# THE RECRUITMENT AND RETENTION OF COMMUNITY HEALTH WORKERS IN SMALL CITIES, TOWNS, AND RURAL COMMUNITIES

by

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# ABSTRACT

This study focused on the recruitment and retention of community health workers (CHWs) who work outside of large urban centres in small cities, towns, and rural communities in Canada. The study had three objectives: (1) to describe what CHWs working in small cities, towns, and rural communities have to say about their jobs, their working conditions, and their roles within the health care system; (2) to investigate these CHWs' experiences of, and motivations for, pursuing a career in the home support sector; and (3) to develop recommendations to inform the design of policies and programs for the recruitment and retention of CHWs in small cities, towns, and rural communities.

The study employed a qualitative research design informed by a feminist approach to health services research aimed at fostering "bottom-up" policy development informed by the perspectives of marginalized health care workers. The research process was carried out in partnership with a regional health authority in British Columbia, Canada. Data collection took place in four Vancouver Island communities: Campbell River, Parksville, Port Alberni and Port Hardy. Semi-structured interviews were conducted with 32 participants across the four study communities. The majority of the participants (n = 17) were unionized CHWs. The other respondents included nurses, managers, team leaders, and a scheduler. All interviews were transcribed and thematically analyzed. Study findings were later reported back to and validated by the participants.

The study found that CHWs in the study communities performed a wide range of duties that extend beyond standard definitions of home support, of particular relevance to smaller communities with limited access to other health and social services. The primary facilitator of CHW recruitment and retention was the opportunity to build positive relationships with clients. Wages were the primary barrier to CHW recruitment and retention, in particular the wage disparity between community- and facility-based workers. Other barriers included the costs associated with paying for one's own mobile phone and using one's own vehicle on the job, CHWs' unpredictable schedules, and feeling isolated from other members of the health care team.

# TABLE OF CONTENTS

# LIST OF TABLES

# LIST OF FIGURES

# ACKNOWLEDGEMENTS

# CHAPTER 1: INTRODUCTION

Home support does not have the 'sex appeal' of emergency medicine, forensic pathology, or cosmetic surgery. There probably will never be an adrenaline-soaked prime-time drama about the trials and tribulations of community health workers (CHWs). Like much of the work traditionally done by women, home support is least visible when it is done well and most visible when it is not done at all (Graham, 1983). The various outcomes of this work – a safe shower, a healthful meal, or a feeling of social connectedness – weave a safety net that helps frail seniors and people with disabilities live independently and in their own homes. A key goal of my dissertation is to make readers aware of this invisible work and to help them understand the skill and dedication of, and the challenges faced by, the CHWs who do it.

## "DEFINITIONS OVERLAP BUT THEY ALMOST NEVER COINCIDE"
*– J. Russel Lynes*

To comprehend my exposition of what CHWs do, at least in one part of Canada, one must first understand the concepts and categories that underlie my analysis. Had I chosen a different topic, I might have been able to achieve this simply by inserting a glossary into my dissertation. However, home support and the workers who provide it are not so easily characterized. This is less a reflection of the nature and content of the work, and more a reflection of the regional variation in how home support is managed and delivered. Banerjee (2009) observed that we lack "a common language" with which to define and describe long-term care in

Canada.[1] He could just as easily have been referring to home support. The service, which I define below, falls within the broader continuum of home and community care. Like other health services provided through Canada's publicly-funded health care system, home and community care is co-funded by the Canadian federal government. It is primarily administered at the provincial or territorial level, with the exception of several federally administered programs for specific populations, including the First Nations and Inuit Home and Community Care Program, the Veterans Independence Program, the Royal Canadian Mounted Police Health Services Program, and the Canadian Forces Health Services Program (Canadian Home Care Association, 2008). There are no national standards for home and community care, which the Canada Health Act designates as an extended, rather than medically necessary, service.[2] The Canadian Healthcare Association (2009) summarized the implications of this situation:

> The five principles of the 1984 Canada Health Act – universality, public administration, comprehensiveness, portability and accessibility – outline the conditions under which the federal government will fund health services. The principles apply only to insured health services that cover hospital care (acute, rehabilitation and chronic) and medical services. They do not apply to other services, including outpatient rehabilitation care. Home care remains an uninsured service under the Act, listed only as an extended service to which the five principles do not apply. It therefore has no protection under the Act. Provinces and territories have implemented standards to address quality and type of service. Although governments are obliged to provide some services through public funds, there are no uniform standards to ensure the quantity or type of services to be provided. There is inconsistency

[1] For the purposes of his analysis, Banerjee (2009) defined long-term care as "facilities that provide indefinite care for the elderly," a category that excludes home support (p. 31).

[2] The Canada Health Act, the federal legislation that governs publicly funded health insurance, has been criticized for privileging "medically necessary" care – that is, care provided by physicians and care provided in hospitals (Coyte, 2000).

across the country in terms of eligibility for home care, public coverage of services, residency requirements, and access to services. There is also variability in wait times for services and service delivery. (Canadian Healthcare Association, 2009, p. 17)

Home and community care programs exist across Canada, yet there is no legislative obligation at the federal or provincial/territorial level to provide similar services or programs to Canadians, or to apply consistent standards and policies. The Canadian Healthcare Association (2009) further noted that there is variation within provinces and territories in access to and provision of services, as well as in the use of co-payments and user fees.

These structural and legislative characteristics have resulted in considerable variation in definitions, service delivery, and data collection practices in the home and community care sector. A national report on home and community care in Canada's provinces and territories noted that "valid comparisons cannot be made because of the absence of data definitions and the variation of data collection methods and reporting across Canada" (Canadian Home Care Association, 2008, p. viii). As a result, there are numerous definitions – of home and community care, the services that fall under this umbrella, and the workers who provide those services – in use. These definitions range in scope, presumably according to the purpose for which the definition is to be used and, in some cases, the data available to operationalize it.

Although Canada's policy and health service delivery regimes contribute to the proliferation of definitions and data collection practices, the lack of consistent terminology is not a unique feature of the Canadian home and community care sector. Other jurisdictions have similar challenges with inconsistent language, which

may result from national or regional differences in the structure of health care systems or the design of policies. This may also be related to the fact that many of the frontline workers in home and community care systems are not regulated professionals, which leads to variation in job titles. The latter issue is discussed in greater detail in a subsequent section of this chapter.

My purpose here is not to present an exhaustive typology of the many definitions of home and community care (or home care or home support) currently in use. However, I will comment on two key features of these definitions: first, the phrase "home care" is sometimes used as shorthand for the full spectrum of services encompassed by what I refer to as home and community care (see, for example, Canadian Institute for Health Information, 2007; Canadian Home Care Association, 2008). These services are variously referred to as home care, home health services, or home and community care. In my dissertation I use the term "home and community care" which I define below. Second, most definitions distinguish between care provided by regulated professionals (e.g., registered nurses, physiotherapists, occupational therapists) and care provided by unregulated health workers (e.g., CHWs). In my dissertation, I use the term *home care* to refer to in-home services provided by registered nurses and other professionals, and *home support* to refer to in-home services provided by CHWs.

## Home and Community Care

I conducted my research in British Columbia (BC), Canada's westernmost province. Accordingly, I use the terminology used by BC's Ministry of Health Services and the health authorities responsible for health service delivery in the

province. In BC, home and community care includes a range of services delivered in

the home and in the community (see Figure 1).

**Figure 1: The Continuum of Home and Community Care[3]**



Glossary

HOME SUPPORT

Personal care services, such as assistance with bathing and dressing as well as help with medications and simple wound dressings.

HOME CARE

(also known as Home Nursing and Community Rehabilitation)

Services delivered to clients in the community by nurses, physiotherapists and occupational therapists.

ASSISTED LIVING

Housing for people with low to moderate levels of disability who require daily personal assistance to live independently.

RESIDENTIAL CARE

24-hour nursing supervision and care for people with complex needs.

PALLIATIVE CARE

(also known as end-of-life care)

Provided in hospital, residential care settings, and at home, for people in the advanced stages of a serious progressive illness, nearing death.

These services should form a well-coordinated continuum of care, but the reality is that they are fragmented and inadequate.

Other home and community care services include adult day care, supportive housing, community mental health services and others. A complete list can be found at www.health.gov.bc.ca/hcc/.

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[3] Figure source: Cohen, Tate and Baumbusch (2009), by permission.

In-home services include home support, home care nursing, rehabilitation, and palliative care (British Columbia Ministry of Health Services, n.d.a). Community-based services include adult day programs[4], meal programs, assisted living[5], residential care[6], and hospice care[7] (British Columbia Ministry of Health Services, n.d.a).[8] Home and community care also includes case management[9], a service that spans both home and community (British Columbia Ministry of Health Services,

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[4] Adult day programs consist of supportive group programs and activities for community-dwelling seniors and adults with disabilities. Activities might include personal care services, therapeutic recreation and social activities, caregiver respite, education and support, meals, and transportation (British Columbia Ministry of Health Services, 2007).

[5] Assisted living is a type of housing aimed at seniors and people with disabilities who can live independently but who need assistance with day-to-day activities. In BC, these residences are provincially regulated. The Government allows both publicly-subsidized and private-pay assisted living residences. Residents typically have access to a shared dining room and can pay for additional services. Home support providers deliver services to clients living in these residences (British Columbia Ministry of Health Services, n.d.b). In 2008, there were 4,393 assisted living beds in BC (Cohen et al., 2009).

[6] BC's home and community care guide states that "residential care facilities provide 24-hour professional nursing care and supervision in a protective, supportive environment for people who have complex care needs and can no longer be cared for in their own homes" (British Columbia Ministry of Health Services, 2007, p. 10). In 2008, there were 24,616 residential care beds in BC (Cohen et al., 2009).

[7] A hospice is "a residential home-like setting where supportive and professional care services are provided to British Columbians of any age who are in the end stages of a terminal illness or preparing for death" (British Columbia Ministry of Health Services, 2007, p. 13).

[8] One could reasonably argue that assisted living, residential care, and hospice care represent in-home services, in the sense that the people who rely on these services live where they receive their care. However, the BC Ministry of Health Services seems to define in-home services as those delivered in private residences that are not part of an assisted living or residential care facility. This distinction is muddied by the fact that CHWs in BC deliver home support services to clients living in assisted living facilities.

[9] Case managers "act as coordinators to help clients obtain home and community care services. They determine the nature, intensity and duration of services that would best meet clients' needs and arrange their services. The case manager will stay in touch with the client to arrange care services and make any adjustments necessary in the event their care needs change" (British Columbia Ministry of Health Services, 2007, p. 17).

n.d.a). A chapter that characterizes the context (Chapter Three) includes further

detail about how British Columbians access home and community care services, as

well as an overview of the structure of the BC health care system.

## HOME SUPPORT

Home support is one of the in-home services delivered through BC's home

and community care system. This service, which is the focus of my dissertation, is

defined in this way by BC's Ministry of Health Services:

> Home support services are designed to help clients remain independent and
> in their own home as long as possible. Home support provides personal
> assistance with daily activities, such as bathing, dressing, grooming and light
> household tasks that help to maintain a safe and supportive home. (British
> Columbia Ministry of Health Services, n.d.a)

In practice, the scope of home support services often extends beyond personal

assistance and "light" [*sic*][10] household tasks to encompass basic health care tasks,

including assistance with activities such as bowel or catheter care, medication

administration, and physiotherapy. CHWs also provide social support and relational

care. They perform all of these tasks in clients' homes and do not typically visit the

local home support office on a daily basis. CHWs spend part of each workday in their

cars traveling from client visit to client visit. Researchers, policy-makers and home

support advocates often cite the gap between standard definitions of home support

and the realities of those who provide (and receive) the service (Aronson &

Neysmith, 2006). I revisit this gap and the true breadth of what CHWs do in a

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[10] Messing, Chatigny, and Courville (1998) challenged the gendered categories of 'light' and 'heavy'
work in their ergonomic analysis of the work of female and male hospital cleaners. They did not find
any compelling reasons to divide work in this way, as female and male study participants were
comparably physically stressed by the tasks that constituted the categories of 'light' and 'heavy'
work.

chapter describing the research findings (Chapter Five).

Home support clients include frail seniors, people with disabilities, convalescent patients recently discharged from the hospital, and individuals receiving palliative care (Cohen et al., 2006). Although the client population is diverse, two studies conducted in BC have shown that the average home support client is a woman over the age of 65 years who lives in poverty. One study, which analyzed Ministry of Health Services continuing care data from 2003, showed that 70 percent of home support clients in BC were women, and 82 percent of clients had annual pre-tax incomes of less than $15,000 CDN (Cohen et al., 2006). Another study, which used 2004/05 data from the BC Linked Health Database, showed that long-term users of home and community care were more likely to be women than men, and were more likely to live in the lowest income decile (McGrail et al., 2008). These demographic statistics are consistent with Canadian data from the 2003 cycle of the National Population Health Survey, which showed that the average age of home and community care clients was 62 years, and that two-thirds of clients were female (Wilkinson, 2006).

## COMMUNITY HEALTH WORKERS

CHWs are the paid caregivers who provide home support services in BC. Before explaining who they are and what they do, I must distinguish between CHWs as they operate in BC and the broader category of "community health worker." A report commissioned by the World Health Organization defined community health workers as:

> any health worker carrying out functions related to health care delivery; trained in some way in the context of the intervention; and having no formal

professional or paraprofessional certificated or degreed tertiary education. (Lehmann & Sanders, 2007, p. 4)

The care providers that this definition refers to can be found in low- and middle-income countries, as well as in underserviced and rural communities in high-income countries. They may be paid or unpaid. They provide a range of services, including first aid, health education, nutrition, maternal and child health, family planning, environmental sanitation, communicable disease control, interpretation and translation, cultural competency, and advocacy (Lehmann & Sanders, 2007; U.S. Department of Health and Human Services, 2007). Their roles and responsibilities vary considerably around the world, as do their titles.[11]

Like their counterparts in other countries, CHWs working in the BC context carry out functions related to health care delivery. However, BC's CHWs are paid workers with formally defined roles and training requirements. Accordingly, it would not be appropriate to 'lump them in' with the lay and unpaid community health workers described above. The CHWs who are the focus of my study are paid care providers who work in the home support sector. In other jurisdictions, comparable workers are known by titles such as personal support workers, personal care workers, home health attendants, home health aides, homemakers, and (to muddy the discussion further) home care workers. For the purposes of my study, I refer to these workers as CHWs, which is what they are called in BC.

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[11] A review paper that examined community health workers in the global context cited 36 different names for community health workers from at least 20 countries (Lehmann & Sanders, 2007). The authors noted that this list is "not exhaustive…and does not include a range of lay health workers who now render different forms of services for people living with HIV and AIDS" (Lehmann & Sanders, 2007, p. 3).

Like their clients, the majority – an estimated 90 percent – of CHWs are women (Armstrong & Laxer, 2006; Montgomery, Holley, Deichert, & Kosloski, 2005). The gendered aspects of this workforce and the work they perform are taken up in greater detail in a chapter that reviews the relevant published literature (Chapter Two). At present, aspiring CHWs in BC are required to complete a six-month certificated training program[12] (the Health Care Assistant program, known until 2009 as the Combined Home Support/Resident Care Attendant program). The training program, which is available at both public and private colleges, has a common curriculum.[13] Graduates of this program are eligible to work in both the community and in residential care facilities. In addition to college training, CHWs seeking employment in BC's home support system are typically required to have a FOODSAFE[14] certificate, a current level "C" basic life saving certificate, and a valid BC driver's license (Vancouver Island Health Authority, 2009a). At present, there are no pan-Canadian training standards or minimum employment qualifications for CHWs, though some provincial-level standardization initiatives are in place (Pan-Canadian Planning Committee on Unregulated Health Workers, 2008). I describe how BC's

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[12] Although offered at a college, secondary education is not required. The admission requirements, which vary by college, range between having a Grade 10 reading level to Grade 12 English completion with a grade of C or better, or equivalent.

[13] BC's Ministry of Advanced Education and Labour Market Development is responsible for ensuring that all post-secondary institutions in BC that offer the Health Care Assistant program adhere to the common curriculum. However, this may be difficult to achieve in practice because of a lack of resources for monitoring BC's many colleges.

[14] The FOODSAFE program teaches safe food handling techniques (Province of British Columbia, 2006).

CHWs are remunerated and how their work is organized in the context chapter (Chapter Three).

## UNREGULATED HEALTH WORKERS

The lack of standardized training and minimum employment qualifications reflects CHWs' status as unregulated health workers. The Canadian Nurses Association (2008) defined unregulated health workers as:

> an umbrella term used to describe care providers or assistant personnel who provide some form of health service and who are not licensed or regulated by a professional, governmental or regulatory body. (p. 1)

Unlike registered or licensed professionals (e.g., physicians, registered nurses, licensed practical nurses), unregulated health workers do not have a legislated scope of practice, a protected title, mandatory educational requirements, professional standards for practice, or a professional conduct review process (Canadian Nurses Association, 2008). Because they are not licensed or regulated, we have limited capacity to collect (quantitative) data about them. As the Canadian Healthcare Association (2009) noted, "We know less about formal caregivers than informal caregivers" (p. 59).[15] This is somewhat paradoxical given that formal caregivers are an official part of the health care system, so one would assume that there are systems in place for keeping track of them. However, there are several structural barriers that make data collection about unregulated health workers challenging. These include variation in record-keeping practices across jurisdictions

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[15] Informal caregivers are the spouses, family members, friends, or neighbours who provide unpaid care to loved ones, such as frail seniors, people with disabilities, or children with chronic illnesses. This category does not encompass usual day-to-day caregiving, for example that which a parent might provide for a healthy child.

and employers, a high proportion of hard-to-track part-time or casual workers, and difficulty reconciling workers' many role titles and definitions (Canadian Nurses Association, 2008; Health Council of Canada, 2005; MacAdam, 1999; O'Brien-Pallas, Birch, Baumann, & Tomblin Murphy, 2000; Pan-Canadian Planning Committee on Unregulated Health Workers, 2008).

How occupations are classified in the National Occupational Classification (NOC) system, which standardizes how labour force data are collected in Canada, represents a further barrier to gathering accurate data about unregulated health workers. This is especially pronounced in the case of CHWs, who work in private homes belonging to their clients. As a consequence of *where* they work (and not necessarily *what* they do), the NOC classifies CHWs' work differently than that of workers who provide similar services in hospitals and nursing homes (Lilly, 2008). Specifically, the NOC includes CHWs in the category of "visiting homemakers, housekeepers and related occupations," a category that includes housekeepers and foster parents (Human Resources and Skills Development Canada, 2009).[16] This group falls under the broader category of "sales and service occupations." On the other hand, the NOC classifies workers who perform similar tasks in hospitals, nursing homes and health facilities as "nurse aides, orderlies and patient service

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[16] According to Human Resources and Skills Development Canada (2009), "Visiting homemakers provide ongoing or short-term home support services for individuals and families during periods of incapacitation, convalescence or family disruption. They are employed by government, non-profit and home care agencies, or are self-employed. Housekeepers perform housekeeping and other home management duties in private households, embassies and other residential establishments. Companions provide elderly and convalescent clients with companionship and personal care in residential settings. They are employed by home care agencies or may be self-employed. Foster parents care for children or family members in their homes under the direction of a foster parent agency" (para. 1).

associates," a group that is part of the category labeled "health occupations." This makes it difficult to compare workers within or between occupational categories, a situation that is exacerbated by the fact that there are no provincial/territorial or national professional organizations that might serve as an alternative source of labour force data (Canadian Institute for Health Information, 2006a). As a consequence of these factors, "there is little or no reliable information describing the Canadian home [and community] care workforce or its working conditions" (MacAdam, 1999, p. 5).

## HEALTH HUMAN RESOURCES FOR HOME SUPPORT: WHERE ARE THE CHWS?

The question, "Where are the CHWs?" has multiple meanings when posed in the context of the Canadian health care system. The preceding section pointed out the difficulties inherent in capturing data about CHWs and other unregulated health workers. This lack of data is one of the reasons CHWs are often left out of Canadian health human resources planning and policy, which tend to be developed on the basis of labour force data for particular health professions (primarily medicine and nursing) and demographic projections of anticipated need for health services (Federal/Provincial/Territorial Advisory Committee on Health Delivery and Human Resources, 2005). The failure to account for CHWs in health human resources policy and planning also is related to the social, economic, and professional value assigned to these workers and their work, as well as the values that underlie policy-making (Hankivsky, 2004). These notions are taken up at length in the literature review chapter (Chapter Two).

The question, "Where are the CHWs?" has a different meaning when one considers what is known about health human resources in home support. There are two primary drivers of demand for home support services. One driver is population aging because seniors represent the majority of home support clients. It is projected that about one-fifth of the Canadian population will be over age 65 by the year 2026 (Cranswick & Dosman, 2008). Another driver is a shift in the locations where certain health services are provided. This shift, from institutions such as hospitals and residential care facilities into community settings such as the home, has characterized three decades of health system restructuring in Canada (Baranek, Deber, & Williams, 2004; Coyte & McKeever, 2001; Dyck, Kontos, Angus, & McKeever, 2005).

Policy decisions may change what services fall under the umbrella of home support, with implications for who receives home support and what services they receive. Both have implications for health human resources, and for the working lives of CHWs. In BC, the introduction of two policies altered the nature of home support delivery in the province. In 1994, "stand-alone" housekeeping provided in the absence of other care needs was eliminated from the list of eligible home support services, while in 1999 a policy was introduced that required the home support system to prioritize clients at the highest level of need rather than prioritizing preventive care aimed at keeping clients with more moderate needs out of hospitals and residential care facilities (Cohen et al., 2009). McGrail et al. (2008) found that, between 1994/95 and 2004/05 the long-term home support client population was increasingly composed of seniors between the ages of 85 and 89.

The services they received also changed, in that home support clients received less personal care and more clinical services. McGrail and colleagues (2008) suggested that this reflects "an increasing focus of these types of care [home health services] on clinical needs rather than other services to seniors who are long-term users of home health services" (McGrail et al., 2008, p. 38). These changes have implications for CHWs who care for clients with increasingly complex needs. Many CHWs perform tasks assigned to them by registered nurses.[17] The changing nature of client care, as well as the assignation of tasks, has expanded the range of CHWs' duties.

Policy changes and population aging have changed the landscape of home support delivery. The federal government estimated that the workforce must increase by a factor of three to meet future demand for home and community care services (Human Resources Development Canada, 2003). It may be challenging to achieve this goal, as researchers and policy-makers within the home support sector have been calling attention to a worker shortage since at least 2000.[18] While the high proportion of unregulated health workers means that we must interpret labour force statistics with caution, researchers estimated that on average, 10 to 13 percent of jobs in this sector remain unfilled (Castle, 2008; Eaton, 2005; Hussein & Manthorpe, 2005). Estimates of annual turnover – that is, workers who terminate their employment a short time after being hired – range from 25 to 170 percent

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[17] These tasks are sometimes referred to as "transfers of function" or "delegated tasks." I use the term "assigned" in my dissertation.

[18] For example, Armstrong and Daly (2004); Canadian Healthcare Association (2009); Cushman, Barnette, and Williams (2004); Dawson and Surpin (2000); Denton, Zeytinoglu, Davies, and Hunter (2006); General Accounting Office (2001); Human Resources Development Canada (2003); Hussein and Manthorpe (2005); and Stone and Weiner (2001).

(Denton et al., 2006; Laditka, 2009). In spite of what seem like the ingredients for a *bona fide* health human resources crisis, several experts have noted a paucity of research on topics such as the nature of the CHW shortage (General Accounting Office, 2001), the development and maintenance of a supply of qualified CHWs (Stone, 1999), and macro-level health human resources planning in the home and community care sector (O'Brien-Pallas et al., 2000).

THE STUDY

The problem at the heart of my research – recruitment and retention of CHWs who work outside of large urban centres in small cities, towns and rural communities – became apparent to me as I tried to reconcile the gap between the evidence of a looming health human resources crisis in the home support sector and CHWs' absence from Canadian health human resources policy and planning. I chose to focus specifically on CHWs in small cities, towns, and rural communities for three reasons: first, rural places tend to be worse off when it comes to having enough health care providers, which has implications for the home support system (Canadian Institute for Health Information, 2006b; Hay, Varga-Toth, & Hines, 2006). A pan-Canadian study on rural home care and home support found that "the main challenge for all jurisdictions was lack of health human resources" including CHWs (Canadian Home Care Association, 2006, p. 2).

Second, rural home support is different from urban home support, which suggests a need for place-specific research; findings from research conducted in urban settings cannot necessarily be generalized to non-urban places. Rural populations tend to be older than urban populations (15 percent age 65+ compared

with 13 percent age 65+) (Dandy & Bollman, 2008). People living in rural communities tend to fare worse than their urban counterparts with respect to several health indicators. In general, "rural residents of Canada are more likely to face poorer socio-economic conditions, to have lower educational attainment, to exhibit less healthy behaviours and to have higher overall mortality rates than urban residents" (Canadian Institute for Health Information, 2006b, p. v). Canadians living in rural communities have a higher prevalence of smoking, poor self-reported health, obesity, arthritis and rheumatism, and diabetes, as well as higher rates of injury, poisoning, motor vehicle collisions, and suicide (Ostry, in press). Yet they fare better than urban residents on other health indicators, such as a lower prevalence of stress, mental disorders, asthma, and most cancer deaths (Ostry, in press).

Forbes and Janzen (2004) compared rural and urban home care and home support users using data from the 1996/97 and 1998/99 cycles of the National Population Health Survey. They found that rural home care and home support users were more likely to receive help with housework and less likely to receive personal care assistance. The authors speculated that this might be due to urban-rural differences in the implementation of home support policy changes such as the elimination of stand-alone housekeeping and the prioritization of high-needs clients. They suggested that this difference might also be due to the "stoic and independent nature of rural residents and greater availability of informal support networks in rural areas" (Forbes & Janzen, 2004, p. 234). On the other hand, when Allan and Cloutier-Fisher (2006) analyzed administrative data from the BC health care system (1998/99), they found that other variables, such as being older (age), being female

(gender), and being poor (income) had a greater influence than did geographic location on access to and use of home support services. The data in the above-cited studies are about ten years old, and much has changed in home support since then. However, these studies do point to the different landscapes – both geographic and socio-demographic – of home support delivery in urban and rural places.

Finally, most of the Canadian research on CHWs has been conducted in urban communities.[19] A notable exception is the work of Sims-Gould and Martin-Matthews (2008; 2010a; 2010b), which includes (though is not exclusively focused on) rural CHWs. Researchers who have examined home support provision in small cities, towns, and rural places have primarily focused on the community- and system-level impacts of health care restructuring in Ontario[20] and British Columbia.[21] I have not identified a body of research that addresses the working lives and working conditions of CHWs in small cities, towns, and rural communities through a literature search or through consultation with experts in the field. Accordingly, there is a gap in our knowledge of CHWs in general, and specifically in relation to the recruitment and retention of home support providers in small cities, towns, and rural communities.

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[19] For example, Aronson, Denton, and Zeytinoglu (2004); Aronson and Neysmith (1996, 2006); Denton, Zeytinoglu, Davies, and Lian (2002); Denton, Zeytinoglu, Kusch, and Davies (2007); Neysmith and Aronson (1996); Zeytinoglu, Davies, and Hunter (2006); Zeytinoglu and Denton (2005); Zeytinoglu et al. (2007); and Zeytinoglu, Denton, Webb, and Lian (2000).

[20] For example, Chouinard and Crooks (2008); Cloutier-Fisher and Joseph (2000); Cloutier-Fisher and Skinner (2006); Skinner and Rosenberg (2006); and Williams (2006).

[21] For example, Ceci and Purkis (2009); Hanlon and Halseth (2005); Hanlon, Halseth, Clasby, and Pow (2007a); Hanlon, Rosenberg, and Clasby (2007b); and Skinner (2008).

My research was intended to make a contribution towards filling this gap. The study had three objectives: first, to describe what CHWs working in small cities, towns, and rural communities have to say about their jobs, their working conditions, and their roles within the health care system. Second, to investigate their experiences of and motivations for pursuing a career in the home support sector. Third, to develop recommendations to inform the design of policies and programs for the recruitment and retention of CHWs in small cities, towns, and rural communities. To achieve these objectives, I used a qualitative research design based on the idea that CHWs are a relatively untapped source of expert knowledge about what drives recruitment and retention, knowledge that could add new insights to health human resources policy and planning in the home support sector.

My choice of methods reflects my political and intellectual grounding as a feminist health services researcher with a longstanding interest in the experiences of the health care workers – primarily women – who are paid to care. My approach reflects the growing acceptance of qualitative methods in health services research (Shortell, 1999). It is informed by a desire to generate "counter-discursive accounts of [health care] reforms based on the experiences of marginalized health care workers" (Mykhalovskiy et al., 2008, p. 197). My aim is to conduct research that gives voice to workers' experiences and expertise, to facilitate "bottom-up" rather than "top-down" policy development. This approach is consistent with the belief that care ethics ought to be "grounded in practice through bottom-up studies" (Dahl, 2009, p. 649). I am committed to integrated knowledge exchange – that is, the involvement of stakeholders or potential research knowledge users throughout the

entire research process (Canadian Institutes of Health Research, 2009, para. 11). To accomplish this, I worked collaboratively with decision makers within the home and community care system to design and implement this study. The study design and research process are described in detail in the methods chapter (Chapter Four).

I conducted my research in four communities on Vancouver Island, a large island off the southwest coast of BC. The communities are Campbell River (2006 population: 36,461), Parksville (2006 population: 26,518), Port Alberni (2006 population: 17,548) and Port Hardy (2006 population: 3,822).[22] The study communities were chosen in consultation with decision makers who were aware of my intention to focus on small cities, towns, and rural communities. Throughout the research process, I grappled with whether these communities were "rural enough" to access the place-specific phenomena and experiences I sought to understand. The fact that there is no simple, commonly-agreed upon definition of "rural" presented a challenge, as this category encompasses many places and communities that span a wide spectrum of social, economic, and geographic characteristics (Bryant & Joseph, 2001; du Plessis, Beshiri, Bollman, & Clemenson, 2002; Pitblado, 2005; Public Health Agency of Canada, 2002).

Statistics Canada's Metropolitan Area and Census Agglomeration Influenced Zones (MIZ) classification system is a commonly used method of categorizing communities in terms of rurality. The strengths of this system are its capacity to

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[22] These data are drawn from the 2006 Census of Canada, the most recent census cycle available at the time of writing. I have chosen to use these population figures because they are consistent with other community-level data cited in Table 1 (e.g., seniors as a proportion of the population, visible minorities as a proportion of the population), as well as in the descriptions of each community included in the methods chapter (Chapter Four).

move beyond a dichotomous rural/urban definition and to enable comparison between urban areas and four categories of rurality (Canadian Institute for Health Information, 2006b). When the study communities are categorized according to this classification system, only one of them – Port Hardy – is officially classified as rural (see Table 1). The other four communities (Campbell River, Parksville and Port Alberni) are categorized as urban census agglomerations, municipalities with an urban core population of at least 10,000 people.

# Table 1: The Study Communities

| Community | 2006 population | Population density (per km²) | Rural and small town classification |
|---|---|---|---|
| Campbell River | 36,461 | 9.6 | Urban, CA |
| Parksville | 26,518 | 325.5 | Urban, CA |
| Port Alberni | 17,548 | 881.0 | Urban, CA |
| Port Hardy | 3,822 | 93.7 | Rural, weak MIZ |
| British Columbia | 4,113,487 | 4.4 | N/A |

*Definitions*

Census agglomeration (CA): An area consisting of one or more neighbouring municipalities situated around a major urban core. A census agglomeration must have an urban core population of at least 10,000. A census metropolitan area (CMA) must have a total population of at least 100,000 of which 50,000 or more live in the urban core.

Metropolitan influenced zones (MIZ): A measure of the degree to which populations living outside of larger urban centres (e.g., CAs and CMAs) are socially and economically integrated with these urban centres.

Weak MIZ: more than 0%, but less than 5%, of the employed labour force living in the community works in any CA/CMA urban core.

Moderate MIZ: at least 5%, but less than 30%, of the employed labour force living in the community works in any CMA/CA urban core.

Strong MIZ: 30% or more of the employed labour force living in the community works in any CA/CMA urban core.

No MIZ: includes all communities that have a small employed labour force (less than 40 people), as well as any community that has no commuters to a CMA/CA urban core (that is, none of the employed labour force living in the municipality works in any CMA/CA urban core).

However, as Bowker and Star (2002) pointed out, classification systems tell only part of the story. Kulig et al. (2008) criticized rurality indexes like the MIZ for "implying that rurality is a static feature rather than in a dynamic state" because they often are used to compute scores that situate communities on continuum of rurality (p. 29). Moreover, the MIZ "does not deal with or is not related to the *social* [emphasis added] representations of rural and urban" (Canadian Institute for Health Information, 2006b, p. 20). Rather, it conceptualizes rurality in terms of population density and commuting patterns, factors that affect island dwellers differently. While the four study communities may not be "rural" in the strictest sense of the term, they are on an island accessible from BC's mainland only by air or water. The majority of Vancouver Island's population is concentrated in the southern part of the island, while the four study communities are situated in the island's central and northern regions. Parksville, the most central of the study communities, is 150 kilometres by road from Victoria, Vancouver Island's largest city (pop. 330,000) and BC's provincial capital, located on the southern tip of the island (see Figure 2). Victoria is 196 kilometres from Port Alberni, 267 kilometres from Campbell River, and 497 kilometres from Port Hardy. The four study communities are at least several hours' drive from Victoria, the island's only census metropolitan area. Road conditions can sometimes be poor in some of the mountainous, heavily forested, and coastal areas of the highway that connects the communities on Vancouver Island. The study communities are closer to Nanaimo, the island's second-largest city (pop. 85,000), home to a busy ferry terminal and many "big box" retailers not found in some of the smaller communities. This city is 36 kilometres from Parksville, 85

kilometres from Port Alberni, 156 kilometres from Campbell River, and 386 kilometres from Port Hardy.

**Figure 2: Map of Vancouver Island**[23]

One ought also to consider that the home support systems in each of the four study communities – and thereby the CHWs working in them – serve clients in nearby communities. As Table 2 shows, the majority of these communities have small populations and some are accessible only by water, air or gravel logging road. While some CHWs might live and work in the study communities, they regularly commute into smaller nearby communities to serve their home support clients. This commuting pattern adds an element of rurality to the experiences captured in my study. While I do not claim to provide the definitive account of rural home support, I am confident that my choice of study communities enabled me to capture the place-specific phenomena and experiences that underpinned my objectives.

## Table 2: Surrounding Communities Receiving Home Support Services

| Study community | Surrounding communities served by the study community's home support system | 2006 population | Accessibility |
|---|---|---|---|
| Campbell River | Cortes Island | 950 | Accessible by water or air |
| | Gold River | 1,362 | Accessible by road |
| | Quadra Island | 2,700 | Accessible by water or air |
| | Sayward | 341 | Accessible by road |
| | Tahsis | 366 | Accessible by road |
| Parksville | Coombs | 1,327 | Accessible by road |
| | Dashwood | 1,037 | Accessible by road |
| | Errington | 2,549 | Accessible by road |
| | Qualicum Bay | 397 | Accessible by road |
| | Qualicum Beach | 8,502 | Accessible by road |
| | Whiskey Creek | Not available | Accessible by road |
| Port Alberni | Bamfield | 251 | Accessible by gravel logging road |
| | Marktosis | 661 | Accessible by water or air |
| | Sproat Lake | 1,837 | Accessible by road |
| | Tofino | 1,655 | Accessible by road |
| | Ucluelet | 1,487 | Accessible by road |
| Port Hardy | Alert Bay | 556 | Accessible by water or air |
| | Port Alice | 821 | Accessible by road |
| | Port McNeill | 2,623 | Accessible by road |
| | Sointula | 594 | Accessible by water or air |
| | Woss | 400 | Accessible by road |

*Notes:*

2006 population data for the majority of these communities was obtained from the BC Stats website. Population data for Cortes Island, Quadra Island and Woss were obtained through community websites.

Data on community accessibility was obtained from community and tourism websites.

To collect my data, I conducted semi-structured interviews with 32 participants across the four study communities. The majority of the participants (n = 17) were unionized CHWs, 14 of whom had permanent positions. The remaining three CHWs were unionized and employed on a casual basis (that is, they worked "on-call"). The regional health authority directly employed all CHWs who participated in the study. The other participants included five nurse leaders, three community care coordinators, two home support leaders, two licensed practical nurses, one community health nurse, one regional manager, and one scheduler.

All of the study participants were asked to comment on the CHWs' jobs, working conditions, and roles within the health care system. The participants were asked to provide their insights into the drivers of CHW recruitment and retention, as well as to recommend strategies for improving CHW recruitment and retention. The participants also were asked to comment on the unique aspects of working in the surrounding rural communities. Their responses were transcribed and thematically analyzed. The results of these interviews are synthesized in the findings chapter (Chapter Five). Recommendations based on the research findings and follow-up consultations with CHWs and other home support stakeholders in the four study communities are presented in the concluding chapter (Chapter Six). These recommendations are intended to inform policy design and the organization of work within the home support sector. They may be of interest to policy makers, managers, union representatives, and CHWs, as well as other researchers with an interest in home and community care.

## THE STRUCTURE OF THE DISSERTATION

In the chapter that follows (Chapter Two), I review the literature, situate what CHWs do as a form of feminized care work that is both ancillary and precarious, and describe the health human resources challenges that plague the home support sector. The context chapter (Chapter Three) situates my research in relation to the broader demographic and policy contexts in Canada, as well as in relation to health service delivery in BC. The methods chapter (Chapter Four) provides an overview of how I conducted the research, which is followed by a synthesis of the research findings (Chapter Five). The dissertation concludes with a discussion of the strengths and limitations of the study design and some recommendations to address the recruitment and retention of CHWs in small cities, towns, and rural communities (Chapter Six).

# CHAPTER 2: LITERATURE REVIEW

The purpose of this literature review is to situate CHWs and their work in relation to the literature that pertains to my research. This chapter draws on both theoretical and empirical knowledge about CHWs and their work to describe what we know about the CHW workforce, their working conditions, and the health human resource issues in the home support sector. The chapter begins with a description of the literature search process, which is followed by an overview of a theoretical framework. This framework draws on feminist perspectives on gender and care giving, critical studies of health care work (in particular, the concept of ancillary work) and labour studies (specifically, the concept of precarious employment). I then summarize what the literature says about CHWs and their working conditions, with the goal of bridging CHWs' realities with theoretical perspectives on devalued, feminized care work. The chapter concludes with an overview of what we know about health human resources in home support.

## LITERATURE SEARCH PROCESS

The literature in this review was gathered through a multi-stage process. Much of the literature reviewed here was collected as part of my ongoing and in-depth engagement with the themes that lie at the heart of my research. I have been collecting relevant literature since 2002 and have amassed over 700 articles, book chapters, and policy documents, as well as having published in the area (Sharman, 2007; Sharman, McLaren, Cohen, & Ostry, 2008). My personal library is primarily

composed of journal articles (475+ articles), books (100+ volumes), and reports or policy documents (70+ items) published between the mid-1970s and the present.

As part of the process of developing the proposal for my doctoral research, I conducted a focused literature search to identify materials that pertain specifically to health human resources issues in rural home support. As my topic spans a range of disciplines, I searched the health databases, Medline and the Cumulative Index to Nursing and Allied Health Literature (CINAHL), a broad-based social sciences database (Sociological Abstracts), and two databases that include policy documents and other "grey" literature (Public Affairs Information Service (PAIS) and the National Library of Canada website). My search was limited to English-language literature published between January 1988 and January 2008. I have since supplemented this search with relevant literature published between February 2008 and March 2010.

Where available, I used each database's thesaurus to identify and define relevant search terms, including Medical Subject Headings (MeSH) terms where applicable. I also searched for key papers to determine how they were indexed and conducted additional searches using those terms. Search terms varied considerably across disciplines and databases. As noted in the introductory chapter (Chapter One), this is a common feature of the home support literature, as there is a great deal of variety in the terminology used to describe workers and their work.

The relevant home support and CHW-related search terms included: allied health personnel, caregivers, community health worker, home care, home care agencies, home care services, home health aide, home health aides, home health

care, homemaker services, and home nursing. Health human resources search terms included: employee retention, health human resources, health manpower [sic], health personnel, labor conditions, labor force, labor turnover, personnel selection, and working conditions. Rural health search terms included: rural, rural areas, rural health, rural health personnel, rural health services, rural population, and medical services, rural. I also conducted combined searches (e.g., home care services and health manpower, home health care and rural health personnel) to identify articles that used both keywords.

Broad-based search terms (e.g., home care services, health personnel, and rural health) yielded thousands of results, while combined searches tended to yield few or no records. To identify relevant publications, I scanned titles and read abstracts. The search revealed several publications pertaining to working conditions in the home support sector, health human resources in the home support sector, and rural home support. My search did not produce any articles specifically pertaining to health human resource issues in rural home support, which suggests a gap in the literature.

## THEORETICAL FRAMEWORK

This section of the literature review chapter establishes the theoretical framework for my research, which draws on several bodies of literature, including feminist perspectives on gender and care giving, critical studies of health care work (ancillary work), and labour studies, in particular analyses of changing employment relationships (precarious employment). I provide a theoretical context for thinking about CHWs' work as a form of undervalued, feminized labour. The subsequent

sections of this chapter summarize the empirical data about CHWs' working conditions and health human resources in the home support sector.

*THE FEMINIZATION OF CARE WORK: THEORIZING ABOUT CARE AND GENDER*

Feminist researchers seeking to make a connection between care and work emphasize the "dual nature" of caring, for it demands both labour and love (Graham, 1983). This dual nature is captured by the distinction between caring *for*, which "refers to the instrumental and tangible tasks involved in caring" and caring *about*, which "encompasses its expressive and affective dimensions" (Baines, Evans, & Neysmith, 1991, p. 15). These states are not mutually exclusive, in that one may care *about* someone while caring *for* them. This is true of both paid, formal caring relationships and unpaid, informal caring relationships. As Milligan (2003) noted, "Caring relationships in the formal sphere (e.g., the long-stay ward, residential care homes, etc.) can, and often do, involve varying degrees of emotional attachment" (p. 458). Milligan (2003) cautioned against fragmentary understandings of care that parse it into separate components. Care often involves the blurring of boundaries between formal and informal, public and private, work and love.

Care work is relational and situated. Chattoo and Ahmad (2008) described caring in terms of "relational autonomy," in which the caregiver and care recipient's selves are "constantly reconstituted as a balance between notions of interdependence or legitimate dependence on the one hand and independence on the other" (p. 561). Power dynamics are inherent in care giving, which has the potential to oppress both caregivers and care recipients (Bondi, 2008). Dodson and Zincavage (2007) used the example of certified nursing home assistants to show

how the family-like bonds between unrelated paid caregivers and care recipients, and the managerial rhetoric of workers being "just like family," can be both a source of job satisfaction and a site of exploitation for paid caregivers. As George (2007) noted, female care givers often cope "by internalizing stereotypical female roles defined by self-sacrifice, silent suffering, altruism, piety, holding up against the odds, keeping harmony rather than asking for help and turning to religion" (p. 33). Pfefferle and Weinberg (2008) cautioned that such assertions of meaning might make care givers vulnerable to exploitation.

Benoit and Hallgrímsdóttir (2008) define care work as a subcategory of service work that is characterized by face-to-face service to individuals in an effort to enhance their capabilities and that either directly or indirectly maintains daily life (p. S7). Paid care workers represented more than 12 percent of employees (1.8 million people) in Canada in 2008. Approximately 80 percent of paid care workers are female (Benoit & Hallgrímsdóttir, 2008). As the latter statistic suggests, care work takes place in a gendered division of labour in which women primarily perform the paid and unpaid work associated with the care of partners, children, seniors, and people with disabilities or illnesses (Finch & Groves, 1983; Varcoe, Hankivsky, & Morrow, 2007). As suggested by this unequal division of labour, care work (and, more broadly, caring) is feminized (Baines et al., 1991; Cancian & Oliker, 2000). By this I mean that the capacity to care is associated with women and is perceived to be an inherently 'feminine' trait, sometimes purported to be linked to women's biological capacity for reproduction. As a consequence of the socially constructed feminization of caring, women do the majority of paid and unpaid care

work in contemporary Canadian society. For example, in 2005, Canadian women spent 49.5 minutes per day engaged in caregiving, while Canadian men spent 24.2 minutes per day performing similar tasks (McLaren, Godley, & MacNairn, 2009).[24] While men's share of caregiving increased by about five minutes between 1986 and 1995, women still performed more than twice the amount of caregiving provided by men (McLaren et al., 2009).

Like other feminist scholars of care work, I seek to disrupt the association between care work and women/femininity. The assumption that caring comes 'naturally' to women "fails to consider the socially patterned sex roles and the processes of socialization through which sex is translated into gender" (Baines et al., 1991, p. 17). Biology is not destiny. Rather, women are taught to care through processes of gender socialization. These same processes contribute to the feminization of care work, for "what counts as caring is determined as much as by who does it as by what is done" (Graham, 1983, p. 21). Women and men thus experience caring and the socially constructed obligation to care differently. Occupations are segregated by gender and women tend to be overrepresented in the "caring professions" such as nursing, social work, and teaching (England, Budig, & Folbre, 2002; Graham, 1983). Though they represent a relatively small proportion of the workforce, men working in feminized caring professions may experience a phenomenon known as the "glass escalator," which "push[es] men upward and outward into the higher-status, higher-paying, more 'masculine' positions within

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[24] Baby/child care and care of household adults are examples of constituent items in the category of "caregiving" used in this analysis (McLaren et al., 2009).

these fields" (Harvey Wingfield, 2009, p. 5). However, the "glass escalator" is racialized as well as being gendered, which means that all men do not experience the phenomenon uniformly, as demonstrated by Harvey Wingfield's (2009) research on Black men in nursing.

The division of caring labour is not merely demarcated by biological sex and socially constructed gender, as exemplified by the work of researchers like Harvey Wingfield (2009). An exclusive focus on the feminization of care work risks essentializing women's experiences, which in fact are highly varied as a result of social differences such as class, race/ethnicity, age, immigrant status, sexual orientation, ability, body size, and geographic location (Varcoe et al., 2007). The concept of intersectionality is intended to capture these differences, in particular the notion that women experience gender simultaneously with other factors. These intersections shape how individuals and groups experience care work. For example, immigrant women and women of colour are overrepresented among care workers in general (Baines et al., 1991; Das Gupta, 1996) and among CHWs in particular (General Accounting Office, 2001; Montgomery et al., 2005). Globalization has accelerated the movement of female care workers within and across national borders, which has resulted in the formation of transnational caring relationships referred to as "global care chains" (Ehrenreich & Hochschild, 2003). Factors such as income and social class determine which women can afford to pay other women to do their care work (e.g., by hiring a nanny or eldercare provider) and which women are paid to do the care work of others. Care work thus emerges as a racialized and classed phenomenon as well as a gendered one.

Our perceptions of work are shaped by the social location of the worker. Because we live in a patriarchal society, feminized labour, including care work is persistently undervalued and poorly paid (Baines et al., 1991). In their discussion of this phenomenon, Benoit and Hallgrímsdóttir (2008) cited the "devaluation thesis," which holds that:

> because the activities associated with caring work are generally conflated with what are assumed to be universal and natural female characteristics, the skills and expertise associated with caring work go unrecognized. Similarly, other scholars have argued that the care sector relies, both implicitly and explicitly, on a highly gendered assumption that women who seek out caring work are motivated by altruistic orientations and the emotional rewards of this work. Implicit here is a second assumption – that aspects of work understood to motivate people in other sectors of the economy, such as wages and benefits or reasonable work hours, are secondary considerations for women engaged in carework. (p. S7)

England et al. (2002) tested this thesis in their research on how care work is compensated. They found that those who do care work suffer a wage penalty – that is, they "receive, on average, lower hourly pay than we would predict them to have based on the other characteristics of the jobs, their skill demands, and the qualifications of those holding the jobs" (p. 455). After adjusting for factors such as sex, education level, and unionization rates, the authors found that working in a caring occupation (e.g., teaching, nursing, childcare) still led to a statistically significant net wage penalty of five to six percent for both women and men (England et al., 2002). The extent of the penalty varied by and within occupational groups; for example, female childcare workers experienced a 41 percent wage penalty while male childcare workers experienced a 12 percent wage penalty. The authors posited several reasons for the existence of such a wage penalty, including the economic

dependence of care recipients, the association of care with women and mothering, and the tendency of market wages to be lower in jobs involving intrinsic motivation (i.e., where altruism is perceived to be its own reward).

*INVISIBLE WORK AND THE SOCIAL CONSTRUCTION OF SKILL*

The social construction of skill affects how we value care work. Phillips and Taylor (1980) observed that skill is "saturated with sex…it is the sex of those who do the work, rather than its content, which leads us to its identification as skilled or unskilled" (p. 85).[25] Defining care work as unskilled reinforces its status as a form of invisible work. Nardi and Engeström (1999) described four kinds of invisible work. Work can be invisible because it is done behind the scenes, in invisible places. It can be invisible because it is defined or seen as routine or manual, but actually requires considerable problem solving and knowledge. Work can be invisible because it consists of "informal work processes that are not part of anybody's job description but which are crucial for the collective functioning of the workplace" (Nardi & Engeström, 1999, p. 1). Finally, work can be invisible because it is done by socially invisible people, such as CHWs.

Care work encompasses all four dimensions of invisible work. It "remains persistently difficult to see" (Sandelowski, 2000, p. 11) not because the tasks are so minute as to be imperceptible, but because the taken-for-granted status of care work renders it functionally invisible (Star & Strauss, 1999). Twigg (2000) noted

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[25] The use of the term "sex" in this quotation is most likely a reflection of the era in which Phillips and Taylor (1980) published their research. It is more appropriate to think of occupations as being both gendered and sexed, in that social and biological aspects of identity and physiology mediate them. Nevertheless, I have retained this quote from Phillips and Taylor (1980) because the notion that skill is sexed – and gendered – is significant, as was their paper at the time it was published.

that care work remains hidden because it is a form of "dirty work," both in the sense that care work involves intimate contact with bodies and their excreta and in the sense that it consists of "degrading tasks that are integral to society, but that society does not want to acknowledge, and are by common consent hidden" (p. 405). Care work takes place in private spaces (the home), which renders it further invisible. It is performed by socially invisible workers, who I would count among the "missing bodies" analyzed by Casper and Moore (2009) in their recent book of the same title. As they ask, how is it that "certain places, spaces, policies, and practices in contemporary society...exhibit and celebrate some bodies while erasing and denying others" (Casper & Moore, 2009, p. 3)? The irony is that care work is most visible when it is not done (Graham, 1983). Care work is therefore best understood as a complex gendered phenomenon with tangible consequences for workers and the visibility and value of their work.

*ANCILLARY WORK*

Some care work is also a form of ancillary work. The term "ancillary" means subordinate or auxiliary (Random House, 1997). Whether a worker is considered ancillary hinges on whether that worker is counted as part of the health care team. The distinction between ancillary workers and other health care workers is sometimes drawn on the basis of whether workers are involved in direct patient care. While physicians, nurses, and other professionals are considered to be core members of the health care team, CHWs are often classified as ancillary workers, as are dietary, housekeeping, maintenance, clerical, laundry, and security workers (Armstrong, Armstrong & Scott-Dixon, 2006). Eighty-eight percent of ancillary

workers are women and female-dominated jobs are more likely to be defined as ancillary (Armstrong & Laxer, 2006). As a consequence of the feminization of ancillary work, "the skills, effort, responsibilities, and working conditions involved remain invisible and undervalued" (Armstrong et al., 2006, p. 4). The assumption that certain skills come 'naturally' to women, as well as ancillary workers' tendencies to learn their skills outside of the formal education system and to work cooperatively or in teams, make ancillary workers, their skills, and the work they do less visible (Armstrong & Laxer, 2006).

Categorizing work as ancillary has tangible consequences for how it is valued and organized. In Canada, 53 percent of women in ancillary health care occupations earn incomes below the poverty level compared with approximately 27 percent of men in ancillary health care occupations (Armstrong & Laxer, 2006). Jobs defined as ancillary are more likely to be contracted out (i.e., privatized). For example, hospital cleaning and dietary services are often contracted out on the basis of their classification as "hotel services," a categorization based on the assumption that cleaning hospital rooms and preparing meals for sick patients are comparable with cleaning hotel rooms and preparing room service meals for hotel guests (Kahnamoui, 2005). The reality is different because of concerns about infection control or the potential consequences of not meeting patients' special dietary needs. Designating certain types of workers as ancillary obscures their contributions to patient care, which may be direct, as in the case of CHWs, or indirect, as in the case of laundry or dietary workers.

Defining work as ancillary hinges on whether workers are counted as key members of the health care team. When work is deemed ancillary, this affects how it is valued, which in turn shapes how workers are compensated, whether they receive social benefits, how their work is organized, and the extent of their job security. These factors determine the degree of precariousness inherent in an occupation. Precarious employment "encompasses forms of work involving limited social benefits and statutory entitlements, job insecurity, low wages, and high risks of ill health" (Vosko, 2006, p. 3). It is shaped by employment status, form of employment, and dimensions of labour market insecurity, as well as social location and social context (e.g., occupation, industry, geography). Precarious employment is gendered, in that it affects men and women differently. Other dimensions of social location, such as class, race/ethnicity, and immigration status also shape precarious work.

Though not a new phenomenon, precarious employment is on the rise in North America, Europe, and Australasia (Quinlan, Mayhew, & Bohle, 2001; Vosko, 2006). The standard employment relationship, a normative model of employment consisting of full-time permanent wage work done by a worker at an employer's worksite, has been eroded by the increase in precarious employment (Vosko, 2006). The standard employment relationship is based on assumptions about the gendered division of paid/unpaid labour (male "breadwinner"/female "caregiver"). More men than women work in jobs that conform to the standard employment relationship (i.e., full-time, permanent jobs), while women are overrepresented among precariously employed workers (i.e., part-time and temporary workers) (Vosko,

2006). Since most labour laws and policies are written with the standard employment relationship in mind, the feminization of precarious work has implications for the statutory protections available to female workers.

Precarious employment has been associated with poor occupational health and safety as indicated by injury rates, disease risk, and exposure to hazards, as well as increased psychological morbidity (Quinlan et al., 2001; Virtanen et al., 2005). Women's work is "more likely to involve … [injuries] associated with chronic, slowly developing conditions such as musculoskeletal problems or stress-related illness" (Messing et al., 2003, p. 620). Reluctance to report injuries or unsafe practices is another indicator of employment precariousness (Armstrong & Daly, 2004). Female workers are "less likely than men to make claims for workplace injury under workers' compensation and even less likely to receive compensation when they do" (Armstrong et al., 2006, p. 58). Female workers thus remain uncompensated and uncounted in injury statistics, which leads to underestimation of the hazards inherent in their work and perpetuates the mistaken belief that women's work is safer than men's work (Messing et al., 2003).

## WHAT DO WE KNOW ABOUT COMMUNITY HEALTH WORKERS?

Having established the theoretical framework that informs my understanding of what CHWs do, I now summarize what the literature reveals about CHWs and their working conditions. This literature is remarkably consistent in its characterization of CHWs and their work. It shows how these workers, the majority of whom are women, receive low wages and few benefits, have little control over their work schedules, and face considerable occupational health and safety risks.

*DEMOGRAPHIC COMPOSITION OF THE HOME SUPPORT WORKFORCE*

The home support workforce is highly feminized, as is the case with many care giving occupations. Approximately 90 percent of CHWs are women (Armstrong & Laxer, 2006; Canadian Women's Health Network, 2009; Eaton, 2005; Montgomery et al., 2005). The racial and ethnic composition of this workforce likely varies from place to place. Because there is a paucity of research on CHWs working outside of urban settings, we lack data about the demographic composition of the home support workforce in these places. However, US data show that there tends to be a higher proportion of women of colour and immigrant women in the direct care workforce (Dodson & Zincavage, 2007). For example, Potter, Churilla and Smith (2006) analyzed US data about the direct care workforce and found that 53 percent of female workers were non-white, compared with 29 percent of workers in other sectors. Other predictors of full-time employment in the direct care workforce include having limited educational attainment (high school diploma or less), being the only adult in their households (i.e., being single, divorced, or widowed), and having children under the age of 18 years.

*WAGES AND COMPENSATION*

CHWs tend to earn lower wages than the average worker, which suggests the presence of a wage penalty, though compensation and benefits vary by position and by region (General Accounting Office, 2001; Kaye, Chapman, Newcomer, & Harrington, 2006; Stone & Wiener, 2001). Wages and benefits both depend on factors such as whether CHWs are unionized, whether they work in the public or private sector, and whether their position is permanent or casual. Using 2000 data,

the Canadian Women's Health Network (2009) estimated that the average Canadian CHW earned approximately $16,000 CDN per year. Several American researchers have estimated CHWs' average hourly wages. Their estimates range between $7.97 and $12.51 USD per hour (Dodson & Zincavage, 2007; Eaton, 2005; Muntaner et al., 2006; Probst, Baek, & Laditka, 2009). Potter et al. (2006) noted that "33 percent of women working in the direct care workforce live in families whose income is at or below 150 percent of the poverty level, compared to 13 percent of all other workers" (pp. 368-369). Some workers hold more than one job as a way of increasing their incomes. For example, one third of the respondents in Dodson and Zincavage's (2007) study noted that they held more than one full-time job because of low wages.

Some CHWs are not compensated for the time they spend travelling between clients' homes, which means that they must work more than eight hours to earn eight hours' pay (Potter et al., 2006). CHWs are typically required to use their own vehicles to get to and from clients' homes. Employers sometimes compensate their workers for mileage incurred on the job but workers do not always feel that this compensation is sufficient. For example, CHWs in the northern city of Sudbury, ON recently protested the rate at which they are compensated for travel (Carmichael, 2010). CHWs may receive few or no health or social benefits from their employers, particularly if they are not unionized or are casual employees. George (2007) noted that 40 to 50 percent of CHWs in the US lacked health insurance.

Also of note is that CHWs tend to earn less than facility-based workers (Canadian Healthcare Association, 2009). In 2008, unionized CHWs in BC earned

approximately $1.80 to $3.55 CDN less per hour than their facility-based counterparts (Ivanova, 2009). Although this is a narrower gap than Lilly's (2008) finding of an average mean wage gap of $4.56 CDN between hospital and home-based employees in the Toronto area, it still represents a considerable difference given that CHWs and facility-based workers in BC have the same training. Lilly posited several reasons for the wage gap: hospital-based workers are more qualified, hospital based-work is more difficult or stressful, or home-based workers are more likely than hospital-based workers to be women and to be from racialized groups, and therefore more likely to earn lower incomes. However, Lilly concluded that it is the location rather than the content of the work or the nature of the workforce that dictates how it is valued. As she put it, "The medical versus social nature of the duties performed by [CHWs] has become secondary to the medical versus social nature of the setting in which these activities take place" (Lilly, 2008, p. 285). Lilly suggested that the dichotomy between the medical and the social (the hospital and the home) – a dichotomy that could also be understood in terms of the public/private divide – is reinforced by the legislative privilege accorded to hospitals, uneven patterns of unionization and regulation across settings, biases in how occupations are classified (see discussion in Chapter One), and competition from other labour groups.

*PRECARIOUS EMPLOYMENT IN THE HOME SUPPORT SECTOR*

Home support work is precarious work. CHWs are overrepresented among part-time, casual, and shift workers (Montgomery et al., 2005; Muntaner et al., 2006). The Canadian Women's Health Network (2009) estimated that 41.3 percent

of CHWs work part-time. CHWs often work in shifts and may be on-call, which means that their schedules can be irregular and difficult to predict. This is partly a reflection of the nature of the work in this field, as many of the services CHWs provide are most needed in the morning and in the evening (e.g., dressing, bathing, feeding, helping people in and out of bed) (Potter et al., 2006). It also reflects the feminization of precarious work, as women are more likely to work part-time and to be casual or shift workers (Menénendez, Benach, Muntaner, Amable, & O'Campo, 2007). These kinds of employment arrangements may affect CHWs' work-life balance. Williams (2008) noted that workers with irregular schedules or who work on-call may be less satisfied with their work-life balance because they do not have enough time with their families or for other activities, and may suffer from role overload. The negative effects of irregular work tend to be more pronounced among female workers (Williams, 2008).

*ANCILLARY WORK IN THE HOME SUPPORT SECTOR*

Home support work is ancillary work, in that CHWs tend to work alone in their clients' homes and are rarely integrated into the health care team. Because of this, they may feel isolated (Canadian Healthcare Association, 2009; Heard, 1993; Keefe, 1999). Home support workers spend more time with their clients than most other health care providers, yet they are frequently not included in care planning meetings. Excluding CHWs from such meetings means a loss of opportunities to benefit from home support workers' detailed knowledge about their clients' health status or personal circumstances. CHWs use their frequent and close contact with clients as a tool to help them identify signs of illness. For example, a study

conducted in Swedish nursing homes found that certified nursing assistants gleaned information about their clients while interacting with them in their everyday life, like when they helped clients get dressed or eat a meal (Tingström, Milberg, & Sund-Levander, 2009). Notably, the workers in this study were able to detect signs of illness in cognitively impaired clients by observing their nonverbal cues. Integrating CHWs into the care planning process might enable home support provider organizations to take advantage of CHWs' firsthand knowledge about clients, which is typically not included in clients' charts or care plans (Tingström et al., 2009). Failure to integrate CHWs into health care teams has been linked to CHWs' job dissatisfaction and ultimate turnover (Heard, 1993).

*OCCUPATIONAL HEALTH AND SAFETY IN THE HOME SUPPORT SECTOR*

In addition to making them feel isolated, working alone may put CHWs at higher risk of being injured at work (Morgan et al., 2008). Because they work alone, CHWs tend to have less access to assistance from supervisors or co-workers, have minimal or no access to safety equipment (e.g., mechanical lifts), and work in personal residences not designed to accommodate their needs (Meyer & Muntaner, 1999; Paris-Seeley, Raschke, Watzke, Jones, & Halsted, 2000). As a consequence of their working conditions, CHWs "face numerous hazards including excessive manual lifting, psychological stress, chemical hazards, infectious agents, violent residents, and the handling and disposal of sharps" (Myers, Kriebel, Karasek, Punnett, & Wegman, 2007, p. 795). Dodson and Zincavage (2007) cited US data showing that injury rates among certified nursing assistants, a comparable population of workers, are among the top five of all occupations in the country.

Zeytinoglu et al. (2000) found high rates of self-reported and diagnosed musculoskeletal disorders among CHWs, who are primarily exposed to such injuries when engaging in high-risk activities including lifting or transferring clients (Paris-Seeley et al., 2000). A study of CHWs in one US state showed that the greatest proportion (35.7 percent) of injuries were to the lower back (Meyer & Muntaner, 1999). Data from the British Columbia Workers' Compensation Board indicated that 36 percent of CHWs' injury claims were due to overexertion injuries from client handling (Heacock et al., 2004).

As a predominantly female workforce, CHWs are at high risk of physical, sexual, and verbal abuse from their clients or clients' family members (Keefe, 1999; MacAdam, 1999). Clients, particularly those suffering from dementia, may be aggressive towards care providers, particularly during personal care (Morgan et al., 2008). The racialization of home support work means that some CHWs may face racism on the job (Das Gupta, 1996). The workers are often given limited information about their clients, so they may be unaware of the risks posed by the client, the client's family members, or an unsafe living situation (Stevenson, McRae, & Mughal, 2005).

Some CHWs also risk injury from motor vehicle collisions as they travel between clients' homes (Meyer & Muntaner, 1999). Weather is an important, though often overlooked, factor in CHWs' occupational health and safety (Skinner, Yantzi & Rosenberg, 2009). Bad weather may affect workers' ability to get to and from work, or to travel between clients' homes. Skinner et al. (2009) noted that the policies governing community care often overlook "the contextual differences between

institutional and non-institutional settings that include weather among other geographical and socioeconomic contingencies" (p. 687). Place shapes the working lives of CHWs, and may influence whether health policies work (or do not work) as intended in actual practice settings.

In a study of violence against nursing home aides, Morgan et al. (2008) found that organizational-level factors contributed to violence against workers, and might be one site for interventions aimed at improving workers' safety. Workers in Morgan et al.'s (2008) study expressed frustration at being blamed for causing aggression and feeling like they were at the bottom of the organizational hierarchy. They reported a lack of action by leaders to address the problem of client aggression, and they wanted to be respected and actively involved in decision-making processes. Other studies have shown associations among violence against health care workers, inadequate staffing, and low support from co-workers and supervisors (Shields & Wilkins, 2009). Time of day also may be a factor. Shields and Wilkins (2009) found that Canadian nurses working the night shift were at higher risk of on-the-job abuse by patients.

## CLIENT SAFETY

CHWs' working conditions have implications for their clients' safety. The majority of research about patient safety has focused on institutions such as hospitals (Doran et al., 2009; Lang et al., 2006). However, an emerging body of research about client safety in home care and home support has identified several unique characteristics of home-based care that have implications for client safety, including the links among client, family, caregiver, and provider safety, the settings

in which the care takes place (i.e., homes), the multiple dimensions of safety in home care (physical, emotional, social and functional), the increased autonomy and choice experienced by clients, families and caregivers, and the demographic characteristics of home care clients, many of whom are elderly and live alone (Doran et al., 2009). Specific safety risks include polypharmacy (clients being prescribed more than five medications), declines in physical function, cognitive impairment, and a history of falls (Doran et al., 2009). Some clients have a combination of two or more safety risks, which renders them potentially more vulnerable to adverse events.

Estimates of the adverse event rate in home care and home support range from 5.5 to 13 percent (Doran et al., 2009; Sears, 2008).[26] Adverse events include new falls, unintended weight loss, new emergency room visits, and new hospital visits (Doran et al., 2009). Sears (2008) noted that the majority (two thirds) of adverse events experienced by home care and home support clients are preventable. Working conditions may contribute to the risk of adverse events. For example, Wilkins and Shields (2008) studied the correlates of medication error (by nurses) in Canadian hospitals and found that poor co-worker support was significantly related to medication error, as were poor job security and working overtime.

Unregulated health workers like CHWs may experience risks to client/patient safety associated with the way their work is organized (Canadian

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[26] Estimates of the adverse event rate in the acute care setting range from six to 16 percent (S. Sheps, personal communication, November 29, 2009).

Nurses Association, 2008).[27] For example, unregulated health workers' training and qualifications vary across jurisdictions, which may result in a disjuncture between what workers are trained to do and the competencies required for their jobs (Canadian Nurses Association, 2008). The registered nurses with whom they work may not be aware of unregulated health workers' background or training. Since nurses sometimes assign specific tasks to unregulated health workers, this lack of knowledge about workers' background or training could lead to unsafe assignment of duties (Canadian Nurses Association, 2008). Unregulated health workers like CHWs sometimes work with little supervision, which may also compromise client/patient safety.

Some experts have called for regulation of these health workers as a strategy to promote client/patient safety. Potential benefits of regulation could include the use of consistent titles and training requirements, clear and consistent practice standards, and provision of a mechanism through which to respond to charges of worker misconduct (Canadian Nurses Association, 2008). However, the Canadian Nurses Association (2008) emphasized that not all experts support the regulation of these workers. Some see regulation as a potential barrier to maintaining a stable workforce and to fostering a system that is flexible enough to respond to fluctuations in demand for services. For example, regulation might pose a challenge

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[27] I use the term "client/patient" here as unregulated health workers care for individuals variously referred to as clients or patients, depending on what sector they work in. For example, in home support, the term "client" is used, while it is customary to say "patient" in hospitals. Unregulated health workers can be found in all of these environments.

in rural and northern regions that already face challenges in maintaining an adequate supply of health human resources.

*JOB SATISFACTION IN THE HOME SUPPORT SECTOR*

When viewed as a whole, the preceding discussion of CHWs' wages, benefits, scheduling, and safety seems to paint a rather bleak view of working conditions in the home support sector. The issues raised above contribute to the health human resource challenges discussed in the section that follows, and serve to situate CHWs within the broader framework of thinking about feminized, ancillary, and precarious work. However, it is important to note that, in spite of the challenging conditions in which they work, many CHWs derive considerable satisfaction from their jobs. George (2007) cited research showing that CHWs and comparable workers draw a strong sense of pride from their work despite being poorly paid and looked down upon for doing menial tasks. This feeling of pride is rooted in the belief that the workers "directly … [contribute] to their patient's comfort and dignity and … [know] more about the patient than other more skilled health workers who … [depend] on them" (George, 2007, p. 32).

Pfefferle and Weinberg (2008) had similar findings when they studied how certified nurse assistants in nursing homes made meaning of their work despite its devaluation and the physical and emotional demands inherent in it. They found that devaluation was manifested in numerous ways, such as a lack of respect from managers and supervisors, and having little autonomy to structure their daily work, which resulted in unpredictable schedules. In the face of these challenges, these certified nurse assistants used various strategies to assert the value of their work.

Some thought of their work as "good work" or "God's work," others emphasized closeness to residents, and some drew satisfaction from caring for those who could not care for themselves (Pfefferle & Weinberg, 2008, p. 955). These researchers found that certified nurse assistants' "meaning making represents an effort to assert a positive identity rather than accept the stigmatization associated with their work" (Pfefferle & Weinberg, 2008, p. 952). Other research has shown a link between job satisfaction and workers' ability to interact with their clients in a way that makes them feel as if they are making a difference in the lives of their clients and clients' families (Navaie-Waliser, Lincoln, Karuturi, & Reisch, 2004).

Worker-client relationships are a recurring theme in the rural health research literature. Moules, MacLeod, Thirsk, and Hanlon (in press) described the complex and multifaceted nature of good working relationships between public health nurses and their clients in northern communities, the elements of which were at one level "common sense and at another level reflective of highly skilled competencies and practices." They explained how nurses entered into and maintained relationships with their clients, which were mediated by the social overlaps characteristic of small communities. This dual role – as health care provider and as community member – is frequently mentioned in the literature (Kulig et al., 2008; Robinson, Pesut, & Bottorff, 2010). Care providers in rural communities sometimes take advantage of the informal networks afforded by close community ties, which may enable innovation (Lum & Aikens, 2009; Robinson et al., 2010). At times nurses in Moules et al.'s (in press) study judiciously crossed professional boundaries – for example, bringing groceries to a client who did not

have enough food to feed her children. By doing so, these nurses, "were able to hold to personal values while attuning their practice to the needs of families" (Moules et al., in press). Dahl (2009) observed that some Danish CHWs used a similar strategy, which she described as doing more than the prescribed tasks for their clients, as a form of resistance against the neoliberal restructuring of care.

Other recurring themes in the literature about CHWs' job satisfaction and recruitment and retention highlight the importance of supportive co-workers and supervisors. Navaie-Waliser et al. (2004) surveyed home health employees to determine which factors were associated with workers' job satisfaction. The leading factors included working for a quality agency with a good reputation and having adequate office support. Supervision and teamwork were strong themes in Noelker, Ejaz, Mene, and Bagaka's (2009) research about long-term care workers. They found that long-term care workers who were more satisfied with the supervision they received were less stressed by their unpredictable schedules. They also found positive benefits of teamwork and peer mentorship, which points to the potential benefits of better integrating CHWs and workers performing similar roles in other settings into health care teams. This emphasis on workplace relationships supports Lanham et al.'s (2009) argument that "efforts aimed at improving health care quality should consider the role of the relationships among organizational members," a category that includes both clinicians and non-clinicians (p. 45). They identified seven characteristics of relationships, including trust, respectful interaction, diversity, and communication. All of these characteristics could easily be applied to

our efforts to understand and improve relationships between clinicians and non-clinicians in the home support sector.

Denton et al. (2007) studied home care workers' job satisfaction and propensity to leave. They found that a lack of organizational support and job security were highly significant predictors of less satisfaction among agency workers. They also found that workers who reported an emphasis on the "business" side of care at their agency were more likely to report lower job satisfaction. They found that older workers reported lower job satisfaction compared with younger workers, but were less likely to leave their jobs. Denton et al. (2007) argued that this may be linked to older workers' precarious position in the labour market. On the other hand, workers who were more satisfied with their pay or who worked more hours per week reported higher job satisfaction (Denton et al., 2007).

The literature reviewed above shows that, in spite of the devaluing of their work, many CHWs derive considerable satisfaction from their relationships with clients and their work as caregivers. The literature also shows that workers who feel as if they are part of a team, and who are well supported by their managers and co-workers tend to have higher job satisfaction. These findings point toward several strategies for enabling the recruitment and retention of CHWs. The health human resources challenges that characterize the home support sector are discussed below. Potential solutions to these challenges are described in the concluding chapter (Chapter Six).

The home support sector faces difficulties recruiting workers. State employed CHWs in Finland and Denmark recently demonstrated outside of parliament, carrying banners that read "Union of Disregarded Workers" and "Poor and Overworked" (Dahl, 2009). Researchers, advocacy groups, and home support provider organizations across North America have been calling attention to the critical nature of the worker shortage for over ten years (Armstrong & Daly, 2004; General Accounting Office, 2001; Stone & Wiener, 2001). In 2000, experts observed that the US home and community care industry was "experiencing the highest rates of direct-care vacancies and turnover in its history" (Dawson & Surpin, 2000, p. 226). These are persistent challenges. US estimates suggest that the average vacancy rate ranges from 10 to 12 percent (Castle, 2008; Eaton, 2005). Forty-eight percent of home care agencies surveyed in the 2001 US Home Care Aide Staffing Survey indicated that they had unfilled home care aide positions (Cushman et al., 2004). Moreover, 34 percent of respondents indicated that they had refused home care admissions because of worker shortages, which may be an indication of future problems if the sector continues to have difficulties with recruitment (Cushman et al., 2004). Like the USA, the United Kingdom suffers from a chronic shortage of home care workers, with average vacancy rates of 10 to 13 percent (Hussein & Manthorpe, 2005).

The home support sector also has difficulty retaining workers. Turnover, defined as the "voluntary termination of employment by the employee, usually (but not always) within a short period of time after being hired," is a challenge (Bowers,

Esmond, & Jacobson, 2003, p. 37). Turnover estimates for CHWs and comparable workers vary widely. Denton et al. (2006) suggested that turnover rates for CHWs range from 25 to 40 percent, double to triple the rates for other Canadian health care workers. Several US studies have examined turnover rates among nurse aides and certified nursing assistants working in nursing homes. Potter et al. (2006) found that annual turnover rates in direct-care occupations ranged from 40 to 166 percent. Castle (2008) found a turnover rate of 64.4 percent among facility-based nurse aides. Probst et al. (2009) found annual turnover rates of between 69 and 171 percent among certified nursing assistants in long-term care facilities, while Eaton (2005) estimated a range of 30 to 100 percent, Donoghue (2010) reported a rate of 74.5 percent, and Bowers (2003) reported a range of 85 to 100 percent. A Canadian study, in contrast, found that CHWs had average job tenures of six to seven years (Human Resources Development Canada, 2003), and BC data suggested that many of the province's CHWs have been in the field for many years, as evidenced by their seniority levels (Ivanova, 2009). Accordingly, turnover statistics should be interpreted with caution because there are no readily available national data about staff turnover, nor are there standardized definitions, so most estimates are based on studies of limited samples (Castle, 2008). The wide range in these estimates may also be due to geographical or agency-level variations in turnover rates (Cushman et al., 2004; Stone & Wiener, 2001).

Castle (2008) noted that turnover has been linked to higher operating costs for facilities, lower job satisfaction among caregivers, and negative health outcomes for facility residents. High turnover leads to shorter average job tenure among

CHWs (Kaye et al., 2006), which is costly for employers because of the expenses associated with hiring and training replacement workers. It can have negative consequences for clients (e.g., disruptions in the continuity of their care). And, high turnover leaves CHWs with few mentors and opportunities for on-the-job support and training from more experienced colleagues (Stone & Wiener, 2001).

Turnover is associated with both intrinsic (individual attributes and characteristics) and extrinsic factors (organizational characteristics) (Bowers et al., 2003). Intrinsic factors include being young, being better educated, having a history of short-term employment, and being male (Bowers et al., 2003). These factors may reflect the "glass escalator" phenomenon referred to earlier in this chapter, as well as the greater mobility that might come with being younger, having higher education, and potentially having few or no dependents. Extrinsic factors include low pay, few benefits, insufficient hours of work, limited opportunities for advancement, inadequate training or orientation, chronic understaffing, lack of acknowledgement or reward for good work, feelings of isolation, and feelings of alienation from the health care team (Bowers et al., 2003; Cushman et al., 2004; Heard, 1993; Human Resources Development Canada, 2002). Bowers (2010) found higher turnover rates among certified nursing assistants working in for-profit facilities. Turnover also has been linked with having "few professional development opportunities, … [performing] physically and emotionally demanding work, and understaffing" (Probst et al., 2009, p. 268). The home support sector must also compete with nursing homes and hospitals for employees, and both competitors

tend to offer workers higher pay and more consistent or predictable schedules (MacAdam, 1999).

*HEALTH HUMAN RESOURCES POLICY*

The home support sector faces considerable health human resources challenges, which may become more acute as the population ages. It is predicted that to meet increased future demand for home and community care services, the number of CHWs and professional providers (e.g., registered nurses, physiotherapists, social workers) in Canada must be increased by a factor of approximately three (Human Resources Development Canada, 2003). In spite of current and projected worker shortages, CHWs are virtually invisible in Canadian health human resources planning and policy, which has traditionally focused almost exclusively on physicians and registered nurses (Federal/Provincial/Territorial Advisory Committee on Health Delivery and Human Resources, 2005). While these professionals play a very important role in the health care system, physicians and registered nurses "constitute less than a third of the paid labour force in health and social services" (Armstrong & Armstrong, 2002, p. v). A 2003 review of health human resources planning and policies in Australia, France, Germany, Sweden, and the United Kingdom found that none of these countries had formal planning in place to meet the need for ancillary workers, a category that includes CHWs (Bloor & Maynard, 2003). This is a significant oversight given that ancillary occupations represent 35 percent of all health care jobs (Armstrong & Laxer, 2006).

There seems to be greater awareness of the implications of a care worker shortage in the United States, which may translate into inclusion of these workers in

American health human resources planning and policy. Officials from 42 states responding to a survey about the long-term care workforce identified recruitment and retention of frontline care workers as a major priority, and 30 states indicated that they were engaged in related workforce initiatives (Stone & Wiener, 2001). In 2006, the United Kingdom launched a large-scale data collection effort, the National Minimum Data Set for Social Care (NMDS-SC), as part of a broader strategy to improve the recruitment and retention of care workers.[28] The program aimed to collect demographic information about the social care workforce from employers (e.g., home care workers, residential care workers, social workers, occupational therapists), including age, gender, job role, hours worked, training and qualifications (Cole, 2007; see also Department of Health, 2006). Participation in the program was voluntary. By January 2009, the database contained over 280,000 individual worker records (Keenan, 2009).

Home and community care labour force issues related to ancillary workers do not appear to be accorded equal priority in Canada despite facing recruitment and retention challenges similar to those in the United States and the United Kingdom. Attention to home and community care at the national level has focused on the need to establish national standards for short-term acute home care, acute community mental health, and end-of-life care (Health Council of Canada, 2005). Although these efforts reflect valid concerns about home care for post-acute, mental

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[28] The term "social care" refers to services provided to seniors and other care recipients (e.g., people with disabilities) in their homes or in facilities. It encompasses what is referred to here as home support.

health, and palliative care clients, they do not devote sufficient attention to the shortage of paid care workers in the home support sector.

CHWs are invisible in Canadian health human resources data sources. As the Canadian Home Care Association (2008) noted, "Despite the magnitude of the human resource issue, most jurisdictions do not have easy access to the current number of paid individuals working in the home care sector and the number of informal caregivers or volunteers is not well defined" (p. xvii). CHWs' lack of representation in health human resources data is the result of being unregulated health workers. The lack of professional or regulatory bodies makes data collection about unregulated workers "impossible," since there are no provincial or national organizations keeping track of these workers (Canadian Institute for Health Information, 2006a). Researchers and policy makers in search of data about home support workers are limited to broad-based national surveys such as the Canadian Labour Force Survey or the Census, which have their own limitations with respect to accurately capturing information about this workforce, as discussed in the introductory chapter (Chapter One). Lack of sufficient data about the CHW supply (e.g., number of workers, geographic distribution) and CHW characteristics (e.g., age, job satisfaction, health status, turnover rates, levels of burnout) will hamper health human resources planning efforts (Federal/Provincial/Territorial Advisory Committee on Health Delivery and Human Resources, 2005).

CONCLUSION

This chapter began with a brief description of the literature review process. It was followed by a summary of the literature that comprises my theoretical

framework, which integrates feminist perspectives on gender and care giving, critical studies of health care work (ancillary work) and labour studies, particularly the concept of precarious work. What CHWs do as a form of feminized care work is persistently undervalued because of gendered assumptions about the work and the people who perform it. These assumptions intersect with class, race/ethnicity, and other social locations, though gender is the primary focus of this research because the overwhelming majority of CHWs are women and care work is strongly associated with being female.

There is not a significant body of literature about the CHWs who work in small cities, towns, and rural communities, and so I summarized what is generally known about the working lives and conditions of CHWs and comparable workers. Much of this literature focuses on workers who provide care in the home, and in some cases workers who are employed in facilities such as nursing homes. In this literature, place tends to be conceptualized in terms of the site of care provision (home or community versus facility), rather than geographic location (urban versus rural). While it does not draw out the specific experiences of CHWs working outside of urban settings, it does provide the reader with an understanding of who CHWs are and how their work is organized and compensated. Given that these are key factors in CHW recruitment and retention, the inclusion of this literature provides a context for understanding health human resources in the home support sector, and points toward possible solutions to the challenges of CHW recruitment and retention. It also serves to link many of the characteristics outlined in the overview of my theoretical framework to the realities of the home support workforce.

The final section of this chapter described the health human resources challenges that are pervasive in the home support sector, which struggles with job vacancies and high turnover. In light of population aging and increased demand for home support services, which are discussed in greater detail in the context chapter (Chapter Three), this may prove to be a significant challenge for the Canadian health care system. However, CHWs tend to be overlooked in health human resources policy and planning. CHWs' absence from health human resources policy and planning seems paradoxical in light of broader trends of health care restructuring and the shift of care from institutions to communities. I examine these trends in the chapter that follows, which provides a policy context for my research.

# CHAPTER 3: CONTEXT

This chapter is intended to set my research findings in context. "Contexts" might be a more appropriate term, as the contextualization occurs at multiple levels, from the national to the regional. The chapter begins with an overview of Canada's aging population and the implications for paid and unpaid caregivers. It then presents data about home and community care utilization and spending in Canada. This section is followed by a discussion of health care restructuring in Canada, specifically the shift in the location of care from institutions to communities. This shift, which is characteristic of many health care restructuring processes, has implications for the home and community care sector, including increased demand for services and the workers who provide those services. It must be considered in relation to the health human resources challenges discussed in the previous chapter (Chapter Two). Having established a national policy context, I shift my focus to the provincial level so as to situate my study in BC. A brief description of the province is followed by an overview of the BC health care system. I then focus specifically on BC's home and community care system, which is followed by a description of Vancouver Island and its regional health system. These regionally-focused discussions serve to situate the description of the study communities in the research methods chapter (Chapter Four). The chapter concludes with an overview of how home support work is organized in BC.

CANADA'S AGING POPULATION

At the time of the 2006 Census, the Canadian population was approximately 31.6 million people, 13.7 percent of whom were aged 65 years or older (Martel & Malenfant, 2006).[29] It is expected that one in five Canadians (21.2 percent) will be aged 65 or older by the year 2026, a growing proportion of whom will be over 80 years of age (Cranswick & Dosman, 2008). Seniors over the age of 80 tend to have more complex health care needs than younger seniors. In 2009, approximately 500,000 Canadians were living with Alzheimer's disease or a related dementia, a number that is expected to double in 25 years (Alzheimer's Society of Canada, 2009). The number of chronic conditions, such as Alzheimer's disease, arthritis, diabetes, heart disease, and others, is the strongest determinant of the frequency with which seniors use health care services (Rotermann, 2005). Moreover, seniors tend to be higher users of health care services relative to their share of the population (Rotermann, 2005). While researchers have refuted the "apocalyptic demography" that often comes with discussions of population aging (Evans, McGrail, Morgan, Barer, & Hertzman, 2001), the growing number of seniors in Canada will have implications for health service delivery and utilization.

Canada's aging population will affect caregivers, both paid (formal) and unpaid (informal). In 2007, about 20 percent of Canadians aged 45 years and older provided unpaid care to a senior (Cranswick & Dosman, 2008). Researchers estimate that 80 percent of all seniors' care in Canada is provided by unpaid caregivers (McGrail et al., 2008) who have been the focus of many studies (Lilly,

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[29] Canada had a population of approximately 33.6 million people in 2009 (Statistics Canada, 2009b).

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Laporte, & Coyte, 2007). While unpaid caregivers will continue to play a significant role in care giving, several socio-demographic shifts may reduce the available supply of unpaid caregivers. More women are now in the labour force, people are living and remaining at home longer than before (often with much more complex needs), and family and household structures are changing, with smaller, geographically dispersed families becoming more common (Lilly et al., 2007). As a consequence of these shifts, Canadian data suggest that there will be a relative decrease in seniors' reliance on informal supports (e.g., adult children, spouses), with a corresponding increase in their dependence on formal caregivers such as CHWs (Keefe, Carrière, & Légaré, 2004).

## HOME AND COMMUNITY CARE UTILIZATION AND SPENDING IN CANADA

Home and community care, which includes home care and home support, represents an important component of the formal (i.e., paid) care system. In Canada, home and community care services are often divided conceptually into three functions. First is *acute care substitution*, in which home and community care services are used to provide care for people who might otherwise be in acute care facilities (McGrail et al., 2008). Second is *long-term care substitution*, in which these services are used as a substitute for residential care provided in a long-term care facility (McGrail et al., 2008). Finally, the *maintenance and prevention function* serves to meet the needs of people with health and/or functional deficits, thereby maintaining their ability to live independently at home (McGrail et al., 2008). In many cases, these services are used to prevent health and functional breakdowns that might otherwise lead to hospitalization or institutionalization. There is

sufficient evidence to support the cost-effectiveness of home and community care services as substitutes for acute and long-term care (Hollander & Chappell, 2002; Hollander, Chappell, Havens, McWilliam, & Miller, 2002; Soderstrom, Tousignant, & Kaufman, 1999), though McGrail et al. (2008) observed that less attention has been devoted to the maintenance and prevention function of home and community care. However, some studies do point to the cost-effectiveness of this function of home and community care (Hollander, 2003; Szebehely, 2005).

In 2003, approximately 11 percent of Canadians aged 65 years or older received publicly funded home and community care services (McGrail et al., 2008). During the same period, total public spending for home and community care was estimated to have been $3.4 billion CDN (2007 dollars) (Canadian Institute for Health Information, 2007).[30] Per capita public spending for home and community care ($93.60 CDN in 2003/04) grew an average of six percent per year between 1994/95 and 2003/04, while the number of government-subsidized home and community care users (26.1 per 1,000 population) increased by only one percent (Canadian Institute for Health Information, 2007). This suggests that individual users are consuming more resources, and that service delivery is more intense (i.e., a smaller number of clients are receiving more hours of care) and more specialized (i.e., more nursing care, less help with housework). These findings are echoed in the BC data (Cohen et al., 2006; McGrail et al., 2008) and in research from the United

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[30] McGrail et al. (2008) cautioned that the CIHI (2007) data do not include information about private expenditures for home and community care services, and may also be compromised by provincial/territorial variation in methods of data collection. However, they concluded that "these are the best comparable data available at present, and the trends over time give some broad context for [home and community care] use in BC" (McGrail et al., 2008, p. 14).

Kingdom (Lymbery, 2010). It is difficult to determine whether the intensification of service delivery is driven by younger post-acute or older long-term home and community care clients, though there are data to support the contention that these services are becoming increasingly clinical. Researchers have observed differences between short-term home and community care users, who tend to be younger and use more home care, and long-term users, who tend to be older and use more home support (McGrail et al., 2008). This is likely due to the specific needs and circumstances of short term, convalescing clients, which differ from those of long-term users, who are typically people with disabilities or seniors suffering from multiple chronic or long-standing conditions.

In the majority of Canadian provinces and territories, home and community care falls under the jurisdiction of the provincial or territorial ministries of health.[31] As mentioned in the introductory chapter (Chapter One), there is no legislative obligation at the federal or provincial/territorial level to provide similar home and community care services or programs to Canadians, or to apply consistent standards and policies. As a consequence, there is variation across jurisdictions in terms of which organizations are responsible for the direct planning, management, and delivery of home and community care, and the levels and cost of available services (Canadian Home Care Association, 2008). However, the Canadian Healthcare Association (2009) noted that there are four basic models of service delivery in Canada:

[31] New Brunswick is one exception, where professional health care services are administered by the provincial Department of Health and Wellness and long-term home support services are administered by the Department of Social Development (Canadian Home Care Association, 2008).

1. In Saskatchewan, Manitoba, Nunavut, Northwest Territories, Quebec, and Prince Edward Island, home and community care services are managed and delivered by provincial or territorial government employees (public employees).

2. In British Columbia, New Brunswick, and Newfoundland and Labrador, home care services are delivered by public employees, while home support services are delivered by a mix of public employees and private home support agencies (private employees). The home and community care system is administered by public employees.

3. In Alberta and Nova Scotia, public employees administer the home and community care system, public and private employees provide home care services, and private employees provide home support services (through contracts with private agencies).

4. In Ontario, publicly funded Community Care Access Centre (CCAC) employees provide single-entry coordination into the home and community care system. All publicly paid home care and home support services are contracted to the private sector, which includes a mix of for-profit and not-for-profit agencies.

As this scan suggests, the structure of the home and community care sector varies considerably across Canada.

Home and community care spending and utilization are shaped by the broader health policy context. This context is in turn shaped by the values that underlie policy making (Hankivsky, 2004) – for example, whether service users are conceived of as primarily citizens (with rights) or as consumers (able to exercise choices) (Lymbery, 2010). Lewis (2006) argues that the "accumulation and use of power is crucial to the health policy process," a process she found to be dominated by academics, people with medical qualifications, and men. Health care restructuring, a process involving changes to governance, ownership, and underlying beliefs about the role of the state, citizens, and the private sector, has changed the landscape of home and community delivery in Canada. A particularly salient aspect of this process is the shift in the location of care from institutions (e.g., hospitals) to communities (e.g., homes) (Coyte & McKeever, 2001; Malone, 2003; Milligan, 2000). Cartier (2003) described this as a process of "place switching," in which the costs of sub-acute and daily life care are offloaded from institutions to the sphere of the care recipients, their families, and communities. As Dyck et al. (2005) explained, people's homes now "dominate the landscape" of home care (p. 174).

The shift from institutions to communities is based on several assumptions. At the core is a liberal model of citizenship, which "assumes that, for the most part, autonomous individuals are able to attend to their own basic needs" (Hankivsky, 2004, p. 5). Under this model, dependency on the state is the exception, not the rule. Illness, disease, and disability are perceived to be deviations from normal functioning, rather than a normal part of life, and care work is not seen as an

71

integral part of citizenship (Hankivsky, 2004). The liberal model of citizenship shapes the values and assumptions that underlie health policy in Canada, and informs how we perceive and value home and community care.

These assumptions are evident in the justifications used by government for shifting care out of institutions and into communities: first is the assumption that home and community care is less costly than institutional care (Baranek et al., 2004). Second, governments assume that home and community care is of higher quality, in the sense that "services delivered 'closer to home' respond to consumer preferences and can enhance consumer choice, independence, and quality of life" (Baranek et al., 2004, p. 4). Gleeson and Kearns (2001) argued that a moral polarity underlies this shift. This polarity "opposes the 'dehumanizing' institution to the more humane environment of community care" (p. 62), and is based on an "imagined geography" of home and community care (Parr & Philo, 2003, p. 474) that blurs the boundaries between private space and public or 'institutional' space (Milligan, 2000). Lymbery (2010) suggests that this polarity is related to the binary opposition between 'independence' and 'dependence' upon which social care policies are premised, and which casts dependence in a pejorative light.

These policies rest on the notion that all homes are suited to care provision, when in fact individual circumstances differ widely (Wiles, 2005). Exley and Allen (2007) discussed the tensions that arise from this notion in their research of how the provision of end-of-life care in the home affects unpaid caregivers. They disrupted the assumption that home is always superior to an institution, and observed that home-based end-of-life care can be extremely stressful for care

recipients and providers. They concluded, "Perhaps being cared for at 'home' is not about 'home' as a physical space, but rather about being accompanied by those you care about and having the privacy and comforts associated with the domestic setting" (p. 2325). Robinson et al. (2010) had similar findings in their study of rural palliative care, in which some respondents viewed hospital deaths positively, "particularly if the admission occurred in the last 48 hours of life, and if the hospital was located within the community" (p. 81).

The shift from institutions to communities is based on the implicit assumption that women are available to do care work in the home, whether they are doing so as paid employees or unpaid family caregivers (Walker, 1983). Benoit and Hallgrímsdóttir (2008) linked this shift to a gendered "ideology of familialism," which favours the family (and by extension, the home) as the best site of care (p. S8). It reflects the gendering of places and spaces, and the association between women and the home (Massey, 1994). Health care restructuring has increased the burden of paid and unpaid care work on Canadian women (Armstrong & Armstrong, 2004). As explained in the literature review (Chapter Two), an increasing number of paid caregivers are in precarious jobs. Cartier (2003) suggested that this reflects a broader trend toward neoliberal cost minimization strategies that disproportionately affect female workers. The shift of care from institutions to communities has had a disproportionate effect on women because it increases and changes their caring labour (Neysmith, 2000).

This shift in the site where care is provided has taken place over three decades of restructuring of the Canadian health care system, a process rooted in the

retreat from an interventionist welfare state that began in the early 1970s (Armstrong & Armstrong, 2001). The interventionist model was replaced by a neoliberal one characterized by a strong emphasis on market mechanisms, including competition and private delivery of services. Increasing health care costs, external financial pressures from an economic recession, and periods of reduced health care funding prompted this restructuring. Provincial health ministries began to look to home and community care programs as substitutes for institutional care in the early 1980s (Ostry, 2006). The recession in the early 1990s was followed by $20 billion CDN in cuts to federal transfer payments to the provinces, which resulted in drastic downsizing of the acute care sector (Ostry, 2006).

Between 1989 and 2003, Canada experienced a 40.4 percent reduction in the number of hospitals and a 36.1 percent reduction in the number of hospital beds available nationwide (Ostry, 2006). This downsizing contributed to the shortening of inpatient stays and the increased use of outpatient care and day surgery. There was a corresponding increase in the number of patients requiring care at home. The majority of Canadian provinces regionalized their health care systems in the 1980s and the 1990s, which led to a greater emphasis on home and community care (Armstrong & Armstrong, 2001). The shift to home and community also accelerated because of advances in medical technology, such as laparoscopic surgery that enabled earlier discharge of patients and facilitated care at home. All of these factors combined to increase demand for home and community care, as well as increase the acuity level of clients in the home support system.

HEALTH CARE RESTRUCTURING: IMPLICATIONS FOR CHWS

Restructuring has had considerable effects on workers, clients, and informal caregivers in the home support sector (e.g., Aronson, 2002; Aronson & Neysmith, 1996, 2006; Cohen et al., 2006; Denton et al., 2006; Sharman et al., 2008). For example, the movement of patients with acute and complex care needs into community settings has resulted in the intensification of CHWs' work and diminished their capacity to provide relational care, the aspect of care that encompasses the interpersonal, emotional dimensions of home support, which are essential to the care giving experience (Aronson, 2003; Chichin, 1992; Piercy & Woolley, 1999; Woodward, Abelson, Tedford, & Hutchison, 2004). Unlike the task-based aspects of home support (e.g., bathing or dressing a client), relational care is hard to see, difficult to measure, and rarely included in formal descriptions of what home support workers do (Aronson & Neysmith, 2006). It is often the first casualty of home support restructuring, which tends to favour task-based care.

Work is restructured in such a way that CHWs often feel compelled to rush through their work. For example, long-term care workers in an Ontario study reported that they were unable to provide emotional support to residents 60 percent of the time because of time pressures on their work (Armstrong & Daly, 2004). Workers in Morgan et al.'s (2008) study noted that lack of time to provide care to clients, particularly those suffering from dementia, limited their ability to involve clients in their own care, despite workers' knowledge that a slower pace was more in keeping with the principles of quality dementia care. Rushing their care "often made residents upset, agitated, and aggressive" (Morgan et al., 2008, p. 341).

75

Hjalmarsson (2009) studied the introduction of hand-held computers in home help services in Sweden. She described how time has two dimensions in home help services: time spent caring for clients and "indefinable time," which consists of activities such as telephone conversations with clients' relatives or health professionals, meetings, travel time, and other activities. Rather than build this indefinable time into workers' schedules, managers in Hjalmarsson's study viewed it as an inefficiency to be monitored and controlled through technology. While the studies cited here focus on facility-based workers, these issues resonate with our knowledge about CHWs' working conditions. For example, rushing and not having enough time to provide care is a recurrent theme in the research about CHWs (Cohen et al., 2006; Sims-Gould & Martin-Matthews, 2010b).

Rushing may put CHWs at increased risk of injury (e.g., from rushing through a physically demanding task such as lifting a client out of a bathtub). Organizing work in this way limits workers' ability to develop meaningful, supportive relationships with their clients. Hjalmarsson (2009) described this as a form of instrumental rationality, in which care work is structured so that workers must fulfill their duties or tasks in the most effective way, and put aside any responsibility for the feelings and experiences of the people for whom they are caring. Bondi (2008) asserted that this is a false distinction, for it is not wholly possible or desirable to separate the instrumental and emotional dimensions of care.

CHWs' working conditions are further compromised by the increasing casualization of home support work (Sharman et al., 2008). As discussed in the literature review (Chapter Two), CHWs increasingly work part-time or "on-call"

with no guarantee that they will care for the same clients from one day to the next. This approach to scheduling diminishes the continuity of care and is an indicator of the workers' precarious employment (Vosko, 2000, 2006). Restructuring places an ethical burden on CHWs who try to balance the strict rules imposed on care delivery with the standards of ordinary human morality or decency (Stone, 1999). Some CHWs shorten their own lunches or rest breaks to provide extra care to their clients, or visit clients outside of their paid work hours (Cohen et al., 2006). Aronson and Neysmith (2006) described how CHWs sometimes insert themselves as "shock absorbers between their clients and the damaging impacts of government policy" (p. 37). Dahl (2009) used the language of "invisible buffer" to describe a similar phenomenon that she observed among Danish CHWs (p. 649). Other CHWs have reported feeling coerced into providing additional, unpaid care for their clients (Keefe, 1999).

## THE BRITISH COLUMBIA CONTEXT

Having established the national policy context, I shift my focus to the provincial level to provide readers with a more detailed understanding of the setting in which the data for this study were collected. BC is the westernmost province in Canada. Situated on the Pacific coast, BC is "nearly four times the size of Great Britain, 2.5 times larger than Japan, and larger than any American state except Alaska" (BC Stats, 2008b, p. 1). Its size means that the province is home to a variety of climates and geographies. BC has a population of approximately 4.4 million people. It is a diverse population, with a large and growing immigrant population, as well as a strong Aboriginal presence. It is also an aging population. In 2007, 14.1

percent of BC's population was over the age of 65 years, while 28.1 percent of the

population was between the ages of 45-64 years (BC Stats, 2008b).

*THE BC HEALTH CARE SYSTEM*

Like Canada's other provinces and territories, BC has a publicly funded

health care system. Since 2001, health care services in BC have been managed and

delivered by five health authorities (see Figure 3), which are responsible for

governing, planning, and coordination of health services within their regions

(British Columbia Ministry of Health Services, 2009).[32] The five health authorities

are composed of smaller health service delivery areas. The sixth authority, the

provincial health services authority, manages other provincially-based health

services (e.g., cardiac care, cancer care, transplantation services). Its primary role is

"to ensure that BC residents have access to a coordinated network of high-quality

specialized health care service" (Provincial Health Services Authority, 2009).

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[32] In 2001, BC underwent a process of health system restructuring that merged 52 health authorities
into the six entities described here.

**Figure 3: BC's Health Authorities and Health Service Delivery Areas[33]**



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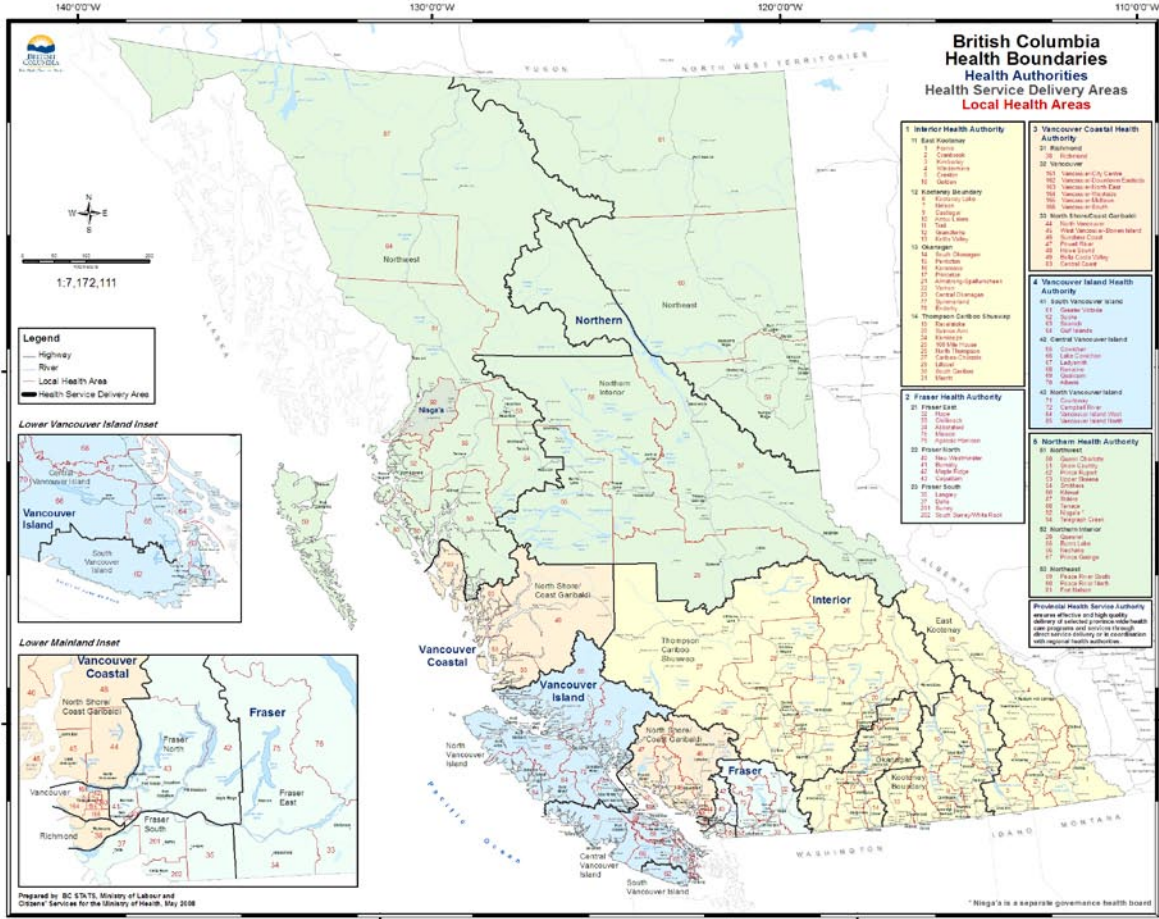
[33] Figure source: BC Stats (2008c), by permission.

BC residents are insured through the Medical Services Plan, which covers medically required services delivered by physicians and some other health care providers, including hospital care and diagnostics. The province also has a Pharmacare Program, which provides subsidized access to eligible prescription drugs and designated medical supplies (BC Stats, 2008b).[34] In 2001, BC ranked second in Canada in per capita health funding. It fell to sixth place by 2007, with the country's lowest annual increase in per capita health funding (Cohen, Tate, & Baumbusch, 2009).

## *THE BC HOME AND COMMUNITY CARE SYSTEM*

As described in the introductory chapter (Chapter One), BC's home and community care system consists of home care and home support, as well as other services such as adult day services, case management, and community rehabilitation (Canadian Home Care Association, 2008). Publicly funded home and community care services in BC date back to the late 1970s, when the provincial government "introduced coverage of home nursing care and residential care services," which "was followed in 1981 by subsidization of home support services" (McGrail et al., 2008, p. 15). Provincial legislation provides the framework for home and community care services in BC, including the Continuing Care Act, the Community Care and Assisted Living Act, and the Hospital Insurance Act.

Service delivery varies across BC's five regional health authorities because home and community care is organized and delivered at the regional level. For example, the 2004 British Columbia Health Atlas, which mapped provincial health

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[34] Access to the Pharmacare program is based on a family's ability to pay.

service utilization across the province, showed that the provincial average was nine home support users per 1,000 population (McGrail, Schaub, & Black, 2004). However, the utilization rate ranged from 7.8 users per 1,000 population to 11.3 users per 1,000 population in the five regional health authorities (McGrail et al., 2004).[35] The authors further noted that there was a seven-fold variation in home support use across the local health areas that comprise each regional health authority (McGrail et al., 2004). This variation across and within regions may be due to differences in how services are governed or delivered, as well as because of geographic and demographic differences between and within the regions. BC uses both the public and the private sector for home health services delivery. While professional services (e.g., nursing, rehabilitation) are delivered through the public system, home support and personal care services are provided both through the regional health authorities and through contracted private organizations (Canadian Home Care Association, 2008).

To be eligible for home and community care services, potential clients must undergo a standardized home and community care needs assessment process. The assessment is conducted by a health care professional (usually a registered nurse), who assesses the potential client's health status and health history, medications, capacity to manage activities of daily living (e.g., eating, dressing), family and social supports, and income level (Vancouver Island Health Authority, n.d.). Purkis, Ceci

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[35] The rates ranged from: Fraser Health Authority - 7.8 users per 1,000 population; Vancouver Island Health Authority – 8.4 per 1,000 population; Interior Health Authority – 9.2 per 1,000 population; Vancouver Coastal Health Authority – 10.6 per 1,000 population; and Northern Health Authority – 11.3 per 1,000 population (McGrail et al., 2004).

and Bjornsdottir (2008) observed that some elderly home and community care clients undergoing this assessment strive to appear healthier or more competent than they really are, perhaps out of a sense of pride or a desire not to burden the health care system. Their work points to the potential complexity of the assessment process, as well as the possibility of gaps between assessed and actual need.

There are other eligibility criteria for home and community care: potential clients must be either a permanent resident or Canadian citizen, must reside in BC, must be 19 years of age or older, and must suffer from "ongoing, health related problems which do not require care in an acute or rehabilitation program" (Canadian Home Care Association, 2008, p. 9). These health problems have a typical duration of at least three months and tend to be due to a progressive or chronic condition. Potential clients may also access the service on a short-term (two week) post-acute illness basis or for palliative (end-of-life) care.

Home and community care clients are not assessed fees for direct care professional services (home nursing, community rehabilitation, social work, in-school health services, assessment and case coordination). Home support is an income-tested program, though palliative care clients and those requiring two weeks' post-acute illness home support are exempt from income testing. Fees are assessed on the basis of an income calculation.[36] The Canadian Home Care Association (2008) noted that in 2006 about three-quarters (72 percent) of BC

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[36] The income testing considers household income less deductions for taxes, universal childcare benefits, basic living expenses and, if applicable, earned income. Clients who receive a range of government financial benefits (e.g., the Guaranteed Income Supplement, a disability allowance, a war veterans allowance) are not required to pay a daily charge for home support services (Canadian Home Care Association, 2008).

home support clients did not pay a daily charge for services. About four percent of clients paid up to $10 CDN per day, while seven percent of clients paid between $10 and $20 CDN per day. This is a reflection of the poverty level incomes of the home support client population. In 2003, 82 percent of home support clients over age 65 years reported pre-tax incomes of $15,000 CDN or less (compared with 53.9 percent of BC's seniors, overall) (Cohen et al., 2006). During the same period, 80 percent of BC's home support clients were over age 75 years, and approximately 70 percent were women (Cohen et al., 2006). The Canadian Home Care Association (2008) report did not include information about the fee levels paid by the remaining 17 percent of clients. Despite searching two BC government websites (the Ministry of Health Services and VIHA), I was unable to find a breakdown of fee levels for home support, which are assessed based on the client's income.

In 2003/04, the latest period for which data were available at the time the Canadian Institute for Health Information published its 2007 report on home and community care spending and utilization in Canada, there were 12.5 government-sponsored home support users per 1,000 BC inhabitants, compared with a national average of 14.1 users per 1,000 population (Canadian Institute for Health Information, 2007).[37] BC, Newfoundland, and Saskatchewan were the only provinces below the national average. BC and Saskatchewan had the lowest average annual growth in real per capita spending on home and community care services in 2003/04 (2.4 percent in BC and 3.2 percent in Saskatchewan), compared with a

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[37] The CIHI statistics group home care and home support users into a single group to arrive at this rate.

national average of 6.2 percent (Canadian Institute for Health Information, 2007).[38] While data about home support utilization were available, the methodology section of this report notes that a breakdown of spending on home care and home support was not available for BC at the time of publication. The Canadian Home Care Association (2008) analyzed 2005/06 spending data to show that BC's annual public expenditures for home and community care were $519 million CDN, which represented 4.5 percent of total provincial health expenditures and a per capita expenditure of $121.99 CDN (Canadian Home Care Association, 2008).[39]

Researchers who examined 10 years (1994/95 to 2004/05) of BC home and community care data from the BC Linked Health Database found that the BC home and community care system now reaches fewer seniors overall, with a smaller number of long-term (over 90 days of service) clients (McGrail et al., 2008). McGrail et al. (2008) suggested that an intensification of service delivery has taken place, which they attributed to an increasing focus on clinical needs, rather than assisting long-term users with personal care. Cohen et al. (2009) suggested that this shift can be attributed to two significant policies introduced in BC. First, in 1994, "stand-alone housekeeping," meaning housekeeping in the absence of other care needs, was eliminated from the list of services available through the BC home support system (Cohen et al., 2009). Second, in 1999, a policy was introduced that required the

[38] The Canadian Institute for Health Information (2007) noted that the analyses were done for 1994/95 to 2003/04 because expenditure data were available only up to 2003/04. See Canadian Institute for Health Information (2007), page 4, note iv.

[39] These estimates draw on provincial data from 2005/06. The expenditure figures include both home care and home support (the report does not provide a breakdown of expenditures by service, presumably because of a lack of data) (Canadian Home Care Association, 2008).

home support system to prioritize clients assessed at the highest levels of need and risk (Cohen et al., 2009). As a consequence of these changes, the BC home support system "is increasingly focused on providing personal and more medically-oriented services (e.g., simple wound dressings and medication management) to people with multiple chronic conditions" (Cohen et al., 2009, p. 40). These policy changes are indicative of the values that underlie home support policy in BC, as well as how these policies conceptualize the roles of the state and of citizens.

These changes have not gone unnoticed in BC. In 2008, the provincial government was criticized in a report by BC's Auditor General, who stated that the government was "not adequately fulfilling its stewardship role in helping to ensure that the home and community care system was meeting the needs of an aging population" (Cohen et al., 2009, p. 11). The government also was criticized in a report on the home and community care system written by the British Columbia Medical Association (2008), the association that represents the province's physicians. This report called for an immediate funding increase to home care and home support programs, and emphasized the need to prioritize care focused on maintenance and crisis prevention.

## VANCOUVER ISLAND

As mentioned in the introductory chapter (Chapter One), I conducted my research in four communities located on Vancouver Island, the largest island off the west coast of North America (Tourism British Columbia, n.d.a). It is comparable in size to the Netherlands and Taiwan. The Strait of Georgia, Johnstone Strait, and Queen Charlotte Strait separate Vancouver Island from Mainland BC, which is

accessible by air or water. The region boasts the mildest climate in Canada, making it a popular retirement destination. In 2008, Vancouver Island had a population of just under 741,000 (BC Stats, 2009a). Approximately 36 percent of the Island's population is over the age of 65, compared to a provincial average of 14.5 percent (BC Stats, 2009a). The greater number of seniors means that there are more potential home support clients in the region. About one half of the Island's population (348,151) can be found in the Greater Victoria area, an urban centre located on the southern tip of the island (BC Stats, 2009a). The remainder of the population is distributed across the island, with lower population density in the northern region of the Island.

*THE VANCOUVER ISLAND HEALTH AUTHORITY*

The Vancouver Island Health Authority (VIHA), which has an annual budget of $1.6 billion CDN and employs approximately 17,000 people (Vancouver Island Health Authority, 2009b), delivers health services to the residents of Vancouver Island. These services are provided "across a widely varied geographic area covering approximately 56,000 square kilometres, including Vancouver Island, the Gulf and Discovery Islands and part of the BC mainland opposite northern Vancouver Island" (Vancouver Island Health Authority, 2008, p. 2). VIHA serves many remote and isolated communities accessible only by water or air, such as Quatsino, Sointula, and Alert Bay (see Figure 4, Vancouver Island Health Authority map).

**Figure 4: Map of Vancouver Island Health Authority**[40]
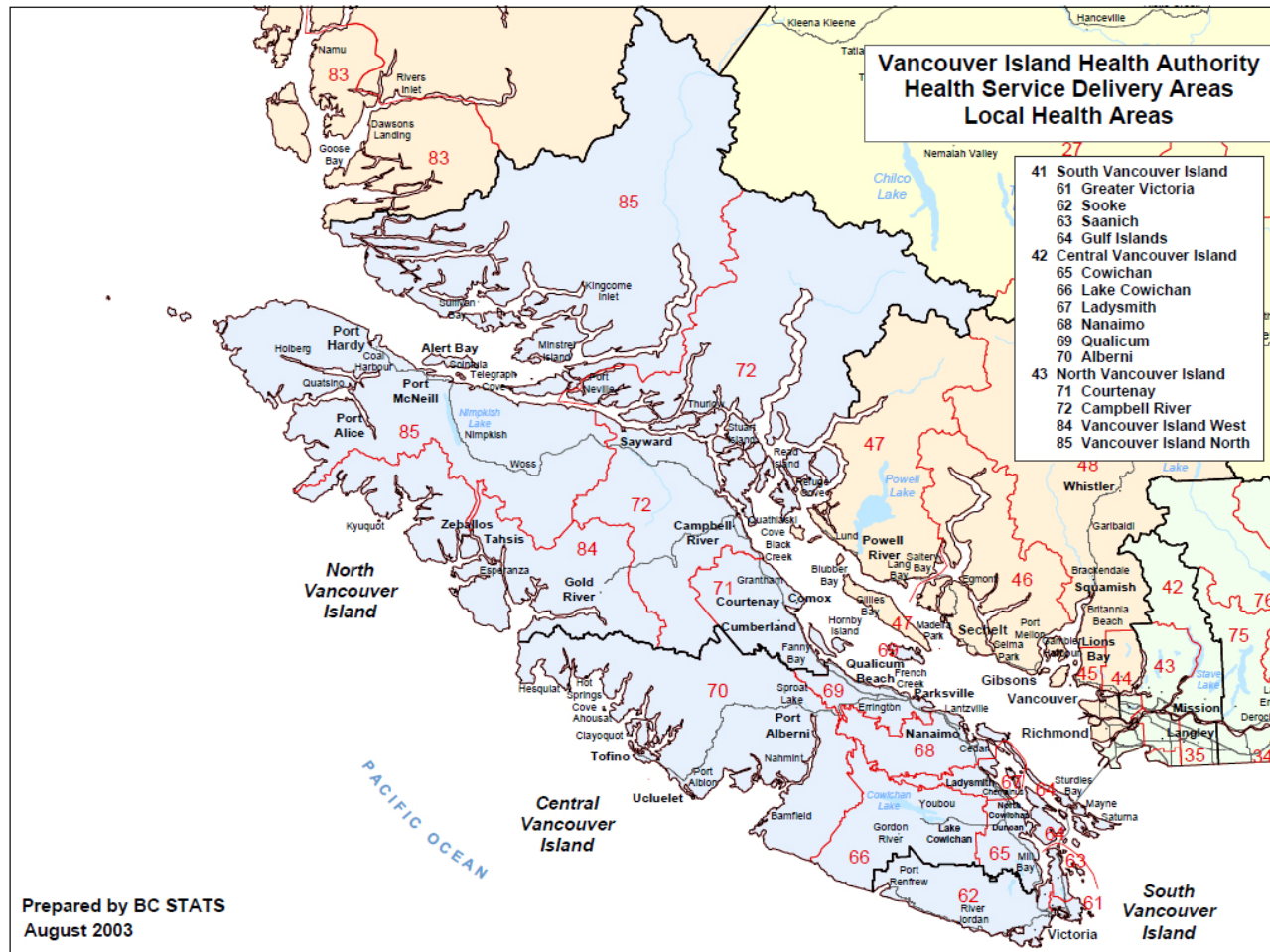


[40] Figure source: BC Stats (2009), by permission.

VIHA estimates that two of every five people it serves have a confirmed chronic condition, which means that it has the highest proportion of people with chronic illnesses of BC's five health authorities (Vancouver Island Health Authority, 2008). This may be due, in part, to the higher proportion of seniors on Vancouver Island. Approximately nine percent of the population VIHA serves is over age 75 years, compared with seven percent for the whole of BC. The majority of seniors are concentrated in the southern part of the Island, but the greatest growth in this population is taking place in the central area. VIHA projects that there will be a 20 percent increase in the proportion of the population aged 85 or older in this region by the year 2010 (Vancouver Island Health Authority, 2008). The northern region is also experiencing growth in its seniors' population.

*HOME SUPPORT PROVIDED BY VIHA*

In 2008/09, VIHA delivered 2,719,170 hours of home support and 171,480 home nursing service visits (Vancouver Island Health Authority, 2009c).[41] On an average day, the health authority provides 7,450 hours of home support (Vancouver Island Health Authority, 2009c). By 2010, VIHA predicts that the North Island health service delivery area will experience an 18 to 22 percent increase in home support hours and a 16 to 19 percent increase in the number of home support clients, while the Central Island area will experience a 45 to 49 percent increase in hours and a 40 to 44 percent increase in the number of clients (Vancouver Island Health Authority,

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[41] When asked for demographic data about the CHW workforce at VIHA, a representative indicated that they did not have the administrative/clerical resources to extract the necessary data from their records (personal communication, May 7, 2009).

2006).[42] These regions will likely face health human resource challenges in meeting such significant increases in demand for services. Home support service provision falls within the purview of VIHA Home and Community Care, a division of the Health Authority that "serves adults who need health care and support services to help with activities of daily living such as dressing, bathing, toileting, eating and transferring (moving from and into a chair or bed)" (Vancouver Island Health Authority, 2008, p. 9). It provides these services through a range of programs including nursing, physiotherapy, occupational therapy, nutritional support, social work, case management, home support, adult day programs, and assisted living programs (Vancouver Island Health Authority, 2009d).

## THE ORGANIZATION OF HOME SUPPORT WORK IN BC

Having established the various regional contexts in which my research is situated, I now describe how home support work is organized in BC. Some of the information in this section is derived from academic and grey literature, while other data are drawn from my preliminary research in the four study communities. The purpose of this section is to provide readers with an understanding of the structure and constraints that shape CHWs' working conditions in BC. In 2004/05, the average home support client in BC received about 17 hours of home support per month (McGrail et al., 2008). CHWs provide a range of home support services in clients' homes,[43] including personal care (bathing, dressing), meal preparation and

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[42] The study communities Parksville and Port Alberni are located in the Central Island Health Service Delivery Area. The study communities Campbell River and Port Hardy are located in the North Island Health Service Delivery Area.

[43] Clients' homes may include a private house, apartment, or assisted living residence.

feeding, social support, environmental support ('light' housekeeping), and basic health care (e.g., assistance with catheters, bowel care, physiotherapy). CHWs also perform tasks for specific clients that are assigned by registered nurses.

Most CHWs in BC are unionized, though they are not all members of the same union because union membership differs across communities. The three unions in BC that represent CHWs are the Hospital Employees' Union (HEU), the United Food and Commercial Workers (UFCW), and the BC Government Employees' Union (BCGEU).[44] Though union representation varies across the regions, most CHWs in BC are paid according to the collective agreement negotiated by the Community Subsector Association of Bargaining Agents. As of April 1, 2009, "the hourly wage for a [CHW] range[d] between $18.39 and $20.11 CDN per hour, depending on seniority" (Ivanova, 2009, p. 7). Recent research has shown that over one half of BC's CHWs earn less than $30,000 CDN per year (Ivanova, 2009). This is likely a result of the increasing casualization of the home support workforce, as fewer and fewer CHWs have the guaranteed hours that come with permanent full- or part-time positions.

Ivanova (2009) noted that CHWs' hourly wages are lower than the $21.94 CDN hourly rate earned by workers with equivalent training in BC's long-term care facilities. CHWs also tend to earn less overall because of their unpredictable schedules, which often translate into fewer paid hours of work. The distinctions between CHWs and facility-based workers are important because these workers

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[44] With respect to union representation in the four study communities, CHWs in Campbell River, Port Alberni, and Port Hardy are represented by UFCW local 1518. CHWs in Parksville are represented by HEU Local District 69, CHW Local Parksville and District Home Support.

have equivalent training and perform similar functions, yet there are several important differences in their working conditions. These differences tend to disadvantage CHWs. For example, facility-based workers do not need to use their own vehicles to the extent that CHWs do because they only need to travel to and from their workplace (rather than between clients' homes). CHWs may visit upwards of 10 clients in a day, whose homes may be geographically dispersed. This takes time and results in wear-and-tear on CHWs' vehicles, especially for those serving clients in rural or remote areas where roads may be unpaved or poorly maintained. It also adds risk to the CHWs' work because more time spent on the road increases their chance of motor vehicle collisions and the other perils of inclement weather and poorly maintained roads.

Because they are not based in a single facility, CHWs rely heavily on mobile phones as a means to communicate with their co-workers. The majority of CHWs pay for their mobile phone use out of pocket, though one recent home support redesign initiative included employer-supplied mobile phones (Groves, 2008). CHWs' primary point of contact is the scheduler, who advises them of their daily schedules as well as any changes to that schedule. CHWs also use mobile phones to contact their nursing leaders (registered nurses) for clinical advice or to advise them about changes in a client's condition. A mobile phone is a safeguard for CHWs working in isolated or dangerous areas, as it can serve as a means through which to "check in" with co-workers and loved ones.

The isolation of CHWs, who tend to work alone in clients' homes, is another point of distinction with facility-based workers. Workers in facilities have the

advantage of working in a team-based environment with greater access to their colleagues and to other members of the health care team. CHWs may occasionally be scheduled for a "two-person" visit – that is, when a client's care needs are heavy enough that it is deemed necessary to provide two CHWs simultaneously – but they rarely have other opportunities for face-to-face interaction with co-workers. Team meetings and ongoing training are offered infrequently, primarily due to a lack of necessary human and financial resources. The care giving environment itself represents a further distinction between home support and facility-based work. Unlike CHWs, who work in private homes not usually designed as spaces for care giving, facility-based workers provide care in buildings designed for the express purpose of care giving and have access to the requisite equipment (e.g., ceiling lifts, hospital beds, and specially designed baths and showers).

Unlike their facility-based counterparts, CHWs do not have regular shifts. Whereas facility-based workers tend to have regular, predictable schedules (and can usually expect to be scheduled for a full day's work), CHWs are assigned work on an hour-by-hour basis. Their schedules change frequently and often at the last minute, due to factors such as unpredictable changes in clients' conditions or other CHWs' sick leave. Work hours are assigned on the basis of seniority, with the most senior workers having the first choice of potential shifts. Seniority is calculated on the basis of the number of hours worked, not the date of hire, which may disadvantage casual workers who tend to work fewer hours. The way work hours are allocated means that many CHWs have more than one job to make ends meet. Some are "on-call" with both home support services and a facility, some provide

private seniors' care, while others work outside of health care (e.g., house cleaning or catering).

The minimum shift length in BC is two hours (British Columbia, 2009).[45] CHWs must provide their employers with a "window" of availability – typically, 10 hours on any given day (e.g., 8:00 AM - 6:00 PM, or 12:00 PM - 10:00 PM) during which they must be willing to accept a work assignment. However, they are paid only for the hours they actually work. An eight-hour shift one day might involve a four-hour visit with one client from 8:00 AM - 12:00 PM, four half-hour visits between 12:00 PM - 2:00 PM, and then one two-hour visit between 4:00 PM and 6:00 PM. Another shift might include two one-hour visits between 1:00 PM and 3:00 PM and two one-hour visits between 8:00 PM and10:00 PM. CHWs with regular full- or part-time positions are guaranteed a certain number of hours of work per week (usually in the range of 25 to 40 hours). Casually employed CHWs receive no guarantees of work. No CHWs have guarantees of when they will work or for whom they will provide care. Accordingly, CHWs cannot rely on having the same schedule, income, or client group from one week to the next. This makes it difficult for them to maintain a reasonable work-life balance, particularly those juggling childcare, eldercare, and other family responsibilities. It is also challenging for CHWs who have more than one job, which is not uncommon because of the low wages and unpredictable schedules characteristic of the occupation.

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[45] The minimum shift length was reduced from four to two hours in 2002, with the passage of Bill 48, an amendment to BC's Employment Standards Act.

Through a presentation of national, provincial, regional, and community-level data, this chapter has established the local contexts in which to situate the research findings. It points to how dynamics operating at multiple levels, including population aging and health care restructuring, affect home health service delivery, which in turn shapes the working conditions of CHWs. The chapter that follows describes how the primary research was conducted.

# CHAPTER 4: RESEARCH METHODS

In this chapter, I describe the methods used in conducting my research. The chapter begins with an overview of the study objectives and research questions. I then describe the research design, which utilized qualitative methods to investigate CHW recruitment and retention in small cities, towns, and rural communities. Integrated knowledge exchange – in this case, the involvement of decision makers at VIHA – was integral to the study design, as outlined below. I offer brief profiles of each of the four study communities (Campbell River, Parksville, Port Alberni, and Port Hardy). The participant recruitment process is described, as are the characteristics of the study participants. I provide an overview of the data collection and analysis processes, which is followed by a description of the knowledge translation activities undertaken for this study.

## STUDY OBJECTIVES AND RESEARCH QUESTIONS

The goal of this study was to identify and examine factors contributing to the recruitment and retention of CHWs working in small cities, towns, and rural communities, with a particular focus on how their working lives and working conditions shape their decisions to enter and remain employed in the home support system. As I explained in the introductory chapter (Chapter One), my interest in the broader topic of CHW recruitment and retention is rooted in CHWs' puzzling absence from Canadian health human resources policy and planning in the face of a worker shortage in the home support sector. This predicament seems shortsighted given the increased demand for home support services that may come with

population aging, the trend toward community-based health service delivery, and the increasing complexity of the services delivered through the home support system.

There are three reasons for my specific interest in CHW recruitment and retention in small cities, towns, and rural communities: first, rural communities face unique challenges in recruiting and retaining health care providers, including CHWs. Second, rural home support is different from urban home support. What we know about the recruitment and retention of urban CHWs might not be entirely generalizable to the rural or small town environment. Finally, most Canadian research about CHWs has been conducted in urban communities. Research on home support in rural places has primarily focused on the community- and system-level impacts of health care restructuring. Accordingly, there is a gap in our knowledge of CHW recruitment and retention. My research was intended to make a contribution toward filling this gap, by addressing the following study objectives and research questions.

*OBJECTIVES*
1. To describe what CHWs working in small cities, towns, and rural communities say about their jobs, their working conditions, and their roles within the health care system;

2. To investigate these CHWs' experiences of and motivations for pursuing a career in the home support sector; and

3. To develop recommendations to inform the design of policies and programs for recruiting and retaining CHWs in small cities, towns, and rural communities.

*RESEARCH QUESTIONS*

1. How do CHWs in small cities, towns, and rural communities describe their work and working conditions? What tasks do they perform? What services do they provide? What is their role within the health care system in rural and remote areas?

2. How do CHWs in small cities, towns, and rural communities experience their work? What are the benefits and challenges of their work? Does their work take a physical or mental toll on them? What motivates them to do this work?

3. What factors do CHWs in small cities, towns, and rural communities and other stakeholders identify as contributing to the recruitment and retention of rural and remote home support workers? What strategies might improve recruitment and retention of these workers?

RESEARCH DESIGN

I used a qualitative research design to achieve my objectives and to answer my research questions. Qualitative approaches are suited to explanatory or descriptive research, and should be used when little is known about a phenomenon (Marshall & Rossman, 1989; Morse & Field, 1995). It would have been challenging to execute a quantitative research design based on administrative data given the gaps and inconsistencies in available data sets, as discussed in both the introductory

chapter (Chapter One) and the literature review (Chapter Two). Most importantly, my choice of research design reflects my political and intellectual grounding as a feminist health services researcher. Qualitative methods are increasingly accepted in health services research, an approach traditionally characterized by quantitative methods (Shortell, 1999). I am committed to carrying out research that highlights the perspectives and experiences of frontline health care workers, and to translating those perspectives and experiences into policy. My approach is informed by the concept of "immanent critique"[46] as articulated by Mykhalovskiy et al. (2008), particularly the desire to utilize marginalized health care workers' experiences as the basis for counter-discursive accounts of health care reforms. As mentioned in the introductory chapter (Chapter One), I am interested in facilitating "bottom-up" rather than "top-down" policy development – in this case, health human resources policy informed by the "health human resources" (i.e., the workers) themselves. The University of British Columbia's Behavioural Research Ethics Board and the Joint University of Victoria-VIHA Research Ethics Board both granted ethical approval for the study (see copies of ethics certificates in Appendix A).

*INTEGRATED KNOWLEDGE EXCHANGE*

My research was driven by a commitment to integrated knowledge exchange, which the Canadian Institutes of Health Research (2009) defined as the involvement of stakeholders or potential research knowledge users throughout the entire

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[46] Immanent critique is a philosophical approach to the analysis of cultural forms by locating contradictions in the requisite rules and systems that produce those forms. Methodologically, researchers aim to contextualize both the object of study and the ideological basis of the object. This strategy has its roots in the work of Hegel and Marx and was further developed by critical theorists, particularly Adorno, a member of the Frankfurt School along with Marcuse and Habermas.

research process. In the case of my research, this meant working with decision makers from VIHA from the beginning of the research process. I first approached Dr. Lynn Stevenson, VIHA's Chief Nursing Officer, in May 2007, to express my interest in conducting a study about CHWs in small cities, towns, and rural communities. She directed me to Ms. Lynda Foley, VIHA's Director of Home Health Care, who in turn connected me with Ms. Barb Warren, the Home and Community Care Manager for the Comox Valley and Campbell River areas of Vancouver Island. In these initial communications it was established that CHW recruitment and retention was of significant interest to VIHA; the health authority was facing considerable staffing challenges and had limited research capacity to explore the underlying reasons for the health human resource issues in home support.

I had my first teleconference with four home and community care leaders on June 8, 2007. During this meeting, the leaders shared with me their challenges in the area of CHW recruitment and retention. They indicated that my study findings would be of direct relevance to their staffing issues. An early champion of my research, Ms. Warren became my primary point of contact in the months that followed. We communicated regularly by e-mail and telephone about project-related matters. As VIHA did not have the funding to cover the costs of my research, I obtained funding in the form of a $50,000 CDN grant from the British Columbia Medical Services Foundation (grant #BCM07-0156). Ms. Warren advised me in the development of this application, which was submitted for consideration in October 2007. VIHA's Chief Nursing Officer and Director of Home Health Care each wrote a letter of support to accompany the application.

When funding was secured from the British Columbia Medical Services Foundation, in mid-January 2008, I conversed with Ms. Warren to discuss the next steps. This was followed by a telephone meeting with the home and community care leaders in late January 2008. During this meeting, I sought the leaders' advice about which study communities would be appropriate for the conduct of the research, as well as strategies to recruit the study participants. Their input was incorporated into the research ethics applications I submitted to the Joint University of Victoria-VIHA Research Ethics Board (January 2008) and the University of British Columbia's Behavioural Research Ethics Board (February 2008). Ms. Warren and I were in regular contact by e-mail and conversed again in early April, at which time we discussed strategies for study recruitment. As a result of this discussion, the home support leaders in Campbell River, Parksville, Port Alberni, and Port Hardy distributed a one-page recruitment flyer to their CHWs.

Data collection and analysis were conducted in the summer and fall of 2008. Both processes are described in further detail in a subsequent section of this chapter. In early 2009, I approached Ms. Warren to update her about my progress. At this stage, she suggested that I contact Ms. Lynn Johnstone, the newly-appointed manager for Home Support in VIHA's Central and North Island regions. Ms Johnstone, in turn, suggested I contact Ms. Cathy Woodhurst, a Home Support Leader who specialized in education. Ms. Woodhurst advised me in the development of key knowledge translation activities – two community-based reporting and feedback sessions were subsequently held in April and May 2009. In February 2010, I presented my research at VIHA's research grand rounds in Victoria, BC. In March

2010, VIHA team members were presented with a plain language final report of the study findings.

As this chronology suggests, my involvement with VIHA spanned nearly three years and involved a range of stakeholders. It was not without its challenges. At times it was labour intensive to maintain working relationships with my colleagues at VIHA, particularly when I was engrossed in the data collection and analysis processes. It was challenging to accommodate the health system's timeline for information (the sooner, the better) with my timeline for carrying out the study, which was contingent on securing funding, securing ethics approval, and then undertaking the lengthy process of collecting and analyzing the data and writing the appropriate reports. Others have described the mismatched timelines of decision makers and researchers among other challenges associated with these types of collaborations (Chafe & Dobrow, 2008). Nonetheless, working with decision makers in this capacity provided me with unparalleled access to the health system, as well as unique opportunities to devise a research design informed by the needs and priorities of the relevant decision makers. My partnership with the health authority also facilitated participants' recruitment and knowledge translation activities, which are described in subsequent sections of this chapter.

## THE STUDY COMMUNITIES

In consultation with my colleagues at VIHA, I selected four communities located in two of VIHA's three health service delivery areas, North Island and Central Island. Both health service delivery areas (HSDAs) are large and socio-geographically diverse with below-average health status, growing senior

populations, and mounting demand for home support services. The four study communities – Campbell River, Parksville, Port Alberni, and Port Hardy – vary in size and socio-demographic characteristics, but they resemble one another in that their local home support systems all serve clients in nearby rural areas. The community profiles provided here include an overview of characteristics such as population demographics and density, income and employment rates, education, the local economy, and geographic location. The community profiles should not be considered to be comprehensive descriptions of each place. Rather, they are intended to orient readers to some of the key characteristics of each community, so as to point to the unique experiences of care giving that take place in each one.

The community-level data presented below point to the socio-spatial dimensions of home support – what some authors refer to as the "geography of caring" or the "place embeddedness" of care (Conradson, 2003; Hanlon et al., 2007a). Places are uniquely constituted by intersections of the social, the political, the economic, the geographical, and the temporal. People experience places differently according to their individual social location (i.e., how they are socially 'placed' by factors such as gender, race/ethnicity, immigrant status, social class, etc.). Places thus have both material and symbolic dimensions that operate on multiple levels (e.g., individual, community). They are "contexts in which we live, settings to which we feel attached, but also shape our experiences (e.g., the provision and receipt of health care; the process of ageing; the impacts of social and economic restructuring)" (Wiles, 2005, p. 101). Notions of community and the experiences of giving or receiving care also may differ across and within places

(Milligan, 2003). Accordingly, this study was designed to capture the specific configurations of care in a range of small city, town, and rural settings on Vancouver Island.

*CAMPBELL RIVER*

The self-described "Salmon Capital of the World," Campbell River is the third largest city on Vancouver Island, situated on the island's eastern shore. This oceanfront city takes pride in its beautiful marine setting and the natural resources that surround it. Once a pulp and paper mill town, Campbell River has increasingly focused its attentions on attracting tourists in search of outdoor adventures like hiking, mountain biking, whitewater rafting, and fishing. The city's tourism website notes that Campbell River "features many of the amenities of a big city without sacrificing its friendly small-town character" (Tourism Campbell River, 2009). In 2006, the community had a population of about 36,461 people (Statistics Canada, 2007a). The median age of the population was 42.8 years, somewhat older than the provincial median of 40.8 years (BC Stats, 2009b). Seniors represented about 13 percent of the population, just below the provincial average of 14 percent (BC Stats, 2009b). There are five seniors' residential facilities in Campbell River. Yucalta Lodge, Sunshine Lodge, Evergreen Manor, New Horizons Care Home, and Sunshine Manor offer 24-hour residential care for complex care clients. Ironwood Place is appropriate for seniors who require assisted living but not 24-hour care.

In the 2006 census, about 65 percent of Campbell River's adult (age 15+ years) population indicated that they were at least the third generation of their family to live in Campbell River, though the community did see a four percent

population increase between 2001 and 2006 (Statistics Canada, 2007a). "Visible minorities" [47] made up a relatively small proportion of the population – only three percent in 2006, compared to a provincial average of 25 percent (BC Stats, 2009b). Aboriginal peoples represented approximately 10 percent of the local population in 2006, compared to a provincial average of five percent (BC Stats, 2009b). Historically, the area that is now known as Campbell River belonged to the Sto:lo Coast Salish people, and subsequently the Wei-Wai-Kum people of the Laichwiltach Nation (now called the Kwakwak'awakw). Europeans first contacted local First Nations people in 1792, when Captain George Vancouver arrived at the village of Tsa-Kwa-Luten on Quadra Island.

In addition to tourism, forestry and mining are important local industries in Campbell River. The major local employers are Weyerhauser, North Vancouver Island Mining, Timber West Forest North Island Region, Quinsam Coal Corporation, Catalyst Elk Falls Pulp and Paper, and Western Forest Products. The top industries by labour force are accommodations and food services, forestry, fishing, hunting and agriculture, manufacturing, and health care and social assistance (BC Stats, 2009b). In 2006, Campbell River had a labour force participation rate of 64.6 percent and an unemployment rate of 8.8 percent (BC Stats, 2009b).

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[47] "Visible minority," a term used by Statistics Canada, is defined as persons, other than Aboriginal peoples, who are "non-Caucasian in race or non-white in colour" (Statistics Canada, 2008). Use of the term has been criticized nationally (e.g., by the Canadian Race Relations Foundation) and internationally (e.g., by the United Nations Committee on the Elimination of Racial Discrimination) because it is suggestive of significant homogeneity among the experiences of those so classified, and it tends to "other" the people included in the category (Canadian Race Relations Foundation, n.d.). Given that it is the official categorization of Census data, the term is used here albeit with diffidence.

In 2005, the median after-tax income for all census families was $54,593 CDN, while the median after-tax income for female-headed lone parent families was $25,862 CDN (BC Stats, 2009b). The prevalence of low income – that is, the percentage of a specific group that falls below Statistics Canada's low-income cut-off – for all economic families after tax was 8.5 percent, compared to a BC average of 9.9 percent. Among female-headed lone parent families, the prevalence of low income was 28.3 percent, compared to a BC average of 25.6 percent. Seniors fared better, with a prevalence of low income of 3.4 percent, compared to the provincial average of 7.3 percent. Homes in Campbell River had an average value of $273,482 CDN, while the average rent was $682 CDN per month (BC Stats, 2009b).

Among the population aged 25 to 64 years, about 30 percent of the community residents have completed high school or equivalent as their highest level of education, 25 percent have a college degree, 17 percent have an apprenticeship or trades certification, and approximately 10 percent have a baccalaureate degree or higher (BC Stats, 2009b). The educational institutions in Campbell River primarily offer elementary or secondary level education. There are 13 elementary schools, two middle schools, and two high schools. There is an elementary school in each of the surrounding communities of Sayward, Quadra Island, Cortes Island, and Read Island. North Island College and Discovery College have campuses in Campbell River. The Health Care Assistant program is available at the local Discovery College campus, producing 12 graduates per program cohort.

Parksville has been described as a "definitive British Columbia summer town" (Tourism British Columbia, n.d.b). The city is known for its beautiful beaches and tourist attractions. Resorts and motels occupy much of the sandy coastline, which is dotted with arbutus trees. Tigh-Na-Mara Resort and Conference Centre is one of the community's largest employers. In 2006, Parksville had a population of about 26,518 (Statistics Canada, 2007b). The community is a popular retirement destination, which may explain the 9.2 percent population increase that took place between 2001 and 2006. Seniors represented about 33 percent of the population, more than double the provincial average (BC Stats, 2009c). The median age of the population was 56.4 years in 2006 (Statistics Canada, 2007b). There are 10 residential seniors' facilities in the Parksville area. Their rates range from $2,250 to $3,300 CDN per month, some with a daily rate. All of these facilities include a range of services from long-term, to assisted living, to independent living programs (one independent living residence, five long-term care facilities, and one assisted living facility). VIHA operates the Arrowsmith Lodge and Trillium Lodge.

About 50 percent of the adult (age 15+ years) population is at least the third generation of their family to live in Parksville. Like Campbell River, Parksville is less ethnically diverse than the provincial population. Visible minorities and Aboriginal peoples each represent three percent of the population, below the provincial averages of 25 and five percent, respectively (BC Stats, 2009c). The Sto:lo Coast Salish First Nation inhabited the area before the arrival of Europeans in the late eighteenth century. Parksville grew because of a logging boom on Vancouver Island,

and soon became a popular destination for tourists from around the Island who came to enjoy the community's beaches and other amenities. Parksville was not incorporated as a city until 1981; before that time, it was known as a village (1945) and then a town (1978).

Tourism has continued to dominate Parksville's economy, particularly as the forestry and fishing industries have declined. The city's main industries now include tourism, retail, services, construction, light industry, and services for seniors. The top industries by labour force are health care and social assistance; construction; and accommodation and food services (BC Stats, 2009c). In 2006, Parksville had a labour force participation rate of 43.8 percent (BC Stats, 2009c). The unemployment rate was 6.8 percent (BC Stats, 2009c). In 2005, the median after-tax income for all census families was $48,989 CDN, while the median after-tax income for female-headed lone parent families was $28,232 CDN (Statistics Canada, 2007b). The prevalence of low income for all economic families was 5.4 percent, while it was 34.6 percent for female-headed lone parent families. Among seniors, the prevalence of low income was only 1.3 percent, well below the BC average of 7.3 percent (BC Stats, 2009c). The average value of homes in Parksville is $293,040 CDN; the average cost of a rental property is $852 CDN per month (BC Stats, 2009c).

Among the population aged 25 to 64 years, about 30 percent have completed high school or equivalent as their highest level of education, 20 percent have a college degree, 15 percent have an apprenticeship or trades certification, and approximately 13 percent have a baccalaureate degree or higher (BC Stats, 2009c). There are nine elementary schools, three middle schools, and three secondary

schools in Parksville. Malaspina University College and Discovery College have campuses in the Parksville-Qualicum area. The Health Care Assistant program produces 12 graduates per cohort at the local Discovery College campus.

*PORT ALBERNI*

Port Alberni is a blue-collar waterfront community located at the head of a deep inlet on the west coast of Vancouver Island, the opening of which is framed by the Broken Group Islands and Cape Beale in Barkley Sound. Long dependent on shipping and forestry, Port Alberni is reinventing itself as a tourist destination surrounded by "surging rivers filled with salmon and trout" and "a rain forest filled with giant trees towering more than 61 metres into the heavens" (City of Port Alberni, n.d.). In 2006, Port Alberni had a population of 17,548 people, which decreased slightly (1.1 percent) between 2001 and 2006 (Statistics Canada, 2007c). The median age of the population was 44.7 years (Statistics Canada, 2007c). Seniors represented 18.6 percent of the city's population (BC Stats, 2009d). The community has four long-term care homes, one assisted living facility, and one independent supportive living residence. Three of the long-term care facilities are publically funded through VIHA.

About 64 percent of Port Alberni's adult (age 15+ years) population is the third generation of their family to live in the community. Port Alberni is somewhat more ethnically diverse than Campbell River and Parksville, with visible minorities representing six percent of the population (BC Stats, 2009d). This proportion is only one-fifth of the provincial average. The community has a strong Aboriginal presence, which represented 12 percent of the population (more than twice the provincial

average of five percent) (BC Stats, 2009d). The Tseshat and Hupacasath peoples of the Nuu-chah-nulth are the First Nations indigenous to the Port Alberni valley. The Nuu-chah-nulth territory is on the central west coast and extends into the Alberni Inlet. The Nuu-chah-nulth Tribal Council office is based in Port Alberni. The local First Nations' communities are active in providing education and support, needs arising from the consequences of the Alberni Residential School, which was open from 1920 to 1973.[48]

Port Alberni always has been an industry-dependent town. In the past, the primary industries were mining, fisheries, and forestry. The forestry industry is currently the major regional employer (including Catalyst Paper, which produces mechanical printing paper, the Alberni Pacific Division lumber mill, and other smaller sawmills). However, the community has suffered economically because the lumber is no longer sold to the local mills. The local workers who are dependent on the industry are virtually held hostage by market fluctuations and corporate structural changes initiating mass layoffs. For example, 185 people were laid off from Catalyst Paper in September 2007 following a decision to indefinitely

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[48] Residential schools operated by churches of various denominations in Canada from the 1840s to the mid-1990s. Their purpose was to force the assimilation of 100,000 to 150,000 Aboriginal and First Nations children into Canadian society. Many children suffered physical, psychological, or sexual abuse while in the residential schools, while others became sick or died. Children in residential schools were forbidden from speaking their traditional languages or engaging in traditional cultural practices. The destructive legacy of residential schools continues to reverberate throughout Canada's Aboriginal, First Nations and Métis communities. Thousands of lawsuits have been filed against the Government of Canada because of these abuses; one of the most prominent criminal suits was brought against the dormitory supervisor (1948-1968) of the Port Alberni Residential School, Arthur Plint. He pleaded guilty to 18 counts of assault and indecent assault and was sentenced to 11 years in prison.

shutdown one of their two paper machines. Because the shutdown status was not permanent, the laid-off workers did not qualify for severance benefits.

Declines in logging and salmon stocks have shifted the focus of the local natural resources economy to tourism. The city's tourism website notes that a drive down "Port Alberni's wide 50's era boulevards offers visitors a unique insight into the historic transition of a North American town: from rugged wilderness, to bustling industrial center, to environmentally conscious adventure playground" (Alberni Valley Tourism, 2009). Sport fishing, hiking, and kayaking are marketed as main attractions in the Alberni valley. The city capitalizes on its proximity to the Pacific Rim National Park on the west coast of the island, near the communities of Tofino and Uclulet, famous for surfing and other outdoor adventure sports. Port Alberni serves as a supply and service centre for the remote communities in the central and west coast areas. The illegal growing and selling of marijuana also represents a large part of the local economy.

The top industries in Port Alberni by labour force are retail trade; health care and social assistance; accommodation and food services; and agriculture, forestry, fishing, and hunting (BC Stats, 2009d). The 2006 labour participation rate was 56.3 percent, while the unemployment rate was 7.6 percent (BC Stats, 2009d). In 2005, median after-tax income for all census families in Port Alberni was $47,785 CDN, while the median after-tax income for female-headed lone parent families was $23,332 CDN (Statistics Canada, 2007c). The prevalence of low income for all economic families was 7.9 percent, while it was 27.2 percent for female-headed lone parent families and 1.8 percent for seniors (BC Stats, 2009d). The average value of

owned dwellings in Port Alberni was $196,832 CDN, while the average rent was $602 CDN per month (BC Stats, 2009d).

Among the population aged 25 to 64 years, about 28 percent have completed high school or equivalent as their highest level of education, 20 percent have a college degree, 18 percent have an apprenticeship or trades certification, and approximately seven percent have a baccalaureate degree or higher (BC Stats, 2009d).  There are six elementary, two middle, one secondary, and two alternative schools (one of which is distance-based and self-paced). Discovery College and North Island College both have campuses in Port Alberni. The Health Care Assistant program is available at both colleges. The local Discovery College campus graduates 12 new Health Care Assistant at the completion of each 27-week program (three intakes per year). North Island College offers a 40-week part time program (the full-time program is available only at the Comox campus).

*PORT HARDY*

The smallest and most northern of the study communities, Port Hardy, is the last town before the wild and windy northern tip of Vancouver Island, Cape Scott. Its slogan, "Live the adventure!" reflects the community's rugged island landscape. Located "in the heart of a wilderness paradise," Port Hardy is a destination point for kayakers, bird watchers, canoeists, cyclists, divers, hikers, hunters, and fresh and salt water sports fishers (District of Port Hardy, 2009). It is the largest of the northern Vancouver Island towns and has community resources such as an airport, a hospital, and health services including a public health office, a mental health office, dentists, a chiropractor, general practitioners, and an ambulance service.

In 2006, Port Hardy had a population of 3,822 people, representing a 16.4 percent decrease since 2001 (Statistics Canada, 2007d). The median age is 38.9 years making it a 'younger' community than the other three study communities (BC Stats, 2009e). Seniors represented 8.1 percent of the population in 2006 (BC Stats, 2009e). VIHA operates the community's lone seniors' residence, Eagleridge Manor. About 65 percent of adults (age 15+ years) in Port Hardy were the third generation of their family to live in the community. As in Port Alberni, visible minorities represented six percent of Port Hardy's population (BC Stats, 2009e).

Twelve percent of the population of Port Hardy was Aboriginal peoples (BC Stats, 2009e). The area was first occupied about 8,000 years ago by what later became known as the Kwakwaka'wakw First Nation. European settlers arrived and built a town in Hardy Bay in the early 1900s. By 1914, 12 families had settled, built a school, sawmill, church, and hotel. By 1916, a trail connected Port Hardy to Coal Harbour, once a thriving commercial whaling station and a Royal Canadian Air Force seaplane base during World War II, and the community was on its way to becoming the central North Island supply centre it is now. The community was incorporated in 1966. It was named after Vice-Admiral Sir Thomas Masterman Hardy, former captain of H.M.S. Victory, Vice Admiral Lord Nelson's flagship at the Battle of Trafalgar.

Local industries include fishing, logging, mining, wind power, and eco-tourism. The top industries by labour force are retail trade; manufacturing; accommodation and food services; and educational services (BC Stats, 2009e). The 2006 labour participation rate was 73.6 percent, while the unemployment rate was

12.1 percent (twice the provincial average of 6 percent) (BC Stats, 2009e). In 2005, the median after-tax income for all census families in Port Hardy was $50,149 CDN, while the median after-tax income for female-headed lone parent families was $27,002 CDN (Statistics Canada, 2007d). The prevalence of low income for all economic families was 7.8 percent, while it was 37.5 percent for female-headed lone parent families and 0.0 percent for seniors (BC Stats, 2009e). The average value of owned dwellings was $157,177 CDN and the average rent was $626 CDN per month (BC Stats, 2009e).

Education levels in Port Hardy are comparable with the other study communities. About 25 percent of community residents between the ages of 25 and 64 years have completed high school or equivalent as their highest level of education, 20 percent have a college degree, 15 percent have an apprenticeship or trades certificate, and approximately 12 percent have a baccalaureate degree or higher (BC Stats, 2009e). The community has three elementary schools, one high school, and one alternative secondary school. There are four private schools run by the Kwakiutl, Gwa'sala-'Nakwaxda'xw, and Quatsino First Nations, including elementary schools and the Avalon Adventist Academy.[49] The North Island Community College has a campus in Port Hardy, offering adult education and courses in first aid, office management, and tourism. The Health Care Assistant Program is not currently available at this campus.

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[49] This is a private school (kindergarten to grade 10) run by the Seventh Day Adventist church.

The study participants were recruited with the assistance of home support leaders in each of the four study communities, who distributed one-page participant recruitment flyers (see Appendix B) to all CHWs and staff members by appending the flyer to each person's pay stub. This approach was chosen in consultation with the home support leaders, who believed that this would be the best way to reach CHWs, who tend to work alone, do not have work-related e-mail addresses, and rarely have the opportunity to attend team meetings. Sims-Gould and Martin-Matthews (2010b) noted that this approach is not without its challenges, as potential participants may fear reprisal from their employer for participating in the study. In light of such concerns I was careful to word the recruitment flyer so as to make it clear that the study was not being conducted by VIHA, nor would their employers have access to participants' names or data. All participants were paid a $25 CDN honorarium for their participation in the study.

The inclusion criteria for CHWs and other stakeholders (e.g., managers, home care nurses) were as follows: the participants had to be English speakers, over the age of 18 years, able to provide informed consent, currently employed by VIHA, and currently working in one of the four study communities. There were no exclusion criteria. With these inclusion criteria as a guiding framework, I recruited 32 participants across the four study communities.  There were no exclusion criteria. With these inclusion criteria as a guiding framework, I recruited 32 participants across the four study communities. The majority of the 32 participants (n = 17) were unionized CHWs, 14 of whom had permanent positions. The remaining three

CHWs were unionized casuals (that is, they worked on-call). The regional health authority directly employed all of the CHWs who participated in this study. The other respondents included five nurse leaders, three community care coordinators, two home support leaders, two licensed practical nurses, one community health nurse, one regional manager, and one scheduler.

Two of the CHWs and one licensed practical nurse were male; all of the other participants were female. With the exception of one CHW, all of the study participants appeared white.[50] This is atypical of the broader demographics of the CHW workforce, but reflects the demographic composition of the four study communities, which are less ethnically diverse than are larger urban areas. As shown in Table 3, the CHW participants were primarily middle-aged women in permanent positions with an average of ten years' tenure.

**Table 3: CHW Study Participant Characteristics**

| Characteristic | Distribution (N = 17) |
|---|---|
| Gender | Female: 15<br>Male: 2 |
| Age range & mean | 29 – 65 years<br>mean = 50 years |
| Employment status | Permanent: 14<br>Casual: 3 |
| Job tenure, range & mean | 1 -28 years<br>mean = 10.3 years |

Interestingly, the sample in Sims-Gould and Martin-Matthews's (2010b) study of BC CHWs was similar in composition. The majority of participants in their study were women with a mean age of 50 years who had worked in home support for over 10

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[50] We asked participants to tell us their country of origin but we did not ask about their ethnicity.

years, which may point to the characteristics of this workforce in this region of Canada. It may also point to the challenges of recruiting younger, less experienced workers. A limitation of my sample was the failure to recruit younger CHWs, as well as the small number of casual workers. The data presented in the findings chapter (Chapter Five) suggest that younger, casual workers may be more likely to leave home support and have relatively short periods of employment. Several of the CHW participants offered to encourage their younger, casual colleagues to participate in the study, but this did not result in any additional participants. The CHW participants speculated that this might be due to younger workers' conflicting responsibilities (e.g., childcare) or a fear of managerial reprisal (i.e., not getting called for shifts) for participating in the study. This may have occurred in spite of efforts to dissociate the study from VIHA, and to reassure participants that their confidentiality would be strictly protected.

## DATA COLLECTION

With the help of a research assistant, semi-structured interviews were conducted with 32 participants across the four study communities. Data collection took place over a three-month period. The first series of interviews was conducted in May 2008, during visits to Campbell River, Port Alberni, and Parksville. During the first trip, all of the interviewees were CHWs. The second series of interviews was conducted in June 2008. These interviews, with non-CHWs (i.e., home support leaders, nurse leaders, and a community service coordinator) also were conducted in Campbell River, Port Alberni, and Parksville. The third series of interviews took place in Port Hardy in August 2008. The participants included CHWs and non-CHWs.

An additional three interviews were conducted by telephone to accommodate participants who were not available for in-person interviews during the community visits.

All the interview participants provided their informed consent to participate in the study (see consent form, Appendix C). The participants were asked a series of questions from a standard interview guide. One interview guide was developed specifically for the CHWs (see Appendix D1), while a second interview guide was developed for the non-CHWs (see Appendix D2). The CHWs were asked to provide some basic information about their education and employment history, their schedule, wages and benefits, their most recent day at work, their relationships with their managers, co-workers, and clients, and drivers of recruitment and retention. The non-CHWs were asked to provide information about their role within the home support team and the nature of their working relationships with the CHWs, as well as to comment on CHWs' tasks, training, qualifications, and recruitment and retention. With the participants' permission, the interviews were audio recorded using a digital recorder. Five participants did not consent to audio recording. During these interviews, the interviewer took notes by hand and later transcribed them. An experienced transcriptionist transcribed the audio-recorded interviews. All of the audio recorded interview transcripts were checked against the original recording for accuracy.

## DATA ANALYSIS

The interview transcripts were iteratively analyzed to develop descriptions of CHWs' working lives and working conditions, as well as factors contributing to

their recruitment and retention. During the initial data analysis phase, I independently read all of the interview transcripts, as did my research assistant. We each identified recurring themes in the data, which my research assistant and I discussed during our initial data analysis meeting. At this meeting we developed a list of shared codes used to label abstract concepts illustrated in the raw data, and we visually mapped these codes to understand how they might interrelate. I then revisited all of the data based on the findings of our collaborative data analysis, so as to refine further the codes and themes. Throughout this process, the codes were grouped and regrouped under broader categories, so as to identify and describe the connections among the concepts. Detailed notes – an "audit trail" – were taken throughout the data analysis process to document how and why analytical decisions were made. In addition to referring back to previously published literature and consensus-based decision making within the research team (my research assistant, my PhD supervisory committee, and me), the data analysis process was informed by "member checking" during the knowledge translation phase, as described in the next section.

KNOWLEDGE TRANSLATION TO PARTICIPANTS

Knowledge translation was an essential part of the research process. The use of an integrated knowledge translation approach ensured that this process was informed by the expert opinions of decision makers within the health care system. I also made an effort to interact with the study participants, particularly the CHWs, as a means of both sharing and validating my emerging findings. In April 2009, all of the study participants were e-mailed a plain-language summary of the research findings (see Appendix E). Some home support leaders shared printed versions of this summary with their staff. The summary included a contact e-mail address. I received written feedback from some participants by e-mail, all of which was positive and confirmed that I was 'on the right track'.

In an effort to provide a networking and learning opportunity for CHWs in the study communities, I organized a CHW learning session in April 2009. The session took place in Parksville and included 19 participants (14 CHWs, two nurse leaders, one community service coordinator, one community practice resource person, and one licensed practical nurse) from Campbell River, Parksville, and Port Alberni. This session was organized in partnership with VIHA. I compensated participants for the costs of travelling to and from the session and provided refreshments. This session was a valuable opportunity to share and discuss the study findings with the participants, as well as to brainstorm potential solutions to the recruitment and retention challenges identified through my research. The session participants' feedback is incorporated into the recommendations presented in the concluding chapter (Chapter Six). The learning session also included a

presentation and question-and-answer session with team members from a neighbouring community who had successfully implemented a home support redesign aimed at addressing recruitment and retention challenges (Groves, 2008). Participants from Port Hardy were not able to attend the session in Parksville because they did not have the budget to travel to this location. I travelled to Port Hardy and presented the findings to a small group of home support staff members in May 2009. In February 2010, I presented the study findings in Victoria at VIHA's research rounds.

CONCLUSION

In this chapter, I described the research methods I used to conduct this study of the recruitment and retention issues of CHWs working in small cities, towns, and rural communities. I used qualitative methods to explore this understudied phenomenon in four communities on Vancouver Island (Campbell River, Parksville, Port Alberni, and Port Hardy). Throughout the research and knowledge translation process I made an effort to include decision makers and participants, so as to validate the findings and facilitate "bottom-up" policy development. The findings of the research are discussed in the next chapter (Chapter Five).

# CHAPTER 5: FINDINGS

This chapter begins with a description, based on workers' accounts, of *what* CHWs do. In the section, "A day (or night) in the life of a CHW," I present workers' accounts of what they do as a means to convey the breadth and complexity of their work, which goes beyond standard definitions of home support to encompass the relational dimensions of care. This section includes a lengthy excerpt from one CHW's interview, which vividly illustrates how each task is intimately connected to the context and conditions of the care provided, and how these discrete activities combine to make a "day in the life" of a CHW. The next section, "Health human resources in the home support sector," shifts the focus to why CHWs do what they do. It presents an overview of the factors that influenced the participants' initial decision to seek training or employment in the home support sector. This section captures both individual preferences and experiences (e.g., a desire to work with seniors or past experience in the care giving sector) and personal circumstances (e.g., being part of an employment program or finding work that fit with parenting responsibilities). In so doing, it captures some of the salient characteristics and concerns of the home support workforce.

I then discuss facilitators of, and barriers to, CHW recruitment and retention. This section is framed in terms of the dynamics between communities (home support) and facilities (nursing homes, long-term care facilities, etc.). The primary facilitators are the quality and continuity of the care provided and the relationships developed with clients, as well as the independence and variety offered. This section

also incorporates a discussion of the intrinsic rewards of home support, as well as CHWs' requisite range of duties, level of maturity, and presence of "common sense," as a means to convey the participants' impressions of who is best suited for this work. The barriers to recruitment and retention are framed in terms of how health work in communities (people's homes) is undervalued in relation to similar work provided in facilities. This is manifested in the persistent disparity between community and facility employees' wages, which the participants perceived to be unfair given the nature and conditions of their work. Specific working conditions discussed in this section include doing more than "just housekeeping," offloading costs to CHWs (i.e., they incur personal expenses), working alone, the challenges of teamwork and communication, and occupational health and safety concerns. The chapter concludes with a discussion of some of the unique characteristics of rural home support. The implications of my findings for health human resources policy and practice are discussed in the concluding chapter (Chapter Six).

## A Day (or Night) in the Life of a Community Health Worker

When I originally designed the protocol for the interviews with the CHWs, I included this question: "Please describe a typical day at work." Once I was in the field and began talking with the CHWs, it soon became apparent that a 'typical' day (or night) did not exist.[51] While one could potentially make this observation about almost every job, work in the home support sector is particularly unpredictable because of the scheduling practices described in the context chapter (Chapter

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[51] I changed the question to: "Please describe your last shift," which was more meaningful to the participants.

Three), as well as the variability in clients' conditions. The variation also arises from the breadth of tasks that CHWs perform for their clients. This chapter begins with an overview of some of these tasks, illustrated by examples and quotations from the study participants. The chapter is organized this way because, to understand *why* CHWs do what they do (i.e., the dynamics that underlie recruitment and retention), readers must first understand *what* CHWs do.[52]

The diversity and complexity of CHWs' work are invisible to most people because what CHWs do is undervalued, as outlined in the literature review chapter (Chapter Two), and because it takes place in private spaces, behind closed doors in clients' homes. Home support clients make up a relatively small proportion of the population. Most people – especially those in positions to set research agendas, influence policy, or make decisions about the health care system – have little or no direct interaction with home support, which means that what CHWs do is not obvious or apparent. We need to understand the nature of CHWs' work to appreciate why home support matters to some of the frailest of citizens and to their loved ones, what skills are needed to do this work well, and how difficult it might be to perform it in isolation. This section of the findings chapter is intended to give readers the lenses they need to 'see' what CHWs do, as well as to provide a foundation for understanding the subsequent discussion of health human resource issues in the home support sector.

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[52] I believe that it is important to include the caveat that what is presented here is my interpretation of the CHWs' accounts, written from my perspective as someone who is not a CHW. I did my best to validate my findings with CHWs, as described in the methods chapter (Chapter Four).

While reading the CHWs' descriptions of their work, in the transcripts of the interviews, I noted the different tasks they mentioned when they were asked to explain what they did for their clients. The breadth of this list, reproduced below, is remarkable (and even it does not represent the full scope of CHWs' duties). As you scan the list, consider that CHWs have relatively limited training, they usually work alone, and their average client is a frail senior living in poverty (Cohen et al., 2006). Consider as well that these tasks are done in a particular place and time, in the context of an individual client's specific, shifting, and often complex needs. A task such as "put on support socks" might appear relatively straightforward until you consider that the client may have limited mobility arising from a disorder such as multiple sclerosis, or is aggressive and confused because of Alzheimer's disease.

- Assist with bathing and showering (may include washing, bed baths, etc.)
- Help brushing teeth
- Help with dressing
- Put on support socks
- Help with prosthetics
- Assist with urinary catheters
- Assist with colostomies or bowel care
- Assist with application of physician prescribed creams or ointments
- Assist with medication administration
- Assist with physiotherapy
- Transfer client in or out of bed, in or out of a wheelchair, etc.
- Ensure client is in a safe position
- Make the client comfortable
- Assess for bed sores
- Assess for signs of physical abuse or neglect
- Monitor client's condition
- Do laundry
- Keep client's environment safe and clean
- Offer social interaction
- Provide emotional help
- Support client psychologically
- Inform the client of community, national, or international events or affairs

- Learn about the client's history
- Obtain requested information for the client
- Be an advocate for the client
- Prepare meals
- Shop for food

This list of tasks goes beyond personal assistance (assistance with activities of daily living and other assigned tasks) and housekeeping (cleaning, laundry, and meal preparation) to encompass assessment, advocacy, and social support. In this way it is richer than the standard definitions of home support presented in the published literature, which tend to focus on personal assistance and housekeeping, rather than on assessment and observation or the relational aspects of care (Aronson & Neysmith, 2006).

It is apparent that traditional definitions of home support strip away many of the nuances (and in some cases, such as relational care, whole categories of tasks) inherent in what CHWs do. They also fail to capture the fact that CHWs usually work alone in clients' homes, with limited access to information or support from other members of the health care team. This is particularly challenging given the growing complexity of CHWs' work, which results from the increased severity of clients' conditions and the shift of care from institutions to communities. Because the workers' words add depth and meaning to this discussion, I have included several direct quotations below. They are the CHWs' responses to our question about what kinds of services they provide to their clients:

Bathing, sometimes just an assist, making sure that they get in and out of the shower okay. Just washing their back. And some people it's full washing. Some it's just meals. Meal prep[aration]. Very short meals, like, mostly microwaveable, something really quick. Medications, eye drops, couple of colostomy, transferring them, transferring from the bed to the wheelchair or vice versa. (*Participant A-5, CHW with 6 years' experience*)

We go in and help them with activities of daily living. We help them get up in the morning, brush their teeth if need be, you know, helping with prosthetics if they have them, get dressed, get washed. Set them up with meals. Advance meals. Information -- if you see that there's a need or a family member's saying something about something and you know something that will help them. We've got lots of information for directing to Red Cross if they need equipment.  Medichair's [a supplier of home medical equipment] another one. Certain numbers, we interact with our office and they have a lot of information that they can give us that we can hand -- help these folks with. Going to bed at night, I don't do that, but I mean, then you help them, again. Undress, get ready for bed, get comfortable, medications. Really spending a lot of time with the medication 'cause there can be so many med[ication] errors and you want to make sure that everything's just right, the right person and all this other stuff. So a lot of that. There's a lot more duties, like, we don't do a lot of housekeeping, but if, say, the floor's got something spilled and it's sticky, I think most of us with common sense would just, say, "Okay, I'm just going to spot wash this floor," and if it's dragged all over the whole floor, it's not really a big deal to do that. We have some that are incontinent and they will be leaving their underwear in unusual places. So you're looking for stuff like that, finding it and -- on the floors you're trying to keep on top of the smells. Plus the hygiene and stuff. (*Participant B-4, CHW with 19 years' experience*)

Q:     And can you describe what your clients are like? Like what sort of -- maybe what their needs are in terms of care? What they need from you?

A:     They need a lot of personal care and the clients really range in the type of needs. Like, some really have a strong need because they, if they have Parkinson's or ALS [Amyotrophic lateral sclerosis], they can't put their clothes on. We put them on for them. And then there might be somebody who just needs help with a shower, getting in and out with a transfer belt and it's not so hard. And then they can dress themselves a little bit more so it really ranges with the needs. And sometimes I get back to the time, because sometimes we don't have a lot of time with the clients who need more time. So that becomes difficult and sometimes we have to rush clients and that's tricky, too. And if they're on oxygen or if they have dementia, can't rush them. So then you get sort of behind in your schedule so it makes it tricky. So there can be a lot of stresses that happen in the job and you just go with the flow. [Laughs] (*Participant C-4, CHW with 6 years' experience*)

> A lot of what we do is normal human interaction, psychologically comforting. We're their -- the connection. We bring the world to them and they tell us about themselves and give us history. Yeah, it's such a fabulous thing, really. (*Participant C-7, CHW with 20 years' experience*)

These quotations are intended to give readers a better understanding of what CHWs do, to set the stage for subsequent discussions of key issues, such as how these workers and their work are valued. They show the diverse range of tasks that fall under the category of 'home support', as well as the multifaceted role that CHWs occupy (as caregiver, advocate, cook, cleaner, and friend).

It also is important to convey that home support is not composed of a series of discrete tasks, performed in a uniform manner for all clients across environments. Rather, this work is intimately tied to context (the places where CHWs work), to time (length of shift, time of day, how much time is allocated to each client visit) and to clients' shifting conditions (physical and mental health, cognitive function, social support, etc.). I believe that the best way to appreciate this is by reading the CHWs' own accounts of their work. To this end, I have included a CHW's description of her most recent day at work.[53] The informant is female, with approximately 30 years' experience in the home support sector:

> A:      Today was bedlam. The morning was good. I go and do a lady who has MS [multiple sclerosis].
> Q:      And is that the lady you've been seeing for so many years?

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[53] This excerpt is long by conventional academic standards, which instruct researchers to abstract short illustrative quotations from their interview transcripts and to contextualize them with interpretations based on (emerging) theory. However, to do so, in this case, would strip away the narrative richness that I am trying to convey. Accordingly, I have chosen to include this participant's full description of her most recent day at work. I was prompted to do so by Armstrong, Armstrong and Scott-Dixon (2008), who used a similar approach in *Critical to Care* to develop a fuller picture of ancillary work.

A:     Yeah, yeah, and we're always -- her body is always changing and of course she's getting weaker. And we're always trying to find some new way to do things and we come on something, then quite often I'll go home and think about it and think, "Now how can we -- how can we get around this or how can this not happen again?" or whatever. And you come up with all kinds of things. She wanted her hair washed and she wanted it washed, washed, not, like, that dry shampoo, and I said to her, "Well, why don't we try this?" because she has an electric chair... So what we do now is we put her feet in the tub and she leans forward really easy. So I have another person with me...

Q:     Another CHW?

A:     Yeah, and we put a towel around her neck and then we've got one of those long hair capes. So we do her feet and her legs at the same time and we wash her hair. So it's all forward now for her and she gets her hair washed and she feels like it's washed. Instead of -- that dry shampoo is yucky stuff.

Q:     Yeah, good problem solving.

A:     Yeah, and then, like, her feet got done and you know how people's skin gets so dry on their legs and stuff, you know, and then we use cream on it and all that kind of stuff. And then one of the things that we looked at was, it was a very tiny bathroom and we needed some place for everybody to stand. So we figured that out too and then things have just sort of evolved from there. And like I said, when something comes up we sort of address it. Or she'll say, "I'll leave it with you." And quite often I'll come up -- she couldn't use her hands anymore. She can use her arms, but she can't move her hands, hold on to anything. So we ended up by taking one of these hair bungees, putting it on her hands and putting a pen through it. Now with being able to move her wrists, she can write again. So -- and she's getting weaker again, so we're going to have to look at something stronger now, you know. So it is kind of neat to be able to find these little...

Q:     Well, that continuity must be such a huge deal for you guys. To know that you're going to see her over time and that you can kind of strategize together, right?

A:     It's really nice and the family gets used to you and you become sort of -- they don't worry about who's coming in. It's like, "Good morning," you know, and you know the routine and you go through it all and it's just -- yeah, it's comfortable.

Q:     So when did you get to her place this morning?

A:     Seven thirty.

Q:     And then was that a two-hour visit for cleaning and bath and stuff?

A:     Today was a two-and-a-half, because I have a half hour where I vacuum the house or mop a floor or clean a bathtub or whatever. But because I go there daily, I can usually, like, get the bathroom cleaned one day and another day I'll get the vacuuming done. So I kind of fit it in here and there. We usually don't do the housework anymore, but I'm not a person that says no. I believe that when you look around and you think, "Oh, my house is dirty," and they're already in enough stress with their diseases and things like that, what's a half an hour?  So...

Q:      Yeah, kind of bend the rules and just take care of her that way?

A:      Well, no, I learned not to bend the rules too much 'cause they break. [laughs] I've been rapped a few times for, you know, "You're not supposed to be doing that." But with her, I have actual permission to go ahead and do it.

Q:      That's good. And so what -- so basically when you saw her today, it was pretty much, you know, getting her bathed and ready for the day, doing a bit of cleaning around the house?

A:      Yep, yep, hair wash day, vacuum the house through, did the bathroom. Bathrooms are, like, ick.  We're there five days a week. We're using it five days a week, clean it, right.  So -- yeah, I just -- I don't think we should be -- I would say that that's basically the homecare worker's bathroom and if we leave it dirty, that's a reflection on us, you know, yeah.

Q:      So when you finished up with her, then where did you head next?

A:      Then I go to [assisted living facility], and this week has been a little bit crazy because something must be going through, because we've had a lot of sick, a lot of people going to hospital. A lot of people claiming they're really dizzy.

Q:      Like, a flu or a cold or something like that?

A:      I don't know what it is and it just seems to hit, sort of, you know, we'll get two or three symptoms that are similar and then that'll stop. And then it might be other people, but it's different symptoms.  I don't know what it is.

Q:      Some kind of mysterious pattern.

A:      And it can be at opposite ends of the building.

Q:      You never know who plays bridge together or whatever, though, right, like, [inaudible, voices overlap] might socialize or...

A:      That's right, yeah.

Q:      So and how many folks were you seeing at... [assisted living facility] today?

A:      Today?  Well, it's usually anywhere from 11 to 15.

Q:      And are those -- like, are you mostly doing medications? Or what kind of stuff are you doing for those folks?

A:      Some of them are med[ication]s. Some of them, we're there to get them up and get them going. Because I don't know why, but people would sleep all day, you know, if you didn't get them up and interested in what was going on and stuff. And health checks and then, like, we have catheter bags we do and showers, I do showers. And then in the afternoon I do the big, in the Jacuzzi tubs and that, like, everybody is...

Q:      All the baths in the bathroom?

A:      It was bath envy there when we opened the tubs. Everybody suddenly needed a bath. It was great though, you know, and they still go out there, you know, a year later and they go out and they're -- a whole room full of people, right. "I had my bath." "Great."

Q:      Because the bath facilities are really nice and...

A:      It's a big Jacuzzi tub with the slide down on the front of it and it's just, the room is done in a lilac colour and we have lots of tropical-looking plants.

They're not real but, you know, and it's just a really nice, relaxing room. And then you hit that button with the Jacuzzi on it and they're just, like, "Ah!"

Q:      They're good to go.

A:      Oh, they're good to go, yeah.

Q:      And then so what -- about what time did you finish up then, after seeing everyone at the [assisted living residence]?

A:      I finished there around three-ish and then I went out into community again and I did a lady who has Alzheimer's. So she needs a med[ication] check and I also check to make sure that -- she doesn't seem to have a sense of smell. So I'm going through these little containers [sniffing noises], you know, sniffing to make sure and I found one, it was just, like, "Oh, okay, this has got to go."

Q:      Oh, like, rotten food?

A:      Yeah, and I don't know, with Alzheimer's and that, I find that quite often they don't have a sense of smell. And they will eat things that really shouldn't be eaten.

Q:      So yeah, they really need someone keeping an eye on those things and...

Q:      And a nose.

A:      Yeah, and then make sure they're eating and make sure they've been eating, you know, because they can stash stuff all over the place. That's one of the problems we have in... [assisted living facility] is they're all over the place. They stash food, they hide it here, they hide it there.

Q:      So kind of, you think they've been eating, but they actually have been putting it in the planter or something like that?

A:      Um-hum. Or in their bedside table or something they've put in the fridge and it's six months old. Like, you can't eat this.

Q:      Yeah, it's a science project.

A:      Yeah, look, it's growing a beard, it's ready to go.

Q:      It's not a Chia Pet [an animal-shaped clay figurine covered with chia, a plant].

A:      Yeah, exactly.  We have quite a few people there with pets too, lots of cats, some dogs. I like that. 'Cause I know the one lady has Alzheimer's and she says that's what she comes home to, is her pet.

Q:      Kind of therapeutic and then with this lady that you were doing the med[ication] check with at the end of the day, was she your last client of the day?

A:      She was my last client for the day and so I was finished and home by five-thirty. (*Participant C-6, CHW with 28 years' experience*)

This excerpt conveys a great deal about the CHW, her clients, and her work

processes. In the space of one 10-hour shift, this CHW used her assessment and

other skills, as well as her creativity and commitment, to provide what she

considered to be good quality, appropriate care to a diverse range of clients in different spaces. While the level of detail in this excerpt made it stand out from the other CHW interview transcripts, its content reflects what I heard from all of the CHWs interviewed for this study. This participant's account of her most recent day at work richly captures the complexity of a day (or night) in the life of a CHW.

## HEALTH HUMAN RESOURCES IN THE HOME SUPPORT SECTOR

Now that I have provided a sense of *what* CHWs do, I shift my focus to *why* CHWs do what they do – why they seek employment in home support, why they stay, and why they leave. The "why" gets at the health human resource challenges that inspired this research. As outlined in the introduction, part of the rationale for this project was the apparent disjuncture between what many insiders describe as a critical worker shortage in the home support sector and the absence of CHWs (and other unregulated workers) from health human resources policy and planning. My research attempts to bridge this gap, so as to inform strategies to ensure a sustainable home support labour force, particularly in light of the increased demand for this service that may come with the aging of the general population. This section begins with an overview of CHWs' reasons for entering the home support sector. I then describe several facilitators and barriers to CHW recruitment and retention, which are framed in terms of the distinctions between working in the community (i.e., home support) and working in facilities. A key issue, which is discussed in further detail in relation to these facilitators and barriers, is competition for workers between the community setting and facilities. This competition is linked to the perceived disparities between these work environments, which seem

131

persistently to favour facilities. The facilitators and barriers identified in this chapter inform the recommendations for recruitment and retention outlined in the conclusion (Chapter Six).

## WHAT FACTORS INFLUENCED PARTICIPANTS' INITIAL DECISION TO SEEK TRAINING OR EMPLOYMENT IN HOME SUPPORT?

The CHWs I interviewed gave many reasons for their initial seeking of training or employment in the home support sector. Some of their reasons were linked to personal preferences or past experiences, while others were linked to individual or family circumstances. Many participants had previous experience (both paid and unpaid) in the health care sector. Several participants specifically mentioned a desire to work with seniors. Some had provided volunteer work in hospitals and long-term care facilities. For example, one CHW, who had worked in home support for over 25 years, cited her experiences volunteering as a "candy striper"[54] when she was a high school student. It was then that she discovered her affinity for seniors. She "ended up trading all [her] shifts for extended care," including the (presumably more desirable) shifts on the "baby wing" (*Participant C-6, CHW with 28 years' experience*). Another participant had experienced similar volunteer work: "I always had a good relationship with senior citizens in my younger years, as well. I used to visit in the hospital, volunteer, play cribbage with them, things like that.  Take them for walks" (*Participant A-2, CHW with 10 years' experience*).

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[54] The term "candy striper" refers to volunteer workers in hospitals.  The term originated because of the resemblance of the volunteers' red and white striped uniforms to candy canes.

Before entering the home support sector, some participants had been hired by friends to provide privately paid care to their loved ones living in long-term care facilities (to supplement the care that these individuals received from facility staff). For some of these CHWs, these experiences served as gateways to employment in home support. One participant described how doing this work led to her realization that it was a viable career option:

> I was mainly taking people out in their wheelchairs and making sure they get fresh air and basically that was it. Sometimes taking them out for coffee and things like that. And -- but that got me talking to the other workers in the facilities and it made me realize that I could do it. (*Participant C-3, CHW with 4 years' experience*)

Another CHW had been the privately paid caregiver to an elderly woman living alone. She later provided similar assistance to some of her neighbours: "I always looked after neighbours and helped them shower and -- when they didn't feel safe, they always phoned me before I became a community health worker" (*Participant C-1, CHW with 6 years' experience*). This same participant also mentioned that she had a history of working in the service industry (restaurants, bars, beauty salons). Another participant noted that he had "been in the human services for 23 years," including having worked as a correctional officer and in group homes (*Participant A-2, CHW with 10 years' experience*).

Other participants chose to enter the home support sector as a way to accommodate their personal circumstances. For some, it was part of a strategy to transition from social benefits (unemployment insurance, social assistance) to paid employment. In one case, a participant's CHW training program was funded through a federal government employment-training program (*Participant A-5, CHW with 6*

*years' experience*).[55] Several participants chose to work in home support after taking an aptitude test at a publicly funded employment centre. Another participant was on income assistance (welfare) at the time she opted to take the Health Care Assistant training program:

> I needed to get off of welfare. I had met my husband and we decided that we wanted to stay together but for me to do that, I needed to have a job. This was a six months' course and you could get out and be -- almost guaranteed of work. (*Participant B-4, CHW with 19 years' experience*)

Her comment likely references the "spouse in the house" policies that prevent single income assistance recipients from retaining their benefits when they choose to cohabitate with a partner. Another participant said that she became a CHW because her cousin was taking the training and it sounded like a good job. When asked what kept her there, she answered candidly, "I'm not too sure ... I hate this job ... I need $15 an hour at least, and there aren't a lot of other options here" (*Participant D-5, CHW with 6 years' experience*). Her comment points to the challenges of working in a small community, particularly for workers with limited post-secondary education and training.

For other participants, working in the home support system enabled them to combine parenting with paid work. One participant, who was a single parent at the time she became a CHW, noted that she was attracted to the work because she could work during the day. As she explained, "I was a single parent of a six year old and a three year old. I couldn't work shift work. It's hard to get daycare at night. [Laughs] I

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[55] CHWs that entered the workforce before the Health Care Assistant Certificate requirement was implemented may have different qualifications. Their employment decision-making processes and range of options may have differed from those of their more recently hired colleagues.

mean, it just is" (*Participant B-3, CHW with 17 years' experience*). Another CHW was attracted to home support because the flexible schedule enabled her to share the care of her four young children with her husband, who also worked full-time. As she explained, "I could have gone into a facility and made more money, you know, but I chose this because it suited my family and it suited my lifestyle" (*Participant A-4, CHW with 10 years' experience*).

CHWs have many reasons for initially seeking training or employment in the home support sector. These include individual characteristics or preferences (e.g., an affinity for seniors), previous experience in the caring sector as a volunteer or paid caregiver, being on social assistance or participating in an employment program, and needing a job that they could balance with their parenting responsibilities. Many of the factors cited here reflect the demographics of the wider home support workforce (most home support workers are women and parents), as well as the feminization of paid and unpaid care giving, both of which are discussed in the literature review (Chapter Two). They also reflect the varied circumstances that shape potential CHWs' decisions about training and employment.

## CHW RECRUITMENT AND RETENTION: FACILITATORS AND BARRIERS

To understand the facilitators and the barriers to CHW recruitment and retention, one must be aware of two key contextual factors. First are the similarities and differences between providing care in the community (i.e., home support) and providing care in facilities. Both settings produce a similar 'product' – care giving – but they do so under different conditions, and their products are assigned a different value (both monetary and symbolic). Second is the competition for

workers that results from the fact that, in BC at this time, potential employees complete a single health care assistant college training program that makes them eligible to work in either setting. Upon graduation, some people choose home support employment, some people choose facility employment, and some remain "on-call" for both sources of employment. Some workers may remain content with their initial choice, while others may choose the alternative (leaving home support to work in a facility, or vice versa, though anecdotal evidence suggests that the former is more common), or they may leave the sector altogether.

## WHAT FACTORS FACILITATE CHW RECRUITMENT AND RETENTION?

In this section, I examine the facilitators of CHW recruitment and retention. Many issues are the same in terms of what attracts and keeps a qualified workforce. The primary facilitators of CHW recruitment and retention have to do with the "what" and the "who" of this type of work, by which I mean the type of care CHWs are able to provide, as well as the individual's personality type, preferences, and motivations. The quality and continuity of care provided and the relationships formed with clients were the main facilitators identified by the participants. The participants referred to their own independence, enjoyment of working alone, and preference for variety as reasons why they enjoyed home support. In this section I integrate the participants' discussions of the intrinsic rewards of care giving, as well as their references to maturity and "common sense" as a means of determining who is best suited to do this work. The relational dimension of care (which I interpret to include relationships, rewards, and preferences) is a strong facilitator of CHW recruitment and retention, just as it figures prominently in CHWs' own definitions of

136

what they do. It dovetails with our assumptions that care giving carries with it its own rewards, and that some people – women – are more 'naturally' suited to provide it.

The quality and continuity of the care provided, and the nature of the relationships formed with clients, are the most important facilitators of CHW recruitment and retention. CHWs take great pride in their work. They are deeply committed to their clients and the philosophy that people should be supported to remain in their homes, a philosophy that underlies home support. When asked to explain what they liked best about working in home support, the majority of the CHWs I interviewed emphasized the type of care that they were able to provide, the clients and the relationships they were able to develop, and other non-financial rewards of their work. One respondent cited the capacity to spend one-to-one time with clients as an important part of his rationale for choosing to work in home support over working in a facility:

> [T]he one part I absolutely love with home support is I'm giving a half an hour or an hour or more with a client. I'm there at that client with that period of time and nothing's going to deter me from that. If I have to lock the door, I will. Rip the phone off the wall, I will, because I'm there to do that. I'm saying that to compare to an institution approach where you're lucky if you get five minutes. And in that five minutes you may be interrupted ten times and it's – you're not there. You're there but you're not. You're not there for that person, you cannot focus on that person. (*Participant A-1, CHW with 2 years' experience)*

Working with clients one-to-one in their homes enables CHWs to focus on the individual, and to work at a pace and over a time span that facilitate relationship building and the provision of higher quality care:

> I do have a window every so often of looking at what it's like in a facility and I find it too fast paced. Not that I couldn't keep up because I have actually

worked in a facility before. And I enjoyed it. But I found that you could connect with people better [in home support]. You have – you could create rapports and relationships and you could give better care to people. Keeping their dignity intact and – it's not so rushed. (*Participant A-4, CHW with 10 years' experience*)

This participant was careful to affirm that her decision to work in home support was not because she lacked the skill to keep up with the pace of facility-based care. The kind of care CHWs can provide in community is more rewarding to them: "I was appreciated in the facility, but I find I'm more appreciated [in home support] and to me, that's rewarding" (*Participant B-2, CHW with 1 year's experience as well as previous experience working in a facility*). Working in the community also seems to give CHWs the capacity to work at a slower (that is, not rushed) pace. This may be an outcome of their working conditions, as working alone with a single client may provide CHWs with the capacity to adapt to their client's pace. This is particularly salient when considering particular tasks that are difficult to rush, such as bowel care, or types of clients, such as clients with dementia or mobility issues.

One participant derived satisfaction from the connection between her efforts and the broader goal of keeping clients independent and at home: "I go home at the end of the day and I feel like I have helped to keep that person in their home, that they're happy" (*Participant C-6, CHW with 28 years' experience*). In small communities, relationships with clients might be especially close, or might stem from existing community ties. As one participant observed, "A lot of our clients know each other and they do communicate to each other through us. A lot of times I will go to clients where they're members of my extended family or friends that I've known for years" (*Participant A-4, CHW with 10 years' experience*). Working in the

community enables CHWs to help clients, one person at a time, in a way that is consistent with their own beliefs about what constitutes good quality care.

Working in the community also appeals to workers who enjoy independence and variety. Several respondents specifically mentioned that they appreciate the independence that comes with working on their own:

> Because you don't have a boss looking over your shoulder and you have a little bit more independence and you get to make your own decisions and you can just care on your own terms more. (*Participant C-3, CHW with 4 years' experience*)

The nature of their work enables CHWs to work independently, without direct supervision in the workplace (i.e., the client's home). They make their own decisions about client care, based on their training and experience, with the benefit of having access to supervisors if they need support: "I'm kind of working on my own. But I still have people to turn to if I need people" (*Participant A-5, CHW with 6 years' experience*). This supported independence also has its downside, as CHWs do not always feel that they are part of a team, neither do they always believe that they have sufficient access to expert advice from supervisors. These challenges are discussed in further detail in the following section on barriers to CHW recruitment and retention.

Working in clients' homes means that CHWs care for a diverse range of clients in equally diverse settings on any given day (or night). Some respondents indicated that they enjoyed the variety inherent in their work. As one CHW explained, "What keeps the job interesting…is because you never know what's behind door number one or door number two" (*Participant C-6, CHW with 28 years'*

*experience*). Her colleague echoed the opinion, emphasizing that she preferred

variety to routine:

> I like the fact that my days are so varied and I don't really know where I'm going to be and I don't know who I'm going to see and it keeps it really interesting. I'm not a routine person. (*Participant C-3, CHW with 4 years' experience*)

The non-routine nature of the work also creates learning opportunities for CHWs: "I

learn something new every day" (*Participant B-1, CHW with 23 years' experience*).

Although some of the CHWs saw this variety as a positive factor, it is important to

note that such learning opportunities often stem from the fact that CHWs' schedules

frequently change from day-to-day, often at the last minute. This irregularity also

has drawbacks when it affects CHWs' earnings and work-life balance, as well as the

quality and continuity of care they are able to provide. I examine this issue in further

detail in a discussion of the barriers to CHW recruitment and retention.

Independence and variety, as well as the opportunity to establish meaningful

relationships with clients and to provide high quality care, were all identified as

facilitators of CHW recruitment and retention. These non-financial rewards are

linked to who CHWs believe are suited to this kind of work. Though many of the

participants argued that they should be paid a higher wage (equal to or greater than

that earned by facility-based workers), they repeatedly emphasized that they were

not motivated by money. One participant described her affinity for the work in

conflicted terms, yet almost like a calling: "It's one of those things that you either

like it or you don't and I find that people like it – that like it, love it" (*Participant C-6,*

*CHW with 28 years' experience*).

Those unsuited to this work "run after the first two weeks" (*Participant C-2, CHW with 8 years' experience*) or "were hired, gone in one day, and just never showed up for another shift" (*Participant B-4, CHW with 19 years' experience*). Some participants thought that government-funded training programs (e.g., 'welfare to work' programs that involve mandatory job training for people on income assistance) produced graduates who lacked the qualities of a good CHW. As one participant explained,

> I'm not saying everybody on income assistance is not trustworthy. Of course that's not what I'm saying. But there are people who don't really want to work that are being forced into work and those are not the kinds of employees that we want applying to home support. (*Participant C-8, home support leader*)

Other participants criticized health authority-funded training for similar reasons. For example, one nursing manager suggested that people who were attracted to subsidized training programs might not have the right qualities to succeed at this work:

> [Y]ou know, you don't have people that have their heart set in health care, that they're sometimes in different situations and, 'Oh well, that sounds good. The money sounds good'. And they get by, but they're not suitable. There's not a caring bone in their body. If people aren't caring, you can't teach people to care. (*Participant B-6, nurse leader*)

It may also be the case that the CHWs who resigned after only a short time on the job did not feel that they had sufficient training or support to work in the community.

Several CHWs expressed disdain for workers who are motivated by money. Other participants described the "dirty work" that characterizes home support – dealing with urine, feces, and naked bodies – as a means of differentiating those who

do the job for the love of it from those with financial motivations: "At $18 an hour or $25 an hour, shit is shit" (*Participant A-1, CHW with 2 years' experience*). Higher wages cannot mask the fact that CHWs are dealing with unruly, leaky bodies. A good CHW is mature, empathetic, and able to deal with death and illness (*Participant C-2, CHW with 8 years' experience*). Her work – for it is almost always a woman – serves a higher purpose. These CHWs' comments echo England et al.'s (2002) analysis, summarized in the literature review (Chapter Two), of the wage penalty suffered by those who do care work, which they linked to the gendered assumption that such work carries with it intrinsic (i.e., non-financial) rewards that compensate for below-market wages.

The intrinsic rewards of care giving, and CHWs' commitment to their clients, influence how they talk about who is suited to do the work and how they define their range of duties and skill set. Several respondents referred to differences in how CHWs interpret their responsibilities or range of duties. Some of the contested areas include housekeeping tasks such as vacuuming, mopping floors, and cleaning bathrooms. Strictly speaking, CHWs are expected to adhere to the client's care plan, a document developed by nursing staff during the initial home support assessment and revised on an ongoing basis. In practice, some CHWs go beyond it. As one participant explained,

> If you're going to give somebody a bath, you should be cleaning that bathtub after you're finished. Like, it just takes five minutes, seriously. Do it. Cleaning up a spill on the floor or a spot on the wall or something, is not bad. Like, you're in a person's house which is different than a facility. You don't call on the janitor, you're kind of everything. (*Participant B-4, CHW with 19 years' experience*)

Though it is against official policy, several participants reported that they sometimes do extra favours for clients during their off-hours (i.e., unpaid work).[56] These favours might include extras such as caring for pets, buying food, household items or gifts for family members, or undertaking some home maintenance (e.g., changing a faucet, installing blinds). One CHW told a moving story about using the Internet to research where to find an elderly client's favourite brand of cookies because the client was no longer able to shop for herself. This CHW (*Participant C-1, CHW with 6 years' experience*) remembered to buy a package of these cookies the next time she drove to Nanaimo to shop at a "big box" store, and took them to the client the next time she was scheduled to see her. The client was so touched that she cried. The CHW seemed to derive as much pleasure from this thoughtful gesture as did the client.

The variations in how CHWs define the boundaries of their work can sometimes lead to frustration with other workers, and sometimes conflict with colleagues. These conflicts may manifest themselves in written exchanges among CHWs in the client's home support binder (described later in the chapter), at team meetings, or through interactions with supervisors (sometimes framed in terms of 'tattling' or seeking 'Brownie points'[57]). The CHWs that were strict about their range of duties expressed frustration about the CHWs who did extra activities because their clients came to expect such attention from all the CHWs they encountered

[56] The practice of providing unpaid help to clients has been addressed in the literature (see, for example, Aronson and Neysmith (2006); Cohen et al. (2006); Keefe et al. (1999)).

[57] A credit earned by favourably impressing a superior. The term originated from the practice of awarding achievement points to Brownies in the Girl Guides.

(*Participant A-3, CHW with 10 years' experience*). Doing favours for clients "makes it really hard for the next worker" (*Participant A-5, CHW with 6 years' experience*). It may also compromise a client's ability to remain independent (*Participant C-1, CHW with 6 years' experience*). Some of the CHWs told their employers about these breaches of protocol. Several of the participants used the language of "rats" and "Brownie points" to describe this situation. For example,

> The only trouble with [bending the rules] is, you get some of the newer girls going in and your client will say, "Well, she does this for me and she does that." And then they're trying to make Brownie points, so they'll go back to the office and say, "She does this and she does that…" and then it's one vicious circle. (*Participant B-1, CHW with 23 years' experience*)

The "vicious cycle" and search for "Brownie points" cited by this CHW may be an indicator of competition for shifts (that is, the perception that painting another CHW in a negative light might lead to more favourable work opportunities, or the notion that one might benefit from gaining a supervisor's favour), or a lack of opportunities for CHWs to meet as a group to discuss their roles and responsibilities.

Variation and competition among workers seem to be linked to some intergenerational dynamics among the workers, which are often framed in terms of life experience, maturity, or "common sense." Several of the participants referred specifically to common sense when discussing variation among workers' care delivery. For example, one CHW described a client who was disabled by rheumatoid arthritis. This CHW would do extra cleaning for the client because of her disability. Her co-workers did not necessarily do the same things for the client:

> …and one of our new workers, when she was just new, refused to do her [the client's] dishes 'cause the dishes weren't on the care plan. And I'm just like, "Why? Why are you like…" You know, I mean, have some common sense. But

common sense doesn't really seem very common. (*Participant B-3, CHW with 17 years' experience*)

One participant noted that variations in what is done for clients may be linked to differences in CHWs' training because relatively recent graduates would have received different instructions about CHWs' roles and practices from those received by CHWs who have been in the field for many years and who received their training decades ago (or who entered the sector before college training was mandatory) (*Participant D-4, scheduler*). These variations sometimes lead to conflicts among the workers, especially about what they do and how it should be done. Several of the CHWs referred to the lack of common sense among new graduates and young CHWs, who were considered to lack life experience and important basic skills, such as how to cook, clean house, or make a proper bed (*Participant A-2, CHW with 10 years' experience and Participant B-1, CHW with 23 years' experience*). Some of the respondents viewed the younger workers as less responsible, difficult to manage, or having a poor work ethic compared with their older counterparts (*Participants A-7 and B-5*). Mature workers, on the other hand, were seen as having common sense: "It's just life experience that will help you do the job more than the training you've received" (*Participant A-1, CHW with 2 years' experience*). Because the majority of participants were between the ages of 30 and 64 years, I am not able to contrast their opinions with those of new graduates or workers who are in their twenties. The notion of common sense is an interesting reflection of the way the skills and tacit knowledge inherent in care work are conceptualized, as outlined in the discussion of skill in the literature review.

CHWs are employed in a sector that is characterized by considerable barriers to both the recruitment of new employees and their retention, which are discussed below. Although faced with serious challenges in finding and keeping workers, as outlined in the literature review, the home support sector, nonetheless, seems to be able to attract a core group of dedicated CHWs.[58] The participants in this study identified the quality of care, their relationships with their clients, and some meaningful intrinsic rewards, as well as the independence and variety associated with working in the community, as factors that attracted them to and kept them in their jobs. Their accounts focused on the intangibles – how the job fit with their individual personality and work style, how it enabled them to form relationships with clients and to deliver care that complemented their values. This perspective, in turn, shaped how some of the CHWs defined their range of duties and the "common sense" necessary to perform complex care work. It also influenced some of the dynamics among the CHWs, which are further examined in a discussion of teamwork and access to information about clients. The facilitators of the work stand in stark contrast to the barriers discussed in the next section, which relate more strongly to the content of the work and how it is valued.

### WHAT ARE THE BARRIERS TO CHW RECRUITMENT AND RETENTION?

The preceding section about the facilitators of CHW recruitment and retention captured one dimension of the health human resources issues faced by the home support sector. To understand more fully these issues, however, one must

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[58] This may explain the finding in a Canadian study that home support workers have an average job tenure of six to seven years (Human Resources Development Canada, 2003), or that many CHWs in BC have been in the field for many years, as evidenced by their seniority levels (Ivanova, 2009).

also examine the barriers. Facilitators and barriers are perhaps best understood as two sides of the same coin. CHWs are not naïve, nor are they martyrs. Although the study informants emphasized the relationships they formed and the work's intrinsic rewards, and were sometimes willing to go beyond the call of duty for their clients, they were acutely aware that their work is undervalued, both socially and financially. Because of the dynamic between work in the community and in facilities, which I referred to at the outset of this section, the undervaluing of home support is often framed in terms of the differences between the community sector and long-term care facilities.

The undervaluing of home support is manifested in the persistent wage disparity between home support and facilities, which CHWs believe is not an accurate reflection of the scope of their work or the responsibility that comes with providing complex care to high-needs clients while working independently. In addition to the wage disparity, CHWs must absorb other costs associated with working in the community: they must pay for their own vehicles, maintenance, and fuel, they must pay for their own mobile phones, and they must make themselves available for up to 50 hours of work per week, even though they will only be required for a maximum of 40 hours and typically work far less. CHWs do not benefit from the support and shared information that comes with a team-based environment. They sometimes struggle to obtain accurate information about their clients, using a range of communication methods. Continuity of care is not guaranteed because of the unpredictable schedules that are a hallmark of home support. This unpredictability also has implications for CHWs' wages and work-life

balance. By virtue of working in the community, CHWs may be at higher risk of injury and their working environment may be less safe. Fundamentally, these factors root back to the differences in how work in the community is valued.

When asked about potential barriers to CHW recruitment and retention, the majority of the respondents mentioned the wage disparity between community employment and facilities employment. Several participants commented that the required 6-month college program is skewed towards facilities, with attention given to facility-based care. For example, students spend "minimal" if any time training in the community as part of their college program (*Participant A-6, community service coordinator*). In spite of these differences, all students graduate with the same credentials and have the option of working in the community or in a facility. Some participants emphasized the importance of equal pay for health care workers with the same training. As one participant said, "Take down the wall. Pay us the same as you pay everybody else with the same credentials" (*Participant C-7, CHW with 20 years' experience*). Another participant described CHWs as "kind of the lowest paid in the union situation on the totem pole" (*Participant A-2, CHW with 10 years' experience*). Given the discussion of intrinsic rewards described in the above section about facilitators, this should not be taken as solely a financial issue. Rather, it is rooted in CHWs' frustration with how their work is valued, as indicated by their wages.

The participants sought to combat the belief that home support is "just housekeeping" (*Participant B-3, CHW with 17 years' experience*). Although home support straddles the boundary between health and personal care, its personal

aspects (cooking, cleaning, bathing, and otherwise attending to clients' activities of daily living) are often highlighted. This is linked to the feminization of care work discussed in the literature review (Chapter Two), as well as the differential valuing of work (both paid and unpaid) that takes place in the home. The undervaluing of home support was a source of considerable frustration for the participants:

> They're [CHWs] kind of treated like they're second class because they work out in the community. And I think that the whole thing has to be turned around, because they're actually the backbone, you know, because they're keeping people out of facilities. (*Participant D-4, scheduler*)

This is why some respondents called for a re-valuing of home support and for more respect for CHWs, as a recruitment and retention strategy. As one respondent put it, "They got a bloody hard job and I think they need more recognition" (*Participant B-6, nurse leader*). Many participants strongly emphasized that caring for a client in the community is more difficult than caring for someone in a facility. The idea of greater responsibility was a theme that arose in many of the interviews. One home support nursing manager explained,

> It's really complex, yeah, and, you know, it's way more complex than a facility where there's always another set of eyes or ears around. You're way more accountable in a facility and yet in the community, where you have the highest degree of responsibility and integrity and working independently, you're paid less and you have the least support. So there's something wrong with the whole valuing of community health care in the way that we – the discrepancy in pay is a huge example. (*Participant C-8, home support leader*)

CHWs working in the community have more responsibility because they work alone. This was exemplified in one CHW's account of dealing with a client who had died. The CHW arrived at her client's home, only to find the door locked. The client did not answer the phone, which was unusual, so the CHW notified her office. By coincidence, the client's son arrived at the client's home. He broke down the door

149

and entered the home with the CHW, where they found the client dead in her living room. The CHW described how she had to comfort the client's son, help him call the police, and wait for an ambulance to arrive, all while having her own emotional reaction to her client's death (*Participant C-5, CHW with 8 years' experience*).

As this example illustrates, home support is clearly more than "just housekeeping." CHWs often perform multiple roles and juggle multiple responsibilities. This circumstance is exacerbated in crisis situations, such as the one described above. In facilities, workers are part of a team and have more direct access to support from co-workers, nurses, other health care team members, and supervisors. A CHW working alone in the community does not have this option, and must shoulder the additional responsibility that comes with being on one of the front lines of care giving. CHWs working in small communities may carry even more responsibility than do their urban counterparts, by virtue of having a broader range of duties. This notion is discussed in further detail later in this chapter, in a section focused on some of the unique aspects of providing home support in small communities and rural places.

In addition to the wage disparity, several other financial burdens are offloaded to CHWs, which serve as yet another marker of how CHWs' work is undervalued. For example, CHWs consider mobile phones to be an essential tool for workers who spend much of their day on the road or in clients' homes. The phones have a myriad of uses. A client may be out or otherwise unable to answer the door, so if a CHW does not have a mobile phone with her, then she has no way of contacting the client or the office to determine whether something is wrong. Some

clients may not have telephones because they live in rural areas without phone service (*Participant B-3, CHW with 17 years' experience*), or because they live in poverty and cannot afford a phone. CHWs that work the night shift in isolated or dangerous areas may rely on their mobile phones as a way to protect their own safety. They also use their telephones to communicate with their supervisors about changes in their clients' condition:

> We're not provided any kind of compensation for having cell phones. But having a cell phone is great because right after I've been to that client, I can just call the nurse leader. I know I'm going to get her answering machine and I can just say, "So-and-so, I noticed this and I noticed that, and I just want you to know this." And then close my phone and it's out of my mind. Whereas if you didn't have that, you'd have to, you'd have notes and remember to call them later when you get home or, you know, it's probably not going to happen. (*Participant C-3, CHW with 4 years' experience)*

Mobile phones are essential tools that contribute to clients' care and workers' safety, so most CHWs pay for their mobile phones out of their own pockets *(Participant C-3, CHW with 4 years' experience and Participant C-4, CHW with 6 years' experience*). Another expense offloaded to CHWs is the cost of using and maintaining their own vehicles, which CHWs require to get to and from their clients' homes. Many respondents identified being required to use their own car as a specific barrier to entering or remaining in the home support sector. Having a reliable vehicle is a prerequisite to working in home support, though it is a costly expense for many workers. As one CHW observed, CHWs "may drive good cars but they're financed to the hilt" (*Participant C-2, CHW with 8 years' experience*). New graduates and young workers might not own reliable vehicles, or might not have enough money to cover the cost of maintaining a vehicle because they are repaying their student loans (*Participant B-4, CHW with 19 years' experience*).

CHWs are compensated for using their vehicles, but several respondents indicated that the current rate of compensation for mileage ($0.50 CDN per kilometre) is not sufficient, particularly given the high costs of fuel. CHWs are not given additional compensation for the wear-and-tear of their vehicles, which can be costly for workers who might travel up to 300 kilometres in a given week. One CHW estimated that she lost $6,000 CDN per year on the value of her vehicle due to the excessive mileage (*Participant D-5, CHW with 6 years' experience*), while another kept both a winter car and a summer car because her vehicle "takes a beating" when driven in bad weather (*Participant C-5, CHW with 8 years' experience*). This kind of wear and tear is especially pronounced for CHWs who serve clients in rural or outlying areas, which may require driving considerable distances on poor roads or in poor weather conditions (*Participant B-3, CHW with 17 years' experience*). CHWs expressed frustration that they were not compensated for routine maintenance and extra costs such as winter tires (*Participant C-4, CHW with 6 years' experience*), as well as for damage to their vehicles sustained on the job (*Participant A-2, CHW with 10 years' experience and Participant C-7, CHW with 20 years' experience*). CHWs are required to have business auto insurance, which is another financial burden (*Participant B-1, CHW with 23 years' experience and Participant D-5, CHW with 6 years' experience*).[59]

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[59] There is a Crown corporation in the province that provides universal auto insurance. The rates are based on several factors including the way the vehicle is used. Rates for those who drive for business purposes are higher than for those who drive to commute to work or school or who use their vehicle for pleasure.

Another cost offloaded to CHWs is the requirement that they make themselves available for 10 working hours every day that they are scheduled to work. This requirement does not translate into 10-hour shifts (though in some cases it might); rather, it means that a CHW must leave open a 10-hour window in which the home support schedulers can assign work. The hours that fall within this window may not be consecutive – for example, a CHW might work from 7:00 AM to 10:00 AM, 12:00 PM to 2:00 PM, and 3:00 PM to 5:00 PM for a total of seven hours of work spanning 10 hours. The time that elapses between client visits is not paid. Travel time is scheduled into individual client care blocks (though this does not always correspond with what occurs in practice). The CHWs I interviewed seemed to be less concerned about the unpaid time that occurred between client visits, and more concerned that the 10-hour window was too long.

> [CHWs] have to be available 10 hours a day. That's 50 hours a week. Out of that 50 hours you may get paid 20 or 30 hours, at the maximum you will get paid 40 hours. Every single solitary week of your life you have to give away 10 hours. (*Participant C-7, CHW with 20 years' experience*)

Another CHW called for shortening the 10-hour window to eight or nine hours, because "I just don't like to have to be there for that 10-hour block on somebody else's time without being paid" (*Participant B-4, CHW with 19 years' experience*). A nursing manager framed the issue somewhat differently, noting that the 10-hour window is too long because of the complexity of the home support client base (*Participant C-10, nurse leader*). The 10-hour window of availability also made it challenging for CHWs to be on-call with other employers, which was difficult for CHWs who juggled multiple jobs to "make ends meet."

Paying for a mobile phone, using one's own car, and being available for 10-hour windows exacerbate the wage disparity between employment in communities and facilities. The unpredictable schedules that characterize home support also have financial and practical implications for CHWs. Their unpredictable schedules were second only to the wage disparity among the key barriers to recruitment and retention identified by the participants. Home support is inherently unpredictable because of the changing circumstances of individual clients. A change in one client's condition – perhaps her health worsens and she is transferred to an acute care setting – can have a ripple effect across the home support schedule. As one respondent, a community service coordinator, explained:

> [CHWs] don't know from one week to the next what they're going to get. And I can't promise them because our schedule has changed, you know, I mean, if we have a couple people going to facility or someone passes away or goes into the hospital, it changes our workload hugely. You could get five people discharged from the hospital, changes our workload hugely. So -- and we can't predict any of that. (*Participant A-6, community service coordinator*)

Some CHWs believed that they had no control over their work lives or schedules. A CHW noted that her schedule "changes constantly" (*Participant C-2, CHW with 8 years' experience*). Some CHWs expressed frustration that they often received early morning (before 7:00 AM) phone calls notifying them that their schedule had changed for the day. Such last-minute changes made achieving a reasonable work-life balance challenging, especially for the CHWs who relied on childcare services for their own children. The changes also made it difficult for the CHWs to predict their weekly earnings, particularly casual workers who did not have a guaranteed number of hours each week. One participant (a casual CHW) noted that she once

could count on 30 hours of work in a given two-week period, but more recently had

been getting only four hours (*Participant C-5, CHW with 8 years' experience*).

Another casual CHW said,

> I've never had 80 hours in two weeks, never, from the beginning. I think I got
> 79 hours once, since I started, in two weeks. But I've been getting between
> 32 to 42, or something like that, since January, in two weeks, and you can't
> survive. (*Participant C-1, CHW with 6 years' experience*)

This participant found her situation particularly frustrating because she entered

into the Health Care Assistant training program under the impression that she

would be able to find steady, well-paid work upon graduation (*Participant C-1, CHW

with 6 years' experience*). Both respondents coped with this situation by juggling

multiple jobs, as do many of their co-workers. Some workers worked on an on-call

basis for a facility (or facilities), others worked in educational or social service

settings, and still others worked in the service industry (house cleaning, catering). A

home support leader observed that the CHWs "often have to get a second job in

order to make a go of it, and then often we lose them because the hours aren't

consistent" (*Participant A-8, home support leader*). This situation is somewhat

paradoxical given the challenges of recruiting and retaining home support sector

workers. One would assume that, in the face of increasing demand for services and

insufficient numbers of workers to provide care, that there would be more than

enough home support hours for those interested in working. The unpredictable

schedules are likely a byproduct of how home support hours are allocated (on the

basis of seniority) and in what quantity they are assigned (shifts can be as short as

two hours). The shift lengths are a disincentive to workers with more than one

option: "...If you are on call at three places, home support tends to be on the bottom

of the barrel because you're going to pass up a seven-hour shift for ... two hours of home support?" (*Participant A-4, CHW with 10 years' experience*).

The unpredictable schedules characteristic of home support also have implications for the quality and continuity of care provided, the relationships formed with clients, and workers' access to information about their clients. These are all important facilitators to CHW recruitment and retention; the CHWs expressed frustration about situations that they believed compromised the quality and continuity of care or their relationships with clients. One CHW, commenting on her unpredictable schedule, stated: "Continuity and consistency is the name of the game, both for us and for the client" (*Participant C-7, CHW with 20 years' experience*). She linked continuity to CHWs' ability to use their observation and assessment skills:

> Half of our job is observation, like both for your safety, their safety and their demeanor, right? And, if I've been going regularly, then I know some of your idiosyncrasies and habits and that. If I've never been there before, they send me to Mrs. Brown, I go there and if she's sitting there drooping and such I don't know that that isn't her natural way. I don't know that she's had a TIA [transient ischemic attack or 'mini-stroke'] yesterday. Like, I don't know that I -- that's something I need to report and -- do you understand what I'm saying? (*Participant C-7, CHW with 20 years' experience*)

CHWs may not be able to fulfill all of their duties when caring for a newly assigned client. For example, "Nine chances out of ten, you'll never get them in a bathtub because they do not know you. They do not feel secure with you, and it's one of those things" (*Participant B-1, CHW with 23 years' experience*). This is another dimension of CHWs' shifting circumstances – no two lists of tasks are the same, for each activity takes place (or in this example, does not take place) in the context of an

individual client's situation. This can be very frustrating for clients. One CHW described her first encounter with a client:

> I've gone into one client yesterday and she says, "Oh my, you're 45th. You're the 45th person I've had and I've only been on the service for under three months." Forty-five people going through your home is a lot. (*Participant A-4, CHW with 10 years' experience*)

CHWs are often confronted with clients' frustration with the system. Some clients complain that they have to keep training CHWs about the specific requirements of their care (*Participant A-2, CHW with 10 years' experience*). Clients sometimes become stressed or angry about the lack of continuity, and "they lash out at you" (*Participant C-5, CHW with 8 years' experience*). This can be extremely stressful for CHWs.

This situation is often exacerbated by CHWs' lack of information about their clients. When being newly assigned to a client (especially at the last minute), a CHW will initially obtain information about the client from the scheduler, who calls to notify the CHW about her assigned clients and hours. The scheduler will provide the CHW with key information, such as the client's condition, age, and medications, as well as describe the client's living arrangements and whether there are pets present (*Participant C-5, CHW with 8 years' experience*). Some of the CHWs spoke very positively about their interactions with the schedulers and expressed appreciation for the challenges of the job – "they're like air traffic controllers" said Participant A-2 (*CHW with 10 years' experience*). Others expressed frustration with the gap between the schedulers' understanding of the CHWs' jobs and what they actually did: "One of these days I'd really like to drag the schedulers out of their chairs and take them with me so that they know exactly what we do" (*Participant B-1, CHW with 23 years'*

*experience*). The CHWs also indicated that the schedulers did not always have enough information about the clients. The care plans were not always up-to-date because the assessments were not reflective of changes in the clients' conditions, particularly given the staffing and workload challenges among the higher echelons of the home support sector. More detailed information about the clients was kept in binders located in the home support offices, but the CHWs did not always have time to attend their respective offices during business hours, and the offices were closed in the evenings and on the weekends (*Participant C-2, CHW with 8 years' experience and Participant C-7, CHW with 20 years' experience*).

CHWs also access information available in the clients' homes, in the form of a communication book, a key tool. These books, kept at each client's home, contain important information about the client's care plan and health status. They also serve as a means to track the care provided and any changes in the client's condition. Several CHWs spoke positively about the communication books, describing them as an "excellent tool" (*Participant C-4, CHW with 6 years' experience*). They could find important information, such as "who their daughter is, who their doctor is, their care card, everything is there and that's great" (*Participant C-6, CHW with 28 years' experience*). The books were seen as particularly helpful when seeing a client for the first time because the CHWs could determine the client's care needs. They were also viewed as a useful tool for casual workers (*Participant C-3, CHW with 4 years' experience*), though one CHW noted that it was difficult to know what to read if the client had not been seen in several months and there were only a few minutes available to review the book (*Participant D-5, CHW with 6 years' experience*).

Nevertheless, the communication books presented challenges. One CHW described them as "a waste of time" (*Participant B-4, CHW with 19 years' experience*), noting that CHWs wrote too much in them and that the information was redundant or irrelevant. These books were a source of conflict for some CHWs, who wrote "nasty notes" to each other (*Participant C-6, CHW with 28 years' experience*), or who included information that was deemed inappropriate, such as: "Oh, she's [client] fighting with her son again – it was hell in here" (*Participant C-3, CHW with 4 years' experience*). These books are kept in the clients' homes, and thus the clients and their family members have access to them. In addition, the clients' family members will use the books as a way to communicate with the CHWs (e.g., they will write "nasty little notes or whatever saying 'You have to do this and you have to do that'"), which one CHW considered inappropriate (*Participant B-1, CHW with 23 years' experience*). Several participants thought that CHWs could benefit from training in "what real charting is" particularly because the communication book was believed to be a legal document with implications for CHWs' liability in terms of documenting and "signing off" on tasks (*Participant C-2, CHW with 8 years' experience and Participant C-7, CHW with 20 years' experience*).

At times, the CHWs needed to access information or support that was not available in the communication book. The CHWs usually worked alone, so this information or support was primarily available via the telephone. The CHWs might have called a nursing leader for advice or clarification about a specific task, such as a task assigned by a registered nurse, or they might have called to advise about a change in a client's condition. Communication between the CHWs and the nursing

leaders primarily took place by having the CHWs leave messages on their nursing

leaders' voice mail. Several participants opined that they had good access to their

nursing leaders, and one CHW made the link between access to nursing leaders and

feeling valued as a worker: "The individuals that we have as supervisors, nurse

leaders and stuff, they've created an open-door policy. And we feel free to access

them whenever we need them, and we feel important" (*Participant B-4, CHW with

19 years' experience*). This access was significant to the CHWs because it was

consistent with their training:

> They tell you in the course, if in doubt, phone the supervisor. I mean, they
> slam it into you and then when I phoned [my supervisor], especially one of
> the people…she just made you feel terrible and stupid, and isn't it better to
> phone even if it wasn't necessary? (*Participant B-4, CHW with 19 years'
> experience*)

Other CHWs believed that they did not have sufficient access to the nursing leaders,

a situation exacerbated because they needed timely access to information or

support. One CHW described how she had to breach protocol to ensure that a client

who was "in distress, he was in agony" received access to home care nursing. She

could not make contact with personnel at the home support office, so she

circumvented the usual order of things and directly called home care nursing

(*Participant C-6, CHW with 28 years' experience*). Several respondents expressed a

desire for more feedback from the nursing leaders to "close the loop." One home

support leader identified this as an area in need of improvement:

> I think maybe the response isn't the issue, it's the nurse leader
> communicating back to the CHW what the outcome was. 'Thanks for your
> info, I checked with the case manager, there are additional reasons why we
> have to put in this service that you're not aware of. But we need to keep the
> service level this high.' Some of that communication back, I think gets missed
> for CHWs. So they end up feeling like there's no point in telling anybody

anything because nothing's ever done about it anyway. (*Participant C-8, home support leader*)

CHWs are committed to delivering high quality care to their clients. They want to feel valued and they want to believe that their skills and contributions are respected. They want to feel like members of a home support team.

Because CHWs primarily work alone, it is difficult to create a sense of teamwork. The home support system does not typically have daily team meetings as might occur in a facility setting.[60] Team meetings occur infrequently. One CHW noted that her team met for an hour every two months. She found these meetings to be very helpful because they gave her the opportunity to see her co-workers, receive updates about the clients, and learn tips and tricks from other CHWs (*Participant D-5, CHW with 6 years' experience*). The CHWs tended to see each other on an irregular, informal basis; they occasionally saw their fellow CHWs when they were assigned to a two-person visit (i.e., when a client's care needs were deemed sufficiently high as to require the help of two workers). For many of the CHWs, these two-person visits were their main opportunity to meet and share information with colleagues. One CHW described this positively: "It's just kind of a little bit of a relief valve for me to meet with another CHW" (*Participant C-3, CHW with 4 years' experience*). Two-person visits offered limited opportunities to discuss the needs of shared clients, however, because the CHWs indicated that they were careful to protect their clients' confidentiality (e.g., avoid discussing one client while caring for another). The CHWs would meet each other outside of scheduled work hours, though "it's hard because a

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[60] Daily team meetings are an aspect of home support redesign being piloted in cities across BC.

lot of times you'll see each other out in the community and that's not an appropriate place to be discussing [clients]" (*Participant B-4, CHW with 19 years' experience*). For some CHWs, these accidental encounters were the only way they had access to certain client information. One CHW met a colleague in a neighbouring community and was informed that the health status of one of their shared clients had deteriorated significantly. The CHW was unaware of the change and had a shift scheduled with the client the following day. The office had not informed her of the client's change in condition (*Participant D-5, CHW with 6 years' experience*).

Communication among CHWs and their colleagues, as well as teamwork, is one way to protect the safety of workers who usually work alone. Their working conditions can pose risks to their health and safety. CHWs work in private homes that are not designed with care giving in mind (though some may have been retrofitted with ramps and handles). Clients' bathrooms may not be properly fitted for someone who requires assistance in or out of the bath or shower. Clients may lack lift equipment or adjustable beds (*Participant A-5, CHW with 6 years' experience*). Some clients live in run-down housing or dangerous conditions, as discussed in the following section about violence in the workplace. Other clients live in isolated rural or remote areas, as discussed in a later section about rural home support.

Several participants commented that their clients' care needs and living conditions occasionally differed from those noted in the initial assessment. As one CHW put it, 2:00 PM is different from 11:00 PM in the middle of winter (*Participant C-2, CHW with 8 years' experience*). Elderly clients might "rise to the occasion" while

being assessed, giving a false impression of their level of health and competence (*Participant C-7, CHW with 20 years' experience*). This finding was echoed in Purkis, Ceci, and Bjornsdottir's (2008) work about home care, which described how elderly clients strive to appear healthier or more competent than they actually are during assessment meetings with health care providers. A nurse leader noted that CHWs are often the ones to draw attention to the gaps in clients' care plans and the reality of their conditions. According to this respondent, the CHWs would sometimes read a care plan and say, ""That'll never work"…because the client sometimes kind of performs for the professional and they'll [CHW] give the true picture…So it really validates that CHWs know their clients. They have the most client contact of anyone in the health care system" (*Participant C-10, nurse leader*).

The extent of their contact with clients, as well as their working conditions, can put CHWs at risk of on-the-job injury. Many of the CHWs reported being injured at work. The majority of such injuries were to the upper body (back, neck, arm, shoulder), primarily as the result of lifting, slipping, or falling. One CHW reported acquiring lice from a client, and reportedly received a precedent-setting workers' compensation benefit (*Participant B-1, CHW with 23 years' experience*). In some situations, numerous CHWs can be injured at a client's home before any intervention takes place. For example, a participant was one of five CHWs injured in separate incidents, over a short period, at a client's home. She was not able to work for 17 months as a result of the injury, and she noted that it was six months before her employer commenced sending two CHWs at a time to care for the client (*Participant C-2, CHW with 8 years' experience*). This example brings to light that

gaps in information may be hazardous to CHWs' health, as well as some of the risks inherent in caring for clients in their private homes.

CHWs are also at risk of violence or aggression on the job. As discussed in the literature review, CHWs may suffer physical, sexual, and verbal abuse at the hands of their clients or clients' family members. The majority of participants who related experiences of violence on the job had been threatened or attacked by clients, many of whom suffered from dementia or mental illness. For example, one client came out of a shower holding a gun (*Participant B-1, CHW with 23 years' experience*), while another client said, "I'll kill you, get my gun out and kill you, you're trying to steal my money" (*Participant A-1, CHW with 2 years' experience*). Another client chased his CHW to his vehicle while threatening to kill him (*Participant A-2, CHW with 10 years' experience*). A participant told us that a client with schizophrenia who "lived in a place we call drug central" started "flipping a switchblade open and closed" while she cleaned his home (*Participant B-3, CHW with 17 years' experience*). The CHWs reported being cornered by clients, and of their habit of ensuring that they had clear escape routes mapped out in their minds. Some of the CHWs felt unsafe in some clients' environments, describing their homes to be in poor condition, some of which are located in rundown or isolated areas, with little or no lighting. One CHW developed her own system for checking in with her husband when she worked the night shift:

> Mostly my fears were around the nighttime when I worked the night shift because we could sometimes be working as late as twelve o' clock. And some of the streets in Parksville and Qualicum are not so safe. And, I used to go into an apartment building and I used to bring my flashlight with me, it's like a torch. And that was for safety. And what I would do is I'd call my husband. I only had a 15-minute check, a TOF [transfer of function, which refers to a

164

task assigned by a registered nurse] medication check to do. And so I'd go in and I'd do the medication administration and then come out and call my husband just to let him know that I'd got out of the building safely. And what I was concerned about was just the type of people that lived in the building and the corridors and sort of hidden corridors and I thought, "Oh, what if somebody was hiding behind there?" And there were some homeless people living in some of the apartment buildings with some of the residents. So it was kind of scary. (*Participant C-4, CHW with 6 years' experience*)

The CHWs associated their working conditions with recruitment and retention considerations. One participant told the story of a novice CHW who was so badly frightened by a client that she left home support (*Participant D-4, scheduler*). Other CHWs linked the risks inherent in their work with their desire for wage parity with employees of facilities. As one CHW explained, "We go into a hovel and we've got no supervision. You know, obviously we have supervisors, and if we need them we can phone them. But if a bad situation happens that goes really worse, you've got nothing. You've got to be checking your escape route, so we've got way more responsibility [than facility-based workers]" (*Participant B-4, CHW with 19 years' experience*). Several CHWs also emphasized the need for positive and proactive responses from supervisors when they reported incidents:

> If nobody had followed up on it that would have bothered me. As long as I'm willing to do my part, they have to make sure that they're going to do theirs and keep everybody, you know, so that it's not – you're not going to get into a situation where you can't get out. So they have to protect us, too. (*Participant B-1, CHW with 23 years' experience)*

This CHW provided another example of the values the CHWs assigned to "closing the loop" when supervisors took steps to respond to the CHWs' concerns. It is worth noting that several of the respondents who had experienced violent incidents on the job spoke positively about their supervisors' responses to the situations.

Having discussed what CHWs do, why they do it, and the dynamics that underlie CHW recruitment and retention in the study communities, I will conclude with a discussion of some of the unique aspects of providing home support in small communities and rural places. Communities with small populations may have few home support clients, which may exacerbate the challenges with unpredictable scheduling common to the home support sector. When a client dies or is moved to a long-term care facility, this can create a gap in the availability of home support work. One CHW noted that it was virtually impossible to get a permanent full-time posting in her community because there are so few home support clients (*Participant D-5, CHW with 6 years' experience*). A scheduler reported that that they were unable to give shifts to aspiring CHWs who wanted to work in their nearby small home community because, "right now, we don't have any clients there" (*Participant D-4, scheduler*). Some communities have few CHWs, which creates a different set of challenges for workers seeking to book time off for holidays or needing to take leave for illness, and for schedulers trying to ensure that all clients are cared for.

CHWs working in small communities may have a broader range of duties than their urban counterparts. For example, in Port Hardy, "We do things that they don't do in other areas" (Participant D-3, licensed practical nurse). In this community, Meals on Wheels, an organization that prepares and delivers meals, is only available three days a week and there are no taxis, so CHWs might play an even more important function in the life of a frail, isolated client. Some CHWs might

choose to go 'beyond the call of duty', as suggested by the earlier discussion of CHWs doing unpaid favours for clients or providing services not included in their official list of responsibilities (e.g., certain housekeeping tasks, picking up gifts for family members). Having fewer health and social services available in communities may create the conditions for innovation, as members of the health care team work together to devise solutions to challenges. Close community ties, both professional and personal, contribute to this. As one manager put it, "We're small and we're all sort of connected, you know, I work with the manager for acute care and I work with the manager for mental health. So if we've got shared clients like that, we can kind of come up with a solution" (*Participant D-6, manager*).

The community socio-economic context also influences recruitment and retention. The decline of resource-based industries such as logging that has occurred in some of the study communities has shifted migration patterns. Some communities have seen a population decline due both to more out-migration and less in-migration, while other communities have aging populations. Aspiring CHWs living in some small communities may not have ready access to college training (the Health Care Assistant program). Small communities also face challenges in retaining trained care providers:

> And I know that they ran a course, must have been about a year ago, and we didn't have anybody from Sointula that took the course. But the people that took the course in Port McNeil and Alert Bay and Port Hardy, they all went and worked in the city. They went to bigger centres to work. (*Participant D-7, community health nurse*)

The high cost of living in some rural, isolated, or remote communities (e.g., those accessible only by air or water) can be a barrier to recruitment and retention.

167

Staples like food and fuel often cost more because they must be transported into rural, isolated or remote areas, and these additional costs increase an individual or family's overall cost of living. Since CHWs cannot always predict their take-home pay, working in home support may not provide a stable enough income to cover the costs that come with living in a smaller or more rural place.

CHWs working in rural or remote communities must grapple with the challenges and additional costs that come with travelling to and from these places. CHWs may be required to drive long distances in poor weather conditions to get to clients' homes (*Participant C-11, nurse leader*). This can result in wear and tear on vehicles, an issue discussed earlier in the chapter. CHWs reported working or travelling through mobile phone "dead zones" where they were unable to use their telephones to call for help (*Participant C-7, CHW with 20 years' experience*). One client reportedly joked to a CHW that one needed "a canoe and a rifle" to find his home (*Participant C-1, CHW with 6 years' experience*), though this joke was not too far from one home support leader's description of how difficult it was for the CHWs to find some of their clients' residences:

> No city lights. Well, you know, the way we're instructing some CHWs is, you know, "You go down this road and it's – you'll see a white mailbox and then you'll see a gate on your right and the third unmarked driveway on your left after the white gate on the right is the home and it's a long windy driveway." And I mean, there are no lights, so it's really hard to find directions. Often there are no markers, like a house number or whatever. They're [CHWs] really out there on their own. (*Participant C-8, home support leader*)

The clients' homes may be isolated from their neighbours' (*Participant D-1, community care coordinator*), and some CHWs reported encounters with domestic (guard dogs) and wild animals (bears, cougars) on the job. These conditions

underscore the risks inherent in working alone, as well as the importance of equipping CHWs with the right tools and information to do their jobs.

Island-based communities present unique challenges when it comes to travel. In the past, CHWs serving the remote island community of Sointula, which is only accessible by ferry, were required to pay the cost of their ferry trips. VIHA, the regional health authority, has since agreed to cover the cost of the ferry because they found that it was a deterrent to finding workers willing to care for clients living on the island. The ferry, which runs on a set schedule, may have a full load or may not run because of poor weather, which may mean that a CHW is unable to leave the island, and must stay overnight (*Participant D-3, licensed practical nurse and Participant D-4, scheduler*). Because there is no hotel on the island, a stranded CHW might stay with a co-worker who lives on the island or sleep in the common room at the local seniors' home. CHWs do not receive extra pay if they are required to stay overnight (*Participant D-4, scheduler*).

Study participants raised population size, availability of health and social services, community socio-economic context, access to training, and travel conditions as characteristics of rural home support delivery. These place-specific factors provide the context for the preceding discussion of CHW working conditions and drivers of recruitment and retention. They point to the importance of accounting for the *where* of home support in health human resources policy and planning.

CONCLUSION

This chapter sought to describe the *what* and the *why* of what CHWs do, to make their work visible, and to lay the foundations for recommendations about how to improve recruitment and retention in the home support sector. The chapter began with a description, based on CHWs' own accounts, of a day in the life of a CHW. This was followed by a discussion of the factors that influenced CHWs' initial decisions to seek training or employment in the home support sector. An overview of the facilitators of CHW recruitment and retention focused on key factors such as the quality of care provided and the relationships formed with clients, and a discussion of barriers emphasized the undervaluing of CHWs' work in relation to comparable work done in facilities. The chapter concluded with a discussion of some of the unique characteristics of rural home support.

My findings revealed some of the complex dynamics that influence health human resources in the home support sector. Although the study focused on small towns and rural communities, many of the issues echo those experienced by CHWs working in urban areas, which suggests that they reflect broader patterns in how care work is valued. This domain is therefore of both theoretical and practical importance. With this in mind, the next chapter outlines recommendations for policy and practice based on these findings.

# Chapter 6: Conclusion

A key goal of my research was to shed light on the work CHWs do, and the skill and dedication that they bring to it. I also sought to raise awareness of the challenges faced by these workers, and how these challenges intersect with health human resources issues in the home support sector. A feminist perspective informed my approach to the topic, as did a commitment to health services research. I conducted my research with the intention of fostering "bottom-up" policy development. In this way, my approach was consistent with Hankivsky's (2004) call for "discursive space" in policy for care providers and care recipients. As she notes, "Home care policies can be substantially improved if the perspectives of patients and caregivers are enjoined with those of 'expert' policy makers" (Hankivsky, 2004, p. 116).

Creating this discursive space sometimes means making room for alternative narratives, or counter-discursive accounts, of health care reforms (Mykhalovskiy et al., 2008). Such counter-discursive accounts, particularly from marginalized health care workers like CHWs, have the potential to deepen our understanding of health policies, the health system, and system challenges such as worker shortages. My research is one such counter-discursive account, in the sense that it attempts to tell the story of CHW recruitment and retention from the worker's perspective. This perspective is rarely reflected in research and policy and it differs from official

accounts, like the BC Ministry of Health Services definition of home support referenced in the introductory chapter (Chapter One), of what CHWs do.

Whether decision-makers integrate my findings into health human resources policy and planning remains to be seen. My study was intended to bridge a gap between evidence for a worker shortage in the home support sector and CHWs' absence from Canadian health human resources policy and planning. Yet the mere existence of this evidence-policy gap may not be a sufficient call to action when weighed against the other contextual factors (e.g., budgetary constraints, politics) that shape decision-making processes. As Lewis (2006) notes, the health policy process is marked by the accumulation and use of power, and is dominated by university-affiliated men with medical qualifications – a far cry from the demographic categories CHWs occupy. It is challenging to surface the experiences and concerns of unregulated workers doing feminized care work in an environment marked by neoliberalism and dominated by professional elites.

## REVISITING THE STUDY OBJECTIVES

My research, which focused on the recruitment and retention of CHWs who work outside of large urban centres in small cities, towns, and rural communities on Vancouver Island, had three primary objectives: (1) to describe what CHWs working in small cities, towns, and rural communities say about their jobs, their working conditions, and their roles within the health care system; (2) to investigate these CHWs' experiences of, and motivations for, pursuing a career in the home support sector; and (3) to develop recommendations to inform the design of policies and programs for recruiting and retaining CHWs in small cities, towns, and rural

communities. The first and second objectives were the focus of my findings chapter (Chapter Five). The third objective is the focus of this chapter and is addressed in a subsequent section. However, I will first revisit the literature as it relates to my findings so as to contextualize the recommendations that follow.

## Revisiting the Literature

My review of the literature showed that CHWs tend to be women, many of whom are also people of colour and/or immigrants. These workers tend to have low educational attainment. A high proportion of them are single parents. My findings were largely consistent with the literature, in that the majority of study participants were women with high school or college-level educations. Several of the CHWs in my study had dependent children, though the mean age of participants (50 years) meant that most of them were not caring for small children. Some of the participants were part of the "sandwich generation," caring for children as well as dependent adults (elderly parents, disabled family members, etc.). My sample was also less ethno-racially diverse than would be expected based on the workforce demographics typically reported in the literature. This is likely a reflection of the demographics of the study communities, in which visible minorities represented between three and six percent of the population (compared to a provincial average of 25 percent). Several participants mentioned that they trained as CHWs through 'welfare to work' or employment programs. This points to the ways in which neoliberal policy regimes contribute to the maintenance of an available pool of 'unskilled' feminized labour.

The literature shows that CHWs are often paid low wages, though wage rates vary and depend on factors such as whether workers are unionized and whether they work in the public or the private sector. The literature also indicates that CHWs tend to earn less than their facility-based counterparts. CHWs in my sample earned an hourly wage well above BC's general minimum wage ($8.00 CDN per hour) with hourly wages ranging between $18.39 and $20.11 CDN per hour depending on seniority (Ivanova, 2009).[61] However, the irregular schedules characteristic of work in the home support sector were a barrier to earning a living wage for many CHWs, since they could not count on reliable part- or full-time hours. This is reflected in Ivanova's (2009) finding that the majority of BC's CHWs earn less than $30,000 CDN per year. Aspiring CHWs expecting to work full-time at $18.00-$20.00 CDN upon graduation from the Health Care Assistant program may be disappointed by the realities of their schedules and wages. Evidence of a worker shortage does not seem to be sufficient motivation to make the structural changes necessary to ensure that CHWs who want to are able to work full-time.

Moreover, CHWs in my study earned less than their facility-based counterparts. In 2008, they tended to earn between $1.80 and $3.55 CDN less per hour than workers doing similar jobs in facilities (Ivanova, 2009). CHWs in my study raised concerns about the need to pay for their own mobile phones and use their own vehicles without appropriate compensation. These issues did not feature

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[61] At present, BC has the lowest statutory minimum wage in Canada. The province has a $6 First Job/Entry Level minimum wage that applies to employees with no paid work experience before November 15, 2001. These workers are eligible for the $8/hour minimum wage after they have worked for a total of 500 hours with one or more employers (British Columbia Ministry of Labour, 2005).

prominently in the literature, which may be a reflection of when some of the literature was published (i.e., before mobile phones became commonly used or seen as an essential tool for CHWs). It may also be a reflection of the fact that much of the literature has focused on urban areas. Using one's own vehicle is highly significant for workers living and working in small communities and rural places where bad weather, poor road conditions, and little or no access to public transit increase a person's dependence on their vehicle.

The literature portrays home support as a sector marked by increasing casualization and precariousness, in that workers often work part-time or on-call. Many CHWs in my study were precariously employed, though casual workers had less stability than permanent workers because they did not have a contract that guaranteed a minimum number of hours of work per week. However, all CHWs suffered from the irregular schedules characteristic of their work. These irregular schedules created financial challenges for workers trying to ensure a stable, predictable income, as well as those who were trying to juggle more than one job. CHWs in my study were also concerned about the required 10-hour window of availability, which was written into their collective agreement.

The literature indicates that CHWs tend to work alone and are not usually well integrated with the health care team. Their working conditions put CHWs at risk of injury on the job, both due to accidents and violent encounters with clients and their family members. CHWs usually worked alone, save for two-person jobs for high-needs clients. Many of my study participants felt isolated from their co-workers (fellow CHWs, nurses, and schedulers). Such isolation created a range of

challenges. Because workers had few opportunities to interact with fellow CHWs, workers sometimes had conflicts about client care. This often occurred because of differences in work style or different interpretations of CHWs' range of responsibilities. I found that these conflicts tended to manifest along inter-generational lines, with some of the middle-aged workers in my study raising concerns about the lack of "common sense" among younger CHWs. This may be a reflection of a lack of opportunities for sustained training and mentorship among workers, as well as few opportunities for team building through regular meetings and in-service training. Since workers had few outlets for communication with one another, conflicts between CHWs would sometimes play out in the pages of the communication book or through communication with supervisors that some workers interpreted as "tattling" or efforts to gain "Brownie points." Again, this may point to issues inherent in the organizational culture, both due to a lack of teamwork and competition for shifts.

In my study, issues raised by CHWs with respect to communication with nurses tended to focus on the need for real-time support when caring for clients. In the study communities, the home support system is organized in such a way that there are far more CHWs than nurses available to support them. As a consequence, CHWs tend only to have phone access to their nurse colleagues, and their calls sometimes go to voicemail. Since CHWs are caring for clients during specific blocks of time, they may not be able to get the real-time support they need. This is a key issue in a province where the home support client base has become increasingly high-needs due to policy changes described in the context chapter (Chapter Three).

CHWs do more than "just housekeeping" and they do not always believe that their skills and training match their clients' needs.

Several CHWs in my study raised the issue of communication with schedulers, a key point of contact for workers who rarely visit the home support office. CHWs emphasized the importance of having accurate, up-to-date information about their clients. These workers' unpredictable schedules meant that they were often seeing clients for the first time, and did not always know what to expect from these visits. CHWs needed current, relevant information to care for their clients, and to make up for gaps in the continuity of the care provided. They also needed information to help them stay safe since they tended to work alone. Most of the participants in my study had harrowing tales of encounters with violent or aggressive clients, many of who suffered from dementia. This is a reflection of the increasing acuity of the home support client population in the study communities. It is an indicator of the risks faced by this predominantly female workforce.

With respect to health human resources, my review of the literature showed that CHW turnover is linked to low pay, few benefits, insufficient hours of work, chronic understaffing, limited opportunities for advancement, lack of job security, and inadequate training, as well as feelings of isolation and alienation from the health care team, lack of organizational support, lack of acknowledgement or reward for good work, and performing physically or emotionally demanding work. CHWs' job satisfaction and retention are linked to a feeling that they are contributing to a client's comfort and dignity, that they are making a difference in

their clients' lives, that they are doing good work, and that they have positive relationships with their clients, supervisors, and co-workers.

My findings aligned with the literature, with wage rates emerging as a key barrier to recruitment and retention. While CHWs earn more than twice the BC minimum wage, they earn less than their facility-based counterparts. This may be a barrier to recruitment, as is the requirement that CHWs own reliable vehicles and mobile phones. It might simply cost less to work in a facility, particularly for recent college graduates with student loans or other debts. Wages also are a barrier to retention – specifically, the wage disparity as well as the lower-than-expected and unpredictable wages that result from CHWs' irregular schedules. The majority of the study participants discussed wages in terms of the disparity with those offered by facilities, which they viewed as evidence of the undervaluing of their work. In this way, my findings create a nexus between two main facilitators of recruitment and retention – wages and feeling valued. Wages are symbolic as well as economic. Feeling valued can come from having wages that one perceives as fair. It can also come from feeling like one's supervisors and co-workers appreciate one's work. The CHWs in my study emphasized the importance of the relationships they developed with their clients, which were a main driver of recruitment and retention. Again, workers emphasized the differences between community- and facility-based care in terms of the quality of care and relationships that they were able to achieve in the community. These community/facility distinctions emerged as a strong theme in my study and may represent an area for future development in CHW recruitment campaigns.

My research also adds a new dimension of "place" to the literature on this topic by having been conducted in four island-based communities. In addition to the demographic and recruitment and retention issues described above, CHWs in my study emphasized the importance of community context as a driver of health human resources in the home support sector. Small population sizes mediated the availability of shifts and the CHW pool, but they also created the potential for innovative cooperation between sectors of the home and community care system. CHWs in under-resourced small communities played a different type of role in their local health care system because of a lack of other resources (e.g., Meals on Wheels, adult daycare). In this sense, some CHWs had a broader range of responsibilities than their more urban counterparts. Distance and travel featured as key issues for the study participants, who served clients in various outlying communities as well as in their home communities. In some cases, this involved going to and from a nearby community by ferry, while for others it meant navigating long distances over gravel roads into poorly lit rural areas. Participants also discussed the broader community socio-economic context. The study communities, the majority of which are making the transition from resource-based to more diversified economies, are experiencing shifts to in- and out-migration patterns that may mediate the availability of potential CHWs. All of these issues point to the importance of accounting for place, and for examining what is unique about home support in non-urban settings.

RECOMMENDATIONS

In this section, I present a series of recommendations that draw on the findings from my research, the published literature, and input from the learning session I held with CHWs in April 2009. In making these recommendations, I am cognizant of the fact that there is no one-size-fits-all strategy for recruiting and retaining CHWs who work in small cities, towns, and rural communities. As Kelly argues,

> an ethical approach to rural health must pay attention to the lived experiences of individuals, who are formed by complex political, economic, and social realities that represent the unique space, place, and time dimensions of the rural context. (as cited in Robinson et al., 2010, p. 102)

Ideally, health human resource policies and programs ought to be tailored to each community's specific characteristics, capacities, and challenges. This may not always be feasible when dealing with system-wide issues, yet the need for a tailored approach ought to be kept in mind, particularly when working outside of urban settings.

*Raise CHW wages:* The wage disparity between community and facility-based workers emerged as a key issue in my findings. As such, I propose that CHWs' wages be increased so that they are on par with pay rates in facilities. Ivanova (2009) estimated that implementing this change would cost the BC home support system an additional $24.1 million CDN per year if all other aspects of the system remained unchanged. This would have an immediate economic impact on CHWs and would signal to them that their work is as valuable as that which is done by their facility-based colleagues.

*Provide CHWs with mobile phones:* Mobile phones are essential tools for CHWs, who usually work alone and who spend their workdays in clients' homes or travelling between visits. The phone serves as a means to stay in regular contact with nurses and schedulers, as well as a mechanism for helping to keep CHWs safe, particularly when they work in isolated areas. VIHA does not currently provide CHWs with employer-supplied phones, nor do CHWs receive compensation for paying out-of-pocket for their own mobile phones. There is at least one community in BC where this is being done. A home support manager in the small coastal community of Sechelt, BC, arranged for employer-supplied mobile phones for the CHWs on her team (Groves, 2008). Providing CHWs with phones would relieve them of a hidden cost associated with choosing to work in the community, and would help to level the playing field between community and facility-based workers.

*Examine mileage compensation rates:* CHWs are currently compensated at a rate of $0.50 CDN per kilometre. Participants in my study felt that this rate did not capture all of the costs associated with using their own vehicles on the job due to high fuel costs and vehicle maintenance. CHWs working in rural communities experience the added vehicle wear and tear associated with driving long distances over rugged terrain. There is a need to investigate current compensation rates to determine whether they are equitable, as well as whether CHWs working in rural communities might need to be paid an additional subsidy because of the driving conditions they contend with.

*Schedule work in a consistent and predictable manner:* Unpredictable schedules were a key concern for CHWs in my study, as they make it difficult to

achieve work-life balance and disrupt the continuity of care that is critical to building relationships with clients. CHWs want predictable schedules. There is a precedent for this in Sechelt, BC, where workers have successfully transitioned to fixed schedules (Groves, 2008). Addressing this recommendation would require collaboration between employers and the unions that represent CHWs, as current scheduling practices are written into the collective agreement that governs their work. It also necessitates the development of models specifically tailored to the circumstances of CHWs who work in small communities where there may be few CHWs or clients. There may be opportunities for creative solutions to scheduling challenges in small communities. For example, CHWs could work regular shifts both in the community and in the local long-term care facility, since their college training qualifies them to work in both settings.

*Hold regular team meetings with CHWs:* Meetings could happen face-to-face or by teleconference or videoconference in geographically dispersed regions. These meetings would serve a range of purposes: first, they would build relationships among CHWs and with other members of the home and community care team. Second, they would provide the opportunity to share knowledge within the team – for example, about a client's changing condition or unique needs. These meetings would also provide nursing staff with the opportunity to discuss client care with CHWs and could inform care planning. Third, they would provide employers with the opportunity to offer ongoing training to CHWs through in-service training sessions. Such meetings could be built into the redesigned schedule addressed in the preceding recommendation. As above, there is a precedent for this: the home

support redesign in Sechelt, BC includes daily home support team meetings (Groves, 2008).

*Offer the Health Care Assistant college program in all communities:* The required Health Care Assistant college program should be offered in all community colleges in order to create opportunities for aspiring CHWs to train in or near their home communities. For small or rural communities that do not have a local or nearby college system, the health authority could explore alternative training models – for example, a condensed intensive training program offered at a local community centre. Offering training in small cities, towns and rural communities is likely to increase the uptake of the program, as well as the likelihood that CHWs will work in or near their home communities upon graduation.

*Offer ongoing CHW training in communities, including targeted support for new employees:* Specialized training should continue once new CHWs enter the workforce, particularly in the form of orientation by and mentorship from more experienced CHWs. This could help to bridge the knowledge and generation gaps between new and senior CHWs, and aid in the transmission of the specialized knowledge several study participants described as "common sense." VIHA is in the process of implementing a comprehensive CHW orientation program that includes face-to-face meetings. There is a related need to offer more ongoing training opportunities for CHWs in or near their home communities. These training opportunities could be tailored to the needs of each community – for example, if many clients in a rural community have multiple chronic conditions, the local health region could offer training specific to these clients' needs. Training opportunities

could include in-service training offered at team meetings, online courses, or short workshops on specialized topics such as caring for cognitively impaired clients or culturally safe care for Aboriginal clients. Such training would provide CHWs with the opportunity for continuing professional development.

*Create a province-wide association for CHWs:* Three unions represent CHWs across BC and are responsible for collective bargaining. However, these workers do not have a dedicated, CHW-led association mandated to advance their interests or foster their leadership. The creation of such an organization could enable CHWs to forge relationships and mobilize across communities, recognize common challenges, and identify promising solutions. CHWs working in rural and remote communities could form their own "caucus" within the organization. This association may be able to build on data (and political momentum) generated by the BC Care Aide and Community Health Worker Registry, a regulatory database introduced by the provincial government in January 2010.[62] Though it is not the same thing as an association, this registry might provide the impetus for a CHW association since it will provide a mechanism through which to identify CHWs working in the public system. In designing this association, BC may also want to look to the Personal Support Worker Network of Ontario, a division of the Ontario Community Support Organization (Personal Support Worker Network of Ontario, 2010).

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[62] The purpose of this registry is to "provide a database of credentialed ("registered") care aides and community health workers who are eligible for employment in publicly-funded organizations and settings" (BC Care Aide and Community Health Worker Registry, 2010). CHWs working in the private sector may register, though at the present time it is not mandatory for them to do so. The registry is also mandated to establish and improve standards of care in the care aide and CHW occupations, and to promote professional development for care aides and CHWs and to assist these workers in identifying career opportunities.

*Implement targeted CHW recruitment strategies:* My findings suggest that people with an affinity for seniors, including those with volunteer experience and those with unpaid caregiving experience, might be potential CHWs. Supporting seniors' independence is especially critical in small or rural communities, where rural older people are "at greater risk of being placed in a nursing home even though they may have the same, or even lower, level of care needs than their urban counterparts" (Lum & Aikens, 2009, p. 51). People living in small cities, towns and rural communities might consider following this career path as a means to support seniors in their community, particularly if they value the relationships and one-on-one care that are the hallmark of home support. My findings indicate that CHW recruitment strategies could target people who enjoy working independently in a variety of settings, as well as those who enjoy working one-on-one with clients.

In addition to these recommendations, decision-makers ought also to look to examples of innovative models for home support organization and delivery. There are several models that address some of the challenges identified in my dissertation. For example, the team-based home support model that was successfully implemented in the BC communities of Kelowna and Sechelt, which both serve surrounding rural areas (Cohen, Hall, Murphy, & Priest, 2009; Groves, 2008). This model has several important features which include the implementation of CHW-level team leaders who lead daily CHW meetings, fixed schedules (so that CHWs know exactly when and how many hours they are going to work), cluster care (when feasible, client visits are grouped by geographic area), and the aforementioned employer-provided mobile phones. This model was found to

improve CHW recruitment and retention, occupational health and safety, and job satisfaction (Groves, 2008). Ivanova (2009) estimated that province-wide implementation of this model would increase the average costs of home support delivery in BC by seven percent, or $19.3 million CDN.

Another model tailored to the needs of rural communities that merits further exploration is the 24-hour flexible in-home support pilot program described by Lum and Aikens (2009). The program was based around the question, "What do you need to stay at home today?" In this model, which was piloted in a small rural community in Ontario, home support clients were eligible for 24-hour emergency response, assistance from CHWs with mobility, bathing, housekeeping, and meal preparation, safety, security and reassurance checks, as well as links to a range of other services and supports (e.g., transportation, recreation, social services). CHWs on the night shift were paired with a community paramedic who provided specialized care to frail clients. I offer these examples as a means to show that innovation is already taking place in the Canadian home support system. It goes without saying that any program must be properly evaluated before being implemented in other jurisdictions.

Implementing my recommendations or redesigning home support services would add an additional burden of cost to BC's home support system, but it would also contribute to its long-term sustainability. Improving working conditions in the home support sector will facilitate CHW recruitment and retention, and may make this an appealing career for the next generation of CHWs as well as ensuring that the public receives safe, competent, and ethical home support.

## LIMITATIONS OF THE STUDY

My findings should be interpreted in light of the study's limitations. First, the study communities may not be sufficiently "rural" to capture the unique characteristics of rural home support delivery. This is mitigated by the inclusion of the surrounding communities, as well as by the decision to collect data in Port Hardy. However, my study is not the definitive account of rural home support delivery, nor does it capture the spectrum of remote communities. Moreover, my sample was primarily composed of middle-aged CHWs with permanent contracts. As such, my findings do not reflect the unique experiences of younger workers who may be recent graduates or who may be balancing work in home support with the personal and financial responsibilities that come with having young families.

The study does not include a specific discussion of home support delivery in Aboriginal communities, which could be seen as an oversight given that 46 percent of Canada's Aboriginal population lived outside of urban centres in 2006 (Statistics Canada, 2009a). This was a deliberate choice, made for two reasons: first, home support delivery in on-reserve Aboriginal communities is administered through the federal First Nations and Inuit Home and Community Care Program. As such, the

187

organization and infrastructure differs from that organized at the provincial level, which would make it difficult to compare my findings across the study communities. Second, because my research did not focus specifically on home support in Aboriginal communities, I did not believe that I was in a position to conduct research in keeping with the principles of ethical Aboriginal health research (Canadian Institutes of Health Research, 2007). Home support delivery in Aboriginal communities merits a study of its own.

Finally, my research focused on CHWs who were unionized and employed directly by the regional health authority. Accordingly, I was not able to capture the experiences of non-unionized CHWs or those who were employed by private agencies. I chose to exclude these CHWs because my purpose was not to compare the experiences of unionized and non-unionized, or public- and privately-employed, CHWs. This limits the generalizability of my findings, particularly given the range of home support models in place across Canada. Employment in the private sector represents another area for future research.

## DIRECTIONS FOR FUTURE RESEARCH

In addition to the need for research on home support in rural and remote Aboriginal communities and the experiences of CHWs working in the private sector, there are several other areas in need of further research. There is also a need for research specifically focused on younger CHWs – for example, the workplace experiences of recent graduates of the six-month college training program. At the provincial level, BC's new Care Aide and Community Health Worker Registry offers a range of opportunities for research. Future studies might examine the registry's

initial implementation process or its impact on CHW and care aide recruitment and retention, or they might delve deeper into the quantitative data workforce data it generates. There is a need for further study of innovative home support models – for example, an in-depth evaluation of the home support redesign in Sechelt. To date, evaluation has been conducted in-house. This model represents an opportunity to study innovation in context, particularly given that a number of communities across the province.

## CONCLUSION

CHWs perform an important function in our society, caring for elderly and vulnerable people. In many cases, CHWs enable their clients to remain relatively independent and to remain in their homes, helping them to avoid institutionalization, speed their recovery, or provide comfort at the end of their lives. Home support is an essential service in light of the demand that likely will come with demographic changes and health system restructuring. The importance of home support may be construed in terms of cost-effectiveness, the notion that it is a better use of taxpayers' dollars to keep people out of institutions. Its importance should also be viewed as a matter of social values and not merely economic value, which begs the question: what are the values that underlie our health system? And perhaps more important, what should they be? My hope is for a system that promotes the dignity of and respect for all health care workers and those they care for.

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# APPENDICES

## APPENDIX A: ETHICS CERTIFICATES

*The University of British Columbia*
*Office of Research Services*
**Behavioural Research Ethics Board**
*Suite 102, 6190 Agronomy Road, Vancouver, B.C. V6T 1Z3*

# CERTIFICATE OF APPROVAL - MINIMAL RISK

| PRINCIPAL INVESTIGATOR: | INSTITUTION / DEPARTMENT: | UBC BREB NUMBER: |
|---|---|---|
| Jean A. Shoveller | UBC/Medicine, Faculty of/Health Care & Epidemiology/Public, Environmental & Occupational Health | H08-00006 |

| INSTITUTION(S) WHERE RESEARCH WILL BE CARRIED OUT: | |
|---|---|
| **Institution** | **Site** |
| UBC | Vancouver (excludes UBC Hospital) |

**Other locations where the research will be conducted:**
Research activities will be conducted in rural and remote community settings on Vancouver Island. The Vancouver Island Health Authority (VIHA) is a project partner. We have submitted an ethics application to the University of Victoria/VIHA Joint Sub-Committee, as our Principal Investigator (Dr. Ostry) is a faculty member at the University of Victoria. We will therefore require ethics approval from VIHA and the University of Victoria, as well as the University of British Columbia. Interviews with research participants will take place in locations chosen by and convenient for participants, which may include their office, their home, a parked vehicle (the majority of participants spend a significant proportion of their workday driving from appointment to appointment) or a restaurant/coffee shop. Participant observation will be conducted in health authority workplace settings (e.g., home support offices, team meetings) and in public community settings (e.g., researchers will do a community "walk-through" in order to gauge the extent or health service availability or the nature of local industries). Participant observation will NOT be conducted in home support clients' homes in order to protect client confidentiality.

**CO-INVESTIGATOR(S):**

Barb Warren
Pamela A. Ratner
Aleck S. Ostry
Zena Sharman

**SPONSORING AGENCIES:**

British Columbia Medical Services Foundation

**PROJECT TITLE:**
An Investigation of Factors Contributing to the Recruitment and Retention of Rural and Remote Community Health Workers

**CERTIFICATE EXPIRY DATE:  March 14, 2009**

| DOCUMENTS INCLUDED IN THIS APPROVAL: | | DATE APPROVED:  March 14, 2008 | |
|---|---|---|---|
| **Document Name** | | **Version** | **Date** |
| **Protocol:** | | | |
| Research proposal | | N/A | February 13, 2008 |
| **Consent Forms:** | | | |
| Consent form | | N/A | February 13, 2008 |
| **Advertisements:** | | | |
| CHW recruitment advertisement | | N/A | February 13, 2008 |

**Questionnaire, Questionnaire Cover Letter, Tests:**
Interview guide                                    N/A        February 13, 2008
**Letter of Initial Contact:**
CHW contact letter                                 N/A        February 13, 2008
**Other Documents:**
Peer review report                                 N/A        January 8, 2008

The application for ethical review and the document(s) listed above have been reviewed and the procedures were found to be acceptable on ethical grounds for research involving human subjects.

**Approval is issued on behalf of the Behavioural Research Ethics Board
and signed electronically by one of the following:**

Dr. M. Judith Lynam, Chair
Dr. Ken Craig, Chair
Dr. Jim Rupert, Associate Chair
Dr. Laurie Ford, Associate Chair
Dr. Daniel Salhani, Associate Chair
Dr. Anita Ho, Associate Chair
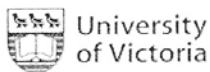
University of Victoria

UVic/VIHA Joint Research Ethics Sub-Committee
Human Research Ethics, University of Victoria
PO Box 1700, Stn CSC, Victoria BC, V8W 2Y2
Tel (250) 472-4545  Fax (250) 721-7836  Web www.research.uvic.ca

Vancouver Island Health Authority, Memorial Pavilion, Kenning Wing
1952 Bay Street, Victoria BC, V8R 1J8
Tel (250) 370-8261  Fax (250) 370-8106  Web www.viha.ca

VANCOUVER ISLAND
health authority

# UVic/VIHA Joint Research Ethics Sub-Committee
## Certificate of Approval

| Principal Investigator | Department/School | Supervisor |
|---|---|---|
| Aleck Ostry | SOSC | N/A |
| Faculty | | |

Co-Investigator(s):
Barb Warren, Research Advisor, VIHA

Project Title: **An Investigation of Factors Contributing to the Recruitment and Retention of Rural and Remote Community Health Workers**

| Protocol No. | Approval Date | Start Date | End Date |
|---|---|---|---|
| 2008-13 | 27-Mar-08 | 27-Mar-08 | 26-Mar-09 |

## Certification

This certifies that the UVic/VIHA Joint Research Ethics Sub-Committee has examined this research protocol and concludes that, in all respects, the proposed research meets appropriate standards of ethics as outlined by the University of Victoria Research Regulations Involving Human Subjects and the Vancouver Island Health Authority Research and Evaluation administration.

Dr. Richard Keeler
Associate Vice-President, Research, UVic

Dr. Peter Kirk
Director, Research and Academic Dev't, VIHA

This Certificate of Approval is valid for the above term provided there is no change in the procedures. Extensions or minor amendments may be granted upon receipt of "Request for Continuing Review or Amendment of an Approved Project" form.

2008-13   Ostry, Aleck

212

## *Home Care Staff in Mount Waddington Communities*
## Invited to Participate in Interviews about their Jobs
## July 7-10, 2008

The University of Victoria's Rural and Remote Home Support Project is inviting *Community & Home Care Staff – Community Health Workers, Nurse Leaders, Case Managers, and Schedulers* to participate in interviews about their experiences working in rural and remote communities. You will be paid **$25.00 in cash** as a thank you for your participation in an interview. We will also **reimburse you for childcare during the interview** if you need someone to watch your kids while we interview you.

The goal of our study is to **learn more about recruitment and retention of Community Health Workers (CHW) in a rural or remote community (including small cities and towns) on Vancouver Island**. If you decide to participate in an interview, we'll ask you questions about things like your day-to-day tasks and responsibilities, your relationships with CHWs and other co-workers, the good things and not-so-good things about working in a rural or remote community, and your education and training. We'll also ask for your suggestions about how to improve recruitment and retention of CHWs in your community.

**The interview will take about an hour.** *We will be in the North Island region July 7-10.* You can pick the time so that the interview fits with your schedule. The interviewer will be a member of our research team (Zena Sharman or Rachel Rees), who'll meet you somewhere in your community that's convenient for you (e.g., an office, a coffee shop, your home, the library or community centre).

It's perfectly okay if you volunteer to be in the study and then change your mind. We'll still give you the $25.00 as a thank-you for the time you've already spent participating in the study. We will also still cover the cost of childcare during the interview. All of your answers will be kept anonymous (for example, we won't associate your name with a direct quote) and the only people to see them will be the members of the research team.

At the end of our project, we are going to write a report summarizing our findings, including recommendations to the Vancouver Island Health Authority about how to improve recruitment and retention of CHWs in rural and remote communities. W**e will also report our findings back to you and your co-workers through presentations or information sheets.** We're going to tell other researchers about our findings by writing research papers and giving presentations at conferences. We will always do our best to protect your privacy.

**If you would like to volunteer for an interview or you want more information about the project, please contact:**

Rachel Rees, Project Research Assistant, University of British Columbia

*Phone:* **(604) 827-3445** (we'll call you back right away so that you don't have to pay the long-distance charges!)
*E-mail:* **[ruralandremoteCHW@gmail.com](mailto:ruralandremoteCHW@gmail.com)**

*The Principal Investigator of our study is Dr. Aleck Ostry, an Associate Professor in the Department of Geography at the University of Victoria.*

University of Victoria | British Columbia Canada

UBC

**The University of British Columbia**

**An Investigation of Factors Contributing to the**

**Recruitment and Retention of Rural and Remote Community Health Workers**

You are invited to participate in a study called "An Investigation of Factors Contributing to the Recruitment and Retention of Rural and Remote Community Health Workers" that is being conducted by Dr. Aleck Ostry (Principal Investigator) and Ms. Zena Sharman (co-Principal Investigator).

Dr. Ostry is an Associate Professor in the Department of Geography at the University of Victoria (e-mail: ostry@uvic.ca, phone: 250-721-7336). Ms. Sharman is a PhD Candidate in the Interdisciplinary Studies Program at the University of British Columbia (e-mail: zsharman@interchange.ubc.ca, phone: 604-827-3284). Please feel free to contact them if you have any questions about the study.

This study is funded by the British Columbia Medical Services Foundation.

**Purpose and Objectives**

The purpose of this study is to *identify and examine factors contributing to the recruitment (finding workers) and retention (keeping them employed) of Community Health Workers (CHWs) in rural and remote Vancouver Island communities*, with a particular focus on how rural and remote CHWs' working lives and working conditions shape their decisions to enter and remain employed in the home support system. The objectives of the study are as follows:

1. Describe rural and remote Community Health Workers' perspectives about their job content, working conditions, and their roles within the health care system;
2. Investigate rural and remote Community Health Workers' experiences of and motivations for pursuing a career in the home support sector; and
3. Develop recommendations to tailor and target recruitment and retention strategies for rural and remote Community Health Workers.

**Importance of this Research**

Research of this type is important because Vancouver Island, like many regions, has difficulty finding (recruiting) and keeping (retaining) CHWs. This is a particular challenge in rural or remote communities, which already face additional barriers to accessing health services. Demand for home support services – and, by extension, for CHWs – is likely to increase as Canada's population ages. This study will provide information to be used in the development of strategies for recruiting and retaining CHWs in rural and remote communities.

**Participant Selection**

You are being asked to participate in this study because you are:

A) A current or former **Community Health Worker** working in a rural or remote community who is English-speaking and currently or formerly employed by the Vancouver Island Health Authority (directly or indirectly via an agency). Former employees must have worked in the sector in the last 10 years.

B) A **Home Support Stakeholder** (e.g., managers, home care nurses, human resources staff, union representatives) working in a rural or remote community who is English-speaking and employed in the home support, community care, or human resource sector.

**What is Involved in Participation**

If you agree to voluntarily participate in this research, you will be asked to participate in a 1-2 hour interview conducted in person by a member of the research team. The interview will take place in a location convenient for you (e.g., your home, a coffee shop, your office, your workplace). CHWs will be asked to reflect on what their jobs entail and their role within the health care system, their experiences of and motivations for doing the job, and their perspectives on factors contributing to recruitment and retention. Former CHWs will also be asked to reflect on their reasons for leaving the home support sector. Other stakeholders will be asked to comment on factors contributing to CHW recruitment and retention. Interviews will be audio-recorded with participants' permission. Some participants will also be invited to participate in a 1-hour follow up interview, in which they will be asked to provide their opinions on emerging study findings.

**Inconvenience**

Participation in this study may cause some inconvenience to you, including finding time to travel to and from interviews, as well as time for participation in the interviews. Every effort will be made to conduct interviews under circumstances most convenient for you.

**Risks**

Some participants may feel stressed during the interview process (e.g., when telling the interviewer about a difficult experience, such as the loss of a favourite client). We will take steps to minimize this risk, including "checking in" with you during the interview process and giving you the opportunity to take a break, reschedule or cancel the interview.

**Benefits**

The potential benefits of your participation in this research include the opportunity to share your experiences and expertise about the home support sector, and to contribute to CHW recruitment and retention strategies specifically targeted at rural and remote communities.

**Compensation**

As a way to compensate you for any inconvenience related to your participation in the initial interview, you will be given a $25 honorarium and, if applicable, compensation for childcare. If you agree to participate in this study, this form of compensation must not be coercive. It is unethical to provide undue compensation or inducements to research participants. If you would not participate if the compensation was not offered, then you should decline.

**Follow-up Interviews**

A sub-sample of participants will be invited to participate in follow-up interviews 1-3 months after the initial in-depth interview. Your participation in follow-up interviews is *optional*. These subsequent interviews will enable "member checking" (e.g., asking for participants' feedback on the emerging data analysis) and will provide an opportunity for reflection on relevant issues. If you volunteer and are selected to participate in a follow-up interview you will receive a $25 gift certificate for a local business (e.g., restaurant, coffee shop, movie theatre, book store).

**Voluntary Participation**

Your participation in this research must be completely voluntary. If you do decide to participate, you may withdraw at any time without any consequences or any explanation. If you do withdraw from the study your data will not be used. You will not be asked to return the $25 honorarium, compensation for childcare, or $25 gift certificate (follow-up interview participants only) if you decide to withdraw from the study.

**Anonymity**

Please note that there will be limits to anonymity due to the small sample size in this study. However, we will mitigate this challenge by protecting your anonymity through removal of all identifying details (e.g., your name, the name of the community where you live and/or where you work, job title, etc.) from study data. You will be identified only through a unique participant identification number in our records. We will use a pseudonym in place of your name if quoting you in papers, reports or presentations.

**Confidentiality**

Please note that there will be limits to confidentiality due to the small sample size in this study. However, we will mitigate this challenge by protecting your confidentiality and the confidentiality of your data by storing all electronic files on password-protected computers accessible only to the research team. Paper data files and interview recordings will be stored in locked cabinets accessible only to members of the research team.

**Dissemination of Results**

It is anticipated that the results of this study will be shared with others in the following ways: in a report to project partners, in a pamphlet for participants and community members, through presentation at academic conferences and through publication in academic journals.

**Disposal of Data**

Data from this study will be disposed of five years after the completion of the study. Electronic data will be deleted and paper copies will be shredded.

**Contacts**

Individuals that may be contacted regarding this study include Dr. Aleck Ostry and Ms. Zena Sharman. Their contact information is included on page 1 of this consent form. In addition, you may verify the ethical approval of this study, or raise any concerns you might have, by contacting the Human Research Ethics Office at the University of Victoria at 250-472-4545 or ethics@uvic.ca and the VIHA Research Ethics office at 250-370-8620.

Your signature below indicates that you understand the above conditions of participation in this study and that you have had the opportunity to have your questions answered by the researchers.


| | | |
|---|---|---|
| *Name of Participant* | *Signature* | *Date* |

*A copy of this consent will be left with you, and the researcher will take a copy.*

**Honorarium Payment**

Please initial here to confirm that you received your $25 honorarium payment: _____

If applicable, please initial here to confirm that you received your childcare reimbursement: _____

If applicable, please initial here to confirm that you received your follow-up interview gift: _____

**Follow-up Interviews**

Would you be interested in being added to the pool of potential participants for follow-up interviews? These interviews will take place 1-3 months from now. The purpose of this interview is to get your feedback on emerging research findings and reflect on relevant issues.

1. Please check one:
   ☐ Yes

   ☐ No

➔ *If you answered yes to #1, please answer questions #2 and #3.*

2. May we contact you if you are selected to participate in a follow-up interview?

   Please check one:

   ☐ Yes

   ☐ No

3. Please provide your contact information.

   E-mail address:

   Phone number(s) [*you may list only your preferred contact numbers*]:

        Home:

        Work:

        Cell phone:

   May we leave a message on your voicemail? Check one: ☐ Yes     ☐ No

   Preferred mailing address (e.g., home, work, P.O. box):

APPENDIX D1: SAMPLE CHW INTERVIEW GUIDE

***Interview Guide for current Community Health Workers***

<u>Brief introductory script for interviewer</u>: Thank participant for signing the consent form. Assure participant that her confidentiality will be fully protected, and that information from this interview will only be shared among members of the research team. Ask participant to refrain from using clients' names during interview in order to ensure client confidentiality. Mention that there is no right or wrong answer to these questions; we are just interested in *her experiences*. Ask participant if she has any questions before beginning the interview.

<u>Demographic data</u>

1. How old are you?

2. What country were you born in?

3. What language do you speak at home?

4. What is your marital/family status?

    a. Married/common-law
    b. Single (includes separated/divorced/widowed)

5. If you are a parent, how many children do you have?

    a. Are you a single parent?

6. Are you responsible for the care of other dependents (e.g., elderly or disabled family members)?

7. How long have you lived in this community?

<u>Working conditions</u>

8. How long have you been a Community Health Worker? (public/private?)

9. How long have you worked for your current employer(s)?

10. What is your education level?

    a. No high school diploma
    b. High school diploma
    c. Post-secondary diploma
    d. University degree (Canadian or non-Canadian)

11. What training or qualifications did you need for your current job?

    a. Where did you do your training?

    b. How long was the program?

    c. Do you remember how much it cost?

    d. Did you pay your tuition?

e.  Did you have any kind of government subsidy while in training?

f.  Was it a full-time or part-time program?

12. Have you had opportunities for in-service training and skills upgrading?

13. Are you a member of a union?

a.  If yes, which one?

14. What kind of worker are you? (permanent, casual, other)

15. Please tell me about your work schedule.

PROMPTS: Is it predictable? Do you have any input in arranging your work hours? Are you on a rotation? Do your shifts and hours vary from week-to-week? Are you able to work with the same clients over time?

16. If you are comfortable providing this information, what is your hourly wage?

a.  Under $10/hour
b.  $11-14/hour
c.  $15-19/hour
d.  $20+/hour

17. Are you satisfied with your wages? Do they seem like fair compensation for your work?

18. Does your employer provide benefits?

a.  If yes, please describe your benefits package.
b.  Are you satisfied with your benefits package?

19. Please tell us about your most recent day at work.

PROMPTS:

a.  What time do you begin work?
b.  Do you work split shifts?
c.  How many clients do you see?
d.  What type of clients do you provide services to?
    PROMPTS: Age, disability, acuity levels, gender, socio-economic status, ethnicity/race, housing conditions, clients with dementia, mental health issues, palliative?
e.  What services do you provide?
f.  Do you have adequate supplies to be able to do your work (e.g., gloves, sharps containers, transfer belts, soap, office supplies)?
g.  How long does an average visit take?

        h.  How much time do you spend traveling between appointments?

               i.  Does your employer provide a travel allowance?

               ii.  Is it sufficient? If not, what would be more satisfactory?

               iii.   Do you get scheduled breaks?

        i.  How much time do you spend in meetings with supervisors or co-workers?

               i.  Are you compensated for these meetings?

        j.  What time do you finish work?

20. How are your time and duties structured? Do you get to decide what you're doing and when?

21. Do you skills generally match your clients' needs?

        a.  Do you have access to professionals such as RNs, physiotherapists, etc. for assistance?

22. How do you communicate with other CHWs about clients or other work related issues?

        a.  Do you use a communication log?

        b.  What kind of information do you enter in this log?

        c.  How useful is this log?

23. Please describe your interactions with case managers, supervisors, schedulers, and other health care professionals.

        a.  Is there a formal or regular way of exchanging information and coordinating activities with these people?

24. How would you communicate serious changes in a client's health or an incident of aggression or violence from a client?

25. Have you been in a situation in which you have feared for your clients' safety or your own safety?

26. Have you ever done unpaid overtime work (e.g., staying late with a client or picking up their prescriptions or grocery items on your own time)? Have you ever brought items to clients that they cannot afford (e.g., extra clothing, food, medicine)?

27. Do you consider your community to be rural or remote?

        a.  If yes, what is it about your community that makes it rural/remote?
        b.  How different is it for you to see rural as compared to urban clients?
            PROMPTS: travel time, weather, geography, access to services

<u>Recruitment and retention</u>

28. What motivated you to take this job?

        a.  What motivates you to continue doing this job?
        b.  What do/did you enjoy most about your job?
            PROMPTS: relationships with clients, helping people, compensation (pay/benefits), flexibility, co-workers

    c.  What do/did you dislike most about your job?
       PROMPTS: compensation (pay/benefits), isolation, abusive clients, feeling pressed for time, work-related ill health

29. How do you talk to your friends and family about your job?

30. Do you think that the home support system faces difficulties recruiting workers? Please explain your answer.

    a.  If you answered yes, what strategies might be used to overcome this challenge?

31. Do you think that the home support system faces difficulties retaining workers? Please explain your answer.

    a.  If you answered yes, what strategies might be used to overcome this challenge?

32. Is there anything else you would like to add that we did not cover in the interview?

33. How did you hear about our research study?

PROMPTS: recruitment letter, poster, word of mouth, etc.

34. Would you like us to report our findings back to you?

35. If yes, how would you like us to report them to you?

    a.  In a presentation
    b.  In a report
    c.  In a summary
    d.  In a brief pamphlet
    e.  Other (please specify)

*Interview Guide for Other Stakeholders:*

*(e.g., managers, home care nurses, nurse leaders, schedulers)*

<u>Brief introductory script for interviewer</u>: Thank participant for signing the consent form. Assure participant that her confidentiality will be fully protected, and that information from this interview will only be shared among members of the research team. Ask participant to refrain from using clients' names during interview in order to ensure client confidentiality. Mention that there is no right or wrong answer to these questions; we are just interested in *her experiences*. Ask participant if she has any questions before beginning the interview.

1. How long have you lived in this community?

2. What is your occupation?
   a. How long have you been working in this occupation?
   b. How long have you worked for VIHA?
   c. How long have you been employed in home care?


3. Please describe your job:
   a. responsibilities
   b. schedule
   c. amount of time in office and in clients' homes

4. Please describe how your job relates to the work of the CHWs?
   a. What is your role in the home care/home support team?
   b. How does your job relate to CHWs?
   c. How does it relate to other team members?

5. How would you describe the nature of your working relationships with CHWs?

6. Do you have formal times, tools, or processes for communication with the CHWs? Are these communication strategies helpful? Do you have any suggestions for improving communication?

7. What are the different designations for CHWs? We hear about full-time, part-time, permanent, casual - are these interchangeable or distinct?

8. How many full-time postings are there? How many part-time?

9. How often are postings posted? Is it as-needed? Are they posted at a scheduled time (such as annually, monthly, etc.)?

10. How many casuals are there working out of your office?

11. Beyond scheduling differences, do you observe any differences between casual and permanent employees? (i.e. their training or skill level, their communication style)

12. How do you perceive the relationships among the various CHWs (permanents, casuals, full-time, part-time, etc.)?

13. Are there differences in how CHWs in different job categories provide the direct care? (differences in training, tasks, skill level)

14. Do you experience any differences when working with CHWs in different job categories?

15. Do you feel the CHWs' training and skills match the clients' needs?
    a. Do you think they are appropriately trained and skilled when they start?
    b. Do you think the CHWs receive adequate continuing education?

16. For Nurse-Leaders: Please tell us about transfer of functions (TOFs)? What kinds of tasks get transferred to a CHW? Why are TOFs needed?
    a. PROMPT: try to get at the effectiveness of TOFs – do they work as planned? Would they improve anything about the TOF process?

17. For Nurse-Leaders and Case Managers: Who sets up the care plan? Is there a process for evaluating or re-assessing the care plan? Do the CHWs have input in it?

18. Who decides the length of client visits? Are visit lengths re-evaluated?

19. Is there a method or process for connecting clients to other resources beyond the scope of CHWs' jobs? (i.e. housework, physical therapy, grocery shopping, any tasks that cannot be provided by family members).

20. Do you think that the home support system faces difficulties recruiting workers? Please explain your answer.
    a. Please describe how this situation affects your workplace.
    b. If you answered yes, what strategies might be used to overcome this challenge?

21. Do you think that the home support system faces difficulties retaining workers? Please explain your answer.
    a. Please describe how this situation affects your workplace.
    b. Why do CHWs quit? [Probe for more details – how long do they stay in the job? Where do they go? Etc.]
    d. If you answered yes, what strategies might be used to overcome this challenge?

22. Do you consider your community to be rural or remote? Please explain your answer.
    e. If you answered yes, why do you consider it to be rural? What about your community makes it rural or remote?

f.  How does the rurality/remoteness affect the CHWs' work?
g.  Does the rurality/remoteness of your community affect recruitment and retention of CHWs? Please explain how.


23. Is there anything you would like to add that we did not cover in the interview?


24. How did you hear about our research study?

    PROMPTS: recruitment letter, poster, word of mouth, etc.

25. Would you like us to report our findings back to you?


26. If yes, how would you like us to report them to you?
    a.  In a presentation
    b.  In a report
    c.  In a summary
    d.  In a brief pamphlet
    e.  Other (please specify)

APPENDIX E: PLAIN LANGUAGE SUMMARY OF FINDINGS

**Research Update:**

**Community Health Worker Recruitment and Retention Study**

Dear participants,

In the summer of 2008, you generously volunteered your time for an interview about your experiences working in the home support sector. We talked to 32 people – a diverse group made up of community health workers, managers and leaders, nurses, and schedulers and coordinators – in four communities (Campbell River, Parksville, Port Alberni and Port Hardy).

We've spent the time since then reading over the notes and transcripts from our conversations with you. We were looking for common themes to help us understand what helps and hinders CHW recruitment and retention. This research update summarizes what we've found. We encourage you to share your feedback with us. You can e-mail your comments to ruralandremoteCHW@gmail.com.

**What we heard from you:**

*CHWs care!* CHWs care about their clients and value the opportunity to build relationships with them. Several participants talked about choosing home support over working in a facility because they feel that they can give better quality, one-to-one care to their clients. As one participant explained, in home support, "you could create rapports and relationships and you could give better care to people. Keeping their dignity intact and – it's not so rushed". The job, consequently, has non-financial rewards that complement the wages earned: "I go home at the end of the day and I feel like I have helped to keep that person in their home, that they're happy."

*CHWs want higher wages!* The wage disparity between CHWs and care aides in facilities was a source of concern for most participants. CHWs have the same training, and the additional responsibility that comes with working alone in clients' homes. And yet, they are paid less than their facility-based counterparts. In the words of one participant, CHWs are "kind of treated like they're second class because they work out in the community. And I think that the whole thing has to be turned around, because they're actually the backbone, you know, because they're keeping people out of facilities". Many participants called for wage parity between home support and facilities. Others mentioned the additional costs to CHWs that come with using their own cars and cell phones.

*Close the window!* The 10-hour window of availability was a source of frustration for many CHWs. As one participant explained, CHWs have to be available for 10 hours a day, and "out of that 50 hours you may get paid 20 or 30 hours, at the maximum you

will get paid 40 hours. Every single solitary week of your life you have to give away 10 hours".

*Unpredictable schedules are challenging!* Home support is unpredictable. A client's condition might change at the last minute, or a CHW might call in sick. This makes it hard for CHWs to predict their schedules (and their pay cheques) on a daily or weekly basis. As one participant said, "[CHWs] don't know from one week to the next what they're going to get". This situation was experienced by both casual CHWs and CHWs with postings, though it's especially challenging for casuals who don't have guaranteed hours. Unpredictable schedules make it difficult to plan your life, especially if you are juggling more than one job or you are taking care of kids.

Unpredictable schedules can also make it difficult to build relationships with clients, since CHWs might not see the same people on a regular basis. This makes it hard to assess changes to a client's condition, and can also make it hard to build rapport with the client. Clients sometimes express frustration at this, while others won't let CHWs perform their full range of duties on the same visit. For example, "Nine chances out of ten, you'll never get them in a bathtub…because they do not know you, they do not feel secure with you…".

*Communication matters!* Good communication is essential for delivering client care and keeping workers safe. CHWs seek up-to-date information on all their clients, especially when visiting a person for the first time. CHWs have a number of different communication tools at their disposal. Many participants spoke positively about the use of communication books, though some suggested that more training on how to use them appropriately is needed. The phone is also an essential tool for CHWs; they use it to keep in touch about schedule changes and to obtain information about client care.

CHWs emphasized the need for real-time support from their supervisors, and the value of a work environment that supports good communication: "The individuals that we have as supervisors, nurse leaders and stuff, they've created an open-door policy, and we feel free to access them whenever we need them. And we feel important". Several participants noted that they would appreciate a follow-up from their nurse leader or supervisor, for example, if the CHW called about a change in a client's condition. Participants recognized that this would be challenging to implement because of CHW to supervisor ratios.

*CHWs are part of the health care team!* CHWs want to feel like they are part of the health care team. In addition to open lines of communication, many participants talked about how much they appreciate the opportunity to meet with other CHWs since they usually work alone. Participants spoke positively about team meetings, which give CHWs the opportunity to get updates about their clients and learn tips and tricks from colleagues. They also provide CHWs with a safe space to have confidential discussions about clients.

**Next steps:**

We're sharing our findings with you in this report. We're working with VIHA to present our findings to home support staff in Parksville at the end of April, and we're also planning a trip to Port Hardy. We're going to incorporate feedback from you and others into our final report, where we'll include some "real world" recommendations about how to improve CHW recruitment and retention. We'll share that report with you when it is finished.

**Tell us what you think:**

If you have any comments about this research update, please drop us a line! You can e-mail us at [ruralandremoteCHW@gmail.com](mailto:ruralandremoteCHW@gmail.com).

Thank you for taking the time to share your thoughts and experiences with us!

Sincerely,

The CHW research project team

(Zena Sharman, Aleck Ostry, Jean Shoveller, Pamela Ratner & Rachel Rees)