wide networks of Philippine health care aides, they did not provide additional contacts for the study because their co-workers have young children and multiple jobs.

In order to recruit more health care aides, the research project was presented at the Directors of Care, Personal Care Homes meeting. With the permission of the Winnipeg Regional Health Authority, directors of personal care homes who were interested in supporting the research and recruitment process were asked to contact the principal investigator. Directors from two personal care homes agreed to participate and circulate an advertisement for the research project within their personal care home. This recruitment method yielded three more interviews. The interested health care aides contacted the principal investigator, discussed the

research project and interview process and scheduled an interview. In total, ten health care aides were contacted and invited to participate in an interview. Three health care aides declined, and seven agreed to participate. All seven health care aides who agreed to participate in the study completed an interview.

Health care aides

Health care aide participants consisted of seven women who emigrated from the Philippines and currently work as health care aides in personal care homes. All health care aides were capable of speaking, writing and reading English, although for each of them, it was their second language.

Health care aides were purposefully sampled to include subjects of different ages and lengths of residence in Canada. The sample includes health care aides with different lengths of residence in Canada in order to capture the experiences of Filipino health care aides over time and shed light on the changing structure of the long-term care labour force. This technique enabled historical comparison of the factors that propelled the migration and shaped the employment of Filipino health care aides. Health care aides were also purposively sampled to include health care aides from different personal care homes, including for profit and not-for profit facilities. Many of the health care aides work in multiple facilities or health care sectors and provided information about a range of long-term care work settings. This was particularly valuable because these health care aides imparted comparative insight about the long-term care system.

Three of the health care aides have worked in personal care homes for over 25 years, offering insight into the history of personal care homes in Winnipeg and the changing role of

health care aides. These health care aides were key informants, and their interviews lasted approximately two hours due of their extensive knowledge of personal care homes and Philippine health care aides. In addition to questions about their migration and work experience, they also discussed the history of health care aides in Winnipeg, their changing role within long-term care and changes to personal care homes over the past 25 to 35 years. These key informants provided a historical perspective on the development of a Philippine health care aide labour force, and its relation to different waves of Philippine immigration, and the changing structure of long-term care.

Health Care Aide Interviews

A qualitative method was chosen to facilitate an in-depth examination of the migration experiences of Filipino health care aides in the Philippines and Canada. Using a life history approach, a series of 1 to 2 hour semi-structured open-ended interviews were conducted with Filipino health care aides working in personal care homes in Winnipeg, Manitoba. The interview guide was a modified version of the questionnaire developed by Spencer et al. (2010) for an international study of migrant care workers (See Appendix 5). This questionnaire was developed and pilot tested across four countries (Spencer et al., 2010). In addition to interviews, each participant was administered a short questionnaire at the start of the interview to obtain basic demographic characteristics, employment history and migration dates (See Appendix 6). Five out of seven interviews were recorded and subsequently transcribed. Two of the health care aides chose not to have the interview recorded, so notes were taken during the interview, and transcribed immediately afterwards. Field notes were recorded throughout the interview process and included descriptive information, observation and some “informal interviewing” (Corbin and

Strauss, 2008: 124). Following each interview, the principal investigator wrote a memo that included a summary of the interview, followed by observations (such as points where an interviewee became emotional), and insights that emerged during or following the interview.

Life History Method

The life history method is a qualitative approach that employs biographical narratives in oral or written form (Chase, 2005). Although it often entails an extensive biography that encompasses most of a person's life, it also refers to the in-depth study of a significant aspect of a life, such as migration (Chase, 2005). This study utilized the latter approach, investigating the migration and employment experiences of Filipino health care aides through semi-structured open-ended interviews. This method enabled an in-depth exploration of the journey from the Philippines to Winnipeg's personal care homes.

Life history evidence is particularly effective for researching both migration and gender (Bauer and Thompson, 2004; Chase, 2005). Migration narratives "connect on the one hand transitions that they experience through migration between cultures; and on the other hand, the often-hidden connections and differences between men's and women's experiences" (Bauer and Thompson, 2004: 334). Though critics of the life history method point out that reliance on memory and testimony cannot be verified, the processes of introspection and remembering "yield fascinating double insights, not only on the past itself, but also on how movement to another country leads to new views by migrants of their family and community of origin." (Bauer and Thompson, 2004). This process of reflection and revision is of particular interest to the study of transnational migrants because it illustrates their changing perspectives over time and across cultures.

Feminist scholars have promoted life history methods because of their potential to challenge conventional research that does not adequately represent the experiences of women (Bauer and Thompson, 2004; Chase, 2005; Langness and Frank, 1981). By treating women as social actors, life histories provide in-depth accounts of women's lived experiences. This approach can shed light on the structural forces that shape the health care aide labour force, while also exploring the ways in which women experience and negotiate migration and employment (Mattingly, 1998). It goes beyond the rational economic theory of migration, addressing gendered and aspects of human experience such as family obligations, personal ambitions, social networks, non-economic reasons for migration, cultural norms, and the pain of family separation.

Challenges Recruiting Health Care Aides

There were several challenges that arose during recruitment. Confusion over the differences between health care aides, home care workers and other care workers was an issue throughout the recruitment process, especially when relying on other people to facilitate recruitment. There are no formally recognized terms for health care aides, and differences in job titles vary across industries (acute care, residential care, home care) and even within some sectors of health care (home care aides versus home health aides; supportive housing versus personal care homes). It is important to ensure that anyone involved in recruitment of care workers (formally or informally) understands the job title and the type of facility targeted for recruitment.

The second challenge that arose was gaining access to health care aides. This was achieved through a contact within the community, but it took several attempts, as well as

networking with various community groups, before the right contact person was identified and agreed to help with the recruitment process.

Once a community contact was established, potential health care aides expressed reluctance to participate for a variety of reasons. The most commonly cited reason was that they are too busy; many of them hold multiple jobs and have children and families to care for. It should be noted that recruitment took place during the aftermath of massive flooding in the Philippines that displaced millions of Filipinos in the metro Manila area. This crisis may have increased pressure on Filipinos in Winnipeg to financially support their relatives abroad making them less likely to take the time to participate in an interview.

Data Analysis

With the permission of health care aides, interviews were recorded and subsequently transcribed. Immediately following the interviews, field notes were typed into interview transcripts. During interviews that were recorded, field notes documented 'informal interviewing', observations about the interview, and interpretive insights. Field notes were typed following each interview.

The questionnaire gathered basic demographic characteristics of the study sample (age, gender, immigration status, employment status). Basic descriptive statistics (means, standard deviation, and frequency distribution) were compiled to characterize the features of the study population.

Interview transcripts, field notes and questionnaire responses were analyzed using NVivo 8 software. A preliminary coding scheme was developed and cross-referenced with the literature on immigrant health care aides, Philippine migration, and long-term care policy in Canada.

Transcripts and interview field notes were read and re-read to identify themes in health care aides' and health policy stakeholders' responses. This process generated a preliminary list of themes for each component of the study: health care aides and health policy stakeholders. The key themes that emerged from the health care aide and health policy components were compared to determine similarities and differences. Once the coding scheme was finalized, the transcripts and field notes were coded using NVivo 8 software.

Narratives are subjective texts shaped by health care aides and researchers; they should be analyzed within the context of other evidence (Bauer and Thompson, 2004). The research project also analyzed documents and reports related to the employment of Filipino health care aides and the organization of care work in personal care homes including the Auditor General's Report (2009), collective agreements, and Statistics Canada tables and reports. Statistical evidence of migration trends was also examined. Observations of the experiences of Filipino health care aides were embedded within the policy context as well as the theoretical perspectives on the global migration of care workers, the structure of the health care labour force, and social network theory of migration.

Ethical Considerations

All appropriate measures have been taken to protect the privacy and confidentiality of the health care aides. Audio recordings, transcripts, questionnaires and any other potentially identifying information is stored in a locked filing cabinet. Names and any identifying information, including location of work, will not be disclosed to anyone outside of this project. Health care aides and health policy stakeholders are identified by numbered codes. All recordings, transcripts and field notes are identified only by a randomly assigned study number.

Identifying information on all transcripts, tapes and field notes has been altered or deleted. All precautionary measures were described to potential study health care aides in the consent form prior to study participation. After seven years, all information gathered from health care aides will be destroyed in compliance with established ethical guidelines. All health care aides were asked to sign written informed consent forms. Due to the nature of topics discussed in interviews, some issues were emotional, but health care aides were advised that they need only to answer questions and express their views when they wish to do so. Ethical approval was attained from the Health Research Ethics Board at the University of Manitoba. Permission to recruit health care aides was also attained from the Winnipeg Regional Health Authority and participating institutions.

CHAPTER FIVE

Results

This chapter presents the results from interviews with health care aides and health policy stakeholders. The chapter is divided into two sections. The first section presents the key themes that emerged from interviews with health care aides regarding their migration and employment histories. This section follows health care aides on their journey from the Philippines to Winnipeg's personal care homes. The second section focuses on the personal care home labour force and presents the findings from interviews with health care aides and health policy stakeholders. This section situates the employment experiences of health care aides within the long-term care policy context.

Section I. From the Philippines to Winnipeg's Personal Care Homes

Description of Study Population

The health care aides in this study immigrated to Canada over a period of forty years, between 1969 and 2009. Six out of seven health care aides were Canadian citizens and one had landed immigrant status. Their ages ranged from 40 to 60 years and older (See Figure 1). Six of the health care aides were married and six had children (See Figure 2). Among health care aides who had children, all of their children were living in Canada.

The women came from different regions of the Philippines with various levels of education (See Figure 3). Three had attained university degrees, two had some university, and two cited their health care aide certificate as their highest level of education. Among the women who had obtained university degrees, one had a Bachelor of Arts in education, one had a Bachelor of

Figure 1. Age Distribution of Health Care Aides

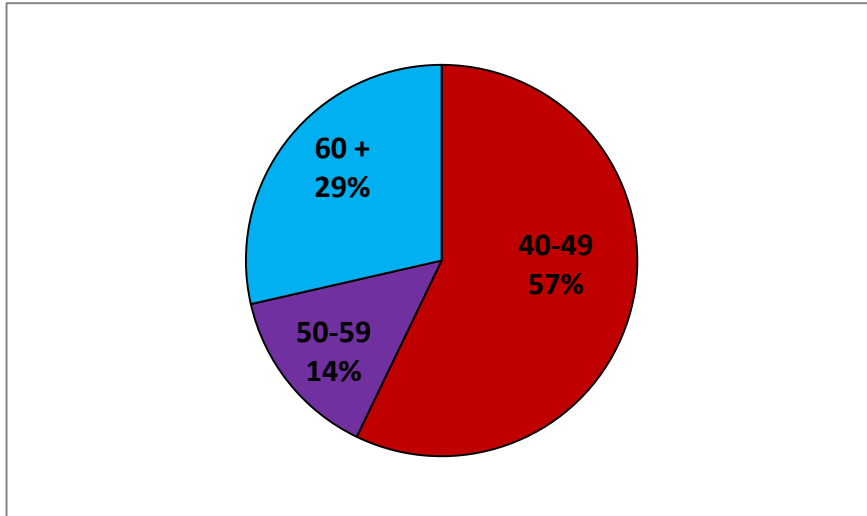


Figure 2. Health Care Aides Selected Demographics

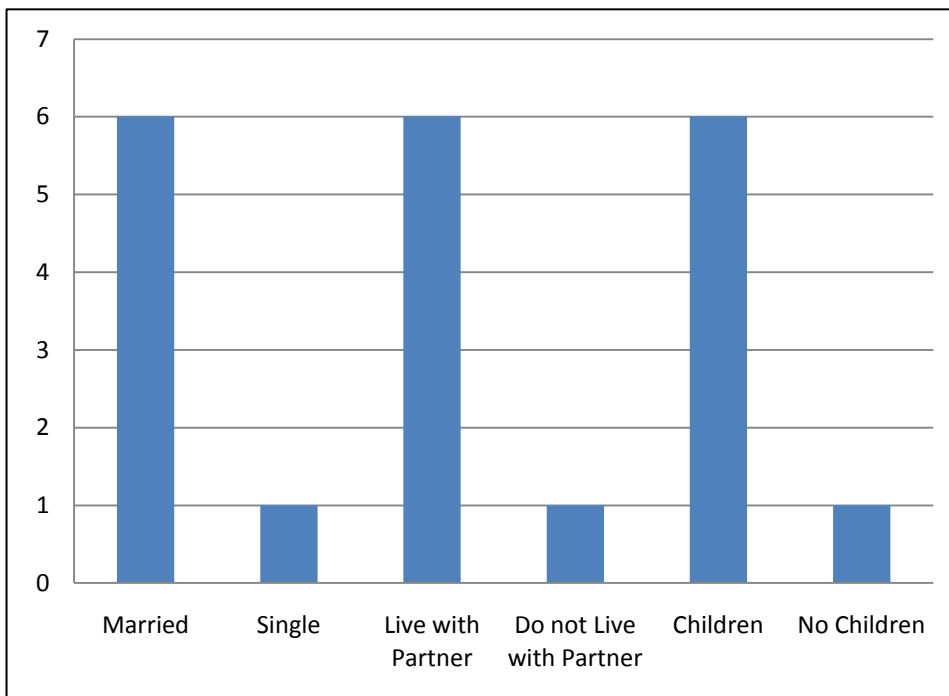
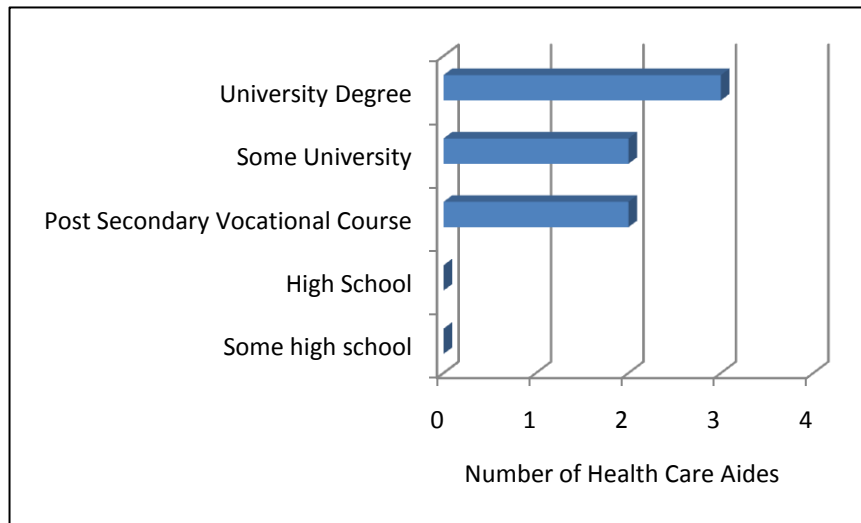


Figure 3. Highest Level of Education Attained



Science in accounting and one had a Bachelor of Science in biology. None of the health care aides came to Canada with the intention to work as health care aides; they each decided to work in long-term care after arriving in Canada. In fact, no one had previous work experience or training in elder care from the Philippines. Their experience working in personal care homes ranged from four months to 35 years. They worked in for-profit and not-for profit facilities and several of them worked in multiple facilities and different sectors of long-term care.

Poverty, Unemployment and Underemployment in the Philippines.

When asked why they decided to emigrate, health care aides cited poverty, unemployment or underemployment as a primary reason for migration. Despite their diverse educational backgrounds, they struggled to support themselves and their families. Some of the health care aides grew up on farms in rural Philippines and described the challenges of poverty and unemployment:

To leave the Philippines, we were nine in that family, nine children. So my sister, my

eldest sister was the one who came here first. My dad was a farmer and my mom was a house wife. So imagine 9 children. The way of living back home, there is lots of people but lack of jobs. Even though you want to work, there's no jobs. I think that why some people they end up...you can't blame them, they end up stealing, because of the jobs, they want to work they can't work. My sister, she used to work in a factory and then she was sponsored as a job acceptance to work in Canada, then after two or three years that she was here she sponsored us as a family. (HCA-05)

The reason for leaving the Philippines is the life we had. My parents are farmers, but not like farmers here. They are having hectares of lands, portions of lands that you are cultivating for planting rice. We are eight children in the family, the life there is hard compared to here. Not like here, when you have kids the government is helping you with the child tax benefit and everything. But there you have to have your own. So with 8 kids and when you look at the news internationally, you say, oh I want to, and some of my cousins are in the States too, so I'm kind of envious, "Oh I want to go there too, I want to have a better life too". (HCA-08)

HCA-03 grew up on a farm and moved to the city to work in a garment factory where she was eventually recruited to work in Winnipeg's garment industry. She described the challenges she faced trying to support herself on the wages she earned:

I had a big family, I have eight siblings, and I am the eldest girl. I have four brothers before me. I was working in the city, and it's really hard. The way you work there, is not even enough for yourself. We are paid by day, not an hour. And you're renting too, you know? Because I live in the province, so I have to have a room to rent. I had a dream

that one of these days I'm hoping that I have to increase my education. So...that's the one thing that I prepared to move to come to Canada, is because Canada, is like spreading around in the Philippines at that time that it's a nice country. (HCA-03)

In addition to unemployment, underemployment and low-wages propel Philippine migration.

Three health care aides had university degrees, two of whom held professional jobs before moving to Canada. Although they had professional jobs, their income was not enough to provide basic necessities for their families. For example, HCA-06 worked as an accounting clerk, but the “pay was very little” and the hours were very long; she worked ten hours a day, six days a week. Similarly, HCA-07 worked as a high school teacher, and her husband was as an electronic technician. Their combined salary was not enough to support their family:

I was professional and my husband had a good job too, but it was really hard... That's the frustrating, even though you have a degree, most of the professionals don't have a job. I have a good job, but the salary that we are earning is not enough. That's the main point. So that's why most of the professionals they go in different countries to have a better future, for greener pastures. (HCA-07)

Health care aides commonly described their migration as a search for ‘greener pastures’. Canada represented the greener pastures they were looking for. When asked about their preconceptions of Canada, health care aides recalled three basic features: jobs are plentiful and easy to acquire, it is politically stable and of course, it is extremely cold. HCA-05 described her expectations of life in Canada:

It was a peaceful country, lots of jobs lots of opportunities for people. Just work and you will be good. It's up to you how to make yourself better. Cause back home the politics,

no good. Like here you have lots of benefits, even though you are paying taxes it's still good because it pays back. Now I can see, the place is nice and clean, not like back home. (HCA-05)

When HCA-03 was 23 years old, Canadian immigration officers recruited her and several of her co-workers to work in Winnipeg's garment industry. She recalled her interview with Canadian immigration:

The funny thing that they asked me one time that I can really remember is "Why do you want to go to Canada?" I said: "I think what I read in some books or history about Canada is Canada is really a nice country even though it's cold". So I said: "I want to try to go there and find a better job". And they're happy when I said that, and that I want to help my family one of these days. (HCA-03)

HCA-03 passed the screening process and moved to Canada in 1969, joining the first wave of Filipino garment workers to migrate to Winnipeg. She was the first member of her family to move abroad, and credited her taste for adventure and her desire to support her family for her decision to immigrate. According to Dalayoan et al. (2008), 289 recruits arrived in Winnipeg from the Philippines in 1969, following the first group of Filipino garment workers that arrived the previous year.

Like most of the garment workers who were recruited to work in Winnipeg's factories, HCA-03 was a young single woman. She described her experience living and working with other garment workers:

The Canadian immigration is so good to us. We are in a group. Then, they're the one who find a place that we have to stay in. So I had some girls that I made [friendship], so

three of us go together in one second floor. So we shared the rent. So, that time, while it is really hard. You know? We found that far from your country and your family is really hard. I can't explain that, I said, "Why I'm here?" We share, you know. My friends, we talk, like especially when we come home. We talk about what we are doing here, and you know, kind of emotional . . . Yeah, we support each other. We cried. It's true. After that, well, we made [friendships with] some of the girls too, and then we had fun when the immigration will come and pick us up and bring us to a place that we are getting together. So we are happy. . . I don't know, but as I said, first to go away from your country and your family is really emotional if you are thinking about it. But we survived.

HCA-03 was emotional when she recalled her settlement experience. It was challenging, but she found friendship and support from Winnipeg's burgeoning Filipino community. Although HCA-03 was the only participant recruited to work in the garment industry, three other health care aides came to Manitoba following female relatives who worked in garment factories.

Migration and Social Networks

According to social network theory, the first migrants are pioneers; they don't draw on migrant networks to facilitate their migration. Once migrant networks are established, however, they tend to expand, increasing the likelihood of subsequent migration. HCA-03, who had the earliest date of entry to Canada, was the only participant who did not have a familial connection to Manitoba before she immigrated. The other six health care aides had at least one relative who preceded them (See Table 1). Most of them were sponsored by their relatives and immigrated through a family reunification program. Three of the health care aides were sponsored by a relative who worked in Winnipeg's garment industry. One participant, HCA-08, came to Canada through the

live-in caregiver program to work for her aunt. Although she came to Canada through the temporary work program, her aunt hired her and paid for her travel and recruitment fees.

Table 1. Date of Entry and Social Networks

Participant	Date of Entry into Canada	Year began work as a HCA	Preceded by relatives	Sponsored by relatives	Had a social connection to a PCH
HCA-03	1969	1975	No	No	Yes
HCA-04	1975	1976	Yes	Yes	Yes
HCA-05	1981	1983	Yes	Yes	Yes
HCA-06	2009	2010	Yes	Yes	Yes
HCA-07	2004	2006	Yes	Yes	Yes
HCA-08	1992	1997	Yes	No	Yes
HCA-09	1990	2000	Yes	Yes	Yes

For several health care aides, the migration of their relatives sparked their interest in migration. For example, when asked if she had always wanted to leave the Philippines to work, HCA-07 responded:

At the beginning no, but when my brother came here. That's the time, "Oh maybe I could live there too." (HCA-07)

HCA-08 described how the migration of her relatives inspired her to work abroad:

So with 8 kids and when you look at the news internationally, you say, oh I want to, and some of my cousins are in the States too, so I'm kind of envious, "Oh I want to go there

too, I want to have a better life too.” (HCA-08)

As Philippine migration to Manitoba accelerated, transnational ties among migrants and their families in the Philippines expanded. For some health care aides, their desire to immigrate to Canada traced back to the previous migration of their relatives. HCA-08 commented that she envied her cousins and the ‘better life’ they had achieved through migration. HCA-07, on the other hand, did not aspire to work abroad. It wasn’t until her brother immigrated to Canada, that she considered following his lead.

HCA-05 immigrated to Canada in 1981; she was sponsored by her sister who had been recruited to work in Winnipeg’s garment industry. She described her family’s immigration process:

HCA-05: My sister, she used to work in a factory and then she was sponsored as a job acceptance to work in Canada, then after two or three years that she was here she sponsored us as a family.

PI: So she worked in a garment factory?

HCA-05: Yes, I forgot the name. We were so lucky to come here. For us that’s a good step for us. We were six who came here first, after that seven. My three sisters they were married and they were older, at that time you have to be up to 18 years old or you can’t come. So I have three brothers and a sister, and me and my mom and my dad who came.

Health care aides’ migration patterns suggest that women’s migration can be instrumental for subsequent family migration. Six out of seven health care aides had sponsored multiple family members to immigrate to Canada. The only participant who had not sponsored any relatives was HCA-06, the most recent arrival in the group. Having been in the country for less than a year,

she had already begun the process to sponsor one of her sisters, and she planned to eventually sponsor her other three sisters through the Provincial Nominee Program.

HCA-08 did not immigrate through a family-reunification stream; she came to Canada through the Live-in Caregiver Program. She decided to immigrate to Canada specifically to help her other family members immigrate in the future:

HCA-08: I'm planning to live and to immigrate. And I'm planning to bring my family. That's the purpose I came, to sponsor my family.

Since her arrival in 1992, she has helped 16 relatives immigrate to Canada:

HCA-08: We were lucky to have the Provincial Nominee Program. The Provincial Nominee Program already I sponsored already two in-laws, my younger brother and my sister, and my brother in law and my sister in law.

PI: So how many all together?

HCA-08: Sixteen. Because through Provincial Nominee my brother came first, so four, and then my sister came and she had five kids, so seven, and then my sister-in-law came, my husband's younger sister with two kids, and then at first, before, I have my brother in law, so 16. Before I'm just by myself (laughs), and then I sponsored my husband, and then we had three kids. And then 16 all in all I brought here.

While poverty and unemployment propelled their migration, transnational connections among Filipinos provided the opportunity and resources to move abroad. Most of the health care aides in this study immigrated through family reunification programs, and all but one have since sponsored relatives from the Philippines to Manitoba. Having a close relative in Canada reduces

the costs and risks associated with migration. It also introduces the possibility of immigrating through the federal family class stream or Manitoba's family support stream. Within a year after the first garment workers arrived, the industry began to promote family sponsorship, and family reunification has constituted a major source of Philippine immigrants ever since (Dalayoan, 2006). Today, the family support stream of the Provincial Nominee Program constitutes the largest source of Philippine immigrants to Manitoba (Manitoba Labour and Immigration, 2008).

Barriers in the Labour Market

All of the health care aides immigrated to Canada in search of work to support themselves and their families. Some of them were single women, obligated to send remittances to their families abroad. Others had children of their own to support. The high cost of immigrating puts additional financial pressure on recent immigrants. They came in search of greener pastures, but many of the health care aides encountered multiple barriers in the labour market such as accreditation, language requirements and job insecurity. The barriers they faced as immigrant women provided the context for their decision to work in personal care homes.

Three out of seven health care aides had university degrees from the Philippines (See Figure 3), but none of them were able to work in their chosen field in Manitoba. HCA-07 was a high school teacher, HCA-06 was an accountant, and HCA-08 was enrolled in a Master's program in biology when she left for Canada. Their credentials from the Philippines were not recognized in Manitoba.

Sponsored by her brother through the Provincial Nominee Program, HCA-07 moved to Canada along with her husband and her children in 2004. HCA-07 – a school teacher in the Philippines – emphasized the importance of her credentials in the immigration process:

My eldest brother first came here. Then we applied, because we were qualified, we have degrees and good jobs. But I believe even though we have relatives here, if we were not qualified, no education or training, I don't think we can go here. That's the main point. It doesn't matter how many relatives you have, if you are not qualified for a certain level of skills I don't think anybody can come here in Canada. (HCA-07)

According to the Department of Labour and Immigration website, Provincial Nominee applicants “must be able to provide proof that you have the training (including any license or certification), work experience and language ability to find employment in your intended occupation in Manitoba, soon after you arrive.” (Manitoba Labour and Immigration, 2011) Although her university degree, work experience and English proficiency qualified HCA-07 to immigrate under the Provincial Nominee Program, she learned, after arriving, that she was not qualified to work as a teacher in Manitoba. For HCA-07, this discovery was devastating:

Before I left my country, I set my mind already that it's going to be a different life when I go to Canada, but I didn't expect that it's going to be worse. I tried to apply what I learned in the Philippines, but wherever I go, they are looking for certificates from here. So how can I if I just came here? So, to make it short, they didn't recognize my paper. I was miserable. It's really hard. Back home you were a teacher, and as a teacher we didn't get high pay or much pay, but you know the respect. It's totally different here. Wherever you go you are respected by all the people. But when you come here you're just nothing. It was really different because I felt I have to start from zero, which I did. So I tried to apply but I don't know it was really hard for me to find a job because they said I wasn't qualified.

Speaking English as a second language created additional barriers for health care aides seeking employment. HCA-07 described how her English language skills impeded her search for a teaching job, and how she came to accept this limitation:

I didn't understand it at the beginning but as time goes on I learned to accept and understand because our main language is totally different. I know I can speak English but not as fluent as you are so I understand now. Let's say, I was a teacher in the Philippines and they gave me a chance to teach right away. I can speak English but still it's different, so I understand now.

HCA-06 felt that her oral English skills prevented her from working as an accountant in Manitoba. She did not want the interview recorded; the following is an excerpt from field notes:

HCA-06 would like to work as an accountant, but she only has a level seven, not an eight or nine and feels that her oral English skills are not high enough to qualify. She said that her reading and writing skills are good because in the Philippines all of the paper work is done in English, but people communicate in Tagalog, so her spoken English is not as advanced as her reading and writing. She would like to take a course to qualify as an accountant here, and is considering doing it in two years time. But also said she plans to be a health care aide for the foreseeable future.

HCA-08, who had almost completed a Masters degree in biology before immigrating to Canada, came to Canada through the Live-in Caregiver Program. Despite her educational achievements, she did not have any expectations about her job future in Canada:

PI: When you came here as a live-in caregiver, did you have any other expectations about what kind of job you would look for after you finished working as a live-in

caregiver?

HCA-08: No, I didn't have any idea what kind of job I can land here. I didn't know what is my capabilities, that I can contribute to Canada.

It is possible that HCA-08's expectations about job opportunities in Canada differed from HCA-07, in part, because she arrived through a different immigration category. In order to work as a live-in caregiver, HCA-08 would have provided evidence of her ability to work as a caregiver, and not as a biologist. In contrast, through the Provincial Nominee Program, immigrants must demonstrate their employability in their field of education. It is possible that the application process and eligibility requirements impact the employment expectations of potential immigrants.

Not all of the health care aides had post-secondary degrees, however. Two health care aides could not afford the cost of university in the Philippines:

It's because when I want in the Philippines my parents cannot afford to send me to school. I want to be a nurse, that's my dream. I want to be a nurse. (HCA-03)

Before I want to go for nursing, but my parents cannot afford it. That's really my ambition. (HCA-09)

For others, their education options were limited by the costs associated with certain programs, in particular, the high cost of nursing and medical degrees.

HCA-05: Yeah, back home I really wanted to be a nurse but it's too expensive. I took business administration because it's cheaper.

HCA-08: When I was a kid, I really want to serve people. I dream of becoming a doctor,

just to help somebody. But it's because of the life we have back home, to go for medicine, you still have to have lots of money, it's expensive.

For HCA-05 and HCA-08, the opportunity to immigrate to Canada came in the middle of their educational programs. For example, HCA-05 moved to Canada in 1981, two years into a degree in accounting. Shortly after arriving in Canada, she was working three jobs, making it very difficult to return to school:

So I have 3 brothers and a sister, and me and my mom and my dad who came. And I worked 3 jobs. I was 17, turning 18. Then I tried to go back to school at Herzing, imagine I worked three jobs. We were living at my elder sister's. It's really hard, because it's too many people, it's crowded. So I have to stop going to school and find a job, I worked at two nursing homes.

From the perspective of health care aides, they had a limited range of work options. Their work histories included jobs with poor working conditions, heavy physical labour, low wages and precarious employment. Having experienced layoffs in Canada and the Philippines, many of the health care aides were particularly concerned with job security. Below, HCA-07 describes her experience in the Canadian workforce:

I tried to apply in the school division and they accepted me as a teacher assistant, but if you have family, you need to survive. Even if you have your family here, you have to live on your own, they have their obligations too. Practically speaking I quit because they were just giving me two hours a day as a teacher assistant because they start at 9:00 and end at 11:30. How can I live like that? So I better quit. And then I applied to day care. I enjoy working with the kids, I worked as a daycare assistant for six months and then

they laid me off. I got laid off. I was frustrated again. Oh my goodness. I tried to work at McDonalds, at first they don't want to accept me because I was not qualified. I'll be honest with you. I didn't tell them that I work as a teacher. I told them that I had experience to work at McDonalds back home so that way they accepted me. It's just like a song. When it's rock song you have to do the rock movements. So I denied that I was a teacher. Then they accepted me, that's the way it is. After they laid me off, I was frustrated. Back home we were stable; I regret to come here in the beginning. I was crying the whole year. After I was laid off, my sister-in-law works as a health care aide. I was really frustrated to find a job and I thought to myself, how come I have a degree and no one wants to accept me. I was crying. After maybe 6 months with no job at all, my sister in law says "if you don't want to be laid off then you better get a health care aide". I was thinking not only for myself but the benefits of my kids.

Regardless of their credentials from the Philippines, all of the health care aides were confronted with limited options in the labour market. Those who had obtained university degrees felt that they had to start from "zero", while those that came without any post-secondary education described the disadvantages they faced in the Philippines and Canada. All of them had dreams of higher education, for themselves and their children.

I like to be a nurse, so I can do really my job properly. It's not only tender loving care. It's other things too. I wish I can be a nurse. It's easy to say but it's hard to do....I'm old but that's my goal. (HCA-05)

I've got lots of dreams too, to go back to school. Maybe I can just have my kids to do that for me. (HCA-08)

Dreams of becoming a nurse featured prominently, and several health care aides expressed their hope that their children would become nurses or their dismay that they chose not to. Others, like HCA-06 and HCA-07, hope to take courses in accounting at some point in the future. Although they have held on to their aspirations, when asked where they think they will be in five to ten years, almost all answered that they expect to be working as health care aides:

Oh still working [as a health care aide]. I still have 14 years before I go for my retirement. (HCA-08)

HCA-07 was uncertain, but maintained her goal of going back to school:

Maybe, (laughing), maybe I can still work as a health care aide, maybe in home care. Most of my time, maybe, I'll be working in business company. Yeah. I want to be an accountant. I like dealing with numbers. (HCA-07)

She continued:

Only here in Canada I really felt the deepest sense of frustration really honestly. I never experienced this before, only in Canada. It's better now. I was crying the whole time. It's really hard, when you are highly respected by all the people and when you come here you are just nothing. But I'm OK now. (HCA-07)

For HCA-07, coming to terms with her lack of employment options is a challenging and ongoing process. Not all of the health care aides described similar experiences. Some perceived their work as a major accomplishment, an improvement from factory work in Winnipeg and the Philippines. What they did have in common was that all of the health care aides were faced with barriers that limited their options in the labour market, and financial responsibilities and

constraints that prevented them from pursuing their educational goals. As immigrants, they faced additional challenges in the labour market including accreditation and language barriers. As mothers and daughters, they were obligated to financially support their families in Canada and abroad. These two factors – financial need and limited opportunities for work– created the context for health care aides’ decisions to work as health care aides.

Employment and Social Networks

In light of the barriers they faced in the labour market, health care aides drew on their social networks to obtain information about the job market. Each participant had a family member or friend working in long-term care who influenced her decision to work as a health care aide. Among health care aides with the earliest dates of entry to Canada (HCA-03, HCA-04, HCA-05), their social connections to long-term care workers were non-familial, consisting of friends, friends of friends and acquaintances. Health care aides with later dates of entry to Canada (HCA-06, HCA-07) arrived with established ties to personal care home workers; some were sponsored by relatives who worked in long-term care, and others had multiple family members working as health care aides. Social connections provided information about the job and educational programs, encouragement and, in some cases, referrals for positions in personal care homes. These social networks acted as pathways linking migrants to employment opportunities in long-term care.

As mentioned above, HCA-03 migrated to Canada in 1969 to work in a garment factory. In 1967, just two years before her arrival, health care facilities in Manitoba began to recruit Filipino nurses (see Background chapter). By 1969, the Filipino community in Winnipeg largely consisted of nurses and garment workers. The simultaneous recruitment of garment workers and

nurses from the Philippines created social connections between the two groups within the relatively small Filipino community. In the case of HCA-03, this led to her decision to work in a personal care home:

I had a friend that I asked her, where do you work? She says to me that I'm working in a nursing home. That friend of mine is a nurse from the Philippines but she first came from United States. It's because only a few Filipinos at that time, we most know each other. Because they're a nurse, so you know. I told her: "how to get in?" She said you can just go there and apply and they will interview you . . . To be as a health care aide at that time, they are not forcing us to have a certificate.

HCA-04 immigrated to Canada in 1975. She described her settlement experience as difficult and was emotional when she recalled her first year in Winnipeg. She stayed home while her husband worked and often felt isolated and longed to go back to the Philippines. When her landlord, who worked in a nursing home, offered to help her get a job as a health care aide, her outlook changed. Work provided her with the social interaction that she had missed and helped her adjust to life in Canada. Having given up her job when she married her husband, HCA-04 found her new career empowering:

It's good that women work, you cannot just say yes to your husband, you need to earn money so that you can say no. (HCA-04)

HCA-05 learned about health care aide work through her sister's friend. Her sister, who had helped her immigrate to Canada, was recruited to work in Winnipeg's garment industry.

PI: When you first came, you had three jobs. How did you end up finding out about working in a nursing home?

HCA-05: My sister's friend, who I only knew that they were our relatives when we came here. She worked in a nursing home. So that time you don't even have to have a certificate. You didn't even have to have experience. You just know somebody in there and they will train you.

According to Waldinger and Lichter (2003), migrant social networks are more likely to flourish in a workplace if there are few restrictions on entry, such as language or education requirements. HCA-05's comment illustrated the connection between the lack of formal training requirements and referral based hiring practices. At the time that the above three health care aides first obtained work in personal care homes, there were no training or certification requirements for health care aides. Health care aides described how their friends or relatives helped them obtain jobs in specific facilities. In the 1990s, personal care homes began to require certification for health care aides. The health care aides who arrived since the 1990s described how family members and relatives encouraged them to take the health care aide training program:

I worked with my aunt as a live-in caregiver for three years. After that I got my immigrant status. From there I already worked as a cashier at superstore. That is the time I decided. Some of friends I have, and then my aunt also who is an RN. And they said, "health care aide is better for you, because for security reasons and it is in demand." So, I tried, I'm working as a cashier at superstore, only for four hours. So from there, I decided to take a health care aide course, and they're offering before for four months and a half only. So I took it for four and half months. (HCA-08)

HCA-07 commented:

The first is my sister-in-law. And then after my sister in law, I made a decision; I can be

a health care aide too. And then here comes another, my sister in law, and she's a health care aide now... You know she graduated as a computer engineer. (HCA-07)

HCA-07 specified that her sister-in-law did not encourage her. Rather, she learned about the field through her example:

She never encouraged me, I just thought I could take that course too. As I told you before, doing health care aide, there is a money, flexible hours where you can have time with your family and then the third reason, you can develop your ability to interact with different kinds of people. I love that way. (HCA-07)

HCA-06 on the other hand, described how her family members encouraged her to take the health care aide training program:

HCA-06 arrived in Canada about one year ago, and has been working as a health care aide for four months. She was sponsored by her cousin who also works at a personal care home. Her cousin encouraged her to take the health care aide certification course because it is only four months and then she can work and make a decent wage. Her cousin convinced her it was the best option for her. She has three cousins working in personal care homes in Winnipeg, as well as several friends from the Philippines who are working as health care aides in Winnipeg. (Excerpt from field notes).

HCA-06 arrived in Canada with established social connections to personal care home workers: her sponsor was a health care aide and she had several relatives and friends from the Philippines working in Winnipeg's personal care homes. HCA-06's social networks supported her immigration to Winnipeg and encouraged her to work in long-term care. Thirty-five years after HCA-03 first learned about a job opportunity in a personal care home through a friend who was

a nurse, social networks among Filipino health care aides have expanded considerably. In addition to facilitating migration, social networks link Filipino immigrants with employment opportunities in long-term care by conveying information about the job market, training programs, job openings and providing referrals.

Employers and Social Networks

Employers also use social networks. According to health care aides and managers, referral-based hiring is common within Winnipeg's personal care homes. As a result, personal care homes often employ multiple family networks. A long-term care administrator commented on the extent of social networks within long-term care facilities:

There's a lot of networking. In fact, in most personal care homes it's amazing the number of relations that are working together, because they know the place, they know the people. So this cousin and that cousin, you know? I do think that networking has an impact. (HP-01)

When asked why social networks are prevalent within the personal care home workforce, health policy stakeholders tended to emphasize the role of health care aides, rather than employers:

Because people go where, well their friends say, "I'm working down the street, why don't you come?" So they come where the friends are because they're comfortable. (HP-05)

I think that when you're immigrating to Canada, my perspective is there's a lot of family, so a lot of relations. So if you're coming to Winnipeg for something, you already know that you have 10 or 15 members of your family here, you come to Winnipeg, and if they're working in health care already, then you work in health care as well. (HP-01)

We also see families where one member comes over, gets established, and then starts to sponsor other family members. Quite often families are involved in the health care industry, similarly with the Philippines. (HP-04)

Although health policy stakeholders emphasized how health care aides' social networks influenced their choice of work, one of the managers indicated that she made considerable efforts to avoid hiring staff from the same social group:

In terms of the staff, we try, we don't actually have a predominant ethnic group. Probably Filipino is the most in numbers, but we also have an awful lot of Africans and some eastern Europeans, so we know we, and a couple of Chinese folks, so we've got sort of a mish mash of nationalities and I think that's sort of an important thing to look at because you tend to attract the same ethnic group if you're not careful. (HP-05)

According to HP-05, hiring extended family members creates problems for management because it reinforces worker solidarity:

I think you're not always sure what you're getting. Sometimes I think family bonds are stronger than work. So, you know, sometimes you end up...and I know from other facilities...you end up with people that you tend to carry, because the family aren't going to say "well, they aren't really good workers". So, you can sort of have people that aren't as talented sort of hidden in the mix and no one's really going to say that they don't really pull the load or whatever, because they're either family or friends of friends, so they're not wanting to, sort of, pull them out and say "this person isn't doing so well". (HP-05)

HP-05 also expressed concern over the ethnic bonds present in the workforce. In particular, she was concerned that the predominance of one ethnic group encouraged employees to speak in their mother tongue while at work:

I also think that when you get ethnic mixes and they're all the same, language can be an issue. They tend to, whichever language it is, tends to come to the surface. Regardless of what language you speak, you tend to go to your mother language and so it's hard for them to drop that mother language when they get on the floor, unless it's, you know very culturally inappropriate to the facility that you don't speak another language. I mean, here we say "you speak the language of the resident, that's okay" or French or English, depending on who you're talking to. We try really hard to keep it to basically the Canadian languages. (HP-05)

HP-05 argued that familial and ethnic bonds create unfavorable conditions in the workplace, so she made an effort to avoid hiring through word of mouth in order to maintain a 'diverse' workforce. However, there are several advantages associated with referral-based hiring. According to Waldinger and Lichter (2003), referrals reduce the costs and risks of hiring new staff, in part because the employee has a stake in the performance of the new recruit, especially if it is a family member. Using employees' informal networks to bring forth new recruits also allows employers to avoid the cost of recruitment strategies, and they do not have to increase wages or improve working conditions to attract Canadian-born workers. None of the health policy stakeholders acknowledged the benefits of this recruitment strategy for employers or long-term care institutions. In fact, they tended to emphasize the role of health care aides in

perpetuating this practice. Nevertheless, health care aides and health policy stakeholders identified informal social networks as a significant factor contributing the high concentration of Filipino health care aides.

Incentives

When health care aides were asked why they chose to work in long-term care, they identified several features of the job that they found attractive. Their responses were strikingly similar, which may reflect widespread perceptions of health care aide work. There were four aspects of the work that all health care aides felt were particularly important: 1) health care aide jobs are in demand; 2) the training period is relatively short; 3) jobs are secure; and 4) wages are relatively high:

It is a stable job, even though it is hard, there are no layoffs, it's always in demand because people are aging (HCA-04, paraphrased)

In my opinion, it's because when you arrive you want to work at once. So the health care aide course is the best course to take. It is only four months and there aren't any layoffs. It's good pay. (HCA-06)

The difference is, it is a short course, and they can make more money, more than minimum, than McDonalds. (HCA-05)

Job security was a priority for most of the health care aides, especially for those who had endured layoffs in the Philippines and in Winnipeg. The collapse of Winnipeg's garment industry left thousands of Filipino immigrants, mostly women, out of work. The economic impact was so profound that it influenced health care aides' choice of work, whether or not they

had ever worked in a factory.

I worked in the garment and then after two years, because our contract is two years, eh. It's because it's getting more harder and harder for working in a factory . . . I'm thinking if there's no more sewing company, what will I do? I don't know nothing. So I decided to see how to work in a restaurant. I like it but it's different, I'm looking for a place I really want to work and stay there if possible . . . So where I started to work at [personal care home] they offered us, if we want to go to school to take the diploma for health care aide. So I'm in a hurry to volunteer to go. (HCA-03)

When I came my dad told me, "forget that garment factory type of thing, since you are here try to experience another field." (HCA-09)

Working in a hospital, in a facility, it's a secure job, there's not layoffs or something. If you go to a company or something, sometimes they have layoffs because they're going poor or bankrupt or something. So what am I going to do? But if you are working in a facility in a hospital or nursing home, those are forever. If they're going to close, it will take long. That's why I decided to go for health care aide course. (HCA-08)

It's because now they are receiving 15 or 16 dollars in an hour plus premium, where can you find a job like that? For a sewing factory? If you can have that, and that one that you've been there until you're going to retire and you have the security of your job as full time. If you go to a sewing factory and they close, or you have it happen to you... With this kind of job it's security about your full time job, it's there already, the only thing is you have to go to work! (HCA-08)

For some of the health care aides, particularly those who hoped to move into other areas of work,

the opportunity to improve their English skills and gain experience working with people provided additional incentives to work as health care aides. Flexible hours were also an attractive feature, as it allowed women to balance work and family life. HCA-07, who had two small children and hoped to go back to school, identified these features:

Doing health care aide, there is a money, flexible hours where you can have time with your family and then the third reason, you can develop your ability to interact with different kinds of people. I love that way... There's the money, and aside from that, I'm still learning and developing my English ability. (HCA-07)

Health care aides identified several incentives to work as health care aides: job demand, security, wages, and the short training period (or lack of formal training requirements in the past). These incentives reflect health care aides' previous experiences in the labour market: unemployment, job insecurity, low wages and lack of recognition for their education. Compared to their previous employment, health care aides felt that working in personal care homes was more secure and higher paying. They valued the short training time because it allowed them to enter the workforce quickly and provide financial support to their families in Canada and abroad. The emphasis on job security and widespread references to sewing factories suggests that Filipino health care aides' work preferences have been influenced by the collapse of the garment industry and the economic impact it had on Winnipeg's Filipino community.

Section 2: A Closer Look at Personal Care Home Work

The reasons that health care aides cited for their decision to work in long-term care were strikingly similar, as though they were commonly held beliefs about the job. But five out of seven health care aides have been working as health care aides for more than ten years, and the

industry has changed considerably since they entered it. The notion that the job is in demand and secure, and that training programs are short and accessible, was not always congruent with health care aides' experiences or with changes in the sector.

Health Care Aide Training Programs

In Manitoba, health care aides are an unregulated workforce. There is no registration examination for health care aides to enter practice and there is no regulating body for graduates. Health care aides working in personal care homes are required to obtain a health care aide certificate, but there are no standards or regulations for certification programs. There are over ten training programs in the province and they vary significantly in terms of entrance requirements, length of program, length of practicum, content, and graduation requirements (See Table 2). Some of the programs require high school and proof of English proficiency while others accept students with a grade ten education and have no English language prerequisites. The programs range from four months to one year in duration, and the practicum component ranges from four to ten weeks. With no standards in place for content or competency, each program differs in terms of course requirements, curriculum, examinations and graduation requirements.

Tuition fees vary considerably among programs. While publicly funded colleges such as L'École Technique et Professionnelle offer the health care aide program for \$1800, the majority of programs are delivered by private for-profit schools charging between \$5000 to \$8500. Some of the programs offer only three months of instruction. Fifteen years ago, health care aide training programs were offered through long-term care institutions; health care aides obtained certification on the job, at the cost of the employer. Since training programs have shifted to

private for-profit vocational schools, tuition costs have risen sharply, raising concerns about access to education and the quality of unregulated education programs provided by for-profit corporations.

Table 2. Health Care Aide Certification Programs, Duration and Tuition Fees

College/Program	Duration of Program (Months)	Duration of Practicum (Weeks)	Tuition (Dollars)
Robertson College	5	8	5900
Herzing College	4	8	5982
CDI College	7	10	8491
Academy of Learning	5	4	4800
Red River Community College	5	6	2203
University College North	5		2665
L'École Technique et Professionnelle College Universitaire de St-Boniface	6		1800
Assiniboine Community College	6		2595
St. James Assiniboia School Division, Continuing Education	4	6	2795
Urban Circle Training Centre	12	6	N/A

Managers of personal care homes were particularly concerned with the lack of minimum standards and the absence of a common curriculum for health care aides. According to health policy stakeholders, some educational programs are better than others, and personal care homes prefer to hire health care aides trained at specific institutions. They argued that standards are necessary to reduce discrepancies between educational institutions and ensure that health care aides are qualified for an increasingly complex workload. Several health policy stakeholders

compared the current training programs for health care aides to the regulated model for nursing and other health care professions:

Health care aides, it used to be that they didn't have to be certified. Now they need to have a health care aide certificate. There aren't any regulations at this point in time relative to having to have an approval process, there isn't a competency assessment. For example, in most health care professions, there is entry level competencies, this is the minimum standard that an educational program can have to graduate. That doesn't exist within health care aide programs. What we're finding is that there are some very good programs and there are some not so good programs. Therefore, when a health care aide is arriving, there's a huge continuum of skill and knowledge they are bringing to the job. You need to know which programs are good, which are not, which are acceptable. (HP-01)

There is some variation in the training programs. I can't speak to which ones are better than others, but I certainly hear comments about you know, sites prefer to hire from certain education programs, because they feel they can rely on them more. (HP-03).

I think the health care aide training needs to be looked at in some ways. I mean, basically they are trained to do the basics, which is all the [activities of daily living]. They learn a little anatomy and physiology, some disease process, but it's not really, very, I don't think it's very set, like if you train to be a nurse for certain requirements. I think to be a health care aide it depends on the school you go to and what their requirements are. (HP-05)

There is no publicly available information rating the different educational institutions, but their reputations vary considerably among employers. Managers and administrators prefer to hire health care aides trained at certain institutions, and expressed concern about the quality of some programs. Notably, none of the health care aides interviewed identified differences among the various programs, so it is possible that they are unaware of the negative reputation of some institutions. In addition to concerns about discrepancies between programs, some managers expressed concern about the quality of education overall. For example, HP-05 commented:

I think there really should be much more of a set curriculum that everyone has to do...I'm not so sure that it's always just the skill sets, the physical skill sets, I think sometimes they need to spend a little more time on communication, because I think that's lacking, especially new students. When you get them they are so wound up with getting the task done that they forget that it's a person that they are doing it with. (HP-05).

Some managers had suggestions to improve training programs, but there are no accepted standards of what health care aide training should constitute. One administrator identified the need to determine the knowledge and skills that health care aides require to provide quality care:

There's probably 15 different programs in the city. Some are very structured and they have clinical content. But no one tells them what a health care aide has to know or not know... I definitely think that with health care aides we need to move towards identifying what are the core competencies that health care aides need in order to safely provide quality care in a personal care home and home care and acute care. And then ensure that all programs are, ensure that when a person graduates they've met that core competency. (HP-01)

On the other hand, an administrator of long-term care cautioned that regulations could create recruitment problems. HP-03 was concerned that regulations would restrict the pool of potential health care aides, leading to a shortage of workers:

Well it's been debated for quite some time . . . Would it be beneficial? Certainly.

Anytime you introduce consistent standards there's a benefit to doing that. But there's also a price to pay for that. So if you start elevating a standard, not that that is bad, but you start getting more restrictive on who can go in. So the trade-off is always we need health care aides, they are the bulk of our workforce, if we restrict entry into programs, do we have fewer people that go into the programs? So what's more important: consistent standard of care or having enough hands to get the job done? (HP-03)

Implementing minimum standards would likely screen out some students. Given the large proportion of immigrant health care aides, education and language requirements could reduce the number of candidates. Several health care aides chose to work as health care aides because they were restricted entry into other occupations or educational programs. On the other hand, a standardized curriculum and minimum practicum component would not restrict entry into the field. If regulations resulted in longer training periods, it is possible that some would chose not to take the course because of the time required in school. For several health care aides, the short-training period was an incentive to work in the field. According to the union representative, the privatization of training programs reduced access to the occupation because health care aides can no longer earn income while training. She further cautioned against expanding the length of education programs:

The course needs to be accessible to workers. Nurses tend to be graduates from high school going straight into nursing, spending two to four years and then moving into a career. With health care aides, quite often, these are let's say more mature students and therefore need an income to support families while they're doing this and we need to make that possible...Training is a full time job in itself. And a lot of health care aides that they are drawing from are mature, experienced workers already who can't take, three, four, six months off of work to do this, for the most part. (HP-04)

It is also possible that the absence of regulations reduces access for potential students because of the high cost of tuition. Many of the health care aides interviewed had been encouraged by their friends or relatives to enter the field, and in turn encouraged others to join them. Until recently, tuition fees were relatively low, and several health care aides were trained on the job. With tuition costs on the rise, health care aides may reconsider recommending the training program to friends and relatives, and many expressed concern over the sharp rise in fees. When asked if she would recommend working as a health care aide to her recently arrived relatives, HCA-08 responded:

If I had a choice that I can give like health care aide, why not? Because flexibility with the job, and demand on the job. Because a health care aide there are lots of things that you can do. You can go in a facility, in a hospital and you can go in home care which is in demand right now. Most of them are taking, but the only thing I had a thing with a health care aide is the tuition fee. They are increasing and increasing it. Really. What are they making it as a business now? They're really increasing it. 6000 now. So they're increasing and increasing, what are they doing? They're making it as a business. (HCA-08)

HCA-05 expressed similar concern regarding for-profit training programs and described the difference between her training in 1983, and the current training system:

They offered the course while you are working we can go to...there is the in-service, so from 1:00 we have a teacher from Red River, actually she was the in-service coordinator. Then we have the pamphlets. Then we just read it, we only paid like \$35 for everything. We read then we take the test. How many modules only? Then we took the test and then that's it. It's not that long. I don't remember, it's not like now. For me it's a money maker. Because we are the ones who is training the new students now, we train them.

(HCA-05)

There are at least ten training programs for health care aides in Manitoba, and many of them operate multiple training sites within Winnipeg and throughout the province. Some for-profit training programs, such as Robertson College, have intakes for new students as often as every six to eight weeks. According to Red River College's "Graduate Satisfaction and Employment Report", 99 students graduated from their health care aide training program in 2009, up from 74 in 2007. Their student survey found that 37 percent of 2009 health care aide graduates had full time positions, and 30 percent held part time positions (Red River College, 2010), suggesting that there may be more than "enough hands to get the job done".

Casual and Part time Employment

When health care aides described their work as secure, they referred to growing demand, unions, and the stability of the health care industry compared to the private sector. There was, however, one aspect of their employment that was relatively insecure: the availability of full time positions. According to both health care aides and managers, new workers can expect to work in

casual positions for years until they have garnered the seniority to secure a regular part time position. Competition for full time employment is high and it can take several years in the workforce to obtain a regular position. Health policy stakeholders saw casual employment as necessary but problematic because it leads to scheduling problems and chronic understaffing. Health care aides described casual employment as unreliable and inadequate, and preferred full time and regular arrangements. Unlike managers, health care aides tended to view understaffing as the result of mismanagement, and not an inevitable outcome of casual and part time work.

Health policy stakeholders identified the need for more full time positions:

Because of the way that work is structured, there are a lot of part time jobs, and the full time jobs are quickly eaten up. So that you have health care aides who have to work two or three different jobs: a .4 here, a .4 here, a .6 here. Many health care aides, from my perspective, because their salaries are not that dramatic, are holding down a full time job at one location and taking up a part time job at another. So they have to balance that with family, plus and balance their own life. That's a huge issue in terms of recruitment/retention, being able to offer more full time work with a good compensation level and good benefits. (HP-01)

It's not the ideal training, but it tends to be the way that you work because you are starting at casual, then you tend to apply for small EFT then you work your way up to full time. That's just the nature of the beast. That's really how everyone works and you don't necessarily get the shift of choice at first, like maybe you have to work nights until you either acquire seniority, so that the next decent position that comes up you've got more hours than the next person. You really have to know going into this profession that you

have to put the grunt work in to be able to work your way into a position on a shift that you really want. (HP-05)

According to HP-02, facilities keep health care aides underemployed so that they are willing to pick up extra shifts:

I have a full time staff, and what we call a .4 staff, four days. Who's going to pick up extra shifts? The .4. So if I'm short-staffed or understaffed and put that shift up on the available shift notice, which we keep here. It's going to be a part time person who's going to pick up that shift for a couple of reasons. One is full time usually they're satisfied, and by the way sometimes full time staff have part time jobs too, to make ends meet . . . So it's in the best interest of the organization to have part time staff to fill in their hours. So you almost create a need in your staff to pick up extra hours. Which again, only serves the organization. (HP-02)

Employing health care aides on casual and part time basis ensures that a facility has a reserve of staff willing to pick up extra shifts to cover sick days and holidays. This practice, however, can lead to coordination problems. Health care aides with casual or part time positions tend to hold several jobs in order to earn sufficient income, which can complicate scheduling. This problem is compounded by the variation in remuneration offered by different facilities and across different sectors.

There is a lot of casual out there. For a variety of reasons. You have to have a decent base of people to call for sick time replacement or vacation or if there's an outbreak or if you need extra staff. So, there is always, you always have to have a certain amount of

casuals on your books. The drawback to that is that people who work casual work casual in lots of places. So, if you have a casual that was exclusive to you, then you would maybe only need two casuals. But, if you have six casuals who work at six places, the more they work, the more numbers you need because if you want them to work Monday, six people might get there before you. (HP-05)

There was a move many years ago to create a bunch of part time jobs. So I get a part time job at facility A, I can't feed my family on it, but I don't have enough seniority to get a full time job there because those are limited. So I have a part time job in facility A and a part time job in facility B. So when extra shifts come available in facility A, I can't take them because I have to go to work in facility B. So there is a real coordination issue here, and we have taken the position in the public realm of the creation of more full time jobs . . . For some reason, it's extremely difficult to get owners or managers to understand that at \$15 an hour, you probably need full time work to support a family. (HP-04)

Here's another dilemma we run into, even with our part time staff. We post shifts, someone's gone away on holidays, but we only pay \$13.15 an hour. So the staff has picked up those shifts, and maybe they've picked up four shifts over the next month. But their other employer now posts a shift on that same day, and there they're going to get \$17 an hour, so then the day before we're getting sick calls. Because they are going to take the \$17 an hour shift and drop the \$13 an hour shift. (HP-02)

From the perspective of health care aides, schedule coordination problems stem from management practices. According to HCA-08, some facilities post shifts well in advance and schedule their casual employees as soon as a shift comes up, while other facilities wait until the last minute, leading to schedule conflicts and short-staffing.

I can't understand about the shortage they're saying because there are lots. But the thing is, how a facility manage their staff to stay in there. You know? Just like here, OK, you are hired as casual. The casual is only for sick times, but you have no sick times. If I'm a casual, I'm not going to wait at home and wait for you 24/7 to call me if there's a sick call. Of course I have to go to another facility if they have a good schedule for me there, I have to stay there. So it depends the facility how they handle their staff, how they schedule their staff. If I have a vacation next week, you should give that to your part time and your casual schedules already, but here no. They wait until the last minute. You can't wait until the last minute, people are looking for a job too. I'm not going to stay at home in my house waiting for your call. That's why I take this job because it's in demand, I want to do this. So if there's a facility that .5 or .4 and there's lots of pick up, I'll stay there. (HCA-08)

Although managers complained that there were not enough full time positions, most of them felt that they offered as many full time jobs as possible. One of the long-term care administrators claimed that employers make an effort to offer full time positions, and that, from an employee's perspective, there are benefits to casual and part time work.

I think that a lot of employers, we actually like creating full time jobs because it's attractive from a recruitment point of view. It depends on the size of the facility. There's

a lot of factors that go into creating the schedules and the EFTs. Some of it is as simple as the size of the unit. So I can tell you that employers are very cognizant of the need to maximize full time employment. And there's a great debate in health care . . . I'll tell you the dirty little secret in health care: there are a lot of employees that like part time work.

He went on to say:

You have to remember when you work in a system where there are vacancies, that's ideal. If vacancies decrease that becomes problematic. Because if you really do want to work full time and you want to pick up extra shifts, those extra shifts may not be available. So that's the dynamic that's always played in the system. (HP-03)

For health care aides who want a flexible work schedule, part time and casual employment can be beneficial. Casual staff benefit from vacancies, but there is no guarantee that shifts will become available. All of the health care aides interviewed expressed their preference to work full time. HCA-06, who is the newest health care aide, described her experience as a casual employee:

Health care aides start off part time and casual, only experienced workers get full time positions. She would prefer to have full time employment. She said casual is difficult because, "you never know if you are working tomorrow, it's like being a doctor, you're on call all the time". Though she can say no to picking up shifts, she feels that she should say yes, and has never denied a shift because she's on "probation" and knows that they are evaluating her performance. Tomorrow she is going to interview for a second job, she is hoping to have two jobs until she can get a full time position. (HCA-06, excerpt from field notes)

HCA-09 worked for seven years before she was able to obtain a full time position. She described how she coped with part time work:

Before I was only .6 when I started. Sometimes there's no call whatsoever, I do agency too just to combine. I experience from agency too, I did home care for a year. (HCA-09)

Health policy stakeholders identified a need for more full time employment, although some of them indicated that they offered as many full time positions as possible. On the other hand, the union representative and one of the managers argued that personal care homes keep a large portion of their health care aide staff underemployed to maintain a flexible labour force. For health care aides, casual and part time arrangements are insufficient and unreliable, and all of them had sought multiple jobs in order to earn sufficient income.

Working Conditions

Health care aides described their work as stressful, demanding but also rewarding. They identified several factors that contribute to the physical and emotional stress of their job including resident health, staffing levels, resident-on-staff violence, and perceptions of long-term care. According to health care aides and health policy stakeholders, these factors impact the work experiences of health care aides as well as the quality of care provided to residents. Despite the difficulties they encountered at work, health care aides regarded their work as essential caregiving that is both intellectually and emotionally rewarding.

Resident Health

Health care aides and health policy stakeholders identified a trend toward increasing medical acuity and behavioral problems among personal care home residents. According to health care

aides, residents are older and sicker than ever before. They are more likely to have dementia, particularly severe dementia, be immobile and require total assistance for activities of daily living. They require higher levels of care and display challenging and sometimes violent behavior. For health care aides, this has resulted in a heavier workload, injury and burnout.

Not that much [Alzheimer's disease] before, it's more independent at that time. I think it's more older the people that coming now into a home. Like the age of 90s. Very seldom that the residents come at the age of 60s or 70s. Mostly on their 90s, 80s, so the heavy care that you have to provide to them are really more heavier. (HCA-03)

The residents that come over are more aggressive now, and more Alzheimer's coming. (HCA-03)

Before, the work was easier, now health care aides have a heavier work load. In the past, residents needed care, but they were still independent, health care aides would just give assistance. Today they are mechanical lift. (HCA-04, excerpt from field notes)

What I find is . . . not many nursing homes are having a level one or level two people that can walk and ambulate themselves. But most of them are mechanical lift, especially when they have stroke. And they need people too. . . Because these people are saying, "when I come I'm walking, and then tomorrow I decline." They're deteriorating. (HCA-08)

Health care aides were particularly concerned with aggressive and violent behavior among residents. All of the health care aides had encountered violence in the workplace. The following quotations describe some of their experiences working with violent residents:

[Aggressive behavior] it is increasing. You know what, some nursing homes, if there is a unit that all the Alzheimer's was there, some Alzheimer's are really violent, they shout too. Shout here, swear here, swear there. It depends, there's a time that they're really bad, and there's a time that they're good. So you re-approach them. They don't know what they are doing, and if you talk to them they calm down. It depends how you talk to them, you approach them. You have to have the experience really, because some of them really are violent. (HCA-03)

Sometimes they pull your hair, they kick you, they spit on you, they throw food on you, anything that they can...If it's like that, we report it to the nurse, and to our supervisor, and then they say, you leave them. But, OK, leave them for now, then you have to come back later, and they're like that again later, so what are you going to do?... Or sometimes they sedate them, they can be calmed down. But that's so sad to be sedated. It's hard. It's so hard. Sometimes I cry. I cry because, I'm so frustrated. Very frustrated. (HCA-05)

Oh yeah, they're kicking, they're punching you. But what are we going to do? They have health problems; they don't know what they're doing. Sometimes they're just kicking you, punching you, and everything. I say, "OK we're just changing you" and they're going to be calm. But sometimes if they have: "Oh it hurts, why are you touching me like this?" We just let go, because we know how severe their...what their feeling is. They feel the pain or something. (HCA-08)

I was being kicked. She just grabbed me...my glasses, my lens popped out. I was being kicked, I was hit on my chest. Twice they grabbed my glasses. Just recently. But she has

that Lewis disease... That one you don't know when she going to attack you. She make nice nice, then all of the sudden, zoom! I'm feeding her, so I'm more close. But now when I come to her room, I usually take my glasses off. (HCA-09)

When asked how long-term care has changed over the course of their careers, health policy stakeholders identified increased burden of medical illness as one of the most significant changes affecting personal care home residents. According to health policy stakeholders, residents have higher rates of mortality, frailty, chronic health conditions, advanced dementia, and behavioral and psychiatric symptoms associated with dementia:

Probably the biggest change is the kind of resident population that we're looking after today. Be it the last 10 years or the last 15 or 20 years, we're looking after probably a more complex, more fragile population than we did years ago. So people are coming in with more complex health issues, and the reason we know that, is we know that the length of stay in a personal care home is much shorter today than it was 10 years ago. If you use that as a proxy to measure acuity, which is a pretty good one, it would tell you that we're looking after a frailer, and providing for 'end of life' care to this population

So there's been a huge shift. The idea that you came into a home and stayed there for 10 years is pretty rare now. It's generally, the average length of stay is probably about 2.5 years now. (HP-03)

Right now we have 60 percent, 70 percent of people with dementia, that will close to creep up to 100 percent, there are so many other housing options. Personal care homes will become for those that have quite advanced dementia that are very challenging.

We're going to have to keep evolving or else we're not going to be able to provide good

quality, safe care. (HP-01)

HP-01 and HP-05 further argued that health care aide training programs and staffing ratios should respond to the complexity of residents' care needs:

The care needs and the regulations and expectations around most care needs are becoming so complex. There's such a significant need for education, for support. It's just really becoming a specialty area. Working with residents with behavioral and psychiatric symptoms of dementia, it's really an art, and being able to mentored in that role and having the right education and support I think is a huge issue. (HP-01)

The type of resident that we look after now is a lot more heavy needs, behavior, a lot more chronic care, a lot more complicated care. And yet, we're still doing the same thing with the same staff. (HP-05)

Staffing Levels

Health care aides and health policy stakeholders were concerned about the staffing levels in personal care homes. According to health care aides, working conditions are stressful and impact the provision of care. Health policy stakeholders, like HP-01 above, felt that the current staffing levels are insufficient to accommodate the complex care needs of personal care home residents. One administrator, however, argued that staffing levels in Manitoba are relatively high compared to other Canadian provinces.

Health care aides argued that the current staffing levels create stressful working conditions and limit their ability to provide quality care. When asked if they thought staffing levels were adequate, six out of seven health care aides answered that the ratio of health care aides to

residents should be increased in order to support an increasingly heavy workload. Health care aides described the workload as physically and emotionally exhausting.

If you have more staff, the more care, you know, the more care you're giving to them, because it's not only limited. If you have a short staff the care is limited. Because the more heavy you have with your staff, of a short staff, the more sick they have. It's not fun to go to work if you're more tiring every day. Because if you have heavy lifting and that's the time like every day that's the one you're doing because you're full time or something. You think you're tired also doing that. You're thinking of not even going back. But if you're light and it's OK for you, you love going back to work and you have energy to go back to work. But if you're having heavy loads everyday... ooooh... Before I have lots of sick... I want to get sick... to recover. (HCA-08)

With heavy workloads and chronic understaffing, health care aides often have to ration out care. Health care aides gave accounts of situations where they were unable to respond to residents' needs or provided inadequate care due to time and staff constraints. Health care aides were often emotional when they shared these stories.

For the people who care, time is never enough. For the people who don't care, who cares? Three o'clock will be done . . . Sometimes there are three people who put their light on, everybody needs to go to the washroom. What are you going to do? And sometimes you can't leave them alone, you have to wait. So what happens to the two? They end up doing it in their chair. Sometimes they still have this eh [their mind]. And they are so embarrassed that they did it in the chair. Imagine if you are in that case, what are you going to do? Staff can't do anything about it too, because she's not just

standing there doing nothing, she's taking care of this person. So we need more help.
(HCA-05)

If you work midnight, you have to get everyone up at five in the morning and put them to the chair. That's inhumane! Because they have a quota to get them up to help the day staff. If you have extra staff to do that you don't need to wake them up at five in the morning. Those poor old residents, the old people. Having more staff would improve in the morning. They don't need those night staff to get up people at five in the morning just to help those day staff. (HCA-08)

We should have another short shift staff especially for feeding time. Because sometimes we are doing left and right feeding, we are in between them...It's always the budget the budget. (HCA-09)

When residents have to wait for help, they can become agitated and aggressive:

Oh boy they get mad because you are not there once they ring you! They're really mad. Once you step into the room, they're saying lots of nasty things already for you, "An hour waiting for you!" ... "I've been here for two days waiting for you!" (HCA-09)

In 2007, the Government of Manitoba announced that they planned to increase the staffing levels in personal care homes to 3.6 care hours per resident-day. Interviews with health policy stakeholders revealed that the initiative was not fully implemented, and only some personal care homes were able to hire additional staff. According to managers and the union representative, the modest improvement did not solve staffing problems:

Keep in mind that back in the 1970s personal care homes were basically started where

residents were fairly independent, they were designed and set up and staffed for people with very basic needs. They were still active; there were very few wheelchairs, all fairly actively engaged in activities. Now, for the most part, I would say 75 percent of residents are wheelchair bound and require mechanical lifts, and the actual day to day work is physically more challenging. The other piece of it is that there are so many more options out there, and people are aging more successfully, and living in alternative settings, so personal care homes have become the place mostly the place where people with dementia reside and those that have very complex, very challenging needs. Health care aides are, they are working flat out, and they are doing very physical, very emotional, mentally challenging work. On a day shift they probably have 10 to 12 residents to care for. On an evening shift they may have 20 and on a night shift they may have 40, and that's with the improved staffing. So they are trying to balance all of those care needs. (HP-01)

Nursing homes, heaven forbid that they have a little bit more people or resources than they have mandatory work. As I said earlier, these are people that deserve dignity at the end of their lives. I know health care aides, if they're done bathing, dressing, feeding and walking, they'll sit down and read someone their letter. They won't stop working. There is enough work for twice as many health care aides. So if we could look at staffing-up a little bit more, making the resident's life that much better and a safer work environment for the staff, that would be my one change. (HP-04)

I would say the health care aides because the health care aides do the brunt of the hands-on care. They're the ones that make the difference to the residents . . . because if you have five extra minutes with a client, it's a long time for that person and would make a huge difference. You could comb their hair and talk to them as opposed to combing their

hair and racing out to the next one and trying to give care without giving the idea that you're in some sort of race, is a real skill. The reality of it is that you've always got the next job forming in your mind, so it's really hard to make them feel that they're important. (HP-05)

Managers were disappointed that staffing levels have remained stagnant for over three decades.

As one manager stated:

It's just a smidgen, I think over the years that I've been in long-term care, I would have thought that more effort would have been put in [to staffing]. (HP-04)

On the other hand, HP-03, an administrator, maintained that Manitoba had made significant progress compared to other Canadian provinces:

Manitoba's been fortunate over the years, we have some of the best staffing levels in 24 hour nursing homes in our personal care program in the country. The metric we use for that are the paid hours per resident-day. We're kind of about, right now, we're about 3.3 or 3.4 paid hours per resident in terms of total nursing care. It's going to be going up to 3.6, which will put us on par with Alberta in terms of having the best staffing in the country.

To put it in perspective, we're probably closer to 3.4 now, paid hours per resident-day. Ontario's at about 2.3 or 2.4. Ontario's not seen as the benchmark to strive for, so I'm not saying ...but you know, I think we're doing what we can, it's not perfect, it's never

enough. I can tell you I've never heard anybody say they've got enough staffing. Our other challenge is we have to do it slowly anyways because there are only so many health care professionals available in the system. So you create jobs one place, it creates vacancies elsewhere, there are tradeoffs in everything. (HP-03)

Health care aides and health policy stakeholders identified staffing as one of the most significant challenges in long-term care. Health care aides often work short-staffed, compounding the problems posed by low staffing levels. Their work is physically and emotionally challenging, and many call in sick due to exhaustion. They are often unable to provide care to residents in need, leaving them feeling ineffective and powerless.

Rewarding Work

Health care aides face several challenges including part-time and casual employment arrangements, the complexity of residents' care needs, resident-on-staff violence, physically strenuous work and inadequate staffing. Though the work is stressful and demanding, it is also highly rewarding. Health care aides regarded their work as essential caregiving provided to people who require high levels of care. They developed and utilized skills, particularly when dealing with people with dementia or providing personal care to frail residents. They valued their relationships with residents and families, and felt that they made a positive impact on residents' quality of life. Many of them referred to Filipino cultural ideals to explain the meaning and value of their work.

Health care aides commonly professed their love for their job and the residents they care for, including health care aides who were still struggling to adjust to it. According to health care aides, love, compassion and a strong work ethic are essential qualities for health care aides to

possess. Although financial incentives drew them into the field, they emphasized their love for the job and their compassion for residents. Those who lack these qualities, they warned, provide inadequate care.

You know I love my job. I think so. I love looking after the residents. I love, I put makeup on them. When they came their hair is so messy, their nails are long. When they got there you fix them up, totally makeover. I just love that. I just love it when I make them look good, happy, improve them. I'm enjoying it. I'm not looking at the bad side, I'm always looking at . . . I enjoy coming to work every day. (HCA-05)

Health care aide is a tough job. Very tough job. It's a gift. Really it's a gift. You have to be gifted to work as a health care aide. If you don't have that, or you don't have the patience, you can't. Health care aides have to be really caring, caring and honest. (HCA-05)

Even though, they say it's a messy job. But when you love people I don't think it's messy. (HCA-05)

You have to love your job, or else, don't be a health care aide. (HCA-04)

I think you should go to work the main reason is not only to earn money. You should go to work because you care for them, because if you don't care for them you cannot do your job well . . . You learn to . . . you go to work because you love your work, you care for the residents, and if you feel that way I think you can do your job well. You go to work not because you want to earn money, it should be the second or third reason why.

(HCA-07)

The care that health care aides provide is complex and multi-faceted. In addition to providing “love” and social interaction, health care aides performed critical tasks that impact resident health and quality of life. Health care aides monitor residents’ health conditions, including sores, rashes, weight loss and respiratory problems. Some described cleaning residents carefully and frequently to reduce the risk of irritation or skin breakdown, and emphasized the connection between their work, health outcomes and quality of life. Among health care aides who aspired to become nurses, attending to residents’ health conditions was particularly rewarding.

When I make the resident happy. I love...let’s say when they lost weight and when I help them gain weight, or let’s say they have sores and I help them. Some of them when they come from the hospital they have lots of sores, then they improve. It’s a gift...it’s priceless, you know, the feeling. It’s not the money, when you make the residents happy it’s priceless. I know, it’s funny, some groups are heavy and some are not, some residents are heavy and some are not. When you make this person eat, because sometimes they don’t eat at all, and then you make them eat, it’s priceless. I make this person eat and then I make them happy. When they don’t eat and then they get sick, that’s so sad. I think make them happy is the best thing. (HCA-05)

I think, when they’re almost close to dying. When you really have to keep an eye...how’s their breathing? How’s their skin condition? Something like that. Sometimes I cry too!

(HCA-09)

A simple thing that you do for the senior, it makes a big difference. Imagine, they want to have a bath. What if there were no health care aides? You know? That’s a very specific

example, it makes a big difference . . . The most important thing is I can find my way to help people, especially the seniors. Because they really need somebody to do the things which they cannot do by themselves. (HCA-07)

Working with frail elderly populations with high rates of dementia and other chronic health conditions requires complex skills. Residents often resist care and many exhibit behavioral and psychological symptoms of dementia. HP-01 described providing care to residents with dementia as an art (Please see page 90), and health care aides emphasized the skills they utilized when working with resistant or aggressive residents.

It depends, there's a time that they're really bad, and there's a time that they're good. So you re-approach them. They don't know what they are doing, and if you talk to them they calm down. It depends how you talk to them, you approach them. You have to have the experience really, because some of them really are violent. (HCA-03)

Health care aides highlighted the skills they used to perform activities of daily living and to interact with residents. They also valued the opportunity to improve their English language skills and learn about different cultures. Several of health care aides applied the skills they learned as health care aides when caring for their own children or parents.

I can apply it to my mother, because she is old already. And aside from that, I learned so many things. I apply it to my kids, especially when they have a fever, you know simple like that. I always get a benefit from what I'm doing now. (HCA-07)

Health care aides found it particularly rewarding when residents or their family members acknowledged or expressed appreciation for the work that they do.

It's rewarding when families notice, when they are thankful that you are giving good care to their parents, that you are a good health care aide. (HCA-04)

It's priceless every time they appreciate what you do. Like [resident's name] her sons and her daughter-in-law came and she called me personally to introduce me to her family. See, that's priceless! That's really nice. (HCA-05)

I have one resident that used to be a nurse. Dealing to her family, she said, "I don't know how to repay her, what she do to me is a billion dollars, I don't know how to repay her". It's because if you look after the old folks that they still have their mind, they really appreciate what you are doing. And you feel good for that, even the family. Because their mother is still have her mind, when the family come over she tell the story what's going on to that day, day after day. And the family will see you or, "Oh you're the one that look after my mom, thank you for everything that you did". (HCA-03)

Health care aides were often subjected to insults from residents, and complaints from family members and other staff. Several health care aides felt that their work is undervalued and that their skills are underestimated. In this context, expressions of gratitude reaffirmed the value of their work.

Drawing on Filipino cultural ideals of caregiving gave meaning and value to their work. They often explained the meaning of their work within the context of Filipino culture.

For us, we look after our parents, if you just think about your parents; you will be a good health care aide. I see residents as parents. (HCA-04)

It was our tradition, we never send our parents to a nursing home, we always take care of

them. When we came here, it's different. So then, the way we care of the residents, it is the way we care of our parents. (HCA-05)

As a daughter it's naturally you have to help your parents, no matter what you have to help them. It's a part of our culture. (HCA-07)

In my country, there's not personal care home, there's no . . . all seniors are with their family. Unlike here, I don't know why the children are sending their family or their grandma to the nursing home . . . the most important characteristic of Filipinos are close family ties. I'm not saying that they don't love their mom, but in our opinion, we can prove that we love our parents by means of it she will stay with us, we are the one who will look after them, instead of let somebody to take care of your mom. She's your mom. That's the way we believe. Close family ties. (HCA-07)

Health care aides commonly compared their role as health care aides to that of dutiful daughters and referred to feeling “at home” in personal care homes. They drew on Filipino cultural ideals and traditions of caregiving to impart value and meaning to their work. In some cases, health care aides used these assertions to indicate their superior work ethic. In other cases, they employed cultural references to describe their relationships with residents and the rewarding aspects of providing care to those in need.

CHAPTER SIX

Discussion and Conclusion

This chapter presents a discussion of the study findings and related theoretical and policy implications. The chapter is divided into four sections. Section I examines the social, economic and historical context of the migration and employment of Filipino health care aides. Section II examines long-term care policies and practices that contribute to the high concentration of Filipino health care aides in Winnipeg's personal care homes. Section III analyzes the results of the study using the three theoretical perspectives reviewed in Chapter 3. Section IV outlines the policy recommendations based on the results of the study. The chapter ends with a discussion of the study's limitations and final conclusions.

Section I. The Migration and Employment Histories of Filipino Health Care Aides

The study identified several factors that influenced the migration and employment decisions of Filipino women: poverty and unemployment in the Philippines, migrant social networks, barriers in the labour market, financial incentives and non-economic rewards. Health care aides cited poverty, unemployment and underemployment as their primary reasons for emigrating from the Philippines. Although health care aides had diverse educational backgrounds, they each struggled to provide for themselves and their families. Those who were able to obtain jobs in the Philippines endured poor working conditions, long hours, low wages and job insecurity. Whether they lived on farms in rural Philippines or worked as professionals in large cities, each of them felt that migration was their only option to secure sufficient income for themselves and their families.

The study found that migrant social networks act as pathways linking migrants to employment opportunities in long-term care. While poverty and unemployment propelled their migration, transnational connections among Filipinos provided the opportunity and resources to move abroad. HCA-03 was the only participant who did not have a familial connection to Manitoba at the time of her migration. Each of the other six health care aides had at least one relative in Manitoba who preceded her. Five out of seven health care aides emigrated through family reunification programs, and all but one have since sponsored relatives from the Philippines to Manitoba. Health care aides' family migration patterns suggest that women's migration can be instrumental for subsequent family migration.

Once in Canada, health care aides faced multiple barriers in the labour market, including accreditation and language barriers. Health care aides with post-secondary degrees were unable to work in their field of study. With limited employment options, these women endured low wages, poor working conditions and employment insecurity.

Immigrants applying through the Family Support Stream of the Provincial Nominee Program must demonstrate that they are employable in Manitoba. Both of the health care aides who immigrated through this channel were professionals but discovered they were unable to work in their chosen field once in Manitoba. They expected to obtain professional jobs in Manitoba and were disappointed with their employment outcomes. It is possible that the application process and eligibility requirements impact the employment expectations of potential immigrants.

According to Reitz (2007), there is persistent under-utilization of the skills of Canada's highly educated immigrants. Although Canadian immigration policy favors the selection of

skilled and educated immigrants, the greater need has been for less skilled immigration to meet demand in low level occupations, such as health care aides. As a result of this growing gap, “skilled immigrants often do not succeed in getting those professional and other highly-skilled jobs for which they are presumed to be qualified” (Reitz, 2007: 2). Three of the health care aides in this study had university degrees from the Philippines. Once in Manitoba, none of them were able to attain work in their field of expertise.

In light of the challenges they faced in the labour market, health care aides turned to their relatives and friends to find information about job opportunities and educational programs. Each participant had a family member or friend working in long-term care who influenced their decision to work as a health care aide. These social ties conveyed information about employment in personal care homes and in some cases provided job referrals that ultimately directed Filipino immigrants into the long-term care sector.

The simultaneous recruitment of Filipino nurses and garment workers in the late 1960s resulted in social connections between both groups within a small community of mostly female immigrants. HCA-03, who was recruited to work in Winnipeg’s garment industry in 1969, learned about employment opportunities in nursing homes through a friend from the Philippine community who worked as a nurse. She recounted how she and other Filipino garment workers learned about job openings in nursing homes after completing two year contracts with garment factories. Similarly, HCA-05 learned about health care aide work through her sister’s friend who worked in a nursing home. Her sister, who had helped her immigrate to Canada, worked in one of Winnipeg’s garment factories. The recruitment of nurses and garment workers from the Philippines has been well documented. Less well known is the movement of Filipino garment workers and their relatives into the long-term care sector. Interviews with Filipino health care

aides indicate that the formation of the Filipino health care aide labour force in Winnipeg traces back to the social connections between Filipino garment workers and nurses beginning in the late 1960s.

Migrant social networks connected potential migrants in the Philippines with job opportunities in Winnipeg. The garment industry accelerated this process by encouraging Filipino workers to sponsor their family members (Dalayoan et al., 2008). This provided the industry with a steady flow of workers without the cost of international recruitment. Throughout the 1970s and 1980s, thousands of Filipino men and women migrated to work in Winnipeg. Many sponsored their friends and family members, securing them employment in Winnipeg's garment factories. (Dalayoan et al., 2008).

According to social network theory, once in place, migrant social networks tend to expand. The migration histories of health care aides support this hypothesis. Health care aides with the earliest dates of entry to Canada (HCA-03, HCA-04, HCA-05) were introduced to personal care home workers through friends and acquaintances they met in Manitoba. Health care aides with later dates of entry to Canada (HCA-06, HCA-07), arrived with established ties to personal care home workers. For example, when HCA-06 arrived in 2009, she had multiple family members and friends from the Philippines working as health care aides in Winnipeg's personal care homes. Thirty-five years after HCA-03 learned about a job opening in a Winnipeg nursing home, social networks among Filipino health care aides have significantly expanded.

In addition to facilitating migration, social networks link Filipino immigrants with employment opportunities in long-term care by conveying employment information. Health care aides identified four key incentives conveyed by family members or friends that influenced their

decision to work as health care aides: 1) jobs are in demand; 2) the training period is relatively short; 3) jobs are secure; and 4) wages are relatively high. The emphasis on these job features reflects health care aides' previous experiences in the labour market including unemployment, lack of recognition for their education, low wages and job insecurity. Descriptions of incentives were notably consistent among health care aides, who often learned about the job through social networks. This suggests that ideas about health care aide work are constructed and communicated through social networks and may reflect the social and economic context of the Filipino community in Manitoba.

In the early 1990s, Winnipeg's garment industry suffered significant job losses (Bloskie, 2005) and by 2000, over half of all garment manufacturing jobs were outsourced to offshore factories (Cash, 2007). Thousands of production workers were terminated; most of them were immigrant women (Cash, 2007; Kusch, 2009). The collapse of the domestic garment industry featured prominently in health care aides' discussions of employment security. Garment factories represented uncertainty, and health care aides commonly contrasted manufacturing jobs with the relative stability of the health care sector. Asis (2006) argues that Filipino migrant workers have become "migration savvy", able to adjust to fluctuations in the international labour market. In this case, health care aides' employment preferences responded to their personal experiences in the labour market as well as the changing demands for Filipino labour in Manitoba.

In addition to financial incentives, health care aides valued the non-economic aspects of their work, regarding it as essential caregiving that is intellectually and emotionally rewarding. Health care aides highlighted the skills they used to perform activities of daily living, personal and supportive care and to interact with residents. Several health care aides described the

specialized interpersonal skills they employed when working with residents exhibiting behavioral and psychiatric symptoms associated with dementia.

Health care aides commonly professed their love for their job and the residents they care for. Love, according to health care aides, is an essential feature of health care aide work. As presented in Chapter 5 (page 101), HCA-04 asserted, “You have to love your job, or else, don’t be a health care aide.” Frequent references to love illustrated the numerous, and sometimes contradictory ways that love factors into their work (Faier, 2007). Some health care aides professed their love for their work immediately after describing the financial incentives that enticed them to enter the field. They often asserted their love for their work in the context of discussing the poor working conditions and stigma associated with personal care homes.

In her study of Filipino migrant women working in Japanese hostess bars, Faier (2007) argues that Filipino women assert their agency through frequent expressions of love for their Japanese husbands. According to Faier (2007), when professing their love for their husbands, Filipino migrant women were “claiming a sense of humanity, countering the stigma associated with their work in bars, and articulating a sense of themselves as cosmopolitan, modern, and moral women.” (Faier, 2007: 149). Faier contrasts their assertions of love and agency with their experiences of poverty, stigma, their status as immigrants, and the power differences embedded in their relationships with their Japanese husbands.

Similarly, by professing their love for their work and the residents they care for, health care aides asserted their agency and positioned themselves as valuable, skillful and moral women. The term love took on a variety of meanings in the context of health care aides work. In some cases love referred to a skill or a form of social interaction. For example, HCA-03

described her use of love in her everyday work, “Some of them really are violent...If you know how to approach them, just give them love and they calm down.” (HCA-03). Love for residents countered the negative perceptions of health care aide work, as HCA-05 stated, “Even though, they say it’s a messy job but when you love people I don’t think it’s messy.” (HCA-05). Health care aides commonly compared residents to their parents, drawing on Filipino cultural ideals of love and caregiving to impart value and meaning to their work. By invoking their love for their work, health care aides minimized the stigma of working in personal care homes, and emphasized the personal and cultural value of their work.

Although their migration and employment decisions were primarily based on financial need, once employed as health care aides, health care aides developed an appreciation for the non-economic aspects of their work. They viewed their work as critical caregiving to residents with complex health and behavioral problems and highlighted the skills, work ethic and compassion that their job demands.

Section 2: The Long-Term Care Policy Context

Interviews with health policy stakeholders identified several aspects of the long-term care policy context that impact the composition of the workforce and contribute to the high concentration of Filipino health care aides in Winnipeg’s personal care homes. The lack of formal requirements for health care aides and the absence of regulations for certification programs enabled Filipino social networks to expand in the workforce. For-profit vocational schools may also contribute to the high proportion of Filipino health care aides by maintaining lenient admissions criteria and marketing health care aide work as continuously expanding.

In Manitoba, health care aides are an unregulated workforce. There is no registration examination for health care aides to enter practice and there is no regulating body for graduates. In fact, there is no registry for health care aides in Manitoba. Personal care homes require that health care aides obtain a certificate but certification programs are unregulated. There are more than ten training programs in the province and they vary significantly in terms of entrance requirements, length of program, length of practicum, content, and graduation requirements (See Table 2).

Community colleges have entrance requirements that may systematically disadvantage immigrant students. For example, students applying to Red River College's health care aide training program must be residents of Manitoba, have a Manitoba high school diploma, and if they speak English as an additional language, they must attain a minimum score on the Canadian Language Benchmark test. In contrast, some of the for-profit schools do not require high school diplomas, have no standardized criteria for English proficiency and accept international students. Students who do not meet community college requirements may have to enroll at private for-profit schools with less restrictive admissions criteria. The limited enrollment capacity and admissions criteria of public educational institutions may have expanded the market for for-profit health care aide programs. With less restrictive entrance requirements, for-profit programs likely sustain the supply of immigrant health care aides, but at a high cost. Tuition fees at for-profit schools have risen sharply, forcing students to pay up to four times more than their community college counterparts.

Until the 1990s, there were no formal requirements for health care aides. Personal care homes were responsible for training their staff, and health care aides received an income while undergoing instruction. In the 1990s, personal care homes began to require certification. Health

care aides who entered the workforce prior to 1990 had no formal training; rather, they secured employment through referrals. As presented in Chapter Five (page 71), HCA-05 described the process of obtaining her first job in a personal care home:

That time you don't even have to have a certificate. You didn't even have to have experience. You just know somebody in there and they will train you. (HCA-05)

Waldinger and Lichter (2003) argue that migrant social networks tend to expand in a workplace if there are few restrictions on entry, such as language or education requirements. Under these conditions, employers are free to make use of their employees' social networks to bring forward new recruits. Recruitment through informal networks reduces the cost and risks associated with hiring, in part because the employee has an interest in the performance of the new recruit. With no formal requirements for health care aides throughout the 1970s and 1980s, Filipino social networks expanded in personal care homes.

According to social network theory, training requirements such as certification limit the scope of social networks in the workplace because they disadvantage immigrants and formalize the hiring process. The move to require certification for health care aides in the 1990s may have restricted access, but it did not bar immigrants from entering the workforce.

As training programs are unregulated, there are no standardized qualifications for health care aides entering or graduating from educational programs. While some public institutions adopted standardized admissions criteria, many for-profit schools have not, facilitating access for immigrant students. Several health care aides in this study chose to work as health care aides, in part, because they were restricted entry into other occupations or educational programs. Implementing minimum standards would likely screen out some students. Given the large

proportion of immigrant health care aides, education and language requirements could reduce the number of candidates.

Conversely, the absence of regulations may disadvantage some health care aides. Facilities have different minimum requirements for health care aides. Some facilities only hire health care aides with recognized high school diplomas, while others accept health care aides with a grade 10 level of education. Personal care homes require their staff to read and write in English or French, but there is no standardized measure to ensure minimum proficiency. HP-01 described routinely screening candidates for their English ability, frequently turning health care aides away who did not meet her standards. In effect, the entrance requirements of some training programs do not correspond to the minimum qualifications of all long-term care facilities. With no standards in place for training programs, they are free to accept students who do not meet the employment requirements of long-term care institutions. The lack of regulations may facilitate access to training programs, but it does not ensure that health care aides are qualified for employment.

In fact, the reputations of educational programs varied considerably among employers. Managers prefer to hire health care aides trained at specific institutions and expressed concern about the quality of some programs. They argued that standards are necessary to reduce discrepancies between educational institutions and ensure that health care aides are qualified for an increasingly complex workload. None of the health care aides identified differences among the various programs, so it is possible that they are unaware of the negative reputation of some institutions. There is no publicly available information rating the different programs, placing health care aide students in a vulnerable position. In 2008, British Columbia implemented a standard curriculum for all health care assistant training programs in the province. If an

employer believes that a health care aide has received inadequate training, they are obligated to report it. Although health policy stakeholders identified significant issues with Manitoba's training programs, there is no system in place to improve training programs or to ensure accountability.

In their study of live-in caregivers in Canada, Bakan and Stasiulis (1995) demonstrate how recruitment agencies serve as gatekeepers determining who is, and who is not, an appropriate caregiver for Canadian families. In the case of health care aides, vocational schools act as gatekeepers. Unregulated certification programs control how many health care aides enter the workforce and impose as many or as few restrictions on entry as they chose. Some for-profit training programs have intakes for new students as often as every six weeks. Although they market health care work as perpetually in demand, the proliferation of for profit schools may have saturated the market with health care aides. Health care aides starting out in the workforce are unable to obtain regular work, and many work in casual positions for years before obtaining full time employment.

Despite the abundance of training programs and the large pool of casual workers, the notion of a health care aide shortage persisted. The high proportion of immigrant health care aides shaped policy stakeholders' perceptions of the labour market. The growing concentration of immigrant women was often viewed as an indication of a labour shortage and used as a rationale for avoiding regulations and increasing staffing. For example, a senior administrator cautioned that regulations would restrict the pool of potential health care aides, creating a shortage of workers (see page 83):

So the trade-off is always we need health care aides, they are the bulk of our workforce,

if we restrict entry into programs, do we have fewer people that go into the programs?

So what's more important: consistent standard of care or having enough hands to get the job done? (HP-03)

The above comment suggests that Manitoba's reluctance to regulate health care aide training programs is part of a strategy designed to maintain a steady supply of low-skilled workers. The phrase "having enough hands to get the job done" conjures an image of health care aides as unskilled workers performing manual labour. The benefits of this recruitment strategy are not supported by research (Amstrong et al, 2008; Cangiano et al. 2009; Fujisawa and Colombo, 2009; Walsh and O'Shea). Low-levels of training have been linked to recruitment and retention problems (Fujisawa and Colombo, 2009; Leons et al, 2001). Several studies recommend elevating training standards in order to increase quality of care, improve the status of health care aides and thereby increase recruitment and retention (Amstrong et al, 2008; Cangiano et al. 2009; Fujisawa and Colombo, 2009; Walsh and O'Shea).

Just as health care aides tended to view their work as secure and in-demand, administrators, managers and the union representative espoused the idea of a perpetual shortage of health care aides, but there is no data quantifying the number of health care aides or estimated staffing needs. British Columbia developed a mandatory registry for health care assistants, but there is no body that registers or documents the number of health care aides in Manitoba. Some community colleges publish graduate statistics, but none of the for-profit schools publicize their enrollment numbers.

Some health care aides and managers challenged the notion of a shortage. HCA-08 argued that there are many unemployed and underemployed health care aides looking for work,

“I know they said that it’s a shortage but there are lots of people who really wants a job.”

Managers did not dispute the notion of a shortage, but they argued that it stems from the structure and organization of care work and not from a shortage of available workers. When asked if she had difficulty recruiting health care aides, HP-05 responded, “We don’t have any problem with our staff. All of our positions are full. I think it’s hard to get good health care aides.” Her comments suggest that there is a shortage of competent health care aides, not an absolute shortage of workers. HP-01 agreed that facilities experience shortages, but proposed that it is primarily a recruitment and retention problem due to low wages and the lack of full time positions. HP-02 and HP-04 further argued that the abundance of casual and part time positions creates scheduling conflicts that lead to chronic understaffing. According to HP-02, facilities intentionally keep their workforce underemployed to maintain a flexible labour force. Their comments indicate that recruitment and staffing problems stem from a shortage of full time positions rather than a shortage of workers.

For the union representative, a shortage of health care aides means more bargaining power, and for administrators of long-term care, it is part of a rationale to avoid regulations and maintain current staffing levels. For-profit schools also have a stake in perpetuating the notion of a health care aide shortage and an ever-increasing demand. The websites of for-profit training programs extol the benefits of taking their health care aide course: “You’ve chosen a profession that’s exploding right across the country. Health Care Aides have their choice of opportunities. The biggest challenge may be in choosing the position that’s best for you.” (Robertson College, 2011). More students mean higher profits, and for-profit schools achieve this goal through extensive advertising campaigns and recruitment strategies that market health care aide work as continuously expanding. The vulnerable economic position of health care aides starting out in

the workforce does not correspond to the widespread notion that health care aide work is in demand, secure and well paying. Still, the expectation of job security persists, and it compels health care aides to take on high tuition costs and precarious employment with the hope that it will one day pay off.

Section 3: Theoretical Implications

The three theoretical perspectives presented in Chapter 2 offered complementary explanations for the high concentration of Filipino women working in the health care aide labour force. The first perspective positions Filipino health care aides within the global migration of women seeking work. According to this perspective, contemporary female migration patterns are shaped by global structures of inequality that direct migrant women from low-income countries into the care sectors of high-income countries. This theoretical framework highlights the connection between Filipino women's experiences of poverty and income inequality in the Philippines and their migration and employment in long-term care in Canada. The women in this study were part of a global movement of female migrant labour. They came to Canada specifically to obtain work to support themselves and their families. Poverty, unemployment and underemployment were driving forces of their migration. Whether they were professionals or garment workers, each participant was unable to earn sufficient income to support themselves or their families. From their perspectives, migration was the only alternative to a life of poverty.

The journey from the Philippines to Winnipeg's personal care homes however, was not straightforward. In Manitoba, health care aides are not recruited internationally. None of the health care aides migrated with the intention to work in personal care homes and they had no previous education or work experience in the field. Once in Canada, health care aides faced several disadvantages in the labour market including unemployment, poor working conditions, and low-wages. By comparison, personal care home positions were viewed as stable, secure and well compensated. Employment barriers in the Philippines and in Canada initiated their quests for secure employment and ultimately contributed to their decisions to work in personal care homes.

According to Bakan and Stasiulis (2005), the relative decline in the demand for construction and production workers and the expansion of the global market for service workers augmented “the proportional exodus of female migrant labour”. Filipino migration to Winnipeg has historically been gendered. The first waves of Filipino migrants consisted of nurses and garment workers, most of whom were young, single women. The collapse of the domestic garment industry altered the demand for migrant female labour in Winnipeg. Health care aides’ migration histories revealed that Filipino garment workers moved into the long-term care sector starting in the 1970s in order to escape working conditions within the factories. The study also found that the decline of the garment industry during the 1990s influenced health care aides’ choice of work whether or not they had ever worked in a factory. Health care aides viewed their work as a comparatively secure employment option accessible to Filipino women. The findings from this study support the hypothesis that the high concentration of Filipino women working within the care sector is linked to the relative decline in the demand for production workers, but there is no available research quantifying this phenomenon.

The theoretical work on globalization and care work suggests that care work is not only gendered, but increasingly embedded in global structures of inequality. This perspective connects the prevalence of Filipino health care aides in Canada to poverty and underdevelopment in the Philippines. Poverty and financial insecurity did compel the migration of Filipino health care aides. On the other hand, experiences of poverty in the Philippines did not directly connect health care aides with health care aide work in Canada. Their decisions to work in long-term care grew out of their experiences as immigrants in Canada as well as their social ties to other health care aides.

The second perspective focuses on the gendered and racialized division of labour in long-term care, arguing that the demand for immigrant health care aides is a structural feature of Canada's health care labour force. According to this perspective, gender and racial categories reinforce the subordinate status of immigrant care workers in the health care system. The study identified several connections between the social status of Filipino women and the characteristics of health care aide work. The women in this study chose to work as health care aides specifically because they were disadvantaged in the labour market. As immigrants, their credentials were unrecognized and their English skills presented an additional barrier. They had limited employment options, and several of them underwent periods of unemployment. Health care aides described their dreams of higher education and occupational mobility, but their socio-economic status and financial obligations prevented them from long-term study. Ultimately, their employment in personal care homes was linked to their social and economic status as immigrant women.

According to Armstrong et al. (2008), the high concentration of immigrant women working as health care aides is connected to the working conditions within personal care homes. Although personal care home residents are older and sicker than ever before, staffing levels in many of Manitoba's personal care homes have not increased in more than thirty years. As a result, health care aide work is physically strenuous and unsafe. Health care aides regularly encountered violence and struggled to provide quality care using limited resources.

Cangiano et al. (2009), argue that the 'low skill' categorization of health care aides is problematic, reflecting the short training programs and predominance of immigrant women in the work force. Health care aides and managers highlighted their skills sets, including "soft skills" such as communication, compassion and patience, as well as the more clinical and

technical components of their work. The value that health care aides and managers attached to their skills did not correspond to the training requirements for health care aides. The absence of regulations for health care aide certification and relatively short training period reflects the low value accorded to their work, and by extension, the marginal position of the women who perform it.

Whereas feminist scholars (Armstrong et al., 2008; Nestel, 2006) emphasize the connection between job characteristics and the status of immigrant women; Massey et al. (1993) argue that high concentrations of foreign-born workers will lower the social status of a job, regardless of its characteristics. Jobs with high numbers of immigrants are labeled “immigrant jobs” leading to stigmatization. The high concentration of immigrant women within the health care aide labour force impacted health policy stakeholders’ perceptions of the labour force. The proportion of immigrant health care aides reinforced the notion of a shortage, which in turn was used to justify low staffing levels. The industry’s reliance on immigrant labour was also used as a rationale to avoid regulations for educational programs. This suggests that the growing proportion of immigrant women working as health care aides alters the social status accorded to the occupation thereby increasing the demand for immigrant health care aides.

The literature on immigrant women within the health care labour force highlights the relationship between occupational hierarchies and social categories such as gender, race and country of origin. According to this theoretical framework, the high concentration of immigrant health care aides is inextricably linked to the low status accorded to this occupation. While some features of the job are consistent with the low-status designation including the short training programs, casual appointments, low-staffing levels and workplace violence, other features of the job are not. For example, health care aides generally felt well compensated for their work. In

Manitoba, health care aides working in personal care homes can earn more than double the minimum wage and regular employees receive additional benefits. Almost all personal care homes in the province are unionized so health care aides perceived their work as relatively secure. The assumption that health care aide work is a low-status occupation overlooks the financial incentives that attract immigrant women to the field. By focusing on the ranking of health care aides relative to other health care professions, this framework does not explain women's reasons for working in long-term care, nor does it account for the high concentrations of Filipino women relative to other ethnic groups.

The third theoretical perspective – social network theory – focuses on the informal social processes impacting the supply of migrant labour. This orientation differs from the previous economic and structural theories because it gives precedence to the social context within which migrants make decisions and seek employment (Portes, 2007). By doing so, social network theory offers an explanation for the high proportion of Filipino health care aides compared to other ethnic groups.

The study found that immigrant social networks act as pathways linking migrants to employment opportunities in long-term care. Transnational familial connections among Filipinos created opportunities to move abroad. According to Massey et al. (1993), immigration policies that promote family reunification increase the strength and scope of migrant social networks: “They reinforce migrant networks by giving members of kin networks special rights of entry” (450). Most of the health care aides in this study immigrated through family reunification programs and all but one have since sponsored relatives from the Philippines to Manitoba. Within a year after the first garment workers arrived, the industry began to promote family sponsorship, and family reunification has constituted a major source of Philippine immigrants

ever since (Dalayoan, 2006). Today, the family support stream of the Provincial Nominee Program constitutes the largest source of Philippine immigrants to Manitoba (Manitoba Labour and Immigration, 2008).

Once in Canada, female migrants experienced multiple barriers in the labour market, including language barriers and accreditation. Given these conditions, health care aides drew on social networks to gain information about job opportunities. Friends and family members encouraged new migrants to pursue work as health care aides for several reasons: the short training period, relatively high wages, labour market demand and employment security. In addition to facilitating migration, social networks link Filipino immigrants with employment opportunities in long-term care by conveying information about the job market and providing referrals.

Employers also use social networks to recruit new employees. According to health care aides and managers, referral-based hiring is common within Winnipeg's personal care homes. Waldinger and Lichter (2003) argue that migrant social networks tend to expand in a workplace if there are few restrictions on entry, such as language or education requirements. In the past, the absence of formal requirements for health care aides facilitated referral-based hiring and enabled social networks to increase in scope. In the 1990s, personal care homes began to require certification for health care aides. This changed the way that social networks directed Filipino women to work in long-term care. Health care aides who arrived since the 1990s were encouraged by family members to enroll in health care aides training programs.

This study employed multiple theoretical perspectives that offer complementary explanations for the high concentrations of Filipino health care aides working in personal care homes. The first perspective is a macro-level approach, arguing that global inequalities direct

women from low-income countries into the care sectors of high-income countries. This perspective highlights the connection between health care aides' experiences of poverty in the Philippines, their migration to Canada and the growing demand for health care aides. The second perspective focuses at the meso-level of the gendered and racialized division of labour within long-term care. This perspective illustrates the relationship between the high concentration of immigrant health care aides and the structure of labour within personal care homes. The third perspective, social network theory, offers a micro-level theory of migration and employment. The study found that social networks facilitated the movement of Filipino migrants into long term care institutions and have contributed to their occupational segmentation.

Section 4: Policy Recommendations

Based on the study findings, the following policy actions are recommended:

1. Health policy stakeholders identified significant discrepancies among health care aide certification programs. This impacts the skill levels of health care aides and disadvantages health care aides trained at institutions with negative reputations. It is therefore recommended that the province of Manitoba establish guidelines for health care aide certification programs including entrance requirements, curriculum and graduation requirements.
2. In recent years, for-profit schools' tuition fees have risen sharply and are significantly higher than community colleges. Some community colleges have entrance requirements that may disproportionately restrict immigrant students. Those who do not meet these requirements have to pay up to four times the tuition at private for-profit schools. In addition, the entrance requirements of some certification programs do not correspond to the minimum qualifications required for all health care aide positions. It is therefore recommended that the Province establish minimum entrance requirements for all health care aide certification that correspond with employers' standards.
3. The notion of a health care aide shortage influenced health policy decisions. However, the number of existing health care aides remains unknown. It is therefore recommended that the province establish a registration system for certified health care aides. This would facilitate evidence-based assessments of staffing needs and facilitate future research. A registry could also enable employers to identify health care aides who have committed serious violations.
4. According to personal care home managers and health care aides, the lack of full time

and regular employment contributes to recruitment and retention problems and leads to chronic understaffing. It is recommended that facilities increase the number of full time positions for health care aides.

5. The current staffing levels in personal care homes contribute to stressful and dangerous working conditions for health care aides and impede the delivery of quality, patient-centered care. As a first step, it is recommended that the province of Manitoba fully implement the 3.6 care hours per resident day policy announced in 2007. Research on personal care home staffing suggests that 3.6 care hours is insufficient to provide quality, safe care (HCFA, 2001). Further research is therefore required to determine the appropriate staffing levels for personal care homes in Manitoba.
6. Health care aides reported an increase in the level of violence in personal care homes, putting health care workers and residents at increased risk of injury and even death. Specialized units or facilities for patients with behavioral and psychological symptoms of dementia are required in order to accommodate their needs and reduce the levels of violence in personal care homes. It is also recommended that all health care aides undergo sufficient training to prepare them to work with patients exhibiting behavioral and psychological symptoms of dementia.

Limitations

The results of the study were based on semi-structured interviews with seven health care aides and seven health policy stakeholders. Purposive sampling yielded a diverse group of health care aides. Participants worked in various types of facilities (non-profit and for-profit) and across different sectors of long term care. Their dates of entry to Canada spanned forty years and their experience in long-term care ranged from four months to 35 years. Given the small sample size, however, one must be cautious about generalizing from the results of the study. Comparing the experiences of health care aides working in different types of facilities (for-profit, non-profit, public) was not possible given the limited number of participants. On the other hand, in-depth interviews provided rich illustrations of issues identified in the literature on immigrant care workers. The themes that emerged from interviews with health care aides corresponded to findings in related research projects and also presented topics for future research.

The recruitment of health care aides presented several challenges (See Chapter 4). Three health care aides declined to participate in the study because they held two or more jobs and had young children. Several participants declined to provide referrals for potential candidates citing that most of their coworkers have multiple jobs and family responsibilities. The reluctance of women who hold multiple jobs to participate in this study likely introduced a sample bias favoring women with regular, full time employment. Five out of seven participants held full time positions, and they had each worked as health care aides for ten years or more. While health care aides holding multiple jobs may have been underrepresented, the participation of women with decades of experience offered additional insight into the history of personal care homes in Winnipeg and the changing role of health care aides over time. Due to the lack of published data on health care aides, it is difficult to determine whether or not the study sample is

representative of health care aides in Manitoba. Their average age, length of employment and type of employment arrangement are unknown.

The participant population included seven Filipino health care aides whose native language is not English. Most Filipino immigrants working in personal care home have attained varying degrees of fluency in English; some speak it extremely well, others less well. All participants had attained a sufficient degree of fluency in English to allow the interview process to go forward satisfactorily. There were points during the interview when the principal investigator had difficulty understanding a phrase or word spoken by a participant. When such issues arose, the interviewer asked for clarification until both parties were satisfied that they had communicated effectively. During the transcribing process, it was sometimes difficult to understand participants' statements. If the principal investigator was unsure about a word or statement, it was noted within the transcript. In order to avoid misinterpreting a participant's statements, the passage or section surrounding any uncertain words or statements was highlighted and left out of the analysis and results.

Life histories are not simply transcriptions of participants' pasts; they are constructed through a joint process between narrator and the researcher (Jones, 2004). The interviewer guides the conversation, chooses questions to include, and topics to omit. Participants' comments are part of a dialogue between the researcher and her subjects; they are "not purely spontaneous testimony" (Bauer and Thompson, 2004: 347). Following interviews, the researcher organizes life histories by editing and coding the data. It is not necessarily analyzed in chronological order, or in the sequence of the original transcript. More often, the data are arranged in a way that is meaningful and efficient for the researcher to interpret (Jones, 2004). The researcher determines what is relevant and what is not, and imbues the stories with meaning

and coherence drawn from her subjects. Although the presence of the interviewer is usually invisible, she plays an active role in crafting the narratives of participants from the interview process to the final text.

Given the subjective processes involved in qualitative inquiry, results should be analyzed within the context of other evidence (Bauer and Thompson, 2004). In order to strengthen the validity of the research findings, the study employed data triangulation. Data triangulation refers to the use of multiple data sources in a single study (Creswell, 2009; Patton, 2003). Data collected from interviews with health care aides were compared and contrasted with the findings from interviews with health policy stakeholders. This process illuminated commonalities as well as inconsistencies between both data sources. According to Patton (2002), using multiple data sources to find inconsistencies strengthens the credibility of results by “offering opportunities for deeper insight into the relationship between inquiry approach and the phenomenon under study” (248).

Cross referencing interviews with health care aides and health policy stakeholders revealed connections between the migration and employment experiences of Filipino health care aides and the policy context of personal care homes in Manitoba. This process also highlighted discrepancies between and within each group of participants. For example, the study found that health policy stakeholders’ and health care aides’ perceptions of a labour shortage were inconsistent. Although the sample size limits the generalizability of the results, the comparative approach provided an in-depth analysis of the concentration of Filipino health care aides, taking in to account the social, historical, economic and policy context of their migration and employment.

Conclusion

The health care aides in the study immigrated to Canada over a period of forty years, between 1969 and 2009. Although their migrations spanned four decades, their histories revealed several common factors that contributed to their decisions to immigrate to Canada and take up employment in personal care homes. The women came from different regions of the Philippines with various levels of education and types of employment, but they were all unable to afford basic necessities for themselves and their families. While poverty and unemployment prompted their desire to migrate, transnational connections to Manitoba provided them with the resources and opportunity to move to Canada. Most of the health care aides migrated through family reunification programs with the support of family members who had previously settled in Winnipeg.

Once in Canada, health care aides encountered multiple barriers in the labour market. Their high school and post secondary credentials from the Philippines were not recognized in Manitoba and their English skills posed an additional disadvantage. In pursuit of employment, health care aides turned to their friends and family members to gain advice on the labour market and to obtain referrals for job openings. These social networks acted as pathways linking Filipino immigrants with employment opportunities in personal care homes. In addition to providing referrals, social networks communicated incentives about health care aide work that attracted Filipino immigrants to the occupation. They furnished a key part of the connection between female migration from the Philippines and Manitoba's long-term care labour market.

The migration histories of Filipino health care aides suggest that the origins of the Filipino health care aide workforce trace back to the formation of the Filipino community in

Manitoba. The simultaneous recruitment of nurses and garment workers from the Philippines resulted in social connections between both groups in a relatively small community. After learning about job opportunities from Filipino nurses working in personal care homes, garment workers began to take up work as health care aides. Over time, migration to Winnipeg accelerated and the networks of Filipino women working in personal care homes expanded.

The study also identified several aspects of the long-term care policy context that sustain the supply of immigrant labour and promote the expansion of Filipino social networks in the workforce. Until the 1990s, there were no formal requirements for health care aides. This enabled Filipino women without recognized education credentials and with varying degrees of fluency to enter the workforce. Facilities began to require certification in the 1990s, but there are no regulations for certification programs. While some programs require up to a year of training, others are only four months in duration, a much more accessible option for immigrants eager to enter the workforce. There are no standard admissions criteria for health care aides, so schools vary significantly in terms of entrance requirements. Most community colleges require Manitoba equivalent high school diplomas and some require a minimum score on standardized language tests. In contrast, several for-profit schools do not require high school diplomas and have no standardized language criteria. On one hand, the lack of regulations facilitates the entry of immigrant women into the long-term care labour force. On the other hand, it contributes to the low-skill categorization of health care aides and may force a disproportionate number of immigrant health care aides to pay higher tuition fees compared to Canadian born students.

The tension between formal requirements and the supply of immigrant labour illustrates the dynamic processes at play in the health care aide labour market. The regulatory environment sustains the flow of immigrant labour, but it may also increase the system's dependency on

migrant women. The high concentration of immigrant women may have actually altered the organization and demand for health care aide labour. Foreign born health care aides constitute a critical labour source and for-profit schools have responded to this market. At the same time, the high concentration of immigrant health care aides shapes perceptions of the occupation. Their presence in the labour force is often interpreted as evidence of a shortage and reinforces the low skill categorization of their work. These conditions may generate reluctance among native-born workers to fill these positions, increasing the demand for immigrant health care aides. In effect, the high concentration of immigrant health care aides does not simply reflect the social status accorded to the work, it actually alters it (Massey, 1993).

Life history interviews identified a complex confluence of circumstances that lead to health care aides' migration and employment in personal care homes. Their stories also revealed the ways in which women experience and negotiate migration and employment. In their quest for economic security, health care aides found a job that was highly rewarding and culturally meaningful. By asserting the value of their work and highlighting their skill sets, Filipino health care aides countered the stigma associated with their job and positioned themselves as critical care providers.

As the population ages, the health care aide labour force will need to be strengthened and expanded. This demographic shift will not only increase the number of personal care home residents, it will alter the resident population health profile (Doupe, 2011). The long-term care system will need to attract qualified health care aides to provide increasingly complex care. Given the high prevalence of immigrant women, effective human resource planning requires an understanding of the demand for immigrant health care aides as well as the factors that motivate them to enter the workforce. Yet, until recently, there has been relatively little research on health

care aides and the essential role they play in the health care system. This study addressed this gap in our understanding by exploring the context of Filipino women's migration and employment in personal care homes. It also examined the long-term care policies and practices that facilitate the movement of immigrant women into the health care aide labour force. But if we wish to better understand the relationship between global women's migration and the changing demand for labour in our health care system, much more research is required.

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Appendices

Appendix 1.

Proportion of Immigrants, Visible Minorities and Canadians of Filipino Origin in the Health Care Aide Workforce (2001 and 2006)

	<u>Canada</u>		<u>Winnipeg</u>	
	2001	2006	2001	2006
Proportion of immigrant health care aides	23.6	26.0	37.5	45.4
Proportion of visible minority health care aides	18.4	21.5	32.9	40.5
Proportion of Filipino origin	5.4	5.6	19.0	21.0

Note: From Statistics Canada (2008). Census of Population. Statistics Canada catalogue no. 97-564-XCB2006005 and Statistics Canada (2004). 2001 Census of Population. Statistics Canada catalogue no. 97F0012XCB2001050.

Appendix 2.

Composition of Canada's Nursing Workforce

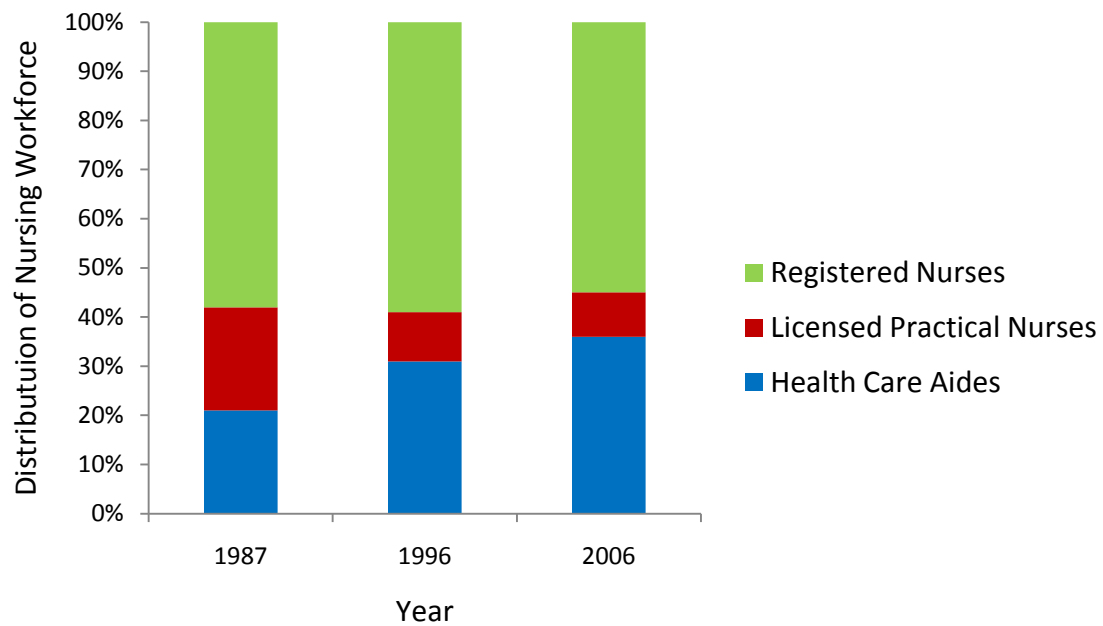


Figure 1. Note. 1987 and 1996 figures adapted from Pyper (2004). 2006 data from Statistics Canada (2008). Census of Population. Statistics Canada catalogue no. 97-564-XCB2006005

Appendix 3.

Proportion of Immigrants and Non-Immigrants by Occupation and Sex, 2006

	Born in Canada		Born outside Canada	
	Male	Female	Male	Female
All Occupations	40.9%	37.1%	11.7%	10.3%
Health Care Aides	9.9%	63.4%	3.6%	23.1%
Licensed Practical Nurses	6.3%	77.0%	1.6%	15.1%
Registered Nurses	4.7%	76.0%	1.5%	17.4%

Note: From Statistics Canada (2008). Census of Population. Statistics Canada catalogue no. 97-564-XCB2006005

Appendix 4.

Proportion of Filipinos, Immigrants and Visible Minorities in Winnipeg's Nursing Workforce

	Proportion of Filipino Origin		Proportion of Immigrants		Proportion of Visible Minorities	
	Female	Male	Female	Male	Female	Male
Health Care Aides N=5945	17.1	3.9	35.5	9.9	30.6	9.8
Licensed Practical Nurses N=955	14.7	1.0	14.1	4.2	21.5	4.7
Registered Nurses N=7390	6.7	0.9	16.2	1.8	12.4	2.0
Nurse Managers N=195	0.0	0.0	7.7	10.3	0.0	5.1

Note: From Statistics Canada (2008). Census of Population. Statistics Canada catalogue no. 97-564-XCB2006005

Appendix 5.

Semi-Structured Interview Guide - Health Care Aides

Adapted from: Spencer, Sarah; Martin, Susan; Bourgeault, Ivy Lynn and O'Shea, Eamon (2010). *The Role of Migrant Care Workers in Ageing Societies: Report on Research Findings in the United Kingdom, Ireland, Canada and the United States*. Geneva: International Organization for Migration (IOM).

Migration History

Let us discuss how it is that you came to Canada.

- How did you decide to come to Canada?
 - What were the reasons to leave your home country?
 - Were you always thinking about coming to Canada or did want to go elsewhere?
 - Where?
- What were the circumstances that brought you here?
 - What was your financial situation?
 - Did you migrate specifically to work as a health care aide with the elderly?
 - Do you feel it was entirely your decision to go abroad, or was it more a family or collective decision?
- What were you told/what did you know about Canada by different people?

- What were your expectations?
- Did you have relatives or friends in Canada?
- How did you travel from your country of origin to Canada?
 - Who sponsored your trip?
- How long did you plan on staying here when you first came?
- How long do you plan to stay now?

Employment History

Let us now discuss your employment history.

- What is your work experience prior to coming to Canada?
 - Have you always worked in health care or elderly care?
 - Please tell me about the type of jobs you held back at home?
 - Describe the challenges you faced.
- Now, I would like to talk about your work history in Canada.
- Why did you look for work as a health care aide in personal care homes? (explore reasons for entering type of job and type of care setting they are working in)
 - Describe all the different jobs you have had in this country.
 - Can you tell me how you found this/these job/s?

- Did you come here through a recruitment agency?
 - Could you tell me about the process of applying to the agency and for a job in Canada?
 - Are you still in touch with the agency that arranged your work?
- If you did not go through a recruiter, who helped you to come to Canada?
- Did friends or family help you?

Current Position

Let us now discuss your current position.

- Describe a typical working day
 - Do you work part time or full time?
 - What are you responsible for doing at work?
 - Do you feel that any of the activities you take on fall outside of your responsibilities?
 - Are you satisfied with your current salary from your job?
 - Tell me about the things you like most about your job.
 - Is your current position satisfying?
 - Does it meet your expectations?
 - Describe the challenges you face in your job.
Probe further about the context of their work including wages and working conditions.
 - Have you ever experienced violence at work?
 - Do you think your work is valued by others?
 - Your employers?
 - The residents?
 - Family members?

- I would like to understand what kind of training is needed to do your job. Can you tell me more about your education history and training that prepared to do your current job?
 - Do you think that your previous training before coming to Canada is adequate in your opinion to the tasks you're given?
 - What skills do personal care homes look for/expect/value in health care aides?
 - What skills do co-workers, clients and family members look for/expect/value in health care aides?
 - Is it ever difficult to use your skills?
 - I am also wondering whether you have received any on-the-job training at this facility/Are there opportunities for professional development?
 - Can you describe the training?
Probe for example for English language classes
 - If you have not received any training support, would you like to receive training support, and if so, what kind?
(If you received some training, would you like to receive more?)

Relations at Work

- I am curious about the elderly you work with.
 - How would you describe your attitude to ageing and older people?
 - How would you describe people's attitude in your home country towards ageing and older people?
 - Do you think that this attitude is different in any way to that of Canadian people?
 - Has your attitude changed since coming and working here?

- What do you think is the general attitude of older people to Filipino workers?

Remittances

Let us now discuss sending money to the Philippines.

- Do you send money or gifts to your family in the Philippines or elsewhere?
 - Why do you send money home?
 - When did you first start sending money/gifts home?
 - Has the amount of money you send home changed over time?
 - Has the economic recession affected your family here, in the Philippines, or abroad?
 - Has the economic recession impacted the amount of money you send to the Philippines?
 - Has it changed the demand for remittances?

Future

- I would like you to think a little bit about the future now. I wonder if you could tell me where you think you will be in one, five or ten years.
 - Do you think you will still be living in Canada?
 - Do you think you will go back to the Philippines?
 - Do you think you will be working as a health care aide?

Appendix 6.

Questionnaire – Health Care Aides

Demographic Profile

Please fill in, and tick, the following demographic questions as appropriate.

Gender: Male Female

Age: 20-29 30-39 40-49 50-59 60+

Marital Status: Married Divorced Separated Single Widowed

1. If you are married or with a partner, where does he/she currently live?

With me

Not with me Explain: _____

2. Do you have children? Yes No

If yes: How many children do you have? _____

Are they with you in Canada? _____

What are their ages? _____

3. What is your country of birth? _____

4. What languages do you speak? _____

5. What is the highest level of schooling that you attained? (Tick ONE only)

Some elementary school

Vocational school

Elementary school

Some college

Some high school

College (B.S. or B.A. degree)

Specify college:

High school

Post graduate education

Post secondary vocational course.
Specify course:

6. Please list country of educational training, duration of training and year attained below.

Country _____ *Duration* _____ *Year Attained* _____

Country _____ *Duration* _____ *Year Attained* _____

Country _____ *Duration* _____ *Year Attained* _____

7. How many years have you worked as a health care aide? _____

8. What was your country of last permanent residence prior to migrating to Canada?

9. Did you work as a health care aide in that country? Yes No

If yes:

For how long? _____

10. Date of entry into Canada (*month/year*): _____/_____

11. What was your immigration category? Skilled worker Refugee Family class

12. What is your current immigration status? _____

13. Are there people who are financially dependent on you? Yes No

14. If yes, please specify how many and who they are. _____

15. Do you send money back to people in your home country? Yes No

Appendix 7.

Semi-Structured Interview Guide: Health Policy Stakeholders

- What are some of the most significant changes that you have seen in the organization of long-term care over the last 10 years?
 - How have these changes affected the staffing of personal care homes?
 - Have staffing levels changed? Has the mix of occupations (nurses, health care aides, others) shifted?
 - Has the role of health care aides changed? Have there been changes in their skill requirements?
- What aspects of long term care have improved?
- What aspects of long term care have not improved or require additional improvement?
- In your opinion, what are the most significant challenges facing long-term care in Manitoba?
 - How do these challenges impact health care aides?
 - Working conditions? Staffing? Immigration?
- What kinds of solutions can be taken to improve personal care homes?
 - Are there any current initiatives to improve long-term care in the province?
 - What is the role of health care aides in these solutions?